ENVIRONMENTAL AND AFFECTIVE FACTORS AS DETERMINANTS OF RISKY SEXUAL BEHAVIOUR AMONG ADOLESCENTS WITH VISUAL IMPAIRMENT IN SOUTHWESTERN NIGERIA

BY

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CERTIFICATION

I certify that this thesis was carried out byOKOLIBibiana Ifeoma in the Department of Special Education, Faculty of Education, University of Ibadan, under my supervision.

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DEDICATION

This work is dedicated to the Blessed Virgin Mary, Mother of Perpetual Help

and

My Dearest Mother, Nneoma Beatrice Ijeoma Okoli

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ABSTRACT

Adolescents with visual impairment find it difficult to engage in safe sexual practices because of their disability, and their inability to access sexuality information. Past studies on risky sexual behaviour persistently focused on adolescents without visual impairment to the neglect of adolescents with visual impairment. This study, therefore, was designed to examine peer pressure, school climate, parenting style, sexual attitudes and emotional intelligence as

determinants of risky sexual behaviour among adolescents with visual impairment in southwestern Nigeria.

Ecological System Theory provided the framework, while the survey design of the *ex-post facto* type was adopted. The purposive sampling technique was used to select 12 integrated schools in the six southwestern states: Ekiti (one), Lagos (four), Ogun (four), Ondo (one), Osun (one) and Oyo (one).Snellen's chart was used to screen adolescents with visual impairment to ascertain their visual acuity. Three hundred and eleven adolescents with visual impairment totally were enumerated. The instruments used were Peer Pressure ($\alpha = 0.84$), School Climate Student ($\alpha = 0.92$), Parenting Style ($\alpha = 0.84$), Sexual Attitudes ($\alpha = 0.85$), Emotional Intelligence ($\alpha = 0.97$) and Adolescents Risky Behaviour ($\alpha = 0.73$) scales. Data were subjected to descriptive statistics, Pearson's product moment correlation, multiple regression and t-test at 0.05 level of significance.

Respondents' age was 17.00 ± 0.72 years, and 53.7% were male. School climate (r=0.21) and emotional intelligence (r=0.24) had significant positive relationships with risky sexual behaviour while parenting styles, peer pressure and sexual attitudes did not. There was a joint contribution of the independent variables to risky sexual behaviour among adolescents with visual impairment ($F_{(5;\ 288)} = 5.05$; adj. $R^2 = 0.07$), accounting for 7.0% of its variance. Emotional intelligence (β=0.20) and School climate (β=0.08) contributed to risky sexual behaviour but parenting styles, peer pressure and sexual attitudes did not.There was a significant difference between the female ($\bar{X}$ =17.15) and male ($\bar{X}$ =16.69) adolescents' sexual attitudes and tendency to engage in risky sexual behaviour, indicating that female adolescents with visual impairment displayed a higher tendency to engage in risky sexual behaviour.

School climate and emotional intelligence influenced risky sexual behaviour of adolescents with visual impairment in southwestern Nigeria. Efforts should be made by parents, teachers, school administrators and counsellors to create enabling environment and educate adolescents with visual impairment, particularly the females, on the consequence of risky sexual behaviour.

Keywords: Emotional intelligence, Risky sexual behaviour, Adolescents with visual impairment

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Sexuality is an intrinsic aspect of human life generally and as such, its expression is a natural tendency of all human beings whether old or young disability notwithstanding. Accordingly, sexual development during adolescence which involves physical changes, attitudes, expressions of intimacy, and the defining of practices within a sexual and romantic context, is a normal expectation even for those living with disabilities. Yet, according to State-wide Vision Resource Centre (SVRC) Donvale, Australia**,** there is a wrong assumption that people with disabilities are asexual, that is they are not sexually active and as a result, they are not at risk of sexually transmitted infections (Meredith, 2012). On the contrary, people with disabilities are sexually active and highly susceptible to common risk factors for sexually transmitted infections (Kelly, Stacy, Kapperman and Gaylen, 2012).This tendency to engage in risky sexual behaviour could be attributed to poverty, illiteracy and low self-esteem (Nduta, 2007). Moreover, research reports indicate that sub-Saharan Africa remains the region most affected by HIV infections among people living with disabilities (World Health Organisation, 2009; Kendi, Mweru and Kinai, 2012; Umoren and Adejumo, 2014). Subsequently, the involvement of people living with disabilities in risky sexual behaviour and the attendant negative consequences in sub-Saharan Africa necessitate extensive research.

