RISK PRACTICES AMONG OUT OF SCHOOL FEMALE ADOLESCENTS IN IBADAN NORTH LOCAL GOVERNMENT AREA

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CERTIFICATION

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DEDICATION

The research work is dedicated to the Almighty God for His abundance blessings and for seeing me through this programme and to my parents Mr and Mrs Ibiyemi for their support financially and spiritually during the programme.

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ABSTRACT

Adolescence is a time of transition from childhood to adulthood and is marked by a number of developmental milestones. The National Adolescent Health Policy in Nigeria defines adolescents as individuals between ages 10 and 24 years. Although adolescents are generally a healthy segment of the society, threats to their health often stem from their practice of risky behaviours. Risk behaviours are attitudes, lifestyle such as unprotected sexual intercourse, multiple sexual partners, sex for money, early sexual initiation, alcohol consumption, tobacco smoke and drug use, that predisposes an individual to unwanted pregnancy,unsafe abortion, infertility, sexually transmitted infections (STIs), HIV/AIDS. Limited research on substance use and risky sexual behaviours had been conducted among out of school female adolescents.Most previous studies and interventions on risky practices among adolescents in sub-Saharan Africa and Nigeria target in-school adolescents because they are easily accessible and easier to organize. Few have focused on those female adolescents who are not in school. The risky behaviours considered in this study are: Substance use and sexual risk behaviours. The objective of the study was to determine the risk practices among out of school female adolescents in Ibadan North Local Government Area.

A community based cross-sectional study was designed to measure and identify the various risk practices and factors influencing risk practices among out of school female adolescents in Ibadan North Local Government Area. A Multistage random sampling method was used to select the study areas using ballot papers. The study population was out of school female adolescents aged 10 to 24 years who dropped out of school or had finished either primary or secondary schools and are now learning trade or serving as apprentice. A self-administered questionnaire was used to collect data from 305 sample size. The respondents were purposively selected fromtheir houses, shops/ offices and in the market areasfrom the 8 randomly selected communities which are: Oketunu, Oremeji areas, Mokola, Premier Hotel areas, Samonda, Polytechnic areas, Agbowo and OjuIrin..A pretested questionnaire was used to document socio-demographic information, lifestyles, sexual behaviours, alcohol use, tobacco use and the use of drugs among the 10% of the sample size. The reliability of the questionnaire was tested using Chrobach's Alpha. The reliability coefficient was 0.8 which was close to one. This showed that the instrument was reliable.

The mean age of respondentswas 18.52 years (SD±3.271). A total of 188 (61.6%) respondents had had sex, 103 (54.8%) did not use condom during the last sexual encounter. The mean age of sexual initiation was 17.51 years (SD± 2.4). 123(12.2%) had had sex for money. A total of 76 (40.4%) of sexually active respondents had more than two sexual partners. Age was significantly associated with risky behaviours (p = 0.00). Out of the total respondents, 119(39.0%) respondents had ever taken alcohol. Of these, 54(45.4%) are current drinkers. 26(8.5%) had ever smoked cigarettes. The drugs used were Heroine 9 (3.0%), cannabis 8(2.6%) and cocaine 3(1.0%).Chi-square test was used to find associations between independent variable and outcome variable. There is significant relationship between working for money and the use of condom, alcohol consumption and sex for money (0.00, 0.02 and 0.02). It was also found that alcohol use and sexual contact were strongly associated with who the respondents live with (p=0.00 and 0.00). There was a significant relationship between substance use and having sexual contact and sex for money (p =0.00 and 0.01).Out of the total respondents, 226 reported that HIV/ AIDS transmission is one of the consequences of substance use, while 196 reported that engaging in sexual risk behaviours can hold back educational career. This showed fair knowledge on the negative consequences of risky behaviours.Modifying social and educational activities of adolescents in the communities through multi domain approach are effective ways tominimise risk practices

This study has given the understanding of the relationship between substance use and sexual risk behaviours among adolescents because many of these behaviours are inter- related. The research has also contributed to the existing knowledge on adolescents' risky behaviours in the Department of Health Promotion and Education

Key words: Adolescents, out of school females, sexual risk behaviours, tobacco use, alcohol consumption, drug use.

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CHAPTER ONE

INTRODUCTION

1.1 Background

According to the World Health Organization (WHO), adolescents are persons aged 10- 19 years of age (WHO, 2004). Worldwide,current estimates put the population of adolescents at 1.2 billion. One in every 5 people is an adolescent (The Guttmacher Institute Report, 2009). It represents a transition from childhood to adulthood; they are usually adventurous in all spheres of human endeavours including sexual practices (Element, Gwede, Robert and Dermott, 2001). The National Adolescent Health Policy in Nigeria defines adolescents as individuals between ages 10 and 24 years (National Adolescent Health Policy Department of Primary Health Care and Disease Control, 1995).As a sociocultural phenomenon, this period is characterized as a stage in which one is confronted with role-models for emulating life in adulthood and with the major symbols and values of one's culture and community. Secondary sexual growth, changes in hormonal secretion, emotional, cognitive and psychosocial development occur at the period of adolescence (The Guttmacher Institute Report, 2009).This is also known as the puberty stage, resulting in sexual curiosity and experimentation, thus they frequently negotiate and adjust to increased demands for a more autonomous lifestyle and thereby engaging in risk behaviours. In general, young people are vulnerable to HIV/AIDS and other reproductive health problems due to their participation in risky behaviours.

Risky behaviours are attitudes, orientation, habits,associations, and lifestyle such as unprotected sexual intercourse, early sexual initiation, multiple sexual partners, early marriage, transactional sex, unsafe abortion, substance use (alcohol and tobacco use) that predisposes an individual or group of people to adverse health conditions that can disrupt developmental growth and future career. It is estimated that nearly two-thirds of premature deaths and one-third of the total disease burden in adults are associated with risk behaviours such as substance use and sexual risk behaviours that began in youth (WHO, 2008). Adolescents especially females, are most vulnerable to unsafe sex, thus also bear the brunt of the consequences.

A substance (drug) is any natural or chemical other than food that is taken to change mood, behaviour, feelings, and or the psychological state of the target youth (Ministry

of Health/World Health Organization, MOH/WHO, 2003). Consumption of alcohol, cigarette smoking and drug use are considered as substance use. Drinking alcohol is strongly related toinconsistent condom use, high sexual sensation seeking, and multiple sexual partners that expose them to HIV and STIs (Lepusic and Radovic, 2013).

Engaging in risk behaviours can terminate adolescents' educational career, hold back their potentials and also affect the nation negatively (Inyang, 2009). This effect can be physical (headaches, trouble sleeping) or psychological (unhappiness, loneliness, sadness, moodiness). Sexual risk behaviours among female adolescents have long term consequences such as infertility and increased rates of maternal and infant mortality and morbidity (Slap, Lot, Huang, Daniyam, Zinkand Succop, 2003). The gravity of the problem is highlighted by the result of the 2008 Demography and Health survey (DHS) which revealed that 23% of adolescents aged 15-19 years are already mothers or are pregnant with their first child; 20% of women in Nigeria are sexually active at the age of 15 and the median age for first sex stood at 17.7 years for women and 20.6 years for men (Muyibi, Ajayi, Irabor and Ladipo, 2010). These expose them to sexually transmitted diseases and Human Immunodeficiency Virus (HIV) infections, as well as unsafe abortion. Ten million youths (ages 15-24) worldwide are living with HIV and every day, an estimated 6,000 youths are infected with the virus (UNFPA, 2005).

There are many factors influencing the participation in risky behaviours among female adolescents. These include: religion/culture, family relationship, peer influence, socio economic influence, age, early marriage and mass media. Understanding the factors influencing risk behaviours and patterning of risk-taking is crucial to the development of intervention programmes. Protecting female adolescents in risk behaviours involve a range of approaches. The multi-domain approach (involving acombination of individual, family, school and communityelements) has successfully reduced smoking, drinking and risky sexual behaviour, but again study results werea little mixed (Muller, Bockelbrink and Reinhold, 2008)

1.2 Statement of problem

Risk behaviours are those that can have adverse effects on the overall development and well-being of youth, or that might prevent them from future successes and development. It also

prevents them from participating in their typical experiences for their age group for example, teen pregnancy can preclude youth from experiencing typical adolescents events such as graduating from school (dropping out of school) or from developing close friends with peers. Risk behaviours that have been identified are substance use and sexual risk behaviours.

Smoking is a health risk. Cigarette smoking damages health and causally related to lung cancers because of the constituents of tobacco smoke but many are unaware that smoking increased cardiovascular and other lung diseases. One third of adolescents who experiment with cigarettes will become daily smokers (Centres for Disease Control and Prevention 1998).According to a study conducted among female out of school adolescents in Ibadan, 40% of 215 are current smokers (Adebiyi**,** Faseru**,** Sangowawaand Owoaje,2010).According to a study, it was shown that there is an increase in female involvement in substance use(Lepusic et al., 2013).Drinking alcohol is strongly related to inconsistent condom use, high sexual sensation seeking, and multiple sexual partners.

Adolescent girls are confronted with numerous challenges, and the decisions they make can have both short- and long-term consequences for their health and well-being.Adolescent girls are more vulnerable to risky behaviours including rape, harassment and sexual exploitation, and physical and verbal abuse because they are less able to prevent or stop such manifestations of power especially those whose sexual partners smoke or drink alcohol. The reported rate in Ibadan of such coercions was 55% (Ajuwon, Olley, Akin-Jimboand Akintola, 2001) the commonest being unwanted touches and kisses. These practices commonly resulted in sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV), unwanted pregnancy and unsafe abortion (Olukoya and Ferguson, 2001).

Limited research on substance use and risky sexual behaviour has been conducted among female adolescents. Few studies have explored the range of risky behaviours in young persons because many of these behaviours are inter- related. The understanding of these relationship will help in developing appropriate interventions to address them. Most previous studies and interventions on risky practices among adolescents in sub-Saharan Africa and Nigeria target in-school adolescents because they are easily accessible, easier to organize. Few have focused on those who are not in school. Hence the need for this study.

Furthermore, none of the existing studies that seek to understand risky behaviours of adolescents have explained the perceptionof out of school female adolescents of what they

believe constituterisky behaviour and their knowledge towards risky behaviours. Yet, an exploration of their level of knowledge on the consequences of risky behaviours deepens understanding of the problem and how best to address them

1.4 Justification of the study

The study is to document the risk practices among out of school female adolescents in Ibadan North Local Government Area and to assess their knowledge on the consequences of risky practices and to also identify the factors that influenceout of school female adolescents to such risky practices that results into the above problems. The understanding of these factors will help develop appropriate intervention.

1.5 Research questions

1. What are the risk practices among female adolescents?
2. What is the attitude of female adolescents towards risky practices?
3. What is the level of knowledge of female adolescents on consequences of risky practices?
4. What are the activities taken by female adolescentsto prevent negative consequences of risky practices?
5. What are the factors that contribute to participation in risky behaviours?

1.6 Research Objectives

Broad Objectives:

To determine the risk practices among out of school female adolescents in Ibadan North Local Government Area (LGA).

Specific objectives:

1. To assess the knowledge of female adolescentson the consequences of risky practices
2. To determine the participation of female adolescents in risky behaviours
3. To identify activities taken by female adolescents to prevent negative consequences of risky practices.
4. To identify factors that contribute to participation in risky behaviours among female adolescents

1.7 Hypothesis

1. There is no significant relationship between the participation of risky behaviours among female adolescents and their age.
2. There is no significant relationship between the participation of risky behaviours among female adolescents and religion
3. There is no significant relationship between who they live with and participation in risk behaviours
4. There is no significant relationship between participation of risk behaviours and whether they are working for money or not.
5. There is no significant relationship between the attitude of female adolescents towards sexual risk behaviours and substance use

1.8 VARIABLES: The following variables were used to answer the study question:

Dependent/ Outcome variable:

- knowledge, attitudes and practices towards risk behaviours

Independent/Exposure variables

- Socio- demographic factors: Age, who they live with, Type of work , Educational Status of both parentsand Occupation of parents

Operational definition

Risk Behaviours:

Risk behaviours are attitudes, lifestyle such as unprotected sexual intercourse, multiple sexual partners, sex for money, early sexual initiation, alcohol consumption, tobacco smoke and drug use, that predisposes an individual or group of people to markedly increased risk of having casual, unexpected sexual intercourse and by so doing, expose them to unwanted pregnancy sexually transmitted infections(STIs) and HIV/AIDS.

CHAPTER TWO

LITERATURE REVIEW

2.1Nature and characteristics of Adolescents and Young persons

The nature of adolescent development is the pattern of change that begins at conception and continues through the life span. This is a period between ages 10-19 years. During this stage of life, adolescents experience more growth than any other time in their life except for infancy. This nature of adolescent is characterized by processes and periods, developmental transition and developmental issues. Young people is best understood as a period of transition from the dependence of childhood to adulthood's independence.Adolescents and young adults are a critical segment of any human society being the direct link between its future (children) and past (older adults) since they are for the most part preoccupied with preparation for the full assumption of adult roles and responsibilities.This results in awareness of sexuality thus they frequently negotiate and adjust to increased demands for a more autonomous lifestyle. The United Nations, for statistical purposes, defines young people as those persons between the ages of 15 and 24.

Worldwide, there are more than one billion youths within the ages of 15–24 years, most of who live in developing countries. In general, adolescents and young people are vulnerable to HIV/AIDS and other reproductive health problems. Many health risk behaviours are established during adolescence, and often maintained into adulthood, affecting health and wellbeing in later life. In the UK, the major problematic risk behaviours among young people include tobacco, alcohol and illicit drug use and sexual risk behaviour. Although some behaviours, such as smoking, have declined among young people in the UK over the past 10-20 years, health survey data indicate that the levels of most risk behaviours are still high, especially compared with other high-income countries(UNICEF, 2007). They generally exhibit behaviours and personality patterns due to biological, psychological, sociocultural and economic factors that are peculiar to their age-cohort

Biological and Physiological development

Biological processes involve physical changes in an individual's body. These changes occur as they move from childhood into physical maturity. This includes; genes inherited from parents, the development of the brain, height and weight gains, advances in motor skills and the hormonal changes. Biological process is the period of puberty. Puberty is the most important marker for the beginning of adolescence; it is the period of rapid physical maturation involving hormonal and bodily changes as well as psychological and social development. Puberty usually begins between the ages of 10 and 12 in girls and 10 and 14 in boys. In some cases, puberty does not occur within the normal age range. Two classes of hormones that are involved in pubertal change in males and females are androgens and oestrogens.The endocrine system consists of glands in various parts of thebody that release h ormones into the bloodstream. The hormonal changes of puberty begin in the hypothalamus, which begins graduallyto increase its production of gonadotropin-releasing hormone (GnRH) during the two years prior to puberty. The increase in GnRH causes the pituitary gland to release gonadotropins follicle stimulating hormone (FSH) and luteinizing hormone (LH) that stimulate the development of gametes (egg cells in ovaries / sperm in testes).

