# PERCEPTION AND PRACTICE OF SEXUALITY EDUCATION AMONG MALE PARENTS OFADOLESCENTS IN ALIMOSHO LOCAL GOVERNMENT, LAGOS STATE, NIGERIA

**BY**

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# DEDICATION

I Dedicate This Work To My Father And My King, Jehovah Jireh, For Seeing Me Through The Mph Programme. I Know That If It Wasn't For God, I Wouldn't Have Come This Far.

Thank You Jesus!!!

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# ABSTRACT

Sexuality Education Is The Highly Important Information Provided To Adolescents To Help Them Make Responsible Decisions As It Concerns Their Sexuality And Their Sexual Health. Despite The Importance Of Sexuality Education However, Many Parents Still Shy Away From The Topic. Much Of Research On Sexuality Education Has Focused On Female Parents And So Little Is Known About The Practice Of Sexuality Education Among Male Parents In Nigeria. This Study Was Therefore Conducted To Examine The Perception And Practice Of Sexuality Education Among Male Parents Of Adolescents In Alimosho Local Government, Lagos State, Nigeria.

A Descriptive Cross-Sectional Study Was Conducted Among Male Parents Of Adolescents In Alimosho Local Government, Lagos State, Nigeria, With A Total Of 320 Consenting Male Parents Being Randomly Selected For The Study. A Semi-Structured Questionnaire With Five Sections Comprising Socio-Demographic Characteristics, Perception, Practice Of Sexuality Education, Factors Influencing Practice Of Sexuality Education And Suggestions On How To Improve Male Parents' Practice Of Sexuality Education, Was Used To Collect Quantitative Data. Descriptive Statistics And Chi-Square Test Were Used For Data Analysis With The Level Of Significance Set At P=0.05. Respondents' Perceptions About Sexuality Education Were Scored And Classified Into Two Groups Such That 0-4 Was Classified As 'Negative Perception' And 5-9 Was Classified As 'Positive Perception'.

Respondents' Mean Age Was 45.5±6.8 Years, 71.6% Were Yorubas, 21.9% Igbos, While 3.1% Were Hausas. Ninety-Five Percent (95.0%) Were Married, 1.3% Divorced, 1.6% Single Parents And 2.2% Were Widowers. Ninety Percent (90.0%) Of The Respondents Agreed That Sexuality Education Is Very Essential For Adolescents, 80.3% Agreed That Parents Should Be The Main Source Of Sexuality Education To Their Adolescents, 85.9% Agreed That Sexuality Education Can Help Prevent Teenage Pregnancy, While 87.5% Agreed That Sexuality Education Helps Adolescents Protect Themselves From Rape And Sexual Abuse. 40.0% Of The Respondents Had Never Provided Sexuality Education To Their Children. 57.0% Of Those Who Had Ever Provided Sexuality Education To Their Adolescents, Reported That They Initiated The Discussion The Last Time While 92.2% Reported That They Felt Comfortable The Last Time The Discussion Took Place. Among The Components Of Sexuality Education Discussed, Majority Of The Respondents (75.8%) Discussed Hiv/Aids And Other Stis; 63.3% Discussed

Pregnancy And Related Issues, While 24.2% Discussed Contraceptives. 42.8% Of The Respondents Revealed That They Do Not Know How To Provide Sexuality Education, While 51.9% Report That Training Could Motivate Them To Provide Sexuality Education To Their Adolescents. There Was Also A Significant Association Between The Age, Marital Status And Religion Of Respondents And Their Practice Of Sexuality Education.

The Practice Of Sexuality Education Is Still A Bit Low Among Male Parents Of Adolescents In Alimosho Local Government. Awareness And Training Programmes Must Therefore Be Organized To Improve The Practice Of Sexuality Education Among These Male Parents.

**KEYWORDS**: SEXUALITY EDUCATION, MALE PARENTS, ADOLESCENTS, PRACTICE OF SEXUALITY EDUCATION

**WORD COUNT**: 454

# CERTIFICATION

This is to certify that this Study was carried out by Adenrele, Yetunde Christianah of the Department Of Health Promotion And Education, Faculty of Public Health, under my supervision.

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# List of Abbreviations

| | |
|---|---|
| **AIDS** | Acquired Immuno-Deficiency Syndrome |
| **CDC** | Centre For Disease Control |
| **FCHE** | Federal Centre For Health Education |
| **HIV** | Human Immunodeficiency Virus |
| **IPPF** | International Planned Parenthood Federation |
| **NPC** | National Population Commission |
| **SIECUS** | Sexuality Information And Education Council Of The United States |
| **STIs** | Sexually Transmitted Infections |
| **UNAIDS** | Joint United Nations Programme On Hiv/Aids |
| **UNESCO** | United Nations Educational, Scientific And Cultural Organization |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations Children's Fund |
| **WHO** | World Health Organization |

# Operational Definition Of Terms

**Sexuality Education**: Refers To The Process Of Passing Instructions On Issues Relating To Human Sexuality, Such As Human Sexual Anatomy, Reproduction, Contraception, Puberty, Relationships And Marriage.

**Adolescents**: Persons Between The Ages Of 10-19

**Youth**: Persons Between The Ages Of 15-24

**Perception**: The Way In Which Something Is Regarded Or Interpreted

**Practice**: The Application Or Use Of Ideas, Beliefs, Theories Or Methods

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background Information

According to Kamalpreet (2012), sex education is a lifelong process of building a strong foundation for sexual health through acquiring information and forming attitudes, beliefs, and values about identity, relationship and intimacy. Sexuality is an integral part of the personality of everyone, be it men, women or children. It is a basic need and aspect of being human that cannot be separated from other aspects of life and it influences thoughts, feelings, actions and interactions and thereby mental and physical health (Dyson, 2010).

Sex Education has however been a bone of contention over the years because as many stakeholders of child and adolescent health and education believe, it is very dicey, with the key issue being 'How far do we go in sex educating young ones?' Many parents shy away from the topic, because they believe teaching sex education to children would make them promiscuous. Those who do want to sex educate their children, don't know how to go about it. As noted by Olubayo-Fatiregun (2012), parents who ought to be the primary educators of their children and communicate to them specific values about sexuality, play the least role in this area. Some parents have suggested that government agencies would be best to provide comprehensive sexuality education, while others have suggested the school teachers. Yet there are others who consider sexuality education as being immoral, contrary to religious and traditional values and likely to encourage pre-marital sexual activity.

The debate over the significance of sexuality education was re-iterated by Dienye (2011), who while quoting UNESCO, stated that the challenge for sexuality education is to reach young people before they become sexually active, whether this is through choice, necessity (e.g. in exchange for money, food or shelter), coercion, or exploitation. For many developing countries, this discussion will require attention to other aspects of vulnerability, particularly disability and socio-economic factors. Furthermore, some students, whether now or in the future, will be sexually active with members of their own sex. These are challenging and sensitive issues for those with the responsibility of designing and delivering sexuality education, and the needs of those most vulnerable must be taken into particular consideration.

Adolescents, being at a very crucial stage of their development, are one of the most critical group of people in the society and country at large who need protection from the dangers and implications of risky sexual behaviours through early and accurate information on sexual matters (Olubayo-Fatiregun, 2012). Because youth and adolescence are times of physical, emotional and psychological development when decisions about relationship formation and sexual debut occur, it is viewed as a particularly salient period in which to address sexuality (Smith and Harrison, 2013). Sexuality education seeks both to reduce the rate of potentially negative outcomes from sexual behaviours like unwanted or unplanned pregnancies and infection with sexually transmitted diseases, and to enhance the quality of relationships. It is also about developing young people's ability to make decisions over their entire lifetime (Kasonde, 2013). Issues like teenage pregnancies, HIV/AIDS and other Sexually Transmitted Infections among adolescents, and an increase in rape cases of children and adolescents, have made it very imperative that sexual and reproductive health education takes a centre stage in the education of young ones, and the crux of this duty falls on parents, who make the major decisions in the lives of their children.

## 1.2 **Statement of the Problem**

According to the Nigeria 2013 Demographic and Health Survey key findings (NPC and ICF Macro, 2014) women and men in Nigeria tend to initiate sexual activity before marriage. Nearly one-quarter of women age 25-49 have had sexual intercourse by age 15 and more than half by age 18. The median age at first sexual intercourse is 17.6 years for women and 21.1 years for men age 25-49. This report is synonymous with that of Briggs (1998) who stated that pregnancy is common among school girls in Nigeria, but that most girls do not carry their pregnancies to term, due to the disgrace of childbirth out-of-wedlock. Donenberg, Bryant, Emerson, Wilson, Pasch (2003) also reported that teenagers are initiating sex at earlier ages and early sexual debut is associated with higher HIV exposure because it is linked to more frequent sexual intercourse, more lifetime Sexually Transmitted Diseases (STDs), less consistent contraceptive use, and more sexual partners.

According to Olubayo-Fatiregun (2012), 'there is a high rate of sexual abuse among adolescents in the society, secondary schools, tertiary and other institutions of learning. These have resulted in unwanted pregnancies, teenage parenthood, illegitimate children, feeling of shame and emotional instability. In some cases, abortion is attempted or committed, and this sometimes

leads to the premature death of both mother and child. The primary cause of these lamentable circumstances is simply because adults in a position to instruct the young ones are too often filled with shame and guilt about sex.'

In Sub-Saharan Africa, available evidence suggests that parent-child communication about sex-related matters is not very common and at times is fraught with discomfort, especially communication with fathers (Biddlecom, Awusabo-Asare and Bankole, 2009), though parent-child sexuality communication has been identified as a protective factor for adolescent sexual and reproductive health, including HIV infection (Bastien, Kajula and Muhwezi, 2011).

The inability/failure of parents to discuss sex and relationship related issues with their children has been known to have adverse effects, with many of these children resorting to information they get on the internet and from friends; information that is incorrect and incomplete at best.

Though a considerable number of studies on parents' practice of sexuality education have been carried out, majority of these studies have focused primarily on female parents, with the male parents not being fully investigated. As a result, there is little knowledge on:

1. Male parents' perception of sexuality education,
2. Male parents' practice of sexuality education,
3. Factors influencing male parents' practice of sexuality education.

This study was therefore designed to address these concerns.

## 1.3 **Justification**

Charity, they say, begins at home. The home is the place where a child is meant to get firsthand knowledge about issues like sexuality and relationships, particularly with those of the opposite sex. The home, really, is the first point of contact of a child with the outside world and the training a child receives at home, forms, to a large extent, much of what that child would be as an adult.

Most communities in Nigeria are patriarchal. The fathers play the major leadership role in the home. Major decisions, as it concerns the home and everything that happens in and around it, are made by fathers. Also, fathers are the major breadwinners and so a lot of importance is attached to fatherhood.

Much of research however has focused on mothers, while the role of fathers or male parents has been to a large extent, undermined. This, however, should not be the case, as both parents are very important, with mothers generally doing more of the explicit nurturing, while fathers tend to be more involved in play, particularly physical play such as 'rough and tumble'. Also, nowadays, fathers do much more hands-on care-giving than they did a generation ago: changing diapers, getting up at night, taking children to the doctors, sharing drop-offs and pick-ups, and helping with homework (Harvard Extension School, 2013).

Research has also shown that children who have a good relationship with their fathers tend to have lesser psychological problems later in life. Sarkadi (2008) in a research on the involvement of fathers and children's developmental outcomes, stated that 'Our detailed 20-year review shows that overall, children reap positive benefits if they have active and regular engagement with a father figure.' Adolescents and children generally, need a father figure they can look up to and talk to about the issues that affect them, such as sexuality and relationship issues. This strengthens the bond between fathers and their children. Fathers therefore need to play a more active role in the sexual and reproductive health and education of their children.

Provision of sexuality education has been proven to be an effective means of reducing the rate of teenage pregnancies, with its attendant consequences. It has also been shown to be effective against rape and sexual abuse. Provision of sexuality education to adolescents, helps these adolescents know their rights as it concerns their reproductive health, thus making it difficult to coerce or force them into having non-consensual sex.

Provision of sex education to adolescents has also been shown to reduce their risk of contracting HIV and other sexually transmitted infections. According to Dienye (2011), 'an individual with a sound sexuality education is more likely to impact lives, as he/she is alive to his/her responsibilities of reducing the occurrence and spread of STDs. On the other hand, without a well-planned sexuality education programme, adolescents become victims of at-risk sexual behaviours, unprotected sexual activity, intercourse with high risk partners, and inconsistent use of condoms.'

All these and more make it very necessary for parents, particularly fathers, to provide sexuality education to their children. But before intervention programmes aimed at improving male parents' practice of sexuality education can be developed however, there is a need to acquire

adequate knowledge on the perception of these male parents to sex education and on the factors that could hinder or motivate these male parents to provide sexuality education to their children.

This study is therefore justified based on the fact that findings from the research would be helpful in the planning, designing, implementation and evaluation of interventions aimed at improving the practice of sexuality education by male parents of adolescents. Findings could also be helpful in the design and funding of comprehensive age-appropriate curricular and programmes on Sexuality Education for Adolescents.

## 1.4 Research Questions

1. What perception do male parents in Alimosho Local Government, Lagos State, have towards sexuality education?
2. To what extent are these male parents involved in the sexuality education of their adolescents?
3. Which components of sexuality education do these male parents practice?
4. What factors promote or hinder sexuality education among male parents?

## 1.5 Broad Objective

The broad objective of the research was to investigate the perception and practice of sexuality education among male parents of adolescents in Alimosho Local Government, Lagos State.

## 1.6 Specific Objectives

The specific objectives of the research were:

1. To assess the perception of male parents in Alimosho Local Government, Lagos State, to sexuality education.
2. To determine the extent to which male parents have been involved in the sexuality education of their adolescents.
3. To identify the components of sexuality education that male parents practice.
4. To identify the factors that influence the practice of sexuality education by male parents.

## 1.7 Hypotheses

**Hypothesis 1**: there is no significant association between the ages of male parents and their practice of sexuality education.

**Hypothesis 2**: there is no significant association between the religion of male parents and their practice of sexuality education.

**Hypothesis 3**: there is no significant association between the occupation of male parents and their practice of sexuality education.

**Hypothesis 4:** there is no significant association between the marital status of male parents and their practice of sexuality education.

**Hypothesis 5:** there is no significant association between respondents' perception and their practice of sexuality education

# CHAPTER TWO

## LITERATURE REVIEW

### 2.1 Nature of Adolescence and Youth

Adolescence is defined as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to19. It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy (WHO, 2014). Youth on the other hand, is best understood as a period of transition from the dependence of childhood to adulthood's independence and awareness of our interdependence as members of a community. Youth is a more fluid category than a fixed age-group (UNESCO, 2014).

The number of adolescents and youths in the world today is nearly two billion and growing and is the largest youth cohort in history (Diamond, 2012). In developing countries, thirty per cent of the population is under the age of 15 and another 19 per cent is between the ages of 15 to 24 years old. In the poorest countries, some 60 per cent of the population is under the age of 25 (UNFPA, 2010). These adolescents are shaping social and economic development, challenging social norms and values, and building the foundation of the world's future. Maturing earlier than previous generations, both physically and socially, adolescents and youth have high expectations for themselves and their societies, and are imagining how the world can be better. Connected to each other like never before through new media and because of globalization, they are driving social progress and directly influencing the sustainability and resilience of their communities and their nations (UNFPA, 2014). Adolescents and young people therefore represent the future of every society (UNESCO, 2013).

