INFLUENCE OF REPRODUCTIVE HEALTH EDUCATION PROGRAMMES AND SERVICES ON SEXUAL BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS IN DELTA STATE, NIGERIA

BY

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CERTIFICATION

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DEDICATION

This work is dedicated to the GREAT I AM THAT I AM,

My husband and children.

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ABSTRACT

Reproductive Health Education Programmes and Services (RHPS) have been developed to help adolescents acquire knowledge and skills to express their sexuality in life enhancing ways. It is however, noted that the monitoring and evaluation of RHPS have not been done by Delta state personnel to ascertain its effectiveness in curbing at-risk sexual behaviour of in-school adolescents in the State. Studies revealed that 80% of patients with abortion complicated issues are adolescents. Therefore, ignoring the reproductive and sexual health needs of adolescents will have dire consequences. The at-risk sexual health problems among in-school adolescents in Delta State can no longer be ignored due to its enormous consequences that affect not only the adolescents but families, communities and the nation at large. This has led to the increasing demand for expanded programming on RHPS. This study, therefore, evaluated Reproductive Health Education Programmes and Services and their impacts on Sexual behaviour among in- school adolescents in Delta State, Nigeria.

The study adopted ex-post facto research design. The multi-stage, cluster random and purposive sampling technique were used to select 1939 respondents (1,515 students; 346 teachers; and 78 Health care providers) from 26 public secondary schools in Delta State. Three questionnaires: Questionnaire for Health Care Providers RHPS-HCP (r-0.74), Questionnaire for Students RHPS-STD (r-0.84), and Questionnaire for Teachers RHPS-TCP (r-0.81) were used. These were complemented with two sessions of FGD held with students. Five research questions were answered and nine hypotheses tested at 0.05 level of significance. Data were analyzed using percentages; t-test and multiple regressions. The qualitative data were content analysed.

Reproductive Health Educational Programmes (RHEP) ($F_{(4, 1510)} = 7.921$; $p<.05$), Reproductive Health Services (RHS) ($F_{(3, 1511)} = 15.221$; $p<0.5$) and Youth-Friendly Health Services Environment ($F_{(3, 1511)} = 35.299$; $p<0.5$) had significant influence on in-school adolescents sexual behaviour. The relative contribution of RHEP was ranked as follows: family life education ($\beta = 0.145$), peer education ($\beta = 0.066$); the relative contribution of RHES was ranked as follows: contraceptive counselling ($\beta = 0.137$), and HIV/STIs counselling ($\beta = 0.179$). Teachers did not observe significant positive changes in students' sexual behaviour and also

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Reproductive Health Knowledge of in-school adolescents was not significant. Focus Group Discussions revealed that students agreed to delay sexual initiation and avoid abortion. Peer education was ranked as the most influential on the sexual behaviour of in-school adolescents followed by Sexuality education, Family life education and HIV/AIDs education. The study provided data base evidence that ongoing RHEP was curbing at-risk in-school adolescents' sexual behaviour.

Reproductive Health Education Programmes and Services (RHPS) influence adolescents' sexual behaviour. Unfortunately, human and material resources, funds and poor Youth-friendly Services Environments constitute obstacles to meeting the sexual needs of in-school adolescents in Delta State of Nigeria. Hence, Delta State Government should allocate more funds, embark on periodic assessment of the programme, and the youth should be encouraged to get involved in the programmes.

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CHAPTER ONE

INTRODUCTION

Background of the Study

Sexual behaviour preference among adolescents, like adults, can vary greatly because sexual thoughts and feelings present throughout life are often accentuated during adolescent period and sexual behaviour among adolescents has grown in recent years. Sexual behaviour can take the form of expression of masturbation or sex with a partner. Adolescents are the most important group in a society and any country's most valuable assets in respect of their sizes and characteristics. The period of adolescence is normally accompanied by new development, creating new identity, often confusing emotional responses, a broadening of physical, social awareness and physiological functioning. The Adolescence stage of life is probably the most challenging and complicated period of life to handle, describe, study and experience (Berger and Thompson, 2004). Bail (2005) described adolescence as the period of life when the mutual influence of body chemistry manifests in the secretion of hormones and ginger physical maturity which in turns calls for heightened emotionality. Ogunsola (2005) asserted that the sexually active age group of man is between 15-49 years. Gribble (2010) emphasized that the population size of adolescents (ages 15 to 24) is currently 1.2 billion and is expected to continue growing for at least 20 more years. Programme of Action (2003) opined that adolescents may not constitute 100 percent of our population but they certainly make up 100 percent of our country's future.

Focus on Young Adults (2004) stated that Reproductive health is an increasingly global health issues, with the swelling wave of young people, access to reproductive health information and services becomes critical so that they can choose the number of children they want, and obtain the information and services to avoid unplanned pregnancy, Human Immune Virus/Sexually Transmitted Infections (HIV/STIs), to make choices that support the pursuit of educational goals and the development of life skills necessary for national and local leadership position. Adamchak (2000) revealed that successful reproductive health programmes helps young people (adolescents) to develop life planning skills; respect the need and concerns for themselves and other young adults as well as provide respectful and confidential clinical services for monitoring and evaluating adolescent reproductive health issues by Health care providers and other stakeholders. Focus on Young Adults

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(2003) stated that providing adolescents with specialized reproductive health information, counseling and services are very crucial and Reproductive Health Programmes have been developed for young people in Nigeria. Its primary goal is to help Nigeria adolescents gain the knowledge and skills needed to express their sexuality in life-enhancing ways. The six key concepts amplified are those developed by the National Guidelines Task Force in 1999 are: Human Development, Relationship, Personal Skills, Sexual Behaviour, Sexual Health, Society and Culture.

Ejembi (2011) defined Reproductive Health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes". Reproductive health refers to the health and well-being of women and men in terms of sexuality, pregnancy; birth and their related conditions; diseases and illness. Adolescent Reproductive Health (ARH) can be defined as possessing basic reproductive health information, skills in negotiating sexual relationships, access to affordable, confidential, and reproductive health services (Insel and Roth, 2004). Hamilton, Martin and Ventura (2002) revealed that with an estimated one billion adolescents alive today; the world is experiencing the largest adolescent population in history. In most developing countries, family planning clinics have not been seen as relevant to young women, especially unmarried women. Moreover, young men are not even encouraged in traditional family planning setting, where clinics are made available, adolescent females often avoid them probably out of fear that their wishes for understanding, privacy and confidentiality will not be respected (World Health Organisation, WHO, 2002).

WHO (2004) asserted that reproductive sexual behaviour during adolescence has far-reaching consequences for the lives of the young adolescents in adulthood. Therefore, there is need for adolescents to know about their sexual functioning in order to secure a healthy sexual life towards adulthood. This is because Humans are sexual being and sexual activity offers the most intense physical pleasure. Moronkola (2008) stated that if there is any behaviour that characterized the at-risk lifestyle choices of adolescent over the years, it is that of pre-marital sex and unsafe sexual behaviours. Fasubaa and Olugbenga (2005) revealed that sexual behaviour displayed by adolescents are of various types and it is worthy of note that modalities in sexual activities have changed with young people more willing and eager to experiment

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different discovery through intuition or otherwise variations in foreplay and coitus. WHO (2002) stated that young people face significant challenges to their health and well-being. These include high-risk behaviours, such as alcohol, tobacco, drugs use, sexual behaviours that can lead to adolescent pregnancy, Sexually Transmitted Infections(STIs), Human Immuno-deficiency Virus(HIV) Acquired Immune Deficiency Syndrome (AIDS), mental health concerns, learning disabilities, with school failures and school drop-out, serious family problems etc. Sexual activity, in general, is associated with a number of risks, including STIs/HIV/AIDS, emotional distress, pregnancy and abortion through failure to and non-use of birth control. This is particularly true for the adolescents as they are not emotionally and financially mature (Ponton, 2000).

Moronkola and Odumbo (2001) citing Arkutu (1995) revealed that several health survey and social studies have shown that 60-70% adolescents in many African countries are sexually active and 70% of girls have been pregnant at least once by the time they are 18 years old. Segun (2006) stated that sexuality begins before birth and lasts a lifetime, and it is influenced by ethical, spiritual, cultural and moral factors. It involves giving and receiving sexual pleasure as well as enabling reproduction. Sexuality education is the process of acquiring information and forming attitudes and beliefs about sex, sexuality, identity, relationships and intimacy. Family life education is “an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, ageing as well as their social relationships in the socio-cultural context of the family and society” (IPPF, 2005). HIV/AIDs education can be defined as acquisition of necessary knowledge and skills about HIV and AIDs and sexually transmitted diseases (STDs). Peer educators “are people selected for their leadership potential in helping others. They are trained to help other participants learn through demonstration, listening, role playing, encouraging, serving as role models, providing feedback and supporting healthy decisions and behaviour" (Advocate for Youth, 2005). The various Reproductive health education programmes are Education and Information/Communications, Family Life education, HIV/AIDS education, Peer Education, Sexuality education, Social networking, Mass media and print.

Focus for Young Adult (2001) opined that Reproductive Health services are the care, attention, help and counsel given to maintain and promote adolescent

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reproductive health such as counseling in contraceptives usage, pregnancy/STIs/HIV/AIDS, and health clubs, adolescent's clinics and youth friendly service centers. RHS consist of Referral Counseling, guidance services, skills in contraceptive methods, HIV/AIDs/STIs risk assessment/screening/testing, and Adolescents' clinics that provide treatment of incomplete abortion, pregnancy testing, Antenatal/Postnatal care, and Adolescents multi-services centers providing recreational activities and youth-friendly health services which are hospital-based. Igwebuike (2008) defined Evaluation as a process of describing something in terms of selected attributes and judging the degree of acceptability or suitability of that which has been described. The "something" that is to be described and judge may be any aspect of the educational scene, but it is typically a total school programme, a curricula procedure of an individual or group of individuals.

In the late 90s under the leadership of Action Health Incorporated (AHI), the Federal Ministry of Health and Non Governmental Organizations which includes Girls Power Intiative (GPI) came together to draw up guidelines for the teaching of Sexuality Education in Nigeria drawing on their experience on the field. UNFPA has supported the Federal Ministry of Health to establish a National Reproductive Health Working Group that brings together various stakeholders in the Reproductive Health arena to discuss issues of common concern. One significant outcome of this initiative is the ongoing National mapping of the areas of operation of the various reproductive health organizations working in the country (FMOH, 2002 and http//wwwunfpa.org/report2001/conseque.htm). Based on the national Council on Education approval and the willingness of the Ministry of Education, Delta State to teach Sexuality education, Family Life and HIV/AIDS Education (FLHE) in schools, the FLHE Modules with support from UNFPA were reduced into Schemes of work using relevant Career subjects. These Schemes of Work are the Girls Power Initiative (GPI)/Ministry of Education (MOE) adaption of the UNFPA version with minor adjustment as suggested by relevant subject experts to include issues of human trafficking and reflects the depth, appropriateness and inter-relatedness of the curricula content. It is a legacy for posterity and it was hoped that heads of schools, teachers and students would demonstrate a sense of commitment and zeal in the implementation of these schemes to bring the best in the sexual behaviour of youths in Delta State. Delta State Action committee on AIDS (DELSACA) prints Information

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Educational Communication materials and T-Shirts to educate youths on HIV/AIDS prevention and the needs to abstain from premarital sex (FMOH 2002, GPI 2002 & http//wwwunfpa.org/report2001/conseque.htm).

In the area of adolescent reproductive health, in-school population and family life education (POP/FLE) was introduced in most of the public secondary schools in 13 local government areas in Delta State. State master trainers and school teachers of selected subjects were trained, while Guidance Counselors were trained on adolescent health and counseling. These teachers in turn were mandated to train peer educators from among their students, using training guidelines developed under the POP/FLE project. The teachers also facilitated the formation of school health clubs that are managed by the trained peer educators. Furthermore, service providers in the State have received some training on the provision of youth friendly health services including HIV/AIDS counseling. In and out of school youths and adolescents in 13 local government areas out of the 25 have been reached through various RH education programmes specially for them under the state sub-programmes. An entertainment-educative television programme titled 'I Need to Know' which aimed at raising awareness about adolescent sexual and reproductive health issues was also part of the RHEPS. It focuses primarily on reducing risky sexual behaviour (as opposed to covering a variety of risk behaviours such as drug use, alcohol use, and violence.)

The objective of the Reproductive Health programmme and services in Delta State are to equip adolescents with accurate and comprehensive information on their sexuality, support sexual skills to postpone early sex initiation for those who are not yet sexually active, access to protective measures to prevent unwanted pregnancy, STIs/HIV/AIDS for those who have been initiated to sex; protection and care for sexual abuse and exploitation; and resist practices that could be harmful to their health like drug abuse, cultism, etc. and to have access to a range of youth-friendly services that are designed to promote their sexual behaviour positively and reproductive health needs. In order to address these problems and to meet the reproductive health and sexual needs of adolescents, various programmes as discussed above have been designed and implemented. All over the world and in Delta State, various strategies and approaches have been developed to provide young people with reproductive health information and services but with various challenges of financial constraints, lack of adequate records and documentation, lack of enabling policies, inadequate training and refresher courses for planners/providers, poor networking, monitoring

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and evaluation of programmes, urban concentration of Adolescent Reproductive Health Programmes/Services (ARHPS) and inadequate youth- friendly services (Okonta 2007 and FMOH,1997).

However, despite the increasing thirty three (33) numbers of Non-governmental organization being set-up and Government readiness to protect the rights of the Nigerian adolescents, the at risk sexual reproductive health problems of adolescents can no longer be ignored because the consequences are enormous and affects not only the adolescents but families, communities, and the nation at large which have led to the increasing demand for expanded programming of ARHS, but the questions is what kind of programme is effective? Are the education programmes flexible enough to curb the at-risk sexual behaviour of in-school adolescents' positively at reasonable cost and in sufficient coverage and numbers in Delta state? Therefore, this study evaluated influence of Reproductive Health Education Programmes and Services of Government on Sexual Behaviour among in-school adolescents in Delta State of Nigeria.

Statement of the Problem

The period of adolescence is a life phase in which young people are particularly vulnerable to health risks, especially those related to sexuality and reproduction, HIV/AIDS, unwanted pregnancy, unsafe abortion, too-early marriage and childbearing, sexually transmitted infections and poor nutrition. Young people are growing up in an environment of dynamic change. For some, this complexity provides opportunity and choice; for others, it means a struggle for survival (Adamchack, Bond, MacLaren, Magnani, Nelson and Seltzer, 2000). The teaching of Family Life, HIV/AIDs Education, Peer Education and Sexuality Education in the school system in Delta State to curb at-risk in-school Adolescents and young people sexual behaviour have various challenges of poor monitoring, lack of evaluation of programmes, inadequate funds, poor updates of records and documentation, lack of enabling policies, inadequate training and refresher courses for planners/providers, socio-cultural-economic factors, inadequate youth-friendly services, poor networking, urban concentration of Adolescent Reproductive Health Programmes and Services (ARHPS) as noted by (Odelola, 2004; Labelle, 2007; Okonta, 2007 and Moronkola, 2008).

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Action Health Incorporated (2002) observed that as Adolescents enter puberty, their interest in sex increases. The monitoring and evaluation of RHEPS have not been done by Delta State Government to ascertain how programme activities are working, meeting its objectives, whether there are critical needs inhibiting its progress and how the programmes interact with other events and forces in the communities. Despite this, an incident of rape was reported by Delta Rainbow Television of an adolescent by her teacher in one of the Secondary School on the 20th of November, 2008. In Udu Local government area, Onwian Aladja, packs of used condoms were found littered in a secondary school by 2.00pm after school hours; while in some secondary schools in Warri South Local government, there have been reported cases of sexual harassment of female students by their male teachers and male adolescent during School hours. Arch-Bishop Goodswill Avwomakpa came on air in a programme at Ughelli in 2008, lamenting the prevailing incidence of lesbianism and rape among youths in Delta State. The Nigeria Association for the Promotion of Adolescent Health and Development (NAPAHD) observed that a Hospital based research has shown that 80 percent of patients with abortion complicated issues are adolescents (Adepoju, 2005 and Ejembi, 2011).

The survey findings and investigations at Central Hospital, Warri revealed that adolescents
attending ante-natal clinic sessions from January 2008-December 2011 were 1482 in number (Central Hospital ante-natal records, Warri, 2010).

Action Health Incorporated (2002) and Okonta (2007) warned that a lot of young people have been misinformed and have involved them in risky sexual behaviours, including unprotected sexual intercourse resulting in unwanted pregnancy, unsafe abortion, and STIs, Including HIV/AIDS. Others have been involved in risky sexual related behaviours, like taking psychoactive substances and alcohol abuse. They advocated that parents should know how to discuss these sensitive issues with their children while the school takes care of formal sexuality education.

Population Reference Bureau (2010) emphasized that ignoring the reproductive and sexual health of youths today will have dire global consequences for decades, and with global attention on the Millennium Developmental Goals (MDGs), countries that recognize the importance of healthy young adult (ages 15-24) also have a better chance of reaching their targets for Goal 3 of the MDGs of promoting gender equality and empowering women to delay sexual initiation, Goal 4 of reducing child

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mortality by preventing teenage pregnancy and abortion complications, Goal 5 of improving maternal health by engaging in sexual intercourse with the use of condom and family planning and Goal 6 combating HIV/AIDS by avoiding sexual intercourse with more than one partner or a partner infected with an STIs. However, Government and Non-Governmental organizations have organized series of programmes and services geared towards curbing the negative sexual behaviours of in-school adolescents. The question is to what extent have these Reproductive Health programmes and services been able to curb positively the sexual behaviour of adolescents in Delta State of Nigeria? The need to evaluate the effectiveness of reproductive health programmes and services on sexual behaviour of in school adolescent in Delta State of Nigeria becomes imperative. Therefore, this study evaluated the influence of RH Education Programmes (sexuality education, family life, Peer Education and HIV/AIDS education (SEFLPEHE) and Services such as counseling/referral for STIs/HIV/AIDs; Youth friendly clinics, health clubs, and recreational facilities on sexual behaviour among in-school adolescents in Delta State of Nigeria.

Research Questions

The study provided answers to the following research questions:

1. Would inadequate funds influence the Reproductive health education programmes and services of Government on sexual behaviour among in-school adolescents in Delta State?
2. Would culture influence the Reproductive health education programmes and services of Government on sexual behaviour among in-school adolescents in Delta State?
3. Would Adolescents policy influence the Reproductive health education programmes and services of Government on sexual behaviour among in-school adolescents in Delta State?

Hypotheses

The following hypotheses were tested:

1. Reproductive health educational programmes of Government will not significantly influence the sexual behaviour among in-school adolescents in Delta State, Nigeria.

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2. Reproductive health services of Government will not significantly influence the sexual behaviour among in-school adolescents in Delta State, Nigeria.
3. Reproductive Youth-friendly service environment of Government will not significantly predict sexual skills developments to influence the sexual behaviour among in-school adolescents in Delta State, Nigeria, Nigeria.
4. Teachers will not significantly predict positive changes in the sexual behaviour among in-school adolescents despite the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria.
5. Health Care providers will not significantly predict positive changes in the sexual behaviour among in-school adolescents with reference to the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria.
6. There will be no significant difference between male and female in-school adolescent's sexual behaviour of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria.
7. There will be no significant difference between rural and urban in-school adolescent's sexual behaviour of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria.
8. There will be no significantly Reproductive Health knowledge to influence positively sexual behaviour among in-school adolescents of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria.
9. There will be no relative significant influence of each RHEP of Government on the sexual behaviour among in-school adolescents in Delta State, Nigeria.

Delimitation of the Study

This study was delimited to the followings:

1. Ex-post facto research design
2. Multi-stage sampling procedure
3. A total of one thousand nine hundred and thirty nine (1939) respondents (1515 male and female in-school adolescents in SS 2, 294 teachers, 26 Principal and 26 Vice principal,78 health care providers, 26 public schools, 9 (nine) local governments and three senatorial district in Delta State, Nigeria).

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4. Independent variables of reproductive health educational programmes and services and dependent variable of sexual behaviour.

5. Descriptive statistics of frequency counts, percentages and charts for analyzing the demographic data. A Modified adapted standardized questionnaire by Focus for Young Adult Research Series (2000) as instrument for data collection. Cronbach alpha was used for the reliability of the instrument, multiple regressions to test hypotheses 1-4 and 7-8; and T-test to test hypotheses 5-6 at 0.05 level of significance.

6. 15 (fifteen) trained research assistants.

7. Focus for young adult standard for evaluating adolescents' reproductive Health issues was used. The percentage gotten is reflected on appendix C

Limitations of the Study

The following limitations were encountered during the course of this study:-

Some Students, Health care providers, Principal and Teachers were unwilling to be photographed as physical evidence that the researcher was in the study area. The extraneous variable of Mass Media Reproductive Health Education Programmes of a drama series titled "I need to know" and "the travail of Onos" on Delta Broadcasting Television. The inconsistency in the school Calendar as a result of Nigeria Labour congress strike action kept the respondents from school and this delayed the researcher's work for some period of time.

Significance of the Study

Adolescent is a significant group of any nation and globally, programmes and services to curb and prevent at risk sexual behaviour and diseases of adolescent have demonstrated limited results. This can be seen in the daily increase of illegal and complicated abortion-related problems, increase teenage pregnancy rates, early motherhood; prevalence of STIs/HIV/AIDS, rapes among adolescents in Delta State. This study revealed that Reproductive Health Education Programme and Services to promote sexual health of in-school adolescent is ongoing and have reached its intended audience. The findings of this study revealed that there is need for Delta State Government to prioritize more allocation and release of funds, educate, train and

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motivate more health personnel's for RHEPS. The result of this study would provide information for advocacy to donor agencies especially UNFPA, institutions and policy makers not to relent in their effort to promote positive sexual behaviour among in-school Adolescents. It would also help all stakeholders handling Reproductive Health programmes and services for in-school Adolescents, of the need to have well-documented and disseminated programmes and services to curb negative sexual behaviour of adolescents in Delta State and to constantly update and modify standardized instrument to evaluate their RHPS not only for short term purpose but also for long term purpose. The study discovered that most of the teachers whom have been trained to teach and offer RHPS in the schools were mainly Biology teachers instead of Physical and Health Education teachers who are better equipped to teach RHPS to in-school Adolescents in Delta State. The study would help Delta State Government officials of UNFPA to confirm that programme activities are working and there was no significant positive impact of the RHPS on sexual behaviour of in-school Adolesents in the State.

The findings of this study would be made available to the State Commissioners of Education and Health and Chairman of all local government council in Delta State with a view to encouraging them on the need to create more youth friendly clinic/centers at their local government level and to advocate for more qualified health educator personnels to be trained consistently to handle the ARHPS in schools and not just any subject teachers. In addition, this study would also be a useful strategy to detect pitfalls and the challenges confronting Government in handling RHPS of in-school adolescents. This would help to develop and establish future programmes and training centers that would respond to the special needs of adolescents and young people. This study would bring to limelight the need to make RHPS a prioritized subject from JSS 1 – SSS 3 in all schools in Delta State. This would help to curb negative risky sexual behaviours among in-school adolescents in Delta State. The findings would reveal to educational planners, ministries, school administrators and teachers the need to create more youth-friendly service environment that will promote the sexual health of in-school adolescents in Delta State. Finally, it would serve as a reference point to other people who may be interested in a similar study in the future and a baseline for future research that can

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contribute to knowledge as well as other researchers who will use this study and identify other areas of research problems.

Operational Definition of Terms

Adolescence: an individual who develops from stage of puberty into adulthood.

Adolescent: a young person who is developing from a child into an adult, between ages of ten to nineteen.

Sexual Behaviour: refer to all actions and response related to pleasure seeking.

Negative sexual behaviour: Masturbation, lesbianism, gay, early initiation to sexual intercourse, unprotected sex etc.

Sexuality: is a vital and central aspect of human throughout life and encompasses sexual orientation, gender identities, sex, pleasures, intimacy and reproduction.

Sexuality Education: focuses on the individual, specifically, individual sexual activity, biology, relationships, sexual orientation and sexual behavior, STIs, gender roles, attitudes, and values.

Evaluation: is to find out, assess, decide a careful appraisal and significant of a phenomena in terms of standard, to assess the weakness or strength of how a current status measures, and determines both qualities and quantities of effectiveness of an issue or a programme. The three phases of evaluation are: process, impact and outcome evaluation.

Process evaluation: is the process by which the programme is being implemented.

Impact evaluation: measures the programme effectiveness in terms of intermediate objectives and changes in predisposing, enabling and reinforcing factors.

Programme: list of items, events, and plan of what is to be done, coded collection of information, data.

Reproductive Health Services: are the care, attention, help and counsel given to maintain and promote adolescent sexual and reproductive health such as counseling, contraceptives counselling/ usage, STIs/HIV/AIDS counselling and youth friendly services.

Reproductive Health Programmes: are school based educational programmes such as sexuality education, family life, HIV/AIDs education and peer education.

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Human Resources: are those responsible in teaching in-school Adolescents the RHEP and also render services to promote their sexual skills, e.g. Teachers, Health Care provider and Principal.

Youth Friendly-Services Environment: are health clubs, peer clubs, adolescent's clinics and recreational facilities.

In-school Adolescents: are teens within the age range of 14-19years attending public secondary schools.

Government Programmes and Services: are all the UNFPA programmes and services carried out in some public schools in Delta State.

Acronyms:

ARH: Adolescent reproductive health

RH: Reproductive health

USAID: United State Agency for International Development

RHPS: Reproductive health programmes and services

RHEP: Reproductive health educational programme

HCP: Health care provider

Geographical Description of the Study Area

Delta State was created on the 27th of August, 1991 following the creation of states exercise of that historic year. She was created from the old Bendel State. The states bordering Delta State are Edo to the North, Ondo to the North – West, Anambra to the East and Rivers to the South – East on the Southern flank is the bight of Benin. The major ethnic groups are Urhobo, Igbo, Ezon, Isoko and Itsekiri. The ethnic language is the mother tongue based on the particular tongue, but English Language is widely spoken and most of the non-literate population understand and speak "waffy", that is "pidgin" English. All the ethnic groups claim a common Ancestry; consequently, their cultures are similar, but they are mostly christians but few still practice traditional religion.

Delta States is rich in major tubers and root crops such as Cassava, Coco-yams, Yams, and Sweet-Potatoes. Industries in Delta state include Glass Factory at

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Ughelli, the African Timber and plywood factory, Sapele and Asaba Textile Mills. Delta state is endowed with crude oil; ranking second after Rivers state in Nigeria. The Celebration of traditional festivals is an annual community event throughout Delta state. Important festivals celebrated in the State are Adane Okpe, Iyeri, Edjenu, Okere Juju, Ine, Ulor, Ukwata and Oghene-Uku etc. The state capital is located at Asaba. The present civilian Governor is Dr. Emmanuel Uduaghan. It was called the "big heart" by Chief Onanefe Ibori former Governor, but the Slogan presently by the current Governor is "The finger of the Lord".The State is divided into three senatorial districts (zones) –North senatorial, Central senatorial and South senatorial. It comprises 25 Local Government Areas. They are: Oshimili, Aniocha, Aniocha South, Ika South, Ika North-East, Ndokwa West, Ndokwa East, Isoko South, Isoko North, Bomadi, Burutu, Ughelli South, Ughelli North, Ethiope West, Ethiope East, Sapele, Okpe, Warri North, Warri South, Uvwie, Udu, Warri Central, Ukwani, Oshimili North and Patani.

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CHAPTER TWO

REVIEW OF RELATED LITERATURE

The study evaluated the influence of reproductive health educational programmes and services of Government on sexual behaviour among in-school adolescents' in Delta State of Nigeria. Therefore, this chapter presents the theoretical and empirical literature relevant to the study area through a review of related literature under the following sub- headings:

Theoretical Review

1. Concept of Adolescence.

a. Definition of Adolescence.

b. Historical developmental growth of Adolescence.

c. The challenges of adolescent stage of life.

d. Developmental growth changes during Adolescent stage of life

e. Psychosocial process and sub-stages of Adolescents Development.

f. Categorical problems of Adolescents.

g. Characteristic developmental growth of Adolescent.

2. Concept of Reproductive Health

3. Adolescent Reproductive Health.

a. Definition of Reproductive health

b. Components of Reproductive Health

c. Concept of Adolescent reproductive Health

d. Sexuality context of adolescents

e. Adolescents sexual behaviour

f. Types of sexual behaviour.

g. Dangerous sexual behaviour and experiences among adolescents.

h. Socio-cultural context and sexual behaviour among adolescents.

i. Factors influencing adolescents' risky sexual behaviour.

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j. Causes of early sexual involvements among Adolescents.

k. Objectives of adolescent reproductive programmes and services

4. Theoretical Framework.

a. Theory of Reasoned Action.

b. Theory of planned behaviour

5. Concept of Evaluation

a. History and Development of Evaluation in Health Education.

b. Models for Evaluation

c. Types of Evaluation

d. Rational for Adolescents Policy.

Empirical Review

6. Adolescent Reproductive Health Programmes:

a. Sexuality education

b. Family life education.

c. HIV/AIDS education

d. Peer education

e. Teacher's knowledge and attitudes towards adolescents' sexual behaviour.

7. Adolescent Reproductive Health services:

a. Counseling and Referral services:

i. Contraceptives counseling/usage

ii. HIV/AIDs testing/Screening

iii. STIs Test/Screening

b. Youth Friendly Service Environment:

i. Peer Club

ii. Health Clubs

iii Recreational facilities

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8. Institutional Roles on Reproductive Health Programmes & Services to in-school adolescents.

9. Adolescents reproductive health situations in Nigeria.

10. Appraisal of literature.

Concept of Adolescence

Adolescence is a period of individual between the ages of 10 and 19 years of age and that period in which the individual life begins at the end of childhood and closes at the beginning of adulthood. The word adolescence is a Latin word (adolescence) meaning to grow. It is the period between childhood and adulthood. Egbule and Eresegbefe (2005) described adolescence as the period when the individual is in the process of transfer from irresponsible age of childhood to the self reliant and responsible age of adulthood. Adolescence is a period between childhood and adulthood. It is a choked difference of not belonging to a particular set of accepted society stage and this outwardly moves them to accept their peers and walk by the common practices amongst their age group. Melgosa (1990) defines the adolescence stage as a period of life where all human doubts, hesitation and uncertainties appear. It is a period of confusion, challenges, fears, uncertainties, and where social content of peers, schools, neighborhood, friends, families, communities influence adolescent health and risk behaviour.

Komolafe (2004) described adolescents as a group who constantly engage in activities which appear or vary contrary to the norms, ethics and value of society. Eshiet (2003), citing Hall, the founder of developmental psychology, defined adolescence as a period of “storm and stress” and the age of great ideas and the beginning of theories as well as the time of simple adaptation to reality. Okonkwo & Iliaka (2003) citing Chauhen reaffirmed, that adolescence is the period in life span, during which boys and girl move from childhood to adulthood mentally; emotionally; socially and physically. It is the period when the individual is capable of begetting an offspring. Berger and Thompson (1998) expressed that adolescence is the most challenging and complicated period of life to describe, study and experience. Adolescent, according to Scripture Union West Africa [SUWA] and Fellowship of Christian Students [FCS] (2006) is a “between age” - one who is between childhood

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and adulthood". It is a transition between two worlds – the world of children and the world of adults. James Dobson, an American Christian psychologist describes this period as a period of "turbulent" voyage, where you leave the safe harbour of childhood to enter into the open sea of adulthood .In humans, mature sexual desire usually begins to appear with the onset of puberty. Ikekhu and Oniyama (2006) viewed adolescence from an individualistic perspective. To him, despite the difficult nature of adolescence, it is a period of rebirth. It is a period of rebirth because of the genetic changes and new social order including advancement in cognition that help adolescents think realistically about their new world.

Adamchack (2000) stated that adolescent is often used to describe young people ages 10-19, young adults generally refers to those ages 15-24 and youth may refer to all young people ages 10-24. Ofordile (2002) stated that adolescence is a critical point in human life when sexual and moral passions come to fruition and attain maturity and that adolescence status are with uncertain and diffuse guidelines, engendering equally uncertain and diffuse behaviour, a period of questioning and searching for not only the meaning of life but also for a concrete way to go about living that life. There are different signals as to what adolescent's age should be, between the ages of 12-21, others have put it at 11-18, and 13-17. All these age brackets are acceptable by what the Nigerian constitution defines adolescence to be, which is between 13-17 years, while an adult is 18 years and above (Komolafe, 2004). Therefore, adolescent is between childhood and adulthood, any consideration that qualifies the child to be looked at as above a child and below an adult is adolescence.
Adolescent is the transitional years of life when the foundation of adult personality is somatically, psychosomatically and sexually laid. They are group of people who are in teens of age. It span from 12 – 19 years. Ikekhua & Oniyama (2006) opined that Adolescent is a fundamental period of physical basis for emotional, social, intellectual and economic maturity. The age of adolescent, in principles means that the child must develop heterosexual feeling with affection for other persons in the opposite sex.

The Adolescent is mostly misunderstood by the society; an indisputable fact remains however, that adolescents are group who constantly engage in activities which appear or are very contrary to the norms, ethics and values of the society. Consequently, the need for independence oftens lead most adolescents to take a position and views different from those of their parents and other adults and to act in

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conformity with their peers even if those acts are unconventional. National Guideline Task Force (1996) describes adolescence as the period of psychosocial development between the onset of sexual maturity (puberty) and early adulthood during which people define their self identity, sex roles and relationship with other persons. It is considered as the time of transition from childhood to adulthood during which there are physical changes associated with puberty (UNDP, WHO, 2002).

Adolescence is a period of self discovery and self definition. Egbule and Eresegbefe (2005) citing Rogers described adolescence as a process of achieving the attitudes and beliefs needed for effective participation and functioning in the society. Adolescence is a period of development which begins when the physiological; psychological and hormonal developments within the child take place. This is true because their hormonal sexual characteristic starts manifesting physically. Adolescence is the transition from childhood to adulthood. It is one of the most dynamic stages of human development. It is a time of marked physical, emotional, and intellectual changes, as well as changes in social roles, relationships and expectations (Oniyama, 2009)

History and Developmental Growth of Adolescence.

Hall in 1904 with the publication of his two-volume work on Adolescence initiated the scientific study of adolescence history. His contribution also advanced the study of adolescence because scholars about the second decade of life acted synergistically with broader scholarly activity within developmental science pertinent to the theoretical, methodological, and applied features of the study of human development across the life span. Hamburg (1974) did much to provide the foundation for this integration, in that he made a compelling case for viewing early adolescent period as a distinct period of the life course and one that provides an exemplary ontogenetic window for understanding key person-context processes involved in coping and adaptation. Based on such evidence, Petersen (1988) noted that basic theoretical and empirical reviews in several areas have permitted the advance of research on adolescence. Some areas of behavioural science from which adolescence researchers have drawn its life-span are developmental psychology, life-course sociology, social support, stress and coping, and cognitive development; important contributing areas in the biomedical sciences include endocrinology and

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adolescent medicine. The recent maturation to adolescent of subjects in major longitudinal studies has also contributed to the empirical knowledge base.

The psycho-social of adolescence include the development of capacity for concern about the feelings of others. The emotion of love and affection is associated with people. The adolescent is able to discriminate people with whom he/she likes to associate and build up an affectionate association (Ishola, 2001). The adolescent becomes very closely attached to one another because of intense feelings of love. Love becomes source of joy. The physical attractiveness is one or the sources of joy and pleasure. There is erotic feelings and fondness for the opposite sex during the adolescents' stage of life. This emotion of love is directly related to sexual impulse. Ariba (2000) noted that the changes accruing during adolescence are natural and primarily intended to help the child to cope with sex, reproduction and social life. The rapid spurt growth and body changes taking place in adolescents make them vulnerable to displaying sexual behaviours that are inappropriate and which has the potential to make them face different reproductive sexual health problems.

The Challenges Of Adolescence Stage of Life

Puberty marks the time in life when a person is first capable of sexual reproduction. Researchers have designated pubescence as the period extending from the first evidence of sexual maturation, breast development in girls and changes in genitals of boys to the onset of menstruation in girls and the production of spermatozoa in boys. A prestigious developmental psychologist Robert Havighust in Brown (2002) revealed the following challenges of adolescence which varies with each individual according to their socio-economic, cultural context. The general challenges can be listed as follows in the western societies, with the corresponding adaptations, valid outside the western world:

1. **Adjusting to his new mental capacity:** Every day, new intellectual skills are discovered and improved upon because of surrounding influences and the access to the adult world. The

   Adolescent begins to analyze facts in a more abstract and more mature way.

2. **Establishing vocational goals:** The adolescent type of desired profession begins to appear. This will determine the choice of studies or professional apprenticeship.

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Young people must be flexible enough to adapt to the available employment opportunities.

3. **Confirming independence with respect to parents:** Although actual independence does not occur until later, adolescents need to think about emotional and psychological independence from their parents. Often this brings with it parent-child contrasts in points of view, in moral judgments and in behaviour.

4. **Establishing healthy friendships:** The role of group is fundamental in adolescence. For this reason, the young person must become integrated in it, without following blindly. Dealing naturally with members of the opposite sex must also be accepted.

5. **Learning to control sexuality:** With the onset of sexual maturity, adolescents must make a series of important decisions in relation to their own sexual behaviour. Sexuality activity is determined by cultural, moral, and healthy aspect and must be practiced with complete responsibility.

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TABLE 1: DEVELPONMENTAL GROWTH CHANGES DURING ADOLESENTS' STAGE OF LIFE.

NOTABLE CHANGES IN ADOLESCENT GIRLS	
STAGES	
Breast Development	
1. Pre pubertal; nipple elevation only	1.Pre pubertal; no pubic hair
2. Small, raised breast bud	2. Sparse growth of hair along labia
3. General enlargement of rising of breast aerola	3. Pigmentation, coarsening and curling, with an increase in amount
4. Further enlargement with projection of areola and nipple as secondary mound.	4. Pubic Hair Growth 5. Hair resembles adult type, but not spread to medial thighs.
5. Mature, adult contour, with areola in same contour as breast, and only nipple projecting.	
NOTABLE CHANGES IN ADOLESCENT BOYS	
1. Genital Development	1. Prepubertal; no change in size or proportion no pubic hair
2. Testes, scrotum and penis from early childhood	
3. Enlargement of scrotum and testes; reddening	2. Sparse growth of hair at base of penis and change in texture in skin of scrotum; little or no Penis enlargement.
4. Increase first in length then width of penis; growth of Testes and scrotum.	3. Darkening, coarsening and curling, Increase in amount.
5. Enlargement of penis with growth in breath and of glands; further growth and scrotum, darkening of scrotal skin	4. Hair resembles adult type, but not spread to medial thighs.
Adult Size and shape genitalia	5. Pubic Hair Growth adult type and quantity, spread to medial thighs

Source: Data –Tanner -Growth at adolescence, Oxford: Blackwell Scientific Publications, Brown (2002)

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TABLE 2: Psychosocial process and sub stages of Adolescent Development

Sub Stage	Emotionally to a new	Cognitively Related	Socially Related
Early adolescence 11-14years	Adjustment to a new body image ,adaptation to emerging sexuality	Concrete thinking, early moral concepts	Strong peer effect
Middle adolescence 15-17years	Establishment of emotional situation from parents	Emergence of abstract thinking ,expansion of verbal abilities and conventional to increased school demands	Increased health risk behavior, sexual impulse rate in peers
Late adolescence 18-21years	Establishment of a personal sense of identity further separation from parents.	Development of abstract, complex thinking ;emergence of post conventional morality	Increased impulse control; emerging social autonomy; establishment of vocational capability.

Source: Reprinted from Ingersoll GS, Psychological and development, in McAnarnarey E. Textbook of adolescent medicine @ 1992, with permission from Elsevier.

The most profound changes in a man are during adolescent. At pre-adolescent the pubescent experience development of secondary sexual characteristic while the primary sexual characteristic get matured. At the climax of adolescent, the adolescent is fully matured for reproduction. The engines of human sexuality will ginger the adolescent towards heterosexual relationship and try to experiment whenever they are really matured. (Ikekhu & Oniyama, 2006) The attendant outcome of the above is that the adolescent then experience increase sexual urges and drive of the urges leads most of the controlled and uncontrollable adolescent to pre-marital sexual interaction. Sexual desire at adolescence is so intense that resistance level among adolescents

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becomes low in the midst of this, peers pressuring the adolescent to experiment on sexual act. At this stage also, sex impulses and curiosities begin to show. Adolescent children engage in activities leading to organism such as masturbation, nocturnal emission, and sexual intercourse and in some cases heterosexual practice (Ikekhu & Oniyama 2006). During adolescence, teens develop a stronger recognition of their own personal identity, including recognitions of a set personal, moral and ethical values, and greater perception of feelings of self-esteem or self worth. Psychosocial and cognitive development is best understood when divided into three period: early adolescence (11-14 years), middle adolescence (15-17 years), and late adolescence (18-21 years).Each of these distinct periods of development is marked by the mastery of new emotional, cognitive and skills.

Evidence according to Feldman (1996) shows that adolescent engages in free school unprotected sexual acts. Some go out with fellow students, at times with teachers and other age mates and adults outside the school setting even in school uniforms for sexual activities. Some engages in indiscriminate sexual act for grades while in school. Categories of them, especially girls, go for it for pleasure and form habit from it that they become promiscuous (Feldman, 1996).Problems like early pregnancy, death resulting from crude abortion of unwanted pregnancy, contact venereal diseases and HIV/AIDs arise as a result of premarital sex acts by adolescent (Ikekhu & Oniyama,2006) . It was based on the above view, that WHO (1995) citied by Nnabueze (1998) stated that the number of women (15-19) who experience a pregnancy is expected to increases by 25% from 1995 – 2020. The implication, according to Nwabueze (1998), is teenage child bearing teen mothers have decreased level of educational attainment, and more likely to live in poverty and experience health problem more frequently than older mothers. In addition, according to him, their children experience more frequently, problem than children of older mothers.

The "Ages" of Adolescents

Adolescents are not just teenagers. Adolescents include 10-24 year-old. Adolescence is not one developmental stage, but three developmental stages:

- Early adolescence (10-14 years of age)
- Middle adolescence (15-17 years of age); and
- Late adolescence and young adults (18 -24 years of age)

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Expert opinion about the age range for adolescence varies by organization and agency. The Health Resources and Services Administration are 11-21. The Centers for Disease Control and Prevention (CDC), (2000) defines the age range for adolescents as 10-19 and refers to 20-24 year olds as young adults, but often group's adolescents and young adults similar to adolescents. The three separate stages are important to consider when planning strategies and programmes to meet the developmental needs of adolescents.

Characteristic Developnmental Growth Of Adolescents

There are five major characteristics developmental growth common to Adolescents these are:

(a) INTELLECTUAL DEVELOPMENT: IT INCLUDES:

- Moving from concrete to abstract thinking.
- An intense curiosity and wide range of intellectual pursuits, view of which are sustained over the long term.
- High achievement when challenged and engaged.
- Preferences for active over passive learning experiences.
- Interest with interacting with peers during learning activities.
- An ability to be self-reflective.(Campbell, 2006)

(b.) SOCIAL DEVELOPMENT: IT INCLUDES:

Modeling behaviour after that of older students this includes:

- Immature behaviour when social skills lag behind mental and physical maturity.
- Experimenting with ways of talking and acting as part of searching for a social position with peers.
- Exploring questions of racial and ethical identity and seeking peers who share the same background.
- Exploring questions of sexual identity in visible and invisible ways.
- Feeling intimidated or frightened by the initial middle school experience.
- Linking fads and being interested in popular culture.
- Overreaching the ridicule, embarrassment and rejection.
- Seeking approval of peers and others with attention-getting behaviours. (Thompson 2006)

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(c) PHYSICAL DEVELOPMENT: IT INCLUDES:

- Restlessness and fatigue due to hormonal changes.
- A need for physical activity because of increase energy.
- Developing sexual awareness and often touching and bumping into others.
- A concern with changes in body size and shape
- Physical vulnerability resulting from poor health habits or engaging in risky behaviour (Cousoc, 2005)

(d.) EMOTIONAL AND PSYCHOLOGICAL DEVELOPMENTS: IT INCLUDES:

- Mood swings marked by peaks of intensity and unpredictability.
- Needing to release energy, with sudden outbursts of activity.
- A desire to become independent and to search for adult identity and acceptance concern about physical growth and maturity.
- A belief that their personal problems, feeling and experiences are unique to themselves.(Leonard, 2005)

(e.) MORAL DEVELOPMENT: IT INCLUDES:

- Understanding the complexity of moral issue and not seeing everything in "black and white".
- Being capable of and interested in participation in democracy.
- Impatience with the pace of change and understanding how difficult it is to make their own change.
- Needing and being influenced by adult role models who will listen and be trustworthy.
- Relying on parents and important adults for advice but wanting to make their own decisions.
- Judging others quickly but acknowledging one's own faults slowly, (Henshaw,2003).

Categorical Problems of Adolescences Stages of Life.

The problems facing adolescents was classified into six broad categories by Brown (2002), they are:

1) Conduct problems: such as rudeness, aggression, disobedience, fighting, stealing, armed robbery, offences and hyper activity.

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2) Personality problems: such as shyness, withdrawal, exclusives, phobia, fear, neurosis and psychosis.
3) Socio-psychological problems: some are enuresis (bed wetting), uncompress, masturbation, somnambulism, stammering, asthma, obesity, stress, sleep disorder and stuttering.
4) Learning disabilities: such as mental retardation, schizoid, autism, under achievement, academic difficulties, inattentiveness and absentmindedness.
5) Socialized delinquencies: such as juvenile delinquency, sex offences, fire setting, Gangsterism, drug-addiction, alcoholism, prostitution and promiscuity and
6) Socio-cultural problems: such as teenage pregnancy, financial problems, admission problem, unemployment, problem of choice of vocation and armed robbery offence.

Concept of Reproductive Health

WHO (2002) defined Reproductive health as "a state of complete physical, mental and social well-being, and not merely the absence of diseases or infirmity, in all matters related to the reproductive system and to its functions and processes." Reproductive health is a state of physical, mental and social well being and not merely the absence of disease or infirmity in all matters related to the reproductive system, its functions and processes (Federal Ministry of Health, 2005). Akande (2002) asserted that Reproductive health more than any other health field has an impact that extends beyond the individual and family, to the large and even to the whole world as a whole. Reproductive health is a life cycle approach and not just the concern during a woman so called reproductive years (ages 15-45 years) but a lifelong concern for both women and men from infancy to old age.

Three critical points of Reproductive Health challenges are:

- At birth
- During adolescence and
- During the reproductive years.

Components of Reproductive Health:

- Safe motherhood, comprising pre-natal safe delivery, postnatal care including breast feeding.

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- Family planning information and services.
- Prevention and management of infertility and sexual dysfunction in both men and women.
- Prevention and management of complications of unsafe abortion.
- Prevention and management of reproductive tract infections especially STIs including HIV/AIDS.
- Adolescent reproductive health.
- Active discouragement of harmful practices such as female genital mutilation (FGM), domestic and Sexual violence.
- Management of Reproductive tract cancers. (Senderowitz, 2003).

Concept of Adolescent Reproductive Health

Adolescent health and youth development go hand-in-hand. Youth who, with support from their families and communities, successfully engage in the development tasks of adolescence are more likely to choose health-promoting behaviors and avoid activities that can lead to negative health and life outcomes. Youth development is both a philosophy and an approach to policies and programs that serve young people. The underlying philosophy of youth development is holistic, preventive and positive. It focuses on the development of assets and competences in youth as the best means of fostering good health and avoiding negative choices and outcomes (National Adolescent Health Information Center, 2004).

Essential elements of the youth development approach are:

- Youth are viewed as valued and respected assets to society.
- Policies and programs are focused on the evolving developmental needs and tasks of adolescents, and involve youth as partners rather than clients.
- Families, schools and communities are engaged in developing environments that support youth.
- Adolescents are involved in activities that enhance their competence, capacity, caring, character and civic engagement.
- Adolescents are provided an opportunity to experiment in a safe environment and to develop positive social values and norms.
- Adolescents are engaged in activities that promote self-understanding, self-worth, a sense of belonging and resiliency.

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National Adolescent Health Information Center (2004) stated that extensive work and research in the field of adolescent health over the past 30 years provides a wealth of information about strategies that can effectively support the health and well being of youths. Analyzing and applying "lessons learned" from this research can assist in making informed decisions about those strategies that most likely have a positive effect on the health of adolescents.

Four types of strategies shown to effectively support the health and well being of adolescents are:

1. Decreasing the Risk Factors that contribute to risky behaviors and poor health outcomes.
2. Increasing the protective factors that contribute to resiliency and healthy outcomes.
3. Providing Opportunities for young people to successfully meet the developmental needs of adolescence.
4. Building Healthy Communities and Schools that support and nurture adolescents.

Senderowitz (2003) stated that successful reproductive health programmes for adolescents tend to be most successful when they:

1) Accurately identify and understand the group to be served.
2) Involve adolescents in the design of the programs;
3) Work with community leaders and parents
4) Remove policy barriers and change providers' prejudices;
5) Help adolescents rehearse the interpersonal skills needed to avoid risks;
6) Link information and advice to services;
7) Offer role models that make safer behaviour more attractive;
8) Invest in long-enough time programmes and resources.

Association of Maternal and Child Health Programme (2002) stated that adolescent Health is the optimal state of well being in all areas of life- physical, emotional, cognitive, social and spiritual. By using the broad definition of health, adolescents are healthy when they:

1. Engage in healthy behaviors that contributes to a healthy lifestyle;
2. have the capacity to thrive in spite of stressors in life;
3. successfully engage in the development tasks of adolescence; and

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4. Experience a sense of wholeness and well-being.

Why Focus on Adolescent Health?

- Adolescence is one of the most dynamic stages of human growth and development. The rate of developmental changes during adolescence is second only to infancy
- Adolescence is a time of redefining and developing relationships, with parents, family and peers. It is important to understand adolescence in the continuum of lifespan. The experiences of childhood have a significant impact on adolescence, while adolescence lays a foundation for the experiences in adulthood.
- Good health (physical, emotional, social and spiritual) enables young people to make the most of their teenage years.
- Some adolescents" unsafe choices or vulnerable situations can have immediate, life-threatening, and costly consequences.
- Adolescent health provides the foundation for adult health status. Life-long patterns of healthy behaviors are established at this time.
- Unhealthy adolescent behaviors can become long-term risk factors for chronic health conditions in adulthood.
- Mixed messages and expectation from adult and the media, regarding adolescent independence, responsibilities and sexuality make it all the more important to help guide youth as they grapple with life's new complexities.(Minnesota Department of Health,2002)

As young people navigate the changes of adolescence, it is critical that they receive the guidance, support and encouragement that foster healthy development. The health and well being of adolescents is shaped by the world in which they grow and the people that surround them. Young people who are educated and healthy are more likely to become contributing members of society and consequently to our economic prosperity.

Factors That Affect Adolescents Health

National Adolescent Health Information Center (2004) discovered that there is no single solution to address the complexity of adolescent health needs and issues. The health of adolescent is shaped by; Parents and families, health care systems,

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media, Peers, neighbourhoods, employers, social norms, government, policies and laws, Schools, community organizations, religion and communities. These factors impact young People's sense of health and well being by affecting their capacity to withstand life stressors, their ability to transit in developmentally appropriate ways, and their ability to make decisions about health behaviours. There are a small number of negative effect of adolescents Health. In fact, 70% of adolescent death and illness are caused by six categories of risk behaviours such as behaviour that result in unintentional and intentional injury (eg violence and suicidal behaviours.), alcohol and other drug abuse, sexual behaviours that result in unintended pregnancy, HIV infection and other sexually infections, tobacco use, unhealthy dietary behaviours, and inadequate physical activity (www.focusas.com/sexualbehaviour.html, 2004).

Many studies confirm that most health risk behaviors among adolescents are interrelated. Likewise, many protective factors –things that reduce health risks- are interrelated. It is important to understand how to promote healthy behaviors among youths, understand the underlying causes and motivations, and what circumstances make unhealthy behavior seem attractive. Youth who engage in one unhealthy behavior, who for example smoke or drink-are more likely to develop a cluster of unhealthy behaviors and habits.

Characteristics of effective adolescent health programmes.

Spring (2000) identifies eight characteristics that can directly impact adolescents and their families to be the guiding research-based principles for building systems to support healthy adolescents and young adults as follows:

1. Adolescent should be viewed as resources to be nurtured and supported, not problems to be fixed.
2. Strategies should be well integrated and coordinated.

- There is a diversity of strategies that focus not only on adolescents, but also on their social environment including families, peers, schools, and communities.
- A combination of prevention, health, promotion and health youth development strategies are used.

3. Youths should be involved and engaged as active partners in the design, implementation and evaluation of strategies.
4. There should be a good fit between strategies and the adolescents on which they focus

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- The strategies are responsive to cultural, ethnic and other forms of diversity.
- They are developmentally appropriate.

5. The people involved should understand adolescent health and well being.
6. There should be a focus on building and strengthening relationships.

- The strategy focus on strengthening families. Teens that have warm, involved relationships with their parents are more likely to do well in school, have better social skills and have lower rates of risky sexual behaviors than their peers.
- The strategy purposely focuses on building supportive adult-youth relationships.

7. Young people are supported to make successful transitions.

- They help youths develop basic skills
- They help young people find and become involved in meaningful roles in their communities.
- They strengthen the social supports available to adolescents and their families.

8. They should provide an array of opportunities for young people so that risk behaviors are not the desirable option open to youths.

Ishola, Adedimeji and Adedokun (2001) and Odelola (2004) stated that the major reproductive health problems faced by adolescents in Nigeria are those of high rate maternal mortality, reproductive tract infections, infertility, ectopic pregnancy, unwanted pregnancy as well as recurrent spontaneous unsafe abortions, cervical cancer, Vesico Vagina Fistula (VVF), prenatal mortality, menstrual and sexual abnormalities and high fertility rate. In this regard, Ariba (2000) suggested the need to fully address such health problems in the reproductive health programme to produce well-informed and adjusted adolescent in our society. Adio-Moses (2004) reported in a survey of female secondary school students in Ibadan engaged in prostitution nowadays as they see sex as a power game instead of shared pleasure, and so use it to get financial reward, therefore increase the spread of STIs especially among females. Further still, adolescents may fall prey to sadists who simply desire to use them and dump them.

The bizarre activities of money bags in Nigeria had put the adolescents in a very dangerous position as the girls are used for moneymaking and some adolescent males who are lovers of easy money also fall prey to sugar mummies who use their sperm for money making (Babagbalu, 2006). Obioha (2004) in Ajakaiye (2002) postulated that poverty deprived people of the access to information, health facilities, schools

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and media, which limit their access to information on HIV / AIDS. Also among the poor, harsh economic conditions often push families that are unaware of the risk of HIV / AIDS to send their children to work force where they might be forced into sexual abuse as part of the struggle for survival.

Lindberg, Ku and Sonenstein (2000) ascertained that in Nigeria reproductive health education including messages to encourage abstinence and promote the use of condoms and contraceptives by those who are sexually active, is the front line of efforts to prevent pregnancy, AIDS and other STDs among adolescents. They believed that school-based instruction is a primary mode of reproductive health education. Firstly, it will reduce sexual risk behaviour by delaying the age of first sexual intercourse, and secondly, it will reduce level of sexual activities and increasing contraceptive or condom use. Parents can serve as influential source of reproductive health education for adolescents. Reproductive health education through school and parents are important steps in promoting safer sexual behaviour among teenagers. In spite of this, parents continue to under estimate their influence over children's decision about sex; they believed that teenage friends are mostly influential. The report of Potter (2007), in a survey carried out by The National Campaign to Prevent Teen Pregnancy, stated that (88%) of them agreed that it would be easier for them to postpone sexual activity if they were able to have honest conversation about the FLHE topics. One in four (23%) of them stated they have never discussed sex, contraception, or pregnancy with their parents; and about six out of ten (59%) revealed their parents are their role models for healthy responsible relationship.

WHO (2002) stated that Reproductive and Sexual Rights is the human rights of women and the girl child to have control over and decide freely and responsibly on matters related to their sexual and reproductive health; free of coercive discrimination and violence. Reproductive and Sexual Rights are as follows:

- Reproductive and sexual health as component of overall lifelong health.
- Reproductive decision – making.
- Equality and equity for men and women of all spheres of life.
- Sexual and reproductive security including freedom from sexual violence, coercion and the rights to privacy.

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Adolescents Sexuality Context

In the beginning of the 19th century, the new noun "Sexuality" which was then referred to as the quality of being male or female has developed in terms of meaning. Adolescent sexuality refers to sexual feelings, behaviour and development in adolescents and is a stage of human sexuality. UNAIDS and UNFPA (2001) asserted that adolescence in Nigeria average age of first sexual intercourse for girls is just over 16 years and a little higher for boys and by the time they turn age 20, more than three quarters of Nigeria girls and boys have had sexual intercourse. National AIDs and STD control Programme (1999) revealed that more than one million teenage boys and girls acquire a sexually transmitted disease in Nigeria every year. In 1998, 60% of all the AIDs cases reported in Nigeria were among people of aged 12-24 years, which is early and middle adolescence stage of life. Advocate for Youth (2001) confirmed that a study of 330 female rape victims in Edo State, in the south-south of Nigeria reported that a majority of rape victims were females ages 13 to 19. Kuti (1995) stated that "adolescent sexuality is a reality! Today young people reach physical maturity earlier and marry later. Society has a responsibility to ensure that they make responsible sexual choices". Unfortunately, majority of the adolescents are highly ignorant about the consequences of involving themselves in risky sexual behaviour.