Physical changes

According to Boys $ Girls clubs of America, 2004, adolescence go through many changes as they move from childhood into physical maturity. Early, prepubescent changes occur when the secondary sexual characteristics appear. Girls may begin to develop breast buds as early as 8 years old. Breasts develop fully between ages 12 and 18.Pubic hair, armpit and leg hair usually begin to grow at about age 9 or 10, and reach adult patterns at about 13 to 14 years.Menarche (the beginning of menstrual periods) typically occurs about 2 years after early breast and pubic hair appear. It may occur as early as age 9, or as late as age 16.

The average age of menstruation in the United States is about 12 years.Girls growth spurt peaks around age 11 and slows around age 16. Physical changes are levelling off and ending around 16. Boys may begin to notice that their testicles and scrotum grow as early as age 9. Soon, the penis begins to lengthen. By age 17 or 18, their genitals are usually at their adult size and shape.Pubic hair growth -- as well as armpit, leg, chest, and facial hair -- begins in boys at about age 12, and reaches adult patterns at about 17 to 18 years.Boys do not start

puberty with a sudden incident, like the beginning of menstrual periods in girls. Having regular nocturnal emissions (wet dreams) marks the beginning of puberty in boys. Wet dreams typically start between ages 13 and 17, with the average at about 14.5 years.By 16, boys have stopped growing but their muscles continue to develop. Boys are considerably taller and heavier than girl. Their voices change at the same time as the penis grows. Nocturnal emissions occur with the peak of the height spurt. Boys' growth spurt peaks around age 13 and slows around age 18.

Adolescents and young people are not just marked by physical changes. Young people also experience cognitive, social/emotional and interpersonal changes as well.

Cognitive development

Adolescents are not only biological beings, they are mental beings. Considerable changes take place in cognition during adolescence. Cognitive development simply means changes in the way they think about their social lives. Thinking abilities expand. Adolescents have greater ability to see different perspectives, resulting in more empathy and concern for others. Boys and girls refine and clarify their values. Many are able to see the bigger societal picture and may show an interest in justice, history, politics or patriotism. There is a greater capacity to set goals, think about one's rolein life and consider career options. Boys and girls are better able to makedecisions, act independently and rely on themselves. There is an increase in mature behaviours, especially adult-type responsibilities such as handling money, holding down a job or managing time. Boys and girls are able to express their thoughts and ideas more clearly. While boys experience their thoughts and feelings as separate, girls are able to process thoughts and feelings simultaneously and express them verbally. Because the brain continues to develop until about the age of 24, a teen's judgment and decision-making skills vary in maturity level from one time to another. Memory capabilities also vary during this time (Boys $ Girls clubs of America. 2004)

Emotional development

Adolescents gain a more realistic sense of themselves as adults. Independence increases.Although there is less confusion regarding bodily changes, teens continue to be extremely concerned with appearance. In the search for identity, teens explore different roles,

looks, values, lifestyles or friendships. Minority of youth may try to define themselves by identifying closely with their own racial or ethnic groups. Teens have a greater sense of self-control and theability to compromise. There is a movement from self-centeredness to real sharing. All experiences are intense and emotional.Interest in ethical and religious issues grows as adolescents form their own standards and values(Boys $ Girls clubs of America, 2004)

Social development

As young people grow and develop, they are influenced by outside factors, such as their environment, culture, religion, school, family and the media.Family tensions decrease as peer pressurelevels offand teens establish new, adult relationships with parents. The peer group remains important, but one-to-one relationshipsare increasingly significant. Friendships are based more on real intimacy,sharing thoughts, feelings and less on simply doing things together or common interests. Strong same-sex friendships continue to exist,but cross-gender friendships become more common (Boys $ Girls clubs of America, 2004)

2.2 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 as their attitudes towards personal, economic, political and ecological risks. As a result of all of its pervasive use, risk has come to be regarded as natural phenomena especially when it comes to discussing behaviour among adolescents (Devereux,1998). Perceived risk is based on correct identification of very real, actual danger.The information that young people also receive regarding risk taking behaviours is crucial because it influences not only their knowledge and attitudes, but also their abilities to avoid negative outcomes of such behaviour.

2.3 Risk behaviours among Female adolescents

Risk behaviours are attitudes, lifestyle such as unprotected sexual intercourse, multiple sexual partners, sex for money, early sexual initiation, alcohol consumption, tobacco smoke and

drug use, that predisposes an individual or group of people to markedly increased risk of having casual, unexpected sexual intercourse and by so doing, expose them to unwanted pregnancy sexually transmitted infections (STIs) and HIV/AIDS (Olugbenga, Adebimpe, and Akande,2014).Risk behaviours are those that can have adverse effects on the overall development and well-being of youth, or that might prevent them from future successes and development.

2.4 Types of risky behaviours

For the purpose of this study, early sexual initiation, multiple sexual partners, limited contraceptives use, transactional sexual relationship, alcohol consumption, cigarette smoking and use of drugshave been identified as types of risk behaviours among female adolescents that predispose them to unwanted pregnancy, unsafe abortion, HIV/AIDS and STIs.

Early sexual initiation

Early sexual initiation means having sexual intercourse for the first time before age 13 years.In the US, sexual debut before age 16 is generally considered early. How one defines early sexual intercourse should be defined according to statistical distribution of age at first intercourse within the country of residence (Darroch, Frost and Singh, 2001). Findings from National AIDS and Reproductive Health Survey show that the median age of sexual debut among youths is 17years in females and 21years in males (NPC and ORC Macro, 2009).The age of initiation of sexual intercourse is one of the types of sexual risk behaviours, given that sexually active young women are at risk of multiple outcomes including early pregnancies, vesico- vagina fistula, and sexually transmitted infections.This is because young people who begin sexual activity early may appear more likely to have sex with high-risk partners or multiple partners and less likely to use condoms (WHO, 2000).

In Nigeria and all over the world, the long years of continued education has created a big gap between the age of puberty and age at marriage, thus increasing the likelihood of sexual initiation and unprotected premarital sex. In Northern regions of Nigeria, where child marriage is common, nearly 80% of girls marry by age 18 (NPC and ICF Macro, 2009**).**According to a study conducted among adolescents in Anambra, about one third of the respondents, 120 (34.37%) were sexually active as at the time of this survey with 65.7% (230) being males and 34.3% (120) being females. The mean age at initiation of sexual

activity was 15.08 years while modal age was 15 years and the youngest was 10 years (Duru, Ubajaka, Nnebue, Ifeadike andOkoro, 2013).The findings indicating similarities with thatof the National Demography Survey Data (NDHS) revealed that nearly half (48.6%) of adolescents aged 15-19 are sexually active (NDHS, 2008).

Multiple sexual partners

Multiple sexual partners' means having sexual intercourse with more than onesex partners in the past 6 months. Sex with multiple sexual partners is common among Nigerian adolescents. Multiple sexual partners are associated with other risk behaviours including not disclosing HIV status to sex partners and less consistent use of condoms. Such risks include transmission of HIV/AIDS and STIs unwanted pregnancy, teenage births and induced abortions, often by quacks, are however associated with their sexual practice life threatening complications, maternal deaths, and morbidity in survivors being the result.

In Niger State, 54 % of sexually active adolescents reported having more than one sexual partner (Amazigo, Silva, Kaufman and Obikeze, 1997). Most of them were males (66%) than females (44%), more in school (55%) adolescent than out of school adolescents (53%). Among adolescents' university students in Ibadan, 48% reported having many sexual partners (Makinwa- Adebusoye, 1992). A study reported benefits associated with multiple sexual partnership among adolescents. Generally, the benefits that study participants associated with having several sexual partners centred on the perceived potential to reinforce their acceptance among their peers (Izugbara and Modo, 2007). The brief review suggests that most adolescents in the country are sexually experienced, with a tendency for multiple sex partnerships

Limited contraceptive use

Contraception is the deliberate use of artificial birth controlmethods to prevent pregnancy as a consequence of sexual intercourse. The major forms of artificial birth controls are barrier methods, of which the most common is the condom; the contraceptive pills, which contains synthetic sex hormones that prevent ovulation in the female; intrauterine devices such as the coil, which prevent the fertilized ovum from planting in the uterus.

Limited contraceptive use such as , condoms or in consistent use of condoms during sexual intercourse is also a sexual risk behaviour among female adolescents as this predisposes them

to unwanted pregnancy, unsafe abortion, HIV/AIDS and STIs.Adolescents'specific attitudes toward pregnancy affect the likelihood that they will practice contraception and use condoms(Moore, 1995). Many of the female adolescents lack negotiating skills of condom use with their sexual partner due to fear of rejection resulting into serious health challenges. Female education has been seen as a key determinant of contraceptive use (NPC and ORC Macro, 2004). Better educated women are also argued to have more knowledge of contraceptive methods or of how to acquire them than are less educated women because of their literacy.

Several studies show that sexually active Nigerian adolescents do not use contraceptives. It was reported by Abdullahi, (2012) from the National Demographic Health Survey conducted in 2010 that 90% of Nigerian adolescent women from the age of 14-24 in Northern Nigeria have no access to contraceptives. Also another studies in Nigeria indicate that more than 60% of women with unplanned pregnancy were not using contraceptives (Fayemi and Oladepo, 2011). Anotherreasonsfor poor contraceptives use include lack of awareness, limited access to contraception, fear of side effects and objection to its use by partners or family members. A study has shown that contraceptive use among the sexually active adolescents was 29% at their first sexual exposure but rose to 75% at their last sexual exposure and the most commonly used contraceptive methods were male condom (90%) and oral contraceptive (8.2%) while the most common reasons for having premarital sex were peer group pressure 50.0% (60) and monetary gains 27.5% (33) (Duru, et al., 2013.)

Transactional sexual relationship

Transactional sexual relationships are sexual relationships where the giving of gifts or services is an important factor. In western world, transactional sex is common in the form of sex in exchange for rent, phones, clothes, drinks, drugs, grades or school tuition. This sexual relationship is very common in sub-Saharan Africa where it involves relationship between older men and younger women or girls. The participants that engage in transactional sexual relationships frame themselves not in terms of prostitutes/clients, but rather as girlfriends/ boyfriends, or sugar babies/sugar daddies (Hoefinger, 2010).

Factors influencing involvement in transactional sex among students include poverty, broken homes, peer influence and desire to make cheap money. The study suggest that most students who engage in transactional sex rarely use measures of protection such as condoms and this

predisposes them to SITs and HIV/AIDs. Most of the partners who engage students in risky sexual behaviour are of higher social and economic status. In Nigeria, about 10 percent of females and 26 percent of males aged 15-24 years engaged in transactional sex in 2005 (Wusu, 2011).

Substance use

Substance (drug) is any material, natural or chemical other than food that is taken to change mood, behaviour, feelings, and or the psychological state of the target youth (Ministry of Health/World Health Organization, MOH/WHO, 2003). Substance abuse occurs when a person uses drugs or consumes alcohol excessively and typically causes significant problems in person's life (Simmons, 2008). Drugs most frequently abused by adolescents are,cannabis (marijuana), heroin, cocaine, amphetamines. For the purpose of this study we considered alcohol and tobacco (cigarettes smoking)

Further reported that school truancy, loneliness, sleeping problems, sadness, suicidal ideation, suicide plans, mental distress, lack of parental, peer pressure and poverty were associated with substance use (tobacco, alcohol, illicit drugs), while school attendance, parental supervision, and connectedness were protective factors for substance use (Peltzer,2000).Environmental variables such as curiosity and experimentation are important factors for substance use among male adolescents while in females, such determinations are more likely to be emotional and psychodynamic in nature (Miller, 1997).

Reports from school surveys in countries across Africa show that the use and abuse of alcohol and drugs such as cocaine by adolescents start with alcohol and cigarettes. Another study by Peltzer (2000) on substance use among school-going adolescents in six African countries (Kenya, Namibia, Swaziland, Uganda, Zambia, Zimbabwe) indicates 6.6% of students surveyed engaged in risky alcohol use (two or more per day for at least 20 days or more in the past month) and 10.5% engaged in illicit drug use three or more times ever.

Alcohol consumption

Alcohol consumption is a behavioural problem defined relative to age and is considered problematic below a certain age or stage in life. Young people by virtue of their stage in development are likely to engage in drinking 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, tranquiliser, 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.

Alcohol has effect on the central nervous system and eliciting poor coordination (WHO, 1998). Short term effects are seen in road accidents, most especially since the adolescents have low tolerance levels. Other short term effects include lowering of inhibitions, which lures the adolescents in sexual risk behaviours especially unsafe sex. Long term effect include dependence, chronic intoxication, liver cirrhosis, toxic psychosis, gastritis, pancreatitis and peripheral neuropathy. Social effect include family dysfunction, disorganization, crime and fall in productivity.

The prevalent rate of alcohol consumption among adolescents in different parts of the world gives room for concern. The situation in Nigeria shows that there is high prevalence of alcohol consumption among adolescents and there is a high probability that the frequency of alcohol drinking will continue to increase (Adeyemo, 2010) coupled with the fact that there is no legal minimum age for drinking in the country. According to a study conducted among adolescents in Ibadan, out of 609 respondents, 223(36.6%) ever drank alcohol out of these, 147(67.7%) are still current drinkers (Omole, 2004).

Drinking alcohol is strongly related to inconsistent condom use, high sexual sensation seeking,multiple sexual partners and HIV and STIs.According to a study conducted among female adolescents, there is an increase in female involvement in alcohol use (Lepusić et. al., 2013).Alcohol use among adolescents is also associated with a broad array of risk behaviours, including tobacco use and drinking and driving. In addition, studies on college campuses have shown that students who do not drink neverthe-less experience adverse second hand effects of drinking, including victim-ization e.g., verbal or physical threats and actions and personal intrusion by those who have been drinking e.g., disruption of sleep or study habits (Wechsler, 1998).

