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Predictors of Sexual Abstinence Knowledge and Attitude among In-School Adolescents in South-West, Nigeria

By

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Abstract

This study investigated the influence of some demographic variables on the knowledge of and attitude towards sexual abstinence among in-school adolescents in South-West Nigeria.
A descriptive survey research design was adopted for the study. Three hundred respondents comprising of 151 males and 149 females were randomly selected from six secondary schools in south-west Nigeria. Five research instruments were used to measure; sexual abstinence knowledge and attitude scale (0.84 & 0.63); self-esteem scale (0.77) religious orientation measure (0.73); general self-efficacy scale (0.80); sexual abstinence self-efficacy scale (0.79) and parent-adolescent communication scale (0.90). Six research questions. Data were analyzed at 0.05 level of significance using Pearson Product Moment Correlation (PPMC) and Multiple Regression analysis.
The findings revealed that self-efficacy- ($r = .370^{**}$, $p(.000) < .01$); sexual abstinence self-efficacy- ($r = .449^{**}$, $p(.000) < .01$); parent-adolescent communication- ($r = .233^{**}$, $p(.000) < .01$) and religiosity- ($r = .135^{*}$, $p(.020) < .05$) correlated positively and significantly with knowledge of sexual abstinence; Also, self-efficacy, ($r = .360^{**}$, $p(.000) < .01$), sexual abstinence self-efficacy ($r = .411^{**}$, $p(.000) < .01$), parent-adolescent communication ($r = .411^{**}$, $p(.000) < .01$) and religiosity ($r = .158^{**}$, $p(.006) < .05$) showed positive and significant correlation with attitude towards sexual abstinence. Furthermore, all the variables jointly accounted for 34.9% variance in the prediction of sexual abstinence

knowledge; and 43.0% variance in the prediction of attitude towards sexual abstinence.
Based on the findings of this study, programmes promoting sexual abstinence should be organized more in worship centres so as to increase sensitization and awareness.
Keywords: General Self-efficacy, Sexual abstinence, self-efficacy, Self-esteem, Parent-adolescent communication, Religiosity.

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Introduction

Premarital sexual experimentations among youths now appears to be a reality that cannot be ignored with activities such as vaginal, anal and oral sex, hugging, kissing and sexual touching; exhibitionism, pornography among several others becoming common activities in adolescent relationships (Baron &Bryne, 1997 cited in Akindele-Oscar & Ayodele, 2004). Despite religious, cultural and legal sanctions against premarital sexual activities in communities in principle, there is seemingly no change in sexual attitude and behaviour of adolescents in practice. Several studies have also reported that increased premarital sexual activities among adolescents have contributed to the rising incidence of unplanned pregnancies and have unduly exposed many to abortions, sexually transmitted infections (STIs) HIV/AIDS and other risky health conditions (American Medical Association, 1997; Asuzu, 2013).

In the African context, particularly Nigeria, increase in premarital sexual activities among adolescents has been attributed to the eroded cultural values, societal norms and traditions in form of sexual revolution which has encouraged early sexual debut and cohabitation before marriage (Ayodele, 2011). Many have also reported that in the olden days, premarital sex was not a common phenomenon in the society as many youth through the influence of parents and community elders were guided by a sense of sexual purity and piety. However, the contemporary environments (such as poverty, homelessness, living independently in hostels beyond parental watchful eyes, uncontrolled access to innumerable modern technological gadgets and social media, alcohol etc) which

adolescents are exposed to has further provided ample opportunities for sexual experimentations among the adolescents and the antecedent negative consequences (Isiugo-Abanihe & Oyediran 2004). This has led to the promotion of sexual abstinence as the best available option for preventing sexually transmitted infections, including HIV/AIDS and has also become the primary response to reduce adolescent pregnancy, abortion and all other negative consequences of early sexual debut among adolescents and young adults.

Sexual abstinence is the practice of restraining oneself from indulging in vaginal sex for a specific purpose (Thomas, 2000). It also implies "postponing sex", "never had vaginal sex", or "refraining from further intercourse if already experienced (Santelli, Kaiser, Hirsch, Radosh, Simkin, & Middlestadt, 2006). According to Haignere, Gold and McDaniel (1999), there are two categories of sexual abstinence, these are: primary abstinence which refers to refraining from sexual intercourse by those who are virgins and secondary abstinence which refers to refraining from sexual activities after having been sexually active in the past which implies a present decision to abstain from further sexual activities.

