INFLUENCE OF SEXTING, RELIGIOSITY AND PERCEPTION OF VULNERABILITY TO HIV/AIDS ON SEXUAL RISK BEHAVIOR AMONG UNIVERSITY STUDENTS

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CERTIFICATION

This is to certify that this study was conducted by **Olowookere Olamiji Mary** with Matric No PSY/14/2043 at Federal University Oye-Ekiti under my supervision of Dr Abiodun M. Lawal in partial fulfillment of the requirement for the award of Bachelor of science in Department of Psychology, faculty of social science, Federal University Oye-Ekiti, Oye -Ekiti, Ekiti.

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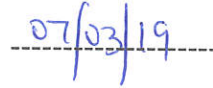
Head of Department

DEDICATION

This research is dedicated to almighty God for without him I might not be alive to finish this study, my parent, my uncle and my siblings. Thank you all for your support and encouragement. I love you all, God bless you.

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I return all glory, honor, thanks and adoration to God Almighty for his divine love, care, grace, mercy, favor protection over my life and the understanding he bestowed upon me through my stay in FUOYE, and for the successful completion of my project, may His praise never cease in my life.

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ABSTRACT

Extent of sexual risk behaviour among university students is worrisome to all stakeholders in reproductive health-related disciplines and those concerned. The research aimed to determine the influence of sexting, religiosity and perception of vulnerability to HIV/AIDS on sexual risk behaviour among University students. Ekiti state university was used as the population where 313 participants (158 males, 155 female) with mean age of 21.47 years (SD = 2.436) responded to structured questionnaires consisting of religiosity, perceived vulnerability to HIV/AIDS and sexual risk behaviour scales. Four hypotheses were tested using One-way ANOVA and t-test for independent samples. Results showed that extent of receiving sexually explicit pictures and messages influenced risk of sexual behavior $F(3, 309) = 8.701$; $p < .05$. Extent of sending sexually explicit pictures and messages influenced sexual risk behavior $F(3, 309) = 6.411$; $p < .05$. Religiosity significantly influenced sexual risk behavior $t = -3.258$; $df = 311$, $p < .01$. Perceived vulnerability to HIV/AIDS significantly influenced sexual risk behaviour $t = -7.801$; $df = 311$, $p < .01$). This study shows that sexual risk behavior is a problem needed to be tackled by health/social sector, failure to do this might lead to continue growing rate of sexual risk behavior among students. Programme/seminar should be made available for both parents and 'students to know the consequence of sexual risk behavior.

Keywords: Sexual risk behavior, sexting, religiosity, perception of vulnerability to HIV/AIDS

Word Count: 229

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Sexual Risk Behaviour isthe behaviour that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies. Sexual risk behaviour includes having sex at an early age, having multiple sexual partners, having sex while under the influence of alcohol or drugs, and unprotected sex (Centres for Disease Control and Prevention, (2010). Sexual risk behaviour can mean two similar things: the behaviour itself, and the description of the partner's, this could be unprotected vaginal, oral, or anal intercourse. The partner could be a nonexclusive partner, HIV-positive, or an intravenous drug user. Risky sexual behaviour can be sex without condom use, mouth-to-genital contact, starting sexual activity at a young age, having multiple sex partners, having a high-risk partner, someone who has multiple sex partners or infections, sex with a partner who has ever injected drugs or engaging in sex trade.

Many researchers had examined sexual risk behaviour in different populations that include truck drivers (Lawal, (2013); Lawal&Olley, (2017), students, youths (Odimegwu&Somefun,(2017), commercial sex workers (Kakchapati,Singh,Rawal, Lim,(2017). However, among the factors found to be associated with sexual risk behaviour, variables such as sexting, religiosity and perception of vulnerability to HIV/AIDS are still inadequate in literature especially among university students in Nigeria. In view of this, the researcher examines influence of sexting; religiosity and perception of vulnerability to HIV/AIDS on sexual risk behaviour among students in universities located in Ekiti state.

Sexting according to oxford dictionary is the act of sending sexually explicit text messages and/or photographs between cell phones. Sexting is sending, receiving, or

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forwarding sexually explicit messages, photographs or images, primarily between mobile phones. This process may also include the use of a computer or any digital device, The term was first popularized early in the 21st century and is a portmanteau of sex and texting, where the latter is meant in the wide sense of sending a text possibly with images. In August 2012, the word sexting was listed for the first time in Merriam-Webster's Collegiate Dictionary.

In 2013, it was found that sexting is usually used to improve the relationship and sexual satisfaction in a romantic partnership. Sexting thus can be regarded as a behaviour that ties into sexuality and the subsequent level of relationship satisfaction experienced by both partners. Also, a study was conducted byDrouin, Vogel ,Surbey, and Stills(2013), and it was found out that sexting is also associated with attachment styles, as those with 'attachment avoidance' are more likely to engage in sexting (just as these individuals are also more likely to engage in casual sex). Thus, instead of increasing intimacy in these types of relationships, sexting may act as a buffer for physical intimacy. Apart from sexting, another variable examined in the current study is extent at which students serve their God, which is referred to as religiosity.

Religiosity according to oxford dictionary is the quality of being religious or pious (devout or God fearing) especially when zealous (to exhibit enthusiasm or strong passion). Religiosity is difficult to define, but different scholars have seen this concept as broadly about religious orientations and involvement. It includes experiential, ritualistic, ideological, intellectual, consequential, creedal, communal, doctrinal, moral, and cultural dimensions. Sociologists of religion have observed that the people's beliefs, sense of belonging, most of the times are not congruent with an individual's actual religious beliefs since there is much diversity in how one can be religious or not.

Perception of vulnerability to HIV/AID, has become an involving issue in Nigeria ever since the first case of AIDS was registered in 1982, the epidemic has continued to increase. Despite the general nature of HIV/AIDS, it was not until 2000 that the Nigerian government recognised HIV/AIDS as a major health problem FRN, (2000). This motivated the government to have interest in this issue, which make them to organize campaign in the media and post billboards in cities, towns, and villages letting people know about the danger of the disease, mode of transmission and prevention. Non-governmental organizations also involve themselves in the campaign.

In Nigeria and other countries youth are the most vulnerable to HIV/AIDS since they are the most sexually active population and have shown to have multiple sexual practices (Okpani&Okpani,(2000); Demilson,(2008). Statistics have also shown that young people within the age bracket of undergraduate are the high-risk group of Hiv/Aids UNAIDS (2000) and this is because of lack of communication between parent and child about sexuality, high level of illicit sexual act and poverty (Obinna,(2005), Uzokwe,(2008). In view of the inadequacy in understanding how some sex-related factors as contributed to engagement of university students in various forms of sexual risk, the researcher examined the influence of sexting, religiosity and perception of vulnerability to HIV/AIDS on Sexual Risk Behaviour among university students in Ekiti state, Nigeria.

1.2 STATEMENT OF THE PROBLEM

Sexual risk behaviour isthe behaviour thatincreases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies. This behaviour is a problem not only to the individual who engage in it but also to the society, and this is because of the effect it has on the individual which in turn as a say in how that individual will act or behave when it come s to sexual activities.

The problem with the study according to previous studies like that of Idoko, Sholarin, &Agoha, (2015) who's examined the influence of age, gender, religiosity and family factors on sexual attitude and of university of Ibadan undergraduate, and Haglund and Fehring (2009) who works on the association of religiosity, sexual education, and parental factors with risky sexual behaviour among adolescent and young adults, was that they only look at the influence of religiosity on Sexual risk behaviour, not trying to look at other factors like sexting and how it can have effect on Sexual risk behaviour, which is what this study will be looking at. It has been noted that undergraduates who involve in sexting exhibit sexual risk, also religiosity (how dutiful an individual is to his/her religion) and perception of vulnerability to hiv/aids (what people think about hiv/aids, how they see the diseases) will determine if an individual will engage in sexual risk behaviour.

The following research questions shall be provided answers at the end of the study:

1.Will receiving sexually explicit pictures and messages influence sexual risk behaviours among university students?

2. Will sending sexually explicit pictures and messages influence sexual risk behaviours among university students?

3. Does perception of vulnerability to HIV/AIDS influence sexual risk behaviours among university students?

4. Will religiosity influence sexual risk behaviours among university students?

1.3 PURPOSE OF THE STUDY

The purpose of the study is to examine the influence of sexting, religiosity and perception of vulnerability to HIV/AIDS on Sexual Risk Behaviour among university students in Ekiti state, Nigeria. The specific objectives are as follows:

1. To examine if receiving sexually explicit pictures and messages will influence sexual risk behaviours among university students.

2. To examine if sending sexually explicit pictures and messages will influence sexual risk behaviours among university students.

3. To examine if religiosity will influence sexual risk behaviours among university students.

4. To examine if perception of vulnerability to HIV/AIDS will influence sexual risk behaviours among university students.

1.4 RELEVANCE OF THE STUDY

A research into the relationship between sexting, religiosity, perception of vulnerability to HIV/AIDS, and sexual risk behaviouris considered significant because it would help in giving an insight into the student's perception on sexual risk behaviour, their belief on sexual risk behaviourand how their religion in turn influence their belief about it. It should also reveal the cause of sexual risk behaviour, what they see as norms when it comes to sexual activities, why student especially engage in sexual risk behaviour, and the necessary steps that can be taken to curb or mitigate sexual risk behaviour among undergraduates in Nigeria and the public.

