

INFLUENCE OF SOURCES OF INFORMATION ON SAFE SEX PRACTICES AMONG ADOLESCENTS IN NIGERIA

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Abstract: Factors like lack of accurate information on safe sex practices and parents' reluctance to discuss sexual matters with their children over the years have led to prevalence of reckless sexual behaviors like premarital sex, unprotected sex unwanted pregnancy, abortion, and school dropout as well as their contracting sexually transmitted infections like HIV/AIDS and VVF. This study therefore, focused on the sources of information for safe sex practices. Survey research method was used in the execution of the study. 399 samples were randomly selected from the population of the study. Three educational zone out of the six education zones in the state where purposively selected to reflect the three senatorial zones in Anambra State of Nigeria. These are Aguata education Zone (for Anambra South senatorial zone), Awka education Zone (for Anambra Central senatorial zone) and Otuocha education Zone (for Anambra North Senatorial Zone). The questionnaire interview and discussion guide were used to gather data for the study. Data obtained were analyzed using tables and simple percentages. Results showed among other things that although respondents indicated school as their major source of information, a significant number of the respondents preferred parents to be their source of information on safe sex practices and there is a relationship between respondents' major source of information on safe sex practices and their sexual behaviour. Based on the outcome of the study, the researcher recommended among other things, that human development interventionist should design a programme that would encourage parents to feel free in discussing sexual matters with their children as well as sharing with them, basic information imperative for safe sex practices.

Keywords — Sources of Information, Safe Sex Practice, Adolescents, Sexual Behaviour and Disposition.

I. INTRODUCTION

Adolescents' sexual and reproductive health has become one of the major focal points in health researches as well as a key target in policy formulation and implementation. On the political and institutional fronts, the Cairo Programme of Action, for instance, contributed and is still contributing behaviours in raising awareness of the vulnerabilities,

health risks, and special needs of adolescents, and urged increased efforts to assure adolescents' safe passage to adulthood [1]. The realization that more than half of current Human Immunodeficiency Virus (HIV) infections occur before age 25 has also contributed to make adolescents an essential focus in HIV prevention efforts [2]. Adolescents are enmeshed in the process of developing their own identity and establishing interpersonal bonds beyond the family, including romantic and sexual relationships. This period of emotional and sexual maturation entails continuous experimentation and learning, as well as exposure to potential reproductive health risks, such as unintended pregnancies, sexually transmitted infections (STIs,) and HIV infection [3].

Among the adolescents, these risks are often exacerbated by inadequate information, social prejudices that hamper a suitable sexual education, rigid and stereotypical gender roles, fear of stigmatization, and restricted access to reproductive health services [4;5]. The focus of sexually transmitted disease-prevention efforts on adolescents is not only justified by their increased exposure to potential health risks but also because they are more amenable to behavioural change than adults; establishing safe sexual habits from the start is easier than changing risky sexual behaviours already entrenched (Schutt-Aine & Maddaleno, 2003). Furthermore, behavioural patterns established during this critical life stage have major repercussions throughout adulthood [6]. This sexually related problem is worst in Sub-Saharan Africa, which ranks highest in reproductive health problems [5, 7]. [7] for example, reported that 26% of girls between 15 and 19 years and 66% of girls between 20 and 24 years had premarital sexual relationship in Nigeria in 1990. Previous studies in Africa according to [8] showed that there was increase in the rate of premarital sex and a decline in age of sexual debut among adolescents.

These reports are corroborated by [9] and reports from National Center for HIV, STI and TB Prevention, (2006) where there found that sexually transmitted infections (STIs) are a growing health threat to adolescents throughout the world. Besides early sexual practices, adolescents are especially at the risk of contracting STIs, because they are likely

to have a higher number of sexual partners and more simultaneous partners than older age groups [10]. Notwithstanding the risks of unprotected sex, many adolescents still engage in risky sexual practices that put them at risk for STIs and other negative health outcomes. In line with this [11] writes,

These burgeoning adolescent groups who constitute more than 12 per cent of the population of Nigeria and are expected to rise sharply over the years are often prone to unplanned sex, unwanted pregnancy, unsafe abortion, sexual coercion, sexual violence, sexually transmitted infections and even HIV. Because they are uninformed, or poorly informed, about the implications of their reproductive behavior and health risks especially from under-age sexual practices and other anti-social practices, are found to be highly vulnerable to antisocial behaviours such as violent crimes, unsafe sexual activities and drug abuse, among others.