Sexual abstinence programs encourage adolescents and youth to abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other STIs. For instance in Uganda, Kenya, and Zimbabwe studies have reported that increase in sexual abstinence is associated with declining HIV acquisition among adolescents and youths (Cheluget et al., 2006; Kamali et al., 2000; Mahomva et al., 2006). According to Kirby (2001) adolescents' knowledge of and attitude towards sexual abstinence are strong antecedent to sexual behaviour and the reasons adolescents remain sexually abstinent are complex and multifaceted.

Over the years, the theory of reasoned action (TRA) (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) has been used to explain attitude towards abstinence. According to this theory, specific behavioural intentions are the determinants of behaviours, and intentions are determined by attitudes and subjective norms

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regarding the behaviour. Thus, for example, adolescents and youths will intend to practice abstinence when they evaluate that behaviour positively and believe significant others think they should practice abstinence. A valuable feature of the TRA is that it directs attention to the basis of people's attitudes and subjective norms. Attitudes toward behaviour are seen as reflecting behavioural beliefs about the consequences of performing the behaviour. Subjective norms are seen as reflecting normative beliefs about whether specific reference persons or groups would approve or disapprove of the behaviour. With respect to early sexual debut among adolescents and youth, perhaps the most widespread behavioural beliefs are that early sexual activities increase the risk of pregnancy and HIV infection. Other key considerations are beliefs about the social consequences of sexual activity, such as the impact on educational or career goals, self-respect, and parental respect if one engages in sexual intercourse. However, most of the time, an adolescent's attitude is determined by the level of information available to him/her and in the context of this study sexual abstinence knowledge involves an understanding of what sexual abstinence is and entails. In order to develop effective comprehensive sexuality interventions for young people in Nigeria, there is need to identify demographic and psychological factors as well as social context which influence the adoption of abstinence.

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Globally, communication is an essential parenting skill which makes possible the function of the family to transmit cultural heritage from generation to generation. It is within the family context that the initial and primary process of socialization as well as sexual socialization takes place. However, in most societies, parents and many family members do not find educating children about sex easy. Since premarital chastity was the norm and sex is traditionally a very private subject rarely discussed with adolescents. Some parents may feel uncomfortable talking with children about sex because they are reluctant to expose their own lack of knowledge of human anatomy, physiology, or other related information.

Parents may worry about how much information to give at what age, based on the belief that the provision of this information will lead adolescents to sexual experimentation. Also, parents in assuming a conscious teaching role or as unintentional conveyors of knowledge and attitudes may not always possess accurate or current information. Thus, they may sometimes unconsciously transmit erroneous "facts" or myths and superstitions, causing potential problems for the adolescent who acts on the basis of the information. Nonetheless, research on parent-adolescent communication has documented that the quantity, frequency and timing of parent-adolescent communication are important factors in sexual outcomes, including knowledge about sexuality, reproductive health, sexual attitudes, sexual behaviours and intentions (Babalola, Tambashe and Vondrasek 2005, Durojaye, 2008; Uwakwe, Amusan-Ikpa, Ofole, Akanbi, Ojukwu and Ejiofor, 2014). According to Lagina, (2002 and Whittaker, (2010) positive parent's adolescent communication helps in establishing individual values and making healthy sexual decisions and when parents communicate their beliefs and values about sexual abstinence it may affect sexual risk-taking. On the other hand, Babalola, Vondrasek and Brown (2001) reported that parental control and the fear of the parents is a key family factor motivating sexual deviance among adolescents.

Although in the past, in many Nigerian societies, attempts at providing sex education for young people are hampered by religious and cultural objections by parents who believe that sexual issues should be limited to married adults, and that information on such issues should be inaccessible to the young ones in order to promote chastity (Adegoke 2003a;2003b). Religiosity defined as one's personal belief in, dedication to, and activity in religion is now viewed as playing a protective and mediating role in sexual risk-taking behaviours. An individual's degree of religiosity can shape various aspects of life. Irrespective of the differences in religious beliefs and orientations among cultures in Nigeria, there seem to be uniformity in the views of all the religious sects on the appropriate sexual attitudes and behaviour (Sholarin, Emerenwa & Onyebuchukwu, 2015). According to McCree, Wingood,

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DiClemente, Davies, and Harrington (2003), adolescents who are religious have higher self-efficacy in communicating with new and steady male partners about sex, STDs, HIV/AIDS and pregnancy prevention, and in refusing an unsafe sexual encounter. These adolescents were also more likely to initiate sex at a later age. However, declining religious activity was associated with larger increases in alcohol use among males and greater frequency of sexual intercourse for females. In addition, Beckwith and Morrow (2005) reported that the impact of religiosity and spirituality is that the more religious a person tends to be, the more likely he or she will also hold conservative attitudes about sex and spirituality is highly correlated with conservative sexual attitudes. Also, Rostosky, Wilcox, Wright and Randall (2004) reported that adolescents who maintain high levels of religiosity are more likely to avoid risky behaviour.