The study will be helpful to individual undergraduate student in the sense that it will help them in making decisions when it comes to sexual activities and how to have healthy sexual life, which in will affect their reproductive health. Also, when they don't engage in sexual risk behavioursuch as unprotected sex, the rate of unwanted pregnancy will reduce, and this will improve the society at large.

CHAPTER TWO

LITERATURE REVIEW

2.1 THEORETICAL FRAME WORK

2.1.1 Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model that tries to explain and predict health s by focusing on the attitudes and beliefs of individuals. The HBM was developed in the 1950s as part of an effort by social psychologists in the United States Public. Since then, the HBM has been adapted to explore a variety of long- and short-term health s, including sexual risk behaviours and the transmission of HIV/AIDS. (Rosenstock, Strecher& Becker, 1994):

The HBM is based on the understanding that a person will take a health-related action (i.e., use condoms) if that person:

- Feels that a negative health condition (i.e., HIV) can be avoided,

- Has a positive expectation that by taking a recommended action, he/she will avoid a negative health condition (i.e., using condoms will be effective at preventing HIV), and

- Believes that he/she can successfully take a recommended health action (i.e., he/she can use condoms comfortably and with confidence).

The Health Belief Model is a framework for motivating people to take positive health actions that uses the desire to avoid a negative health consequence as the prime motivation, for example, HIV is a negative health consequence, and the desire to avoid HIV can be used to motivate sexually active people into practicing safe sex. Similarly, the perceived threat of a

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heart attack can be used to motivate a person with high blood pressure into exercising more often.

Itis important to note that avoiding a negative health consequence is a key element of the HBM. For example, a person might increase exercise to look good and feel better. That example does not fit the model because the person is not motivated by a negative health outcome even though the health action of getting more exercise is the same as for the person who wants to avoid a heart attack.

The HBM can be an effective framework to use when developing health education strategies. A large research study reviewed 46 studies of HBM-based prevention programs published between 1974 and 1984. The HBM-based programs focused on a variety of health actions. The results of the meta-analysis provided substantial empirical support for the efficacy of the HBM. Health belief model (HBM) is based on six key concepts which include the following:

Perceived severity: Perceived severity refers to the subjective assessment of the severity of a health problem and its potential consequences. The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviour to prevent the health problem from occurring or reduce its severity. Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles. For instance, an individual may perceive that flu is not medically serious, but if he or she perceives that there would be serious financial consequences because of being absent from work for several days, then he or she may perceive flu to be a particularly serious condition.

Perceived susceptibility: Perceived susceptibility refers to subjective assessment of risk of developing a health problem. The health belief model predicts that individuals who perceive that they are susceptible to a health problem will engage in behaviour to reduce their risk of developing the health problem. Individuals with low perceived susceptibility may deny that they are at risk for contracting an illness. Others may acknowledge the possibility that they could develop the illness, but believe it is unlikely. Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviour. Individuals who perceive a high risk that they will be personally affected by a health problem are more likely to engage in behaviour to decrease their risk of developing the condition.

Perceived benefits: Health-related behaviours are also influenced by the perceived benefits of acting. Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease. If an individual believes that an action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action. For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer.

Perceived barriers: Health-relatedis also a function of perceived barriers to acting. Perceived barriers refer to an individual's assessment of the hindrance to behaviour change. Even if an individual perceives a health condition as threatening and believes that a action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour. In other words, the perceived benefits must outweigh the perceived barriers in other for behaviour change to occur.

Cues to action: The health belief model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviour. Cues to action can be internal or external. Physiological cues (e.g., pain, symptoms) are an example of internal cues to action. While external cues include events or information from close others, the media, or health care providers promoting engagement in health-related behaviours. Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and do not have reliable access to health care may require more intense external cues to get screened.

Self-efficacy: Self-efficacy was added to the four components of the health belief model in 1988. Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour. Self-efficacy was added to the health belief model to better explain individual differences in health behaviours. The model was originally developed to explain engagement in one-time health-related behaviours such as being screened for cancer or receiving an immunization. Eventually, the health belief model was applied to more substantial, long-term behaviour change such as diet modification, exercise, and smoking. Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-efficacy) was a key component of health behaviour change.

2.1.2 AIDS Risk Reduction Model (ARRM)

The AIDS Risk Reduction Model (ARRM), introduced in 1990, provides a support for explaining and predicting the change efforts of individuals particularly in relationship to the sexual transmission of HIV/ AIDS. A three-stage model, the ARRM includes several variables from other change theories, including the Health Belief Model, "efficacy" theory, emotional influences, and interpersonal processes. The stages, as well as the hypothesised factors that influence the successful completion of each stage, are as follows (Catania, Kegeles and Coates, 1990):

STAGE 1: Recognition and labelling of one's as high risk

Hypothesised Influences:

- knowledge of sexual activities associated with HIV transmission;
- believing that one is personally susceptible to contracting HIV;
- believing that having AIDS is undesirable;
- social norms and networking.

STAGE 2: Making a commitment to reduce high-risk sexual contacts and to increase low-risk activities

Hypothesized Influences:

- cost and benefits;
- enjoyment (e.g., will the changes affect my enjoyment of sex?);
- response efficacy (e.g., will the changes successfully reduce my risk of HIV infection?)

- self-efficacy; knowledge of the health utility and enjoyability of a sexual practice, as well as social factors (group norms and social support), are believed to influence an individual's cost and benefit and self-efficacy beliefs.

STAGE 3: Acting. This stage is broken down into three phases:

1. information seeking.

2. obtaining remedies.

3. enacting solutions.

Depending on the individual, phases may occur concurrently, or phases may be skipped.

Hypothesised Influences:

- social networks and problem-solving choices (self-help, informal and formal help);
- prior experiences with problems and solutions;
- level of self-esteem;
- resource requirements of acquiring help;
- ability to communicate verbally with sexual partner;
- sexual partner's beliefs and s.

In addition to the stages and influences listed above, the authors of the ARRM (Catania et al., 1990) identified other internal and external factors that may motivate individual movement across stages. For instance, aversive emotional states (e.g., high levels of distress over HIV/AIDS or alcohol and drug use that blunt emotional states) may facilitate or hinder the labelling of one's s. External motivators, such as public education campaigns, an image of a person dying from AIDS, or informal support groups, may also cause people to examine and potentially change their sexual activities.

2.1.3 Theory of Reasoned Action (TRA)

The theory of reasoned action (TRA) is one of the three classic models of persuasion. The theory is also used in communication discourse as a theory of understanding. The theory of reasoned action was developed by Martin Fishbein and IcekAjzen in 1967 and was derived from previous research that began as the theory of attitude. The theory aims to explain the relationship between attitudes and behaviours within human action. TRA is used to predict how individuals will behave based on their pre-existing attitudes and al intentions. An individual's decision to engage in a behaviour is based on the outcomes the individual expects will come because of performing the behaviour.

The theory of reasoned action serves to understand an individual's voluntary behaviour. The ideas found within the theory of reasoned action have to do with an individual's basic motivation to perform an action. TRA says that a person's intention to perform a behaviour is the main predictor of whether they perform that behaviour. According to the theory, intention to perform a certain behaviour precedes the actual behaviour. This intention is known as al intention and comes because of a belief that performing the behaviour will lead to a specific outcome. al intention is important to the theory because these intentions "are determined by attitudes to behaviours and subjective norms". al intention is a function of both attitudes and subjective norms toward that behaviour. However, the attitudes and subjective norms are unlikely to be weighted equally in predicting behaviour. Depending on the individual and situation, these factors might have different impacts on al intention, thus a weight is associated with each of these factors. The theory of reasoned action suggests that stronger intentions lead to increased effort to perform the behaviour, which also increases the likelihood for the behaviour to be performed.

According to the TRA theorists there are three conditions that can affect the relationship between al intention and behaviour. The first condition is that "the measure of intention must correspond with respect to their levels of specificity". This means that to predict a specific behaviour, the al intention must be equally specific. The second condition is that there must be "stability of intentions between time of measurement and performance of behaviour". The intention must remain the same between the time that it is given and the time that the behaviour is performed. The third condition is "the degree to which carrying out the intention is under the conscious control of the individual". The individual always has the control of whether to perform the behaviour.

Research using the Theory of Reasoned Action (TRA) has explained and predicted a variety of human s since 1967. Based on the proposition that humans are rational and that the s being examined are under volitional control, the theory provides a construct that links individual beliefs, attitudes, intentions, and (Fishbein, Middlestadt& Hitchcock, (1994). This theory explains why an individual engage his/her self with sexual risky by linking individual beliefs, attitude, intentions, with sexual behaviour

TRA has been frequently used as a framework and predictive mechanism of applied research on sexual behaviour, especially in prevention of sexually transmitted disease such as HIV. In 2001, Albarracín, Johnson, Fishbein, and Muellerleile applied theory of reasoned action (TRA) and theory of planned behaviour (TPB) into studying how well the theories predict condom use. To be consistent with TRA, the authors synthesized 96 data sets (N = 22,594) and associate every component in condom use with certain weight. Their study indicates that the theories of reasoned action and planned behaviour are highly successful predictors of condom use. According to their discussion, "people are more likely to use condoms if they have previously formed the corresponding intentions. These intentions to use condoms appear to derive from attitudes, subjective norms, and perceived al control. These

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attitudes and norms, in turn, appear to derive from outcome and normative beliefs. Nevertheless, whether behaviour was assessed retrospectively or prospectively was an important moderator that influenced the magnitude of the associations between theoretically important variables.