Ogwu (2006) reaffirmed that sexuality is the application of educational process for the development of an understanding of physical, mental, emotional, social and economic, and psychological phase of human relations as they affect male and female relationships. Sexuality describes the whole area of personality related to sexual behaviour and is a natural and healthy part of living. Sexuality education is a topic in reproductive health programmes and services that if properly focused will prevent early and unprotected sexual activity, early childbearing, promote healthy use of contraceptives, prevents STDs/HIV/AIDs, Teenage pregnancy, promote sexual health etc. The success of a programme lies in the assessment or evaluation of its strength and weakness. Reproductive health programmes with qualitative services towards adolescent sexual behaviour is essential. Adolescent's sexuality according to Ponton (2000) is defined as "sexual feelings, behaviour and development in adolescent and stage of sexuality. Sexuality is a vital aspect of teen's lives and sexual behaviour of adolescent is influenced by culture, norms, their sexual preference and the issue of social control such as age of consent and love.

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Adolescent sexuality is a universal problem that has concern both the general society and the medical community. Sexuality and personal identity are key adolescent issue (Weinstern & Rosen, 1991). Adolescents are sexually active at this stage of life and the problem of handling sexuality is a forceful task behaviour confronting them (Ogharaerumi 2008). They communicate by talking about sex, engaging in sexual roles and slang's and reading variety of literatures (magazines , novels , pamphlets) on sexual issues. Oladimeji (1999) asserted that sexual activity among unmarried adolescents in Nigeria is high and rising. If this early-unprotected sexual intercourse is not checked, it could lead to many unintended pregnancies, unsafe abortion and abortion related complications. Adolescence sexuality in a nutshell is one of the major challenges confronting adolescent globally. Ponton and Justice (2004) stated that adolescent sexuality development is complex and dynamic, as children get older, they gain a greater sense of their sexual self enhanced by inter play of biological and social changes as the individual matures through childhood into adolescence. They further stated that sexual interest increases with age and biological changes, but in our contemporary Nigeria society, the environment of the adolescent affects his / her sexual orientation and education.

Adolescents Sexual Behaviour

WHO Resource Guide (1999) stated that "Sexual and reproductive behaviours during adolescence and young adulthood, whether within or outside marriage have immediate and long term consequences, many of which can be emotionally or physically harmful" as well as socially and spiritually. Klindera (1996) opined that arousal of sexual feelings and desire is a common phenomenon in the daily life of adolescent particularly after the pubertal stage. This process is brought about by the expansion of the blood vessels to the genital organ and the attendant increase in blood pressure. Mel (2008) opined that adolescence are advised to abstain from premarital sex and simultaneously they are encouraged to play safe or keep to one sexual partner and almost every programme and advertisement on the media employs provocative sexual imagery to draw patronage to commercial products and services, consequent upon these pressures; many have sunk in the mud. Adams and Berzonsky (2003) asserted that adolescent sexual challenges is accentuated by the unfamiliar excitement of sexual arousal, the attention connected to being sexually attractive, and

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the new level of physical intimacy and psychological vulnerability created by sexual encounters which are profoundly influenced by the social and cultural context they live. Ogwu (2006) opined that high-risk sexual behaviour and HIV/AIDS prevalence has been well documented in school setting.

Despite the concerns of society and parents, children do engage in sexual acts alone as well as with others. Some adults think that positive discussion about sex will lead to inappropriate and premature experimentation of sex on the part of their adolescents. Some school of thought suggested that lack of honest and clear information leads to an increase in both unusual and unsafe sexual practices of adolescents (Herbert, 2006). However, there are little data or information in regards to these claims, it is important to give positive messages to children especially adolescents and to avoid associating sexuality with shame. In Nigeria, there are over 24 million adolescents aged 10-19, in spite of several challenges that come with surviving in today's fast changing world. The traditional norms and behavioural controls that once guided adolescents' sexual behaviour are declining due to several factors which include poverty, rural urban migration, and the influence of the world media, cyber collaboration, discussion forum and chat room system of cyber café, exhibiting nudity, public expression of sex as a sign of love and civilization, decadence in moral value and other unwholesome practices which encourage social vices in the society.

Forsberg (2005) opined that "the survey that have so far been devoted to the internet make clear reference to both the opportunities and the risks involved. She stated further that the opportunities include the ease with which one can search for new (positive) contacts, test and investigate one's own sexual identity and try out new (virtual) sexual activities on line. The risks include the danger of young people being tricked into meeting people off-line who turn out to be different to how they presented themselves on –line, which may expose them to unsolicited pornography and sexual contact. The rapid growth of technological development of Internet and cable television has led to various changes as regards pornography, homosexuality; lesbianism etc. the negligence of not including same-sex sexuality into adolescent sexuality research until the 1990s reflected people's belief and attitudes in accepting "homosexuality is nothing abnormal" (Herlitz, 2004).

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Group sex is a mere recent discovery in adolescent sexuality. Forsberg (2005) "revealed that there is a marked discrepancy between the sex with men (15%) than twice as many boys and young men as girls/young women saying they could imagine trying group sex or trying it again. Adolescent is the time when an individual is overwhelmed by a number of simultaneous developments. It is a period when an individual has energies and many opportunities are presented with vital decisions which affect his/her future personality. Adolescents' behaviour usually varies according to cultural, environmental and socio-economic status; therefore their sexual health needs may vary considerably across the world (Odelota, 2004). It follows then that any health programme must be designed to take into consideration these factors.

Human sexual behaviours, like many other kinds of activities engaged in by human beings, is generally govern by social rules that are culturally specified and vary widely. These social rules are referred to as "sexual morality"- what can and cannot be done by society's rules and 'sexual norms'- what is and is not expected. Sexual ethnics, morals and norms relate to issues including deception/honesty, legality, fidelity and consent. Some activities, known as sex crimes, are illegal in some jurisdictions', including those conducted between (or among) consenting and competent adults (examples of adult-adult incest). Scientific studies suggest sexual fantasy, even of unusual interests, is usually a healthy activity. Some people engage in various sexual activities as a business transaction. When this involves having sex with or performing certain actual sexual acts for another person, it is called prostitution. Other aspect of the adult sexual behaviour includes telephone sex, strip clubs, pornography and the likes.

It is a well known fact that nearly all societies consider it a serious crime to force someone to engage in sexual behaviour with someone who does not consent or agree. This is called sexual assault and if sexual penetration occurs, it is called rape, the most serious kind of sexual assault. The details of these desalinations may vary among different legal jurisdiction. Also, precisely, what constitutes effective consent to have sex varies from culture to culture and is frequently debated. Laws regulating the minimum age at which a person can consent to have sex (age of consent) are frequently the subject of political and moral debate, as is adolescent sexual behaviour in general. And it is possible to engage in sexual activity especially by adolescents without a partner, primarily through masturbation and or sexual fantasy.

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Sex hormones which presents itself during adolescence, promotes such effects as protein synthesis, muscle development, bone growth and development of secondary sexual characteristics. In male, this involves rapid increase in height; shoulder becomes deeper, growth of hair at the armpit and at the abdomen around the external reproduction organs. Specifically, the effects of male hormone (testosterone) are production of reproductive cells called spermatozoa in the testes. The female sex hormones are estrogens and progesterone. The effect of estrogens includes enlargement of the breasts, enlargement of the pelvis, rapid increase in height and appearance of hair in pubic regions. The first menarche occurs and subsequently regular monthly menstruation (Odelola, 2004).

Diepold and Young (1999) enumerated sexual behaviour associated with adolescent as follows: dating; petting; masturbation and homosexual contact, Alzae (1978) and Soyinka (2000) discovered oral genital contact as a sexual behaviour among adolescence. Owuamanan (1982) however listed five types of sexual behaviours found among adolescents as in kissing, breast/genital fondling, embracing; holding hands and sexual intercourse. An adult's focus on a particular behaviour of an adolescent may have undesirable effects; prohibitions may actually focus interest on the forbidden. Thus, adult admonition may play a pivotal role in determining whether sexual experiment remains exactly that or becomes more entrenched developmentally (Larsson, 2002). Negative Sexual behaviours' are illegal, non consensual, dangerous and needs to be discouraged among adolescents. This may be best accomplished by giving the child or adolescent more options.

Online Journal of Human Sexual Behaviour (2003) stated that there are many variations of sexual activities and often multiple names for any given Sex acts and practices. The general names include:

- Bare backing: Lying on the back barely
- Erotic messages
- Group sex
- Sexual Fantasy
- Masturbation
- Oral sex
- Oral stimulation of nipples
- Sexual intercourse

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- Foreplay sexual activity, such as touching the sexual organs and kissing, which take place before people have sex.
- Anal intercourse and
- Pornography.

Types of Sexual Behaviour:

There are different types of sexual behaviours: defining "normal" sexual behaviour can be very difficult and will often reflect an individual's own sexuality and prejudices. In general, normal sexual behaviour is not associated with undesirable sequel either to the individual or to society. Sexual risks are sexual behaviours that put an individual at risk for:

- Unplanned pregnancy.
- STIs.
- HIV infection.
- Still birth.
- Early initiation of sexual activity.
- Sexual intercourse without the use of condom.
- Multiple sexual partners.
- Sexual intercourse with a partner infected with a STIs or HIV/AIDs.

WHO (1995) defines Sexual health as the integration of the physical, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that it enhances personality, communication and love. Sexual activity can be defined as genital contact. It may be viewed also as the viewing of pornography or verbal propositioning of sexual feelings (West, 1998). Normal sexual behaviour generally has three purposes. For reproduction, for pleasure; to promote and strengthen interpersonal relationship and psychological intimacy. Online Journal of Human Sexual Behaviour (2003) listed the following types of sexual behaviours:

1. Abstinence: Sexual abstinence means refraining from any sexual stimulation. (Technically this includes refraining from masturbation as well as sexual involvement with another partner). Abstinence protects individuals from acquisition of STIs, but general abstinence is usually advocated for moralistic reasons rather than health reasons.

2. Masturbation: Masturbation refers to self-stimulation or manipulation of one's own genitals for sexual pleasure. Mutual masturbation is where two people will

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manipulate each other's genitals for sexual gratification. Mutual masturbation is a common homosexual behaviour and is now promoted widely as safe sex behaviour. There is many masturbation techniques. They may involve stimulation of the genitals, stimulation of extra-genital sites, the use of various parts of the body to provide the stimulus and an assortment of inanimate objects or "toys" which may increase sexual pleasure. However, most masturbatory behaviour involves manual stimulation of the genitals or adjacent areas, with or without associated fantasy. Almost all men and women masturbate at some time in their lives; strong taboos make open discussion and data collection difficult on Masturbation. In general the practice is most common in young males, however, masturbation has greater acceptance amongst those with higher (tertiary) education than those who left school at an early age.

3. Coitus: general vaginal intercourse is firmly established as the most desirable or usual sexual behaviour. Extra-vaginal coitus is considered unhealthy, abnormal or perverse by some sections of society. It should be clearly recognized that extra-vaginal intercourse (e.g. anal intercourse) is a common sexual behaviour and is not limited to homosexual men.

4. Anal Intercourse: anal intercourse is a common component of homosexual behaviour but as already mentioned, is also a significant heterosexual behaviour. The anus is an erotically sensitive area closely related to the genitalia in both innervations and muscular response. However, fecal soiling to some degree is often a problem and contributes to the higher incidence of STDs with this practice. Anal intercourse without a condom is considered totally unsafe in the current climate of concern about HIV infection.

5. Oro-genital Acts: means physical touching for pleasure with mouth contact

-Fellatio refers to mouth contact with the penis.

-Cunnilingus refers to mouth contact with the female genitalia.

Dangerous sexual behaviours and sexual experience among the Adolescents

Sexual experience in adolescents has its roles in their biological development. The arousal of sexual feeling is a common phenomenon in the daily life of the adolescents particularly after the pubertal stage (Klindera, 1996). This process is brought about by the expansion of the blood vessel to the genital organs and the attendant increase in the blood pressure. Consequently the genital organs in boys are erected and seductive behaviours in girls are produced. Sexual behaviours depend

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largely on societal constrictions and the level of cultural permissiveness which dictate the modes of sexual practices (Crystal, 1990). While the biological determinants may have strong influence on individual's sexual behaviour, the agents of socialization such as the family, peers, religious institutions and mass media have powerful repressive effects on it (Anikweze, 1998). Moreover, the development of heterosexual relationships is a significant milestone in the emotional life of the adolescents.

In the less sophisticated African society boys and girls play love by engaging in many culturally acceptable methods without necessarily involving in sexual intercourse. The methods they adopt include boys bullying the girls, twisting their arms, snatching their scarf's while the girls delight in screaming, pretentious cursing, beating the boys on the back and attempting to run away (Charles, 1998). Contrary to these culturally acceptable sexual behaviours, the contemporary youths and adolescents do sometimes involve themselves in ill sorts of sexual misbehaviors' which take the forms of masturbation, homosexuality and promiscuity (Alli, 1993). Masturbation is being considered by Ryerson (1994) as the process of genital stimulation and sexual gratification of one self. It is quite common among most adolescent's boys and girls. It occurs when these young adults are pressed by sexual desires most especially when they do not have access to the opposite sex or when they are scared by the possible consequences of such premarital sexual intercourse.

A homosexual is a person who seeks for sexual gratification from a partner of the same sex (Ajala, 1987). The society views many form of homosexual behaviours as abhorrent and it attracts social stigma in the community. Promiscuity in adolescence is a sexual perversion or reckless sexual activities with the opposite sex, a behaviour that characterized the pubertal stage. This phenomena (promiscuity) according to Piot (2001), predisposes the adolescents to infection of venereal diseases. Generally sexual activity among unmarried adolescents in Nigeria is growing and rising unabated. According to Nigeria Demographic and Health Survey (2002) the median age at first intercourse for girls is just 16 years (three - quarters of the year earlier than median age at marriage). By the ages of 18 and 20 respectively, 63 to 80 percent of female adolescents have experienced intercourse. Furthermore, in the same survey of more than 5500 urban youths aged 12 to 24; 81 percent (44 percent of females and 37 percent of males) had experienced' sexual intercourse. Similarly, findings were reported in another study of fertility trends and determinants in African countries, of these, 83% of female and 72% of males had intercourse by age 19

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(Makinwa and Feyisetan, 1994). However, about 60% of them did not know pregnancy was possible at first intercourse.

In another study of secondary male students, lle -Ife, 80% was found to be sexually active in the past year with- more than half reporting sex with multiple partners. (Jinadu and Odesanmi,[1993). This trend in adolescents sexual behaviours is said to be the result of earlier menarche, social change and modernization, which had lengthened the socially defined period of adolescence, increased 'educationa1 opportunities and at the same time have weakened traditional family - centered constraints on sexual behaviour, especially in urban areas (Oladimeji, 1999). A serious and growing' problem associated with teenage sexual activity' is the spread of sexually transmitted infection (STIs). According to Center for International Research, U.S. Burean of the Census (1993) the results of a study of HIV prevalence in patients attending clinics showed a range of infection from zero percent in Edo and Osun to 12.7 percent in Kano and 22.4 percent in Jigawa. This is an indication that majority of sexual active adolescents are engaging in unprotected and unhealthy sexual behaviours. Nationwide, 5.9 percent of 15 to 19 years old females currently use contraceptives with two-third reported to be using condoms, foaming tablets or IUDS (Goddard, 1995). It is also evident that sexuality education intervention programmes` will go a long way in creating awareness for the youths, on the consequences of their sexual decisions and it will also help them make wise and informed decisions as regarding sexual matters.

The International Conference on Population and Development of 1994 in Cairo and the Fourth World Women's Conference of 1995 in Beijing agreed that more attention should be given to the reproductive and sexual health problems of the adolescents. More importantly, it was the consensus of opinions among the participants at the two conferences that sexuality education for teenagers and adolescents should highlight the following problems; unwanted pregnancies, pregnancy related complications, unsafe abortions, high rate of maternal death and sexually transmitted diseases or infections. Sex related concepts and issues only appear scantly in the syllabuses of biology and its related subjects, such as health science, home economics and integrated science in secondary schools.

Findings from studies including those of Okonta (2007) and Freedom (2000) have shown a high level of sexual activities among Nigerians adolescents. It is also the consensus of these studies that most teenagers and adolescents have more than one

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opposite sexual partners and that most adolescent boys do patronize prostitutes. When pre-marital pregnancies occur, Ladan (1997) confirmed that most girls, who reported abortion, mentioned their sexual partners as the principal source of advice in reaching the decision to terminate the pregnancy. With respect to how and where the abortion should be carried out, most teenage girls usually take to self-medication while only a few visit private clinics as a means of inducing abortion.

Intercourse is occurring at an earlier age than ten years and in greater numbers. The mean age of first intercourse is about 16 years, and by the age of 18, nearly 60% of adolescents report that they are sexually active. There is also a reported increase in the number of sexual partners at a given age. Casual sex is still an important part of adolescent sexual activity, although most sexual experience in adolescents probably occurs in the context of a steady relationship. Explanations for the initiation of sexual intercourse include curiosity, peer pressure and the need to be loved. The rates of sexual experience are greater in males than in female (Odibo, 2005). Some adolescents do not believe that an act of sexual intercourse at first attempt can result to pregnancy. There are some who believes that pregnancy will not happen because two guy's sperm cancel each other out and if one have sexual intercourse often but not every day. Some adolescents have experienced sexual intercourse as early as 14 years Anikweze (2005). Nzokia (2001) reported that in Kenya and even in Nigeria, boys perceived sexual activity as part of their initiation into manhood, viewing fathers' as a sign of masculinity. Failure to have sexual intercourse was seen as carrying the risk of losing status among their peers. According to Nzokia's report boys believed that when you impregnate a girl, everybody gets to know you are a real man. Even girls start respecting you because they know that you are tough. Contracting STIs seemed acceptable as part of the process of gaining experience and thus keeping with the dominant view of masculinity.

This type of erroneous belief and perception of sexual activity encourages adolescents to indulge in risky sexual behaviours, thinking that it is normal. Some youth's belief that urination after sexual intercourse, will get rid of any infection, that might have been transmitted (Araoye, 1996). Gender power imbalances, lack of assertive communication and negotiation skills, limited parental and family support for chastity hinder adolescents to engage in safe sexual relations. Assertiveness helps one to say "no" to unpleasant demand or suggestion from peer or "sugar" daddies/mummies" who entice adolescents with money in order to involve them in

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sexual intercourse. They capitalize on the poor economic situation, promising them to pay their school fees or buy beautiful dresses for them (Araoye, 1996). Assertive behaviour makes one feel better about oneself, confident in control and one is respected by others. It helps to prevent sexual exploitation and to resist peer pressure. It helps to prevent coercion. Coercion behaviours include forced sexual intercourse, such as rape, unwanted touching, incest, assault, threats, seduction and even forced abortion. Many parents find it difficult to communicate effectively with their adolescents about sexual health issues.

Recent research by Moore (2005) indicates that adolescents continue to resist the use of condoms even in the context of safer sex practices and STIs. Males are more likely to place the responsibility on their partners and females express distaste for condoms. It has been suggested that heterosexuals do not believe that they are at risk, that STIs like AIDS has been seen as a disease of the sexually deviant or other stigmatized groups (e.g. drug users) and that HIV transmission has been identified with groups, not sexual practices (Kippax, 2006).

Socio-Cultural Context and Sexual Behaviour of Adolescents

United Nation Educational, Scientific and Cultural Organization (UNESCO) (2002) described culture as what should be regarded as the set of distinctive, spiritual, material, intellectual and emotional features of society or social group, and it encompasses, in addition to arts and literatures, lifestyles, ways of living together, value systems, traditions and beliefs etc.Culture can also be defined as all the behaviours, ways of life, arts, beliefs and institution of the population that are pressed down from generation to generation (Edward, 1971). It has been called “the way of life for an entire society”. As such, it includes codes of manners, dress, language, religion, rituals, norms of behaviours such as law and morality and system of belief etc.

From the foregoing, culture links closely with social cultivation. It is the progressive refinement of human behaviour. It follows that, the behaviours being displayed by adults in a particular society and the characters found in it will help young ones to grow in the ways of that society (culture). Many at times, the character a person becomes and the behaviours he or she displays is gotten from his environment and people living in it (White, 1999). This is because young ones easily cultivates what they see their elders display in their immediate environment in terms

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of behaviours. When a child lives in an environment where the people around smokes a lot, the tendency that the child will later become a smoker in life is very high. Likewise, where adults displays some sexual behaviours in presence of the adolescent or where adolescents can easily take a good look at them, will instill in that person (adolescent) a desire to practice such behaviours since they find pleasure in it (White, 1949). Generally, parent monitoring and parent child education or other psycho educational techniques are useful (Gagmon, 2003).

Risky sexual behaviours among adolescents makes them to be vulnerable to sexually transmitted diseases including HIV/AIDS, unwanted pregnancies among the adolescent girls, young fatherhood among the adolescent boys and more. (The adolescents then will continue to engage in early sexual debut, unsafe sexual activity, multiple and casual sexual partners (Odelola, 2004). Culturally, adolescents have acceptable sexual behaviours that involve body contact (kissing, necking, romance) and exchange of materials without necessarily engaging in sexual intercourse. However, these trends have changed in the contemporary society, and these implicate the adolescents through different sexual misconducts contrary to the culturally accepted norm.

In the less sophisticated African society, boys and girls play love by engaging in many culturally acceptable methods without necessarily involving in sexual intercourse by boys bullying the girls, twisting their arms, and snatching their scarfs while girls delight in screaming, pretentious cursing, beating the boys on the back and attempting to run away. Contrary to these, the contemporary youths have implicated themselves in all sorts of sexual misbehaviours', which take the form of masturbation, homosexuality and promiscuity (Oladoye 2004). Homosexuality and promiscuity predispose the adolescents to infections of venereal diseases including HIV / AIDS and quite often unwanted pregnancies, abortion, stillbirth, and even death.

Some cultures and individuals believe that abstinence can in fact be harmful, due to the accumulation of sexual fluids. When counselling clients with STDs and advising abstinence (e.g. until test of cure has been done) it is worthwhile getting some idea about the client's attitude towards abstinence. Premarital sex is not the best for any girl. A night with a boy friend could produce a lifetime of regret. However, Sokoya (2000) in Santock and Yussen (1992), observed the following as the reasons why many girls engaged in heterosexual relationships: (i) intense pressure from a boy

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friend; (ii) to satisfy sexual drives; (iii) to satisfy curiosity; (iv) to express some degree of affection to a boyfriend; (v) for financial gain; and (vi) for sexual desires unrelated to loving and caring. A decent (groomed) girl child will save herself from the embarrassments of unintended pregnancies by preventing herself from falling in love indiscriminately or get into "courtship wrongly".

Mann (2004) highlighted that these sexual behavioural factors are difficult to be prevented among youths because of (i) lower average age (age 9-12) at first intercourse; (ii) high acquisition rate of new partners than other age groups; (iii) increased likelihood of being involved in two or more sexual relationships simultaneously; (iv) higher rate of acquiring new sexual partners and inconsistent condom use. Other factors Mann (2004) stated include a higher proportion of all sexually transmitted infections, which may go unnoticed. For example, Chlamydia and pelvic inflammatory diseases such as lower abdominal pain, tenderness in abdomen, and profuse offensive vaginal discharge.

She stressed further that the pelvic inflammatory diseases had become so rampant in Nigeria contemporarily due to the rapidity at which the female child grows. Most girls attain sexual maturity too early (ages 8, 9, 10); and their sexual processes are exhibited too early, thus their sexual involvement, sexual abuse, teenage pregnancy, induced abortion, rape, and girl swoop. Further still, increased risks of re-infection are probably due to poor hygiene, poor toileting and poor partners' notification, and difficulty in accessing sexual health services. Sokoya (2000) citing McQueen (1999) noted that pelvic inflammatory diseases ravaging Nigerian society are predicated on abnormal sexual behaviour. This coitus behviour is found to be against the norms and standards of the society and also against the normal and natural process. Labelle (2007) opined that sexual content is regularly marketed to younger children, pre-teenagers and teenagers which affects adolescent's sexual activities and beliefs about sex. He stated further that television movies and music are not the only medium that influence the adolescents, the Internet too provides teenagers with seemingly unlimited access to information on sex and pornographic shows; as well as a steady supply of people willing to talk about sex with them (adolescents) online .

Culturally, teenagers' believed that sexual behaviour is normal. Most teenage girls believe that sex equals the expression of love, whereas, some of them are just flirting. However, teenage boys do not see sex as ultimate expression of commitment; but a casual activity, due to what they see on television. These in turn trivialize the

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importance of sexual responsibility to lack of frequent portrayals of sexual risks on television. As Sokoya (2000) and Onawola (2004) posited, the range of teenage sexual behaviour is based on misconceptions and erroneous beliefs and perceptions of sexual activities that include:

(l) all teenagers are having sex; (2) Sex denotes adulthood; (3) Older teenagers (adolescents 17 – 19) who are not having sex are sick. Okanlawon (2004) revealed that firstly, adolescent boys believe that impregnating a girl make everybody to know a boy is a real man and make girls to start respecting him. Secondly, that contracting STIs seems to be acceptable as part of the process of gaining experiences and thus keeping with the dominant view of masculinity. Thirdly, boys believe that when they get burnt' {contract STIs}, is a sign of initiation into manhood. Okanlawon (2004) advised that adequate teenagers' knowledge on the facts about human reproduction, contraception, and sexually transmitted diseases (STDs) is necessary for the adolescents. From the foregoing, researches revealed that about half of the over 60million people who have been infected with HIV/AIDS in the past 20 years are between the ages of l5years and 24years. School health education programme present information about the risk of sexually transmitted diseases, pregnancy risks, and contraception, but has little or no effect on whether or not teenagers initiate sex or use contraception.

Labelle (2007) contended that young people freedom to know that teenagers who are sexually active and do not consistently use contraceptives will usually become pregnant and have to face potential life-altering decisions about resolving their pregnancy through abortion, or early teenage parenthood. Commitment and values differs so widely in society, that schools cannot be very thorough or consistent in the treatment of moral issues. Parents are supposed to know some important information about adolescent behaviours, such as: the younger the age of a child at first intercourse, the more likely the experience will be more coercive; and that forced sexual intercourse is related to long-lasting negative effects like abandonment of sex totally even when at marriageable age, lack of care and love.

Okanlawon (2004) suggested that the involvement in children's life and transmission of religious and values to children's life by parents and other adults at school, church and community will bring greatest success in preventing risky, immoral, and unhealthy behaviour. This is because teenagers will be able to differentiate between devotion and infatuations and help them to make the distinction

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in their own hearts. Nonetheless parents will have to be models too when it comes to transmission of sexual knowledge. Sex when started at the right time with the right guidance could bring about enjoyment, pleasure and special understanding of its consequences, thereby resulting in caution (Moronkola 2000, Adio-Moses 2004).

Wallis (1995) confirmed that every sexually active teenager contracts an STD each year; and that the most prevalent includes gonorrhea, syphilis, candidacies, herpes and HIV/AIDS. Female adolescent are more susceptible to STIs, probably because of their biological make up or because they have less protective antibodies or because of their narrow and less mature cervix compared to the older women. Adolescent sexuality and its consequences have been a concern of numerous societies across many generations and for good reasons. Teenage pregnancy, teenage childbearing and acquisition of sexually transmitted diseases (STDs) bring unique set of cost not only to the adolescents involved but also to the larger society. Despite all these, it could result to sadness, pain, unwanted pregnancy, confusion, and lack of caution and infection of STDs. UNESCO (2009) identified unwanted, miss-term, or unintended pregnancy has a major part of numerous social, economic, emotional, and cultural aspects of modern life of adolescents. Pregnancy, for a young adolescent with a bright academic and career future ahead is definitely a hindrance, many young women find it difficult to go through the experience that unwanted pregnancy initiated. Adio-Moses (2000) stated that the stress of revealing teenage pregnancy to parents could be nerve-racking, saddening and never easy.

Navigation (2007) reaffirmed that pregnancy in adolescent brings various sorts of emotional problems. Some want their babies, to love but may not be aware of the special cares involved. Some feel guilty and anxious, which bring depression to the extent of needing psychiatrist's help. Their babies may also be underweight due to poor eating, smoking, drinking, and less likely to seek prenatal care (Moronkola, Odu and Nwajei, 1999). Population Reference Bureau (2000) and Adio-Moses (2004) reported that up to one third of adolescent women in some communities in their childbearing ages are infertile with 80% of the infertility being attributed to STIs. Ogharaerumi (2005) highlighted social economic and health consequences of unwanted pregnancies as follows: high incidence of school dropouts especially among the girls, poverty because of little or no means of catering for herself, her pregnancy and the baby, psychological disturbance of feeling of guilt and shame, neglect relatives, increased rate of child abandonment (baby dumping), which is one of the

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consequences that attracts public health concern, induced illegal abortions, and complications of unsafe abortion, high rate of maternal and infant mortality due to haemorrhage, infection, pregnancy induced hypertension, increased rate of cases of vesico vagina fistulae (VVF) and recto vagina fistulae (RVF), early marriage and childbearing can limit educational opportunity and expose youths to dangerous health risks.

In the view of the above, Ariba (2000), Ishola, Adeneji and Adedokun (2001) and Odelola (2004) opined that the major health problems faced by pregnant adolescents in Nigeria are those of high rate of maternal mortality and reproductive tract infection. Adolescent is a period of increased risk taking and typically their sexuality is viewed as inappropriate and troublesome rather than as normal and healthy. Moore and Rosenthal (1993) stated that despite recognition of the subjective aspects of adolescent's sexuality; it fails to address the intra-psychic and interpersonal processes that influence whether intercourse occurs and whether protection is used. Focusing and understanding these subjective dimensions is the key to developing an evaluation of effective interventions programmes and services to prevent and reduce risky sexual behaviour among adolescents in Nigeria.

Moreover, the need for programmes that can provide accurate information, education, ensure access to services and develop life skills about trends overtime in adolescents sexual behaviour is crucial for promoting adolescence sexual health. Sexual health is the ability to enjoy and express one's sexuality free from the risks of sexually transmitted infections, unwanted pregnancy, coercion, violence and discrimination. Research is also necessary to establish the baseline data on knowledge; attitudes, belief, and practices of adolescents sexual behaviour for developing the strategies whose impact over a period of time could be evaluated (ASRHP, 2003).

Despite the caution being placed on programs, movies etc, adolescents easily obtain these materials and view them when they want. It is not uncommon to find ex-rated movies in the collections of an adolescent. After watching all these stuffs, they tend to display sexual behaviours that put them at health risk (Cladwell, 1999). Moreover, many young people especially adolescents in Warri South West are unaware of what constitutes risky sexual behaviours. Even if they appreciate the risk of STD, many adolescents believe that they are invulnerable themselves. Even when

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they know the risk, most adolescents ignore it. Young women may engage intentionally in risky sexual behaviours in cultures when marriage is highly valued and a woman's status depends on finding a husband and having children.

Some parents on their part unknowingly perpetuates adolescents improper sexual behaviour due to the fact that they over express their sexual desire for each other (Jackson, 1990). In a family setting where both parents kiss, embrace indiscriminately, pronounce romantic words, loose guard to dress improperly, even watch romantic movies in the presence of their adolescent children and even their friends, has the potential to make these children want to try all that and which they usually do unusually. Sexual behaviour like any other social behaviour is always in a context. It is the interface between structural characteristics of the preventing socio-cultural situation and the psychological state of the individual. In the adolescent years, the informal context of home environment provides a framework (whether smoothening or constraining) which structures behaviours, perhaps in different ways found in formal context of school and influence of groups and associations in wider environments. (Online journal of human sexual behaviours, 2003)

As with other behaviours, human intelligence and complex societies have produced among the most complicated sexual behaviours of any Mammal. Most people experiment with a range of sexual activities during their life time though they tend to engage in only a few of these regularly. Most people especially adolescents enjoy some sexual activities. However, most societies have defined some sexual activities as inappropriate (wrong person, wrong activity, wrong place, wrong time etc.) Some people enjoy many different sexual activities, while the other avoid sexual activities altogether for religious or other reasons. Historically, some societies and religions have viewed sex as appropriate only within marriage.

Common Harmful Traditional Practices- includes:

- Female Genital Cutting (FGC)
- Forced early marriage
- Puberty initiation rites
- Labour and delivery practices e.g. *gishiri cuts*
- Male child preference and discrimination against the girl child

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Factors Influencing and implications of Adolescents Risky Sexual Behaviours

According to Okanlawon (2002), adolescent's risky sexual behaviours are associated with various factors such as:

(i) Non-perception or risk in their sexual behaviour.

(ii) Lack of information on reproductive and sexual health issues.

(iii) Failure of parents/families to provide adequate information and support of chastity.

(iv) Lack of assertive communication, negotiation and refusal skills.

(v) Gender power imbalances

(vi) Poverty

Sexual risks are sexual behaviours that put an individual at risk for unplanned pregnancy, STIs, HIV infection and other health problems related to pregnancy and childbearing, sexual risks includes:-

- early initiation to Sexual activity
- Sexual intercourse without the use of contraceptives
- Sexual intercourse without the use of condom
- Sexual intercourse with more than of one partner and
- Sexual intercourse with a partner infected with a STIs or HIV.

Factors Contributing to the Rapid Increase in Sexually Transmitted infections/Diseases among adolescents

There are many negative implications associated with adolescent's dangerous sexual behaviours. The implications according to (Okonta, 2007) include:

(i) High rate of STIs.

(ii) Early sexual activities lead to early child bearing and early marriage.

(iii) Child birth at an early age could be detrimental to adolescent's health due to nutrition needs of both mother and fetus.

(iv) Early marriage contributes to overpopulations. Overpopulation is associated with low life expectancy, higher mortality rate and more diseases and illness conditions.

(v) Adolescent girls who get pregnant early are at great risk of obstructed labour which can lead to the death of both the mother and the baby.

(vi) Vesico-Vagina Fistula (VVF) is common among adolescent mothers due to obstructed labour.

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(vii) Maternal death is three times higher for teenage mothers than for women in 20-29 age groups.

(viii) Females aged 10-14 years are five times more likely to die during pregnancy and child birth than female aged 20-24 years.

(ix) Children born to adolescent mother face higher risks of illness and death than those born to mothers aged 20-29 years.

The term sexually transmitted disease (STDs) is used to describe a group of infectious diseases in which the main mode of spread (transmission) is by sexual activity or contact. Sexually transmitted diseases are also known as venereal diseases. Sexually transmitted diseases are infectious diseases that are in most cases transmitted through contact with an infected person. Sexual intercourse can be pleasurable and satisfying but it can also be dangerous to one's health. God ordained sexual intercourse for pleasure, companionship and multiplication. This may be genital to genital, mouth to genital or vice versa, or genital to anus. STDs can be transmitted by sexual intercourse which is a big public health problem. Throughout the world, cases of sexually transmitted diseases have been steadily increasing each year for the past 20 years. In some countries, like Britain and Nigeria; the main reason for this is the sexual freedom that exists today, especially in Western countries. Many young men and women have sexual relations with several different partners before they marry, married people often have extra-marital affairs, and many homosexual men have large numbers of sexual contacts. Where these relationships are brief, numerous or casual, there is a real possibility that those involved may contact a sexually transmitted diseases.

According to Anon (2002) a person' chances of acquiring and developing sexually transmitted infections/ diseases are:

i. The greater the number of sexual partners the greater the chance of infection.
ii. The manner of selection of sexual partners. Persons selecting mates indiscriminately run greater risk of getting infected,
iii. The frequency of intercourse - as the number of intercourse increases so does the chance of one's exposure to infection if one of the partners is infected for example street girls and prostitutes,
iv. specific sexual practices such as anal intercourse is associated with a high risk of HIV infection, the virus that causes AIDS,
v. The timing of sexual intercourse can affect the likelihood of infections

especially during the menstruation, the HIV infected blood can easily be transmitted from the woman to a man.

Some of these are due to biological, Psychological, socio-cultural and demographic factors (Hogan, 2000).

i. the introduction of birth control pills and new contraceptive methods have removed the fear of pregnancy,

ii. prostitution is on the increase,

iii. advancement of urbanization and industrialization, greater mobility and inter-country travel have contributed to the spread of sexually transmitted diseases to areas where they did not exist before,

iv. There is frequent premarital and extra-marital intercourse which permit promiscuity and multiple sexual contacts.

v. The young people of this present generation are maturing earlier and many are sexually active hence the risk of infection.

vi. some bacteria are becoming resistant to anti-biotic therapy,

Social stigma attached to sexually transmitted diseases does not help the matter because infected victims are ridiculed thereby discouraging infected people to seek for treatment. Lack of knowledge to recognize symptoms and obtain early treatment is also an important factor.

Factors Influencing Sexual Activity among Young People Include:

- Earlier onset of sexual maturation and the accompanying natural increase in body secretions (sex hormones) which stimulate sexual urges in adolescent boys and girls.
- Pressure by the peer group and adults on young people to engage in sexual relations.
- Increasing socio-economic problems which result in pressures of young people to exchange sex for money.
- Glamorization of sex in the mass media without equally highlighting the associated risks.
- Permissive attitude of society towards premarital sexual relations for boys as part of their predatory sexual socialization.
- Culture which places higher value on child-bearing as a greater achievement for girls.

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- Parents who give out their daughters in marriage at an early age for economic gains or under the guise of protecting her from herself or temptation from others.
- Delayed marriage for reasons of increasing focus on educational/career pursuits. While marriage is being delayed the other factors listed above combine together to influence sexual activity among young people (Focus for young adult, 2000)

Why Young People are At Risk of STDs/HIV/AIDS?

- Most young people know very little about STDs/HIV/AIDS, even when they are sexually active.
- Many young people engage in sexual relationships with more than one partner.
- Even when sexually active young people know about STDs/HIV/AIDS most of them don't protect themselves from being infected
- Even when infected, many young people are often reluctant to seek treatment for STDs
- Some young people especially females, exchange sex for money for varying socio-economic reasons.
- Many young people are coerced into exploitative sexual relationships which they have little control over in their homes, school or work places (Moronkola, 2008 and Okonta, 2007).

Health Consequences of contracting STIs/HIV/AIDS

STDs can lead to serious health problems if they are not treated early and properly. These health complications include:

- Chronic lower abdominal pain
- Menstrual problems
- Problems with passing urine
- Infertility
- Ectopic pregnancy
- Death

Causes of Adolescents Early Sexual Involvement

Sexual activity is a natural act whose natural consequence is the creation of new humans. Adolescent as stated earlier are sexually active group of persons beyond what older people and religious leaders think they are (Moronkola, 2003). This is due

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to the sexual drive, peer pressure, perverse social environment, and poor reproductive health knowledge. The followings can be stated as factors leading to early sexual involvement among adolescents:

1. **Peer pressure** – Adolescents spent more time with their friends. They relate in crowd through their clique. One of the characteristics of adolescent relationship among their peer groups according to Oniyama (2004) is the formation of clique and cloud. Adolescents participate in crowd activities like watching football match, attending social gathering etc. Through peer groups, adolescent learn about social norms and values, dressing habit, body movement , style of talking and language use etc. All these peer group activites especially those that involve sex / sexual activities tends to push the adolescent towards early sexual experimentation (Oniyama, 2004). In a Kaiser family foundation study of United States teenagers, 29% of teens reported being pressurized to have sex, 33% of sexually active teen reported being in a relationship where they feel things were moving too fast sexually and 24% had done something sexual they didn't really want to do due to peer pressure. Several polls according to the study indicated peer pressure as a factor in encouraging both girls and boys to have sex.

2. **Sexual Drive** - At puberty, the adolescent does experience the pouring out of sex hormones into their blood streams being the natural biological way of motivating them to develop maturation of the sex organs, function and capabilities of reproduction, the attendant outcome is that the adolescent then experience increased sex urges and the drive of the urges leads most of the uncontrollable adolescent to pre- marital early sexual interactions and experimentation (Ikekhu & Oniyama 2006). Ikekhua and Oniyama (2006) further illustrated that when in these early urges for sex, relation so early in life, as it happens in several instance lead unwary adolescent into early marriage from which most of them are often not prepared for leading to new trends and waves of experience of challenges, frustration and crises.

3. **Perverse Social Environment**: Man by nature is a biological being and social animal. However, the quality of our social environment tends to expose the adolescents to sexual involvement. Our hedonistic culture constantly bombards us with erotic images and promotes the messages that an active sex life is essential to health, sanity and happiness. Sexual pleasure has become one of the false gods

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worshipped by modern society, alongside the pursuit of wealth, power and status (Oletu, 2007). People discuss sexual issue freely in the society in the presence of the young adolescents these days. These consequently corrupt the adolescents mind and always want to experiment by all means possible.

4. **Loose parental control**: - Many parents these days often find themselves busy with one economic activity or the other. Most parents don't have time to check, educate and guide their children's action. Ogharaerumi (2008) and Unruh (1994) stated that many adolescents involve in premature sex because their parents don't talk to them about it. Many parents are too loose to talk or discuss sexual issue with their children. Many adolescents involve themselves in early sex ignorantly due to the looseness of their parents or failure of their parents to talk to them about the negative and emotional side of sex (Moronkola, 2008 and Lickona, 1994].

5. **Media influence: -** The media is a strong weapon of sexual development and behaviour modification. The media include television, radio, video, Internet, newspaper, magazine etc. The media activities influence most adolescent behaviour through their messages. Study according to Lickona (1994) and Kimberly (2005) shows that the increase rate of marital sexual involvement was due to increase rate of emotional movies produced, sold and shown to the public on television and video Films.

Research findings according to Michael and Kimberly (2005) revealed that most adolescents' use of Internet service on sexuality education is negative, which enhance unhealthy sexual activity and behaviours among adolescents. Adolescent's use of internet for communication, expressing development issues relating to their identity, peer, interaction and sexuality is increasing daily. Previously according to Ogharaerumi (2008), most adolescent search for information about sexuality were gotten through the mass media (TV, magazines and movies) but the Internet is presently being explored for sexuality information, communication, dating, cyber sex activities. The Internet and television are the major source of sexuality information mostly available to adolescent.

Fasubaa and Olugbenga (2005) opined that "Adolescents sexuality behaviour in Nigeria and sub-Saharan African is seriously going through transformation from what it used to be in the past". This can be attributed to the effect of modernization caused

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by industrialization, education, exposure; and enculturation through importation of various foreign cultures, which were alien to the Nigeria's culture in particular and African as a whole." However, the following is all related to later onset of sexual intercourse

- Having better educated parents.
- Supportive family relationship
- Parental supervision
- Sexually abstinence friends
- Attending religious programmes e.g Church frequently.

Objectives of Reproductive Health Programme and Services:

1. To promote adequate develop responsible sexuality; permitting relations to equity and mutual respect between the genders and contributing to improving the feeling of life of individuals.

2. To ensure adolescent have access to information; education; services needed to achieve good sexual health and exercise their reproduction rights and responsibilities

3. Innovation (Skills) programmes must be developed to make counseling and services for reproductive health accessible to adolescents.

4. Program should help prevent STI / HIV/ AIDs and avoid rejection of sexual behaviour, provides conceptive knowledge.

5. Supports from guidance / parents in line with convention on the rights of the adolescent (1994)

6. Focus primary on sexual behaviour (as opposed to covering a variety of risk behaviours such as drug use, alcohol use, and violence in addition to sexual behaviour).

7. Measures programme impact on one or more of the following sexual behaviours:-

- ➢ Initiation of sex
- ➢ Frequency of sex
- ➢ Number of partners
- ➢ Use of condoms
- ➢ Use of contraceptive more generally

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➢ Composite measures of sexual risk e.g – frequency of unprotected, sex, STIs rates, pregnancy rates and birth rates.

Objectives of Adolescents Reproductive Health Programmes and Services:

1. Focus on reducing risky sexual behaviour (as opposed to covering a variety of risk behaviours such as drug use, alcohol use, and violence.)
2. To equip adolescents with accurate and comprehensive information on their sexuality;
3. Support sexual skills to postpone early sexual initiation for those who are not yet sexually active;
4. Access to protective measures to prevent unwanted pregnancy, STIs/HIV/AIDS for those who have been initiated to sex;
5. Protection and care for sexual abuse and exploitation; and resist practices that could be harmful to their health e. g drug abuse, cultism, etc.
6. Access to a range of youth-friendly services that are designed to promote their sexual and reproductive health needs.
7. To promote and develop responsible sexuality; permitting relations to equity and mutual respect between the genders and contributing to improving the feeling of life of individuals.
8. To ensure adolescent have access to information; education; services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.
9. Innovative (Skills) programmes must be developed to make counseling and services for reproductive health accessible to adolescents and supports from guidance / parents in line with convention on the rights of the adolescent (1994).
10. Program should help prevent and reduce the incidence of common problems that adolescents currently face such as STIs/HIV/AIDs, human trafficking, unsafe abortion, and avoid negative sexual behaviour provide contraceptive knowledge. (UNESCO 2008 AND GPI/FMOH 2001).

Theoritical/Conceptual Framework

Theory is a set of formulations designed to explain and predict facts, events which can be observed. Conceptual framework is a representation, either graphically around which a concept is built. (Moronkola, 2006).Models is blueprint or a miniature

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sample that summarizes data and methods which help the reader to have an understanding of the entire package within a short period of time (Bowling 1997 and Igwebuike, 2008). Theory is a set of formulations designed to explain and predict fact, events which can be observed.

Theory of Reasoned Action

The theory of Reasoned Action (TRA) was first developed by Ajzen and Fishbein in 1973. It considers that human beings are usually rational in making their decisions and in engaging in a given behaviour, and will therefore act in accordance with their preferences. Intention is a determinant of behaviour, and actions that are not intentional (not under volitional control). The theory recognizes two determinants of intentions: the personal attitudes affecting the behaviour, and the influence of social pressure in performing or not performing behaviour. Theory of Reasoned Action suggests that a person's behaviour is determined by his/her intention to perform the behaviour and that this intention is, in turn, a function of his/her attitude toward the behaviour and his/her subjective norm. The best predictor of behaviour is intention. Intention is the cognitive representation of a person's readiness to perform a given behaviour, and it is considered to be the immediate antecedent of behaviour. This intention is determined by three things: their attitude toward the specific behaviour, their subjective norms and their perceived behaviour control.

The TRA hypothesizes that attitudes and beliefs affect behaviour primarily through their shaping of behavioural intentions, which are the proximal determinants of people's actions. These intentions are a function of two factors, behavioural attitude and social influence. Behaviour attitudes towards the activity in question represent the individual's positive or negative evaluation and affective judgments about performing the specific behaviour.These attitudes, in turn, are shaped by behavioural beliefs about the personal consequences of engaging in the behaviour in question as modified by their value to the individual. According to the TRA, behavioural intentions are also influenced by people's perception of social pressures to perform the behaviour in question.

Applying the TRA to predicting the enactment of risk-reducing sexual behaviours, however, is complicated by the complexity of the term "safer" sex. The practice of lower-risk sexual activities can involve a number of different, and not necessarily correlated, strategies including the use of condoms, limiting the number of

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sexual partners, having sex with others who are known to be uninfected with HIV, and avoidance of specific risky sexual activities, such as anal intercourse (Friedland & Klein, 1987). TRA may be used to study the individuals' intentions to safe sex (Vanlandingham et al, 1995).

Attitudes would reflect the individuals' beliefs about their evaluation of condom use during sexual intercourse and it is represented by a weighted relationship between:

- behavioural belief that condom use will result in a certain outcome (condom use will reduce the risk of AIDS);
- and the outcome evaluation of how pleasant or unpleasant the effect of AIDS would be as a consequence of non-compliance with condom use (if AIDS is contracted, the likelihood of dying).

Subjective Norms is an expression of the individual's subjective judgment of the external pressure to perform or not and to comply or not with behaviour:

- the person's normative beliefs, i.e. beliefs that specific individuals or groups think he or she should (or should not) perform the behaviour (my friends think that using condom is vital for protection of AIDS),
- and the motivation to comply with the behavioural expectations and norms of key social figures in their life (the cost of non compliance with condom use with their friendship groups)

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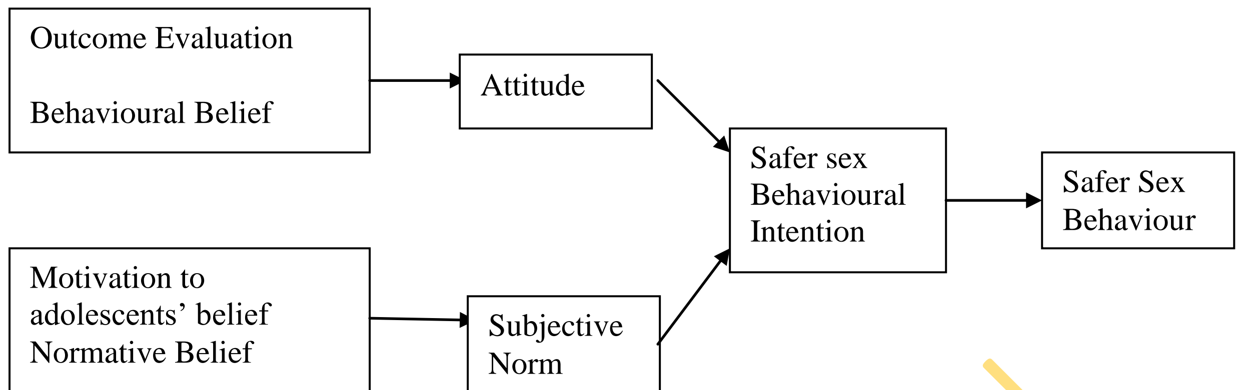
Fig 1: Theory of Reasoned Action



Source: Ajzen and Fishbein, 1973.

History and Theory of Planned Behaviour

Ajzen and Fishbein formulated the Theory of Reasoned Action (TRA) in 1980. This resulted from attitude research from the Expectancy Value Models. Ajzen and Fishbein formulated the TRA after trying to estimate the discrepancy between attitude and behaviour. This TRA was related to voluntary behaviour. Later on behaviour appeared not to be 100% voluntary and under control, this resulted in the addition of perceived behavioural control. With this addition the theory was called the Theory of Planned Behaviour (TPB). The theory of planned behaviour is a theory which predicts deliberate behaviour, because behaviour can be deliberative and planned (Aronson, Wilson and Akert, 2003). This theory is also used in evaluation studies. Other usages of the model include: voting behaviour, consumption prediction, disease prevention behaviour, birth control behaviour (Jaccard & Davidson, 1972). Examples of items which can be researched with the theory of planned behaviour are whether to use condoms when having sex, whether to wear a seat belt and whether to check oneself for disease etc. The theory of planned behaviour holds that only specific attitudes toward the behaviour in question can be expected to predict that behaviour. In addition to measuring attitudes toward the behaviour, we also need to measure people's subjective norms – their beliefs about how people they care about will view the behaviour in question. To predict someone's intentions, knowing these beliefs can be as important as knowing the person's attitudes.

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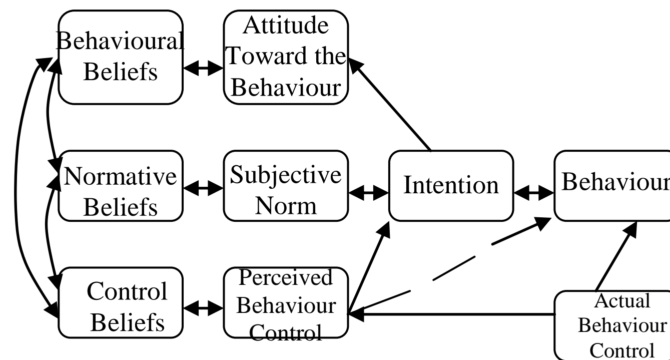
Figure 2: Conceptual Model on Theory of Planned Behaviour



Source: Ajzen, I. (1991) The theory of planned behaviour, Organizational Behaviour and Human Decision Processes, 50, Pg. 179-211.

Perceived behaviour control refers to the beliefs about the degree of control of the behaviour. It is a weighted relationship between the control belief and the perceived power:

- control belief describes the person's perceived obstacles and opportunities for performing specific behaviour (in the study of safe sex, this will refer to access to the necessary skills and resources required to use a condom successfully during sex, if they do not know how to use a condom, they will be less motivated to use it);
- and perceived power refers to the person's perceived degree of control over the behaviour (whether to facilitate or inhibit condom use).

Theories Explaining Adolescent Risk-taking:

Adolescent risk-taking behavior can be analyzed from several different perspectives. Risk-taking theories based on dispositional traits examine individual differences between persons that might account for reasons why people take risks (Kaplan, 1980; Botvin, 1986; McCord, 1990; Peterson, Compas, brooks-Gunn, Stemmler, Ey & Grant, 1993). However, most of the research in this area is not conclusive enough to state that dispositional traits are causal factors in adolescent risk-taking (Milistein & Igra, 1995).Biological models of adolescent risk-taking examine genetic factors, neuro- endocrine influences, and pubertal events (Irwin & Millstein, 1986; Cloninger, 1987; Udry, 1988 1990). Another approach entails using the development perspective to explain risk-taking in light of the biopsychosocial changes that occur during adolescence. Risk-taking is seen as a way of coping with

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normal development tasks such as exploration; achieving autonomy (Lavery, Siegel, Cousins, & Rubovits, 1993; Millstein & Igra, 1995) and difficulties adolescents face in making decisions (Furby & Beyth-Marom, 1992).Another perspective is to examine stable differences such as sensation-seeking or locus of control (Zuckeran, Eysenck, & Eysenck, 1978; Milistein & Igra, 1995). Bronfenbrenner's (1979), Ecological theory describes the social world of adolescents in several microcosms of contact. Parental monitoring of adolescent behavior has also been associated with adolescent risk-taking (Millstein & Igra, 1995). In reviewing the theories, it appears that none offer conclusive insight into the risk-taking behavior of adolescents.

Sensation-seeking: Sensation-seeking is "a need for varied, novel, and complex sensations and experiences and the willingness to take physical and social risks for the sake of such experiences" (Zuckerman 1979). This personality construct consists of four dimensions: thrill-and adventure-seeking, experience-seeking, and boredom susceptibility (Zuckerman, 1979). Thuen (1994) examined risk-seeking behaviors versus safety-seeking behaviors among Norwegian adolescents to determine their relationship to injury-related behaviors. Sensation-seeking scores were negatively correlated with safety-seeking and positively correlated with risk-taking. The thrill and adventure-seeking subscale was the strongest predictor of risk-seeking. In examining athletic injury, Smith, Ptacek, and Smoll (1992) assessed sensation-seeking as a moderator variable between sport-specific stress and athletes' injury vulnerability. Results showed that those low in sensation-seeking appeared to be at higher risk of injury following sport stress when compared to high sensation seekers. High sensation seekers had better coping skills for stress. Satinder and Black (1984) studied cannabis use and sensation-seeking orientation among college students. Cannabis users scored higher on all four sensation-seeking scales compared to none users. Another study found that adolescents who preferred hard rock or heavy metal music reported higher level of sensation-seeking overall compared to those who preferred pop music or mainstream rock music (Arnett, 1992).

Locus of Control: Locus of control is the perception one has of the control he or she has over the events that occur in one's life. There is an internal/external dimension to this trait. Internal control refers "to the perception of positive and/or negative events as being a consequence of one's own actions and thereby under personal control; external control refers to the perception of positive and negative events as being unrelated to one's own behaviors in certain situation and therefore beyond personal

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control" (Rotter, Seeman, & Liverant 2002).Locus of control has been studied very little in conjunction with sensation-seeking among adolescents. Kohler (1996) examined the relationship between locus of control, sensation-seeking, critical-thinking skills, and risk-taking among adolescents. He found a significant correlation between risk-taking (as measured by sensation-seeking) and the variables of gender, critical thinking and locus of control.

Some studies address locus of control in relation to actual participation in risk-taking behaviors by adolescents. McIntyre, Saudargas, and Howard (1991) found that having an external locus of control orientation is a significant predictor of pregnancies occurring early in adolescence. Crisp and Barber (1995) reported that among adolescent drug users, those with an internal locus of control know they are taking risks, while those with an external locus of control believe they are invulnerable to risk, particularly, HIV.

Risk from a Decision-Making Perspective.

Furby and Beyth-Marom (1992) proposed that adolescent decision-making might be different from that of adults when it comes to risky behaviour. The proposed differences are as follows: (1) adolescents and adults may consider different options; (2) adolescents and adults may differ identifying the possible consequence of an option chosen; (3) adolescents and adults may place a different value on possible consequences; (4) adolescents may access the likelihood of consequences differently; and (5) adolescents may use a difference decision rules.

Concept of Evaluation

Igwebuike (2008) citing Tyler (1949) stated that evaluation is the process of examining the match between learner outcomes and programme objectives. Scriven (1972) describes evaluation as the process of comparing the actual effects of a programme with demonstrated target population needs. Clark (1991) opined evaluation which comes from the Latin words "valere" to mean "value", to be "strong", and to have worth of something. WHO (2000) stated that evaluation is a powerful tool that can inform and strengthen School Health Programmes. It can be used to document the effects of action. Most evaluations seek to provide information about the extent to which a program is being implemented as planned and producing the intended effect .The Society for Public Health Education (SOPHE) indicated that

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evaluation was a critical skill area and an important element in the professional preparation for Health educators (Green and Lewis, 1986).They argued further that health educators should demonstrate the effectiveness of their programmes through evaluation to improve the credibility of their specific programme and health education in general. Programme evaluation uses various qualitative and quantitative procedures to determine if a programme has been implemented as planned. It also determines the degree to which the programme has met its goals and objectives.

Purpose of Evaluation

The purposes of evaluation are as follows:

- Provide information to policy makers, sponsors, planners, administrations and participants about the implementation and effect of the program.
- Provide feedback to those involved to project planning to determine which parts of the programmes are working well and which is not.
- Make improvement or adjustments in the process of implementation.
- Demonstrate the value of the efforts implemented by the school, parents; students, providers, commonly members.
- Documents experience from a programme so that it can be shared with others. (WHO, 2000).

Three phases of Evaluation are:

1. Process evaluation: is understood as the set procedures, means and instruments used to achieve the intended objectives and goals. Process evaluation is done to assess overall effectiveness and improve the programme. Evaluation is often limited by scarce resources, time, personnel or budget. Program offers study impact on youths without full understudying whether or how well the interventions were implemented (WHO, 2000). In this study the process evaluation will be based on the knowledge acquired by adolescents based on the RHP and services they have been exposed to the quantitative and qualitative information provided by those in the schools responsible for delivery of RHPS. Evaluation assesses how and how well the interventions are being implemented. It answers to questions:

- To what extent are the interventions being implemented the way they were intended?
- To what extent are the interventions reaching the individuals in the target group (coverage of program)?

