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Experience, Help Seeking Behaviour, and Perceived Self-Efficacy to Prevent Sexual Coercion among Female Secondary Schools Students in Ibadan, Nigeria

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Abstract
Sexual coercion (SC) is a major public health problem with short- and long-term reproductive and mental health consequences among survivors. This study assessed the experience, help-seeking behaviour, and perceived self-efficacy to prevent SC among female secondary school students in Akinyele Local Government Area (LGA), Oyo State, Nigeria. The descriptive cross-sectional survey involved 399 consenting students who were interviewed using a 43-item questionnaire that explored respondents' socio-demographic characteristics, experience of SC (physical, sexual, and psychological form), help seeking behaviour and perceived self-efficacy to prevent SC. Data collected were analysed using descriptive and Chi- square analysis. Respondents' mean age was 15+1.4 years. Ten percent of the respondents have had sex; the majority of those sexually experienced reported that their sexual debut was non-consensual. More than half (59.1%) of the entire students had experienced at least one form of SC, 16.4% had experienced the three forms of SC; 7.3% had been raped. Most survivors of SC revealed that the perpetrators were close persons (friends) and most incidents of SC occurred in schools. More than half of the survivors did not seek help either during (56.8%) or after (53.8%) the incident of coercion. The study also found an association between confidence level, and lifetime experiences of SC ($p<0.05$). SC is a common experience among secondary school students. Appropriate multiple interventions including training of students via peer, teacher and parent-led approaches as well as actions at policy levels are recommended to address this challenge.

Keywords:
Sexual Coercion,
Sexual Behavior,
Female Students,
Experience,
Help-seeking behavior,
Perceived Self-efficacy.

L'Expérience, le comportement de recherche d'aide et auto-efficacité perçue pour prévenir la coercition sexuelle chez les étudiantes du secondaire à Ibadan, au Nigeria

Résumé
La coercition sexuelle (CS) est un problème majeur de santé publique ayant des conséquences graves pour la durée longue ou court sur la santé reproductive et mentale des survivants. Cette étude a évalué l'expérience, le comportement de recherche d'aide et l'auto-efficacité perçue pour prévenir la CS chez les élèves du secondaire de la zone de gouvernement local d'Akinyele (LGA), dans l'État d'Oyo, au Nigéria. L'enquête transversale descriptive a impliqué 399 étudiants consentants qui ont été interrogés à l'aide d'un questionnaire de 43 points qui a exploré les caractéristiques sociodémographiques des répondants, l'expérience de CS (forme physique, sexuelle et psychologique), le comportement de recherche d'aide et l'auto-efficacité perçue pour prévenir la CS. L'âge moyen des répondants était de 15 $\pm$1,4 ans. Dix pour cent avaient déjà eu des relations sexuelles ; la majorité de ceux qui ont eu une expérience sexuelle ont déclaré que leurs débuts sexuels n'étaient pas consensuels. Plus de la moitié (59,1 %) de l'ensemble des étudiants avaient connu une forme de CS, 16,4 % avaient connu les trois formes de CS ; 7,3 % avaient été violées. La plupart des survivants de CS ont révélé que les auteurs étaient des personnes proches (amis) et la plupart des incidents de CS se sont déroulées dans les écoles. Plus de la moitié des survivants n'ont demandé de l'aide ni pendant (56,8 %) ni après (53,8 %) l'incident de coercition. Nous avons également trouvé une association entre le niveau de confiance et les expériences de vie de CS ($p<0,05$). CS est une expérience courante chez les élèves du secondaire. Des interventions multiples appropriées, y compris la formation des élèves via des approches et des actions dirigées par les pairs, les enseignants et les parents au niveau politique, sont recommandées pour relever ce défi.

