

**DETERMINANTS OF RISKY SEXUAL BEHAVIOR AMONG ADOLESCENT IN
NIGERIA**

BY

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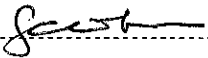
CERTIFICATION

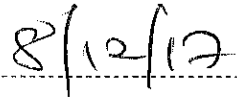
This is to certify that **BALOGUN NOAH TOBILOBA** of the Department of Demography and Social Statistics, Faculty of Social Sciences, Federal University Oye-Ekiti, carried out this research “determinants of risky sexual behavior among adolescents in Nigeria” in partial fulfillment of the award of Bachelor of Science (B.sc.) in Federal University Oye-Ekiti under my supervision.

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DEDICATION

I sincerely dedicate this project to Almighty God, the creator of heaven and earth, the king of kings, who by His grace and mercies has spared my life from the beginning of my Undergraduate program till this very moment. Also to my ever supportive and dedicated parents, Mr. and Mrs. Balogun.

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Firstly, I want to appreciate Almighty God for this big opportunity to start and complete this thesis. During the course of this study I received an immense and credible support and assistance from a lot of people. However, I will just mention a few because only God can really acknowledge and reward everyone's effort toward the success of this study.

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LIST OF ABBREVIATIONS

HIV- Human immune deficiency virus

AIDS- Acquired immune-deficiency syndrome

UNAIDS- united Nations programme on HIV/AIDS

WHO- World health organization

STD- Sexually transmitted diseases

STI- Sexually transmitted infections

IAFF- International association of fire fighters

NCHS- National center for health statistics

RSB- Risky sexual behavior

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Abstract

The study examined the “Determinants of risky sexual behavior among adolescent in Nigeria. However, the study on “Determinants of risky sexual behavior among adolescent in Nigeria was drawn from NDHS 2013 survey for adolescents from age 10-21 years of age who are currently residing in Nigeria. For the purpose of analysis, this study makes use of descriptive analysis and inferential analysis; however, in supportive of descriptive statistics, inferential analysis, Pearson Chi-square test was used to ascertain relationship while logistic regression analysis was used in testing the study hypotheses. The univariate analysis disclosed that the prevalence rate of risky sexual behavior is low using number of partner as 4% of male adolescents involved in risky sexual behavior (RSB) while female adolescent was found to be less than 2%. As it were, more than 80% of the adolescents had their sexual experience while they were below 18 years for both sex. The Pearson Chi-Square test of relationship disclosed that contraceptives usage has significant effect on whether an adolescent would practice risky sexual behavior. The study concluded that socio-demographic and socio-economic factors determines the height and level at which an adolescent involve in risky sexual behavior.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

An adolescent is simply defined as any person in the age range of 10 to 21 years. It is the period of time between childhood and adulthood when puberty occurs. It is best described as a transition period where the adolescent is no more a child but has now also grown enough to be addressed an adult. As the child grows, the body changes and as he enters puberty, his sex hormones come alive and he begins to experience sex drive. Adolescence extends roughly through the entire second decade of life. Growing into adolescence is a gradual process and this has to do with different stages of development. The first stage is the early adolescence, which covers the period of 11-14 years. The second is middle adolescence from 15-18 years, and the third is late adolescence, from 18-21 years. It is the period in which pattern of behavior which has long-life consequences are formed and become established. For instance, it is in adolescence that many individuals begin sexual relations and some become involved in risky sexual behaviors with life threatening consequence. An individual's sexual debut is embedded with multiple personal and social connotations. For adolescents, it is one of the first transitions from adolescence to adulthood. The increase in adolescent pre-marital sexual activity in conjunction with the multiplicity of sexual partners have led to an increase in the incidence of unwanted pregnancies and sexually transmitted infections (STI) (ARFH 1997). The high incidence of the acquired immune deficiency syndrome (AIDs) among persons now in their 20's globally implies that, many contracted HIV in their adolescent age (Busari 1996). Studies from several parts of the country have reported high level of sexual activity among unmarried adolescents of both sexes with progressively decreasing age of debut, risky sexual practices, including unprotected sexual

intercourse with multiple partners. Girls, most often, bear the consequences of early sexual activity in: unwanted pregnancies, teenage births and abortions, often by quacks. Sexually transmitted diseases occur in both sexes and when inadequately treated, result in chronic reproductive tract infections and infertility

Obviously, the manifestation of this sexual behavior is the child's right and it is up to parents and adults to ensure that this right is respected. Nevertheless, a prominent study has clarified that children and adolescents with sexual behavior problems have been opened to variety of family dysfunction that may impact on them the development of sexually inappropriate behavior (Bentovim, 1998). It is equally important to note that the provision for healthy sexual development is premised on allowing the child to experience and learn about proper sexual activities of his/ her own age group.

Essentially, the family structure has been theorized to have several influences in proper upbringing of adolescents. For instance, children have easy access to biological parents, higher parental involvement, more enjoyable parent-child relationship, rare cases of disagreements between children and parents among the in-tact families. To be specific, the concern of how divorce affects children has been the subject of interest over the past years. Research has indicated that divorce has long-term effects on children. According to Whitehead (1993); adolescents do not recover after parental divorce and the chaos of the family can have long-term emotional effects on them. For instance, studies on divorce show that it is a life-altering experience for offspring who must bear the actions of their parents (Wallerstein & Lewis, 2004). At this juncture, it is interesting to note that the rates at which unmarried adolescent engage in sexual activities and unsanctioned reproduction has become serious concern across the globe. An array of socio-demographic and economic factors have been said to be significantly associated

with risky sexual behavior in developing countries and Nigeria specifically. For instance a study on determinants of risky sexual behaviors among secondary school students in Delta State Nigeria showed that emotional intelligence, self-esteem, media and religiosity had relationship with risky sexual behavior in the study area.

However it is important to examine determinants of risky sexual behavior to suggest various ways to curb the widespread risky sexual activities of adolescents in Nigeria.

1.2 STATEMENT OF THE PROBLEM

It is pertinent to note that the involvement of adolescents in delinquent activities is on rapid increase in Nigeria. As a result, a child with faulty socialization process at an early stage in life is more likely to be delinquent in later life.

High Rate of Sexually Transmitted Infections and HIV/AIDS: There is evidence that most of the adolescents seen in STD clinics had previous history of vaginal intercourse. In Cross River State, 13.1% of the sexually active female adolescents have had genital tract infection. In Abia State, 19.3% boys and 9.5% girls claimed they had been infected with gonorrhoea and syphilis. Data from Niger State show that 15.4% of sexually active adolescents had contacted STDs.