Young people, however, especially adolescent girls and young women, suffer disproportionately from negative sexual and reproductive health outcomes, which challenge their ability to contribute to their communities' and countries' development. These young people face substantial social and economic barriers in accessing sexual and reproductive health information and services, which is evidenced by persistently high levels of unmet need for contraception, maternal mortality, and the incidence of HIV. Young women aged 15 to 19 are twice as likely to die in childbirth as adult women, and half of all new HIV infections occur in young people

between the ages of 15 and 24. Such negative sexual and reproductive health outcomes have economic, social, and health consequences that affect young people throughout their lives, as well as their families, countries, and the global community at large (Youth Health and Rights Coalition, 2011).

## 2.2 Adolescent Sexuality

Sexuality is the expression of sexual sensation and related intimacy between human beings. Psychologically, sexuality is the means to express the fullness of love between a man and a woman. Biologically, it is the means through which a child is conceived and the lineage is passed on to the next generation. Sexuality involves the body, mind, and spirit; sexuality is complex and spans a vast array of human experiences including family relationships, dating, sexual behavior, physical development, sensuality, sexualization, reproduction, gender, body image and more. It is a fundamental and natural part of being human, for people of all ages (International Planned Parenthood Federation, 2014). For most adolescents and young people, adolescence is a period of enormous vibrancy, discovery, innovation and hope. Adolescence is also the time when puberty takes place, when many young people initiate their first romantic and sexual relationships, when risk-taking is heightened and 'fitting in' with peers becomes very important. It can also be a challenging time for young people, who are becoming aware of their sexual and reproductive rights and needs, and who rely on their families, peers, schools and health service providers for affirmation, advice, information and the skills to navigate the sometimes difficult transition to adulthood. This transition may catalyze a range of challenges including HIV infection, other sexually transmitted infections (STIs), unintended pregnancy, low education attainment or dropping out of education and training (UNESCO, 2013).

Though adolescent sexuality has been a bone of contention over the years, it is however, a public health issue. According to Forcier and Garofalo (2013), 'From Aristotle's early treatises on sexual desire, to Sigmund Freud's theories of psychosocial development, adolescent sexuality has been a controversial topic for virtually every generation. As the 21st century unfolds, society will continue to be challenged by adolescent sexual behavior and its consequences. Although medical providers often discuss adolescent sexuality in terms of "risk", it is important to remember that sexuality, sexual behaviors, and sexual relationships are an important and necessary part of human development. Responsible sexual behavior (e.g., delaying initiation of

sexual intercourse, choosing caring and respectful partners, increasing the use of condoms, and using effective contraception) is an important public health issue.'

All young people are sexual beings, whether or not they are sexually active. Sexuality is about a lot more than having sex. It is about each young person's growing awareness, experience and expression of eroticism, sexual pleasure, intimacy, sexual orientation and gender identity. It is also about the social rules, economic structures, political battles and religious ideologies that surround physical expressions of intimacy and the relationships within which such intimacy takes place (IPPF, 2014).

Several theoretical frameworks have been developed to describe the nature of the sexual health and sexuality of adolescents. One of such models was developed by Dennis Dailey from the University of Kansas. This model is called 'Circles of Sexuality'. In this model, Dailey uses five interconnected circles to describe the various components of sexuality. These components include:

**Sensuality**: The ability to enjoy and experience pleasure from one's own body and from the body of others. It includes body image, skin hunger, sexual response, touch, taste, smell, hearing, sight, and fantasy.

**Intimacy**: The ability to be emotionally vulnerable with another and to have that vulnerability reciprocated. It includes liking, loving, disclosure, trust, caring, and sharing.

**Sexual Identity**: The perception people have of themselves as sexual beings. It includes gender, gender roles, biological sex, sexual orientation, and gender identity.

**Sexual and Reproductive Health**: The anatomical and physiological systems and processes that are related to clinical aspects of sexuality. It includes menstruation, pregnancy, infertility, menopause, Sexually Transmitted Infections (STIs), contraception and abortion.

**Sexualization**: The use of sex and sexuality to manipulate others. Topics include flirting, seduction, withholding sex, sexual harassment, and rape (Health Care Education and Training, 2014).

Young people need to learn to know their own personal values and beliefs about relationships and sex. Whether sexuality education occurs in school or in the context of the family, it should be more comprehensive than the simple provision of information. It is therefore important that young people develop skills so that they: can make sound decisions about sex and relationships and are able to stand up for those decisions; have the insight to recognize situations that might

turn risky or violent, and know how to avoid them and how to deal with them if they do arise; know how to find accurate information from reliable sources; know how and where to ask for help and support and know how to negotiate protected sex and other forms of safe sex including safety and refusal skills (Dyson, 2010).

Adolescents therefore need to be trained on how to properly handle their sexuality and that is what necessitates the need for sexuality education for these adolescents. Increasing knowledge on adolescent sexuality is very essential for the design of intervention efforts/programmes that ensure that our adolescents are safe and healthy.

## 2.3 Sexuality Education for Adolescents

Sexuality Education according to Akpama (2013) is described as the information and skills acquired by an individual to help that individual deal with human sexuality. It is the information provided to adolescents to help them make realistic and responsible decisions about sexual behaviours such as dating practices, courtship, mate selection and social roles. Sexuality Education, according to the Sexuality Information and Education Council of the United States, is also defined as a lifelong process of acquiring information and forming attitudes, beliefs, and values. It encompasses sexual development, sexual and reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles.

Improving the sexual and reproductive health of young people is a global priority. Interventions which aim to promote healthy sexual behavior typically aim to delay sexual debut, decrease the number of sexual partners and increase condom use. In spite of concerns that sexuality education may contribute to early sexual experimentation among young people, this is not supported by evidence. On the contrary, findings from studies conducted in developing countries suggest that sexuality education has the potential to positively impact knowledge, attitudes, norms and intentions (Bastien, Kajula and Muhwezi, 2011).

Sexuality education aims to equip children and young people with the information, skills and values they need to have safe, fulfilling and enjoyable relationships and to take responsibility for their sexual and reproductive health and well-being. It also aims to contribute to behaviour change, including reducing unprotected and unwanted sex, and reducing harmful behaviour, including sexual offences such as assault and abuse (Family Planning, 2014). In the words of

Dienye (2011), 'Sexuality Education ensures a better understanding of the influence of society on everyday interactions. Thus, the ability to exercise self-control and determine one's sexual behavior by conforming to certain principles as they concern sexual behaviours, are the bases of sexuality/sex education.' According to Dienye (2011), the following should constitute the content of sexuality education: human growth and development, relationships, life skills, sexual attitude and behavior, sexual health, society and culture.

Traditionally, sexuality education has focused on the potential risks of sexuality, such as unintended pregnancy and STIs. This negative focus is often frightening for children and young people: moreover, it does not respond to their need for information and skills and, in all too many cases, it simply has no relevance to their lives (FCHE, 2010). There is therefore the need for a more comprehensive sexuality education programme for young children and adolescents. Comprehensive Sex Education is about providing children and adolescents with age-appropriate sexual health education that will help them take personal responsibility for their health and well-being. According to Family Planning (2014), the characteristics of effective sexuality education programmes include:

1. Both school and home contribute to sexuality education.
2. Trained educators are used.
3. A comprehensive range of topics is addressed, including contraception.
4. Psychosocial factors which affect behavior, including values, norms and self-efficacy are addressed.
5. Programmes begin before a young person first has sex.
6. Participatory learning methods are used.
7. Children and young people are taught using small group work.

When young people are equipped with accurate and relevant information, when they have developed skills in decision making, negotiation, communication and critical thinking, and have access to counseling and SRH/HIV services that are non-judgmental and affordable, then they are better able to:

1. Take advantage of educational and other opportunities that will impact their life-long well-being;
2. Avoid unwanted pregnancies and unsafe abortions;

3. Improve their sexual and reproductive health and protect themselves against STIs including HIV; and
4. Understand and question social norms and practices and contribute to society (UNFPA, 2014).

The home and the school have been recognized as good places for teaching children sexuality education

2.31 **Home-based Sexuality Education**

The family in general and parents are recognized by many disciplines as most influential in affecting a given child's behavior including sexual identity. Engaging parents in sex education matters therefore has a definite impact on the sexual health of the young (Nambambi and Mufune, 2011). Daily occurrences in the home provide opportunities for discussions on sexuality, making parents the primary sex educators of their children. This important role begins in infancy and as children go through each stage of growth and development, parents can provide the vital education and guidance that is needed to make healthy sexual choices (Sieswerda and Blekkenhorst, 2006).

Family communication about sexual issues can be a vehicle for shaping positive, affirming attitudes around sexuality, and it can help to reduce the consequences of sexual ignorance: embarrassment and discomfort, early sexual activity, unintended teenage pregnancy, sexually transmitted infections, sexual abuse and exploitation (Gossart, 2002). Family based sexuality education can: allow for the sharing of family values, provide accurate information to children, build effective decision-making skills, and counteract negative and exploitative sexual messages in the media (Gossart, 2002). Bellavance (2014) is of the opinion that parents/caregivers/adults can support the development of healthy sexuality by:

1. Providing age-appropriate sexuality information on such topics as puberty, reproduction, healthy relationships, sexual orientation and gender identity, boundaries and body image;
2. Helping build critical-thinking skills to separate fact from fiction in media, such as TV, music, video, games, pornography and other depictions of sexuality;
3. Starting an open and honest dialogue; Ask questions and most importantly, listen;
4. Supporting adolescents in understanding they have both rights and responsibilities in their relationships. Encouraging and modeling characteristics of healthy relationships.

Intervening and providing guidance when characteristics of unhealthy relationships and/or sexual violence occur;

5. Addressing ways to deal with peer pressure; encouraging independence while setting clear boundaries.

## 2.32 School-based Sexuality Education

The issue of school-based sexuality education is controversial. Various stakeholders of school health (parents, teachers, government agencies and Non-Governmental Agencies) have divergent views on school-based sexuality education for young children and adolescents. In the United States, school-based sexuality education curriculum is of two types:

**Abstinence-Only Curriculum**: these teach that abstaining from sexual activity is the only acceptable choice for unmarried adolescents. In many such programs, contraception is usually not mentioned or is discussed only in terms of the failure rates of contraceptive devices (Hartmann, 2002).

**Abstinence-Plus Curriculum**: these discuss abstinence from sexual activity as the first and best choice for adolescents, yet include a scientific discussion of contraception, sexually transmitted diseases, and other sexuality issues as crucial elements of life-time sexuality information (Hartmann, 2002).

Schools are however vital partners in helping young people learn how to take responsibility for their health and adopt lifetime health-enhancing attitudes and behaviours. Health education, integral to the primary mission of schools, provides young people with the knowledge and skills they need to become successful learners and healthy and productive adults (CDC, 2013). School-based sexuality education complements and augments the sexuality education children receive from their families, religious and community groups (Aniebue, 2007). According to Akande and Akande (2007), the primary goal of school-based sexuality education is to help young people build a foundation as they mature into sexually healthy adults.

In Nigeria, school-based sexuality education is particularly important for the teeming population of Nigerian children. At school, many of these children learn about vital components of their sexuality; things they might hitherto not learn at home. Akande and Akande (2007) reported that

a study in Benin revealed that 55% of secondary school girls have had sexual intercourse by age 16 years and 40% admitted to at least one previous pregnancy.

In all, school-based sexuality education programmes should:

1. Be medically accurate and consistent with scientific evidence.
2. Be tailored to students' needs and the contexts and educational practices of communities.
3. Use effective classroom instructional methods.
4. Allow students to develop and demonstrate developmentally appropriate sexual health-related knowledge, attitudes, skills and practices (CDC, 2013).

## 2.4 Reducing Age of Sexual Initiation among Adolescents

Adolescents are becoming sexually active at an increasing earlier age than before. A key period of sexual exploration and development occurs during adolescence. During this time, individuals begin to consider which sexual behaviours are enjoyable, moral, and appropriate for their age group. Many teens become sexually active during this period (Collins, Elliot, Berry, Kanouse, Kunkel, Hunter, and Miu, 2004). The Nigeria Demographic and Health Survey 2013 findings showed that one in four girls were sexually active by age 15. Household survey data indicate that in developing countries (excluding China), around 11 percent of females and 6 percent of males aged 15-19 claim to have had sex before the age of 15 (UNICEF, 2011). Sexual intercourse is commonly initiated during adolescence and early initiation of sexual intercourse has been linked to increased risk of sexually transmitted infections (STIs) and pregnancy during adolescence (Kaestle et al., 2005).

Nowadays, early sexual initiation is seen by some adolescents as being 'matured'. To some, one is not a 'big boy' or girl till he/she has 'done it' and in a bid to impress their friends, they engage in sexual activities at a time when they are not ready to bear the consequences of such actions. Escobar-Chaves and Anderson (2008) confirm this by saying 'adolescents are engaging in sexual risk-taking behaviours at an earlier age, often before they are developmentally ready to deal with the potential outcomes.'

The consequences of early sexual initiation are far reaching. Findings from a number of cross-sectional studies suggest that early initiators of sex may indeed continue with patterns of behavior that place them at higher risk than peers who have delayed first intercourse. Retrospective reports of early sexual debut have been correlated with a greater number of sexual

partners, lower levels of condom use, a greater chance of unintended pregnancy and a higher risk of self-reported Sexually Transmitted Diseases (STDs), as well as with other risk behaviours, including weapon carrying and drug use (O'Donnell, O'Donnell and Steuve, 2001). This is confirmed by Rector, Johnson, Martin and Noyes (2003), who went further to state that 'early initiation of sexual activity and higher numbers of non-marital sex partners are linked in turn to a wide variety of negative life outcomes, including increased rates of infection with sexually transmitted diseases, increased rates of out-of-wedlock pregnancy and birth, increased single parenthood, decreased marital stability, increased maternal and child poverty, increased abortion, increased depression and decreased happiness.'

A number of factors have been shown to influence the age of sexual initiation among adolescents. Social-psychological theories of health behavior and empirical research suggest that timing of first sexual intercourse is influenced by a broad array of individual and social environmental factors (Sieving, Eisenberg, Pettingell and Skay, 2006). These factors include: the media (the TV), peers and the family. A lot of television programmes, movies and advertisements contain sexual content. Viewing of television programmes containing sexually explicit materials could be a motivating factor for adolescents to initiate sex. The American Academy of Paediatrics has suggested that portrayals of sex on entertainment television may contribute to precocious adolescent sex (Collins et al., 2004). Adolescents may be exposed to sexual content in the media during a developmental period when gender roles, sexual attitudes, and sexual behaviours are being shaped. This group may be particularly at risk because the cognitive skills that allow them to critically analyze messages from the media and to make decisions based on possible future outcomes are not fully developed (Gruber and Grube, 2000). Furthermore, TV may create the illusion that sex is more central to daily life than it truly is and may promote sexual initiation as a result, a process known as media cultivation. Exposure to the sexual models provided by television also may alter beliefs about the likely outcome of engaging in sexual activity (Collins et al., 2004).

Peers also have a great influence on the timing of sexual debut. Peer norms, attitudes and conduct modulate the sexual behavior of adolescents to a great extent. Perceived peer approval of intercourse, peers themselves being sexually active, and peers breaking rules, are all associated with a higher probability of early experience with coitus (Bobakova, Geckova, Klein, van Dijk, Reijneveld, 2013). Longitudinal studies have found that adolescents who perceive that

their friends favour postponing sexual intercourse are themselves more likely than others to do so. These perceptions may be shaped by a combination of friends' attitudes and adolescents' own attitudes. Adolescents who are highly involved with their friends may find themselves in social contexts that encourage early dating and entry into romantic relationships, which have been linked to earlier sexual initiation (Sieving at al., 2006). Also, youths who are sexually active tend to believe that most of their friends are sexually active as well, and this, for them, outweighs the costs of sexual involvement. They believe that sex overall is rewarding, and that it is all right for unmarried adolescents over age 16 to engage in intercourse (National Association of Social Workers, 2001).