Mots-clés:
Coercition sexuelle,
comportement sexuel,
étudiantes, expérience,
comportement de recherche d'aide,
auto-efficacité perçue

Introduction

Sexual coercion (SC) is a major public health problem. SC is an unwanted sexual activity that occurs when an individual is under pressure, threat, or forced in a non-physical way (1). It encompasses diverse experiences, ranging from non-contact forms such as verbal sexual abuse and forced viewing of pornography, as well as unwanted touch or fondling, to attempted rape, forced penetrative sex (vaginal, oral, or anal), sex trafficking, blackmail, threat or psychological intimidation and forced prostitution (2). Although both males and females are at risk of SC, females are disproportionately affected. According to the Centre for Diseases Control and Prevention (CDC), one in five women has been raped during their lifetime, one in two women has experienced other forms of SC while most SC against women is perpetrated by the men they know (3). Both young males and females have experienced SC but more young females are vulnerable to coercive sex than their male counterparts (4). For example, nearly half of the female survivors of coercive sex were raped before they were eighteen (4).

A review conducted by the World Health Organization (WHO) in 2004 estimated the global prevalence of childhood SC to be about 27% among girls living in South and Central America, the Caribbean, Indonesia, Sri Lanka, Thailand, Eastern Europe, the Asia-Pacific region, North Africa, Russian, Ukraine, and Belarus. Lifetime prevalence of SC reported by women aged 15 to 49 years in the WHO multi-country study ranged from 6% in Japan to 59% in Ethiopia, with rates in the majority of settings falling between 10% and 50% (2). In addition, nearly 1 in 5 women, or approximately 22 million have been raped in their lifetimes (5). Studies have also shown that the rate of SC among female adolescents in Nigeria ranged between 11% and 55% while the prevalence of reported rape cases among female adolescents in Nigeria is about 5% (6-7). Similarly, studies conducted in Ibadan among adolescents (8) and female apprentice tailors (9) on SC revealed a prevalence between 4% and 55.1%.

Previous studies in the country have focused more on the knowledge, experience, prevalence, and predictors of SC among both male and adolescents (6,10). Only female adolescents (11), students in the tertiary institution (12) and few have addressed help-seeking behaviour and perceived self-efficacy to prevent SC among female adolescent survivors. This study's findings addressed these gaps in knowledge among female students in secondary schools in Ibadan, Nigeria.

Materials and Methods

The setting

This study was a descriptive cross-sectional survey conducted in 2017 in Akinyele, one of the five Local Government Areas (LGA) in Ibadan metropolis, Oyo State, Nigeria. Ibadan is the capital city of Oyo State and the third-largest metropolitan area in the country with a population of about 2.9 million. Akinyele was created in 1976 with a population of about 211,359. Most of the dwellers in the area are Yoruba, the major ethnic group in South West, Nigeria. As at 2017 when the study was conducted, there were 32 government-owned and 37 privately-owned secondary schools in the LGA.

Sampling Procedure

Based on a sample size using lifetime experience of SC and potential of non-response, this study estimated the sample size to be 399 respondents. A five-stage sampling technique was adopted in the selection process. First, a list of the 69 secondary schools in the study area was compiled and stratified into two: public and private. There were 32 and 37 registered public and private secondary schools respectively. Second, proportionate sampling was used to determine the number of schools to be selected from each stratum. Twenty-five percent of the total number of schools in each stratum was selected for the study i.e., 8 out of 32 public schools and 9 out of 37 private schools through balloting technique. Third, the senior secondary classes one and two were purposively selected in selected schools. Fourth, proportionate sampling was adopted to determine the number of respondents that will be selected from each selected school. To facilitate this process, the total population of students from selected classes in the schools was obtained from the school authorities and respondents were selected based on the sample size. Fifth, in each selected class, systematic sampling via balloting technique was used to select the number of respondents.