Undoubtedly, sexual behaviour is a core part of human development. According to Nwoke, Okafor and Nwankwo (2012), sexual behaviour is a form of bodily affection that may be geared towards procreation (one potential objective of sexual intercourse), spiritual wholeness, and the pleasure of every activity relating to sexual satisfaction. It can also be described as activities one does with others like kissing, stimulating touch and oral sex (Ihaje and Nase, 2015). It similarly encompasses sexual activities, any form of sexual interaction, conversation, touch and other activities which relate to sexuality and relationships. Further, it is a pattern of individual's response towards sexuality and sexual behaviour of others in society.

Sexual behaviour is an essential part of human existence which can be categorized into healthy and risky sexual behaviour. Omeje, Ekwueme and Ugwu (2013) state that a healthy sexual behaviour refers to those sexual activities that do not pose a danger to the individual involved and to others in society. Risky sexual behaviour, on the other hand, is a concept that researchers have had difficulty defining due to the big display of behaviour and negative outcome linked with the concept. The trouble of defining the concept of risky sexual behaviour, measuring the complex concept has been more challenging. Nonetheless, variables that have been frequenting used in the literature to describe risky sexual behaviour include early introduction to sexual intercourse, unsafe (unprotected) sexual activity, irregular condom usage, transactional sexual intercourse (sex in swap for money or for other basic needs) or having sexual intercourse with many partners or with someone who has other partners (Diala, Olujimi, Harri and Feyisetan, 2011; Azuike, Iloghalu, Nwabueze, Emelumadu, Balogun and Obi, 2015; Ofole, 2016). To this end, it can be argued that a congruent perspective of risky sexual behaviour may imply acts or conducts (behaviour) that multiplies one's chances of contracting sexually transmitted infections (STI), unwanted or unplanned pregnancies and a host of other adverse sexual reproductive health outcomes. In other words, sexual behaviour is considered risky when it raises concern and poses problems to the individual and to others in society.

In this study, the sexual-risk behaviour of adolescents includes early sexual debut, trans-generational and transactional sex, and having sex with multiple sexual partners. Early sexual debut refers to a situation where the first instance of sexual intercourse occurs at a rather early or young age while trans-generational sex refers to sexual intercourse with persons of different generations, with wide age gaps, and, therefore, with power distance between them. Transactional sex denotes sexual activities done for any form of reward. Although clinicians find it difficult to discern that adolescents are engaging in risky sexual activities, especially since they are not likely to give this information voluntarily, this behaviour is often known via the diagnosis of sexually transmitted infections (STIs), HIV or pregnancy.

Research within and across the border has shown that adolescents' sexual activities have clearly not been without risks (Kost, Henshaw, and Carlin, 2010; Oluwatosin

andAdediwura, 2010; Sharma and Mufune, 2011; Olusimbo, Olayinka and Ayodeji, 2012). The Centre for Disease Control and Prevention (CDCP), USA (2010) reported that "nearly half of all high school students are sexually active". Furthermore, 39 percent reported not to have used condoms, and those who did not use contraceptives at the last time they engaged in sexual intercourse, according to the report were 77 percent. Similarly, a study in Namibia reported that over 18.4 percent adolescents between the ages 13 and18years had practised sexual intercourse. It was also reported that the most of these adolescents were male (Sharma and Mufune, 2011). Another study observed that in Uganda 12.8 percent male and 16.1percentfemale below the age of 15 years had experienced sexual intercourse and over 11 percent had multiple sexual partners (Uganda Demographic and Health Survey 2012). One other study revealed that 62.7 of young males and 53.6 young females never used condoms at last sex (Ugandan Aids Indicator Survey 2011). Furthermore, a study conducted in Gauteng, South Africa, revealed that highest number of sexually active adolescents practise or engage in unprotected sex. It was established that a 55 percent had numerous partners while 52 percent engaged in sexual intercourse without condoms (Thomas, 2009).

