Developing Country Studies
ISSN 2224-607X (Paper) ISSN 2225-0565 (Online)
Vol.7, No.9, 2017

Knowledge and Effect of Sex Education on Adolescent Sexual and Reproductive Health in Oyo State, Nigeria

Taiwo, Patricia A[1] Bamidele Bolaji R[1] Agbana Richard D.[2]
1.Department of Sociology, Faculty of the Social Sciences, University of Ibadan
2.Department of Community Medicine, Faculty of Basic Medical Services, Afe Babalola University

Abstract
Adolescence is an important aspect of human development and so is their sexual health. Several studies have focused on prevalence of sexual practices and pregnancies among this unique group, very few have however, focused on the knowledge and effect of sex education on their sexual health especially in Oyo state. Social Action theory and health belief model were utilized as framework for explanation. A survey was carried out on 400 secondary school adolescent students in Ibadan North Local Government Area selected through multi-stage sampling procedure. A structured questionnaire was used to collect information on content of sex education received, knowledge and effect of sex education on adolescents' sexual and reproductive health. Ten in-depth interviews were conducted with parents of the adolescents. Quantitative Data was analyzed using inferential statistics while the qualitative data were content analyzed. Findings revealed that adolescents were aware of pubertal changes with more females having higher knowledge of their sexuality than their male counterparts. But when asked other questions, adolescents showed incomplete knowledge on sexuality. About 42% got informed from their schools, 17% from their homes, 15% from friends and 20% from the internet. Adolescents reported that teachers and parents/guardians had taught them on the need to practice abstinence during interactions on sexual issues. Sex education taught at home was reported to be more emotional and moral-laden. Hence large proportions (over 60%) reported they had not initiated sexual activities although not because of sex education received. There is need to establish more programs that target both knowledge and behavioral change for adolescents' sexual health, while increased parent-adolescence communication on sexual issues should be encouraged for more positive impact.
Keywords: adolescent sexual health, sex education, abstinence, reproductive health

1. Introduction

Adolescent sexual health and behaviour have attracted and aroused scholarly concerns both at the national and global spheres. Evidences from various local and national surveys have shown that young people in Nigeria face challenges of early sexual initiation, early marriages, single parenthood and unsafe sexual practices with the consequences of increasing rate of unwanted pregnancies, unsafe abortions, and sexually transmitted infections (STIs), including HIV and AIDS, (National strategic framework on the health and development of adolescents and young people in Nigeria 2007-2011). Studies have reported that this is usually caused by factors such as adolescents vulnerability to sexual risk because of their exploratory and adventurous tendencies (Glasie 2006), culture of silence and low comfort level among older family members to engage in sexuality discourses with adolescents (Nwokocha 2011, Nwokocha and Taiwo, 2012), misinformation about the risk of pregnancy or STIs posed by unprotected sex. (Adedimeji, Omololu, Odutolu, 2007), misinformation from peers and unmonitored internet sources National association of schools psychologist (NASP 2003), and most importantly, the lack of access to accurate and comprehensive information regarding sexual health (Wellings K et al 2006)

Inadequate sexual orientation of adolescents have also led to problems such as interrupted schooling, falling prey to criminal activity, abortion, ostracism, child neglect, school adjustment difficulties for their children, adoption, lack of social security, poverty, repeated pregnancy and negative effects on domestic life. (Bonell, Allen, Strange, Copas, Oakley, Stephenson & Johnson 2004). The World Health Organization (2002) estimated that more than 33% of the disease burden and 70% of premature deaths among adults are caused by behavioral patterns such as smoking, violence, and risky sexual behavior developed in adolescence. Obviously, most men and women become sexually active during adolescence (Glasie 2006). Furthermore, reproductive health problems for both sexes are compounded by the societal norms, gender imbalances as well as patriarchy (Marston and King 2006) and the double standard for sexual behaviour in the society, where restraint is expected of girls and excesses are tolerated for boys, (Wellings 2006). Consequently, boys are seen to experience sexual liberty, while girls in a world of silence about their reproductive right and health, are exposed to more sexual risks than the male counterparts. Following this is the result of 23 percent of girls aged 15-19years (17 percent of which have had a child and 5 percent of which are pregnant with their first child), having begun childbearing (NDHS 2013) and about 60% unsafe abortions annually credited to female adolescents in Nigeria (CAUP 2006) .

These and other reasons make accurate and comprehensive information regarding sex education an important aspect of adolescents' life. Although several studies and intervention programmes have suggested and

worked on sex education being introduced to adolescents via the secondary schools, very few studies have evaluated the effects of such programmes on their sexual and reproductive health. Usually, the assumption is that in-schools adolescents are more 'knowledgeable' than other groups of adolescents (Nwokocha and Taiwo, 2012). The paper therefore aims at examining the knowledge, content and the effect of sex education on the reproductive and sexual health of in-school adolescents, as well as examining parents knowledge and contribution to adolescents sexual and reproductive health in Oyo state, Nigeria.