Doswell, Braxter, Cha, and Kim (2011) examined sexual behaviour in African American teenage girls and applied the theory as a framework for understanding this behaviour. The theory of reasoned action can explain these behaviours in that teens' al intentions to engage in early sexual behaviour are influenced by their pre-existing attitudes and subjective norms of their peers. Attitudes in this context are favourable or unfavourable dispositions towards teenage sexual behaviour. Subjective norms are the perceived social pressure teenagers feel from their friends, classmates, and other peer groups to engage in sexual behaviour. As a framework, the TRA suggests that adolescents will participate in early behaviour because of their own attitudes towards the behaviour and the subjective norms of their peers. In this case, intention is the wilful plan to perform early sexual behaviour. Findings from the student showed that the TRA was supportive in predicting early sexual behaviour among African American teenage girls. Attitudes towards sex and subjective norms both correlated with intentions to participate in early sexual behaviour in the study's sample.

2.1.4. Theory of Divergent Modes of Religiosity (DMR).

This theory intends to explain how religion are created, transmitted, and changed. The DMR theory was first developed by Harvey Whitehouse following his ethnographic fieldwork in Papua New Guinea. The theory state that religions tend to amalgamate around two divergent modes named Imagistic and Doctrinal which are well-known primarily by their ritual practices. The imagistic mode is characterized by infrequently performed, high rituals

(initiation rites) and is associated with small scale, exclusive religious groups, while the doctrinal mode is characterized by frequently performed, low arousal rituals (daily recitations of sacred texts) and is associated with larger inclusive communities, as found in the major world religion.

The theory state that these differing ritual patterns promote the transmission of religious traditions by core memory processes Imagistic rituals arouse strong emotion and generate vivid, flashbulb like, episodic memories, while doctrinal rituals repetitive nature means that rather than individual events the experiences over time are stored in procedural and semantic memories.

Imagistic mode: The imagistic mode of religiosity involves collective rituals that are infrequent and highly emotional. Examples of these types of rituals include various initiation rites and rites of passage. The often dysphoric and highly emotional nature of these types of rituals activate the episodic memory system, resulting in detailed autobiographical memories. These dysphoric rituals can produce an extreme form of cohesion with the group, known as identity fusion. DMR posits that fusion with other group members will also motivate the individual to act out extreme forms of altruism, especially when the group is threatened. Therefore, the imagistic mode of religiosity prevails when a group's survival depends on extremely high levels of cohesion.

Doctrinal mode: The doctrinal mode of religiosity refers to collective rituals that are frequent, usually routinized, and generates relatively little affect. Examples of this type of collective ritual would include Holy Communion and Call to prayer. Due to the repetitive nature of these types of rituals, semantic memory systems are thought to be activated and function similarly to organizing other general schemas and scripts of general knowledge. In contrast to the imagistic mode, these routinized rituals tend to produce less intense group

identification, which serves to promote trust and cooperation but not extreme self-sacrifice. DMR posits that the historical transition from small-scale societies to the invention of agriculture brought about the need for large-scale cooperation and collective identity.

2.2. CONCEPTUAL FRAMEWORK

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│              │   │              │   │   PPERCEPTION OF  │
│   SEXTING    │   │ RELIGIOSITY  │   │   VULNERABİLITY   │
│              │   │              │   │    TO HIV/AIDS    │
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             │                             │
             │    SEXUAL RISK BEHAVIOR     │
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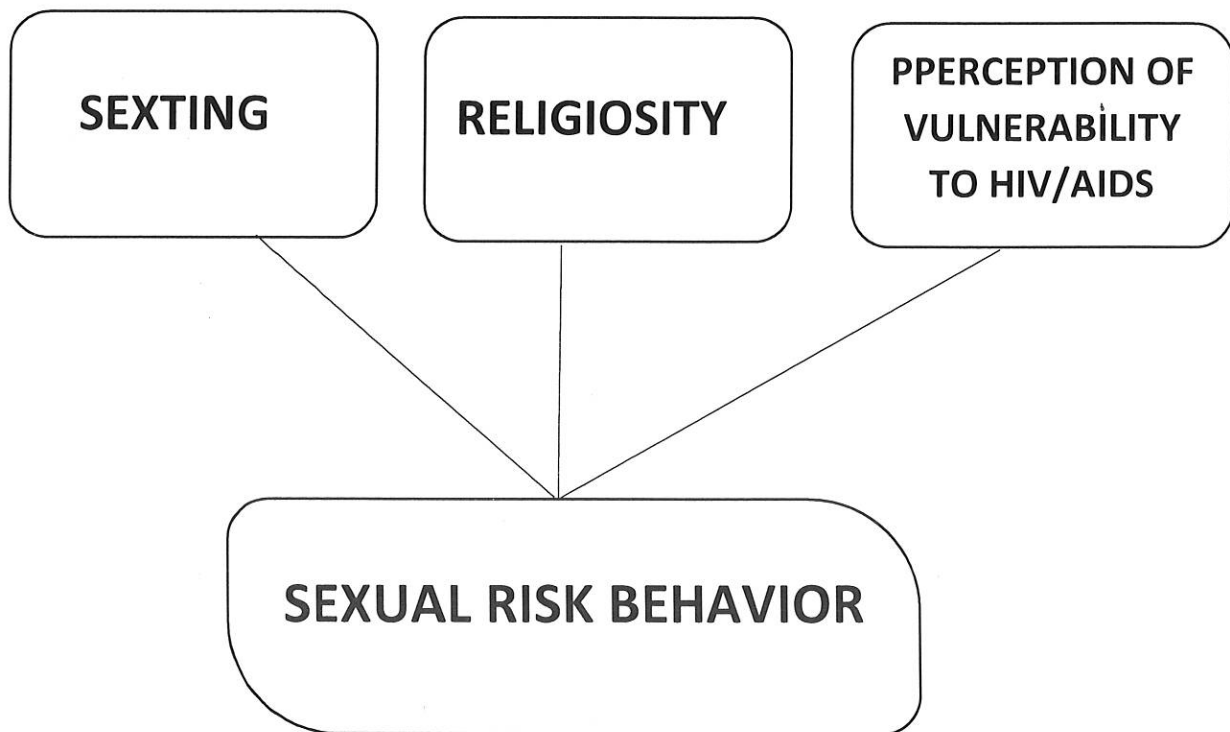
This diagram above shows that there is a relationship between sexting, religiosity, perception of vulnerability to HIV and AID and Sexual risk behaviour. (Source: author field work (2018)

2.3 RELATED STUDIES

2.3.1 Sexting and Sexual Risk Behaviour

Benotsch, Snipes, Martins and Bull (2012) worked on sexting, substance use, and Sexual Risk Behaviour in young adults. According to Benotsch et al (2012), cell phone use has become more widespread over the past decade. Young adults are frequently early

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adopters of new technologies, including cell phones. Most prior research examining sexting, the act of sending sexually explicit or suggestive images via text message, has focused on the legal or social consequences of this behaviour. The current study focused on the public health implications of sexting by examining associations between sexting, substance use, and sexual risk behaviour in youth young adults (N=763) completed online questionnaires assessing demographics, cell phone use (e.g., texting, sexting), substance use, and Sexual Risk Behaviours.

Sexting was reported by a substantial minority of participants (44%). Compared to their non-sexting counterparts, participants who engaged in sexting were more likely to report recent substance use and high-risk sexual behaviours, including unprotected sex and sex with multiple partners. Of those who engaged in sexting, a considerable percentage (31.8%) reported having sex with a new partner for the first time after sexting with that person. In multivariate analyses, sexting was associated with high-risk sexual behaviour after accounting for demographic factors, total texting behaviours, and substance use Results suggest that sexting is robustly associated with high-risk sexual behaviour. Many individuals exchange explicit or provocative photos with long-term sexual partners, but at least some participants in this study were incurring new sexual risks after sexting.

Houck, Barker, Rizzo, Hancock, Norton and Brown (2014) worked on sexting and sexual behaviour in at-risk adolescents. The study aimed to examine the prevalence of sexting (sexually explicit messages and/or pictures) among an at-risk sample of early adolescents as well as the associations between sexting s and sexual s, risk-related cognitions, and emotional regulation skills. It also aimed to determine whether differences in risk were associated with text-based versus photo-based sex Seventh-grade adolescents participating in a sexual risk behaviour prevention trial for at-risk early adolescents completed a computer-based survey at baseline regarding sexting (having sent sexually explicit messages and/or pictures), sexual

activities, intentions to have sex, perceived approval of sexual activity, and emotional regulation skills. Twenty-two percent of the sample reported having sexted in the past 6 months; sexual messages were endorsed by 17% (n = 71), sexual messages and photos by 5% (n = 21). Pictures were endorsed significantly more often by females (χ [2] = 7.33, P = .03) and Latinos (χ [2] = 7.27, P = .03). Sexting of any kind was associated with higher rates of engaging in a variety of sexual behaviours, and sending photos was associated with higher rates of sexual activity than sending text messages only. This was true for a range of s from touching genitals over clothes (odds ratio [OR] = 1.98, P = .03) to oral sex (OR = 2.66, P < .01) to vaginal sex (OR = 2.23, P < .01). Sexting behaviour (both photo and text messages) was not uncommon among middle school youth and co-occurred with sexual behaviour. These data suggest that phone behaviours, even flirtatious messages, may be an indicator of risk. Clinicians, parents, and health programs should discuss sexting with early adolescents.

