PATTERN OF RISK-TAKING BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS IN IBADAN NORTH LOCAL GOVERNMENT AREA OF OYO STATE, NIGERIA

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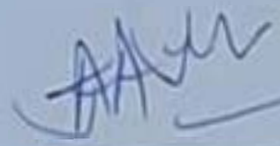
CERTIFICATION

I certify that this project was carried out by Omole Grace Toyin in the department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Nigeria under my supervision.



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DEDICATION

This work is dedicated to the Fountain of Knowledge who granted the Grace to acquire knowledge.

And

To all kids out there, you are worth it!

ABSTRACT

Adolescents and other young persons (AYP) are important because of their sheer size. In Nigeria, twenty-one million persons representing 25% of the population are adolescents. Although adolescents are generally a healthy segment of the society, threats to their health often stem from their practice of risky behaviours. Many of the previous studies on adolescents in Nigeria focused on single risky behaviour, rather than multiple risky behaviours, which usually combine to undermine the health of adolescents. The objective of this study was to document the prevalence of multiple risky behaviour among secondary students in Ibadan North Local Government Area, Oyo State, Nigeria.

This descriptive study was conducted among students in four secondary schools randomly selected by balloting in the LGA. In each selected school, two arms – one for the Senior Secondary School One (SSS1) and another for the Senior Secondary School Two (SSSII) were selected by balloting for the Interview. All the students found in each selected arm participated in the study. Four Focus Group Discussions

(FGDS) were conducted among the students, while four in-depth interviews were conducted with the counselors of the schools. A pretested questionnaire was used to document socio-demographic information, alcohol and the use of other drugs, unsafe sexual behaviour, and drunk driving among 609 students.

FGD findings showed that the students consider smoking, alcohol consumption and abortion among others as constituting risky behaviour. The finding of the (IDI) revealed that smoking and truancy were perceived as the risky behaviours. The questionnaire sample consisted of slightly more males 316 (51.9%) than females 293 (48.1%). The mean age was 15.7years, (SD± 2.1). A total of 223(36.6%) consisting of 126(56.5%) males and 97(43.5%) females had ever taken alcohol. Forty-five (7.4%) subjects had ever smoked cigarettes. Of these, thirty-three (73.3%) were current smokers. The other drugs abused were glue 23(3.8%), cocaine 19(3.1%), cannabis 23(3.8%) and heroin 14(2.3%). Out of the 188(30.9%) students that had had sex, 73(38.8%) did not use condom during the last sexual encounter. Seventy-two (10.2%) respondents had driven a

motorcycle while drunk. A lolal of 74 respondenls (12.2%) used aicohol and had sex wilhoul condom. Fifteen (2.5%) respondents engaged in three risk behaviours (alcohol use, sex wilhoul condom and cigarelle smoking), while nine (1.5%) engaged in all risk behaviours examined. More male 42 (13.3%) lhan females 17 (5.8%) particlpaled in multiple risks; and more SS2 studenls 33(10.9%) lhan SS1 26(8.6%). More studenls between 14 - 17 years appeared to have parlicipated in risky praclices (87.3%) lhan younger (9.7%) and older adolescenls (4.8%) (P=0.0000).

In conclusion, many adolescents in this study had parlicipaled in nsky behaviours, which can undermine lheir heallh. Peer education and training of leachers are effective ways to help the students reduce involvement in risky praclices.

Keywords: Student-adolescent, nsky-behaviour, counseling, secondary school, Ibadan.

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CHAPTER ONE

INTRODUCTION

Adolescents as defined by World Health Organization (WHO) are young people between the ages of 10 and 19years (WHO, 1994). The penod of adolescence mark a transition from childhood to adulthood. Adolescents are no longer children, but not yet adults. This is the time when extensive changes occur in physiological and biochemical systems and behaviour. However, environmental and social influences have altered and drastically changed the period of adolescence. Adolescents constitute a huge chunk of the world population, making up one billion, one sixth of the world's total population according to Allan Gullmacher Institute (AGI, 1998). In Nigeria, there is absence of reliable statistics about the size and composition of adolescents. This has given rise to estimations and projections about the population of the adolescents. Accurate figures may be lacking until Nigeria arrives at acceptable and official census figure. The 1990 Nigeria Demographic and Health Survey (NDHS) report tries to determine the number of adolescents, to do this, the NDHS divides the adolescents between ages 10-14, 15-19 and 20-24

They give the percentage of the adolescents between 10-14 as 13.6%, ages 15-19 as 8.4% and 20-24 as 6.7%. This brings the total number to 28.7%. According to this projection, by 1996 they will be over 29 million and by 2016, it is estimated that adolescents will be over 62 million (Omololu, 1997). Another group, Advocates for the Youth, gave the percentage of adolescents in the population to be 25% (Advocates For The Youths, 1995). Among this huge number, 20% were in secondary school (Ngozi, 1992).

In the last two centuries, biological changes in humans have lowered the age of menarche and onset of puberty. Before the industrial age, such changes commenced by the age of 16 but nowadays, it is 12.5 years (Hamburg and Takanishi, 1989). Generally, adolescents tend to mature reproductively (age 10-15) faster than they do socially. This invariably means adolescents can and do make many important decisions that have lifetime consequences, even though they are immature emotionally, cognitively and mentally. As a result of the inequality in the development, adolescents find themselves in state of vulnerability (Hamburg and Takanishi, 1989). Early adolescence period triggers a chain of psychological, emotional, physical and social changes in the child. These ere times of stress, innovation and youthful

experimentation. The child finds himself/herself possessing adult physical attributes and capabilities without being emotionally prepared on how to deal with challenges that come with the growth. This brings the adolescent to a period of self-reappraisal about his/her relationship with the family and community. The adolescent starts a period of experimentation that is developmentally appropriate to his/her age but most of the time such experimentation carries high risks.

The physical changes in adolescent triggers sense of self-centeredness and also initiate the adolescent struggle for independence. This independence is sometimes reflected in tendency to take risks, questioning of established social attitude and norms. This independence also entails gradual separation from the close, childlike identification and dependence on his or her family. This takes the form of testing alternative views, behaviours and tastes. The adolescent increasingly identifies with behaviours, which are different from the adolescent's family values (Parry-Jones, 1994) During this early adolescence, young persons begin to make decisions that affect them throughout life. Many of the problems of adolescents appear during the early years between 10-14 years (Eccles, Midgley, Wigfield, Buschanan, Redman, Flanagan and Iver, 1993) Researchers have

further shown that the risky behaviours embarked upon at early adolescence tend to persist into later life. For instance, experimentation with alcohol and other psychoactive substances does not necessarily commit the young adolescent to a life course of this behaviour, but it alters the probabilities of continuance in this behaviour (Hamburg and Takanishi, 1989). This is also a period that marked the beginning of downward spiral for some adolescents in terms of academic performance, loss of confidence and performance and increased family conflicts on issues related to controls and autonomy (Buchanan, Eccles and Berker, 1992; Simmons and Blyth, 1987).

By the middle adolescence (15-19 years), there is full physical maturation with the sexual energy being at its peak especially for boys. There is therefore increase in high risk taking as a means of outlet of their boundless energy. This stage also marks the beginning of intense involvement in peer sub-culture, conformity with the ideals of this group and sexual experimentation. All these tendencies have both positive and negative outcomes. Some of these negative outcomes and potential life threatening behaviour may be sexually transmitted diseases, accidents related to substance use, unwanted pregnancy, school dropout and fallout in family relationships. Long-term effects

include cardiovascular diseases in adult life, heavy smoking and chronic alcoholism, liver diseases, lung cancer and even death. All these consequences tend to narrow considerably the potentials to have healthy life options and thereby increasing the number of cases of preventable mortality and morbidity (Neinstein, 1996).

By late adolescence, the adolescent has fully settled down to the trend of behaviour he/she is most likely going to engage in throughout the lifetime. At this stage, if such an adolescent had problems in early and middle adolescence, it will only worsen in form of depression, suicidal tendencies and emotional disorders (Neinstein, Juliani and Shapiro, 1998). Throughout the stages of adolescence, there is persistence of identity and personality problems. Most adolescents engage in several risky behaviours and the prevalence of those that participate in them increases with age. According to United States of America, Youth Risk Behaviour Survey (YRBS) (1995), 80.4% of adolescents had engaged in one form of risky behaviour or the other.

Statement of the problem

Interest in the reproductive health of adolescents and young persons continues to grow throughout the world. In Nigeria, for example, several researches have been conducted to explore the nature of risky sexual behaviours among adolescents including students and out-of-school youth. (Amazigo, Silva, Kaufman and Obikeze,1998; Ajuwon, 2000; Fawole, 2002). Despite increasing knowledge of risky sexual behaviour among adolescent population, some gaps remain. Two gaps in knowledge prompted the conduct of this study. First, the bulk of previous studies have focused only on one risky behaviour such as sexual behaviours (Adegbenro, 1995; Oladepo and Brieger, 2000), and cigerette smoking (Ntoampe,1992). Few studies have explored the range of risky behaviours that young persons practice. It is important to explore the range of risky behaviours in young persons because many of these behaviours are inter-related. The understanding of these relationships will help in developing appropriate interventions to address them.

Secondly, none of the existing studies that seek to understand risky behaviours of adolescents have explored the perception of the adolescents of what they believe constitute risky behaviour. Yet, an

exploration of their perception of the risky behaviours deepens understanding of the problem and how best to address them. Thus, this study contributes to existing knowledge of risky behaviours among adolescents in Ibadan Nigeria.

Research questions

1. What behaviours do adolescents perceive to be risky?
2. To what extent do adolescents engage in these behaviours?
3. What are the factors influencing these behaviours
4. What are the gender differences among adolescents who engage in these behaviours?
5. What are the implications of these findings for implementation of interventions?

Objectives of the study

General Objective

The general objective of the study is to document the prevalence of risk-taking behaviours among secondary school students in Ibadan North Local Government.

Specific Objectives

1. To identify behaviours that adolescents perceive as risky.
2. To document the extent to which secondary school adolescents adopt multiple risk-taking.
3. To examine reasons why secondary school adolescents engage in risk-taking behaviours.
4. To document the extent to which family background influence risk taking.
5. To examine the gender differences that exist among risk takers.
6. To document attitudinal dispositions of students to risk-taking.
7. To recommend strategies for reducing tendencies to engage in multiple risks by the adolescents.

Operational definitions

Adolescents: Adolescents are young people between the ages of 10-19 years. (WHO, 1994). This is a period when the adolescents experience growth spurt that make them acquire adult capacity to reproduce. It is also a period when the young persons acquire a sense of identity, and this is shown by gradual disengagement from the family and increasing identification with the peers. For the purpose of this

study, students that are older than this age group but are still in the classes under survey will also be studied as part of adolescents.

Youths: These are young people between the ages of 15-24 years. The period of youth extends between the middle of adolescence to young adults.

Risk: This is the possibility of suffering loss. A condition associated with a higher likelihood of negative or undesirable outcomes. Risk is an important aspect of growing up among adolescents especially with the intention of assuming adult roles.

Risk-behaviours: They are specific activities that cause health problems. Risk behaviours can also be actions taken as a result of turbulence experienced by the perpetrator. Such behaviours often have adverse effect on health. (Kelbe et al, 1993).

Secondary education: This is a form of education received after primary education. Secondary education prepares the student for higher institution or functions of junior cadre in ministries, companies and establishments.

Risk taking behaviours understudy

Based on literature review, the following behaviours were identified as risk behaviours common in adolescents.

1. Use of alcohol and drugs
2. Cigarette smoking
3. Drunk driving
4. Unsafe sex/ sex without condom
5. Multiple sexual partners
6. Violence and perpetration of sexual coercion on others.
7. Early sexual initiation

CHAPTER TWO

LITERATURE REVIEW

In this chapter, the period of onset of adolescence, characteristics of adolescents will be discussed. In this chapter also, adolescent interaction with the environment will be discussed as well as specific risks that the adolescents take. Multiple risks taken and the prevalence of multiple risks will be discussed as well as theoretical frameworks to explain adolescent's risk-taking behaviour.

The onset of adolescence

Adolescence is a period when extensive changes occur both physiologically and biologically among the children that have attained puberty. The period of onset of adolescence have drastically changed over the centuries. The period is now shorter with the adolescents' average at menarche being 12.5 years (Harmburg and Takanishi, 1988). There is enormous diversity in the physical maturation of adolescents in this second decade of life. At the onset of adolescence, the boys and girls are physically immature, at the end of the decade, they are both physically and sexually mature with many already married, pregnant or having their own children. Apart from this, many

already develop lifelong habits, some of which are harmful to their health. It is also at this period that the individual capacity for abstract and critical thought develops along with increased sense of self-awareness and emotional independence. Some theories have been postulated to explain the period of adolescence.

The psychoanalytic theory: According to Coleman (1980), adolescence start from upshots of instincts that occur as a result of puberty. The adolescents experience individual awakening sexuality, which leads him/her to the process of disengagement from the family and his/her tendency to look for love objects outside the home; thus severing his emotional ties with the parents. The resultant feelings of loss are soon satiated by peers outside the family framework. At this stage, the adolescent idolizes role models such as stars. It is a stage of non-conformity and rebellion, a maladaptive behaviour stemming from the inadequacy of the psychological defences to cope with inner conflicts. This results in "mood swings" and inconsistency in behaviour (Blos, 1946).

Focal theory: According to Coleman (1980), previous theories are theories of abnormality. The adolescent needs a theory of normality. To him, the focal theory considers adolescence period not only as

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period of difficulty, but also that of stability. This theory recognizes the ability for the adolescent to be able to cope with the pressure inherent in adolescent process.

Lifespan developmental psychology: This approach was popularized by Brooks-Gunn, Petersen and Eichorn, (1985) who believe that the adolescent interacts with environment and thereby affects his/her development. Adolescence is a stimulus, eliciting reactions from environment. The adolescent is a processor, making sense from the behaviour of others.

Social and health problems of adolescents

Hormonal changes causes the adolescents to experience growth spurts and physical, emotional and social changes. This makes the adolescent to have problems coping with his physical changes. This can result in identity crises, inability to behave in a socially acceptable manner. The fact that adolescent period fall within the transition period from childhood to adulthood often put the youngsters in a dilemma of how to meet the society expectations. While they are sometimes chided for being forward, they are at other times rebuked

for being childish. These changes also increase their potential for anxiety and resolve to prove their worth (Ikwuako, 1997).

Social problems such as broken homes, absentee head of household as well as busy parents tend to act negatively on the adolescent to take unnecessary risks that consequently affect their health.

Another social problem encountered by the adolescent stems from the rapidly evolving environment with explosion in communication and entertainment. This exposes the adolescents to pressures, harmful choices in drugs, alcohol and increasing sexual risks. Coupled with this problem is lack of adequate information and health services that cater exclusively for the adolescents (WHO, 1994).

Characteristics of adolescence

The characteristics of adolescence are diverse consisting of both positive and negative expressions starting with the positive ones:

The positive characteristics include the following:

- Ability to form abiding same-sex friendship among peers.
- Going into personal relationship in vocational sphere (WHO, 1986)

- Creativity pulls and idealism.
- Assumption of single parental responsibility especially in areas of single parent or widowed conditions (WHO, 1998)
- Guilt and anxiety sharing
- Feeling of empathy for human, animal mate and inanimate objects which can be displayed by fierce devotion
- Peer loyalty and devotion

The negative characteristics include:

- Substance use and abuse for feeling of euphoria, sedation, relaxation and cool feeling (Primm, 1990).
- Seeking escape from laid down rules and regulations
- Willful disobedience of parental rule to assert independence (Hoffman, 1996)
- Sexual experimentation as a result of curiosity and inquisitiveness (Marchan-Hamann, 2002)
- Negative ways of dissipating excess energy such as fighting and dangerous driving.

- Using appetite depressants to reduce weight especially smoking by the females (Baltimore Sun, 1997)

Adolescents and culture

The culture and society that the adolescents find themselves have a tremendous impact on their behaviour. Cultural practices and cultural permissiveness affect the adolescents both negatively and positively. In both first decades of the 20th century in the United States, the family is very important and divorce rate is low. In such times, most problems encountered by educators among adolescent includes chewing gum, getting out of line. Today, it is estimated that 60 percent of adolescents spend part of their childhoods with a single parent who is often not there (Kean, 1989). Sexual permissiveness is also the bane in the society especially pre-marital sex (Adeyemo and Brieger, 1995; Youssef and Fee, 1993) premium placed on virginity before marriages in many cultures is being undermined by urbanization, rural-urban migration and loss of cultural values.