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- Are teachers being trained and is the training effective?
- Is the curriculum meeting students' needs?
- Quality of program

2. Impact evaluation: implies the number of adolescents who shows changes in knowledge level of Reproductive health; adoption of positive behaviours as in avoiding premarital sex, delay onset of sexual initiation, avoiding masturbation and posses the ability to zip-up.
3. Outcome evaluation: - implies if programme met long term goals; objectives decreases morbidity; diseases, mortality and increase quality of sexual life of adolescents. It measures the extent to which a programme achieves specific objectives. It can demonstrates the benefits of the programme or illustrate the need for further programmes. It demonstrates (1) changes in behaviour, increase in knowledge, changes in traditional belief; increase confidence to use new skills and improvements in social and environmental conditions that are relevant. Outcome evaluation (measures changes in terms of overall objectives and changes in health and social benefits or the quality of life. The development and effective implementation of adolescent reproductive health interventions must be a priority for many areas of the world if the next generation is not to be decimated by HIV. It is likely that intervention that combines a behavioural and structural approach will be those most likely to succeed, although adolescent reproductive health has been on the health and education agenda for many years, there is still considerable apathy towards implementation of intervention programmes in many countries. While this is in part because of vociferous opposition from the "moral minority" it is also because of the lack of robust evidence about what works and what does not. The recent systematic reviews that highlight the lack of effect of intervention on objective biological outcome measures despite demonstration on effect on report behaviour have importance implication for future research design. Health promotion on practitioners, teachers, and educational and health researchers need to work together to define research priorities and ensure that the promising interventions are appropriately and rigorously educated using objective, well validated marked of effectiveness (UNESCO and WHO, 2004). Impact and outcome evaluation measures changes in outcomes, such as: changes in behaviour, changes in knowledge and attitudes,

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changes in interactions with parents, changes in community norms and whether outcomes are due to programme efforts or other factors.

Adolescent reproductive health, programmes and services in Nigeria has been able partially to achieve process evaluation (i.e the process by which the programme is being implemented) but the impact and outcome evaluation needs overhauling. Impact evaluation measures the programme effectiveness in terms of intermediate objectives and changes in predisposing, enabling and reinforcing factors (FMOH, 2005). Evaluation of the effectiveness of programmes in modifying behaviour requires a considerable research effort, necessitating expertise, time and money. The actual amount of resources needed varies with the scope of the evaluation. Process evaluation is simpler than outcome evaluation, and the latter may be restricted to a carefully selected sample of schools. Evaluation is useful and complete only when its results are reported, commented by those who are involved; used to improve program efforts (WHO, 2000).

Table 4.

Examples Of Outcome Data

Evidence Category	**Students**	**Teachers and Staff Development**
Behaviour	Reported activities while in high – risk situations	Appropriate use of recommended classroom procedures.
Skills	Ability to display refusal skills in stimulated high – risk situations relating to HIV infection	Ability to respond appropriately to students questions about sensitive topics.
Attitude	Perceptions about ones personnel susceptibly to HIV/STIs	Confidence in being able to modify students' high risk behaviours.
Knowledge	About Reproductive Health etc.	Knowledge about the instrumental principles relevant to modify student's activities.

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Process and outcome evaluation are important to assess the extent to which objectives have been achieved, and together provide a basis for interpretation of the results (http://www.unesco.org/2000/education). Evaluations of RH efforts are essential to understanding overall program effectiveness:

- What are current levels and types of efforts by schools for adolescent reproductive health? To what extent are programs providing services that meet the definition of comprehensive reproductive health? To what extent do programs involve parents, community leaders, health service providers, and school personnel?
- What types of programs have been most successful in gaining community and political support and becoming institutionalized in school settings
- What types of programs have been successful in addressing gender-specific issues in reproductive health? Are school-based programs reaching both boys and girls? Are gender-segregated or gender-integrated approaches most effective in promoting positive attitudes and behavior?

  Regarding health services and the school environment
- Which services can most efficiently and cost effectively be provided through school-based health clinics?
- What training approaches, including content, techniques, and length of training are most effective in preparing providers of reproductive health services to young people?

Unfortunately, the vast majority of RH programs in developing countries have not been evaluated or even described in detail. Much information remains within countries and is difficult to access. Evaluation that has been conducted is generally weak, because of a number of factors including limited resources and evaluation expertise, lack of clarity about the purpose, goals, and objectives of program efforts, and limited access to essential RHPS data.

Models of Curriculum Evaluation

There are numerous models of evaluation as follows: (1) Tylerian model (2) Decision Making Model (3) Transaction model (4) Responsive evaluation (5) Goal free model (6) accreditation model and (7) Adversary model. House (1978) and Igwebuike (1990; 1991; 1992).

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Tylerian Model

The Tylerian model is one of the time-honoured models of evaluation. It is also referred to as objectivist model (Ikponmwosa, 1991) and behavioural model (Igwebuike, 1990). It aims at collecting evaluation information through the use of objective and quantitative methods. Information is sought about the extent to which the expected behavioural changes have been achieved. The models compress the 'actual outcome' with the 'intended outcome' during the implementation of a curriculum package. The model was popularized by Tyler, one of the early proponents of curriculum studies, though it was used before Tyler by people like Bobbit and Harrap. It seeks evaluation information about learning outcomes or expected changes in behaviour. Other antecedents during curriculum implementation are marginalized. It relies heavily on testing, grading, assessing and measuring achievements of the learners in relation to pre-determined objectives. The model is still very popular.

There are a number of criticisms of this model. The first is that it does not take care of unintended or unplanned outcomes. The second is that it neglects antecedents or concomitants like learners' needs, perceptions, attitudes and teachers' attitude to, and perceptions of the curriculum package. The third which agrees with Bohla's (1990) view is that the information obtained from tests is too myopic to provide a comprehensive basis for making judgement about the worth of the curriculum package. The fourth is that, it is often a source of threat to teachers and learners who use the curriculum package or programme.

Decision Making Model

Following the criticisms of the Tylerian model, other models started to emerge. One of these is the decision making model. The two types of the decision Making model are: CIPP Model (Stufflebeam, 1971) and EIPOL Model (Dave, 1979).

CIPP stands for four elements – Context, Input, process and Product. There are four parameters for curriculum evaluation Context, Input, process and Product. Context evaluation defines the relevant environment and describes the desired (expected) and actual conditions pertaining to the environment. It identifies needs not met and opportunities not used and diagnose the problems that prevent needs from being met and opportunities from being used. Input evaluation provides information for

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determining how to use resources to meet the aims and objectives of the curriculum programme. Process evaluation aims at detecting or predicting problems design of the procedure or its implementation, and maintaining a record of procedure as it occurs. Product evaluation aims at measuring and interpreting attainments both at the summative and formative evaluation levels (Igwebuike, 2008).

EIPOL represents Environment, Input, Process, Outcomes (immediate) and long range outcomes. This model is a modification of CIPP model. Product in the CIPP model was modified by breaking it into learning outcomes: immediate, intermediary and long-term impact of the programme, despite the inclusion of contexts and process in this model. It is still classified under the general umbrella of objective evaluation (House, 1978). The model inherits therefore some of the criticisms of the Tylerian model.

Factors Shaping Adolescent Reproductive Decision Making

Researchers are increasingly turning their attention to antecedents, factors that precede and influence how adolescents make decisions about sexual and health behaviors. Antecedents can be positive, a protective factor, or negative, a risk factor. While research can show the relationship of antecedents to sexual decision making, it is more difficult to identify which antecedents most influence reproductive health outcomes. Research has found that the level of knowledge about reproductive health and sex, as well as community and family norms and values about reproductive health and sex, influences adolescents reproductive health decisions.

The Rationale for an Adolescent Policy

Most national health programmes provide for children and the aged, recognizing their susceptibility to certain diseases due to biological factor, adolescents are less vulnerable to these diseases of childhood and of the elderly, hitherto, little emphasis had been placed in these counts on the health needs of this age group. Although the National Health Policy and Strategy to achieve health for all Nigerians' of 1988 provides an open-ended framework for all persons living in Nigeria to have access to health care services, a specific policy on adolescent health is necessary on the following premises:

In adolescence, the effects of debilitating childhood illnesses and nutritional deficiencies manifest in psychological and other problems, adolescents are more prone to injury than any other group as they are more physically mobile and less

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mentality inhibited on this mobility, Adolescent is the period when individuals develop their capabilities by trying out new behaviours, skills, opportunities, hobbies and relationship, each of which has health implications .In Nigeria, as in other societies, young people are more involved in community work, sports, combat operations etc., and are therefore more prone to physical injury. Adolescents constitute about 30% of the Nation population; adolescent health is a crucial delivery strategy in such context as AIDs, STIs and drug abuse control programmes which present largely unfamiliar challenges (FMOH, 2005). When unfavourable economic conditions impose serious hardships on adolescents, they are tempted to engage in risky and anti-social behaviours and practices such as violent crimes, unsafe sexual activities and drug abuse, which pose serious health challenges.

TABLE 5: PROMOTING HEALTHY BEHAVIOUR

Concept	Definitions
(1) Individual Factors	Individual characteristics that influence behaviour, such as knowledge, attitudes, belief; and personality traits.
(2) Interpersonal Factors	Interpersonal processes, primarily groups; including family; friends and peer that provide social identity support and role definition.
(3) Institutional Factors	Rules; regulations, policies and informal structures that may constrain or promote recommended behaviours.
(4) Community Factors	Social networks and norms or standard that exist formally or informally among individuals, groups and organizations.
(5) Public Policy Factors	Local state and federal policies and laws; that regulate or support healthy actions and practices for disease preventing early defection; control and management.

Source: M.E Murphy (2003). Promoting healthy behaviour, Health Bulletin 2p.5 Adopted from National Cancer Institute.

Policy Declaration

Government of Nigeria realize that the adolescents have peculiar health needs that must be urgently met; they therefore, agree that a specific policy is required to address and meet these peculiar needs and the Nigeria Government thereby adopt and undertake to subscribe to this national policy on adolescent health with the following objectives:

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- To promote the acquisition of appropriate knowledge by adolescents
- To create an appropriate climate for policies and laws necessary for meeting adolescent health needs.
- To train and sensitize adolescents and other relevant groups in the skills needed to promote effective healthcare and health behaviour.
- To facilitate the provision of effective and accessible information, guidance and services for the promotion of health, the prevention of problems and the treatment and the rehabilitation of those in need.
- To facilitate the acquisition of new knowledge concerning interaction between adolescents and those who may provide them with healthcare or influence their behaviour regarding biomedical and psycho-social issues related to adolescents physical, mental and social development (FMOH, 2005).

Sexual and Reproductive Health: Adolescent health problems vary from one socio-cultural setting to another; the following constitute the focus of the programme:

- Sexual behaviour
- Reproductive health
- Nutrition
- Accidents
- Drug abuse
- Education
- Career development
- Parental responsibilities and social adjustment

Initiatives for translating policy and strategy emphasis here is on responsible sexual behaviour and positive attitudes to sexuality as a means of preventing unwanted pregnancy, avoiding sexually transmitted disease etc and these issues can be incorporated into school curricula. Direct service provision may also be undertaken such as special clinics for the adolescents within existing facilities, outreach facilities in schools and other places to which adolescents are attracted (FMOH, 2005).

Reproductive Health Policy

Evaluation of the National Reproductive Health Policy and Strategy (2001), the National Policy of HIV/AIDS/STIs Control (NPHASC, 1997) and the National Adolescent Health Policy (NAHP, 1995), concluded that the Reproductive Health

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policies are adequate. Many were developed in line with both the International Conference on Population and Development (ICPD, 1994) programme of action and the subsequently evolved Africa regional strategy on Reproductive Health. The major objective was ensuring the promotion of optimal Reproductive Health status and the reduction of the Reproductive Health morbidity and mortalities through (among other things), the equitable distribution of health resources giving preference to those at greater risk to health and the undeserved health resources communities. The problem has however been with the implementation as the current level of access does not reflect strict adherence to the implementation of the policies. However, very often there are no laws to back up most of the principles enumerated in the policies, there are little or no funds made available for the implementation and even "while the provisions of the policies are relevant to promotion of reproductive health, their targets are sometimes contradictory" (NRHPS, 2001). Moronkola (2007) opined that ill-health behaviour of young people, apart from having negative effects on their health status; has also implications for their academic performance; behaviours like abuse of drugs; premarital sex; cultism; demonstration; poor nutritional intake; clandestine; abortion ecological perspective and levels of influence.

Reproductive Health Programmes

Evaluation of the National Curriculum on Reproductive Health for Nurses/Midwives (NCRHN/M, 2001); reproductive health curriculum for community health extension workers (CHEWs, 2002) national training manual; Adolescent's Health and Development (NTMAHD, 2001) primary school/junior secondary school family life, HIV/AIDS Education curriculum (PS/JSS FLHAEC, 2003), and interactions with health care providers and clients, it was observed that although the programmes as enumerated in the documents were in theory adequate and designed to meet the needs of most segments of the population, many aspects were either not implemented or could not be accessed by clients. Majority of the programmes target adult women (presumable married) and leave out the men and adolescents. For example health talks and services at family planning (FP) clinics usually discountenance the male partners of the female clients. Even when condom is discussed as a method of FP, the emphasis is usually more on the woman collecting for her male partner. Also, little or no attention is paid to adolescent RHE and RHS

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because certain communities ensure that many sexually active adolescents are denied access to RHE and RHS. This culture, coupled with the fact that there are no provisions made for illiterate/semiliterate and out-of-school adolescents also helps to deny most rural adolescent's access to RHE and RHS (FMOH, 2002).

Reproductive Health Services

Interactions with the health care providers, the clients and other stakeholders as to the quantity, quality, adequacy and accessibility of the reproductive health education and reproductive health services, it was observed that reproductive health service in Nigeria are provided by three main groups of people. These are, government employed health care providers in public health institutions either independently or in collaboration with international; non-governmental organizations (local and international) and private for profit health care providers, some well trained, many untrained.

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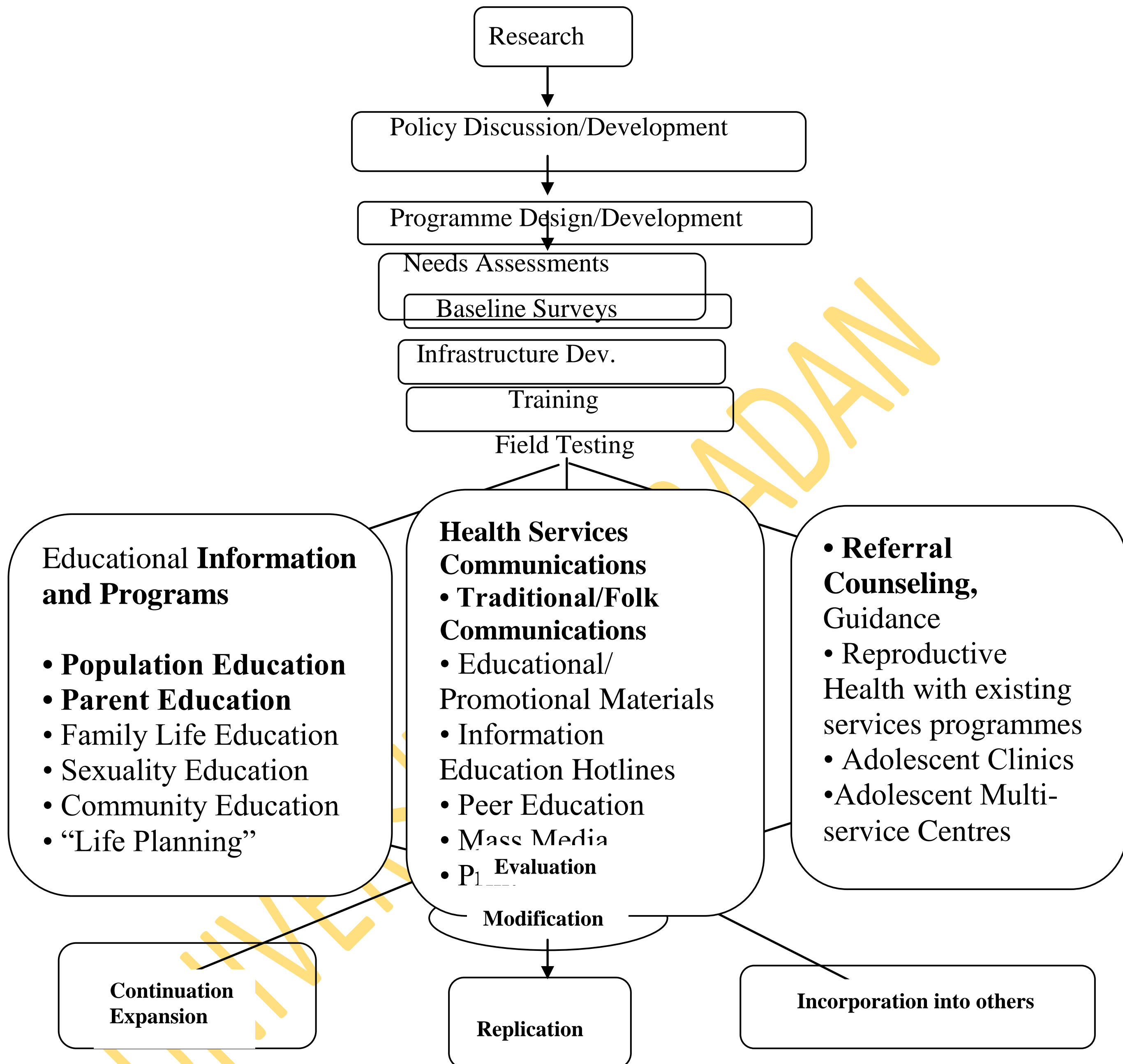
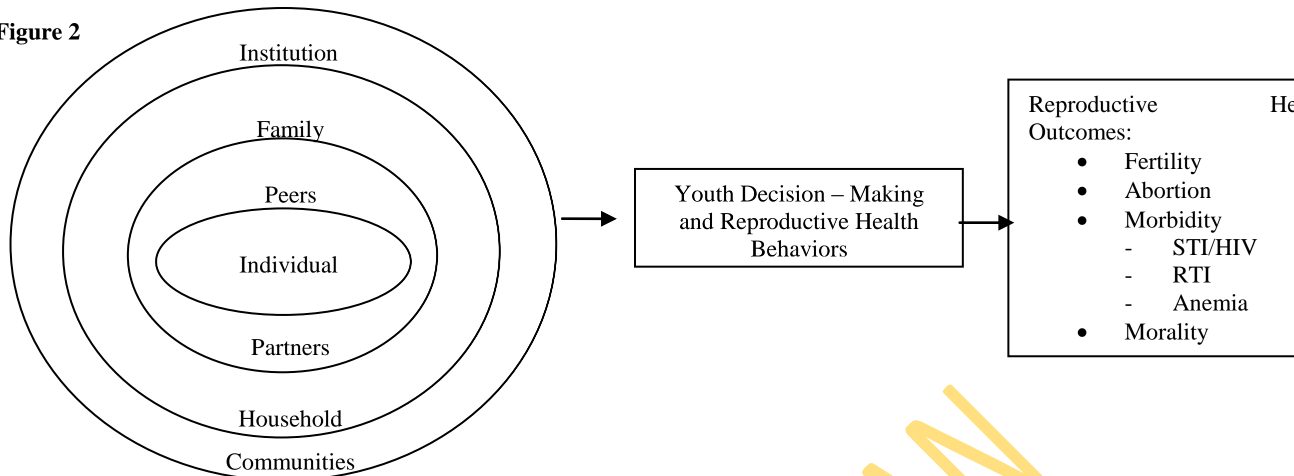
Figure 3: Programme Development and Project Components: Information and Services for Adolescents



Source: (WHO/UNFPA/UNICEF, 2002)

FACTORS THAT INFLUENCE ADOLESCENT REPRODUCTIVE HEALTH

Figure 2



Individual

- Age and Gender
- Place of residence
- Knowledge, attitudes And beliefs
- Self Efficacy
- Skills:
  - motivation to do well in school
  - actively engaged in learning
- Alcohol and drug use
- Other related risky behavior
  - depression, stress
  - running away from home
- Sexual and Physical abuse

Peers and Partners

- perception of peer behaviors
  - perception that peers are sexually active
  - perception that peers are using alcohol or drugs
- Relationship with partner(s)
  - age and income differentials
- Exchange of money or goods for sex
  - sexual pressure
- sense of commitment with partner

Family and Household

- Law educational and economic level
- Family attitudes
  - devaluing education
  - supporting early marriage and childbearing
  - Discouraging young people's access to information and services
- Harmonius relationship with family
  - quality interaction with family
  - family's values are communicated to youth
  - supervision by adult family members

Institutions

- Connectedn
  Religious O
- Connectedn
  - Availability
  - A Safe Scho
  - Academic P
  - aspirations
- Availability
  - Leisure Acti
  - Counseling
  - Sexual Abus
- Relationship
  Adults Thr
  Institutions

Mass Media (pornography sexually permissive and violent media)

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EMPIRICAL REVIEW

Reproductive Health Programme and Adolescents Sexual Behaviour

WHO Fact Sheet (2003) opined that ado1escence is a period exploration and experimentation, but young people often lack the knowledge, experience and maturity to avoid the grave risks that confront them. In the developed and developing countries adolescents can face overwhelming problems, among them early pregnancy, high school drop-out rates, substance abuse and violence, making them more vulnerable to life-threatening disease and conditions. Alan Guttmacher Institute (2002) stated that programmes that aim to educate adolescents about sexual and reproductive health need to be combining with programmes aimed at motivating them to apply what they have learnt in their lives. They should also be combined with efforts to make it easier for adolescents to obtain any preventive or curative health services they might need from competent and empathetic health workers. Sexual coercion in adolescence needs to be fought at different levels. Laws requiring severe punishment for this crime should be passed and energetically enforced, and public opinion should be mobilized to become fiercely intolerant of it. Girls and women should be protected from sexual harassment and coercion in educational institutions, work places and in other community settings. Preventing too early pregnancy may require the enactment and enforcement of laws that specify a minimum age for marriage, as well as actions to mobilize families and communities to give their daughters the additional time they need to grow and develop from girlhood into womanhood before becoming wives and mothers. Alongside this, health services should be ready to provide adolescents who are pregnant with the antenatal care they need, or to obtain a safe abortion where this is permitted by law. Effective care / during child bearing is important to ensuring the survival of mothers and their babies, and the prevention' problems such as Vesico vaginal fistulas (Alan Guttmacher Institute, 2002).

An adolescent comprises 20% of the total world population, 85% of whom live in developing countries. Low education and high unemployment often compound the problems of developing world adolescents, Furthermore, the adolescent population in developing countries is burgeoning, with the number of urban youth growing a projected 600% between 1970 and 2025 (WHO Fact Sheet, 2003), For the most part, young people's problems have been ignored, with little understanding of the potential impact of a generation at risk on the future. If today's young people are to realize their adult potential, new solutions must be found, These solutions Will be

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based on understanding the complexities of adolescent cultures, how they experience risk and what factors contribute to their vulnerabilities Frequently, sexuality presents the first challenge to healthy adolescent grow& often unplanned, and sometimes pressured, adolescent sexual relations occur before young people have adequate knowledge of contraception, sexually-transmitted diseases (STDs) or health services available to them (WHO Fact Sheet, 2003).

In developing countries, girls under 18 have a maternal mortality rate that is two to five times higher than women 18 to 25. Between 1 and 4.4 million adolescent abortions occur each year, most of which are unsafe, performed by unskilled practitioners illegally. One out of 20 adolescents contracts a curable STD, excluding viral / infections at least 1 million cases in persons under 25 each year. STDs often go undetected oz untreated among young women, who, embarrassed or stigmatized by the presence of a STD, are reluctant to seek help. Yet STD agents, such as Chlamydia and human papilloma virus, can have dire consequences at later times, such as infertility or cervical cancer STDs may also facilitate the transmission of HIV. Although the overall world population living with HIV/AIDS appears to be declining, evidence shows that new HIV infections among adolescents are rising Worldwide, more than half of all new HIV infections occur in the 15 to 24 age group (Likoye, 2004). In South Africa, the rate of pregnant teens (15 to 19) with HIV doubled between 1994 and 1996. Although young people may' know how AIDS is transmitted and prevented, many believe their risk of infection is minimal. In one study in Malawi, 90% of teenage boys reported having at least one sex partner in the previous year but very few used condoms. Girls appear to have a significantly higher incidence of HIV infection than boys. Statistics from Uganda show girls having six times more HIV infection than boys, even though the rate for teenage girls has dropped 50% since 1990 (Wachira, 2005).

HIV/AIDS and Adolescents Sexual Behaviour

A high proportion of young urban Nigerians, both male and female, had been reported to be sexually active (Makinwa-Adebusoye, 1992) and they engaged in indiscriminate and unprotected sexual intercourse. The age at which the youths become sexually active, the degree of sexual activity and the number of sexual partners determine their risk of contracting HIV infection. The risk posed by unprotected sexual intercourse in the youths is reflected in disproportionately high rate of HIV and other STD infections (Braverman and Strasburger, 1994). Nigerian

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youths living in urban centers have been found to be sexually active at an early of sexually experienced males and 40% of comparable females had had their first sexual encounter by their 17th birthday (Makinwa-Adebusoye, 1991). A pilot study in South-West Nigeria revealed that over 60% of sexually active respondents had two or more sexual partners. Most of these sexually active respondents aged 19 years and below (Olayinka and Osho, 1997). In Nigeria, according to a report from the Federal Ministry of Health (F.M.O.H.) and as confirmed by Olayele (2000), over four million Nigerians, mostly those in their prime of life were estimated to have contracted HIV infection by the end of 1998.The best hope for minimizing the spread of HIV/AIDS is to reduce the frequency with which the youths and other individuals initiate behavior that may result in HIV infection. For the youths to avoid unnecessary risk and for them to take necessary precaution, they must appreciate the risk that is present. The series of prevention programmes must be organized and implemented with full and active involvement of the youths in such programmes (Ogundele and Farotimi, 2009). The youths can be important advocates for them and can also provide input into what they need to know about HIV and AIDS. Young Nigerians are an important target for HIV prevention interventions. The 10 to 19 year age group accounts for approximately one-fourth of Nigeria's population of 117 million (UNAIDS, 2001). Surveys confirm that many youth participate in risky sexual practices, including unprotected sex with multiple partners (Araoye and Adegoke, 1996; Ekweozor *et al*., 1995). One study of secondary school students found that only 36% of sexually active males and 21% of sexually active females were consistent condom users (Araoye and Adegoke, 1996). HIV also disproportionately affects young adults. In a study of sexually transmitted disease (STD) clinic attendees in Ibadan, Ekweozor and colleagues found that persons aged 21-30 years accounted for 65% of the cases of HIV infection; many of these individuals probably became infected in adolescence (Ekweozor *et al.,* 1995). Antenatal sentinel surveillance data from Nigeria show that HIV prevalence among young persons aged 20-24 years is 10% compared to 5% for adults aged 25 years and above (Nigerian Federal Ministry of Health, 2000), a finding that suggests that the epidemic is on the rise.

Governmental and other agencies have targeted HIV/AIDS prevention education for adolescents mainly at students because they are readily accessible (Nigerian Federal Ministry of Health and Human Services, 1995). Unfortunately, most young people of high school age in Nigeria are not in school (63% of boys and 69% of girls)

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(UNAIDS, 2001). Thus the prevention needs of out-of-school youths remain relatively neglected. Research indicated that out-of-school adolescents in Nigeria are generally more sexually active than their counterparts in school (Nichols *et al*., 1985; Speizer *et al.,* 2000). One potentially vulnerable out-of-school group is young women in apprenticeships. Apprentices and their instructors operate in Nigeria's large informal economy, which consists of small businesses that lack government recognition, registration, or support. Persons operating in this sector do not have access to commercial sources of credit, earn low incomes, and have no employment security or minimum wage (Meager, 1995). Almost 60% of HIV in Africa occurs in people aged 24 years and below. The youths constitute the future generation. If HIV/AIDS is allowed to continue spreading at the current rate, there is the danger that quite a number of youths will not reach adulthood. Many families will be destroyed and there will be many orphans for communities to care for. This is the concern of this paper. There is the urgent need to protect the future generation against HIV/AIDS. The most realistic way to do this is to promote awareness campaign through organized prevention education programmes. The best hope for minimizing the spread of HIV / AIDS is to reduce the frequency with which the youths and other individuals initiate behaviour that may result in HIV infection. For the youths to avoid unnecessary risk and for them to take necessary precaution, they must appreciate. Okonta (2007) stated that there has been an increasing awareness of the need to pay special focus on the adolescent and their sexual and reproductive health. This article reviews the sexual and reproductive health of adolescents in the Niger Delta Region (NDR) of Nigeria. The objective is to bring to focus these important issues in the region. Adolescents in the Niger Delta Region engage in unhealthy sexual behaviour characterized by early age at sexual initiation, unsafe sex and multiple sex partners.

Peer Education and Adolescents Sexual Behaviour

Peer education programmes have been found to be very useful and functioning well in Benin, Botswana, Ghana, Jamaica, Kenya and Zambia (Fee and Youssef, 1994). Examples of such education programmes include lectures on HIV infection and AIDS; lectures on sex education. Different teaching methods can be used such as discussion, seminar, symposium, role play, telling stories, songs, poems, group debate and quiz competitions. Audio-visual materials can be used such as pictures, charts, posters, video recordings and films. Formation of Anti-AIDS clubs by the youths can

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be very useful to implement the various education programmes. It is hoped that if these education programmes are well organized and implemented, the youths can stay free of HIV infection and become healthy parents in future (Odujinrin and Akinkuade, 1991).

In their own study, Kasule, Mbizvo, Gupta, Fusakaniko, Mwateba, Mpanju-Shumbusho, Kurioti and Padachy (1997) concluded that it is clear from their analysis that teenagers engaged in premarital sex at an early age when they are ignorant about the health consequences of sexuality. Nevertheless these adverse effects of premarital sex could be prevented by educating and increasing awareness through a well structured reproductive health education at an early age. Klepp, Ndeki, Thuen, Leshabari and Seha (1996) also recommended reproductive health education for adolescents to increase their awareness/knowledge of reproductive related issues. Bernett (1997) also wrote that lack of information put adolescents at risk of unplanned pregnancy or STDs and there is the need for sexual health education to prevent these problems and help their future reproductive health challenges.

Peer Education Reduces Risky Sexual Behaviours.

Journal of America College Health (2003), Health Education Research (1995), Focus for Young Adult (2000) and AHI (2005) revealed the benefits of Peer Education as follows:

- Studies show that adolescents who believe their peers are using condoms are also more than twice as likely to use condoms compared to teens who do not believe their peers use condoms.
- In the United States, a peer education program targeting mostly black, urban female's ages 12 through 19 significantly improved HIV/AIDS knowledge and preventive behaviours. Before the program, 44 percent sexually active participants reported not using condoms compared to 33 percent after the intervention. Reports of sex in the previous two weeks fell from 21 percent at baseline to 14 percent at follow-up.
- Evaluation of a sexual health peer education program in Peru in 2000 found that, compared to controls, participating males had increased knowledge about pregnancy prevention and reported reduced incidence of sexual initiation and increased use of contraception at most recent sex.

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- An evaluated peer health education program in Cameroon showed increased use of modern contraceptive methods and increased condom use at most recent sex among participants versus comparison youth. The program was more effective among in-than out-of-school youth.
- The West African Youth Initiative implemented peer education programs in schools and out-of-school settings in Ghana and Nigeria. Evaluation showed that peer education significantly increased condom use among in-school youth. The proportion of youth reporting use of modern contraception methods increased significantly from 47 to 56 percent while use in comparison areas decreased slightly.
- In an alternative school in Florida, a peer education program resulted in increased reports of condom use at most recent intercourse (up from 45 to 55 percent) and fewer reports of unprotected sex (down from 15 to 4 percent) among sexually active students.
- A program in the South identified peer leaders in the gay communities of two small cities. The leaders were then trained to talk individually with their peers about HIV risk behaviours. As a result, the proportion of men who engaged in any unprotected anal intercourse in a two-month period decreased from 36.9 percent before the intervention to 27.5 percent after the intervention.
- Trained peer educators are a more credible source of information for some youth than are adult educators because they communicate in readily understandable ways and serve as positive role models while dispelling misperceptions that mostly youth are having sex.

Adolescents and Sexual Initiation and Niger-Delta Region

In a study of 410 adolescent girls in a rural community in Rivers State, 62% of them had initiated sexual intercourse, 43.6% of girls aged between 12 and 17 years and 80.1% of girls aged between 17 and 19 years had had sex. About 14% of the girls initiated sexual intercourse by age 10 – 14 years. Similarly in another study in Rivers State, 78.8% of the 768 adolescents aged 14 – 21 years had been sexually exposed and the mean age at sexual initiation was 15.04 years with 2% of them having initiated sex at the age of 12. Anochie, also in Rivers State, documented that 12.4% of

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the 534 female students studied had initiated sexual intercourse by 11 years. Studies from other States in the NDR show a similar trend. In Calabar, Cross River State, the mean age at sexual initiation was 13.7 years. In Delta State, a UNFPA sponsored baseline survey which included 1013 adolescents showed that 34.4% of adolescents aged between 15 – 19 years have had sex, while another study of 516 secondary school students also in Delta State, showed that 69% of them have been sexually initiated.(Ekpu, 2004; Okonta, 2007; Okonofua, 2003 and GPI, 2006).

Apart from this risk adolescents in the NDR are exposed to at sexual debut, their subsequent sexual behaviour makes them continually at risk of pregnancy and STIs including HI/AIDS. In Rivers State, 34.3% of the sexually active girls have intercourse at least once in a week. Also 51% of the sexually initiated girls have been exposed to more than one sexual partner, with 6% sexually exposed to more than five sexual partners. In Cross River State, 22.6% of the sexually active adolescents have more than one more sexual partner and in Delta State about one-third of the sexually active adolescents have had more than one sexual partner (Okonta, 2007). In a FGD among Secondary School Students in Edo State, participants acknowledged that sexual activity was common among their peers, starting at an early age and often involving multiple sexual partners (UNFPA, 2005).

Unintended Pregnancy and Abortion

Unwanted pregnancy is also a notable outcome of adolescent sexual activity in the NDR. Most studies have documented an 'ever pregnant' rate between 18.4% and 39.1%. These pregnancies have in most cases been terminated. Documented rate of abortion among 'ever pregnant' adolescent girls in the NDR ranged between 33.0% and 88.6%. In some studies about 10% of sexually active adolescents have had more than three abortions. It is pertinent to mention here that in Nigeria, the law restricts abortion. Thus most of these abortions are done illegally and by unskilled personnel under septic conditions. About 610,000 induced abortions are carried out in Nigeria annually. It is estimated that 20,000 out of the 50,000 maternal deaths are related to abortion and its complications. In a hospital based study up to 80% of the patients admitted for abortion complications were adolescents. Pregnant adolescent girls who do not succeed in procuring an abortion go o to have a delivery and exposed to the risks associated with teenage pregnancy, labour delivery. In the South –South zone, 11.3% of women aged 15 – 19 years had given birth. In Abia State, of the 10.9% of

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girls who became pregnant after their first sexual intercourse, 36% had a delivery (Briggs, 1998; FMOH, 2000; WHO, 2004; Okonta, 2007and Aziken, Okonta and Adedapo, 2003).

Adolescents Sexual Knowledge

Adolescence is a critical period of development with dramatic physical and emotional changes that affect young people's health. All adolescents (youth ages 10—19) experience profound physical changes, rapid growth and development, and sexual maturation—often about the same time as they begin developing new relationships and intimacy. For many young people, adolescence is the time when they have their first sexual experience. In addition, young people experience psychological and social changes as they develop attitudes; abstract and critical thinking skills; a heightened sense of self awareness; responsibility and emotional independence; communication patterns; and behaviours related to interpersonal relationships (Weiss et al., 1996; WHO, 1998). They need reliable information as they deal with new experiences and developments. Adolescents need to know what is happening to their bodies, for instance, when they experience menstruation or wet dreams.

Adolescents have limited knowledge of and access to contraception. The main sources of information on sexuality, conception, pregnancy, and contraception for young people are friends and the media (UNDP/UNFPA/ WHO/World Bank, 2000). Numerous myths persist among young people about how to avoid conception, e.g., one cannot get pregnant at first intercourse or if standing up during intercourse, if a girl has not started menses, or if a boy is younger than the girl (Watson, 1999). Adolescents may believe that abstinence will cause infertility, poor sexual performance, or painful childbirth at a later date (Watson, 1998).

Such myths can lead adolescents to engage in behaviours that put their health and development at risk. Case studies in various countries have shown that contraceptive use is as low as 1 % among female and 9% among male 17—24-year-old college students in Vietnam. Only 10% of female and 20% of male secondary school students in urban areas of Nairobi, Kenya, and 12% of females and males under the age of 20 from Chile practice contraception regularly (UNDP/UNFPNWHQ/World 8ank, 2000).

Lack of access to contraceptive methods is related to a variety of issues: poverty that leaves people unable to afford contraceptives, policies and practices that

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make it difficult for adolescents to obtain reproductive health services, and reluctance to provide information and access to young people. And even when services are available, adolescents may face hostility and disapproval from health workers, or fail to use the services because they fear disclosure of their sexual activity (Watson, 1999; Senderowitz, 1997).

There is a demand from both students and parents for education about family life, reproductive health, and population issues. In a UNFPA essay contest, adolescents from all over the world expressed their support for responsible reproductive health programmes. They highlighted the lack of equality between the sexes and argued the need for the following:

better information regarding the joys and dangers of sexual relationships, accurate information about AIDS and other STIs, access to advice relating to early marriage, greater male involvement in family responsibility, and support and guidance as they make their transition to adulthood (Popnews, 1996). Students in Ugandan schools listed the following topics as priorities for learning about sexual development: girl-boy relationships, bodily changes during puberty, dealing with parents, and HIV and STI (Watson, 1998). A Youth Counseling Centre in Asmara, Eritrea, funded jointly by UNFPA and Norway's Save the Children Fund, was packed with children and young adults only six weeks after it opened in early November 1996. The Centre provided adolescent counseling on sexual health and 5Th AIDS, and advice on reproductive health and family planning (UNFPA, 1999).

It is a common assumption that adequate knowledge of RH issues by adolescents will affect their perception of these issues and so determine their sexual behaviour. Reports from the NDR indicate that adolescents have some knowledge on sexuality and RH. In Delta State, about 48.3% of respondents aged 12 – 14 years and 78.3% of respondents 15 – 19 years knew that disease could be transmitted during sexual intercourse. Similarly 71.8 of 1013 adolescents knew that STIs could be prevented by use of condom. Also about 89.3% of adolescents in Delta State had heard of HIV / AIDS. Forty percent and 46.7% said that HIV could be prevented by abstinence and use of condom respectively. In Rivers State, study results show that adolescents were equally aware that condoms could prevent both unwanted pregnancy and STI. Most adolescents get their information on RH from their peers, the print and electronic media and from school education. Parents and health care providers are not a common source of information on RH Education**.** The Delta State house-hold

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survey 2003 showed that about 77% of adolescents aged 12 – 17 years were enrolled in Secondary School. This situation is quite encouraging as school based adolescent health programmes has the potential of reaching a large percentage of adolescents in the State (Briggs, 1998; FMOH, 2000; WHO, 2004; Okonta, 2007and Aziken, Okonta and Adedapo, 2003).

Initiatives and Programmes on ASRH by International and Local NGOs in the NDR

The UNFPA operates in 3 of the 9 States in the NDR. Their activities in the area of ASRH include:

1. Provision of adolescent friendly RH services.

2. Development of the Family Life Education (FLE) curriculum and teaching of same in secondary schools. UNFPA is also involved in the training of health workers to offer adolescent friendly RH services. One of their most conspicuous activities however is the broadcast of the programme "I need to know". This is an educational TV drama series by adolescents that impacts information on ASRH.In Rivers State, the wife of the former Governor, Justice Mary Odili, initiated an adolescent RH programme called "The Adolescent Project TAP". TAP sponsors a TV programme called the "adolescent forum" and has conducted adolescent forum for in-school adolescents. TAP has also sponsored some adolescents in skills acquisition and established a temporary half-way home for female adolescents in especially difficult circumstances. In Edo State, Women's Health and Action Research Centre (WHARC) has also contributed significantly to improving ASRH by conducting research into adolescent health and health seeking behaviour. Significant among their activities was an intervention to improve treatment-seeking behaviour and prevention of STIs among adolescents in Edo State and Delta State, the Public Health Impact Research Centre (PHIRC), Asaba, is another NGO involved in promoting ASRH. It has organized school outreaches and has set up a youth centre in Asaba. PHIRC has solely sponsored a conference on adolescent RH in the Niger-Delta (Briggs, 1998; FMOH, 2000; WHO, 2004; Okonta, 2007and Aziken, Okonta and Adedapo, 2003).

Sexual Behaviour and Culture

The term "sexual behavior" can refer to all actions and response related to pleasure seeking. "Sex" was the underlying motive of every life-enhancing activity. Sexually permissive cultures not only allow a less fettered expression of adult

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sexuality, but may give little attention to the sexual behaviors of children as long as they are not blatantly displayed. Sexually supportive cultures, believing that sex is /indispensable to human happiness, encourage early sexual expression as a means of developing adult sexual competency and positive sexual attitudes, The children in sexually permissive and sexually supportive societies display a similar developmental pattern that is not apparent in sexually restrictive and sexually repressive societies. In pubescence, girls rapidly accelerate into a phase of intense sexual experience, culminating in the acquisition of basic sexual techniques at the adult level. Boys follow a similar pattern, but their learning process is not as rapid or complete because they are usually experimenting with younger girls. Heterosexual patterns replace masturbation and homosexual activities for the majority of both boys and girls. In adolescence, there is increased sexual activity with peers and adults for both boys and girls; and it is believed that birth control is facilitated by the practice of multiple partners. Marriage is common for late adolescent girls, but boys may delay marriage for economic considerations and continue their adolescent sex patterns for longer periods (Ford and Beach, 1951).

There are four stages of childhood and adolescence in which the focus of the body shifts between a primary and a secondary concern. The first stage is from birth to approximately 6 years of age. The physical body is primary; and sexual interests, -curiosity, arousal and behavior are spontaneously expressed unless or until the child is taught to repress or inhibit her/his pleasure orientation. The second stage is from approximately age 6 to pubescence (approximately age 12). The physical growth ratio slows, the basic gross and fine motor coordination is accomplished and reliable and the primary attention of the child shifts to the mental realm. The desire for sexual pleasure continues; however, most children are thoughtful and discriminating about their sexual behavior and expressions. Their needs for privacy and autonomy characterize this stage. The third stage is pubescence to early adolescence, and the age range is highly variable approximately ages 13 to 15: As the hormones come into play the body is once again primary, with rapid growth spurts, the development of secondarily sex characteristics, sensations of increased intensity and a new awareness of the physical self and its impact.

The sexual maturation of a child reflects the overall pattern of development, from absorption in and dependency on the family of origin through the gradual acquisition of a sense of the autonomous self, to the confidence and desire to establish

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an intimate bond and form the family of choice. The erotic response of infancy is global, undifferentiated and polymorphous perverse. In childhood, it moves toward a genital focus (more surely for boys than for girls) and is expressed through purposefully directed masturbatory activity and perhaps some negotiated social interaction (often with same sex partner). In adolescence, this motivation of curiosity and self gratification emerges into one of sexual reciprocity and mutual sharing. Partnerships are increasingly stable, interdependent and emotionally intimate, It is well to note that this developmental schema appears to be stable in all cultures, whether they he sexually repressive, restrictive, permissive or supportive; however, it is enhanced by, but not dependent on, the child's ability to engage in sexual behavior and is seen as a mental construct in the absence of Sexual experimentation.

There is considerable evidence that adult sexual health and pleasure are positively correlated with age appropriate childhood sexual behavior. The interplay between the individual sex drive, importance of sex in a person's life and the sexual values of the culture (sex-negative or sex-positive messages) will determine the opportunity for sexual behavior in childhood and adolescence. The strongly sexed child may struggle through what constitutes a repressive childhood in a sexually negative culture, but emerge as a sexually healthy adult because s/he took every possible opportunity to be sexual and-maintained a positive sexual focus despite censure and sanction (typically a male pattern). More at risk in our culture is the moderately sexed child or low sexed child who accepts the culturally negative-values, is sexually inactive end unaware during childhood and finds him/herself out of phase with the sexual expectations of adulthood (typically female pattern).

Although it is currently popular to attribute all sex specific differences to cultural factors, it may well be that there are inherent differences; these constitute a major child rearing concern. A close look at American child rearing practices suggests that in terms of adult attitudes, boys exist in a heterosexually permissive sepulture. These is some expectation that "boys will be boys," which includes sexual experimentation and behavior; and as long as they do not blatantly flaunt their sexual interest and activities in front of adults, they receive little censure. Girls, on the Other hand, are reared in what is essentially sexually restrictive society in that their sexual interest, and certainly sexual behavior, is neither sanctioned nor ignored by adults. Conversely, girls are expected to be non sexual in childhood and adolescence. Sexual interest, curiosity and, especially, sexual experience cause girls to be devalued by

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family and parents group alike. Sexual innocence, inexperience and ignorance are cultural value for girls. They are permitted to express curiosity and receive information, about their future reproductive function as their gender role is programmed. Sexual intercourse is presented as the gift they are to give the man they love--a marital duty, necessary for impregnation. They might, on occasion, enjoy it, but the pleasure aspect is reportedly dependent on love and is not considered sufficient reason for their engaging in sex, (Man have sex because they love sex, women have sex because they love the man), Girls are taught to withhold and begin to use their sexuality as a negotiable commodity. Concurrently, they are taught to devalue women who sell their sexuality, the prostitute being held out as the greatest threat to the sanctity of female virtue and family values. Girls are expected to be the guardians of cultural mores by restricting or diverting the male sex drive.

Boys are taught that it is their nature and their right to pursue sexual gratification, but that girls who, like themselves, seek sexual experience and pleasure, are less valued in society than girls who deny them sexual favors. Boys may be more egalitarian in their attitudes about their "sexual partner," expecting her to be uninhibited, willing and responsive. Although they appreciate and enjoy sex with a responsive partner, they expect her not to engage in sex with others, even though they may give themselves permission to do so. Often, without conscious awareness, they devalue the sexually responsive girl that they enjoy and dedicate themselves to a relationship of sexual frustration with a girl who uses her sexuality for secondary gain. The girl who, true to the double standard, has sex to please and control the boy, rather than, to please herself, offers a sense of security to an unsure male. If she does not enjoy sex or pretends that she is disinterested except to accommodate her partner, he need not worry that she will actively seek hr willingly respond to sex with others. He may seek sex or pleasure outside his primary relationship and value, in a social sense, his non-sexual mate, if her prudishness is a shame, she may also seek outside sexual gratification and be seductive, responsive, assertive and/or experimental with another partner.

Sexuality Education and Sexual Behaviour

Psychological research shows that comprehensive sexuality education and HIV prevention programmes are effective in reducing high-risk sexual behavior in adolescents. Based on over 15 years of research, the evidence shows that behavioral

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intervention programs that promote appropriate condom use and teach sexual communication skills reduce risky behavior and also delay the onset of sexual intercourse.

High-risk sexual behavior among adolescents can lead to serious long-term health consequences such as sexually transmitted diseases (STDs), HIV/AIDS and on intended pregnancy. According to the Centers for Disease Control and Prevention (CDC) (2004) approximately 870,000 pregnancies occur each year among women 15-19 years old, and about 3 million cases of STDs are reported annually among 10- 19-year- old Other statistical models suggest that half or more of all HIV infections occur before age 25, and is one of the leading causes of death in adolescents.

Psychologists are leading efforts to develop behavior based sexuality education and intervention programs designed to help young people to develop good decision-making and communication skills, and increase knowledge about disease transmission and prevention. Responding to the continuing health threats associated with risky sexual behavior, the American Psychological Association passed a resolution in 2005 promoting widespread implementation of comprehensive and empirically supported sex education and HIV prevention programs for adolescents. According to the findings in the report, APA (2004) has developed the following recommendations.

- Programmes to prevent HIV and sexually transmitted diseases among youth should provide clear definitions of the behaviors targeted for change, address a range of sexual behaviors, be available to all adolescents (including youth of color, gay and lesbian adolescents, adolescents exploring same- sex relationships, drug users, adolescent offenders, school dropouts, runways, mentally ill, homeless and migrant adolescents), and focus on maximizing a range of positive and lasting health outcomes.
- Only those programmes whose efficacy and effectiveness have been well-established through sound scientific methods should be supported for widespread implementation.
- New programmes to prevent HIV and sexually transmitted diseases among youth should be tested against those programs with proven effectiveness.
- Each year, almost 750,000 women aged 15—19 become pregnant. Overall, 71.5 pregnancies per 1,000 women aged 15—19 occurred in 2006; the rate declined 41% from its peak in 1990 to a low of 69.5 in 2005 (CDC, 2004).

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- •The majority of the decline in teen pregnancy rates is due to more consistent contraceptive use; the rest is due to higher proportions of teens choosing to delay sexual activity (CDC, 2003).
- However, for the first time since the early 1990s, overall teen pregnancy rates increased in 2006, rising 3%. It is too soon to tell whether this reversal is simply a short-term fluctuation or the beginning of a long-term increase (CDC, 2003).
- •Black and Hispanic women have the highest teen pregnancy rates (126 and 127 per 1,000 women aged 15—19, respectively); non-flispanic whites have the lowest rate (44 per 1,000) (CDC, 2004).
- The pregnancy rate among black teens decreased 45% between 1990 and 2005, more than the overall U.S. tcen pregnancy rate declined during the same period (4l %) (CDC, 2004).
- 'Eighty-two percent of teea pregnancies are unplanned; they account for about one-fifth of all unintended Pregnancies (America Psychology Association, 2005).
- •Two-thirds of all teen pregnancies occur among I S—19-year-olds (CDC, 2004)
- CHILDBEARING
- 'Ten percent of all U.S. births are to teens (Alan Guttmacher Institute, 2002)
- •Fifty-nine percent of pregnancies among I 5—19-year-olds ended in birth in 2006. (CDC, 2004) 'In 2006, there were 42 births per 1,000 women aged 15—19. The rate has dropped by 32% since 1991, when it was 62 per 1,000, but increased 4% between 2005 and 2006 (Abma, 2004)
- •Seven percent of teen mothers receive late or no prenatal care. Babies born to teens are more likely to be low-birth-weight than are those born to women in their 20s and 30s. (America Psychology Association, 2005).
- Teen mothers are now more likely than in the past to complete high school or obtain a GED, but they are still less likely than women who delay childbearing to go on to college. (America Psychology Association, 2005).
- ABORTION
- •There were 200,420 abortions among l5—19-year-olds in 2006 (CDC, 2004).
- 'Twenty-seven percent of pregnancies among 15—1 9-year-olds ended in abortion in 2006 (CDC, 2004).
- 'The reasons teens give most frequently for having an abortion are concem about how having a baby would

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- Change their lives, inability to afford a baby now and feeling insufficiently mature to raise a child. (America Psychology Association Resolution, 2005).
- As of January 2010, 34 states require that a minor seeking an abortion involve her parents in the decision. (America Psychology Association, 2005).
- 'Six in 10 minors who have abortions do so with at least one parent's knowledge. The great majority of parents support their daughter's decision to have an abortion.
- In most parts of sub-Sahara Africa, sex is generally considered a taboo subject for discussion within the society and especially within y. This occurs irrespective of the fact that ever so often, the subject sexuality education pops up in the media, school and other groups in the society and thus in the collective consciousness of all (Ojerinde, 1997).

Recently, the Nigerian Catholic bishops, in a conference meeting, called on Nigerian parents to the current comprehensive sexuality education guidelines a by the National Council on Education to be integrated into the school curricula (Catholic Secretariat, 2005). They advocate sexuality education should be taught at home by parents. The question is: Are parents knowledgeable enough to handle education of their children at home? Even those parents knowledgeable, how many of them can muster up the co table issues in human sexuality for their children? Wilson (2000) reported that parents in London stated that they would like to take a more active role in talking to their teenage sons' daughters about sex but feel poorly equipped to do. She posited that the more open and honest parents are with their children about sex, the longer young people delay sexual activity. Ray (2000), on the hand, reported that parents in Sweden want schools to play a major role in sexuality education. Epstein (2000) commented that it paradoxical that, while children were dealing with questions about sexuality and relationships everyday in the classroom, their parents and teacher are anxious about the whole question of whether to teach them sexuality education or not.

A study carried out by Tauna (1992) among 10-16 year-olds in a northern Nigeria showed that among their sources of information on production, pregnancy, birth control and HIV/AIDS, television ranked first, newspaper second, radio third, teachers fourth and parent fifth. This study went on to recommend formal sexuality education in the school, since parents do not seem to be up to the task. In another

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study by Action Health Incorporated (1990), carried out in Lagos, many young people said that they learn about sexuality from soft-sell magazines, such as Ikebe Superstar, Lolly, Fantasy and Hints. The images prevailing in the entertainment media imply that sex is largely risk free and that everyone is doing it - a very wrong impression. Okafor (1998), while studying source of sexual information of young people in Anambra State, found that books, magazines and newspapers ranked first, school ranked second, radio and TV ranked third, while parents ranked seventh Ariba (2000) warned that since the world has become a global village, events occurring in other parts of the world that previously remote are becoming instant influences on pattern behaviours in other parts. When these influences are negative impart on the recipient populations could be catastrophic such populations are well informed and have evolved the appropriate behaviour to cope with such information. Through the media (Print and electronic), the Internet and direct Interaction with foreigners visitors, our young population is becoming exposed to obviously classified information on sex, including hot pornography. Yet this population has not been well prepared to handle such information. This could lead to sexual health problems, such as rape, incest, premarital sex, teenage pregnancy, sexually transmitted infections (STIs), HIV/AIDS, unsafe abortion, etc.

AHI (2000) insisted that if a child is taught about what changes to expect as he grows older, he will be psychologically prepare to accept those changes as normal and take charge of his life. He will be less vulnerable to receiving wrong information that could lead to risky sexual behaviour. Therefore, the child deserves to know about sexuality and what changes to expect during puberty in order to lead a normal, healthy and fulfilled life. AHI (1997) further warned that parental attitude and behaviour pose a serious threat to young people's sexual health education. Parents often admonish their children to live 'moral lives' and preach the value of virginity, especially for girls. Yet many of them fail to set positive examples for their children in their own gender attitude and sexual behaviour. Herant and Donald (1992) observed that it is suggested that children be educated sexually at home. But many parents find the prospect very bewildering. It often entails considerable uncertainly and discomfort for all involved (both parents and children) not to mention the factual sexual knowledge of most parents (passing on misinformation to children). They then liken it to the case of a blind man attempting to lead the blind. Indeed most parents know nothing more

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than how to pet sexual act. Human sexuality covers a far broader field than sexual intercourse. Many parents do not possess such knowledge.

Most parents traditionally try to protect their children from sexual information in the false belief that ignorance will encourage chastity. Yet the terrible result of increase in moral laxity, promiscuity, unwanted pregnancies, unsafe abortion, STIs. HIV/AIDS among young people has become a cause for concern. WHO (1994) observed that taboos universally associated with sexual behaviour usually make it extremely difficult, if not impossible, for parents to discuss sexual activity and the risks associated with their growing children. Most parents would rather leave this responsibility to teachers and/ or other adults whom they believe to be in a better position to deal with such sensitive issues.

WHO (1992) stated that parents have always expressed their inadequacy to discuss the explicit issues of sexuality with their children. This inhibition could be attributed to cultural and religious beliefs and practices, lack of communication skills, and inadequate knowledge of sexuality. It is important that parents have a thorough understanding of who we are as human beings, and why we manifest certain behaviours at different stages of development; so that they can use this knowledge to assist their children go through life successfully. Unfortunately, most parents in Nigeria are yet to live up to expectation as far as communication on sexual matters is concerned. Melgosa (2001) posited that family's role in sexuality education is irreplaceable. It is unwise to assume that children are capable of discovering correct sexual orientation on their own. There is need to establish the beginning of sexuality education in the family in the preschool years (3-5 years). Small children are usually curious about all parts of their bodies and they notice the differences between men and women. They begin to ask 'why do I have this, or why don't I have that? Sexuality education begins with the first question related to sex. Parents must understand that answers should be natural, simple and correct enough for children to understand, this will create a healthy attitude towards sexuality.

Walsh, Parker and Cushing (1999) remarked that the benefits parental involvements in sexuality education extend beyond the contribution it can make to improve ease of communication between parents and children. If parents are to have influence on the events that occur in their young adult's lives, they should learn to lay the groundwork of sexuality education early at home. Children start to learn about sexuality well before preschool age. Although parents often described as the primary

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sex educators of their children, many studies have proven otherwise. Hence, the need for this study to find out the sexuality education practices of parents of young secondary school students in Enugu Education Zone, Enugu State. According to Asuzu and Asuzu (2007) human sexuality may be defined as the totality of all that is characteristics of human sexes — male and female — especially those that distinguish them most from each other. It also involves an individual's perception practice of the qualities that are characteristic of maleness femaleness (Barber, 1988). Notably, there is growing speculations that sexuality is not for the old, and has thus added to negativities often associated with old age. Hence, the notion that sexuality is a lifelong process goes contrary to the thinking of some elderly people, their children, and healthcare providers (Kennedy et al., 1997). This may have accounted for the very little attention, until recently, targeted at sexuality among older adults (Spence, 1992) particularly menopausal women.