Unintended Pregnancy: In Rivers State, 27% of the sexually active girls claimed to have been pregnant at least once. In Abia State, 4.9% of the sexually active girls admitted to have been pregnant, while 2.5% of their male counterparts admitted getting a girl pregnant. Pregnant adolescent girls who do not succeed in procuring an abortion go on to have a delivery and are exposed to the risks associated with teenage pregnancy, labor and delivery.

Unsafe Abortion: In Nigeria, the law restricts abortion – thus, most abortions are done illegally under septic conditions. In Rivers State, 24.8% of sexually active girls have had at least one abortion, out of which 7.3% had had more than three.

High Maternal Mortality: Pregnant women aged less than 15 years were 4-8 times more likely to die during pregnancy and childbirth than pregnant women aged more than 19 years. In Nigeria, abortion complications are responsible for 72% of all deaths among teenagers aged less than 19 years. Anochie & Ikpeme noted infant mortality to be 30% higher for infants born to women aged 15-19 years than for those born to women 20 years and above.

The incidence of teenage pregnancy, sexually transmitted infection (STIs) and HIV infections among our youth has become alarming. The fact that adolescents are in the age of high sexual drive causes many to engage in unsafe sex, premarital sex and prostitution. Male adolescents were also reported to have had sexual experience from early age of 14 years. Casual observation shows that single parents spend insufficient time with their children. Some parents would even travel to distant places, leaving the children at the mercy of nannies and guardians. Some of these children lack parental care and attention and may end up becoming delinquent and most often would engage in early sexual intercourse even among them. Many of these parents whom are divorced, single, separated, widowed, etc. subject their adolescent children, especially the females to child labor and make them hawk in market places, streets and motor parks. In so doing, they expose these adolescents to sexual harassment from older males. Some parents encourage their teens into early sexual intercourse and prostitution, unknowingly, by neglecting their responsibilities toward them.

The problem of high fertility and rapid population growth

Nigeria has a growing population and what can also be referred to as an increasing population. The 1991 census figure put Nigerian population at about 89 million people with the growth rate of 2.82 and the total fertility rate as revealed by Post Enumeration Survey (PES) at 5.89 percent. The Nigeria Demographic and Health Survey (NDHS), (2003 and 2008) put the total fertility rate at 5.7 percent as against that of 1999 (NDHS) which was 5.2 percent. Going by 2006 Nigerian National Population Census, Nigeria had a population of one hundred and forty million, three thousand and five hundred and forty two (140,003,542) (National Bureau of Statistics, 2009). The growth rate was 3.02 percent per annum. The population is capable of doubling itself in less than twenty three years. In addition, the United Nations estimates of 2009 put the Nigerian total population at one hundred and fifty one million, thirty thousand and four hundred (151,030,400). Nigeria is the most populous country in Africa and also the most populous among the black nations of the world. Globally, Nigeria is among the ten top countries with the largest population, in fact, the seventh among the countries with the largest population in the world (United Nations, 2009).

Nigeria population is increasing mostly due to the effect of the first factor, that is, high birth rate. For instance, Crude Birth Rate (CBR) was 39.0 and 44.6 in 1990 and 1991 respectively (NPC, 2000). It was 42.0 in 2003 (NDHS, 2003). All these buttress the fact that there is high CBR in Nigeria. Nigerian population has gathered momentum. It will continue to increase for some time even if there is a change favorable towards family planning and birth control. Increasing population at the expense of socio-economic development is inimical to people's wellbeing and development. An increasing population has consequences and implications most especially for a country like Nigeria.

The problem of HIV/AIDS

Almost three decades into the HIV/AIDS pandemic, the virus has become one of the top ten leading death causes worldwide. In low-income countries the disease even is the fifth leading death cause (WHO, 2008). AIDS is currently recognized as more than a health and biological problem (Hasnain & Levy, 2005); it is presently a major international health concern which is threatening to wipe off the whole human existence if adequate precautions are not taken. The entire world including the Sub-Saharan African countries are exerting all kinds of precautionary efforts –not limited to medical- to curb the detriments of HIV/AIDS in their countries. However, these enormous efforts have been insignificant in quelling the prevalence of HIV/AIDS. In 2007 alone, there were 33 million people with HIV/AIDS worldwide. Throughout the year, about 2.7 million people became infected with the virus and two million people died of HIV-related causes (UNAIDS, 2008). This means that every fifteen seconds, somebody dies of AIDS and every twelve seconds, somebody is infected with AIDS (WHO, 2008). Therefore, more panaceas are expected to be explored in order to achieve a significant annihilation of HIV/AIDS.

Nigeria is an example of a nation battling with the prevalence of HIV/AIDS; the disease is alarmingly threatening the Nigerian social and economic sphere. Researchers documented that HIV was first detected in Nigeria in 1986 (Amanyeyiwe, Laurel, Aneesa, Taye, Mehta-Steffen & Valdenebro et al., 2008) and since the discovery, the number of infected young people has increased in threefold; from 1.8% in 1991 to 5.8% in 2001, after which a slight decline was observed (from 5.0% in 2003 to 4.4% in 2005), with prevalence as high as 16% in some parts of the country (Kombe, Galaty & Nwagbara, 2004; Amanyeyiwe et al., 2008). Evidently, Nigeria has been identified as the second largest HIV infected people in the world (USAID, 2010) and the

infection now stands as one of the leading causes of death among people aged 15-49 years across all the geographical regions (Kombe, Galaty & Nwagbara, 2004). With all these statistics in mind, and with the understanding that HIV/AIDS has caused tremendous pain to millions of people, one begins to wonder as Campbell (2004) asks, why people involve themselves in risky sexual behavior which could result into a slow, excruciating, and untimely death and why the best strategic and purposive campaigns in several countries are mostly unsuccessful in curbing the prevalence of HIV/AIDS.