Sex education involves a comprehensive course of action, calculated to bring about the sexually desirable attitudes, practices and personal conduct on the part of the children and adults that will best protect the individual as a human and the family as a social institution, (Kearney 2008). Rubin and Kindendall (2007) expressed that sex education is not merely a unit in reproduction and teaching how babies are conceived and born it has a far richer scope and goal of helping the youngster incorporate sex most meaningfully into his present and future life to provide him/her with some basic understanding on virtually every aspect of sex before the time he reaches full maturity. Literature abounds on adolescents' sexuality as it has been a sensitive aspect of the life of the youth. In a research conducted in Turkey, it was observed that 82.3% of the students were aware of the changes in their own bodies, and 69.2% of them had knowledge about the place and the functions of their reproductive organs. Findings also established that 55.2% of the students had knowledge about puberty prior to the phase, and most girls (78.2%) acquired this knowledge through their mothers, whereas the boys (25.4%) acquired theirs from the media. Also, there existed a significant difference ($p < 0.00$) in the experience of pubertal symptoms between boys and girls. Such difference included the level of disturbance caused by puberty symptoms, the individuals informed about the symptoms, the feelings and the style of dress in puberty, and situations such as being happy or unhappy about the symptoms differ according to the sex of the student. It was also observed that the perception of puberty symptoms was different for boys and girls (Saadet et al 2011). Contrary to these however, a cross sectional study was conducted on awareness of pubertal changes in secondary school children of Bagalkot, Karnataka. Out of 502 students, of which 394 (78.49%) were boys and 108 (21.51%) were girls, only 19.8% of the boys and 9.25% of the girls had correct knowledge regarding secondary sex characters. Nearly third-quarter (74.1%) of the girls did not have prior knowledge about menstruation and 66.7% of the girls used unhygienic pads during menstruation. Only a quarter of the boys and girls had correct knowledge about Sexually Transmitted Diseases. About 58.6% of the boys and 60.1% of the girls had either correct or some knowledge about HIV transmission. 52.3% of the boys and 46.3% of the girls had either correct or some knowledge regarding the prevention of HIV/AIDS. (Dorle, Hiremath, Mannapur and Ghattargi, 2010)

In the field of adolescent sexual health, two views have been identified they are the abstinence-only and the comprehensive sex education. Abstinence sex education on the one hand, teaches abstinence as the best way to stay sexually safe and frowns at sex before marriage. Comprehensive Sex education on the other hand, provides young people with the tools to make informed decisions and build healthy sexual relationships. It stresses the value of abstinence while also preparing young people for when they become sexually active. It further provides medically accurate information about the health benefits and side effects of all contraceptives, including condoms, as a means to prevent pregnancy and reduce the risk of contracting STIs, including HIV/AIDS; encourage family communication about sexuality between parent and child; teach young people the skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances; and teaches young people how alcohol and drug use can affect responsible decision making (source: SIECUS fact sheet 2009). Proponents of abstinence-only education argued that sex before marriage is inappropriate or immoral and that abstinence is the only method which is 100 percent effective in preventing pregnancy and STIs. Many of such groups emphasized that condoms are not fool-proof in preventing pregnancy or STIs, In addition, many scholars who advocate on practicing abstinence only, are deeply concerned that information about sex, contraception and HIV can encourage early sexual activity among young people (Chris, Priya & Todd (2002). Studies further disclosed that it is comprehensive sexual education and not abstinence-only that will delay first sexual activity (Dicenso, Guyatt, William, et al 2002; Wanc, Cormich, Kosmin, 2003, Alford, Cheetham, Hauser, 2005) Abstinence-only sexual education was criticized of lacking strong evidence of effectiveness because of faulty designs (Kirby 2002; Underhill, 2007). In one exhaustive study, the World Health Organization reviewed 47 sexuality education programs in both developed and developing countries in another study, the U.S. National Campaign to Prevent Teen Pregnancy reviewed over 250 programs in the United States and Canada. Both found that, in almost all programs, sexuality education did not lead to either the initiation of sexual activity or an increase in the frequency of sex among youth (Katz and Finger, 2002). Inyang and Inyang, (2013) in their article on "Nigerian secondary school perspective on abstinence-only sex education as an effective tool for promotion of sexual health in Niger delta secondary school students", discovered that 80% of the respondents could not define sex education and the general perspective on abstinence only sexual education was negative. According to Inyang and Inyang (2013), abstinence only sex education can work with a timely and early introduction in the lives of the adolescence before the child gets into the age bracket (13-21 years) where they might have been exposed to different views about sex. Outside this, more knowledge on sexuality is