UNESCO (2002) note that young people all over the world have common needs; to achieve full and healthy development, a positive and stable family life, an understanding about their bodies including the emotional and physical capacities that enable them to have sexual relations and reproduce. With these assets, young people are more likely to succeed in school have quality of life and relationship and contribute to the economy and productivity of their countries. Without them, they face interrupted schooling, personal insecurities, ill health and diminished economic opportunity.

Reproductive Health Education and Family Life Education in Schools

Family is one of the core aspects of population education. It encompasses issues on family life, sex, the environment and health. International Planned Parenthood Federation (2008) defined family life as an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, ageing as well as their social relations in the socio-cultural context of the family and society. Family life education provides information on population education, family life, sex, the environment and health.. Family life education has its root on sexuality and is a tool to good health of the society and is one of the core aspects of population (Olugbenga and Fasuba, 2005). Reproductive health education according to UNESCO/UNFPA (2007) is an educational experience aimed at developing capacity of adolescents to understand

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their sexuality in the context of biological, psychological, socio-cultural and reproductive dimensions and to acquire skills in managing responsible decisions and actions with regard to sexual and reproductive health behaviour.

Schools are special environment that exist for the purpose of enhancing the learning process. They are sensitively built environments housing very special segment of the population. The largest number of young people today is the largest ever and majority of them are attending schools. The health and reproductive health behaviour of young people will have both immediate and long term consequences. Most societies share a vision for their children, that they will reach adulthood without early pregnancy, complete their education, delay initiation of sexual activity until they are physically, socially and emotionally mature and avoid HIV infection and other Sexual Transmitted infections (STIs) (Adepoju, 2005).

While family life education is perceived as a tool to good health of the students, Olugbenga & Fasubaa (2005) enumerated the following as the basic concept of family life education for the students:

a) Need to have respect for other especially persons of the opposite sex. This is based on premise that if young ones can truly learn this, it will make them to understand what respect means and hold on to it as a value, so that they could refrain from behaviour which is potentially harmful to others.

b) The need for self-respect, self esteem and high self-concept. The concept will allow the young ones to be exposed to the variety of life options they will encounter while growing up, get them prepared for life eventualities and also tactically equip them to make appropriate choice in the presence of different alternatives e.g. choosing to finish different formal education and avoid early pregnancy.

(c) The young ones need to know that behaviour has consequences. This is possible in a way that, individuals should control their behaviour and must be ready to accept the responsibility for whatever the consequences of their behaviour.

(d) The need on how to withstand social pressures. Young ones are prone to face pressure on many issues from many quarters while growing up. Pressure may come from their peers in the society where early adolescents' sexual activity is prevalent. Pressure also may arise from parents, relatives and neighbours on issues of life. The teaching of family life education will help adolescent to recognize these types of social pressure and help them to deal with them in a responsible manner.

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Adepoju (2005) observed that the youth who constitute ages 10- 24 and 36-70 percent of Nigerian population are found to be highly involved in antisocial behaviours such as violent crimes, unsafe sexual activities and drug abuse among others. He added further that, the adolescents' dilemma has been attributed to their great lack of information and knowledge about the implication of their behaviour on their sexual health and the general welfare of the nation. The introduction and institutionalization of sexuality education is one immediate effort that must be made to address this problem and to create awareness about these sexuality based problem. Reproductive health and population education should be addressed within the context of a health-promoting school, based on the principles and actions that were identified in the Ottawa charter for Health Promotion (WHO, 1986). The charter recommended actions in four key realms which included the following:

i. Create Health Public at the local, district and national levels.

ii. Develop supportive environment which include the physical and psychosocial school environment.

iii. Re-orient health service in the schools to address issues of family life reproductive health population issues and other school health promotion efforts.

iv. Mobilize community action, that is, to engage the school and community in efforts that call attention to current challenges related to family life, reproductive health and population issues.

A. Health-promoting school should attempt the following

1. Foster health and learning with all measures at its disposal.
2. Engage health and education officials, teachers, students, parents and community leaders in effort to promote health.
3. Strive to provide a healthy environment, skill based health education and school health services along with school and community projects and outreach, health promotion of staff, nutrition and food safety programmes, opportunities for physical education and recreation and programme for counseling, social support and mental health promotion.
4. Implement policies, practices and other measures that respect an individual's self-esteem, provide multiple opportunities for success and acknowledge good efforts and intensions as well as personal achievements .The schools do not address family life, reproductive health and population issues, they miss an opportunity to positively affect student' education, quality of life, relationship and ultimately the economy and

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productivity of nations. For example, pregnant girls often drop out of school to care for and support their babies. Without a school diploma, adolescent parents often drop out of school to care and support their babies without being qualified for jobs or can get low-paying jobs which do not adequately support the family. Schools have been identified as appreciate sites for family life, reproductive health and population education. Schools have the potential to reach a large portion of the world's children and adolescents. More children in school are an efficient way to reach school-aged youth as well as teachers and staff. Children who attend school can also be involved in school based activities that include outreach to family and community members and out-of-school children. Since schools are part of the communities where they are located, they are in a good position to have insight into how best to address these issues in a culturally appropriate and acceptable way (Rice, 1999).

During the critical development period of adolescent, schools have the opportunity to improve children's health, self-esteem, life skills and beahviour with interventions to promote health and prevent diseases (WHO, 1996). Schools have the opportunity to address young people before they initiate sexual and other risk behaviours. Educating adolescents lays the groundwork for a life time of healthy habits since it is often more difficult to change established habits than is to create good habits initially (Kirby, 1994). How reproductive health is addressed in childhood will set the stage for how the population will deal with many health issues in years to come (Rice, 1995).

Teachers can play an important role in influencing health. Teachers are absolutely critical, not only to the development of individuals but to the development of nations as well. Teaching, more than any other profession influences who we are and influences societies in which we live (Education International, 2008). Teachers and schools staff play a key role in carrying out efforts to address family life, reproductive health and population education. Staff meeting is one useful forum of developing teacher and school staff's support and commitment. Reproductive health education is described by UNESCO/UNFPA as educational experiences" aimed at developing capacity of adolescents to understand their sexuality in the context of biological, psychological, socio-cultural and reproductive dimensions and to acquire skills in managing responsible decisions and actions with regard to sexual and reproductive health behaviour" (UNESCO/UNFPA, 1998).

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Schools are strategic entry points for addressing family life, reproductive health, and population education. Schools have the potential to reach a large portion of the world's children and adolescents as many children attend school. In the developing world, where the last 30 years have seen an impressive improvement in enrolment rates, more than 70% of children currently complete at least four years of preliminary education (UNICEF, 1996). Between 1985 and 1995, the global gap in school enrolment between boys and girls narrowed in developing countries because of efforts to enroll more girls (Cooper, 1999). During the critical developmental period of adolescence, schools have the opportunity to improve children's health, self-esteem, life skills, and behaviour with interventions to promote health and prevent diseases (WHO, 1996). Many young people initiate sexual intercourse while they are enrolled in school (Weiss, Whelan & Gupta., 1996). Schools have the opportunity to address young people before they initiate sexual and other risk behaviours. Educating adolescents at this key juncture in their lives can lay the groundwork for a lifetime of healthy habits since it is often more difficult to change established habits than it is to create good habits initially (Kirby, 1994). How reproductive health is addressed in childhood will set the stage for how the population will deal with many health issues in years to come (Rice, 1995).

Benefits of Reproductive Health, Family life and Population Education

The practical benefits of greater investment in family life, reproductive health, and population education according to United Nations (2000) include:

(a) Individual and Public Health Benefits:

• Delayed initiation of sex

• Reduced unplanned and too-early pregnancies and their complications

• Fewer unwanted children

• Reduced risk of sexual abuse

• Greater completion of education and later marriages

• Reduced recourse to abortion and the consequences of unsafe abortion

• Slower spread of sexually transmitted diseases, including HI V/AIDS.

(b) Social Development Benefits:

• Progress towards gender equity, social participation and grassroots partnerships for development

• Better preparation of young people for responsibility now and as adults and skills development to facilitate response to social change and opportunity

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• Stronger primary health care systems with emphasis on health promotion
• Stronger, more relevant education systems.

Schools can encourage and support parents and families to communicate with their children about family life, reproductive health, and population issues through organizing seminars and workshops. Intergenerational studies have found that when there is communication between parents and children regarding reproductive health issues, it is often limited to 'threats and warnings without explanations (Wilson, Mparadzi & Lavelle, '1992). A study in Germany found that among parents, 90% of mothers and 80% of fathers believed that they knew the most favourable time for conception; however, only 78% of mothers and 67% of fathers actually knew the correct information (Kluge, 1994).

Schools can provide an avenue for facilitating change in thinking about harmful traditional practices. Some traditional practices, such as female genital mutilation, norms that favour early marriage, and fewer reproductive health options for women than for men, have been harmful to young people's health. Female genital mutilation, the most serious of these, is deeply entrenched by strong cultural dictates, but it can cause severe physical and psychological damage (UNFPA, 2000). Between 85 and 114 million females in the world have been subjected to female genital mutilation, most of them when they were young girls or just before puberty—a time when they might still be in school. Thus, the school may provide a timely and effective avenue for intervening in an effort to facilitate a change in thinking about this practice, as well as considering its role and function in society. NDHS (2003) and Oladapo (2008) argued that contraceptive prevalence rate in Nigeria has increased tremendously. However, this result contradicts the reports of Oni and MacCarthy (1991) and Oderinde (1998) on lower knowledge of contraceptive use among women. Current and pass studies show improvement in the knowledge of family planning.

Majority (41%) reported they heard a family planning message on radio / television. This result is consistent with the reports of Isiugo-Abanihe (1996), Wilson (1998), Yahyah (2000), Oyewo (2004), Ayangunna and Oyewo (2007) that indicated that advertisement of family planning has received tremendous impetus throughout the country, including the use of drama, folk-media and music that eulogize the virtues of small family. At the same time, HIV / STI / AIDS pandemic has had a profound impact on condom advertisement on both radio and television. It could be inferred from table 4a that majority of the respondents (38.5%) obtained

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contraceptives from medical doctors, 25% from nurses, 24% from pharmacists and 12% from other sources. Table 4b also shows 'where' respondents received their contraceptives. Majority (52.5%) of the women admitted receiving contraception services from hospital, 9% from maternity home, 29.5% from health centers, and 6% from family planning clinic and 3% from chemist / shops and other sources. These results find support in the study of Akingbade (2008) who opined that women in southwest Nigeria know about family planning methods and where such services could be obtained. Their general concern is about the side effects of contraceptive methods, which could be addressed through campaigns and education programmes.

The total fertility rate in Nigeria is one of the highest in the world: it is 5.7 percent. That is, a Nigerian woman will give birth to an average of six children in her lifetime (Isiugo-Abanihe, 1996; Ladipo, 2008). Currently, Nigeria population stands at 140,003,542 (The Guardian, 2007). Crude birth rate is at 15 per 1,000 populations; the country's growth rate is at 2.6 percent; infant mortality rate is 75 percent, while percentage of the population of persons, whose age is less than 15 years, is put at 45 percent, and those whose age is 65+ years is 3 percent. Life expectancy for males is put at 47 years and females at 48 years (Nigerian Demographic Survey, 2003; Population Reference Bureau, 2009).

Consequently, family planning reduces maternal and infant morbidity as well as stems rapid population growth in the shortest possible time (FRN, 1996). Family planning, according to Isiugo-Abanihe (19996; 2003) helps women avoid unwanted pregnancies, dangerous abortions and childbearing under circumstances that threaten life. The use of effective and culturally accepted methods, administered in a clean environment by qualified medical personnel, will be profoundly beneficial to the teeming population of Nigerian women, many of whom are literally dying in ignorance (Isiugo-Abanihe, 1996). Sexuality refers to all aspects of being sexual. It is reflected in the total expression of individual's entire personality. It is shaped by one's values, attitudes, behaviours, physical appearance, beliefs, emotions, personality, likes and dislikes and spiritual selves as well as the ways in which people have been socialized (engender Health, 2005). Sexuality begins at birth and lasts a lifetime and it is influenced by ethical, spiritual, cultural and moral factors. It involves giving and receiving sexual pleasure, as well as enabling reproduction. Sexuality is a total sensory experience, involving the whole mind and body-not just the genitals. This is why Akinade and Sulaiman (2006) affirmed that sexuality transcends beyond sex.

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According to them, while sexuality is all aspects of being sexual, sex connotes either the dimension of being male or female or physical sex i.e. physical activity involving the genitals. The word sex is also used as gender but connotes sex and roles.

Fatiregun (2004) observed that there is usually a mix-up between the word sexuality and sexual intercourse. According to him, most people view them as the same but sexual intercourse is only an aspect of sexuality and is a means by which reproduction takes place, while sexuality has a broad base meaning which emphasizes the way in which people express their sexual feelings. It could also mean a condition characterized and distinguished by sex. Sexuality according to Akinade and Sulaiman (2005) refers to sexual acts and behavior, individual's attitudes and behavior on sexual issues. This includes individual preferences about sexual acts, such as masturbation, kissing or sexual intercourse and sexual behaviors such as dressing in certain way, sexual identity and sexual orientation. Human sexuality deals with how people experience and express themselves as sexual beings, in terms of gender, gender identity, gender roles and sexual orientation (Rye 2001).

Human Sexuality and Religion

A Joint Committee of the Methodist and Presbyterian churches wrote an occasional paper on human sexuality in 1998. The committee affirmed the joy of human sexuality as something that was given by God to be enjoyed and for which people of God should give thanks. It emphasizes the benefits in advances in contraceptives in recent years, which have helped people to celebrate sexuality and to engage in sexual activity for itself and not for its procreative purpose. This has brought about freedom to value sexual activity for itself.

The committee was of the view that the term sexuality is associated with sex in terms of sexual intercourse but that though sexuality includes sex, it cannot be reduced to certain arts, urges and drives. Sexuality is an aspect of what one is as a human being, whether or not one engages in activity considered to be 'sexual'. Sexuality is man's way of living in the world as female and male persons. It is about the whole personality; it includes our gender as male and female, which is biologically determined (genetic and hormonal). It also includes gender roles as masculine and feminine.

The committee further affirmed that sexuality vitalizes human need to relate to other human beings. It empowers man's erotic attractions. It energizes our physical,

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emotional and spiritual relationship and may be celebrated alone. Furthermore, because sexuality is about the whole personality, it influences all human interactions, including business relationship, the way people behave in meetings and in positions of power, casual and deep personal friendship and parenting: it strongly influences one's erotic impulse which in turn influences the need to move into deep physical, emotional and spiritual communication and communion with other people. The mystery of human sexuality, as viewed by the Joint Committee (1998), is the mystery of the need to reach out and embrace others that require a willingness to be known and be loved. This desire usually leads to an attraction towards the opposite sex. However, experience shows that it can also lead to attraction towards the same gender or both, though the traditional ideology rests on the belief that the only acceptable intimate relationships are those involving people of opposite sex. Omar (2003), looking at sexuality from the Islamic point of view, is of the opinion that sexual desire in humans is as normal as the desire for food or shelter. Human sexual desire is not only for reproduction but also for pleasure. It is therefore wrong to consider the control of human sexuality since it must be expressed.

Gender Role Differentiation

Gender identity is the sense of being male or female which most children acquire by the age of three, while gender role is the mental set of expectation that prescribes how female and male should behave, think, act and feel in the society (Akande and Sulaiman, 2003). Ekpu (2004) sees gender roles as the culturally expected pattern of behaviour and attitudes determined to be appropriate for males and females. It also includes the attitudes, rights, duties and obligations that are part of the role of being a man or woman. Sex role is the term originally used to refer to the different positions and behaviours of women and men (Lueptow, 1984). Gender roles are developed in particular social and cultural contents (JMPPQC, 1984). For most of human history, gender roles have evolved within a patriarchal fame where power and control are exercised by men. However, over the last hundred years or more, the patriarchal gender roles have been increasingly challenged as most now accept that human kind was created males and females as equals in God's image. Ekpu (2004) was of the view that each culture determines its own appropriate sex roles. According to her, what is expected in one society in terms of masculine and feminine behaviors is not necessarily accepted in another. In some cultures, some

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forms of behaviour that are considered to be masculine are considered to be feminine and vice versa. In other culture, little distinction is made between sexes. The culture of a particular society greatly influences the roles they expect from each gender. It also influences the way a man relates with his wife and family.

Sex differences in most societies usually emerge immediately after birth. The 'pink and blue' treatment applied to boys and girls after scan had revealed the sex of the child confirms this. After birth, differences appear in hairstyles, clothes and toys. Later on in life through observation and imitation, boys and girls learn appropriate gender roles and expectations.

The confusion about roles spills over into marriage. Marriage roles that were formerly assigned by society must now be worked out by the persons involved. New husbands and wives frequently face a clarification. There are more role tension and conflicts between the spouses since the situation is more confused.

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million women in developing countries become pregnant when they do not want a child and over a million terminate unwanted pregnancies through unsafe abortion.

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Adolescent Reproductive Health Programmes and Services

Six programming principles are suggested below as tools for program planners to use in designing expanded sexual and reproductive health programs for young people. These principles build upon the study Group's findings, and upon the sources of insight described at the beginning of improving fit of adolescents needs for future programme for Sexual and Reproductive health in Developing Countries by Huges

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and McCauley, (2000). First, the current behavior of young people indicates that they want sexual and reproductive health information and skills, but lack access to sources with which they are comfortable. Second, health-risk-behavior and adolescent-development theories suggest that young people need to learn the skills involved in adopting healthy behaviors. Thirdly, resource constraints to meet large numbers of young people, these principles are intended to offer guidance for identifying needs and available resources and liking and strengthening a wider-than-usual variety content, providers, and settings to create appealing, flexible, effective and sustainable programs at significant scale.

The six programming principles are:

1. Recognize and address the fact that the program needs of young people differ according to their sexual experience and other key characteristics.
2. Start with what young people want and with what they are doing already to obtain sexual and reproductive health information and services.
3. Include building skills (both generic and specific to sexual and reproductive health) as a core intervention.
4. Engage adults in creating a safer and more supportive environment in which young people can develop and learn to manage their lives, including their sexual and reproductive health.
5. Use a greater variety of settings and providers – private and public, clinical and nonclinical – to provide sexual and reproductive health information and services.
6. Make the most of what exists, build upon and link existing programs and services in new and flexible ways so that they reach many more young people.

Adamchak (2000) revealed that successful reproductive health programmes help young people (adolescents) to develop life planning skills; respect the need and concerns for themselves and other young adults as well as provide respectful and confidential clinical services for monitoring and evaluating adolescent reproductive health issues by Health care providers and other stakeholders. Studies revealed that adolescent mean age of early sexual initiation is 15.04 years with 2% of them having been initiated into sex at the age of 12 (Okonta, 2007). He stated further that lack of reproductive health programmes and services; lack of involvement of adolescents in planning; implementing, monitory, and evaluation process, has led to high level of

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adolescents involvement in sexual behaviour particularly in Delta State. Moreover, adolescents sexual activities of unsafe sexual behaviour has led to a high rate of STIs, unintended pregnancy and illegal abortions; early marriage. Advocates for Youth (2001) confirmed that a study of 330 female rape victims in Edo States in the south-south of Nigeria reported that majority of raped victims were females ages 13 to 19. Action Health Incorporated (1992) also carried out a study in Benin city which revealed that fifty five (55) percent of secondary school girls had sexual intercourse before the age of sixteen (16), one hundred and forty six (146) out of every one thousand (1,000) women who give birth in Nigeria are under nineteen (19) years (AHI, 1992). Negussie; Knut, Berit and Johanne (1999) revealed that Research based adolescent ASRH (Adolescent Sexual and Reproduction health) programmes up till now are limited to few institutes in Africa countries, and are mostly non-governmental organizations. "Successful" programmes are often featured by non controlled randomized studies, which will obviously be unpublished reports in peer-reviewed journals, or widely circulated within the scientific community, which often has a little scientific evidence other than what the programme owners would say about which program approaches are effective to deal with the health behaviour of adolescents (Frost and Forrest, 1995).

Nzeagwu (2004) opined that adolescent pregnancy and child bearing is increasing. It is considered a serious societal problem now than before. A common dangerous sexual behaviour among adolescents is unprotected coitus (sexual intercourse). Herbert (2002) attributed that the solution to this problem is to educate young people especially adolescents about the risk of unprotected, penetrative sex and teaching them about abstinence and safer sex instead of leaving them uninformed. Ironically Nigerian reluctance to confront this problem openly and directly highlights the difficulty that parents, schools etc face in dealing with a typical sexuality in adolescents and in suggesting appropriate and alternate forms of expression of their sexual behaviour. Brien (1982) suggested that curriculum design should have a comprehensive teacher manual, content of instruction should cover anatomy, puberty, changing relationship.; (decisions, parents, friendship, dating, sex roles; homosexuality, sexual activity (such as recluses, pregnancy, birth control disease, parenting & lifestyle). Smith (2003) propose that an alternative to proper sexual behaviour in adolescence is comprehensive Sexuality Education, which emphasizes

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broad based knowledge of all aspects of sexuality, thereby enabling students to make informed decisions about sex.

In addition, it incorporates discussion of sexual feelings and desires, risk-reduction strategies and rehearsal of relationship, communication and negotiation skills not only in schools but parent too should be involved by teaching their adolescents about sexuality. Researchers have indicated that such RHE programmes are significantly more effective in delaying sexual activities in adolescents and reducing sexually transmitted infections (STIs) and unwanted pregnancies among adolescents in the society.

Delta State household survey (DSHS) (2003) showed that about 77% of adolescents aged 12 – 17 years were enrolled in secondary school. This situation is quite encouraging as school based adolescent's health programmes has the potential of reaching a large percentage of adolescents in the state. Lack of adequate recreational facilities and equipment has motivated young people to regard sexual activties as a recreation. Lacks of reproductive health knowledge by adolescent and parents to know that pregnancy possibility can occur at first intercourse, use of contraceptive in preventing STIs/HIV/AIDs; poverty and economic hardship of parents to provide basic needs for the female child has prompt them into early sexual behaviour to make money respectively. Adolescents' reproductive health needs and ability to access services differ depending on whether they are sexually active, in schools, working, living in urban or rural areas; or exposed to sexual violence. Programmes that involve youths; community leaders and parents can identify a program's needs and goals more effectively and can ensure broads community support (UNFPA, 2000).

Adamchak et al (2002) emphasized that including evaluation components to RHEPS can help ensure that programmes have clearly defined goals, measurable objectives, and plans to sustain and expand programs into the future. WAYI (West African Youth Initiative) (2004) project used peer educators to provide reproductive health and sexuality information and counseling to young people ages 12 to 24. Evaluation found significant positive effects on participants' knowledge, perceived self-efficacy and behaviour. Participants' increased knowledge and use of modern contraception's significantly increased. Compared to control, participants were more willing to ask for or buy contraceptives, especially condoms and foaming tablets, and

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reported that they had taken measures to protect against STIs, including HIV (Journal of Social Science, 2005).

The Sexual pressure on adolescents presently explains one of the reasons for the high rate of sexual promiscuity and lack of control of sexual urge or behaviour among adolescents. These pressures are quite different compared to previous generations. In view of the findings stated above and despite the existence of Reproductive health programmes and services by non-governmental organizations in the country, the skills to curbing adolescents sexual behavior is still a problem. Adolescents need effective programmes, skills, and services concerning their sexual and reproductive health. Adolescents first contact of a sexual and reproductive health programme is when they must deal with a pregnancy or a sexually transmitted disease.(Studies in Family planning, 2001).Moreover, adolescents also seek services, preliminary findings from community-based studies underway in India, Nigeria and Cameroon indicate that adolescents often treat themselves with patent medicines or home remedies and pay visit to private providers such as traditional healers, pharmacists, or quack physician (Studies in Family planning, 2001 & Okonofua, 1997). (Studies in Family planning's, 2001) Despite these problems and the fact that adolescents represent almost one fourth of the World population(WHO,2002) it is obvious that the challenges confronting the existing reproductive health programmes and services on adolescent sexual behaviour are diverse and multiple. Reproductive health programmes will help to solve the problems of unwanted pregnancies, illegal abortion, child abandonment, infants and maternal mortality, rape, single parenthood and school drop-out which are peculiar to adolescents and young adults in our society (Odelola, 2004). Research has shown that in most cases, except where there has been a reproductive Health programmes and Services Intervention, the knowledge of adolescents regarding sexual and reproductive health issues is very poor; Action Health Incorporated (AHI, 2003).

Moronkola (2003) noted that adolescents have poor knowledge about reproductive issues, this he attributed to unsatisfactory efforts on the teaching of Health Education. Furthermore, the past and current neglect of the health of adolescents and young person's coupled with traditional practices and societal changes have increased the vulnerability of this group within the population to reproductive ill-health. Evaluation is widely believed and seen as fault finding which

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often makes implementers uncomfortable to undertake the exercise (Advocate for Youth, 2005). The need for evaluation of RHEPS is very crucial besides expanding knowledge about adolescent sexuality and development in general; there is a dire need for information that can be used to guide the development and expansion of school health programmes. This type of information must be collected through evaluations that have been developed and implemented with sufficient care so that their findings can be convincing.

Types of Adolescent Reproductive Health Programmes

1. Sexuality Education

Sex education also called "Sexuality Education" or informally "Sex Ed" is a broad term used to describe education about human sexual anatomy, sexual reproduction, sexual intercourse, human sexual behaviour, and other aspects of sexuality, such as body image, sexual orientation, dating, and relationships. Alan Guttmache Institute (2010) stated that Sexuality is an aspect of human development across the lifespan. The rapid biological and psychological changes that occur during adolescence enhance the importance of sexuality during this critical period. During puberty, hormones increase adolescent's attraction to potential sexual partners and enables their bodies to reproduce. Psychological development enhances teen's abilities to negotiate sexual relationships and to realize that their physically mature bodies encourage adult like interactions, including romantic relationships and a greater degree of autonomy from parents.

Sexuality according to Oganwu (2005) is a central part of being human throughout life and it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality and relationships education involves learning about feelings, relationships, gender roles, body image, and sexual development, being safe and reproductive health. It supports children to develop personal and interpersonal skills to recognize, name and express their feelings appropriately and to develop their communication and negotiation skills. Sexuality is expressed and experienced in thoughts, fantasies, desires, belief attitudes, values, behaviours, practices, roles and relationship. While sexuality can include all of these dimensions, not all of them are always experienced or expressed (Kpangbam, 2004). Sexuality education is defined as an age-appropriate, culturally relevant to teaching about sex and relationships by providing scientifically accurate, realistic, non-

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judgmental information. It provides opportunities to explore one's own values and attitude and to build decision-making, community and risk reduction skills about many aspects of sexuality (CDC, 2008). School provides an important opportunity to reach large numbers of young people with Sexuality Education before they become sexually active, and offers appropriate intervention structure for formal curriculum (UNESCO, 2009).

Ariba (2005) opined that man's sexuality is integrated, into his total life 'development as a health entity and a source of "creative energy". Sexuality education may be regarded as a method of achieving appropriate and safe sexual behaviour by a given population through systematic persuasion. Sexuality education and sex education have been used interchangeably. This is in error because, in as much as they are related, sex and sexuality mean different things. Sex refers to one's reproductive system and gender behaviour, as male and female. It is gender (male or female). Sexuality on the other hand is a composite term; it is the total expression, of who we are as human being. It encompasses our whole psychosocial development – our values, mental attitudes, physical appearance, beliefs, emotions, likes and dislikes, our spiritual selves, and all the ways in which we have been socialized. It involves our sexual identity, psychic orientation and our entire self-concept. It begins at birth and lasts a life time (Action Health Incorporated, 1998). Kirby (1999) stated that sexuality includes not only physical and sexual desire, but also issues of identity, societal and gender roles and human relationship including those with family, peers and partner. Sexuality education is 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, affections, intimacy, body image and gender roles (National Guidelines Task Force, 1996).

Sex Education, which is sometimes called sexuality education or sex and relationships education, is the process of acquiring information and forming attitudes and beliefs about sex, sexual, identity, relationships and intimacy. Sexuality education is also about developing young people's skills so that they can make informed choices about their behaviour, and feel confident and competent about acting on these choices. It is widely accepted that young people have a right to sexuality education. This is because it is means by which they are helped to protect themselves against abuse, exploitation, unintended pregnancy, sexually transmitted diseases and HIV and AIDs.

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It is also argued that providing sexuality education helps to meet young people's right to information about matters that affect them, their right to have their needs met and to help them enjoy their sexuality and the relationships that they form. The term sexuality is derived from the term sex. Sex is something you do while sexuality is something you are. This way of understanding sex highlight the difference between the act of sex and the individual experience of sexuality, which is an intrinsic part of who we are, one that can't be separated out of ourselves any more than our ethnicity or religious/spiritual beliefs.

Sexuality is a complex aspect of our personality and self. Our sexuality is defined by sexual thoughts, desire and longings erotic fantasies, and experience. In many ways sexuality is the forces that empower us to express and display strong, emotional feelings for another person and is a natural stimulus for the procreation of our species. The 'thing' that attracts one person to another may not always be sexual-it could be sense of humour, personality, likeability, compatibility, or intelligence. Sex or Sexuality may only be a secondary consideration. Sometimes, part of our sexuality can be suppressed-some people have sexual desires about particular friends or associates, but don't act on or talk about those desires. Other has general sexual desires or fantasies about people of their own sex (that is, same sex), but don't explore or discuss those thoughts and feelings. Common avenues for sex education are parents, caregivers, friends, school programs, religious groups, popular media, and public health campaigns. Sexuality education in different countries varies. For example, in France sex education has been part of school curricula since 1973. Schools are expected to provide 30 to 40 hours of sex education, and pass out condoms to students in grades eight and nine in January 2000, the French government launched an information campaign on contraception with TV and Radio spots and the distribution of five million leaflets on contraception to high school students.

Skills for teaching sexuality education

If sexuality education is going to be effective, it needs to include opportunities for young people to develop skills, as it can be hard for them to act based on only having information. The skills young people needs as part of sexuality education are linked to life-skills that are more general. Being able to communicate, listen, negotiate with others, ask for and identify sources of help and advice, are useful life-skills, which

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can be applied to sexual relationships. Effective sexuality education develops young people's skills in negotiation, decision-making, assertion and listening. Other important skills include being able to recognize pressures from other people and to resist them, dealing with and challenging prejudice and being able to seek help from adults- including parents, cares and professionals-through the family, community and health and welfare services. Sexuality education that works also equip young people with the skills to be able to differentiate between accurate and inaccurate information, and to discuss a range of moral and social issues and perspectives on sex and sexuality, including different cultural attitudes and sensitive issues like sexuality, abortion and contraceptives.

Objectives of Sexuality Education

Sexuality education aims to reduce the risks of potential negative outcomes from sexual behaviour, such as unwanted or unplanned pregnancies and infection with sexually transmitted diseases including HIV. It also aims to contribute to young people's positive experience of their sexuality by enhancing the quality of their relationships and their ability to make informed decisions over their lifetime. Effective sexuality education must contribute to helping young people to be safe and enjoy their sexuality. The sexuality education that parents provide to their children can be supplemented by planned learning opportunities, in churches, mosques, synagogues and other places of worship, community, youth' agencies, and schools. The report from various studies has shown that most' young people look up to their parents as, their most important source of information about sexuality. Friends are the second most important source, school courses rank third, and television is fourth. More than two-thirds of young people have talked to their parents about -sexuality. Two thirds of adult have talked with their own children about sexual issues and in numerous studies, most parents report that they are uncomfortable discussing sexual issues with their children and welcome assistance from more formal programmes (The NARAL Foundation, 1997).

Sexuality according to Oletu (2007) is a lifelong process that starts at birth and ends at death. It involves all aspects that reflect personality and behaviours of one being a male and female. Sexuality is that state of being human. It encompasses sex, gender, gender identity, sexual orientation emotional attachment, love and reproduction. It is much more than sexual feelings, sexual thoughts, attitudes,

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experiences, learnings, ideas, values, imagining and behaviour of a person. Whether male or female is a totality of who you are, what you believe, what you feel and how you respond (Oletu, 2007). In contrast, sexuality education focuses on the individual: specifically, individual sexual activity, biology, relationships sexual orientation and sexual behavior, STDs, gender roles, attitudes, and values (GPI/SMOH.2001). Adolescence sexuality behaviour has increase negatively mainly due to viewing of pornography site in the internet. This exposes adolescents to various health problems like unwanted pregnancy, unsafe abortion, which could lead to damages or ruptured uterus, Vesico vaginal Fistula, septicemia, heamorrhage and possible death. As children get older they gain a greater sense of their sexual self enhanced by an interplay of biological and social changes as the individual matures through childhood into adolescence. Adolescent sexuality is an area of research studies that needs urgent attention due to the entirely new arena of communication on sexuality pattern along with adolescents overriding artful development.

The primary goal of sexuality education is the promotion of adult sexual health. Sexuality education seeks to assist young people in understanding a positive view of sexuality, to provide them with information and skills about taking care of their sexual health, and to help them acquire skills to make decisions now and in the future. WHO (2000) opined that comprehensive sexuality education programme have four main *goals:*

i. To provide accurate information about human sexuality and sexual skills.

ii. *To* provide an opportunity for young people to develop and understand their values, attitudes, and beliefs about sexuality.

iii. To help young people develop interpersonal skills; and

iv. To help young people exercise responsibility regarding sexual relationships, including addressing abstinence, how to resist pressures to become prematurely involved in sexual intercourse, and encouraging the use of contraceptive and other sexual health.

Sexuality and relationships education supports and provides Adolescents with the opportunity to develop and explore:

- Attitudes, values and insights – providing opportunities for young people to question, explore, and assess sexual attitudes.

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- Relationships and interpersonal skills – supporting young people to develop interpersonal skills.
- Responsibility – assisting young people to exercise responsibility regarding sexual relationships.
- Information – providing accurate information about human sexuality.

Sexuality and relationships education involves more than teaching factors. It is also about providing opportunities for children to:

- Feel good about being male or female.
- Appreciate their bodies.
- Practice making healthy decisions.
- Develop and maintain healthy relationships.
- Express feelings and behaviours in appropriate ways.
- Develop confidence and skills in taking, listening and thinking.

The Basic of Sexuality Education

Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviours of individuals. Its various dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles, and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns. Sexuality education is a lifelong process that begins at birth. Parents, family, peers, partners, schools, religion, and the media influence the messages people receive about sexuality at all stages of life. These messages can be conflicting, incomplete, and in accurate. SIECUS, along with many other national organizations, believes that all people have the right to comprehensive sexuality education that addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from the cognitive domain (information); the affective domain (feelings, values and attitudes); and the behavioural domain (communication, decision-making, and other relevant personal skills).

Comprehensive school-based sexuality education that is appropriate to students' age, developmental level, and cultural background should be an important part of the education program at every grade. A comprehensive sexuality education program will

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respect the diversity of values and beliefs represented in the community and will complement and augument the sexuality education children receive from their families, religious and community groups, and health care professionals. The primary goal of sexuality education is the promotion of sexual health. In 1975 the World Health Organization defined sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching, and that enhance personality, communication, and love, every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation.

There is public and professional consensus about what is sexually unhealthy for teenagers. Professionals, politicians, and parents across the political spectrum share a deep concern about unplanned adolescent pregnancy, out-of-wedlock childbearing, sexually transmitted diseases, including HIV/AIDs, sexual abuse, rape, and the potential negative emotional consequences of premature sexual behaviours. There is, however, little public, professional, or political consensus about what is sexually healthy for teenagers. The public debate about adolescent sexuality has often focused on which sexual behaviours are appropriate for adolescents and has ignored the complex dimensions of sexuality. However, becoming a sexually healthy adult is a key developmental task of adolescence and achieving sexual health requires the integration of psychological, physical, societal, cultural, educational, economic, and spiritual factors. Sexual health encompasses sexual development and reproductive health, and such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values.

Adults can encourage adolescent sexual health by providing accurate information and education about sexuality, fostering responsible decision-making skills, offering young people support and guidance to explore and affirm their own values, and modeling healthy sexual attitudes and behaviour. Society can enhance adolescent sexual health by providing access to: comprehensive sexuality education; affordable, sensitive, and confidential reproductive health care services; education and employment opportunities. Most scholars and activists argue that adolescents should

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be encouraged to delay sexual behaviours until they are ready physically, cognitively, and emotionally for mature sexual relationships and their consequences. This support should include education about intimacy; sexual limit setting; resisting social, media, peer, and partner pressure; the benefits of abstinence from intercourse; and the prevention of pregnancy and sexually transmitted diseases.

Issues of Adolescent Sexuality Education

Adolescent sexuality refers to feelings, behaviour and development in adolescents and is a stage of human sexuality. Sexuality is often a vital aspect of teenagers' lives. The sexual behaviour of adolescents is, in most cases, influenced by their culture, norms and mores, their sexual orientation, and the issues of social control such as age of consent laws. In human, mature sexual desire usually begins to appear with the onset of puberty. Sexual expression can take the form of masturbation or sex with a partner. Sexual interests among adolescents, like adults, can vary greatly. Sexual activity in general is associated with a number of risks, including sexually transmitted diseases (including HIV/AIDs) and unwanted pregnancy. This is considered particularly true for young adolescents, as adolescents' brains are not neurally mature (several brain regions in the frontal lobe of the cerebral cortex and in the hypothalamus important for self control, delayed gratification, and risk analysis and appreciation are not fully mature until ages 25 - 30). Partially because of this, most adolescents are deemed less emotionally mature and not financially self-sufficient.

Moreover, discussions about adolescent sexuality and sexuality education often revolve around adults' perceptions of how "things should be" rather than a realistic understanding or appreciation of the dynamics of adolescents" lives. An adolescent is the time when young people develop the knowledge, attitudes, and skills that become the foundation for their healthy adulthood. Recognizing that nearly all Americans eventually become sexually active, an effective sexuality education program would ensure that young people have the information and skills they need to make responsible decisions about their sexuality – whether they make those decisions as adolescents or adults.

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Suggested Approaches of Teaching Sexuality Education

There is need for instructional materials to effectively teach sex education and positive attitudes. The instructional programme and materials must be goal oriented. It should include the cultivation of healthy frankness about scientific teaching about life, demonstrating the dangers of promiscuity and including sexual responsibility (Adesina, 1991). However, various approaches have been suggested by scholars. Schiller (1977) suggested that group centered approach will be effective in teaching sex education, showing of chart, displaying of pictures, contribution of the media, teaching some diseases that can be contacted from sexual intercourse like syphilis, gonorrhea, and HIV/AIDs. This is because students are helped to become free and more responsible in their behaviours. He went further to say that "as a result of the group-centred approach which helps them develop self-awareness and self acceptance of their sexuality, plus understanding of problem solving techniques through really testify definite changes in the girls' attitude occurred.

Thus far, arguments have gone on who should teach sexuality education and from various arguments in the past; the suggestion has been that teachers are the best source of information to teach sex education. Since students considered that sex education should be taught in schools (Dareen Massey, 1990) and teachers also have needs as well as young people, effective knowledge and attitude is needed, therefore, what are the right approaches of teaching sexuality education?

1. Teachers should develop the confidence to teach sexuality education and keep their cool.

a. The teacher should know the subject and areas such as knowledge of the physical and emotional development of young people;

- The skills to enable young people to discuss issues about relationships and sexuality;
- Confidence in oneself as a sexual being;
- Support from colleagues in school and continuing support from outside;
- The skills to work with parent and school governors (principals);
- An awareness of the resources available for sex education; and
- Knowledge about the law as it relates to sex.

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b. The teacher should speak students' language to make easy communication and understand.

c. There is need to be forthright; direct question deserve direct answers.

d. Select topics to be taught, how it is taught and when it is taught is very important. Planning must be thorough and the topics selected should meet important criteria for selection of subject matter discussed at several other point in the curriculum.

2. Accurate information about the physiological and psychological aspects of sex should be presented to all.

3. The Judeo-Christian traditions within which we live should be understood and dealt with sensibly in the framework of present-day- society.

4. To achieve proper sexual stability and mental health which are undisputed requirements for maturity, is to instigate and preserve with a sound sexuality education for everyone. This goal means that those who are in a position to instruct would do well to admit freely to what they do not know, at the same time teaching that which they do know to be the truth. They must educate, not indoctrinate; teach facts, not fallacies; formulate a code of ethics, not preach strict self-denial; be objective, not subjective; be democratic, not autocratic, and seek knowledge not emotionally biased constructs, (Read and Greene, 1973).

5. Manley (1985) opined that parents must be constantly invited and informed as regards how teachers are dealing with sexuality education in the schools. This will help parents assess the films, books and other teaching materials which the students will use and should know exactly what is going on in the schools. Parents who have difficulty in presenting sex education information to their youngsters will find that the school experience creates a teachable moment to open up communication.

6. Esien (1974) highlights the followings as approaches to teaching sexuality education:

i. Organizing seminars on sexuality education;

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ii. Role of the media on sexuality education. This means instead of the "bad" immoral films; a seminar or viewpoint programme could be organized to educate the young and old on sexuality education;

iii. Physiological chart of human body illustrating human reproductive system;

iv. Pictures on sexuality education showing sex organs.

Students' Sources of Sexuality Education Knowledge

Gagnon (1965) found that an overwhelming majority of both male and female students expressed a preference for parents as the primary source of sex information for the young. About 90% of the respondents indicated a preference for their mother as a major source; 80% indicated the father, 60% the family doctor; 40% the school, 25% the church; 25% books; 10% siblings; only 5% preferred friends as a primary source. In the 90s, adolescents' source of sexuality education varies from siblings, peers, novels, films, teachers and parents. Moreover, when mothers give sex instruction to their children, it is limited almost exclusively to the facts of menstruations and pregnancy. Details of intercourse, prostitution, and contraception, as examples, are much more frequently learned from peer groups than from any other source (Gagonon, 1965). Even so, young people report dissatisfaction with the information available at both home and school. Parents, they feel, are frequently too embarrassed to talk openly and meaningfully about sex, whereas information offered at school tend to be meaningless, sketchy or ill-timed. Over 70% of adolescent boys and girls report that their parents cannot talk to them freely about sex (Sorrenson, 1973). But it would appear that young people are just as nervous about talking with their parents about sex as their parents are/as having any interest in sex, (Baron and Byrne, 1977). Children therefore deduce that sex is distasteful and unpleasant thing for their parents and that they engage in any sexual activity only minimally.

However, adolescents have expressed the opinion that lessons in schools are the best way for them to learn about sexuality education (Lynda Clarke, 1982). This is so because presently most adolescents gain their knowledge of sex education from friends, rather than from parents or school, clearly often unreliable and unsatisfactory sources. The preference of the majority of young people to receive sex education at school is a further important argument in the rationale for including it in the curriculum; it is more likely to be benefit if it is received in a milieu where young

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people feel best able to cope with it. A reasonable deduction from Farrell's evidence is that although many adolescents are sexually active, accurate information and advice is not reaching them, or at least they are failing to head it in the form in which it is presented (Farrell, 1985). The school is the place where much of our national culture in terms of custom and religion, art, literature are taught and for the school to play a constructive role in the socialization of young people without including sex education is to deny sex education importance and fundamental instincts and needs (Farrell, 1985). A parent child communication guide aimed at building skills for parents to discuss Sexual Reproductive Health issues with their children has been finalized. A multimedia Information Education Communication campaign on maternal health was also supported in the thirteen local government areas, with State specific Information Education Communication materials developed following the conduct of a formative research.

Reasons for Low Awareness of Students to Sexuality Education

There are many factors that significantly affect a child's emerging sexual knowledge, attitudes and conduct. The way in which their parents love, fondle, and hold the infant; the soothing or harsh sound of their voices; the feel or their skin, the smell of their bodies: "Even when parents avoid discussing sex altogether, children nevertheless detect their attitudes- stressful or happy- through silent communications (Calderone, 1966)

1. The need to provide sex education for adolescents has been well documented and widely acclaimed but the debate about how it should be done continues and is the major cause of low awareness of the knowledge and attitude of students towards sex education.

2. The idea by some group of people that we are experienced, "sexual revolution" while others feel that profound changes have been taking place in the sexual attitudes and behaviour of a great many people, particularly the young. This has made room for people to think it a taboo to discuss sex and acquire knowledge of sex education that produce positive attitude.

3. The non-challant attitude of parents to sex education in school, their negative attitude for their children to talk, discuss or ask them about sexual matters, their belief that sex education might be presented in too dehumanized a

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fashion in the class-room, or that there is "too much too soon", most especially for primary school children. Adults, it is clear, often do not have the skills or knowledge to be confident about sexuality for themselves, let alone for young people.

4. The fear by teachers and parents that too much knowledge too soon encourages them to want to experiment.

5. Societal belief with no foundation in truth is by no means held only by the uneducated and unsophisticated. However, highly educated professional people can hold a curious (possibly dangerous) collection of sexual misconception. Error thus begets error, and illogical attitudes and information filter through all ages, educational, and socio-economic levels.

6. The society also has a particularly dangerous and groundless- argument that sexuality is a simple phenomenon that one learns naturally.

7. The World Health Organization (WHO) states that ignorance, not knowledge of sexual matter is the cause of "sexual misadventure" (Calderone, 1965). This means, society's ignorance of knowledge of sex education breeds more problems in sexual matters.

8. There is also the concern of the qualifications of those teaching it. Most of the teachers teaching sex education receive no special training before hand "some of these teachers obtain their material from non-professional sources, some avoid subjects of real importance to their students" (Dager and Harper, 1959), still others inject religious prejudice and personal guilt in their sex instruction, which probably does the student more harm than good (Dager, 1966).

9. Lack of Visual Aids and good illustrations of subjects like contraceptives, pregnancy, and abortion and venereal disease as well as the sexual "sale" of mass media (Television) of pornographic adverts and films which create negative knowledge is also part of the low awareness of knowledge of sexuality education.

10. The Church also has failed to highlight the society on sexuality education moral. Paul was probably the first Christian to speak out specifically on sexual

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morality while present day Pastors and Reverends shy away from discussing its importance to life and to build up a happy marriage. Paul the Apostle however advocates that marriage is a means of avoiding fornication, although he apparently considered sexual abstinence a more admirable goal in life. Therefore the Church's neglect of an important topic as moral agency also contributes to the low awareness of students towards sexuality education, knowledge, attitude and practices.

Supporting Parents in their Roles as Sexuality Educators

Parents and families play a major role in ensuring adolescent sexual health. Parents are the primary sexuality educators of their children. They educate both by what they say (and do not say) as well as by how they behave. Research indicates that young people who are able to talk to their parents about sexuality often behave more responsibly. Reproductive health knowledge and skills by parents themselves to discuss reproductive health issues with their adolescents still has some shortcomings. In the past, parents use traditional weapon of fear by presenting sex as a taboo for young persons, which no longer works in this age of knowledge explosion and overwhelming peer pressure to engage in sexual activities.

Changes in the expression of adolescent sexuality in the United States find their origins in the sexual revolution and were the focus of the "culture wars". The U.S. federal government policy under George W. Bush emphasized sexual abstinence or chastity, particularly in sex education with a focus on abstinence –only sex education rather than the harm reduction approach of the safe sex focus. It extended this approach to foreign policy, using foreign aid to pressure NGO's into ending condom education in their countries. There is an ongoing debate between those advocating comprehensive, medically accurate sex education and those seeing anything other than abstinence-based education as opposed to "the values held by most Americans". Teen sexuality is influenced by the mass media today more than any other time in history. Internet, television, music video and sexually explicit lyrics all contribute to adolescents' attitudes and behaviour concerning sexual activity. Only 9% of the sex scenes on 1,300 of cable network programming discusses and deals with the negative consequences of sexual behaviour.

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2. Family Life Education

Most existing school-based RH programmes are described as family life education, which International Planned Parenthood Federation (IPPF) defines as "an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, ageing as well as their social relationships in the socio-cultural context of the family and society" (IPPF, 1985). Family Life Education has been conceptualized differently in various contexts, and hence it has been defined in different ways. The definition adopted at the International Planned Parenthood Federation Seminar on Teachers and National Development, held in Lesotho, in 1987 was: "Family Life Education includes a study of self awareness, understanding of others, sexuality, marriage and parenthood. The knowledge gained and skills developed will contribute to the individual's ability to cope both with social change and with relationships in society as a citizen, spouse or parent".

It has also been defined as an "educational process designed to assist young people in their physical, social, emotional and moral development as they prepare for adulthood, marriage, parenthood, ageing as well as their social relationships in the socio-cultural context of the family and society". Family life education has been conceived as an "education for human development, which seeks to ensure that each adolescents approaching adulthood is equipped with the skills and personal reserves to cope with the challenges of everyday life in society, within acceptable societal structures, and to adapt to change with experience and equilibrium".

Family life education, therefore, is a broader concept than sex or sexuality education. It does not simply deal with the human sexual development and sexual behaviour. It is aimed at enabling individuals to understand and appreciate the institution of family and the family life in proper perspective. It focuses largely on developing among learners the ability to understand themselves and the family and the society in which they live and interact, to think rationally and independently, to clarify the traditional values and their own values and to take informed decisions about their own individual selves and the family life.

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Scope of Family Life Education

The scope and sequence is to enable students through life skills focus on education processes, to achieve their potential and assure their healthy contribution to the social, cultural and economic development. Life skills are defined by the World Health Organization (WHO) as the abilities that engage one to adopt positive behaviours that allow one to deal effectively with the demands and challenges of everyday life. Life skills have various classifications. For the purposes of the life scope and sequence, life skills can be classified as the following:

1. Social and Interpersonal skills;
2. Cognitive skills; and
3. Emotional coping skills

Social and interpersonal skills include:

- Communication;
- Refusal;
- Assertiveness, and
- Empathy skills.

Cognitive skills include:

- Decision-making;
- Critical thinking; and
- Self-evaluation

Emotional coping skills include;

- Stress management skills;
- Self awareness; and
- Skills for increasing internal locus of control

Objectives of Family Life Education

Family Life Education aims at enabling the learners:

- To understand the importance of the institution of family, it's changing composition and structure, functions, family roles and responsibilities and interrelationship between family resources and family welfare.
- To appreciate physical, physiological, psychological and social changes and developments during the process of growing up, conception and consequences

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of adolescent pregnancy, and to be aware of the HIV/AIDs pandemic and implications of drug abuse.

- to understand the significance of marriage, responsible parenthood, changing gender roles' and male responsibilities in the family life; and
- to develop positive attitude and responsible behaviour towards various issues of family life and to appreciate traditional family values.

Major Components and Contents of family life education:

There are variations in the scheme of content of family life education based on approaches adopted in different contexts. When viewed broadly, family life education has two major components: family life, sex and sexuality. The scheme of content of family life education, therefore, contains the following elements:

a. **Concept of Family:** Definition of family, types of family – nuclear, extended, functions of family – reproduction, physical maintenance, rearing of children, ensuring physical, emotional and social security, socialization and social control, continuity, companionship and association; family roles, relationships and responsibilities- changing gender roles and division of family functions, male responsibility, responsible parenthood, care for mother and child, care for the aged ensuring physical, emotional and social security, family resources, community resources, size of the family and its needs for better quality life.

b. **Marriage:** Marriage as the basic social institution, free and full consent of individual spouses; age at marriage, child marriage, consequences of early marriage; marriage life, communication between spouses, male responsibility, care for reproductive health; divorce consequences.

c. **Gender Roles:** Equality and equity based on harmonious partnership between male and female members; promoting the fulfilment of women's potential through health care, education, skill development, ability to earn beyond traditional occupations, employment opportunities outside the household, and making them self-reliant, participation in the decision-making process, discriminations against women; need to eliminate violence against women; need for change in the perception of the social worth of the girl child, adequate health care and nutrition, education and opportunities for realization of the full potential of the girl child, role-stereotypes and

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discrimination within the family, impact of prenatal sex selection, female infanticide and higher rate of girl child mortality.

d. **Process of Growing Up:** Physical change and development during adolescents, phases of adolescence, male and female body make-up, conception and pregnancy, pre and post-natal care, adolescent pregnancy; socio-cultural development – emotional development, identity development, body image, self-esteem and self-concept, social relationships, changing relationships with parents, peer groups and the opposite sex, gender roles-stereotyped gender role development, proper gender role development.

e. **HIV/AIDs:** Basic information-meaning of HIV/AIDs, routes of HIV transmission, effects of HIV infection, how HIV is not transmitted, STDs and AIDs; HIV/AIDs: prevention and control – sexual relationships, blood, mother to child, no risk behaviour, risky behaviour, sexually transmitted diseases.

f. **Drug Abuse:** What is drug and drug abuse, factors promoting drug abuse, symptoms of drug addiction, drug dependence, and effects of drug abuse, myths and misconceptions about drug intake, prevention and responsibility?

3. **HIV/AIDs EDUCATION**

Acquired immune deficiency syndrome or acquired immunodeficiency syndrome (AIDs) is a disease of the human immune system caused by the human immunodeficiency virus (HIV). This condition progressively reduces the effectiveness of the immune system and leaves individuals susceptible to opportunistic infections and tumors. HIV is transmitted through direct contact of a mucous membrane or the bloodstream with a bodily fluid containing HIV, such as blood, semen, vaginal fluid, preseminal fluid, and breast milk. This transmission can involve anal, vaginal or oral sex, blood transfusion, contaminated hypodermic needles, exchange between mother and baby during pregnancy, childbirth, breastfeeding or other exposure to one of the above bodily fluids. HIV/AIDS education programs have also highlighted the benefits of interactive teaching methods and teaching negotiation skills. Ogharaerumi (2005) found that negotiation skills enhance students' ability to delay sex or to use condoms. Wilson and Colleagues (1992) concluded that interactive teaching methods are "better than lectures at

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increasing condom use and confidence in using condoms and at reducing the number of sexual partners" will help in preventing HIV/AIDS.

HIV/AIDs are pandemic diseases. As of 2009, AVERT estimated that there are 33.3 million people worldwide living with HIV/AIDs, with 2.6 million new HIV infections per year and 1.8 million annual deaths due to AIDs. In 2007, UNAIDS estimated: 33.2 million people worldwide had AIDs that year; AIDs killed 2.1 million people in the course of that year, including 330,000 children, and 76% of those deaths occurred in Sub-Saharan Africa. According to UNAIDS 2009 report, worldwide, some 60 million people have been infected, with some 25 million deaths, and 14 million orphaned children in Southern Africa alone since the epidemic began. Genetic research indicates that HIV originated in West-Central Africa during the late nineteenth or early twentieth century. AIDs were first recognized by the U.S Centers for Disease Control and Prevention in 1981 and its cause, HIV identified in the early 1980s.

Although treatments for AIDs and HIV can slow the course of the disease, there is no known cure or vaccine. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but these drugs are expensive and routine access to antiretroviral medication is not available in all countries. Due to the difficulty in treating HIV infection, preventing infection is a key aim in controlling the AIDs pandemic, with health organizations promoting safe sex and needle exchange programmes in attempts to slow the spread of the virus.

Objectives of HIV/AIDs Education

Students will be able to:

❖ Identify some of the sensitive issues connected with preventing, acquiring, and coping with HIV/AIDs.

❖ Examine personal knowledge in terms of what they already know and what they want to know.

❖ Consider how HIV/AIDs affect many more people than it infects.

❖ Understand what impact education has on eradicating myths, misinformation, and ignorance regarding people living with HIV/AIDs.

❖ Identify and understand persuasion and propaganda techniques (e.g., loaded words, unsubstantiated claims, etc)

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❖ Identify behaviours that demonstrate respect for persons.
❖ Consciously evaluate what is being read, heard, or viewed.
❖ Describe the effect of the spread of HIV/AIDs on families.
❖ Describe how parents/caregivers communicate ideas and feelings about HIV/AIDs.
❖ Seek out information from people who may be acknowledgeable (e.g. parents, teachers, guidance, counsellors, community agencies, and health care workers).
❖ Demonstrate ways to communicate about HIV/AIDs with parents/caregivers.

Objectives of a programme normally give a big picture of what content, methods and evaluation procedures the programme should adopt. A programme like the HIV and AIDs education therefore requires a critical reflection when constructing its objectives so that it result to change of behaviour not only at cognitive domain but more so at the affective domain level which may lead to behaviour change among the learners (Freire, 1974; Likoye, 2004). Based on this argument, the present study tried to analyze the HIV/AIDs education programme's objectives in light of the needs of the youth in secondary schools in Kenya based on the findings of the existing studies.

Objective 1: Acquisition of necessary knowledge and skills about HIV and AIDs and sexually transmitted diseases (STDs).

The assumption underlying this objective is that it would enable effective drawing of the HIV and AIDs education programme's content and learning experiences which would expose the learners to the right knowledge and skills. That is, the content that gives the youth relevant knowledge from time to time to enable them adopt and adapt to such behaviour that would prevent and control HIV and AIDs spread among the youth in general. The authors believe that any new information that emerges regarding management of HIV and AIDs spread would be included in the content through its upgrading in order to imbue the youth with relevant (necessary) knowledge from time to time. The present study therefore holds that the objective under discussion deals entirely with knowledge of HIV and AIDs, which should bring awareness among the recipients of that knowledge. Studies also show that there is high level of awareness or knowledge of the HIV and AIDs among learners in various learning institutions in Kenya (Likoye, 2004; Irimu, 2003; Ladhani, 2005). However, some of the studies, (Likoye, 2004; MOEST, 2001) cast doubt on the HIV and AIDs education programme's knowledge as a

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result of the observed outcome from students exposed to the programme. For instance, Likoye (2004) argues that HIV and AIDs awareness effort should be carried out in such a way that during the process, learners should acquire knowledge that is part of life experiences which should enhance behaviour change amongst the youths. Conscientization according to Ongunya (1975) is a process by which human beings as knowing beings reach a deeper awareness of both the sociocultural reality on which their life is built of their ability to transform their behaviour to suit changes that exist in their settings from time to time. Education therefore opens up possibilities for free choice and individual decision. Education (knowledge) should help the individual to explore many aspects of the world and even his/her own feelings and emotions (Freire, 1974).