Several studies have shown that the current course of the epidemic is unlikely to change unless the people affected, and those at risk, make a concerted effort to adopt preventive measures (Hasnain, 2005; Erinosh, Joseph, Isiugo-Abanihe, Dike, & Aderinto, 2013). Containment of the AIDS epidemic thus depends on effecting change in behavior and lifestyle to break the chain of transmission. The change in behavior becomes more challenging for the reason that the forces that form and stimulate human behavior that is injurious to health are very complex and poorly understood. In recent years, increasing attention is being paid to the manner in which cultural practices influence risk sexual behaviors related to HIV infection transmission (Airhihenbuwa & Webster, 2004). Though the association of contentious cultural issues with HIV risk behaviors exists in all societies, it is much more pronounced in Nigeria with a population of about 140 million people distributed among 389 ethnic groups. Studies have shown that the poor understanding of sexuality and its cultural contexts by many HIV and AIDS stakeholders may be responsible for the low success levels recorded against HIV/AIDS campaigns (Oladepo & Fayemi, 2011; Oyediran, 2003; Uwah & Wright, 2012). Hence, the inadequate use of cultural cues of people in Nigeria might be the single reason for the unsuccessful use of contraception campaigns in Nigeria.

The problem of unintended pregnancy and induced abortion

Studies have consistently indicated that large numbers of Nigerian women experience unwanted or mistimed pregnancies and births. According to a 1997 survey of women in southwestern Nigeria, at least 27% of women had ever been pregnant when they did not want to be. Similarly, in a survey conducted in southwestern and northern Nigeria in the mid-1990s, 20% of women reported ever having experienced an unwanted pregnancy. The 2003 Demographic and Health Survey (DHS) found that of live births to women in the previous three years, 15% were reported to be unplanned. It has been estimated that about 12% of all pregnancies in Nigeria (not including those that result in spontaneous abortion) end in induced abortion, and another 9% result in unplanned births.

Unintended pregnancy poses significant public health risks. One consequence of unwanted pregnancy is induced abortion. In the mid-1990s, the abortion rate in Nigeria was estimated at 25 per 1,000 women. At this rate, approximately 760,000 abortions will occur in 2006. Because abortion is illegal in Nigeria except to save a woman's life, many procedures are conducted under unsafe conditions and carry a substantial risk of maternal morbidity and mortality. It is estimated that about 25% of women who have abortions in Nigeria experience serious complications.

More also, it is estimated that 46 million abortions are performed each year, 20 million of which occur in countries where abortion is prohibited by law (Glenn, 2002). Understanding the influence of marital status on adolescents' sexual behavior is critical.

Contraceptive prevalence is lower in Nigeria than in most countries in sub-Saharan Africa with a high level of unmet need for contraception in spite of the high rate of sexual activity and

contraceptive knowledge, this low contraceptive use has contributed to the high rate of unintended pregnancy in the region. Unintended pregnancies are more likely than intended pregnancies to end in negative health outcomes, including low birth weight, infant and child mortality, and maternal morbidity and mortality.

Yet another problem is the communication gap between parents and the adolescents on reproductive and sexual health issues. This study, therefore, intends to find out the contributions of parents marital status to adolescent sexual behavior in Nigeria.

1.3 JUSTIFICATION OF THE STUDY

One in every five people in the world is an adolescent. Current estimates put the population of adolescents worldwide at 1.2 billion and 85% of them live in developing countries.

Adolescents are not a homogenous group; their needs vary enormously by age, gender, region, socioeconomic condition, cultural context, etc. Similarly, their sexual and reproductive health needs vary considerably across different groups, cultures and religion.

Adolescents' sexual activities are on the rise and rapidly emerging as a public health concern. Secondary sexual growth, changes in hormonal secretion, emotional, cognitive and psychosocial development result in sexual curiosity and experimentation, often in situations of little reproductive health information or services. There is consensus that adolescents engage in high risk sexual behavior that predisposes them to reproductive health problems. This is as a result of physiological and psychological changes that cause them to desire sexual intercourse and take risks, leading to unfavorable sexual and reproductive health indices including unintended pregnancies, unsafe abortions, early childbearing, sexually transmitted diseases, and Acquired Immune Deficiency Syndrome (AIDS).

Studies from several parts of the country have reported high level of sexual activity among unmarried adolescents of both sexes with progressively decreasing age of debut, risky sexual practices, including unprotected sexual intercourse with multiple partners. Girls, most often, bear the consequences of early sexual activity in: unwanted pregnancies, teenage births and abortions, often by quacks. Sexually transmitted diseases occur in both sexes and when treated, result in chronic reproductive tract infections and infertility.

Young people, aged 15-24, accounted for an estimated 45% of new HIV infections worldwide in 2007. About 16 million girls, aged 15-19 years, give birth every year, most in low- and middle-income countries. An estimated 3 million girls of the same age group undergo unsafe abortions every year.

At this crucial point in time, the study on adolescents' sexuality is expedient due to the fact that the adolescents lack adequate care and affection from their families respectively. In-fact, these adolescents often receive misguided information from both peer groups and the media in Nigerian society.

This study through its findings would create the necessary awareness to understanding the various determinable factors that affect risky sexual behavior among adolescents in Nigeria.

It will also equip the adolescents with some of the dangers involved in pre-marital sexual intercourse and therefore make them to manage their teenage age with more caution. The findings of this study would be very useful to governmental ministries and agencies like Ministries of Health and Education; Non-Governmental Agencies as well as sundry stakeholders in packaging effective and result oriented interventions on adolescents. Lastly, it will

contribute positively to the expansion of knowledge in the area of adolescent sexual behavior and also serve as an important reference tool for future researchers in the field.

1.4 RESEARCH QUESTIONS

- What is the level of risky sexual behavior among adolescents in Nigeria?
- What are the determinants of risky sexual behavior among adolescents in Nigeria?

1.5 RESEARCH OBJECTIVES

1.5.1 GENERAL OBJECTIVE OF THE STUDY

The general objective of the study is to bring into lime-light the determinants of risky sexual behavior among adolescents in Nigeria.

1.5.2 SPECIFIC OBJECTIVES

The Specific objectives of the study are to:

- Ascertain level of risky sexual behavior among adolescents in Nigeria.
- Examine the determinants of risky sexual behavior among adolescents in Nigeria.

1.6 DEFINITION OF TERMS

- **ADOLESCENTS:** An adolescent is any person in the age range of 10 to 21 years.
- **RISKY SEXUAL BEHAVIOR:** Risky sexual behavior are defined by the increased risk of a negative outcome, which can take two pathways: risky sexual are those which increase the chance of contracting or transmitting diseases. (IAFF)

- **ABORTION:** The world health organization (WHO) define abortion as pregnancy termination prior to 20 weeks gestation or a fetus born weighing less than 500g. The national center for health statistics (NCHS) define abortion as a fetus or embryo removed or expelled from the uterus during the first half of gestation-20 weeks or less, or in the absence of accurate dating criteria, born weighing less than 500g.