expected by the adolescents. Sex education can also be received through agencies like schools, peer groups and the home but most parents are reluctant about giving adolescents comprehensive sex education and a good number of adolescents have misconstrued certain issues on their sexuality because parents are generally also shy and embarrassed to talk about such (Afifi 2008). Most parents have argued that they were not taught anything of such and also culturally and according to the traditions, sex is not what children should know about. Durojaiye (2005) observed that in most African homes, parents are not fully equipped to answer questions on sexual matters usefully. Even those who try to educate them, pass on faulty information to their children. The whole subject thus becomes surrounded by secrecy and the children now become too embarrassed to discuss these matters with their parent. But the inclusion of sex education into school curriculum has not only reduced the risk, but also met with its own challenge; the teachers. In 2002, the Federal Ministry of Education approved the teaching of sexuality and life planning education in the secondary schools. Some teachers and school administrators find sexuality education personally objectionable or lack sufficient understanding of the subject and thus are reluctant or refuse to go along with such programs (Smith, Kippax, and Aggleton, 2000). In a study conducted by Oshi, Nakalema and Oshi (2005) in South Eastern Nigeria on sex education and HIV/AIDs, the findings revealed that teachers are not passing on this knowledge because of cultural and social inhibitions. In addition, teachers have not been receiving adequate training and motivation on information, education and communication for HIV/AIDs sex education. Recently, it has been discovered that although sex education on abstinence only has been able to reduce STIs, unwanted pregnancies and the rest, nevertheless it has not been able to stop adolescents from engaging in sexual activities which has to do with behavior, which the social action and the health belief model in this study tries to explain.

2. Theoretical discourse

2.1. Social Action Theory

Social action theory was developed by the German sociologist Max Weber (1864-1920). To him, an action is said to be social when an individual attaches meaning to an action which takes account of the behavior of others and its thereby oriented to its course, and how do meanings come into being, they come by interpretation of actions, subjective interpretation of actions. The understanding of actions is based on the subjective interpretation an individual can procure from the actions. relating the postulate of the social action theory to the subject matter of the study; adolescent, adolescents take actions based on the interpretation they can give to the act as it is oriented towards another even as social actions are borne out of the thought process this proffers explanation to the argument of scholars as regards abstinence-only and the comprehensive sex education, just as Kirby (2007) observed that abstinence only sex education, which includes teachings of no-sex until marriage yields little or no result, according to this explanation adolescent behavior is not affected by externalities, neither by rules, nor religious doctrines nor the warnings embedded in abstinence programs rather adolescents actions are borne from their interpretation of the meaning attached to the action, also several scholars have found out that adolescents reproductive health has more to do with behavior rather than the influence of a religion or any of the institutions, Bearinger said It is evident that neither the abstinence-only nor the ABC (abstinence, be faithful, use condoms) focus of the last few years has brought about the desired outcomes for adolescent sexual and reproductive health. Given that no single educational or communication program appears to lead to lasting behavior change, a stronger focus on behavior is crucial. hence what was missing in abstinence only program was that explanation of adolescents action begins with observing and interpreting the subjective inner state of the adolescent, by subjective inner state, Weber referred to the capacity of the actors to act on their interpretation, understanding, meaning and judgment and to exercise rational choice in the society (Morrison 2008:351), adolescents actions can therefore be explained, Weber distinguished between two levels of understanding, the **Aktuelles verstehen**; which is also called the "direct understanding" which means the obvious actions. For example seeing a pregnant girl, or a teenager breastfeeding a baby. For Weber this is not a sufficient level of understanding to explain social action.

The second level of understanding is the **Erklarendes verstehen**, also called the "explanatory understanding" which refers to understanding of the meaning of the act in terms of the motives that gave rise to it. Motives are the underlying rationale why an action is carried out, motives are reasons/meanings which seems to the actor an adequate ground for the action in question (Emaikele 2010:96). For instance the reasons why the girl indulged or got involved in sexual activity could range from early marriage, money, unemployment, peer pressure, curiosity, rape, pornography, watching of sex tape, ignorance, prostitution and others. And so the causal explanation of the adolescent action can be established, an essential feature of a cause is that it precedes the effect; but the cause of an action is not exactly its intended outcome but the mental experience and anticipated consequences before carrying out the action (Mennelll 1978:24) the motives of adolescents are guarded by their mental experience, a lot of information are being passed on to their brains as their bodies undergo biological and hormonal changes and there is heightened curiosity as explained by Kirby (2007).

Furthermore, most adolescents sometime out of curiosity and adventurous tendencies usually fill their

minds with pornography, from the media, nude pictures in magazines; engage in sex texting, erotic films and videos. One of the most influential ways through which adolescents get this informations is the internet, since its getting cheaper daily to access pornographic sites, movies, and there are a lot more portable platforms like their cell phones, android phones, and MP 3 devices. These make them get exposed more often to sexual desires and urges each time they come in contact with the pornos coupled with their pubertal consequences. Thus, adolescents can be exposed to sex early enough and therefore attracted to the immediate consequence of their act which is pleasure, and instant gratification of their libido. These are what trigger the adolescent behavior and in like manner, their motive is built around the values of the adolescents either personal or societal values. Weber stated that the society is the product of human action which is usually connected to the values and valued end. Most of the time, these values are easily learnt from sub-groups or peers and family relatives. Although adolescents are under supervision of the society, family, educational systems nevertheless they make can decided to make decisions and take some actions which they may consider rational depending on the interpretative means they attach to it and the approval from their peers and role models

2.2 Health Belief Model

Developed in the early 1950s by social psychologists Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegeles, and Howard Leventhal at the U.S. Public Health Service. The Health belief Model (HBM) suggests that people's beliefs about health problems, perceived benefits as well as barriers to action and self-efficacy explain engagement (or lack of engagement) in health behavior. A stimulus, or cue to action, must also be present in order to trigger the health action. HBM is based on six key concepts Perceived Susceptibility, Perceived Severity, Perceived Benefits, Perceived Barriers, Cues to Action and Self-Efficacy