However, indoctrination is viewed as reducing the possibilities of free choice and decision. It is regarded as an attempt to persuade and coerce the individual to accept a particular viewpoint or belief, to act in a particular manner and to profess a particular value and way of life. Although there is claim of high level of knowledge among the learners by various studies, Hussein (2005) in his study on socio-economic and cultural factors in the transmission of HIV and AIDs among the school and college going youths in central division of Garissa district in Kenya observed that many young people were unaware of what constitutes risky sexual behaviour that could expose them to HIV and AIDs infection. And a few who understood such behaviour believed that they were invulnerable. This leads to casting of doubt on the knowledge, which has been acquired since the inception of the programme in schools in the year 2000. A similar view as advanced by Johnston (2000) that even though knowledge about the nature and transmission of HIV and AIDs is over 90.0% among Kenyan youth, however, perceptions towards chances of contracting the virus are disturbingly poor. A study by Ego (2005) on readability of HIV and AIDs printed materials used by students in Kenyan's secondary schools revealed that young people already know something about sex and HIV and AIDs, however, the information could be inadequate and wrong or incomplete. She still casts doubt on the knowledge acquisition among the learners in the HIV and AIDs education programme thereby suggesting that there is a gap between the objectives and the actual HIV and AIDs education delivery and behaviour change in Kenyan's secondary schools.

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Discussions with the respondents from Siaya district secondary schools revealed that since the introduction of the programme in the year 2000, its content has not been reviewed to keep it in tandem the emerging issues in HIV and AIDs management especially among the youths.For instance, materials on voluntary counselling and testing (VCT) services were clearly missing from the content of the programme. The respondents also observed that the programme lacked practical orientation and only concentrated on delivery of superficial knowledge integrated in various subjects in the secondary education curriculum. That is, the programme is mainly taught as a contemporary theme in the secondary education curriculum. The forgoing suggests that there seems to be a gap between the objectives and actual HIV and AIDs education programme delivery and behaviour change in schools. This however may be emanating from the nature of presentation of that knowledge itself or lack of proper focus. The youths in school are exposed to HIV and AIDs education Knowledge in form of contemporary themes which they expect to memorize during examinations and not to influence them to change their behaviour.

Objective 2: Appreciation of facts and issues related to HIV and AIDs

This objective is purported to deal with affective domain of the learners. Appreciation here may refer to a person being aware of a phenomenon and being able to perceive it. At a higher level, appreciation may refer to a person's ability to identify with the knowledge relating to a phenomenon like HIV and AIDs and readily verbalizes the information to others. As it was discussed in acquisition of knowledge, high HIV and AIDs knowledge among the youth is revealed by several studies; however, some indicators of low appreciation of high-risk levels among the youth also exist. That is, high prevalence level of HIV and AIDs is still reported among the youth; early pregnancies which suggests that no use of HIV and AIDs protective measures.

Discussions with students in Siaya district secondary schools revealed that lack of appreciation of HIV and AIDs control measures still exist as early pregnancies among the school girls is still common. This suggests that the youths are indulging in unprotected sex. Schools were reported by the respondents as hindering appreciation of HIV and AIDs protection measures as they said that being found with a condom in school was an offence and a breach of school rules and regulations. The student

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discussants therefore felt that schools are not providing enabling environment for them to really understand and appreciate HIV and AIDs control measures. The students added that VCT services are very rare in schools thus denying them an opportunity to develop courage to go for such services as most of the time they are confined in schools with a lot of academic work. Interviews with teachers also revealed that VCT services are not within reach of the students. Teachers also added that the secondary education curriculum is so congested, that even guidance and counselling sessions are not allocated in the school programmes. Agyei, (1992) allude to this fact that there is a wide disparity between contraceptive knowledge and use. From their findings of a study in Uganda, they reported that ¾ of the youths knew that condoms prevent STDs, yet fewer than 13.0% of males and virtually no female (less than 1.0%) said they used condoms during their sexual encounters. A study by Mumah (2003) among physically challenged youths in Rachuoyo district in Kenya revealed that youths harboured very negative attitude towards condom use. That is, 93.3% of the respondents did not use condoms yet more than 56.0% had two or more sexual partners. They gave a reason that they trusted their partners. This suggests that they do not appreciate control measures against HIV and AIDs spread, thus ignoring them during sexual activities.

The present study also revealed that female students in Siaya district secondary schools still experienced early pregnancies, an indication that the students indulge in unprotected sex. The present study therefore holds that some of the learners in Siaya secondary schools have not yet come to realize and appreciate HIV and AIDs control measures like use of condoms during sexual intercourse thereby risking their lives with contracting HIV. If appreciation refers to awareness, then awareness is a state of being conscious. The present study therefore casts doubt on whether the learners of the programme are conscious of the control measures of the scourge. Likoye (2004) expounds on the term consciousness by observing that it is a state of alertness to any stimulus. And as such, it is a state of awareness of the immediate reality (like the HIV and AIDs). To be conscious of something in this sense implies being in state of alertness by way of senses, the mind or both. However, this is lacking among the Kenyan youth based on the already cited research findings. This therefore puts the appreciation objective to doubt, thus the suspected gap between the objectives and

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actual HIV and AIDs education programme's delivery and behaviour change in secondary schools.

Objective 3: Develop life skills that would lead to AIDs free life

The present study holds that a learner should develop a positive attitude towards a programme like the HIV and AIDs education before developing the life skills. Discussions with students revealed that they believed to have developed life skills like negotiation for safer sex, promotion of information regarding HIV and AIDs prevention among the youth and community at large. Interviews with teachers on the other hand showed that early pregnancies are still rampant among school girls in the district. The teachers therefore reported that the girls seem not to be knowledgeable on the risks that exist in relation to indulging in unprotected sex. This implies that they are unable to negotiate for safer sexual encounters. Teachers also reported that most of the school girls hang out with youths who belong to the risk group; the touts and taxi drivers. This tends to expose them to more risk of contracting the disease. A study by Nyinya (2007) on attitude of pupils on the HIV and AIDs education programme within Kisumu municipality in Kenya revealed that students had negative attitude towards the programme. However, Allport (1969) defines attitude as a mental state predisposing one to action, that is, a disposition to act for or against an object. Like appreciation, attitude is a term, which describes involvement of the student who is willing to grant a positive feeling about something. It further means that the student goes out of his/her way to express it and even seeks instances in which he/she can communicate it to enable the student participates in prevention and control of HIV and AIDs spread among the youths. It is the disposition of this study that a good communicator is also a good negotiator and is therefore fully aware or conscious of the phenomenon he/she is talking about. Life skills as used in the objectives of the HIV and AIDs Education Programme are believed by this study to encompass all those ways by which students can escape contracting the HIV. They are expected to know their risk levels and act responsibly. They should be acquainted with the interdependence of humanity, which does not allow for individualism (Njoroge and Benaars, 1987). The authors also tried to find out whether the students in Siaya district secondary schools had developed these life skills as a result of the programme. However, if the objectives were guideposts for development of life skills among the

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youths, then the prevalence of HIV would have reduced. This therefore casts doubt between the objectives and actual HIV and AIDs education programme's delivery and behaviour change among the youths in Siaya district secondary schools.

Objective 4: Identify appropriate sources of information on HIV/AIDs related issues

The objective refers to students' ability to develop attention to selected content of the programme. The student therefore expresses interest, appreciation, values and develops emotional sets towards the HIV and AIDs materials. The present study revealed that students never get time to identify resources in order to improve their knowledge and skills about HIV and AIDs. The student respondents reported that in schools the HIV and AIDs education resources just gather dust in the libraries since they are not updated therefore are boring to read. Some of the content does not reflect on the learner's expectations since the content was not developed with the learner's literacy level in mind. Therefore, language used in writing these materials should be simplified for better understanding of the concepts by the learners. Teachers also reported that even if students were to read the information regarding the HIV and AIDs education, this was not provided for in the school time as emphasis is put on examinable subjects. A study by Ladhani (2005) on knowledge, attitude and practices towards HIV and AIDs among urban upper primary school children in Kisumu revealed a high (97.0%) level of HIV and AIDs awareness. However, only 48.6% of the respondents perceived themselves to be at risk of contracting HIV. A similar study by Ochieng (2005) revealed that there is a misconception that a person with HIV always looked unhealthy. The symptoms of HIV and AIDs are facts documented in HIV materials. If students were involved in identifying these materials to read what the materials contain, they would be clear about several issues including such misconceptions. The present study also revealed that the learners in Siaya district did not (Ongunya et al. 1977) have time to read extra materials on HIV and AIDs apart from what they are taught either in classroom or by invited guests. The reason for this is that the secondary education curriculum is too congested and therefore learners only concentrate on examinable materials to improve their grades. This suggests that there is a gap between objectives and actual HIV and AIDs education programme's delivery in schools.

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Objectives 5: Making decisions about personal and social behaviour

Education is a process that makes the learners explore many aspects of the world and even their own feelings and emotions, thereby leading them to make choice and personal decisions on world phenomena. Personal decision making regarding social behaviour is of a higher level than mere appreciation of facts. It involves adjustment of an individual's behaviour due to an interaction between the individual's feelings and knowledge about a phenomenon like HIV and AIDs. The term adjustment hereby refers to a behaviour that appears in the social interaction between two persons, or may refer to one's whole outlook on life. It therefore involves internal balancing of self-concept and self-ideal and how these affect the entire environment in which one lives. In a situation of HIV and AIDs spread among the youth, adjustment involves emulating such behaviours that enhance control and prevention of the scourge as well as discarding those others that promote the spread of it. Decision making as an objective in the programme is therefore taken by this study to refer to the balancing of overt behaviour with some role concept. By making decision on social behaviour, the learner identifies with his/her role within the society after conceptualizing the phenomenon in question. External forces therefore do not influence personal decision making once an individual has conceptualized and internalized a phenomenon like HIV and AIDs. Discussions with the respondents in Siaya district secondary schools revealed that VCT services were rare since they were not brought to schools. A few respondents who have ever gone for such services would do it during school holidays or through church/non-governmental organizations which are community based. This was an indication that very few learners in Siaya district know their zero-status. However, the respondents suggested that the VCT services should be introduced to schools in order to enable more learners go for HIV tests as well as counselling. This therefore brings doubt between the objectives and actual HIV and AIDs education programme's delivery in schools. However, a study by Wachira (2005) among 400 undergraduate students in Nairobi's universities revealed that 94.0% of the respondents were aware of vital facts concerning HIV and AIDs and VCT, but only 45.0% of them showed that they knew their zero-status. They however reported that the main barriers hindering use of VCT were stigmatization (51.0%) and fear (37.0%) of being positive.

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Scope of HIV/AIDs Education

Although HIV and AIDs education needs to be tailored to the context in which it takes place and to the people who are being educated, there are some key areas that HIV and AIDs education programmes need to cover. It is important that the information provided is a balance of the social and emotional aspects of HIV/AIDs as well as biological and medical information.

Comprehensive HIV and AIDs education includes:

How to protect and promote one's health

- Basic knowledge of HIV and AIDs – including how to protect oneself from HIV infection.
- Learning about treatment and care – including an understanding of voluntary counselling and testing (VCT) and antiretroviral drugs.

Social and Emotional Aspect

- How to maintain a healthy level of self-confidence and self esteem.
- Coping with difficult and risky situations.
- Coping with loss.

Sexual

- Learning about different sexual orientations and the development of sexuality

Promotion of equity, including gender issues

- Understanding that social, biological, economic and cultural factors affect vulnerability to HIV.
- Understanding that men and women have similar rights in society and family.

Overcoming stigma and discrimination and promoting human rights

- How to show support for HIV positive people and how not to discriminate against or stigmatize people living with HIV.
- Understanding the importance of confronting HIV and AIDs in the community. Providing the right information is only part of carrying out comprehensive HIV and AIDs education. For the education to be effective, this information needs to

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be absorbed and remembered. Active learning encourages people to engage with information by giving them the opportunity to apply it.

Content of HIV/AIDs Education

The contents must be:

- Specifically adapted and appropriate for various levels – primary/secondary/tertiary, vocational, formal and non-formal learning environments.
- Focused and tailored to various groups including children/orphans and vulnerable children (OVCs), young people out of school, people with HIV, minorities, refugees and internally displaced persons, men who have sex with men, sex workers, injecting drug users, prisoners;
- Including prevention knowledge, attitudes, and behaviours covering sexual transmission, drug use including injecting, and other risk factors;
- Be focused on stigma and discrimination as well as care, treatment and support.

The Issues

Unfortunately when it comes to HIV and AIDs education, ideological and religious views often conflict with science. America has one of the highest teenage pregnancy rates out of the high-income countries, despite evidence that young people are having sex, the ideological message of sexual abstinence until marriage plays a key role in sex education. Abstinence-only programmes often do not teach people about contraception and safer sex and therefore many young people remain unaware of how to protect themselves.

***4.* Peer Education**

Peer educators “are people selected for their leadership potential in helping others. They are trained to help other participants learn through demonstration, listening, role playing, encouraging, serving as role models, providing feedback and supporting healthy decisions and behaviour"(Advocate for Youth, 2005). UNAIDS and WHO (2001) stated the social factors make the school aged young people to HIV infection; peer pressure; poverty; alcohol; insufficient education and understanding of HIV/AIDs related issues etc. and behavioural change is also deferred by the lack of appropriate education on sexual and reproductive health in social and educational

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institutions.

Benefits of peer education include:

- Young people-are likely to listen to, and imitate peers that are well liked and respected.
- Peer educators who model examples of healthy behaviors of other peers and help them avoid taking risks.
- Peer educators can support, encourage and help their peers both inside and outside of school sessions.
- Peer educators may assist you by presenting the session, thereby allowing more time for individual attention in small groups and for wider access to a larger group of young people.
- Peer educators may be able to help manage and solve problems among the group.
- By serving in this capacity, young people boost their self-esteem, learn valuable and marketable skills. Make contacts, and perhaps take more pride in their lives and behaviours prior to their roles as peer educators.

Advantages of PEER EDUCATION in RHPS

- Peer education allows participating youths to develop their leadership skills and improve their sense of self-worth (Peplinsky, 1995).
- RH peer educators often become respected by students as a source of credible information. Researchers in Chiang, Mai, Thailand, found that being a peer educator gave girls social legitimacy to talk about sex without the risk of being stigmatized as someone who is sexually promiscuous. The peer educators were successful in facilitating group discussions about sex, educating their peers about their bodies, helping them to develop communication and assertiveness skills, and changing social norms (Cash & Anasuchatkul, 1995).
- Teachers in a Puerto Rican community in the United States found that working with peer educators allowed them to have more fulfilling relationships with young people and to see their students as a valuable resource (Vince-Whitman, 1992).

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- Peer counselors in Khon Kaen, Thailand helped adolescents use information and health service resources (Thongkrajai, Stoeckel, & Kievying, 1994).
- Peer promoters can provide a valuable link to health services. In the experience of Mojisola Opabunmi, a peer promoter for MUDAFEM in Ibadan, Nigeria, "The peer promoter program makes services more acceptable and accessible than health centers, which are located away from the easy reach of students and, in most cases, manned by adults."

Parents' Attitudes Towards Sexuality Education

Although no one can deny the right to parents to educate and influence their children to act wisely, most schools of thought recognized that this is best done alongside other agencies in society. Many parents do not want the responsibility of teaching in area they find embarrassing or where they may be unsure of some of the facts, still involving parents in the aim, rather than trying to pass the responsibility to them entirely.However, parents in Nigeria often react negatively to the idea of introducing sex education to the Secondary school curricu6lum. Parents' controversy is often rooted in the prejudice, fear and guilt that historically made the subject a taboo. Durojaiye (1972), Hake (1972), Araoye (1978) and Olayinka (1981) pointed out the negative belief and reactions of parents to the idea of introducing sexuality education to the secondary school curriculum are based on the assumption, that sex education is very sinful, it corrupts the mind and that it will create morbid curiosity to experiment; it may lead to sexual promiscuity and a general moral decay among the youths.

Parents also have the belief that if adolescent do not know about sex they will avoid it, and will consequently lead sexually pure lives. The knowledge of parents to contraception, veneral diseases, abortion, are low and therefore their attitude towards especially contraceptives are biased thus affecting their negative attitude of sex education knowledge in these areas. Moronkola & Falaye (1999) revealed in a study that parents suggested that Health teacher or worker within the school setting is best suited to teach sexuality education. Parents need to know important information such as the younger the age of first sexual intercourse, the more likely that the experience was coercive; and that forced sexual intercourse is related to long-lasting negative effects (Murphy, 2005).

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The followings are all related to late onset of sexual intercourse

- Having better educated parents.
- Supportive family relationship
- Parental supervision
- Sexually abstinence friends
- Attends Church frequently.

Moronkola & Falaye (1999) findings revealed that parents have a positive attitude towards the teaching of sex education as a school subject and prefer female teachers teaching sexuality education with particular preference for health education teachers or workers in the school setting. Marvis (1995) stated that most parents want to prepare their adolescents for sexual relationships but they find it difficult to discuss sex with their teenagers Mothers are more knowledgeable in the area of menstruation and pregnancy although in our country Nigeria, some of the mother's knowledge of menstruation is shallow and this knowledge will only be of help to the female and not the male. This shows that only a part of the total constituents of sex education is being given at home. The attitude of some mothers to their daughters when questioned on sexuality and intercourse was always frowned at and sometimes ignored. In Nigerian traditional setting, it is assumed that the best way of preventing sexual immorality among the youths is to keep them in complete ignorance of sexual matters. This will then results to lack of knowledge on sex education.

Presently, the teaching of sexuality education has been accepted and allowed to be taught under Health Education. Sexuality education in the school curriculum does not even bother parents like in the past, but they fail to know what their children are being taught, they are not bothered if they learn or are not learning about sexuality education. This is so because most Nigeria parents don't have the time to go through their children books, question them in area of difficulty and provide answers to them. This shows that their attitude is negative to sex education.

Teachers' Knowledge and Attitude to Sexuality Education

In spite of all the debate on sexuality education on whose hand to place it due to teacher's attitude towards it is still controversial. However, sexuality education is in the school curriculum but inadequate and ineffective due to the prevailing attitudes of some teachers. This attitude stems from the knowledge they gain themselves. Brien

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(1982) suggested that curriculum designers should have a comprehensive teacher manual, content of instruction should cover anatomy, puberty, changing relationship, decisions, parents, friendship, dating, sex roles; homosexuality, sexual activity such as pregnancy, birth control disease, parenting & lifestyle.

Teachers have needs as well as young people. Some of them recognize that work is needed on their own values (Knowledge) and attitudes about sexuality. Goldman (1988) agreed with teachers' inadequate knowledge, he stated further that maintaining that trust between teachers (adults) and children is betrayed when lies or half-truths are told because the adult cannot bring himself, or herself to discuss sex honestly". Jackson (1990) argues that teachers' fears exposed children to danger and induce fear and confusion. From the above, it shows that teachers themselves are confused as teaching what the real knowledge of sexuality education is all about and the attitude expected of the students.

In the areas of teaching, some of the teachers lack instructional materials; model and the methodologies use in classrooms should be consistently updated. They lack skills to teach sex education because they have inadequate knowledge about the skills themselves, they also want to have knowledge about the law as it relates to sex in order to teach it in totality. Teachers also express fear of lack of support from colleagues, government, and parents, however, "some teachers have the experience of involving parents and colleagues from early stage onwards in the area of sex education; this approach demands commitment, time and support, which are not always readily available, although the appointment of health education coordinators and inspectors for personal and social education may ensure that development goes on" (Doreen, 1990).

Students Knowledge and Attitudes Towards Sexuality Education

It is unfortunate that for many children the process of sexuality education in the home remains clouded by mystery and misconceptions. Every child will eventually learn that he has a very personal body that is ever available for exploration. When a particular child is discouraged or frightened away from his exploration by ill-concealed disgust, anger, or embarrassment, he is building a foundation of negative reaction that might well culminate in distaste for physical contract of any kind (Read and Greene, 1973).

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The attitudes of students to sexuality education studied by Lynda Clark (1982) shows that some students like the scheme that covered relationship with the opposite sex. Some preferred the area of sexually transmitted disease, pregnancy and abortion. A girl reacted to the area of contraception by this statement. "The bits about contraception make me think twice about having a sexual relationship and not using contraception". A girl also said" I didn't like the sound of the diseases but we had to be told these things to warn us". Most of the boys and girls said there was nothing they disliked in the scheme when answering their questionnaire.

This talk was given before the questionnaire and some of them said that the speaker covered some subjects they knew about already or that the information came too late. The boys dislike the pregnancy area and girls said the issue of menstruation was boring since they know about it already. Some wanted films on childbirth or abortion and others wanted information on miscarriage, premature delivery and handicap; and films showing sexual intercourse. The boys wanted to know more about venereal diseases, abortion and contraception including the safest time to have sexual intercourse, sexual relationships and more about the female 28-day cycle" while the girls wanted to know more about sexually transmitted disease, abortion, pregnancy and contraception.

However, most teenagers will have sexual experience but still exercise worries about their sexual activity. The above research by Lynda shows that their knowledge of sex education is very low and faulty; and their attitude is also negative; because some adolescents do not know that a women will get pregnant if her partner says he will be "careful" or "pull out" the penis on time will prevent pregnancy. This entices some of the females to indulge in sexual intercourse because they feel it is fun and safe because they lack knowledge of sexual matters. That's if a women forgets to take a couple of pills she could be pregnant, that love does not necessarily mean a girl should have sexual intercourse with a boy. Some girls feel there is nothing bad in having sexual intercourse with a boy if they love him, while some don't use contraceptive and therefore are ignorant of the fact that sexual intercourse could lead to pregnancy or death. There is also the reaction of girls, worries about sex before the age of consent, what to do if they suspected they were pregnant or how to tell their parents. Some girls also fail to know the signs of pregnancy. Some students feel there

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is nothing bad in having sexual intercourse for self-satisfaction and does not need a strong relationship or the promise of love (marriage) before they should engage in it. Some girls believe they need a very secure emotional relationship based on a lot of love and trust before they engage in sexual intercourse. However, most students (both boys and girls) preferred their peers to their teachers and parents in teaching sexuality education information because they find it difficult to be honest and sincere to ask questions they need answers from their teachers or parents. Some of adolescent females don't like to ask question in the presence of the males because they feel it is 'bad' to ask questions on sex and most boys find it uneasy in the presence of the female sex; this leads them to behave to the opposite sex as if they hate them. This needs to be corrected among the adolescents.

Who should teach sexuality education?

Sexuality education is almost as imprecise and all encompassing a subject name as health education itself, and many of the same issue and problems confronted in sexuality education are important in health education at larger. Sexuality education is almost like health education in micro-cosm, and indeed the two often equate with each other in the public mind (Health Education Journal, 1990). Cowley et al, (1981) posed this question: should sex education be a 'subject' at all, or be subsumed under subject areas such as biology and 'home craft' and religious education? Similar arguments of integrations versus specialization apply to health education. Does integration lead to duplication or alternatively incomplete and uncertain coverage of topic?

However, in recent year sexuality education and health education are often confusingly intermingled associated terms; the future development of health education in the school may be closely bound up with that of sex education. Sexuality education has also long been considered as part of health, personal or social education in schools, all of which has received recognition as vital components of the curriculum over a number of years. Dallas (1974) condemned sexuality education as a meaningless term and it has been contested before and since with disputes about its sentence and it influence; sex education is very important both in the primary and secondary schools. Health Ministry International Document (1986) places sexuality

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education within health education, and describes it as “a crucial; part of preparing children for their loves now and in the future as adults and parents.”

Hendrok (1970) stated that “sexuality education should not only be taught at teenage stage but from the scratch”. This is important because sex is no longer set apart (aside) and secrecy about sexual matters is rapidly disappearing. In fact, nearly all the secrets of sexual behaviour have been discovered and experienced. Hendrock stressed further that the teaching of adequate knowledge of sexuality education is needed and very important to create a positive attitude rather than negative attitude among the adolescent in our society. From Hendrock’s statement sexuality education should not only be taught in school but also at home. Spanier (1978) support Hendrok’s view, stating that “a good sexuality education will need to commence before a child has had the chance to acquire incorrect or misleading information, which will be necessary for him to later unlearn or re-learn.” He suggests that as soon as the child enters school each year, the child should be presented with materials that are appropriate to his sexual socialization at the point in time.

Teachers and parents also believe that sexuality education is really moral education and therefore a responsibility of the religious teaching. Since the school is the place that much of our national, culture, art and literature, and so on, are first experienced in-depth and sex has always been a major influence in these areas. “For the school to attempt to play a constructive role in the socialization of young people without including sexuality education is to deny the importance of fundamental instincts and needs” Paul Hayton (1985) and since most parents don’t have the time to impart sexuality education moral, the religious group has also looked at it as unnecessary, therefore, the school (teachers) should teach sexuality education. The teachers should be willing and ready to teach it; and the same qualification for teaching as in most other field. Sexuality education should be made a subject with inclusion of sex guidance among the school teenagers, which ever clinical sexual counselling (to change the student’s behaviour in something healthy and responsible). Sexual counselling intervention reduces the risk of unwanted pregnancy. However, for the battle for effective sex education in schools to be won, educators must rationally plan and start to implement programmes which they feel will best meet the needs of the children. It should start early and throughout life.

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Conclusively, there is no doubt about the importance of sexuality education in our society. Sexuality education is not only useful to the adolescents but also to adult of a given society. Sexuality education is more than the teaching of biological facts but also of instruction, protection, preservation, improvement and development of one's sexuality and responsible parenthood (family). It builds adequate knowledge and positive wholesome attitude towards sex. However, the problems of inadequate knowledge of sexuality education range from teenage pregnancy, abortion, venereal disease, cervical cancer, early marriage, drop-out-of school, depression, shame and death. Finally, parents and teacher's knowledge of sexuality education are inadequate and their attitudes to it are negative. Students' sources of sex education knowledge are inadequate and hence negative attitude. The teachers should therefore ensure appropriate teaching materials for sexuality education teaching. This will help correct their family life; secondary schools should not only include sexuality education in its curriculum but also teach and give adequate information by using instructional materials to build positive attitude in individual sexuality.

Adolescents Reproductive Health Services

(a) Youth – friendly services: are Adolescents Reproductive Health services that are provided at convenient and private hours for adolescent. The following characteristics are essential for an ideal youth friendly ARH services.

- Friendly staff (provider) to adolescents.
- Understand and knowledgeable about adolescents' concerns and needs.
- Counsellors use language that is understandable to youth.
- Providers spend adequate time with them.
- Youth/adolescents drop-ins are welcome and accommodated.
- Provides information and audio-visual materials on Rh services.
- Counselling and examination rooms ensure privacy.
- Facilities are conveniently located.
- Availability or referral for medical services.

STIs Screening: are sexually transmitted infections that prevail to a disease that is spread through sexual intercourse e.g. gonorrhea, syphilis, Chlamydia, cardideda, cervical cancer, etc. The guided sexual exploration among adolescents lead to infection with diseases that are sexually transmitted and increase in earlier initiation into sexual activity, promiscuity and poor access to contraception; contraceptive

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counselling; youth friendly services can be attributed to STIs among adolescents and youth adult. Condom which is one of the most effective strategies for combating the spread of HIV and STIs is a controversial issue of discussion among parents who believe that condom promotes early sexual initiation with its attudent sexual health problems (NDHS, 2008).

Counselling: Can be described as professional advice about an issues, problem to assist motivate, redirect; etc others to have a focus and see the need to take up a different decision that may be contrary to his or her own opinion. It is to advice; recommend constructive suggestions to an individual. It involves professional training strategies, skills and experience. Counselling is a professional guidance services to individual by applying the techniques of psychological testing. Counselling service content for adolescent includes:-

- Reproductive Health.
- HIV/AIDs – strategies to avoid unsafe sex.
- STIs.
- Contraceptive methods.
- Negotiation skills and self-esteem.
- Referrals for additional services etc.
- STIs screening referral.
- Abortion related problems.
- Teenage/unwanted pregnancy.

Modern contraceptives for adolescents are:-

- Condom
- Oral contraceptives in school.
- Injectables
- Ferm/jelly
- The plant
- Spermicide

(Injectables, Ferm/jelly, The plant, Spermicide: Out School)

Adolescents counselling should provides:

- Determine youth's needs.
- Information on preventing STIs.

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- Contraceptive types, usage.
- Treat their needs with respect.
- Encourage them to ask questions.
- Listen to actively
- Provides IEC during counselling sessions.
- Provides referral information for obtaining services.

Counselling Issues

Counselling issues should provide specific approach to working with adolescents. The approach are as follows:

- The philosophical approach to counselling using the counselling protocol.
- Counsellor attitudes, skills and strategies necessary to effectively use the protocol with adolescents.
- Counsellor and adolescent rights and responsibilities.

Philosophical Approach to counseling using the counseling protocol

The constructivist approach acknowledges the view that personal interpretation of the world is not fixed and therefore can be modified and replaced as new information becomes available to the individual (Brammer, 1993). The constructivist approach is concerned with the adolescent's search for the meaning of life within his or her social and cultural setting. Existentialism emphasizes that humans are free to choose and are therefore responsible for their choices and actions (Corey, 1996). The counselling protocol combines a constructivist philosophy with an existentialist approach to counselling. The combined philosophy is well suited for adolescents who are trying to make sense of their lives through the different stages of their development (Geldard & Geldard, 2003). In the context of this approach, the adolescents are seeking to understand the meaning of the sexual decisions that they make.

The combined approach also stresses the quality of the therapeutic client—counselor relationship and emphasizes the relationship as the major factor that leads to constructive personal understanding and change with far less emphasis on the counselor's techniques (Corey 1996).

The Counselling Process

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The approach addresses the counselling process by depending on a central core of primary counselling functions, Geldard & Geldard (2003) state these primary functions as:

- Relationship building
- Assessing the problem
- Addressing the problem

It adapts a counselling approach that emphasizes the use of counselling micro-skills, as the counsellor progresses through the counselling protocol. Therefore, questions are not merely to be asked of the clients, but counsellors are to integrate the appropriate attitudes, skills and strategies as they discuss the clients' responses. This protocol promotes the use of a single counselling session. This is thought to be a useful approach for working with adolescents who may generally find it difficult committing to multiple counselling sessions. The protocol encourages movement through the primary counselling functions and hence should provide the adolescent with resolution at the end of the session.

The counselling approach used in the protocol acknowledges that counselling adolescents can be different from counselling adults. It recognizes and encourages the use of the following combination:

- Giving information and guidance - directive information that is useful when the client may need assistance with decision-making.
- Counselling - The counsellor skillfully facilitates the adolescents in exploring their own issues and coming to their own decisions and plans for action.

Counselors Attitude

Geldard & Geldard (2003) stated that in order for counselling to be successful with adolescents, the counsellor will need to demonstrate the following personal qualities:

- Empathy: Empathy is the ability of the counsellor to understand and identify with the client's situation during their session it is necessary for the counsellor to focus on understanding how the client sees the world, their experiences and their feelings
- Congruence or Genuineness: The counsellor must be sincere in the relationship with the client, not saying one thing and meaning another and not hiding their true feelings. Adolescents will easily identify inconsistencies with the counsellor's feelings and attitudes,

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- Unconditional Positive Regard: This involves the counsellor being non-judgemental and accepting of the client's behaviour regardless of how offensive it may seem. It is difficult to create a trusting counselling relationship and to gain the confidence of the client without this quality.

Counselling Micro Skills

These are skills that the counsellor uses as she/he manoeuvres through the counselling session using the questions/pointers outlined in the protocol. Only the skills most relevant to this protocol will be discussed. The counselling micro skills below are listed as presented by Geldard and Geldard (2003) with the explanations of their use.

(a) Observation: This is the most useful skill when making an assessment of adolescents. Some areas to pay attention to when observing adolescents are: general appearance, behaviour, mood, what is said and how it is said.

(b) Active listening: Active listening takes into consideration the need for the counsellor to not only listen to the client but to also indicate for the client that he or she is listening.

The counsellor must be sincere in the relationship with the client, not saying one thing and meaning another and not hiding their true feelings.

The following cues should be employed as appropriate during counselling sessions:

i. Non-verbal responses: Eye contact, appropriate facial expression, nodding.
ii. Encouragers:"Mm-hm", "OK", "Really" used in a non-judgemental manner.
iii. Reflection of content and feeding: This is about rewording only the important aspects of what the client has said; for example, "you're feeling pressured for sex when you are alone with him at his house".
iv. Summarizing: Briefly feeding back in your own words the salient features in the client's story.
v. Clarifying: Restating or paraphrasing is useful when you want to be sure that you understand the client's question or statement. It also assures the client that you are truly listening and want to understand clearly what is being said.
vi. Noticing what is missing: it is important to note what is left out of the adolescent's story and to carefully invite the client to discuss these missing narratives as they can provide useful information about clients.

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(c) Giving Feedback: Feedback involves providing the adolescents with information about what they have previously stated and serves several purposes. Forms of feedback include:

i. Giving compliments: often adolescents get feedback that is related to what they have not done well. During the counselling sessions, however, the counsellor is encouraged to provide the clients with positive feedback where possible.

ii. Making Affirmation: his is when the counsellor acknowledges and verifies a positive effort that the client has made. For example, an adolescent has indicated that he is managing to use condones whenever he has sex. The counsellor could say, "You obviously are doing very well with your decision to use condoms consistently".

iii. Normalizing: this is a very important skill especially when working with adolescents because it puts some perspective to their world when they feel they are going crazy. This skill allows the counsellor to tell the client that feelings associated with an extreme situation are normal, if that is the case.

iv. Reframing: Adolescents tend to view their situations from a very shortsighted or narrow perspective. Reframing encourages them to see the larger picture and not just what they can see in the moment. Care must be exercised, however, when using this skill to ensure that the adolescent has the opportunity to discard the larger picture of their lives as detailed from the counsellor and reframe it.

(d) Questioning: Questioning can be used as a means of gaining information and is a necessary part of any counselling session. However, when working with adolescents, questions need to be used in moderation so as not to get into a question and answer format during the session. Allowing the adolescent to freely express their thoughts and feelings should be a consistent focus of the counsellor.

Several types of questions will be useful when using the Adolescent Sexual Decision-making Counselling protocol as discussed below:

i. Open-ended question: These encourage the adolescent to respond in a manner that will result in an open discussion. An example of an open-ended question is 'What were the circumstances that led you to decide to have sex?"

ii. Closed-ended questions: these types of questions usually require only one- word answers and limit the adolescent's response. An example of a closed- ended question is "Are you sexually active?"

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iii. Transitional questions: These are very useful with adolescents as they encourage them to move from talking about one thing to another. They can be used to focus the adolescent on specific areas of the session. An illustration of this type of question is 'You have told me how your mother feels about your boyfriend; now tell me how do you feel about him?"

iv. Goal-oriented questions: these are direct questioning that allows the adolescent to think about how things could he different. Such as "what might happen if you left your present partner?'

v. Questions that exaggerate or highlight consequences: These questions encourage the adolescent to see how well he/she is handling a situation and helps him/her discover his/her strengths. "So what prevents you from getting pregnant or contracting an STI?'

(e) Challenging: The counsellor may use this skill when he/she feels or recognises that the adolescent is stuck on one aspect of an issues or problem and the counsellor perceives that the adolescent needs to be encouraged to move on to other issues of see the problem via a different light.

(f) Disclosure Skills: This involves the counsellor sharing appropriate information about himself with the adolescent. This often makes the adolescent feel understood and further fosters the development of adolescent trust and confidence in the counsellor and encourages the adolescent's disclosure on sensitive matters. Care must be taken however, to ensure that the focus of the session returns on the clients' needs.Allowing the adolescent to freely express their thought and feelings should be a consistent focus of the counsellor.

Counseling strategies

Counselling strategies are used to enhance the counselling process as discussed below:

1. Identification of the problem

Using the various counselling techniques described above (counsellor attitude and skills) and the counselling session guide outlined in the protocol, the counsellor is able to, with the adolescent, identify the problems that maybe influencing the adolescent's sexual decision-making and subsequent behaviour

2. Observation of Behaviour

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The counsellor should be very observant of the adolescent's behaviours throughout the counselling session in order to reflect feelings to the adolescent. The adolescent can also be encouraged to observe his own behaviour via the use of a diary or journal.

3. Psycho Education

The counsellor should share relevant knowledge and experiences with the adolescent in order for the adolescent to integrate useful information into his own body of knowledge.

4. Setting Consequences for Behaviour

Establishing rewards for the adolescent to gain when he/she achieves set goals will positively reinforce desired behaviours. This often occurs naturally in the adolescents' life as he/she moves away front undesirable behaviours with negative consequences to more appropriate behaviours with positive outcomes.

5. Identifying Personal triggers

A trigger is an activating event that leads to something else. The protocol encourages the counsellor to explore with the adolescent what the triggers are as it relates to him being in a potentially risky situation. Recognition of these triggers becomes important to the adolescent as he/she seeks to avoid or manage possible risk situations.

6. Finding More Appropriate Ways to Get Needs Met

The counsellor needs to guide the adolescent through exploring how he can meet his personal needs without becoming the object of another's sexual gratification.

7. Setting Lifestyle Goals

Lifestyle goals provide a sense of direction for adolescents as they go through the unforeseen territories of their lives. Goal setting also provide motivation for an adolescent to maintain goals previously attained, Goals can take several forms including:

I. Task oriented goals: These goals are geared toward meeting material needs or making behavioural changes.

II. Relationship-oriented goals: These goals are set for the purpose of the adolescent defining relationships between themselves and others with whom they come in contact.

8. Role Play

Role-playing allows for the exploration of several aspects of the self. It can also be a useful skill when making choices and getting at ones feelings and belief's that are not

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easily verbalized. In the protocol, role-playing is used to show how an adolescent could discuss or negotiate sexual decision with a prospective sexual partner.

9. Assertiveness Training

Since adolescents are often powerless in their relationships, they need to be assertive. Assertiveness provides a non-defensive way of presenting one's point of view. Here are steps involved in being assertive that are explored in the protocol:

- Listening to the other person
- Validating what the other person has said
- Believing in your right to present a point of view
- Being prepared to negotiate a compromise
- Being prepared to accept that differences do exist

10. Making Decision

Adolescents need help to make good sexual decisions and counsellors need to enable them to use available resources to make good decisions. The counsellors also need to teach the adolescent the skills of healthy sexual decision-making and provide them with the information they need to assist them in decision-making. Here are the stages of decision-making:

- Identifying unhelpful decision making response patterns
- Exploring risks associated with change or with not changing
- Exploring lifestyles goals
- Identifying losses involved in choosing
- a Examining alternatives
- Informing others of a decision
- Maintaining a commitment to a decision

11. Negotiation Skills

Negotiation is a useful skill in trying to achieve one's desired outcome. It is exceptionally useful for adolescents to optimize this skill.

- Be clear and state the reasons why you want to do the desired behaviour.
- Identify rebuttals/responses to your friends or prospective partner's anticipated response.
- Shift the focus of the discussion towards yourself and your feelings, beliefs, intentions, etc.

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- Establish what behaviours you just definitely will not accept (refusals).

12. Male Condom Demonstration Skills

Accurate condom use skills are key to safer sex practices for the adolescent. It is important that adolescents be able to demonstrate proper condom use skills. It should not be taken for granted that the adolescent knows and or practices the correct use of male latex condoms. The steps for use are as follows:

- Make sure the penis is erect.
- Move the condom to the side of the package and ensure that there is air in the package. Also check the expiration date. Do not use if condom has expired or if package appears flat.
- Tear the flat section of the package and remove the condom.
- Hold the tip of the condom and squeeze the air out.
- While holding the tip on the penis, unroll the condom onto the base of the penis.
- After use, remove the condom carefully making sure that no semen spills or leaks from the condom. Remove before the penis becomes flaccid or limp.
- Tie the condom and discard in the garbage. Do not flush down the toilet.

Rights and Responsibilities of Adolescents and Counsellors

Rights are privileges provided through guidelines that dictate how persons in society should be treated and the services to which they should have access (McDonald, 2000). Responsibilities are things for which an individual will be held accountable (McDonald, 2000). Adolescents are often not aware of their rights and responsibilities. McDonald outlined them here to provide information to counsellors about the rights of adolescents with the aim of educating them should a related issue surface during the session. The rights and responsibilities of the counsellor are also outlined so that counsellors are also knowledgeable about their rights in this role as the counsellor and to conduct the session in an ethical manner.

The rights and responsibilities specified will be limited mainly to those related directly to adolescents' sexual health and to counselling.

Adolescents' Rights

1. Adolescents have the right to access health services. This includes:

✓ The right to confidentiality — if confidentiality needs to be broken, the conditions under which this occurs should be discussed with the adolescent.

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- ✓ The right to be treated fairly and equally without being discriminated against by reason of one's:
  - sexual choice/practices
  - involvement in sexual activity
  - disease status (e.g. being HIV positive)
  - social circumstances (race, colour, socioeconomic status, area of residency, etc.)
- ✓ The service should involve the provision of non-judgmental health information. This means that information should not be withheld from adolescents due to the discriminatory attitude of a service provider.
- ✓ Access to adequate, affordable and geographically accessible 'easy to reach' health services.
- ✓ The provision of contraceptive services — counselling and method of choice.
- ✓ To receive health service with or without the presence or consent of patients or guardians.
- ✓ To be informed/advised about the nature and effects of any treatment given. To seek another health professional who is able to deliver services adhering to the above rights.

2. Adolescents have the right to consent to sexual activity. However, sexual activity below the legal age of consent (16 years) is an offence under the law regardless of whether the adolescent 'consents" or not.
3. Adolescent women have the right to choose to have children and to determine the number.
4. Adolescents have the right and the ability to participate in decisions on matters in which they are directly involved, (The Convention on the Rights of the Child, 2001.)

Adolescents' Responsibilities

- ✓ Adolescents have the following societal responsibilities:
- ✓ To inform parents or guardians of their health care needs.
- ✓ To be open with information in order for the Health Care Provider to provide the relevant care.
- ✓ To take responsibility for their actions and behaviours,

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✓ To follow-up on appointments scheduled and treatment modality recommended.
✓ To seek relevant information about issues those affect them.
✓ To report any sexual misconduct by adults or peers to the appropriate authorities. -

Counsellors' Rights

Counsellors have the following rights:

- To withdraw counselling services.
- To be respected by clients.
- To access support.

Counsellors' Responsibilities

Counsellors have several responsibilities to their clients as highlighted below:

1. Duty to Refer: Counsellors are expected to appropriately refer adolescents to other health professionals and or services determined necessary, after completing the counselling session. The counsellors should ensure that the adolescents have all the relevant information in order to access service at the point to which they are referred.
2. Duty to Report: (Mandatory Reporting) When discussing sexual decision making with adolescents, it is highly likely that the issue of mandatory reporting will surface. With the change in the Child Protection Law in Jamaica in 2004, counsellors are now legally required to report child sexual abuse on reasonable suspicion. This is termed mandatory reporting. Counsellors using their protocol will be expected to report any suspicion of child sexual abuse that surfaces in the counselling session.
3. Duty to Protect: Counsellors are expected to protect the safety and confidentiality of their clients.

Adolescent Health Club: Is a general or private center or club where adolescents go to care for each other's health needs as well as a center for discussing issues relating to their reproductive health, sexual health, sexual behaviour, relationship, family life etc.

- Health compromising behaviours and lifestyles established during the teens and early twenties have effects on multiple major chronic illnesses of later life.

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- There is a marked contrast between the self-report profile of health of young people and the persistently high rates of health compromising behaviour and health problems with major implications for later health.
- With the exception injury and possibly some forms of mental illness, both the primary care and hospital sectors appears to deal with comparatively minor causes of health morbidity. Few consultations take place addressing the lifestyle determinants of later health.
- For most of the preventable causes of chronic illness in later life the profile of lifestyle risk factors appears well established by the early twenties.

Adolescent Peer Club

A peer group is a social consisting of humans. Peer groups are an informal primary group of people who share a similar or equal status and who are usually of roughly the same age, tended to travel around and interact within the social aggregate. Members of a particular peer group often have similar interests and backgrounds, bonded by the premise of sameness. However, some peer groups are very diverse, crossing social divides such as socioeconomic status, level of education, race, creed, culture, or religion.

Institutional roles on reproductive health programmes and services to positively influence adolescents sexual behaviour:

1. The Role of Parents/Guardians

Parents are the primary sexuality educators of their children. They educate both on what they say and how they behave. It is important to begin deliberate education at the earliest childhood level; however, adolescence stage poses new challenges for many parents. In homes where there is open communication about sexuality, young people often behave more responsibly. At a minimum, such communication may help young people accept their own sexual feelings and actions, with open communication, young people are more likely to turn to their parents in times of trouble; without it, they will not. (http://www.unesco.org/2000/education).

2. The Role of School, Teachers and Educational Administrators

Schools are important places where young people can acquire knowledge and skills that equip them for responsible lifestyles now and in the future. The power and potential of schools to address Health is because more children than ever are receiving

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education. Schools are an efficient way to reaching school-age youth and their families with health information in an organized way. In the developing world, more than 70 percent of children currently complete at least four years of schools. The last 30 years have seen an impressive improvement in enrolment rates, particularly in developing countries. Girls' primary school enrolment grew from 39 percent in 1960 to 72 percent in 1995 (UNICEF, 1996). The promotion of children's health through schools is being recognized globally as an important means of influencing health behaviour. It has been an important goal of WHO, UNESCO, and other international agencies for more than 40 years. The goal has gained significant momentum in recent years. Rationale for incorporating RH programmes into schools, because they hold the potential to have a positive effect on the health and learning of students. School is an appropriate setting which can be use to contribute to the development of healthy sexuality. The promotion of reproductive health through a coordinated school-based approach is desirable for the following financial, developmental, and practical reasons:

A. Developmental Needs

During puberty, adolescents go through profound changes that they need to understand as part of growing up. Young people are in the early stages of developing attitudes, communication patterns, and behaviour related to sex and relationships (Weiss, 1996). Weiss and colleagues also noted that many youths are enrolled in schools where they initiate intercourse. By providing RH programmes early, particularly before the initiation of sexual activity, it is still possible to encourage the formation of healthy sexual habits (WHO, UNFPA & UNESCO, 2003). Schools can promote healthy messages and establish helpful norms about sexuality and reproductive health. In particular, primary schools have the opportunity to reach many children who drop out before secondary school.

B. Practicality and Appropriateness of the School Setting

Many of the elements upon which to build RH programs in schools already exist. Health services of some form or another are provided for students in almost every country, and most countries have an ongoing school health programmes that could become the starting point for a more integrated approach (WHO, 2000).School-based or school-linked clinics have shown to facilitate student access to the services often necessary to support behavioural change. Research on multiservice health centers in schools indicates that students use them not only for primary care but for more

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sensitive issues, such as mental health, sexual abuse, and reproductive health (UNAID/WHO,2001).Young people face the greatest challenges regarding the HIV/AIDS pandemic. Once they become sexually active, they often have several short-term relationships that involve sex and do not consider correct and consistent condom use. In many cases, certain social factors make school aged young people vulnerable to HIV infection. These include: peer pressure, poverty, alcohols, lack of sufficient information, education and understanding of HIV & AIDS related issues as well as intravenous drug use. Behaviour change is also deterred by the lack of appropriate education on sexual and reproductive health in social and educational institutions.

C. Financial needs:

3. The Role of Health Care Providers

Health care organizations and providers have the responsibility to provide young people with affordable, sensitive, and confidential sexual and reproductive healthcare services. As professionals, health care providers cannot afford to allow their personal or religious views becloud their obligations to assist young people who come to seek information and services.

4. The Role of Policy Makers

Public policies on adolescent sexual health should be based on knowledge of adolescent development, accurate data, and established theoretical basis for program effectiveness, ongoing evaluation and adequate funding and support (http://www.unesco.org/2000/education).

5. The Role of Religious and Community Leaders

Religious and Community Leaders are often called opinion leaders. They are highly respected by the people and have a responsibility to assist young people deal with reality by giving them a consistent set of messages regarding community values about such issues as sexual behaviours, responsibility and future planning. When these leaders understand and accept the importance of addressing young people's needs, it becomes easier for them to promote these issues among members of their community (http://www.unesco.org/2000/education).

6. The Role of the Mass Media

The mass media have become a major source of information about sexuality; mass media professionals can exercise their influence by providing accurate

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information and modeling responsible behaviours. The communication of accurate information adds realism and helps adolescents gain insights into their own sexuality. By so doing young people will be able to make responsible decisions about their behaviour (http://www.unesco.org/2000/education).

Adolescent Reproductive Health Situation in Nigeria

Nigeria has made significant progress in the provision of Family Life and HIV Education (FLHE) to young people through the educational system in the last few years. Following the National Council on Education's (NCE) approval of the National Family Life and HIV Education Curriculum in 2003, several activities aimed at ensuring the curriculum's implementation has taken place. These activities include the integration of the FLHE curriculum into career subjects, the development of a trainers' resource manual, in-service training of teachers, and the recent development of career subject-specific teachers'guides by the Nigerian Educational Research and Development Council (NERDC)/ Action Health Incorporated, 2005).

Despite these laudable efforts, there remain major gaps. Action Health Incorporated (AHI) has continued to work with key stakeholders especially the Federal Ministry of Education's HIV and AIDS Unit and State Ministries of Education to address these gaps. In pursuance of these efforts, AHI has presented the Family Life and HIV Education Students "Handbook as part of their efforts to address the lack of age appropriate student textbooks for FLHE and supplement the approved texts for all FLHE career subjects in the educational system. In the past, it was normal to protect adolescents from receiving education on sexual matters as it was falsely believed that ignorance would encourage chastity; yet, the rampant unprotected sexual activities among adolescents and the devastating consequences is evidence of the failure of this approach (Action Health Incorporated and Sexuality Information and Education Council of the United State-SIECUS, 1996). Studies of the sexual and reproductive health behaviour of Nigerian youths confirm that they had not been formally taught about sexuality. Their information on this important subject came from peers, news magazines and biology classes. Though a high percentage expressed the view that they have 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

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one in which they were forced to have sexual intercourse (Action Health Incorporated, 2003).

The 1999 National Conference on Adolescent Reproductive Health in Nigeria reviewed the status of the country's compliance with the platform for action adopted by the International Conference on Population and Development in 1994. In its report, the conference affirmed that, "The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health service". In Nigeria, like many other developing countries, adequate attention has not been given to adolescent reproductive health, despite the fact that recent data has shown that age at menarche is dropping; there is early initiation of sexual activity; there is a high incidence of teenage pregnancy; and that teenager's account for 80% of unsafe abortion complications treated in hospitals. Generally speaking, arising from our socio-cultural heritage, issues relating to sexuality are usually not openly discussed. However, documented evidence shows that there has been a breakdown of other socio-cultural norms, values and practices that used to serve as checks to premarital sexual activity (Time for Action, 1999).

In Nigeria, adolescents from 10-24 year age group constitute about 30% of the population and it is projected that by 2015 the group will account to half of the population. Creating access to sexual and reproductive health information and services for this large segment of the population is therefore a compelling national responsibility. The magnitude of the sexual and reproductive health problems of the youths in Nigeria is high and calls for urgent attention. The UNFPA, international and local NGO's have been the major stakeholders in adolescent sexual reproductive health programme activities in Nigeria by providing adolescent friendly reproductive health services, development of family life education, curriculum and teaching of same in secondary school as well as training health workers to offer adolescent friendly RHP and services (Ariba and Ishola, 2006).

Faubaa and Olugbenga (2005) agreed with Vision Project (2005) that "adolescents sexuality behaviour in Nigeria and sub-Sahara Africa is seriously going through transformation from what it used to be in the past" which they attributed to the effect of modernization caused by Industrialization, education; exposure; and culturalization through importation of various foreign cultures in particular". The adolescents' stages occupy an exciting but potentially dangerous position in any country. Nigerian adolescents are sexually active; by age 18, 63% of female adolescents have

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experienced intercourse, by age 20 the percentage increases to 80%. Findings from situation analysis carried out among youths in Ibadan in 1995 showed that many adolescents are introduced to sex at an early age; about 21.4% of them had experienced sexual intercourse at the mean age of 15 years. These sexual activities are largely unprotected, which portends immediate and future dangers to young persons. Research findings have confirmed that many adolescents engage in pre-marital sexual activities and forms of risky behaviours, which have adverse reproductive health consequences (Pebly and Feyisetan, 1989; ARFH 1998).

Inyang (2007) revealed that poor economic factor, cultural norms; lack of information, belief, social pressure, curiosity and experimentation, unnecessary exposure, perception of sexual activity, breakdown in traditional values and gender power imbalance are the causes of adolescents involving in sexual behaviour early in life. Young Nigerians face risks associated with early sexual debut and marriage and with early pregnancy and unsafe abortion. Sexual abuse and female genital mutilation (FGM) are also common. Contraceptive use is 6.6% among 15-19 years old and 16% among 20-24 year olds. In 1998, 60% of reported AIDS cases in Nigeria were among 15-24 year olds. While abortion data are sparse, available evidence suggests that the majority of abortions occur among teenage girls. A large number of NGOs in Nigeria are involved with YARH, but most of these NGOs are involved in small neighbourhood programmes. In 1999 a local youth oriented NGO, Action Health International, organized a national YARH conference; in response, the Federal Ministry of Health published a draft National Strategic Framework for Adolescent Reproductive Health. However, neither this national strategy nor the accompanying policy has been acted upon.

In August 2001, the government took a major step and approved a national curriculum for sexuality education for upper primary, junior secondary, senior secondary and tertiary institutions. Less than a month ago, 46 master trainers completed training to guide implementation of the curriculum in all 774 local education districts, which will be completed over the next two years. WHO (2002) revealed that Adolescents Reproductive Health programmes issues should comprises: STIs, HIV/AIDS, teen pregnancy; abortion; family planning, teen parenting; early marriage, Human sexuality, Child and adolescent development (physical and mental),Consequences of unprotected sex, Unwanted Pregnancy,

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Unsafe abortion, Contraception and contraceptive method, Human reproduction, Relationship (intergenerational; peers; opposite sex),Gender (identity) socialization can be developed to improve their reproductive and sexual health/well-being issues, promote awareness of safe sexual behaviours, to provide a place where they can receive information about and gain access to contraceptive and related services. Okonta (2007) was of the view that adolescent sexual and reproductive health programmes and services have been limited mainly to policy formulation on the part of the Government. "He stated further that the state government in Nigeria especially in the Niger-Delta has little or no programme of their own to promote adolescents health in their respective states. There are no state adolescent health committees as stipulated by the national policy."

The National Adolescent Health Policy in 1995 has among its objectives the promotion of acquisition of appropriate knowledge by adolescents; to train and sensitize adolescents and other relevant groups in skills needed to promote effective health care and healthy behaviour. The policy in achieving these objectives stated that there shall be committees on adolescent health at the National, State and Local levels of Government in Nigeria. The Federal Ministry of health, the sole controller of Health policies in Nigeria is expected to assist the State and Local Government Areas in the development and implementation of adolescent health programmes and services.

United Nation Fund Population Association (UNFPA) (2004) reported that of the 240 Reproductive health facilities inspected in Delta State; only 16% had space for adolescent services and only half of these provide youth friendly services. Comprehensive evaluation programme should of a necessity include advocacy, networking, information, education and communication (IEC) and community participation. However, activities on Adolescent Sexual and reproductive health programmes and services mostly at the state levels have been supported and performed actively by United Nation Fund Population Association (UNFPA), International and Local Non-Governmental Organization (NGOs) in the Niger-Delta. AHI (2004) revealed a story of a 12 year old girl, who had never been told anything about sex, was lured into an abandon room and raped by a teacher. The school found out and arrested him; the principal received a dozen anonymous letters from current students, saying that they too had been assaulted by him. The man had worked in the school for 13years." Studies in Family Planning (2001) revealed that the research base

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knowledge concerning programme effectiveness is weak, especially for developing countries, like Nigeria. The literature is replete with case studies; evaluation studies are too few and often poorly designed, and too inconclusive to yield reliable guidance about programme effectiveness.

However, Reproductive Health 0utlook (2004) enlisted Reproductive Health Services for Adolescents as follows: Pregnancy testing, Maternity care/delivery services, STIs screening and treatment, HIV/AIDS testing, Contraceptive counseling, Abortion services, Post – abortion care, Infertility counseling, Gyneacological examinations, Aneamia testing, Breastfeeding counseling, Nutrition counseling, Parenting classes and Others. The reproductive health needs of youths in their teens and early twenties have continued to be of great concern to policy makers, individuals, donor agencies, non-governmental organizations and parents in Nigeria and elsewhere in the world. The problems of teenage sexual activities which manifest mostly in high rates of unwanted pregnancies, school drop-outs and illicit abortion have further heightened because of social change and the influence of modernization. Increasing urbanization and new innovation in technology and communication have exposed young people to foreign ideas, which tend to have consequential effects not only on their well being but also on their family, the community and on the economic development of the nation at large (Advocate for Youth, 2000).

According to Makinwa – Adebusoye (1992), as many as 75% female and 81% of male adolescents reported that gonorrhea is the most common STIs among adolescents. The urgency in addressing the specific reproductive and sexual health needs of young people has been accentuated in recent times by the scourge of the HIV/AIDS epidemic, as there have been reports of established cases in Nigeria. Adolescent sexual and reproduction health programmes and services have been limited mainly to policy formulation and there is no commitment of a specified percentage of annual budgets in Nigeria to monitor; evaluate and plan effective reproductive programmes to positively and effectively handle adolescence health issues especially their sexual behaviour. High rates of unwanted pregnancies and unsafe abortions among young women also present enormous risks to their health, resulting in high levels of mortality (Bandrup – Lukanow, et al 1991).The Nigerian National Reproductive Health Policy and Strategy affirms that reproductive health is the right of women, men and adolescents.

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The objectives of the government directly addressing youth reproductive health include:

- To increase the proportion of people, including adolescents, who have access to accurate and comprehensive reproductive health information and services by 50%.
- To increase knowledge of reproductive biology and promote responsible behaviours of adolescents regarding prevention of unwanted pregnancy and sexually transmitted infections.
- To increase access to appropriate reproductive health information to all in-school and out of school adolescents.
- To introduce into school curricula, sexuality and family life education.
- To increase access to comprehensive youth-friendly health services including counseling for all young people, and youths with disabilities to 20%.
- To initiate and support the enactment and review of laws relevant to adolescent health.
- To promote the enactment of laws to eliminate early marriage by determining a minimum age for marriage.