Adolescents constitute31.6 percent of Nigeria's ever-growing population (National Bureau of Statistics, 2013). Studies within Nigeria among this population have also demonstrated increasing rate of risky sexual behaviour contrary to previous moral and cultural values (Diala, Olujimi, Harris and Feyisetan, 2011; Azuike et al., 2015, Ofole, 2016). Nwankwo and Nwoke's (2009) study conducted in Imo State, Nigeria amongst 478 male and female adolescents aged10 to19, found that majority of the adolescents (47.4 percent) have had sex. 39.7percent of them were practising unsafe sex and a total of 43.9 percent had multiple partners and 12 percent indicated to have engaged in sex without condoms. Similarly, a recent study conducted by Azuike *et al.,* (2015) revealed that 24.1 percent of children between the ages of 12-24 admitted to previous sexual exposure. Majority of them had numerous sex buddies; they were reported to have learnt about sexual intercourse from the media. 74.7 percent of the respondents had unprotected sex during their first encounter and 83.3 percent of those who had been pregnant aborted the pregnancy.

NAIIS (Nigeria HIV/AIDS Indicator and Impact Survey) (2018) revealed a national HIV/AIDS prevalence rate of 1.5% for people between 15-64 years. Women aged 15–49 years are more affected by HIV/AIDS than men (1.9% versus 0.9%). The estimated population of people living with HIV (PLHIV) aged 0 – 64 years is 1.9 million while the estimated treatment gap comprises 800,000 PLHIV. Among adults aged 15-64 years, HIV/AIDS prevalence rate varies by geopolitical zones, with the highest prevalence rate in the South-south Zone (3.1%) and the lowest prevalence rate in the North-west Zone (0.6%). Disaggregation of the HIV/AIDS burden by age shows that an estimated 75% of PLHIV are 15-49 years old and 8% adolescents (10-19 years). Prior to the NAIIS(2018), national HIV prevalence rate was estimated at 3.4%, while the estimated population of PLHIV in Nigeria was 3.4 million (Federal Minisrty of Health, Nigeria, 2013)

Data on sexual and reproductive health (SRH) outcomes in Nigeria highlight the imperative of focusing on adolescents.At 576 maternal deaths per 100,000 live births, Nigeria accounts for roughly 14 percent of the global burden of maternal mortality (Natonal Population Commission/ICF International, 2014). Global evidence shows that young girls bear a higher burden of maternal mortality and morbidity. The median age at first sexual intercourse is 17.6 and 21.1 years for women and men respectively, while the median age at first marriage is 18.1 and 27.2 years for women and men respectively (NDHS, 2013).It is currently estimated that 1.3 million adolescent girls and 780,000 adolescent boys are living with HIV worldwide, and 79% of new HIV infection among adolescents are in sub-Saharan Africa (Silva, 2015). As adolescents account for 31.6 % of Nigeria population, 1 in 20 of them contracts a sexually transmitted infections each year, and half of all cases of HIV/AIDS infection take place among people under the age of 25 years (UNFPA, 2015). It is also claimed that about 40% of new HIV/AIDS infection occurs among young people in Nigeria and this trend is attributable to the rampart cases of early sexual debut and early marriage which increase adolescents' HIV/AIDS vulnerability (UNICEF, 2017).