Zeroing in on secondary school students, most of whom are adolescents and which constitute the population of this study, [12] found that between 50 and 80 percent of sexually active male secondary school students in Ile Ife had multiple sexual partners, and only eight percent out of them used condom during sexual intercourse. The Nigerian Federal Ministry of Health in a similar study conducted in 2017 found that the median age at first sexual intercourse in Nigeria was 18. Also the Nigerian Federal Ministry of Health (2003) in a National HIV/AIDS and Reproductive Health Survey came out with the shocking revelations below:

With a rate of 112 births per 1,000 females of age of 15-19 years, Nigeria adolescents have one of the highest levels of fertility in the world. About 12% of teenagers have had their first child birth before the age of 15 years and almost half became mothers before the age of 20 years. About two/fifths of teenage pregnancies in Nigeria are believed to end up with induced abortion, with majority being carried out by untrained personnel and in unsafe environments. Adolescents constitute the majority of cases of abortion-related complications admitted in Nigerian hospitals.

Adolescents' unsafe sexual practices which has assumed a greater dimension in Africa in recent times has resulted to serious socio-economic and health problems in the developing continent. These

problems include girls dropping out of schools, "baby dumping" (child abandonment), induced illegal abortion, and increased maternal and infant mortality rate, [13]. Based on the foregoing discussion a fundamental question that begs for answer is: What is responsible for the unsafe sexual practices among adolescents? Researchers have identified a number of factors responsible for those behaviours to include: adolescents risk taking behaviour, their anxiety and embarrassment about sex, peer opinion, poverty and deprivation, social intolerance and discrimination against young people, traditional cultural practices and lack of information which stands out, [5, 14].

Assessing sexuality information is therefore, a serious challenge to the society particularly in developing society. For instance, Population Council in 1991 reported that adolescents were often scolded, refused information, or turned away by health workers when they sought help on reproductive sex and other related issues. Even where the information is available, it is often scanty and insufficient, not credible and in many cases, inadequate (Sai, 1995). Sai, further posits that because sexuality is hardly taught in schools and in most places it is regarded as a taboo for parents to discuss such issues with their wards or children and because there are very limited formal ways of receiving reliable and relevant information, adolescents rely on weak sources such as their peers [14], corroborated this report where he finds that most Nigerian adolescents pick unhealthy sexual behaviour via peer groups. As a result, such information is often inaccurate and may not provide the needed basis for informed decision. Consequently, whether safe sex practice is hardly taught in school or discussing it with parents is viewed as a taboo, these adolescents still get some information on sexual issues which may be positive or negative to their sexual health. Against this background, therefore, this study examines the sources of information through which adolescents in Anambra State gain knowledge of safe sex practices and how the information affect their sexual lives.

Statement of the Problem

There seems to be an increased problem in Nigeria today as to moral laxity, promiscuity, unwanted pregnancy, abortion, Sexually Transmitted Infection (STI) e.g. HIV/AIDS, forced marriage, school dropout, baby dumping and other undesirable consequences of unsafe sex practices among adolescents. The increase in these problems could be attributed to ignorance of adolescents about safe sex practice. Incidentally, ignorance as a social problem can be tackled with adequate information. This is why [15] opines that "through the acquisition of information, education and skills, individuals are able to discern and choose; to take control over their environments and to work for the improvement of existing conditions". Impliedly, adolescents in

Nigeria are likely to live above the afore-mentioned moral and social problems if they are sufficiently informed about safe sex practices. However, it is not certain how the respondents' get information on safe sex practices; the nature of information they are exposed to; the influence the information they get has on them; the use they put information on safe sex practice to and their preferred source of information on safe sex practices. The researchers considered this a gap in knowledge which the study hoped to fill. In other words, this study sought to determine major sources of information on safe sex practices for adolescents and the implication of the information to safe sex practices among the respondents.