In many studies conducted in developing countries, young people report that they would prefer to receive sexual and reproductive health information, training in skills, and services from well-informed, caring adults, especially parents (UNFPA, 2001). Okonta (2007); Okonofua (2003); and Okonkwo and Iliaka (2003) indicated from available data that adolescents in south-south of Nigeria engage in unhealthy sexual behavior characterized by early age of sexual partners, sexual debut, unintended pregnancy STIs/HIV/AIDS, abortion, early marriage, e.t.c. “In Rivers State, 34.3% of the sexually active girls have intercourse at least once a week” (Anochie and Ikpeme, 2001). In Cross River State, 22.6% of the sexually active adolescents have more than one sexual partner (Etek, Ihejieamaizu and Etuk, 2004). In Delta State, about one-third of the sexually active adolescents have had more than one sexual partner (Oboro and Tahowei, 2003). In Edo State, sexual activity was common among peers starting at an early age and involving multiple sexual partners. Ministry of Health (2004) discovered that a pre-existing STI increase the susceptibility to acquiring HIV infection. The 2003 HIV zero-prevalence sentinel survey showed that in the south-south zone the highest prevalence of HIV was in the

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age group 20 – 24 years. These young people must have contracted the infection as adolescents. STIs if not properly treated could lead to infertility in future. Precisely in 2007, there was an increase rate of lesbianism and homosexuality problems among adolescents at Ughelli in Delta State.

One-third (36.5 million) of Nigeria's total population of 123 million are youths between the ages of 10 and 24 (The Bureau, 2001). By 2025, the number of Nigeria youths will exceed 57 million (World Population, 2000). Lack of sexual health information and services places these young people at risk of pregnancy, abortion, sexually transmitted infections (STI), HIV/AIDS. In addition, early marriage and childbearing limit youth's educational and employment opportunities. Yet effective innovation programmes can provide youths with the sexual health information and services they need (Advocate for Youth, 2001).

Performing or seeking an abortion is illegal in Nigeria, except to save a woman's life. Yet, experts estimate that more than 600,000 Nigeria woman obtain abortion each year (Otiode, 2002). One study found that one-third of female obtaining abortions were adolescents. Hospital-based studies showed that up to 80 percent of Nigeria patient with abortion-related complications were adolescents. Among sexually experienced youths ages 18 to 24, 72 percent of males and 81 percent of females had ever used contraception. Males were most likely (43 percent) to have used condoms than females (31 percent), the rhythm method. About seven percent of marriage teenage women reported using any method of contraception; less than five percent used a method. Fifty-three percent of unmarried, sexually active teenage women used any method of contraception; over 29 percent used a modern method (Nigeria Demographic and Health Survey, 2003).

Among sexually active, single youths, reasons for non use of contraception included fear of complications (46.7 percent of males and 48.5 percent of females) and religious beliefs (12.0 percent of males and 21.2 percent of females). Forty percent of youths believed that condoms would reduce sexual pleasure. (Nigeria Demographic and Health Survey, 2000).While most youths ages 15 to 24 knew about HIV/AIDS and gonorrhea, less than 15 percent of females and 27 percent of males knew about syphilis and less than five percent knew about human papillomavirus, among 15 to 19 year old, over 37 percent of women and 19 percent of men had no knowledge of an STI. Among 20 to 24 year olds, 30.8 percent of women and 4.3 percent of men lacked knowledge of any STI. (Advocate for Youth, 2003). Among

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sexually active youths in one study, 87 percent of males and 78 percent of females knew that having sex with stable partner and using condom consistently could prevent HIV infection. Although many youths chose contraception to prevent disease with casual partners, these youths did not choose condoms significantly more often than other methods. During obstructed labour, occurring most frequently in adolescent pregnancies, young mothers may experience vesico vaginal fistula (VVF). Young women who experience VVF face a grim future, including rejection by their families and survival by prostitution. Seventy percent of an estimated 2000, a case of VVF occurs in Northern Nigeria. (The Centre, 2000) and there are indications also in South-South Nigeria.

The findings of a situation analysis (ARFH 1998) on family life education in 1998 in 66 public secondary schools in Oyo State revealed the following:

- Sexual debut in boys was 13.5 and 14.5 in girls
- Average number of sexual partners for girls was 1.5 and for boys was 2.0
- Nearly 40% of students sampled admitted to having had sexual intercourse
- Among the females sampled at least 20% have had one abortion
- Reasons for indiscriminate and unprotected sexual activities were poverty, peer pressure, lack of information, negative media influence and lack of parental guidance
- Low level of productive health and HIV/AIDS knowledge amongst the students in the schools sampled.
- Parents and teachers expressed concern over the sexual and reproductive health behaviors of young people and strongly canvassed for an urgent intervention.

Other problems were inadequate SRH information, lack of access to services, poverty and economic hardship leading to an increasing number of girls engaging in risky sexual practices such as exchanging sex for money and other material gains. The vulnerability of young person's within or out of school to the risks of HIV/AIDS has consequently been increased. In addition, some respected cultural norms and values have been eroded by the influx of foreign culture such as youth's exposure to indecent films and obnoxious materials on the Internet. The conflicts generated in youths by these cultural influences and the dilemma of recognizing what are normal or acceptable social and sexual practices can only be resolved by providing them with

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safe preventive, curative and rehabilitative SRH services. The expanded life planning education is one of the approaches to addressing the needs of youths in Nigeria.

HIV/AIDS has emerged as one of the major socio-medical concerns in the world, most especially in Africa and Nigeria in particular. In many parts of Africa, between 10 and 20 percent of those aged 15 to 24 are already infected with HIV, and of all new HIV infections one third are in young people living in sub-Saharan Africa. This represents about 65% of all new infections in young people worldwide. In Nigeria, those aged between 15 and 29 account for 19.5% of the total cases (UNAIDS, 2004). Adolescent Reproductive Health (ARH) programming has been propelled in the last decade and a half by the demographic and socio-economic realities of the relative and absolute number of the population group in the West Africa sub-region.

Therefore, the need to evaluate the effectiveness of current reproductive health programmes and services on sexual behaviour of in-school adolescents. Are they effective why are there still increase in teen pregnancy and other sexual and reproductive health- related problems among adolescents? Are they accessible and affordable to enhance positive sexual behaviour and skills to encourage adolescents in the South to esteem chastity to negative sexual lifestyle? Okonta (2007) opined that there is need for monitoring and evaluation of Reproductive Health programmes to assess implementation of programmes, identify challenges and pitfalls, in order to establish components of successful programmes.

There are two realities to these problems, according to Focus on Young Adults (2005) which are:

1. Many of the evaluation on Reproductive Health programmes and services for adolescents have been short-term and are thus unable to show changes in sexual behaviour and other reproductive health outcomes; such as pregnancy and STIs rates.
2. Programmes most often evaluated are those that provide information about sex and reproductive health, clinical services to youth are by themselves insufficient to reduce adolescents' risky sexual behaviour. All these prevailing issues have been a pathetic burden, and serious concern to the researcher. Therefore, the need to evaluate ineffective in the current programmes.

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Moreover, the recent global recognition of the importance of adolescent is an indication of their potentials to influence the course of human history.

Appraisal of Related Literature

Adolescence is a period of increased risk-taking and therefore susceptibility to behavioural problems at the time of puberty and new concerns about reproductive health. The sexual development of young people is a critical part of their growing up and adolescent's reproductive health is increasingly becoming a government priority. An adolescent of today faces significant challenges to their health and well-being. This chapter reviewed related literature on the followings: the concept of adolescents, the various challenges and categorical problems associated with adolescents, concept of reproductive health and adolescent's reproductive health, types of sexual behaviours of adolescents, socio-cultural factors context and adolescents experiences, characteristics of adolescents stage of life, factors that predispose adolescents to risky sexual behaviours with its implications and Parents and Teachers views on the teaching of Sexuality Education and Family Life Education.

Okonkwo and Iliaka (2003), Okonofua (2003), ARFH (2006) and Okonta (2007) reviewed that adolescents in the South-South of Nigeria are confronted with unhealthy sexual behaviours characterized by early age of multiple sexual partners, sexual debut, unintended pregnancy, STIS/HIV/AIDs, unprotected sex, early marriage and child bearing, masturbation, lesbianism, homosexualism, unsafe abortion, school dropout, reproductive health related morbidities such as pelvic infection, vesico-vaginal fistula (VVF), sexually transmitted infection (STIs) and increased maternal mortality. At the Federal level of Nigeria, the United Nation Fund Population (UNFPA) supported the Federal Ministry of Health to operationalise the Reproductive Health (RH) programme and develop a RH policy for the country, which has been adopted by the National council on health together with the policy project of United States Agency for International Development (USAID), WHO and WORLD BANK have organized programmes to promote the RH of Adolescents and other young adults in the country. Adolescents focused organization like Action Health incorporation (AHI), Adolescent Health information Project (AHIP) and Girls Power Initiative (GPI) Organization have since the early 1990s carried out empowerment programmes for adolescence using Comprehensive Sexuality Education (FMOH 2002 and http//wwwunfpa.org/report99/conseque.htm).

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Henshaw (2003) opined that most adolescent pregnancies are generally unintended but the recent trends in teen pregnancy rates are a very significant marker of female adolescent sexual behaviour and reproductive health not only because a pregnancy can have implications for an adolescent health and well-being but also adolescent pregnancy rates can be a fairly direct indicator of young women's opportunities and capacity to control their sexual and reproductive health.In view of the findings and demographic data stated above, it is obvious that the challenges confronting the existing reproductive health programmes and services of adolescent sexual behaviour are diverse and multiple. Despite the commitment of many policy makers, Government and Non-Governmental Organisations advocate in addressing the ever-increasing sexual and reproductive health needs of adolescents, calls for appropriate programmes, services, and funding have gone largely unanswered (Population Reference Bureau, 2010).Reproductive health programmes and services to youths are insufficient to reduce at-risk sexual behavior of adolescents such as STIs rates, pregnancy, abortion related problems (Advocate for Youth, 2005).

The conceptual theoretical framework dealt on the Theory of Reasoned Action, Theory of Planned behaviour and theories-explaining adolescent's risk- taking behaviours. This revealed that people only change in their behaviour when expose adequately to action oriented programmes that are implemented in line with stated objectives, in enhancing healthful skills for sexual healthy behaviours and overall development. History and development of Evaluation in Health Education, Adolescents' reproductive programmes of Family life, HIV/AIDS education, sexuality education and peer education and services of counseling on contraceptives, HIV/AIDs/STIs, Health clubs, Peer Clubs and Youth friendly Services were discussed extensively. United Nation Children's Fund (UNICEF) (2000) also indicated that Adolescents Reproductive programme and Service is affected by number of factors including ethnicity; lack of insurance coverage, socio-cultural context; inconvenient clinic hours; inadequate transportation, attitude and behaviours of health professionals and lack of assurance of confidentiality. Huges & McCauley (2002) opined that few scientifically based evidence exist about which programme approaches are most effective in shaping healthy sexual behaviours of adolescents in developing countries. This implies that careful evaluation and research must be enhanced to positively influence sexual behaviour of adolescents. However, despite the constraints of financial and human resources, coupled with the great size of youth population; there

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is need to consistently evaluate current programmes and services to ensure less costly ways to reach young people.

Vision Project (2005) stated that "with proper guidance and motivation adolescents can significantly affect and improve the socio-economic and political situation of their society" like Nigeria. The above issues demand serious and concerted effort of all stakeholders in Health. Despite various NGOs in the Nation and the efforts of UNFPA and other International organizations, research still indicates that current programmes often do not match the needs and health seeking behaviours of adolescents in developing Countries and existing research and evaluation studies indicated that there is a poor fit between current programmes and the needs of young people (Huges & McCauley, 2002). According to Huges & McCauley (2002) a number of studies indicated that programmes are successful in increasing young people's knowledge about reproductive health issues and services. They stated further that peer-education and community programmes are likely to be an effective way to reaching young people. In seeking new programming approaches, the work of WHO/UNICEF/UNFPA (2002) recently revealed that the objectives/purposes of adolescents' health programmes and services are: to promote healthy development, to provide reproductive care when needed, services intervention should include promoting a safe and supportive environment, providing information and counseling, building skills, and improving health services. Sexual behaviour can be positive when appropriate skills are taught through reproductive's health educative programmes and services.

The various roles of institutional organizations were described to enhance quality reproductive health programmes using school-based Health Education. Adolescents' reproductive health status in Nigeria was also reviewed. Research indicates that adolescents prefer to obtain reproductive health information and services in the school settings. An effective reproductive health programmes and services for adolescents will equip and promote not only their sexual health in curbing their at-risk sexual behaviour positively, but also build healthful skills for optimal health. Health Canada (2003) stated that the promotion of adolescent sexual health involves equipping young people with relevant knowledge, motivation and behavioural skills to enhance their sexual behaviour and avoid sexual health related problems. WHO (2002) stated further that professional responsibilities and roles of health care provider in adolescent reproductive programmes and services should

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include teaching; counseling; clinical section; organizational role; advocacy; and professional roles which should be embedded in child health; health education; mental health or community health course or should be briefly touched upon as part of a reproductive health courses. These problems can be reduced if the government can partner effectively with other stakeholders like NGOs and put in place machinery to evaluate the efforts of the NGOs since Population Reference Bureau (2002) in a study in Nigeria showed that evaluation of peer education programme implemented in nine communities showed that peers educators significantly increase knowledge, self-efficacy, willingness to purchase contraceptives and were more effective among secondary school students. Research findings of this nature can be used to improve and expand positively adolescents' sexual behaviour.

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CHAPTER THREE

METHODOLOGY

The methods and procedure used for this study were discussed under the following sub-headings:-

1. Research design
2. Population
3. Sample and Sampling Techniques
4. Research Instrument:
5. Validity of the Instrument
6. Reliability of the Instrument
7. Field testing of the Instrument
8. Procedure for data collection
9. Procedure for data analysis.

Research Design

The Ex-Post Facto Research Design was used for this study. The choice of the design is because it attempts to determine the cause for any observed difference which effect is already in existence of the effectiveness of reproductive health programmes and services on sexual behaviour of in-school adolescents in Delta State, Nmigeria. According to Adeyemo (2006), its general approach may be more analytic and often focuses on a particular variable or factor which aim is to gather data that does not involve manipulation of experimentation of the research context as it describes a situation as it is. Igwebuike (2009) stated that using Ex-Post Facto research design, the researcher does not manipulate or control variables and the cause-effect relationship established are tentative in nature.

Population

The population for this study comprised all Local governments, health care providers, teachers and in-school adolescents from Public Secondary Schools in Delta State, Nigeria (see Appendix A).

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Sample and Sampling Technique:

A total of one thousand nine hundred and thirty nine (1939) respondents were sampled. A multi-Stage sampling procedure was used in conducting the survey involving six stages. In the first stage simple random sampling technique was adopted to select all the three senatorial district as shown on table 3.1, In the second stage, purposive sampling technique was used to select the first three local governments from the selected senatorial district each totaling nine (9) local government areas out of the twenty-six local government area in Delta state. In the third stage, convenient sampling technique was used to select all the schools within the nine local governments area selected for the study which totals twenty–six public schools. In the fourth stage, cluster random sampling technique was used to select 1515 in-school adolescents (832 male and 683 female) in SS2 as shown in table 3.2, SS 2 in-school Adolescents were chosen because they have been exposed to the RH education programmes and services. However, SS3 were not part of the study sampled because they were not in school as at the time the study was carried out. In the fifth stage, the purposive sampling technique was used to select 294 out of 844 teachers, all 26 Principal and 26 vice principal whom have been trained on RHEPS by UNFPA and World Bank. In the sixth stage, the purposive sampling technique was used to select the first three most senior staff from the health care centers (providers) within the study area in Delta State of Nigeria.

Stage 1- The first three Local Government from the first three senatorial district in Delta State in the table where RHPS have been offered between 1999- 2010 was sampled for the study, which is represented as in the table below:

Table 3.1: Total number of nine Local governments selected for the study from the 3 senatoral districts in Delta State.

(1)	**North Senatorial district (zone)**	**(2)Central senatorial district (zone)**	**(3)South senatorial district**
1	Aniocha North	4. Udu	7. Warri South
2	Ukwuani L.G.A	5. Ughelli South	8. Burutu
3	Ika North East	6. Uvwie	9. Isoko North

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Stage 2: Cluster sampling technique was used to randomly select students and teachers for the study as shown below:

Table 3.2:

S/N	L.G.A	SCHOOLS	LOCATION OF SCHOOL	SAMPLED STUDENTS			SAMPLED TEACHERS		
				M	F	TOTAL	M	F	TOTAL
1	Aniocha North senatorial district	(i)Ezechima M/S/S, Obior	Obior	15	11	26	2	4	6
		(ii) Ezi S/C/S, Ezi	Ezi	16	17	33	1	1	2
		(iii) Boy's Model S/S Onicha-Olona	Onicha- Olona	18	11	29	4	4	8
		(iv) Onicha-Ugbo G/G/S, Onicha-Ugbo	Onicha-Ugbo	-	20	20	-	4	4
		(v) Pilgrim Baptist G/S, Issele-Uku	Issele-Uku	53	-	53	3	3	6
2.	Ukwuani North senatorial district	(i)Ndokwa S/C/S, Obiaruku	Esimike estate obiaruku	13	16	29	2	3	5
		(ii) St. George's G/S Obiaruku	Edem Onah Str eetObiaruku	28	36	64	4	8	12
3.	Ika North East	(i) Ika G/S I&II, Owa	Old L/A Rd. Boji-Boji, Owa	102	-	102	11	9	20
		(ii) Umunede M/S/S, Umunede	Hospital Rd. Ilele Qutr.	19	19	38	8	4	12
4.	Udu	(i) Owhrode M/S/S Owhrode	Along Otor-Udu Rd, Owhrode	6	15	21	1	8	9
		(ii) Egini G/S, Egini	College Rd, Egini	21	19	40	1	7	8
			TOTAL	291 `	164	455	37	55	92

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5.	Uvwie	Alegbo S/S I, Effurun	Old Ugbomoro	61	71	132	2	22	24
		(ii) Urhobo College I&II, Effurun	Warri/Sapele Rd, Effurun	30	-	30	1	18	19
		(iii) Our Lady's H/S I&II, Effurun	Airport Rd, Effurun	-	52	52	3	24	27
		(iv) Ekpan S/S I, Ekpan-	Hospital Rd, Ekpan	59	71	130	1	33	34
6	Ughelli South	(i) Otu-Jeremi S/S., Otu- Jeremi	Ughevweghe	37	12	49	6	2	8
		(ii) Ekakpamre G/S, Ekakpamre	Gbaregbolor	25	16	41	5	1	6
7.	Warri south	(i) Essi College II,	Warri	60	51	111	4	14	18
		(iii) Yowuren College II,	Warri	16	19	35	3	12	15
		(iii)Uwangue College I	Warri	70	73	143	1	19	20
8.	Burutu Delta South	(i) Mein G/S, Kiagbodo	Kiagbodo	29	25	54	3	1	4
		(ii) Burutu G/S, Burutu 2(Two)	Burutu	34	37	71	3	-	3
9.	Isoko North	(i) St. Joseph, Ozoro	Ozoro	53	27	80	4	4	8
		(ii) Emevor G/G/S., Emevor	Emevor	13	15	28	3	1	4
		(iii) Ileulogbo G/S., Oweh Ologbo	Owhelogbo	29	25	54	6	1	7
		(iv) Iyede S/C/S., Iyede	Iyede	25	25	50	3	2	5
			TOTAL	541	519	1060	48	154	202

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Research Instrument

The research instrument for this study was the modified adapted standardized instrument developed by Focus for Young Adult Research series (2000) with the observational approval of the Researchers' supervisor and other lecturers in the department was used to solicit information from the respondents. Three sets of

questionnaire were used for this study for three groups of respondents which include the students, teachers, and Health Care Providers. The first set was titled Evaluation of reproductive health programmes and services on adolescents' sexual behaviour questionnaire (RHP-HCP) were administered to Health care providers. The second set of questionnaire titled Evaluation of reproductive health programmes and services on adolescents' sexual behaviour questionnaire (RHP-STD) was administered to Students and the third set of questionnaire titled Evaluation of reproductive health programmes and services on adolescents' sexual behaviour questionnaire (RHPS-TCP) was administered to Teachers.

The three sets of instruments were in four sections. SECTION A was on demographic data of the respondents, SECTION B elicited information on Reproductive Health Programmes (sexuality education, Family life, HIV education, and Peer education programmes-(FLHEPS), SECTION C elicited information on Reproductive Health Services (Counseling/referral on contraceptives/HIV/AIDS/STIs, health club, youth friendly services (CRHS-YF) and SECTION D elicited information on sexual behaviour/skill (SBSK), Reproductive health policy (RHPO) and Reproductive health Programmes and Culture (RHPCUL). Section B, C, D, constituted some close ended questions with "Yes" or "No" and Strongly agree (SA) = 4 points, Agree (A) = 3 points, Disagree (D) =2 point and Strongly disagree (SD) = 1 point designed in line with the Likert scale of summated rating which afforded the respondents options to indicate the extent of agreement or disagreement, and very few open ended questions. Questionnaire as an instrument is suggested by Ofo (2004) to be the most appreciated where ever the population size is large.

Validity of the Research Instrument

To ensure the validity of the instrument for this study, a draft of the standardized questionnaire by Focus for Young Adult 2000 series was adapted and modified severally by the researcher's supervisor and five other lecturers in the Department of Human Kinetics and Health Education and Adult Education in the University of Ibadan, Ibadan, Oyo State, for the content and construct validity of the instrument. Comments, criticism, suggestions from the instrument were studied carefully and corrected thus ensuring the face validity of the instrument. Pre-testing of the instrument prior to the real study was done and this enabled the researcher to

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discover few ambiguities contained in the questions that would have constituted other limitations and difficulty for respondents in answering the questionnaire, which also was used to improve the validity of the instrument.

Akinwumiju and Osiki (2006) stated that validity is concerned with the soundness; the effectiveness of the measuring instrument to ensure the instrument measures what it is meant to measure. Araoye (2004) affirmed that the final aim of any research is to provide useful information, basic to the validity of the questionnaire in asking the questions in the least ambiguous ways when selecting a standardized instrument for use in any research work. The instrument must have the ability to measure what the researcher purports to measure.

Reliability of the Research Instrument

Reliability which is the basic concept in a research procedure is the degree of consistency or accuracy of data by their stability, repeatability and precision. It is the persistency of an instrument in correctly measuring what is intended to measure with the result remaining more or less the same after administration of test on more than one occasion in a similar situation (Nworgu, 2006). Thomas and Nelson (2001) described reliability as the degree to which a test measures consistently whatever it measures. Reliability is the percentage of total variance that is true variance (Igwebuike, 2000). The determinations of the reliability coefficient were done using Cronbach Alpha coefficient technique to establish the reliability of the instrument at 0.05 alpha levels. Researchers revealed that the alpha is an unbiased estimator of reliability. Copies of the approved version of the corrected questionnaire were administered to 25 respondents in Ethiope West local government area of Delta State drawn from Agbarho grammar schools comprising of 10 in-school adolescents in SS 2, 10 teachers, 5 health care providers. Cronbach's Alpha reliability coefficient was RHPS-HCP = 0.74, RHPS-STD = 0.84, and RHPS-TCP = 0.81. These were considered high enough for the study.

Field Testing of the Instrument

Pre-testing of an instrument prior to the real study enabled the researcher to discover few ambiguities contained in the questions that may constitute other limitations not envisaged during the study was discovered which help to map out

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plans to handle the difficulty respondents had in completing the questionnaire. The pre-test or pilot test survey instrument comprised 10 in-school adolescents in S.S. 2, 10 teachers, 5 health care providers who were not part of the study in Delta State. Kerlinger (2000) and Thomas and Nelson (2001) revealed that pilot study or field testing is essential requirement to the development of sound research and helps to sought out whether the instrument used for a research is reliable, meaningful and sensitive as well as improve and provides additional knowledge that will add to the quality of the research during the actual fieldwork.

Procedure for Data Collection

The researcher collected a letter of introduction from the Head of the Department of Human Kinetics and Health Education for herself and the 15 research assistants who were trained on the procedure and guidelines to be used to administer the instruments (see Appendix B). Ethical Clearance Issues**:** Permission to conduct the study was obtained from Delta State Ministry of Education and all sampled Public secondary schools authorities through the Principal. The purpose of the study was explained to all respondents. A written statement was also included on the introductory part of the questionnaire that further explained the study purpose, emphasizing on the confidentiality of the research information and voluntary nature of participation. Due to the sensitive nature of the research information, no names of the respondents were required and those not willing to be part of the study were exempted. The school teachers were requested to avoid coming close to the classroom while the students were filling the questionnaire.

The researcher gave the letters to the principals of the sampled schools in the nine Local government sampled for the study in Delta State. The respondents were given the modified adapted standardized questionnaire directly with the help of the research assistants, the principal and form teachers (which was within the intervals of 2 weeks). The questionnaires were retrieved from the respondents immediately they were completed. Some of the questions were read and interpreted to some of the public schools in rural areas in Pidgin English. The total numbers of 2,050 questionnaires were distributed to the three groups of respondents while 1993 were retrieved and found useful. This accounted for 94.6% returns. The 1939 questionnaire were coded, analyzed and used for the study.

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Procedure for Data Analysis

The completed questionnaires were collated, coded and analyzed using both descriptive and inferential statistics. Descriptive statistics of frequency counts, percentages, bar and pie charts were used to describe section A of the questionnaire which dealt with the demographic characteristics of the respondents, while inferential statistics of Multiple regression was used to test for hypotheses 1-4, 7 and 8, T-test was used to test hypotheses 5-6, for Section B-D dealt with independent and dependent variables. Percentage count was used to describe the three Research Questions. Decisions for each of the eight hypotheses were tested at 0.05 level of significance. The reason for using multiple regressions was because it is a method for studying the effects and magnitude of the effects of more than one independent variable on the dependents variable by using principles of correlation and regression (Kerlinger and Lee, 2000).

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CHAPTER FOUR

RESULTS, ANALYSIS AND DISCUSSION OF FINDINGS

This study evaluated the influence of Reproductive Health Education Programmes and Services on Sexual Behaviour among in-school Adolescents in Delta State of Nigeria. This chapter presents the results and discussion of findings as follows:

Data was collected using three different sets of the modified adapted standardized questionnaire developed by Focus for Young Adult Research Series (2000). Section A of each set of questionnaire collected information on demographic characteristic of the respondents which include Students, Teachers and Health Care Providers. Section B –C of each of the instrument obtained information on the independent variables of Reproductive Health Education Programme (FLHEPS) and Services (CRHS-YF) while Section D instrument obtained information on the dependent variable of Sexual behaviour (SBSK). Other variables are Reproductive Health policy (RHPO) and Reproductive Health programme and Culture (RHPCUL).

The sampled used consisted one thousand, five hundred and fifteen (1515) students, 294 teachers 26 Principal, 26 vice-principal and 78 Health Care Providers. Five research questions and eight null hypotheses were tested at 0.05 alpha level of significance. The results were classified in tables, bar chart and pie chart and discussed in three phases. The first phase which represented the demographic data of the respondents was classified in tables using descriptive statistics of frequency counts and percentages (%), bar chart and pie charts. The second phase presented the results to answer the research questions using percentages. The third phase presented the results using parametric statistics of multiple regressions and t-test tested the eight hypotheses. The results of the data were presented as follows:

Demographic Data of Respondents (Students)

Table 4.1: Frequency Distribution of the respondents (Students) by Sex

Sex	Frequency	Percentage
Male	832	55.0
Female	683	45.0
Total	1515	100.0

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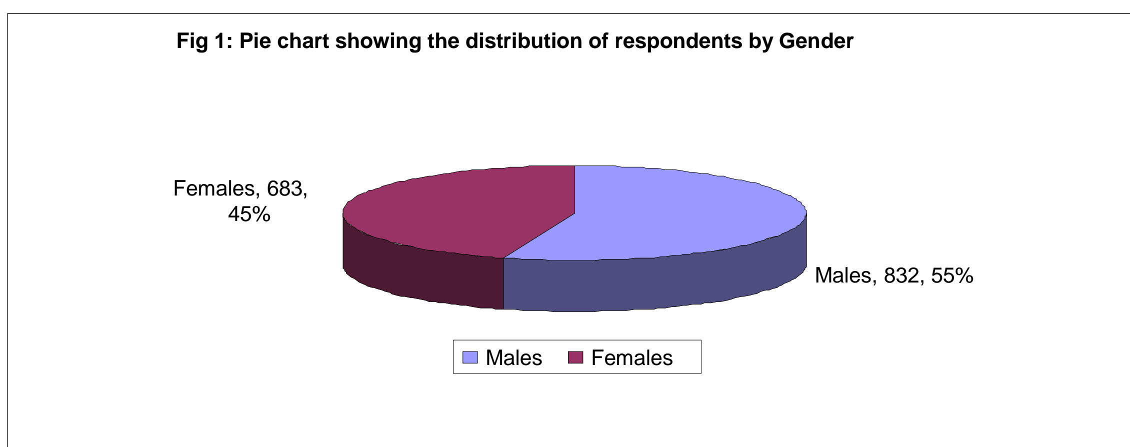

Table 4.1 and chart above showed that 832 (55%) were Male and Female 683 (45%) respectively. This revealed that more male students have been exposed to RHPS of Government. This confirmed the findings of some scholars that the population of the girl-child attending school is still not encouraging. Therefore, the educational needs of the female Adolescents must be encouraged to build positive sexual skills that will help them to make informed reproductive health decision.

Table 4.2: Frequency distribution of the respondents (Students) by Religion

Religion	Frequency	Percentage
Christianity	1418	93.6
Islam	50	3.3
Traditional religion	47	3.1
Total	1515	100.0

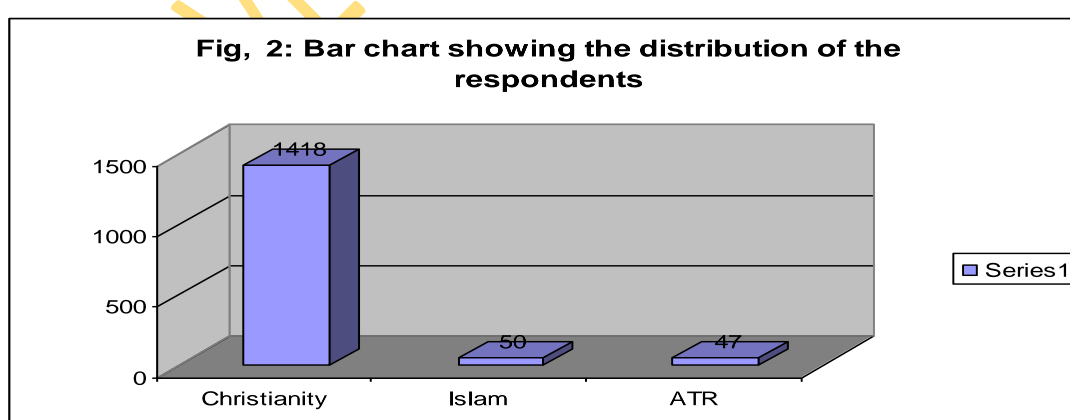

Table 4.2 and chart showed that there are 1418(93.6%) Christians among the respondents, 50 (3.3%) Muslims and 47(3.1%) traditional believers. This revealed that there are more Christian's students in the schools under study.

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Table 4.3: Frequency Distribution of the respondents (Students) by Age

Age	Frequency	Percentage
10-14	341	22.5
15-19	981	64.8
20-21	193	12.7
Total	1515	100.0

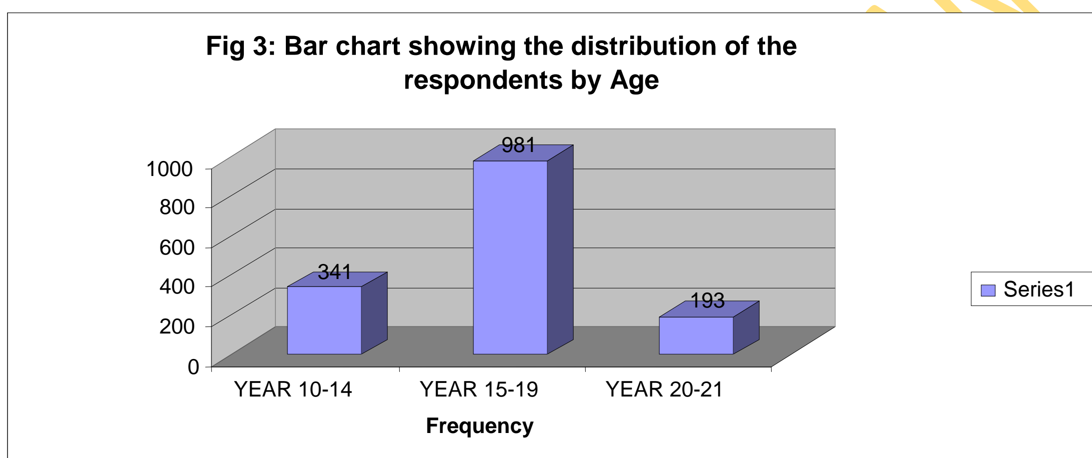

Table 4.3 and chart showed that 341(22.5%) of the respondents are of age 10-14 years, 981(64.8%) are of age 15-19 years while 193(12.7%) are of age range 20-21 years respectively. This revealed that a higher percentage of the students in SS 2 class are Adolescents.

Table 4.4: Frequency Distribution showing desired level of educational attainment for the future.

Level of Education	Frequency	Percentage
Secondary	126	8.3
Technical/Vocational, School	143	9.4
University/College	574	37.9
Post University Graduate	672	44.4
Total	1515	100.0

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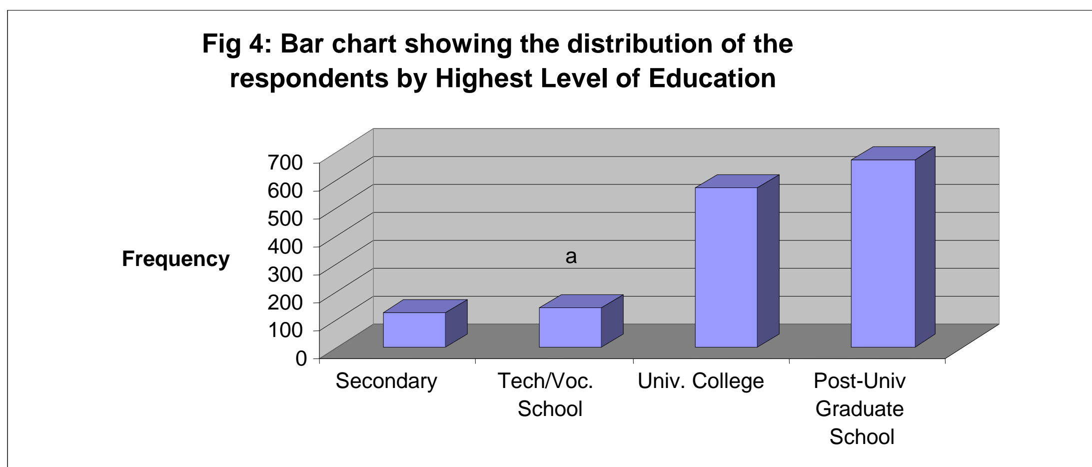

Table 4.4 and chart showed the levels of Education each of the respondents desired to attain in the future. 126(8.3%) indicated secondary education, 143(9.4%) Technical/Vocational School Education, while 574(37.9%) indicated University or College of Education, and 672(44.4%) indicated Postgraduate Education. This revealed that a higher percentage (82%) of in-school Adolescents desired to attain a University degree in the near future in Delta State which will help in promoting a higher number of the females when married to seek family planning methods to positively enhance their Reproductive Health status.

Table 4.5: Frequency Distribution showing how Students value good education.

How important is it to you that you get a good education?	Frequency	Percentage
Not very important	94	6.2
Quite important	230	15.2
Very important	1191	78.6
Total	1515	100.0

Table 4.5 above showed how important it is that each of the respondents gets a good education. 94(6.2%) of them indicated not very important, 230(15.2%) indicated quite important and 1191(78.6%) of the respondents indicated it was very important respectively. This revealed that the awareness of the value of education to menial contract off-shore jobs through communities' efforts without certificate in Delta state is increasing.

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Table 4.6: Frequency Distribution of the respondents (Students) by Extra-curricular Activities

S/N	Statements	No		Yes	
		Frequency	Percentage	Frequency	Percentage
1	Sports Club, Teams	1181	78.0	334	22.0
2	Drama Club	1011	66.7	504	33.3
3	Debate Club	1200	79.2	315	20.8
4	Academic, Discovery Club	1293	85.3	222	14.7
5	Religious Club	1289	85.1	226	14.9
6	Others	1403	92.6	112	7.4

Table 4.6 above revealed the Extra-Curricular Activities the respondents are involved in as shown below:

Sports Club/Team: No (1181, 78.0%), Yes (334, 22.0%); Drama Club: No (1011, 66.7%), Yes (504, 33.3%); Debate Club: No (1200, 79.2%), Yes (315, 20.8%); Academic, Discovery Club: No 1293, 85.3%), Yes (222, 14.7%); Religious Club: No (1289, 85.1%), Yes (226, 14.9%); Other Clubs: No (1403, 92.6%), Yes (112, 7.4%) respectively. This showed that most in-school Adolescents are not fully engaged in extra-curricular activities. This may be one of the reasons in- school adolescents engage in at-risk Sexual behaviours.

Demographic data: Health Care Providers (HCP).

Table 4.14: Frequency Distribution of Respondents (HCP) by Sex

Sex	Frequency	Percentage
Male	17	21.8
Female	61	78.2
Total	78	100.0

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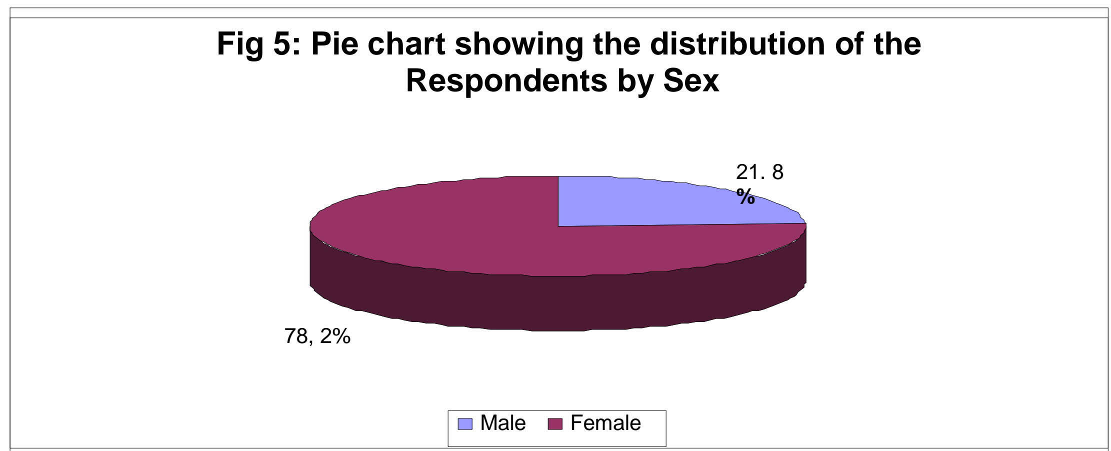

Table 4.14: and chart above showed that 17(21.8%) of the respondents are males, 61(78.2%) are females. This showed that a very high percentage of the respondents were females.

Table 4.15: Frequency Distribution of Respondents (HCP) by Religion

Religion	Frequency	Percentage
Christianity	75	96.2
Islam	1	1.3
Traditional Belief	2	2.6
Total	78	100.0

Fig 6: Bar chart showing the frequency distribution of the respondents by Religion

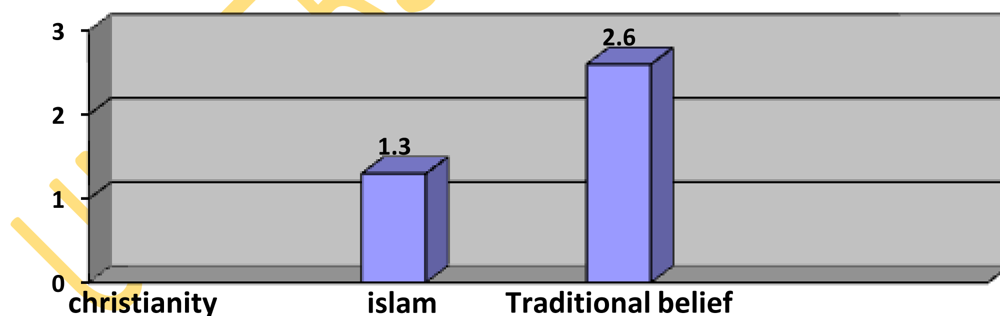

Table 4.15 and chart showed that (96.2%) of the respondents are Christians, 1(1.3%) person is a Muslim while 2(2.6%) of them belonged to the Traditional Religion. Could their religion have influence on their RHP and services to in-school Adolescents in Delta State?

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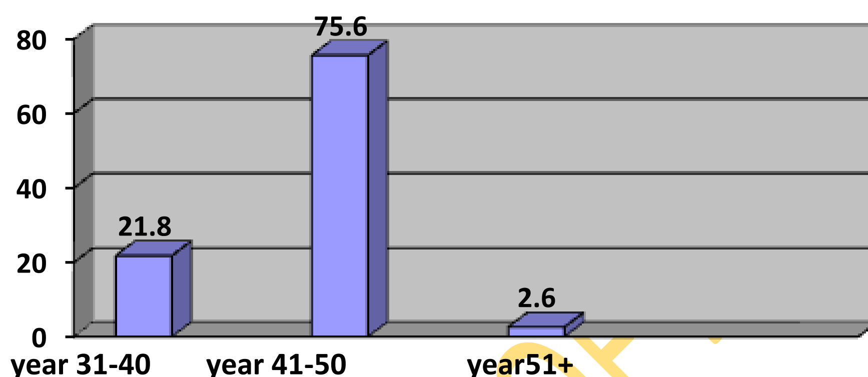
Table 4.16: Frequency Distribution of Respondents (HCP) by Marital Status

Marital Status	Frequency	Percentage
Single	17	21.8
Married	59	75.6
Widowed	2	2.6
Total	78	100.0

Fig 7: Bar chart showing the frequency distribution of respondents (HCP) by Marital Status



In table 4.16 and chart above showed that 17(21.8%) of the respondents are single, 59(75.6%) are married while 2(2.6%) are widowed. This showed that a high percentage of the respondents are married.

Table 4.17: Frequency Distribution of Respondents (HCP) by Educational Qualification

Educational Qualification	Frequency	Percentage
No Formal Education	1	1.3
Primary Education	6	7.7
Secondary Education	6	7.7
OND,HND	33	42.3
University Graduate	32	41.0
Total	78	100.0

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Fig 8 : Bar chart showing the distribution of the respondents by Highest level of Education

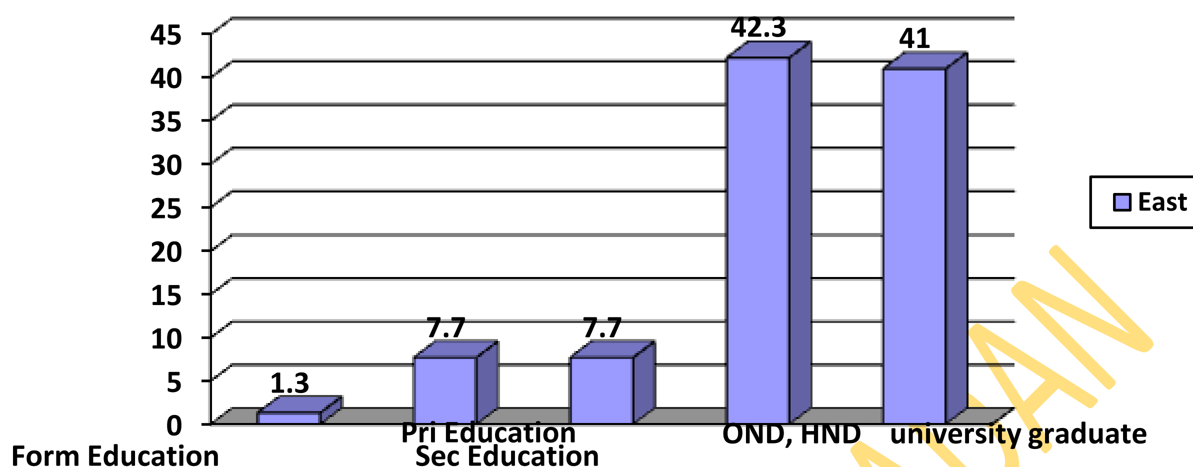

Table 4.17: and chart showed that 1(1.3%) respondent had primary education, 6(7.7%) each had primary and secondary Education, 33(42.3%) had the OND, HND certificates while 32(41.0%) had the University Certificates respectively. This revealed that a high percentage of the HCPs personnel's are University graduates. This revealed that a high percentage of the HCP personnels have high educational qualification and were therefore able to handle in-school Adolescents issues.

Table 4.18: Frequency Distribution of Respondents (HCP) by Age

Age	Frequency	Percentage
31-40	**55**	**70.5**
41-50	**19**	**24.4**
51 & above	**4**	**5.1**
Total	**78**	**100.0**

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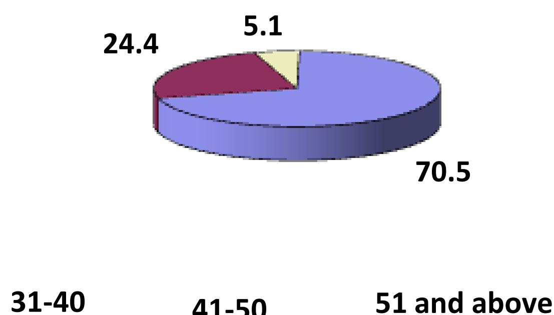
Fig 9 : Pie chart showing the frequency distribution of respondents (HCP) by Age



In table 4.18 and chart above showed that 55(70.5%) of the respondents are aged 31-40 years, 19(24.4%) are of age group 41-50%) years while 4(5.1%) are 51 and more years. This showed that a high percentage of the HCP are still in their active working age.

Table 4.19: Frequency Distribution of Respondents (HCP) by Structure of Facility

Structure of Facility	Frequency	Percentage
Youth only	29	37.2
Integrated Services	49	62.8
Total	78	100.0

Table 4.19 showed that 29(37.2%) of the respondents are in the youth only facility group while 49(62.8%) belonged to the integrated services group. This showed that most of the RHPS for in school Adolescents are fully youth-friendly since they are totally focus on several services to meet the RH needs of in-school Adolescents.

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Table 4.20: Frequency Distribution of Respondents (HCP) by position in the Center

Youth position in the Center	Frequency	Percentage
Director	7	9.0
Health Educator	8	35.9
Counselor	6	7.7
Doctor,	1	1.3
Nurse, Midwife	41	26.9
Outreach Worker	4	5.1
Others (specify)	11	14.1
Total	78	100.0

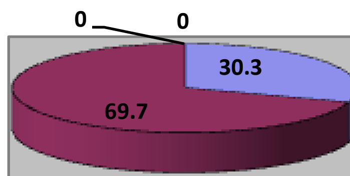
In table 4.20 above showed that 7(9.0%) Directors, 28(35.9%) Health Educators, 6(7.7%) Counselors, 1(1.3%) Doctors, 21(26.9%) midwives, 4(5.1%) outreach workers and 11(14.1%) others respectively.

Demographic Data of Respondents: Teachers'

Table 4.21: Frequency Distribution of the Teachers by Sex

Sex	Frequency	Percentage
Male	105	30.3
Female	241	69,7
Total	346	100.0

Fig 10: Pie chart showing the frequency distribution of the Teacher by Sex



male and female

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Table 4.21 above and chart showed that 105(30.3%) of the respondents are males while 241(69.7%) are females. This showed that a very high percentage of the respondents are female.

Table 4:22 Frequency Distribution of the respondents (Teachers) by Religion

Religion	Frequency	Percentage
Christianity	284	82.0
Islam	50	14.5
Traditional Belief	12	3.5
Total	346	100.0

Fig 11: Bar chart showing the frequency distribution of the respondents (Teachers) by Religion

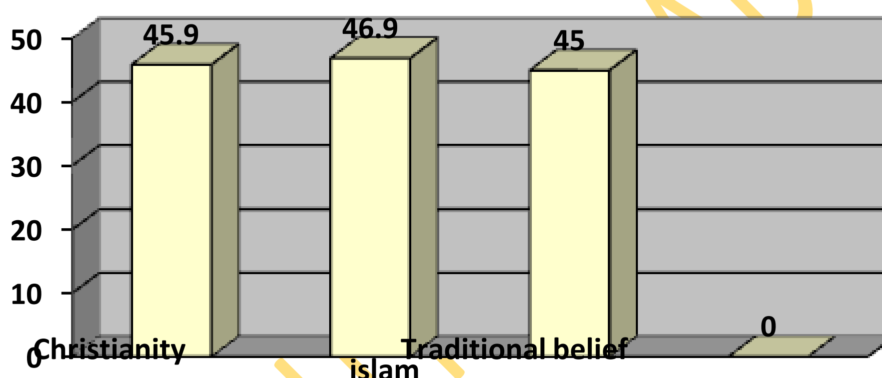

Table 4.22 and chart showed that 284 (82%) of the respondents are Christians, 50 (14.5%) are Muslims while Traditional Believers were 12 (3.5%). A high percentage of the respondents were Christians. This may influence the RHPS of Government on in-school Adolescents Sexual behaviour, because available research showed that religion affects Reproductive health issues of an individual.

Table 4.23: Frequency Distribution of the respondents (Teachers) by Marital Status

Marital Status	Frequency	Percentage
Single	151	43.6
Married	195	56.4
Total	346	100.0

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Fig 12 : Bar chart showing the frequency distribution of the respondents (Teachers) by Marital Status

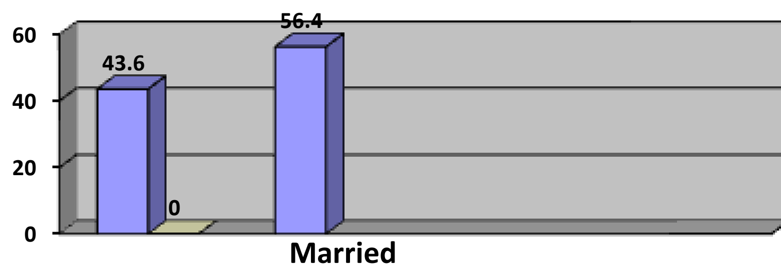

Table 4.23 and chart showed that 151(43.6%) of the respondents are single while 195(56.4%) are married.

Table 4.24 Frequency Distribution of the respondents (Teachers) by Educational Qualification

Educational Qualification	Frequency	Percentage
OND,HND	166	48
University Graduate	180	52
Total	346	100.0

Fig 13: Bar chart showing the distribution of the respondents by Highest level of Education

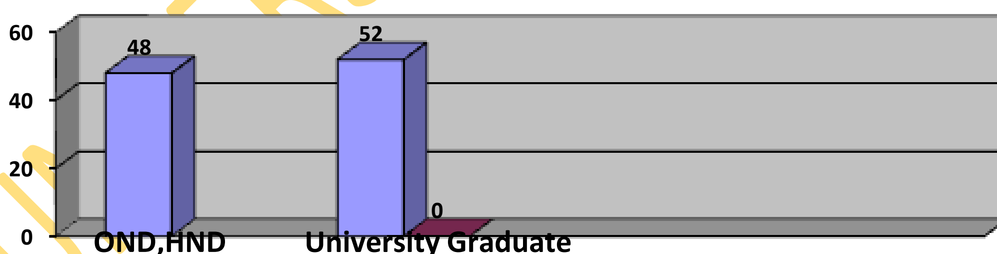

Table 4.24 and chart showed that 166(48%) had OND/HND educational qualifications while 180(52%) had University Educational qualifications. This showed that a high proportion of the teachers are actually qualified to handle Adolescents issues.

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Table 4.25: Frequency Distribution of the respondents (Teachers) by Age

Age	Frequency	Percentage
25-40	192	55.5
41-50	154	44.5
Total	346	100.0

Fig 14 : Pie chart showing the frequency distribution of the respondents (Teachers) by Age

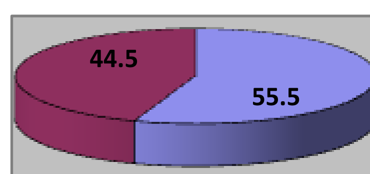

Table 4.25 and chart showed that 192(55.5%) of the respondents were between ages 25-40 years while 154(44.5%) were between ages 41-50 years respectively. This showed that many of the personnel are still in their active working years and may likely be effective to relate easily with in-school Adolescents issues.

Table 4.26: Frequency Distribution of the respondents (Teachers) by Type of Community

Type of Community	Frequency	Percentage
Rural	124	36
Urban	222	64
Total	346	100.0

Table 4.26 confirmed the findings of Okonta (2007) that most of the RHPS are highly concentrated in the urban areas in Nigeria. There is need for Government and NGOs to increase their manpower and resources to meet the RH needs of in-school Adolescents in the rural area. This confirmed the findings of Odibo and Ogharaerumi (2007) that prevalence of Teenage Pregnancy is high in rural area than urban areas in Delta State, Nigeria.

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Table 4.27: Frequency Distribution of the respondents (Teachers) by Subject Taught

Subject Taught	Frequency	Percentage
Biology	109	31.5
Social studies	64	18.5
Physical Health Education	34	9.8
English language	49	
Total	90	26
	346	100.0

Table 4.27: showed that 109 (31.5%) of the respondents teach Biology, Social studies 64 (18.5%) Physical Health Education 34(9.8%), integrated science 49 (14.27%) and English language 90 (26%) respectively.

Research Question 1: Would inadequate funds affect the Reproductive health Education programmes and services of Government to positively influence the sexual behaviour of in-school adolescents in Delta State?

Table 4.28: Funds and RHEPS on In-school Adolescents Sexual Behaviour

	Educational Qualification	Funds			
		Teachers		HCPs	
		No	Yes	No	Yes
	Non-Graduate	40 46.0%	153 59.1%	4 44%	9 13%
	University Graduate	47 54.0%	106 40.9%	5 56%	60 87%
	Total	87 100.0%	259 100.0%	9 100.0%	69 100.0%

Critical value 639.13; df = 1; significance level 0.05, X^2= 478.951

Table 4.28 above showed the distribution of the Funds available by Educational Qualifications. It was observed that 153(59.1%) non-graduate Teachers and 106(40.9%) graduate Teachers agreed that inadequate funds had significant effect on RHEPS to curb at-risk sexual behaviour among in-school adolescents, 4(44%) non-graduate HCPs and 5(56%) graduates HCPs disagreed. The researcher discovered through oral interview with Dr Ejiro the assistant director of UNFPA Delta state

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chapter that inadequate funds had been a major setback to the effectiveness of RHPS to curb at-risk sexual behaviour of in-school Adolescents in Delta State. He expressed that the state government had not been financially supportive to complement the efforts of the donor agency (UNFPA). He stated further that there has not been a positive reflection of in-school sexual behaviour because sexual behaviour is attitudinal and UNFPA have done extensive coverage of public schools in the State for the state government to embark on drastic strategies to extend to other private schools in the State and promote the efforts of UNFPA since 1999 is sustained. This shows that in-adequate funds resources were found to be affecting the RHEPS to positively curb in-school Adolescents Sexual Behaviour in Delta State, Nigeria. When the data above was tested with chi-square statistics, it was discovered that the calculated value X^2 of 478.951 was greater than the critical value of 639.13. Therefore, the research questions that inadequate fund would not affect the Reproductive health services (STIs/ HIV/AIDs/contraceptive counseling/referral and Health clubs) of Government to positively influence the sexual behaviour among in-school adolescents in Delta State was rejected. This confirmed the submission of Okonta (2007) that the challenges of financial resource constraints and budget allocation and release for more research, training and refresher courses for planners/providers in monitoring and evaluating Adolescent Reproductive Health Programmes and Services needs urgency.

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Research Question 2: Would culture affect the Reproductive health programmes and services of Government to positively influence the sexual behaviour among in-school adolescents in Delta State?

Table 4.29: Culture and RHPS on In-school Adolescents Sexual Behaviour:

S	Statement	Students		Teachers		HCPs	
		No	Yes	No	Yes	No	Yes
1	Placement of high value on early fertility	437 28.8%	1078 71.2%	17 4.9%	329 95.1%	8 10.3%	70 89.7%
2	Value placement of chastity, virginity in your culture	456 30.1%	1059 69.9%	18 5.2%	328 94.8%	12 15%	6 85%
3	Your culture permits sexual intercourse before marriage	663 43.8%	852 56.2%	17 4.9%	329 95.1%	35 44%	43 56%
4	Culturally you can live with someone of the opposite sex	513 33.9%	1002 66.1%	17 4.9%	329 95.1%	50 64%	28 36%
5	Your culture frowns at contraceptive usage	664 43.8%	851 56.2%	32 9.2%	314 90.8%	57 73%	21 27%
6	Unmarried girls & boys in my community encourage peers to early sexual initiation	631 41.7%	884 58.3%	21 6.1%	325 93.9%	60 77%	18 13%

Critical value 560.67; df = 1; significance level 0.05, X^2 = 154.646.