Omeje, Ekwueme and Ugwu (2013) suggest that risky sexual behaviour constitutes a significant factor in the proliferation of sexually transmitted infections (STIs) and that the

adolescents are the chief stakeholders of this menace. In corroboration, other scholars also observed a high rate of coital sex, increased exposure to the risk of HIV infection and sexually transmitted diseases, unplanned pregnancy, maternal health risk, illiteracy, destitution, social stigma, sexual coercion and a host of other problems among adolescents (Ofole, 2013; Ofole and Agokei, 2014; John, Okolo and Isichei, 2014). Famutimi and Oyetunde (2014) and Rashid and Mwale (2016) argue that majority of adolescents engage in sexual exploitation and experimentation devoid of sufficient information about sexuality, placing them in danger of the attendant consequences aforementioned. On the other hand, the case of people with speech, hearing and visual impairment, and other forms of disability is a double jeopardy because they are limited in one way or the other, which affects their full awareness and active participation in the affairs of their environment (Kassa, Luck, Bekeleand Riedel-Heller, 2016).

However, this present study is concerned with adolescents with visual impairment. Nwamuo, Ugwuegbulam and Okoro (2012) describe visual impairment as the irreparable loss of sight in an individual due to disease, injury or malfunctioning or degenerative conditions that have defied medical intervention such as refractive correction, medication or surgery and which qualifies an individual to receive additional support to compensate for the limitation of visual capability in carrying out normal daily activities. According to Komolafe (2015), the term visual impairment refers to a condition of no sight to partial but defective vision. Millais (2010) notes that visual impairment is a condition in which an individual lacks visual insight as a result of physiological or neurological factors. As such, this disability can happen to a person at any given stage in life.

Society generally tends to classify both total blindness and low vision/partial sightedness as one and the same condition owing to the fact that the term visual impairment is usually used loosely to encompass the totally blind, the low-vision and the partially sighted (Okoli, Olisaemeka and Ogwuegbu, 2012). Ibitoye (2017) describes adolescents with visual impairment as persons who have a low vision which makes them miss the opportunity of spontaneous movement in order to widen their knowledge. Visual impairment which is the result of a functional loss of sight occasioned by a number of eye disorders may involve a range of vision loss which includes partial sightedness, blindness

and low vision or impairment in vision that yet with medical care, negatively influences the victims' academic performance (Ejimanya, Okelola and Okoli, 2017;citing Chukwuka, 2014). Partially sighted individuals are those whose vision is distorted due to some error of refraction such as myopia, hyperopia, astigmatism and presbyopia (Chukwuka, 2010). The totally blind persons refer to individuals who cannot read and write print in spite of all optical corrective procedures. In other words, the totally blind persons have no vision at all. Olukotun (2003) asserts that low vision denotes "having a minimal functioning and usable residual vision" and as such, a person with low vision is neither sighted nor completely blind. However, in this study, visual impairment is conceptualized as low vision and total blindness.

It is well documented that adolescents with visual impairment engage in sexual behaviour with limited or inadequate information inherent in sexuality and reproductive health. In this connection, Grace (2003) and Katuta (2011) opine that the engagement of adolescents with visual impairments in harmful sexual conduct is due to accrued factors such as lack of information on the state and expression of "maleness" or "femaleness", physical susceptibility, the necessity for support and care, the need for guidance in moving around, life in institutions, and the seeming general assumption that individuals with visual impairments are not capable of being reliable witness for themselves, thus exposing them to abuse. Likewise, adolescents with visual impairment from poor households have been shown to be particularly prone to risky sexual behaviour, lured to transactional sex because of their economic status, this (economic status) also limit their negotiating ability with regard to safer sex practice (Kendi, Mweru,and Kinai, 2012; Sithinyiwe and Ngonidzashe, 2016).

Krupa, Chelsea, Esmail, and Shaniff (2010)identify some issues affecting sexual health education of individuals living with visual impairment which include, among others, the incapability of the victims in accessing information with their eyes, societal norms that restrict tactile learning, unavailability of information specially packaged for persons living with visual impairment (for instance, the absence of material on sexual health in braille), insufficient training of families, insufficient classroom teachers, and insufficient rehabilitation counsellors, and the non-existence of nonverbal communication

skills in people with visual impairment. The State-wide Vision Resource Centre (SVRC, 2012) also affirms that there are many misconceptions about the sexuality of adolescents with visual impairment. The most common of these misconceptions is that the blind children and youth are asexual and as such, they do not need information about their sexuality. The needless misconceptions about the sexuality of adolescents with visual impairment largely account for their potential physical, mental, and social risks as well as their inability to see, cultivate and follow proper sexual conduct.

