SEXUAL AND REPRODUCTIVE HEALTH PRACTICES AMONG IN-SCHOOL FEMALE ADOLESCENTS IN IDEMILI NORTH LOCAL GOVERNMENT AREA, ANAMBRA STATE

OLISA, UJUNWA UCHENNA

PG/M.Sc/16/81843

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION

FACULTY OF EDUCATION

UNIVERSITY OF NIGERIA, NSUKKA

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Title Page

Sexual and Reproductive Health Practices among In-School Female Adolescents in Idemili North Local Government Area, Anambra State

By

Olisa, Ujunwa Uchenna

PG/M.Sc16/81843

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Approval Page

This project has been approved for the Department of Human Kinetics and Health Education, University of Nigeria, Nsukka.

By

_____
Dr. (Mrs). E. N. Nwagu
Supervisor

Date_____

_____
Dr. C. U. Ugwu
Internal Examiner

Date_____

_____
Prof. J.O. Okafor
External Examiner

Date _____

_____
Prof. J. E. Umeifekwe (JP)
Head of Department

Date _____

_____
Prof. D. U. Ngwoke
Dean, Faculty of Education

Date_____

Certification

Olisa, Ujunwa Uchenna a postgraduate student in the Department of Human Kinetics and Health Education with registration number: PG/M.Sc/16/81843, has satisfactorily completed the requirements for the degree of Master of Science (M.Sc) in Public Health Education. The research work embodied in this project is original and has not been submitted part or in full for any diploma or degree of this or any other University.

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Olisa, Ujunwa Uchenna
(Student)

Date: _____

Dedication

This project is dedicated to my family members.

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Olisa, Ujunwa Uchenna

Researcher

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Abstract

The purpose of the study was to determine sexual reproductive health practices among in-school female adolescents in Idemili North LGA, Anambra State. Eight specific objectives with eight corresponding research questions and six null hypotheses guided the study. The study utilized descriptive survey research design. The population for the study was all the in-school female adolescent numbering 6,021. A sample of 400 students was used for the study. The instrument for data collection was 15-item structured questionnaire on SRH practices. Ten items on the questionnaire were on safe and unsafe sex practices and 5 were on contraceptives use of sexual and reproductive health practices of adolescent. Frequency and percentages were employed to analyze research questions. Chi-square statistics was used to test the null hypotheses. Findings showed that in-school female adolescents 36.6 per cent engaged in safe sex practices and 25.7 per cent engaged in unsafe sex practices. Also 12.0 per cent of in-school female adolescent used contraceptives. There was a significant difference in the proportion of in-school female adolescent that engaged in safe sex and unsafe sex based on age ($p<.05$) and no significant difference existed in the proportion of in-school female adolescent that used contraceptives ($p>.05$). There were significant differences in the proportion of in-school female adolescents that engaged in safe sex and unsafe sex practices based on class and religion ($p>.05$). There was a significant difference in the proportion of in-school female adolescents that used contraceptives based on age and class ($p<.05$). Based on these findings, it was recommended that there was need for government, school authorities and Anambra State Secondary Education Board to expand and intensify sex education for in-school female adolescent.

CHAPTER ONE

Introduction

Background to the Study

The Globe is inundated with expressions of increasing concerns about a world under treat of diseases, especially sexually transmitted infections (STIs) and unplanned pregnancies through sexual and reproductive health (SRH) practices. Sexual and reproductive health practices of adolescent have been an important topic recently due to its impact on the group involved and the society at large. It came to the fore against the background of the worldwide increasing trend in the rates of liberal sexual behaviour and activity, with its attendant reproductive health implications and sequence. A significant number of adolescent girls around the globe are sexually active and this proportion increases steadily from mid to late adolescence (Chandra-Mouli, Mccarraher, Phillips, Williamson, & Hairsworth, 2014). Nearly a quarter of girls aged 15-19 years are married with an estimated 16 million adolescents giving birth each year globally (United Nation [UN], 2015). Almost half of the women aged 20-24 years in Asia and African are married by age 18 years, putting them at a higher risk for early pregnancy, repeated pregnancies, maternal disability and death (Williamson, 2013; World Health Organization [WHO], 2015). The rate at which adolescent girls grow and make decision related to sexual and reproductive health is becoming more frequent than ever before. Today's adolescent girls are being bombarded with erotic stimuli and messages through movies, music, novels and magazines (Ngwu, 2012). There is increases in the growth rate of adolescent around the globe.

Population of the adolescent is on the increase. Half of the world's population is younger than 25 years old and 9 out of 10 young people live in developing countries (WHO, 2014). These young people face profound challenges such as higher rates of early marriages, unintended pregnancy, HIV and other sexually transmitted infections, maternal mortality and` morbidity. In sub-saharah Africa, adolescents and young adults ages 10-24 are faced with high level of unintended pregnancy and a disproportionately high HIV burden and this is particularly among adolescent girls (Population Council, 2016). Adolescent girls are at a higher risk of practicing unsafe sex. They also bear the brunt of the consequences. It is estimated that nearly two-third of premature deaths and one third of the total disease burden in adults are associated with behavioural factors that began in adolescent and unprotected sex is mentioned among these factors (WHO, 2008). Nigeria accounts for roughly 14 percent of the global burden of maternal

mortality (Demographic Health Survey [DHS], 2013). Global evidence shows that young girls bear a higher burden of maternal mortality and morbidility. Existing data showed that the average age of sexual debut is roughly 15 years of age among adolescent girls in Nigeria (DHS, 2003, 2008 & 2013). Adolescent girls in Nigeria are sexually active and complications of pregnancy, child birth and unsafe abortion are the major causes of death among these girls aged 15-19 years (Ojo, Aransola, Fatusi, & Akintomide, 2011).

Adolescent SRH is one of the most susceptible health issues that the world has been facing. The SRH practices of adolescent are different from those of adults and are still poorly understood in most parts of the world. Adolescent girls' sexuality is leading to adolescent pregnancy, unsafe abortion, reproductive tract infections and social problem. Additionally, inappropriate connectedness with parents or even older adults prevent transmission of health messages that would have helped the adolescent girls adopt healthy sexual practices. In African, adolescent girls in many societies are confronted with pressure to engage in sexual practice and are seen to be vulnerable (Christiansen, Gibbs, & Chandra-mouli, 2013). Actually early pregnancies among adolescent girls are still on high increase in low and middle income countries including Nigeria. Young girls facing unplanned pregnancies often aimed to the option of abortion. Study has shown that each year, almost 3 million girls age 15-19 years undergo, unsafe abortion and are often administered by unskilled providers (Christiansen, Gibbs, & Chandra-mouli, 2013). In the context of this study adolescents will be referred as adolescent girls within the ages of 10 to 19 years of age that are in school.

The term in-school female adolescents are a collection of young girls at school. Saaku (2017) defined in-school adolescent as a group of secondary school children or youth (encompassing early, middle and late adolescents). In this study in school female adolescents could be either boarding or day secondary school students who are within the age of 10- 19 years. In school adolescents are chosen as subjects for this study because they are the adolescents in school that enjoy independent life devoid of adult control. Again they are groups of people with the same characteristics that can be easily assessed. Adolescent girl's lives can be very stressful, full of experimentation and striving to discover self identity. Adolescents are considered the most vulnerable group in terms of being prone to SRH issues because their lifestyles are predominantly marked by adventure seeking and experimentation. Adolescent girls are caught in between the web of childhood and adulthood and as such find it difficult to operate

either as a child or adult. The period of adolescence in female is a period of physical and psychological preparation for safe motherhood practices.

Practice is something that is done habitually or customarily. Amoran and Onwube (2013) stated that practice is the actual application of an information or use of plan. It involves the act of rehearsing a behavior over and over or engaging an activity again and again. Hornby (2006) conceived that practice is a method, procedure or process used in a particular field or profession. Sally (2004) asserted that practice is an established way of doing things especially one that is developed through experiences and knowledge. When practice relates, to health, it is referred to as health practice. Practice is therefore seen in this study as a consensual and non-consensual ways in-school female adolescent are involved in their sexual and reproductive health.

Sexual health encompasses healthy sexual development, equitable and responsible relationship and sexual fulfillment. Reproductive health Matter-RHM (2001) described sexual health as having the freedom to choose how to express one's sexuality (or how not to). The RHM noted that sexual health also involves understanding one's body, being comfortable with oneself and her sexual desires, having desirable sexual relationship with others and learning to cope with the aftermath effects of such relationships. According to Federal Ministry of Health-FMOH (2005), sexual health is part of reproductive health which includes healthy sexual development, equitable and responsible relationship, sexual fulfillment and freedom from illness. Healthy sexual development is built on the acceptance of one's self and good communication with his/her partner. People who develop healthy intimate relationships believe in themselves and in people around them. Equitable and responsible relationships according to Insel and Roth (2006) include open, honest communication, sexual privacy, using contraceptives, safer sex practices like use of condom and hugging, sober sex and clear discussion on sexual consequences. Sexual fulfillment entails that in sexual relationship love making must be with the primary aim of satisfying both sexual and psychological needs. Satisfaction of sexual desires and the quality of the relationship are more important to overall sexual satisfaction than sophisticated or erotic sexual techniques. World Health Organization (2010) noted that, while sexual health is often assumed within reproductive health, it is in fact a wider term as sex does not always involve reproduction. Most policies of programmes on reproductive health are aimed at women of reproductive years. Yet older people, for example require information that responds to their sexual health needs rather than to reproductive health. Some of these aspects of sexuality they explore are masturbation, fondling/caressing, oral sex, kissing and hugging. Contextually sexual health is seen as the

integration of intellectual and social aspect of human being in ways that positively enrich and enhance personality and love.

Reproductive health is now recognized as a crucial part of general health and central feature of human development. As such, national conference of General practitioners (1994) stated that, reproductive health covers the entire life span of an individual. The General Practitioners further believed that it is a reflection of health during childhood, adolescence and adulthood and therefore sets the stage for health beyond the reproductive years for both men and women and affect the health of next generation. Spielberg (2007) associated reproductive health with having satisfying and safe sex life, that is been free from fear of unwanted pregnancy and of the risk of contacting disease. Reproductive health of adolescent girls is crucial since it determines the health of future generation to come, therefore guiding against experimentations with certain life style practices capable of ruining their life such as premarital sex is very important (Shankar, Dudeja, Gadekar, & Mukherji, 2017). With urbanization and liberal attitudes in contemporary Nigeria society, there is an increased likelihood of indulging in sexual proximity at an early age. Hence adolescent girls are at risk of unwanted pregnancies, reproductive tract infections (RTIs) and also a spectrum of social and psychological consequences such as discontinuation of education, forced early marriages, unplanned pregnancies, unsafe abortions and depression (Shashikumar et al., 2012).

Reproductive health has been defined by several authorities. World Health Organization (2008) defined reproductive health as state of complete physical mental and social well being in matters related to reproductive systems, functions and processes. This implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit, in this last condition are the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of their choice for regulation of fertility, as well as other methods of birth control which are not against the law and the right access to appropriate health care services that will enable women go safely through pregnancy and childbirth. International Conference on Population and Development [ICPD] (1994) affirmed that reproductive health in the context of primary health care should include: family planning, counseling, information, education, communication and services for prenatal care, safe delivery and post natal care, especially breast feeding and infant and women's health care. The ICPD further stated that it also included prevention and appropriate treatment of infertility, prevention of abortion and the management of the

consequences of abortion, treatment of reproductive tract infections, sexually transmitted infections (STIs) and other reproductive health conditions.

In the present study, sexual and reproductive health will be regarded as a state of complete physical, mental and social wellbeing in all matters relating to reproductive system, this therefore involves adolescent girls sexual practices which enable them to remain free from unplanned pregnancy, regulate their fertility, avoid abortion and its complications, reproductive tract infections, forced early marriage and discontinuation of education. Since the common components are many, this study will be restricted to such components as safe sex, unsafe sex, and family planning. These components form the bedrock of the present study.

Components of sexual and reproductive health appear to have areas of commonality. Spielberg (2007) corroborating ICPD's reproductive components and multi-dimensional nature of reproductive health listed various components of reproductive health to include safe motherhood, family planning, sexually transmitted infections, HIV and AIDS and Gender Base violence. Reproductive health components as summarized by Benagiano (1994) are responsible reproductive sexual behaviour, available family planning services, effective maternal care and safe motherhood, effective control of reproductive tract infections, prevention and management of infertility, elimination of unsafe abortion, unwanted pregnancy, sexual abuse, prevention and treatment of malignancies of reproductive organs and sound adolescent health and sexuality. Effective reproductive health depends largely on the state of sexual health. WHO (2010) listed the components of sexual and reproductive health to include improving safe motherhood-antenatal, prenatal, postpartum and neonatal care, providing high quality service for family planning including infertility services, eliminating unsafe abortion, combating sexually transmitted infections (STIs), prevention and management of cervical cancer and other sexual and reproductive health morbidities, promotion of sexual health care and safer sex, unsafe sex practices, increasing capacity for strengthening research and prorgramme development.

Safer sex entails that both partners should be aware of and practice sex safely to guide against sexually transmitted infections. Chukwu, Iornengen, Fiase, Chia, Haruna, and Hamina (2017) stated that safe sex is the adoption of sexual practices which does not predispose self and partners to sexually transmitted infections (STIs) or pregnancy. Safe sex practices among college students is particularly important considering the burden of unplanned pregnancy, abortion and other STIs in this population, (Addoh, Sng, & Loprinze, 2017). Safer sex is not limited to safer sex behaviours. it broad perspectives encompasses knowing one's body, obtaining regular exams

for sexually transmitted disease and prevention of unplanned pregnancy, and responding to physical changes with appropriate medical intervention, thus lowering the chances of HIV transmission (Robinson, 2001). Contextually safe sex practices is seen as sexual activities which especially involves sexual intercourse in which various measures such as proper use of condom and practice of monogamy are taken to avoid STIs, unplanned pregnancy and abortion.

Unsafe sex practice is a means of increasing one's likelihood of STIs and unplanned pregnancy. Unsafe sex practices are common in people infected with HIV and in those at high risk of infection (Joseton, 2003). Unsafe sex practices has been defined as sex between a susceptible person and a partner who has a sexually transmitted infection (STI), without taking measures to prevent infections. Unsafe sex practice therefore cannot be defined wholly because sex is only unsafe with respect to the context in which it occurs or measured directly from reported behaviours. Contextually unsafe sex practices is seen in this study as the involvement of in-school female adolescents in unprotected sexual practices without taking necessary precautionary measures to avoid contracting STIs including HIV, abortions, unintended pregnancies and emotional stress.

Family planning is means of controlling conception. Family planning refers to the controlling of both the number and timing of births through utilization of contraception associated with improved maternal and neonatal health outcomes, hence, contributing to the attainment of Millennium Development Goals (MDGs) (Cleland et al., 2006). Family planning is defined as the possibility of the individuals, married men and women to attain their desired number of children and choose the spacing and timing of their births through use of contraceptive methods (WHO, 2013). Family planning was contextualize as process of giving advice to adolescent girls/couples to take responsible decisions about pregnancy and help them to achieve their desire with respect to avoiding unplanned pregnancies, securing desired pregnancies, timing pregnancies and limiting the family size. Many factors have been identified as responsible for in-school female adolescent SRH practices. These factors are categorized as demographic, social, environmental or psychological. However, the present study was concerned with examining the demographic variables.