The family also influences adolescent sexual behavior. Parents are expected to monitor their children's activities, as well as identify, sift and package information and services for their children. Because parents are in regular contact with their children, they help to shape both their behavior and the social context in which they grow up (Biddlecom, Awusabo-Asare and Bankole, 2009). It has been reported by Bobakova et al (2013) that strong parental bonding and monitoring, good communication with parents, and living in a complete family, are associated with delayed sexarche and other aspects of healthy sexual behaviours. Parent-child closeness is associated with reduced adolescent pregnancy risk through teens remaining sexually abstinent, postponing intercourse, having fewer sexual partners, or using contraception more consistently. For example, parent-child connectedness or closeness is related to both daughters' and sons' postponement of sexual intercourse and to more consistent contraceptive use by sexually active teenagers (Miller, 2002). There is growing evidence that various preventing dimensions- connectedness or love, maternal support, behavioural control or monitoring, and parent-child communication- are positively associated with reduced levels of risk-taking behavior among adolescents. Some studies also support the proposition that adolescents are less likely to engage in sexual risk-taking behavior when they reside with a parent-especially two parents- or when they identify with the views of their parents (Biddlecom at al., 2009). Parents therefore, need to make out time for their children. They also need to monitor their children's activities and even their friends too.

## 2.5 HIV/AIDS among Adolescents and Youth

HIV/AIDS is one of the major health challenges in the world. This pandemic has claimed the lives of many people in the world including those in working-age group (economically active population) and hence threatening economic development of countries which are severely affected by the disease (Lwelamira, Sarwatt and Masumbuko, 2012).

Globally, 34.0 million (31.4 million – 35.9 million) people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide (UNAIDS, 2012).

More than thirty years into the HIV and AIDS pandemic, it remains one of the most serious challenges to global public health. Around the world, 5 million young people are living with HIV. And with 41 percent of new HIV infections occurring among young people, that means that every 30 seconds, another young person becomes HIV positive (Advocates for Youth, 2008). Despite stable rates of HIV diagnosis in older populations, the rate of HIV diagnoses from 2006 to 2009 increased in teens 15-19 and youth 20-24 years of age, and was highest in the 20-24 year old age group. New HIV infections are heavily concentrated among young people aged 15-24 years, i.e., youths. Youths account for 60% of people living with HIV/AIDS and 40% of new infections in Africa (Lwelamira et al., 2012). Undiagnosed HIV cases are thought to be highest among young people. The US Centers for Disease Control and Prevention (CDC) estimates that:

1. More than half of all undiagnosed HIV infections are youths aged 13-24.
2. Of HIV diagnoses among 13 to 19 year olds, almost 70 percent are to black teens.
3. Almost 80 percent of all adolescent infections are to males. Nine out of ten adolescent male HIV infections result from male-to-male sexual contact. The same proportion of adolescent females is infected from heterosexual contact (United States Department of Health and Human Services, 2012).

Adolescent HIV/AIDS is a separate epidemic and needs to be handled and managed separately from adult HIV as not only do these adolescents face problems in accepting their HIV status, need for life-long treatment and other positive family members but also have sad memories of their lost/dead parent (s) and a big question mark in the future regarding health, education, career

and marriage. An adolescent is an individual who gets infected with HIV once but stays infected and affected for life (Naswa and Marfatia, 2010).

The majority of HIV infections among adolescents are contracted through sexual activity. The presence of other sexually transmitted infections (STIs) can also facilitate HIV transmission. Adolescents and young adults are physiologically and behaviorally at higher risk for acquiring STIs. An estimated three million cases of STIs other than HIV are acquired each year among persons between ten and nineteen years old. Youth under the age of twenty-five account for two-thirds of the total number of cases of STIs diagnosed annually. Rates of chlamydia, gonorrhea, and human papilloma virus (HPV) are particularly high among sexually active female teens. An individual's risk is affected by STI prevalence among the pool of potential sex partners. African-American and Hispanic teens, for example, are disproportionately overrepresented among AIDS cases and cases of other STIs. Given that sexual networks tend to be homogeneous by race, these youth are more likely to face greater prevalence of HIV among their sex partners (Gale Encyclopedia of Education).

The children perinatally infected with HIV, as the immune system weakens, grow slowly and become vulnerable to recurrent infections and illnesses. Hence, as they become adolescents, they are already physically stunted and vulnerable to innumerable infections. Many HIV-infected children, especially those with low CD4 counts, do not mount protective antibody response against measles even after proper immunization, and thus continue to be susceptible in their adolescence and later adulthood (Naswa and Marfatia, 2010).

Some of the risk factors and barriers to prevention of HIV/AIDS according to the Center for Disease Control and Prevention (CDC) HIV/AIDS fact sheet 2008 include:

**Early age at sexual initiation**: According to CDC's Youth Risk Behavioral Survey (YRBS), many young people begin having sexual intercourse at early ages: 47% of high school students have had sexual intercourse, and 7.4% of them reported first sexual intercourse before age 13. Women and men in Nigeria tend to initiate sexual activity before marriage. Nearly one-quarter of women age 25-49 have had sexual intercourse by age 15 and more than half by age 18. The median age at first sexual intercourse is 17.6 years for women and 21.1 years for men age 25-49 (NPC Nigeria and ICF International, 2014). HIV/AIDS education needs to take place at

correspondingly young ages, before young people engage in sexual behaviors that put them at risk for HIV infection.

**Heterosexual Transmission**: Young women, especially those of minority races or ethnicities, are increasingly at risk for HIV infection through heterosexual contact. According to data from a CDC study of HIV prevalence among disadvantaged youth during the early to mid-1990s, the rate of HIV prevalence among young women aged 16–21 was 50% higher than the rate among young men in that age group. African American women in this study were 7 times as likely as white women and 8 times as likely as Hispanic women to be HIV-positive. Young women are at risk for sexually transmitted HIV for several reasons, including biologic vulnerability, lack of recognition of their partners' risk factors, inequality in relationships, and having sex with older men who are more likely to be infected with HIV (CDC, 2008).

**Men who have sex with men (MSM)**: Young MSM are at high risk for HIV infection, but their risk factors and the prevention barriers they face differ from those of persons who become infected through heterosexual contact. According to a CDC study of 5,589 MSM, 55% of young men (aged 15–22) did not let other people know they were sexually attracted to men. MSM who do not disclose their sexual orientation are less likely to seek HIV testing, so if they become infected, they are less likely to know it. Further, because MSM who do not disclose their sexual orientation are likely to have 1 or more female sex partners, MSM who become infected may transmit the virus to women as well as to men (CDC, 2008).

**Sexually Transmitted Diseases (STDs)**: The presence of an STD greatly increases a person's likelihood of acquiring or transmitting HIV. Some of the highest STD rates in the USA are those among young people, especially young people of minority races and ethnicities.

Lack of close bond between children and their parents has also been implicated among the factors for increased vulnerability of youths to HIV/AIDS (Lwelamira et al., 2012). This therefore emphasizes the need for increased closeness between parents and their adolescents, something that sexuality education can help build.

## 2.6 Rape and Sexual Abuse of Adolescents

Rape may be defined as a type of sexual assault usually involving sexual intercourse, which is initiated by one or more persons against another, without that person's consent (Omoniyi, 2013).

The Encyclopedia of Children's health defines rape and sexual assault as crimes that involve the use of threats, fear tactics, and/or physical violence to force a child or adolescent to submit to sexual intercourse or to engage in other sexual activity (e.g., oral sex, anal sex). Rape or sexual assault, an especially invasive and awful form of sexual abuse, occurs whenever children are forced or coerced into physical sexual activity without their express consent, regardless of the perpetrator's age (Oswalt, 2014). Rape is a traumatic event in the life of a person and has devastating consequences for the survivor. These consequences may be psychological or physical (Omoniyi, 2013). The sexual assault of children and adolescents is a major public health problem. Of adolescents aged 12-17 in the United States, an estimated 8% have been victims of serious sexual assault. One out of every eight adult women or at least 12.1 million American women will be the victim of forcible rape sometime in her lifetime (Bloom, 2003).

The United States Department of Justice reports that:

1. As many as 1 in 3 girls and 1 in 7 boys will be sexually abused at some point in their childhood.
2. Most perpetrators are acquaintances, but as many as 47% are family or extended family.
3. In as many as 93% of child sexual abuse cases, the child knows the person that commits the abuse.
4. Approximately 30% of cases are reported to authorities.
5. Approximately 1.8 million adolescents in the United States have been the victims of sexual assault.
6. 33% of sexual assaults occur when the victim is between the ages of 12 and 17.
7. 82% of all juvenile victims are female.
8. 69% of the teen sexual assaults reported to law enforcement occurred in the residence of the victim, the offender, or another individual.
9. Teens 16 to 19 years of age were 3 1/2 times more likely than the general population to be victims of rape, attempted rape, or sexual assault.
10. Approximately 1 in 5 female high school students report being physically and/or sexually abused by a dating partner.
11. Approximately 1 in 7 (13%) youth Internet users received unwanted sexual solicitations.

12. 4% of youth Internet users received aggressive solicitations, in which solicitors made or attempted to make offline contact with youth.
13. 9% of youth Internet users had been exposed to distressing sexual material while online.
14. 9.2% of cases of maltreatment of children in 2010 were classified as sexual abuse.
15. Over 63,000 cases of child sexual abuse were reported in 2010.

A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling of worthlessness and an abnormal or distorted view of sex. The child may become withdrawn and mistrustful of adults, and can become suicidal (The National Center for Victims of Crime). Sexually abused or assaulted youth often (but not always) find themselves emotionally damaged or even traumatized by their victimization. There are both short and long term effects which may result from such abuse, including intense shame, lowered self-esteem, grief, anger, depression, anxiety and difficulty forming new loving and sexually healthy relationships (Oswalt, 2014).

In Nigeria, there has been a rise over the years in the rape and sexual assault of adolescents, a trend that is very disturbing indeed. Sexual abuse of young people in Nigeria is a true problem in Nigeria although the true extent of its prevalence remains unknown because much of it goes unreported. Sexual abuse of adolescents in Nigeria exists in many forms including sexual harassment, unwanted sexual contact, coercion, rape, incest, prostitution and child-trafficking. Most often, the perpetrators against children are not strangers; they are relatives, neighbours and acquaintances (Action Health Incorporated). An online news agency reported in 2013 that about 678 rape cases were reported in Lagos in the space of a year.

The rape and sexual abuse of adolescents is a very sensitive issue, as many of these children and adolescents find it difficult to report these heinous crimes, because many of them fear that they will be harmed by the perpetrators of the sexual crimes should they report. Many of the adolescents also feel they are in a way responsible for the rape or sexual abuse.

Sexual abuse of adolescents has serious adverse consequences and so must be prevented by all means possible. Sexuality education has been proven to be one effective means of providing children and adolescents with their basic rights as it concerns their sexuality. Parents therefore must provide their children with necessary sexuality education.

## 2.7 Teenage/Adolescent Pregnancies

Teenage/Adolescent pregnancy is pregnancy in girls still in the adolescence period. It is pregnancy in girls between the ages of 12-19. About 16 million women 15–19 years old give birth each year, about 11% of all births worldwide. Ninety-five per cent of these births occur in low- and middle-income countries. The average adolescent birth rate in middleincome countries is more than twice as high as that in high-income countries, with the rate in low-income countries being five times as high. The proportion of births that take place during adolescence is about 2% in China, 18% in Latin America and the Caribbean and more than 50% in sub-Saharan Africa. Half of all adolescent births occur in just seven countries: Bangladesh, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Nigeria and the United States (WHO, 2014). Poverty is correlated significantly with adolescent pregnancy in the United States. Although 38% of adolescents live in poor or low-income families, as many as 83% of adolescents who give birth and 61% who have abortions are from poor or low-income families. At least one third of parenting adolescents (both males and females) are themselves products of adolescent pregnancy (Klein and the committee on adolescence, 2005).

Most adolescents lack the knowledge of safe sex. According to statistics, 80 % of the teen pregnancies are unplanned or accidental. These are due to broken condoms, unprotected sex and some other factors like having sex while being drunk or under influence of drugs (Teenage Pregnancy 101). Teenage pregnancy is the result of curiosity, peer pressures, lack of parental guidance, unawareness of safe sex practices, and poor socio-economic factors. Parents often feel quite embarrassed to discuss about sex with their teenage children. Sometimes they provide wrong information about sex that leads to curiosity. Some also discourage their children to join or participate in any discussions about sex (Teenage Pregnancy 101).

Births to unmarried adolescent mothers are far more likely to be unintended and are more likely to end in induced abortion. Coerced sex, reported by 10% of girls who first had sex before age 15 years, also contributes to unwanted adolescent pregnancies (WHO, 2014). A report by Channels Television on the 15th of July, 2013 stated that the National Population Commission (NPC) disclosed that the occurrence of teenage pregnancy in Nigeria might increase to over 60 million by the year 2013; a report that is both staggering and frightening. According to the President of the Association for Reproductive and Family Health, Teenage/Adolescent Pregnancy is not just a

health issue, but a developmental issue. According to him, 'Young people including adolescents in Nigeria constitute a significant proportion of the population and face unique challenges, which may compromise their health and developmental potentials if not addressed.'(Channels Television, 2013). The President of ARFH therefore called for age-appropriate sexuality education to develop the knowledge and skills that young people need. In Nigeria, early marriage contributes to adolescent pregnancy, particularly in the Northern part of the country, where girls are married off, most times to older men, from the age of 13.

Adolescent pregnancy has adverse effects on the mother, the baby and the community/country at large. Although adolescents aged 10-19 years account for 11% of all births worldwide, they account for 23% of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth. Fourteen percent of all unsafe abortions in low- and middle- income countries are among women aged 15-19 years. About 2.5 million adolescents have unsafe abortions every year, and adolescents are more seriously affected by complications than are older women (WHO, 2014). Pregnant adolescents younger than 17 years have a higher incidence of medical complications involving mother and child than do adult women, although these risks may be greatest for the youngest teenagers. The incidence of having a low birth weight infant (<2500 g) among adolescents is more than double the rate for adults, and the neonatal death rate (within 28 days of birth) is almost 3 times higher. The mortality rate for the mother, although low, is twice that for adult pregnant women (Klein and the committee on adolescence, 2005). Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. These include anaemia, malaria, HIV and other sexually transmitted infections, postpartum haemorrhage and mental disorders, such as depression. Up to 65% of women with obstetric fistula develop this as adolescents, with dire consequences for their lives, physically and socially (WHO, 2014). Also, Children born to adolescents face particular challenges—they are more likely to have poorer educational, behavioral, and health outcomes throughout their lives, compared with children born to older parents (United States Department of Health and Human Services, 2012).

Teenage pregnancy has socio-economic effects. In the United States, teen childbearing costs U.S. taxpayers between $9.4 and $28 billion a year through public assistance payments, lost tax revenue, and greater expenditures for public health care, foster care, and criminal justice services (United States Department of Health and Human Services, 2012). Many girls who become

pregnant have to leave school. This has long-term implications for them as individuals, their families and communities. Studies have shown that delaying adolescent births could significantly lower population growth rates, potentially generating broad economic and social benefits, in addition to improving the health of adolescents (WHO, 2014).