Objectives of the Study

The objectives of the study are to;

1. determine the proportion of respondents that are exposed to information on safe sex practices.
2. identify respondents' major sources of information on safe sex practices
3. evaluate respondents' disposition towards information on safe sex practices.
4. ascertain whether respondents put to practice knowledge gained from information on safe sex.
5. find out the respondents' most preferred sources of information on safe sex practices.
6. determine whether the respondents' major source of information on safe sex practices influence their sexual behaviour.

Hypotheses

The following null hypotheses were tested in the study.

H₀₁: There is no significant relationship between respondents' exposure to information on safe sex practice and their disposition to safe sex practices.

H₀₂: There is no significant relationship between respondents' exposure to information on safe sex practices and their practice of safe sex.

II. THEORETICAL FRAMEWORK

The Health Belief Model (HBM) is one of the most widely used conceptual frameworks for understanding health behaviour. Developed in the early 1950s by a group of US Public Health Service social psychologists, the model has been used with great success for almost half a century to promote greater condom use, seat belt use, medical compliance, and health screening use, to name a few behaviors, [16]. The Health Belief Model is a framework for motivating people to take positive health actions that uses the desire to avoid a negative health consequence as the prime motivation. For example, HIV is a negative health consequence, and the desire to avoid HIV can be used to motivate sexually active people into practicing safe sex. Similarly, the perceived threat of a heart attack can be used to motivate a person with high blood pressure into exercising more often, Becker (1974). It's

important to note that avoiding a negative health consequence is a key element of the HBM, Conner & Norman (1996). This theory is related to this study in that individuals who are susceptible to unsafe sex practices may likely cultivate favourable attitude to the campaign against it to the level of adoption and advocacy.

III. EMPIRICAL STUDIES

The prevalence of sexually transmitted diseases and other adolescents' sexuality problems in the developed world have made adolescents' sources of information on safe sex practices attractive to researchers seeking to unpack wide range of issues around the subject. According to [14] youths pick sexual cues that exposed them to risk-taking behaviours. The drive to address this ugly phenomenon has provoked some empirical studies.

In a survey of Anambra State University (ANSU) undergraduate students' access to sexuality information and its impact on attitude to safe sex practices, [17] found that a significant relationship exist between extent of access to sexuality information by Anambra State University undergraduates and their attitude to safe sex practices. The striking revelation about this study is that high access to sexuality information is related to negative attitude to safe sex practices and low access is related to positive attitude to safe sex practice. The above finding is worrisome as the spread of HIV/AIDS and other sexually related diseases are unprecedented.

A similar finding was the case in a study on the impact of broadcast HIV/AIDS campaigns on sexual lifestyle of selected students in Delta State. The researcher, Ufuophu-Biri (2008), found that irrespective of the differences in the respondents' age, sex and year of study, greater percentage manifest high awareness of HIV/AIDS campaign messages in the broadcast media. This finding however, showed that despite students' full exposure to HIV/AIDS broadcast campaign messages students still maintain the usual sex lifestyle of loose sex without precaution to prevention of HIV/AIDS. In a study which examined the influence of 'zip up' campaign on students' sexual behaviour, [14] found that students exposed to zip up campaign manifest positive change of attitude toward premarital sex.

Hewlett (2012) conducted a review of relevant studies undertaken in the past ten years on youth sexuality and HIV/AIDS prevention in Southern Africa. He found that adults do not believe that children across a range of cultures are able to talk about sex and sexuality, yet studies show that children can and want to discuss sex. For instance Malek, Abbasi, Fagihi, Mahdi, and Ali (2010) conducted a study on the sources of sexual

knowledge acquisition among High School students in Northwest Iran, they found that adolescents who reported a greater number of sex based topics discussed with their mothers were more likely not to have high- risk behaviours. Also in an empirical study on Acquisition of sexual information by in-school adolescents in Auchu polytechnic secondary school by [18] they found that a relationship exists between adolescents’ favourite sources of information on sexual acquisition and their sexual habits. Those of them with positive sexual habits have parents and other family relatives, church/mosque and schools as their favourite sources of information on sexual information.