There are some socio-demographic factors which may determine the sexual and reproductive health of adolescent girls. Some of these factors include age, class and religious affiliation. Class is a variable that has received consistence attention among researchers as a strong influence on sexual and reproductive health. Anene, Ojinaka, and Ndie (2017) in their

study of premarital sex among secondary school students shows that out of the 636 respondents that have had premarital sex, 200 (31.5%) were in SS3, 203 (31.9%) were in SS2, 120 (26.7%) were in SSI and 63 (9.99%) were in JSS3; the authors stated that there is statistical significant association between class of study and pre-marital sex.

Age is a variable that may influence the SRH practices of in-school female adolescent. Age is described as an attributes that differentiate length of life from people to people in the society (Oladapo, 2003). Adolescent age is characterized by rapid physical growth and development as well as sexual maturation. And this change at this stage makes in-school female adolescent become emotionally unstable and develop feelings for themselves, their friends, family member and opposite sex. Anene, Ojinaka, and Ndie (2017) asserted that adolescents aged 14-17 years have had premarital sex. Oladapo (2003) indicated that, majority of people aged 15 to 19 years engaged themselves in unprotected sexual intercourse. Doyle, Mavedzenge, Plummer, and Ross (2012) submitted that high proportions of adolescents between the ages of 15-19 years in sub-saharan Africa are sexually active. Therefore, age is seen as a period that can be marked by the need to try out new things such as sex.

Religious affiliation is another factor that may influence sexual and reproductive health of adolescent girls. This is because religion plays an important role in the life of individual in any society. Its role as a moral builder has been variously acknowledged (Odimegwu, 2004). Coleman, and Testa (2008) Opined that the strength of the relationship between sex and religiosity may vary by gender, culture and religious denomination. Each major religion has developed moral codes covering issues of sexuality, morality, ethics, which have sought to guide people's sexual activities and practices. In order to further understand SRH practices of in-school female adolescent necessitate the use of psychological theories.

The study was anchored on two theories namely: theory of reasoned action and social cognitive theory. The theory of reasoned action was propounded by Fishbein, and Icek Ajzen in 1980, and demonstrated how attitude impact on behaviour. A person's behaviour is determined by his or her liking or disliking of the outcome of the behaviour. It also states that a person's behaviour is determined by his/her intentions to perform the behaviour, and this his/her intention is in turn a function of his/her notion towards the behabviour and his/her subjective norms. The in-school female adolescents who cultivate poor notion towards sexual and reproductive health practices are likely going to be at a higher risk of sexual and reproductive health issues than those who develop positive character towards SRH practices. The theory can be utilized as a

theoretical framework to identify SRH practices among in-school female adolescents in Idemili North Local Government Area, Anambra State.

The study was carried out in Idemili North Local Government Area, of Anambra State. The local government Area is bounded on the North by Oyi and Dunkofia LGA. And the east by Njikoka and Anaocha LGA and on the south and west by idemili South and Onitsha South LGA respectively. The people are hardworking both in education and commerce. There are big markets for commercial activities and adolescent girls do always go to hawk their goods. They walk along the street shouting their wares. The hawking activities often makes them prey to sex exploitation and some end up with unplanned pregnancies. There are many cases of adolescent girls dropping out of school as a result of unplanned and teenage pregnancy, criminal abortions and complications of early child birth. In-school female adolescents in the area appear to be at stage of experimentation, indulging in unhealthy practices being confused, taking decision that can affect their health and future development. It is against this background that the study focused on sexual and reproductive health practices of in-school female adolescent.

Statement of the Problem

Adolescents are in the age group 10 to 19 years. Adolescents throughout the world suffer from unplanned pregnancies, sexually transmitted infections (STIs) including HIV and other serious sexual and reproductive health problems. They have health threats that are predominant and with potential health consequences. Increased urbanization provides hide out for in-school female adolescents to engage in sexual activities that do not conform to our traditional moral standard. Preferably it is expected that norms and virtues which include, holding of one's virginity and chastity till marriage, not staying late out of the house with peers and obeying elders inculcated in these adolescent girls should guide them to live a life devoid of unhealthy sexual practice that exposes them to life threatening conditions. It is also expected that with the increase in the awareness campaign of the vices of harmful practice, the adolescent's girls should be able to make a healthy decision about their sexual life style.

In many African societies, secondary school students have different interests, motivations and strategies for engaging in premarital sexual relationships. Because of these differences, young women have different patterns of sexual and reproductive health practices which include sex with non-marital partners, transactional sex, and multiple partners. Some adolescents believe they cannot contact STIs and as such practice non use of condom, masturbation as the sexual act and oral sex. They watch adults as they engage in sexual activities by watching movies and TV

shows that are sexual oriented. In addition, today's adolescents grow up in a social environment that is considerably more liberal and permissive in sexual and reproductive health issues than that of their parents. The impact of the negative consequences of this situation on the sexual and reproductive life of the adolescent girls cannot be over looked. This therefore poses threats to adolescent girl's health and wellbeing in Idemili North LGA, Anambra state.

Studies that focus on demographic characteristics of SRH among adolescent has received more attention in recent years. However, studies among adolescents that focus on demographic difference in sexual and reproductive health practices are limited despite the permeative of sexual and reproductive during the secondary school years, only a handful of studies have examined sexual and reproductive health practices among in-school female adolescents. However, there is virtually no published study on sexual and reproductive health practices among in-school female adolescents in Idemili North Local Government Area, Anambra state. Therefore, the researcher picked interest to embark on this study to investigate sexual and reproductive health practices among in-school female adolescents.

Purpose of the Study

The purpose of the study was to investigate sexual and reproductive health practices among in-school female adolescents in Idemili North Local Government Area of Anambra State. Specifically, the study sought to examine the:

1. proportion of in-school female adolescents who practice safe and unsafe sex;
2. proportion of in-school female adolescents who use contraceptives;
3. proportion of in-school female adolescents who practice safe and unsafe sex based on age;
4. proportion of in-school female adolescents who practice safe and unsafe sex based on class level;
5. proportion of in-school female adolescents who practice safe and unsafe sex based on religious affiliation;
6. proportion of in-school female adolescents who use contraceptives based on age;
7. proportion of in-school female adolescents who use contraceptives based on class level;
8. proportion of in-school female adolescents who use contraceptives based on religious affiliation;

Research Questions

The following research questions guided the study:

1. What is the proportion of in-school female adolescents who practices safe and unsafe sex?

2. What is the proportion of in-school female adolescents who used contraceptives?
3. What is the proportion of in-school female adolescents who practice safe and unsafe sex based on age?
4. What is the proportion in-school female adolescents who practice safe and unsafe sex based on class level?
5. What is the proportion of in-school female adolescent who practice safe and unsafe sex based on religious affiliation?
6. What is the proportion of in-school female adolescents who used contraceptives based on age?
7. What is the proportion of in-school female adolescents who used contraceptives based on class level?
8. What is the proportion of in-school female adolescents who used contraceptives based on religious affiliation?

Hypotheses

The following null hypotheses were formulated and tested at .05 level of significance to guide the study.

1. There is no significant difference in the proportion of in-school female adolescents who practice safe and unsafe sex based on age
2. There is no significant difference in the proportion of in-school female adolescents who practice safe and unsafe sex based on class level.
3. There is no significant difference in the proportion of in-school female adolescents who practice safe and unsafe sex based on religious affiliation.
4. There is no significant difference in the proportion of in-school female adolescents who use contraceptives based on age.
5. There is no significant difference in the proportion of in-school female adolescents who use contraceptives based on class level.
6. There is no significant difference in the proportion of in-school female adolescents who use contraceptives based on religious affiliation.

Significance of the Study

The results of the study will be of immense benefits to health educators, teachers, counsellors, health administrators, curriculum planners, health personnel, ministry of health and researchers in many ways.

The results on in-school female adolescents who practices safe and unsafe sex revealed that in-school female adolescents engaged in safe sex and unsafe sex practices. The findings may be useful to counsellors, health educators, and school administrators. The counselors will provide appropriate counseling services that will encourage the adoption of safe sex practices among adolescents girls, this therefore may guide the adolescents girls on sexual practices that will in turn not pose treat to their present life and in future. The school administrators will provide time for teaching of sex education lessons and include it in the curriculum, health educators will use the result as a guide to educate and encourage positive desirable sexual and reproductive health practices.

The result on in-school female adolescents who use contraceptive showed that low proportion of in-school female adolescent uses contraceptives. The findings will be useful to health educators, and school administrators in various capacities. These beneficiaries will be better equipped to conduct group discussion with the in-school female adolescent on sexual and reproductive health practices in order to enhance a behavioural change. Health educators will use the result to teach the students on types of contraceptives and the ones that are readily available for preventions of sexual transmitted infections and avoidance of unplanned pregnancies.

Findings revealed that there was a significant difference in the proportion of in-school female adolescent that engaged in safe and unsafe sex practices based on age. Also, there were no significant difference in the proportion of in-school female adolescent that engaged in safe and unsafe sex practice based on class and religion. The findings may be of research assistance to health educators, and health personnel who will use the result to carry out further research on similar topic. Health educators and health personnel may know how to plan their programmes to cover the socio-demographic characteristics of age, class and religion of the subject.

Findings revealed that there was a significant difference in proportion of in-school female adolescents that uses contraceptives based on religion and there were no significant difference in the proportion of in-school female adolescents that uses contraceptives based on age and class. The findings may be of immense help to researchers, ministry of health, health educators, and health personnel. With the findings, health educators and health personnel may come to understand the level of contraceptive use among adolescents girls based on age, class and religion. Findings may help the health educators in creating awareness on the benefits of adopting practices on contraceptive use among the sexually active adolescent and the consequences of inappropriate actions. This will enable the adolescent girls to make informed

decision on the use of contraceptives. Through the findings on contraceptive use adopted by in-school female adolescents, in-school female adolescents may adopt appropriate and curtail inappropriate sexual practices towards sexual and reproductive health thereby promoting the health and well being of the girl child, the finding may serve as a resource base to other scholars and researchers interested in carrying out further research in the field subsequently.

The theory of reasoned action applied in this study posits the main determinants of behaviour that is behavioral intention. Theory of reasoned action further stresses that behavioural intentions are influenced by attitude towards performing the behaviour and the subjective norms associated with the behaviour. The subjective norm of a person is determined by the approval or disapproval of referents (people who are important to the person), and accepted by the person's motivation to comply with those referents. The essence of this theory in the present study is that if in-school female adolescents' intention to adopt either safe or unsafe sex practices such as use of contraceptives, the in-school female adolescents would have the motivation to adopting such a behaviour continually. However, if the referents disapprove of safe sex practices or behaviour, in-school female adolescent would discard or discontinue such behaviour. Therefore, this scenario may probably explain the results of this study which showed that low proportion of the in-school female adolescent engaged in both safe and unsafe sex practices, and uses contraceptives.

Scope of the Study

The study was delimited to sexual reproductive health practices of in-school female adolescents. It sought to investigate the safe sex practices, unsafe sex practices and the use of contraceptives by in-school female adolescents in Idemili North LGA of Anambra State. The study further explored the variables of age, class level and religious affiliation against sexual and reproductive health practices of the respondents.

CHAPTER TWO

Review of Related Literature

Abundant literature exists in the area of sexual and reproductive health both in developed and developing countries including Nigeria. Some of the works related to this present study will be hereby presented under the following subheadings:

Conceptual Framework

Sexual and reproductive health

Practices

Sexual behaviours/ reproductive health rights

Adolescents (In-school female adolescent)

Social demographic factors associated with sexual and reproductive health

Theoretical Framework

Theory of reasoned action (TRA)

Empirical Studies on Sexual and Reproductive Health Practices

Summary of Literature Review

Conceptual Framework

Sexual and reproductive health.

Sexual health encompasses problems of sexual development, equitable and responsible relationship sexual fulfillment. According to Pan American Health Organization (2001) sexual health is the experience of the ongoing process of physical, psychological and social-cultural well-being related to sexuality. Sexual health is evidence in the free and responsible expressions of sexual capabilities that foster harmonious, personal and social wellness, enriching individual and social life. Satcher (2001) define sexual health as key part of our identity as human beings together with the fundamental human rights to privacy, a family life, a living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease. Robinson, Bocking, Rosser,Miner, and Coleman (2002) sees sexual health as an approach to sexuality founded in accurate knowledge, personal awareness, and self acceptance where one's behaviour, values and emotions are congruent and integrated within a person's wider personality structure and self definition. Sexual health involves an ability to be Intimate with a partner, to communicate explicitly about sexual needs and desires to be sexually functional (to have desire, become aroused, and obtain sexual fulfillment), to act intentionally

and responsibly, and to set appropriate sexual boundaries. Sexual health has a communal aspect, reflecting not only self acceptance and respect, but also respect and appreciation for individual's differences and diversity, and a feeling of belonging to and involvement in one's sexual cultures. Sexual health includes a sense of self esteem, personal attractiveness and competence, as well as freedom from sexual dysfunction, sexually transmitted disease, and sexual assault/coercion.

Sexual health affirms sexuality as a positive force enhancing other dimensions of one's life. WHO (2006), defined sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable safe sexual experience, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006). Department of Health and Human Services (2012) asserted that sexual health is a state of well being in relation to sexuality across the life span that involves physical, emotional, mental, social and spiritual dimensions. The Department further asserted that it is an intrinsic element of human health and based on a positive, equitable and respectful approach to sexuality, relationships, and reproduction, that is free of coercion, fear, discrimination, stigma, shame and violence. It includes: the ability to understand the benefits, risk, and responsibilities of sexual behaviour, the prevention and care of disease and other adverse outcomes, and the possibility of fulfilling sexual relationship. Contextually sexual health is seen as the integration of intellectual and social aspect of human being in ways that positively enrich and enhance personality and love.

Sexuality is a central aspect of being human throughout life (WHO, 2002). The WHO opined that sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Therefore reproductive process also appears to be an aspect of sexual health. Sexuality is experienced and expressed in thought, fantasies, desires, beliefs, attitude, values, behaviours, practice, roles and relationship. Samuel (2010) opined that sexuality is the quality of being sexual; it is a part of the total person: physical, emotional, social, intellectual, and spiritual. He added that sexuality is a part of person's total personality from birth to death. Samuel further stated that sex is affected by the way we walk, think and feel, and the way we talk to and touch others. Samuel further also maintained that the young, old, people with disabilities, people from all races, all sizes are affected by sexuality; and further asserted that there are sexual behaviours involving physical feelings to sexual intercourse. Touching,

hugging and kissing are pleasurable physical activities. They can satisfy emotional needs such as, that of love and therefore they are emotional fulfilling.

The concept of reproductive health and what it means originated in the World Health Organization (WHO) and was based on the WHO definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Fathalla (1992) elaborated further on the concept and defined reproductive health as not merely the absence of disease, rather it is a condition in which the reproductive process is accomplished in a state of complete physical, mental, and social well-being. This implies that people have the ability to reproduce, that women can go through pregnancy and child-birth safely, and that reproduction is carried to a successful outcome, that is infants survive and grow up healthy. It implies further that people are able to regulate their fertility without risks to their health and that they are safe in having sex. This laid the foundation for the definition agreed at the 1994 United Nations International Conference on Population and Development (ICPD), as follows: Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law; and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health according to Action Health Incorporated-AHI (2003) is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and process. AHI further states that it is the ability to have a satisfying and safe sex life, capability to reproduce and freedom to decide if, when and how often to do so. They stressed that this refers to ensuring the optimization of the care of processes by which human beings can produce offspring. They further opined that men and women of all ages must care for their reproductive health to ensure optimum attainment of their physical, social and mental well-being. The female and male reproductive process makes procreation possible. The reproductive

process is functional throughout life in males but only functional during the females reproductive years. The maturation of male and female secondary sex hormones sets in during puberty stage.