Despite the few studies on the different facets of sexuality of persons with visual impairment, available literature has been able to reveal some sexual activities and experiences of adolescents with disabilities in Nigeria and across the globe. For instance, a study conducted by Alamrew, Tareken, Alamirew and Asres (2014) on risky sexual behaviour and its associated factors among people with disabilities in Dessie, Ethiopia, revealed that 301 (73.1 percent) out of 412 respondents have had intercourse. Out of this number, 153 respondents (50.8 percent) were below the age of 18 years and the median age at sexual debut was18 years. According to the findings of the above study, 174 (57 percent) of them accepted to have had sex out of their own personal interest, 68 (22 percent) reported their own case as due to peer pressure and 3.7 percent was due to an economic problem. On the issue of the kind of disability, the study also reported that 35 percent of the total respondents were people with visual impairment, 34 percent represented the physically handicapped, 14.6 percent comprised leprous affected persons, and 11.4 percent had hearing impairment. Similarly, a study conducted in Tanzania showed that almost half of the people with one disability or the other have had sex before the age of 19 (Margaret, Raphael and Herman, 2009). The case is more serious in Kenya, as a similar study carried out showed that 89 percent of people with disability were sexually active and 29percent of them experienced their first sexual intercourse below the age of16 (Handicapped International, 2007).

A descriptive analytical study of the National Longitudinal TransitionStudy-2 (NLTS-2) Federal Database conducted by Kelly, Stacy, Kapperman and Gaylen (2012) on the sexual experiences of adolescents with visual impairment in comparison to adolescents without disabilities, revealed that 57percent of adolescents with visual impairment

reported having sexual intercourse as against 65 percent of those with normal sight. Similarly, roughly 40 percent of adolescents with visual impairments and about 50 percent of those with normal sight are said to have had sex three months prior to the time of the investigation. There is almost no significant difference in their use of condoms, as 64 percent of people with loss of vision were reported to have used condoms while 54 percent of those with normal sight used condoms. However, the use of other control measures apart from condom varied between samples. The authors further contended that adolescents with visual impairment may experience similar rates of infections. This contention corroborates the submissions of the Centre for Disease Control and Prevention (CDCP) that the rates of Chlamydia had increased and that the largest numbers of reported cases of chlamydia and gonorrhoea were among teenagers aged 15–19 including children with special needs (Centres for Disease Control and Prevention, 2009).

In Nigeria, there are systematic challenges that hinder adolescents with visual impairment from accessing Sexual Reproductive Health (SRH) services. For instance, the Nigerian Adolescent Reproductive Health Policy (NARHP) has failed to adequately recognize and address the prejudice, negative attitudes and accessibility concerns confronting adolescents with disabilities when accessing sexual and reproductive health-care and services. As a result, there has been a low utilization of SRH services among adolescents with visual impairment. For example, the database of the Infectious Disease Institute of the University College Hospital (UCH), Ibadan, Oyo state, Nigeria, on patients with disabilities receiving treatment on sexually transmitted infections, including treatments for HIV shows that 37 people between the ages of 39 and 81 came for treatment from 2008 to 2013 while from 2014 to 2017, only 26 people between the ages of 31 and 74 came for treatment. Out of this number, a total of 28 people were patients living with visual impairment. These data further accentuate the fact that adolescents with visual impairment are unlikely to volunteer themselves for treatment when infected with sexually transmitted infections (STIs), or HIV and may be spreading the disease secretly. The under-utilization of SRH services among adolescents with disabilities, most especially those living with visual impairment may be attributable to factors such as financial barriers, stigmatization, providers' attitudes and reliance on a known person often a family

member to attend health clinics which infringes their privacy and confidentiality. All these dynamics are, perhaps, responsible for the prevalence of the negative effects of sexuality and reproductive health outcomes among adolescents living with visual impairment (Centres for Disease Control and Prevention, 2009; Ngilangwa, *et al.*, 2016).