From the foregoing, it would be right to say that not all sources present adolescents with unhealthy sexual information. Thus, where adolescents are constantly exposed to sound sexual information on safe sex practice, they are properly equipped to understand and cope with the ruinous but avoidable intricacies and complications of both unprotected and pre-marital sex [14].

A summary of the above review of empirical studies show that:

- In spite of high access to information, negative attitude to safe sex practices are still on the increase.
- External factors like parents, peers, friends and the media influence attitude formation toward sex and sexuality.
- Lacuna exists regarding how adolescents’ in Anambra State source information on safe sex practices, their preferred source of information and the influence of source of information over their sexual behaviour. The researcher considered this a gap in knowledge which the current study hopes to fill.

IV. METHODOLOGY

The researchers used survey research method to execute the study. The area of study was Anambra State. The study targeted specifically students in Community Secondary School Isuofia; Pioneer Secondary School (GSS) Umuchu; Igwebuik Grammer School Awka; Ezi-Awka Community Secondary School Awka; Community High School Igbariam and Community Secondary School Nsugbe.

The 2012 population of government owned secondary schools in Anambra State is 122, 914. The choice of government owned secondary schools was because they met the purpose of the study, there is presence of government owned secondary schools in every town in the State but not every town in the State has private owned secondary schools. The six education zones (Aguata, Awka, Nnewi, Ogidi, Onitsha and Otuocha) in the State make up the above figure (Planning, Research & Statistics, Ministry of Education Awka, 2018). A sample of 399 students of

government owned secondary schools in Aguata, Awka South and Anambra East Local Government Areas (LGAs) were selected from the population of 122,914 students in Anambra State.

The sample size was determined using Cohen, Manio and Morrison (2007) pre-determined table, which has proved effective in Educational and Social Scientific researches (Fraenkel and Wallen, 2009). Three educational zones out of the six education zones in Anambra State were purposively selected to reflect the three senatorial zones in the State. These are Aguata zone (for Anambra South), Awka zone (for Anambra Central) and Otuocha zone (for Anambra North). Purposive sampling technique was also used to select one local government from each of the selected education zones and lastly, all the secondary schools in the selected local government area were listed on separate bags (a bag for each local government area) from which two secondary schools from each of the LGA’s were selected for the study by means of random sampling without replacement. Details of the LGA’s and Secondary schools that emerged as the actual study areas and the sample size for each secondary school are presented in the Table 1 below:

TABLE 1: SENATORIAL ZONES/ LGAS/ SECONDARY SCHOOLS SELECTED FOR THE STUDY AND THEIR CORRESPONDING SAMPLE SIZES

Senatorial Zones	Education Zones	LGAs	Schools	Sample Size
Anambra South	Aguata Zone	Aguata	CSS Isuofia	80
			PSS (GSS) Umuchu	60
Anambra Central	Awka	Awka South	IGS Awka	90
			Ezi-Awka CSS Awka	60
Anambra North	Otuocha	Anambra East	CHS. Igbariam	44
			CSS Nsugbe	55
Total				399

Source: Planning, Research & Statistics, Ministry of Education Awka, 2018

The distribution of the questionnaire copies was based on proportional stratified random sampling technique. The questionnaire used to elicit data for the study. A twenty-five (25) item questionnaire was drawn and administered to 399 respondents. The questionnaire was divided into two parts. Part 1 dealt with the demographic characteristics of the respondents. Part 2 contained information which sought to answer the research questions of the study. The copies of questionnaire were administered on

face to face basis; the distribution of the copies of the questionnaire to the respondents was in line with the sharing formula indicated in the table above.