Instrument for Data Collection

A 43-item questionnaire containing open-ended and closed-ended questions was developed and used for data collection. The questionnaire consisted of five sections labelled as A, B, C, D, and E. Section A focused on the personal characteristics of respondents, their parents, and living condition; Section B documented the sexual behaviour of the respondents including if they had ever had sexual intercourse and the context in which their sexual debut occurred; section C documented the experience of the students on three forms of SC (physical, sexual, andpsychological). Respondents were asked whether or not they had ever experienced any of physical, sexual, or

psychological forms of coercive sex, and whether they have had such experience during the six months preceding the study. Section D identified the help-seeking behaviour among those who had ever experienced any of the forms of SC. Section E assessed their perceived self-efficacy to prevent SC. The study formulated 12 statements to which participants were asked to confirm if they are 'not confident at all', have 'little confident' or 'very confident'. Prior to its administration, the questionnaire was pretested among 40 female students in two schools in another LGA in Ibadan to determine students understanding of the questions. The reliability coefficient obtained from this process was 0.9.

Data Collection Process

The questionnaire was administered by trained interviewers using a face-to-face procedure. The interviews were conducted in designated classrooms or an open space in a quiet environment that was free from distractions and ensured privacy within the school premises. The interviewers were trained on the objectives of the study, interview techniques, and ethical issues.

Data Analysis

After the completion of each interview, the questionnaire was reviewed, sorted, edited, and coded manually using a coding guide. The data were entered into a computer and analysed using IBM SPSS version 20.0. Responses on sexual behaviour, SC, and help-seeking behaviours are presented in frequencies and percentages. Respondents perceived self-efficacy was measured on a 24-point perceived self-efficacy scale; anyone who reported 'not confident at all', 'little confident', and 'very confident' to any of the 12 statements to was awarded 0, 1, and 2 points respectively; higher score indicates better level of confidence. The study categorized confidence score <8 as 'not confident at all', 9-<16 represents 'little confident' while >16 indicates that the respondents were 'very confident' to prevent SC. Results are presented as frequencies and percentages. Descriptive and inferential statistics (Chi-square test) were utilized for the analysis. A p-value less than or equal to 0.05 was considered statistically significant.

Ethical Considerations

The Ethics Review Committee of the Oyo State Ministry of Health approved the study protocol before the commencement of data collection. Permission was obtained from the administrators of the schools before commencing the data collection process. Written informed consent was obtained from the respondents after providing adequate information on the purpose of the study, that data collected will be used for research, and that participation in the study was voluntary. The confidentiality of participants' information was assured, as privacy was guaranteed. This is because no identifiers were included in the questionnaire.

Respondents who had experienced SC and requested help or need any form of support were promptly referred to a youth-serving organization with experience in providing care and support to survivors of SC.

Results

Socio-demographic profile

The profile of the respondents is shown in Table 1. Their ages ranged from 13 to 19 years with a mean of 15.16+1.42 years. More than half (53.1%) of the respondents were within the age bracket 15-19 years. Over half (54.5%) of the respondents were Christians (54.4%), 75.4% were from a monogamous family, while 84.2% lived with both parents. The majority of respondents' parents had tertiary education (father-53.9%; mother-44.1%), were traders (father-34.8%; mother-54.9%) and married (91.0%).

Table 1: Socio-demographic Profile of Respondents (N=399)

Variables	No	%
Age (years)		
10-14 (Early adolescents)	137	46.9
15-19 (Late adolescents)	262	53.1
School type		
Public	212	50.1
Private	187	49.9
Class		
SS1	226	56.6
SS2	173	43.4
Religion		
Christianity	217	54.4
Islam	182	45.6
Family type		
Monogamy	301	75.4
Polygamy	87	21.8
Separated/Divorced	11	2.8
Living condition		
Living with both parents	336	84.2
Living with single parent	41	10.3
Living with relative	19	4.8
Living alone	2	0.5
Living with a friend	1	0.2

Table 2: Sexual Behaviour of Respondents (N=399)

Sexual Behaviour	No	%
Ever had sex		
Yes	40	10.0
No	379	90.0
Age at first sex (n=40)		
Early childhood (1-4yrs)	2	5.0
Late childhood (5-9yrs)	10	25.0
Early adolescent (10-14yrs)	18	45.0
Late adolescent (15-19yrs)	10	25.0
Description of first experience (n=40)		
Non-consensual	30	75.0
Consensual	10	25.0