There is a plethora of literature on risky sexual behaviour among adolescents (for instance, Katuta, 2011; Kendi, Mweru and Kinai, 2012; Umoren and Adejumo, 2014).However, a key concern is that most previous studies gave little attention to adolescents with disabilities particularly persons living with visual impairment. In addition, there is a scarcity of research targeting Nigerian adolescents. Most research targeted adolescents in developed countries with a better policy on the health of persons living with disabilities. Furthermore, some experimental studies were carried out on persons with visual impairment without an insight into the environmental and affective determinants of their risky sexual behaviour. It, therefore, becomes imperative to examine how some environmental and affective factors could predispose adolescents living with visual impairment to risky sexual practices. Undoubtedly, the outcome of this study will have a helpful impact on sexual education and policy-making for adolescents with visual impairment.

Studies show that there are many environmental and affective factors which may influence risky sexual behaviour. Environmental factors that may likely relate to risky sexual behaviour include peer group, school climate and parenting styles.By way of illustration, a synthesis of the research literature shows that inconsistent findings have been reported on the basis of peer pressure. Forming intimacy with same and opposite sex is one of the hallmarks of the teenage years as most teens consider friendship and cordial relationship with their peers important (Adeyemo and Williams, 2010). As parental support decreases at the teenage years and peers' support increases, peers tend to be more intimate and supportive, thereby creating a strong hold on the teenagers (Helsen, Volleberg and Meeus, 2000). Peer pressure can be viewed as the insistence and encouragement of persons of the same age group to cause an individual to do something (Santor, Messervey and Kusumakar, 2000). In other words, peer pressure refers to the influence exerted on one by peers or other groups that encourage one to change one's

attitudes, ideologies, principles, behaviour and values, in order to conform to those of the influencing group or individual.

As a formidable socializing instrument, peer group attachment is a dominant socializing agent that can significantly influence the views and behaviour of adolescents. However, it is noteworthy that the exact direction of peer pressure on adolescents' behaviour is not clear. On one hand, findings on alcohol use, smoking, drug use and delinquent behaviour have revealed that adolescents have tendency to socialize with persons who are of same behavioural patterns (Lansford, Dodge, Fontaine, Bates and Pettit, 2014). These kinds of selection patterns is likely to increase an incorporation of risky behaviour among adolescents of diverse groups (Haye, Green, Pollard, Kennedy and Tucker; 2014). Additionally, a study conducted by Prinstein, Boergers and Spirito (2001) found that adolescents who manifest destructive behaviour like substance use, aggressiveness and suicide attempt are also reported to have compelled their pals to engage in related behaviour. In other words, adolescents may also likely take to behaviour or habits when they realise their mates engage in similar acts (Podhisita, Xenos and Varangrat, 2001).

Succinctly, based on literature, sexual activities among adolescents are significantly influenced by others, especially their sexually active peers (Benda and DiBlaso, 1994; Blum and Mmari, 2005). For instance, all the ten (10) studies conducted by Blum and Mmari (2005) examining the relationship between perception of peers' sexual behaviour and their personal sexual practices reported a positive relationship between the two factors. Evidently, pregnancy risk increases among adolescents when an adolescent has a friend who has been pregnant (Blumand Mmari, 2005). Risky sexual behaviour of adolescents with visual impairment could also be traced to the kind of company they keep. Adolescents with visual impairment may easily be lured into risky sexual behaviour by their peers especially sighted peers. For example, Alamrew *et.al*, (2014) observe that peer pressure is one of the reasons for sexual initiation among adolescents with visual impairment. This fact is due to their reliance on the sexual information given to them by their friends who have assisted them in one way or the other. They may not bother to scrutinize the information to find out if it is appropriate for their

sexual behaviour. As a result, it may be logical to assert that peer pressure has a strong effect on adolescents, particularly those with visual impairment, who, more often than not, become victims of bad peer influence as far as risky sexual behaviour is concerned.