Apart from this, some cultural practices put the adolescents especially females at high risk of harmful cultural practices. Such practices include female genital mutilation (FGM), preference of male

child, importance placed on having children resulting in childhood marriages and early childbearing. Social and religious values often permit married men to have multiple sexual partners while wives are expected to be absolutely faithful to their husbands (Ankrah, 1991; King, 1990 and Lloyd and Montgomery, 1996).

The adolescent and the environment

External factors have a tremendous impact on the decisions that the adolescent takes, how he/she behaves. Values are often placed on friends and peers as sources of information, which is often inaccurate, misleading or false. Other influential groups include the family members, mass media, community institutions and legal system.

The role of the media in shaping adolescent behaviours cannot be over-emphasized. Media is the main source of reproductive health information outside the schools. This has being predominantly radio and television. In Asian societies, studies have revealed that T.V is the third major influence on the adolescents after parents and peers. Often, several intimate sexual activities are shown on TV (Advocates For Youth, 1995). In U.S.A, for example, it is estimated that roughly three sexual acts were presented per hour in the television soaps, out

of which only one in every six acts of intercourse is between married couples. In the daytime serials non-marital intercourse is portrayed twice as often as marital intercourse. In these presentations, it is rare for the actor/character to develop STD or become pregnant. (Advocates For the Youth; 1995).

Apart from information, the media provides role models for the adolescents to emulate. Such role models have powerful influences on the adolescent. Another powerful influence on the adolescent is the peer group and friends. The disengagement from the family and greater identification with peer introduces the adolescents to new behaviours and sensations. Sometimes, family crisis such as divorce, separation and remarriage may force the adolescent to seek new security with peers (Bingham and Crockett, 1996, Washington Post, 1996). Such peer relationship may be positive or negative. In cases where the relationship is negative, it may facilitate adolescent involvement in risky behaviours. However, where peer pressures have been positively utilized, they tend to reduce the prevalence of high-risk behaviour among adoloscents (Lein, Sondag and Drolet, 1994;).

The family also plays a very crucial role in the life of the adolescent contrary to the fact that, adoloscent is the time of "flying

from the nest", troubles at home usually affect the adolescent outside. The bedrock of violence, homicide and suicidal tendencies springs from family dysfunction and unstable home environment. Anti-social behaviours that some of the adolescents exhibits outside the home were at times reflection of what is obtained in the various households (Hirschi, 1969 and Jansen, Fitzgerald, Ham and Zucker; 1995).

The concept of risk

Risk is a condition associated with higher likelihood of negative or undesirable outcomes. According to the Royal Society of The United Kingdom (1992), it is the probability that a particular adverse event occurs during a stated time period or results from a particular challenge. The particular event in this study is the adolescent period, relationship to wider social structure as well es their attitudes towards personal, economic, political and ecological risks. Risk occupies a place of pride in contemporary culture as it is a tool used to foresee and control the future in disparate sphere, such as health care, transport, crime control, environmental protection end business management (Heyman, Henriksen and Maughan, 1998). As e result of all of its, pervasive use, risk has come to be regarded as a natural phenomena especially when it comes to discussing behaviour among

adolescents (Devereaux, 1998). Perceived risk is based on a correct identification of very real, actual danger. Perceived risk may also be shaped possibly by an individual's inaccurate interpretation of reality, personal fears and biases. Behaviour change may be undertaken by adolescents who perceive themselves to be at risk but be unwilling to alter the situation or reduce the risk (Mbizwo, Siziyas, Olayinka and Adainchak, 1997). The antecedent for risk is protection. This is the lowest end of risk variable (Jessor, Van der Bos, Vanderryn, Costa and Tubing; 1995).

Specific Risky Behaviours

Use of Alcohol

Alcohol had been termed as a gateway drug. It is usually the precursor to other hard substances. It is also known as a social drug because continual ingestion usually commenced either during the childhood or as a social drink in the adolescence. Alcohol by definition is a drug that may be classified as sedative, tranquilliser, anaesthetic or hypnotic depending on the amount consumed at any given time. Alcohol is rapidly absorbed into the stomach and small intestine. Maximum concentration is reached about one hour after consumption

Over the years, adolescents and young people have increasingly participated in alcohol consumption and heavy binge drinking (WHO, 1986). Alcohol has effect on the central nervous system and eliciting poor coordination. Short-term effects are seen in road accidents, most especially since the adolescents have low tolerance levels (Parks, 1995 and WHO, 1998). Other short-term effects include lowering of inhibitions, which lures the adolescents in sexual risk taking especially unsafe sex (Fritz, Woelk, Bassett, McFarlan, Routh, Tobaiwa and Stall; 2002; Leigh and Stall, 1993). Long-term consequences include dependence, chronic intoxication, liver cirrhosis, toxic psychosis, gastritis, pancreatitis and peripheral neuropathy (Parks, 1995). Social effects include family dysfunction, disorganisation, crime and fall in productivity.

Studies conducted all over the world showed a marked increase in alcohol consumption by the adolescents. For example in Canada, about 52 % of males and 35 % females between the ages of 15 and 19 reported excess consumption of alcohol. (Galambos, 1998). In Central and South America, 12% of those that consumed alcohol in excess were adolescents (UNFPA, 1998). In a report of fatally injured male drivers in the United States, 70 percent have alcohol in their blood. In a

worldwide study by WHO (1998), among adolescents who had consumed alcohol in the past one month the following consumption rate by developed and developing countries alike were presented in the lable below.

Table 1

Consumption of alcohol among young persons around the world.

Country	% Males	% Females
Spain	85	78
United Kingdom	80	82
Japan	10	3
Canada	52	35
Chile	77	50
Brazil	23	17
Zimbabwe	40	17

Source: WHO,1998.

In a longitudinal study conducted among secondary school students in Ilorin, Kwara state, between 1988 and 1998. A total of 1041 students interviewed in 1988, 42 percent were current users of alcohol; in 1993, it had decreased to 16 percent and in 1998, it was found to be constant in 16 percent (Adelekan, 2001). Alcohol consumption increased in severity as the adolescent years progressed. According to Youth Risk Behaviour Survey (Kolbe, Kann and Collins, 1993) study in the United States of America, 23 percent of 9th graders and 30.1 percent of 10th graders use alcohol. The study also discovered that 18-21 years olds were three times more likely to have used alcohol than 12-13 years olds. About 3.5 percent of high school seniors drink alcohol daily. Twenty-nine percent had had five or more drinks in a row at least once in the previous week (Johnston, O'Malley and Bachman, 1995).

Tobacco Use

Tobacco use is legal everywhere in the world. It is also the most widely distributed and commonly used drug in the world today. Smoking habits are initiated during the adolescence. The overwhelming social acceptability makes smoking an attractive behaviour to the adolescents. Some factors are responsible for the

early initiation of smoking behaviour. Some of the factors include, the nicotine content of the tobacco. This content is highly addictive making it difficult for smokers to kick the habit. Experimentation is another factor. The experimentation suggested an adult activity making it attractive to the adolescent who crave adult role. Peer pressure is also an important factor in adolescent smoking habit. In the group that smokes, non-smokers will be viewed as too young, deviant or socially inferior. Tobacco smoking causes more deaths than any other psychoactive drugs. Annually, it results in about 3 million premature deaths. It is also responsible for about 30 percent of all cancer deaths in developed countries. Young people who smoke stand the risk of experiencing episodes of cough, shortness of breath and phlegm production (Parks, 1995). As the adolescent grows older, there occurs tobacco related diseases such as myocardial infarction, stroke, aortic aneurysm and peptic ulcer. Among pregnant women, tobacco smoking leads to low birth weight and foetal death (Watson and Hold, 1986).

In developed countries, per capita consumption of tobacco is decreasing due to vigorous campaign by their governments. In developing countries however, smoking incidence is on sharp increase due to increase advertising, sponsorship of sports events by tobacco

companies and lack of will power on the parts of government to dissuade the activities of the tobacco companies (Roemer, 1983).

The overwhelming majority of tobacco smokers start the habit during adolescence (WHO, 1995). About 30% females and 28% male adolescents in Canada smoke (Galambos and Tillon-Weaver, 1998). In Scotland 10% of males and 14% of females adolescents are regular weekly smokers (OPCS, 1988). In United States of America, 10% adolescents reported daily smoking behaviour (Neinstein, 1996). In another health survey study 65% 9th graders and 75% of 12th graders reported to have tried tobacco (YRBSS, 1991).

There are also emerging trend of younger initiates as low as 12 years old in Canada (NCHT, 1989). In the developing countries, there is reverse in male, female distribution with more males smoking than females. In studies carried out in Nigeria, Onadeko, Awotedu and Onadeko (1987) reported a prevalence of 30% for males and 2.1% for females in higher institutions of learning. The WHO prevalence for Nigeria in 1985 is 27% for males and 8% for females. In a study carried out in Ilorin, 1.5% of secondary school students smoke (Adelekan, 2001). Addiction to smoking is very high especially among

the adolescents with 90% of smokers remaining addicted before 20 years of age (Kandel and Logan, 1984).

Use of other drugs

Other drugs most frequently abused by adolescents include Cannabis (Manjuana), Cocaine, Heroine, Amphetamines (LSD) and solvents such as petrol, glue and paints. Some reasons were adjudged to be factors responsible for smoking and use of hard drugs such reasons according to Newcomb, Maddahian and Bentler (1986) include:

- Use of drugs by family and peer groups especially closest friends.
- Exploration and experimentation, as well as social acceptance.
- As means of seeking changes in the consciousness and mood, low self esteem, to relieve stress and act socially, to challenge authority.

- To reduce boredom as a rite of passage and as a response to the subtle end hidden meaning of the media as well as enhancing body image and sexual acceptability.
- Deviant behaviour and challenge to parental authority.

Cannabis: With the exception of alcohol and cigarette, cannabis is one of the most widely used drugs apart from tobacco and alcohol among the adolescents. It is obtained from hemp *Cannabis sativa*. The resin from the flowering is used to produce the active ingredients of hashish. The dried leaves are called ganga. To consume the plants, the dried leaves are mixed with tobacco, taken with drinks or incorporated with foods. The combination of Cannabis with alcohol and tobacco produces a lethal effect and dependency.

The most common reaction to Cannabis is the development of colours and sounds, interference with perception of both time and space and paranoia. Other reaction includes euphoria, relaxation and altered consciousness. Effect of Cannabis can last for many hours (Parks, 1995). Cocaine, heroine, methadone and other stimulants produce tolerance and strong psychological dependence. These drugs tend to affect mesolimbic reward system of the central nervous system

They affect it in such a way as to induce intense cravings and preconscious drive to use. They are also known to increase alertness and activity (Rinaldi, Steindler, Wilford and Godwin, 1988).

Hallucinogens: These drugs affect sensation, emotions and awareness. They cause distortion of perceived reality. They are mescaline, MDA (Methylene dioxyamphetamine).

Opiates: They are generally used to relieve pain (Neinstein, 1996).

Minor tranquillisors: These include diazepam (Valium), Alprazolan (Zanax) and chlordiazepoxide (Librum). They are taken to reduce anxiety but they also promote physical and psychological dependence.

Volatile solvents: Such substances include glue, petrol, cleaning spirit, paint thinner. They are widespread among adolescence of low-income stratum. Such substances depress the central nervous system and cause disorientation, ataxia, convulsions and lead poisoning (Parks, 1995; WHO, 1998).

More young people use these drugs to create fantasy and illusion in their world. Some also use it to escape reality from their unstable world. More girls are now using the drugs especially tranquillizers (WHO, 1985).

Stages In Drug Use

MacDonald documented the stages in drug use in 1987. The stages include:

Stage 0: This is showing curiosity stage. The adolescent may exhibit strong desire for acceptance and the tendency to accept immorality and testing of mood altering drugs without suffering any dire consequences.

Stage 1: Learning about drug induced mood swings. Peer pressure is intense in this stage. The consumption of drugs is limited to small groups and weekends. There is exhibition at discomfort with the family, school and social problems are relieved for a short while.

Stage 2: Seeking drug induced swings. Having learned about its practical use, the adolescent seeks the highs. The adolescent may learn about ways of acquiring the drugs and uses it mostly to relax regularly on weekends and occasional weekdays. Behaviour changes occur in the school performance as well as decrease in extra-curricular activities.

Stage 3: Being preoccupied with drug-induced mood swings. The teen loses control of his/her life. New deviant behaviours like stealing, truancy, lying is introduced. Drug dealing may start. The adolescent life is now centred on obtaining drug to get high at all costs.

Stage 4: This is known as the burnout stage. Adolescent's drug use is now to feel normal. Drug may no longer produce euphoria. The adolescent will be commonly referred to as "Zombie" and "space cadets" (Rogers, 1984).

In 1995 in a study carried out in United States of America 4.7% of high school seniors are current users of Marijuana, Cocaine 3%. In this study, the majority of the student consider hard drug as constituting a great risk to the user. However, only 24.8% considered one or two daily intake of alcohol as being harmful to their system. Students tend to believe that there is lower risk for occasional users of drugs like Marijuana, LSD, and Cocaine (Neinstein, 1996). In another study among University students in Ibadan, 17% of the 100 level students had used Marijuana more than once in the past month. This increases as the level increases. Amphetamins, Barbiturates were lower at 7.6% to 5.8% among the study in Lagos. Marijuana use among secondary school students remains low at 11% (Anumonye,

1980), stimulants 2%. Adelekan and Adeniran (1988) reported a prevalence of 14.3% cocaine and heroine among patient admitted in a Psychiatric hospital (Aro). In a 1993, street survey of 'Area boys' and 'girls' (urban social miscreants and petty criminal gang) by Ekpo, Adelekan, Inem and Agomoh, (1995) 90% of them were using heroin and Cocaine.

Sexual activities

The changes that the adolescent experienced are in biological areas and psychological areas. In the biological sphere, physical maturation signals distinct maturity of sexual organs and initiation of sexual behaviour. The psychological changes may promote exposure of adolescents to new health risks such as sexual activities. This is because physical changes increase sexual motivation, sexual attractiveness and concerns about self-esteem (Udry, Billy, Groff and Ray, 1985; Udry, Talbort and Morris, 1986). Sexual feelings in themselves are not harmful to health, although expressions of them are often greeted by anxiety and anger by adults and fear, guilt or shame by the adolescents themselves. It is usually combination of

these responses that combine to drive the sexual feelings of the adolescent haywire or repressed as the case may be. Repressing the feelings may be due to lack of communication between the adolescent and the family, peer, religious bodies or the combination of all (Wagner, 1980; Rob, Reynolds and Finlayson, 1990). The feelings may be out of control due to tendency to experiment, assume adult roles and sudden acquisition of emotional and at times financial independence (WHO, 1996). The adolescent are also faced with many sexual problems which they may have little or no control over. Such problem includes sexual harassment or abuse especially of girls by older men (Ajuwon, McFarland, Hudes, Adedapo, Okikiolu and Lurie, 2002; Mature, McFarland, Fritz, Kins, Woelk, Ray and Rutherford, 2002), sexual variation, homosexuality and lesbianism and incest. Three sexual activities put adolescents at risk of undesirable consequences.

The first one is early sexual debut. The risk involved in this behaviour is related to early pregnancy and adolescent mothers, sexually transmitted infections (STIS), HIV and AIDS, as well as cessation of schooling. Studies in Nigeria and Ghana shows median age of first sexual intercourse to be 16 years among girls in Nigeria

end 17 years for both boys end girls in Ghana (Brieger, Delano, Lane, Oladepo and Oyediran, 2000). In another study conducted in Ilorin, the mean age of the adolescents to be 11.3 years. (Abdulkarim, Mokuolu and Adeniyi, 2003). Adolescent mothers constitute a high percentage of births in both the developed and the developing countries (DHS, 1994; Harrison K.A., 1985; Nigeria Demographic and Health Survey, 1992 and WHO, 1993), where most of these births are to mothers that are under 20 years of age. Early motherhood carries its own risk and this includes vesico-vaginal fistula, low birth weight, perinatal and maternal mortality, haemorrhage, infection obstructed labour, cephalopelvic disproportion (Daly, Azefor and Neisah, 19 years (Brabia, Kemp and Obinge, 1995 and Nobel, Cover and Yanagishita1994 and Shane, 1997). This drametically increases maternal mortality rate among the adolescents. Annually according to World Health Organization, 60,000 adolescent women die from such health problems related to childbirth (WHO, 1998). The maternal mortality rates among adolescents in some selected countries points to this fact. In Ethiopia, it is 1,270 per 100,000 women between 15 to 19 years. In Nigeria 80% of all cases of fistulae occur to women between

15 and19 years (Brabia, Kemp and Obinge, 1996; Nobel, Cover and Yaganishita, 1996).