Self-esteem refers to individuals' opinion of their self-worth or their ability to feel positive about themselves or an overall evaluation of one's self-worth or value as a person (Harter, 2003). It has also been identified as one of the factors that have the potential to influence health behaviours such as the decision to abstain from sex or not (DeBruijin, Kremers, van Michelen & Brug, 2005). A key argument has been that low self-esteem places the individual at a high risk for taking part in risky behaviours such as risky sexual activities, including having unprotected sex and not limiting sexual partners This suggests that adolescents with low self-esteem are more likely to be involved in risky behaviours. youth who have low self-esteem compared to those with higher self-esteem may be more likely to engage themselves into sexual risky behaviours such as having multiple sexual partners, sexual initiation at an early age, using condoms inconsistently and/or incorrectly (Boden and Horwood, 2006). Also, Geckil and Dundar (2011) reported an important association between self-esteem and health risk behaviours of adolescents. They found that adolescents who scored low on self-esteem had higher scores for health risk behaviours.

Self-efficacy has been defined as the individual's belief in their capability and capacity to carry out goal directed behaviours within

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an activity context. It is how confident one feels about tackling certain tasks, challenges, and contexts (Hughes, Gaibraith, & White 2011; Goetz, Cronjaeger, Frenzel, Ludtke, & Hall 2010). Perceived self-efficacy, as put forth by Bandura in Chilisa, Tihabano, Vista, Pheko, Losike, Mosime, Mpeta, and Balogun (2013) as the extent to which individuals' belief in their ability to succeed in specific situations has been suggested to be a strong predictor of carrying out a recommended deed for instance abstinence and safer sex practices. In general, it is reported that persons who have confidence in their ability tend to view difficult tasks as meaningful challenges, even while others may deem similar tasks as discouraging. Individuals with a high sense of self -efficacy, put in effort to take on, or not take on risky sexual decisions and persistence to continue striving despite barriers and setback that may undermine their motivations while on the other hand low self-efficacy may result in the individual having low aspirations, not trying harder and even giving up easily (Afolabi & Obuseh, 2013; Tsai, Chuang, Liang, & Tsai 2011) Self-efficacy beliefs are cognitions that determine whether health behaviour change will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and failures (Schwarzer, 2001). It is directly related to health behaviour, but it also affects health behaviours indirectly through its impact on goals hence the way an individual perceives his/her self can influence behavioural choices.

In the context of this study, apart from the general self-efficacy, the domain specific self efficacy which is the perception that one can engage in protective behaviour has been highlighted as a key factor in predicting health-promoting behaviours. One of such behaviours is sexual abstinence self-efficacy, which is the individual's belief in their ability to abstain from sexual activities effectively. Sexual abstinence self-efficacy has been found to be a substantial predictor of practicing sexual abstinence in adolescents.

Moreover, demographic factors such as age, gender and family type could affect sexual behaviour and abstinence decision among adolescents. According to Kabiru and Ezeh, (2007) age is a key determining factor in sexual debut and the likelihood of reporting

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sexual activity increases with increasing age (Whitbeck, Yoder, Hoyt, Conger 1999; Zulu, Dodoo &Ezeh, 2002). However, younger adolescents decision to be abstinent may be driven more by moral beliefs rather than by societal and contextual factors that play an increasingly important role in decision making in adulthood (Izugbara, 2007; Ott, Pfeiffer, Fortenberry 2006). Hence, the association between age and primary abstinence has led to the arguments for programmes promoting abstinence among pre-pubertal girls and boys whose sexual identity is still in the formative stages. However, with increasing age before marriage due to education and desire for economic independence, larger proportions of adolescents are involved in early sexual activities. Also, Idoko, Muyiwa and Agoha (2015) reported that the influence of family dynamics such as the parents-adolescents relationship, family structure - single parents families, monogamous and polygamous families cannot be ignored in the study of adolescent sexual abstinence. The effectiveness of sexual abstinence education requires the joint effort of both parents either in monogamous or polygamous families. Also, Kabiru & Ezeh, (2007) affirms that there are differences in males and females adolescents' attitude to sexual abstinence. Female adolescents are more motivated to abstain due to a desire to avoid pregnancy while for male adolescents it may be the desire to avoid STIs/HIV.