V. DATA ANALYSIS AND RESULT

Three hundred and ninety nine (339) copies of the questionnaire were distributed to the respondents. After sifting and editing, three copies of the returned questionnaire were wrongly filled hence they were discarded. The import is that the study recorded 0.8 % mortality rate. Hence, our analysis was based on the 99.2% response rate, which the researcher consider significant sample enough to make objective analysis. Demographic analysis of data collected showed that 182 (46%) were male while 214 (54%) indicated female. In terms of age bracket, 147 (37%) were within the range of 10-14 years, 15-19 years were 235 (59%) while 20-24 were 14 (4%). For data on year of study, 40 (10.10%) respondents indicated Junior Secondary School (J.S.S) 1 as their year of study, 60 (15.2%) indicated J.S.S. 2, 62 (15.7%) indicated J.S.S. 3, 106 (26.7%) indicated Senior Secondary School (S.S.1), while 88 (22.2%) indicated S.S.2 and 40 (10.1%) indicated S.S. 3 as their year of study. All 396 (99.3%) respondents were Christians. Data on respondents’ parents situation shows that 304 (76.8%) parents of respondents live together, 29 (7.3%) parents of respondents live in different towns, six (1.5%) parents of respondents were divorced, 48 (12.1%) respondents indicated one of their parents was dead, three (0.8%) indicated that both of their parents were dead while six (1.5%) indicated that their parents were separated.

Data on fathers’ occupational distribution of respondents showed that nine fathers of respondents (2.3%) were artisan, 246 (62.1%) were business men, 76 (19.2%) were civil servants, 17 (4.3%) were religious leaders, 11 (2.8%) were pensioners while 37 (9.3%) indicated any other. Data on mothers occupational distribution of respondents showed that 20 (5.0%) were artisans, 210 (53.0%) were business women, 122 (31.0%) were civil servants, nine (2.3%) were religious leaders, 15 (3.8%) indicated pensioner, while 20 (5.1%) indicated any other, which included occupations as braiding of hair, baby sitting etc The respondents were asked whether they have had sexual intercourse. Responses to this question showed that 81 (20.5%) have had sexual intercourse, 306 (77.2%) have not had sexual intercourse while nine (2.3%) indicated can’t say. Also, 30 (7.6%) of respondents indicated that sex was necessary at their age, 336 (84.8%) indicated that sex was not necessary at their age, while 30 (7.6%) indicated can’t say. On the issue of whether condoms are effective in preventing STIs and HIV/AIDS, 257 (66.9%) indicated no, 95 (24.7%) indicated yes while 32 (8.3%) indicated can’t say. However, on the issue of whether knowledge received about safe sex practices is useful to respondent, 283 (73.7%) indicated yes, 79 (20.6%)

indicated no while 22 (5.2%) indicated can’t say. Respondents were asked an open-ended question pertaining specific ways the knowledge of information on safe sex practices is useful to them. An aggregation of their response revealed that 290 (75.5%) of the respondents answered that it has aided them to avoid pre-marital sex, 68 (17.7%) answered that it has aided them to know how to protect themselves during sexual intercourse, 25 (6.51%) answered that it has helped them to know the consequences of unsafe sex, while one (0.26%) said it is not useful.

Research Question One: What proportions of the respondents are exposed to information on safe sex practices?

TABLE II: ANALYSIS OF RESPONDENTS’ EXPOSURE TO INFORMATION ON SAFE SEX PRACTICES

Response Category	No of Response	Percentage
Mass media	34	8.9
Internet/social media	61	16.0
Parents	98	25.5
School	117	30.5
Health worker	28	7.3
Caregivers	4	1.0
Guardians	7	2.0
Friends/peer group	30	7.8
church	8	2.1
total	384	100

Source: Field survey, 2019

N/B the number of respondents reduced to 384 since only respondents who were exposed to information on safe sex practices responded to this question.

Out of the 384 respondents that indicated awareness of the information on safe sex practices, 117 (30.5%) indicated school as their major source of information, 98 (25.5%) indicated parents, 61 (15.9%) indicated internet/social media, 34 (8.9%) indicated mass media, 30 (7.81%) indicated friends /peer group, 28 (7.3%) indicated health workers, eight (2.1%) indicated church, seven (1.8%) indicated guardian while four (1.0%) indicated caregivers.

Research Question Three: What is the respondents’ disposition to information on safe sex practices?