Cigarette smoking/Tobacco use

Tobacco smoking is a growing public health problem in the developing world. Smoking is a health risk, a pattern of behaviour usually acquired during adolescence. Smoking can be viewed as a rite of passage from childhood to adulthood. Cigarette smoking contains over 4,700 chemical compounds of which about 60 are carcinogenic, and cigarette smokers face continual exposure to them for years. In Western countries, 13% to 35% of adolescents smoke (Sasco and Kleihues, 1999) .Youth is a time of experimentation and it is estimated that every day between three and five thousand youth try the first cigarette (Greydanus and Patel, 2005).

Cigarette smoking damages health and causally related to lung cancers because of the constituents of tobacco smoke but many are unaware that smoking increased cardiovascular and other lung diseases.Tobacco use in adolescence is associated with a range of health compromising behaviours, including being involved in fights, carrying weapons, engaging in higher-risk sexual behaviour and using alcohol and other drugs. An adolescent's first cigarette is usually obtained from a friend or family members (Simon-Morton, Chen, Abroms, Haynie, 2004). The most recent National Youth Tobacco Survey conducted by the United States Centre for Disease Control and Prevention found 28% of high school and 12% of middle-school students reported tobacco use (Bloch,Mowery and Carabalo, 2004**).** Studies, have been demonstrated a higher prevalence in males than females.According to a study conducted among adolescents in Ibadan, (45) 7.5% of 609 adolescents claimed to have smoked before out of these, 33(73%) are still smoking (Omole, 2004).One third of adolescents who experiment with cigarettes will become daily smokers (Centres for Disease Control and Prevention 1998).Also, the earlier a smoker quits smoking the less the hazard, as evidence suggests that much of the projected mortality from smoking can be prevented by stopping.

Use of other drugs

Other drugs most frequently abused by adolescents include Cannabis (Marijuana), Cocaine, Heroin, Amphtamines (LSD) and solvents such as petrol, glue and paints.Cannabisis one of the most widely used drugs among adolescents apart from alcohol and cigarette smoking. Cannabis tend to affect mesolimbic reward system of the central nervous system. They are also known to increase alertness and activity (Rinaldi, Steindler, Wilford and Godwin, 1988).Some reasons were adjudged to be factors responsible for smoking and use of hard

drugs such 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 and to reduce boredom.

2.5 Factors influencing Participation of Female Adolescents in Risk Behaviours

Religion

Religious beliefs and spiritual connectedness are also significantly associated with the high risk behaviours among female adolescents. Religiosity is a protective factor for a number of adolescent risk behaviour (Fatusi and Hindin, 2010). Religious beliefs may encourage virtues such as prosocial behaviour and positive psychological states such as hope, which, in turn, may impact mental health and life-satisfaction (Loewentha, 2007). Further functions of religions may include satisfying basic needs (e.g., for security, self-regulation, autonomy, and connectedness (Baumeister, Bauer and Lloyd,2010). Study showed that females who had higher religiosity scores were more likely to have higher self- efficacy in communication with both new and steady partners about sex, refusing sex, refusing unsafe sexual encounter (Adeyemo and Williams, 2010). Culture and individual values may influence the way religion is manifested in behaviour and adolescent development.Women in developing countries tend to smoke less, and this may be due to socio-cultural or religious reasons. Teenagers who are more actively involved in religious activities and those who avoid general nonsexual high-risk behaviours tend to initiate sex later than other teenagers (Halpern, 1994). In all likelihood, the effects of religiosity and avoidance of risk operate through social influence mechanisms.

Family relationship

The family as a unit of care can mitigate adolescent problems (Slap, et al., 2003). Family cohesion is conceptualized to include the degree of commitment, help and support that family members provide. Low family cohesion is associated with adolescent risk behaviour while high family cohesion is associated with effective parenting. From time to time, peers and the

community may be more or less influential, but parents and family are constant elements in most young people's lives despite fluctuations in their relative importance. Studies have shown that most out-of-school adolescents do not live with their parents and are found most times on the street, market places or motor parks hawking or serving as shop assistants to others (Sallah, 2009)

Although many parents want their adolescent children to know about abstinence, contraception, and how to prevent HIV and other sexually transmitted infections (STIs), they often have difficulty in communicating about sex. However, studies have shown that family relationship and effective communication on sex does not encourage early initiation of intercourse but on the contrary, communication concerning sexual matters between parents and their adolescent children serve as a protective factor. Indeed, data from the 2008 NDHS shows that only half of Nigerian men and one-third of Nigerian women agree that adolescents aged 12-14 years should be taught about condom use for HIV prevention (NPC and ICF Macro, 2009). Studies have shown that young people who feel close to their parents consistently show more positive psychological development, behavioural competence and psychological well-being.

Another study shows that those who received the information from their parents and schools were low, 10.4% and 5.0%, respectively (Duru, et al., 2013). However, parenting monitoring and effective communication with the adolescent may prevent association with deviant peers. Adolescents aged 12 to19 years report that parents are the greatest influence regarding sexual decision making and values (37% compared to 33% for friends 6% for siblings, and 5% for the media). Younger parents are more likely to discuss about sexuality issues than older parents (Duru, et al., 2013). Some studies support the proposition that adolescents are less likely to engage in risk-taking behaviour when they reside with a parent especially two parents or when they identify with the views of their parents (Rodgers, 1999). In accordance with Ethiopian study, having one or both parents who are smokers is associated with the initiation of adolescent smoking (Al-Yousaf and Karim, 2001).Parents needs to be involved in intervention programmes on adolescents risk behaviours because of their significant influence on adolescents' health and well-being.

Socio-economic status

Children are born into a specific socio-economic environment that strongly influences the possibilities young people will have to achieve and sustain good health as well as a high level of well-being (Currie, Molcho, Boyce, Holstein, Torsheim and Richter, 2008b). Several studies have shown that social disadvantages in early life can involve further social and health-related disadvantages and can significantly impact the further development of health and well-being in later life. There is an unequal distribution of tobacco, alcohol and illegal substance use among socio-economic groups (Goodman and Huang, 2002). For example, some risk behaviours are more sensitive to family socioeconomic circumstances than others.

Also, one of the hallmarks of adolescence is the individual's preparation to become economically self-sufficient in adulthood. In general, educational exposure and skills development are important to position young people to be comfortably placed on the socio-economic ladder. While it is clear that the young people have potentials to make significant contribution to the economy, they are all too frequently subject to a disproportionate burden of unemployment, which sometimes leads to psychological stress, juvenile delinquencies which manifest as increased participation in crime. About a half of young Nigerians are believed to enter the labour market without any secondary or technical education. Over 10% of males and 29% of females aged 15-19 years have never been to school. They have also received very little pre-vocational training directly related to the development of skills needed in the world of workStudies have shown an increasing rate of young people's involvement in reported criminal cases with increasing unemployment contributing to youth involvement in drugs and substance abuse.

Studies have documented the association between socio-economic status and sexual behaviour (Whiteside, 2001). Perceived factors reported by the non-abstinent respondents as obstructing their adoption of abstinence include uncontrollable sexual urges (46.7%); peer pressure (17.8%) and financial or material benefits (13.3%).Majority of the adolescent agreed that being economically dependent on a romantic partner hinders adolescents' ability to abstain from premarital sex especially adolescents whose sexual partners are often older, richer and more powerful men with whom they may be unable to negotiate sex for fear of losing economic benefits(Oladepo, et al.,2011).

Age

Age is a crucial factor in the development of risk behaviours. As children grow and develop, systematic changes can be observed in terms of the risk behaviours they engage in and the social influences surrounding them (Richter and Settertobulte,2003). Not surprisingly, age and age at menarche strongly affect the likelihood of sexual initiation and teenage pregnancy (Halpern, 1994).Older female adolescents and those who reach menarche at younger ages, because of their longer intervals of exposure, are more likely than their younger peers to become sexually active and to get pregnant (Resnick, 1997). It is perhaps unsettling that many of these trends are negative. While some behaviours increase with increasing age and for the majority of adolescents decline after early adulthood is reached, other behaviours show a slight decline in adolescence without any increase in adulthood. The regular consumption of substances increases around the age of thirteen in particular. This is not surprising as experimentation with so-called 'adult' behaviours is considered normal for teenagers in many countries and cultures (Currie, Roberts, Morgan, Smith, Settertobult, Samdal, Barnekow and Rasmussen,2004)

Peer influence

Adolescence is marked by establishment of close, intimate relationships with same and opposite sex peers. Next to family, the school environment and peer group gain increasing importance. Young people's social influences clearly affect their likelihood of engaging in risky behaviours, particularly early sexual debut, non-use of condoms, smoking and alcohol consumption. For example, having friends who smoke or drink alcohol and sexually active or who do not use condoms enhances one's own risk of these behaviours (Miller, 1997). A study which looked at the influence of peer pressure on sexual risk behaviour among Nigerian adolescent's shows pressure from friends played a major role in the experiences of first sexual intercourse and this pressure could range from subtle name calling to physical harassment. Many of the adolescent get wrong information from their peers which might be greatly miss leading coupled with economic hardship in the country which pushes these adolescents' especially young girls to have sex primarily for financial gain not minding the consequences. The role of peers as a source of information has also been documented .The importance of the peer group for the configuration of behavioural patterns probably increases by the same amount as the degree to which psychological and social detachment from the parents takes place. The time spent with peers continuously increases throughout adolescence

(Updegraff, Mchale, Grouter and Kupanoff, 2001). Thus, it is plausible to assume that the peer group has a strong influence on the attitudes and behavioural patterns of young people.

Mass media

The mass media (including music, television and most recently, the internet) are an important part of adolescent's community. The excessive use of the internet has recently attracted the attention of the scholars. Studies have shown the influence of internet use on the sexual behaviour of adolescents in Nigeria.Given the popularity of the Internet amongst adolescents in Nigeria, some researchers have investigated the relationship between young adults' involvement with online sexual content (including online chats, meeting partners, and looking for romantic and sexual relationships) and the development of their sexuality.For example a study examined the influence of internet use on the sexual behaviour of young adults in Nigeria. The results revealed that as the use of the internet increased, participants reported a greater extent of risky sexual behaviour(Adebayo, Udegbe and Sunmola, 2006). Media sources like television served as the most common source of information on sex. Studies in Nigeria have reported increasing negative effect of media on adolescent sexuality due to unrestricted access and increase in sex content.Other media sources like television served as the most common source of information on sex and substance use (Oyediran, Feyisetan and Akpan, 2011)

Early marriage

Early marriage is promoted in the belief that it serves as a preventive mechanism against pre-marital sex. Seventy-three percent of girls within ages 13 and 19 years are married in the North-East States of Nigeria. These marriages are usually aimed at reinforcing family linkages which in turn Foster/enhance political, economic, and social alliances. However, early marriage has implications for reproductive health problems and increased risk of HIV infection (Action Health Incorporated, 2006).Early marriage has been linked with gender inequality and violence. Married adolescents are likely to have less access to sexual and reproductive health information. The consequences of early marriage include early first birth that increases the risk of dying in pregnancy as exemplified by studies which showed that 6 out of 100 married girls in North-East Nigeria die during pregnancy. Also infants of adolescent mothers are more likely to die before age 5 thus contributing to high infant

mortality rates. Furthermore, adolescents are prone to obstructed labour and studies show that obstructed labour is responsible for 9 out of 10 vesico-vaginal fistulae cases in North East Nigeria.

Knowledge on risk Behaviours

The information that young people receive regarding risk taking behaviours is crucial because it influences not only their knowledge and attitudes, but also their abilities to avoid negative outcomes of such behaviour. Poor child- parents/guardian/teacher communication and a culture of silence around youth sexuality with heavy reliance by youth for sexuality information and counsel on unreliable sources like their peers and the mass media contribute to major factors for low level of knowledge on consequences of risk behaviours (Esiet and Whitaker, 2002 ; Huaynocal, 2013) . According to the study carried out among adolescents in Anambra, it showed that only about 40% of respondents have been formally thought about sexual issues, of this number, 50%received the information from their friends' and peers and 37.0% from mass media. (Duru, et al., 2013). Many are unaware that engaging in risky behaviours can disrupt developmental growth and future career. For example, many adolescents who engage intobacco smoking are un aware that it can lead to cardiovascular and other lung diseases (Greydanus, et al., 2005).

In Nigeria, HIV prevalence is higher among adolescent ages 20-24 years. Moreover, the much higher HIV prevalence among female youth is observed alongside with lower levels of comprehensive knowledge of HIV and condom use during higher risk sex. Increase knowledge about HIV and STIs transmission and prevention can reduce risky behaviour and also delay the onset of sexual intercourse (Johnson, Carey, Marsh, Levin, Scott-Sheldon, 2003).

2.7 Interventions to protect female adolescents from risk behaviours

There are several interventions aimed at preventing or ameliorating the impact of risky practices among adolescents. Most intervention programmes have targeted single riskbehaviours, but there are proposals for interventions to take a broader approach, to address multiple problems and precursors.

Policy and mass-media interventions

A recent UK review concluded that increasing tobacco prices are effective in reducing smoking initiation and cessation in young people, although the impact on different socioeconomic groups is unclear (Godfrey, Iceand Lake, 2009) There is robust evidence that alcohol pricing is inversely related to alcohol consumption, and that increased pricing is effective in reducing harmful outcomes such as high sexual sensation and inconsistent condom use. However, the evidence for the impact of increased pricing on alcohol consumption among adolescents and young adults is less robust (Brennan, Purshouseand Taylor, 2008).