The second one is having multiple partners. This risk is widespread among the university students in University of Ilorin aged between 15 – 24 years where as many as 68% males and 15.9% females had more than two partners. (Araoye, 1995). In another study carried out among high school students aged between 16-21 years in Kwangju, Korea, 33% males and 68% females reported two or more partners. (Gayun, 1996). Multiple partnerships can bring about sexual networking. These in turn open up the adolescent to the risk of STIS, HIV and AIDS. Out of the estimated 333 million new STIS cases that occur in the world, every year, at least 111 million occur in young people under 25 years (WHO, 1995). Globally, more than half of all new HIV infections are among adolescents between 15 and 24 years old. (UNAIDS and WHO, 1996). Out of the estimated 10 million adolescents living with HIV, majority is likely to develop AIDS during the next 3 to 15 years (WHO, 1998).

The third risk likely to develop from adolescents sexual activities include engaging in unprotected and unsafe sex. Unprotected or unsafe sex brings about the twin problem of unplanned pregnancy and

sexually transmitted infections, which was mentioned earlier. Unprotected sex is usually associated with alcohol consumption in the following studies, Isarabhakdi,(1995), Jong Kwo Lim, Han Hyong Kim, Hye Ryun Kim, Dong Hyan Chang and Joo Hyung Kim, (1995) and Cadelina, (1998). Isarabhakdi, (1995), survey among adolescent factory workers aged between 13 – 25 years in Chiang Mai, Thailand, found that those who consumed alcohol had four times higher odds of having unprotected and casual sex. Jong Kwo Lim et al (1995) in their research among university students aged 15-29 years in Seoul, Korea reported inconsistent condom use in the students' sexual relations. Ehrenfeld (1994), study among pregnant adolescents attending antenatal clinic in Mexico City found inconsistent condom use to be as a result of spontaneity of the sexual act.

Violence and sexual coercion

Violence: Violence is an antisocial behaviour that usually has its roots in childhood (Robins, 1966). The difference between environmental and individual characteristics originates in childhood as the child grows up. This difference constantly brings him/her into conflict with the

surroundings such behaviour may be coercive, impulsivity or neuropsychological deficit. These serious offending habits emerges early as under controlled behaviour (Farrington, 1989; Moffit, 1990). Coupled with this is the problem of disorganized and dysfunctional family. Such have profound impact on the social development of the child. One of the most important factors bringing about violence in adolescence is deprivation. Deprivation may be in form of marital disruption, parental illness, social dependency, overcrowding at home and poor family relationship which can be seen in over beaning father or disagreement in mode of discipline between the parents (Henry, Caspi, Moffitt and Silva, 1996).

Violence usually starts with victimisation and this is widespread among family members and intimates (Straus and Gelles, 1986). Exposure to violence in any form in the youth is known to increase the risk of violence tendencies for the youth in later life. Adults who witness violence in their family were at increased risk of perpetration of physical abuse against their spouses, siblings or dependents (Hotaling and Sugarman, 1986). Violence and intentional injury accounts for more than one-third of all injury related deaths in U.S.A in 1993 (O'Carroll, Harel and Waxweiler, 1993). Such violence accounted for

$26 billion expenses in indirect death and hospitalisation in U.S.A in 1985 (Rice and Mackenzie, 1989). Violence, weapon carrying and fighting also increase rate of morbidity and hospitalisation. The adolescents between ages 15 and 24 are at highest risk of head and spinal cord injuries (O'Carroll, Harel and Waxweiler, 1993). Rates of physical abuse are highest among older children and young adolescents (Froehlke, 1991).

Sexual coercion

Sexual coercion is the use of force or the attempt to force another individual through violence, threats, verbal insistence, deception and economic circumstances to engage in any sexual activity against his or her will (Heise, Moore and Toubia, 1995). Oftentimes, sexual coercion stems from societal cultural practices. Such practices teach females to defer to male authority. As such older male relatives, uncles, teachers, masters, neighbours usually coerce the female to accede to their sexual advances (Network, 2002). Gender stereotypes and cultural beliefs cast females as submissive and the makes as aggressive/powerful. This therefore opens the females to violence, sexual exploitation and STIS. In many societies, good girls and wives are submissive, departure or questioning of the

norm is unaccepted. This makes it impossible for the woman to refuse unprotected or forced sex (Irvin, 2000). The adolescents are also exposed to problem from HIV infected males who believe that having sex with virgins can cure them of their HIV status (Irvin, 2000).

Females more than males are affected by sexual coercion from previous studies. In a study among female trade apprentice youths in Ikorodu, 20% of those sexually active reported that their first sexual intercourse was forced on them (Dada, Oluseha and Ajuwon, 1998). According Orobuloye et al (1993), 15% of the female hawkers surveyed at bus and truck stations in Ibadan were raped by their male partners. Some of the females coerced to have sex by their fiancé actually dump them after the act on the assumption that, if she can accept to have sex with them, he can also have it with others (Network, 2002).

Multiple risk behaviour among adolescents

High-risk behaviour among adolescents is many and they vary among the age of the adolescents as well as the sex. In studies carried out over the years, multiple risks rose with age with the younger adolescents at the lowered end and older adolescents at the higher

end of the risk scale (Galambos and Tilton-Weaver, 1998 and Jackson and Hornberk, 1989).

In the research carried out by Baume (1996) and WHO (1998), alcohol is used as gateway drugs to engage in other risky behaviour like sexual risk, unsafe sex, drunk driving and using other hard drugs (Lowry, Holtzman, Trunan, Kann, Collins and Kolbe, 1994). In a study conducted among teenagers, students in U.S.A, Hingson, Strunin and Berlin (1990) found out that teenager who used alcohol or drugs before intercourse were less likely to use condoms.

It has also been recorded that adolescents who drink have a higher likelihood of having multiple sexual partners, casual sex, unplanned sex and intercourse with commercial sex workers (Mataure et al, 2002).

Another multiple risk tendency is for the adolescents who drink and drive, since alcohol impairs judgements such adolescents invariably get into accidents and sustain injuries. This is a common epidemic in developed countries (Neinstien, 1996 and YRBSS, 1992 and WHO, 1993).

According to Allan Guttmacher Institute (1994), adolescents who engage in other high-risk behaviour such as drinking and drug use are more likely than others to be sexually experienced. It has also been documented that increased alcohol and hard substance use increase among the adolescents, as they grow older.

General studies on multiple risks

Some of the works done on multiple risk-taking includes the work of Coggan, Disley, Pattemson and Norton, (1997) among the New Zealand adolescents. The study focuses on road safety, substances' use, sexual behaviour and personal safety. They used questionnaires to examine the high-risk behaviour of the high school adolescents. In their findings, majority of the students (78% and 63%) admitted using marijuana and cigarette. Out of the 40% that engages in sexual intercourse, 61% did not use condom consistently. Green, Kremar, Walters and Jerold, (2000) in their work targeting adolescent risk-taking behaviour in England found out that risky behaviour stems out of the bid to seek sensation, feelings of invulnerability experience seeking, boredom, susceptibility, thrills and adventure seeking.

In their work, Kurther, Higgins and D'Alessandro (2000) adolescent risky-behaviour are viewed as personal decision rather than that of morality or convention. Domain judgement of risk according to the writer played more important role in adolescent risk taking. According to Parsons, Siegels and Cousins (1997), the perceived benefits accounted for significant variance in behavioural intentions of the adolescents that take high risks. Closely associated with these findings is the work of Caceres, Marin, Hudes, Reingold and Rosasco (1997), where paid sex and homosexual activities were viewed as protected devices. In the study carried out in Athens, Greece, majority of respondents admitted performing risky behaviour such as smoking, drunk driving, binge drinking at a consistently higher odd risk to null value of between OR=3.2 to 18.6.

On the issue of older siblings, affecting the younger ones, D'Amico and Fromm (1997) found a positive correlation between perceived positive expectations of the younger ones.

In the works of Stanton *et al* (1997), Petridou, Zavitsanos, Dessypois, Frangakis, Mandyla, Doxiadis and Trichopoulous (1997), Boyer, Shafer, Wibbelsman, Seeberg, Teitle and Lovell (2000); Guillone and Moore (2000), ethnicity was found to play a significant

role in high risk behaviour. Burke (1994) indicated that in early teens, involvement in risk-taking is rudimentary but this progresses, as the adolescent grows older. He further identifies a new trend in the problem, saying that there is increase in violent and suicidal death rate from child abuse and higher teen birth rate.

Flisher and Chalton (1995) reported that adolescent engage in risky behaviour that results in adverse mental, physical and emotional consequences. Kelly also believes that current attempts to vigorously regulate the behaviour of the youth will only result in clashes with the authority (Kelly, 2000).

CONCEPTUAL FRAMEWORKS

Three conceptual frameworks will be used in this study to explain adolescent risk-taking behaviour. They are Health Belief Model (HBM), Social Learning Theory (SLT) and Precede Framework.

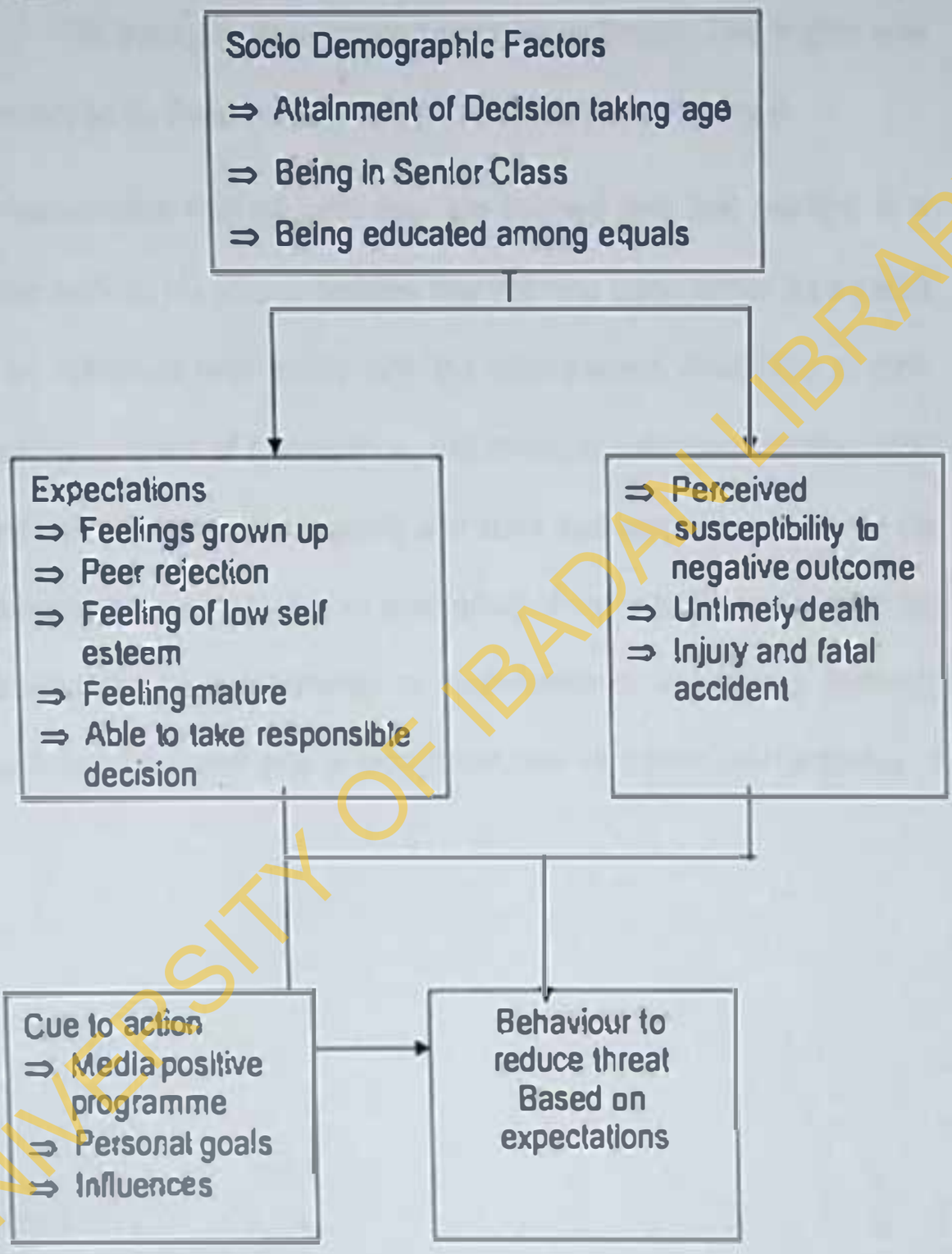
Health Belief Model

Health Belief Model is a psychological model developed in the 1950s as part of an effort by social psychologist to explain reluctance of the public to participate in prevention programmes. According to Ross and Mico (1980), whether or not person practises particular health

behaviour can be understood by two factors namely the degree to which a person perceives a personal health threat and the perception that a particular health practise will be effective in reducing such risk. Personal health threat is influenced by the general health values. This includes interest and concerns about health, specific beliefs about vulnerability to a particular disease and consequences of such disease. It explains people,s practise of health and helps in prevention of high-risk behaviour such as AIDS risk.

Health Belief Model helps us to understand why people practise health behaviour and predict some of the circumstances under which people's health behaviour change. In order to develop an effective intervention, one must increase vulnerability and also increase perception that particular health behaviour will reduce the risk.

FIGURE 1: APPLICATION OF HEALTH BELIEF MODEL TO RISKY BEHAVIOUR

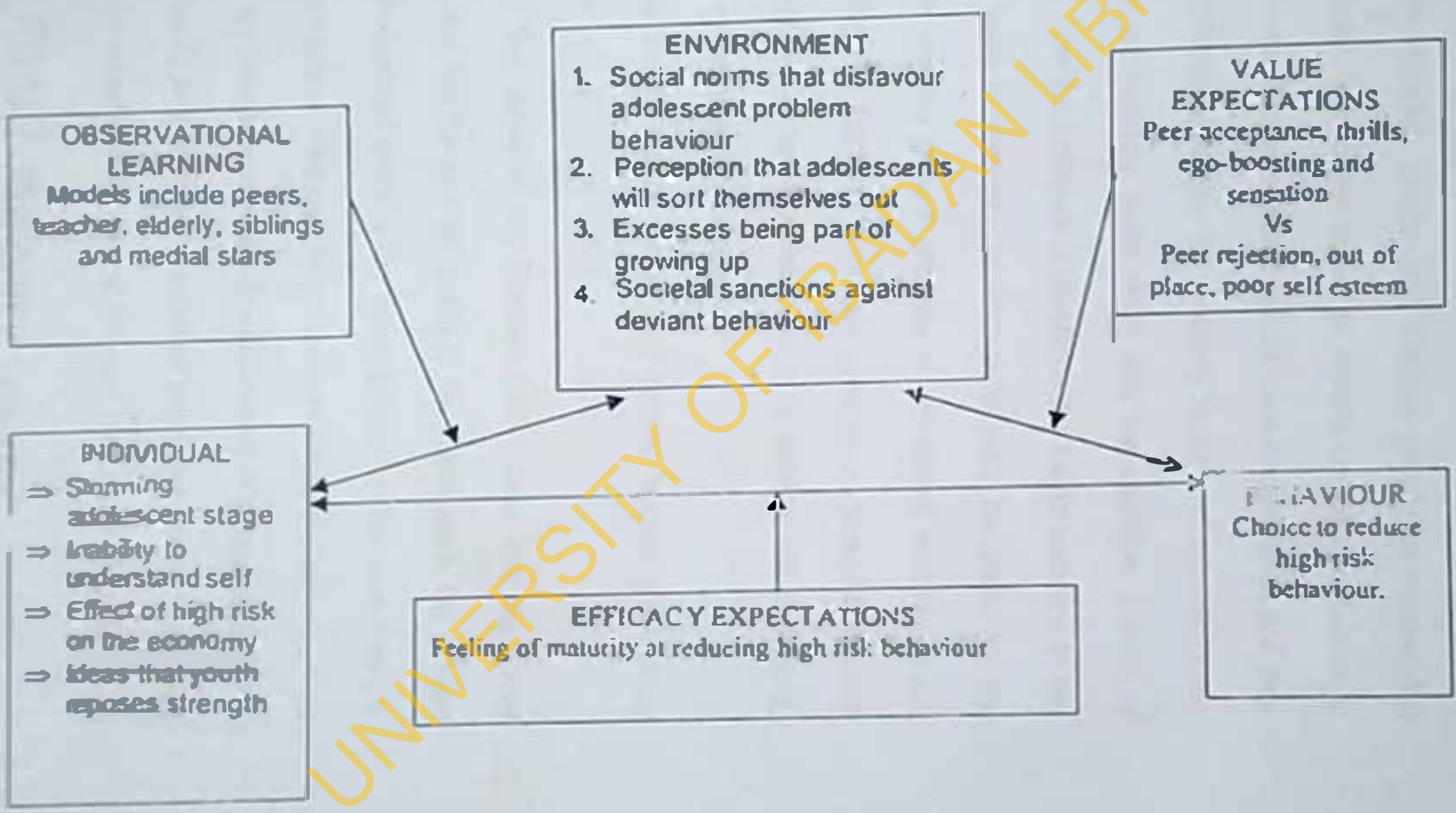


Social Learning Theory

This theory is also known as cognitive theory. This theory was popularized by Bandura (1973,1993). Central to this theory is the assumption that all behaviour are learned and that learning is a social activity. He also postulates that learning came about as a result of an individual relationship with the environment. According to him, learning consists of Observation and Imitation. Individual adolescence tends to imitate teachers, peers and stars that take risk in order to be accepted by such teacher or peer group. Peer modeling may also be accentuated by inducements or reinforcements (reinforcing factors). Such as money and gifts or recognition they earn from such activities.