TABLE III: RESPONDENTS DISPOSITION TOWARDS INFORMATION ON SAFE SEX PRACTICES

Response Category	No of Response	Percentage
Positive	296	77.1

Negative	84	21.8
Can't say	6	1.1
Total	384	100

Source: Field survey, 2019

N/B the number of respondents reduced to 384 since only respondents who were exposed to information on safe sex practices responded to this question.

The researcher sought to ascertain the respondents' disposition towards information on safe sex practices. Thus, 296 (77.1%) indicated "Positive", 84 (21.9%) indicated "Negative" while 6 (1.5%) indicated "Can't say"

Research Question Four: Do respondents put knowledge gained from information on safe sex practices to use?

TABLE IV: RESPONDENTS' ABILITY TO PUT INTO PRACTICE THE KNOWLEDGE GAINED FROM INFORMATION ON SAFE SEX PRACTICES

Response Category	No of Response	Percentage
Yes	65	16.9
No	277	72.1
Can't say	42	11.0
Total	384	100

Source: Field survey, 2019

N/B the number of respondents reduced to 384 since only respondents who were exposed to information on safe sex practices responded to this question

Table IV above revealed that 65 (16.9%) respondents indicated yes to the question: Do you practice safe sex? 277(72.13%) indicated no, while 42 (10.9%) indicated cant' say. Similarly, on whether respondents would attribute their willingness to practice safe sex due to the nature of information received on safe sex practices, 65 (16.9%) indicated yes, 277(72.1%) indicated no while 42 (10.9%) indicated cant' say.

Research Question Five: Which of the sources of information on safe sex practices do respondents preferred the most?

TABLE V: RESPONDENTS' PREFERRED SOURCE OF INFORMATION ON SAFE SEX PRACTICES

Response Category	No of Response	Percentage
Mass media	20	0.5
Internet/social media	44	11.5
Parents	156	40.6
School	87	22.7
Health worker	43	11.2
Caregivers	3	0.8

Guardians	7	1.8
Friends/peer group	13	3.4
Church	11	2.9
Total	384	100

Source: Field survey, 2019

N/B the number of respondents reduced to 384 since only respondents who were exposed to information on safe sex practices responded to this question.

On response to what source respondents would prefer to get their information on safe sex practices, 156 (40.6%) indicated parents, 87 (22.7%) indicated school, 44 (11.5%) indicated internet/social media, 20 (5.2%) indicated mass media, 43 (11.2%) indicated health workers, 13 (3.38%) indicated friends/peer group, 11 (2.9%) indicated church, seven (1.8%) indicated guardian while three (0.8%) indicated caregivers

Research Question Six: Does your major source of information on safe sex practices influence your sexual behaviour?

TABLE VI: EVALUATION OF RESPONDENTS' SEXUAL BEHAVIOUR AFTER EXPOSURE TO THEIR MAJOR SOURCE OF INFORMATION ON SAFE SEX PRACTICES

Response Category	No of Response	Percentage
Encourage me to indulge in an illicit sex more than before	61	15.9
Encourage me to indulge in an illicit sex as before	87	22.7
Encourage me to indulge in illicit sex less than before	103	26.8
Encourage me to abstain completely from illicit sex	133	34.6
total	384	100

Source: Field survey, 2019

N/B the number of respondents reduced to 384 since only respondents who were exposed to information on safe sex practices responded to this question.

On response to how respondents would describe their sexual behaviour after exposure to their major source of information on safe sex practices, 61 (15.9%) indicated that their sexual indulgence increased more than before after exposure to their major source of information on safe sex practice, 87 (22.7%) indicated "encouraged me to indulge in illicit sex as before", 103 (26.8%) indicated "encouraged me to indulge in illicit sex less than before", 133 (34.6%) indicated "encouraged me to abstain from illicit sex completely" after exposure to their major source of information on safe sex practice.

VI. TEST OF HYPOTHESES

Hypothesis One

Ho₁: There is no significant relationship between respondents' exposure to information on safe sex practices and their disposition to safe sex practices.

To test this hypothesis, the dispositional response in table 3 was cross-tabulated with data on respondents' exposure to information on safe sex practices. Chi-square (X^2) test of independence at 6 degrees of freedom ($df=6$) and 0.05 level of significance ($\alpha=0.05$) shows that the hypothesis received a statistical support (X^2 calculated= 46.3, X^2 critical=12.59). This implies that a significant relationship existed between the respondents' exposure to information and their disposition towards information on safe sex practices.