The impact of media on adolescent behaviour is also important, with studies demonstrating its influence on a variety of health behaviours. Because the use of media technology such as phones, internet is growing among urban based adolescents in Nigeria, behaviour change messages are now being disseminated through phones. Mass media programs can reach a large number of young people of all ages. Also programs using electronic media can be strategic in reaching out- of-school and rural adolescents. While computer and telephone programs can be useful particularly for urban young people and can promote learning through enjoyable activities, a limitation to this model is the financial resource involved while the impact on sexual behaviour may be variable.Evidence for media interventions in preventing sexual riskbehaviour is largely from low-income countries, and suggeststhat, as with smoking, media campaigns are most effectivewhen multiple avenues are used simultaneously and aresustained over time (Delgado and Austin, 2007)

School-based programmes

The evidence picture for school-based interventions focused on modifying individual characteristics through curriculum-based interventions is very similar across risk behaviours(Faggiano, Vigna-Taglianti and Versino, 2005).While knowledge-giving school-based interventions are necessary, they appear insufficient in themselves in preventing risk behaviours. Intensify efforts to achieve Universal Basic Education (UBE) and eliminate illiteracy should be given to female adolescents. Expand the integration and teaching of family life (FLHE) and anti- tobacco education into relevant subject curricula at all levels and various institutions. The Family Life and HIV/AIDS Education (FLHE) is an example of strategy specifically developed to suit the Nigerian context. FLHE aims to provide young people with knowledge, positive attitudes and skills to foster behaviour change and thus

reduce their risk of acquiring HIV/AIDS and other reproductive complications.Legislative restrictions on smoking in enclosed public places need to be enforced

Family/parenting programmes

Parenting/family-based programmes have been shown to impact on smoking, drinking and illicit drug use behaviour, but their effects on sexual behaviour have been less well studied. The most promising family intervention, highlighted in recent Cochrane reviews, is the Strengthening Families Program for Parents and Youth which has been shown to significantly reduce smoking, alcohol and sexual behaviours. These Programmes include: clarifying expectations; appropriate discipline; managing strong emotions; effective communication and peer skills(Foxcroft, Ireland and Lowe, 2003)

Abstinence-only Sexual Education with livelihood skills

Sexual education is a lifelong process of acquiring information on sex and forming attitudes, values and beliefs. It involves sexual development, sexual and reproductive health, interpersonal relationships, affection and intimacy(SIECUS, 2008). Abstinence-only sexual education teaches the adolescents to abstain from premarital sexual intercourse because of the advantages it offers. Such advantages include prevention of unintended pregnancies and prevention of contracting HIV/AIDS and other sexually transmitted infections. According to the Federal Law of the United States of America (USA), every school-aged child should not engage in sexual activity (Kirby, 2005). Some studies also recommend abstinence-only sexual education with information on contraception and risk-reduction behaviour for sexually inactive adolescents.It can be deduced that abstinence-only sexual education denies adolescents the necessary information necessary to empower them for premarital sexual activity. According to a study, sexually active respondents stated that a factor obstructing their adoption of abstinence was the feeling that sexual intercourse was a normal practice, which young people could not do without (Oladepo et al., 2011).However, psychological research has shown that comprehensive sex education and HIV prevention programs is an intervention designed to help young people develop good decision-making and

communication skills. Increase knowledge about HIV and STIs transmission and prevention can reduce risky behaviour and also delay the onset of sexual intercourse (Johnson, Carey, Marsh, Levin, Scott-Sheldon, 2003).

Economic and livelihood issues which are major developmental challenges for young people in Nigeria need to be addressed. The challenges of this intervention include its cost. Moreover, resources are needed not only for vocational training or livelihood skills but also for post-graduation support, to achieve the desired outcome for the beneficiaries of the intervention.

Multi-domain interventions

The multi-domain approach (involving acombination of individual, family, school and communityelements) has successfully reduced each of smoking, drinking and risky sexual behaviour, but again study results werea little mixed (Muller, Bockelbrink and Reinhold, 2008). One review of interventions to reduce sexualrisk behaviour found that multi-modal youth development programmes had a significant effect on increasing contraception use and reducing pregnancy rates among girls (Scher, Maynard and Stagner, 2006).These interventions largely included people from low income urban settings and were more effective in girls thanboys. Another review found that interventions that includeeducation, skill-building and contraception promotion components significantly reduce unintended teenage pregnancies (Flay, Graumlich and Segawa, 2009).From the reviews of these approaches we can draw some conclusions regarding the overall effectiveness of different approaches for preventing single risk behaviours, and, indirectly, the potential effectiveness of these approaches for preventing multiple risk behaviours.

2.8 Conceptual Frame Work

Conceptual framework emphasizes intensions of adolescents to perform behaviours and factors that influences the intensions. Concepts and theories are used to provide a conceptual framework for understanding, interpreting and predicting the development, dynamics and outcome of adolescent risk behaviours. Two conceptual framework will be used in this study to explain adolescent risk- taking behaviour. They are Health Belief Model (HBM) and social learning theory (SLT).

Health Belief Model:

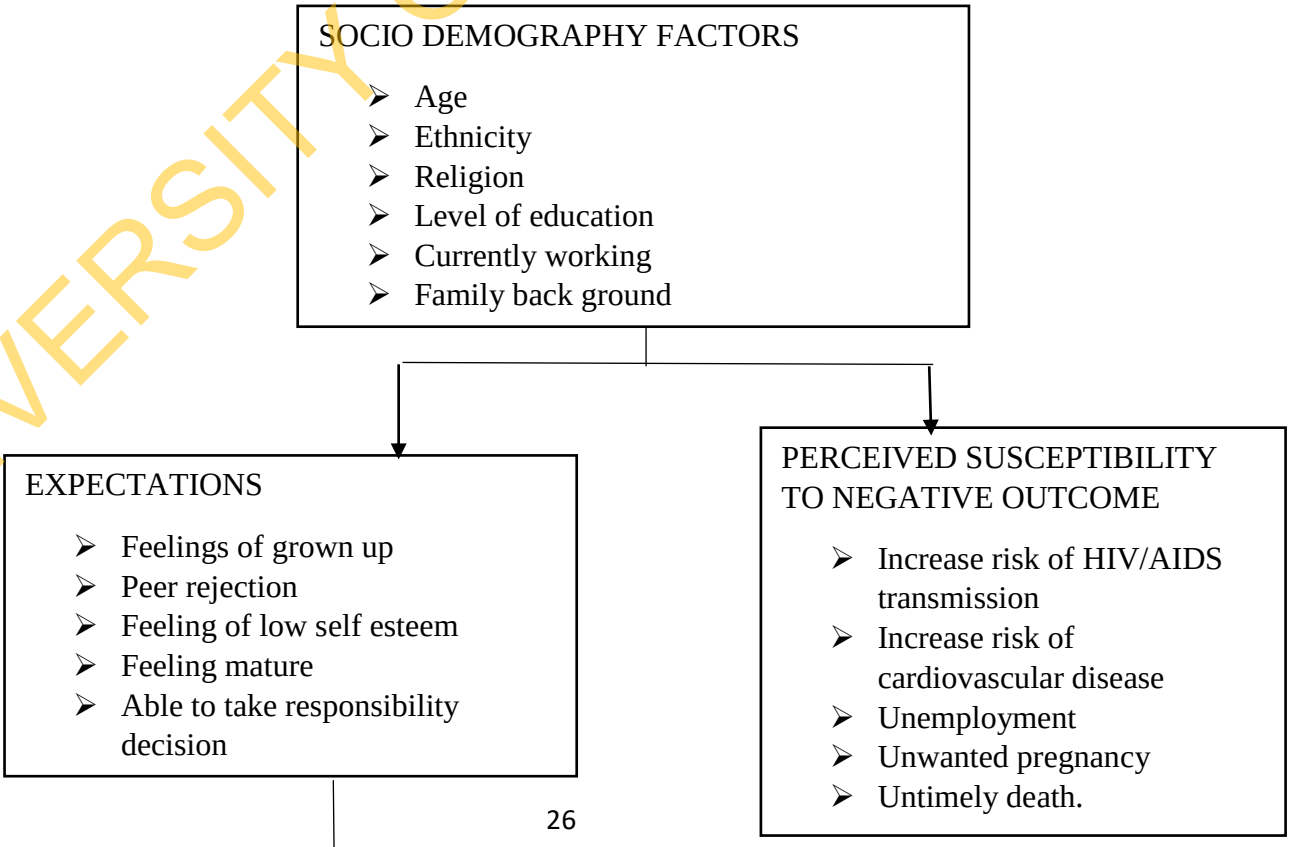
Health Belief Model is a psychological model developed in the 1950s as a part of an effort by social psychologist to explain reluctance of the public to participate in prevention programmes. The model explains that people's belief about health problems, perceived benefits of action and barriers to action and self-efficacy explain the engagement or lack of engagement in health- promoting behaviour. 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.

For instance, individuals who believe they are at high risk of contracting STIs, HIV and who have received sexual and behavioural change education may be easily persuaded to use condom or abstain from sex, whereas individuals who believe they are at low risk of HIV and do not have access to sexual and behavioural change information may require more intense external cues in order to be able to consider using condom or abstaining from sexual intercourse. This explains people's practice of health and helps in prevention of high-risk behaviour.

Health Belief Model helps us to understand why people practice 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 health behaviour will reduce the risk.

Interventions may also aim to alter the cost- benefit analysis of engaging in a health-promoting behaviour (i.e. Increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy of various behaviours to reduce risk of HIV and

STI, identifying common perceived barriers (i.e. feeling shy to buy condoms, in ability to negotiate condom use with partners and rejection by peers). Intervention may also boost self - efficacy by providing training in specific health promoting behaviours.A stimulus, or cue to action, must also be present in order to trigger the health-promoting behaviour.



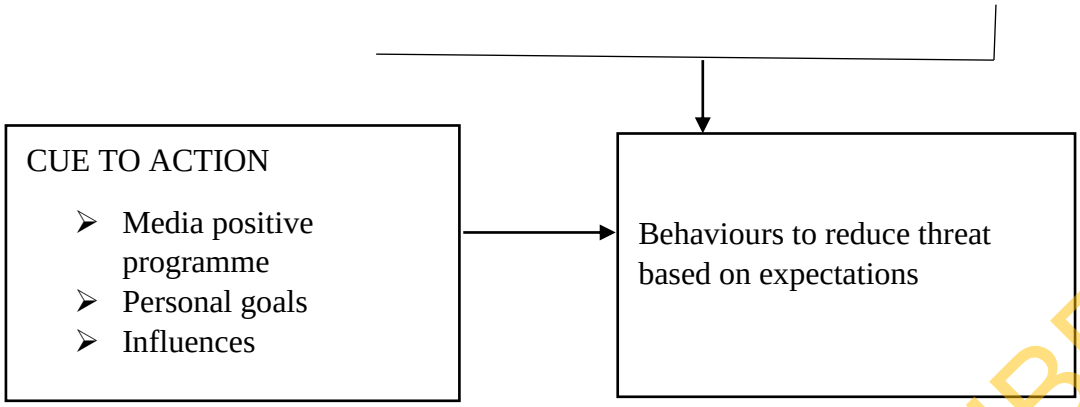


Figure 1: Application of Health Belief Model to Risky Behaviours

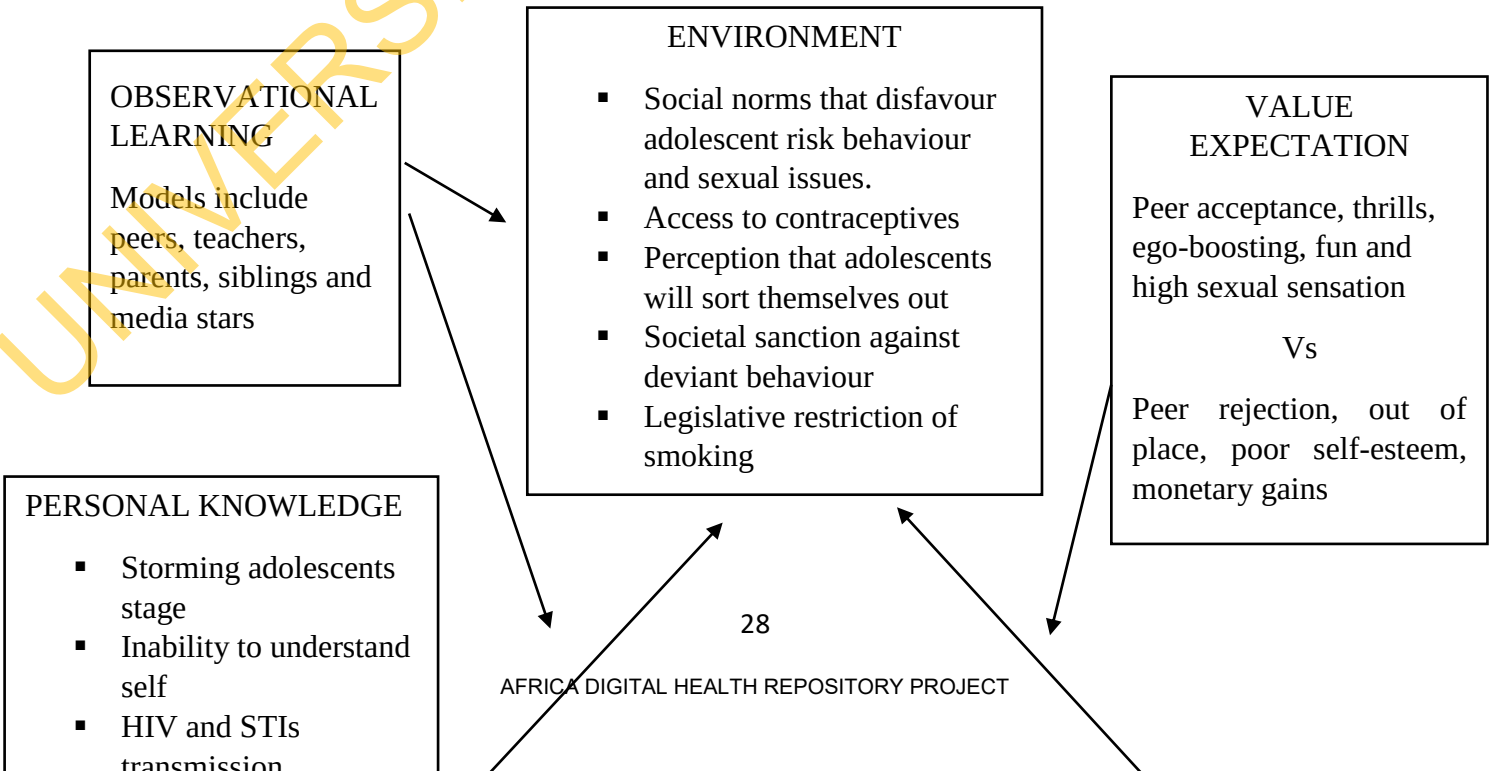
Social learning theory

This theory is also known as cognitive theory. This theory was popularized by Bandura. The theory is grounded in the belief that human behaviour is determined by a three – way relationship between cognitive factors, environmental influences and behaviour. Bandura proposes that perceivedself-efficacy lies at the centre of human behaviour (Bandura, 1994). He also postulates that learning came about as a result of an individual relationship with environment.According to him, learning consists of Observation and initiation.