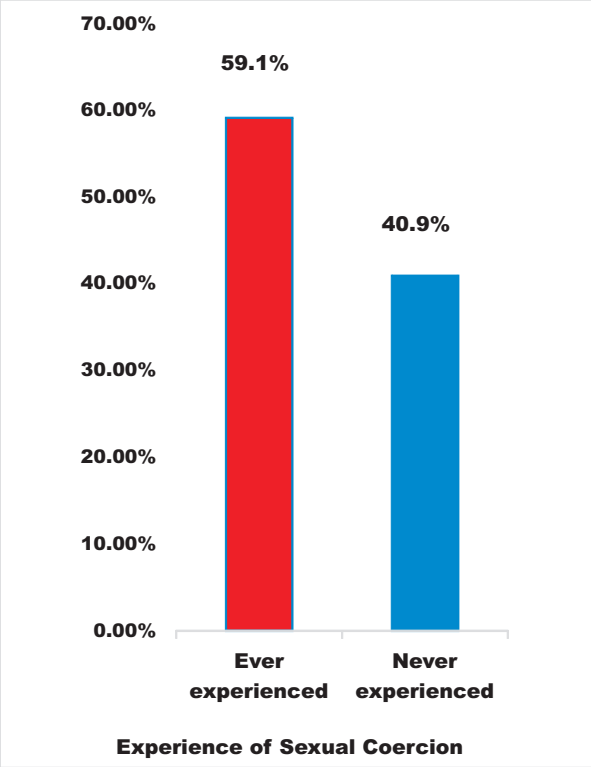

Figure 1: History of Experience of any Form of SC

Sexual Behaviour

Forty respondents (10%) reported that they have had sexual experience, 90% had never done so. Age at sexual debut ranged from 2 to 17 years with a mean of 11.5+4.01. Of those sexually experienced, 75% described their first sexual experience as non-consensual (Table 2).

Experience of Sexual Coercion

Majority (59.1%) of the respondents had experienced at least one form of SC, 40.9% had never (Figure 1). Among those with a history of SC, "being called a sexually suggestive name" was the most common form of SC experienced (36.3%). This is followed by unwanted touch of the breast

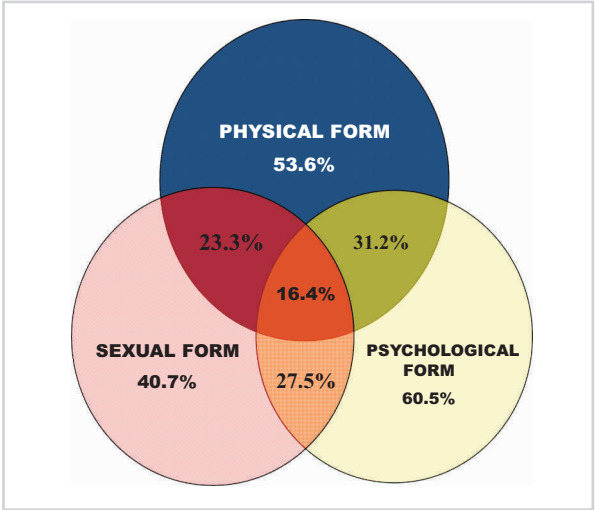

Figure 2: Overlap in the Lifetime Experience of Sexual Coercion

and backside (25.1%), 7.3% had been raped. The current (six months preceding the study) experiences of SC showed a high prevalence ranging between 91.0% and 98.1%. The overlap in the experience of each of the forms of SC is shown in Figure 2. More than half of the respondents had experienced only psychological (60.5%), physical (53.6%) forms of coercion while 40.7% had experienced a sexual form of coercion; 16.4% had experienced all the three forms of coercive behaviour. The majority reported that the perpetrators of SC were friends, boyfriends, and neighbours; while schools and homes were the most common sites for the perpetration of SC (Table 4).