FIGURE 2

SOCIAL LEARNING THEORY AND RISK-TAKING BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS



The Precede Model

Green, Kreuter, Deeds and Partidge (1980) developed the Precede model. The model helped to identify contributory factors to health problems. Three important factors were distinguished and they are the predisposing factor, the enabling factor and the reinforcing factor. The predisposing factor deals with the cognitive domain of knowledge, how the individual understands the health problem. In this case the issue is tendency to engage in risky behaviour by the adolescents and the general attitudes of adolescent students to risk taking behaviours. Enabling factors are adequate personnel to counsel youth, availability of logistical factors such as barriers and facilitators, economic status as well as occupation.

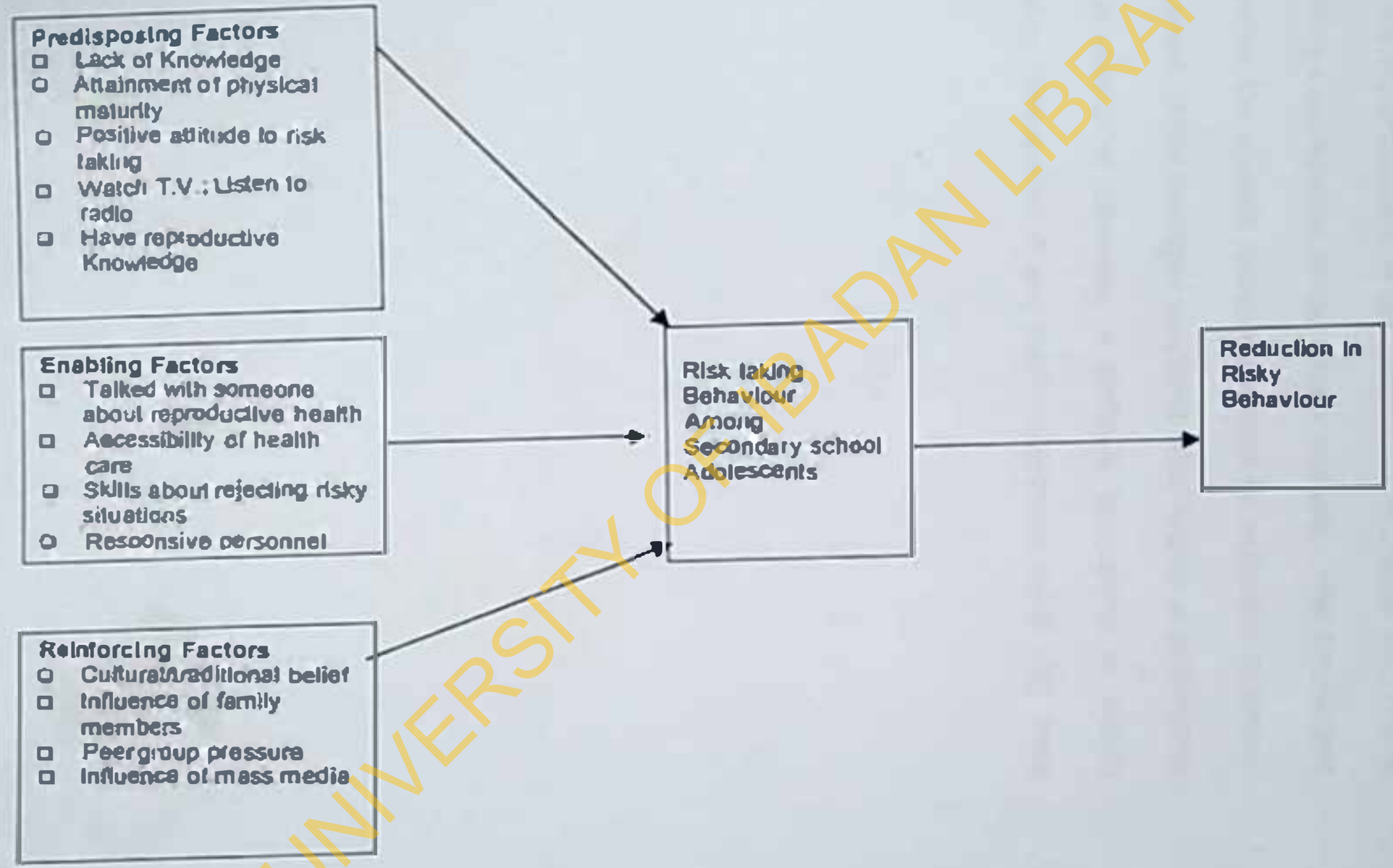
Reinforcing factors include influence of culture, religion, peer group and media.

The first phase of any Precede model deals with the social diagnosis and this includes the quality of life. In this phase the general problem is identified which is risk taking behaviour. The next phase is the epidemiological diagnosis, which involves health problems such as morbidity and mortality as well as the prevalence of the health risk. The specific health problem here is high-risk behaviour among secondary school adolescents. Phase three involved the behavioural diagnosis

such as utilization and preventive actions. The fourth phase deals with educational diagnosis and this give insight into the factors affecting health behaviour, while phase five is about the specific intervention needed for reducing that risk behaviour. Phase six is the actual implementation phase. Figure 3.

ADAPTATION OF PRECEDE MODEL TO RISKY BEHAVIOUR

EDUCATIONAL DIAGNOSIS BEHAVIOURAL DIAGNOSIS EPIDEMIOLOGICAL DIAGNOSIS



The Precede model had helped in intervention purposes. Not only that, phase six, which is the administrative diagnosis, is the stage where the implementation of the programme is carried out. This is done using a combination of intervention strategies. After intervention programme, the precede model made room for evaluation to assess the success of the strategies employed. This helped in determining how successful or otherwise, a particular programme is. Health education components of any health programme deals with these factors.

Hypotheses

Four hypotheses were formulated for this study. They are:

1. There will not be no significant difference between sex of the student and their pattern of risky behaviour
2. There will not be significant difference in the sexual behaviour of those who work after school and those who do not.
3. There is no significant difference between risk behaviour of the student and there age.
4. There is no significant difference between student's risk behaviour and their class.

CHAPTER THREE

METHODOLOGY

Research design

The research design is an exploratory cross sectional survey aimed at exploring and identifying the risky behaviours of secondary school students. The study combined the use of qualitative and quantitative methods to determine prevalence of risk behaviour among students. The qualitative method was used to identify the behaviours that students perceive to be risky and this was followed by a survey that explore the extent to which they had practiced the behaviour

The study area

Oyo state was carved out of the western region in 1976. the population of the state was 3,888,789 according to the 1991 population census. The state has thirty-three local government areas.

Ibadan is the capital of Oyo state consisting of eleven local government areas. Five of these are within the metropolis and six at the suburbs. Ibadan is situated about 126 kilometers north of Lagos. Ibadan is a predominantly Yoruba city with the population of about 1.2 million (National Population Commission, 1991). Other ethnic groups

also reside in different locations of the city such as Hausas in Ojoo and Sabo, Igbos in Ekoledo-Onireke and Oke-Ado and the Nupes in Mokola. Ibadan is a regional center for commerce and education. This is also where the first university, the university of Ibadan is sited (Scultz; 1975). Adeyemo and Brieger (1994) divided Ibadan metropolis into three areas namely, the inner core, the transitional zone and the peripheral.

The inner core consists of the indigenous oldest part where the early settlers live. Most of the residents belong to the low income socio-economic stratum. Housing types is often of mud construction.

The transitional zone surrounds the inner core. These are mostly areas where the middle class lives. The periphery areas in the suburbs that have overtaken the former farming settlements. The housing types are of modern blocks in well-laid out housing estates. The population density of the inner core area is the highest at about an average of 150 persons per 10 – 16 house per hectare (Adedapo,1995), making it highly congested and over crowded. The peripheral zone on the other hand is less congested with properly laid out streets. the local government area is divided into 12 wards. Democratically elected Chairman assisted by elected councilors

representing the wards in the local government heads the administration.

The occupation of the indigenes consist of civil servants, artisans and traders in clothing materials, motor vehicle spare parts, provisions and sbuilding materials. The predominant religion includes Christianity, Islam and traditional religions (Awolalu, 1983).

The study took place in Ibadan North Local Government Area which is one of the five LGAs that was carved out of the Ibadan Municipal government in 1991. It has its headquarters in Gate area of the city. It shares boundaries with Ibadan North-East, Ibadan North-West, Lagelu, Ido and Akinyele local government areas. The major residential areas include old and new Bodija, Ashi Mokola, Oke-Ilunu , Sango ,University quarters, Agbowo and Bashorun. The local government has 22 public secondary schools which makes it one of the areas with the highest concentration of secondary schools in the metropolis. Some of these secondary schools were previously owned by religious organization but were later taken over by the government.

The study population

The study population was students in senior secondary schools one end two. Under the 6-3-3-4 system of education adopted in

Nigeria, the first 6 years are spent in primary school, the next 3 years in the junior secondary school and the next 3 years in senior secondary and the last 4 years are spent in the institution of higher learning. (Jaiyeoba, 1995). Based on this system, the senior secondary school age coincide with the periods of early-middle adolescence. However, for the purpose of this study, students whose age are more than this age group but are still found in the classes examined were taken to be part of the study. It is at this stage that a developmental change in the adolescent brings about era of experimentation in high risk behaviour (Agu; 1987: Brieger, Delano, Lane, Oladepo and Oyediran, 2000).

Sampling techniques

A multi-stage sampling technique was used to recruit the respondents. The first process is enumeration of all schools in the LGA. There are twenty-two government owned secondary schools in the area. Twenty were coeducational and two are single sex schools (male/female).

The two single sex schools were purposively selected.

Out of the remaining 20 co-educational schools, two schools were selected by balloting. This brings the number of selected schools to four (Table 2).

After the selection of schools, the number of SSS One and SSS Two arms in each school chosen was enumerated. Out of this two arms each were chosen randomly using the ballot method form each of SSS One and SSS Two classes. This brings the selected classes to sixteen arms. The selected classes in the various schools are listed in Table 2.

All the students selected in each of the earmarked class were invited to participate in the study. All those invited agreed to take part in the survey. Response rate is 100%.

Table 2

Distribution of arms per school

Name of School	Number of arms in SSS one class	Arms chosen	Number of arms	Arms chosen
St. Patrick's Grammar School. Bashorun	6	2	5	2
St Louis Girls' Gram. Sch. Oke- Itunu.	8	2	7	2
Community Sec. Sch. Mokola	6	2	5	2
Methodist Gram. Sch. Bodija.	7	2	6	2
Total	27	8	23	8

Table 3

Population of selected schools and the sample size

SCHOOL	SSS ONE	SSS TWO	TOTAL	SAMPLE
St Patrick's Gram. Sch.	375	295	670	152
St. Louis Gram. Sch.	455	320	775	153
Comm. Sec. Sch.	390	305	695	152
Methodist Gram. Sch.	412	315	727	152
TOTAL	1632	1235	2867	609

Instrument for data collection

Data for the study were collected using both qualitative and quantitative data collection tools. The in-depth interview and focus group discussion (FGD) were used to collect information that was incorporated into the quantitative (questionnaire) data collection tool.

In-depth interviews

Four school counselors, (one each from the project schools) were interviewed. The issues covered in the interview were identification of risky behaviours that they have encountered among the students (Appendix I)

Focus group discussion

A discussion guide was developed for the FGD. (Appendix II). Issues covered in the FGD includes what the students perceive as risky behaviour, types of risky behaviours, age at which adolescents start to date, the kind of substances that adolescents use. Others include use of alcohol, pregnancy episodes, ways of preventing pregnancy and if they have been forced to have sex before.

Four young adults were trained by the researcher on how to administer the questionnaire. The duration of the training was one hour. The trainees were instructed first on assuring the respondents about the confidentiality of the information given. This was followed by training on how to select classes and students for the interview and to ask and explain difficult questions to the students.

Permission and assistance were sought from both the school principal and the vice principal (academic) of each school, first for FGD and later for administration of the questionnaire.

The Questionnaire

The questionnaire was divided into six sections. (Appendix III)Section one dealt with demographic data of the student. This contains questions on age, sex, class, occupational and educational status of both parents. Section two contains use of drugs, alcohol consumption, number of times used and significant others that drink alcohol or smokes cigarettes or other psychoactive substances. Section three is about sexual behaviour. Here the respondents were asked for the age at initiation of sex, number of sexual partners, use of condom and episodes of pregnancy. Section four is about sexual coercion, whether they have been forced to have sex. Questions also

include the type of force used. Section five is about physical abuse episodes experienced by the student. This physical abuse is about being beaten or forced to undergo punishment unjustly. The last section dealt with the attitudes, that is whether the respondents aggress with a set of questions, disagree or undecided.

Rollability and validity

Validity was ensured throughout the process of data gathering. To help validate the instrument, in-depth interview was conducted among the counselors and FGD was also conducted among the students for the purpose of providing ideas about areas to be covered in the questionnaire. Secondly some of the questions on WAYI questionnaire on reproductive health were used. The questions had been pilot tested among adolescent in different parts of Nigeria and Ghana

Reliability was ensured by asking the questions in simple English with the permission to explain any difficult areas for some respondents who may have difficulty with comprehending the questions.

Finally, the questionnaire was pre-tested among 30 students of the Bishop Odubanjo Memorial Grammar School, Ashi, Ibadan

randomly selected from SSS One and SSS Two before it was administered.

To ensure confidentiality, interviewers were instructed to ask questions anonymously. They were also instructed to assure the respondents of the confidentiality of the information given.

Data analysis

The in-depth interviews and the FGD data were transcribed from the tape recordings, the information given were then analyzed bringing out the salient points in them. The information gathered from the interviews and discussions were incorporated into the questionnaire. The data from the questionnaire was analyzed using the Epi-info software statistical package. Frequency tables were generated as well as test of association between the selected variables done using the chi-square distribution.

Limitation of the study

There are two limitations to this study. One, four schools were studied and the result may not be generalised to students from all the schools in the local government. Another problem is that the study was limited to only students from the senior secondary classes, adolescents who may be found in the junior

secondary section are not included due to time and financial constraints. Future studies will be focused on these groups.

CHAPTER FOUR

RESULTS

The results of the study were organized into two sections. Section one presents the qualitative data derived from the in-depth interview of the school counselors (IDI) and Focus Group Discussion (FGD), while section two deals with quantitative data from the questionnaire administration.

In-depth interviews

The counselors interviewed identified eight behaviours they perceived to be risky. These are smoking of cigarettes, taking psychoactive drugs, drinking, 'stealing', 'truancy', 'coming late to school', 'ganging up to disobey the school authority and involvement in occultism. The counselors believed the behaviours to be risky because of likely repercussions on the students later in life. As one counselor puts it,

"a truant will leave for school in the morning, putting on uniform but never get to school... later on he/she will become a dropout".