Therefore, this study seeks to examine the predictors of sexual abstinence knowledge and attitude among adolescents in South West Nigeria.

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Objectives of the Study

The main objective of this study was to investigate the predictors of sexual abstinence knowledge and attitude among adolescents in South-West, Nigeria. Specifically, this study:

➢ Examined the pattern of relationship that exists between parent-adolescent communication, general self-efficacy, sexual abstinence self-efficacy, self-esteem, religiosity, age, gender, family

type and sexual abstinence knowledge and attitude among adolescents in south-west, Nigeria.

➢ Investigated the joint contribution of parent-adolescent communication, general self-efficacy, sexual abstinence self-efficacy, self-esteem, religiosity, age, gender, family type and sexual abstinence knowledge and attitude among adolescents in south-west, Nigeria.

➢ Explored the relative contribution of parent-adolescents communication, general self-efficacy, sexual abstinence self-efficacy, self-esteem, religiosity, age, gender, family type on sexual abstinence knowledge and attitude among adolescents in south-west, Nigeria.

Research Questions

The following three research questions were answered and one hypothesis was raised in the study:

1. What is the relationship between the independent variables (parent-adolescent communication, general self-efficacy, sexual abstinence self-efficacy, self-esteem, religiosity, age, gender and family type) and the dependent variable (sexual abstinence knowledge and attitude)?

2. What is the joint contribution of parent-adolescent communication, general self-efficacy, sexual abstinence self-efficacy, self-esteem, religiosity, age, gender and family type on sexual abstinence knowledge and attitude?

3. What is the relative contribution of parent-adolescent communication, general self-efficacy, sexual abstinence self-efficacy, self-esteem, religiosity, age, gender and family type on sexual abstinence knowledge and attitude?

Hypothesis

The Null hypothesis stated that:

1. There will be no significant difference in sexual abstinence knowledge and attitude of male and female in school adolescents.

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Methodology

This study adopted descriptive survey design. The design was used because the researcher did not manipulate any variables of interest that occurred prior to the beginning and the end of this study. This design was also used as it helps the researcher to examine the relationship between variables. The population for this study consists of all in-school adolescents in South-west, Nigeria.

Sample and Sampling Technique

The study adopted a multi-stage random sampling technique. Three states; Oyo, Ekiti and Ondo State were randomly selected as representing South-western states. From each of the states, two local government areas were randomly selected. In Oyo State, Ibadan-North Local government and Akinyele Local Government, Ondo state-Akure-South and Ifedore Local government while in Ekiti State-Ikere and Ado-Ekiti Local government were randomly selected. Moreover, in each of the local government areas, one secondary school was selected to make a total of six secondary schools. Finally, fifty (50) senior secondary school one and two (SS1 and SS2) students were randomly selected from each of the schools as participants in the study.

Measures

The study made use of self report questionnaires which was divided into sections A & B to gather information from the respondents. Section A comprises of the demographic information of the participants such as age, school, gender, type of family, educational qualification and occupation of parents and religious affiliation while section B comprises of the following standardized instruments:

Sexual Abstinence Scale (Asuzu, 2013)

The scale is divided into six (6) sub-scales. In this study, three subscales i.e. Knowledge of sexual abstinence (6 items), attitude towards sexual abstinence (5 items) and sexual abstinence self efficacy (4 items) sub-scales were used. The scale contains items such as "Abstinence is good but it is generally impossible for

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anyone to practice". The response format ranges from Strongly Disagree (SD) = 1 to Strongly Agree (SA) =5. The Reliability Coefficient of the knowledge of sexual abstinence scale was 0.84, attitude towards sexual abstinence 0.63 and sexual abstinence self efficacy was 0.79 respectively.

Self-Esteem Scale (Rosenberg, 1965)

The scale originally scale comprises of ten items and for the purpose of the study, all the items were adapted. The scale consists of items such as "At times, I feel I am no good at all" and "I feel that I have a number of good qualities". The response formats ranged from Strongly Agree (SA) to Strongly Disagree (SD). The reliability established by the internal consistency for the scale was reported as 0.77.