Help Seeking Behaviour

More than half of the survivors of SC did not seek help either during (56.8%) or after (53.8%) the incident of coercion. Of those who sought help, the type of action(s) taken were: screaming for help (15.3%); reporting to parents (14.4%), school authority (11.4%), friends (4.7%), and rebuffing the perpetrator (11.4%).

Perceived Self-efficacy of Sexual Coercion

Variability was found in the level of confidence to take action to prevent SC (Table 5). Thirty-eight percent reported that they were 'very confident' to prevent being a victim of the psychological form of SC. The corresponding figures for prevention of physical and sexual forms of SC are 31.9% and 21% respectively (Table 6). Chi-square analysis was used to determine the relationship between SC experiences and perceived self-efficacy. Findings are presented in Table 6 which shows that the respondents had a significantly better level of confidence to prevent sexual forms of coercive sex ($P<0.009$).

Table 3: Lifetime and Current Experience of SC

	Ever		Six months preceding survey	
Forms of SC	**No**	**%**	**No**	**%**
Physical				
Unwanted touch of breast or backside	100	25.1	91	91.0
Sudden grab of breast or backside	73	18.3	68	93.2
Unwanted kiss	79	19.8	74	93.7
Sexual				
Forced to see sexually-explicit materials	45	11.3	42	93.3
Attempt to forcefully have sex	54	13.5	53	98.1
Forced to have sex	29	7.3	27	93.1
Insistence on having sex	48	12.0	47	97.9
Charmed to have sex	20	5.0	19	95.0
Drugged to have sex	17	4.3	16	94.1
Forced to perform sexual act	23	5.8	22	95.6
Given money or gift in exchange for sex	24	6.0	23	95.8
Psychological				
Called a name that is sexually suggestive	145	36.3	138	95.2
Threatened to be killed if sex is refused	24	6.0	23	95.8
Threatened to be blackmailed if sex is Refused	24	6.0	22	91.7

*Multiple responses

Table 4: Reported Perpetrator and Site for the Perpetration of SC

Variables	**SC form**		
Perpetrator of SC	**Physical No (%)**	**Sexual No (%)**	**Psychological No (%)**
Friend	158 (39.6)	89 (22.4)	94 (23.6)
Boyfriend	44 (14.4)	80 (20.3)	39 (9.9)
Neighbour	1 (0.3)	13 (3.3)	11 (2.9)
Relatives	7 (1.8)	4 (1.1)	2 (0.5)
Uncle	---	7 (1.8)	3 (0.8)
Parents	2 (0.5)		1 (0.3)
Stranger	3 (0.8)	4 (1.1)	8 (2.0)
Teacher	---	2 (0.6)	2 (0.5)
Site for the Perpetration of SC			
School	139 (34.9)	53 (13.6)	70 (17.6)
Home	66 (16.6)	133 (33.4)	57 (14.4)
Party	5 (1.3)	5 (1.3)	2 (0.5)
Church	3 (0.8)	---	3 (0.8)
Neighbourhood	4 (1.1)	3 (0.8)	2 (0.5)
Shop	1 (0.3)	3 (0.8)	1 (0.3)
Hotel	1 (0.3)	3 (0.8)	---
Social media	---	---	2 (0.5)

*Multiple responses

Table 5: Perceived Self-efficacy of Respondents

Statements	Not confident at all No (%)	Little Confident No (%)	Very Confident No (%)	Total No (%)
Can identify and avoid a situation that is likely to lead to sexual coercion	103 (25.8)	82 (20.6)	214 (53.6)	399 (100)
Can report an incidence of sexual coercion to parents	78 (19.5)	56 (14.0)	265 (66.4)	399 (100)
Can report an incidence of sexual coercion to principal	122 (30.6)	114 (28.6)	163 (40.9)	399 (100)
Can report an incidence of sexual coercion to police	135 (33.8)	93 (23.3)	171 (42.9)	399 (100)
Can report an incidence of sexual coercion to older sibling	99 (24.8)	104 (26.1)	196 (49.1)	399 (100)
Can report an incidence of sexual coercion to friends	109 (27.3)	87 (21.8)	203 (50.9)	399 (100)
Can break a relationship with someone who perpetrates sexual coercion	81 (20.3)	43 (10.8)	275 (68.9)	399 (100)
Can take action to prevent myself from being a victim of sexual coercion	53 (13.3)	53 (13.3)	293 (73.4)	399 (100)
Can report to my principal if a teacher request sex	69 (17.3)	71 (17.8)	259 (64.9)	399 (100)
Feel safe from sexual coercion at home	73 (18.3)	66 (16.5)	260 (65.2)	399 (100)
Can ensure a safe conversation with an opposite sex	73 (18.3)	72 (18.6)	254 (63.7)	399 (100)
Can refuse any wrong advice to take alcohol or party from peers	62 (15.5)	47 (11.8)	290 (72.7)	399 (100)