During puberty, girls experience physical changes. The ovaries (there are two, located on either side of the uterus) begin to produce ova, the female reproductive cells also called eggs. The ovaries also begin to produce the hormones estrogen and progesterone. Although the ovaries contain a vast number of eggs, usually only one ovum is released per cycle. The two ovaries release eggs without any definite pattern. The two ovaries sometimes alternate in releasing the eggs or one ovary will release continuously for months when a mature egg leaves the ovary and gets into the fallopian tube, it is called ovulation. Once the egg has been released, the finger-like ends of the fallopian tube sweep around the ovary pick up the ovum and draw it into the fallopian tube. The egg stays alive for about 24 hours, during which it can be fertilized by the male sperm. The fusion of an egg and a sperm (fertilization) results to pregnancy. The fertilized egg travels to the uterus through one of the fallopian tubes for about 3-5 days. If fertilization does not occur, the egg cell dissolves and is absorbed by the body (AHI, 2003). In girls, this period as a specific stage of life requires special attention and consideration (Tegene, & Sisay 2014), because the beginning of adolescence is associated with the onset of puberty and with the discovery of sexual desires (Hsu, Lien, Lion, Chen, & Wang, 2010)

Menstruation, also called menses, is the blood and lining that comes from the uterus when fertilization does not occur. It is the self-cleaning action of a healthy uterus. Menstruation also known as women's monthly period is an important developmental milestone for girls. From puberty to menopause, a woman who is not pregnant will menstruate (AHI, 2003). Stubbs (2008) described menstruation as a phenomenon that carries both a good and bad reputation: "good" in that it signifies growing maturity as well as further fertility potential, but "bad" because of the negative attitudes and fears surrounding menstruation. Menstruation is a normal physiological process indicating beginning of reproductive life but sometimes it is considered as unclean phenomenon. Thakre et al. (2011). The reproductive life of adolescent girls is characterized by the onset of menstruation.

Reproductive health is a universal concern, but is of special importance to women particularly during the reproductive years. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. Men have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than is the case for women. However, men play

particular roles and responsibilities in terms of women's reproductive health because of their decision-making powers in reproductive matters (Federal Ministry of Health [FMOH],s 2005). The roles and responsibilities as concerned with this decision making by men include communication, choice of contraceptives and sober sex. Decisions about sexuality are sometimes difficult because of sexual feelings, pressures and conflicting messages from partners, friends and society. The decision about sexuality can effect one's future health and life plans and impact upon the lives of other people. The best sexual decision are usually one that is consistent with one's values and does not involves risking one's health or breaking the law.

Reproductive health is now recognized as a crucial part of general health and a central feature of human development, National Conference of General Practitioners (1995) listed the components of reproductive health to include programmes such as family planning, child health, adolescent health, immunization, nutrition, treatment of acute respiratory disease and diarrhea diseases, reproductive tract infections, gynecological diseases, HIV infections, STIs, the care of the elderly and other related programmes. According to WHO (2000) the key components of reproductive health include family planning, maternal mortality, abortion, unwanted pregnancy and STIs. The common areas among the above components are STIs, unwanted pregnancy, family planning, abortion, sexuality and maternal mortality. All these components exist in some form or the other in practically all countries but they may operate in isolation (National Conference of General Practitioners, 1995).

Adolescent reproductive health is a state of physical, mental and social well being of adolescents and not merely the absence of disease or infirmity in all matters related to their reproductive system and to its functions and process (FMOH, 2005). Adelola (2005) is of the opinion that reproductive health of the adolescents and young people is important to the overall health and quality of life of any community. Adelola further stated that reproductive health affects people's quality of life, population control, and prevention of gynecological complications and makes for sustainable development. Adelola suggested that reproductive health education will help to solve the problems of unwanted pregnancies, illegal abortion, child abandonment, infant and maternal mortality, rape, single parenthood and school dropout which are peculiar to adolescents girls in the society. In the context of this study, sexual and reproductive health is a state of complete physical, mental and social wellbeing in all matters relating to reproductive system, this therefore involves adolescent girls' sexual practices which enable them to remain free from sexually transmitted infections, unwanted pregnancies, regulate

their fertility, abortion and its complication, reproductive tract infections, forced early marriage, and discontinuation of education.

The scope of SRH was defined in ICPD (1994) programme of action to include the following components (UN, 1995): safe motherhood and child survival, family planning, counselling, information, education, communication and services for prenatal care, safe delivery and post natal care, especially breast feeding, infant and women's health care, prevention and appropriate treatment of infertility, prevention of abortion and the management of the consequences of abortion, treatment of reproductive tract infections; sexually transmitted infections (STIs) and other reproductive health condition; and information, education and counseling as appropriate on human sexuality and responsible parenthood. Reproductive health components as summarized by Benagiano (1994) are responsible reproductive sexual behaviour and they include available family planning services, effective maternal care and safe motherhood, effective control of reproductive tract infections, prevention and management of infertility, elimination of unsafe abortion, unwanted pregnancy, sexual abuse prevention and treatment of malignancies of reproductive organs sound adolescent health and sexuality. Centre for diseases control and prevention International Conferences on Population and Development [ICPD] (2010) stated that sexual health also encompasses problems of HIV and STIs, unintended pregnancy and abortion, infertility, cancer resulting from STIs, and sexual dysfunction. These component are also embedded in reproductive health. Robinson (2001) identified components of sexual health to include, talking about sex in relation to culture, sexual identity, sexual anatomy and body functioning, sexual health care, safer sex, body image, masturbation, fantasy, positive sexuality, intimacy and relationship and spirituality. World Health Organization (2010) listed the components of reproductive and sexual health to include improving safe motherhood-antenatal, prenatal, postpartum and neonatal care, providing high quality service for family planning including infertility services; elimination of unsafe abortion combating sexually transmitted infections (STIs); prevention and management of cervical cancer and other reproductive and sexual health morbidities, promoting sexual health healthcare and safer sex, unsafe sex, increasing capacity for strengthening research and prorgamme development. The components of sexual and reproductive health as related to this study are discussed below:

Safer sex entails that both partners should be aware of and practices sex safely to guide against sexually transmitted infections. Chukwu et al. (2017) stated that safe sex is the adoption of sexual practices which does not predispose self and partners to sexually transmitted infections

(STIs) or pregnancy. Safe sex practices among college students is particularly important considering the burden of unplanned pregnancy, abortion and other STIs in this population, (Addoh, Sng, & Loprinze, 2017). Satcher (2001) in his call to action to Promote Sexual Health and Responsible Sexual Health of its people due to the high levels of unwanted pregnancies and unsafe abortion stated that adolescent girls should be aware of and practice safer sex to guard against unwanted pregnancy and unsafe abortion. Safe sex is sexual contact that does not involve the exchange of semen, vaginal fluid or blood between partners (Better health, 2011). Safe sex activities that allow close person-to-person contact with almost no risk of contacting STIs and unplanned pregnancy as listed by Better Health include cuddling, fantasy, massage, mutual masturbation, masturbation, kissing, sexual intercourse using barriers contraception-such as a condom or female condom. Contextually safe sex practices is seen as sexual activities which especially involves sexual intercourse in which various measures such as proper use of condom and practice of monogamy are taken to avoid STIs, unplanned pregnancy and abortion.

Unsafe sexual practice is a means of increasing one's likelihood of STIs and unplanned pregnancy. Unsafe sexual practices are common in people infected with HIV and in those at high risk of infection (Joseton, 2003). Unsafe sex practice has been defined as sex between a susceptible person and a partner who has a sexually transmitted infection (STI), without taking measures to prevent infections. Unsafe sex practice therefore cannot be defined wholly because sex is only unsafe with respect to the context in which it occurs or measured directly from reported behaviours. Walker, Zabia, and Collumbien (2005) defined unsafe sex as sexual act between a susceptible person and partner who has STIs without taking preventive measures against it. The above further stated that unsafe sex occurs if a susceptible person has sex with at least one partner who has an STI, without taking measures to prevent infection. Contextually unsafe sexual practices is seen in this study as the involvement of in-school female adolescents in unprotected sexual practices without taking necessary precautionary measures to avoid contacting STIs and HIV, abortion, unintended pregnancies and emotional stress.

Contraception or family planning is a means of preventing, limiting and spacing child birth. Contraception or family planning according to AHI (2003) is directed towards prevention of pregnancy and having a satisfying sexual life. AHI further states that it is also birth control methods through which the sperm and egg are prevented from uniting. They maintained that young people can prevent teenage pregnancy by not having sexual intercourse (abstinence) or by use of contraceptives which are devices used for preventing pregnancy. Contraception is the

intentional prevention of conception through the use of various devices, sexual practices, chemicals, drug or surgical procedures thus, any device or act which purpose is to prevent a woman from becoming pregnant can be considered as a contraceptive (Jain, & Muralidher, 2011). Nansseu, Nachinda, katte, Nchagnout, and Nguesta (2015) asserted that contraception or family planning is seen as all the measures undertaken to limit and space birth. Samuel (2010) asserted that family planning has been seen to play a prominent role in national health plans of maternal and child health. Samuel stated that this activity should be considered as an integral part of Maternal and Child Health (MCH). He argued that family planning may be used to prevent another pregnancy because of the health of the mother or in order to enable the mother to devote her time and attention to another child or other family members with illness. Samuel (2010) defined family planning or contraceptive as a mean of controlling birth rate and preventing unplanned pregnancies. Family planning was contextualized as process of giving advice to adolescent girls/couples to take responsible decisions about pregnancy and help them to achieve their desire with respect to avoiding unplanned pregnancies, securing desired pregnancies, timing pregnancies and limiting the family size. There are many family planning methods or contraceptives and the choice depends largely on individual, some commonly used ones are discuss below.

Natural family planning is a method of birth control. Action Health Incorporated (2003) asserted that natural method requires self-control, assertiveness an ability to make decisions about abstaining from sex and sticking to the decision. Natural methods that do not violate any natural moral laws and are not medically objectionable are accepted. They are based on periodic abstinence. They are the safest, most effective contraceptive method (Samuel, 2010). Natural family planning (NFP) is type of Fertility awareness based method that employs abstinence during the fertile window if being used to postpone pregnancy (Palone & Bergus 2009) Different modern methods of NFP are available for family planning (Sitruk-ware, Nath, & Mishell 2015; Smoley, & Robinson 2012), and several have a good level of medical evidence for their effectiveness in avoiding pregnancy.

Injectable is another method of contraceptive. Injectable methods are hormonal injections, which inhibit ovulation and also increase the viscosity of the cervical secretion to form a barrier to sperms (Jain & Muralidhar, 2011). It is usually injected into the muscle tissue on any day on the first seven days of menstrual cycle to prevent pregnancy. AHI (2003) further observed that injectables contain the hormone progestin, which also alters the lining of uterus so

that it cannot accept fertilization. AHI stressed that progestin thickness of the amount of cervical mucus making it more difficult for sperm to penetrate and altering the ability of the fallopian tubes to transport the ovum to the uterus. It gives protection for eight to twelve weeks and a doctor or health provider who is specially trained must administer it.

Oral contraceptives pills are among the most extensively investigated medications ever prescribed. Since 1960, birth control pills have played an important role in contraception. Oral contraceptives prevent pregnancy by suppressing ovulation through combined action of oestrogen and progestin (AHI, 2003). Samuel (2010) believes that this method is widely used and for most people the easiest, and definitely the most reliable.

Male and female condoms are also widely used contraceptives. The male condom is a sheath, usually made of very soft and delicates rubber, which is rolled over the erect penis before the act of penetration takes place (Samuel, 2010). He observed that the idea of interrupting sex to put it is quite intolerable to some but with aids on line and campaign for safer sex, the condom has become much more popular. Insel, and Roth (2006) stated that a man or his partner must put the condom on the penis before it is inserted into the vagina, because the small amount of fluid that may be secreted unnoticed prior to ejaculation often contains sperm capable of causing pregnancy. A female condom is a latex or polyurethane pouch that a woman or her partner inserts into her vagina. Although the female condom is preferred in certain situations because it requires less participation on the part of the male partner, its overall popularity remains far below that of male condom (Insel, & Roth, 2006). Samuel maintained that using it with spermicide may boost its effectiveness in preventing unpregnancy.

Teenage unplanned pregnancy is on the increase because of high rate of sexually active adolescent. Moronkola, and Idris (2000) asserted that sexually active adolescent girls who cannot control themselves from having premarital sex must be aware of contraceptives and should develop positive way of life towards them to met up with social and health implications of adolescent pregnancies, abortion and its complications, infertility, maternal mortality and so on. Owuh (2005) in her study on reproductive health knowledge and determinants of teenage pregnancy among selected female senior secondary school students in Ibadan observed that 76 percent of the sexually-active female adolescents did not use contraception at first intercourse. In addition, while 42 percent of the respondents objected to contraception, 61 percent believe that contraception causes infertility. Safe family planning methods prevent unwanted pregnancies among adolescent girls. Unplanned pregnancy poses significant public health risks. The

demograghic health survey showed that of the women in south western Nigeria, at least 27 percent of them had ever been pregnant when they did not want to be. Similarly, in a survey conducted in south western and northern Nigeria in the mid-1990s, 20 percent of women reported ever having experienced an unwanted pregnancy (International Family Planning Perspective [IFPP], 2006).

Sexual activities among adolescent girls may lead to unwanted pregnancy. However, Samuel (2010) stated that sexual activity among adolescent girls can become associated with traumatic experiences which may change one's outlook for several years, or even for a lifetime. He observed that one of such experiences is unwanted pregnancy. He maintained that unwanted pregnancy results when a baby is to be born into a family in which he is not wanted and loved. For unmarried, intimate caresses between a male and a female can stimulate sexual appetite which may result in intercourse and consequently pregnancy, an unwanted child, an undesirable marriage and grief on the part of the couple, their parents and their friends. Owuh (2005) observed that, some parents in order to meet up with their financial needs, engage their under-aged adolescent girls into street hawking. She attributed this to the poor economic situation of the parents which has forced their adolescent girls into several activities so as to raise money for the family. She noted that these hawking activities are good sources of unwanted pregnancies among the female adolescents. This is because this practice has a high probability of exposing the girls to men who capitalize on their innocence and ignorance and abuse them sexually. The negative consequences of these sexual activities of adolescent girls includes abortion and maternal mortality.

Abortion is determination of pregnancy. Abortion according to AHI (2003) can be defined as the removal by mechanical or chemical means of a fertilized egg from the uterus for the purpose of terminating the pregnancy before 28^{th} week. Samuel (2010) asserts that abortion refers to the voluntary or involuntary loss of the product of conception before it is viable, that is in the first 180 days. Insel, and Roth (2006) defined abortion as an expulsion of an embryo or fetus from the uterus before it is sufficiently developed to survive. Though the number of days may differ among authors, but the consensus is that abortion entails the termination of pregnancy. Abortion among adolescents has led to deaths and health consequences such as barrenness, sterility, infection of the womb, perforating of the uterus, amongst others. Nevertheless, adolescents in Nigeria have continued to seek for abortion with unqualified physicians providing the services in private clinics and hospitals where in most cases unsafe

methods are used resulting to severe health consequences or even death among the adolescents. In Nigeria, 50 percent of maternal deaths are adolescents girls due to illegal abortion while abortion complications accounts for about 72 percent of all death among girls under 10 years (Ayanwale, 2001). WHO (2001) reported that 1,000,000 conceptions occurs each day among the adolescent, about 50 percent of the conceptions are unplanned and about 25 percent are definitely unwanted, resulting in about 150, 000 induced abortions and 5000 deaths every day. World Health Organization (1995) estimated that 19 million of unsafe abortions occur around the world annually and that 68,000 of these result in women's death.