Table 4.29 showed how Culture influences Reproductive Health Programmes and Services of Government on sexual behaviour among in-school Adolescents:

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Placement of high value on early fertility: Students 1078(71.2%), Teachers 329(95.1%), and HCPs 70(89.7%). The percentage rating shows that Students ranked highest, followed by Teachers, and lastly, the HCPs. Value placement of chastity, virginity in your culture: Students 1059(69.9%), Teachers 328(94.8%), and HCPs 66(85%). The percentage rating shows that Teacher ranked highest, followed by the HCPs, and lastly, the Students;

Your culture permits sexual intercourse before marriage: Students 852(56.2%), Teachers 329(95.1%), and HCPs 43(56%). The percentage rating shows that Teacher ranked highest, followed by the Students and the HCPs.Culturally you can live with someone of the opposite sex: Students 1002(66.1%), Teachers 329(95.1%) and HCPs 28(36%). The percentage rating shows that Teacher ranked highest, followed by the Students, and lastly, the HCPs. Your culture frowns at contraceptive usage: Students 851(56.2%), Teachers 314(90.8%), and HCPs 21(27%). The percentage rating shows that Teacher ranked highest, followed by the Students and lastly, the HCPs. Unmarried girls & boys in my community encourage early sexual initiation in my culture, Students 884(58.3%), Teachers 325(93.9%), and HCPs 18(13%). The percentage rating shows that Teacher ranked highest, followed by the Student and the HCPs.

When the data above was subjected to chi-square statistics, it was discovered that the calculated value X^2 154.646 was less than the critical value of 560.67. Therefore, the research questions that culture would not affect the Reproductive health programmes and services offered by Government to positively influence the sexual behaviour of in-school adolescents in Delta State was rejected. This shows that culture plays a vital role in determining effectiveness of the RHPS of Government to positively influence the sexual behaviour of in-school adolescents in Delta State, Nigeria.

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Research Question 3: Would Adolescents Policies influence the Reproductive Health Programmes and Services of Government on the Sexual Behaviour among In-school Adolescents in Delta State?

Table 4.30: Frequency distribution and Relationship of RH Policies influence on Reproductive Health Programmes and Services of Government on Sexual Behaviour among In-school Adolescents in Delta State.

	Reproductive health policy	Students		Teachers		HCPs	
		Disagree	Agree	Disagree	Agree	Disagree	Agree
1	Promote the acquisition of H.K.	239 15.8%	1276 84.2%	5 1.4%	341 98.6%	6 8%	72 92%
2	Facilitate interaction between Adolescents and H.C.P.	555 36.6%	960 63.4%	107 30.9%	239 69.1%	4 5%	74 95%
3	Ensure Political parties, top planning bureaus, religious organizations	559 36.9%	956 63.1%	40 11.6%	306 88.4%	13 17%	65 83%
4	Provide a national coordinating body…	446 29.4%	1069 70.6%	67 19.4%	279 80.6%	7 9%	71 91%
5	Involves NGOs, community leaders, religious bodies, social interest groups	648 42.8%	867 57.2%	35 10.1%	311 89.9%	26 33%	52 67%
6	Allows pregnant adolescents to continue their education	656 43.3%	859 56.7%	137 39.6%	209 60.4%	40 38.8%	63 61.2%
7	Providers to be free from unnecessary legal restrictions	647 42.7%	868 57.1%	70 20.2%	276 79.8%	30 38%	48 62%
8	Ensure a favourable legal/regulatory climate	505 33.3%	1010 66.7%	102 29.5%	244 70.5%	8 10%	70 90%

Table 4.30 showed how Policies influence Reproductive Health Programmes/Services of Government among In-school Adolescents.

Promote the acquisition of Health Knowledge. -Students agreed 239(15.8%), disagreed 1276(84.2%); Teachers- agreed 5(1.4%), disagreed 341(98.6%), HCPs-

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agreed 6(8%), disagreed 72(92%); Facilitate interaction between Adolescents and H.C.P. Students- agreed 555(36.6%), disagreed 960(63.4%); Teachers- agreed 107(30.9%) disagreed, 239(69.1%), 4(5%) HCPs agreed, 74(95%) disagreed; Ensure Political parties, top planning bureau, religious organizations: Students- agreed 559(36.9%), disagreed 956(63.1%); Teachers-40(11.6%) agreed, disagreed 306(88.4%), HCPs- agreed 65(83%), disagreed 13(17%); Provide a national coordinating bodies, social interest groups. Students- agreed 446(29.4%), disagreed 1069(70.6%); Teachers- agreed 67(19.4%), disagreed 279(80.6%), HCPs-7(9%) agreed, 71(91%) disagreed; Involves HCPs, community leaders, religious bodies, social interest groups: Students- agreed 648(42.8%), disagreed 867(57.2%); Teachers- agreed 35(10.1%), disagreed 311(89.9%), HCPs- 26(33%), agreed 67(52%) disagreed; Allows pregnant adolescents to continue their education:: Students- agreed 656(43.3%), disagreed 859(56.7%); Teachers- 137(39.6%) agreed, 209(60.4%) disagreed, HCPs- 30(38%) agreed, 48(62%) disagreed; Providers to be free from unnecessary legal restrictions: Students- 647(42.7%) agreed, 868(57.1%) disagreed; Teachers- 70(20.2%)agreed, 276(79.8%) disagreed, HCPs- agreed 30(30%), disagreed 48(62%); Ensure a favourable legal/regulatory climate: Students- agreed 505(33.3%), disagreed 1010(66.7%); Teachers- agreed 102(29.5%), disagreed 244(70.5%), HCPs- agreed 8(10%), disagreed 70(90%;) respectively. This showed that RH policy plays a vital role in determining effectiveness of the RHPS of Government to positively influence the sexual behaviour of in-school adolescents in Delta State, Nigeria.

When the data above was subjected to chi-square statistics, it was discovered that the calculated value X^2 794.922 was greater than the critical value of 255.25. Therefore, the research questions that would policy affect the Reproductive health programmes and services offered by Government to positively influence the sexual behaviour among in-school adolescents in Delta State was rejected and the alternative upheld. This shows that policy plays a vital role in determining effectiveness of the RHPS of Government to positively influence the sexual behaviour of in-school adolescents in Delta State, Nigeria.

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HYPOTHESES TESTING

This section dealt with testing and analysis of each formulated hypothesis

Hypothesis 1: Reproductive health educational programmes of Government will not significantly influence positively the sexual behaviour among in-school adolescents in Delta State.

Table 4.31a: Multiple regression showing Joint effect of Reproductive health educational programmes on sexual behaviour among in-school Adolescents.

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression Residual Total	1415.628 67463.023 68878.651	4 1510 1514	353.907 44.677	7.921	.000	Significant

R= .143

R^2 = .021

Adj R^2 = .018

Table 4.33a above showed that the joint effect of RHEPS (HIV/AIDS Education, Peer Education, Sexuality Education and Family Life Education) on Adolescents Sexual Behaviour was significant ($F(4,1510) = 7.921$; $R = .143$, $R^2 = .021$, Adj. $R^2 = 0.018$; $p < .05$). 2% of the variation was accounted for by the independent variables.

Table 4.31b: **Multiple regression showing Relative effect of Reproductive health educational programmes on Sexual Behaviour among in-school Adolescents.**

Model	Unstandardized Coefficient		Standardized Coefficient	T	Sig.	Remarks
	B	Std. Error	s Beta			
(Constant)	31.635	1.587		19.938	.000	
HIV/AIDs Education	5.581E-02	.155	.010	.361	.718	Not signi.
Peer Education	.387	.168	.066	2.311	.021*	Significant
Sexuality education	-.144	.173	-.023	-.832	.405	Not signi.
Family Life Education	.832	.162	.145	5.118	.000*	Significant

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Table 4.31b: The result above showed the relative contribution of each of the independent variables on the dependent:

HIV/AIDS Education ($\beta = .010, p > .05$), Peer Education ($\beta = .066, p < .05$), Sexuality Education ($\beta = -.023, p > .05$) and Family Life Education ($\beta = .145, p < .05$) respectively.

The hypothesis one which stated that reproductive health educational programmes of government will not significantly influence positively the sexual behaviour of in school adolescent in Delta state, Nigeria, was therefore rejected. Peer education and Family life education was discovered to be very significant in influencing positively in-school Adolescents'' sexual behaviour while HIV/AIDs and Sexuality education were not significant. The findings of this study could be that the change in the topical issues around HIV/AIDs creates fear instead of appealing to their emotions. However, the possibility of increased negative significant sexual behaviour of in-school Adolescents in Delta State as observed by the researcher could be traced to the fact that attitudinal issues takes a longer time of adaptation changes by people and the sexual hormones of man is always very high during Adolescents stage of life as well as the desire to experiment damning the consequences of action among Adolescents. This findings support the submissions of Adamchak (2000) that successful RHEP helps adolescents develop life planning skills; respect the need and concerns for themselves and other young adults as well as provides respectful and confidential clinical services. It also confirmed Herbert (2002) who discovered that the solution to negative risky behaviour among adolescents is to ensure that they are informed about sexuality education instead of living them uninformed. It is worthy to note that the justification of the study area is supported by Smith (2003) who proposed that an alternative to positive sexual behaviour in adolescence is comprehensive sexuality Education, which emphasizes broad based knowledge of all aspects of sexuality, thereby enabling students to make informed decisions about sex. The findings of this study revealed that the joint effects of Reproductive educational programmes of Government were significant in influencing positively in-school Adolescents Sexual behaviour in Delta State, Nigeria.

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Hypothesis 2: Reproductive health services of Government will not significantly predicts positively the sexual behaviour among in-school adolescents in Delta State.

Table 4.32a: **Joint effect of Reproductive health services of Government on Sexual Behaviour among in-school Adolescents in Delta State, Nigeria.**

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression	2020.522	3	673.507	15.221	.000	Significant
Residual	66858.129	1511	44.248			
Total	68878.651	1514				

$R = .171$

$R^2 = .029$

Adj $R^2 = .027$

It was shown in the table above that the joint effect of Reproductive health services (Counseling and youth friendly clinics, contraceptive counseling and HIV/STIs counseling) on Adolescents Sexual Behaviour was significant ($F(3,1511) = 15.221$; $R = .171$, $R^2 = .029$, Adj. $R^2 = .027$; $p < .05$). 6.6% of the variation was accounted for by the independent variables.

Table 4.32b: **Relative effect of Reproductive health services (Counseling and youth friendly services, contraceptive counseling and HIV/STIs counseling) of Government on Sexual Behaviour among in-school Adolescents.**

Model	Unstandardized Coefficient		Standardized Coefficient	T	Sig.	Remark
	B	Std. Error				
(Constant)						
Counseling	36.452	.573	-.020	63.662	.000	Significant
youth friendly services	-.114	.149	-.020	-.766	.444	Not Sign.
contraceptive counseling	-.442	.095	-.137	-4.662	.000	Significant
HIV/STIs counseling	883	.141	.179	6.274	.000	Significant

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The result above showed the relative contribution of Reproductive health services on Sexual Behaviour among in-school Adolescents.

Counseling (β = -.020, p >.05), youth friendly services (β = -.020, p <.05) contraceptive counseling (β = -.137, p > .05), and HIV/STIs counseling (β = .179, p >.05) respectively. Hypothesis two which stated that Reproductive health services of Government will not significantly predicts positively on the sexual behaviour among in-school adolescents in Delta State was therefore rejected. The findings of this study however contradicts that of Okonta (2007) who stated that Reproductive Health services are inadequate to curb the at-risk sexual behaviour of adolescent positively in the Niger-Delta. The findings of this study confirmed that of UNESCO (2008) that Reproductive Health Services helps to develop skills that in-school adolescents can use positively to handle their sexual behaviour. This study also supported that of Smith (2003) that an alternative to proper sexual behaviour in adolescence is comprehensive HIV/STIs contraceptive counseling services, which emphasizes broad based knowledge of all aspects of sexuality, thereby enabling students to make informed decisions about sex. WHO (2002) revealed that Health Services need to link with other key services for adolescents, so that they become part of a supportive structure and protects young people against dangers and help them to build knowledge, skills and confidence. Hughes and Macauley (2002) confirmed the findings of this study that with the increasing multiplication size of young people; there is need to consistently evaluate current programmes and services to find less costly ways to reach young people. This study agrees with the number nine objective of ARHPCS (1994) who opined that programmes must be developed to make counseling services accessible to adolescents and supports guidance/parents in line with the rights of adolescents.

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Hypothesis 3: Reproductive Youth-friendly services environment (clinics, health/peer clubs, and recreational facilities) of Government will not significantly be effective to develop skills that in-school adolescents can use positively to handle their sexual behaviour in Delta State.

Table 4.33a: Multiple regression showing Joint effect of Youth-friendly service environment on Sexual Behaviour among in-school Adolescents.

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression	4511.178	3	1503.726	35.299	.000	Significant
Residual	64367.472	1511	42.599			
Total	68878.651	1514				

$R = .256$

$R^2 = .065$

Adj $R^2 = .064$

It was shown in the table above that the joint effect of Reproductive Youth-friendly services environment on Adolescents Sexual Behaviour was significant ($F(3,1511) = 35.299$; $R = .256$, $R^2 = .065$, Adj. $R^2 = 0.064$; $p < .05$). 2% of the variation was accounted for by the independent variables.

Table 4.33b: Multiple regression showing Relative effect of Reproductive Youth-friendly services environment (Counselling and clinics, health/Peer clubs and Recreational facilities) on Sexual Behaviour among in-school Adolescents.

Model	Unstandardized Coefficient		Standardized Coefficient S	T	Sig.	Remark
	B	Std. Error	Beta			
(Constant)	34.24	354		96.840	.000	
Counselling and youth friendly clinics	-.576	.101	-.163	-5.684	.000	Significant
Health /Peer club	-.158	.135	-.035	-1.166	.244	Not significant
Recreational facilities.	.741	.080	.251	9.205	.000	Significant

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The result above showed the relative contribution of each of the independent variables on the dependent:

Counseling and youth friendly clinics ($\beta = -.163$, $p > .05$), health/peer club ($\beta = -.035$, $p > .05$), and Recreational facilities ($\beta = .251$, $p < .05$) respectively. Hypothesis three which stated that Reproductive Youth-friendly service environment of Government will not significantly be effective to develop skills that in-school adolescents can use to handle positively their sexual behaviour in Delta State was rejected. Youth friendly clinics and Recreational facilities were found to be significant while Health club/Peer club was not significant. This finding is in support of Action Health Incorporated (2002) findings that Adolescent Youth-friendly services will help adolescents to grow healthy, educated with hopes and opportunities to prevent diseases. This will help in spearheading; documenting research on adolescent sexual and reproductive health needs which may bring about confidentiality between Adolescents and the Counsellors' and help in forming policies on behalf of adolescents. They stated further that RHYFS will encourage young people to use the health facilities and also ensure their needs are adequately met. The findings of this study is in line with Okonta (2007) submission that there are inadequate youth friendly services to curb at-risk sexual behaviour of in-school Adolescents as the relative effect shows that Health and Peer club was not significant. It also supported the findings of Advocate for Youth (2005) that peer clubs allows participants to learn through demonstration, listening; role playing; develop leadership skills; serving as role models, providing feedbacks and supporting healthy decisions and behaviours of young adult. Moore and Rosenthal (1993) revealed that focusing and understanding the subjective dimension of at-risk sexual behaviour of Adolescents is the key to developing an

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effective evaluation of interventions programmes and services to prevent and reduce risky sexual behaviour among adolescents in Nigeria.

Hypothesis 4: Teachers will not significantly predict positive changes in the sexual behavior of in-school adolescents despite the Reproductive Health Programmes and Services of Government on Sexual Behaviour among in-school Adolescents in Delta State.

Table 4.34a: Multiple regression showing Joint effect of Teachers prediction of RHEPS on Sexual Behaviour among in-school Adolescents.

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression	275.853	2	137.926	2.771	.064	Not significant
Residual	17075.870	343	49.784			
Total	17351.723	345				

R = .126

R^2= .016

Adj R^2 = .010

It was shown in the table above that the joint effect by Teachers of Reproductive Health programmes and Services on Sexual Behaviour among in-school Adolescents was not significant (F(2,343) = 2.771; R = .126, R^2 = .016, Adj. R^2 = 0.010; $p > .05$). 2% of the variation was accounted for by the independent variables. This shows that teachers did not observe any positive changes of sexual behaviour among in-school Adolescents' in Delta State, Nigeria.

Table 4.34b: Multiple regression showing relative effect of Teachers prediction of RHEPS of Government on Sexual Behaviour among in-school Adolescents.

Model	Unstandardized Coefficient	Standardized		Sig.	Remark

			Coefficients			
	B	Std. Error	Beta	T		
(Constant)	43.743			17.725	.000	
Reproductive Health programmes	.983	2.468	.131	2.180	.030	Sig.
Reproductive Health Services	-3.734E-02	.451.184	-.012	-.203	.839	Not.sig.

The result above showed the relative contribution of each of the independent variables on the dependent:

Reproductive Health programmes ($\beta = .131$, $p < .05$) and Reproductive Health Services ($\beta = -.012$, $p > .05$). Thus, Hypothesis four which stated that teachers will not significantly predicts positive changes in the sexual behaviour of in-school adolescents despite the RHPS of Government in Delta state was accepted and not rejected. This study when subjected to Multiple regression revealed the relative effect of Reproductive Health programmes was significant and Reproductive Health Services was not significant. Therefore, the joint effect of the null-hypothesis was not rejected. This study supports the stand of UNESCO and WHO (2003) which stated that the schools through the teachers can promote healthy message and establish helpful norms about sexuality and reproductive health Programmes and Services. However, some teachers observed and stated through the open ended instruments that most in-school adolescents in this study still exhibits some at-risky sexual behaviour which the study revealed that 37% engages in masturbation and lesbianism. UNICEF (1996) confirmed the findings of this study that the power and potentials of schools through the teacher to promote reproductive health through a coordinated school based approach is desirable. AHI (2003) stated that the school through the teachers provides little or no sexuality education for young people, leaving them equally misinformed by their peers as the primary source of information on sexuality and family life issues. AHI (2003) stated further that, teachers should help adolescents' to explore other reproductive health topics like body image, gender roles, ways of expressing love and intimacy etc rather than focus on genital-sexual behaviour alone, since young people also engage in kissing, touching, fantasy, sensual and erotic behaviour. The findings of this study revealed that teachers may not observe changes

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due to inadequate instructional material resources. AHI (2010) recommended that the teaching on reproductive health to adolescents requires a number of sessions, the use of television, video players and tapes to aid learning effectiveness in curbing adolescents' sexual behaviour positively. Brien (1982) suggested that curriculum design for RHEP should have a comprehensive teacher manual, content of instruction should cover anatomy, puberty, changing relationship, decisions making, parents, friendship, dating, sex roles, homosexuality, sexual activity (such as pregnancy, birth control disease, parenting & lifestyle) and sexual skills to influence in-school Adolescents sexual behaviour positively. The researcher observed that Students manual on RHEP were in pamphlets and not textbooks in most of the school used for the study.

Hypothesis 5: Health Care provider will not significantly predicts positive changes in the sexual behaviour among in-school adolescents despite the Reproductive Health Education Programmes and Services of Government in Delta State.

Table 4.35a: Multiple regression showing joint effect of Health Care provider prediction of RHEPS on Sexual Behaviour among in-school Adolescents

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression	5032.488	5	1006.498	5.606	.000	Significant
Residual	12927.884	72	179.554			
Total	17960.372	77				

R =. 529

R^2 = .280

Adj R^2 = .230

It was shown in the table above that the joint effect of RHEPS on Sexually Behaviour of in-School Adolescents was not significant ($F(5,72) = 5.606$; $R = .529$, $R^2 = .280$, Adj. $R^2 = 0.230$; $p < .05$). 28% of the variation was accounted for by the independent variables.

Table 4.35b: Multiple regression showing Relative effect of Health Care providers' prediction of RHPS on Sexual Behaviour among in-School Adolescents.

Model	Unstandardized Coefficient	Standardized Coeffic	t	Sig.	Remark

			ients			
	B	Std. Error	Beta			
(Constant)	-151.541	45.310		-3.345	.001	Significant
Reproductive Health programme Experience of HCP in R.H.S		.460	.151	1.404	.165	Not sign.
Health Services.	.645		.107	.944	.349	
	.291	.308	-.100	-.909	.366	Not sig.n
Reproductive Health Policy	-.230	.253				Not sign.
	1.540	.363	.436	4.249	.000	
Health Programme						Significant
Culture	1.996	1.194	.187	1.671	.099	Not sign.

The result above showed the relative contribution of each of the independent variables on the dependent: Reproductive Health Educational programme (β = .151, P >.05), Training, Experience of HCP in R.H.S (β = .107, p >.05), Reproductive Health Services (β = -.100, p >.05), Reproductive Health Policy (β = .436, p <.05) and Reproductive Health Programmes and Culture (β =.187, p >.05) respectively. Hypothesis five which stated that Health Care providers will not significantly predicts positive changes in the sexual behaviour among in-school adolescents despite the Reproductive Health Programmes and Services offered to them in Delta State was rejected.

The findings of this study revealed that the joint effect of RHPS by HCP was significant. This shows that Health Care providers did not observe significant positive changes among in-school adolescent sexual behaviour in Delta State, Nigeria. However, the relative effects of RHEP, TRHS, RHS and culture were not significant to curb in-school adolescent sexual behaviour and RH policy was significant. This findings confirmed the Nigeria Demographic and Health Survey (2003) that one-third of female obtaining abortions were adolescents. Hospital-based studies showed that up to 80 percent of Nigerian patient with abortion-related complications were adolescents. Government Policy (2005) findings revealed that adolescents have peculiar health needs and to facilitate, train, sensitize adolescents and other relevant groups in the knowledge, skills on sexual issues, there is need to promote effective healthcare services through strategic policies. This study also upholds the position of

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the National Adolescents Health Information (2004) that Adolescents health approach to policies and programmes that serve young people for youth development must go hand-in-hand. That is, there is need for partnership of all stakeholders in formulating, planning and executing RHEPS for in-school adolescent's sexual behaviour to be positive.

Hypothesis 6: There will be no significant difference between male and female in-school adolescent's sexual behaviour despite the Reproductive Health Programmes and Services of Government in Delta State.

Table 4.36: T-test analysis showing difference on Sexual Behaviour between male and female in-school Adolescents.

Procrastination	N	Mean	Std. Dev.	Crit-t	Cal-t.	Df	P	Remark
Male	832	36.1912	6.6704	1.96	4.243	1513	.000	Significant
Female	683	34.6323	6.7831					

The above table showed that there was significant difference in the Sexual Behaviour between male and female Adolescents (Crit-t = 1.96, Cal.t = 4.243, df = 1513, $p < .05$ level of significance).

Hypothesis six which stated that there will be no significant difference between male and female in-school adolescent sexual behaviour despite Government Reproductive Health Education Programmes and services in Delta state, Nigeria was rejected. Thus; there is a significant difference between male and female adolescent sexual behaviour in Delta State, Nigeria.

The outcome of this study corroborates the findings of Inyang (2009) and WHO (2000) which revealed that female adolescents are initiated to sex within the age of 10-12years than their male counterparts. Female adolescents attributes that

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their early sexual initiation to shyness towards the opposite sex and timidity. Journal of Human Sexual Behaviour (2003) stated that almost all females and males masturbate at some time in their lives; but in general, the practice is most common among male adolescents. Okanlawon (2004) and Charles (1998) in a related study revealed that in Africa boys and girls play love by engaging in many culturally acceptable methods without necessarily involving in sexual intercourse, boys adopted methods like bullying the girls, twisting their arms, snatching their scarf, while girls delight in screaming, pretentious cursing, beating the boys on the back and attempting to run away. The findings of this study was also in line with Nigeria Demographic and Health survey (2002) whom using 5500 young people aged 12-24, discovered that 44% of female and 37% of males had experienced sexual intercourse by 16 years. Moreover, 83% female and 72% male had intercourse by age 19 (Makinwa and Feyisetan, 1994).

Hypothesis 7: **There will be no significant difference between rural and urban in-school adolescent's sexual behaviour despite the Reproductive Health Education Programme and Services of Government in the Delta State.**

Table 4.37: T-test showing difference in Sexual Behaviour between Urban and Rural areas among in-school Adolescents'.

Adolescents' Sexual Behaviour	N	Mean	Std. Dev.	Crit-t	Cal-t.	df	P	Remark
Urban	808	34.6671	7.0329	1.96	6.341	1513	.000	
Rural	707	36.8416	6.2048					Significant

The above table showed that there was significant difference in the Sexual Behaviour of Adolescents between Urban and Rural Areas in Delta State (Crit-t = 1.96, Cal.t = 6.341, df = 1513, p < .05 level of significance). Based on the above findings, hypothesis seven which stated that there will be no significant difference between urban and rural in-school adolescent sexual behaviour despite the RHEP and services of Government in Delta state, Nigeria was rejected. This shows there is difference between urbarn and rural in-school Adolescents in Delta state. The findings of this study confirmed the position of FMOH (2000) and Okonta (2007) that little or

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no attention is paid to adolescent RHEP and services in the rural area because certain communities ensure that many sexually active adolescents are denied access to RHEP and services. These communities due to culture, couple with the fact that there are no provisions made for illiterate adolescents also helps to deny most rural adolescents access to RHEP and services.

Hypothesis 8: There will be no significant Reproductive Health knowledge to influence positively the sexual behaviour among in-school adolescents of the Reproductive Health Education Programmes and Services of Government in the Delta State.

Table 4.38: Multiple regression showing Joint effect of Reproductive Health Knowledge of in-school Adolescents Sexual Behaviour

Model	Sum of Squares	Df	Mean Square	F	Sig.	Remark
Regression	63.715	1	63.715	1.401	.237	Not significant
Residual	68814.936	1513	45.482			
Total	68878.651	1514				

R =. 030

R^2 = .001

Adj R^2 = .000

It was shown in the table above that the joint effect of Reproductive Health Knowledge on in-school Adolescents Sexual Behaviour was not significant ($F(1,1513) = 1.401$; $R = .030$, $R^2 = .001$, Adj. $R^2 = 0.000$; $p > .05$). Less than 1% of the variation was accounted for by the independent variables. Thus, hypothesis eight which stated that there will be no significant Reproductive Health knowledge to influence positively the sexual behaviour of in-school adolescents despite the Reproductive Health Programme and Services of Government in the Delta State was not rejected. The findings of this study is in line with findings by Moronkola (2003) who noted that adolescents have poor knowledge about reproductive health issues

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which he attributed to unsatisfactory efforts by the Government on the full implementation of the school health policy and teaching of Health Education as a subject of study in the senior secondary schools. Population Reference Bureau(2010) emphasized that ignoring the teaching of reproductive and sexual health of youths today will have dire global consequences for decades, and with global attention on the MDGs, countries that recognize the importance of healthy young adults (ages 15-24) also have a better chance of reaching their targets for Goal 3(promoting gender equality and empowering women),Goal 4(reducing child mortality),Goal 5(improving maternal health),and Goal 6(combating HIV/AIDS, malaria, and other diseases). This study also supported the argument of Nwabueze (1998) that lack of reproductive health knowledge of adolescents implications are teenage child bearing teen mothers, with low level of educational attainment are more likely to live in poverty and experience health problem more frequently than older mothers.

Hypothesis 9: There will be no relative significant influence of each RHEP of Government on the sexual behaviour among in-school adolescents in Delta State, Nigeria.

Hypothesis 9a: Multiple regression showing Relative effect of HIV/ AIDS Education on in-school Adolescents Sexual Behaviour.

Table 4.39

Model	Unstandardized Coefficient		Standardized Coefficients	T	Sig.	Remark
	B	Std. Error	Beta			
(Constant) HIV/ AIDS Education	36.035 -9.588E-02	.552 .142	 -.017	65.311 -.675	.000 .500	Significant

The result above showed the relative contribution of the independent variable on the dependent:

It was shown in the table above that the effect of independent variable (HIV/ AIDS Education) on Adolescents Sexual Behaviour was significant F(3,1511) = .455;

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$R = .017$, $R^2 = .000$, Adj. $R^2 = 0.000$; $P < .05$). About 0% of the variation was accounted for by the independent variables. HIV/AIDS .The result above showed the relative contribution of the independent variable on the dependent HIV/ AIDS Education ($\beta = -.017$, $p > .05$) Hypothesis nine stated that HIV/AIDs Education will not significantly predicts in-school Adolescents sexual behaviour was significant and therefore rejected. The findings of this study corroborate the interviews with that of teachers who opined that early pregnancies are still rampant among school girls in the district. The teachers therefore reported that the girls seem not to be knowledgeable on the risks like HIV/AIDs that exist in relation to indulging in unprotected sex. This implies that they are unable to negotiate for safer sexual encounters. Teachers also reported that most of the school girls hang out with youths who belong to the risk group; the touts and taxi drivers. This tends to expose them to more risk of contracting the STIs/HIV/AIDs disease. The findings of this study confirmed that of Likoye (2004) who argues that HIV and AIDs awareness effort should be carried out in such a way that during the process, learners should acquire knowledge that is part of life experiences which should enhance behaviour change amongst the youths.

However, Agyei (1992) opined that there is a wide disparity between contraceptive knowledge and use in Uganda, he reported that ¾ of the youths knew that condoms prevent HIV/AIDs/STDs, yet fewer than 13.0% of males and virtually no female (less than 1.0%) said they used condoms during their sexual encounters. A study by Mumah (2003) among physically challenged youths in Rachuoyo district in Kenya revealed that youths harboured very negative attitude towards condom use. That is, 93.3% of the respondents did not use condoms yet more than 56.0% had two or more sexual partners. They gave a reason that they trusted their partners. This suggests that they do not appreciate control measures against HIV and AIDs spread, thus ignoring them during sexual activities. However, this study contradicts that of Nyinya (2007) on attitude of pupils on the HIV and AIDs education programme within Kisumu municipality in Kenya revealed that students had negative attitude towards the HIV/AIDS education programme.

Hypothesis 9b: Multiple regression showing Relative effect of Peer Education on in-school Adolescents Sexual Behaviour.

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Model	Unstandardized Coefficient		Standardized Coefficients	t	Sig.	Remark
	B	Std. Error	Beta			
(Constant) Peer Education	35.264 .124	.537 .151	 .021	65.631 .822	.000 .411	Significant

The result above showed the relative contribution of the independent variable on the dependent:

It was shown in the table above that the effect of the independent variable (Peer Education) on Adolescents Sexual Behaviour was significant F (3, 1513) = .676; R = .021, R^2 = .000, Adj. R^2 = 0.000; p < .05). About 0% of the variation was accounted for by the independent variables. The result above shows the relative contribution of the independent variable on the dependent: Peer Education (β = .021, p >.05). Peer Education was found to be significant. The findings of this study agrees with Journal of America College Health (2003) which revealed that Studies show that adolescents who believe their peers are using condoms are also more than twice as likely to use condoms compared to teens who do not believe their peers use condoms. Peer educators often become respected by students as a source of credible information. Researchers in Chiang, Mai, and Thailand (2004) found that being a peer educator gave girls social legitimacy to talk about sex without the risk of being stigmatized as someone who is sexually promiscuous. The peer educators were successful in facilitating group discussions about sex, educating their peers about their bodies, helping them to develop communication and assertiveness skills and changing social norms (Cash & Anasuchatkul, 1995). Peer promoters can be a valuable link of Health Care providers to health services. In the experience of Mojisola (2006), a peer promoter for MUDAFEM in Ibadan, Nigeria, "The peer promoter program makes services more acceptable and accessible than health centers, which are located away from the easy reach of students and, in most cases, manned by adults." The findings of this study confirmed Nigeria Demographic and Health survey (NDHS, 2000) that adolescent and youth in Nigeria receive information on sexual and Reproductive Health Knowledge from these sources:- peers (75% inadequate and mostly erroneous), mothers 35%, teachers 33.4%, television 29.9% and radio 25.4% to

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Teachers in a Puerto Rican community in the United States found that working with peer educators allowed them to have more fulfilling relationships with young people and to see their students as a valuable human resources personnel to their peers on sexual issues (Vince-Whitman, 1992).

Hypothesis 9c: multiple regression showing Relative effect of Sexuality Education on in-school Adolescents Sexual Behaviour.

Table 4.41

Model	Unstandardized Coefficient		Standardized Coefficients	T	Sig.	Remark
	B	Std. Error	Beta			
(Constant) Sexuality Education	36.735 -.320	.561 .162	 -.051	65.494 -1.974	.000 .049	Significant

The result above showed the relative contribution of the independent variable on the dependent:

It was shown in the table above that the effect of the independent variable (Sexuality Education) on Adolescents Sexual Behaviour was significant ($F(1,1513) = 3.895$; $R = .051$, $R^2 = .003$, Adj. $R^2 = 0.002$; $p < .05$). About 0% of the variation was accounted for by the independent variables. The result above showed the relative contribution of the independent variable on the dependent, Sexuality Education ($\beta = -.051$, $p > .05$). Sexuality Education was found to be significant. These findings is in support of AHI (2003) which revealed that adolescents need sexual education and Reproductive Health Knowledge that model and teach positive self worth,

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responsibility, understanding and acceptance of diversity and sexual health. This corroborates WHO (1993) stating "no significant relationship exists between receiving formal sexuality education and initiating sexual activity; rather sexuality education results in postponement or reduction in the frequency of sexual activity and more effective use of contraceptive and adoption of safer behaviour". The primary goal of sexuality education is the promotion of adult sexual health. Sexuality education seeks to assist young people in understanding a positive view of sexuality, to provide them with information and skills about taking care of their sexual health, and to help them acquire skills to make decisions now and in the future. WHO (2000) opined that comprehensive sexuality education programme have four main goals: to provide accurate information about human sexuality and sexual skills, to provide an opportunity for young people to develop and understand their values, attitudes, and beliefs about sexuality, to help young people develop interpersonal skills; and to help young people exercise responsibility regarding sexual relationships, including addressing abstinence, how to resist pressures to become prematurely involved in sexual intercourse, and encouraging the use of contraceptive and other sexual health issues. Moronkola and Adio-Moses (2003) confirmed the findings of this study that Youths and Adolescents who are exposed to sexuality education are not likely to have early sexual debut.

Hypothesis 9d: Multiple regression showing Relative effect of Family Life Education on in-school Adolescents Sexual Behaviour

Table 4.42

Model	Unstandardized Coefficient		Standardized Coefficients	T	Sig.	**Remark**
	B	Std. Error	Beta			
(Constant) Family Life Education	33.083 .719	.556 .146	 .125	59.473 4.913	.000 .000	Not significant

The result above showed the relative contribution of the independent variable on the dependent: It was shown in the table above that the effect of the independent variable

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Family Life Education on Adolescents Sexual Behaviour was not significant (β = .125, p >.05). The findings of this study contradicts that of International Planned Parenthood Federation (2008) defined family life as an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, ageing as well as their social relations in the socio-cultural context of the family and society. Family life education provides information on population education, family life, sex, the environment and health. Family life education has its root on sexuality and is a tool to good health of the society and is one of the core aspects of population (Olugbenga and Fasuba, 2005). This is because the impact of the teachings and values on in-school adolescents in Delta State was found not to be significant. WHO (2004) stated the followings value of Family Life Education enables the learners: to understand the importance of the institution of family, it's changing composition and structure, functions, family roles and responsibilities and interrelationship between family resources and family welfare, to appreciate physical, physiological, psychological and social changes and developments during the process of growing up, conception and consequences of adolescent pregnancy, and to be aware of the HIV/AIDs pandemic and implications of drug abuse, to understand the significance of marriage, responsible parenthood, changing gender roles' and male responsibilities in the family life; and to develop positive attitude and responsible behaviour towards various issues of family life and to appreciate traditional family values. Adepoju (2005) opined that family life education is perceived as a tool to good health of the students
and reproductive health behaviour of young people will have both immediate and long term consequences, since most societies share a vision for their children, that they will reach adulthood without early pregnancy, complete their education, delay initiation of sexual activity until they are physically, socially and emotionally mature and avoid HIV infection and other Sexual Transmitted infections (STIs). This study shows that there is need to teach Family Life Education.

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FOCUS GROUP DISCUSSION AMONG IN-SCHOOL ADOLESCENTS IN DELTA STATE CHECKLIST

Table 43:

	Focus group discussion questionnaire checklist summary of Reproductive Health Programmes and Services of Government on Sexual behaviour among in-school Adolescents in Delta State, Nigeria.	**Yes (%)**	**No (%)**
1	Has helped me to Place high value on avoiding sexual risks	118(78.7%)	32(21.3%)
2	Values my chastity/ virginity now and will avoid unwanted pregnancy	78(52%)	72(48%)
3	Advocate for more friendly service environment and resource personnel	134(89.3%)	16(10.7%)
4	Agreed that lack of materials, IEC and BCC affects RHPS in the State.	114(76%)	36(24%)
5	Peer club, Health clubs and recreational activities distracts adolescents from sexual issues and watching of Pornography	95(63.3%)	55(36.7%)
6	Unmarried girls & boys in my community will be discouraged from early sexual initiation and unprotected sex henceforth	112(74.7%)	38(25.3%)
7	Counseling on RHPS has improve their sexual behaviour	84(56%)	66(44%)
8	Knowledge in RHP like HIV/AIDS education, peer education etc.	99(66%)	51(34%)
9	Changes in interaction with teachers on sexual issues.	53(35.3%)	97(64.7%)
10	Changes in community and sexual cultural norms.	93(62%)	57(38%)
11	Less difficulty in exchanging sexual interaction with opposite sex.	116(77.3%)	34(22.7%)
12	Delay sexual initiation till later.	72(48%)	78(52%)
13	Avoid committing abortion again.	78(52%)	72(48%)
	Avoids Sexual intercourse without the use of contraceptives.	98(65.3%)	52(34.7%)
15	Will henceforth go for HIV/AIDS testing and avoids abortion complication issues.	69(46%)	81(54%)
16	Reproductive health knowledge and attitude have improved.	77(51.3%)	73(48.7%)
17	Changes in interaction with parents on sexual issues.	118(78.7%)	32(21.3%)
18	Easily interacts with Health Care Provider on sexual issues.	89(59.3%)	61(40.7%)
19	Enjoys Contraceptive counselling through the RHPS	81(54%)	69(46%)
20	Advocates that Government should create more Peer Clubs and trains more peer educators in all schools in Delta State as a matter of urgency.	112(74.7%)	38(25.3%)

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The table above revealed that 118 (78.7%) in-school Adolescents respondents agreed that their exposure to RHEPS has helped them to place high value on avoiding sexual risks; 32(21.3%) disagreed. 78(52%) in-school Adolescents respondents values their chastity/ virginity now and will avoid unwanted pregnancy while 72(48%) will not. 134(89.3%) respondents advocated for more Youth friendly service environment and resource personnel and 16(10.7%) approved they are satisfied. 114(76%) respondents stated that lack of materials, Information Education Communication and BCC affects RHEPS in the State and 36(24%) disagreed. 95(63.3%) respondents agreed that Peer club, Health club and recreational activities distracts adolescents from sexual activities and watching of Pornography while 55(36.7%) disagreed. 112(74.7%) respondents stated that unmarried girls & boys in their community will be discouraged from early sexual initiation and unprotected sex henceforth and 38(25.3%) had a contract opinion. 84(56%) agreed that Counseling on RHPS has improve their sexual behaviour and 66(44%) disagreed. 99(66%) in-school adolescents

Knowledge in RHEP like HIV/AIDS education, peer education etc were increase due to RHPS of The Government and 51(34%) was not. 53(35.3%) opined that there is one hangs in their interactions with teachers on sexual issues and 97(64.7%) had a contract opinion. 93(62%) agreed that they now have a changes in their community and sexual cultural norms and 57(38%) disagreed.

However, 116(77.3%) now have less difficulty in exchanging sexual interaction with opposite sex. 34(22.7%) were still having difficulty.72(48%) agreed to delay sexual initiation till later and 78(52%) are still of a contract opinion. 78(52%) agreed to avoid committing abortion again and 72 (48%) had a different opinion. Moreover, 98 (65.3%) agreed to avoid Sexual intercourse without the use of contraceptives henceforth and 52 (34.7%) disagreed. 69(46%) agreed to henceforth go for HIV/AIDS testing and avoids abortion complication issues and 81(54%) had a contract opinion. 77(51.3%) agreed that Reproductive health knowledge and behaviour have improved and 73(48.7%) disagreed. 118(78.7%) agreed to positive changes in their interaction with parents on sexual issues and 32(21.3%) disagreed. 89(59.3%) agreed that they easily interacts with Health Care Provider on sexual issues after their exposure to Government RHEPS now and 61(40.7%) disagreed. 81(54%) agreed they enjoys Contraceptive counselling through the RHEPS and 69(46%) disagreed. 112(74.7%) in-school Adolescents advocated that Government should

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create more Peer Clubs and trains more peer educators in all schools in the State as a matter of urgency and 38(25.3%) had a contract opinion.

Discussion of Findings

The study showed that only 20% of Public schools in 13 L.G.A out of 25 in Delta State have been exposed to RHEPS. Therefore, the school, communities, Government needs to mobilize a wider spread of the current RHEPS for others in-school Adolescents in Delta State. The findings of the study have also revealed that most in-school adolescents have no significant Reproductive Health knowledge despite the RHEPS of Government in Delta State, Nigeria. This means that the programmes that have been mounted up to impact RH knowledge on in-school adolescents in Delta State, Nigeria need over hauling. Furthermore, the findings revealed that RHEPS of Government is positively influencing in-school adolescent sexual behaviour but still below 50% in Delta State; Nigeria. Therefore, there is need for the government of Delta State to release more funds and train more resource personnel to cover the other L.G.A. and schools where RHPS have not been reached.

In addition, the findings of this study revealed that culture, funds, policies, human and resource materials are critically affecting the effectiveness of RHEPS of Government in Delta State, Nigeria. Therefore, there is need for Government and all-stakeholders on Adolescents issues to review the Adolescent policies and enact a bye law through the National Assembly against harmful traditional/cultural practices influencing Adolescents' Sexual Health, to be minimized and gradually to be eradicated. This study has shown the following pitfalls through the open headed items as follows:-Training of Post-Primary Teachers on FLHE is not consistent, three peer clubs established but only one is active in all the twenty-six schools used for the study.

Peer education through peer club is one major programme that curb-at risk behaviour of in-school adolescent but inadequate material, human and financial resources to handle the peer and health club activities. Cultural appropriateness and acceptability of services was established. Youth friendly services environment is inadequate due to lack of enough classroom mapped out for the purpose, inadequate time for interactions, feedbacks, and follow-up and long waiting times during counseling sections. Poor interpersonal relationship levels of some service providers

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about sexuality issues. Poor mechanism in handling the counseling sections, lack of sick-bay clinics in most of the schools, unfriendly youth services environment, and poor coverage by the Delta State Government to cover other schools; L.G.A. and encourage continuity and weak commitment on the part of Delta state Government to support UNFPA efforts for sustenance and continuity. There is need for adolescents and local stakeholders to be involved in programmes and policy planning.

The findings of this study showed that lack of human resources were observed to affects the effectiveness of RHEPS of in-school Adolescents sexual behaviour positively. This study observed that most of the human resource personnel in secondary schools expressed that do not go for consistent training and retraining on how best to render RHPS to adequately meet the Reproductive health needs of in-school adolescents in Delta State. This study also observed that most of the subject teachers trained to handle reproductive health needs of the students as shown in table 4.35 may not have foundation knowledge of health education since they were mainly "Mathematics" teachers. It was observed by this study that Physical and Health Education Subject teachers' educational qualification was not in the related field. This confirmed the submission of United Nation Children's Fund (2000) that Adolescents Reproductive programme and Service is affected by number of factors especially lack of qualified human resources. Vision Project (2005) also confirmed the findings of this study that through the efforts of qualified human resources "with proper guidance and motivation adolescents can significantly affect and improve the socio-economic and political situation of their society". Therefore, there is need for the Delta State Government to ensure that each subject teachers teaches only subject in their related area of qualification. The above issues demand serious and concerted effort of all stakeholders in Health. Table 4.34 above shows that distribution of the Material Resources available by Educational Qualifications. It was observed 139(48.3%) non-graduate Teachers and 149(51.7%) graduate Teachers agreed that Material Resources have significant effect on RHPS to positively influence in-school Adolescent sexual behaviour, while 34(49.3%) non-graduate HCPs and 35(50.7%) graduates HCPs disagreed. The study discovered that most of the school's classroom environments are overcrowded and inadequate for learning. It was also observed that most of the schools have no bay clinics. Action Health Incorporated (2005) opined that for a successful RHPS to meet the needs of Adolescents reproductive and sexual health challenges there is need for multiservice health centers, Provides information and

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audio-visual materials on RH services, Counselling and examination rooms ensure privacy of clients, Recreational facilities, Accommodations for peer clubs to function effectively, Facilities are conveniently located and availability or referral for medical services.

All over the world, various strategies and approaches have been developed to provide young people with reproductive health information and services but with various challenges of lack of adequate records and documentation, inadequate youth-friendly services, lack of enabling policies, inadequate training and refresher courses for planners/providers, poor networking, monitoring and evaluation of programmes, urban concentration of Adolescent Reproductive Health Programmes and Service (Okonta 2007 and FMOH,1997). When table 34 above was subjected to chi-square testing, it was discovered that the calculated value X^2 of 4789.51 was greater than the critical value of 639.13; Therefore, the research questions that lack of material resources would not affect the effectiveness of Reproductive health programmes and services of Government/Non-Governmental Organizations to positively influence the sexual behaviour of in-school adolescents in Delta State was rejected. Anyanwu, Adio-Moses and Obaretin (2008) discovered the negative effect of overcrowded school population and classroom environment could predispose students to communicable diseases. This shows that the Reproductive health programmes and services of Government and NGOs to positively influence the sexual behaviour of in-school adolescents in Delta State was found to be affected by lack of adequate materials resources. Table 4.34 shows that distribution of the Funds available by Educational Qualifications. It was observed that 153(59.1%) non-graduate Teachers and 106(40.9%) graduate Teachers agreed that inadequate funds had significant effect on RHPS to curb at-risk sexual behaviour of in-school adolescents, 48(65.8%) non-graduate NGOs/HCPs and 25(34.2%) graduates NGOs/HCPs disagreed. The researcher discovered through Dr Ejiro the assistant director of UNFPA Delta state chapter that inadequate funds had been a major setback to the effectiveness of RHPS to curb at-risk sexual behaviour of in-school Adolescents in Delta State. He expressed that the state government had not been financially supportive to the efforts of the donor agency (UNFPA). He stated further that there has not been a positive reflection of in-school sexual behaviour because sexual behaviour is attitudinal and UNFPA have done well for the state government to embark on drastic strategies to ensure the efforts of UNFPA since 1999 is sustained. When the data above was tested with chi-

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square statistics, it was discovered that the calculated value X^2 of 4789.51 was greater than the critical value of 639.13. Therefore, the research questions that inadequate fund would not affect the Reproductive health services (STIs/ HIV/AIDs/ contraceptive counseling/referral and Health clubs) of Government/Non-Governmental Organization to positively influence the sexual behaviour of in-school adolescents in Delta State was rejected. This shows that in-adequate funds resources were found to be affecting the RHPS to positively curb in-school Adolescents Sexual Behaviour in Delta State, Nigeria. This confirmed the submission of Okonta (2007) that the challenges of financial resource constraints and budget allocaton and release for more research, training and refresher courses for planners/providers in monitoring and evaluating Adolescent Reproductive Health Programmes and Services needs urgency. The findings of this study support the submissions of Advocate for Youth (2005) that Reproductive health programmes and services to youths are insufficient to reduce at-risk sexual behavior of adolescents such as STIs rates, pregnancy and abortion related problems.

HYPOTHESIS ONE

This hypothesis states that Reproductive health educational programmes of Government will not significantly influence the sexual behaviour among in-school adolescents in Delta State, Nigeria. The result showed that Reproductive health educational programmes of Government were significant in influencing the sexual behaviour among in-school adolescents in Delta State, Nigeria. Therefore, the hypothesis is rejected. This implies that Reproductive health educational programmes are effective in curbing the at-risk sexual behaviour of in-school Adolescents. This findings support the submissions of Adamchak (2000) that successful RHEP helps adolescents develop life planning skills; respect the need and concerns for themselves and other young adults as well as provides respectful and confidential clinical services. Adamchak et al (2000) stated that RHEP should start with what young people want and with what they are doing already to obtain sexual and reproductive health information and services. They opined further that RHEP should make the most of what exists, build upon and link existing programmes and services in new and flexible ways so that they reach many more young people. Okonta (2007) stated that lack of reproductive health programmes and services; lack of involvement of adolescents in planning; implementing, monitory, and evaluation process, has led to

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high level of adolescents involvement in negative sexual behaviour particularly in Delta State. It also confirmed Herbert (2002) discovering that the solution to negative risky behaviour among adolescents is to ensure that they are informed about sexuality education instead of living them uninformed. It is worthy to note that the justification of this study is supported by Smith (2003) who proposed that an alternative to positive sexual behaviour in adolescence is comprehensive sexuality Education, which emphasizes broad based knowledge of all aspects of sexuality, thereby enabling students to make informed decisions about sex. United Nations (2000) revealed that the benefits of RHEP includes: delayed initiation of sex, reduced unplanned and too-early pregnancies and their complications, fewer unwanted children, reduced risk of sexual abuse, greater completion of education and later marriages, reduced recourse to abortion and the consequences of unsafe abortion and slower spread of sexually transmitted diseases, including HI V/AIDS. Reproductive health education according to UNESCO/UNFPA (2007) is an educational experience aimed at developing capacity of adolescents to understand their sexuality in the context of biological, psychological, socio-cultural and reproductive dimensions and to acquire skills in managing responsible decisions and actions with regard to sexual and reproductive health behaviour.

HYPOTHESIS TWO

This hypothesis states that Reproductive health services of Government will not significantly influence the sexual behaviour among in-school adolescents in Delta State, Nigeria. The result shows that Reproductive health services of Government were significant to influence the sexual behaviour among in-school adolescents in Delta State, Nigeria. Hence, the hypothesis was rejected. Supporting this view, WHO Fact Sheet (2003) opined that Programmes and services that aim to educate adolescents about sexual and reproductive health need to be combining with programmes aimed at motivating them to apply what they have learnt in their lives. They should also be combined with efforts to make it easier for adolescents to obtain any preventive or curative health services they might need from competent and empathetic health workers. WHO (2002) revealed further that Health Services need to link with other key services for adolescents, so that they become part of a supportive structure and protects young people against dangers and help them to build knowledge, skills and confidence. Also in support of this study Hughes and Macauley (2002) confirmed that with the increasing multiplication size of young people; there is

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need to consistently evaluate current programme and services to find less costly ways to reach young people. This study agrees with the number nine objective of ARHPCS (1994) who opined that programmes must be developed to make counseling services accessible to adolescent and supports guidance/parents in line with the rights of adolescent. Also in support of this hypothesis McDonald (2000) revealed that Counsellors are expected to appropriately refer adolescents to other health professionals and or services determined necessary, after completing the counselling session. The counsellors should ensure that the adolescents have all the relevant information in order to access service at the point to which they are referred.

HYPOTHESIS THREE

This hypothesis states that Reproductive Youth-friendly service environment of Government will not significantly predict sexual skills developments to influence the sexual behaviour among in-school adolescents in Delta State, Nigeria, Nigeria. The result shows that Reproductive Youth-friendly service environment was significant to influence sexual skills developments to influence the sexual behaviour among in-school adolescents in Delta State, Nigeria. Hence, the hypothesis was rejected. This finding is in support of Action Health Incorporated (2002) findings that Adolescent Youth-friendly services will help adolescents to grow healthy, educated with hopes and opportunities to prevent diseases and may help in spearheading and documenting research on adolescent sexual and reproductive health as well as influence and help in forming policies on behalf of adolescents. They stated further that RHYFS will encourage young people to use the health facilities and also ensure their needs are adequately met. The findings of this study is in line with Okonta (2007) submission that there are inadequate youth friendly services to curb at-risk sexual behaviour of in-school Adolescents as the relative effect shows that Health and Peer club was not significant. It also corrobates the findings of Advocate for Youth (2005) that peer clubs allows participants to learn through demonstration, listening; role playing; develop leadership skills; serving as role models, providing feedbacks and supporting healthy decisions and behaviours. Moore and Rosenthal (1993) revealed that focusing and understanding the subjective dimension of at-risk sexual behaviour of Adolescents is the key to developing an effective evaluation of interventions programmes and services to prevent and reduce risky sexual behaviour among adolescents in Nigeria.Also in support of the findings AHI (2003) stated that Youth –

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friendly services should be provided at convenient and private hours for adolescent. AHI (2003) revealed that the following characteristics are essential for an ideal youth friendly ARH services. Friendly staff (provider) to adolescents, Understand and knowledgeable about adolescents' concerns and needs, Counsellors use language that is understandable to youth, Providers spend adequate time with them, Youth/adolescents drop-ins are welcome and accommodated, Provides information and audio-visual materials on Rh services, Counselling and examination rooms ensure privacy, Facilities are conveniently located and Availability or referral for medical services. This finding is in support of Action Health Incorporated (2002) findings that Adolescent Youth-friendly services will help adolescents to grow healthy, educated with hopes and opportunities to prevent diseases and may help in spearheading and documenting research on adolescent sexual and reproductive health as well as influence and help in forming policies on behalf of adolescents. They stated further that RHYFS will encourage young people to use the health facilities and also ensure their needs are adequately met. The findings of this study is in line with Okonta (2007) submission that there are inadequate youth friendly services to curb at-risk sexual behaviour of in-school Adolescents as the relative effect shows that Health and Peer club was not significant. It also corrobates the findings of Advocate for Youth (2005) that peer clubs allows participants to learn through demonstration, listening; role playing; develop leadership skills; serving as role models, providing feedbacks and supporting healthy decisions and behaviours. Moore and Rosenthal (1993) revealed that focusing and understanding the subjective dimension of at-risk sexual behaviour of Adolescents is the key to developing an effective evaluation of interventions programmes and services to prevent and reduce risky sexual behaviour among adolescents in Nigeria.

HYPOTHESIS FOUR

This hypothesis states that Teachers will not significantly predict positive changes in the sexual behaviour among in-school adolescents despite the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Teachers were not able to predict positive changes in the sexual behaviour among in-school adolescents despite the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Hence, the hypothesis was not rejected. This finding is in support of Ogundele (2009) who stated that Teachers and parents also believe that sexuality education is really moral

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education and therefore a responsibility of the religious teaching. Since the school is the place that much of our national, culture, art and literature, and so on, are first experienced in-depth and sex has always been a major influence in these areas. "For the school to attempt to play a constructive role in the socialization of young people without including sexuality education is to deny the importance of fundamental instincts and needs" Paul Hayton (1985) and since most parents don't have the time to impart sexuality education moral, the religious group has also looked at it as unnecessary, therefore, the school (teachers) should teach sexuality education. The teachers should be willing and ready to teach it; and the same qualification for teaching as in most other field. The teachers should therefore ensure appropriate teaching materials for sexuality education teaching. This will help correct their family life; secondary schools should not only include sexuality education in its curriculum but also teach and give adequate information by using instructional materials to build positive attitude in individual sexuality. Spanier (1978) support Hendrok's view, stating that "a good sexuality education will need to commence before a child has had the chance to acquire incorrect or misleading information, which will be necessary for him to later unlearn or re-learn." He suggests that as soon as the child enters school each year, the child should be presented with materials that are appropriate to his sexual socialization at the point in time. Schools through the teachers can provide an avenue for facilitating change in thinking about harmful traditional practices. Some traditional practices, such as female genital mutilation, norms that favour early marriage, and fewer reproductive health options for women than for men, have been harmful to young people's health. Female genital mutilation, the most serious of these, is deeply entrenched by strong cultural dictates, but it can cause severe physical and psychological damage (UNFPA, 2000).

HYPOTHESIS FIVE

This hypothesis states that Health Care providers will not significantly predict positive changes in the sexual behaviour among in-school adolescents with reference to the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Health Care providers were able to predict significant positive changes in the sexual behaviour among in-school adolescents with reference to the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Hence, the hypothesis was rejected.

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The findings of this study revealed that the joint effect of RHEPS by HCP was significant. This shows that Health Care providers did not observe significant positive changes among in-school adolescent sexual behaviour in Delta State, Nigeria. However, the relative effects of RHEP, TRHS, RHS and culture were not significant to curb in-school adolescent sexual behaviour and RH policy was significant. This findings confirmed the Nigeria Demographic and Health Survey (2003) that one-third of female obtaining abortions were adolescents. Hospital-based studies showed that up to 80 percent of Nigerian patient with abortion-related complications were adolescents. Government Policy (2005) findings revealed that adolescents have peculiar health needs and to facilitate, train, sensitize adolescents and other relevant groups in the knowledge, skills on sexual issues, there is need to promote effective healthcare through strategic policies. It also upholds the position of the National Adolescents Health Information (2004) that Adolescents health approach to policies and programmes that serve young people for youth development must go hand-in-hand. That is, there is need for paternership of all stakeholders for in-school adolescent's sexual behaviour to be positive.

HYPOTHESIS SIX

This hypothesis states that there will be no significant difference between male and female in-school adolescent's sexual behaviour of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. There was significant difference between male and female in-school adolescent's sexual behaviour of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Hence, the hypothesis was rejected.

The findings of this study was also in line with Nigeria Demographic and Health survey (2002) whom using 5500 young people aged 12-24, discovered that 44% of female and 37% of males had experienced sexual intercourse . Moreover, 83% female and 72% male had intercourse by age 19 (Makinwa and Feyisetan, 1994). Case studies in various countries have shown that contraceptive use is as low as 1 % among female and 9% among male 17—24-year-old college students in Vietnam. Only 10% of female and 20% of male secondary school students in urban areas of Nairobi, Kenya, and 12% of females and males under the age of 20 from Chile practice contraception regularly (UNDP/UNFPA/WHO/World Bank, 2000). Pregnant adolescent girls who do not succeed in procuring an abortion go o to have a delivery

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and exposed to the risks associated with teenage pregnancy, labour delivery. In the South –South zone, 11.3% of women aged 15 – 19 years had given birth. In Abia State, of the 10.9% of girls who became pregnant after their first sexual intercourse, 36% had a delivery. In a study of 410 adolescent girls in a rural community in Rivers State, 62% of them had initiated sexual intercourse, 43.6% of girls aged between 12 and 17 years and 80.1% of girls aged between 17 and 19 years had had sex. About 14% of the girls initiated sexual intercourse by age 10 – 14 years. Similarly in another study in Rivers State, 78.8% of the 768 adolescents aged 14 – 21 years had been sexually exposed and the mean age at sexual initiation was 15.04 years with 2% of them having initiated sex at the age of 12. Anochie, also in Rivers State, documented that 12.4% of the 534 female students studied had initiated sexual intercourse by 11 years. Studies from other States in the NDR show a similar trend. In Calabar, Cross River State, the mean age at sexual initiation was 13.7 years. In Delta State, a UNFPA sponsored baseline survey which included 1013 adolescents showed that 34.4% of adolescents aged between 15 – 19 years have had sex, while another study of 516 secondary school students also in Delta State, showed that 69% of them have been sexually initiated.(Ekpu, 2004; Okonta, 2007; Okonofua, 2003 and GPI, 2006).