The counselors agreed that risky behaviours are rampart. When asked of the frequency of encountering risk-taking students during the course of their work, one counselor said these occur everyday. A counselor cited the example of a group of male students who jumped

over the fence of their school to satisfy their crave for smoking cigarette. Cases of reported risky behaviours came to the counselors from teachers who daily interact with the students in and out of the classroom. Other sources include students and classmates who interact with the affected students. When counselors were asked to cite specific cases of risky behaviours they have dealt with, they mentioned truancy especially among boys. On such occasions they counseled the students of the dangers of such behaviour. Another frequently mentioned problem was decline in academic performance. To take care of such problems, the counselors said they normally invite the parents of the students in order to determine the cause of the decline; they also invite the class teacher of such student for discussion on how to halt the problem

Cases of pregnancy, abortion, and the use of hard drugs only come to them once in a while. Factors that influence risky behaviour were said to be peer pressures influence of the media and family dysfunction.

Focus group discussion findings

Students' perception of risky behaviour

There is a slight gender differences in the perception of risky behaviour among FGD participants. For instance, male students

perceived the following behaviours to be risky. Use of psychoactive drugs, alcohol consumption, having unprotected sex that can lead to HIV/AIDS, smoking of cigarettes and injuries due to abortion. Other risky behaviour mentioned include fighting, truancy, staying outside the school gate during school hours and joining bad groups that can expose them to "occultism". A male participant went further to say that risky behaviour is

"to be going to parties, smoking, joining bad gangs and engaging in premarital sex"

Another participant says risky behaviours are:

"things that are dangerous to your health"

On the other hand females believe that in addition to what the males' participant mentioned, going out with bad friends from lessons also constitutes risky behaviours. According to one participant:

"bad people from different homes introduce you to something you know is very bad ... like going out with boys"

The participants believe that several factors predispose students to these behaviours. Such factors include boredom, arrogance, poverty leading one to prostitution and being spoilt from a rich home. As a participant put it:

"bad behaviours are done by students whose parents are rich. You cannot see any poor student doing it"

Other participants see such behaviours as copying what was seen in the television or read in books, others see it as a fallout of pride, as the participant explained, when a girl was 'too proud', she was set up by boys and got raped. Another participant sees it as a way of hitting back at a strict parent. As she put it:

"when the parents are too strict, if you are at the age of 12, by 15, you feel I am old enough to take care of myself ... so you try to do something that would make your parents flare up in order to defy them"

Specific risk behaviour

Use of drugs

Participants identified psychoactive drugs commonly used by students. These are alcohol, marijuana, amphetamines, petrol, coke, 'joints' and coffee. The participant believed that peer pressure is the primary reason why adolescents use alcohol. Examples of alcoholic beverages commonly used are Guinness, Star, Regal Gin, Narcotics and Coffee. It takes up to four bottles to get one drunk. Effects of smoking, alcohol

and use of drugs include damage to the tummy, brain damage and reduction in the size of the lungs (a male participant)

Sexual behaviour

When the students were asked questions on when is ideal time for boys and girls to start going out together, answers range from ages 12, 13 and 16 among the male participants, while the females believe the age should be 16, 18 - 20 years or when you are emotionally matured to do so. Some of the participants believed that pre – marital sex is bad, while others believed that if the parties are going to marry each other, they could have sex. For pregnancy prevention, the boys believed that the girls should take the responsibility since they are believed to know more about contraception than boys. The girls on the other hand believed that when some of their mates are pregnant, they abort it. They were however unanimous in believing that abstinence is the best way to avoid pregnancy and that premarital sex is bad. The various methods that can be used to abort pregnancy as mentioned by participants include the use of contraceptives, *Alabunkun*, (analgesic) use of concoction, consulting doctor, flagyl, vedan (monosodium glutamate), potash, sprite and lime with gin. A female participant believe when a girl urinate immediately after sexual intercourse, she will not be pregnant.

The participants alleged that they have been punished unjustly by teachers, older siblings and parents for perceived wrong doing like suspicion of going else where when they send them on an errand even when they did not do that. They said they felt bad afterwards.

Survey Results

Demographic characteristics of the respondents

The total number of respondents surveyed was 609. Their ages were presented in Table 4 and it ranged from 10 – 24 years with the mean age of 15.7 years. (SD _+ 2). More of the respondents 156(25.7%) were 15 years old, followed by 127(20.9%) who are 16 years. Only one respondent is 24 years old and this have the lowest frequency of 0.2%.

There were slightly more males 316 (51.9%) than females 293 (48.1%). Majority of the respondents were Christians, 432 (70.9%) while 169 (27.8%) were Muslims and 7 (1.1%) were in the traditional religion group. Most of the students were living with both parents 491 (80.6%). Two hundred and thirty-three (38.3%) work to earn money after school, while 273 (61.2%) do not work.

Table 4

Demographic characteristics of the respondents. (N = 609).

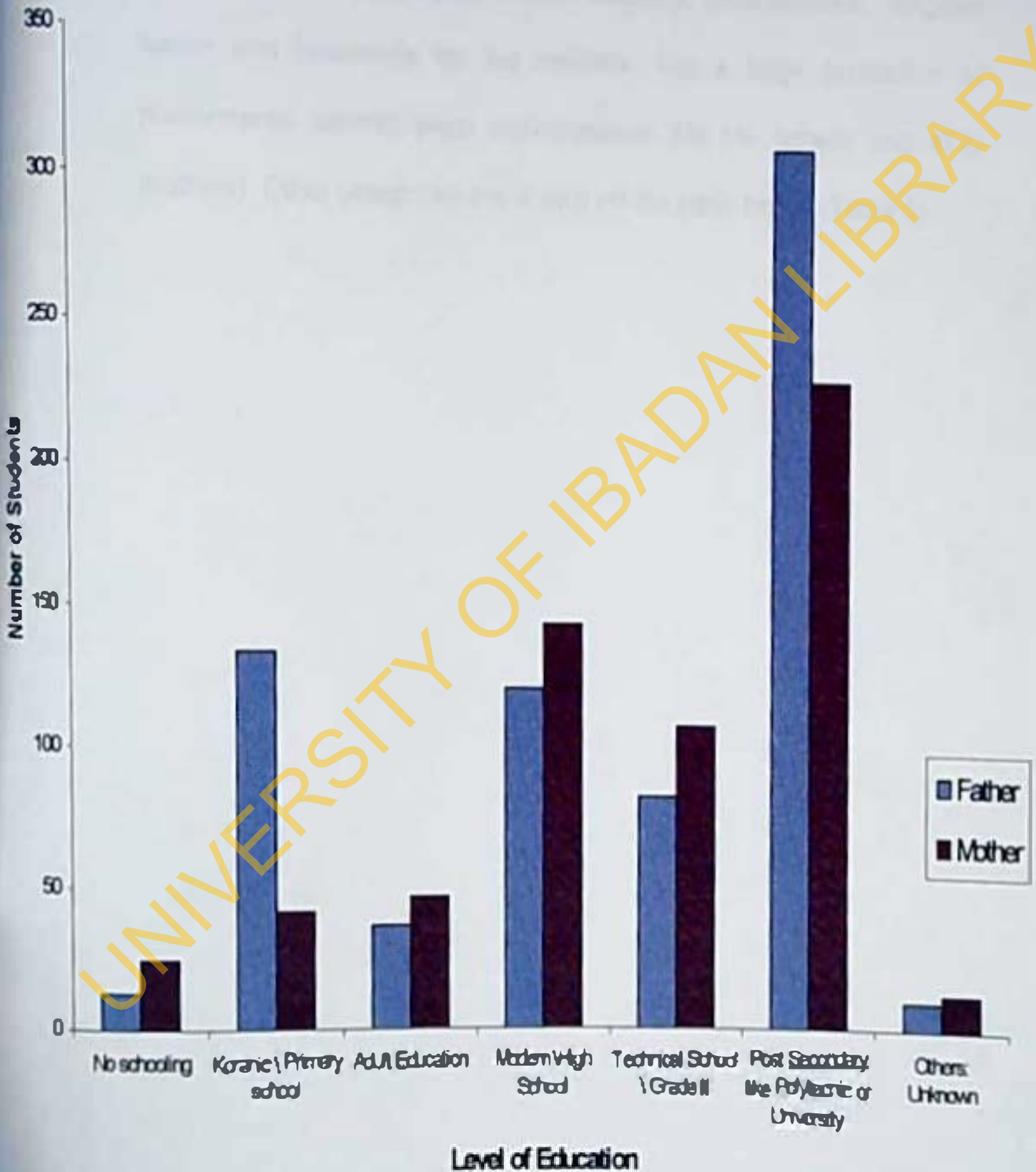
Demographic characteristics	No	%
Age		
10-13 years	59	9.7
14 – 17 years	452	74.2
18 – 21 years	78	12.8
Above 21 years	20	3.3
Sex		
Male	316	51.9
Female	293	48.1
Religion		
Christianity	432	70.9
Islam	169	27.8
Traditional religion	7	1.1
Jehovah witness	1	0.2
Living arrangement		
Living with both parents	491	80.6
Living with father only	39	6.4
Living with mother only	73	12.1
Guardian	4	0.7
Others	2	0.2
Work history		
Work to earn money after school	233	38.2
Do not work to earn money after school	373	61.3
Don't know	3	0.5
Class of respondents		
SSS ONE	305	50.1
SSS TWO	304	49.9

Parents' level of education

Respondents were asked the level of education of their parents. Slightly more than half of the respondents reported that their fathers' highest level of education is tertiary institution like the polytechnic and university; 311(51.1%). The same trend was also found among the mothers as shown in Figure 4.

Fig 4

Respondents' Parent's Level of Education



Parents' occupation.

Parents' occupation was broadly categorized into six namely civil servant, self-employed, artisan teaching, professionals, religious leader and housewife for the mothers. For a large proportion of respondents' parents were self-employed. (36.5% fathers and 47% mothers). Other categories are shown on the table below (Table 5).

Table 5

Respondents' parents' occupation

TYPE OF OCCUPATION	FATHER		MOTHER	
	N = 609	Percentage	N = 609	Percentage
Civil servant	129	21.1	69	11.3
Business / self employed	222	36.5	386	47.0
Artisan	67	11.0	27	4.4
Teaching	56	9.2	101	16.2
Professionals	111	18.2	62	10.2
Religious leader	24	3.9	8	1.3
Housewife	-	-	52	8.5

Use of drugs

Alcohol consumption

When asked on alcohol consumption, 223(36.6%) had tasted alcoholic beverage before. Of these, 147(67.7%) are current drinkers. Of the 147 respondents who are still drinking alcohol, the frequency of drink, type of drink and significant others in their lives who drink were surveyed. The findings showed that 23.8% drink alcohol daily, 44% do so monthly. Beer is frequently drunk more than other alcoholic beverages (Table 6). Classmates (44.2%) were most frequently quoted as acquaintance that consumed alcohol than others (Table 7).

Table 6

Respondents' pattern of use of alcohol.

Use of alcohol	N = 609	Percentage
Ever drank alcohol?		
Yes	223	36.6
No	386	63.4
Still drinking?	N = 223	%
Yes	147	67.7
No	76	32.3
Frequency of consumption	N = 147	%
Daily drinkers	35	23.8
Once a week	33	23.4
More than once a week	14	9.5
Once a month	65	44.2
Ever gotten drunk ?	N = 147	%
Yes	53	36.1
No	94	63.1
Type of alcohol consumed		
Beer	47	32
Palm wine/wine	39	26.5
Stout	6	4.1
Whiskey /Gin	24	16.3
Others (burukutu, Don Simon etc)	31	21.1

When asked about significant others who consumed alcohol, the result showed that respondents classmates 65(44.2%), has the highest frequency while mothers 20(13.7%) has the lowest. (Table 7)

Table 7

Respondents' significant others who consume alcohol.

Significant others who drink	No *	% *
Father	55	37.1
Mother	20	13.7
Brother / sister	45	30.5
Guardian	32	22.2
Teacher	53	36.1
Classmates	65	44.2

* Multiple responses are included.

Cigarette smoking

Respondents were asked if they had ever smoked cigarette. Findings showed that 45(7.5%) of the total respondents claimed to have smoked before. Out of these, 33(73.3%) are still smoking. Substances smoked are cigarettes, 24(53.3%), pipes, 8(17.8%) and tobacco leaf, 16(35.6%) (Table 6).

Cigarette smoking

Respondents were asked if they had ever smoked cigarette. Findings showed that 45(7.5%) of the total respondents claimed to have smoked before. Out of these, 33(73.3%) are still smoking. Substances smoked are cigarettes, 24(53.3%), pipes, 8(17.8%) and tobacco leaf, 16(35.6%) (Table 8).

Table 8

Use of cigarette and other substances the respondents

USE OF CIGARETTE	FREQUENCY N = 609	%
Ever smoked ?		
Yes	45	7.4
No	564	92.6
Still smoking ?	N = 45	%
Yes	33	73.3
No	12	26.7
Type of substance*		
Cigarettes	23	53.3
Pipe	8	17.8
Tobacco leaf	16	35.6
Indian hemp	15	33.3
Pawpawleaf	10	22.2

- Multiple responses are included.

The reported use of other psychoactive drugs showed that kola nut has the highest number of users, 110(18.1%) and the lowest had been ephedrine, 11(1.8%). (Table 10). In all 208(34.2%) respondents had used any form of psychoactive drugs before, while 102(48.6%) are still using it. Occasional users made up more than half of the users 61(59.8%) (Table 9).

Table 9

Pattern of use of psychoactive drugs by respondents.

Pattern of use of psychoactive drugs	N = 609	%
Ever used drugs?		
Yes	208	34.2
No	401	65.8
Still using drugs?		
Yes	102	48.6
No	106	51.4
Frequency of drug use	N = 102	%
Every day	18	17.6
Every week	23	22.5
Occasionally	61	59.8

Table 10

Types of psychoactive drugs used by the secondary school students in Ibadan.

TYPE OF DRUGS	No N = 208	%
Cannabis	15	3.5
Valium	24	3.9
Ephedrine	11	1.8
Heroine	14	2.3
Morphine	15	2.5
Cocaine	19	3.1
Kolanut	110	18.1
Glue	23	3.8
Librium	16	2.6
Mescaline	12	2.0
Petrol	22	3.6
Mogadon	15	2.5

- Multiple responses are included.

Sexual behaviour

One hundred and eighty-eight respondents (30.9%) reported that they had ever had sex. Out of these, 92 (48.9%) reported having sex in the one month preceding the survey, 39(20.8%) of these had sex with people other than their boy or girlfriends. Age at first intercourse range from 10 – 24 years with more than half (59.9%) having done so during the period between 14 – 17. The mean age at first intercourse was 14.5 years. ($P = 0.00$). Number of sexual partners range from 1 – 12 (Table 11).

Table 11

Pattern of sexual behaviour among secondary school students in Ibadan.

Pattern Of Sexual Behaviour	N = 609	%
Ever had sex ?		
Yes	188	30.9
No	421	69.1
Sex in the last one month before survey	N = 188	%
Yes	92	48.9
No	96	50.1
Age at first intercourse		
Age range		
10 – 13 years	56	30.1
14 – 17 years	115	59.9
18 – 21 years	11	6.1
Above 21 years	6	3.9
First sexual partner		
Boyfriend/Girlfriend	149	79.3
Uncle	15	8.0
Prostitute	10	5.3
Father	2	1.1
Others	5	7.7
Number of partners in the last six months		
One partner	85	45.2
Two partners	52	27.7
Three partners	13	6.9
More than three partners	20	10.6
None	18	9.6

Condom use

Respondents were asked if they used condom during their last sexual encounter. The percentage of those who reported using condom was 115(61.2%), while 73(38.8%) did not do so. Reasons given for not using condom were that it made sex uninteresting, (53.4%), lack of knowledge about how to use condom (23.3%) (Table 12).

Table 12

Reported use of condom during the last sexual intercourse among secondary school students in Ibadan.

Reported condom use during last sex	N = 188	%
Yes	115	61.2
No	73	38.8
Reasons for not using condom	N =73	%
Sex will be uninteresting	39	53.4
Don't know how to use condom	17	23.3
Sexual act unplanned	4	5.5
Partner will feel one is unfaithful	3	4.1
No reason given	10	14.7

Pregnancy and abortion

Fifty-three respondents had been pregnant or made somebody to be pregnant before. Of these, 29 (54.7%) opted for abortion. Various reasons were given for abortion and they include being not yet ready for the responsibility of parenthood. 19(65.5%), fear of pregnancy, 4 (13.8%). Eight of the respondents are still pregnant as at the time of this survey. (Details of other reasons for abortion are found in Table 13).