Maternal mortality as another component of SRH means the death of the mother due to pregnancy related complications. Okereke et al.(2013) opined that developing countries account for about 99% of an estimated half a million maternal death that occur each year. Bauserman Mnyani, Fank, Chersich, and Mccltgre (2014) defined maternal mortality as the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause except accidents and intentional injuries. In their own view, maternal deaths were subdivided into direct and indirect deaths. Direct deaths are those resulting from obstetric complications during the pregnancy, labour or purerperium, or from interventions, omission or incorrect treatment, or from a chain of events resulting from any of these. Indirect deaths is caused by non-obstetric conditions or disease that may exist before pregnancy but is aggravated by the physiological effects of pregnancy, (Patwardhan et al., 2016).

Practice.

Practice is something that is done habitually or customarily. Amoran, and Onwube (2013) stated that practice is the actual application of an information or use of plan. It involves the act of rehearsing a behaviour over and over or engaging an activity again and again. Horney (2006) opined that practice is a method, procedure or process used in a particular field or profession. Sally (2004) asserted that practice is an established way of doing things especially one that is developed through experiences and knowledge. Samuel, Fash, Odo, and Assian (2007) observed that practice is synonymous with recurring behaviors. Funks, and Wagnals (2013) defined practice as a customary action or proceeding regarded as individuals' habit. When practice relates, to health, it is referred to as health practice. Practice is therefore seen in this study as a consensual and non-consensual ways in-school female adolescent are involved in their sexual and reproductive health

Sexual behaviours/reproductive health rights.

Similarly forms of sexual practices include activities like masturbation and fantasy, touching and fore play, oral genital stimulation and sexual intercourse, kissing, caressing/fondling of breast and genitals.

Masturbation is self stimulation of the genital either in man or woman. It is a primary method of achieving sexual pleasure (Samuel, 2010). Samuel clearly stated that traditionally some societies and religious groups have condemned this sexual act on the basis that intercourse is the right sexual behaviour. Masturbation is the self stimulation of the genitals to achieve sexual arousal and pleasure, usually to the point of orgasm (sexual climax). It is commonly done by touching, stroking, or massaging the penis or clitoris until an organ is achieved. Some women also use stimulation of the vagina to masturbate or use "sex toys" such as a vibrator (Medicine net, 2016). Better health (2011) observed that even though it is normal, some people who masturbate feel ashamed or embarrassed about it. This is partly because masturbation has been labeled as deviant, dangerous and sinful over the years and many of these out-dated myths still exist. Action Health Incorporated (2003) defined fantasies as free play imaginations and images, day dreams and wishful thinking. They further stated that it is not unusual to have different sexual fantasies. Some may include fantasizing about dating, marriage, falling in love, a hero, being close to someone intimately and so on. It is a state of mind similar to that which comes in dreams or form of a feverish imagination. Insel, and Roth (2006), stated that sexual fantasies and dreams become more common and explicit in adolescence than at earlier ages, often as an accomplishment to masturbation. Fantasy, on the other hand according to Samuel (2010), is a dream in a state of wakefulness. Fantasies could be pleasant or evil. Most of them are pleasant. They restore the spirit and are the sources of sexual well being. Due to their moral inconveniences and antisocial contents, they are rejected in a more or less conscious way. Fantasies induce unpleasant sensations which are not too common (Samuel, 2010). He opined that masturbation and fantasy are inseparable.

Touching and foreplay is integral to sexual experiences, whether in form of massage, kissing, fondling or holding. Our entire body surface is a sensory organ and touching almost anywhere can enhance intimacy and sexual arousal (Insel, & Roth, 2006). Oral-genital stimulations are quite common practices. Oral sex may be practiced either as part of foreplay or as a sex act culminating in orgasm. Like all acts of sexual expression between two people, oral sex requires the cooperation and consent of both partners (Insel, & Roth, 2006).

Sexual intercourse is the ultimate sexual experience. Men and women engage in coitus-make love-to fulfill both sexual and psychological needs. The most common heterosexual practices is the man inserting his erect penis into the woman's dilated and lubricated vagina after sufficient arousal (Insel, & Roth, 2006). Heterosexuality refers to sexual attraction and preference for sexual activity with members of the opposite sex while homosexuality is defined as attraction to and preferences for sexual activity with members of the same sex (Samuel, 2010).

Beginning with the convention on the rights of the child in 1989 (CRC, Office of the United Nations High Commission for Human Right, 1989) and repeatedly since 1994, governments have acknowledged that closing gender gap in health and education and providing other opportunities equally for girls and boys are human rights obligations, and are also essential for national and global development and security. In 2012, the 45th session of the United Nations Commission Population and Development (UN, 2012) and the Declaration of the Balio Global Youth Forum (United Nations Population Fund [UNFPA], 2012) elaborated on the ICPD POA Commitments to adolescents, SRHR. Both documents urged government to ensure adolescents' access to quality SRH services and to comprehensive sexuality education (CSE) in and out of school's to eliminate early and forced marriage, to design and implement politics and programmes to climates violence against women and girls, to engage gate keepers including parents and communities and to give adolescents themselves a voice in decision making.

Sexual and reproductive health rights include the right of all persons to: Seek, receive and impart information related to sexuality; receive sexual education; Have respect for bodily integrity; choose their partner; Decide to be sexually active or not; Have consensual sexual relations; Have consensual marriages; Decide whether or not to and when to have children; Pursue a satisfying safe and pleasurable sexual life (WHO, 2014).

Adolescent (in school female adolescent).

Adolescent is the period of human growth that occurs between childhood and adulthood. Adolescent is the period of transition when an individual experiences rapid growth and development, both physical and psychological and changes from child to an adult. World health organization (2001) defined adolescent as the age group of 10 to 19 years. The term in-school adolescent is a collection of young students at school. Saaku (2017), defined in-school adolescent as a group of secondary school children or youth (encompassing early, middle and late adolescents). In this study in school female adolescents could be either boarding or day school students who are within the ages of 10 to 19 years. In school adolescents are chosen as

subjects for this study because they are the adolescents in school that enjoys independent life devoid of adult control. Again they are group of people with the same characteristics that can be easily assessed. Adolescents' lives can be very stressful, full of experimentation and striving to discover self identity. Adolescent are considered the most vulnerable group in terms of being prone to SRH issues because their lifestyle are predominantly marked by adventure seeking and experimentation. Adolescent girls are caught in between the web of childhood and adulthood and as such find it difficult to operate either as a child or an adult. Effort are made by the adolescents to prove to parents/guardian and significant others which peers are prominent, that they are no longer kids. At this stage they embark on many actions that have the potential of causing serious harm to their overall health and future development. The period of adolescence in female is a period of physical and psychological preparation for safe motherhood.

Socio-demographic factors that affect SRH of adolescent girls.

Some variables are capable of influencing sexual behaviours of adolescent girls. Such factors include age, class and religions.

Age is a variable that may influence the SRH of in-school female adolescent. Age is described as an attributes that differentiates length of life from people to people in the society (Oladapo, 2003). At the adolescent girl's age, there is development of secondary sex characteristics/ feature such as enlargement of breast, expansion of hips, hair growth at the pubic area and armpit. These changes at this stage make them become emotionally unstable and develop feelings for themselves, their friends, family member and opposite sex. All these and sexual maturation make them to be anxious of their body changes. Puberty starts earlier in girls usually at the age of 10 and 11 years (National Instituted of Health, 2007). Anene, Ojinaka, and Ndie (2017) in their study asserted that adolescents aged 14-17 years have had premarital sex. Oladapo (2003) indicated that, majority of people aged 15 to 19 years engaged themselves in unprotected sexual intercourse. Doyle, Mavedzenge, Plummer, and Ross (2012) submitted that high proportions of adolescents between the ages of 15-19 years in sub-saharan African are increasingly sexually active.

Religious is another factor that influences sexual and reproductive health of adolescent girls. Religion plays an important role in the life of individual in any society. Its role as a moral builder has been variously acknowledged (Odimegwu, 2004). Coleman, and Testa (2008) Opined that the strength of the relationship between sex and religiosity may vary by gender, culture and religious denomination. Religious function has helped to encourage adolescents girls avoid

actions that they might otherwise have taken (Rostosky, Wilocox, Wright, & Randall, 2004). Each major religion has developed moral codes covering issues of sexuality, morality, ethics, which have sought to guide people's sexual activities and practices. Religious belief has a part to play in adolescent girls SRH practice. The impact of religion on adolescent SRH practice has been widely seen as a positive one. In a study of youths aged 11-25 years, who were not sexually active, the respondent scored significantly higher than sexually active youths on importance of religion on their lives and reported more connection to friends whom they considered to be religious or spiritual. The Influence of religion has been frequently seen as an inhibiting force which may contribute to postponing, reducing or even restricting certain behaviours such as premarital adolescent sexual activity

Class level of adolescent girls has a significant role in understanding SRH practices. Example in a formal academic training the biological sources and study of human anatomy or body parts and their functions help in knowing and identifying the characteristics of sexual organs in reproductive system. Anene, Ojinaka, and Ndie (2017) in their study of premarital sex among secondary school students shows that out of the 636 respondents that have had premarital sex, 200 (315%) were in SS3, 203 (31.9%) were in SS2, 120 (267%) were in SSI and 63 (9.99%) were in JSS3; the authors stated that there is statically significant association between class of study and pre-marital sex.

Conceptual framework

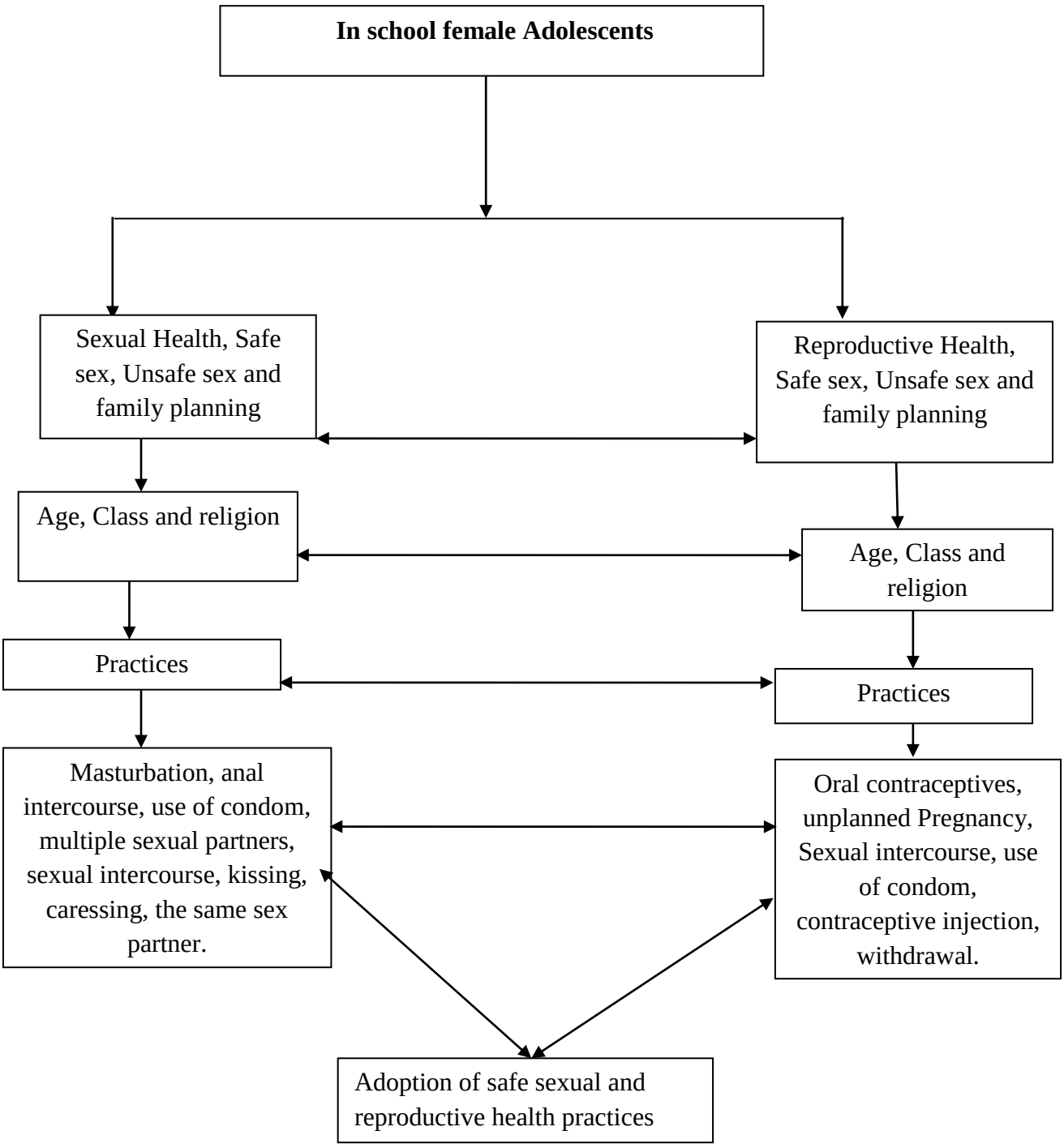


Figure 1: Diagrammatic Representation of the Conceptual Framework

The in-school female adolescents practice based on age, class and religion affect their sexual and reproductive health towards safer sex, unsafe sex and family planning.

Theoretical Framework

Theories play an important role in health education. Theories and models are among health educators most useful tools as they tackle health challenges. Babies (2003) defined theory as a systematic explanation for the observations that relate to a particular aspect of life.

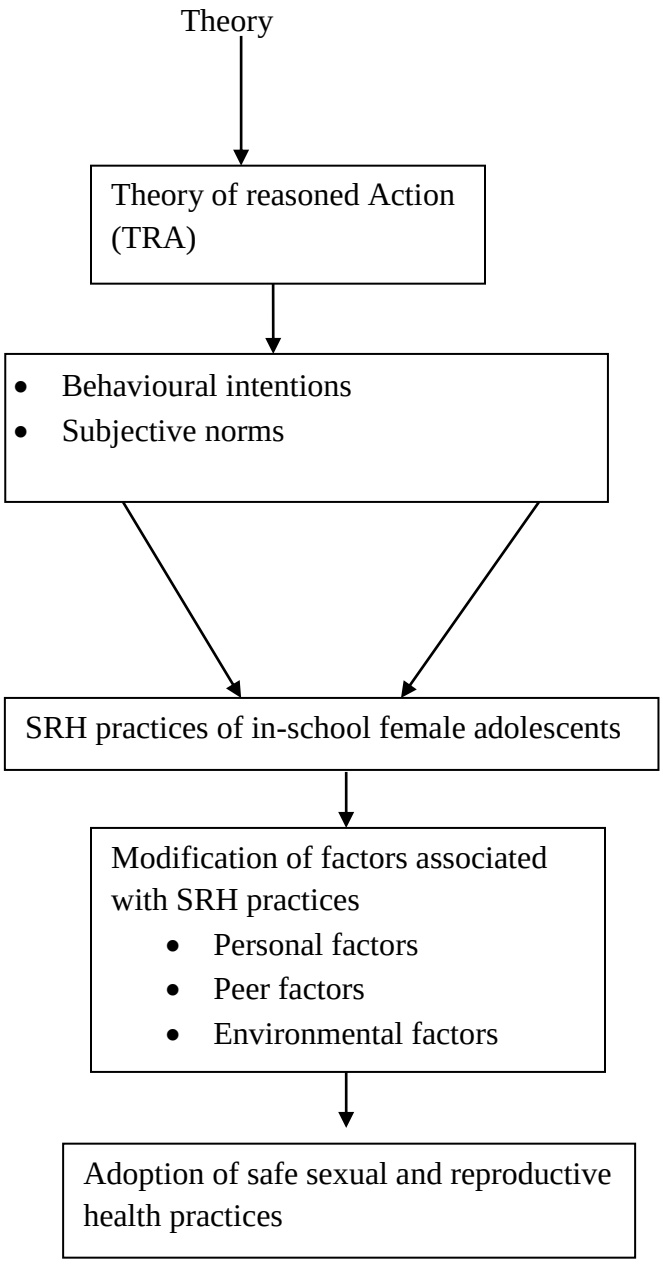
Theory of reasoned action.