Individual adolescence tends to imitate teachers, parents, peers and stars that take risk in order to be accepted by such teacher or peer group. Peer modelling may also be accentuated by inducements or reinforcements (reinforcing factors) such as money and gifts or

recognition they earn from such activities. Modelling positive and healthy related behaviour to youth is extremely important

In the application of SLT, the adolescent is encouraged to observe and imitate and see positive behaviours modelled and practiced, increase their own capability and confidence to implement new skills, gain positive about implementing new skills and experience support from their environment in order to implement new skills by equipping them with skills and self- belief that enable them to put the guidelines into actions consistently in the face of counteract pressure. For example saying "no" to pressure to have sex, or unprotected sex and taking drugs.



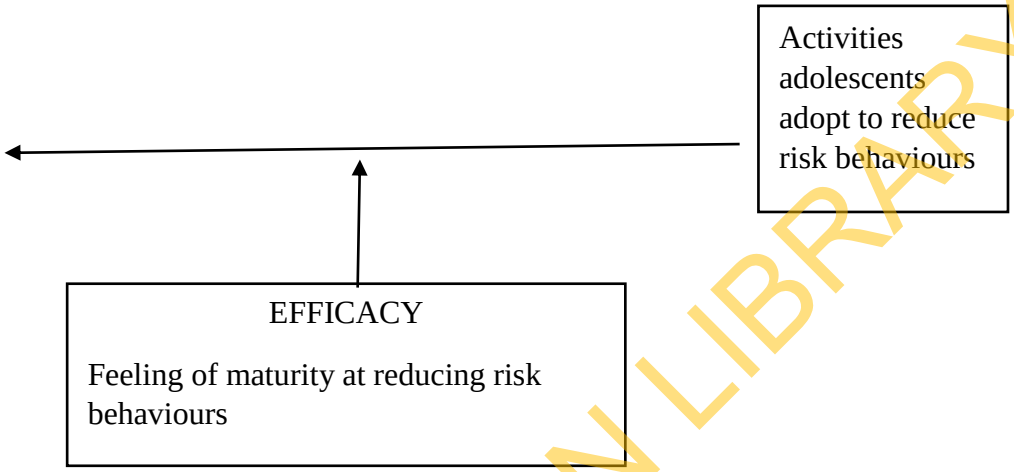


Figure 2: Social Learning Theory and Risk-Taking Behaviours among Out of School Female Adolescent

CHAPTER THREE

METHODOLOGY

3.1. Study Design and Scope

A communitybased cross-sectional study was designed to measure and identify the various risk practicesand factors influencing risk practices among out of school female adolescents in Ibadan North Local Government Area.

3.2. Study Area

Ibadan North LGA constitutes the study setting. There are five Local Government areas in Ibadan metropolis. These are the Ibadan North Local Government, Ibadan North East Local Government, Ibadan South East Local Government, Ibadan South West Local Government and Ibadan North West Local Government. The LGA is one of the five LGAs in Ibadan metropolis. Ibadan is the largest city in black Africa.

Ibadan North Local Government was founded by the Federal Military Government of Nigeria on 27th September 1991. The Local Government with its headquarters at Agodi was carved out of the defunct Ibadan Municipal Government along with others. Ibadan North LGA is located approximately on longitude $8^0$5' East of Greenwich meridian and Latitude $7^0$23' North equators. It has an area of 27 $km^2$and a population of 306,763 people. The male population is given as 153,039 and female population as 153,756, (2006 population census). The estimated population of adolescents girls is given as 25, 593 The Local Government is bounded by other Local Governments. In the North it is bounded by Akinyele Local Government. In the West by Ido Local Government, Ibadan North West and also and bounded in the East by Ibadan North East, Ibadan South East Local Government, Egbeda and Lagelu Local Governmernts.The components of the Local Government cover areas between Beere roundabout through Oke-Are to Mokola, Oke itunu and ijokodo. The other components are areas from Beere roundabout to Gate, Idi-Ape to Bashorun and up to Lagos/Ibadan express way, Secretariat, Bodija, University of Ibadan and Agbowo Areas.

Ibadan is a regional center for commerce and education. This is also where the first university, the University of Ibadan is sited. Ibadan metropolis is divided into three areas namely, the inner core, the transitional zone and 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 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 estate. The peripheral zone on the other hand is less congested with properly laid out street.

This Local Government consists of multi-ethnic nationalities predominantly dominated by the Yorubas. The Igbos, Edos, the Urhobo, Itsekiris, Ijaws, Hausa, Fulanis and Foreigners who

are from Europe, America, Asia and other parts of the world. Majority of the population of Ibadan North Local Government are in the private sector. They are mainly traders and Artisans. A good number of their workers are civil servants who live predominantly around

Bodija Estate, Agbowo, Sango, Mokola, the University of Ibadan and the Polytechnic of Ibadan. The predominantly religion includes Christianity, Islam and traditional religions. Female adolescents in this local government engage in church/mosque activities, work for money such as trading, apprenticeship, artisans, office/shop assistants and hawking foods, drinks and other materials and some are students.

3.2 Study population

The study population was out of school female adolescents aged 10 to 24 yearswho dropped out of school or had finished either primary or secondary schools and are now learning trade or apprentice.

3.3 Sampling Procedures and Sample size.

A multistage sampling technique was used to recruit the respondents in the study.

Stage 1- Random selection of 4 wards from the LGA

Each ward is a cluster which represents a small scale of the total population. A random sampling was used to select which wards to include in the study.

The 12 Wards in Ibadan North Local Government Area

Table1.

Ward	Areas covered by Ibadan North Local Government
1.	Beere, Keninke, Agbadagbudu, Oke Are, Odo Oye
2.	Ode Oolo, Inalende, Oniyanrin and Oke Oloro

3.	Adeoyo, Yemetu, Oke Aremo and Isale Alfa
4.	Itutaba, Idi omo, Oje Igosun, Kube, Oke apon, Abenla, Aliwo/ Total Garden and NTA Area
5.	Bashorun, Oluwo, Ashi, Akingbola, Ikolaba and Gate
6.	Sabo Area
7.	Oke Itunu, Cocacola and Oremeji Areas
8.	Sango, Ijokodo
9.	Mokola, Ago Tapa and Premier Hotel Areas
10	Bodija, Secretariat, Awolowo, Obasa, Sanusi
11.	Samonda, Polythechnic, University of Ibadan
12	Agbowo, Bodija Market, Oju Irin, Barika, Iso Patako, Lagos/Ibadan Express Road

Sample size determination

The minimum number of sample size for the study was used to estimate the proportion of out of school female adolescents' who engage in risk behaviours and practices. This wasobtained by using 5% point's level of precision given by the formula

$$N = \frac{Z_{\alpha}^2 PQ}{d^2}$$ (Leslie Kish Formula)

Where N is the minimum sample size

Z is the standard normal deviation corresponding to a 2 sided level of significant of 5%.

P is the proportion of female adolescents' who practice risk behaviours= 27.3% (0.273) (Omole, 2004)

Q- Proportion of people without risk behaviours =

Q= (1-0.273)

1-0.273= 0.727

D= Degree of accuracy set at 0.05(precision set at 5%)

Therefore, the sample size N=

$$\frac{(1.96)^2 \text{ X } 0.273 \text{ X } 0.727}{0.05 \text{ X} 0.05}$$

$$\frac{3.8416 \text{ X } 0.19847}{0.0025}$$

N= 304.97

~305

For anon- response rate of 10% of 305= 30.5

~31

Therefore, 31 was added to sample size calculated to make the sample size **336**in order to address any possible case of incomplete response

Stage 2- Random selection of 2 communities in each selected 4 Wards

There are about 50 communities in the Local Government. 2 communities were randomly selected from each of the selected 4 Wards.

Stage 3-Purposive selectionof respondents in the 8 communities selected.

The 8 communities selected are: Oketunu, Oremeji areas, Mokola, Premier hotel areas, Samonda, Polytechnic areas, Agbowo and Oju Irin. Out of school female adolescents in the selected enumeratedareas were purposively selected until a proportion allotted for each of the community was filled up.Respondents were purposively selected from their houses, shops/ offices and in the market areas. The respondents were aged 10- 24 years who are learning trade, apprentice, office/shop assistants, and hawkers. The respondents were all females.

3.4Inclusion Criteria

Out of school female adolescents between 10-24years of age that hadfinished primary school but did not continue, or finished secondary schools and who are employed or unemployed were considered eligible.

3.5 Exclusion Criteria

Female adolescents below 10 yearsand above 24 years of age, higher institutions students and those with mental, hearing or speech disabilities were excluded to participate in the study.

3.6 Research instrument (The questionnaire)

The questionnaire was divided into 5 sections (Appendix 1). Section one dealt with demographic data of the respondents. This contains questions on age, religion, level of education, occupational and educational status of both parents. Section two contains life styles, hobbies and interest. In this section, the respondents were asked questions on different activities they engage in such as attend church/mosque activities, visit youth centre, watch television/ listen to radio, spend time with parents/ friends and read books/novels. Section three contains sexual behaviour. Here the respondents were asked for the age at initiation of sex, number of sexual partners, sex in exchange for money, circumstances at first sexual intercourse, use of condom.Section four contains alcohol consumption, tobacco smoke, use of drugs, number of times used and significant others that drink alcohol or smokes cigarette. The last section dealt with the knowledge of respondents on consequences of risk behaviours.

3.7 Reliability and validity

The reliability of the questionnaire was tested by a pre-test of draft questionnaire in 10% of sample size. Chrobach's Alpha was used to determine reliability coefficient. The coefficient

was 0.8 which was close to one. This showed that the instrument was reliable. The Reliability was also ensured by asking the questions in simple English with the permission to explain any difficulty areas for some respondents who may have difficulty with comprehending the questions. The 31 respondents were purposively selected in Oluyole community in Ibadan South West LGA

Validity was ensured throughout the process of data gathering. To help validate the instrument, a self-administered questionnaire was pretested among 31 out of school female adolescents that has the same characteristics as the study population in Ibadan South West Local Government Area in order to point out areas that need correction.

Ethical issues

To ensure confidentiality, the names of the respondents were not included in the pre- tested questionnaire. They were also assured confidentiality of the information given.

3.8Method of data collection

A self -administered questionnaire was used to collect data from 305out of school female adolescents from the 8 selected communities which are: Oketunu, Oremeji areas, Mokola, Premier hotel areas, Samonda, Polytechnic areas, Agbowo and Oju Irin. Two interviewers were employed for the data collection. The interviewers were instructed to assure the respondents confidentiality of the information given.Respondents were also interviewed face-to- face in order to explain areas that need clarification for respondents who have difficulty with comprehending.

3.9 Data analysis and management

Data were entered and imported to Statistical Package for Social Sciences (SPSS) 20 Windows version for analysis. The results were summarised using descriptive summary measures expressed as mean, median, standard deviation, range for continuous variables, and percentage for categorical variables. Chi-square test was used to find associations between categorical variables (independent variable and outcome variable). Odds ratios (OR) with 95% confidence intervals were also calculated. All statistical tests were performed by using two-tailed tests at the 0.05 level of significance. *P*-values less than 0.05 were considered statistically significant. Analysis of data was cross checked for entry error and range checks.

Limitation of the study

There is only one limitation for the study, eight communities were studied and the results may not be generalized to out of school female adolescents from all the communities in the local government.

3.9 Ethical consideration

Informed consent: The nature, purpose and process of the study were explained to the respondents. Informed consent was obtained verbally in order to protect the right of the study participants.

Confidentiality of Data: No names was included in the questionnaire to maintain confidentiality of the participants during and after the collection of data

Beneficence to Participants: The research conducted helps to give a clearer understanding of factors that influence risk behaviours among the study population, thus when timely interventions are made available to the study group will benefit directly from the interventions.

Non – Maleficence to participants: The research was not harmful in any way to the participants as only questions were asked and no new interventions or procedures were involved.

Right to Decline/ Withdrawal from the Study Without loss of Benefits: All participating respondents were provided with a clear purpose of the study. They were also given the opportunity to decide on whether they want to participate or not.

Participants were informed on their right to withdraw from the study at any point without any consequences.

CHAPTER FOUR

RESULTS

4.1Socio demography characteristics

A total of 305 out of school female adolescents completed the self-administered questionnaire. The socio demography characteristics of respondents were presented in (Table 2). The mean age of the participants was 18.52 (range, 12– 24 years). All the participants were single. Among the out of school female respondents, 299(98.0 %) of respondents had finished secondary school and 6(2.0%) finished primary school but did not attend secondary school. Amongst the respondents, 216(70.8%) are Yoruba, 53 (17.4%) are Igbo and 19(6.2%) are Hausa. Majority of the respondents are Christians 226 (74.1%) while 78 (25.6%) are Muslims. Most of the respondents live with both parents 191 (62.6%), Father only 12 (3.9%),

Mother only 31(10.2%), Guardian 34 (11.1%) Sexual partner 37(12.1%). Majority of the respondents have worked for money (60.3%) while 184 (38.7%) have never worked for money. Of these, 157 (51.5%) are currently working for money while 142 (46.2%) are not currently working for money. Of those who are currently working, (33.1%) are shop assistants, (12.1%) are traders, (20.7%) are apprentice who are learning trade.