HYPOTHESIS SEVEN

This hypothesis states that there will be no significant difference between rural and urban in-school adolescent's sexual behaviour of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. There was significant difference between rural and urban in-school adolescent's sexual behaviour of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Hence, the null-hypothesis was rejected. The findings of this study confirmed the position of FMOH (2000) and Okonta (2007) that little or no attention is paid to adolescent RHEP and services in the rural area because certain communities ensures that many sexually active adolescents are denied access to RHEP and services. These communities due to culture, couple with the fact that there are no provisions made for illiterate adolescents also helps to deny most rural adolescents access to RHEP and services.

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HYPOTHESIS EIGHT

This hypothesis states that there will be no significant Reproductive Health knowledge to influence positively sexual behaviour among in-school adolescents of the Reproductive Health Education Programmes and Services of Government in Delta State, Nigeria. Thus, hypothesis eight which stated that there will be no significant Reproductive Health knowledge to influence positively the sexual behaviour of in-school adolescents despite the Reproductive Health Programme and Services of Government in the Delta State was not rejected. The findings of this study is in line with findings by Moronkola (2003) who noted that adolescents have poor knowledge about reproductive health issues which he attributed to unsatisfactory efforts by the Government on the full implementation of the school health policy and teaching of Health Education as a subject of study in the senior secondary schools. Population Reference Bureau(2010) emphasized that ignoring the teaching of reproductive and sexual health of youths today will have dire global consequences for decades, and with global attention on the MDGs, countries that recognize the importance of healthy young adults (ages 15-24) also have a better chance of reaching their targets for Goal 3(promoting gender equality and empowering women),Goal 4(reducing child mortality),Goal 5(improving maternal health),and Goal 6(combating HIV/AIDS, malaria, and other diseases). This study also supported the argument of Nwabueze (1998) that lack of reproductive health knowledge of adolescents implications are teenage child bearing teen mothers, with low level of educational attainment are more likely to live in poverty and experience health problem more frequently than older mothers. Herbert (2002) attributed that the solution to this problem is to educate young people especially adolescents about the risk of unprotected, penetrative sex and teaching them about abstinence and safer sex instead of leaving them uninformed. Ironically Nigerian reluctance to confront this problem openly and directly highlights the difficulty that parents, schools etc face in dealing with a typical sexuality in adolescents and in suggesting appropriate and alternate forms of expression of their sexual behaviour. The findings of this study is in line with Moronkola (2003) who noted that adolescents have poor knowledge about reproductive health issues which he attributed to unsatisfactory efforts by the Government on the full implementation of the school health policy and teaching of Health Education as a subject of study in the senior secondary schools.

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CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

SUMMARY

This study evaluated the influence of Reproductive Health Education Programmes and Services of Government on In-School Adolescent Sexual Behaviour in Delta State, Nigeria. The variables for the study were Reproductive Health Programmes, Reproductive Health Services, Culture, Health Policy and Sexual Behaviour. The study was carried out because of the prevalence of risky sexual behaviour exhibited among in-school adolescent despite the reproductive health programmes and services of government for in school Adolescent in Delta State, Nigeria. It became necessary to evaluate the RHEPS of in-school adolescents' sexual behaviour because of the prevalence of at risk sexual behaviour exhibited among adolescents in the region studied.

The introductory section included the background of the study and statement of the problems. The research questions provided answers to how inadequate funds, culture and Adolescents policies influence RHEPS of government on sexual behaviour among in-school adolescent in Delta State Nigeria. Nine hypothesis tested Reproductive health educational programmes; Reproductive health services; youth friendly service environment, Teachers; Health Care Providers, Reproductive health knowledge, difference between rural and urban in-school sexual behaviour, difference between male and female in – school adolescents and influences of each RHEP (HIV/AIDs, Peer education, Family Life education and Sexuality education) on in-school sexual behaviour.

The review of related literature was done and it extensively discussed topics in areas related to the study as follows: Concept of Adolescents, Reproductive Health Concept of Evaluation, Theoretical Framework, Adolescents Reproduction Health Programmes, and Adolescents Reproductive Health Services in chapter two. The research methodology used for the study was highlighted. Descriptive survey research design of the expose facto type was used because all the variables studied are already in existence and the researcher simply observed those phenomena without any manipulation. A multi-stage sampling technique was adopted for the study, which involved six stages. In the first stage simple random sampling technique was adopted to select the three senatorial district, In the second stage purposive sampling

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technique was used to select the first three local governments from the senatorial district each totaling nine (9) local government areas out of the twenty-five local government area in Delta state. In the third stage convenient sampling technique was used to select all the schools within the nine local governments area selected for the study which totals twenty six public schools. In the fourth stage cluster random sampling technique was used to select 1515 in-school adolescents in SS2 as shown on table 2.2, SS 2 in-school Adolescents were chosen because they have been exposed to the programmes and services. However, SS3 were not part of the study sampled because they were not in school as at the time of this study. In the fifth stage purposive sampling techniques was used to select 294 teachers, 26 Principals and 26 vice principal that have been trained on RHEPS. In the sixth stage purposive sampling technique was used to select the first three most senior staff from the health care provider totaling 78.

The instrument of the study were three modified adapted questionnaire with reliability coefficient of RHP-HCP = 0.74, RHP-STD = 0.84, and RHPS-TCP = 0.81. These were considered high enough for the study. The data was analysed using statistical tools of descriptive statistics of frequencies and percentages with bar charts and pie charts representation for the demographic characteristics of the three sets of respondents and Percentages to describe the five research questions while the parametric statistics of multiple regression and t-test were used to test the null hypothesis formulated for the study, the results were expressed at 0.05 alpha level. A greater perspective of the in-school adolescents respondents were within the age range of 15-19years. From the three research questions answered inadequate funds, culture and policy were significant factors affecting Reproductive Programmes and Services of Governments on in-school Adolescents' sexual behaviours in Delta State, Nigeria. The findings also showed that out of the nine hypotheses tested using three groups of respondents (students, teachers and Health care providers). Seven of the null-hypotheses were rejected and as such were found to be significant while two was not rejected.

Conclusion

Based on the findings of this study, the following conclusion was drawn:

This study revealed that six of the joint independent variables were found as significant predictors of RHPS of Government on Sexual behaviour of in-school

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Adolescents' in Delta State, Nigeria. They are Reproductive Health Educational Programmes, Reproductive Health Services, Youth-friendly services environment and Health Care Providers. There was significant difference between male and female as well as between rural and urban in-school Adolescents' Sexual behaviour in Delta State, Nigeria, Therefore, the six null hypotheses were rejected. However, Teachers did not significantly observed positive changes of the RHPS of Government on Sexual behaviour of in-school Adolescents' and Reproductive Health Knowledge of in-school was not significant. Therefore, the two null hypotheses were not rejected. In addition, Inadequate Human and Material Resources, Funds, and Youth-friendly Services Environments as well as Culture and Policies were found to influence the effectiveness of RHPS of Government on Sexual Behaviour of in-school Adolescents in Delta State, Nigeria. Finally, the relative effects of Peer education, Family Life education, counseling, contraceptive counseling, Youth friendly services, Recreational facilities and HIV/STIs counseling were found to be significant to curb in-school Adolescents Sexual Behaviour in Delta State, Nigeria. The findings of this study revealed that Adolescent reproductive health programmes and services in Delta State have not been able to achieve process evaluation successfully. Moreover, the study revealed the relative effect of HIV/AIDs education, sexuality education; Youth friendly services, Health club and Peer clubs were not significant to influence positively in-school adolescents' sexual behaviour despite the RHPS of Government in Delta State, Nigeria. In addition, Peer education was ranked 46.4% (899) by the respondents as the highest RHEP to positively influence the sexual behaviour of in-school Adolescents in Delta State, followed by Sexuality education 28% (540); Family life 16.3% (396) and HIV/AIDs education 5.3% (104). Conclusively, Youth-friendly clinics, Reproductive health policy and culture were found to be significant to influence positively in-school adolescents' sexual behaviour in Delta State of Nigeria.

Recommendations

The following recommendations were made in accordance with the findings from this study:

1. There is need for government to urgently review the current Adolescents Health Policy and the Reproductive Health Policy to meet the reproductive

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health needs of in-school adolescents in Delta State. Government health policy should be in line with international health standard and Youth Friendly clinical services should be created in all the secondary schools in Delta State for quality health care services on reproductive health issues for in-school Adolescents.

2. There is need for government to urgently put in place strategic Health educators manpower and resources that will from time to time evaluate how clients, resource personnel, and parents perceive the RH Programmes and Services

3. The State Government should allocate and release some of the funds budgeted for HIV/AIDs by the Federal Government allocation to FLHE teachers to assist them in providing youth-friendly services, materials, equipment and facilities for all schools offering RHEPS and to other schools to curb in-school adolescents' sexual behaviour positively in Delta State since UNFPA have reduce their financial support to the State as a matter of urgency.

4. The school health policy maker and Health educators should specifically deal with requirements for logistic support that only Health educators should teach RHPS in all schools in Delta state instead of allowing NGOs to render RHPS for in-school adolescent in Delta State.

5. Funds should be increased, integrated and released into the entire impress given to principals of schools where RHEPS is being offered in Delta State. The State Governments should also release more funds to reach other schools in the State and create more recreational facilities to occupy their time.

6. There should be increase manpower that will adequately be trained and well equipped to meet Adolescent's health needs and challenges in the school settings. They should be adequately motivated via good incentives during each training sections.

7. The State Governments should enact legal frameworks and networking of all stakeholders handling Adolescents issues to consistently evaluate their programmes to check effectiveness of RHEPS in the State.

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8. Principals should be trained to constituently monitor and evaluate RHEPS in their school every year and submit reports to the Government to serve as a yearly summative evaluation report.

9. The State Government should consistently check the activities of RHEPS of NGOs to ascertain if they are updating their programmes to meet the needs of Adolescents as well as to assist them with their various challenges.

10. The State Government should consistently re-train teachers teaching and offering RHEPS to in-schools Adolescents in the State.
11. The State Governments should out rightly ensure that other L.G.A where RHEPS are not being offered in Delta state should start immediately. Behavioral intervention programs reduce high-risk sexual behavior in adolescents.

12. Delta State Governments should ensure that the Principals of schools used for the study should personally create and monitor the peer clubs via Peer educators to ensure its effectiveness in curbing in-school sexual behaviour.

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Contribution of this study to knowledge

This study has contributed to knowledge in the following ways:

The findings of this study have served as formative evaluation of RHEPS of Government to positively influence in-school Adolescents in Delta State, Nigeria. The findings of this study have confirmed that RHEPS of Government is an effective programme that positively influences sexual behaviour among in-school Adolescents in Delta State. RHEPS in Delta State is measurable, ongoing and have clearly defined goals, but there is urgent need for more strategic plans to sustain and extend and expand the programme to more public schools in other Local Governments areas in the State. The findings of this study have provided data based information on the contribution of each of the independents variables towards curbing at-risk sexual behaviour of in-school adolescents in Delta state. The process evaluation of this study has bridge the gap as data base information on the monitoring and supervision of the programme since 1999 to 2010 for Delta State UNFPA personnel in the Ministry to know the effectiveness of RHEPS in curbing the at-risk sexual behaviour among in-school Adolescents in the State. Finally, the findings of this study revealed that

RHEPS is not fully being implemented according to plan and the target coverage audience is 20%. This will assist the recent initiative of the federal and state government on the Training of Master Trainers on family life and HIV Education (FLHE) curriculum which they must as a matter of urgency train not only more manpower in the Colleges of Education but other Tertiary institutions in the country. This is because the school remains the best environment for the teaching of Sexuality education, Family life, Peer Education and STIs/HIV/AIDs education.

Suggestions for further study

The following topics have been suggested for investigation in order to carry out further studies on adolescent sexual behaviour:

1. Evaluation of reproductive health programmes and services of government and non-governmental organizations on out-school adolescents' sexual behaviour in Delta state Nigeria.

2. Evaluation of RHPS of non-governmental organization on school leaver sexual behaviour in Delta state of Nigeria

3. Youth-friendly health clinics/services as predictors of positive sexual behaviours of in-school adolescents in Delta state, Nigeria.

4. Peer education and HIV/AIDS education as correlates of at-risk sexual behaviour of in-school adolescents in Delta State, Nigeria.

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APPENDIX ONE
HEALTH CARE PROVIDER

EVALUATION OF REPRODUCTIVE HEALTH EDUCATION PROGRAMMES AND SERVICES OF GOVERMENT ON SEXUAL BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS MEASURING SCALE (RHP-HCP)

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FACULTY OF EDUCATION

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

Dear Respondents,

This questionnaire is designed to elicit information on the evaluation of reproductive health education programmes and services of Government on sexual behaviour among in-school adolescents in Delta State of Nigeria. Your responses are for research purpose and information supplied will be treated with absolute confidentiality.

Thanking you in anticipation of your cooperation for filling the questionnaire.

Yours faithfully

Ogharaerumi, B.S.U.

Section A: Demographic Data.

Please tick (√) as applicable to you.

Name of your organization____

L.G.A: ____

1. Sex: (a). Male ( ) (b). Female ( )
2. Religion: (a). Christianity ( ) (b).Islam ( ) (c). Traditional belief system ( )
3. Marital Status: (a). Single ( ) (b). Married ( ) (c). Widowed ( ) (d). Divorced ( )
4. Educational Qualification: (a). No-formal education ( )
   (b). Primary School certificate ( )
   (c). S.S.C.E ( )
   (d). OND/HND ( )
   (e). University graduate ( )

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5. Age (s) in years:

(a). 31 – 40 ( ) (b). 41 – 50 ( ) (c). 51 and above ( )

6. Structure of facility:

a) Youth only facility ( )

b) Integrated services ( )

7. Your Position in the center is:

a) Director ( )

b) Health educator ( )

c) Counselor ( )

d) Doctor ( )

e) Professional nurse/midwife ( )

f) Outreach worker ( )

g) Secretary ( )

h) Other specify: ………………………………

SECTION B: REPRODUCTIVE HEALTH EDUCATIONAL PROGRAMMES (FLHEPS)

Please tick (√) as applicable to you, the reproductive Health educational programmes you have offered to in-school adolescent in your center:

1	Peer education	
2	School based health education	
3	Parents education	
4	Family life education	
5	Life planning education	
6	Sexuality education	
7	Community education	

8	Information education communication hotlines/social networking	
9	Behavioral change (BBC)	
10	Peer club	
11	Health talk/sensitization programme	
12	HIV/AIDS education	
13	Bibilotherapy/outreaches	
14	Outreaches e.g.	

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SECTION C: Reproductive Health Services (CRHS-YF)

	Tick any of the Youth-friendly services environment offered to adolescents in your center	
1.	a. Contraceptive /STIs counselling is provided	
	b. treated adolescents with respect	
	c. encouraged adolescents to ask questions	
	d. adolescents needs are determined	
	e. Health personnel provided referral information for obtaining RH services	
	f. Counselor use a kind and inviting tone of voice	
	g. ARHS are provided at convenient hour	
	h. Counselling and examination rooms ensure privacy	
	i. Education materials are displayed and available to adolescents	
	j. Surroundings are inviting to adolescents	
	k General ethnic skills in contraceptive methods	
	l. Health personnel are non-judgmental and understanding in their approach.	
	m. Cost of RHS are affordable	
	n. Facility offers wide range of services	
	o. Record keeping of adolescent personal data.	
	p. Stock keeping of issues.	
	Recreational facilities	

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Section C: Reproductive Health Services offered to in-school Adolescence (CRHS-YF)

	Tick any of the services you have offered to adolescent in your centre according to their age group	**10-14 years**	**15-19 years**	**20-24 years**
2	a Contraceptive counseling and peer education			
	b. Antenatal care			
	c. Maternity care/delivery services			
	d. postnatal care			
	e. HIV/AIDS counseling/Information Education			

	Communication			
	f. HIV/AIDS testing			
	g. STI counseling/			
	h. STI diagnosis /testing			
	i. STI treatment			
	j. Treatment of incomplete abortions i.e. referral counseling/guidance			
	k. Nutrition counseling, Family life and Life planning education.			
	l. Biliotherapy/outreaches and Social networking			
	m. abortion complicated examination			
	n. Pregnancy testing			

		Yes	**No**
3.	In the past 6 months, have you advised any adolescent's students to use contraception specifically for preventing pregnancy?		
4.	Are you aware of any institutional policies on providing contraceptives to adolescents?		
5	Do you provide reproductive health services to adolescents who have HIV or AIDS/STIs problems?		
6	Do female adolescents come to your center for medical treatment as a consequence of incomplete induced abortion?		
7	Do female adolescents come to your center for advice on termination of pregnancies?		

		Very comfortable	**Comfortable**	**Very uncomfortable**
8	How comfortable are you discussing sexual behavior related to STIs/HIV with your adolescents clients?			

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Tick any of the issues/problems mentioned by students who comes to your center

a.	Difficulty in relationship with opposite sex	
b.	Drug abuse	
c.	Sexually transmitted infections	
d.	Masturbation	
e.	Unwanted pregnancy	
f.	Abortion-related issues	

Section D: Sexual Behaviour of In-School Adolescents. Please respond by ticking (√) any of the questions as applicable to you. (SBSK)

A – Agree U – Undecided D – Disagree

	Statement	**Agree**	**Undecided**	**Disagree**
1	Adolescent that attends most of our reproductive health programmes and services now shows Motivation to do well in schools.			
2	Adolescent that attends most of our reproductive health programmes and services are Actively engaged in learning now than before.			
3	Adolescent that attends most of our reproductive health programmes and services shows self efficacy to alcohol and drug usage.			
4	Adolescent that attends most of our reproductive health programmes and services shows ability to resist sexual harassment/advancement.			
5	Adolescent that attends most of our reproductive health programmes and services shows ability to resist sexual pressure.			
6	Adolescent that attends most of our reproductive health programmes and services reproductive shows ability to reject the exchange of money or good for			

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	sex.			
7	Adolescent that attends most of our reproductive health programmes and services shows ability to zip up			
8	Cares and respect their privacy			
9	Seek contraceptive counselling			
10	Now freely discuss menstruation or wet dreams with you			
11	Feels bold to discuss about abortion consequences			
12	Feel comfortable visiting your reproductive health center or clinic			
13	Insist on condom use during sex even if their boyfriend or girlfriend does not want to use it.			
14	Ability to refuse sexual intercourse with a person who offers them gifts			
15	Have developed self – esteem/efficacy to report to constituted authority to sexual harassment from senior relations and male teacher.			
16	Avoids sexual intercourse with a partner infected with an STI/HIV.			
17	Avoid sexual intercourse with more than one partner.			
18	Avoid sexual intercourse without the use of condom.			
19	Avoid sexual intercourse without the use of contraception's.			
20	Uses contraceptives when sexually aroused.			
21	Avoids drug and alcohol.			
22	Refers peers to reproductive health activities services and contraceptives.			
23	Has desire to delay, postpone marriage, stay and finish school.			

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1. **Human resources:** How many of the staff position listed below are assigned at your centre	Full Time	Part Time	Not Available
a. Medical Doctors			
b. Nurse & Midwife			
c. Counsellors			
e. NGO's			
f. Counsellors			

2. **Materials Resources:** - Tick any of the following materials that are affecting Reproductive Health Proogrammes and Services in your centre.	
a. Brochures/Handout	
b. Flipcharts/Books	
c. Posters/Pamphlets	
d. Models	
e. Projectors	
f. Audio-video equipments for presentation	
g. Marker/Writing Materials	
h. Suggestion Box	
i. Record Keepers	
j. First Aid Box	
k. Toiletries	
l. in adequate space	
j. Location	
3. **Funds :**	
a. Lacks of funds from the government affects RHPS in my center	
b. inadequate Funds to purchase relevant materials affects RHPS in my center	
c. inadequate Funds to run vital outreaches on RHPS in my center	
d. inadequate Funds to organize RHPS are not always adequate	
e. inadequate Funds from L.G.A. and Donor agencies affects RHPS in my center	

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List three ways you have been generating funds for your centre to assist in-school adolescent

a. ____

b. ____

c. ____

	Reproductive health policy (RHPO) should:	**Agree**	**Strongly agree**	**Disagree**	**Strongly disagree**
1	Promote the acquisition of health knowledge and status of adolescents.				
2	Facilitate interaction between adolescents and their health care provider in influencing their sexual behaviour positively.				
3	Ensure political parties, top planning bureau and religious organizations support effective policies and regulations of ARHPS.				
4	Provide a national coordinating body that engages various ministries to assist with the appropriate programs/services.				
5	Involves NGO's community leaders, Religious bodies and social interest group in policy dialogue; formulation and deliberations.				
6	Allow pregnant adolescents to continue with their education.				
7	Providers to be free from unnecessary legal and regulatory restrictions.				
8	Ensure a favourable legal and regulatory climate for ensuring that unmarried adolescents of any age receive reproductive health services.				

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	Reproductive Health Programmes and Culture (RHPCUL)	**Yes**	**No**
1	Placement of high value on early fertility in your culture promotes sexual risks due to early sexual initiation.		
2	Value placement on chastity/ virginity in your culture prevents risky sexual behaviour among adolescents.		
3	Your culture permits sexual intercourse before marriage.		
4	Culturally you can live with someone of the opposite sex.		
5	Your culture frowns at contraceptive usage.		
6	Unmarried girls & boys in my community encourage their peers in early initiation as an act the practice for effective performance.		

Adapted from FOCUS for young adult Research Series (2000).

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APPENDIX TWO

STUDENTS QUESTIONNAIRE

EVALUATION OF REPRODUCTIVE HEALTH EDUCATION PROGRAMMES AND SERVICES OF GOVERMENT ON SEXUAL BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS MEASURING SCALE (RHP-STD)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

Dear Respondents,

This questionnaire is designed to elicit information on the evaluation of reproductive health education programmes and services of Government on sexual behaviour among in-school adolescents in Delta State of Nigeria. Your responses are for research purpose and information supplied will be treated with absolute confidentiality.

Thanking you in anticipation of your cooperation for filling the questionnaire.

Yours faithfully

Ogharaerumi, B.S.U. [Mrs]

Section A: Demographic Data

Please tick (√) as applicable to you.

1. Name of School ______________________ L.G.A: ____________________

2. Sex: (a). Male ( ) (b). Female ( )

3. Religion: (a). Christianity ( ) (b).Islam ( ) (c). Traditional belief ( )

4. Class: (a) S.S.S.2 ( )

5. Age (s) in years: (a). 10 – 14 ( ) (b).15 – 19 (20-24)

6. What is the highest level of education you hope to complete?

(a) Secondary ( )

(b). Technical/vocational school ( )

(c). University/college ( )

(d). Post-university/graduate school ( )

7. How important is it to you that you get a good education?

(a) Not very important ( )

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(b). Quite important ( )

(c). Very important ( )

8. Are you involved in any extra-curricular activities at school?

(a). Yes ( ) (b). No ( )

9. If so, what are they? Tick all that apply

(a). Sports clubs/teams

(b). Drama club ( )

(c). Debate club ( )

(d). Academic/discovery club ( )

(e). Religious club ( )

(f). others (*specify* ________________________________

10. What have you done in the last month to earn money for yourself?

(a). Nothing

(b). Employed

(c). Selling goods/small-scale business

(d).Casual labor

(e). Farming

(f). Other (*specify*)____

Section B: Please tick (√) as applicable to you.

Reproductive Health Knowledge of Adolescent (FLHEPS)

	Statement	Yes	No	Don't know
1.	(a) A woman have the greatest chance of becoming pregnant during her period			
	(b) A woman have the greatest chance of becoming pregnant in the middle of her cycle			
	(c) A woman have the greatest chance of becoming pregnant rights after her period has ended			
	(d) A woman have the greatest chance of becoming pregnant just before her period begins			
2.	A girl can get pregnant the first time she has sex?			
3.	A boy can physically make a girl pregnant after puberty			
4.	A girl can be pregnant after puberty			
5.	It is possible for a girl to get pregnant if the boy withdraws before ejaculation			
6.	(a)Safe sex means abstaining from sex			
	(b) Safe sex means using condom always			
	(c) Safe sex means avoiding multiple sexual partners			

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	(d) Safe sex means avoiding sex with prostitutes			
	(e) Safe sex means avoiding and sex till marriage			
7.	A healthy-looking person can be infected with HIV			
8.	Using new condom prevent sexual health problems			
9.	Checking expiration date of condom prevent sexual health problems			
10.	Unroll condom on erect penis prevent sexual health problems			
11.	Open condom wrapper carefully prevent sexual health problems			
12.	Masturbation is the stimulation of the genitals for sexual pleasure			
13.	Contraception is the prevention of conception or pregnancy			
14.	Family Life education is designed to assist young people to prepare for adulthood, marriage, parenthood, family and society.			
15.	Puberty is the growth of hormones that influences the development of sexual maturity			
16.	Sexuality education helps individuals acquire skills to make rational decision now and in the future			
17.	Sexuality can be described as a central aspect of human through life and encompasses sexual orientation, gender identities, sex, pleasure, intimacy and reproduction.			
18.	Peer education is trained to help their peers to demonstrate healthy sexual decisions and behaviour.			
19.	HIV/AIDS education is designed to teach about STIs/HIV/AIDs infections, prevention and management			
20.	Do you appreciate the teaching FLHE in your school.			

Rate 5,4,3,2 for the programme that was most effective in curbing in – school adolescent sexual behaviour

(a) HIV/AIDS Education ☐

(b) Peer Education 3 ☐

(c) Sexuality Education 4 ☐

(d) Family Life Education ☐

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SECTION C: Reproductive Health Services (CRHS-YF)

1. Tick any of this setting you go for help when you have a reproductive health problem?	
a. Clinic/hospital	
b. Health worker	
c. Peer counselor	
d. Youth center	
e. Friend	
f. Parents	
g. Relative	
i. Clubs	
j. others specify	
2. **I seek advice for counseling or treatment from**	
(a)Youth center	
(b) Drug store	
(c) Traditional healer	
(d) Friends	
(e) Hospital/clinic	
(f) Relative	
(G) Teacher	
(h) Peer counselor	
3. **When I had an STI, I prevent infecting my partner by**	
(a) Not having sex	
(b) Used condoms	
(c) Got treated	
(d) Others (specify)	
4. At the school and or center I visited to obtain contraceptives and other Reproductive Health Services I discussed with a:	
(a) Doctor	
(b) Nurse	
(c) Health educator/teacher	
(d) Peer educator/counselor	
(e) Other (specify----------------------------	

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SECTION D: ADOLESCENTS SEXUAL BEHAVIOUR/SKILLS (SBSK)

A - Agreed SA -Strongly Agreed

D - Disagreed SD - Strongly Disagreed

	The reproductive health programmes and services I am exposed to now help to	**A**	**SA**	**D**	**SD**
1	Motivate me to do well in school now.				
2	Activity engaged in learning.				
3	Give me ability to control alcohol and drug usage.				
4	Enhance my ability to resist sexual harassment and report appropriately.				
5	Enhance my ability to resist sexual pressure				
6	Enhance my ability to reject the exchange of money or good for sexual advancement and intercourse				
7	Develop self – efficacy -				
8	Seek contraceptive counseling now when I have problem.				
9	Freely discuss menstruation or wet dreams with my counselor				
10	Feel bold to discuss about abortion consequences				
11	Feel comfortable visiting reproductive health center or clinic to promote my sexual level				
12	Insist on condom use during sex even if boyfriend or girlfriend does not want to use.				
13.	Refuse sexual intercourse with a person who offers me gifts				
15	Reduce being sexually active				
16	Stop oral sex				
17	Obtain services and experience to reduce any pain or discomfort in the genital area.				

	FACTORS AFFECTING REPRODUCTIVE HEALTH PROGRAMMES AND SERVICES: Tick any of these factors that are affecting the effectiveness of reproductive health programmes and services in your scholar health center	
	Statement:	
	1. **Human resources** – Lack of:	

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	a. Medical Doctors	
	b. Nurses	
	c. Teachers	
	e. NGO's	
	f. Social Worker	
	g. Professional counselors	
	h. Counsellors	
	2. **Materials Resources**: - Tick any of these materials that are affecting RHPS in your school.	
	a. Brochures/Handout	
	b. Flipcharts/Books	
	c. Posters/Pamphlets	
	d. Models	
	e. Projectors	
	f. Audio-video equipment for presentation	
	g. Marker/Writing Materials	
	h. Suggestion Box	
	i. Record Keepers	
	j. First Aid Box	
	k. Toiletries	
	l. in adequate space	
	j. Location	
	3. **Funds** :	
	a. Lacks of funds from the govt. affects RHPS in my school	
	b. Funds to purchase relevant materials affects	
	c. Funds to run the peer clubs	
	d. Funds to organize RHPS are not always adequate	
	e. Funds from L.G.A. and Donor agencies affects RHPS in the schools.	
	4. Culture of my people	
	5. Government interference	
	6. Parents interference	

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	7. Teachers inconsistence in handling the programmes.	
	8. Community interference and facilities/equipment	

	Reproductive health policy (RHPO) should:	**Agree**	**Strongly agree**	**Disagree**	**Strongly disagree**
1	Promote the acquisition of health knowledge and status of adolescents.				
2	Facilitate interaction between adolescents and their health care provider in influencing their sexual behaviour positively.				
3	Ensure political parties, top planning bureau and religious organizations support effective policies and regulations of ARHPS.				
4	Provide a national coordinating body that engages various ministries to assist with the appropriate programs/services.				
5	Involves NGOs community leaders, Religious bodies and social interest group in policy dialogue; formulation and deliberations.				
6	Allow pregnant adolescents to continue with their education.				
7	Providers to be free from unnecessary legal and regulatory issues and fine.				
8	Ensure a favourable legal and regulatory climate for ensuring that unmarried adolescents of any age receive reproductive health services.				

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	Reproductive Health Programmes and Culture (RHPCUL)	**Yes**	**No**
1	Placement of high value on early fertility in your culture promotes sexual risks due to early sexual initiation.		
2	Value placement on chastity/virginity in your culture prevents risky sexual behaviour among adolescents.		
3	Your culture permits sexual intercourse before marriage.		
4	Culturally you can live with someone on the opposite sex		
5	Your culture frowns at contraceptive usage		
6	Unmarried girls & boys in my community encourage their peers in early sexual initiation for effective future performance.		

Adapted from FOCUS for young adult Research Series (2000).

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APPENDIX THREE

TEACHERS QUESTIONNAIRE

EVALUATION OF REPRODUCTIVE HEALTH EDUCATION PROGRAMMES AND SERVICES OF GOVERMENT ON SEXUAL BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS MEASURING SCALE (RHPS-TCP)

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

Dear Respondents,

This questionnaire is designed to elicit information on the evaluation of reproductive health education programmes and services of Government on sexual behaviour among in-school adolescents' in Delta State of Nigeria. Your responses are for research purpose and information supplied will be treated with absolute confidentiality.

Thanking you in anticipation of your cooperation for filling the questionnaire.

Yours faithfully

Ogharaerumi, B.S.U.

Section A: Demographic Data.

Please tick (√) as applicable to you. Name of School ______________________________ L.G.A: ______________________________

1. Sex: (a). Male ( ) (b). Female ( )

2. Religion: (a). Christianity ( ) (b).Islam ( ) (c). Traditional belief system (**3. Marital Status:** (a). Single ( ) (b). Married ( ) (c). Widowed ( ) (d). Divorced ( )

4. Educational Qualification: (a). OND/HND ( ) (b). University graduate ( )

5. Age (s) in years: (a). 25– 40 ( ) (b). 41 – 50 ( ) (c). 51 and above ( )

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6. Types of Community: (a). Rural ( ) (b). Urban ( )

7. Subject Taught:

***SECTION B:* Reproductive Health Education Programmes: (FLHEPS)**

Please write and tick (√) as applicable to you.

Please tick (√) as applicable to you, the reproductive Health educational programmes you have offered to in-school adolescent in your center:

1	Peer education	
2	School based health education	
3	Parents education	
4	Family life education	
5	Life planning education	
6	Sexuality education	
7	Community education	
8	Information education communication hotlines/social networking	
9	Behavoural change (BBC)	
10	Preer club	
11	Health talk/sensitization programme	
12	HIV/AIDS education	
13	Bibilotherapy/outreaches	
14	Outreaches e.g.	

s/n	Statement	Yes	No
15	Do you feel comfortable discussing sexual matters with students?		
16	Do you believe you have enough knowledge to discuss sexual matters with your student?		
17	Have you ever discussed your values on premarital sex with your adolescent student?		
18	Contraception is the prevention of conception or pregnancy		
19	Recreational facilities discourage adolescents to be sexually active		
20	Puberty is the growth of hormones that influences the development of sexual maturity		

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21	Sexuality education helps individuals acquire skills to make rational decision now and in the future		
22	Sexuality can be described as a central aspect of human throughout life and encompasses sexual orientation, gender identities, sex, pleasure, intimacy and reproduction.		
23	Testosterone is the hormone responsible for pubertal changes in boys		
24	HIV/AIDS education is designed to teach about STIs/HIV/AIDs infections, prevention and management		
25	Do you feel students appreciate FLHE in the cause of teaching		

SECTION C: Reproductive Health Services (CRHS-YF)

	Tick any of the Youth-friendly services offered to adolescents in your school	
1.	a. Contraceptive /STIs counselling is provided	
	b. Peer and Health Clubs are available to promote positive sexual behaviour	
	c. treated adolescents with respect	
	d. encouraged adolescents to ask questions	
	e. adolescents needs are determined	
	f. Health personnel provided referral information for obtaining RH services	
	g. Counselor use a kind and inviting tone of voice	
	h. ARHS are provided at convenient hour	
	i. Counselling and examination rooms ensure privacy	
	j. Education materials are displayed and available to adolescents	
	k. Surroundings are inviting to adolescents	
	l General ethnical skills in contraceptive methods	
	m. Health personnel are non-jugdemental and understanding in their approach.	
	n. Cost of RHS are affordable	
	o. Facility offers wide range of services	
	p. Record keeping of adolescent personal data.	
	q. Stock keeping of issues.	
	q. Recreational facilities discourages adolescents negative sexual behaviour	

Tick any of the issues/problems mentioned by students who comes for couselling

a.	Relationship with opposite sex	
b.	Drug abuse	
c.	Sexually transmitted infections	

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d.	Relationship	
e.	Unwanted pregnancy	
f.	Abortion-complicated related issues	

Rate 5,4,3,2 for the programme that was most effective in curbing in – school adolescent sexual behaviour

(a) HIV/AIDS Education ☐

(b) Peer Education 3 ☐

(c) Sexuality Education 4 ☐

(d) Family Life Education ☐

SECTION C: Please Respond By Ticking ( ) any of the Question as Applicable to you. Reproductive Health Services (CRHS-YF)

	STATEMENT	YES	NO
1	Are you aware of any facilities that provide reproductive health services to students apart from your school?		
2	Would you allow your adolescent students to seek reproductive health service from a health facility in conjunction with the school own		
	Do you think contraceptives should be available to students in the school		
	Do you give contraceptive to students in the school?		
	Do you offer contraceptive counseling to students in your school?		
	Do you offer STIS/HIV AIDS counseling to students in your school/		
3	How would you assess the reproductive health services on the sexual behaviour of adolescent (a).positive change (b).no change (c). develop positive sexuality		

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SECTION C: Please Respond By Ticking ( ) any of the Question as Applicable to you. Reproductive Health Services (CRHS-YF)

.4.	Tick any of the following RH services your adolescent student have been exposed to curb their negative sexual behavior	
	a. Condom useage anytime they have sex	
	b. Discuss sexual issues with adolescents	
	c. Discuss pregnancy and related problem	
	d. Discuss menstruation and wet dreams	
	e. Prevention of STIs /HIV/AIDS virus	
	f. Contraceptive counseling	
	g. Family life education/counseling	
	h. Organize and monitors the Peer and Health clubs in school premises	
	i. Organize and monitors RH games through recreational facilities in the school	

1. **Human resources**: How many of the staff position listed below are assigned in your school	
a. Medical Doctors	
b. Nurse & Midwife	
c. Teacher	
e. NGO's	
f. Social Worker	
g. Young Adult	
h. Professional counselors	
i. Counsellors	
2. **Materials Resources:** - Tick the following materials that are affecting RHPS in your school/organization.	
a. Brochures/Handout	
b. Flipcharts/Books	
c. Posters/Pamphlets	
d. Models	
e. Projectors	

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f. Audio-video equipments for presentation	
g. Marker/Writing Materials	
h. Suggestion Box	
i. Record Keepers	
j. First Aid Box	
k. Toiletries	
l. in adequate space	
j. Location	
3. **Funds** : Tick any of the followings affecting RHPS	
a. Lacks of funds from the govt. affects RHPS in my school	
b. Funds to purchase relevant materials affects	
c. Funds to run the peer clubs	
d. Appeal funds to organize RHPS are not always adequate	
E. ineffective funding from L.G.A. and State Government affects RHPS in the schools.	

List three ways you have being generating funds for you organization

i. ________________________________

ii. ________________________________

iii.________________________________

iv. ________________________________

SECTION D: Adolescent sexual Behaviour (SBSK)

	Tick any of the following sexual healthy behaviour/skills observed in your adolescent after his/her exposure to reproductive health programme and service in your school:	
	(a) self efficacy to get contraceptives or treatment	
	(b) self awareness about sexuality	
	(c) empathy	
	(d) inter-personal relationship	
	(f) problem solving	

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	(g) negotiation	
	(h) coping with stress	
	(i) coping with emotions	
	(j) decision making	
	(k) Ability to handle menstruation or Wet dreams	
	(i) seeking reproductive health services	
	(m) abstinence from early sexual initiation	
	(n) using contraceptions	
	(o) referring peers to reproductive health activities, services and contraception	
	(p) Ability to develop skills to evaluate their readiness for possible sexual relationship.	

	Adolescent health policy (RHPO) should:	**AGREED**	**STRONGLY AGREED**	**DISAGREED**	**STRONGLY DISAGREED**
1	Promote the acquisition of appropriate knowledge by adolescent				
2	Train and sensitize adolescent and other relevant group in the skills needed to promote their health behaviour				
3	Be coordinated and implemented by NGO's only.				
4	Facilitated the acquisition of new knowledge concerning interaction between them and their health care provider to influence their sexual behavior positively.				
5	Be effective provide accessible information, services for prevention of sexual problems, treatment and reliabilities to those in need.				

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	Reproductive Health Programmes and Culture (RHPCUL)	**Yes**	**No**
1	Placement of high value on early fertility in your culture promotes sexual risks due to early sexual initiation.		
2	Value placement on chastity/virginity in your culture prevents risky sexual behaviour among adolescents.		
3	Your culture permits sexual intercourse before marriage.		
4	Culturally you can live with someone of the opposite sex.		
5	Your culture frowns at contraceptive usage.		
6	Unmarried girls and boys in my community encourage their peers in early sexual initiation as an act the practice for effective performance.		

Adapted from FOCUS for young adult Research Series (2000).

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APPENDIX A

Delta State has three senatorial district as shown in the table below:

(1)	North Senatorial district (zone)	(2)Central senatorial district (zone)	(3)South senatorial district
1	Aniocha North	10. Ethiopc East	18. Warri South
2	Aniocha South	11.Ethiopc West	19. Burutu
3	Ika North East	12.Okpe	20. Isoko North
4	Ika South	13. Sapele	21. Isoko South
5	Ndokwa East	14Udu	22. Patani
6	Ndokwa West	15. Ughelli North	23.Warri North
7	Oshimil North	16. Ughelli South	24 Bomadi
8	Oshimil South	17. Uuwie	25. Warri South West
9	Ukwuani L.G.A		

Stage 1- The first three Local Government of each senatorial district on the table where RHPS have been offered between 1999- 2010 was sampled for the study, which are represented as in the table below:

(1)	North Senatorial distract (zone)	(2)Central senatorial district (zone)	(3)South senatorial district
1	Aniocha North (17)	4. udu	7. Warri South
2	Ukwuani L.G.A	5. Ughelli South	8. Burutu
3	Ika (20) North East	6. Uuwie	9. Isoko North

TOTAL POPULATION OF ALL UNFPA PROJECT SCHOOLS IN DELTA STATE FROM 1999-2010 AS SHOWN BELOW:

	L.G.A	SCHOOLS	LOCATION OF SCHOOL	STUDENT ENROLMENT			STAFF STRENGTH		
				M	F	TOTAL	M	F	TOTAL
1	Aniocha North	(i) Ezechima M/S/S, Obior	Obior	82	64	146	5	8	13
		(ii) Ezi S/C/S, Ezi	Ezi	84	90	174	2	2	4
		(iii) Boy's Model S/S,	Onicha- Olona	95	60	155	9	8	17

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		Onicha-Olona							
		(iv) Onicha-Ugbo G/G/S, Onicha-Ugbo	Onicha-Ugbo		109	109	1	9	10
		(v) Pilgrim Baptist G/S, Issele-Uku	Issele-Uku	282		282	6	7	13
2	Udu	(i) Owhrode M/S/S, Owhrode	Along Otor-Udu Rd, Owhrode	30	81	111	2	15	17
		(ii) Egini G/S, Egini	College Rd, Egini	113	104	217	2	14	16
3	Uvwie	Alegbo S/S I, Effurun	Old Ugbomoro	324	377	701	4	45	49
		(iii) Urhobo College I&II, Effurun	Warri/SapeleRd, Effurun	50		50	3	39	42
		(iv) Our Lady's H/S I&II, Effurun	Airport Rd, Effurun		281	281	6	49	55
		(v) Ekpan S/S I, Ekpan-Uvwie	Hospital Rd, Ekpan	318	381	699	3	69	72
4	Ukwuani	(i)Ndokwa S/C/S, Obiaruku	Esimike estate obiaruku	72	83	155	5	6	11
		(ii) St. George's G/S Obiarku	Edem Onah Street, Obiaruku	151	195	346			
5	Ika North East	Ika G/S I&II, Owa	Old L/A Rd. Boji-Boji, Owa	550		550	22	19	41
		(ii) Umunede M/S/S, Umunede	Hospital Rd. Ilele Qutr.	104	101	205	15	9	24
		(iii) Ute-Ogbeje G/S, Ute- Ogbeje	Ute-Ogbeje, Umunede Akumazi Rd.	128	116	244	19	2	21
		TOTAL		2383	2042	4425	104	301	405

6	Ika South	(i) Ogbemudein M/S/S, Agbor	Agbor	148	142	290	19	24	43
7	Ethiope East	(i) Baptist H/S, Eku	Eku	127	85	212	14	5	19
		(ii)Abraka G/S,	Abraka	137	90	227	6	18	24

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		Abraka							
		(iii) Oghareki G/S, Oghareki	Oghareki	86	74	160	9	5	14
8	Ethiope `West	(i) Ogini G/S, Ogharefe	Oghareki	180	100	280	4	9	15
		(i) St.Ita's G/G/S, Sapele	Sapele		76	76		9	9
		(i) Agbarho G/S, Agbarho	Agbarho	285	317	602	25	16	41
9	Ughelli South	(i) Otu-Jeremi S/S., Otu- Jeremi	Ughevweghe	200	64	264	12	4	16
		(ii) Ekakpamre G/S, Ekakpamre	Gbaregbolor	133	83	216	10	3	10
1 0	Burutu South	(i) Mein G/S, Kiagbodo	Kiagbodo	156	134	290	6	2	8
		(ii) Burutu G/S,	Burutu	181	198	379	6		6
1 1	Isoko North	(i) St. Joseph, Ozoro	Ozoro	286	144	430	8	9	17
		(ii) Emevor G/G/S.,	Emevor	71	81	152	5	3	8
		(iii) Ileulogbo G/S.,	Owhelogbo	157	134	291	11	2	13
		(iv) Iyede S/C/S., Iyede	Iyede	135	136	271	6	4	10
1 2	Isoko South	(i) St. Michael's College, Oleh	Along Emoro Rd. Oleh	165	145	310	9	12	21
		(ii) Irri G/S, Irri	Omo-Ode Rd. Irri	171	150	321	9	5	14
		(iii) Emore G/S, Oleh	Kefas Rd. Oleh	255	213	468	11	11	22
		(iv) Emede G/S, Emede	Emede/Igbide Rd. Emede	72	64	136	8	3	11

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		(v) Igbide G/S, Igbide	Igbide/Emede Rd. Igbide	89	85	174	9	1	10
	Warri South	(i) Essi College II, Warri	Warri	375	390	765	2	39	41
		(ii) Uwangue SS II, Warri	Warri	319	271	590	9	28	37
		(ii) Yonwuren College II, Ubuwague	Warri	86	104	190	6	24	30
		TOTAL		3814	3354	7018			

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APPENDIX B

FOCUS FOR YOUNG ADULT RESEARCH SERIES (2000)

STANDARD FOR MEASURING THE EVALUATION OF REPRODUCTIVE HEALTH PROGRAMMES AND SERVICES OF ADOLESCENTS SEXUAL BEHAVIOUR (1999-2010).

PROGRAM RESOURCES		1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	Funding from government sources is generally adequate.	4	4	0	0	0	0	0	0	4	4	0	0	16
2	Funding from donor sources is generally adequate.	0	0	0	0	0	0	0	0	4	4	4	0	12
3	Staffing for service provision is generally adequate.	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Enough service points and providers exist for reasonable access by most clients.	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Resources are allocated by explicit priority guidelines.	0	0	0	0	0	0	0	0	0	0	0	0	0

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	PROGRAM COMPONENTS	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	Reproductive health services for single adolescents are offered not only in the usual service delivery points but also elsewhere, such as in schools, youth centers or other places where youth are found.	0	0	0	0	0	0	0	0	0	0	0	0	0
2	STI/AIDS information is an integral part of educational efforts.	0	0	0	0	0	4	4	4	4	4	4	4	28
3	Condoms are easily available to youth through accessible channels.	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Post-abortion counseling is an integral part of the youth program.	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Health staff are trained to counsel youth in sexual and reproductive health matters.	0	0	4	4	0	0	0	4	0	4	4	4	24
6	Community-based distribution systems exist and use youth (male and female) as distributors (if none exist, enter 0)	0	0	0	0	0	0	0	0	0	0	0	0	0

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	EVALUATION AND RESEARCH	1999	2000	2001	2002	20 03	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	A regular system of service statistics exists and functions adequately.	0	0	0	0	0	0	0	4	4	4	0	4	16
2	A system exists to monitor secondary data sources (e.g., surveys, censuses, local studies) for the benefit of policy guidance.	0	0	0	0	0	0	4	4	0	4	0	0	12
3	A system exists to bring evaluation and research results to management's attention.	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Special studies are undertaken to address leading policy issues.	0	0	0	0	0	0	0	0	0	0	0	0	0

	POLITICAL SUPPORT	1999	2000	200 1	2002	20 03	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	High-level national government support exists for effective policies and programs.	0	4	4	0	0	0	4	0	0	0	4	4	20
2	Public opinion supports effective policies and programs.	0	0	0	0	0	0	0	0	0	0	0	0	0
3	Media campaigns are permitted.	0	0	0	0	0	4	4	4	4	4	0	0	20
4	Political parties support effective policies and programs.	0	0	0	0	0	0	0	0	0	0	0	0	0
5	The issue is recognized by top planning bureaus.	4	4	0	0	0	0	0	0	0	0	0	0	8
6	Major religious organizations support effective policies and programs.	0	0	0	0	4	4	0	0	0	4	4	4	20

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	POLICY FORMULATION	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	A favorable national policy exists.	4	4	4	4	4	4	4	4	4	4	4	4	48
2	Formal program goals exist.	4	4	4	0	0	0	0	4	4	4	4	4	32
3	Specific and realistic strategies to meet goals exist.	4	4	0	0	0	0	0	4	0	4	4	4	24
4	Ministries other than Health are involved in policy formulation.	4	4	4	0	0	0	0	0	0	0	4	4	20
5	Policy dialogue and formulation involves NGOs, community leaders and representatives of the private sector and special interest groups.	4	0	0	0	0	0	0	4	4	0	4	4	20
6	Government policy supports family life education and other IEC efforts for youth.	4	4	4	4	4	4	4	4	0	0	0	0	32
	ORGANISATIONAL STRUCTURE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	A national coordinating body exists that engages various ministries to assist with appropriate services	4	4	4	4	4	4	4	4	4	4	4	4	48
2	Ministries other than health are mandated to help with project implementation	4	0	0	0	0	0	0	0	0	0	0	0	4
3	NGOs are formally included in policy formulation and deliberations	4	4	0	0	0	0	0	0	0	0	4	0	12
4	The private sector is formally included in policy deliberations	4	0	0	0	0	0	0	0	0	0	0	0	4
	LEGAL AND REGULATORY ENVIROMENT	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	There is a favourably legal and regulatory climate for ensuring that unmarried adolescents of any age may receive reproductive health services.	4	0	0	0	0	0	0	0	0	0	0	4	8
2	Pregnant adolescents are allowed to continue with education.	0	0	0	0	0	0	0	0	0	0	0	0	0

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3	Providers are free from unnecessary legal and regulatory restriction (e.g. services available to adults are available to adolescents as well)	4	0	0	0	0	0	0	0	0	0	4	4	12
	COUNSELOR COVERED ESSENTIAL POINTS IN ARH SERVICES	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	TOTAL
1	Information on preventing STIs is provided	4	4	4	0	0	0	0	0	0	4	4	4	24
2	Counselor treated adolescents with respect	4	0	0	0	0	0	0	0	0	0	0	4	8
3	Counselor listened to adolescents	4	0	0	0	0	0	0	0	0	0	0	4	8
4	Counselor encouraged adolescents to ask questions	4	0	0	0	0	0	4	4	0	0	0	0	12
5	Counselor used and/or provided IEC material during counseling sessions	0	0	0	0	0	0	0	0	0	0	0	0	0
6	Counselor provided referral information for obtaining services	0	0	0	0	0	0	0	0	0	4	0	4	8
7	Counselor explained relevant medical procedures for further provider performing the medical procedure.	4	0	0	0	0	0	0	0	0	0	0	0	4

EVALUATION OF RHPS ON IN-SCHOOL ADOLESCENTS SEXUAL BEHAVIOUR IN DELTA STATE ANALYSES (1999- 2004)

S/N	RHPS Evaluation analysis	X	Mean	S.D	
1.	Program Resources	8	1.33	1.22	
2.	Programme Components	12	2.00	1.83	
3.	Evaluation & Research	0	0.00	0.00	
4.	Political Support	28	4.67	4.26	
5.	Policy Formulation	72	12.00	10.95	
6.	Organizational Structure	36	6.00	5.48	
7.	Legal & Regulatory Environ	08	1.33	1.22	
8.	Counselor Covered Essential Points in Arh Services	28	4.67	4.26	
Grand Mean		-	4.00	-	

GRAND SD - - 3.66

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EVALUATION OF RHPS ON IN-SCHOOL ADOLESCENTS SEXUAL BEHAVIOUR IN DELTA STATE ANALYSES (2005-2010)

S/N	RHPS Evaluation analysis	X	Mean	S.D	
1.	Program Resources	20	3.33	3.04	
2.	Programe Components	40	6.67	6.09	
3.	Evaluation & Research	20	3.33	3.04	
4.	Political Support	40	6.67	6.09	
5.	Policy Formulation	92	15.33	14.00	
6.	Organisational Structure	28	4.67	4.26	
7.	Legal & Regulatory Environ	12	2.00	1.83	
8.	Counselor Covered Essential Points in Arh Services	36	6.00	5.48	
	Grand Mean	-	4.00	-	
	GRAND SD	-	-	5.50	

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Z*-CALCULATION SHOWING THE INFLUENCE OF REPRODUCTIVE HEALTH PROGRAMMES AND SERVICES OF IN-SCHOOL ADOLESCENTS SEXUAL BEHAVIOUR IN DELTA STATE, NIGERIA (1999-2010).

S/No.	Focus For Your Adult Series	Mean	SD	N	Std Error	Z*-Cal	Z.** Crit.
1.	Programme Type (2005-2010)	6.00	5.50	240	0.43	4.65	1.96
2.	Programme Type (1999-2004)	4.00	3.66	240			

8/28 = 0.28 x 100 = 28%.

It was shown that the process and impact evaluation of the Reproductive Health Programmes and Services of Government in curbing the at-risk sexual behaviour amongst in-school Adolescents in Delta State of Nigeria was found to be 28% effective and 72% not effective. This confirmed the findings of hypothesis seven that the reproductive health knowledge of the in-schools Adolescents used for the study was not significant. Focus on Young Adults (2000) opined ten common elements that cause lack of effectiveness of RHEPS on sexual behaviour of adolescents as follows:

- Inadequate foundation in theoretical approaches that have been shown to be effective in influencing other health-related risks,
- Lack of monitoring and consistence evaluation of ongoing reinforcement of clear messages on risky behaviours.
- Lack of basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
- Inadequate activities that address social pressure on sexual behaviours.
- Poor modeling and practice of communication, negotiation and refusal skills.
- Inadequate varieties of teaching methods, designed to involve the participants and have them personalize information.

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- Inadequate incorporation of behavioural goals, teaching methods and materials that is appropriate to the age, sexual experience and culture of the adolescents.
- Poor duration long enough to complete important activities,
- Teachers and peer educators who do not believe in the programmes and services they are implementing.
- Lack of clear focus on how to reduce one or more sexual behaviors that leads to unintended pregnancy, STIs or HIV infection.

The Federal Government recent efforts in training the Master Trainer's may not be effective in improving the Reproductive Health Programmes and Services offered to Adolescents in Delta state since it is only restricted to Master Trainer's in the Colleges of Education. There is need for the Federal and State Government to intensify their efforts to other tertiary institutions in the State and the Nation at large. However, the Z score as shown in the table above to ascertain the effectiveness of RHPS on in-school adolescent's sexual behaviour revealed that over the years there is a progressive significant positive influence of the RHPS on in-school adolescent's sexual behaviour. Moreover, sexual behaviour is attitudinal and very difficult to curb easily. The researcher also observed that:

1. there was no standard set up of a monitoring system to identify indicators and instruments for tracking programmes and services, data analysis to modify and reports if original programmes is not performing as planned, prepared and submit reports.
2. There was poor assess system development and functioning, including training and supervision of staff to provide early feedback if programmes is responsive to adolescents or if it needs any additions.
3. There was no formal mid-term process evaluation to assess quality of programme performance, determine coverage or whether the programme is reaching its intended audience.
4. There were no analyzed data of end of programme measurement that determine what was done to improve quality of programme implementation to assist in making recommendations for programmes and services replication, modification and expansion.

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APPENDIX C

Guidelines used for managing an outside group to undertake data collection. (Research assistant guidelines):

1. There will be a written contract outlining exactly what is to be done; by whom and how much it will cost
2. Instructions specifying the use of data collection methods and instruments.
3. There will be insert provisions to ensure adequate data quality and procedures to minimize data entry errors
4. Advocate to ensure adherence to the sampling plan
5. Include pilot testing of data collection instruments, with findings communicated to a designated staff person.
6. Insist that a designated staff person approve changes made to procedures or data collection instruments.
7. Maintain final approval of all procedures and data collection instruments before they are used.

Sample Training Schedule for Research Assistant

Day 1 9am -11am – introduction

- Review evaluative purpose/objectives
- Discuss possible problems with data collection
- Discuss sample selection
- Provide overview of data collection instrument
- Review data collection instruments

11am-12am– Provide guidelines for conducting questionnaire/interviews

- Divide into groups role play e.t.c
- Discuss experience of role playing

12noon-1pm Break time and interative sections

1-2pm Practice data collection at selected sites

- Review experiences practicing data collection
- Discuss how to resolve problems encountered during data collection
- Role-play corrected procedures
- Plan travel logistics
- Cover administrative and financial details.
- 2pm-3pm Question and answer time.

(Adopted from Miller (2000) in monitoring and evaluating adolescent reproductive health programmes by Focus on Young adult June 2000 research tool series 5].

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APPENDIX D:
SOME PHOTOGRAPHS OF RESEARCH STUDY AREAS IN DELTA STATE

The Researcher at Ekpan Secondary School, Ekpan

The Researcher at Ekpan Secondary School, Ekpan

The Researcher at Alegbo Secondary School, Effurun

From left Prof. Konnie Constance of Human sexuality USA, Mrs Adenike Esihet of Action Health incorporated, Mr. Damaturu of NCCE and the Researcher at Federal Government Training of Master Traineer of FLHE in March 2011 at Lagos, Nigeria.

The Researcher at Urhobo College Effurun

The Researcher and Research Assistant at Yonwuren College II Ugbuwague

The Principal, Researcher and Research Assistant at Yonwuren College II Ugbuwague

The Researcher, Teacher and Research Assistant at Our Ladies Secondary School

Teachers and Research Assistants at Onicha Ugbo Secondary School

The Research Assistant and Respondent at St. Joseph's College, Ozoro

The Respondents at Emevor Grammar School

The Research Assistants, Teacher and Principal of Egini Grammar School

The Respondents and Research Assistant at Igbide Grammar School

The Researcher in front of Urban health Centre, Obiaruku

The Researcher, and Research Assistant with Nurses at Central Hospital, Warri