Sexuality Education is therefore needed to develop the knowledge and skills that young people, particularly young ladies need to prevent them from being pregnant.

## 2.8 The role of fathers in the upbringing of their Children

A father is far more than a person who donates his sperm in the production of a child. A father can be described as any male figure in the life of a child who provides guidance, vision and leadership to the child and every other member of the family. Fathers are far more than just 'second adults' in the home. Involved fathers bring positive benefits to their children that no other person is as likely to bring. Fathers therefore have a direct impact on the well-being of their children (Rosenberg and Wilcox, 2006).

There is no single “right” way for fathers to be involved in the lives of their children. Instead, there are many types of father involvement in all aspects of raising a child. These include playing together, being nearby while a child explores, and taking a child for health checkups. Research has found that the value of father involvement is determined by the quality of the interaction between fathers and their children – for example, a father’s responsiveness to the needs of his child – rather than the amount of time fathers spend with their children (Scott and Hunt, 2011). Children who grow up with active fathers tend to perform better in school. This result may stem from a father’s teaching of self-control, which becomes important as a child progresses through elementary school to middle and high school, with the resulting increase in schoolwork (Verial and Media, 2014). Fathers’ involvement in their children’s lives has been shown to have a positive effect on children and their well-being in many areas for example, an increase in the chances of academic success and in reducing the chances of delinquency and substance abuse (Jones and Mosher, 2013).

A number of studies suggest that fathers who are involved, nurturing, and playful with their infants have children with higher IQs, as well as better linguistic and cognitive capacities. Toddlers with involved fathers go on to start school with higher levels of academic readiness.

They are more patient and can handle the stresses and frustrations associated with schooling more readily than children with less involved fathers (Rosenberg and Wilcox, 2006). The family as a whole also benefits from the involvement of fathers. These benefits come from having loving and nurturing relationships among family members, not only between parents and children, but between a spouse, partner, or relative. Being involved in caring, not only for the child, but for the family can bring greater harmony and fewer arguments. The family tends to enjoy their time together more. Involved fathering brings a greater sense of commitment to the family and less troubling conflict with teenage children (Fogarty and Evans, 2009).

As summarized by Scott and Hunt (2011), the roles of fathers in the lives of their children are in four domains: social-emotional development, intellectual development, language development, and motor development.

**Social-emotional development:**

1. Early involvement by fathers in the primary care of their child is a source of emotional security for the child;
2. Fathers' affectionate treatment of their infants contributes to high levels of secure attachment;
3. When fathers acknowledge their child's emotional response and help them address it with a problem-solving approach, the children score higher on tests of emotional intelligence;
4. Quality father-and-child time increases self-esteem, confidence, social competence, and life skills;
5. Mothers may use more parenting techniques of gentleness and security, while fathers may favor independence and confidence-building. These approaches help children understand the world in different ways; they balance each other.

**Intellectual development:**

1. Early, positive involvement of fathers in intellectually stimulating activities, physical care, and general caregiving activities is associated with lower levels of cognitive delay as measured by children's babbling and their exploration of objects with a purpose;
2. Fathers tend to do more than mothers to promote their child's independence and exploration of the outside world;

3. A number of studies suggest that fathers who are involved, nurturing, and playful with their infants have children with higher IQs, as well as better linguistic and cognitive capacities.

**Language development:**

1. Fathers tend to use more "wh-" questions and more requests for clarification than mothers, both of which encourage conversation;
2. Girls whose fathers read to them are likely to have better verbal skills;
3. Two-year-olds whose fathers use a more varied vocabulary have greater language skills a year later.

**Motor development:**

1. Six-month-old babies whose fathers are involved in their care score higher on tests of motor development;
2. Fathers tend to play more one-on-one, rough and tumble games with their child, which encourages large motor development, lets children explore what their bodies can do, and helps them learn to regulate their emotions when engaging in impulsive physical contact.

## 2.9 Conceptual Framework

The conceptual framework that is used in this research to explain the factors influencing the practice of sexuality education among male parents of adolescents is the **Social Learning Theory**. This theory was propounded by Albert Bandura in the year 1977. Bandura stated that 'Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action.' (Kendra, 2014). He believed that behaviorism alone could not explain all that be observed. He believed that behavior and the environment affected each other. He called this phenomenon reciprocal determination. He extended his theory by braiding in a person's personality with behavior and the environment. After his acknowledgement of mental images, his behaviorism philosophy turned to cognitivism. The beginning of cognitivism led to his expanded research on language acquisition, learning, and self-regulation (Northern Arizona University, 2014).

In social learning theory, Albert Bandura states that behavior is learned from the environment through the process of observational learning. Bandura believed that humans are active information processors and think about the relationship between their behavior and its consequences. Observational learning could not occur unless cognitive processes were at work (McLeod, 2011).

Albert Bandura, who was a psychologist, discovered the importance of behavioral models when he was working with patients with snake phobias. He found that the patients' observation of former patients handling snakes was an effective therapy. The patients in treatment abstracted the information that others, who were like them, handled snakes with no ill effects. These patients considered that information in reflecting on their own behavior. Bandura found that these observations were more effective in treating their phobias than persuasion and observing the psychologist handle the snakes (Hurst, 2014).

The social learning theory has become perhaps the most influential theory of learning and development. While rooted in many of the basic concepts of traditional learning theory, Bandura believed that direct reinforcement could not account for all types of learning. His theory added a social element, arguing that people can learn new information and behaviors by watching other people. Known as observational learning (or modeling), this type of learning can be used to explain a wide variety of behaviors (Kendra, 2014).

There are three core concepts at the heart of social learning theory. First is the idea that people can learn through observation. Next is the notion that internal mental states are an essential part of this process. Finally, this theory recognizes that just because something has been learned, it does not mean that it will result in a change in behavior.

1. **People can learn through observation**: In his famous Bobo doll experiment, Bandura demonstrated that children learn and imitate behaviors they have observed in other people. The children in Bandura's studies observed an adult acting violently toward a Bobo doll. When the children were later allowed to play in a room with the Bobo doll, they began to imitate the aggressive actions they had previously observed. Bandura identified three basic models of observational learning:

   i. A live model, which involves an actual individual demonstrating or acting out a behavior.
   ii. A verbal instructional model, which involves descriptions and explanations of a behavior.

iii. A symbolic model, which involves real or fictional characters displaying behaviors in books, films, television programs, or online media.

2. **Mental states are important to learning**: Bandura noted that external, environmental reinforcement was not the only factor to influence learning and behavior. He described intrinsic reinforcement as a form of internal reward, such as pride, satisfaction, and a sense of accomplishment. This emphasis on internal thoughts and cognitions helps connect learning theories to cognitive developmental theories.

3. **Learning does not necessarily lead to a change in behavior**: While behaviorists believed that learning led to a permanent change in behavior, observational learning demonstrates that people can learn new information without demonstrating new behaviors (Kendra, 2014).

According to Bandura, the following steps are involved in the observational learning and modeling process:

**Attention:**

In order to learn, you need to be paying attention. Anything that detracts your attention is going to have a negative effect on observational learning. If the model interesting or there is a novel aspect to the situation, you are far more likely to dedicate your full attention to learning.

**Retention:**

The ability to store information is also an important part of the learning process. Retention can be affected by a number of factors, but the ability to pull up information later and act on it is vital to observational learning.

**Reproduction:**

Once you have paid attention to the model and retained the information, it is time to actually perform the behavior you observed. Further practice of the learned behavior leads to improvement and skill advancement.

**Motivation:**

Finally, in order for observational learning to be successful, you have to be motivated to imitate the behavior that has been modeled. Reinforcement and punishment play an important role in motivation. While experiencing these motivators can be highly effective, so can observing other experience some type of reinforcement or punishment. For example, if you see another student rewarded with extra credit for being to class on time, you might start to show up a few minutes early each day (Kendra, 2014).

**The Model of the Bandura's Social Learning Theory**:

The model of the Bandura's theory of social learning is also called the Reciprocal Causation Model. This model illustrates how the three factors/variables of Person, Environment and Behaviour can influence learning. These three variables also affect one another. The **personal** factors that influence learning and behavior include: knowledge, expectations and attitude; the **environmental** factors include: social norms, access in community and influence on others (ability to change own environment); while the **behavioural** factors include: skills, practice and self-efficacy (Northern Arizona University, 2014).

**The Social Learning Theory applied to the study:**

The social theory learning theory has been used in this research to explain factors that influence the practice of sexuality education by male parents. Using the Social Learning Theory, these factors have been grouped into three:

**Personal factors**: Some of the personal factors that influence male parents' practice of sexuality education include: age of the male parent, occupation, marital status, perception, expectations, knowledge and attitude of male parents to sexuality education. These were gotten via questions 1 to 9 in the questionnaire and questions 10 to 25.

**Environmental factors**: Some of the environmental factors that influence male parents' practice of sexuality education include: societal norms and beliefs about sexuality education, significant others such as spouses, friends, and religious leaders. These were accessed via questions 45 and 46.

**Behavioural factors**: Some of the behavioural factors that influence male parents' practice of sexuality education include: training and the acquisition of skills on how to provide sexuality education and the constant practice of sexuality education by fathers, which improves their self-efficacy on the provision of sexuality education. These were accessed via questions 26 to 43 and questions 44 to 46.

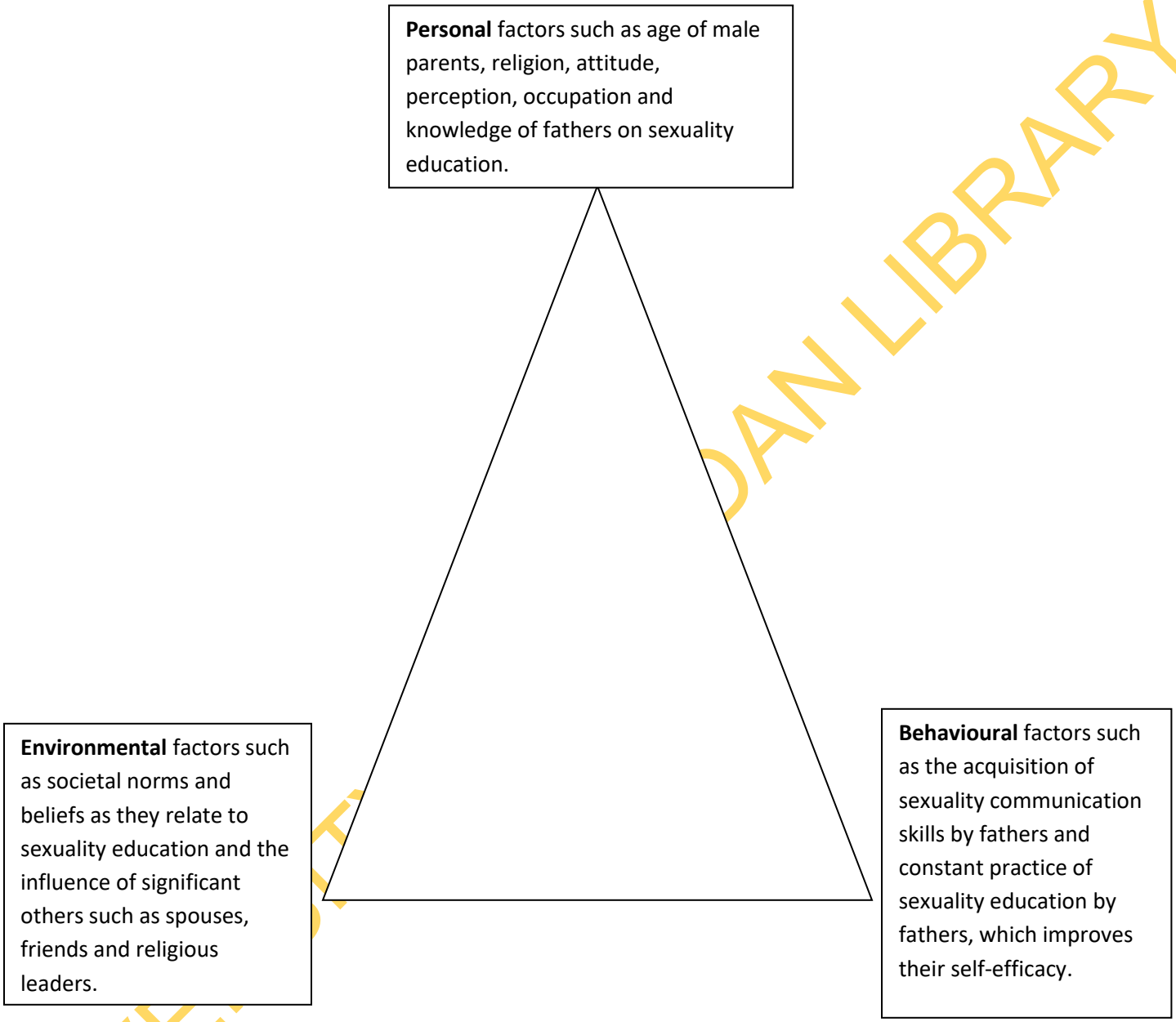


**Figure 2.1 Social Learning Theory Model applied to the Practice of Sexuality Education among male parents**

# CHAPTER THREE

# METHODOLOGY

## 3.1 Study Design

The study was a descriptive cross-sectional study and it examined the perception and practice of sexuality education among male parents in Alimosho Local Government, Lagos State, as well as their socio-demographic characteristics.

## 3.2 Study Area

Lagos State was created out of the former western region by the then regime of General Yakubu Gowon on May 27, 1967 through the States (Creation and Transitional Provisions) Decree No. 14 of 1967, which restructured Nigeria's federation into 22 states. The capital of Lagos State is Ikeja. Prior to this, Lagos Municipality had been administered by the Federal Government though the Federal Ministry of Affairs as the regional authority, while the Lagos City Council (LCC) governed the city of Lagos. Equally, the metropolitan areas (Colony Province) of Ikeja, Agege, Mushin, Ikorodu, Epe and Badagry were administered by the Western Region Government. Lagos State took off as administrative entity on April 11, 1968 with Lagos Island serving the dual role of being the State and Federal Capital. However, with the creation of the Federal Capital Territory of Abuja in 1976, Lagos ceased to be the capital of the state and the capital was moved to Ikeja. Equally, with the formal relocation of the seat of the Federal Government to Abuja on 12 December, 1991, Lagos ceased to be Nigeria's political capital (Source: www.lagosstate.gov.ng).

Alimosho is one of the Local Government Areas in Lagos State. It is the largest Local Government in the state, with a population of 2,047,026 people and sits on a land mass of 137.80km$^2$ . The local government has an estimated population projection of 2,717,945 people by the year 2015. There are seven wards under the Local Government and these include: Omituntun-Olori, Santos/Ilupeju, Akowonjo, Oguntade/Bameke, Egbeda, Alabata, Alaguntan (Lagos Bureau of Statistics, 2012).