Another environmental factor that could influence risky sexual behaviour is the school climate. There is no universally accepted definition of school climate but researchers and specialists use various terms such as atmosphere, feelings, tone, setting, or milieu of the school (Freigberg, 1999; Homana, Barber and Torney-Purta, 2006). A number of authors contend that school climate is a multi-faceted concept that describes the degree to which a school community establishes and upholds a safe school site, a helpful educational, corrective, and substantial atmosphere, and a courteous, credulous, and kind relationships (Steinberg, Allensworth and Johnson, 2011). According to National School Climate Council (2009), school climate is based on patterns of people's experiences of school life and it shows norms, goals, values, interpersonal relationships, teaching and learning practices, support and organizational constructs.

Safe, caring, participatory and receptive school environment is essential for better attachment to school and it offers the best basis for successful social, emotional and academic learning (Blum, McNeely and Rinehart, 2002). According to Cohen, McCabe, Michelli, and Pickeral, (2009), "school climate is associated with safety, healthy relationships, engaged learning and teaching, and school improvement efforts". For the past two decades, reports from series of empirically different fields (for example, risk prevention, health promotion, ethical education, personality studies and mental health) have linked research-based school enhancement recommendations that converge predictably to promote safe, caring, receptive and participatory schools (Centres for Disease Control and Prevention, 2009). Emphasis has also been made on sustained and positive school climates as it enhances safety in the school and community by boosting communication among students and faculty, and thereby decreasing violence (Safe Supportive Learning, 2013). In addition, researchers also contend that a conducive school environment is associated with decreased aggression or violence void of bullying and sexual harassment, irrespective of sexual orientation (Attar-Schwartz, 2009).

Parenting style is an environmental factor of interest to the researcher that could affect adolescent risky sexual behaviour. Lately, the concept of parenting style has turned out to be very relevant in the investigation of adolescents' behaviour. Researchers have postulated substantial proof that parental behaviour all through the stage of adolescence is a key determinant of offspring behaviour (Green, 1995). Collier (1997) observes that adolescents seem to flourish in the area of development when the adolescents' family setting is one of cordial relationships. All adolescents (both the persons living with or without disabilities) need love, care and security. Without this parental affection, they may face some impediments in their sense of belonging and adjustment. Parenting a child living with a disability implies using certain skills to satisfy the child's psychological, physical as well as social needs within the expectations of society (Ball 1998).

Adolescents living with disabilities' vulnerability to at-risk behaviour could be as a result of poor parenting. Parenting style represents the basic approach that parents used in their child-raising practices which are related to the children's behaviour. Parenting style is classified into three main aspects: authoritarian, authoritative and permissive (Baumrind, 1991). The authoritarian parenting style is characterised by parents who are habitually strict or rigid. Authoritative parents are amenable (flexible) and acquiescent to the needs of the child and yet apply reasonable standards of conduct while permissive parents are those who enforce little restrictions, regulations or rules on their children (Baumrind, 1991).

Research has revealed that parenting styles have positive and negative connotations in literature because of the behavioural consequences of children and adolescents (Ang and Groh, 2006; Utti, 2006). For example, studies suggest that adolescents raised by authoritarian parents are at a greater risk of involving themselves in risky behaviour than those who experienced more of a permissive or laissez-faire parenting Adalbjarnardottir and Hafsteinsson, 2001). Moreover, strict or harsh parenting is also believed to be one of the main predictors of adolescents engagement in risky sexual behaviour (Jacobson and Crockett, 2000; Kotchick, Shaffer and Miller Forehand, 2001; Longmore, Manning and Giordano, 2001). One explanation for this phenomenon might be that sexually active adolescents nurtured by harsh parents may decline or disregard any

information concerning the prevention of sexual activity offered by their parents (Meschke, Bartholomae and Zentall, 2002). In some cases, parents may not give any of such information. Hence, adolescents seek such information from their peers, particularly as peers turn out to be a vital part of their life.