Asatsa, Nyagah, Kaithuru and Munywoki (2017) worked on cell-phone sexting and its influence on adolescence sexual behaviourin Nairobi County, Kenya. According to Stephen, Cell phones have emerged as one of the most vital communication gargets worldwide. Nearly every family in the general population possess at least one cell phone. In Kenya, cell phone use by high school students within the school premises, remains outlawed. Educationists and parents have continued to associate poor performance in Language subjects with the increasing use of cell phones due to overuse of the short message service. In the recent past, cases of sexual promiscuity have been reported to be on the rise. There have been incidents of students from various schools in Nairobi and its environs being arrested engaging in sexual activities in clubs and buses. Teenage pregnancy and H.I.V prevalence remains high among the adolescents and youth. This study aimed at investigating the relationship between use of cell phones and adolescent sexual behaviour in Nairobi. The study adopted exploratory sequential mixed method design. A sample of 200 high school students was selected through

simple random sampling technique. Qualitative data was collected using focused group discussion and analysed by use of thematic analysis. Quantitative data was collected by use of questionnaires and analysed by use of simple descriptive statistics. The findings show high prevalence of masturbation, pornography, multiple sex partners and frequent sexual intercourse among adolescents who engage in sexting in Kenya.

In addition, Obakeng L. Makgale and Ilse Elisabeth Plattner (2017) worked on sexting and risky sexual behaviour among Undergraduate in Botswana. According to Obakeng and Ilse Little is known about sexting s among young people living in African countries. This exploratory study investigated sexting s among undergraduate students in Botswana (N = 309, 64.5% female; mean age = 20.3 years). Most participants (84.8%) had received sexts and many (61.8%) had sent sexts at least once in their lifetime. Reasons for sending sexts were to flirt (42.9%), to have fun (24.6%), and/or to initiate sexual activity (17.8%). Only 36.7% of the participants were worried about their sexts being forwarded to others, and 30.2% had forwarded sexts to others. Being sexually active (OR = 4.52), drinking alcohol (OR = 2.52), and having a mother with tertiary level education (OR = 0.40) emerged as significant predictors of sending sexts. Among participants who had sexual intercourse at least once in their lifetime (N = 164), an increase in the frequency of sexting was associated with an increase in the number of sexual partners and with sex under the influence of alcohol and drugs. However, sexting s were not associated with unprotected sex. The results are compared with findings from Western countries and discussed with regard to public health care and safe sex education in Botswana.

2.3.2 Religiosity and Sexual risk behaviour

Haglund and Fehring (2009) works on the association of religiosity, sexual education, and parental factors with risky sexual among adolescent and young adults. The study

examined the association of religiosity, sexual education and family structure with risky sexual s among adolescents and young adults. The nationally representative sample, from the 2002 National Survey of Family Growth, included 3,168 women and men ages 15–21 years. Those who viewed religion as very important, had frequent church attendance, and held religious sexual attitudes were 27–54% less likely to have had sex and had significantly fewer sex partners than peers. Participants whose formal and parental sexual education included abstinence and those from two-parent families were 15% less likely to have had sex and had fewer partners.

Tina, Michael and George(2013) works on The Impact of Religiosity on the sexual behaviours of College Students. The purpose of the study was to determine if frequency of religious attendance and perceived degree of religiosity could distinguish between those students who have and have not participated in selected sexual behaviours. Data were collected from a convenience sample of undergraduate students (n = 408) at a south-eastern university. Students voluntarily completed a questionnaire in a regular classroom setting. The questionnaire elicited information regarding the frequency of attendance at religious services, perceived strength of religious feelings, perception of God's view of sex, and participation in the following sexual behaviours: sexual intercourse (ever, last year and last month), giving oral sex (ever and last month), receiving oral sex (ever and last month), and anal sex (ever). Data were analysed using both univariate analysis (chi-square and analysis of variance) and logistic regression. Results indicated that religiosity variables, especially frequency of religious attendance and religious feelings, were significant predictors of sexual behaviour. Results should be considered by those working with college students in human sexuality.

Montgomery, Stewart, Yeary, Cornell,LeaVonne Pulley, Corwyn, Songth (2014) works on religiosity and sexual risk behavioursAmong African American Cocaine Users in

the Rural South. Racial and geographic disparities in human immunodeficiency virus (HIV) are dramatic and drug use is a significant contributor to HIV risk. Within the rural South, African Americans who use drugs are at extremely high risk. Due to the importance of religion within African American and rural Southern communities, it can be a key element of culturally targeted health promotion with these populations. Studies have examined religion's relationship with sexual risk behaviourin adolescent populations, but few have examined specific religious s and sexual risk behaviours among drug using African American adults. This study examined the relationship between well-defined dimensions of religion and specific sexual s among African Americans who use cocaine living in the rural southern United States.

Baseline data from a sexual risk behaviourreduction intervention for African Americans who use cocaine living in rural Arkansas (N = 205) were used to conduct bivariate and multivariate analyses examining the association between multiple sexual risk behaviourand key dimensions of religion including religious preference, private and public religious participation, religious coping, and God based, congregation based, and church leader based religious support.

After adjusting individualized network estimator weights based on the recruitment strategy, different dimensions of religion had inverse relationships with sexual risk behaviour, including church leadership support with number of unprotected vaginal/anal sexual encounter and positive religious coping with number of sexual partners and with total number of vaginal/anal sexual encounters. Results suggest that specific dimensions of religion may have protective effects on certain types of sexual behaviour, which may have important research implications.

Ofole, and Agokei (2014) work on risky sexual s among female in school adolescent in delta Nigeria: self-esteem, parental involvement and religiosity as predictors. The study adopts descriptive survey design of ex post type to examine extent to which self-esteem, parental involvement and religiosity predicted risky sexual behaviours among female in school adolescents in delta state, Nigeria. The result shows that self-esteem, parental involvement and religiosity have negative relationship with participant's risky sexual behaviour. The independent variables accounted for 30.3% of the variance in prediction of risky sexual. Self-esteem made the highest contribution to the prediction of risky sexual of adolescents while parental involvement made the least contribution. Also, the need for Programme designers, sexuality educators, and Counsellors to Incorporate these variables into activities to delay sexual debut by adolescents was implied from this outcome.

2.3.3 Vulnerability to HIV/AIDS and Sexual Risk Behaviour

Faimau, Maunganidze, Tapera, &Mosomane (2016) work on Knowledge of HIV/AIDS, attitudes towards sexual risk behaviourand perceived al control among college students in Botswana. The study examines the knowledge of HIV/AIDS, attitudes towards risky sexual behaviour and perceived behavioural control among students in Botswana. Data were collected from 445 students randomly selected from the University of Botswana and Boitekanelo College. Hundred and seventy-three males and 272 females participated in the study. The study established that although more than 90% of students correctly identified routes of HIV transmission, misconceptions regarding HIV/AIDS still exist. This includes the belief that people can be infected with HIV because of witchcraft and that only people who have sex with gay or homosexual partners can be infected with HIV. Majority of students were aware of various sexual risks. However, the percentage of students who indicated that "it is difficult to ask my partner to use a condom" was still relatively high (13.5%) based on the assumption that students are supposed to know the consequences of sexual risky

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behaviour. It was also found that male students were 3.48 times more likely to negotiate sex than their female counterparts (OR = 3.48, 95% CI: 1.09 − 11.13) and students who were 18 years and below were more likely to negotiate sex than students above 18 years of age (OR = 2.78, 95% CI: 1.42 − 18.32). Christians are four times less likely to negotiate sex compared to non-Christians (OR = 0.219, 95% CI: 0.095 − 0.506). More than 80% of students were comfortable discussing HIV or sex and sexuality with their friends, boyfriends/girlfriends or partners but uncomfortable discussing the same issues with their parents.

Yitayal, Abebe, Abate, Berihun, Etsegenet, and Amare (2014) works on Perception of risk of HIV and sexual risk behaviours among University students: implication for planning interventions. According to them the university environment offers great opportunity for HIV high-risk behaviours, including unsafe sex and multiple partnerships. Despite recently gained decline of the overall incidence of HIV infection, still significant proportion of youth population are at high risk of HIV infection. The aims of this study were to assess the perception of HIV risk and factors associated with risk perception among students at University of Gondar, Northwest Ethiopia. A cross sectional study was conducted between February and April 2012 among health science students. A total of 384 students were involved in the study using stratified sampling technique. Chi-square test and logistic regression analysis were employed. P-value < 0.05 was considered statistically significant for all cases. Of the total 384 participated students, 200(52.1%) were females. Out of the total study respondents, 202(52.6%) were sexually experienced. One hundred and nine (59.2%) out of 184 males and 93(46.5%) out of 200 females had had sexual experience. About 23(57.5%) of those age below 20 years, 70(52.2%) of 20-24 years old, and 13(61.9%) of those ages of 25 years or older were perceived themselves as if they have no chance of acquiring HIV infection. Students initiated sexual intercourse at early age (≤8 years) were significantly associated with having multiple partnerships (crude OR =3.6, p = 0.002 for male

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and crude OR = 1.7, p = 0.04 for female). Statistically significant difference was observed in the distribution of condom use during sexual intercourse among various age groups (p-value = 0.001). Sexual initiation at younger age, having multiple partnerships, inconsistent condom use, and alcohol and/or drug abuse were significantly perceived as predictor for an increased risk for HIV infection.

Students were engaged in various HIV risk behaviours. Early sexual initiation and alcohol and/or drug abuse were important factors for having multiple partnerships. Poor agreement between having HIV risk behaviours and perception of HIV risk were observed. Attention must be given on the role of alcohol and/or drug abuse in the participation of HIV risk behaviours in the design and implementation of HIV prevention for university students.