**Table 3.1 Local Government Areas of Lagos State by Population Density: 2006**

| Local Government Area | 2006 Population | Area (SQ.KM) | Population density |
|---|---|---|---|
| Agege | 1,033,064 | 17.00 | 60,768.47 |
| Ajeromi/Ifelodun | 1,435,295 | 13.90 | 103,258.63 |
| **ALIMOSHO** | 2,047,026 | 137.80 | 14,855.05 |
| Amuwo/Odofin | 524,971 | 179.10 | 2,931.16 |
| Apapa | 522,384 | 38.50 | 13,568.42 |
| Badagry | 380,420 | 443.00 | 858.74 |
| Epe | 323,634 | 965.00 | 335.37 |
| Eti-Osa | 983,515 | 299.10 | 3,288.25 |
| Ibeju-Lekki | 99,540 | 653.00 | 152.43 |
| Ifako/Ijaiye | 744,323 | 43.00 | 17,309.84 |
| Ikeja | 648,720 | 49.92 | 12,995.19 |
| Ikorodu | 689,045 | 345.00 | 1,997.23 |
| Kosofe | 934,614 | 84.40 | 11,073.63 |
| Lagos Island | 859,849 | 9.26 | 92,856.26 |
| Lagos Mainland | 629,469 | 19.62 | 32,083.03 |
| Mushin | 1,321,517 | 14.05 | 94,058.15 |
| Ojo | 941,523 | 182.00 | 5,173.20 |
| Oshodi/Isolo | 1,134,548 | 41.98 | 27,025.92 |
| Shomolu | 1,025,123 | 14.60 | 70,213.90 |
| Surulere | 1,274,362 | 27.05 | 47,111.35 |
| **TOTAL** | **17,552,942** | **3,577.28** | **4,906.78** |

Source: Abstract of Local Government Statistics, Lagos Bureau of Statistics (2012)

## 3.3 Study Population

Male parents or fathers who live within Alimosho Local Government were the study population of this research. These male parents included single parents, married, divorced or widowed.

## 3.4 Inclusion Criteria

Only male parents who lived within the local government, had children within the ages of 10-19 and were willing to participate in the study were included in the research.

## 3.5 Exclusion Criteria

Male parents who did not have adolescent children, did not live within the district or were unwilling to participate in the research were excluded from the study.

## 3.6 Sample Size Determination

The sample size for the research was determined using the Leslie Kish (1965) formula below:

$$n = \frac{Z^2 p.q}{d^2}$$

Where:

n= desired sample size

Z= the standard normal deviate set at 1.96 confidence interval

p=prevalence of condition under study or proportion estimated to be obtainable in target population

q=proportion that does not have the characteristic being investigated, i.e. (q=1-p)

d=degree of accuracy=0.05

Prevalence of father-adolescent child communication on sexuality issues =29% (Bastien, Kajula and Muhwezi, 2011). The above named authors while analyzing different studies cited a study by Izugbara (2008) as specifying that the member of the family most involved in sexuality discussions in Nigeria was the mother (44%), as compared with the father (29%).

P therefore = 29%

$$n = \frac{1.96 \times 1.96 \times 0.29 \times 0.71}{0.05 \times 0.05}$$

n=316.4

The total sample size for the research was then approximated to **320** respondents, to cater for some non-returned questionnaires

## 3.7 Sampling Procedure

A three-stage Multistage Sampling Technique was used to sample the respondents for the research. Both simple random sampling and proportionate sampling techniques were used for the sampling and selection of respondents for the research.

**Step 1**: There are seven wards under Alimosho Local Government. These wards include: Omituntun-Olori, Santos/Ilupeju, Akowonjo, Oguntade/ Bameke, Egbeda, Alabata, Alaguntan. Simple Random Sampling technique (ballot method) was used to select three out of these seven wards. The three selected wards include: Alaguntan, Egbeda and Santos/Ilupeju.

**Table 3.2 Population of people in each selected ward**

| Ward | Population |
|---|---|
| Alaguntan | 434,076 |
| Egbeda | 501, 045 |
| Santos/Ilupeju | 212,134 |
| **Total** | 1,147,255 |

**Step 2**: The proportion of respondents to be studied in each selected ward was calculated using the formula below:

$$\text{Proportion of ward X} = \frac{\text{Total number of people in ward X}}{\text{Total population of people in the three wards}} \times \text{Sample size}$$

For example: Proportion of respondents to be selected from Alaguntan=

$$\frac{434{,}076}{1{,}147{,}255} \times 320 = 121.08; \text{ approximately } 121$$

**Table 3.3 Sample of respondents selected from each ward**

| Ward | Total Population | Sample selected |
|---|---|---|
| Alaguntan | 434,076 | 121 |
| Egbeda | 501,045 | 140 |
| Santos/Ilupeju | 212,134 | 59 |
| **Total** | 1,147,255 | 320 |

**Step 3**: Households within the selected wards were randomly chosen. Starting from the beginning of each ward, houses were randomly selected with an interval of two houses between each selected house. Simple random sampling technique (using the ballot system) was then used to select the households from which the respondents (male parents) were recruited for the study.

## 3.8 Study Instrument

A validated semi-structured self-administered questionnaire prepared in English Language was the instrument used for the research, to obtain quantitative data (see Appendix I). The questionnaire contained both open-ended and closed-ended questions under the following sections:

A. Socio-demographic characteristics

B. Perception of male parents towards sexuality education
C. Practice of sexuality education by male parents
D. Factors influencing the practice of sexuality education by male parents

### 3.9 Reliability and Validity

The validity of the research instrument was ensured by carrying out an in-house pre-test among colleagues, health education specialists and lecturers at the department of Health Promotion and Education. Inputs from the resource persons were then used to further develop the research instrument.

In order to ensure the reliability of the semi-structured questionnaires, a pre-test was conducted on a sample size of 10% of the sample population (320) to get a pre-test sample of 32. The pre-test was conducted in Agege Local Government, Lagos State. Analysis of the pre-test was done using Cronbach's alpha coefficient technique of the Statistical Package for Social Sciences (SPSS, version 20.0). Cronbach's alpha test is used to test for the internal consistency of an instrument. The analysis of the data obtained from the pre-test yielded a Cronbach's alpha of 0.9 which showed that the instrument was very reliable. The questionnaire was also revised in order to ensure its validity. Question 41 was previously closed-ended, but after the pre-test (both in-house and field), it was changed to open-ended. Also, question 20 ('providing sexuality education is a sin in my religion') under the section of Perception was included in the questionnaire.

### 3.10 Data Collection

Five research assistants (2 females and 3 males) were recruited and trained to collect data using the questionnaires. The objectives and goal of the research were carefully explained to the research assistants, so that they understood the goal of the research and their own roles and responsibilities as research assistants. Training of the research assistants was done by the researcher and took place for two days, while the process of data collection took ten days. Data-collection was done using self-administered questionnaires.

### 3.11 Data Analysis

Data collected were collated and coded by the researcher using a coding guide. The data were then analysed using the Statistical Package for Social Scientists (SPSS, Version 20.0).

Descriptive Statistics and Chi-Square test were used for data analysis with the level of significance set at p=0.05. Results obtained were summarized using frequency distribution tables, charts, and graphs, as shown in Chapter 4.

### 3.12 Ethical Considerations

Participants' consents for the research were obtained using an informed consent form. The confidentiality of information disclosed by each participant was duly assured both during and after the conduct of the research. Also, some ethical considerations such as beneficence, non-maleficence, respect for persons and justice were ensured.

# CHAPTER FOUR

## RESULTS

The results of the analysis of the quantitative data gotten from the research are presented in this chapter. These results are presented and organized into the following sections:

- Socio-demographic characteristics;
- Perception about sexuality education;
- Practice of sexuality education;
- Factors that influence practice of sexuality education;
- Suggestions on how to improve the practice of sexuality education by fathers.

### 4.1 Socio-Demographic Characteristics

The ages of the respondents ranged from 31 to 67 years, with the mean age being 45.5±6.8. The ages of the respondents were further grouped into four categories/age-groups: 30-39, 40-49, 50-59, 60-69. Sixty-eight (68) male parents (21.3%) were in the 30-39 age category; One hundred and sixty-nine (169; 52.8%) were in the 40-49 age category; Seventy-three (73; 22.8%) were in the 50-59 category; while only ten male parents (3.1%) were in the 60-69 age group/category. Majority of the respondents (245; 76.6%) were Christians; Seventy-three (73; 22.8%) were Muslims, while 2 (0.6%) were Traditional worshippers. The respondents were very diverse culturally and ethnic wise. Most of the respondents were Yoruba (229; 71.6%); Seventy (70) of the respondents were Igbo (21.9%), while the Hausa ethnic group accounted for ten (10; 3.1%) of the respondents. Other ethnic groups represented by the respondents include: Igalah (2; 0.6%); Kataf (1; 0.3%); Esan (1; 0.3%); Edo (2; 0.6%); Nupe (1; 0.3%); Idoma (1; 0.3%); Kanuri (1; 0.3%); Calabar (1; 0.3%) and Urhobo (1; 0.3%).

Most of the respondents were self-employed (159; 49.7%); One hundred and thirty (130; 40.6%) were civil servants; Nine (9; 2.8%) were employed in private firms; Eight (8; 2.5%) were politicians, and nine (9; 2.8%) were retired. There was also one lecturer (0.3%) and an actor (0.3%) among the respondents. Three hundred and four (304; 95.0%) of the respondents were married; Four were divorced (1.3%); Five were single parents (1.6%), while Seven of the respondents (2.2%) were widowers. Of the three hundred and four married respondents, two hundred and eighty-two (282; 88.1%) were monogamists while sixteen (16; 5.0%) were

polygamists. One hundred and seventy-six (176; 55.0%) respondents had adolescent children between the ages of 10-14 (early adolescence), while One hundred and forty-four (144; 45.0%) had children between the ages of 15-19 (late adolescence). Table 4.1 below shows other socio-demographic characteristics of the respondents.

**Table 4.1 Respondents' Socio-Demographic Characteristics (N=320)**

| Socio-demographic Characteristics | | No | Percentage (%) |
|---|---|---|---|
| Age*: | 30-39 | 68 | 21.3 |
| | 40-49 | 169 | 52.8 |
| | 50-59 | 73 | 22.8 |
| | 60-69 | 10 | 3.1 |
| Religion: | Christianity | 245 | 76.6 |
| | Islam | 73 | 22.8 |
| | Traditional | 2 | 0.6 |
| Ethnic group: | Yoruba | 229 | 71.6 |
| | Igbo | 70 | 21.9 |
| | Hausa | 10 | 3.1 |
| | Others** | 11 | 3.4 |
| Occupation: | Self-employed | 159 | 49.7 |
| | Civil-servant | 130 | 40.6 |
| | Politician | 8 | 2.5 |
| | Retired | 9 | 2.8 |
| | Employed in private firm | 9 | 2.8 |
| Marital status: | Married | 304 | 95.0 |
| | Divorced | 4 | 1.3 |
| | Single parent | 5 | 1.6 |
| | Widower | 7 | 2.2 |

*Mean age = 45.5±6.8; Median age = 45.0

**Other ethnic groups are as listed in Section 4.1

## 4.2 Respondents' perception of sexuality education

Some questions were asked to examine the perception of the respondents to sexuality education. In answer to these questions, majority of the respondents (288; 90.0%) agreed that sexuality education is very essential for adolescents, while four respondents (4; 1.3%) disagreed. Three hundred and three respondents (303; 94.7%) agreed that sexuality education provides adolescents with the knowledge and skills they need to take care of their sexual health. Most of the respondents (257; 80.3%) also agreed that parents should be the main source/communicators of sexuality education to their adolescents. Two hundred and eighty (280; 87.5%) and two hundred and seventy-five (275: 85.9%) respondents respectively agreed that sexuality education can help prevent sexual abuse/rape and teenage pregnancy. A hundred and thirty-three (133; 41.6%) respondents agreed that it is not easy for parents to discuss sexuality issues with their adolescents, while only eighteen (18; 5.6%) respondents said that it is a sin in their religion to provide sexuality education to adolescents.

A majority of the respondents (298; 93.1%) think sex education should be taught at home. A hundred and fifty-seven (157; 49.1%) respondents believe it is the responsibility of the mother to educate adolescents on sexuality and relationship issues; one hundred and forty-eight (148; 46.3%) believe that it is the responsibility of both parents, while only three (3; 0.9%) believe that it is the responsibility of the father. Most fathers (104; 32.5%) are of the perception that eighteen (18) is an appropriate age for their adolescents to enter into relationships with those of the opposite sex.

The respondents' perceptions were grouped into two categories: Negative perception and Positive perception. Most of the respondents (290; 90.6%) had a positive perception about sexuality education when compared with those who had a negative perception (30; 9.4%). The mean perception score was 6.44±1.46. There was also a significant association between respondents' religion and their perception of sexuality education.

**Table 4.2 Respondents' Perception of Sexuality Education (N=320)**

| Statements | Agree N(%) | Disagree N(%) | Undecided N(%) | Total N(%) |
|---|---|---|---|---|
| Sexuality education is very essential. | 288(90.0) | 28(8.8) | 4(1.3) | 320(100) |
| Sexuality education provides knowledge and skills to take care of sexual health. | 303(94.7) | 15(4.7) | 2(0.6) | 320(100) |
| Sexuality education helps adolescents form beneficial interpersonal relationship. | 279(87.2) | 32(10.0) | 9(2.8) | 320(100) |
| Adolescents now engage in sexual activities at earlier ages than before and therefore need sexuality education. | 280(87.5) | 34(10.6) | 6(1.9) | 320(100) |
| Parents should be the main source of sexuality education to their adolescents. | 257(80.3) | 38(11.9) | 25(7.8) | 320(100) |
| Sexuality education provides adolescents with the knowledge and skills to protect themselves from rape and sexual abuse. | 280(87.5) | 34(10.6) | 6(1.9) | 320(100) |
| Sexuality education can help prevent teenage pregnancy. | 275(85.9) | 35(10.9) | 10(3.1) | 320(100) |
| Sexuality education can make adolescents want to experiment with sex. | 81(25.3) | 92(28.8) | 147(45.9) | 320(100) |
| Parents should be the only communicators of sexuality education to their adolescents. | 33(10.3) | 93(29.1) | 194(60.6) | 320(100) |
| It is not easy for parents to discuss sexuality issues with their adolescents. | 133(41.6) | 59(18.4) | 128(40.0) | 320(100) |
| Providing sexuality education is a sin in my religion. | 18(5.6) | 68(21.3) | 234(73.1) | 320(100) |