Table 2
Demographic characteristics of the respondents. (N =305)

Demographic variables	No	%
Age		
10-14 years	34	11.2
15-19 years	161	52.8
20-24 years	110	36
Mean± SD	18.52±3.271	
Median	18.00	
Range	(12- 24)=12	
Level of education		
Primary	6	2.0
Secondary	299	98.0
Religion		

Christianity	226	74.1
Islam	78	25.6
African traditional	1	0.3
Ethnic group		
Yoruba	216	70.8
Igbo	53	17.4
Hausa	19	6.2
Others	2	0.7
Marital Status		
Single	305	100
Living arrangement		
Living with both parents	191	62.6
Living with father only	12	3.9
Living with mother only	31	10.2
Guardian	34	11.1
Sexual partner	37	12.1
Work history		
Work to earn money	157	51.5
Do not work for money	141	46.2
Don't know	7	2.3
Type of work		
Shop/office assistants	101	33.1
Apprentice	63	20.7
Traders	37	12.1
Don't know	104	34.1

Parent's level of education

Respondents were asked the level of their parents' education.Almost one tenth of the respondents reported that their fathers' highest level of education is tertiary institution like polytechnic and university; 97(31.8%). The same trend was also found among the mothers as shown in Table 3 below

Table 3

Respondents' parents level of education (n= 305)

Parents' level of Education	Father	%	Mother	%
No Schooling	23	7.5	53	17.4
Primary School	40	13.1	53	17.4
Adult education	52	17.0	45	14.8
Modern school	65	21.3	52	17.0
Technical school	28	9.2	11	3.6

Polytechnic or University	97	31.8	91	29.9
Total	305	100	305	100

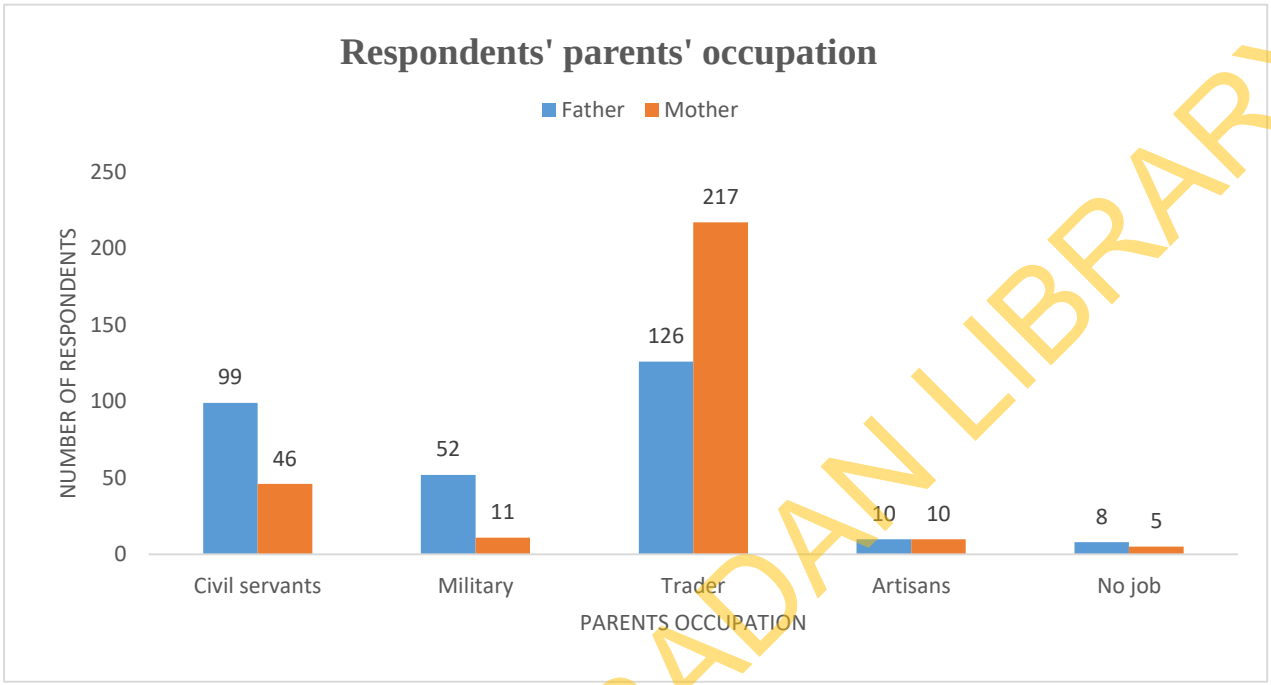


Figure 3: Parents' occupation

When asked on lifestyles and interest, almost all the respondents engaged in church/mosque activities (88.5%), watch television/listen to radio (88.5%), read books (89.2%) while half of the respondents (46.2%) reported they visit youth centre. These are shown in table below (Table 4)

Table 4

Respondents' lifestyles and interest

Life Styles and Interest	N= 305	%
Attend church/mosque activities	270	88.5
Watch television/listen to radio	270	88.5
Read books	272	89.2
Visit youth centre in your community.	141	46.2
Spend time with parents	242	79.3
Spend Time With Friends	221	72.5

Sexual practices and behaviours

Sexual practices of the participants have been summarised in the table below. Of the respondents, 188 (61.6%) of the respondents were sexually active. Amongst the sexually active respondents, 112 (59.6%) had an ongoing sexual relationship with a single partner. The mean and median age at first sexual intercourse was 17.7 ± 2.89 and 18.0 years (range, 11–24 years) respectively.76 (40.4%) of sexually active respondents reported multiple sexual partners (more than one sexual partners) during the previous 6 months.Number of sexual partners range (1-20). Most sexual intercourse happened for pleasure 119(63.3%), 43 (22.9 %) for favour and 26(13.8%) have been raped for sex, of sexually active respondents 23 (12.2%) reported they have had sex for money (Table 5)

Table5

Pattern of sexual behaviour among out of school female adolescents

Patten of Sexual Behaviour	**N=305**	**%**
Ever had sex?		
Yes	188	61.6
No	117	38.3
Age at first intercourse	N=188	
Age range		
10-14	26	13.8
15-19	113	60.1
20-24	49	26.1
Mean+_ SD	17.51+ 2.41	
Median	18	
Range	(24-11) 13	
Circumstances at first sexual intercourse	N=188	
Raped	26	13.8
Pleasure	119	63.3
To receive Favour	43	22.9
Involvement in Sex for money	N=188	
Yes	23	12.2
No	165	87.8%
Number of sexual partners in the last six months		
One partner	112	59.6
Two partners	45	23.9
More than two Partners	31	16.5

4.3 Contraceptive use

With regards to contraceptive uses, respondents were asked if they had ever asked their partners to use condom to prevent pregnancy or HIV, more than half 98(52.12%) of sexually active respondents have never done asked their partners. Respondents were also asked if they use condom during their last sexual encounter. The percentage of those who reported using condom were 85(45.2%) while 103 (54.8%) did not do so. Reasons for non-condom use were lack of knowledge about condom use 37(35.9%) don't like using any methods 29 (28.2%) and 15(14.4%) reported that it made sex uninteresting. (Table 6)

Table 6

Respondents who had asked Partner to use any methods

Respondents who had asked Partner to use any methods	**N= 188**	**%**
Yes	90	47.9
No	98	52.1
Respondents who reported their partners agree to use condom.		
Yes	93	49.5
No	85	45.2
Reported condom use during the last sex		
Yes	85	45.2
No	103	54.8
Reasons for not using condom	**N= 103**	
I'm afraid of losing him	15	14.6
I will not enjoy sex	15	14.6
He will not love me again	7	6.8
Don't like using any methods	29	28.2
Don't know any methods	37	35.9

HIV and STIs perception

Respondents were asked if they have heard of HIV. Majority of the respondents reported to have heard of HIV and STIs 267 (87.5%) while 38(12.5%) reported they have not. Among those who had heard of HIV, 38 (12.5%) perceived to be at risk of HIV and STIs (Table 7)

Table 7

Respondents perception of HIV and STIs

Respondents perception of HIV and STIs	N=305	%
Have you heard of HIV /AIDs and STIs?		
Yes	267	87.5
No	38	12.5
Did you perceive to be at risk of HIV?	N=267	
Yes	59	22.9
No	217	81.2

4.4 Alcohol consumption

When asked on alcohol consumption (Table 8), 119 (39.0%) had tasted alcoholic beverage before. Of these, 54 (45.4) are current drinkers. (38) 12.5% have ever been drunk. 17.4% of those that drink reported that their friends drink, 13.7% reported their fathers to be drinkers while few people reported their mothers (2.8%) as drinkers. Respondents reasons for taking alcohol was that it makes them sexually active 21 (6.9%), reduces anxiety 13 (4.3%), makes them psychologically dependents 15 (4.9%) and because their friends do 14 (4.6%)

Table 8

Respondents' pattern of alcohol use

Use of alcohol	**N=305**	**%**
Ever drank alcohol?		
Yes	119	39.0
No	116	61.0
Still drinking?	N=119	
Yes	54	45.4
No	65	54.6
Frequency of consumption	N=54	
Daily drinkers	7	12.9
Once a week	8	14.8
More than once a week	15	27.8
Once a month	24	44.4
Ever gotten drunk?	N=54	
Yes	38	70.3
No	16	29.7

When asked about the significant others who consumed alcohol, the result showed that friends has the highest frequency 56(19.1%) while mothers has the lowest (3.1%). (Table 9)

Table 9

Respondents' significant others who consume alcohol

Significant others who drink.	No *	%
Father	44	15.0
Mother	9	3.1
Brother/Sister	16	5.5
Friends	56	19.1

* Multiple responses are included

4.4 Cigarette smoking

Respondents were asked if they had ever smoked cigarette. Findings showed that 26(8.5%) of the total respondents claimed to have smoked cigarettebefore.Out of these 9(3.0%) are still smoking. (Table 10)

Table 10

Respondents' use of cigarette

Use of cigarette	N= 305	%
Ever smokedcigarette?		
Yes	26	8.5
No	277	91.5
Still smoking?	N=26	
Yes	9	34.6
No	15	57.7

When asked about the significant others who smoke cigarette, the result showed that friends has the highest frequency 39(13.8%) while brother/sister has the lowest 3 (1.1%). (Table 11)

Table 11

Respondents' significant others who smoke cigarette

Significant others who smoke cigarette	N= *	%
Father	10	3.5
Brother/Sister	3	1.0
Friends	39	13.8

*Multiple responses

As regards use of psychoactive drugs, 20(6.6%) of the total respondents claimed to have taken drugs before.The reported use of drugs showed that Heroine 9(3.0%) and Cannabis 8(2.6%) has the highest number of users. Reasons for taking psychoactive drugs were asked, psychologically independents 5(1.6%), sexually active 5(1.6) and reduces anxiety 10(3.3%) were the most reasons given by the respondents (Table 12)

Table 12

Pattern of use of psychoactive drugs by respondents

Pattern of use of psychoactive drugs?	N=305	%
Ever used drugs?		
Yes	20	6.6
No	285	93.4
Types of drugs	N=20	
Cannabis	8	2.6
Cocaine	3	1.0
Heroine	9	3.0
Reasons for taking drugs	N=20	
Makes me sexually active	5	1.6
Reduces pain and anxiety	10	3.3
Psychologically independent	5	1.6

4.5 Consequences of risk behaviours

Respondents were asked on consequences of sexual risk practices (table 13), most respondents reported that it increases the risk of HIV/AIDs 226(93.4%) transmission while 194 reported that it hold back educational career 194(80.2%). As regards consequences of substance use (consumption of alcohol, tobacco smoke and drug use). Increase risk of HIV/AIDS transmission has the lowest score 88(36.7%) while increase risk of cardiovascular and lung disease has the highest score 205 (90.7%).The other consequences are shown in the table below.

Table 13

Respondents' Knowledge on consequences of risk behaviours

Knowledge on consequences of risk behaviours	N= *	%
Consequences of sexual risk behaviours		
Increase risk of HIV/AIDs transmission	226	93.4
Unwanted pregnancy	218	90.1
Become a teenage mother	213	88.0
Hold back educational career	194	80.2
Consequences of substance use		
Increase risk of HIV/AIDs transmission	83	36.7
Increase risk of cardiovascular disease	205	90.7
Increase risk of addiction	189	83.6
Domestic violence	182	80.5
Loss of employment	160	70.8

*Multiple responses

HYPOTHESIS

1. There is no significant relationship between the participation of risky behaviours among female adolescents and their age.
2. There is no significant relationship between the participation of risky behaviours among female adolescents and religion
3. There is no significant relationship between who they live with and participation in risk behaviours
4. There is no significant relationship between participation of risk behaviours and whether they are working for money or not.
5. There is no significant relationship between the attitude of female adolescents towards sexual risk behaviours and substance use

Comparison of risky behaviours with other demographic variables

In comparing specific risky behaviour with age, the respondents within the middle 20 -24 years have the highest percentage for sexual intercourse (32.5%),alcohol consumption (22.0) tobacco use(4.9%) as well as had sex for money.(Table 14- 21). The statistical test on the above mentioned behaviours were also significant; 0.00, 0.00, 0.03 and 0.00 respectively.

Comparing age of respondents at first sexual intercourse, the results shows that higher number of respondents had had sexual intercourse before the age of 19 years old (35.1%). The p. value at 0.00 shows that sexual initiation is significantly associated with the age of the respondents (Table 14)

Comparing the religion of respondents with risk behaviours, the result shows that religion is not significantly associated with any of the risky behaviours. (Table 21-25)
While Comparing risky behaviours according to Family back ground, it was found that alcohol use and sexual intercourse were strongly associated with who the respondents live with.(p=0.00 and 0.00). Table 30

Comparing those who worked for money with their risk behaviours, there is significant relationship between working for money and the use of condom, alcohol consumption, sex for money. (0.00, 0.02 and 0.02). Table 31

Comparing sexual risk behaviours with substance use. Alcohol use is strongly related to sexual contact and sex with money (p =0.00 and 0.01). The statistical test at 1.51 and 0.622 shows that alcohol use is not significantly associated with the use of condom and number of sexual partners. The same trend goes with cigarette smoking. Cigarette smoking is strongly related with sexual contact and sex for money (0.00 and 0.01). Table 32.