2.3.4 Gender and Sexual Risk Behaviour

Idoko, Sholarin, and Agoha, (2015) examined age, gender, religiosity and family factors on sexual attitude and of university of Ibadan undergraduate students. A sample of 360 respondents 182 males and 178 females participated in the study. Using a questionnaire, four hypotheses were tested using repression and Analysis of variance. It was found that age, gender religiosity, family type, parental care/protection and maternal career/protection jointly predicted, sexual depression, sexual preoccupation negatively maternal protection independently predicted sexual preoccupation negatively family type jointly predicted sexual depression positively. The study had some limitation. is was recommended that religious institution should brace up to their duty that parent be include in drawing up intervention program me aimed at reducing per-marital sex.

María C Mesa-Franco and InmaculadaGarcía-García (2014) work Gender-based differences in the high-risk sexual s of young people aged 15-29 in Melilla (Spain): a cross-

sectional study. Research confirms the existence of gender-based differences regarding the high-risk sexual (non-use of condoms and casual partners) of young men and women. The objectives were to provide evidence for this association; to analyse the reasons why both sexes have sexual relations with casual partners and to ascertain the motives for condom use or non-use during casual sex. A cross-sectional study was performed on a sample of 900 participants, 524 males and 376 females. All participants were 15-29 (20.93 ± 4.071) years of age and came from four different centres (a university, two secondary schools, and a military base) in Melilla (Spain). The participants were given a socio-demographic survey as well as a psychometric text on high-risk sexual. The results found gender-based significant differences for sexual relations with penetration ($p = 0.001$), number of sexual partners ($p = 0.001$), and sexual relations with casual partners ($p = 0.001$). In all of these variables, male participants had higher percentages than female participants. Reasons for having casual sexual relations were also different for men and women, differences were found for the items, opportunity ($p = 0.001$), interest in knowing the other person ($p = 0.015$), physical excitement ($p = 0.056$) and drug consumption ($p = 0.059$). Regarding the reasons for consistent condom use with casual partners, there were differences for the item, my demand of a condom ($p = 0.002$). For the non-use of condoms with casual partners, differences were found for the items, I do not like to use condoms ($p = 0.001$) and condoms lessen sensitivity and reduce pleasure ($p = 0.009$)

Men and women were found to have different high-risk sexual s and practices. Of the motives for having sexual relations with casual partners, male participants considered opportunity and interest in knowing the other person to be more important than the female participants. Regarding condom use, the female participants' demand to use a condom was a significant gender-based difference. In contrast to the young women, the male participants mostly justified not using a condom because it lessened sensitivity and reduced pleasure.

Odimegwu and Somefun (2017) work on ethnicity, gender and risky sexual among Nigerian youth: an alternative explanation.While studies in demography and public health have acknowledged the role of ethnic differences, the influence of ethnicity on youth sexual in Nigeria has received little or no attention. It is important to know how cultural norms and gender roles, which vary by ethnicity, may promote or prevent risky behaviours. Such information could provide insights into previously undetected sexualbehavior in multi-ethnic situations.

The Nigeria Demographic and Health Surveys (NDHS) for 2003, 2008 and 2013 were pooled to examine the relationship between ethnicity and youth sexual reproductive health, peroxide by age at sexual debut, multiple sexual partners (MSP) and condom use at last sexual activity, among the 6304 females and 1549 males who reported being sexually active in the four weeks preceding the survey. Multivariate analysis using a Cox proportional hazard regression model was used to determine the risk factors for early sexual activity among young people (15–24). Logistic regression was used to predict condom use at last sexual activity and MSP. The median age at first sexual activity was 16 for females and 17 for males. 43% of male youths used condoms in their last sexual activity, compared to only 16% among females and a higher number of males (81%) had multiple sexual partners compared to females (35%). For females, elevated risks of first sex was higher among Hausa/Fulanis aged 15–19 and elevated risk of first sex was higher among Yoruba males. This study provides further evidence that to promote protective sexual s among youth in Nigeria, social, cultural and gender-specific tactics should be put in place for the prevention of HIV and other STIs.

2.3 HYPOTHESIS

The researcher aimed to investigate the influence of sexting, religiosity, and perception of vulnerability to HIV/AIDS on sexual risk behaviour. The following hypotheses were tested:

1. Students who always receive sexually explicit pictures and messages from someone will significantly report higher sexual risk behaviourthan those who receive sexually explicit pictures and messages from someone most of the times, rarely or never.

2. Students who always send sexually explicit pictures and messages to someone will significantly report higher sexual risk behaviourthan those who send sexually explicit pictures and messages to someone most of the times, rarely or never

3. Students who are low in religiosity will significantly report higher sexual risk behaviourthan those who are high in religiosity.

4. Students who perceive themselves as low in vulnerability to HIV/AIDS will significantly report higher sexual risk behaviourthan those who perceive themselves as high in vulnerability to HIV/AIDS.

2.4 OPERATIONAL DEFINITION OF TERMS

Sexual Risk Behaviour: This is defined as a behaviour that increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies. It was measured using the 6-item Sexual risk behaviourdeveloped by Lawal (2013). High score on the scale indicates higher sexual risk, while low score indicates lower sexual risk behaviour.

Sexting: This is defined as sending or receiving, sexually explicit messages, photographs or images, primarily between mobile phones. This was measured using two different questions

requesting whether the respondent sends or receives sexually explicit pictures and messages to and from someone by indicating always, most of the times, rarely or never.

Religiosity: This is defined as how dutiful an individual is to his/her religion, or how religious an individual is. It was measured using 14-item Religiosity scale developed byAllport and Ross (1967). High score indicates higher level of religiosity, while low score indicates lower religiosity.

Perception of vulnerability to HIV/AIDS: This is defined as how people perceive themselves to be vulnerable to contracting HIV/AIDS. It was measured using 7-item Perceived Vulnerability to HIV/AIDS adapted from the work of Koopman and Reid (1998). High score indicates higher perception of vulnerability to HIV/AIDS, while lower score indicates lower perception of vulnerability.

Gender: This is an indication on the questionnaire showing whether the student is male or female.

CHAPTER THREE

METHOD

3.1 RESEARCH DESIGN

The researcher adopted the use of ex-post facto research design because none of the variable of the study was subjected to active manipulation; rather they were measure are they occurred. The independent variables are sexting, religiosity and perception of vulnerability to HIV/AIDS. The dependent variable is sexual risk behaviour.

3.2 SETTINGS AND PARTICIPANTS

The study was carried out among undergraduate student of Ekiti State University in Ekiti state. The participants were 313 (158 males, 155 female) with range from 15 to 35 years and mean age of 21.47 years (SD = 2.436), 61 (19.5%) were from 100 level 79 (25.2%) were from 200 level, 115 (36.7%) were from 300 level 48 (15.3%) were from 400level and 10 (3.2%) were from 500 level.

In terms of faculty, 101 (32.3%) were from Social science, 50 (16.0%) were from education, 49 (15.7%) were from Sciences, 28 (8.9%) were from Agriculture, 37 (11.8%) were from Engineering, 37 (11.8%) were from Art and 23 (7.3%) were from Management Science. Regarding religious affiliation, 247 (78.9%) were Christians, 56 (17.9%) were Muslims and 10 (3.2%) were other religions.

Two hundred and sixty-eight (85.6%) stays off campus, 45 (14.4%) stays on campus. Regarding nature of resident while in school, 50 (16.0%) stays with relatives, 127 (40.6%) stays with same-sex friends, 13 (4.2%) stays with parents, 14 (4.5%) stays with opposite sex friends while 109 (34.8%) stays alone. Two hundred and eighty-seven (91.7%) own a cell

phone, 13 (4.2%) share a cell phone with friends, 8 (2.6%) borrow a cell phone from friends and 5 (1.6%) do not own a cell phone.

In term of function of cell phone, 233 (74.4%) uses cell phone to make call, has internet, receives and sends messages/pictures and 80 (25.6%) uses cell phones only to calls, send and receive messages. Sixteen (5.1%) Never use cell phones to receive calls, 61 (19.5%) rarely uses cell phones to receive calls, 125 (39.9%) uses cell phones most of the time to receive calls and 111 (35.5%) uses cell phones to receive calls always. Seven (2.2%) never send sexual explicit messages, 38 (12.1%) rarely send sexual explicit messages, 105 (33.5%) most of the times send sexual explicit messages and 163 (52.1%) always send sexual explicit messages.

3.3   INSTRUMENT

A questionnaire was used to collect data from the field in this present study. The questionnaire was design in sections comprising of standardized scales as follows:

Section A: This section comprises of the demographiccharacteristics of the undergraduate students, such as Sex, Age, level of study, faculty, religious affiliation, residence while in school, and nature resident.

Section B: This section consists of 4 questions ask to know if the participant have access to internet and to know how often the individual the individual receive or send explicit messages or pictures to someone.

Section C: This section measures Perception of Vulnerability to HIV/AIDS using the 7-item scale adapted from Koopmanand Reid (1998). The scale is in 5-point Likert response format ranging from strongly disagree (scored 1) to strongly agree (scored 5). High score on the

scale indicates higher perception of vulnerability to HIV/AIDS, while low score indicates lower perception of vulnerability to HIV/AIDS. Lawal and Olley (2017) reported a reliability coefficient of 0.59 for the scale in their study. In the current study, the researcher reported a Cronbach's alpha reliability coefficient of 0.94.