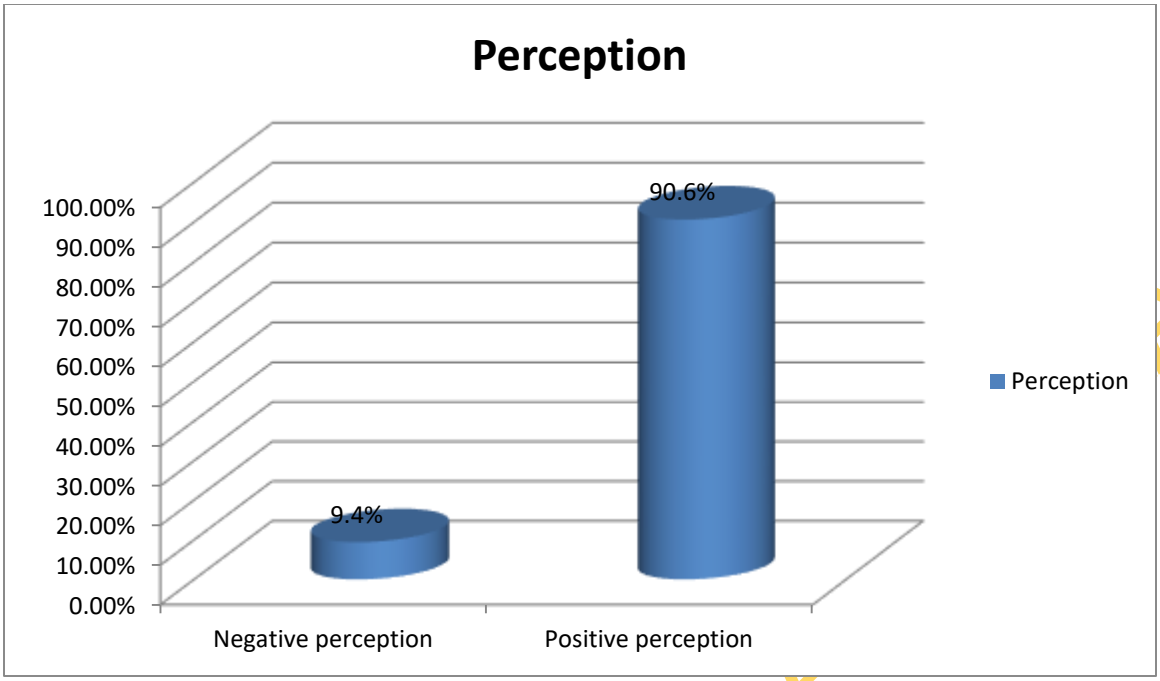


**Figure 4.1 Respondents' Perception about Sexuality Education**

Negative Perception: 0-4

Positive Perception: 5-9

**Table 4.3 Association between respondents' perception and some socio-demographic characteristics**

| Socio-demographic characteristics | Negative N(%) | Positive N(%) | $X^2$ | df | p-value |
|---|---|---|---|---|---|
| **Age**: 30-39 | 3(0.9) | 65(20.3) | 2.674 | 3 | 0.445 |
| 40-49 | 19(5.9) | 150(46.9) | | | |
| 50-59 | 7(2.2) | 66(20.6) | | | |
| 60-69 | 1(0.3) | 9(2.8) | | | |
| **Occupation**$^{+}$: | | | | | |
| Politician | 2(0.6) | 6(1.9) | 7.741 | 7 | 0.356 |
| Self-employed | 18(5.7) | 141(44.5) | | | |
| Civil-servant | 7(2.2) | 123(38.8)6 | | | |
| Retired | 2(0.6) | 7(2.2) | | | |
| Employed in private | 1(0.3) | 8(2.5) | | | |
| Lecturer | 0(0) | 1(0.3) | | | |
| Actor | 0(0) | 1(0.3) | | | |
| **Religion**: | | | | | |
| Christianity | 16(5.0) | 229(71.6) | 12.329 | 2 | 0.002* |
| Islam | 13(4.1) | 60(18.8) | | | |
| Traditional | 1(0.3) | 1(0.3) | | | |
| **Marital Status**: | | | | | |
| Married | 30(9.4) | 274(85.6) | 1.742 | 3 | 0.628 |
| Divorced | 0(0) | 4(1.3) | | | |
| Single parent | 0(0) | 5(1.6) | | | |
| Widower | 0(0) | 7(2.2) | | | |

*p is less than 0.05, which indicates that there is a significant association between the respondents' perception of sexuality education and their socio-demographic characteristics

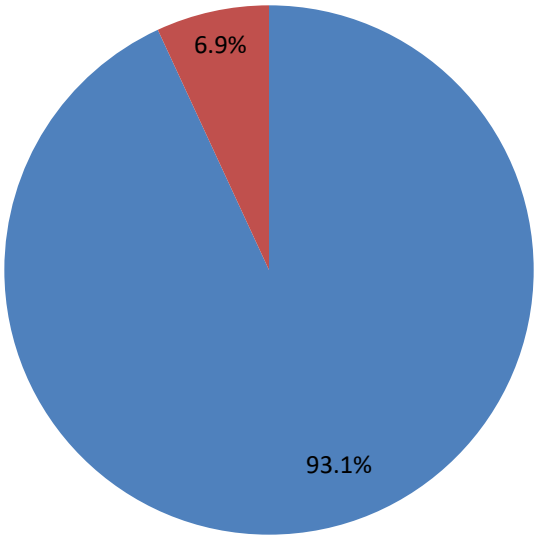


**Figure 4.2 Respondents' perception of teaching sex education at home**

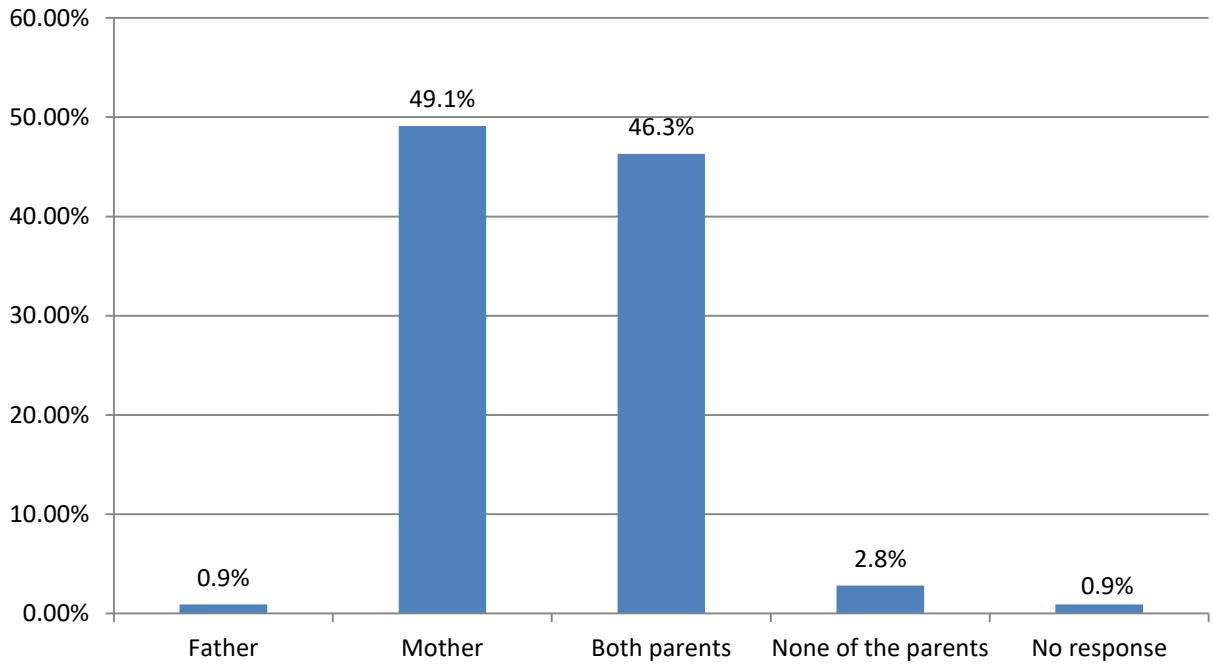


**Figure 4.3 Respondents' perception of who should be responsible for educating adolescents on sexuality and relationship issues in the home**

**Table 4.4** **Respondents' perception of sources outside the home who can educate adolescents on sexuality issues (N=320)***

| Sources | Yes N(%) | No N(%) | Total N(%) |
|---|---|---|---|
| Teachers | 201(62.8) | 119(37.2) | 320(100) |
| Mass media | 114(35.6) | 206(64.4) | 320(100) |
| Social media | 53(16.6) | 267(83.4) | 320(100) |
| Religious leaders | 170(53.1) | 150(46.9) | 320(100) |
| Elder siblings | 111(34.7) | 209(65.3) | 320(100) |
| Health workers | 283(88.4) | 37(11.6) | 320(100) |
| Peers | 23(7.2) | 297(92.8) | 320(100) |
| Uncles and aunties | 61(19.1) | 259(80.9) | 320(100) |

*Multiple responses were allowed

**Table 4.5** **Respondents' perception of the appropriate age for adolescents to enter into relationships with the opposite sex (N=320)**

| Age (years) | No | Percentage (%) |
|---|---|---|
| ≤13 | 5 | 1.5 |
| 14 | 2 | 0.6 |
| 15 | 8 | 2.5 |
| 16 | 40 | 12.5 |
| 17 | 21 | 6.6 |
| 18 | 104 | 32.5 |
| 19 | 20 | 6.3 |
| 20 | 55 | 17.2 |
| 21 | 24 | 7.5 |
| ≥22 | 13 | 4.0 |
| Non response | 28 | 8.8 |
| **Total** | **320** | **100** |

## 4.3 Respondents' Practices Relating to Sexuality Education

One hundred and twenty-eight respondents (128; 40.0%) reported that they had provided sexuality education to their children, as opposed to those who had never provided sexuality education (192; 60.0%). Of the proportion of respondents who had ever provided sexuality education to their children, eighty-four (84; 65.6%) reported that the discussion had occurred within the last six months. When asked to rate how often they discuss sexuality issues with their adolescent children, twenty-nine (29; 22.7%) respondents out of the hundred and twenty-eight (128) respondents who reported that they had ever provided sexuality education to their children, rated the frequency of discussion as 'very often'; forty-three (43; 33.6%) rated the frequency as 'often' and fifty-six (56; 43.8%) rated the frequency of discussion as 'not too often'.

Seventy-three respondents (73; 57.0%) reported that they initiated the discussion of sexuality issues with their adolescents the last time such was discussed; thirty-two (32; 25.0%) reported that their wives initiated the discussion; twenty (20; 15.6%) reported that their adolescent initiated the discussion, while one respondent (1; 0.8%) reported that his friend initiated the discussion.

Majority of the respondents (118; 92.2%) reported that they felt comfortable the last time they discussed sexuality issues with their adolescents, as opposed to the ten (10; 7.8%) who reported that they didn't feel comfortable during the discussion. Majority of the respondents (125; 97.7%) also said they would like to continue to teach their children sex education.

**Table 4.6 Respondents' practices relating to sexuality education**

| Variables | Frequency | Percentage (%) |
|---|---|---|
| **Ever provided sexuality education to adolescents (N=320)** | | |
| Yes | 128 | 40.0 |
| No | 192 | 60.0 |
| **Discussion occurred within the last six months (N=128)** | | |
| Yes | 84 | 65.6 |
| No | 44 | 34.4 |
| **Frequency of discussion of sexuality issues (N=128)** | | |
| Very often | 29 | 22.7 |
| Often | 43 | 33.6 |
| Not too often | 56 | 43.8 |
| **Situation that prompted the discussion the last time (N=128)** | | |
| My child asked a question relating to sexuality | 10 | 7.8 |
| Just of my own free will/I felt it was high time | 68 | 53.1 |
| My child is going to the higher institution | 3 | 2.3 |
| I saw them chatting for a long time on social media | 2 | 1.6 |
| During Bible study | 1 | 0.8 |
| My wife likes to talk about sexuality issues | 7 | 5.5 |
| One of my children's friends got pregnant | 2 | 1.6 |
| A scene in a television programme/movie | 33 | 25.8 |
| An article in a newspaper | 1 | 0.8 |
| My child was experiencing menstrual pain | 1 | 0.8 |
| **Person who initiated the discussion the last time (N=128)** | | |
| Myself | 73 | 57.0 |
| My child | 20 | 15.6 |
| My wife | 32 | 25.0 |
| My friend | 1 | 0.8 |
| No response | 2 | 1.6 |

**Table 4.7 Respondents' practices relating to sexuality education (Cont'd)**

| Variable | No | Percentage (%) |
|---|---|---|
| **Respondents felt comfortable the last time sexuality issues were discussed with adolescent (N=128)** | | |
| Yes | 118 | 92.2 |
| No | 10 | 7.8 |
| **Time respondent discussed sexuality issues with adolescent child (N=128)*** | | |
| After school | 26 | 7.6 |
| During weekend | 61 | 17.8 |
| Seeing them with a friend of the opposite sex | 58 | 16.9 |
| When the adolescents ask questions on sexuality | 66 | 19.2 |
| When the adolescent misbehaves | 47 | 13.7 |
| When issues about sexuality come up in the media | 84 | 24.5 |
| During family devotions | 1 | 0.3 |
| **Adolescent child opened up or asked questions the last time sexuality was discussed (N=127)**** | | |
| Yes | 90 | 70.9 |
| No | 37 | 29.1 |
| **Child respondents feel more comfortable discussing sexuality issues with (N=127)**** | | |
| Male child | 65 | 51.2 |
| Female child | 44 | 34.6 |
| Neither child | 18 | 14.2 |

*Multiple responses were allowed

**Non responses were excluded

**Table 4.8 Respondents' practices relating to sexuality education (Cont'd)**

| Variable | Component | Percentage (%) |
|---|---|---|
| **Components of sexuality education discussed with adolescent (N=128)*** | | |
| Puberty and related issues e.g. menstruation and wet dreams | 82 | 64.1 |
| Pregnancy and other related issues such as abortion | 81 | 63.3 |
| HIV/AIDS and other STIs | 97 | 75.8 |
| Personal hygiene | 85 | 66.4 |
| Marriage and relationships | 64 | 50.0 |
| Sex | 64 | 50.0 |
| Contraceptives such as condom | 31 | 24.2 |

*Multiple responses were allowed

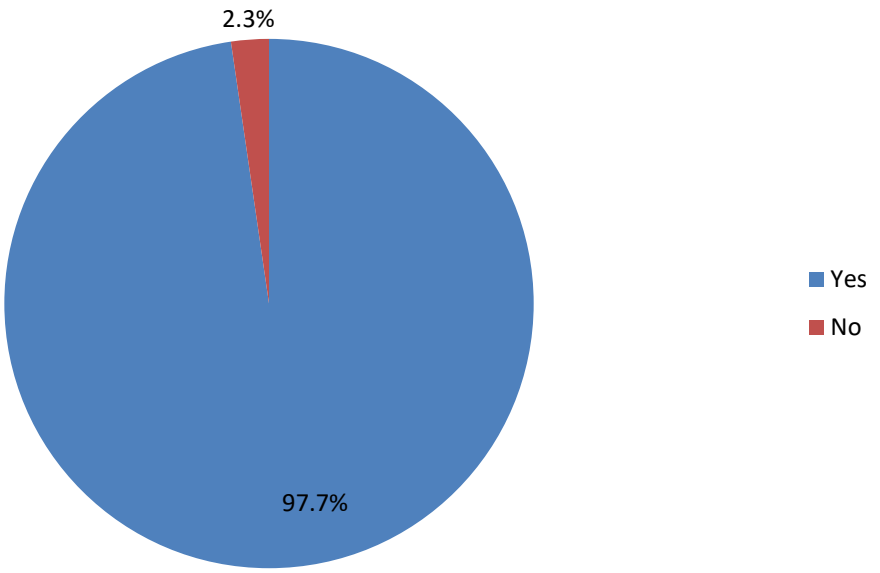


**Figure 4.4 Respondents' willingness to continue to provide sexuality education to their adolescents**

**Table 4.9** **Respondents' responses on appropriate age for starting sexuality education (N=128)**

| Age (years) | Frequency | Percentage (%) |
|---|---|---|
| ≤7 | 14 | 11 |
| 8 | 8 | 6.3 |
| 9 | 4 | 3.1 |
| 10 | 35 | 27.3 |
| 11 | 4 | 3.1 |
| 12 | 18 | 14.1 |
| 13 | 19 | 14.8 |
| ≥14 | 20 | 15.6 |
| Non response | 6 | 4.7 |
| **Total** | **128** | **100** |

## 4.4 Factors Influencing Respondents' Practice of Sexuality Education

Majority of the respondents of this study (164; 51.3%) consider themselves to be knowledgeable enough to provide sexuality education to their adolescents. In reporting some factors that have hindered them from providing sexuality education to their adolescents in the past, one hundred and thirty-seven respondents (137; 42.8%) reported that they don't know how to provide sexuality education; one hundred and two respondents (102; 31.9%) reported that their children would laugh at the idea of providing sexuality education; eighty-six (86; 26.9%) reported that their children are still too young for sexuality education; sixty-seven (67; 20.9%) reported that they are very busy and so don't have the time to provide sexuality education to their children; one hundred and thirty-three (133; 41.6%) reported that they are not always at home; six (6; 1.9%) reported that providing sexuality education is not supported in their religion, while one respondent (1; 0.3%) reported that he is just not comfortable discussing sexuality issues with his adolescent.