Table 14

Respondents' Age by Sexual behaviours

Age group (years)	Ever had sex			X^2	df	pvalue
	Yes	No	Total			
10-14	9(3%)	25(8.1%)	34(11%)	101.731	24	0.000
15-19	80(26.2%)	81(26.6%)	161(52.8%)			
20-24	99(32.5%)	11(3.6%)	110(36.1%)			
Total	188 (61.6%)	117 (38.3%)	305 (100%)			

Table 15

Respondents' Current age by first sexual intercourse

Current Age (years)	Age at first sex (years)				X^2 Value	df	p value
	10-14	15-19	20-24	Total			
10-14	9	0	0	9			
	(4.7%)	(0.0%)	(0.0%)	(4.7%)	405.481	156	0.000
15-19	13	66	3	82			
	(6.9%)	(35.1%)	(1.6%)	(43.6%)			
20-24	4	47	46	97			
	(2.1%)	(25%)	(24.5%)	(51.6%)			
Total	26	113	49	188			
	(13.8%)	(60.1%)	(26.1%)	(100%)			

Table 16

Respondents' age by multiple sexual partners

Current Age (years)	Multiple sexual partners			X^2	df	p value
	Yes	No	Total			
10-14	5	4	9	32.876	14	0.000
	2.7%	2.1%	4.8%			
15- 19	33	47	80			
	17.6%	25%	42.6%			
20-24	38	61	99			
	20.21%	32.4%	52.7%			
Total	76	112	118			
	40%	60%	100%			

Table 17

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

Current Age (years)	**Condom use**			**X^2 Value**	**df**	**p value**
	Yes	No	Total			
10-14	1 (0.5%)	9 (4.7%)	10 (5.3%)	61.363	4	0.000
15-19	34 (18.1%)	47 (25%)	81 (43.1%)			
20- 24	50 (26.6%)	47 (25%)	97 (51.2%)			
Total	85 (45.2%)	103 (54.8%)	188 (100%)			

Table 18

Age by Involvement in sex for money

Current Age (years)	Involvement in sex for money			X^2 Value	df	p value
	Yes	No	Total			
10-14	1 (0.5%)	25 (13.8%)	26 (13.8%)	29.292	4	0.000
15-19	6 (3.2%)	107 (56.9%)	113 (60.1%)			
20-24	16 (8.5%)	33 (17.6%)	49 (26.1%			
Total	23 (12.2%)	165 (87.8%)	188 (100%)			

Table 19

Respondents Age by alcohol consumption

Current Age (years)	Ever consume alcohol			X^2 Value	df	p value
	Yes	No	Total			
10-14	6 (2.0%)	28 (9.2%)	34 (11.1%)			
15-19	46 (15.1%)	115 (37.7%)	161 (52.8%)	36.065	2	0.000
20-24	67 (22.0%)	43 (14.1%)	110 (36.1%)			
Total	119 (39%)	186 (61%)	305 (100%)			

Table 20

Respondents' Age by cigarette smoking

Current Age (years)	Ever smoke cigarette			X^2 value	df	p value
	Yes	No	Total			
10-14	0 (0.0%)	34 (11.1%)	34 (11.1%)	7.446	2	0.02
15-19	11 (3.6%)	150 (49.2%)	161 (52.8)			
20-2	15 (4.9%)	95 (31.1%)	110 (36.1%)			
Total	26 (8.5%)	279 (91.5%)	305 (100.0%)			

Table 21

Respondents' Religion and use of condom

Religion	Use of condom			X^2 value	df	p value
	Yes	No	Total	0.001	1	0.971
Christianity	65 (34%)	79 (42.0%)	144 (76.6%)			
Islam	20 (10.6%)	24 (12.8%)	44 (23.4%)			
Total	85 (45.2%)	103 (54.8%)	188 (100%)			

Table 22
Respondents' Religion by multiple sexual partners

Religion	Multiple sexual partners									X^2 value	df	p value
	2 Partners	3 Partner	4 partners	5 Partners	7 partners	8 partners	10 partners	20 partners	Total	10.053	7	1.86
Christianity	35	10	6	3	3	2	9	1	60			
Islam	10	1	1	1	0	1	2	0	16			
Total	45	11	7	4	3	3	11	1	76			

Table 23

Respondents' Religion by Sexual intercourse before 18

Religion	Sex before 18 (years)			X^2 value	df	p value
	10-14	**15-17**	**Total**	2.683	6	0.847
Christianity	22 (25.2%)	34 (39.1%)	66 (75.9%)			
Islam	5 (5.7%)	16 (18.1%)	21 (24.1%)			
Total	37 (42.5%)	50 (57.5%)	87 (100%)			

Table 24

Respondents'Religion by Involvement in sex for money

Religion	Involvement in sex for money			X^2 value	df	p value
	Yes	No	Total	6.17	1	0.43
Christianity	19 (10.1%)	124 (67%)	143 (76.1%)			
Islam	4 (2.1%)	41 (21.8%)	45 (23.9)			
Total	23 (12.2%)	165 (87.8%)	188 (100%)			

Table 25

Respondents' Religion by alcohol consumption

Religion	Ever consume alcohol			X^2 value	df	p value
	Yes	No	Total	0.662	2	0.718
Christianity	89 (29.2%)	137 (44.9%)	226 (74.1%)			
Islam	30 (9.8%)	48 (15.7%)	78 (25.6%)			
African traditional	0 (0.0%)	1 (0.3%)	1 (0.3%)			
Total	119 (39.0%)	186 (61.0%)	305 (100%)			

Table 26

Respondents' who work for money and use of condom

Currently working for money	**Use of condom**			**X^2 Value**	**df**	**p value**
	Yes	No	Total	22.78	2	0.000
Yes	52 (27.7%)	65 (34.6%)	117 (62.2%)			
No	33 (17.6%)	38 (20.2%)	71 (37.8%)			
Total	85 (45.2%)	103 (54.8%)	188 (100%)			

Table 27

Respondents' who work for money and Involvement in sex for money.

Work for money	Involvement in sex for money			X^2 Value	df	p value
	Yes	No	Total	5.169	1	0.02
Yes	18	103	121			
No	5	90	95			
Total	23	193	216			

Table 28

Work for money	Ever drank alcohol			X^2 value	df	p value

	Yes	No	Total	5.283	1	0.02
Yes	71	86	157			
	(23.3%)	(28.2%)	(51.5%)			
No	48	100	148			
	(15.7%)	(32.8%)	(48.5%)			
Total	119	186	305			
	(39.0%)	(60.9%)	(100%)			

Respondents' who work for money and consume alcohol

Table 29

Respondents who smoke cigarette and work for money

Work for money	Ever smoke cigarette			X^2 value	df	p value
	Yes	No	Total	3.58	1	0.058
Yes	18	139	157			
No	8	140	148			
Total	26	279	305			

Table 30

Family background and risk behaviours status of respondents

Living arrangement	Risk behaviours										
	Have had sex		**Sex for money**		**Use of condom**		**Alcohol use**		**Smoke cigarette**		**Total**
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Both parents	102	89	11	121	48	56	58	133	11	180	115
Father only	7	5	0	9	3	4	6	6	1	11	8
Mother only	21	10	5	19	7	14	13	18	3	28	21
Guardian	22	12	1	22	15	8	19	15	4	30	24
Sexual partner	36	1	6	22	12	21	23	14	7	30	36
Total	188	117	23	193	85	103	119	186	26	270	204
	X^2= 26.005 df = 4 p=0.00		X^2= 8.813 df=4 p=0.066		X^2= 6.008 df= 4 p=0.199		X^2= 19.121 df=4 p=0.00		X^2= 7.511 df=4 p=0.11		

Table 31

Respondents' Alcohol consumption and Sexual risk behaviours

Ever drank alcohol	Sexual risk behaviour							
	Ever had sex?		Sex with money		Use of condom		More Than two partners	Total
	Yes	No	Yes	No	Yes	No		
Yes	104 (55.3%)	15 (12.8%)	16 (8.5%)	81 (43.1%)	51 (27.1%)	51 (49.5%)	30 (60.5%)	104 (55.3%)
No	84 (44.7%)	102 (87.2%)	7 (18.1%)	112 (59.1%)	34 (18.1%)	52 (50.5%)	46 (39.5%)	84 (44.7%)
Total	188 (100%)	117	23 (45.2%)	193	85 (45.2%)	103	76	188 (100%)
	X^2= 54.744 df= 1 p= 0.00		X^2= 6.326 df= 1 p= 0.01		X^2= 2.063 df= 1 p=1.51		X^2=5.314 df=7 p= 0.622	

Table 32

Respondents' cigarette smoking by Sexual risk behaviours

Ever smoke cigarette	Sexual risk behaviours						
	Had sex		Sex for money		Condom use		Total
	Yes	No	Yes	No	Yes	No	
Yes	23 (7.5%)	3 (1%)	6 (2.8%)	15 (6.9%)	11 (5.9%)	11 (5.9%)	23 (7.5%)
No	165 (54.1%)	114 (37.4%)	17 (7.9%)	178 (82.4%)	74 (39.4%)	92 (48.9%)	165 (54.1%)
Total	188 (61.6%)	115 (38.4%)	23 (10.7%)	193 (89.3%)	85 (45.3%)	103 (54.8%)	188 (61.6%)
	X^2= 8.648 df=1 P= 0.00		X^2=7.854 df=1 P=0.01		X^2= 0.231 df=1 P=0.631		

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

Adolescence is a period of identity-forming and great pressure. As this period presents an opportunity for picking up bad habits, it also presents a golden opportunity for behaviour modification. The implications of the study are discussed in this chapter under the following headings: socio-demographic characteristics, sexual risk behaviours, knowledge on consequences of sexual risk behaviours and HIV/AIDS perception, alcohol use among the respondents, tobacco use among the respondents and knowledge of respondents on consequences of substance use.

Socio-demographic characteristics

The age of the respondents ranged 12- 24 years. This is a very impressive age bracket that is best understood as a period of transition from the dependence of childhood to adulthood's independence.161(51.8%) were between the ages of 15-19years and 110(36%) between the ages of 20-24years. A large number of out of school adolescents were exposed to various avenues for engaging in risky behaviours. Tendencies to engage in risky behaviour increases with age among the out of school female adolescents.

About 25.2% live with one parents or relative. The implication of this is that such adolescents may not receive adequate attention and care like those that live with both parents this considerable exposes them to risky behaviours more than those that live with both parents. All the respondents were not married, but 37(12.1%) live with their sexual partner. This implies that they may engage in risk behaviours such as non- condom use and sex for money due to fear of losing such partners. This behaviour predisposes them to sexually transmitted diseases and unwanted pregnancy.

More than half of respondents work to earn money 157(51.5%) and the most common work is shop assistants while 37(12.2%) involved in trading. This may be due to the depressed economy that impoverished the family. Another reason may be due to the fact that they are not in school and no money to further education, thus, engaging in other economic activities as a result of living in an urban areas. Source of earning money may also open up the females to risky sexual practices as well as sexual coercion. The reported rate in Ibadan of such coercion was 55% (Ajuwon, et al, .2001) the commonest being unwanted touches and kisses

The main occupations for a large proportion of the respondents' parents are trading; 41.3% for fathers and 71.1% for mothers. This trend reflects the occupation of the indigenous inner city dwellers that cater for the teeming population**.** 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. The level of education of the majority of fathers (31.8%) is post – secondary or tertiary levels of education, while (29.9%) of the mothers were in this category.

Sexual risk behaviours

Among the study population, 188(61.6%) had had sexual intercourse; this finding is similar to a study conducted among out of school female adolescents in Ekiti State (65.2%) (Fagbamigbe, Adebowale and Olaniyan2011). These results reflect the trends found in urban population, whose adolescents have access to pornographic materials greater and social pressures from media. Other reasons are abolishing of traditional and religious norms that frown on premarital sexual activities (Adekunle and Ladipo, 1992). According to a study conducted among adolescents in Ibadan, perceived factors reported by the non-abstinent respondents as obstructing their adoption of abstinence from premarital sex include uncontrollable sexual urges (46.7%); peer pressure (17.8%) and financial or material benefits (13.3%).Also, agreed that being economically dependent on a romantic partner hinders adolescents' ability to abstain from premarital sex especially adolescents whose sexual partners are often older, richer and more powerful men with whom they may be unable to negotiate sex for fear of losing economic benefits(Oladepo, et al., 2011). This suggested that poverty and the need to survive sometimes force women into risky sexual behaviour, for example, prostitution and multiple partners (Wusu, 2005). In this study, most sexual intercourse happened for pleasure 119(63.3%), 43(22.9%) for favour and 26(13.8%) have been raped for sex. Also, 23(12.2%) of the sexually active respondents had ever had sex for money.

In this study, the mean age of sexual initiation is 17.51 years $\pm$2.41. The implication of this is that adolescents who begin sexual activity early are more likely to have more sexual partners, and therefore are exposed to the risk of STIs, HIV and AIDS. 57.5% of sexually active respondents had had sex before 18 years of age. This exposes such adolescents to early risk-taking and increases their chance of taking sexual risk later in future (Wilson, 1995). Knowing that age at menarche strongly affect the likelihood of sexual initiation and teenage pregnancy (Halpern, 1994). It is therefore important that an intervention programme is

needed to educate the adolescents at the point of puberty to enable them make the right decisions about their sexual behaviour.

40.4% of the respondents who engage in sexual activities have multiple sexual partners ranged between 2- 20 in the last 6 months. Multiple sexual partners are associated with other risk behaviours including not disclosing HIV status to sex partners and less consistent use of condoms. This is similar to study conducted among out of school adolescent in Niger State, 53 % of sexually active out of adolescents reported having more than one sexual partner (Amazigo, et al, 1997). In this study, age group was found to significantly affect the number of sexual partners that respondents have. This implies that as adolescent increases in age they are likely to engage in risk behaviours especially those whohad sexual intercourse early. High-risk sexual behaviour among adolescents can lead to serious long-term health consequences such as sexually transmitted diseases (STDs), HIV/AIDS and unintended pregnancy. According to the Centres for Disease Control and Prevention (CDC), approximately 870,000 pregnancies occur each year among women 15-19 years old, and about 3 million cases of STDs are reported annually among 10- 19- year- olds. Other statistical models suggest that half or more of all HIV infections occur before age 25, and is one of the leading causes of death in adolescents.

The reported prevalence of condom use is low (45.2%) among sexually active respondents, more than half of the sexually active respondents (54.8%) did not use condom the last time they had sex. Condom use is promoted globally as an effective means of reducing sexual risk, more specifically HIV and sexually transmitted infections. Low levels of comprehensive knowledge of condom use and HIV among adolescents contributed to much higher HIV prevalence among female youth at age 20- 24 years. According to this study, the reported reasons for non-condom usage by most respondents was lack of knowledge on condom use (35.9%) and they don't like using any method (28.2%). Although almost half of the respondents' (49.5%) reported that their sexual partners agree to use condom

Knowledge on consequences of sexual risk behaviours

The information that young people receive regarding risk taking behaviours is crucial because it influences not only their knowledge and attitudes, but also their abilities to avoid negative outcomes of such behaviour. Knowledge on the consequences of non-condom was assessed among respondents, most respondents reported that it can lead to HIV transmission few said that it can hold back educational career. Increase knowledge about HIV and STIs transmission and prevention can reduce risky behaviour and also delay the onset of sexual intercourse (Johnson, et al., 2003). Findings have shown that participation in education programs decrease the number of sex partners and increase the use of condoms. In addition, participants develop better skills for negotiating lower-risk sexual encounters and increase frequency of communications about safer sex. Thus, it is necessary to modify social and educational activities to adolescents in the communities through multi domain approach such as religion activities, youth friendly services and educating parents to improve their understanding on the negative consequences of risk behaviour and how the risk can be minimised to avoid future health problems.