Section D: This section measures religiosity using the 14-item scale of religiosity developed by Allport and Ross (1967). The scale is in 5-point Likert response format ranging from strongly disagree (scored 1) to strongly agree (scored 5). High score on the scale indicates higher level of religiosity, while low score indicates lower level of religiosity. The developers of the scale reported reliability coefficient of 0.86 for the scale in their study. In the current study, the researcher reported a Cronbach's alpha reliability coefficient of 0.84.

Section E: This section measures sexual risk behaviourscale developed by Lawal (2013) comprising 6 items. The scale is in 5-point Likert response format ranging from strongly disagree (scored 1) to strongly agree (scored 5). High score on the scale indicates higher sexual risk behaviour, while low score indicates lower sexual risk.Lawal (2013) reported a reliability coefficient of 0.85. In the current study, the researcher reported a Cronbach's alpha reliability coefficient of 0.90.

3.4   PROCEDURE

The researcher used convenient sampling techniques to administer the questionnaire to the 350 participants; the questionnaire was administered to the available undergraduate students Ekiti state University to get data from them and was collected after responding to the tests items. Out of the 350 questionnaires that was administer only 325 were returned, but only 313 was found properly filled were taken for data analyses in this study.

3.5   STATISTICALMETHODS

The demographic data collected were analysed using descriptive statistics such as means, range, standard deviation, frequency distribution and percentages. Hypothesis stated were anlysed using inferential statistics. Hypotheses one and two were tested using one-way Analysis of Variance (ANOVA). Hypotheses three and four were tested with t-test for independent groups to compare and establish group differences.

CHAPTER FOUR

RESULTS

Hypothesis one stated that students who always received sexually explicit pictures and messages to someone would significantly report higher sexual risk behaviourthan those who received sexually explicit pictures and messages to someone most of the times, rarely or never. The result is presented in Table 4.1

Table 4.1 Summary of One-Way ANOVA Table showing influence of extent of receiving sexual explicit picture/messages on sexual risk behaviour

Source	Sum of Squares	Df	Mean Square	F	P
Between Groups	755.656	3	251.885	6.411	<.05
Within Groups	12141.341	309	39.292		
Total	12896.997	312			

From Table 4.1,the one-way ANOVA results shows that extent of receiving sexually explicit pictures and messages influenced sexual risk behaviour among student'sF (3, 309) = 6.411; p <.05. Specifically, undergraduate students who always (X = 25.75) received sexually explicit pictures and messages reported higher sexual risk behaviourthan those who received most of the times (X = 23.86), rarely (X = 21.49) and never (X = 22.62) respectively. Therefore, hypotheses one was confirmed.

Hypothesis two stated that students who always send sexually explicit pictures and messages from someone would significantly report higher sexual risk behaviourthan those who send sexually explicit pictures and messages from someone most of the times, rarely or never. The hypothesis was tested using one-way analysis of variance. The result is presented in Table 4.2

Table 4.2 Summary of One-Way ANOVA Table showing influence of extent of sending sexual explicit picture/messages on sexual risk behaviour

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1004.669	3	334.890	8.701	<.05
Within Groups	11892.328	309	38.486		
Total	12896.997	312			

From Table 4.2, the one-way ANOVA results shows that extent of sending sexually explicit pictures and messages influenced sexual risk behaviour among students' F (3, 309) = 8.701; p <.05. Specifically, undergraduate students who always (X = 25.30) sent sexually explicit pictures and messages reported higher sexual risk behaviour than those who sent most of the times (X = 23.61), rarely (X = 19.68) and never (X = 23.14) respectively. Therefore, hypotheses two was confirmed.

Hypothesis three stated that students who were low in religiosity would significantly report higher sexual risk behaviourthan those who were high in religiosity. The hypothesis was tested using t-test for independent groups. The result is presented in Table 4.3.

Table 4.3: t-test for independent group showing influence of religiosity on sexual risk behaviour

	Religiosity	N	Mean	SD	df	T	P
SRB	High	158	22.8481	7.1045	311	-3.258	<.01
	Low	155	25.1806	5.4338			

From Table 4.3, the result of the t-test shows that undergraduate student low in religiosity (X = 25.1806)significantly reported higher sexual risk behaviour than those high in religiosity (X = 22.8481), t = -3.258; df = 311, p <.01. The result implies that religiosity significantly influenced sexual risk behaviour among undergraduate students. Therefore, hypothesis three was confirmed.

Hypotheses four stated that students who perceived themselves as low in vulnerability to HIV/AIDS would significantly report higher sexual risk behaviour than those who perceived themselves as high in vulnerability to HIV/AIDS. The hypothesis was tested using t-test for independent. The result is presented in table 4.4.

Table 4.4: t-test for independent group showing influence of perceived Vulnerability to HIV/AIDS on sexual risk behaviour

Vulnerabilityto HIV/AIDS		N	Mean	SD	Df	T	P
SRB Low	High	113 200	20.5487 25.9550	6.73609 5.35409	311	-7.801	<.01

From Table 4.4, the result of the t-test shows that undergraduate student with low vulnerability to HIV/AIDS (X = 25.9550) significantly scored higher in sexual risk behaviourthan those with high vulnerability to HIV/AIDS (X = 20.5487), t = -7.801; df = 311, p <.01. The results imply that vulnerability HIV/AIDS significantly influenced sexual risk behaviouramong undergraduate students. Therefore, hypothesis three was confirmed.

CHAPTER FIVE

DISCUSSION, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

5.1 DISCUSSION

The aim of this study is to examine the influence of sexting, religiosity and perception of vulnerability to HIV/AIDS on sexual risk behaviour through the testing of four hypotheses, result shows that all the hypotheses are accepted.Hypothesis one stated that students who always received sexually explicit pictures and messages to someone would significantly report higher sexual risk behaviour than those who received sexually explicit pictures and messages to someone most of the times, rarely or never, one-way ANOVA statistical analysis was used to test the hypothesis and the hypothesis was confirmed. Specifically, undergraduate students who always received sexually explicit pictures and messages reported higher sexual risk behaviourthan those who received most of the times, rarely and never respectively. This was similar to the report by Benotsch et al (2012) which focused on the public health implications of sexting by examining association between sexting, substance use and sexual risk behaviour in youth. The results show that sexting was associated with high risk sexual behaviour. Also, Houck et al (2014) study on sexting and sexual behaviour in at-risk adolescents reported similar result to the findings of this study. Houck et al (2014) result show that sexting of any kind was associated with higher rates of engaging in a variety of sexual behaviours, and sending photos was associated with higher rates of sexual activity than sending text messages only.

Hypothesis two stated that students who always send sexually explicit pictures and messages from someone would significantly report higher sexual risk behaviour than those who send sexually explicit pictures and messages from someone most of the times, rarely or never. one-way ANOVA statistical analysis was used to test the hypothesis and the hypothesis was confirmed. Specifically, undergraduate students who always sent sexually

explicit pictures and messages reported higher sexual risk behaviourthan those who sent most of the times, rarely and never respectively. Asatsa et al (2017) found similar result on their study on cell -phone sexting and its influence on adolescence sexual behaviour. The result from their findings show high prevalence of masturbation, pornography, multiple sex partners and frequent sexual intercourse among adolescents who engage in sexting. Obakeng et al (2017) study on sexting and risky sexual behaviour among undergraduate results also show that sexting was associated with an increase in the number of sexual partners and with sex under the influence of drug and alcohol.

Hypothesis three stated that students who were low in religiosity would significantly report higher sexual risk behaviour than those who were high in religiosity. t-test for independent groups and the hypothesis was confirmed. This finding is supported by some other results by other researcher such as Haglund and Fehring (2009) works on the association of religiosity, sexual education, and parental factors with risky sexual behaviour among adolescent and young adults. The result from the study show that those who viewed religion as very important, had frequent church attendance, and held religious sexual attitudes were 27–54% less likely to have had sex and had significantly fewer sex partners than peers while Participants whose formal and parental sexual education included abstinence and those from two-parent families were 15% less likely to have had sex and had fewer partners. Also, Tina et., al study on works on the Impact of Religiosity on the sexual behaviours of College Students, result from this study indicated that religiosity variables, especially frequency of religious attendance and religious feelings, were significant predictors of sexual behaviour. Montgomery et. al., (2014) study on religiosity and sexual risk behaviours Among African American Cocaine Users in the Rural South show partial similar result with the finding of this study. Result show that religiosity have influence on sexual risk behaviour. Result from the study by Ofole, and Agokei (2014) on risky sexual behaviour among female in school

adolescent in delta Nigeria: self-esteem, parental involvement and religiosity as predictors. The result show that religiosity predict risk sexual behaviour.

Hypotheses four stated that students who perceived themselves as low in vulnerability to HIV/AIDS would significantly report higher sexual risk behaviour than those who perceived themselves as high in vulnerability to HIV/AIDS and the finding was confirmed. This finding is similar to some of the result by other researchers such as Yitayal et al (2014), the result show that Out of the total study respondents, 202(52.6%) were sexually experienced. One hundred and nine (59.2%) out of 184 males and 93(46.5%) out of 200 females had had sexual experience. About 23(57.5%) of those age below 20 years, 70(52.2%) of 20-24 years old, and 13(61.9%) of those ages of 25 years or older were perceived themselves as if they have no chance of acquiring HIV infection. Students initiated sexual intercourse at early age (≤8 years) were significantly associated with having multiple partnerships (crude OR =3.6, p = 0.002 for male and crude OR = 1.7, p = 0.04 for female).