CHAPTER TWO

LITERATURE REVIEW

2.1 OVERVIEW OF THE STUDY

2.1.1 RISKY SEXUAL BEHAVIOR IN AFRICA

In 2009 68% of the world's 33 million HIV positive people lived in sub-Saharan Africa (UNAIDS, 2010). In most countries in this region the HIV/AIDS epidemic is generalized, and therefore prevention strategies must have a broad reach. Schools are one of the few institutions that reach most individuals, and are therefore an obvious option for the dissemination of HIV prevention messages.

HIV prevalence remains high in sub-Saharan Africa and reducing the incidence in adolescence is critical (UNAIDS, 2014). The majority of HIV transmission in sub-Saharan Africa occurs via sex and risk of infection varies by sexual behavior, including early sexual debut (Stockl et al., 2013; Wand and Ramjee, 2012), having multiple partners, and inconsistent condom use (Pettifor et al., 2005). The characteristics of young people's sexual partners might also influence risk and some studies have found having older partners to increase risk among young women (Gregson et al., 2002; Kelly et al., 2003; Pettifor et al., 2005).

2.1.2 RISKY SEXUAL BEHAVIOR IN NIGERIA

The youths in Nigeria account for 32.0% of Nigerian's 140 million people and nearly half (48.6%) of adolescents aged 15-19 are sexually active. About 1 in 5 of sexually active females

and 1 in 12 sexually active males had already engaged in sexual intercourse by the age of 15. Findings from National AIDS and Reproductive Health Survey show that the median age of sexual debut among youths is 17 years in females and 21 years in males.

A study conducted by Ajidahun (2011) has also shown that there is a high level of sexual activities among Nigerian adolescents. Many of these activities include: having more than one sex partners, patronage of prostitutes (among the males), and masturbation when they lack access to opposite sex, lesbianism and homosexuality.

In Nigeria, researches have confirmed that risky sexual behavior is associated with young people. These risky behaviors include: early debut in sexual activities, sex with many partners, low and inconsistent use of condoms, use of drugs and alcohol, anal sexual intercourse and mouth to genital contact.

The Nigeria Demographic and Health Survey of 1999 reported that the median age at first sexual intercourse for girls is just over 16 years. By ages 18 and 20, 63% and approximately 80% respectively have experienced sexual intercourse. Several other studies have reported high rates of pre-marital sexual activities among Nigerian adolescents (Odewole, C.D. (2000).

2.1.3 DETERMINANTS OF RISKY SEXUAL BEHAVIOR

Different studies have been made on determinants of risky sexual behavior among adolescents by different researchers across countries and localities. Some of them are reviewed below.

A study on the magnitude and determinants of risky sexual behavior among youths attending HIV care and treatment clinics in dar-el-salaam region, Tanzania showed that practice of unprotected sex and multiple sexual partnerships was prevalent among adolescents living in

dar-el-salaam. Low STI knowledge and low HIV disclosure status increased the vulnerability and risk of transmission of HIV infection among adolescents. Specific intervention measures including implementing reproductive health counseling in routine CTC should be a priority. The study recommended that intervention measures should take into account age, location, ARV use and other individual related behaviors such as alcohol consumption and condom use.

A comparative cross-sectional study on Risky Sexual Behaviors and Associated Factors Among Male and Female Students in Jimma Zone Preparatory Schools, South West Ethiopia, showed that twenty-two (25.9%) of male and 25(21.6%) of female students had two or more sexual partners. Eighty-three (32.3%), 113(43.5%) male and female students were sexually at risk. Only 8 (9.4%) of the male and 10 (8.6%) of the female students used condom consistently. Female students living away from their parents were 3 times more likely to be at risk than students living with their parents. Female students who consumed alcohol were 7 times more likely to be at risk than those who did not consume alcohol; Male students who consumed alcohol were 2.8 times more likely to be at risk than those who did not consumed alcohol, Male students who chewed khat were 4.6 times more likely to be at risk than students who did not chew khat. In conclusion, Living arrangement, educational status of parents, family connectedness, alcohol consumption and khat-chewing were the major predictors of risky sexual behavior. Therefore, School, family and zonal education office should be involved in reducing the risky sexual behavior of school youth.

Another study on sexual behavior and knowledge of sexually transmitted infections including HIV/AIDS among in school and out of school adolescents' in kumbotso local government area, Kano state Nigeria showed that majority of the respondents attributed premarital sex to influence of erotic film from TV, video and cinemas, while majority of their out

of school counterparts attributed it to peer group influence. Their attitude toward sexuality was positive. The higher the level of knowledge of HIV/AIDS of the teenage respondents the more positive attitude to premarital sex, prostitution and multiple sexual partners and sex education. The out of school respondents were found to be more sexually active, have earlier sexual exposure and there is low and infrequent use of condom among sexually active ones. Their general knowledge of STD/HIV/AIDS is not only hazy and inadequate but also shrouded in misconceptions and strong emotion.

A research study titled Socio-demographic determinants of Sexual Risk Behavior among Senior Secondary Schools Students in a Military Barracks in Nigeria (Chinomso Chinanuekpere Nnebue et al.) observed increased sexual activity among respondents residing in high density quarters. The high-density environment could be exposing them to situation that put them at risk. For example a large family living in a one or two room apartment by virtue of the parent's rank may have the whole family sharing room with parents or older relations of opposite sex or house-help. They may sometimes observe their parents and older siblings indulge in sexual activity and thereafter practice what they observed, sometimes even among themselves.

The study also showed that those respondents doing income generating jobs to support their families and those from low income families were more likely to engage in sexual intercourse. This indicates that young people whose basic needs are hardly met by their parents are at a higher risk of unwanted pregnancy and STIs (including HIV/AIDS). This study showed that Christians were more likely to have ever had sexual intercourse than Muslims ($p= 0.010$), but also revealed that three months prior to this study, more Muslims were found to be sexually active than the Christians ($p= 0.501$).

2.2 THEORETICAL FRAMEWORK

Theories and model are very essential as they help to organize, direct and interpret research. However, this works use the problem behavior theory and other related theories which are valid to explain a theoretical approach of the study.