Table 13

Reported pregnancy outcome among secondary school students in Ibadan.

PREGNANCY OUTCOME	N = 53	%
Child born alive	7	13.2
Child born dead	9	17.0
Abortion	29	54.7
Still pregnant	8	15.1
Reasons given for opting for abortion	N = 29	%
Not yet ready to be a parent	19	65.5
Girl being shy of pregnancy	4	13.8
Don't feel responsible for pregnancy	3	10.3
*Other reasons	3	10.3

* Afraid of parents

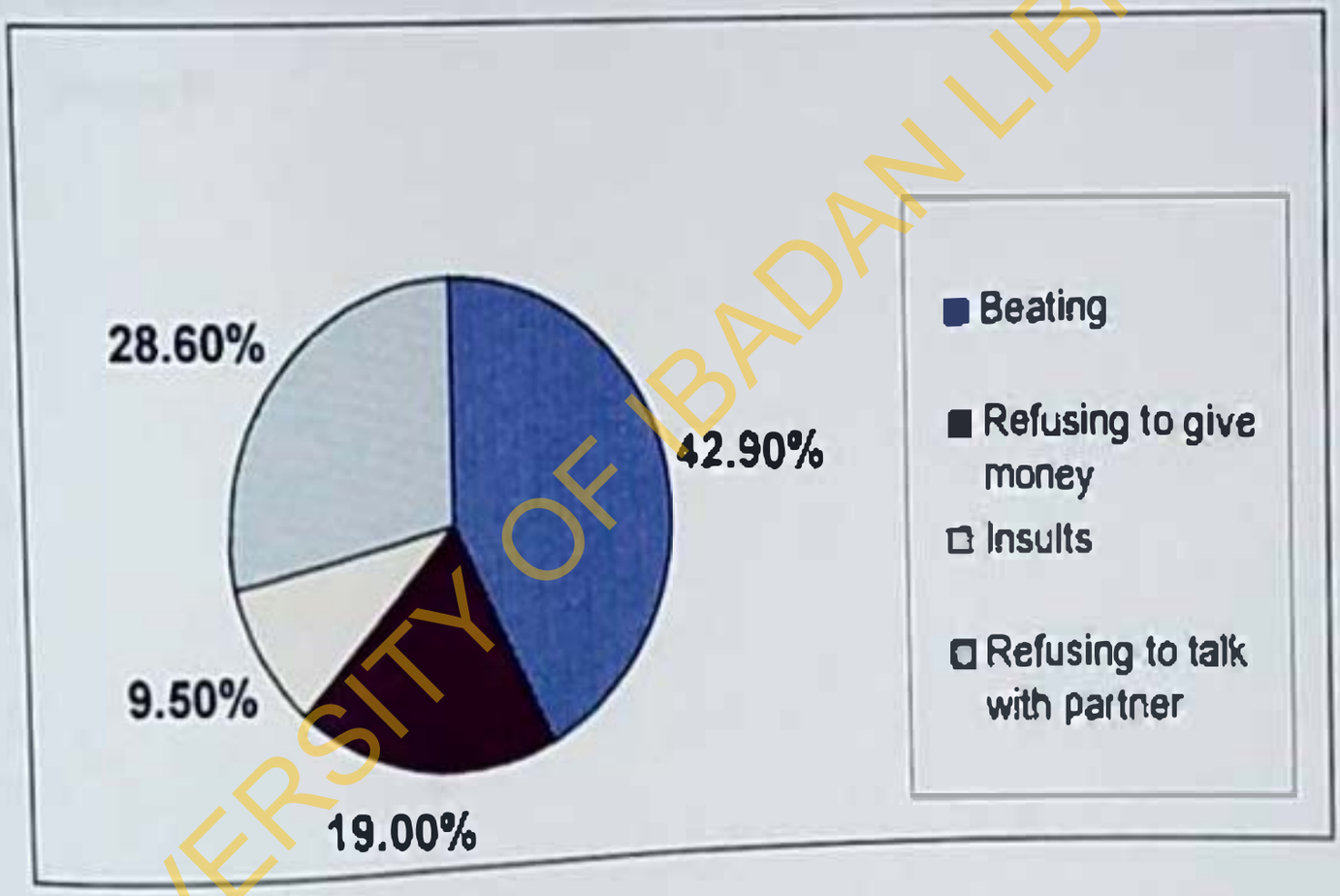
* Don't know what to do with pregnancy.

Sexual coercion

A total of 21 respondents reported that they have forced thier partners to have sex with them before. Forms of coercion used are shown in Figure 5. On the other hand 55 respondents, 20(36.3%) males and 35(63.3%) females reported that they had in turn been coerced to have sex before.

Fig 5

Type of force used to coerce partners

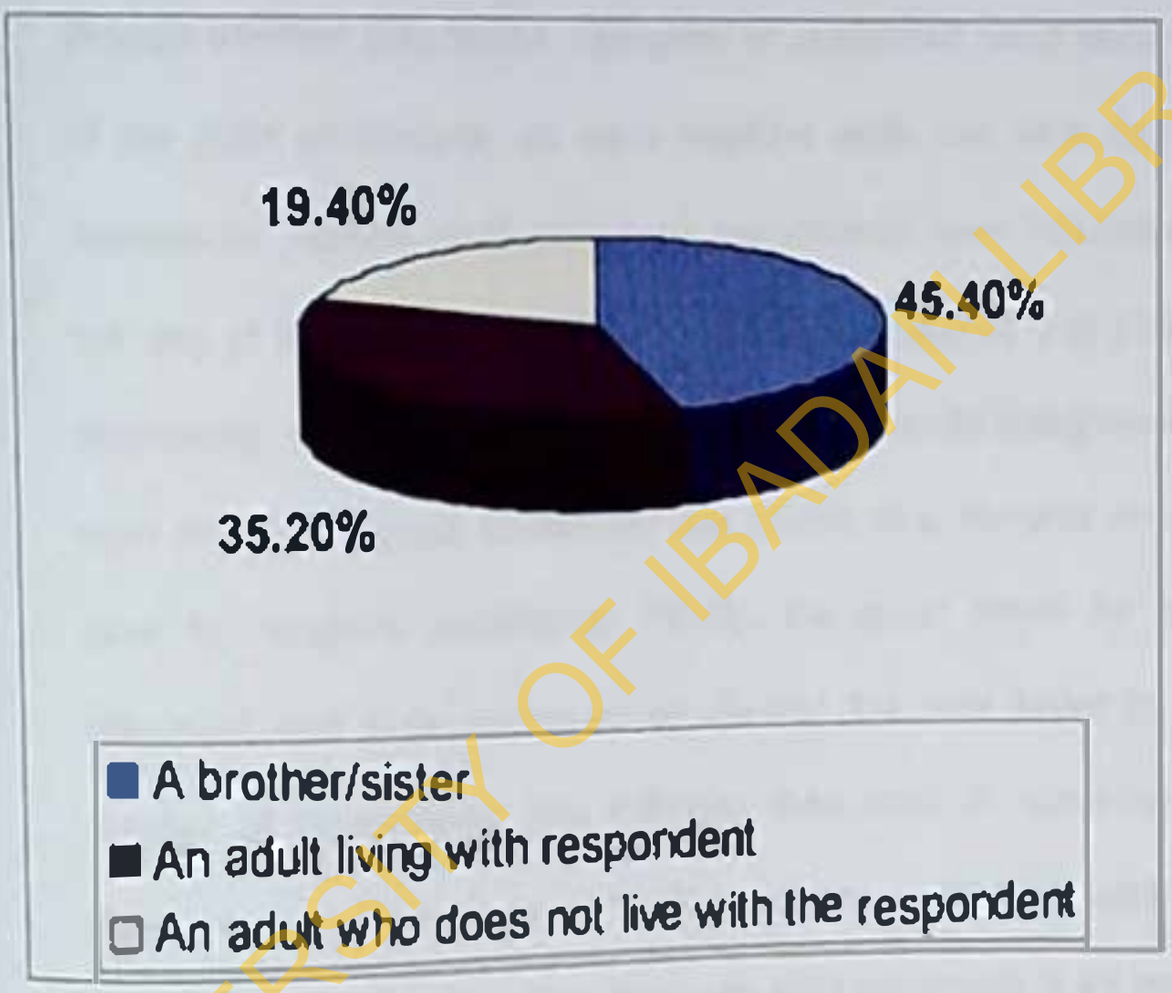


Physical abuse

Respondents were asked if they had been physically abused before; that is being forced to undergo punishment when they were innocent. Out of the total number interviewed, 346 (56.8%) had been abused. Perpetrators ranged from adults living with them to outsiders (Figure 6).

Fig 6

Perpetrators of physical abuse on respondents



Attitude towards risky behaviour

Measurement of attitudinal disposition towards risky behaviour was carried out. Eight statements to which respondents have to indicate whether they 'agree', 'disagree' or 'undecided' were used. Out of the eight statements, six were negative while two were positive statements. Against each statement, respondents were requested to tick any of the items. The responses were later scored. For positive statements, the agreement was scored 3 points while disagreements were allocated 1 point. Undecided was scored zero. Reverse was the case for negative statements. Finally, the mean score for each statement was then calculated by dividing the total score by the number of respondents who indicated their level of agreement or disagreement as the case may be. The mean score for each statement was obtained which is 2. The maximum point obtainable is 24 points. The two positive statements, questions 48 and 50 have mean score of 2.3 and 2.8 respectively. This is higher than the average showing unfavuorable attitudes to adolescents' smoking and unsafe sex. Negative statements responses also differ considerably with questions about having Sugar daddy/mummy having the highest mean of 2.9 representing 78% of the respondents(Table 14)

Table 14

Attitudinal disposition of respondents to risky behaviours.

STATEMENTS	Agree	Disagree	Undecided	Total	EMS	OMS
* Smoking dangerous to health; therefore young people should abstain from it. (P)	417 (69%)	146 (25.6%)	36 (5.9%)	1397	3	2.3
*Young people who cannot abstain form sex should use condom. (P)	436 (72%)	108 (17.7%)	65 (10.6%)	1416	3	2.8
A boy needs to have sex with many girls to show that he is a real man. (N)	143 (24%)	434 (71.3%)	32 (5.3%)	1445	3	2.1
A girl should have sex with many boys to show that she is popular. (N)	72 (12%)	498 (81.6%)	39 (6.4%)	1566	3	2.6
Having sugar daddy/mummy is necessary to get nice things. (N)	94 (15%)	463 (76%)	52 (86%)	1483	3	2.9
Young people need to take alcohol to make them feel okay. (N)	95 (15%)	450 (73.9%)	64 (10.5%)	1445	3	2.3
A boy needs to insist on having sex with a girl even if the she says is no. (N)	147 (24%)	396 (65%)	66 (10.8%)	1335	3	2.1
Young people need to have sex with meny partners and later settle for the best one. (N)	133 (22%)	425 (69.8%)	51 (8.4%)	1408	3	2.3
Total	1537	2920	405	11495	24	19.4

EMS = Expected Mean Score; OMS = Observed Mean Score
N = Negative statement, P = Positive statement

Comparison of risky behaviour with other demographic variables.

In comparing specific risky behavior with age, the respondents within the middle adolescents aged 14 – 17 years have the highest percentage for alcohol consumption, (61.4%), sexual intercourse, (29.9%), early sexual initiation (50.3%) as well as being victims of sexual abuses. (Tables 15 - 20) The statistical test on the above mentioned behaviours were also significant; 0.02, 0.00 and 0.00 respectively. The statistical test at 0.967 shows that age group of the respondents does not significantly affect the number of sexual partners that the respondents have. Comparing age of respondents at first sexual intercourse, the result shows that higher number of respondents had had sexual intercourse by the time they were 17 years old. The p. value at 0.00 shows that sexual initiation is significantly associated with the age of the students.

Comparing the gender of respondents who consume alcohol, there are more males 126(56.5%) than female drinkers 97(43.5%); while the numbers of male smokers double that of female smokers. Thirty-one (68.9%) males to 14(31.1%) female smokers.

Table 15

Respondents' Alcohol consumption by age.

Age group	Ever consume alcohol?		Total
	YES	NO	
10 – 13 years	17	42	59
14 – 17 years	137	246	383
18 – 21 years	51	87	138
Above 21 years	18	11	29
Total	223	386	609

$x^2 = 9.64.$ df = 3 p. = 0.02

Table 16

Respondents who smoke cigarettes by age

Ever smoke cigarette?	Age group				Total
	10 - 13 YEARS	14 - 17 YEARS	18 - 21 YEARS	Above 21 YEARS	
YES	2 (0.3%)	17 (2.8%)	19 (3.1%)	7 (1.1%)	45 (7.3%)
NO	56 (9.2%)	353 (57.9%)	114 (18.7%)	21 (3.4%)	564 (89.4%)
TOTAL	58 (9.5%)	30 (60.7%)	133 (21.8%)	28 (4.5%)	609 (100%)

$x^2 = 48.21$ df = 3 p. = 0.00

Table 17

Respondents' Sexual behaviour by Age.

Ever had sex?	Age group				Total
	10 - 13 YEARS	14 - 17 YEARS	18 - 21 YEARS	Above 21 YEARS	
YES	9 (1.5%)	94 (15.4%)	63 (10.3%)	22 (3.6%)	188 (30.8%)
NO	45 (7.4%)	270 (44.3%)	64 (10.5%)	42 (6.9%)	421 (69.2%)
TOTAL	54 (8.9%)	363 (59.7%)	127 (20.8%)	64 (10.5%)	609 (100%)

$\chi^2 = 48.21$ df = 3 p. = 0.00

Table 18

Respondents' age at first sexual intercourse.

Current Age	Age at first sex								Total
	10 – 13 YEARS		14 – 17 YEARS		18 – 21 YEARS		Above 21 YEARS		
	YES	NO	YES	NO	YES	NO	YES	NO	
10 – 13 YEARS	7	0	34	0	13	2	2	1	59
14 – 17 YEARS	0	0	57	140	44	111	14	76	452
18 – 21 YEARS	0	0	0	0	5	70	5	3	83
Above21 YEARS	0	0	0	0	0	0	7	8	15
TOTAL	7	0	91	140	62	183	30	88	609

$x^2 = 132.3$ df = 39 p. = 0.00

Table 19

Victims of physical abuse by age.

Ever experienced abuse?	Age group				Total
	10- 13 YEARS	14 - 17 YEARS	18 - 21 YEARS	Above21 YEARS	
YES	28 (4.6%)	233 (38.3%)	67 (11%)	18 (3%)	346 (57%)
NO	31 (5.1%)	148 (24.2%)	74 (12.1%)	10 (1.6%)	263 (43%)
TOTAL	59 (9.7%)	381 (62.5%)	147 (23.1%)	28 (4.6%)	609 (100%)

$x^2 = 10.15$ df = 3 P = 0.01

Table 20

Respondents' use of condom during the last sexual intercourse by age.

Condom use	Age group				Total
	10 – 13 YEARS	14 – 17 YEARS	18 – 21 YEARS	Above 21 YEARS	
YES	5 (2.7%)	50 (26.6%)	50 (26.6%)	10 (5.3%)	115 (61.2%)
NO	2 (1.1%)	46 (24.4%)	14 (7.4%)	11 (5.9%)	73 (38.8%)
TOTAL	7 (3.8%)	96 (51%)	65 (34%)	21 (11.2%)	188 (100%)

$x^2 = 13.35$ df = 3 p = 0.004

Table 21

Gender differences of Respondents who had taken Alcohol.

Gender	Ever drunk beer?		Total
	YES	NO	
Male	126 (20.7%)	192 (31.5%)	316 (52.2%)
Female	97 (15.9%)	194 (31.9%)	293 (47.8%)
Total	223 (36.6%)	386 (63.4%)	609 (100%)

$x^2 = 2.79$ df = 2 p = 009

Table 22

Respondents who smoke by gender.