Theory of reasoned action (TRA) was propounded by Fishbein, and Icek Ajzen in 1980, the theory elucidates how attitude impacts on behaviour. A person's Behaviour is determined by his or her liking or disliking of the outcome of the behaviour. It also states that a person's Behaviour is determined by his/her intention to perform the behaviour, and that his or her intention is in turn a function of his/her attitude towards the Behaviour and his or her subjective norms. It aims to explain the relationship between notion and behaviour within human action. It is also used to predict how individuals will behave based on their pre-existing notion and behavioural intentions. An individual's decision to engage in a particular behaviour is based on the outcomes the individual expects will come as a result of performing the behaviour.

Theory of reasoned actions posits that a person's intension to perform behaviour is the main predictor of whether or not they actually perform that behaviour. According to the theory, intention precedes the actual behaviour. This intention comes as a result of a belief that performing the behaviour will lead to a specific outcome. Behavioural intention is important to the theory because these intentions "are determined by attitudes to behaviours and subjective norms". The theory of reasoned action suggests the likelihood for the behaviour to be performed.

This provides a framework for the study of sexual and reproductive health practices. If one perceives an outcome of a behaviour to be positive, he or she will develop a positive practice towards performing such an action and vice versa. The in-school female adolescents who develop poor behaviour towards SRH practices are likely going to be at a higher risk of SRH issues than those who develop positive character towards SRH practices.

Theoretical framework



Schematic representation of SRH practice theoretical framework. The figure above shows how theory of reasoned action relate to the presents study. There is relationship between stages of influence as they directly link to in-school female adolescent SRH practices. In all theories modifies the SRH practices of in-school female adolescent.

Empirical Studies

Ekanem (2010) carried out an experimental research on the influence of school type in modifying sexual behaviour of secondary school adolescents. The objective of the study was to determine the influence of school type in modifying sexual behaviours of adolescents in Benin City. The target population for the study comprised all secondary school students in Benin City. The sample of the study made use of purposive stratified sampling technique, three secondary schools were involved in the study, one co-educational, one all boys and one all girls secondary school. The study made use of sample of 173 adolescent distributed into available number of students in each class since intact classes were used for the study. The instrument used for the study was the adolescents' sexual beahviours inventory (ASBI) developed by the researcher. Descriptive statistics and analysis of co-variance (ANCOVA) were used to determine the difference between the treatment and pre-test and post-test scores. Based on the findings it was concluded that there was significance school type effect on the sexual behaviours of mixed and all girls school were considered. It was also concluded that the type of school student attends determines how successfully a student sexual behaviour can be modified. The study is related to the present study because both was on secondary school students while the difference is that the present study, studies sexual and reproductive health practice of in-school female adolescent and the former seeks to determine the influence of school type in modifying sexual behaviours of adolescents.

Nwalo, and Anasi (2012) carried out a study on access to and use of reproductive health information among in-school adolescent girls in Lagos. Descriptive survey research design was adopted for the study. The sample size consisted of 1,800 girls from senior secondary schools in Lagos state the, sample technique used was simple random sampling. Data collection was through questionnaire. Descriptive and inferential statistics were used for data analysis. Findings revealed that parents were the most accessible source of reproductive health information while the internet was the least accessible. More than 50 percent of the respondents were not using reproductive health-related information regularly. The relationship is that both studies reproductive health among in-school adolescent girls and they both adopted descriptive survey research design but the difference is that the former utilized descriptive and inferential statistics for data analysis while the present adopted statistical package for social science software version 22.

Doyle, Mavedzengo, Plummer, and Ross (2012) carried out a study on sexual behaviour of adolescents in sub-Saharan Africa. The aim of the study was to describe SRH behaviour of adolescents in sub-Saharan African, particularly 15-19 year olds. Data collection was done using DHS of 2000-2010, nine Indicators of adolescents behaviour and one adult attitude towards condom education for adolescents were described. Finding from the study revealed that up to 25 percent of 15-19 years olds reported sex before age 15. In most countries, > 5 percent of females reported marriage before age 15 and > 20 percent had commenced childbearing. Early sexual debut and childbearing were more common among the least educated and/or rural females. Reporting of multiple sexual partners was more common among males than females, but decreases over time were more common among females than male. Urban males and females, with higher education were more common with report of multiple sexual partnerships. Urban youth and those with higher education also reported more condom use. Adult support for condom use education for 12-14 years old has increased over time to 60-65 percent. The relationship is that both were on adolescent sexual health but the difference is that while the former was on sexual behaviour of adolescent the present was on sexual and reproductive health practice of in-school female adolescent.

Ngwu (2012) carried out a research on sexual and reproductive health attitude and behaviour among secondary school students in Enugu State. The aim of the study was to examine sexual and reproductive health attitudes and behaviour of secondary school students. Descriptive survey research design was used, the population of the study consisted of 15, 364 students. The sample size for the study was 768. Multi stage sampling procedure was used. The instrument for data collection was questionnaire. Method of data analysis was done using statistical package for social sciences. The research question was answered using mean and percentage while a null hypotheses was tested using t-test and chi-square statistics. The findings of the study revealed that there were no significance difference in attitude of students towards reproductive and sexual health (RSH) according to gender, public and private schools. There was also significance difference in behaviour of the students regarding RHS according to gender, public and private schools. There was also significance difference in behaviour of the students regarding RHS according to gender, public and private school. The relationship is that both studies were on sexual and reproductive health, they both adopted a descriptive survey research design and multi stage sampling procedures in determining the sample size of the study but the difference is that the former was on attitude and behavior while present is on practice.

Gupta, Mishra, and Prabha (2013) carried out a research on perception regarding sexuality among adolescent girls in rural India. The objective of the study was to assess the knowledge and behaviour of adolescent girls regarding sexuality and to find out their correlation with different socio- demographic variables. Cross-sectional studies of 400 adolescent girls from rural areas of varansi district were selected by adopting appropriate sampling techniques. Data was analyzed with Microsoft excel 2007 and SPSS, version 16th software. Necessary tables were generated and chi-square test was applied for inferential decision. The result of the finding showed that as much as 12.5 percent and 2.75 percent adolescent girls were having premarital romantic and sexual relationship respectively. Extent of awareness about STIs and safer sex were 50 percent and 40 percent respectively. Gupta, Mishra and Prabha (2013) therefore concluded that although involvement in premarital sexual relationship was not too much but awareness regarding STIs and safer sex was not satisfactory. The study was related to present study because both were on adolescent girls while the difference was that the former used cross-sectional research design, SPSS version 16th software in data analysis, and the present study adopted descriptive survey research design and SPSS version 22 for data analysis.

Farih, Khan, Freeth, and Meads (2014) carried out a cross sectional study on sexual and reproductive health knowledge information-seeking behaviour and attitudes among Saudi women. The study design was cross-sectional. The population of the study included all the students registered in all of the schools at the participating University. The sample size constituted 460 Female University students. Structured questionnaires were used to collect data for the study. Quota sampling technique was used for the study. Data were collected through questionnaire. The data was analyzed using IBM statistical package for the social sciences (SPSS) software V.20.0. Finding from the study revealed that there was paucity of information regarding sexual patterns and reproductive preferences among women in the Middle East in general and particularly Saudi Arabia. The study was related to present study because both talked about sexual and reproductive health of adolescent while difference was that the former studied knowledge of information seeking behaviour while the present studied practices.

Aninanya, Debpuur William, Hodgson, and Howard (2015) carried out a study on effects of an adolescent sexual and reproductive health intervention on health services usage by young people in Northern Ghana. The study design was community Randomized trial. The population of the study consisted of adolescents aged 15-17 years. The sampling technique adopted was random sampling. Data collection was baseline (2005) and end line (2008) via cohort survey.

The instrument of data collection was questionnaire developed for male and female participants based on study objectives. The sample comprised of 2,664 adolescent aged 15-17 years at base line. The objective of the study was to assess whether a community based ASRH intervention, using a social learning theory approach, was associated with increased adolescent usage. The data were checked using Microsoft Foxpro 6.0 and analyzed using SPSS 12.0. The study reported increase, in adolescent usage of antenatal and prenatal services. Both studies were related because both talked about sexual and reproductive health but the difference was that the present study was on in school female adolescent practices while the former studies was on intervention on health services usage.

McCauley et al. (2015) carried a research on sexual and reproductive health indicators and intimate partner violence victimization among female family planning clinic patients who has sex with women and men in Western Pennsylvania. Baseline data from a prospective intervention trial were collected from woman ages 16-29 years. The population of the study was 3,455. Instrument for data collection was questionnaire. Mutil variable logistic regression for clustered survey data was used to compare women who has sex with man only (WSM) and woman who has sex with woman and man (WSWM). The difference in social demographic characteristics between WSWM and WSM were assessed via Wald Log-linear, chi-square tests for clustered survey data, with statistical significance level at $P < 0.05$. The finding from the study shows that WSWM were significantly more likely than WSM to report a lifetime history of intimate partner violence (IPV). Controlling for IPV, WSWM reported higher levels of sexual risk behaviours (eg unprotected vaginal sex, unwanted pregnancy and sexually transmitted infections (STIS) and pregnancy testing but less contraceptive care seeking therefore the association between IPV and lifetime STLS diagnosis was greater among WSWM than among WSM. Both researchers carried out a research on sexual and reproductive health, the difference is that the former studies on intimate partner violence viticimization while the present study is based on practice.

Crossland, Hadden, vargas, valades, and Jeffery (2015) carried out a study on sexual and reproductive health among Ugandan youths. The objective of the study was to determine the increase in morbidity, mortality and gender inequality and slow development in sexual and reproductive health. Survey data were collected and analyzed using the lot quality assurance sampling (LQAS) technique from two time periods, 2003-2004 and 2012. Knowledge, behaviours and access to SRH services of youth aged 15-24 years were assessed. Logistic

regression was used to examined factors associated with these indicators. Results from the findings revealed that all indicators have improved between the early and later time periods. Youths knowing where to get HIV tests increased from <40 percent to 80 percent (both sexes). The number of youth reported ever had a HIV test increased from 8 percent to 4 percent (male) and 10 percent to 64 percent (female. 83 percent of female youth, compared with 93 percent of males reported knowing where to obtain condoms. The proportion of youths reporting sexual debut before age 15 years decreased, less for males than that of females. The researcher noted that increased age and level of education were associated with positive change for most indicators. Both study was based on sexual and reproductive health of adolescent/youth but the difference is that the former studied morbidity, mortality gender inequality and slow development while the present study was based on practice.

Chimah, Lawoyin, Ilika, and Nnebue (2016) conducted a study on contraceptive knowledge and practice among senior secondary school students in Ojo military barracks in Nigeria. The objective of the study was to determine the level of knowledge of contraceptive use among senior secondary school students in Ojo military barracks, Lagos. Cross sectional research design was used for the study. Population of the study consisted of 400 senior secondary school student in Ojo military barracks, Lagos. Multi stage sampling technique was employed. Data were collected using pretested, self administered structured questionnaire. The data were analyzed using statistical package for social sciences version 17. The study reported among others that there was a fairly high level of knowledge and relatively low use of contraceptive. The study was related to present study because both used multistage sampling procedure and self administered structured questionnaire while the difference is that the former used SPSS version 17, the present study utilized SPSS version 22.

Saratu, and Mbegbu (2016) carried out a study on Adolescent youths utilization of reproductive health services. The aim of the study was to examine the knowledge of youths on available adolescent/youth friendly services. Descriptive cross sectional design was used for the study. The population of the study was 139,391. The sample size was 427. Multistage sampling procedure was used for the study. The instrument for data collection was questionnaire. Data were analyzed using SPSS version 21 univarte analysis was used to derive percentages and frequencies. Findings from the study revealed that 288 (82%) of the respondents had general knowledge about adolescent/youth friendly reproductive health services (A/YFRHS). More than half 268 (79.5%) of the respondents did not know of a specific A/YFRHS provided in the study.

Friends/peers (215.7%) were the best source of information on A/YFRHS. The most popular services known were family planning (81.6%), voluntary counselling and testing (73.80%) and sexually transmitted diseases (67.3%). The researcher therefore concluded that the participants knew what A/YFRHS were but did not know where to get these services from because they were not aware of the available A/YFRHS facilities. The study was related to the present study because both examines the adolescent reproductive health but while former was based on the utilization of reproductive health services the present was on sexual and reproductive practice.

A qualitative research was carried out by Khanal (2016) on adolescent's knowledge and perception of sexual and reproductive health and services in Nepal. The general aim of the study was to explore knowledge and perception of late adolescent's aged 15 to 19 years towards sexual and reproductive health and services in kapiluasty and Arghakhanchi districts of Nepal. Purposive sampling technique was used for the study. The study comprises of adolescents both male and female who were select for the study. The study design was qualitative study to gain a deeper understanding of sexual and reproductive health problems faced by late adolescents (15-19 years of aged). Data was collected using semi-structured in-depth interviews. Data were analyzed using thematic frame work approach. The findings of the study revealed that almost all participants were aware about some of the common sexual and reproductive health problems such as HIV/AIDs, gonorrhea and syphilis. This study was related to the present study in that it studied sexual and reproductive health while the difference was that the present study studied practice while the other study was based on knowledge and perception

Ngilangwa et al. (2016) carried out a cross-sectional study on accessibility to sexual and reproductive health and rights education among marginalized youth in selected districts of Tanzania. Taro Yamane formular was used to derive the sample size of 400 participants, the instrument used for the study was questionnaire. Those with visual impairment were assisted to complete the questionnaire by research assistants and there were sign Languages interpreters for those who had hearing impairment. The data was coded and analyzed using the statistical packaged for social sciences (SPSS) version 20.0. Data were analysed using both descriptive an inferential statistics, the result of the study showed that young people depended on multiple sources of information about sexual and reproductive health. The leading sources of SRHR information for the majority of the surveyed young people was peers followed by parents, teachers, radio and television. Both studies were on sexual and reproductive health of

adolescents/youths, while the former studied health and rights education the present was based on practice.

Odeyemi, Olufunlaya, Ogunnowo, and Onajole (2016) carried out a research on sexual violence among out of school female adolescents in Lagos State. Descriptive cross sectional study was adopted to sought the prevalence of sexual violence among out of school female adolescents in Lagos. The population of the study was female out of school adolescents who were unmarried and between ages 10 and 19 years working or serving as apprentices in the market. The minimum sample size was established using Cochran's formular. Three hundred and fifty adolescents between the ages of 10 and 19 years were selected for the study, the sample size was determined using the cochran's (1977) formular, the sampling method used was cluster sampling. Data were collected using pretested questionnaire. Epi info 6 statistical software was used for data entry and analysis. Result revealed that 42. 9 per cent of the respondents have had sexual intercourse and median age at initiation was 17 years. Force initiation was reported by 15.8 percent and 36 percent reported that first intercourse was due to coercion. Among the sexually active, only 12.3 percent stated that "It is what the desire". Majority of the respondents 64.1 per cent believed that rape was common in their community, and 20.5 per cent of the sexually active have experienced rape.