Some factors that could motivate respondents to teach their children sex education include: training (166; 51.9%), seeing their spouses provide sexuality education to the adolescents (106; 33.1%), seeing friends provide sexuality education to their own adolescents (105; 32.8%), fear of the adolescent getting pregnant (188; 58.8%), fear of the adolescent being sexually abused (203; 63.4%), and fear of the adolescent being infected with HIV/AIDS and other sexually transmitted infections (STIs) (1; 0.3%).

**Table 4.10 Factors that hinder respondents' practice of sexuality education (N=320)***

| Variables | Frequency | Percentage (%) |
|---|---|---|
| I don't know how to provide sexuality education | 137 | 42.8 |
| My children don't need it | 22 | 6.9 |
| My children would laugh at the idea | 102 | 31.9 |
| My children are too young | 86 | 26.9 |
| I am very busy and don't have the time | 67 | 20.9 |
| They are closer to their mother than to me | 94 | 29.4 |
| I am not always at home | 133 | 41.6 |
| My religion does not support it | 6 | 1.9 |
| I just don't feel comfortable | 1 | 0.3 |

*Multiple responses were allowed

**Table 4.11 Factors that could motivate/promote respondents' practice of sexuality education (N=320)***

| Variable | Frequency | Percentage (%) |
|---|---|---|
| Training on how to provide sexuality education | 166 | 51.9 |
| Seeing their mother teach them sex education | 106 | 33.1 |
| Seeing friends teach their children sex education | 105 | 32.8 |
| Fear of child getting pregnant | 188 | 58.8 |
| Fear of child being sexually abused | 203 | 63.4 |
| Fear of the adolescent being infected with HIV/AIDS and other STIs | 1 | 0.3 |

*Multiple responses were allowed

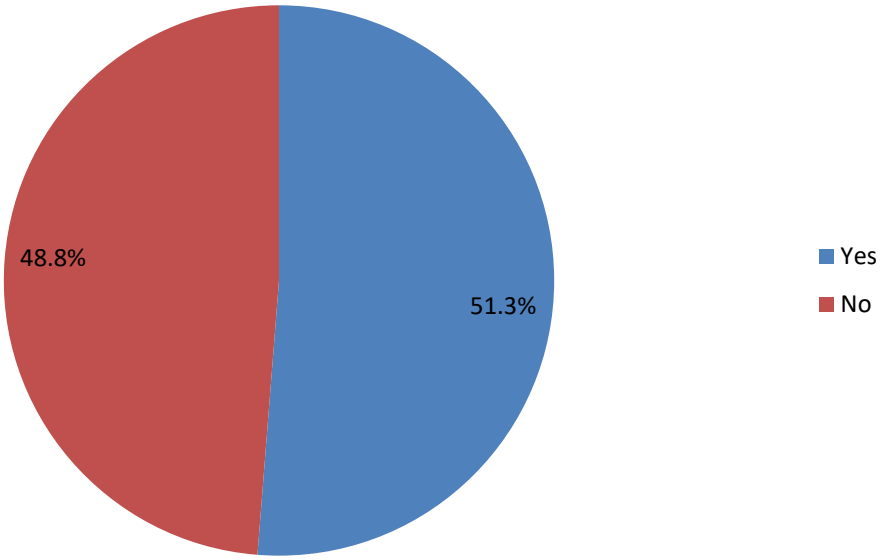


**Figure 4.5 Respondents' responses on if they consider themselves knowledgeable enough to provide sexuality education to their adolescents**

**Table 4.12 Association between respondents' consideration of their ability to provide sexuality education to their adolescents and some socio-demographic characteristics**

| Socio-demographic characteristics | Yes N(%) | No N(%) | $X^2$ | df | p-value |
|---|---|---|---|---|---|
| **Age**: 30-39 | 33(10.3) | 35(10.9) | 9.741 | 3 | 0.021* |
| 40-49 | 77(24.1) | 92(28.8) | | | |
| 50-59 | 46(14.4) | 27(8.4) | | | |
| 60-69 | 8(2.5) | 2(0.6) | | | |
| **Occupation**[+]: | | | | | |
| Politician | 5(1.6) | 3(0.9) | 8.987 | 7 | 0.254 |
| Self-employed | 73(23.0) | 86(27.1) | | | |
| Civil-servant | 72(22.7) | 58(18.3) | | | |
| Retired | 7(2.2) | 2(0.6) | | | |
| Employed in private | 3(0.9) | 6(1.9) | | | |
| Lecturer | 1(0.3) | 0(0) | | | |
| Actor | 1(0.3) | 0(0) | | | |
| **Religion**: | | | | | |
| Christianity | 132(41.3) | 113(35.3) | 4.386 | 2 | 0.112 |
| Islam | 32(10.0) | 41(12.8) | | | |
| Traditional | 0(0) | 2(0.6) | | | |
| **Marital Status**: | | | | | |
| Married | 154(48.1) | 150(46.9) | 4.627 | 3 | 0.201 |
| Divorced | 1(0.3) | 3(0.9) | | | |
| Single parent | 3(0.9) | 2(0.6) | | | |
| Widower | 6(1.9) | 1(0.3) | | | |

*p is less than 0.05, which indicates that there is a significant association between the ages of the respondents and their perception of their ability to provide sexuality education to their children.

[+]Non-response was excluded

## 4.5 Respondents' suggestions on what can be done to improve the practice of sexuality education by male parents

The respondents were asked for their suggestions on what can be done to improve the practice of sexuality education by fathers and they gave various answers. Fifty (50; 34.7%) of the respondents suggested organising awareness and training programmes on sexuality education for fathers; seventy-six (76; 52.8%) suggested that fathers should be encouraged to be more involved in the total welfare of their children; two (2; 1.4%) suggested that fathers currently practicing sexuality education should encourage other fathers to do the same; ten (10; 6.9%) suggested that mothers should engage fathers/carry them along when providing sexuality education to their children; four (4; 2.8%) respondents suggested that children should be trained on sexuality education so that they can implement it in their own families in the future; one respondent (1; 0.7%) suggested that a family sexuality education day should be created, while another respondent (0.7%) suggested that mothers should stop going to work and stay at home to monitor the children.

**Table 4.13 Respondents' suggestions on what can be done to improve the practice of sexuality education by fathers (N=144)***

| Variable | Frequency | Percentage (%) |
|---|---|---|
| Awareness and training | 50 | 34.7 |
| Fathers should be encouraged to be more involved in the welfare of their children | 76 | 52.8 |
| Fathers currently practicing sexuality education should encourage others to do the same | 2 | 1.4 |
| Mothers should engage fathers when providing sexuality education to the children | 10 | 6.9 |
| Children should be trained on sexuality education so that they can implement it in their own families in the future | 4 | 2.8 |
| A family sexuality education day should be created | 1 | 0.7 |
| Mothers should stop going to work and stay at home to take care of the children | 1 | 0.7 |

*Non-responses were excluded

## 4.6 Testing of the Hypotheses

Five hypotheses were postulated in this study and they include:

**Hypothesis 1**: there is no significant association between the ages of the male parents and their practice of sexuality education.

**Hypothesis 2**: there is no significant association between the religion of the male parents and their practice of sexuality education.

**Hypothesis 3**: there is no significant association between the occupation of male parents and their practice of sexuality education.

**Hypothesis 4**: there is no significant association between the marital status of male parents and their practice of sexuality education

**Hypothesis 5:** there is no significant association between respondents' perception and their practice of sexuality education

**Table 4.14 Association between the respondents' ages and their practice of sexuality education (N=320)**

| Age of male parents | Yes N(%) | No N(%) | Total N(%) | $X^2$ | df | p-value |
|---|---|---|---|---|---|---|
| 30-39 | 20(29.4) | 48(70.6) | 68(100) | 10.847 | 3 | 0.013* |
| 40-49 | 63(37.3) | 106(62.7) | 169(100) | | | |
| 50-59 | 39(53.4) | 34(46.6) | 73(100) | | | |
| 60-69 | 6(60.0) | 4(40.0) | 10(100) | | | |
| **Total** | **128(40)** | **192(60)** | **320(100)** | | | |

*p-value is less than 0.05, therefore there is a significant association between the respondents' ages and their practice of sexuality education and the null hypothesis is rejected

**Table 4.15 Association between the religion of respondents and their practice of sexuality education (N=320)**

| Religion | Yes N(%) | No N(%) | Total N(%) | $X^2$ | df | p-value |
|---|---|---|---|---|---|---|
| Christianity | 109(44.5) | 136(55.5) | 245(100) | 9.330 | 2 | 0.009* |
| Islam | 19(26.0) | 54(74.0) | 73(100) | | | |
| Traditional | 0(0) | 2(100) | 2(100) | | | |
| **Total** | **128(40)** | **192(60)** | **320(100)** | | | |

*p-value is less than 0.05, therefore there is a significant association between the religion of respondents and their practice of sexuality education and the null hypothesis is rejected

**Table 4.16 Association between the respondents' occupations and their practice of sexuality education (N=317)[+]**

| Occupation | Yes N(%) | No N(%) | Total N(%) | $X^2$ | df | p-value |
|---|---|---|---|---|---|---|
| Politician | 4(50.0) | 4(50.0) | 8(100) | 6.562 | 7 | 0.476** |
| Self-employed | 60(37.7) | 99(62.3) | 159(100) | | | |
| Civil Servant | 52(40.0) | 78(60.0) | 130(100) | | | |
| Retired | 6(66.7) | 3(33.3) | 9(100) | | | |
| Private firm | 3(33.3) | 6(66.7) | 9(100) | | | |
| Lecturer | 1(100) | 0(0) | 1(100) | | | |
| Actor | 1(100) | 0(0) | 1(100) | | | |
| **Total** | **127(40)** | **190(60)** | **317(100)** | | | |

[+]Non-responses were excluded

**p-value is greater than 0.05, therefore there is no significant association between respondents' occupations and their practice of sexuality education and the null hypothesis is accepted.

**Table 4.17 Association between the marital status of respondents and their practice of sexuality education (N=320)**

| Marital status | Yes N(%) | No N(%) | Total N(%) | $X^2$ | df | p-value |
|---|---|---|---|---|---|---|
| Married | 116(38.2) | 188(61.8) | 304(100) | 10.025 | 3 | 0.018* |
| Divorced | 2(50.0) | 2(50.0) | 4(100) | | | |
| Single parent | 4(80.0) | 1(20.0) | 5(100) | | | |
| Widower | 6(85.7) | 1(14.3) | 7(100) | | | |
| **Total** | **128(40)** | **192(60)** | **320(100)** | | | |

*p-value is less than 0.05, therefore there is a significant association between the marital status of respondents and their practice of sexuality education, thus the null hypothesis which states that there is no association, is rejected.

**Table 4.18 Association between respondents' perception and their practice of sexuality education (N=320)**

| Perception | Yes N(%) | No N(%) | Total | $X^2$ | df | p-value |
|---|---|---|---|---|---|---|
| Negative | 3(10.0) | 27(90.0) | 30(100) | 12.414 | 1 | 0.000* |
| Positive | 125(43.1) | 165(56.9) | 290(100) | | | |
| **Total** | **128(40)** | **192(60)** | **320(100)** | | | |

*p-value is less than 0.001, therefore there is a significant association between respondents' perception and their practice of sexuality education

## 4.7 Logistic Regression Analysis

Logistic Regression Analysis was used to determine the predictors of practice of sexuality education. These predictors include: respondents' age, religion, marital status and perception of sexuality education. Respondents with positive perception of sexuality education were found to be 6 times more likely to provide sexuality education to their adolescents than those with negative perception (OR=6.215, 95% C.I=1.787-21.619). Religion was also associated with an increased likelihood of practicing sexuality education (OR=2.237, 95% C.I=1.231-4.065). Increasing age however, was associated with a decreased likelihood of practicing sexuality education (OR=0.550, 95% C.I=0.397-0.762).

**Table 4.19 Logistic Regression Analysis of the predictors of practice of sexuality education**

| | | 95% C.I | | |
|---|---|---|---|---|
| Variables | Odds ratio | Lower | Upper | p-value |
| Perception (low perception*) | 6.215 | 1.787 | 21.619 | 0.004 |
| Age (30-39*) | 0.550 | 0.397 | 0.762 | 0.000 |
| Religion (Christianity*) | 2.237 | 1.231 | 4.065 | 0.008 |
| Marital status (Married*) | 0.504 | 0.282 | 0.898 | 0.020 |

*Reference variables

# CHAPTER FIVE

## DISCUSSION, CONCLUSION AND RECOMMENDATIONS

### 5.1 Socio-Demographic Characteristics of Respondents

The average age of the respondents was 45 years, implying that most of the respondents were in their mid-forties. A majority of the respondents were Christians and the major ethnic group represented was Yoruba. This is not surprising because majority of the people living in that area are Yoruba. Most of the respondents interviewed were self-employed and majority were married.

### 5.2 Respondents' perception about Sexuality Education

Majority of the respondents agreed that sexuality education is very essential and that adolescents need sexuality education to take care of sexual health. The respondents also agreed that sexuality education provides adolescents with the knowledge and skills to protect themselves from rape and sexual abuse, and that sexuality education can help prevent teenage pregnancy. Most of the respondents agreed that the parents should be the main source of sexuality education to their adolescents. Majority of the respondents also stated that it is not easy for parents to discuss sexuality issues with their adolescents. Only a few respondents say that providing sexuality education is a sin in their religion. In all, majority of the respondents have a positive perception about sexuality education and believe that it is very beneficial to their adolescents.

Most of the respondents (93.1%) agreed that sex education should be taught at home, though a majority (49.1%) were of the opinion that the mother should be responsible for educating adolescents on sexuality and relationship issues in the home, followed closely by those who opined that both parents should be responsible for providing sexuality education to adolescents (46.3%). This slightly agrees with a study reported by Bastien et al (2011). Findings from the study stated that majority of the respondents believed that the home was the best place for sexuality education to take place. A majority also believed that it is the responsibility of both parents to provide sexuality education to children. In support of these also, are the results of a research carried out by Olubayo-Fatiregun (2012), which reported that most respondents of the research agreed that both parents should be the primary providers of sexuality information to their adolescents.

Health workers, teachers, religious leaders and the mass media were the most selected sources outside the home which should be responsible for educating adolescents on sexuality and relationship issues. Elder siblings, peers, social media, uncles and aunties were the least selected sources of sexuality education to adolescents. This is not unusual, however, as these sources, particularly peers and social media, more often than not, provide information that is incorrect or at best incomplete. Many of the respondents (104; 32.5%) also stated that 18 years is the appropriate age for entering into relationships, probably because eighteen is the age where the child enters into adulthood/maturity and in many countries, such as Nigeria, by the age of eighteen (18), the child is legally able to get married.