Religious Orientation Scale (Allport & Ross, 1967)

The original scale comprises of twenty (20) items with two sub-scales measuring both intrinsic and extrinsic religious orientations. However, for the purpose of this study,13 items were adapted for use these are for Intrinsic subscale, items- 1, 4, 6 & 12 e.g. "I enjoy reading about my religion" and for Extrinsic subscales, items- 2, 3, 5, 7, 8, 9, 10, 11 & 13 e.g. "It does not matter what I believe, so long as I am good". The response formats ranged from strongly agree (SA) to strongly disagree (SD). This scale reported a Cronbach alpha of 0.73.

Parent-Adolescent Communication Scale (Jaccard, Dittus & Gordon, 2000)

The scale comprise of two subscales. One subscale comprised of 16 items, which is for an adolescent, and the other comprised of 21 items, which is for a parent or caregiver. Only the subscale for the adolescent was used in this study e.g. "I would be embarrassed talking to my parent(s) about sex". The response format ranges from strongly disagree (SD) to strongly agree (SA). The author reported an internal reliability obtained as Cronbach's alpha 0.90 (Jaccard et al., 2000).

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General Self-efficacy Scale (Schwarzer & Jerusalem, 1995)

The scale comprises of ten items for example; "I can usually handle whatever comes my way" and "I can remain calm when facing difficulties because I can rely on my coping abilities". The response format for this scale ranges from Not at all true (1) to Exactly true (4). The overall internal reliability for the scale is 0.80.

Data Analysis

Data were analyzed 0.05 level of significance using Pearson Product Moment Correlation (PPMC) and Multiple Regression analysis as well as frequency counts and simple percentages.

Results

Table 1: Showing the Demographic profiling of the respondents

Gender	Frequency	Percentage
Male	159	53.0
Female	141	47.0
Total	300	100.0
Age	Frequency	Percentage
< 10 years	19	6.3
11-15 years	167	55.7
16-20 years	110	36.7
21 years +	4	1.3
Total	300	100.0
Type of Family	Frequency	Percentage
Monogamous	220	73.3
Polygamous	80	26.7
Total	300	100.0
Religion	Frequency	Percentage
Christianity	225	75.0
Muslim	62	20.7
Others	13	4.3
Total	300	100.0
Father's Educational Qualification	Frequency	Percentage
First School Leaving Certificate	69	23.0

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O' Level	104	34.7
A' Level	127	42.3
Total	300	100.0
Mother's Educational Qualification	Frequency	Percentage
First School Leaving Certificate	82	27.3
O' Level	137	45.7
A' Level	81	27.0
Total	300	100.0

Research Question 1: What is the relationship between the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication, and religiosity) and dependent variable (sexual abstinence knowledge)?

Table 2: Correlation Matrix showing the pattern of relationship among variables.

Variables	1	2	3	4	5	6	7	8	9	Mean	S.D
Knowledge of Sexual Abstinence	1									12.1033	8.9392
Age	-.015 .799	1								14.3300	3.8389
Gender	.101 .079	-.029 .619	1							1.47	.50
Family type	.049 .395	.090 .121	.142* .014	1						1.27	.44
Self-Esteem	.069 .234	-.003 .964	.058 .319	.082 .157	1					27.7200	4.4633
General	.370**	.048 .406	.047 .415	-.070	-.048	1				24.9567	7.953

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Self-Efficacy	.000			.228	.403						6
Sexual Abstinence Self-Efficacy	.449** .000	-.057 .324	.152** .008	.061 .294	-.099 .086	.134* .020	1			12.1200	3.7762
Parent Adolescent Communication	.233** .000	-.044 .448	.096 .098	.013 .829	-.172** .003	.188** .001	.096 .095	1		40.996	12.8385
Religiosity	.135* .020	.005 .932	.138* .017	-.056 .335	.474** .000	-.005 .926	.066 .253	-.188** .001	1	44.0700	8.0586

** Sig. at .01 level, * Sig. at .05 level.

Table 2 showed that there were significant relationships between sexual abstinence knowledge and self-efficacy, (r = .370**, p(.000) <.01); sexual abstinence self-efficacy (r = .449**, p(.000)<.01); parent-adolescent communication (r = .233**, p(.000)<.01) and religiosity (r = .135*, p(.020)<.05) but no relationship was found between sexual abstinence knowledge and age, (r = -.015, p(.799) >.05); gender, (r = .101, p(.079) >.05); family type (r = .049, p(.395)>.05) and self-esteem (r = .069, p(.234) >.05).