Gender	Ever smoked cigarettes?		Total
	YES	NO	
MALE	31 (5.1%)	285 (46.8%)	316 (51.9%)
FEMALE	14 (2.3%)	279 (45.8%)	293 (48.1%)
TOTAL	45 (7.4%)	564 (93.6%)	609 (100%)

$x^2 = 6.11$ df = 2 p = 0.01

Table 23

Respondents' psychoactive drug use by gender

Drugs	Ever use drugs			
	MALE		FEMALE	
	YES	NO	YES	NO
Cannabis	8	308	7	282
Valium	14	301	10	280
Ephedrine	17	308	4	286
Heroine	10	305	4	286
Morphine	10	305	5	287
Cocaine	12	303	7	284
Kolanut	89	246	41	250
Glue	13	302	10	10
Librium	12	302	4	286
Mescaline	6	308	6	285
Petrol	16	298	6	285
Mogadon	9	304	9	284
Total	*	*	*	*

* * multiple responses.

Table 24

Respondents' Sexual behaviour by gender

Gender	Ever had sexual contact?		Total
	YES	NO	
MALE	124 (20.4%)	192 (31.5%)	316 (51.9%)
FEMALE	64 (10.%)	229 (37.6%)	293 (48.1%)
TOTAL	188 (30.9%)	421 (69.1%)	609 (100%)

$x^2 = 17.38$ df = 2 p. = 0.00

Table 25

Victims of physical abuse by gender

Gender	Ever been abused?		Total
	YES	NO	
MALE	189 (31%)	127 (20.9%)	316 (51.9%)
FEMALE	157 (25.8%)	136 (22.3%)	293 (48.1%)
TOTAL	346 (56.8%)	289 (42.6%)	609 (100%)

$x^2 = 2.26$ df = 2 p. = 0.13

While comparing risky behaviour according to class, SSS Two students have higher numbers of those that consumed alcohol, smoked cigarettes, and had sexual intercourse as shown in Table 26. On the other hand, higher number of respondents who had been victims of physical abuse were in SSS One than in SSS Two (Table 27).

Comparing those who worked after school with their level of risky behaviour, significantly more students 128 (21%) who worked after school engaged in one form of risky behaviour or the other (Table 28).

Comparing the attitudinal disposition of the respondents to risky behaviours, there is significant relationship between attitude to risky behaviour and the age of the respondent, gender and class. ($p = 0.00$, 0.00 and 0.00)

Table 26

Respondents' risky behaviour by class.

Class	Risky behaviour					
	Alcohol consumption		Smoking		Sexual contact	
	YES	NO	YES	NO	YES	NO
SSS One	103 (33.8%)	202 (66.2%)	18 (5.9%)	286 (93.8%)	87 (28.5%)	218 (71.5%)
SSS Two	120 (39.5%)	184 (60.5%)	27 (8.9%)	277 (91.1%)	101 (33.2%)	203 (66.8%)

Table 27

Physically Abused Respondents by class.

Class	Ever been abused?		Total
	YES	NO	
SSS One	179 (29.4%)	125 (20.5%)	304 (49.9%)
SSS Two	167 (27.4%)	138 (22.7%)	305 (50.1%)
TOTAL	346 (56.4%)	263 (43.6%)	609 (100%)

$x^2 = 1.08$ df = 2 p. = 0.29

Table 28

Number of respondents who worked after school and engaged in risky behaviour

	Ever engaged in risky behaviour?		Total
Work after school?	Yes	No	
Yes	128 (21%)	105 (17.5%)	233 (37.2%)
No	169 (27.8%)	207 (34%)	376 (61.8%)
Total	297 (48.8%)	317 (51.2%)	609 (100%)

$x^2 = 15.84$ df = 3 p. = 0.001

Table 29

Analysis of variance of respondents' attitude to risky behaviour by age.

Age group	Number	Total	Means	Variance	Standard deviation
10-13 Years	59	210	3.559	31.182	5.584
14-17 Years	381	1518	3.984	25.010	5.001
18-21 Years	138	858	8.897	31.748	5.835
Above21 Years	29	258	8.897	54.310	7.370

ANOVA

Variation	SS	df	MS	F statistic	p-value
Between	1100.284	3	366.761	12.871	0.00000
Within	17182.616	603	28.495		
Total	18282.900	606			

Table 30

Analysis of variance of respondents' attitude to risky behaviour by gender.

Gender	Number	Total	Mean	Variance	Standard deviation
Male	316	1728	5.468	33.774	5.812
Female	293	1116	3.809	24.895	4.989
Difference			1.659		

ANOVA

Variation	SS	df	MS	F statistic	p-value
Between	418.680	1	418.680	14.191	0.0001
Within	17907.980	607	29.502		
Total	18326.660	608			

Table 31

Analysis of variance of respondents' attitude to risky behaviour by class

Class	Number	Total	Mean	Variance	Standard deviation
SSS One	304	1350	4.441	25.541	5.054
SSS Two	304	1491	4.905	34.828	5.901
Difference			-0.464		

ANOVA

Variation	SS	Df	MS	F statistic	p-value
Between	32.699	1	32.699	1.083	0.298366
Within	18291.168	606	30.183		
Total	18323.867	607			

Bartlett's test for homogeneity of variance

p-value = 0.007

Multiple risky behaviour

Two hundred and fifty-two students (41.3%) out of the entire study population had participated in at least one risky behaviour. Out of these, 144 were males while 108 were females (Table 32). Seventy-four respondents had engaged in at least two risky behaviours (alcohol consumption and having sex without condom.) Fifteen respondents had engaged in alcohol consumption, smoked cigarettes and had sex without condom (Table 33).

Table 32

Respondents' participation in at least one risky behaviour by gender

Gender	Participated in at least one risky behaviour		
	Yes	No	Total
Male	144 (23.6%)	172 (28.2%)	316 (51.8%)
Female	108 (17.7%)	185 (30.5%)	293 (48.2%)
Total	252 (41.3%)	357 (58.7%)	609 (100%)

$X^2 = 6.43$ df = 2 p. = 0.040

Table 33

Respondents' participation in at least one risky behaviour by age

Age group	Participated in at least one risky behaviour		
	Yes	No	Total
10-13 Years	23 (3.8%)	36 (5.9%)	59 (9.7%)
14-17 Years	131 (21.5%)	319 (52.1%)	452 (73.9%)
18-21 Years	78 (12.8%)	0 (0%)	78 (12.8%)
Above 21 Years	20 (3.3%)	2 (0.3%)	22 (3.6%)
Total	252 (41.4%)	359 (58.6%)	609 (100%)

$X^2 = 57.18$ $df = 9$ $p. = 0.000$

Table 34

Respondents' participation in at least one risky behaviour by class

Class	Yes	No	Total
SSS One	120 (19.7%)	185 (30.3%)	305 (50.1%)
SSS Two	132 (21.7%)	172 (28.2%)	304 (49.9%)
Total	252 (41.4%)	357 (58.6%)	609 (100%)

$X^2 = 4.52$ df = 3 p = 0.21

Table 35

Family background and risk behaviour status of respondents

Home background	Participated in risky behaviour?		
	Yes	No	Total
Living with both parents.	225(36.9%)	266(43.7%)	491(80.6%)
Living with Father only.	9(1.5%)	30(4.9%)	39(6.4%)
Living with mother only.	15(2.5%)	58(9.5%)	73(12.0%)
*Others.	3(0.5%)	3(0.5%)	6(1%)
Total	252(41.4%)	357(58.6%)	609(100%)

* Guardians, Uncles etc.

Table 36

Participation in multiple risky behaviours (alcohol consumption, sex without condom, smoking and drunk driving) by classes

Risky behaviour	SSS One	SSS Two	Total
Engaged in one risky behaviour	85 (14%)	81(13.3%)	166(27.3%)
Consumed alcohol and smoked cigarettes.	25(4.1%)	36(5.9%)	61(10%)
Consumed alcohol, smoked cigarettes and had sex without condom.	7(1.2%)	14(2.3%)	21(3.5%)
Consumed alcohol, smoked cigarettes, had sex without condom and drove while drunk.	3(0.4%)	6(1.0%)	9(1.4%)
Did not engage in risky behaviour.	184(30.2%)	168(27.6%)	352(57.8%)
TOTAL	304 (49.9%)	305 (50.1%)	609 (100%)

$X^2 = 6.98$ df = 8 p.= 0.53

Summary of Findings

In summary, the data comprises of indepth interview of the school counselors, Focus Group Discussion of the students and survey questionnaire. The result of in-depth interview brought out the fact that truancy, decline in academic standard and smoking were among the major risky behaviours prevalent among the students.

The Focus Group Discussion brought out the fact that students consider smoking, alcohol consumption and abortion as being part of major risky behaviours. The discussion also brought out the likely reasons why students engage in these risky behaviour and they include questioning parents authority, boredom among others.

The survey results revealed that those of the middle adolescence persistently engaged in all the risky behaviours than others. The male respondents also engaged in risky behaviour more than their female counterparts accounting for the majority in all the risky behaviour examined. More SSS two students had also participated in risky behaviour than the SSS one students.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

The implications of the results are discussed in this chapter under the following headings: socio-demographic characteristics of the students, prevalence of risky behaviours among the respondents, attitude, and multiple risky behaviours, implication for health education and recommendations for reducing the prevalence of those risky behaviours.

Socio-domographic characteristics

The age of the respondents ranged from 10 to 24 years. This is a very impressive age bracket that coincided with the onset of adolescence and its termination in young adulthood (Hamburg and Takanishi, 1989). 74.5% were between the ages of 14 -17years. Specifically, 156 (25.7%) were fifteen year olds. The age range indicates the fact that they have passed through primary education as well as junior secondary. At the senior secondary level, the students were exposed to various avenues for engaging in risky behaviours. Previous studies also support wide differences between the prevalence

of risky behaviour among the primary school, junior secondary and secondary school student (Ajuwon, 2000). Tendencies to engage in risky behaviour increases with age among the adolescents. This implies that students at the upper classes are at most risk of engaging in risky practices.(Kolbe,et al, 1993).

Also this is the stage they are most receptive to information from various sources as a result of their literacy level. This means that education programme such as asserlive skills; AIDS awareness as well as reproductive health can be disseminated more easily through the printed materials. (Dada et al; 1998). Wrong information and misinformation are also easily disseminated among the students at this stage.

About 20% live with one parent or relatives. The implication of this is that such students my not receive adequate attention and care like those that live with both parents this considerably exposes them to nsky behaviour more than those that live with both parents.

Quite a sizeable number (38.3%) of the respondents work to earn money after school. A similar finding has been reported by other studies in Ibadan (Ajuwon et al 2002). This may de due to the depressed economy that impoverishes the family. Another reason may be due to the ease of trading and engaging in other economic activities

as a result of living in an urban area. This however, may have a far reaching adverse effect on the students such as distracting them from their studies. Source of earning money may also open up the females to risky sexual practices as well as sexual coercion. For example, in a study carried out among adolescent hawkers in bus and truck stations in Ibadan, 15% of the respondents were raped by older men. (Orubuloye et al, 1993).

The main occupations for a large proportion of the students' parents are, trading or self-employment, 38.5% for fathers and 47% for mothers. This trend reflects the occupation of the indigenous inner city dwellers that cater for the teeming population of the city (Awokoya, 1983). The implication of this is that many parents may not really have the time to monitor their children adequately. This is due to the fact that the parents may devote more time especially in the daylight hours to struggling for their business at the expense of spending time with their children. This factor was one of the points put forward by one of the interviewed counselors that predispose some of the students to engage in risk taking behaviour. The level of education for the majority of fathers (51.1%) is post-secondary or tertiary levels of education, while (37.8%) of the mothers were in this category.

Risk Behaviours

Use of drugs:

Alcohol consumption among young people is widespread around the world. In a nation-wide study carried out among adolescent students ages between 10 – 21 years in South Africa, Rocha-Silva ,De Miranda and Erasmus(1994) found a prevalence of 42.5% who abuse drugs including alcohol and tobacco. Compared with this study of 36% the rate of consumption is lower. This may be due to the fact that alcohol adverts had been restricted to nine o' clock p.m. thereby placing a restraint on passing the information to impressionable adolescents. Alcohol is seen as a gateway drug to other psychoactive substances. The consumption is rampant because of the social value of the drug in the county. Among the respondents, 8.7% admitted that they have been drunk before. The adverse effect of alcohol consumption and drunkenness is seen in its ability to impair judgment and to generally lower inhibition. This can aid the adolescent in engaging in risky behavoiur, which he/she would otherwise not have engaged in. A lot of cases of unsafe and unprotected sex have been attributed to influence of alcohol as mentioned elsewhere in this study (Jong Kwo Lim et al, 1995). In this study, 23.8% of the respondents were daily drinkers. Consuming alcohol on daily basis has its adverse

effect on students' class attendance. This is because alcohol consumption can impair judgment, cause temporary loss of memory, decline in academic performance, increase in accidents and risky behaviour. (WHO; 1998; Awelenje; 1998) the percentage found in this study is higher than that of the study carried out in USA where daily drinkers among high school seniors are found to be 3.5%. (Johnston, O'Maley and Bachman, 1995). In this study, peers accounted for 44.2% of acquaintances that consume alcohol, this strongly points to peer influence in risk-taking behaviour. This is similar to a study carried out by Okoro (1986) where peer pressure was one of the major reasons for alcohol consumption among youth. Beer was more frequently drunk (32%) than any other alcoholic beverages.

Tobacco use:

In the survey, a total of 45(7.4%) students admitted to smoking. This prevalence is low compared with findings in other studies. Twenty-one percent among adolescents in Lagos and 16% among secondary school students in Ilorin. (Anumonye, 1980; Adelekan et al, 2001) Reasons adjudged for smoking from the FGDs among boys include influences from advertisement where cigarette smoking is glamorized and associated with virility, success, adventure and independence. Other reasons include inducement in form of promotion

of popular sports where youth can answer simple questions and win expensive gifts (Liskin *et al*, 1985, Awelenje; 1998). The low trend in smoking recorded in the survey may be due to the clause imposed on cigarette advertisements in prime time adverts supplying information that smokers are liable to die young. The government policy to limit cigarette adverlisement to such a time in the night when the adolescents most commonly impressed by the glitz of the advertisement would have slept may also be a contributory factor.

Other substances used include paw paw leaf (22.2%), Indian hemp (33.3%) tobacco leaf (35.6%). Further studies are needed in the use of paw paw leaf to determine the psychoactive component in it. Among the smokers, only 26.7% had stopped smoking while 73.3% were still smoking. This is instructive for intervention and educational purposes.

Other psychoactive drugs:

The use of other psychoactive drugs such as cocaine heroine kola nuts mogadon, cannabis and others by the respondents was still low as less than four percent use them. This is lower than the report from one national survey in USA where 12.7% of the respondents had smoked cannabis in the last one month (Blume and Rhinehart, undated). In a similar study among University of Ibadan students 17%

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had used cannabis, while 7.6% used amphetamines and LSD 4.9%. However, kola nut is used widely by the students as 18% of them admitted to using kola nuts at one time or the other. The reason may be the belief that kola nut make students to stay awake to read during examinations. It is therefore important to educate the students about the adverse effects and the health hazards associated with using the stimulant. Such hazards include intensifying tolerance, addiction and caffeine levels in the blood.

The majority of drug users were males. This may be attributed to peer pressure in the sense that the males tend to form larger group bonds than the females. In the case where the group in which the male adolescent moves uses drugs there is higher likelihood that such adolescent will also use drug. Another reason why the drug use is confined to the males may be the tendency to experiment among the males.

Sexual behaviour:

Among the study population. 30.9% had had sexual intercourse; however, more males (72%) than females (34%) had done so. This finding is comparable with the results from study carried out in Ilorin, Kwara State, Nigeria among secondary school students adolescents aged between 10 and 19 years old where males were sexually more

active (32.8%) than their female counterparts (13.7%) (Abdulkarim, Mokuolu and Adeniyi, 2003). The reason for this may be the tendency as mentioned earlier for males to engage in more risky behaviours than their female counterparts. The prevalence of 30.9% is lower than similar studies in Ile-Ife (Jinadu and Odesanmi; 1993) where 60% of male secondary school students were sexually active, and in Ibadan where a prevalence of 59% was reported. (Olaseha and Alao, 1993). However the result in this study was similar to that obtained in Akure where the study showed a prevalence of 29% (Oladepo and Brieger; 1997). These results reflect the trends found in urban population, whose adolescents have greater access to pornographic materials and social pressures from the media. Another reason for high report of sexual activities may be less inhibition and reprisals among the urban students. Other reasons are abolition of traditional and religious norms that frown on premarital sexual activities. (Adekunle and Ladipo, 1992). The popularity of extended families in the rural area as against nuclear families found in the urban centres make it possible for adolescents and young people in the rural areas to b checked in cases of misbehaviour by the elderly ones other than their parents. This is lacking in the urban areas where families are predominantly nuclear. In case where one or both parents are not available to check the

adolescents, there tend to be a gap in supervision and monitoring. This gap can be exploited negatively by the adolescents to engage in risk-taking behaviour that can have adverse effect on the adolescent.