- Perceived Susceptibility: refers to subjective assessment of risk of developing a health problem. Adolescents who have had sex with two or more partners are highly susceptible to STIs, HIV/AIDS, pregnancies, abortion, single parenthood and the likes. The health belief model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviors to reduce their risk of developing the health problem. Adolescents with low perceived susceptibility may deny that they are at risk of experiencing these. Others may acknowledge the possibility that they could develop STDs, but believe it is unlikely. Adolescents who believe they are at low risk of developing STDs are more likely to engage in unhealthy, or risky, behaviors. Adolescents who perceive a high risk that they will be personally affected by a particular health problem are more likely to engage in behaviors to decrease their risk of developing the condition
- Perceived Severity: Perceived severity refers to subjective assessment of the seriousness of a health problem and its potential consequences. The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles.
- Perceived Barriers: These refer to an individual's assessment of the obstacles to behavior change. An adolescents' assessment of the factors that will influence, facilitate or discourage adoption of the promoted behavior. In other words, the perceived benefits must outweigh the perceived barriers in order for behavior change to occur. Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a sexual activity) and discomfort (e.g., shame, pain, emotional effect) involved in engaging in the behavior. For instance, lack of access to affordable health care and the perception that abortion will cause significant pain and probably damage the womb may act as barriers to abort a baby.
- Modifying Variables: The health belief model suggests that modifying variables affect health-related behaviors indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers
- Self-Efficacy: Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behavior Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviors. An individual's ability to do something people generally do not try to do something new unless they think they can do it, if someone believes a new behavior is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier) chances are that it would not be tried.

3. METHODS

The study is descriptive and cross-sectional in design and included the use of both qualitative and quantitative method of data collection. The study was conducted in Ibadan North Local Government Area (LGA) due to the increased report of adolescent involvement in pre-marital sex and teenage pregnancies in the area. Adolescents were selected from three selected secondary schools from the LGA. A structured questionnaire was

administered to 400 adolescents selected through multi-stage sampling. The selection of the three schools from the local government through purposive sampling because of adolescents who can participate in the study at the first stage, the selection of the Senior secondary (SSS1, SSS2, SSS3) classes using stratified sampling techniques at the second stage and the selection of 400 adolescent using simple random sampling (ballot system) at the final stage. Furthermore, 10 in-depth interviews were conducted with parents. The statistical package for social sciences (SPSS) was used to input and analyze the quantitative data after they had been cleaned, while content analysis was used for the qualitative data.

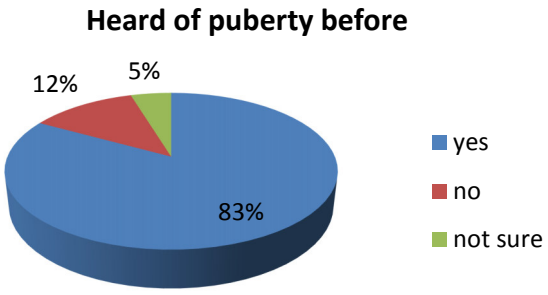
4. RESULTS

Socio-demographically, about 199 females and 184 males participated in the study. Majority of the respondent fell between the ages of 15-20 years (63.7%), with the mean age of 17.2 years. Also, about 35.0% were within age 10-14yrs while 1.8% are within the ages of 20-24years. Of course this age variation is perhaps so because of the category of respondents involved in the study (adolescent students).

4.1. Adolescents' awareness about sexuality

As defined by Rubin and Kinderdall 2007, sex education is not just about reproduction and teachings about how babies are formed but has a more richer scope, this scope includes their awareness about their sexual identity, sexuality and sexual health which then reveals their level of knowledge about sex education. The pie chart and the table 1 below affirms the level of knowledge of the adolescents, the chart shows that majority (83.0%) of the respondents were aware of the meaning of puberty and (5.0%) were not sure of whether they heard about puberty before or not. However, about (12.0%) of the respondents have not heard of the word which shows that adolescents are familiar with pubertal changes.

Awareness of puberty



As illustrated in table 1 below, 51.0 percent of the adolescents understand sex education as stage of maturity, 14. 0 percent understands its difference in boys and girls, 18.0 percent as when hair growing in private part while 17.0 percent understand it as when girls menstruate. About 67.0 percent of the girls know what menstruation is but 23.5 percent didn't know what it means, while 9.0 percent were not sure. Furthermore, 46.5 percent of the male adolescents know the meaning of wet dreams, (42.3%) did not, while (11.2%) were not sure. This reveals that the ladies are more informed than the men about their sexuality.

Table 1: Adolescents awareness about their sexuality.