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Research Question 2: What is the joint contribution of the independent variables (age, family type, gender, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence knowledge)?

Table 3: ANOVA showing the joint contribution of the independent variables (age, family type, gender, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence knowledge).

R	R Square	Adjusted R Square	Std. Error of the Estimate
.590	.349	.331	.7.3132

ANOVA						
Model	Sum of Squares	DF	Mean Square	F	Sig.	Remark
Regression	8329.170	8	1041.146	19.467	.000	Sig.
Residual	15563.496	291	53.483			
Total	23892.667	299				

Table 3 showed that the joint contribution of the independent variables (age, family type, gender, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence knowledge). The table also showed a coefficient of multiple correlation (R = .590 and a multiple R^2 of .349. This means that 34.9% of the variance was accounted for by the predictor variables when taken together. The significance of the composite contribution was tested at $p<.05$. The table also showed that the analysis of variance (ANOVA) for the regression yielded an F-ratio

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of 19.467 (significant at 0.05 levels). This implies that the joint contribution of the independent variables to the dependent variable was significant and that other variables not included in this model may have accounted for the remaining variance.

Research Question 3: What is the relative contribution of the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence knowledge)?

Table 4: showing the relative contributions of the independent variables to the prediction of sexual abstinence knowledge.

Model	Unstandardized Coefficient		Stand. Coefficient	T	Sig.
	B	Std. Error	Beta Contribution		
(Constant)	-24.683	4.387		-5.627	.000
Age	5.976E-02	.111	.026	.538	.591
Gender	-.258	.879	-.014	-.294	.769
Family Type	.808	.985	.040	.820	.413
Self Esteem	.209	.110	.104	1.896	.059
General Self Efficacy	.329	.055	.293	6.015	.000
Sexual Abstinence Self Efficacy	.941	.116	.397	8.087	.000
Parent-Adolescent communication	.124	.035	.178	3.581	.000
Religiosity	.109	.062	.098`	1.762	.079

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Table 4 the relative contribution of the independent variables to the dependent variable, expressed as beta weights showed that for age (β = .026, p>.05), gender (β = -.014, p>.05), family type (β = .040, p>.05), self-esteem (β = .104, p>.05)no significant relative contribution existed. However, for general self -efficacy (β = .293, p<.05), sexual abstinence self-efficacy (β = .397, p<.05), parent-adolescent communication (β = .178, p<.05) and religiosity (β = .098, p<.05) significant relative contribution was shown.

Hypothesis 1: There is no significant difference in the sexual abstinence knowledge of male and female adolescents in South-West Nigeria.

Table 5: showing the significant difference in the sexual abstinence knowledge of male and female students.

Gender	N	Mean	Std. Dev.	Crit-t	Cal-t.	DF	P
Male	159	11.2505	8.8327	1.96	1.761	298	.079
Female	141	13.0650	8.9920				

Table 5 showed that there was no significant difference in the knowledge of sexual abstinence of male and female students adolescents (Crit-t = 1.96, Cal.t = 1.761, df = 298, p> .05 level of significance). Therefore, the hypothesis is accepted.

Research Question 1b: What is the relationship between the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication, and religiosity) and the dependent variable (sexual abstinence attitude)?

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Table 6: Descriptive statistics and Matrix table showing the pattern of relationship among the variables.

Variables	Attitude towards Sexual Abstinence	Age	Gender	Family type	Self-Esteem	General Self-Efficacy	Sexual Abstinence Self Efficacy	Parent Adolescent Communication	Religiosity	Mean	S.D
Attitude towards Sexual. Abstinence	1									13.4884	7.2937
Age	-.100	1								14.3300	3.8389
	.084										
Gender	.085	-.029	1							1.47	.50
	.140	.619									
Family	.037	.090	.142*	1						1.27	.44
Type	.521	.121	.014								
Self Esteem	-.101	-.003	.058	.082	1					27.7200	4.4633
	.082	.964	.319	.157							
General Self-Efficacy	.360**	.048	.047	-.070	-.048	1				24.9567	7.9536
	.000	.406	.415	.228	.403						
Sexual Abstinence Self Efficacy	.411**	-.057	.152**	.061	-.099	.134*	1			12.1200	3.7762
	.000	.324	.008	.294	.086	.020					
Parent Adolescent Communication	.411**	-.044	.096	.013	-.172**	.188**	.096	1		40.996	12.8385
	.000	.448	.098	.829	.003	.001	.095				
Religiosity	.158**	.005	.138*	-.056	.474**	-.005	.066	-.188**	1	44.0700	8.0586
	.006	.932	.017	.335	.000	.926	.253	.001			