In this study, the mean age at sexual initiation is 14.5 years. This is lower than the survey carried out by Abdukarim et al (2003) in Ilorin where the mean age at first intercourse is 11.3 years. Another study carried out by Advocates for Youth among adolescents in developing countries put the median age at sexual initiation at 16 (Advocates for Youth, 1995). This significantly points to early sexual initiation. As many as 30.3% of the sexually active students had had sex by the time they were 13years old. This exposes such students to early risk-taking and increases their chances of taking sexual risk later in future. According to Wilson et al (1995), the earlier young people become sexually active, the more likely they are to change sexual partners and thus the higher their risk of exposure to STIs, HIV and AIDS. Knowing that the mean age at menarche is12.5, years, it is therefore important that an intervention programme is needed to educate the adolescent at the point of puberty to enable them makes the right decisions about their health especially their sexual behaviour.

Half of the respondents who engage in sexual activities have multiple sexual partners between 3 – 12 in the last 6 months. This is

similar to the findings of Awelenje (1998) where 61.1% have more than one girlfriend among the adolescent apprentices in Ibadan. In this study, age group did not significantly affect the number of sexual partners that the respondents have. However there is significant association between the ages of the respondents and whether they had had sexual intercourse before. The risk of infection with STI/HIV/AIDS among persons with multiple sexual partners is well documented by Cates and McPheeleis(1997). they fond that of 50% of all cases of HIV infections occur among young persons under 25 years, two out of every three STIs infections occur among people less than 24 years old. Coupled with this is the fact that, students generally do not go for medical check ups or seek care until they are physically unable to function. Even though government- owned clinics have family planning services, attitude of service provider is negative as any student going there considered promiscuous and will be treated as such. Furthermore, having mulliple sexual partners comprising of various groups of people pinpoints the level of sexual networking among the youth. This increases the chance of spreading the infection beyond this age group.

The reported prevalence of condom use is high among the sexually active students (58.9%). This is a positive development. However, findings may be taken with caution as this behaviour is a reported behaviour with no means of verification. The result of condom use is similar to that obtained in the study of adolescent apprentices in Ibadan North local government where the prevalence is 57.1% (Awolenje, 1998). Thirty-eight percent did not use condom during the last sexual intercourse. This high percentage is a cause for concern as unprotected sex places the young person at the risk of sexually transmitted diseases, unwanted pregnancy and unsafe abortion. Reasons given for not using condom among the respondents include the fact that sex will be uninteresting (53.4%), lack of knowledge about how to use condom (23.3%). There is also the belief that the girl is responsible for contraceptives in any sexual episode (FGD). In similar studies elsewhere, Amazigbe et al (1998), found other reasons to include outright nonchalance among adolescents and thee belief that a slipped condom will destroy the girl's womb. These reasons call for urgent intervention to enlighten the respondents about the importance of using condom and problems that can be encountered from not using it.

Among the respondents that were sexually active, 28% had either been pregnant or made someone to be pregnant before. Out of these 29(54%) opted for abortion. This is a disturbing finding as more than half of those who were pregnant aborted it. In a study carried out by Brabin, Kemp and Obunge (1995), among females in Port Harcourt, Nigeria, 42 percent of the adolescent had undergone abortion. In another study, Persaud (1994) found out that 5 million out of the 50 million induced abortion episodes worldwide occur in women aged 15-19 years. This finding points to the need for a comprehensive educational package both for community members and the adolescent to safeguard against the complications that might arise from abortion.

Sexual coercion

From the survey, a total of 29.3% respondents reported that their first sexual encounter occurred due to coercion. The respondents in turn coerce their partners to have sex with them. Forms of coercion reported include violence, threats, and loss of monetary gift. This was in line with the finding of Heise, Moore and Toubia,(1995) where sexual coercion was reported as taking place among their subject first sexual experience. From the finding there are indications that the reported behaviour may be an underestimation of what really go on as found during the pretest where one of the female respondents wrote

that she was sexually coerced by her father when she was eight years old. Such admissions take courage to say. A lot of the victims found it traumatic to even recount the episode, preferring to consign it to the dark unhappy past.

Also 38% of the respondents admitted to coercing others into having sex with them and the mode frequently mentioned was beating.

Multiple Risks

From the survey, 252 (41.4%) respondents had participated in at least one risky behaviour. When risks were compared with classes, SSS 2 have consistently higher risk behaviour than SSS I. This is similar to the studies of Neinstein (1997) where tendency to take risk advanced with grade. Risky behaviour is also pronounced among those that work after school with (54.9%) engaging in risky behaviour. Generally, number of students who participated in risky behaviour decreases as the number of the behaviour increases. The implication of these findings is that students tend to stick to one risky behaviour. However, this should be taken with caution because, these are reported behaviour. It is also important to know that students that engage in multiple risky behaviours are likely to influence others to join them in such behaviours.

Attitudes towards risky behaviour

Attitudes towards risky behaviour are above average with the respondents scoring persistently more than 2 in all the questions asked. Attitudes towards risky behaviour should be focused upon. Since this is one of the important aspect of health education. Attitude depends on perceived benefit, belief, need availability as well as accessibility to these risk behaviours. According to heath belief model, if there is no perceived benefit, a particular behaviour will not be imbibed. In the same vein, the period of experimentation or a period of embarking on a behaviour as a result of the perceived benefit to be gained from such behaviour. To discourage youth therefore from engaging in risky behaviour, the individual perception of susceptibility should be reinforced among the youths to discourage them from participating in risk-taking behaviour. The reinforcing factors in fonn of media, peer group, training, mass campaigns well as youth counseling will discourage the youths from engaging high risk behaviour.

From the study, a large proportion of the respondents are aware of what the risks are, but such awareness need to be translated into action. In comparing the responses of the attitudinal questions with the level of risks taken by the respondents; the implication is that the avenues on ground may not be enough to discourage the adolescents

from engaging in high risk behaviour. Deliberate efforts must be made to include complimentary intervention strategies.

The messages in the media should be varied taking in the popular models that are the favorites of the adolescents to encourage them to learn social roles from such models. Other factors that can be learnt through social learning theory will include working within the environment especially through family mobilization to disseminate information about reducing risky behavior among the adolescents.

Conclusions

The study looked into the prevalence of risk-taking behaviour among the students in Ibadan North Local Government. The study showed that larger number of adolescents had drunk alcohol, while the lowest percentage is found among those who smoked cigarettes. Schools are major agents of dissemination of information and socialization. Lessons learnt from the study include the fact that reproductive health knowledge about risky behaviour is very low and risky behaviour persists in the sample population. Multiple risk behaviour is still low compared with other similar studies. Specific rates are however, high indicating urgent need for interventions especially for reducing the case of physical abuse as reported in the FGD and survey.

Rocommendations

In line of the prevalence of risky behaviour among the students, the following recommendations are made;

1. Health education curriculum in schools should include avenue for seeking care by the students to avoid taking unnecessary risks.
2. Schools should be encouraged and if possible given incentives to implement the Oyo State policy on teaching reproductive health education in both public and private schools.
3. Students should be trained as peer educators to provide peer counseling to avoid negative peer pressure.
4. Special seminars and talk on assertiveness should be given to the students from time to time on how to avoid high risks.
5. Mass media should provide enlightenment programmes using discussion panels, debates sports and special programmes focused on the youths.
6. More teen clinics should be established end run by care givers who are sensitive to the needs of the adolescents.

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APPENDIX 1

IN-DEPTH INTERVIEW FOR COUNSELORS ABOUT RISKY BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS

Good day Sir/Madam

My name is Omole Grace and I am conducting a research on risky behaviour among secondary school students. As the gatekeeper and counselor for the students, I need your opinions about what constitute risk among the students. I will be grateful, if you can answer the following questions in detail. Thanks for your cooperation.

1. What are risky behaviours from your point of view?
2. How does these behaviours constitute risks to the students?
3. How often have you encountered cases of these risks among your students?
4. What effect does these risks have on the academic performance of the students?
5. What effect does these risks have on the academic performance of other students?
6. What effect does tha risks have on other students?
7. How does the affected students perceive those risks themselves?

8. Are there cases where students have mentioned those risks to you?

9. Are there any risks that the students themselves does not perceive as risks?

10. What is the level of peer influence on perpetration of these risks?

11. What motivates students to take those risks?

12. What discourages students from engaging risks?

13. How often do students that have problems of abuse come to seek help from the counsellor?

14. How successful have you been in helping abused student?

Thank you.

Appendix 2

FOCUS GROUP DISCUSSIONS GUIDELINES FOR RISKY BEHAVIOURS AMONG STUDENTS IN IBADAN NORTH LOCAL GOVERNMENT

Good day and welcome to this group discussion. I am assisting in collecting data for postgraduate programme in department of Health Promotion and Education. We have invited students with similar experiences to share their ideas and perceptions about risky behaviour among adolescents. What are the causes and other relevant opinion. You have been invited to this discussion because your views are important to us. Please do not hesitate to share your opinion even if you think it is wrong. Your opinions will be tape recorded and a colleague will also take notes to ensure that you do not forget anything. No names will be recorded and your opinion is confidential. The information you provide will assist in our research purposes. The discussion will last an hour. Thank you.

1. With whom do you spend most time after school?

2. What sorts of activities do they engage in?
3. What does a typical week looks like?
4. What does a typical weekend look like?
5. Do you work at the end of the school hours?
6. At what age boys and girls start to "go out" together?
7. Do young people who are "going out" together have sex with each other?
8. At what age to young people should start having sex together?
9. Why do young people have sex?
10. Do young people experience any form of pressure to have sex?
11. It is acceptable to have sex before you ere married?
12. What kinds of substances do people use?
13. How and where can they get these substances?
14. Do you drink alcoholic beverages? Mention types.
15. How many cups/bottles can one drink to get drunk?
16. Do you know anybody that is close to you that smokes?
17. Have you tried it before? How does it feel?
18. Have you seen any of your friends that got pregnant before?
19. What did they do about the pregnancy?
20. Have you heard of way of preventing pregnancy and STIs?

21. Have you been abused in one way or the other physically? Explain them
22. Have you been forced to have sex even when you are unwilling?
23. How do you feel afterwards?
24. What do you hope to become in future?

Appendix 3

QUESTIONNAIRE ON RISK TAKING BEHAVIOUR AMONG SECONDARY SCHOOL STUDENTS

Dear Respondents,

We are carrying out a research on risk-taking behaviour among secondary school students in Ibadan North Local Government Area. Please, we would like you to answer the following questions correctly. All answers are strictly confidential since names are not required.

Thank you.

1. What is your date of birth? Day..... Month.....
   Year.....
2. How old were you on your last birthday .....
3. Sex (1) Male ( ) (2) Female ( )
4. What religion do you practice?
   (1) Christianity ( ) (2) Islam ( )

(3) African Religion ( ) other specify

.....

5. In which class are you now? (1) SS 1 ( ) (2) SS2 ( )

6. With whom do you live most of the time? Circle one>

(1) Both Parents ( )2. Father only ( )

(3) Mother only ( ) Others.....

7. How many children does your father have .....

(1) How many boys..... (2) How many girls .....

8. Do you work after school? (1) Yes ( ) (2) No ( )

9. What is the highest level of education that your father has completed?

1. No Schooling (2) Koranic/Primary School (3) Adult Education

4) Modern/High School (5) Technical or Grade Two (6) Post Secondary like Polytechnic or University (7) Other .....

10. What is the occupation of your father?.....

11. What is the highest level of education that your mother has completed?

1. No Schooling (2) Koranic/Primary School (3) Adult Education

4) Modern/High School (5) Technical or Grade Two (6) Post Secondary like Polytechnic or University (7) Other .....

12. What is the occupation of your mother?.....

SECTION B

USE OF DRUGS

13. Have you ever drank alcoholic beverage before?

(a) Yes ( ) (b) No ( ) If no, go to question 20.

14. Do you drink now? (1) Yes ( ) (2) No ( )

15. What type of alcohol do you drink now.....

16. How often do you drink now?

(1) Daily ( ) (2) Once in a week ( ) (3) More than once a week ( ) (4) Once in a Month ( )

17. Have you ever been drunk?

(1) Yes ( ) (2) No ( )

18. How may cup/bottles do you teke et a sitting?

(1) One cup (2) More than one cup (3) One bottle

(4) More than one bottle

19. Who among the following people drink alcohol?

		Yes (1)	No (2)
1.	Father		
2.	Mother		
3.	Brother/ Sister		
4.	Guardian		
5.	Teacher		
6.	Classmates		

20. Have you ever smoked before

1. Yes ( ) (2) No ( ) If No, go to question 24

21. Do you smoke now?

(1) Yes ( ) (2) No ( )

22. Which of these substances do you smoke now?

		Yes (1)	No (2)
1.	Cigarettes		
2.	Pipe		
3.	Tobacco Leaf		
4.	Indian Hemp		
5.	Raw paw leaf		

23. Who among the following people smoke?

		Yes (1)	No (2)
1.	Father		
2.	Mother		
3.	Friends		
4.	Classmates		
5.	Guardian		
6.	Teacher		
7.	Brother/Sister		

24. Do you use the following drugs? Tick all you have used.

		Yes	No
1.	Cannabis		
2.	Valium		
3.	Ephedrine		
4.	Heroine		
5.	Morphine		
6.	Cocaine		
7.	Kola nut		
8.	Glue		
9.	Librium		

10.	Mescaline		
11.	Petrol		
12.	Mogadon		

25. Do you use them now? (1) Yes ( ) (2) No ( )

26. How often? (1) Everyday ( ) (2) Every week ( )

SECTION C: SEXUAL BEHAVIOUR

27. Have you eve had sexual intercourse?

(a) Yes ( ) (2) NO If No, go to question 42

28. How would you describe your first sexual experience

(1) I was forced into it (2) I agreed to have sex

(3) I wanted to experience (4) Other reasons.....

29. Did you have sex in the last one month?

(1) Yes ( ) (2) No ( )

30. How old were you when you first had sex.....

31. Who was your last sexual partner (1) Boy friend/Girl friend ( )

(2) Uncle ( ) (3) Prostitute ( ) (4) Teacher ( )

(5) Father ( ) (6) Others.....

32. Altogether, how many partners have you had in your life.....

33. How many partners have you had in the last 6 months.....

34. Do you use condom during your last sexual encounter

1. Yes ( ) (2) No ( )

35. If no, why.....

36. Have you every being pregnant or made someone pregnant?

1. Yes ( ) 2. No ( )

37. What was the outcome of the Pregnancy?

1. Child born alive (2) Child born dead (3) Abortion (4) Still pregnant

38. If abortion why.....

SECTION D: SEXUAL COERCION

39. The first time you have intercourse. were you forced into it against your Ill? If No, go to question 42.

1. Yes ( ) 2. No ( )

40. Have you ever forced anybody to have sex with you?

1. Yes ( ) 2. No ( )

41. What sort of force did you use?

1. Beating (2) Refusing to give money (3) Insults

4. Refusing to talk to the person

VIOLENCE AND DRUNK DRIVING

42. Have you ever been physically abused before?

(I.e. beaten or forced to undergo punishment)

1. Yes ( ) 2. No ( )

43. By whom?

1. An adult who lived with me (2) An adult who does not live with me (3) A brother/sister who lives with me.

44. Have you ever ridden a motorcycle or drove a car when you are drunk?

1. Yes ( ) 2. No ( )

ATTITUDES

Tick whether you agree undecided or disagree with the following questions.

		Agree	Undecided	Disagree
45.	A boy needs to have sex with many girls to show that he is a real man			
46.	A girl should have sex with many boys to show that she is popular			
47.	Having Sugar Daddy/Mummy is necessary to get nice things			

48.	Young people need to take alcohol to make them feel okay			
48.	Smoking is dangerous to health, therefore young people should abstain form smoking.			
50.	A boy need to insist on having sex with a girl even when she says 'No'			
51.	Young people who cannot abstain from sex should use condom to prevent pregnancy and disease			
52.	Young people need to have sex with many partners and later settle for the best one.			