Use of drugs:

Alcohol had been termed as a gateway drug. It is usually the precursor to other psychoactive 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 consumption among young people is widespread around the world because of the social value of the drug in the country. Among the respondents, 39.0% reported they had ever drank alcohol before, out of these, more than half of them (70%) admitted they have been drunk before. The adverse effect of alcohol consumption and drunkenness is seen in its ability to impair judgement and to generally lower inhibition. This can aid the adolescent in engaging in risky behaviour, which she would otherwise not have engaged in. Drinking alcohol is strongly related to inconsistent condom use, high sexual sensation seeking, multiple sexual partners and HIV and STIs. According to a study conducted among female adolescents, there is an increase in female involvement in alcohol use (Lepusić, et. al., 2013). In this study,45% of those that drink alcohol are current drinkers and 12.9 % are daily drinkers. Consuming alcohol on daily basis has its adverse effect on adolescents. This leads to disorganization, crime and fall in productivity. This is because alcohol use can impair judgement, cause temporary loss, increase on accidents and risky behaviours (WHO, 1998). Apart from influence of parents, adolescents' drinking behaviours has been shown to beeninfluenced by

peer groups, and their relationship with their peer groups (Yeh, 2006). In this study, peers accounted for 56 (19.1%) of acquaintances that consume alcohol. It is primarily through interactions with peers that adolescents learn to define substance use as an acceptable and desirable activity.

Tobacco use:

In the survey, a total of 26 (8.5%) respondents admitted to smoking. This prevalence is low compared with findings in a study conducted among adolescents in Northeast Nigeria, 62 (36.3%) of female adolescents engage in smoking (Salawu, Danburam, Desalu, Olokoba, Agbo and Midala, 2009). 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. Also, in this study, tobacco use have been shown to be influenced by friends (13.8%). This shows risky behaviour is influenced by peer group. This may be due to the fact that they want to gain social acceptance by their peers. Among the smokers, 9 (3%) were still smoking. This shows that some female adolescents still engage in smoking,this is instructive for intervention and educational purpose.

Other psychoactive drugs:

The use of other psychoactive drugs such as cocaine, heroin cannabis and others by the respondents was still low as less than 10 percent use them. This is also similar to study conducted among adolescents in Ibadan. Which showed low prevalence of other psychoactive drugs among respondents (Omole, 2004). Most reasons for taking drugs were that it makes them sexually active (1.6%) and reduces pain and anxiety (3.3%). Educational approach on the negative consequences of taking drugs needs to be intensified among adolescents. This is because young people who have been trained to resist social pressures, who understand the health consequences of smoking and drug use are less likely to start drug use.

Knowledge on Consequences of drug use

Knowledge on the consequences of taking substance use was assessed among the respondents, there was a fair knowledge on the fact that “it increases risk of HIV transmission 226 (93.4%) compared with other consequences. The implication of this is that they do not consider alcohol consumption and drug use to reduce a person’s cognitive ability to consider protective sex. This might be because out of school female adolescents are outside a formal

school system and they miss out of the opportunity for learning in conducive environments. Their level of knowledge on the negative consequences of engaging in risk behaviour is very low. Thus, it is necessary to modify social and educational activities to adolescents in the communities through multi domain approach such as religion activities, youth friendly services and educating parents to improve their understanding on the negative consequences of risk behaviour and how the risk can be minimised to avoid future health problems.

Contribution:

Limited research on substance use and risky sexual behaviour had been conducted among out of school female adolescents. This study has given the understanding of the relationship between substance use and sexual risk behaviours because many of these behaviours are inter- related. The researchhad contributed to the existing knowledge on risk behaviours in Nigeria.

Conclusion:

The study determined the participation of out of school female adolescents in risky behaviours in Ibadan North Local Government and also identified the factors contributing to risky behaviours. The study showed that large number of female adolescents had had sex before the study was conducted.Almost half of them did not use condom the last time they had sexual intercourse. There was also an increase number of sexual partners (ranged 2- 20 partners). The study also showed that larger number of female adolescents had drunk alcohol, while the lowest percentage is found among those who smoked cigarettes. Risk behaviours was strongly influenced by friends as friends are the most reported by respondents to be involved in substance use.

In this study, it was found that age is significantly associated with risky behaviours. As adolescents increase in age, they engage in risky behaviours. The study also showed that family back ground such as who adolescents live with is strongly related to sexual contact and use of alcohol (Table 30). The study also showed that there is no relationship between religion and participating in risky behaviours. Due to lack of money to further education and unemployment among youths some of them engage in transactional sex (sex for money). Also, there is a significant relationship between working for money and use of condom, sex for money and alcohol use. The influence of socioeconomic status is very important in

explaining why adolescents are predisposed to risky behaviours which determine to a large extent who an adolescent would be or become in generations to come. Also the study showed that there was a low level of knowledge on negative consequences of risky behaviours as most of them do not know that engaging in alcohol, tobacco and drug use can predispose them to HIV and STIs. Also, they do not know that engaging in sexual risk behaviours resulting into teenage pregnancy can hold back their career and affect the nationwide. Thus, it is necessary to modify social and educational activities to adolescents in the communities to improve their understanding on the negative consequences of risk behaviour and how the risk can be minimised to avoid future health problems.

Recommendations

In line with the prevalence of risky behaviours among out of school female adolescents, the following recommendations are made:

1. Using the findings of the study as a baseline data, the Ministry of Health and faith-based organizations, international and non-governmental bodies and all adolescent stakeholders should be encouraged to collaborate and cooperate with opinion leaders into impacting and improving the knowledge of out of school adolescents on sexual health and behaviours that promote health.
2. Government should also build youth friendly centres in the communities that will enhance health facilities and adolescent knowledge on consequences of risk behaviours.
3. Parents are the primary sexual educators of the children. Parents should be sensitized on the importance of providing a supportive home environment; maintaining strong ties with them and giving appropriate information on sexual issues according to their ages. This will bring about a level of family connectedness that will effect positive changes in the sexual behaviour of the adolescents.
4. According to this study, most of the risky behaviours respondents engaged in are due to parental influence.Parents should therefore be provided information on good role modelling because children emulate most of their behaviours. The responsibility of sensitizing parents can be taken up by the Ministry of Women Affairs with cooperation from faith-based organizations, representatives of market women, parents and other bodies.

5. Government in collaboration with Community Health Workers should organize a programme to create awareness and also educate out of school sexually active female adolescents on contraceptive use especially condom use that will minimize these risk behaviours since this study shows that most of the sexually active respondents do not know any methods of contraceptives.
6. Government agencies, non-Governmental agencies, and youth related institutions of training should also design programs directed at addressing the problem of drugs as well as teaching them empowerment approaches that serve to keep them away from drugs.They should also be educated on the effect of substance use as a factor that can enhance unprotected sexual intercourseleading to increase HIV/AIDS and STIs transmission.
7. Government should provide educational exposure and skills development that will position out of school young people to be comfortably placed on the socio-economic ladder because female adolescents who work for money are more likely to use condom than those who do not work. As some reported that monetary gains and benefits are factors obstructing their non-condom use.
8. Finally, programs need to effectively address the influence of peer groups, social norms and pressures on adolescents to have sex. The influence of social norms is particularly acute during adolescence, which is characterized by a strong need to fit in with one's peers. Peer education intervention programs offer a unique opportunity to develop and reinforce norms that support risk reduction behaviours. Hence adequate funding should be made available to promote peer intervention program models.

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APPENDIX 1

QUESTIONNAIRE

RISK PRACTICES AMONG OUT OF SCHOOL FEMALE ADOLESCENTS IN IBADAN NORTH LOCAL GOVERNMENT AREA

Introduction,

My name is **IBIYEMI, Monisade Eunice**, I am a Post graduate student from University of Ibadan, Department of Health Promotion and Education.

You have been selected to participate in an interview, which is aimed at collecting information that will be used to assess your level of knowledge, attitude and practices towards risk behaviours. All the information given to the interviewer will not be disclosed to anyone. The interview will not take much of your time. Please note that the questionnaire to be used for the interview does not include the names of respondents and it is only for out of school female adolescents. Your voluntary participation in answering the questions fully and honestly will be highly appreciated.

Thank you.

SECTION 1: DEMOGRAPHIC INFORMATION

Please answer the following questions about yourself: Circle the appropriate response to each of the questions.

1. How old were you at your last birthday? _____years
2. Level of education_____
    1. Primary school
    2. Secondary school
3. What is your religion?
    1. Christian 2.Islam 3. African Tradition
4. What is your ethnic group?
    1. Yoruba 2. Igbo 3. Hausa 4. Others (specify) _____

5. Which of these applies to you now (CIRCLE ONLY ONE ANSWER)
    1. I am Married 2. I am not married

6. Who do you live with?
    1. Both parents 2.Father only 3. Mother only 4. Guardian 5. My sexual partner

7. Father's level of Education

1 .No schooling 2.Primary school 3. Adult Education 4.Modern High school

5. Technical school. 6. Post-secondary like Polytechnic or University 7. Others.

8. What is your father's occupation?

1. Civil servant 2.Military 3. Trader 4.Artisan 5. No job

9. How many children does your father have?

1. How many boys_____ 2. How many girls_____

10. Mother's level of Education

1 .No schooling 2.Primary school 3. Adult Education 4.Modern High school

5. Technical school. 6. Post-secondary like Polytechnic or University 7. Others

11. What is your mother's occupation?

1. Civil servant 2.Military 3. Trader 4.Artisan 5. No job

12. Have you ever worked for money? 1. Yes 2. No

13. Are you currently working for money? 1. Yes 2. NO

14. What type of work do (did) you do?

1. Shop/office assistant 2.Trader 3. Apprentice 4.Others

SECTION 2:LIFESTYLES, HOBBIES AND INTERESTS

15. Please indicate the things you are interested in doing with your spare time **(Respondent may mention more than one activity. Mark** for those that interest respondent**)**

ACTIVITIES	**Yes**	**No**
1. Attend church/mosque activities		
2. Watch Television/ listen to Radio		
3. Read books/Novels		
4. Visit a youth centre		
5. Spend time with my parents/relatives		
6. Spend time with my friends		

SECTION 3: ***ATTITUDE AND PRACTICES OF SEXUAL ACTIVITIES***

Now we would like to ask you about your personal experiences. Please answer truthfully, as your name is not recorded on this questionnaire, and your answers will not be revealed to anyone.

16. Have you ever had a boyfriend?

1. Yes 2. No

17. About how old were you when you had your first boyfriend? _____

17b. Have you ever had sex before?

1. Yes 2. No

18. How old were you when you had sexual intercourse for the first time? _____ (age in years).

19. How many sexual partners do you have? Please indicate _____

20. Does your sexual partner smokes?

1. Yes 2. No 3. I don't know

21. Does your sexual partner takes alcohol?

1. Yes 2. No 3. I don't know

22. Your first sexual intercourse happened in what circumstances

1. At marriage 2. Raped 3.Pleasure 4. For favour

23. Have you ever had sex in exchange for money?

1. Yes 2. No

24. Have you ever asked your partner to use a method to prevent pregnancy or HIV?

1. Yes 2. No

25. If NO why?

1. I am afraid of losing him 2. I will not enjoy sex
3. He will not love me again 4. I don't like using any method.
5. I don't know any method

26. Does your partner always agree to use any methods you have listed above to prevent pregnancy and HIV?

1. Yes 2.No

27. **If YES**, which of the methods? _____

28. Did you use condom the last time you had sex?

1. Yes 2. No

29. Have you heard of HIV/AIDS?

1. Yes 2. No

30. Do you perceive you are at risk of HIV and STIs?

1. Yes 2. No

SECTION 4. ***ATTITUDE TOWARDS SUBSTANCE USE***

Please answer these questions on attitude towards alcohol, cigarette smoking and drug use truthfully, as your name is not recorded on this questionnaire, and your answers will not be revealed to anyone

31. Have you ever drank alcohol?

1. Yes 2. No

32. Do you drink now?

1. Yes 2. No **GO TO 36**

33. Why do you drink alcohol?

1. It make me sexually active
2. Reduces anxiety and pain
3. It makes me independent psychologically and physically
4. My friends do
5. I don't know

34. How often do you drink?

1. Daily 2. Once in a week
3. More than once in a week 4. Once in a month

35. Have you ever been drunk?

1. Yes 2. No

36. Who among the following drink alcohol?

1. Father 2.Mother 3. Brother 4.Guardian
5. Friends 6. None

37. Have you ever smoked cigarette before?

1. Yes 2. No

38. Do you smoke cigarette now?

1. Yes 2. No

39. Who among the following smoke?

1. Father 2.Mother 3. Brother
4.Guardian
5. Friends 6. None

40. Which of these drugs have you taken before?

1. Cannabis (Marijuana) 2. Cocaine 3. Heroine 4. Others (Please specify)

41. Why do you take drugs?

1. It make me sexually active
2. Reduces anxiety and pain
3. It makes me dependent psychologically and physically
4. I don't know

SECTION 5: KNOWLEDGE ON CONSEQUENCES OF RISK BEHAVIOURS

42. Please mark which of the CONSEQUENCES of having sex without using condom

CONSEQUENCES OF HAVING SEX WITHOUT USING CONDOM	**TRUE**	**FALSE**	**I DON'T KNOW**
1. HIV and STIs transmission			
2. Unwanted pregnancy			
3.Become a teenage mother			
4. Hold back education career			

43. Please mark which of the **CONSEQUENCES** of drinking alcohol, smoking cigarette and use of drugs you know.

Consequences of drinking alcohol, smoking and drug use	**Yes**	**No**	**I don't know**
Increase risk of HIV transmission			
Increase risk of cardiovascular disease and lung cancer			
Increase risk of addiction			
Domestic violence			
Loss of employment			

Thank you for your participation!!!