** Sig. at .01 level, * Sig. at .05 level.

Table 6 above showed that there were significant relationships between self-efficacy, (r = .360**, p(.000) <.01); sexual abstinence self-efficacy (r = .411**, p(.000) <.01); parent-adolescent communication, (r = .411**, p(.000) <.01) and religiosity (r = .158**, p(.006) <.05) and sexual abstinence attitude. However, no significant relationship was found between age, (r = -.100, p(.084) >.05); gender, (r = .085, p(.140) >.05); family Type (r = .037, p(.521) >.05) and self-esteem (r = -.101, p(.082) >.05) and sexual abstinence attitude.

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Research Question 2b: What is the joint contribution of the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence attitude)?

Table 7: ANOVA showing the joint contribution of the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence attitude).

R	R Square	Adjusted R Square	Std. Error of the Estimate
.655	.430	.414	5.5836

A N O V A						
Model	Sum of Squares	DF	Mean Square	F	Sig.	Remark
Regression	6833.770	8	854.22	27.399	.000	Sig.
Residual	9072.413	291	1			
Total	15906.182	299	31.177			

Table 7 showed that the joint contribution of the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on sexual abstinence attitude. The table further showed a coefficient of multiple correlation R = .655 and a multiple R^2 of .430. This means that 43.0% of the variance was accounted for by the predictor variables when taken together. The significance of the composite contribution was tested at $p<.05$.

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The table also showed that the analysis of variance (ANOVA) for the regression yielded an F-ratio of 27.399 (significant at 0.05 level). This implies that the joint contribution of the independent variables to the dependent variable was significant and that other variables not included in this model may have accounted for the remaining variance.

Research Question 3b: What is the relative contribution of the independent variables (age, gender, family type, self-esteem, general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity) on the dependent variable (sexual abstinence attitude)?

Table 8: Relative contribution of the independent variables to the prediction of sexual abstinence attitude

Model	Unstandardized Coefficient		Stand. Coefficient	T	Sig.
	B	Std. Error	Beta Contribution		
(Constant)	-11.894	3.349		-3.551	.000
Age	-.121	.085	-.064	-1.428	.154
Gender	-.756	.671	-.052	-1.127	.261
Family Type	1.161	.752	.071	1.544	.124
Self Esteem	-.214	.084	-.131	-2.539	.012
General Self Efficacy	.228	.042	.249	5.454	.000
Sexual Abstinence Self Efficacy	.601	.089	.311	6.762	.000
Parent-Adolescent communication	.208	.026	.366	7.859	.000
Religiosity	.254	.047	.281	5.392	.000

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Table 8 revealed the relative contribution of the independent variables to the dependent variable, expressed as beta weights. There is no significant relative contribution of: age (β = -.064, p>.05); gender (β = -.052, p>.05); family type (β = .071, p>.05); self-esteem (β = -.131, p<.05). However for general self-efficacy (β = .249, p<.05); sexual abstinence self-efficacy (β = .311, p<.05); parent-adolescent communication (β = .366, p<.05), and religiosity (β = .2818, p<.05) significant relative contribution was shown.

Hypothesis 1b: There is no significant difference in the sexual abstinence attitude of male and female students.

Table 9: showing the significant difference in the sexual abstinence attitude of male and female students.

Gender	N	Mean	Std. Dev.	Crit-t	Cal-t.	DF	P
Male	159	12.9033	7.3311	1.96	1.478	298	.140
Female	141	14.1482	7.2204				

Table 4.9 showed that there was no significant difference in the attitude to sexual abstinence of male and female students adolescents (Crit-t = 1.96, Cal.t = 1.478, df = 298, p> .05 level of significance). The hypothesis is therefore accepted.