2.2.1 PROBLEM BEHAVIOR THEORY

Problem behavior theory was developed by Richard Jessor and Shirley Jessor. The theory is a social psychological framework focused to explain the variation in adolescent's involvement in behaviors that are socially defined as a problem and as undesirable by the norms of conventional society and that elicit some form of social sanctions. The fundamental premise of the theory is that all behavior is the result of persons-environment interaction, reflects a field theory perspective in social science (Lewin, 1951). Problem behaviors of interest have included precocious adolescent's sexual behavior. The fundamental rationale of the problem behavior perspective is the interpretation of many of the important transitions that occur during adolescence as behaviors that depart from the regulatory norms defining what is appropriate for that age or stage in life (Jessor and Jessor, 1975). Early sexual experience, problem drinking, delinquency, and illicit drug use represent in adolescence a claim on more adult status or a transition in development, and engaging in such behaviors at a time that is considered too early constitutes a departure from regulatory norms.

Within each of three systems—the personality, the perceived environment, and the behavior—the proneness for problem behavior may be defined. The important personality constructs are favorable attitudes, values, beliefs and expectations to problem behavior. High value on independence and low expectation for academic goals are both conceptualized as favorable to

problem behavior. In the perceived environment system, low support and control from significant others and approval for and models for engaging in problem behavior are the important constructs. Within the behavior system, the degree of involvement in other problem behaviors on one hand, and in conventional behaviors, such as church attendance and school performance on the other, are expected to predict problem behavior. Variation in the time of initial intercourse was related to these personality and perceived environment variables (Jessor, Costa, Jessor, and Donovan, 1983).

2.2.2 SOCIAL ACTION THEORY

The social action theory was propounded by Max Weber, a renowned sociologist. According to Max Weber, "an action is 'social' if the acting individual takes account of the behavior of others and is thereby oriented in its course". Thus social actions of individuals which are somehow influenced, guided or determined by the actions of other individuals are called social actions. Max's theory of social action comprises of four major stages which are highlighted below:

Traditional Stage

This stage is concerned with customs, traditions and their usages. Thus all those actions which are influenced, guided or determined by customs or traditions come under this stage.

Emotional Stage

An emotional reaction to the actions of others comes under this stage. If there is expression of love, hate, sympathy or pity in response to the behavior of other individuals.

Valuation Stage

The social actions which are concerned with values are considered valuation stage. The religious and ethical action comes under. The social value of Islam; we pray five times, Deeping fasts, go to pilgrimage, conduct the jihad etc.

Rational or purposeful Stage

These actions are guided primarily by reason and discrimination. These actions are rational based on some reasons and wanted to get some benefit from others. These are purposeful actions. So, these were the four stages of social actions, which determine human behavior.

Max Weber (1937).

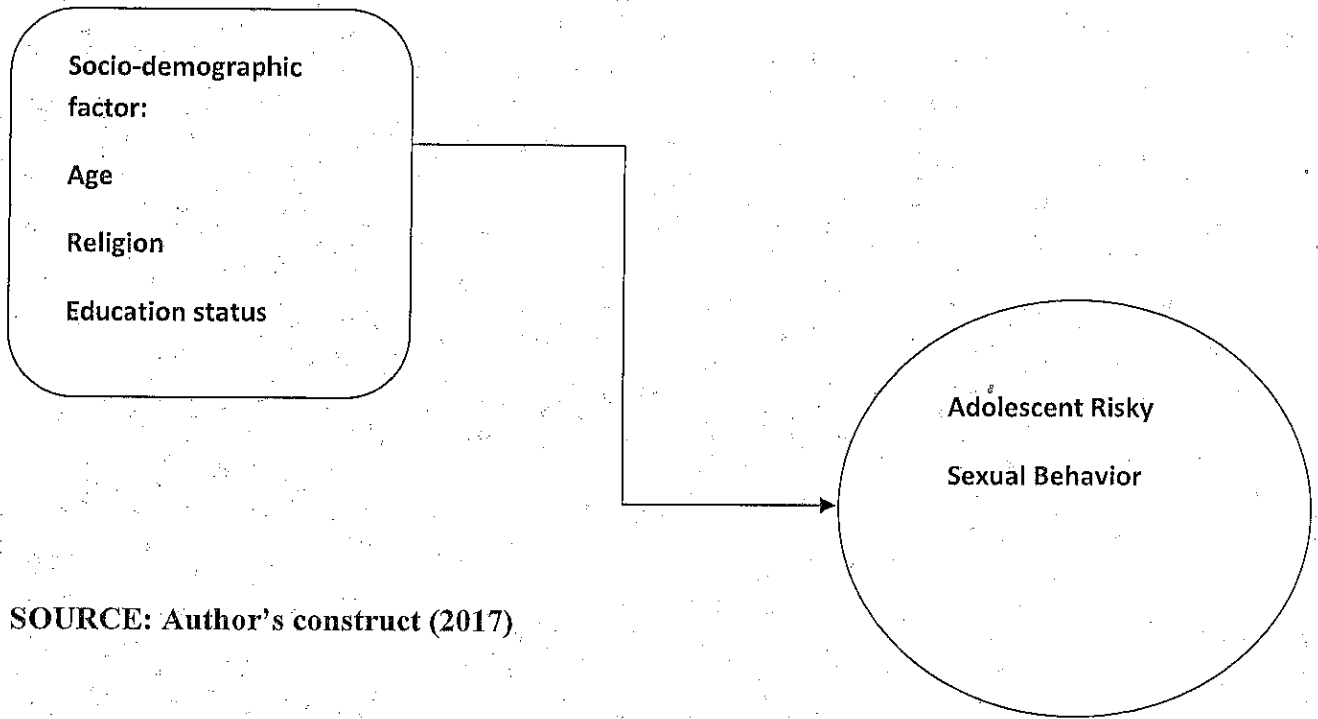
2.3 CONCEPTUAL FRAMEWORK

Adolescents' risky sexual behavior is considered in this conceptual frame work as the dependent variable measured by the number of sexual partners of adolescents.

The independent variables considered are the socio-demographics characteristics of adolescents. However, Age, ethnicity, level of education and income of the respondents are categories of demographic factors of the respondents which will determine the adolescents' risky sexual behavior.