Table 6: Lifetime Experience of at least one Form of SC and Level of Confidence

	Lifetime experience of sexual coercion			
Level of confidence	**Yes No (%)**	**No No (%)**	x^2	**P-value**
	Physical Form			
Not confident at all	16 (34.8)	30 (65.2)	3.568	0.168
Little confident	52 (41.9)	72 (58.1)		
Very confident	73 (31.9)	156 (68.1)		
Total	141 (35.3)	258 (64.7)		
	Sexual Form			
Not confident at all	15 (32.6)	30 (67.4)	9.534	**0.009***
Little confident	44 (35.5)	80 (64.5)		
Very confident	48 (21.0)	181 (79.0)		
Total	107 (26.8)	292 (73.2)		
	Psychological Form			
Not confident at all	21 (45.7)	25 (54.3)	1.061	0.588
Little confident	51 (41.1)	73 (58.9)		
Very confident	87 (38.0)	142 (62.0)		
Total	159 (39.8)	240 (60.2)		

* Significant

Discussion

The current study has added to the body of knowledge on context of sexual debut and experience of SC among adolescents in Nigeria. Adolescence is a period of transition from child to adulthood which is associated with several reproductive health issues that affect their body, behaviour, and perceived self-efficacy to prevent undesirable consequences (13). The experiences of the adolescents during this period of their development have serious implications on the reproductive health and wellbeing of this population (14).

Ten percent of the study participants had had sexual experience with mean of sexual debut at 11.5±4.01 years. This age is lower than 15.08±0.2-15.2±1 years reported in previous studies (15-16). Early sexual debut is problematic because this practice increases the risk of incidence of multiple sexual partners, unprotected sex, sexually transmitted infections, cervical cancer, unintended pregnancies, and unsafe abortion (17). There is also concern that the majority of those sexual experiences described their sexual debut as non-consensual. This finding is in line with a review study on the sexual behaviour of school students in sub-Saharan Africa, with Nigeria inclusive, in which the

prevalence of first sex was reported to vary from 3% to 93% (18). However, this finding is in contrast with several studies conducted across Southwestern and Northeastern Nigeria with a prevalence rate ranging between 27.5% and 63% (15, 19-22).

More than half of the respondents had experienced at least one form of SC. This figure is slightly higher than findings from previous studies conducted in southwestern Nigeria (Ibadan and Lagos States) in which SC prevalence ranged from 11% and 55% (8-23). This difference in prevalence may reflect increase in the extent of the problem among the population studied. It may also be due to the fact that due to increase in reporting of incidence of rape in the media in Nigeria in recent times, the students may have been forthcoming in narrating their experience of SC (23). While experience of any form of coercive sex is problematic, those (16.4%) who had experienced all the forms of coercion may be particularly more vulnerable to serious short-and-long-term consequences.

This study found a prevalence rate of 7.3% for rape, the most severe form of coercive sex. This finding is relatively in line with prior reports that showed prevalence rate of rape between 4 and 6% of all adolescent girls in Southwestern Nigeria (24-25). The consequences of rape are severe and long-lasting including pelvic pain, genital injuries, irritable bowel syndrome, STI, unintended pregnancy, depression, low self-esteem, suicide, and post-traumatic stress disorder (26). Nevertheless, the findings on rape must be interpreted with caution because of the tendency to under-report this behaviour due to sensitivity and stigma associated with it in Nigeria.