Statements	Frequency	Percentage
Views about what puberty entails		
it is a stage of maturity	194	51.0
differences between boys and girls	54	14.1
growing hair in the private part	70	18.3
when girls menstruate	65	17.0
Had knowledge about menstruation before the experience	257	67.1
Did not have knowledge about menstruation before the experience	90	23.5
Not sure if I had knowledge about menstruation before the experience	36	9.4
Knew about wet dreams before the experience	178	46.5
Did not know about wet dreams before the experience	162	42.3
Not sure if I knew about wet dreams before the experience	43	11.2
Ever heard of methods to prevent pregnancy	218	56.9
Never heard of methods to prevent pregnancy	86	22.5
Not sure if I heard of methods to prevent pregnancy	79	20.6
Methods known		
Condoms	109	28.5
Abstinence	70	18.3
Pills	54	14.1
Local methods	42	11.0
Spermicidal	68	17.8
More than one method	40	10.4

This level of knowledge according to the commencement of menarche and spermache shows that female are more knowledgeable than males this can be due to the fact that pubertal changes in the female attracts more attention than that of the male, most female stand the chances of getting to know more about their body at the commencement of the menstrual cycle than the male adolescents.

Also from the response of a female parent

> *"that is compulsory for a female child, especially when she starts seeing her menstruation the first time she sees her menses, I tell her to be careful with the way she plays around with boys, there's a level to which she can play with men and that when she is menstruating she must not have sex with a man so that she will not be pregnant"*
> (IDI/female/42years/female child/18years/UI)

This is in agreement with (Saadet et al 2011) and Nair Parvathy, Grover Vijay L, and Kannan AT study on the Awareness and practices of menstruation and pubertal changes amongst unmarried female adolescents in a rural area of East Delhi in which Two-thirds of the study subjects had knowledge of menstruation. Also, about (56.9%) of the respondents had heard of various methods used to prevent pregnancy with about (28.5%) of them mentioning condoms, (18.3%) mentioned abstinence, (14.1%) percent were aware of pills, 11 percent mentioned local methods, 10.4 percent mentioning spermicide while 17.8 percent mention more than one methods. and 20.6 percent were not sure. However, 22.5 percent had not heard of various methods used to prevent pregnancy. The result implies that the adolescents have knowledge on their sexuality which shows that they are sexually oriented but do not have a broad understanding of the subject. This is also revealed in the percentage of adolescents who know other methods of contraceptives aside from condoms and their response to what puberty means. Table 2 shows that about (73.9%) have received a form of sex education while (26.1%) have not received any form of sex education it also reveals where adolescents got their sex education from and it revealed that (17%) received their sex education at home, (42%) in school, (14.6%) from friends, (20.9%) on the internet while the remaining (5.5%) received their own from others source such as religious gatherings, siblings, newspapers, magazines and so on. This result reveals that majority of the respondents received their sex education in the school.

Table 2 Sources of sex education

Statements	Frequency	Percentage
received any form of information about sex	283	73.9
did not receive information about sex	100	26.1
Place		
Home	65	17.0
School	161	42.0
Friends	56	14.6
Internet	80	20.9
Others	21	5.5

From the data received from the respondents; it can be deduced that most adolescent heard about sex education from the school, School-based sexuality and reproductive health education is one of the most important and widespread ways to help young people improve their reproductive health the educational institution serves as a last resort for parent who cannot dissipate sex education to their children at home, During the interview conducted some parents explained why sex education received at home was low, a respondent said

> *"They (adolescents) are even lucky, during our own time our parent didn't teach us anything because we were living in the farm so there was no opportunity for us to learn such. That time was better than our time our parents didn't teach us such, when we were much younger then our nakedness doesn't have meaning to us"*

This implies that majority of the respondents parents were aware of important of sex education for their children in spite of the fact that some of them failed to do it at home because of their they weren't trained that way and are not ready to teach them either giving reasons that it meant encouraging sex before marriage for them, this corroborate Afifi's findings that most parents have argued that they were not taught anything of such and also culturally and according to the traditions, sex is not what children should know (Afifi 2008) While a couple of them believe it is the responsibility of the mother, a male IDI respondent said;

> *"The mother should take care of that, the mother is closer to the children than I am, I leave home 6am and return 7pm but if they come back from school around 2 o clock they will be with their mother till tomorrow, if a girl starts menstruating it is the mother that will know, she'll not tell me." The mother is responsible for training the child, in terms of the moral teachings, academics, religion it is a woman's work, my responsibility is to support the home financially, and at times be strict with the child to create parental fear into the child"*

Interestingly, some IDI female respondents also believed that sex education is solely the work of the mother, a respondent said:

> *"Every responsibility is on the mother, the father's most time, do not have time, but there are some fathers that are even better than the mothers, in such areas but mainly it's the duty of the mother"*

From the study and the response of the parent it was observed that most parent do not really understand what sex education means, Some parent who said they teach them explained what they taught a male respondent said;

> *"I can say sex education is an explanation given to a child about sex and intercourse with a man and a woman, there is a time that is right for a child to begin to go into such, so that the child will not perish, I teach them by citing examples of four to five of those it happened to and whose life has been destroyed"*

Again this shows one of the reasons mentioned by Durojaiye that most parents do not have adequate understanding of the concept of sex education, (Durojaiye 2005) observed that in most African homes, parents are not fully equipped to answer questions on sexual matters usefully. Even those who try to educate them pass on faulty information to their children and obviously from their response what they pass across to adolescents is abstinence sex education not a comprehensive education. But as a means of shying away from such responsibility support them being taught in school, having only the use of contraceptive as their challenge a respondent said

> *"I support them being taught in school, it's okay it's just in the aspect of telling them about condoms and the likes I do not want them to be taught at all at that stage, although some of them are grown-ups but they have not reached the stage to be taught such, to me, I don't think its proper because if you that it means you are encouraging sex before marriage for the*

children."