This framework is schematically presented below:

SCHEMATIC REPRESENTATION OF CONCEPTUAL FRAMEWORK:



SOURCE: Author's construct (2017)

2.4 HYPOTHESIS

The socio-demographic characteristics of adolescents will likely influence risky sexual behavior among adolescents in Nigeria.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 DESCRIPTION OF STUDY AREA

NIGERIA

The Federal Republic of Nigeria lies on the Gulf of Guinea and has borders with Benin (west), Niger (north), Chad (north-east across Lake Chad) and Cameroon (east). It comprises the Abuja Federal Capital Territory and 36 states. Nigeria is the most populous country in Africa with a population of 173,615,000 as at 2013, Nigeria consist of so many main towns and cities and they are Abuja (federal capital since 1991, pop. 2.71m in 2011), Lagos (commercial centre and former capital, Lagos State, 13.34m), Kano (Kano, 4.03m), Ibadan (Oyo, 3.06m), Port Harcourt (Rivers, 2.01m), Kaduna (Kaduna, 1.64m), Benin City (Edo, 1.45m), Ilorin (Kwara, 1.08m), Maiduguri (Borno, 1.03m), Aba (Abia, 1.01m), Warri (Edo, 933,800), Onitsha (Anambra, 910,800), Jos (Plateau, 900,000), Enugu (Enugu, 870,000), Zaria (Kaduna, 870,000), Akure (Ondo, 847,900), Abeokuta (Ogun, 801,300), Oshogbo (Osun, 795,000), Ife (Osun, 490,000), Ogbomosho (Oyo, 433,030), Oyo (Oyo, 369,894), Sokoto (Sokoto, 329,369), Okene (Kogi, 312,755), Calabar (Cross River, 310,389), Katsina (Katsina, 259,315), Bauchi (Bauchi, 206,537), Minna (Niger, 189,191), Gombe (Gombe, 163,604), Ado (Ekiti, 156,122), Makurdi (Benue, 151,515), Ondo (Ondo, 146,051), Owerri (Imo, 119,711), Gboko (Benue, 101,281), Nsukka (Enugu, 69,210), Jalingo (Taraba, 67,226), Birnin Kebbi (Kebbi, 63,147), Uyo (Akwa Ibom, 58,369), Yola (Adamawa, 54,810) and Asaba (Delta, 49,725). (Commonwealth 2017);

3.2 THE TARGET POPULATION

The target population includes 6,413 male and 14,477 female adolescents drawn from NDHS 2013 survey for adolescents from age 10-21 years of age who are currently residing in Nigeria.

3.3 DATA

The data utilized for this study is the 2013 NDHS dataset. The survey is a nationally representative stratified, self-weighting probability samples of adolescents between ages 10-21.

3.4 SAMPLE DESIGN

The sample for the 2013 NDHS was nationally representative and covered the entire population residing in non-institutional dwelling units in the country. The survey used as a sampling frame the list of enumeration areas (EAs) prepared for the 2006 Population Census of the Federal Republic of Nigeria, provided by the National Population Commission.

A complete listing of households and a mapping exercise were carried out for each cluster from December 2012 to January 2013, with the resulting lists of households serving as the sampling frame for the selection of households. All regular households were listed. The NPC listing enumerators were trained to use Global Positioning System (GPS) receivers to calculate the coordinates of the 2013 NDHS sample clusters.

A fixed sample take of 45 households were selected per cluster. All adolescents who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. In a subsample of half of the households, all adolescents that were either permanent residents of the households in the

sample or visitors present in the households on the night before the survey were eligible to be interviewed.

3.5 DATA PROCESSING AND STATISTICAL ANALYSIS

Analysis of the quantitative data will be done using STATA 12.0 software and will be done at three levels; Firstly, a univariate analysis which will involve taking the percentage distribution and frequency count of the socio-demographic characteristics of the respondents will be carried out. The second analysis will be a bivariate analysis; it will involve cross tabulations of two or more variables. The Chi-Square table will be used to analyze some selected socio-demographic and economic characteristics and the dependent variable. The third analysis will be a multivariate analysis; it will involve using Binary Logistic Regression to analyze the effect of each level of the socio-demographic characteristics on the dependent variable.

3.6 MEASUREMENT OF VARIABLES

The variables to be used are classified into independent and dependent variables. They are briefly discussed in the next page:

INDEPENDENT VARIABLES

VARIABLE	DEFINITION	MEASUREMENT
Age of Respondents	This is a nominal variable; it will be measured by grouping age of the respondents into two year age groups	10-13, 14-17 and 18-21
Level of Education	This is the educational status of respondent. It is a categorical variable divided into two categories.	No Education and Schooling.
Religion	Is measured in three categories	Christian, Islam and Others (including traditionalist).
Ethnicity	These describe the ethnic group of adolescents living in Nigeria.	Yoruba Igbo Hausa Others (Fulani, Igala and Ijaw/Izon).

DEPENDENT VARIABLE

VARIABLE	DEFINITION	MEASUREMENT
Risky Sexual behavior: number of sexual partner.	Adolescents who are currently exposed to Risky sexual behavior, measured by the number of sexual partners they have.	No risk: 0-1 partners Risky: 2-5 partners

3.7 LIMITATIONS OF THE STUDY

- One of the limitations of this study is that not all the data contained in the NDHS for adolescents that constitute the quantitative data was able to serve adequately the purpose of this work, there may be some other factors influencing risky sexual behavior among adolescents that are not contained in the NDHS 2013.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.1 INTRODUCTION

This chapter deals with presentation, analysis and interpretation of the data collected from secondary sources Nigeria Demographic and Health Survey (NDHS, 2013) to show the determinant of risky sexual behavior among adolescent in Nigeria. For the purpose of analysis, this study makes use of descriptive analysis and inferential analysis.

The descriptive analysis describes the relevant aspects of the phenomena under consideration and provide detailed information about these variables such as; age, level of education, religion, place of residence, age at first sexual intercourse, multiple partner as risky sexual behavior and contraceptive use. However, in supportive of descriptive statistics, inferential analysis, Pearson Chi-square test was used to ascertain relationship while logistic regression analysis was used in testing the study hypotheses.

4.2 DATA PRESENTATION

Tables 1: Background Characteristics of Sampled Adolescent in Nigeria

Socio-Demographic Variables	Male		Female	
	Frequency	Percentage (%)	Frequency	Percentage (%)
Risky Sexual Behavior				
Single Partner	6,156	96.00	14,304	98.79
Risky	257	4.00	175	1.21

Contraceptive Use				
Not Using	5,452	85.01	12,847	88.73
Using	961	14.99	1,631	11.27
Wealth Index	2,178	33.96		
Poor			5,288	36.53
Middle	1,364	21.27	3,027	20.90
Rich	2,871	44.77	6,162	42.57
Ever had Abortion?				
No			13,850	95.67
Yes			627	4.33
Place of Residence				
Urban	2,864	44.66	6,052	41.81
Rural	3,549	55.34	8,425	58.19
Region				
North central	937	14.61	2,186	15.10
North east	927	14.45	2,236	15.44
North west	1,962	30.60	4,434	30.63

South east	698	10.88	1,681	11.61
South-South	889	13.86	1,886.	13.03
South west	999	15.58	2,053	14.18
Religion				
Christian	3,042	47.44	6,724	46.67
Islam	3,298	51.42	7,576	52.59
Traditional	43	0.67	107	0.74
Education				
No education	1,073	16.72	4,417	30.51
Primary	756	11.79	1,798	12.42
Secondary	4,128	64.37	7,470	51.60
Higher	456	7.11	791	5.47
Occupation	2,974	46.37		
Unpaid			8,757	60.49
Paid	3,439	53.63	5,720	39.51
Age at First Sex				
<18 years	5,154	84.14	5,154	84.14

18+ years	971	15.86	971	15.86
Current Age				
15-19	3,649	56.47	7,743	53.49
20-24	2,813	43.53	6,734	46.51

Source: Author Analysis, NDHS 2013.