The main perpetrators of SC are those well-known to the survivors including friends, boyfriends, and neighbours which is in line with results from a previous study (27). This implies that respondents who had boyfriends or often socialize with friends and neighbours were more likely to experience SC than those who do not engage in such as SC is seldomly perpetrated by strangers. Also, the most reported site of perpetration are schools indicating the need to implement appropriate interventions in these settings.

Although, most of the respondents rebuffed the perpetrator during the incident, majority who had experienced sexual coercion did nothing during and after the occurrence of the incidence. This reflects a culture in which survivors suffer in silence while perpetrators are not sanctioned (28- 29). Survivors could not do anything during the occurrence of sexual coercion because of lack of preventive skills, the stigmatization and shame associated with this behaviour, and the existing relationship with the perpetrator.

So far, little research has examined adolescents' perceived self-efficacy in dealing with SC. However, this study revealed a high level of confidence among majority of the respondents. The reported high level of confidence among respondents to prevent sexual coercive behaviours may be due to the fact they were recruited in a learning environment (school) where they are often exposed to training, practice, and interpersonal relationships with friends and colleagues which are known boosters of confidence levels. However, this high level of confidence is inconsistent with high levels of SC reported in this study. Planned SC prevention intervention should take advantage of the high morale already demonstrated among the students to address this inconsistency.

Sexual coercion is common among adolescents and this needs to be tackled with the implementation of multiple interventions**.** To start with, awareness /enlightenment campaigns about SC with emphasis on prevention should be targeted at the students beginning from their primary school days. Other stakeholders such as community and government leaders, teachers, parents, health providers, and other adults with whom adolescents often come in contact should be informed on the prevalence of coercion among adolescents, forms of coercion, and the fact that coercion are perpetrated by persons well known to those affected. Sensitization of the general public via media is also crucial in challenging stereotypes which will also help to reduce the associated stigma.

Furthermore, the findings of this study support the need for skill training for the students to boost further their confidence levels. Two types of training are suggested; first, peer counsellors can be trained and empowered with skills which they can transfer to their colleagues to prevent SC and seek help during episodes of coercive sex. Second, teachers also need training that will enable them provide adequate supervision for peer counsellors and integrate SC into existing family life education curricula. Previous research indicate that this approach produces synergistic effects among secondary school students' population (30).

In addition, actions at the community, institutional and policy levels are needed to sensitize policymakers, religious leaders, and other gatekeepers to the reality and impact of SC and the need to create a supportive community environment where SC is not tolerated and help is provided for survivors. Governments and non-governmental organizations (NGOs) need to set up agencies capable of providing support and care for survivors. Finally, existing laws on rape and other forms of coercive sex should be enforced and perpetrators sanctioned to serve as deterrence to potential offenders.

Two limitations are acknowledged in this study. First, due to the sensitivity of sexual coercion in Nigeria, it is possible that respondents under-report the incidence of sexual coercion. To prevent under-reporting, this study

developed the questionnaire to be anonymous, and adequate training was conducted as well as supervision of the interviewers. Second, the sample for this study was drawn from only one LGA in Ibadan. So findings may not be generalizable to the entire students in the metropolis.

Conclusion

In conclusion, adolescents surveyed generally had experienced at least one form of sexual coercion. Many of these forms are perpetrated by friends, boyfriends, and this occurred mainly in schools and homes. Respondents help-seeking behavior both during and after the incidents were discouraging. This is due to lack of preventive skills, fear of stigmatization, and societal reactions. Survivors of SC rarely seek help despite the health consequences they face physically, socially, mentally, and psychologically.

This study has laid the foundation for developing appropriate and effective interventions to address the experience of SC among female SSS students. Therefore, innovative interventions such as peer education, teacher training, and sensitization of stakeholders are recommended for SC prevention.

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Discoveries in Public Health


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