Decision: Since the calculated value X^2 (46.3) is greater than its table value (12.59), our inference then would be that null hypothesis does not hold good which means the two attributes are associated and the association is not because of some chance factor but it exists in reality. This implies that there is a significant relationship between respondents' exposure to information on safe sex practices and respondents' disposition to information on safe sex practices.

Hypothesis Two

Ho₁: There is no significant relationship between respondents' exposure to information on safe sex practices and their practice of safe sex.

To verify this hypothesis, data on respondent's exposure to safe sex practices as in table 1 were cross-tabulated with data on respondents' practice of safe sex in table 4. Chi-square (X^2) test of the hypothesis at 6 degrees of freedom ($df=6$) and 0.05 level of significance ($\alpha=0.05$) gave significant support to the hypothesis (X^2 calculated= 250, X^2 critical=12.59). The import is that significant relationship existed between the respondents' exposure to information and their practice of safe sex practices.

Data in table 8 gave an idea of the direction of the relationship. The data suggest that high exposure to information on safe sex practices is related to low practice of safe sex. Here, 74.5 percent respondents with 'very often' exposure to information on safe sex practices expressed no to practice of safe sex and only 21.5 percent respondents of the same exposure expressed yes to practice of safe sex. The trend is also similar with respondents' who said their exposure to safe sex practices was often. Conversely, out of the 38 respondents whose exposure to information on safe sex practices was 'not often' 26.3% expressed yes to practice of safe sex, and 52.6% expressed no to practice of safe sex. This is also the case for the respondents who expressed

'can't remember' on how often they were exposed to information on safe sex practices. Out of the thirty-two of them, 31.2% expressed yes to practice of safe sex, 15.6% expressed no, while as many as 53.1% expressed 'can't say'.

Decision: Since the calculated value X^2 (250) is greater than its table value (12.59), our inference then is that the null hypothesis does not hold good which means the two attributes are associated and the association is not because of some chance factor but it exists in reality. This implies that there is a significant relationship between respondents' exposure to information on safe sex practices and respondents' practice of safe.

Discussion of Findings

Findings in respect of research question one on analysis of respondents' exposure to information on safe sex practices showed that respondents under study are adequately exposed to information on safe sex practices. This finding is in harmony with the outcome of earlier study by Ufuophu-Biri (2008) that high awareness of HIV/AIDS campaign messages in the broadcast media is the case among selected students of Delta State. The implication of this finding is that information on safe sex practices has already diffused among targeted audience.

Research question two is analysis of respondents' response to major source of information on safe sex practices. It was interesting to find that school teacher was respondents' major source of information on safe sex practices. This finding disagrees with the finding in an earlier study by [17] that interpersonal communication sources (friends & peers) were the dominant sources of sexuality information among ANSU undergraduate students. This finding is a good omen as students see their school teachers as upright and knowledgeable in almost every subject area. Based on this understanding, it behooves on the school teachers to utilize this privilege position to educate the adolescents about their sexual health and safe sex practices.

Research question three is on analysis of respondents' disposition towards information on safe sex practices. It was also interesting to know that majority of the respondents were favourably disposed to information on safe sex practices as 296 (77.1%) of the respondents indicated "Positive". The finding is in consonant with the finding in an earlier study by [14] that students exposed to the zip up campaign manifest positive change of attitude toward premarital sex. This finding also corroborates the Health Belief Model (HBM) theory which states that the individual is likely to take up a health related action (use of condom), if he or she feels that a negative health condition (HIV/AIDS) can be avoided.

It, therefore, would be a welcome development if designated places or centers where adolescents could easily access information on safe sex practices and other sexual matters; as adequate knowledge and information on safe sex practices would not only guard against premarital sex but they will be favourably disposed to the extent of joining in the advocacy of safe sex practices.