The data shows the extent to which adolescent engaged in risky sexual behavior in Nigeria, it was found that the prevalence rate of risky sexual behavior is low using number of partner as 4% of male adolescents involved in risky sexual behavior (RSB) while female adolescent was found to be less than 2%. As it were, more than 80% of the adolescents had their sexual experience while they were below 18 years for both sex. And the sampled respondents were within ages 15-19 years for male (56.47%) while female (53.49%). The contraceptives use among adolescents indicates low usage as majority of them are not using, 85% of male are not using and 88.7% of female are also not using any contraception, leaving only 15% of male are using contraceptives. Majority of the adolescents were classified rich for male (44.7%) female (43%) while 34% of male adolescents were classified as poor and 36% of female were also classified as poor. More so, majority of sampled adolescent were either about completing their secondary education or already completed. Thus majority had secondary education, male 64.4% and female 51.6% while only 16.7% had no formal education among male adolescents and 30.5% of female were not educated. Details of respondent's socio-demographic characteristics can be found in the table 1 above.

4.3 BIVARIATE ANALYSIS

This section focus on the test of relationship between some selected socio-demographic characteristics on risky sexual behavior.

Socio-Demographic Variables	Male		Female	
	No Risk	Risky	No Risky	Risky
Contraceptive Use				
Not Using	86.9	39.54	89.22	48.65
Using	13.1	60.46	10.78	51.35
Pearson Chi-Square (X²)	X ² =437.05	P=0.000	X ² =284.83	P=0.000
Wealth Index				
Poor	34.86	12.	36.65	26.80
Middle	21.18	23.39	20.99	13.83
Rich	43.95	64.39	42.36	59.37
Pearson Chi-Square (X²)	61.20	P=0.000	X ² =20.58	P=0.013
Ever had Abortion?				

No			95.82	83.0
Yes			4.18	17.0
Pearson Chi-Square (X²)			X ² =68.64	P=0.000
Place of Residence				
Urban	44.40	50.84	41.66	54.09
Rural	55.60	49.16	58.34	45.91
Pearson Chi-Square (X²)	X ² =4.1620	P=0.105	X ² =10.98	P=0.025
Region				
North central	14.75	11.37	15.01	22.77
North east	14.69	8.82	15.52	8.9
North west	31.77	2.61	30.69	25.31
South east	11.1	5.65	11.62	10.83
South-South	13.04	33.61	12.97	17.83
South west	14.65	37.94	14.18	14.37
Pearson Chi-Square	X ² =245.85	P=0.000	X ² =16.68	P=0.12

(X ²)				
Religion	46.38	72.85		
Christian			46.36	72.08
Islam	52.48	26.07	52.9	27.28
Traditional	0.65	1.08	0.74	0.64
Pearson Chi-Square	X ² =72.29	P=0.000	X ² =45.91	P=0.000
(X ²)				
Education				
No education	17.22	4.95	30.7	14.81
Primary	11.89	9.5	12.43	11.79
Secondary	64.26	67.07	51.52	58.67
Higher	6.64	18.48	5.35	14.73
Pearson Chi-Square	X ² =72.78	P=0.000	X ² =43.91	P=0.000
(X ²)				
Occupation				
Not Working	47.19	26.82	60.57	54.35
Working	52.81	73.18	39.43	45.65

Pearson Chi-Square (X ²)	X ² =41.40	P=0.000	X ² =2.79	P=0.1970
Age at First Sex	85.29	57.39		
<18 years			83.19	69.84
18+ years	14.71	42.61	16.81	30.16
Pearson Chi-Square (X ²)	X ² =142.58	P=0.000	X ² =17.48	P=0.002
Current Age				
15-19	57.04	15.48	53.69	36.89
20-24	42.96	84.52	46.31	63.11
Pearson Chi-Square (X ²)	X ² =173.54	P=0.000	X ² =19.61	P=0.000

Source: Author Analysis, NDHS 2013.

The table 2 highlighted the effect of some factor associated with risky sexual behavior among sampled adolescents in Nigeria. Use of contraceptives, female adolescent who had influential wealth status, females who had practiced abortion before, urban dwellers and most Christian ladies who had secondary education and young adults who had sex before they got to age 18 years are more likely to involve in risky sexual behavior by having multiple partners. For example, 51% of female adolescent who uses contraceptive had two or more sex partner while

only 48% of such do not use contraceptive. The Pearson Chi-Square test of relationship disclosed a very significant $X^2=284.83$ with $p=0.000$ which implies that contraceptive usage has significant effect on whether an adolescent would practice risky sexual behavior.

Also, 59% among those that practiced risky sexual behavior were rich, 27% goes into risky sexual behavior because of poverty with Pearson Chi-Square $X^2=20.58$ $p=0.013$ which disclosed a significance effect on risky sexual behavior at 5% of confidence.

The bivariate test of association among male adolescent revealed that there is a regional difference in their risky sexual behavior in Nigeria, majority of male adolescent who had multiple partners were from South-West ((38%) followed by South-South (34%) while North East took the least (3%). The results show a significance relationship with ($X^2=245.85$, $p=0.000$). Also majority of male adolescent who uses contraceptives involved in risky sexual behavior (60.4%) while 34% of them do not use contraceptives. Thus contraceptives has a significance relationship with practices of multiple sexual partners among male adolescent with Chi-Square=437.05, $p=0.000$. the adolescent who were rich was found of having risky sexual behavior as it was found that 64% of male who were rich had multiple partners while only 12% were poor with chi-Square value =61.202, $p=0.000$. Furthermore, age at first sexual intercourse was also found to be associated with risky sexual behavior as majority of those who had sexual intercourse before 18 years practices risky sexual behavior while 43% ever had sex after 18 years. Thus age at first sexual intercourse has a significance relationship with practices of multiple sexual partners among male adolescent with Chi-Square=142.58 $p=0.000$. Education of male adolescent was found to influence risky behavior as 67% who had secondary education had multiple partner but reduces to 18% for higher educated.