Another respondent contributed to this discourse by appreciating the fact that sex education is being taught and discussed in schools by saying:

> *"I like the fact that they are been taught in school about it because children are different, some at the age of 12 they have started sleeping with girls while some at the age of 18 are still virgins, personally I was 23 years old before I got to know about sex, its good for them to begin to know about sex now,*

The above statements made by the parents show their low level of comforts in discussing sex education with the adolescents as discovered by Nwokocha 2011. The table 3 affirms the content of sex education received by the respondents, the respondent about (68.7%) have had information on dating and relationship and only (19.4%) had not been taught about dating and relationships, also it reveals that (73.4%)of the adolescents were taught to stay away from sex until marriage, also about (43.6%) have never had been taught about contraceptives, (17.8%) were rarely taught, (18.8%) were sometimes taught, (9.7%) were often taught, while (10.2%) were always taught about contraceptives this shows that a larger proportion of adolescents were not taught about contraceptives and birth control.

Table 3
The content of sex education received (N=383)

Statement	**Frequency**	**Percentage**
Received information on dating and relationships	263	68.7
Did not receive information on sexual relationships	120	31.3
Taught to stay away from opposite sex	281	73.4
Was not taught to stay away from opposite sex	102	26.6
Received information on contraceptives and birth controls		
Never		
Rarely	167	43.6
Sometimes	68	17.8
Often	72	18.8
Always	37	9.7
	39	10.2
School teaches about contraceptives	137	35.8
School does not teach about contraceptives	246	64.2

This shows that the respondent had an abstinence sex education, not a comprehensive education and as observed by the SIECUS fact sheet abstinence education denies adolescents the tools to make informed decisions and build healthy relationships; stress the value of abstinence while also preparing young people for when they become sexually active; provide medically accurate information about the health benefits and side effects of all contraceptives, including condoms, as a means to prevent pregnancy and reduce the risk of contracting STIs, including HIV/AIDS; encourage family communication about sexuality between parent and child; skills to make responsible decisions about sexuality, including how to avoid unwanted verbal, physical, and sexual advances (source: SIECUS fact sheet 2009) also by teaching them to stay away from opposite sex hinder the positive relationship that could have ensued amongst them. The response of the adolescents also shows both the educational institutions; the schools and family; parents teach abstinence sex education. Some teachers and school administrators find sexuality education personally objectionable or lack sufficient understanding of the subject and thus are reluctant or refuse to go along with such programs as discovered by Smith, Kippax, and Aggleton, 2000.

The social action theory stipulates that adolescents' behavior are given by the interpretation an adolescent can give to their actions as a oriented towards others, and the actions are backed up by motives guided by their mental experience and the values learnt from either the larger society or their sub groups; the school thus serve as a mini society which serves as a source and a trigger for behaviors seen in the adolescents. Table 4 examines the effect of the abstinence education adolescents have received on their sexual and reproductive health.

From the table 4 below (64.5%) of the respondents were sexually active while (35.5%) have not had sexual intercourse, (79.8%) have never contracted any sexually transmitted diseases while only (10%) had contracted some which were given to be HIV/AIDS and Gonorrhea a larger proportion of the females have never been pregnant. A total of 61 per cent of the adolescents responded that they benefited from the sex education programme they have received while about 33.5 percent were not satisfied with it and 14per cent were undecided, the figures above and shows a positive impact of sex education on adolescents sexual and reproductive health affirming that it is a positive means of reducing adolescents sexual risk and reducing early sexual initiation amongst adolescents, reducing teenage pregnancy and sexually reproductive diseases this contributes to studies that the World Health Organization have reviewed 47 sexuality education programs in both developed and

developing countries in another study, the U.S. National Campaign to Prevent Teen Pregnancy reviewed over 250 programs in the United States and Canada. Both found that, in almost all programs, sexuality education did not lead to either the initiation of sexual activity or an increase in the frequency of sex among youth (Katz and Finger, 2002).