### 5.3 **Respondents' practices relating to Sexuality Education**

Less than half (40%) of the respondents had ever provided sexuality education to their adolescents, while a larger percentage (60%) of the respondents reported that they had never provided sexuality education to their adolescent children; a trend which has been observed in previous studies also, such as that done by Izugbara (2008) and cited by Bastien et al (2011) which reported that parent-child discussions about sexuality are not common in Nigeria, as some parents tend to portray sexuality education as dangerous, unpleasant and unsavory. Of the proportion of those who had ever provided sexuality education to their adolescents, more than half (65.6%) reported that the discussion occurred within the last six months, though some (43.8%) reported that they do not often discuss sexuality issues with their adolescent children.

Most of the respondents (70.9%) reported that their adolescent children asked questions the last time they (the respondents) discussed such issues with them (the children). This goes to show that more often than not, adolescents will open up and ask questions relating to sexuality issues, if their parents take time to talk with them about such sexuality issues. A larger percentage (51.2%) of the respondents also reported that they feel more comfortable discussing sexuality issues with their male children than with their female children. This corroborates the findings from a research reported by Bastien et al (2011) where the results of the research showed that parent-child communication about sexuality was mainly on same-sex basis. Another study by (Nunduwe, 2012) reported that mothers are more likely to communicate with their daughters about sexuality issues than with their sons, whereas fathers are more likely to discuss sexuality issues with their sons than with their daughters.

A greater percentage of the respondents believe that 10 years is the best age at which to start providing sexuality education for children, probably because ten (10) years is the start of the adolescence period. This is in tandem with the World Health Organization recommendation that formal sex education should start well before age 12 years, since young people are known to be exposed to sex as early as this age. It has been suggested that the precise age at which information should be provided depends on the physical, emotional and intellectual development of the young people, as well as their level of understanding, but that sex education should start early before young people reach puberty, and before they have established patterns of sexual behavior (Asekun-Olarinmoye, Dairo and Adeomi, 2011).

HIV/AIDS and other STIs, puberty, personal hygiene, pregnancy and related issues such as abortion, were the most commonly discussed components of sexuality education by respondents. Marriage, relationships and sex were not as commonly discussed, while contraceptives were the least discussed components of sexuality education. This finding is consistent with reports from a study carried out by Bastien et al (2011) which state that of 6 topics related to sexuality (development and growth, pregnancy and childbirth, preparation for adulthood, sexually transmitted diseases, contraception and abortion), contraception was the least discussed. Male parents' discomfort with talking about contraception could stem from the belief that talking with children about such issues as contraception, could encourage them to experiment with sex.

Most of the respondents (97.7%) show a willingness to continue to provide sexuality education to their children.

### 5.4 Factors influencing respondents' practices relating to Sexuality Education

Majority of the respondents of this research (51.3%) consider themselves knowledgeable enough to provide sexuality education to their adolescents. There was also a significant association between the ages of the respondents and their perception of their ability to provide sexuality education to their adolescents. A larger percentage of the respondents reported inadequate knowledge on how to provide sexuality education, frequent absence from home, and fear of their children laughing, as major factors that have hindered them from providing sexuality education to their children. Some (26.9%) reported that their children are too young to receive sexuality education, while only a few (1.9%) reported that their religion does not support providing sexuality education to adolescents. This agrees with findings from a study carried out by

Asekun-Olarinmoye at al. (2011), where answers such as 'too busy', 'lack of skills', 'children are too young', were given as reasons for not practicing sexuality education.

Respondents also reported training, spouses, friends and fear of their child getting pregnant or sexually abused as factors that could motivate them to provide sexuality education to their children. This stresses the importance of training and significant others (such as spouses, friends and religious leaders) as important influences in the practice of sexuality education.

Identifying factors associated with and predictors of sexuality communication is an important precursor to the development of programs and interventions to improve parent-child sexuality communication (Bastien et al., 2011). Findings from this research have implications for the creation of intervention programmes aimed at improving the practice of sexuality education by parents.

## 5.5 **Hypotheses**

Chi-square test of the stated hypotheses showed a significant association between some of the respondents' socio-demographic characteristics (such as age, marital status and religion) and their practice of sexuality education. Male parents in the 60-69 age group recorded the highest practice of sexuality education, as 60% of them had ever provided sexuality education to their adolescents, while male parents in the 30-39 age group recorded the least practice of sexuality education, as only 29.4% of them had ever provided sexuality education to their adolescents. This may be due to the fact that male parents in the 60-69 age group have had more experience in providing sexuality education to children than those in the 30-39 age group and so were more willing to continue to provide sexuality education than those in the 30-39 age group.

Respondents that were Christians also had the highest practice of sexuality education (44.5%), when compared with those of other religions. Religion is an important factor that influences the practice of sexuality education by parents, particularly in this part of the world. Respondents that were retired were found to provide sexuality education more than respondents in other professions. This may be due to the fact that they are less busy and so have more time to spend with their children. Also, respondents that were divorced and those that were widowed were found to have a better practice of sexuality education than other respondents.

There was also a significant association between respondents' perception and their actual practice of sexuality education. This goes to show that one's perception of a thing could actually influence one's practice of that thing. This has implications for health education, in that if perception can be changed or modified, then it would have a significant effect on practice.

Logistic Regression Analysis showed that respondents with positive perception of sexuality education were 6 times more likely to provide sexuality education to their adolescents than those with negative perception. Religion was also found to be associated with an increased likelihood of practicing sexuality education.

## 5.6 Implications for Health Education and Contribution to knowledge

This study has shown that male parents are willing to provide sexuality education to their children, but there are certain factors that could hinder them from doing so. The major factors influencing the practice of sexuality education by male parents include: inadequate know-how/skill on how to provide sexuality education, 'busyness' and fear of adolescents laughing. Most respondents report that training on how to provide sexuality education to their children could motivate them to practice sexuality education. In light of these findings, comprehensive sexuality education programmes aimed at improving the practice of sexuality education by male parents should be developed and implemented at the community level. Other complementary interventions such as the creation of social support groups are also needed to address these factors.

Advocacy efforts should be targeted at policy makers to ensure that policies are formulated and reviewed to support the implementation of sexuality education programmes for parents at the community level. It is also very important that fund is allocated and released for the implementation of these programmes.

Behavioural change communication intervention programmes such as the production of hand bills, posters, television adverts and radio jingles, aimed at promoting the practice of sexuality education by parents, should also be created.

## 5.7 Conclusion

Adolescents and young people represent the future of every society. For most adolescents and young people, this period of their lives is a time of enormous vibrancy, discovery, innovation and hope. Adolescence is also the time when puberty takes place, when many young people initiate their first romantic and sexual relationships, when risk-taking is heightened and 'fitting in' with peers becomes very important. It can also be a challenging time for young people, who are becoming aware of their sexual and reproductive rights and needs, and who rely on their families, peers, schools and health service providers for affirmation, advice, information and the skills to navigate the sometimes difficult transition to adulthood. This transition may result in a range of challenges including HIV infection, other sexually transmitted infections (STIs), unintended pregnancy, low education attainment or dropping out of education and training. Better education and public health measures can therefore be hugely beneficial to the health and development of these adolescents (UNESCO, 2013).

The practice of sexuality education among male parents in Alimosho Local Government, as proven by this study, is still a bit low and various factors that have hindered the respondents' practice of sexuality education have been identified.

This study has also shown that male parents are willing to provide sexuality education to their adolescents if they are trained on how to do so.

## 5.8 Recommendations

Based on the findings from this study, the following recommendations are offered:

1. Awareness and training programmes should be organized at the community level for male parents in particular and all parents in general, in order to improve their knowledge and practice of sexuality education.
2. Advocacy and sensitization programmes should be used to influence key players and decision makers on the creation and implementation of programmes aimed at improving the practice of sexuality education by parents.
3. Social support groups should be created to encourage the practice of sexuality education by fathers.

4. Further research should be carried out on male parents in the different geo-political zones of the country, to examine if there is a difference in their perception and practice of sexuality education, as the results of this research cannot be generalized for all male parents in Nigeria.

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Serial Number…….

# QUESTIONNAIRE

## PERCEPTION AND PRACTICE OF SEXUALITY EDUCATION AMONG MALE PARENTS OF ADOLESCENTS IN ALIMOSHO LOCAL GOVERNMENT, LAGOS STATE, NIGERIA

Good-day Sir, my name is Adenrele Yetunde and I am a Master of Public Health student from the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan. As part of the requirements for the award of a Masters in Public Health (MPH) degree, I am carrying out a research on 'Perception and Practice of Sexuality Education among male parents of adolescents in Alimosho Local Government, Lagos State, Nigeria'. The result of this research will be useful in the planning and implementation of beneficial health programs on sexuality education for adolescents. The results of this research could also influence policy decisions on sexuality education for adolescents, in terms of implementation and funding of programmes.

I would therefore like to ask you some questions relating to sexuality education. Please note that filling this questionnaire is voluntary and the confidentiality of the information you provide in this questionnaire will be thoroughly ensured. You are to provide only the information requested for in the questionnaire.

I sincerely appreciate your co-operation and interest in participating in this research. God bless you Sir.

## SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Please fill in the gaps or tick (√ ) your response as appropriate.

1. **Your age** as at last birthday (in years) _____
2. **Religion**: 1. Christianity ☐ 2. Islam ☐ 3. Traditional ☐ 4.Others (please specify) _____
3. **Ethnic group**: 1. Yoruba ☐ 2. Igbo ☐ 3. Hausa ☐ 4.Others (specify) _____
4. **Occupation**: 1. Politician ☐ 2. Self-employed ☐ 3. Civil Servant ☐ 4.Retired ☐ 5. Others (specify) _____
5. **Marital status**: 1. Married ☐ 2. Divorced ☐ 3. Single parent ☐ 4. Widower ☐
6. **Type of marriage (*for married only*)**: 1. Monogamy ☐ 2. Polygamy ☐
7. How many children do you have who are between the ages of 10-19 years? _____
8. How many of them are boys? _____ How many are girls? _____
9. Please list their age(s) as at their last birthday_____

## SECTION B: PERCEPTION

Please tick your response in the table below

| S/N | Statement | 1. Agree | 2.Undecided | 3.Disagree |
|---|---|---|---|---|
| 10. | Sexuality education is very essential for adolescents. | | | |
| 11. | Sexuality education provides adolescents with the knowledge and skills to take care of their sexual health | | | |
| 12. | Sexuality education helps adolescents form beneficial interpersonal relationships | | | |
| 13. | Adolescents now engage in sexual activities at earlier ages than before and therefore need sexuality education | | | |
| 14. | Parents should be the main source of sexuality education to their adolescents | | | |

| | | | | |
|---|---|---|---|---|
| 15. | Sexuality education provides adolescents with the knowledge and skills they need to protect themselves from rape and sexual abuse. | | | |
| 16. | Sexuality education can help prevent teenage pregnancy | | | |
| 17. | Sexuality education can make adolescents want to experiment with sex. | | | |
| 18. | Parents should be the **only** communicators of sexuality education to adolescents. | | | |
| 19. | It is not easy for parents to discuss sexuality issues with their adolescents. | | | |
| 20. | Providing sexuality education to children is a sin in my religion. | | | |

Please tick and/or fill in the gaps as appropriate

21. Do you think sex education should be taught at home? 1. Yes ☐ 2. No ☐

22. If **no**, please give reason_____

23. Who do you think should be responsible for educating children on sexuality and relationship issues in the home?

1. Father ☐ 2. Mother ☐ 3. Both parents ☐ 4. None of the parents ☐

24. Who else do you think should be responsible for educating adolescents on sexuality and relationship issues? (please tick as many as suitable)

a) Teachers ☐
b) Mass Media e.g. television, radio, newspapers, posters ☐
c) Social media e.g. Facebook, Twitter, Myspace, 2go ☐
d) Religious leaders e.g. Pastors and Imams ☐
e) Elder siblings ☐
f) Health workers ☐
g) Peers ☐

h) Family members such as uncles and aunties ☐

i) Others (specify)_____

25. At what age do you think it is appropriate for your adolescent child/children to enter into a relationship? (please state) _____

**SECTION C: PRACTICE**

26. Have you ever provided sexuality education to your adolescent child? 1. Yes ☐ 2. No ☐

If no, please move on to **SECTION D**, if yes, please move on to the next question

27. Did the discussion occur during the last six months? 1. Yes ☐ 2. No ☐

28. If 'Yes', when was the last time you discussed/provided the sexuality education?

1. Yesterday ☐ 2. Today ☐ 3. Last week ☐ 4. Two weeks ago ☐ 5. Last month ☐

6. Can't remember ☐ 7. Others (specify) _____

29. How often do you discuss sexuality issues with your adolescent child/children?

1. Very often ☐ 2. Often ☐ 3. Not too often ☐

30. What prompted you to do so the last time?

_____

31. Who initiated the discussion the last time? 1. Myself ☐ 2. My child ☐ 3. My wife ☐

4. My friend ☐ 5. Others (specify) _____

32. Did you feel comfortable the last time you discussed sexuality issues with your adolesecent?

1. Yes ☐ 2. No ☐

33. If no, please give reason(s)_____

34. At what time do you discuss sexuality issues with your adolescent child? (please tick as many as possible)

a) After school ☐

b) During weekend ☐

c) When I see them with a friend of the opposite sex ☐

d) When the adolescents ask questions on sexuality ☐

e) When the adolescent misbehaves ☐

f) When issues about sexuality come up in the media e.g. TV ☐

g) Others (specify)_____

35. Did your adolescent child/children open up or ask questions relating to sexuality and relationships the last time you discussed sex education?

1. Yes ☐ 2. No ☐

36. At what age do you think it is best to start providing sexuality education to your adolescent? (specify) _____

37. Do you allow your children have friends of the opposite sex visit them at home?

1. Yes ☐ 2. No ☐

38. If no, why not? _____

39. If yes, why? _____

40. Which child do you feel **more comfortable** with to talk to about issues relating to sex and relationships?

1. Male child ☐ 2. Female child ☐ 3. Neither ☐

41. What components of sexuality do you discuss with your child/children? (Please tick as many as possible)

a) Puberty and related issues e.g menstruation, wet dreams ☐
b) Pregnancy and other related issues such as abortion ☐
c) HIV/AIDS and other sexually transmitted infections ☐
d) Personal hygiene ☐
e) Marriage and relationships ☐
f) Sex ☐
g) Contraceptives and condom ☐
h) Others(specify)_____

42. Would you like to continue to teach your children sex education? 1. Yes ☐ 2. No ☐

43. If no, why not? (Please state)

_____

**SECTION D: FACTORS INFLUENCING PRACTICE**

44. Do you consider yourself knowledgeable enough to provide sexuality education to your adolescents? 1. Yes ☐ 2. No ☐

45. What are some factors that have hindered you from providing sexuality education to your children in the past? (please tick as many as possible)

a. I don't know how to provide sexuality education ☐
b. My children don't need it ☐
c. My children will laugh at the idea ☐
d. My children are too young for sexuality education ☐
e. I am too busy and don't have the time for that ☐
f. They are not close to me; they are closer to their mother ☐
g. I am not always at home ☐
h. My religion does not support sexuality education ☐
i. Others (specify) _____

46. What are some of the factors that could motivate you to teach your children sex education? (Please tick as many as possible)

a) Training on how to teach children sex education ☐
b) Seeing their mother teach them sex education ☐
c) Seeing friends teach their children sex education ☐
d) Fear of your child getting pregnant ☐
e) Fear of your child being sexually abused ☐
f) Others (specify) _____

**SECTION E: Suggestions**

47. What do you think can be done to improve the practice of sexuality education by fathers? (please state)

_____
_____
_____