The researcher also examined respondents' ability to put into practice the knowledge gained from information on safe sex practices. Finding revealed that majority of the respondents did not practice safe sex. Being exposed to information on safe sex practice is one thing and putting the information into use is another. This assertion proved to be the case in yet another finding of this study. The finding in respect to research hypothesis two indicates that despite high exposure to information on safe sex practices majority of the respondents did not practice safe sex. This finding is not surprising as a similar finding conducted in this area by [17] found that high access to sexuality information is related to negative attitude to safe sex practices.

The most interesting revelation in this study is the finding that respondents most preferred source of information on safe sex practices is parents. One hundred and fifty six (40.6%) of the respondents indicated parents as their preferred source of information on safe sex practices. This finding is in consonant with a survey on youth sexuality and HIV/AIDS prevention in Southern Africa by Hewlet (2012) which found that adults do not believe that children are able to talk about sex and sexuality yet studies showed that children can and want to discuss sex. This finding also agrees with a survey study on the sources of sexual acquisition among high school students in Northwest Iran by Malek, et al (2010) that adolescents who reported a greater number sex based topics discussed with their mothers were more likely to not have high-risk behaviour.

Thus the above finding suggests that if parents discuss sexual issues with their wards or children, most of the problems of unsafe sex practices could have been addressed. As ignorance is the major culprit rather than deliberate action. The onus lies on the parents to establish safe sexual habits from the start rather than changing risky behaviour already entrenched. Adolescents also tended to rely much more heavily on their mothers than their fathers for sexual information, although this varied by gender. This disparity, however, raises question as to the respective roles of parents in the sexual education, and who youth may feel most comfortable while having discussions about sex.

Finally, findings in respect of research question six, which is on the relationship between respondents' major source of information on safe sex practices and their sexual behaviour. The finding revealed that

greater number of respondents abstained completely from illicit sex after exposure to their major source of information on safe sex practices. This finding corroborates with the finding in an empirical study on Acquisition of sexual information by in-school adolescents in Auchi polytechnic secondary school by Kur & Aigbioise (2009) that a relationship exists between adolescents' favourite sources of information on sexual acquisition and their sexual habits. Those of them with positive sexual habits have parents and other family relatives, church/mosque and schools as their favourite sources of information on sexual information. The implication of the above finding is that using appropriate sources of information to convey messages on safe sex practices are very effective in impacting positive change among the respondents. However, the percentages of respondents' who indicated "encouraged me to indulge in illicit sex more than before" (15.9%) and those who indicated "encouraged me to indulge in illicit sex as before" (22.7%) are still very high. Therefore, human development interventionists should redouble their efforts in designing messages on safe sex practices that will affect greater number of adolescents positively, especially in the area of breaching the wide communication gap between adolescents and parents.

VII. CONCLUSION AND RECOMMENDATIONS

This study examined influence of sources of information on safe sex practices among adolescents in Anambra State. The study was anchored on Health Belief Model (HBM). As typical of any scientific study, this study embarked on extensive literature review. The body of literature that was reviewed was sourced from secondary sources. The study adopted survey research with a sample size of 399 respondents which was determined based on a purposive sampling technique. The instrument used in data collection was the questionnaire. Data collected were coded and presented in tables. Simple percentage was used to express the findings and the contingency table of analysis (Cta) was used to verify the two null hypotheses. The findings revealed that the respondents studied were well knowledgeable and had a positive disposition toward information on safe sex practices, but despite this exposure to information on safe sex practices, majority of the respondents do not practice safe sex.

In view of the study findings, the following recommendations were made:

1. Human development interventionist should design a programme that would encourage parents to feel free in discussing sexual matters with children and teach them the basic information on sexual issues.

2. Campaign developers on safe sex messages should focus more on how to bridge the wide gap between high awareness and low practice of safe sex practices.
3. Sex education should be included in school curriculum so that such issues as practice of safe sex would be taught to students. Also, since not all adolescents are in school, it becomes necessary for sexuality education to be taught both at school and at home
4. Health care centers should be made available in strategic places where adolescents can easily go and access information on safe sex practices or other sexual issues.
5. Government should introduce a sexual education programme in hospitals which would prepare parents on ways and when to start educating their children.

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