4.4. HYPOTHESIS ONE

H_0 : There is no significant relationship between gender of adolescent socio-demographic factors and their sexual behavior in Nigeria.

H_1 : There is significant relationship between gender of adolescent socio-demographic factors and their sexual behavior in Nigeria.

CRITICAL REGION: At 0.05 level of significance, Reject H_0 if P-value < 0.05 . Hence, accept if otherwise.

DECISION: Since P-value for Pearson Chi-square of female contraceptives, wealth index, abortion, region, religion, age at first intercourse, age and occupation is < 0.05 , therefore we reject the Null hypothesis and conclude that these factors can significant influence risky sexual behavior among female/male adolescents.

4.5 MULTIVARIATE ANALYSIS:

Logistic Regression for Female Risky Sexual Behavior and Selected Demographic factors

Risky Sexual Behavior	Female Odd Ratio	[95% Conf. interval]	Male Odd Ratio	P>z	[95% Conf. Interval]
Not Using	1.0(RC)				
Using	12.55***	8.26 - 19.07	4.83***	0.000	3.57 – 6.53
Poor	1.0(RC)				
Middle	0.63	0.32 - 1.26	1.63	0.056	.98 – 1.23
Rich	1.19	0.64 - 2.22	1.36	0.229	0.82 – 2.27

Urban	1.0(RC)				
Rural	0.99	0.65 - 1.49	1.39*	0.034	1.03 - 1.90
Region					
North central	1.0(RC)				
North east	1.011	.48 - 2.13	1.18	0.605	.63 - 2.19
North west	1.38	.68 - 2.78	.17**	0.005	.05 - 0.59
South east	0.38**	.20 - .72	1.03	0.915	.54 - 1.95
South-South	0.51 *	0.30 - 0.87	3.29***	0.000	2.10 - 5.17
South west	0.48 *	.27 - 0.85	4.26***	0.000	2.70 - 6.71
Religion					
Christian	1.0(RC)				
Islam	0.41**	.23 - .72	.84	0.393	.57 - 1.24
Traditional	4.90*	1.05 - 22.68	.83	0.821	.17 - 4.00
Age at First Sex					
<18 years	1.0(RC)				

18+	0.71	0.47 - 1.08	1.04	0.795	.77 -1.40
Occupation					
Not Working	1.0 (RC)				
Working	1.26	0.88 - 1.80	2.53***	0.000	1.89 -3.38
Education					
No education	1.0(RC)				
Primary	0.54	0.16 - 1.74	1.56	0.340	.62 -3.95
Secondary	0.99	0.37 - 2.69	1.47	0.380	.62 - 3.50
Higher	1.50	0.50 - 4.52	3.07*	0.019	1.20 - 7.85

Source: Author Analysis, NDHS 2013.

In the table 3 above, the binary logistics revealed some factors that has significant effect on risky sexual behavior among Nigeria adolescents, the significant factors were, contraceptive use, age at first sexual intercourse, education, occupational status, religion affiliation and region of respondents. Female adolescents who were using contraceptives were 12.55 times likely to be involved in risky sexual behavior than those not using. But reduced among male using contraceptive as they were 4.83 times likely to be involved in risky sexual behavior than male not using. The odd ratio of place of residence show that female adolescent in the rural area were 0.99 times less likely to be involved in RSB than urban counterpart. But male in the urban centre were found to be 39% more likely to be involved in RSB than male in the urban male adolescents. Also the odd of female in South West (0.48), South South (0.51) and South-East

(0.38) were all less likely to be involved in RSB while comparing results with male adolescent we have South West (4.26), South South (3.29) and South East (1.03) times more likely to be involved in RSB than those in North Central. Conclusively, it was found that female who were working were 26% more likely to be involved in RSB than those not working while comparing to male who were working, they were 2.53 times more likely to be involved in RSB than those not working, it thus implies that economic status influences RSB.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The study set out to establish and understand the determinants of risky sexual behavior among adolescents in Nigeria. This chapter provides the summary of the findings, discussion of the findings, conclusion of the findings from the research, and recommendations for curbing the risky sexual behavior among adolescents and for further research.

5.2 SUMMARY OF THE FINDINGS

The first objective of the study was to ascertain the level of risky sexual behavior among adolescents in Nigeria. The data in (Table 4.2) shows the extent to which adolescent engaged in risky sexual behavior in Nigeria, it was found that the prevalence rate of risky sexual behavior is low using number of partner as 4% of male adolescents involved in risky sexual behavior (RSB) while female adolescent was found to be less than 2%. As it were, more than 80% of the adolescents had their sexual experience while they were below 18 years for both sex. And the sampled respondents were within ages 15-19 years for male (56.47%) while female (53.49%).

The second objective of the study was to examine the determinants of risky sexual behavior among adolescents in Nigeria. For example, 51% of female adolescent who uses contraceptive had two or more sex partner while only 48% of such do not used contraceptive. It also showed that the rich adolescents engage in risky sexual behavior than the poor adolescents, with the rich adolescents having (59%) and the poor having (29%).

Furthermore, age at first sexual intercourse was also found to be associated with risky sexual behavior as majority of those who had sexual intercourse before 18 years practices risky sexual behavior while 43% ever had sex after 18 years. Education of male adolescent was found to influence risky behavior as 67% who had secondary education had multiple partner but reduces to 18% for higher educated.

5.3 CONCLUSION

The general objective of the study is to bring into lime-light the determinants of risky sexual behavior among adolescents in Nigeria. The findings indicated that female who were working were 26% more likely to be involved in risky sexual behavior (RSB) than those not working while comparing to male who were working, they were 2.53 times more likely to be involved in risky sexual behavior (RSB) than those not working, it thus implies that economic status influences and other socio-demographic factors influences risky sexual behavior (RSB).

5.4 RECOMMENDATION

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

- Emotional intelligence and self-esteem training should be incorporated into the school curriculum of students by the ministry of education in all individual states in Nigeria.
- Religious activities should be encouraged to enhance the moral development of the adolescents in all their phase of life.
- It is therefore important to recommend more education on HIV/AIDS generally among adolescents with the use of mass media campaigns and other core packages.

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