Ndongmo, Ndongwo, and Michelo (2017) carried out a research on sexual and reproductive health knowledge and behaviour among adolescents living with HIV in Zambia. The aim of the study was to explore the sexuality and sexual reproductive health experience and needs. The research design was a non-interventional cross section mixed method. Population of the study consisted of 148 adolescent (63.5%) females aged 15-19 years. The study adopted cross-sectional research design. Purposive sampling technique was used. Adolescents at tertiary hospital were surveyed on their sexuality and SRH experiences. Data were collected through structured questionnaire and have both open and close end questions. Data was analyzed using statistical package for social science (SPSS) version 17.0, descriptive statistic, and frequencies of socio-demographic characteristics were carried out. Chi-square was used to analyze factors associated with different key sexual behaviour, statistical significance were establish at 0.05. Findings from the study revealed that out of 148 adolescents (63.5%) females aged 15-19 years who were surveyed, majority (77.0%) had secondary education; 77.2 per cent currently in school; 40.1% had a boy or girlfriend; 15.1 per cent have ever had sex, of whom only 61.1 per cent reported consistent condom use; 2.1 per cent of girls had been pregnant before, of 52

respondents, 19.2 percent had a sexually transmitted infection (STI) before. Not being in school was a significant predicator, for not knowing where to access information about sex. Both were on sexual and reproductive health but the difference was that the former studied on knowledge and behaviour while the present was based on practice.

Gabriel-Job, Asuquo, and Alabere (2018) carried out a study on determinants of the age at sexual debut among adolescents in secondary schools in Obio/Akpor Local government area of River state, Nigeria. A descriptive cross-sectional school based study was carried out among eight secondary schools in Obio/Akpor LGA. Multistage sampling procedure was used, 426 students aged 10-19 years were used for the study. Semi-structured pretested self administered questionnaire was used. SPSS version 20 was used for analysis, comparison of mean was done using the student's t-test, while the test for between subgroups was carried out using chi-square, the study reported that the prevalence of sexual intercourse was 8.0 per cent with a mean age at sexual debut of 13.0± 2.3years. The study is related to present study because multi stage sampling procedure was utilized in both study but the difference was that the former used descriptive cross-sectional research, and SPSS version 20 while the present study employed descriptive survey research design and SPSS version 22.

Odo, Samuel, Nwagu, Nnamani, and Atama (2018) conducted a research on sexual and reproductive health services (SRHS) for adolescents in Enugu State. Cross-sectional design was adopted to assess the availability and accessibility of SRH services to adolescent. The sample was 1,620 adolescents and sample size was determined using cohen, Manion, and Morrison sample size chart. All instrument used for the study was pre-tested, and data for quantitative were analyzed using descriptive statistics and chi-square test. SPSS version 20.0 was employ for statistical analysis. Finding from the study revealed that majority (86.7%) of the adolescents reported availability of safe motherhood services and (67.5%) reported availability of services for prevention and management of STIs and HIV. The majority reported that these services were geographical accessible but few were financially accessible to adolescents. The relationship was that both studied sexual and reproductive health of adolescents but the difference was that the former was based on health service while the present was based on practice.

Sharifa et al. (2018) carried out a study on knowledge, attitude and practice related to reproductive health among adolescents. The aim of the study was to assess knowledge, hygiene practices during Menses and attitudes of female adolescents in Riyadh female secondary schools regarding reproductive health aspects. Cross-sectional research design was used for the study.

The populations of the study consisted of 2, 452 female students, and the sample size of the study was 350 female students. Multi stage sampling procedure was utilized. Instruments for data collection were questionnaire and assessment scale. Data were analyzed using statistical package for social sciences (SPSS) version 22. Finding from the study revealed that more than two-thirds (6603%) of the participants had inaccurate knowledge while about one-third (33.7%) of them had correct knowledge regarding reproductive health. The researchers concluded that female adolescent had unsatisfactory and positive attitudes towards reproductive health. The relationship was that both were on female secondary school students, they both utilized multi stage sample procedure and SPSS version 22 was used in analyzing the data for both studies. Both studies equally employed questionnaire in method of data collection but the difference is that the former utilized cross-sectional research design while the present used descriptive survey research design.

Summary of Literature Review

Sexual health was conceptualized as the integration of the somatic emotional, intellectual and social aspects of sexual being in way that positively enriches personality, communication and love. Reproductive health is seen as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. Contextually sexual and reproductive health was referred to as a state of complete physical, mental and social wellbeing in all matters relating to reproductive system. This therefore involves adolescent girls sexual practices which enable them to remain free from unplanned pregnancy regulate their fertility, avoid abortion and its complications, reproductive tract infections, forced early marriage and discontinuation of education. Components of SRH health includes improving safe mother-hood antenatal, prenatal, postpartum and neonatal care, providing high quality service for family planning including infertility service, elimination of unsafe abortion unwanted pregnancy, sexual abuse prevention and treatment of malignancies of reproductive system. In the context of this study, adolescents are seen as group of girls aged 13-19 years. In-school female adolescents were described as a group of young girls who are actually in secondary school which can be either boarding or day students. Practice in this study is seen as the way in-school female adolescent view their sexual and reproductive health. Factors that affect SRH practice reviewed in this study include age, class and religion.

The theoretical framework anchored on two theories, theory of reason action (TRA). The theory was used to explain the SRH practice of in-school female adolescents in the area of the

study. The empirical studies reviewed revealed that adolescent girls are more sexually active than their male counterpart and thus there is an increase in unplanned pregnancy, criminal abortions and many birth complications of early childbearing which results to dropping out from schools. Most of the studies were conducted in Sub-Saharan African and European countries. Most of the authors who conducted related studies employed cross sectional research design, descriptive cross-sectional research design and few on descriptive survey research design. Most reviewed studies employed questionnaire as instrument of data collection, only one study was solely on qualitative and few employed both interview and questionnaire. Majority of the sampling techniques adopted were multi stage sampling procedure. Most of data were analyzed using SPSS. Few related study considered age, class and religion as possible factors of SRH practice. Most of studies were on access, knowledge, health services, health care, attitude and behavior of sexual and reproductive health of adolescents. Therefore, age, class and religion have not been widely explored as factors of SRH practice of in-school female adolescents. This undeniable fact created a gap in literature which the present study intends to fill.

CHAPTER THREE

Methods

This chapter presents a description of the research designs, area of study, population, sample and sampling technique, instrument for data collection, validity of the instrument, methods of data collection and methods of data analysis used in this study,

Research Design

In other to achieve the objective of this study, the descriptive survey research design was employed. Frank Fort-Nachmias and Nachmias (2006) defined descriptive survey design as a research design used most predominantly in survey research because it facilitates the gathering of information about a large population by collecting information from a segment/portion of that very population from where generalization can be inferred. This design was successfully utilized by Ngwu (2012) to examine sexual and reproductive health attitude and behaviour among secondary school students in Enugu State. Nwalo and Anasi (2012) also used a descriptive survey research design to study on access to and use of reproductive health information among in-school adolescent girls in Lagos State. Therefore, the design was considered appropriate for use in this study.

Area of the study

The study was carried out in Idemili North Local Government Area (LGA), Anambra State. Idemili North is one of the twenty-one LGAs in Anambra State, the LGA is bounded on the North by Oyi and Dunkofia LGA. And the east by Njikoka and Anaocha LGA and on the south and West by Idemili South and Onistha South LGAs respectively. The LGA is situated at the central part of the State. There are 10 communities that make up Idemili North Local Government Area. (see Appendix C, p.76) The people are hard working both in education and business. There are sixteen public secondary schools distributed within the communities in Idemili North LGA (see Appendix B, p. 75) these secondary schools are filed up with adolescents within the age of 10-19years. The popular market called Ogidi international building materials market is situated at Ogidi community where the Local Government Headquarters is also located. All the communities still have their own big markets. Adolescent girls do hawk their goods in these big markets. The hawking activity often makes them prey to sexual exploitation and some end up with unwanted pregnancies, school dropout, abortion, STIs and premature death. There are many cases of adolescent girls dropping out of school as a result of

unplanned and teenage pregnancy, criminal abortions and complications of early child birth. In-school female adolescents in the area appear to be at stage of experimentation, indulging in unhealthy sexual practices, been confused, taking decision that can affect their health and future development. It is against this back-bone that the study focuses on sexual and reproductive health practices of in-school female adolescents in the area.

Population of the Study

The population of the study consisted of in-school female adolescent in public secondary schools in Idemili North Local Government Area, Anambra State. The population of in-school female adolescent is 6,021 (Post Primary School Management Board [PPSMB] (2017/ 2018). There are fourteen public secondary schools in Idemili North (see Appendix B, p. 75).

Sample and Sampling Techniques

The sample size for the study consisted of 400 in-school female adolescents in Idemili North Local Government Area, the sample is determine using Taro Yamane's formula (1976) (see Appendix D, p. 77). Multistage sampling procedure was employ to draw the sample size for the study.

The first stage involved use of simple random sampling technique to select five schools in Idemili North L.G.A. of Anambra State. In the second stage, simple random sampling without replacement was used to select two classes each from JSS and SSS classes and a total of four classes was selected from each of the selected school for the study. Convenience sampling technique was employed to select 9 students from each of the JSS stream and 11 students from each of the SSS stream of the each of the selected schools. On the completion of this procedure, 36 students were selected in each of JSS classes and 44 students in each of SSS classes of the selected schools. This produced the sample size for the study.

Instrument for Data Collection

The instrument for data collection was researcher structured questionnaire titled "Sexual and Reproductive Health Practices of Adolescent Questionnaire" (SRHPAQ) (see Appendix A, p. 73). The questionnaire was divided into two sections: Section A and B. The section A consisted the bio-data of the respondents. Section B consisted of 15 items on SRHPQ of adolescents girls, the items were assigned Yes or No response options and the respondents were required to place a thick (√) in the box of any option they decide to chose as their answer.

Validity of the instrument.

The validity of the research instrument was establish by giving the draft instrument, the specific objectives and the research question of the study to five experts in the Department of Human Kinetics and Health Education, University of Nigeria, Nsukka. They were requested to critically examine the questionnaire and then to find out if the instrument covers the objectives of the study. They were also required to check for the appropriateness of each item in terms of language as well as the suitability of the questionnaire items that will be included in the instrument and make corrections as they deem fit. Their observations, comments and suggestions were considered before producing the final version of the questionnaire.

Reliability of the instrument.

The reliability of the instrument was established by carrying out a trial-test on twenty in school female adolescent in Idemili South LGA of Anambra state that has peculiar features with Idemili North LGA of Anambra state. The internal consistency for section B of SRHPAQ was computed using split half statistics (Spearman's Brown Coefficient). Based on this the reliability coefficient of .766 was obtained (see Appendix F, p. 79), and was considered reliable for the present study. According to Cohen, Manion and Morrison (2011), if the reliability coefficient attains .70 and above, the instrument should be considered reliable and suitable for gathering information towards achieving the purposes of the study and vice versa.

Method of Data collection

In order to gain access to the schools and the respondents, a letter of introduction obtained from the Head of Department, Human Kinetics and Health Education University Nigeria, Nsukka (see Appendix E, p. 78), was presented to the school principals requesting for permission and co-operation to carry out this study. The principals of the selected schools introduced the researcher to the class teachers for assistance and co-operation in administering the questionnaire. The teacher was briefed on the modalities for administering the instrument. The researcher use direct delivery where by the researcher and the class teachers will supervise the respondents to ensure that there was no exchange of ideas when completing the questionnaire and to ensure high return rate.

Method of Data Analysis

The completed copies of the instrument were screened for completion of responses. The 395 returned copies of SRHPAQ were properly filled out and used for data analysis. Information

from the instrument were coded into IBM statistical package for social sciences (SPSS) version 22, and analyzed to indicate the response frequencies and percentages.

The research questions were answered using percentages while the null hypotheses were tested using chi-square statistics at .05 level of significance. The null hypotheses were rejected if the p-values were less than 0.05 level of significance, however, if the p-values were greater than 0.05 level of significance, the null hypotheses were not rejected.

CHAPTER FOUR

Results and Discussion

This chapter presents and discuses the results of the study on sexual and reproductive health practices among in-school female adolescents in Idemili North Local Government Area of Anambra State. Four hundred copies of the questionnaire were administered to the students to fill out and all were collected back indicating 99% return rate, out of this number five (5) copies were discarded due to lack of completeness of information. The remaining 395 copies were used for analysis.

Results

The following results were derived from the data collected and were presented as shown below:

Research question one.

What is the proportion of in-school female adolescents who practice safe and unsafe sex? Data answering this research question are contained in Table 1.

Table 1

Proportion of In-school Female Adolescents Who Practiced Safe and Unsafe Sex (n = 395)

S/N	Items	Yes
	Safe sex practices	**f (%)**
1.	Do you use condom when having sexual intercourse with your partner	56 (14.2)
2.	Have you used contraceptives or have encouraged your partner to use contraceptives in order to prevent pregnancy	87 (22.0)
3.	Have you been kissed before	199 (50.4)
4.	Do you masturbate	289 (73.2)
5.	Does masturbation satisfy your sexual urge	91 (23.0)
	Cluster %	**36.6**
	Unsafe sex practices	
6.	Do you engage in oral sex with your partner	61 (15.4)
7.	Have you had sexual intercourse with more than one person within a Year	61 (15.4)
8.	Do you engage in anal sex	8 (2.0)
9.	Have you being caressed or touched in a way you were moved to have Sex	261 (66.1)
10.	Have you has sex with the same sex	116 (29.4)
	Cluster %	**25.7**

The result in Table 1 showed that overall, 36.6 per cent of in-school female adolescents engaged in safe sex and 25.7 per cent engaged in unsafe sex practices. This indicates that in-school female adolescents engaged in both safe and unsafe sex practices.

Research question two.

What is the proportion of in-school female adolescents who use contraceptives? Data answering this research question are contained in Table 2.

Table 2

Proportion of In-school Female Adolescents Who Used Contraceptives (n = 395)

S/N	Items	Yes	
		f	(%)
	Do you use any of these contraceptives?		
1.	Contraceptives pills	63	(15.9)
2.	Male condom	72	(18.2)
3.	Female condom	8	(2.0)
4.	Contraceptives injection	56	(14.2)
5.	Withdrawal method	38	(9.6)
	Cluster %	**12.0**	

Data in Table 2 revealed that overall, 12.0 per cent of in-school female adolescents uses contraceptives. This implies that in-school female adolescent has low contraceptives use.

Research question three.

What is the proportion of in-school female adolescents who practice safe and unsafe sex based on age? Data answering this research questions are contained in Table 3.