Table 4

The effect of sex education on adolescents' sexual and reproductive health (N=383)

Statements	Frequency	Percentage
Sexually active	136	35.5
Not sexually active	247	64.5
Ever contracted any sexually transmitted infections	39	10.2
Never contracted any sexually transmitted Infections	344	79.8
Learnt a lot from the sex education received		
Strongly disagree	47	12.3
Disagree	43	11.2
Undecided	55	14.4
Agree	135	35.2
Strongly agree	103	26.9
Use contraceptive if and when I want to have sex		
Strongly disagree	95	24.8
Disagree	54	14.1
Undecided	141	36.8
Agree	56	14.6
Strongly agree	37	9.7

But interestingly, when asked about their decisions in taking contraceptives later on when and if they would have sex, 24.8 percent of the respondents strongly disagreed that they will use contraceptives if and when they want to have sex again while 9.7 percent strongly agreed and 36.8 percent were undecided. About 14.1 percent disagreed while 14.6 percent agreed with statement. This show that although they are informed about the changes in their bodies and the effect of early sexual initiation they lack the ability to make informed decisions and are have imbalanced and medically inaccurate information about the health benefits of all contraceptives. this shows that abstinence only can yield positive result such as reducing the rate of teenage pregnancy and sexually transmitted infections but cannot change adolescents behavior. This is in line with the findings of Underhill et al 2007, he found out that Abstinence-only sexual education does not positively affect the sexual behaviour of adolescents, lacks the message of sexually transmitted infections to its recipients and the positive effect in a few cases does not last for a long time (Underhill et al; Trenholm C, Devaney B, fortson K et al, 2007) and also According to Inyang (2003) abstinence only sex education can work with a timely and early introduction in the lives of the adolescence before the child gets into the age bracket (13-21 years) where they might have been exposed to different views about sex. From the age13 upwards, more knowledge on sexuality is expected by the adolescents, much more in a rapidly changing society with more exposure to informations This evidently shows that adolescents' sexual health or other aspects of their sexuality are not affected by the sex education they have received, this shows that abstinence only can yield positive result such as reducing the rate of teenage pregnancy and sexually transmitted infections but cannot change adolescents behavior.

The findings in this section confirms Max Weber's social action theory which states that The understanding of actions is based on the subjective interpretation an individual can procure from the actions just as Kirby 2007 observed that abstinence only sex education, which includes teachings of no-sex until marriage yields little or no result , according to this explanation adolescent behavior is not affected by externalities, neither by rules, nor religious doctrines nor the warnings embedded in abstinence programs rather adolescents actions are borne from their interpretation of the meaning attached to the action.

Table 5:

Association between sex education and adolescent sexual and reproductive health

		contracted any form of sexually transmitted infections		**Total**
		Yes	No	
received any form of information about sex	**Yes**	29	178	207
	No	9	60	69
Total		38	238	276

Source: field survey, 2015 X = 0.840, df=1, P>0.05

From the chi square result, it shows that sex education has a positive effect on adolescents sexual and reproductive health.

Conclusion

Sex education remains a very crucial ingredient for ensuring behavioural changes and improving the sexual and reproductive health of adolescents all over the world particularly in Nigeria. Furthermore conscious gender balance is however needed in inculcating the necessary discipline and sense of responsibility on both the males and female gender. This is particularly so because the result of the study revealed a huge concentration of efforts towards sex educating the female sex than their male counterparts as more females were observed to be more knowledgeable about their sexuality than the males. This is perhaps so because the consequences of sexual intercourse has more effect on the females than the males. However, when there is a consistent wide gap in the sex education of both sexes, this form of imbalance in the knowledge and behavioural disposition of the parties towards sexual practices will continue to reoccur. Furthermore, strategies of sex educating the adolescent child has been observed to be more moral-laden with less role and impact being felt from the parent to the adolescent child especially the male-child. While this is not unconnected with the patriarchal nature of the Nigerian society and less effect of sexual practices on the males, the culture of silence about sexual discourse has repeatedly being a factor. Again the approach to sex educating a child at the school may be somewhat different from that from the home front. Thus, while these differences require further studies, a reflection on the need to bridge this gap in sex education, become apparent in order to achieve the desired result on adolescent sexual and reproductive health.

Recommendations

- Following the findings from the study, the following recommendations were made:
- There should be a continuity of the content and approach of the sex education that is taught by the teachers and at home by the parents or guardian of adolescent in order to avoid distortion of information and lack of impact. It also necessary to create awareness for both school instructors as well as parents and guardians on the need for comprehensive sex education
- Programs that targeted at both knowledge and behaviorial changes in the sexual activities of adolescents should be organized. Such programs need to go beyond HIV and abstinence only to enrich adolescents' knowledge by including tools and skills like refusal skills, decision making skills, while also stressing the importance of abstinence and the risk of contracting STIs.
- This study was carried out among in-school adolescents, however many of the adolescents at greatest risk such out of school adolescents are eluded by school-based programs because they are not in school Therefore, it is important that both in-school and out-of-school adolescents be reached out to. Also a well-designed impact evaluation is needed to provide evidence about the quality and content of interventions regarding the sexual and reproductive health of adolescents
- Also Parents (both fathers and mothers) need to create an enabling environment that fosters parent-child communication on sexual issues. Parents need to know that citing examples of victims and scolding has long been ineffective because adolescents know more than that and are now more knowledgeable, objective and assertive. There is therefore need for improvement on parent-child communication and the need to examine concordance between what parents believe they are saying to their adolescents and what messages and information adolescents are receiving from these interactions.

Acknowledgement:

The study proposal was initiated for the requirement of the award of a Bachelor of Science degree by the Department of Sociology, University of Ibadan. We acknowledge the contribution of the panel where the study findings was defended and critiqued for better output. The first aspect of this paper was presented at the 20th Nigerian Sociological and Anthropological Practitioners Association (NASA) annual conference in 2016. Again we appreciate the useful comments and suggestions from participants in the conference that have improved the article further.