5.2 CONCLUSION

The result of the study revealed the following

1. Receiving sexually explicit pictures and messages from someone always significantly influence sexual risk behaviour among students than those that who receive sexually explicit pictures and messages from someone most of the times, rarely or never.

2. Sending sexually explicit pictures and messages to someone always significantly sexual risk behaviour among undergraduate students than those who send sexual explicit pictures or messages most of the times, rarely or never.

3. Undergraduate Students low in religiosity significantly engage in sexual risk behaviour than those high in religiosity.

4. Undergraduate students low in vulnerability to HIV/AIDS significantly engage in sexual risk behaviour than those high on vulnerability to HIV/AIDS.

5.3 IMPLICATIONS

The implication of this study is that sexual risk behaviour is still a prevalence social and health problem in institution of higher learning in Nigeria. This behaviour is engaged in by both male and female, just that male is more likely to involve in sexual risk behaviour than female. If solution is provided to solve this problem among undergraduate students, it will continue to grow which will be risk factor to the future of this country. Sexualrisk behaviour could lead to so many things such as, unwanted pregnancy: according to the report by national centre for biotechnology information (2012) an estimated 1.25 million induced abortions occurred in Nigeria in 2012, equivalent to a rate of 33 abortions per 1000 women aged 15 – 49. The estimated unintended pregnancy was 59 per 1000 woman. This is because due to the rate of sexual risk behaviour among undergraduate student, behaviour which is assumes likely to continue after they finish school.

5.4 RECOMMENDATIONS

With the report of the study, it is advisable that health sector in both Higher institution and Nigeria should look for way in educating student more on what the result of sexual risk behaviour are, this could be done through seminar. This seminar should be a continue things which will help to serve as a reminder to everyone whenever they are about to engage in sexual risk behaviour. Also, parent should also train their children in the way of God, result from this student show that religiosity influence sexual risk behaviour. So, parent to endeavour to teach and let their children known the difference between right and left.

5.5 LIMITATIONS

A few limitations in this study had been identified. Firstly, it would have been beneficial if the sample size was bigger, as only undergraduate student of EKSU was used, however the response was not very satisfactory, and a bigger and diversified sample could have resulted in a very rich study. It cannot be claimed that the selected sample is representative of the target population because of the non-probability sampling procedure that was used to choose the sample.

The second limitation is with the topic sexual risk behaviour, many respondent refuse to disclose their attitude toward sexual risk behaviour because as some can view these constructs as sensitive meaning that the answering of certain questions or statements could make some respondents feel a sense of discomfort. It has been clearly highlighted in the consent section of the questionnaire that all the responses of each candidate will be dealt with highest confidential or anonymous manner. This uncertainty can cause respondents to be concerned about the potential negative consequences of answering certain questions.

Another limitation of the study was that some respondents also collect questionnaires but refused to return them on time, thereby causing some delay in the date collection.

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APPENDIX

Frequencies

Statistics

	SEX	Level Of Study	FACULTY	RELIGION	Residence While In School	Nature Of Residence While In School	Access To Phone	Function Of Cellphone	Receiving Calls	Send Sexual Explicit Messages
N Valid	313	313	313	313	313	313	313	313	313	313
Missing	0	0	0	0	0	0	0	0	0	0

Frequency Table

SEX

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	158	50.5	50.5	50.5
	Female	155	49.5	49.5	100.0
	Total	313	100.0	100.0	

LevelOfStudy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	100 Level	61	19.5	19.5	19.5
	200 Level	79	25.2	25.2	44.7
	300 Level	115	36.7	36.7	81.5
	400 Level	48	15.3	15.3	96.8
	500 Level	10	3.2	3.2	100.0
	Total	313	100.0	100.0	

FACULTY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Social Sciences	101	32.3	32.3	32.3
	Education	50	16.0	16.0	48.2
	Sciences	49	15.7	15.7	63.9
	Agriculture	28	8.9	8.9	72.8
	Engineering	25	8.0	8.0	80.8
	Arts	37	11.8	11.8	92.7
	Management Sciences	23	7.3	7.3	100.0
	Total	313	100.0	100.0	

RELIGION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christianity	247	78.9	78.9	78.9
	Islam	56	17.9	17.9	96.8
	Other Religion	10	3.2	3.2	100.0
	Total	313	100.0	100.0	

RecidenceWhileInSchool

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Off Campus	268	85.6	35.6	85.6
	On Campus	45	14.4	14.4	100.0
	Total	313	100.0	100.0	

1

NatureOfResidenceWhileInSchool

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I stay with Relatives	50	16.0	16.0	16.0
	I stay with same-sex friends	127	40.6	40.6	56.5
	I stay with my Parents	13	4.2	4.2	60.7
	I stay with Opposite Sex Friends	14	4.5	4.5	65.2
	Staying Alone	109	34.8	34.8	100.0
	Total	313	100.0	100.0	

AccessToPhone

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	I own a Cellphone	287	91.7	91.7	91.7
	I share a Cellphone with Friends	13	4.2	4.2	95.8
	I borrow a Cellphone from Friends	8	2.6	2.6	98.4
	I do not own a Cellphone	5	1.6	1.6	100.0
	Total	313	100.0	100.0	

FunctionOfCellphone

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	The Cellphone I use makes call, has internet, receives and sends messages/pictures	233	74.4	74.4	74.4
	The Cellphone I use only calls, send and receive messages	80	25.6	25.6	100.0
	Total	313	100.0	100.0	

ReceivingCalls

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	16	5.1	5.1	5.1
	Rarely	61	19.5	19.5	24.6
	Most of the Times	125	39.9	39.9	64.5
	Always	111	35.5	35.5	100.0
	Total	313	100.0	100.0	

SendSexualExplicitMessages

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	7	2.2	2.2	2.2
	Rarely	38	12.1	12.1	14.4
	Most of the Times	105	33.5	33.5	47.9
	Always	163	52.1	52.1	100.0
	Total	313	100.0	100.0	

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
AGE	313	15	35	21.47	2.436
Valid N (listwise)	313				

2

Reliability for Perceived Vulnerability to HIV/AIDS

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	313	100.0
	Excluded[a]	0	.0
	Total	313	100.0

a. Listwise deletion based on all variables in the procedure

Reliability Statistics

Cronbach's Alpha	N of Items
.942	7

Item Statistics

	Mean	Std. Deviation	N
SEX1	1.79	1.313	313
SEX2	1.81	1.228	313
SEX3	2.17	1.312	313
SEX4	1.72	1.159	313
SEX5	1.86	1.205	313
SEX6	1.84	1.205	313
SEX7	1.79	1.188	313

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
SEX1	11.19	39.476	.835	.930
SEX2	11.17	40.118	.858	.928
SEX3	10.81	41.309	.708	.942
SEX4	11.26	40.801	.867	.927
SEX5	11.12	40.701	.834	.930
SEX6	11.14	41.944	.742	.938
SEX7	11.19	41.130	.816	.932

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
12.98	54.974	7.414	7

Reliability for Religiosity Scale

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	312	99.7
	Excluded[a]	1	.3
	Total	313	100.0

a. Listwise deletion based on all variables in the procedure

Reliability Statistics

Cronbach's Alpha	N of Items
.839	14

3

Item Statistics

	Mean	Std. Deviation	N
REL1	4.16	1.014	312
REL2	4.12	1.004	312
REL3	4.10	.955	312
REL4	3.64	1.322	312
REL5	3.80	1.116	312
REL6	4.00	1.047	312
REL7	2.54	1.341	312
REL8	2.44	1.328	312
REL9	3.19	1.211	312
REL10	2.63	1.328	312
REL11	3.43	1.258	312
REL12	3.90	1.120	312
REL13	3.78	1.139	312
REL14	3.58	1.298	312

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
REL1	45.15	80.566	.405	.833
REL2	45.19	80.655	.405	.833
REL3	45.21	80.090	.466	.830
REL4	45.67	75.109	.528	.825
REL5	45.51	76.514	.574	.823
REL6	45.31	78.670	.495	.828
REL7	46.78	75.757	.489	.828
REL8	46.87	76.511	.460	.830
REL9	46.12	76.677	.510	.826
REL10	46.68	75.183	.522	.826
REL11	45.88	76.482	.495	.827
REL12	45.41	78.654	.456	.830
REL13	45.53	79.568	.399	.833
REL14	45.73	76.826	.459	.830

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
49.31	88.967	9.432	14

Reliability for Sexual Risk Behaviour Scale

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	313	100.0
	Excluded[a]	0	.0
	Total	313	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.897	6

Item Statistics

	Mean	Std. Deviation	N
SB1	4.13	1.314	313
SB2	4.22	1.154	313
SB3	3.93	1.402	313
SB4	3.95	1.347	313
S35	3.62	1.454	313
SB6	4.15	1.220	313

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
SB1	19.88	28.802	.766	.872
SB2	19.79	31.316	.673	.886
SE3	20.07	27.399	.815	.863
SB4	20.05	28.170	.794	.867
SB5	20.38	28.929	.658	.890
SB6	19.85	31.173	.637	.891

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
24.00	41.337	6.429	6

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
AGE	21.47	2.436	313
LevelOfStudy	2.58	1.066	313
ReceivingCalls	3.06	.868	313
SendSexualExplicitMessages	3.35	.780	313
VulnerabilityHIVAIDS	12.9808	7.41444	313
Religiosity	49.2907	9.42388	313
SexualRiskBehaviour	24.0032	6.42935	313