Table 3

Proportion of In-school Female Adolescents Who Practiced Safe Sex and Unsafe Sex Based on Age (n = 395)

S/N	Items (safe sex practices)	< 13 years **Yes** **f (%)**	13 – 15 years **Yes** **f (%)**	15 – 19 years **Yes** **f (%)**
1.	Do you use condom when having sexual intercourse with your partner	2 (8.3)	12 (8.5)	56 (14.2)
2.	Have you used contraceptive or have encouraged your partner to use contraceptive in order to prevent pregnancy	4 (16.7)	17 (12.0)	66 (28.8)
3.	Have you been kissed before	7 (29.2)	64 (45.1)	128 (55.9)
4.	Do you masturbate	15 (62.5)	99 (69.7)	175 (76.4)
5.	Does masturbation satisfy your sexual urge	7 (29.2)	22 (15.5)	62 (27.1)
	Cluster %	**29.2**	**30.2**	**40.5**
	Unsafe Sex Practices			
6.	Do you engage in oral sex with your partner	3 (12.5)	10 (7.0)	48 (21.0)
7.	Have you had sexual intercourse with more than one person within a year	4 (16.7)	12 (8.5)	45 (19.7)
8.	Do you engage in anal sex	0 (0.0)	2 (1.4)	6 (2.6)
9.	Have you being caressed or touched in a way you were moved to have sex	15 (62.5)	94 (66.2)	152 (66.4)
10.	Have you had sex with the same sex	3 (12.5)	39 (27.5)	74 (32.3)
	Cluster %	**20.8**	**22.1**	**28.4**

Result in Table 3 revealed that overall, in-school female adolescents aged 15-19 years (40.5%) practiced safe sex; students aged 13-15 years (30.2%) and <13years (29.2%) engaged in safe sex practices. Furthermore, the table showed that the students aged 15-19 years (28.4%), 13-15 years (22.1%), and <13 years (20.8%) engaged in unsafe sex practices. This implies that the students aged 15-19 years, 13-15 years and < 13 years engaged in safe sex practices and unsafe sex practices..

Research question four.

What is the proportion of in-school female adolescents who practice safe sex and unsafe sex based on class? Data answering this research questions are contained in Table 4.

Table 4

Proportion of In-school Female Adolescents Who Practiced Safe and Unsafe Sex Based on Class

S/N	Items (safe sex practices)	JSS Yes f (%)	SSS Yes f (%)
1.	Do you use condom when having sexual intercourse with your partner	22 (12.7)	33 (15.3)
2.	Have you used or encouraged your partner to use contraceptives in order to prevent pregnancy	27 (15.6)	60 (27.0)
3.	Have you been kissed before	70 (40.5)	129 (58.1)
4.	Do you masturbate	119 (68.8)	170 (76.6)
5.	Does masturbation satisfy your sexual urge	41 (23.7)	50 (22.5)
	Cluster %	**32.3**	**40.0**
	Unsafe sex practice		
6.	Do you engage in oral sex with you partner	17 (9.8)	44 (19.8)
7.	Have you had sexual intercourse with more than one person within a year	23 (13.3)	38 (17.1)
8.	Do you engage in anal sex	1 (0.6)	7 (3.2)
9.	Have you being caressed in a way you were moved to have sex	118 (68.2)	143 (64.4)
10.	Have you had sex with the same sex	43 (24.9)	73 (32.9)
	Cluster %	**23.4**	**27.5**

Result in Table 4 indicated that overall, SSS students (40.0%) and JSS students (32.3%) engaged in safe sex practices. The table equally showed that SSS students (27.5%) and JSS students (23.4%) engaged in unsafe sex practices. This implies that SSS students and JSS students engaged in safe sex and unsafe sex practices.

Research question five.

What is the proportion of in-school female adolescent who practice safe and unsafe sex based on religion? Data answering this research question are contained in Table 5.

Table 5

Proportion of In-school Female Adolescent Who Practiced Safe and Unsafe Sex Based on Religion (n = 395)

S/N	Items (safe sex practices)	Christian Yes f (%)	Muslim Yes f (%)
1	Do you use condom when having sexual intercourse with your partner	54 (13.8)	2 (50.0)
2.	Have you used or encouraged your partner to use contraceptives in order to prevent pregnancy	85 (21.7)	2 (50.0)
3.	Have you been kissed before	196 (50.1)	3 (75.0)
4.	Do you masturbate	285 (72.9)	4 (100.0)
5.	Does masturbation satisfy your sexual urge	90 (23.0)	1 (25.0)
	Cluster %	**36.3**	**60.0**
	Unsafe sex practice		
6.	Do you engage in oral sex with you partner	59 (15.1)	2 (50.0)
7.	Have you had sexual intercourse with more than one person within a year	59 (15.1)	2 (50.0)
8.	Do you engage in anal sex	8 (2.0)	0 (0.0)
9.	Have you being caressed in a way you were moved to have sex	258 (66.0)	3 (75.0)
10.	Have you had sex with the same sex	113 (28.9)	3 (75.0)
	Cluster %	**25.4**	**50.0**

Data in Table 5 revealed that overall, Muslim students (60.0%) and Christian students (36.3%) engaged in safe sex practices. The table also showed that the Muslim students (50.0%) and Christian students (25.4%) engaged safe sex practices. This implies that overall, Muslim students engaged in both safe and unsafe sex practices more than Christian students.

Research question six.

What is the proportion of in-school female adolescents who use contraceptives based on age? Data answering this research questions are contained in Table 6.

Table 6

Proportion of In-school Female Adolescents Who Used Contraceptives Based on Age (n = 395)

S/N	Items	< 13 years Yes f (%)	13 – 15 years Yes f (%)	15 – 19years Yes f (%)
	Do you use any of these contraceptive?			
1.	Contraceptives pills	2 (8.3)	16 (11.3)	45 (19.7)
2.	Male condom	2 (8.3)	16 (11.3)	54 (23.6)
3.	Female condom	1 (4.2)	3 (2.1)	4 (1.7)
4.	Contraceptive injection	3 (12.5)	14 (9.9)	39 (17.0)
5.	Withdrawal method	1 (4.2)	11 (7.7)	26 (11.4)
	Cluster %	**7.5**	**8.5**	**14.7**

The results in Table 6 showed that overall, in-school female adolescents aged 15-19 years (14.7%), 13-15 yeas (8.5%) and < 13 years (7.5%) used contraceptives. This implies that in-school female adolescent have low use of contraceptives based on age.

Research question seven.

What is the proportion of in-school female adolescents who uses contraceptives based on class? Data answering this research question are contained in Table 7.

Table 7

Proportion of In-school Female Adolescents Who Used Contraceptives Based on Class (n = 395)

S/N	Items	JSS	SSS
	Do you use any of these contraceptive?	**Yes** **f (%)**	**Yes** **f (%)**
1.	Contraceptives pills	24 (13.9)	39 (17.6)
2.	Male condom	19 (11.0)	53 (23.9)
3.	Female condom	7 (4.0)	1 (0.5)
4.	Contraceptives injection	15 (8.7)	41 (18.5)
5.	Withdrawal method	14 (8.1)	24 (10.8)
	Cluster %	**9.1**	**14.3**

Result in Table 7 indicated that overall, SSS students (14.3%) and JSS students (9.1%) used contraceptives. This implies that in-school female adolescent have low use of contraceptives based on class.

Research question eight.

What is the proportion of in-school female adolescent who uses contraceptives based on religion? Data answering this research question is contained in Table 8.

Table 8

Proportion of In-school Female Adolescent Who Used Contraceptive Based on Religion (n = 395)

S/N	Items	Christian	Muslim
	Do you use any of these contraceptive?	**Yes** **f (%)**	**Yes** **f (%)**
1.	Contraceptives pills	61 (15.6)	2 (50.0)
2.	Male condom	71 (18.2)	1 (25.0)
3.	Female condom	8 (2.0)	0 (0.0)
4.	Contraceptives injection	55 (14.1)	1 (25.0)
5.	Withdrawal method	38 (9.7)	0 (0.0)
	Cluster %	**11.9**	**20.0**

Data in Table 8 showed that overall, Muslim students (20.0%) and Christian students (11.9%) used contraceptive. This implies that Muslim and Christian in-school female adolescent have low use of contraceptives.

Hypothesis one.

There is no significant differences in the proportion of in-school female adolescent that engaged in safe and unsafe sexual practices based on age. Data testing this hypothesis are contained in Table 9.

Table 9

Summary of Chi-square Analysis of Proportion of In-school Female Adolescents That Engaged in Safe and Unsafe Sex Practices Based on Age.

		Safe and Unsafe Sex Practices				
Variable	**n**	**True**	**False**	χ^2	**df**	**P – value**
		O (E)	**O (E)**			
Age						
< 13 years	24	3 (12.5)	21 (87.5)			
13 – 15 years	142	8 (5.6)	134 (94.4)	12.200	2	.002
16 -19 years	229	42 (18.7)	187 (81.7)			
Total	**395**					

Significant P < .05

0 = observed frequencies, E = Expected frequencies, df = Degree of freedom

Data in Table 9 showed the result of chi-square test for independence of no significance difference based on age. The table showed that there was a significant difference in the sexual and reproductive health practices of in-school female adolescent based on age (χ^2 = 12.200, df = 2, p – value = .002). Since the p – value of .002 is less than .05 level of significance the null hypothesis was rejected. This implies that in-school female adolescents differed in their safe and unsafe s practices based on age.

Hypothesis two.

There is no significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sexual practices based on class. Data testing this hypothesis are contained in Table 10.

Table 10

Summary of Chi-square Analysis of Proportion of In-school Female Adolescents That Engaged in Safe and Unsafe Sex Practices Based on Class.

		Safe and Unsafe Sex Practices					
Variable	**n**	**True**	**False**	χ^2	**df**	**P – value**
		O (E)	**O (E)**			
Class						
JSS	173	17 (9.8)	156 (90.2)	3.417	1	.065
SSS	222	36 (16.2)	186 (83.8)			
Total	**395**					

Significant P > .05
0 = observed frequencies, E = Expected frequencies, df = Degree of freedom.

Data in Table 10 showed the result of chi-square test for independence of no significant difference based on class. The table showed that no significant difference was found in the in-school female adolescents that engage in safe and unsafe sex based on class ($\chi^2 = 3.417$, df = 1, P – value = .065). Since the p – value of .065 is greater than .05 level of significance; the null hypothesis was not rejected. This implies that in-school female adolescents did not differed in their safe and unsafe sex practices based on class.

Hypothesis three.

There is no significant differences in the proportion of in-school female adolescent that engage in safe and unsafe sex practices based on religion. Data testing this hypothesis are contained in Table 11.

Table 11

Summary of Chi-square Analysis of Proportion of In-school Female Adolescents That Engaged in Safe and Unsafe Sex Practices Based on Religion.

		Safe and Unsafe Sex Practices				
Variable	**n**	**True**	**False**	χ^2	**df**	**P – value**
		O (E)	**O (E)**			
Religion						
Christian	391	52 (13.3)	339 (86.7)	.467	1	.495
Muslim	4	1 (25.0)	3 (75.0)			
Total	**395**					

Significant P >.05
0 = observed frequencies, E = Expected frequencies, df = Degree of freedom.

Data in Table 11 showed the result of chi-square test for independence of no significant difference based on religion. The table showed that a significant difference was found in safe and unsafe sex practices of in-school female adolescents based on religion (χ^2 = 467, df = 1, p – value = .495). Since the p – value of .495 is greater than .05 level of significance, the null hypothesis was not rejected. This implies that in-school female adolescents did not differed in their safe and unsafe sex practices based on religion.

Hypothesis four.

There is no significant difference in the proportion of in-school female adolescent that uses contraceptive based on age. Data testing this hypothesis are contained in Table 12.

Table 12

Summary of Chi-square Analysis of Proportion of In-school Female Adolescent That used Contraceptive Based on Age.

Variable	n	Contraceptive Use		χ^2	df	P – value
		True	False			
		O (E)	O (E)			
Age						
< 13 years	24	1 (4.2)	23 (95.8)			
13 – 15 years	142	2 (1.4)	140 (98.6)	8.704	2	.013
16 -19 years	229	20 (8.7)	209 (91.3)			
Total	**395**					

Significant P < .05

0 = observed frequencies, E = Expected frequencies, df = Degree of freedom.

Data in Table 12 showed the result of chi-square test for independence of no significant difference based on age. The table showed that a significant difference was found in the contraceptive use of in-school female adolescents based on age (χ^2 = 8.704, df = 2, p – value = .013). Since the p – value of .013 is less than.05 level of significance the null hypothesis was therefore rejected. This implies that in-school female adolescents differed in their contraceptives use.

Hypothesis five.

There is no significant difference in the proportion of in-school female adolescent that uses contraceptive based on class. Data testing this hypothesis are contained in Table 13.

Table 13

Summary of Chi-square Analysis of Proportion of In-school Female Adolescent That Uses Contraceptives Based on Class.

		Contraceptive Use				
Variable	**n**	**True**	**False**	χ^2	**df**	**P – value**
		O (E)	**O (E)**			
Class						
JSS	173	5 (2.9)	168 (97.1)	4.828	1	.028
SSS	222	18 (8.1)	204 (91.9)			
Total	**395**					

Significant p < .05

O = Observed frequencies, E = Expected frequencies, df = Degree of freedom.

Data in Table 13 showed the result of chi-square test for independence of no significant difference in the proportion of in-school female adolescents that uses contraceptives based on class. The table showed that no significance difference was found in the contraceptive use of in-school female adolescents based on class ($\chi^2 = 4.828$, df = 1, p – value = .028). Since the p-value of .028 is less than .05 level of significance the null hypothesis was rejected. This implies that in-school female adolescent differed in their contraceptive use based on class.

Hypothesis six.

There is no significant difference in the proportion of in-school female adolescent that uses contraceptives based on religion. Data testing this hypothesis are contained in Table 14.

Table 14

Summary of Chi-square Analysis of Proportion of In-school Female Adolescent That Uses Contraceptive Based on Religion

		Contraceptive Use				
Variable	**n**	**True**	**False**	χ^2	**df**	**P – value**
		O (E)	**O (E)**			
Religion						
Christian	3914	23 (5.9)	368 (94.1)	.250	1	.617
Muslim	4	0 (0.0)	4 (100.0)			
Total	**395**					

Significant p > .05

O = observed frequencies, E = expected frequencies, df = degree of freedom

Data in Table 14 showed the result of chi-square test for independence of no significant difference based on religion. The table showed that a significant difference was found in the contraceptive use of in-school female adolescent based on religion (χ^2 = .250, df = 1, p – value = .617). Since the p – value of .617 is greater than .05 level of significance, the null hypothesis was not rejected. This implies that in-school female did not differed in their contraceptives use based on religion.

Summary of Major Findings

From the analysis of the data the summary of major findings are as follows:

1. Overall, 36.6 per cent of in-school female adolescent engaged in safe sex practices and 25.7 per cent engaged in unsafe sex practices. This is contained in Table 1.
2. Overall, 12.0 per cent of in-school female adolescent had low use of contraceptives. This is contained in Table 2.
3. Overall, Students aged 15 to 16 years (40.5%); students aged 13 to 15 years (30.2%;) and < 13 years (29.2%) engaged in safe sex practices and students aged 16-19 years (28.4%), 13-15 years (22.1%) and < 13 years (20.8%) engaged in unsafe sex practices. This is contained in Table 3.
4. Over all, SSS students (40.0%) and JSS students (23.4%) engaged in safe sex practices and SSS students (27.5%) and JSS students (23.4%) engaged in unsafe sex practices. This is contained in Table 4.