REFERENCES

Adedimeji A., Omololu F. and Odutolu, A.(2002) "HIV risk perception and constraints to protective Adolescent Health 38: 83–87 *Secondary Schools: Findings from Selected Asia-Pacific* adolescents: systematic review of randomised controlled trials. *BMJ.* 2002; 324(7351):

Bonell C., Allen E., Strange V., Copas A., Oakley, A., Stephenson J., & Johnson A. (2004). The effect of dislike of school on risk of teenage pregnancy: testing of hypotheses using longitudinal data from a randomized trial of sex education. Journal of Epidemiology and Community Health. 59(2), 223 – 230.

Chris ,C., Priya A. J.D., & Todd S 2002 Abstinence Only vs. Comprehensive Sex Education, Arguments for Abstinence-Only Sex Education;12-15

Dicenso A, Guyatt G, Willan A, *et al.*: Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials. *BMJ.* 2002; 324(7351): 1426–1435. PubMed Abstract |

Publisher Full Text | Free Full Text
Dorle A, Hiremath I, Mannapur B and Ghattargi, C. (2010), "Awareness regarding puberty changes in secondary school children of Bagalkot, Karnataka"- A cross sectional study" 2010, October ;4(5) :3016 – 3019
Durojaiye D. (2005) "Importance of impacting sex education on adolescent among selected secondary school in Odeda local government, Abeokuta. Journal.unaab.edu.ng/ugproject/2010bsc shondeo
Dyer S, The value of children in African countries—insights from studies on infertility, *Journal* effect of dislike of school on risk of teenage pregnancy: testing of hypotheses using
Glasier A et al., Sexual and reproductive health: a matter of life and death, *Lancet*, 2006, 368(9547):1595–1607.
Inyang MP and Inyang OP. (2013) Nigerian secondary school adolescents' perspective on abstinence only sexual education as an effective tool for promotion of sexual health
Kirby D 2002. "Do abstinence-only programs delay the initiation of sex among young people and reduce teen pregnancy? The National Campaign for the Prevention of Teen Pregnancy Reference Source
National association of school psychologists NASP 2003 October ;4(5) :3016 – 3019 *of Adolescent Medicine and Health*, 2008, 20(3):275–282
Nwokocha, E. E. (2011). 'Adolescents' socio-economic and cultural vulnerability to HIV/AIDS and other STIs-Research needs and Priorities'. In F.E Okonofua (ed), *identifying priorities for research and documentation on adolescent sexual and reproductive health in Nigeria.* Benin city: VAC Communications
Nwokocha E. E and Taiwo P.A (2012) "Sexuality Education Among Neglected Adolescents: The Case of Out-of- School Female House- Helps" In International Journal of Sociology of the Family. Vol 38, No. 2. Pgs 185-202
Oshinakaleoma 2005 cultural and social aspect of HV/AIDS national centre for biotechnology information perspective.*The Lancet* 2006, 368:1706-28. *Population and Nutrition*, 2007, 25(2):146–157. Princeton reduce teen pregnancy? The National Campaign for the Prevention of Teen Pregnancy
Saadet, Y., Gulumser, D., Yildiz, O., and Fatma, Y., (2011) "The Level of Knowledge and Behaviour of Aadolescent Male and Female Students in Turkey on the Matter of Reproductive Health" In Journal of Sexuality and Disability Vol. 29, No. 3 pp 217-227
SIECUS report of public support of sexuality education (2007) "SIECUS report online at the way back machine Teen and Unplanned Pregnancy
Smith, G., S. Kippax, and P. Aggleton. (2000). "*HIV and Sexual Health Education in Primary and Secondary Schools* 1426–1435. PubMed Abstract | Publisher Full Text | Free Full Text2002. Reference Source 368(9547):1595–1607.
Wellings K, Collumbien M, Slaymaker E, *et al*. (2006): Sexual behaviour in context: a global perspective. *The Lancet* , 368:1706-28.
WHO, Department of Child and Adolescent Health and Development, "What about boys? A WHO/FCH/CAH/00.7, 2000
World Bank. 2002b. *Education and HIV/AIDS. A Window of Hope.*
Underhill K, Operario D, Montgomery P (2007): "Reporting deficiencies in trials of abstinence-only programmes for HIV prevention." *AIDS.* ; 21(2): 266–268. PubMed Abstract | Publisher Full Text
WHO, UNAIDS, UNFPA, UNODC, (2004.) "YouthNet. Protecting young people from HIV and AIDS: the role of health services". Geneva: World Health Organization,
Marston C, and King E (2016) "Factors that shape young people's sexual behaviour: a systematic review". *The Lancet*, 368:1581-600.
Kearney C.A (2008) Helping school refusing children and their parents: a guide for school-based professionals: Oxford University Press
Nair Parvathy, Grover Vijay L, Kannan AT, "Awareness and practices of menstruation and pubertal changes amongst unmarried female adolescents in a rural area of East Delhi", Indian J of Community Med, 2007;32:156-7