Correlations

		AGE	LevelOfStudy	ReceivingCalls	SendSexualExplicitMessages	VulnerabilityHIVAIDS	Religiosity	SexualRiskBehaviour
AGE	Pearson Correlation	1	.456**	-.145*	-.152**	.202**	-.007	-.258**
	Sig. (2-tailed)		.000	.010	.007	.000	.905	.000
	N	313	313	313	313	313	313	313
LevelOfStudy	Pearson Correlation	.456**	1	-.192**	-.092	.033	-.048	-.074
	Sig. (2-tailed)	.000		.001	.105	.565	.398	.191
	N	313	313	313	313	313	313	313
ReceivingCalls	Pearson Correlation	-.145*	-.192**	1	.571**	-.192**	.146**	.225**
	Sig. (2-tailed)	.010	.001		.000	.001	.010	.000
	N	313	313	313	313	313	313	313
SendSexualExplicitMessages	Pearson Correlation	-.152**	-.092	.571**	1	-.400**	.114*	.248**
	Sig. (2-tailed)	.007	.105	.000		.000	.044	.000
	N	313	313	313	313	313	313	313
VulnerabilityHIVAIDS	Pearson Correlation	.202**	.033	-.192**	-.400**	1	-.069	-.472**
	Sig. (2-tailed)	.000	.565	.001	.000		.226	.000
	N	313	313	313	313	313	313	313
Religiosity	Pearson Correlation	-.007	-.048	.146**	.114*	-.069	1	-.243**
	Sig. (2-tailed)	.905	.398	.010	.044	.226		.000
	N	313	313	313	313	313	313	313
SexualRiskBehaviour	Pearson Correlation	-.258**	-.074	.225**	.248**	-.472**	-.243**	1
	Sig. (2-tailed)	.000	.191	.000	.000	.000	.000	
	N	313	313	313	313	313	313	313

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

One-way ANOVA for Hypothesis One

Descriptives

SexualRiskBehaviour

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Never	16	22.6250	6.30212	1.57553	19.2668	25.9832	12.00	30.00
Rarely	61	21.4918	7.41984	.95001	19.5915	23.3921	7.00	30.00
Most of the Times	125	23.8560	6.23039	.55726	22.7530	24.9590	8.00	30.00
Always	111	25.7477	5.58320	.52993	24.6975	26.7980	6.00	30.00
Total	313	24.0032	6.42935	.36341	23.2882	24.7182	6.00	30.00

ANOVA

SexualRiskBehaviour

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	755.656	3	251.885	6.411	.000
Within Groups	12141.341	309	39.292		
Total	12896.997	312			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: SexualRiskBehaviour
LSD

(I) ReceivingCalls	(J) ReceivingCalls	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Never	Rarely	1.13320	1.76066	.520	-2.3312	4.5976
	Most of the Times	-1.23100	1.66437	.460	-4.5059	2.0439
	Always	-3.12275	1.67623	.063	-6.4210	.1755
Rarely	Never	-1.13320	1.76066	.520	-4.5976	2.3312
	Most of the Times	-2.36420*	.97902	.016	-4.2906	-.4378
	Always	-4.25594*	.99906	.000	-6.2218	-2.2901
Most of the Times	Never	1.23100	1.66437	.460	-2.0439	4.5059
	Rarely	2.36420*	.97902	.016	.4378	4.2906
	Always	-1.89175*	.81751	.021	-3.5003	-.2832
Always	Never	3.12275	1.67623	.063	-.1755	6.4210
	Rarely	4.25594*	.99906	.000	2.2901	6.2218
	Most of the Times	1.89175*	.81751	.021	.2832	3.5003

*. The mean difference is significant at the 0.05 level.

One-way ANOVA for Hypothesis Two

Descriptives

SexualRiskBehaviour

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Never	7	23.1429	6.98638	2.64060	16.6815	29.6042	12.00	30.00
Rarely	38	19.6842	7.00620	1.13655	17.3813	21.9871	7.00	30.00
Most of the Times	105	23.6095	6.27341	.61222	22.3955	24.8236	9.00	30.00
Always	163	25.3006	5.92665	.46421	24.3839	26.2173	6.00	30.00
Total	313	24.0032	6.42935	.36341	23.2882	24.7182	6.00	30.00

ANOVA

SexualRiskBehaviour

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1004.669	3	334.890	8.701	.000
Within Groups	11892.328	309	38.486		
Total	12896.997	312			

Post Hoc Tests

Multiple Comparisons

Dependent Variable: SexualRiskBehaviour
LSD

(I) SendSexualExplicitMessages	(J) SendSexualExplicitMessages	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Never	Rarely	3.45865	2.55164	.176	-1.5621	8.4794
	Most of the Times	-.46667	2.42170	.847	-5.2318	4.2984
	Always	-2.15776	2.39462	.368	-6.8696	2.5541
Rarely	Never	-3.45865	2.55164	.176	-8.4794	1.5621
	Most of the Times	-3.92531*	1.17445	.001	-6.2363	-1.6144
	Always	-5.61640*	1.11755	.000	-7.8154	-3.4174
Most of the Times	Never	.46667	2.42170	.847	-4.2984	5.2318
	Rarely	3.92531*	1.17445	.001	1.6144	6.2363
	Always	-1.69109*	.77631	.030	-3.2186	-.1636
Always	Never	2.15776	2.39462	.368	-2.5541	6.8696
	Rarely	5.61640*	1.11755	.000	3.4174	7.8154
	Most of the Times	1.69109*	.77631	.030	.1636	3.2186

*. The mean difference is significant at the 0.05 level.

T-Test for Hypothesis Three

Group Statistics

	VulnerabilityHIVAIDS	N	Mean	Std. Deviation	Std. Error Mean
SexualRiskBehaviour	High	113	20.5487	6.73609	.63368
	Low	200	25.9550	5.35409	.37859

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means							
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Sexual Risk Behaviour	Equal variances assumed	18.264	.000	-7.801	311	.000	-5.40633	.69307	-6.77003	-4.04262
	Equal variances not assumed			-7.324	192.428	.000	-5.40633	.73816	-6.86225	-3.95041

T-Test for Hypothesis Four

Group Statistics

	Religiosity	N	Mean	Std. Deviation	Std. Error Mean
SexualRiskBehaviour	High	158	22.8481	7.10448	.56520
	Low	155	25.1806	5.43375	.43645

8

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means							
		F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference		
									Lower	Upper	
Sexual Risk Behaviour	Equal variances assumed	23.045	.000	-3.258	311	.001	-2.33254	.71590	-3.74117	-.92392	
	Equal variances not assumed			-3.266	293.624	.001	-2.33254	.71410	-3.73795	-.92714	

T-Test

Group Statistics

	SEX	N	Mean	Std. Deviation	Std. Error Mean
SexualRiskBehaviour	Male	158	22.8861	6.68011	.53144
	Female	155	25.1419	5.97227	.47970

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means							
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference		
									Lower	Upper	
Sexual Risk Behaviour	Equal variances assumed	7.775	.006	-3.148	311	.002	-2.25586	.71669	-3.66604	-.84568	
	Equal variances not assumed			-3.151	308.366	.002	-2.25586	.71592	-3.66457	-.84715	

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DEPARTMENT OF PSYCHOLOGY
FACULTY OF SOCIAL SCIENCES
FEDERAL UNIVERSITY OYE-EKITI

Dear respondent,
This questionnaire is designed to obtaining information on questions raised. Your HONEST and CORRECT responses are essential for this exercise to be successful. The information you give is strictly for research purpose only, and therefore will be given utmost confidentiality. Thank you.

SECTION A
DEMONGRAPHIC INFORMATION

Age: ....

Institution...

Sex: Male (   ) Female (   )

Level of Study: 100 (   ) 200 (   ) 300 (   ) 400 (   ) 500 (   )

Faculty: Social Sciences (   ) Education (   ) Sciences (   ) Agriculture (   )   Engineering (   )
        Arts (   ) Management Sciences (   )

Religious Affiliation: Christianity (   ) Islam (   ) Other Religion (   )

Residence while In School: Off Campus (   ) On Campus (   )

Nature of Residence While In School:
I stay with relatives (   ) I stay with same-sex friends (   ) I stay with my parents (   )
I stay with opposite sex friends (   ) Staying Alone (   )

SECTION B: Kindly tick on the bracket in front of the option that best applies to you sincerely
1. Access to Cell Phone:
I own a cell phone (   ) I share a cell phone with friends (   )
I borrow a cell phone from friends (   ) I do not own a cell phone (   )
2. Functions of Cell Phone:
The phone I use make calls, has internet, receive and send messages/pictures (   )
The phone I use only calls, send and receive messages (   )
3. How often do you receive sexual explicit messages or pictures from someone?
Always (   ) Most of the times (   ) Rarely (   ) Never (   )
4. How often do you send sexual explicit messages or pictures to someone?
Always (   ) Most of the times (   ) Rarely (   ) Never (   )

SECTION C: Kindly tick on the best option that explains the extent to which you agree or disagree with each of the statements by using Strongly Disagree (SD), Disagree (D), Undecided (U), Agree (A) and (Strongly Agree).

S/N	Item	SA	A	U	D	SD
1.	There is a good chance I will get HIV/AIDS during the next 5 years					
2.	I am at risk for HIV/AIDS.					
3.	My friends are at high risk for HIV/AIDS.					
4.	There is a possibility that I have HIV/AIDS					