5. Muslim students (60.0%) and Christian students (36.3%) engaged in safe sex practices and Muslim students (50.0%) and Christian students (25.4%) engaged in unsafe sex practices. This is contained in Table 5.
6. Overall, Students aged 15 to 19 years (14.7%), 13-15 years (8.5%) < 13 years (7.5%) used contraceptive. This is contained in Table 6.
7. Overall, SSS students (14.3%), and JSS students (9.1%) used contraceptive. This is contained in Table 7.
8. Overall, Muslim students (20.0%) and Christian students (11.9%) used contraceptives. This is contained in Table 8.
9. There was a significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sex practices based on age (χ^2 = 12.200, *df* = 2, *P* = .002). This is contained in Table 9.
10. There was no significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sex practices based on class and religion (χ^2 = 3.417, *df* = 1, *P* = .065); (χ^2 = .467, *df* = 1, *P* = .495). This is contained in Tables 10 and 11.
11. There was a significant difference in the proportion of in-school female adolescents that used contraceptive based on age and class (χ^2 = 8.704, *df* = 2, *P* = .013); (χ^2 = 4.828, *df* = 1, *P* = .028). This is contraceptive in Tables 12 and 13.
12. There was no significant difference in the proportion of in-school female adolescent who used contraceptives based on religion χ^2 = .250, *df* =1, *P* = .617). This is contained in Table 14.

Discussion of the findings

The findings are discussed under the following headings:

Safe and unsafe sexual and reproductive health practices of in-school female adolescents

Differences in sexual and reproductive health practices of in-school female adolescents

Sexual and reproductive health practices of in-school female adolescents

Data in Table 1 revealed that overall, 36.6 per cent of in-school female adolescents engaged in safe sex practices. The finding was anticipated and therefore not a surprise. This is because at this stage adolescents experimentation of sexual activities becomes common, even when their sexual experimentation are being monitored and restricted. This is in line with Ngwu (2012) who reported that sexual fantasies and dreams become more common and explicated in adolescents than at earlier ages.

Finding in Table 1 also showed that 25.7 per cent of in-school female adolescents engaged in unsafe sex practices. This finding agrees with Mivinga (2012) who reported that some adolescents were sexually active and indulge in unsafe sex for various reasons, most of which had to do with individual perceptions. Nevertheless, the observed safe sex practice of in-school female adolescents in this study is increasing gradually.

Data in Table 2 indicated that overall, 12.0 per cent of the in-school female adolescents used contraceptives. This is because at this stage adolescent girls may be naïve on how to speak out and also may not have heard/or how to use any form of contraceptives. The finding is in line with Boamah et al. (2013) who reported that a good number of adolescents knew at least one contraceptive method, but this knowledge did not influence them to consistently use contraceptives. The finding also agreed with Joyce, Newton, Nkrumah, Mahlako, and Nambile (2019) who reported that contraceptive knowledge does not necessarily translate into use.

Result in Table 3 showed that overall, students age 15-19 year more than those13-15 years and < 13 years engaged in safe sex practices. The finding was anticipated and therefore did not occur by chance. This is because the older students are expected to be educated and knowledgeable about safe sex practices after their exposure to health education and biology. The finding therefore is line with Gabriel-Job, Asuquo, and Alabere (2018) who reported that the prevalence of sexual intercourse of adolescent was low, with a mean age at sexual debut of 13.0. The above further stated that an early and comprehensive sex education is necessary to protect children from initiating sexual intercourse early in life.

Result in Table 4 indicated that overall, SSS students and JSS students engaged in safe sex practices. The finding was expected, because the different classes of study interact with the same environment, and influence each other but the JSS classes are less exposed to sexual activities than the SSS classes. The finding is in line with Gupta, Mishra, and Prabha (2013) who reported that, although involvement in premarital sexual relationship among adolescents was not too much but awareness regarding safer sex was not satisfactory.

Data in Table 5 indicated that overall, Muslim students and Christian students engaged in safe sex practices. The difference is surprising because one would expect the Christian students to have a better practice of safe sex owing to frequent attendance of church and religious feeling. The findings agrees with Odimegwu (2014) who stated that religious practices is a more importance factor than religious affiliation in affecting adolescents sexual attitudes and behaviour in Nigeria.

Data in Table 6 indicated that overall, students aged 15-19 years, 13-15 years and < 13 years uses contraceptive. The finding was anticipated and therefore did not occur by chance. Thus, it is believed that as one advances in age and carries out an action, the individual gains experience in such a practice. The finding disagrees with Chimah, Lawoyin, Ilika, and Nnebue (2016) who reported that there was high level of knowledge and relatively low use of contraceptives.

Data in Table 7 revealed that overall, SSS students and JSS students uses contraception. The slight difference is surprising because one would expect the senior secondary school students to have a clear difference in their contraceptive use owing to more exposure to health-related subjects such as Biology. The findings is in line with Doyle, Mavedzengo, Plummer, and Ross (2012) who reported that adolescents with higher education have higher use of contraceptives like condom.

Result in Table 8 show that overall, Muslim students more than Christian students uses contraceptive. The findings is not expected and thus is a surprise. This is because Christians are seen to be more exposed and are expected to carry out actions she has gain experience from. However, the finding agrees with Tamang, Raynes-Greenow, McGeechan, and Black (2017) who suggested that contraception education should be intensified and directed towards those entering adolescence to encourage youths to adopt contraception at the time of their first sexual relationship. They therefore stated that the influence of religion on use of modern contraception needs further exploration.

Differences in sexual and reproductive health practices of in-school female adolescents

Data in table 9 and 14 showed that there was a significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sex practices based on age and there was no significant difference in the proportion of in-school female adolescents that used contraceptives based on religion. The findings were anticipated and thus not a surprise. Crossland, Hadden, Vargas, Valades and Jeffery (2015) stated that increased age were associated with positive change for most indicators of SRH and similarly Fehring and Ohlendorf (2007) reported that religion influences contraceptives use among women. They also stated that the more religious the women are the less frequent use of contraceptive.

Data in Tables 10 and 11 indicate that there were no significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sex based on class

and religion. The study was not expected and thus surprising. This is because in-school female adolescent irrespective of class or religion may have had access on ways to involve on safe and unsafe sex, this is as a result of the evolvement of technology and genuine discussions of health risk associated with unsafe sex practices. Although there is a general belief that class and religion has little or nothing to do with the student's sexual debut. However, the finding disagrees with Anene, Oyinaka, and Ndie (2017) who indicated that class of study has a significant effect on students involvement in premarital sex; and Hall, Moereau, and Trusell (2011) who reported that increasing frequency of current religion service participation was negatively associated with sexual and reproductive health use among young women, despite sexual experience.

Data in Table 12 and 13 revealed that there were no significant difference in the proportion of in-school female that uses contraceptives based on age and class. The finding was not expected and thus surprising. Technology has turned the world to a global village, thus students presently have equal opportunities to access contraceptive knowledge irrespective of age and class. Chimah, Lawoyin, Ilike, and Nnebue (2016) indicated that there was high level of knowledge and relatively low use of contraceptives among adolescent.

Implications to Public Health and Education

The study of sexual and reproductive health practices of in-school female adolescents is important, since it is an evidence based research aimed at promoting positive changes in sexual and reproductive health practices among in-school female adolescents. The findings revealed among other things that in-school female adolescents engaged in both safe and unsafe sex practice, and low contraceptive use. Teachers, curriculum planners, school administrators and health educators will find means of promoting sexual and reproductive health practices. Similarly adolescent girls will find means of making inform decision on matters concerning their sexual reproductive health practices.

CHAPTER FIVE

Summary, Conclusion and Recommendations

Summary

The purpose of the study was to investigate sexual and reproductive health practices among in-school female adolescents in Idemili North Local Government Area of Anambra State. To achieve the purpose of the study, eight specific objectives with their corresponding research questions were posed and six hypotheses were postulated to guide the study. Literature pertinent to the study were reviewed under conceptual framework, theoretical framework and review of empirical studies. The study utilized a descriptive survey research design. A structured questionnaire designed by the researcher was used to elicit information on sexual and reproductive health practices. The sample for the study consisted of 400 in-school female adolescents in Idemili North LGA of Anambra State. Out of 400 copies of the questionnaire administered, 395 representing 99% were correctly filled and used for the analysis. Frequencies and percentages were used to answer the research question. The hypotheses were tested using Chi-square statistics at .05 level of significance.

The findings that emanated from the study were that: Overall, 36.6 per cent of in-school female adolescent engaged in safe sex practices and 25.7 per cent engaged in unsafe sex practices, overall, 12.0 per cent of in-school female adolescent made low use of contraceptives, overall, Students aged 15 to 16 years (40.5%); students aged 13 to 15 years (30.2%;) and < 13 years (29.2%) engaged in safe sex practices and students aged 15-19 years (28.4%), 13-15 years (22.1%) and < 13 years (20.8%) engaged in unsafe sex practices, over all, SSS students (40.0%) and JSS students (23.4%) engaged in safe sex practices and SSS students (27.5%) and JSS students (23.4%) engaged in unsafe sex practices, Muslim students (60.0%) and Christian students (36.3%) engaged in safe sex practices and Muslim students (50.0%) and Christian students (25.4%) engaged in unsafe sex practices, overall, Students aged 15 to 19 years (14.7%), 13-15 years (8.5%) < 13 years (7.5%) used contraceptive, overall, SSS students (14.3%), and JSS students (9.1%) used contraceptive, overall, Muslim students (20.0%) and Christian students (11.9%) used contraceptives, there was a significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sex practices based on age (χ^2 = 12.200, *df* = 2, *P* = .002), there was no significant difference in the proportion of in-school female adolescents that engaged in safe and unsafe sex practices based on class and religion (χ^2 = 3.417, *df* = 1, *P* = .065); (χ^2 = .467, *df* = 1, *P* = .495), there was a significant difference in the proportion of in-

school female adolescents that uses contraceptive based on age and class (χ^2 = 8.704, *df* = 2, *P* = .013); (χ^2 = 4.828, *df* = 1, *P* = .028), there was no significant difference in the proportion of in-school female adolescent who use contraceptives based on religion χ^2 = .250, *df* =1, *P* = .617).

Conclusion

The findings have shown that in-school female adolescents engaged in both safe and unsafe sex practices, therefore there is need for in-school female adolescent to be educated on the potential health hazards of engaging in unsafe sex practices. Sexual and reproductive health practices of in-school female adolescent based on age, class of study and religion varied slightly, this is because age and class has a significant role to play in the life of an in-school female adolescent in term of SRH practices, and similarly religion. There was no significant difference found in the sexual and reproductive health practices of in-school female adolescent based on class of study and religion and a significant difference was found in sexual and reproductive health practices of in-school female adolescent based on age. Contraceptive use of in-school female adolescent was low based on age, class of study and religion. There was a significant difference in the contraceptive use of in-school female adolescents based on age and class of study, and there was no significant difference found in the contraceptive use of in-school female adolescents based on religion.

Recommendations

Based on the findings, discussion and conclusion of the study, the following recommendations were made;

1. There is need for government, school authorities and Anambra State Secondary Education Board to expand and intensify sex education for secondary school students.
2. There is need for both parents and health educators to try as much as possible to set good examples for the adolescent's girls to follow on sexuality, this they can do by encouraging the development of a set of values in teenage girls that will guide their sexual practices.
3. Since sex is a powerful force, its true meaning has to be exposed to teenage girls both at home and in-schools to enable them make wise decisions based on self control and personal code of conduct that will encourage positive sexual practices.
4. Parents should know the importance of communication in the home. They should discourage their mind on the tradition of not discussing sex with their children and realize

the danger of lack of discussion which is that the adolescents will seek wrong information from their peers.

5. Ministry of health should liaise with ministry of information to censor the type of films, brought into the country and the program that are cured from median houses.

Limitation of the Study

The study was conducted in only one Local government area of Anambra and was limited to only three components of SHR. This limits the sample size and scope for the study which could affect generalization for the whole Anambra state.

Suggestion for Further Studies

Further studies should be carried out on:

1. Sexual and reproductive health knowledge of secondary school students in Idemili North LGA of Anambra State.
2. Sexual and reproductive health practices of secondary school students in other LGA in Anambra State.
3. Similar topics using teachers and guidance counselors in secondary school.

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Appendix A
Consent letter

Department of Human Kinetics and Health Education,
University of Nigeria,
Nsukka.
May, 2019.

Dear Respondents,

SEXUAL AND REPRODUCTIVE HEALTH PRACTICES QUESTIONNAIRE (SRHPQ)

I am a post graduate student of the above institution, conducting a study on sexual and reproductive health practices of in-school female adolescents in Idemili North Local Government Area of Anambra State. The results of this study will provide a means to identify ways towards halting negative SRH practices.

Please feel free to respond sincerely to all the items in the questionnaire. Your responses will be treated with utmost confidentiality and will only be used for the purpose of this research. You are reassured that your honest responses will not be held against you.

Thanks for your cooperation.

Yours sincerely

Olisa Ujunwa

KINDLY PROVIDE RESPONSES TO THE ITEMS BELOW BY PLACING A TICK (√)

Section A: Bio-data (socio demographic variables)

1. Age

   Less than 13 years ☐

   13 to 15 years ☐

   16 to 19 years ☐

2. Class level

   JSS ☐

   SSS ☐

3. What is your religious affiliation

   Christian ☐

   Muslim ☐

Section B: Measure of SRHP: (Please tick (√) to the one that apply to you)

S/N	SEXUAL PRACTICES OF ADOLESCENT	YES	NO
1.	Do you use condom when having sexual inter-course with your partner?		
2.	Have you used contraceptive or have encourage your partner to use contraceptive in order to prevent pregnancy?		
3.	Have you been kissed before?		
4.	Do you masturbate?		
5.	Does masturbation satisfy your sexual urge?.		
6.	Do you engage in oral sex with your partner?		
7.	Have you had sexual intercourse with more than one person within a year?		
8.	Do you engage in anal sex?		
9.	Have you being caressed or touched in a way you were moved to have sex?		
10.	Have you had sex with the same sex?		
S/N	**CONTRACEEPTIVES USE**	**YES**	**NO**
	Which of these contraceptives methods do you use		
1.	Contraceptives pills (drug for prevention of pregnancy)		
2.	Male condoms		
3.	Female condom		
4.	Contraceptive injection (injection for prevention of pregnancy)		
5.	Withdrawal method		

APPENDIX B

LIST OF SECONDARY SCHOOLS IN IDEMILI NORTH

1. **North Diadem high school Abatete M-292; F-239.**
2. **Abana secondary school Abatete M-253; F-349.**
3. **Community secondary school Umuoji M-394; F-413.**
4. **Mater-amabilis secondary school Umuoji F-1102.**
5. **Community secondary school Eziowelle M-66; F-53.**
6. **Community secondary school Uke M-309; F-304.**
7. **Community secondary school Idearu M-101; F-93.**
8. **Anglican Girls secondary school Ogidi F-571.**
9. **Community secondary school Oraukwu M-139; F-139.**
10. **Community Secondary school Obosi M-313; F-341.**
11. **Awada secondary school Obosi M-520; F-626.**
12. **Union secondary school Obosi M-342; F-465.**
13. **Government technical college Nkpo M-364; F-364.**
14. **Urban secondary school Nkpo M-585; F-987.**

APPENDIX C

VILLAGES IN IDEMILI NORTH

Abacha

Abatete

Eziowelle

Ideani

Nkpor

Obosi

Ogidi

Oraukwu

Uke

Umuoji

Appendix D

Taro Yamen's (1967) Simple size determination procedure

$$-n = \frac{N}{1+N(e)^2}$$

$$n = \frac{6{,}021}{1+6,\ 021\ (0.05)^2}$$

$$n = \frac{6{,}021}{1+6{,}021\ (0.025)}$$

$$n\ 1= \frac{6{,}021}{1+\ 15.053}$$

$$n = \frac{6{,}021}{16.053}$$

$$n = 375.07$$

$$n = 375$$