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Discussion

This outcome of this study showed that general self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity had positive relationship with sexual abstinence knowledge and attitude towards sexual abstinence among adolescents. This implies that self-efficacy, sexual abstinence self-efficacy, parent-adolescent communication and religiosity are important and had relationship with sexual abstinence knowledge

and attitude towards sexual abstinence. This corroborates the findings of Supametaporn (2006) who revealed that adolescents who reported high sexual abstinence self-efficacy were more likely to refrain from engaging in sexual activities. Furthermore, it also indicates that self-efficacy is a significant predictor of sexual abstinence knowledge and attitude which echoes the findings of Buhi, (2006); Childs, (2007); Rasberry and Goodson (2007), Tsai et al., (2011) and Chilisa *et al.*, (2013) and provided support for the usefulness of self-efficacy in intention towards practicing sexual abstinence. It is reported that persons who have confidence in their ability tend to view difficult tasks as meaningful challenges, even while others may deem similar tasks as discouraging. A lack of self-efficacy therefore may result in the individual having low aspirations, not trying harder and even giving up easily By implication, the more an adolescent believe in his or her ability to set the goal to abstain from sexual activity the more his or ability to put the knowledge into action and follow through with avoiding premarital sexual behaviour as an adolescent. With regards to parent-adolescent communication, this study agrees with Tetelman, Ratcliffe & Cederbaum, (2008) and Wokocha, (2016) who found that parent-adolescent communication has influence on sexual abstinence of adolescents and the attitude of adolescent towards sexual activities. This means that when there is good and effective parents-adolescents communication, parents are able to promote knowledge of sexual abstinence and hence children develop positive attitude towards sexual abstinence thus promoting healthy sexual behaviour. Also, the family and especially parents have a great influence in guiding adolescent decision through effective communication of values and norms and sexual decisions.

Furthermore, with respect to religion, this study reported that religious beliefs and participation in religious activities help to promote knowledge of and attitude towards sexual abstinence. This corroborates the findings of Aji, Ifeadike, Emelumade, Ubajaka, Nwabueze, Ebenebe and Azuike (2013) who revealed that religion plays an important role in individual's sexuality as its principles, regulations and practices affect everyday interaction. Many [illegible] studies posited that morals, values and

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religious beliefs significantly influence the decision to abstain from sex. It further suggests that the knowledge of sexual abstinence and having positive attitude towards sexual abstinence would have been influenced by religious beliefs. This also implies that teaching of religious values could be a useful tool for inculcating the values of sexual intercourse within the confines of marriage.

On the other hand, findings that self-esteem does not have a significant relationship with sexual abstinence knowledge and attitude among adolescents contradicts the findings of Davies, DiClemente, Wingood, Harrington, Crosby, & Sionean (2003) that adolescents with low self-esteem are more likely to start sex at an early age and have unprotected sex so as to conform to their peers while adolescents with high self-esteem can also start sex early owing to the fact that they can handle whatsoever that happen after. This implies that having either low self-esteem or high self-esteem does not determine whether an adolescent will abstain from sex or not. It further revealed that contrary to the submission of many scholars that self-esteem can influence sexual abstinence, it can be deduced from the findings of this study that self-worth does not determine sexual abstinence among adolescents. It however, remains unclear whether high self-esteem is a good predictor of safe sex behaviours.

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Conclusion

The findings clearly show that several factors ranging from demographic, psychological and social are responsible for knowledge and attitude towards sexual abstinence among adolescents. Since sexuality education is a lifelong process of acquiring information on sex and forming attitudes, values and beliefs, there must be a continuous provision of information for the teeming population of adolescents to drive appropriate knowledge of sexual abstinence and develop positive attitude towards sexual abstinence.

Recommendations

Based on the findings of this study, the following recommendations were made:

Parents should educate and communicate effectively with their adolescents on sexual abstinence they should also pay close attention to the sexual activities of their children and incorporate moral discussion between them from time to time. Adolescents should be encouraged to uphold their commitment and decision to be either a primary abstainer or secondary abstainer as the case may be.

Religious leaders should ensure that purity and chastity is preached in their places of worship. Moreover, programmes bothering on sexual abstinence should be organized since many families encouraged their adolescents to be involved in religious activities in different places of worship. Benefits of sexual abstinence and risk of early sexual initiation should be further emphasized in sex education programmes in secondary schools so as to enable the adolescents form good attitude and belief to sexual abstinence and that knowledge can inform behaviour change.

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Limitations

This study has several limitations. First, the study utilized cross-sectional data; therefore, causality cannot be inferred. The true effect of knowledge on attitude in a study on sexual abstinence can better be determined through a longitudinal study design. Also, due to the sensitive nature of the information sought, participants may have provided socially-desirable responses despite measures taken during data collection to ensure privacy and confidentiality of the information shared by respondents.

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