In addition, permissive or laissez-faire parenting devoid of definite or precise goals plays a docile part in the raising of children (Ang and Groh, 2006; Utti, 2006). Okorodudu (2010) observes that adolescents from permissive parenting are more vulnerable to delinquent behaviour, risky sexual behaviour and a host of other health complications than their counterparts from the homes of other parenting styles. Adolescents raised by authoritative parents are less vulnerable to externalizing behaviour and precisely, they are less likely to engage in at-risk behaviour than adolescents with permissive parents (Steinberg and Silk, 2002; Gonzalez, Holbein and Quilter, 2002). Thus, the occurrence of risky sexual behaviour among adolescents living with disabilities, especially those with visual impairment seems to relate to the styles they are being reared from home. This fact therefore implies that parenting style has the potential to influence cognitive and affective domain of adolescents living with or without disabilities.

The affective factors which can impinge on risky sexual behaviour as identified in the literature include emotional intelligence and sexual attitude. Emotional intelligence level has been shown to partly suggest the extent to which individuals seem to be involved in risky sexual behaviour. Emotional intelligence as a form of intelligence has its roots in the concept of social intelligence coined by Thorndike (1920). However, the concept of emotional intelligence was made more famous by the psychologists (Daniel Goleman1995). According to Goleman (1995), emotional intelligence is a part of an individual that affects every aspect of his life. Expounding on this definition, Bar-On and Parker (2000) defines emotional intelligence as anon-cognitive intelligence that involves a range of emotional, personal, social abilities and skills that inspire an individual's capacity to cope effectively with environmental strains and burdens. Eniola and Busari, (2014) citing Mayer and Salovey, (1997) state that emotional intelligence involves the capacity to observe one's own feelings and emotions and that of others, and to distinguish and use the information gathered to direct one's thought and action. Understanding one's emotions

and how to use them can help to effectively identify who one is and how one interacts with others.

Adolescence stage is often characterized by confusion, anger, anxiety and a spectrum of intense emotion. In fact, the most important neurological developments that occur during adolescence involve structures related to regulation of emotion, long-term planning, impulse control, and risk evaluation (Steinberg and Scott, 2003). Thus, this implies that adolescents who do not have recourse to this aspect of neurological development to view every of their concern critically before taking a decision may likely be caught up in risky behaviour. According to Smith (2002), the link between emotions and behaviour is well documented. Bracket, Warner and Mayer (2004) found that adolescents with lower emotional intelligence reported poor quality peer relations, implying that persons with low emotional intelligence may have difficulty establishing meaningful social interactions. Furthermore, their study likewise revealed that adolescents with lower emotional intelligence confirmed more significant involvement in potentially harmful behaviour such as illicit drugs, excess consumption of alcohol and engagement in more deviant behaviour. This finding is in agreement with Smith (2001), who opines that children who are secluded or rejected by peers are prone to low self-esteem and other emotional misery, have tendency to hate schooling and are vulnerable to wide range of harmful personal and interpersonal consequences including substance abuse, gangster, early (or teen) pregnancy, violence at school, sexual victimisation and re-victimization, and risky sexual behaviour.

Adolescents with low emotional intelligence scores are more likely to be expelled from their schools and this fact implies that emotional intelligence is linked to academic achievement and deviant behaviour at school, mainly for disadvantaged and vulnerable adolescents (Petrides, Frederickson and Furnham, 2004). Other studies on emotional intelligence also showed that emotional skills, as measured by performance-based evaluation, are positively linked to healthy personal and social functioning and academic achievement among students (Mayer, Robert and Barsade, 2008). Still, other empirical evidence showed that students with inadequate emotional skills, especially understanding

and recognizing skills, have more trouble adjusting at school than their counterparts who are more emotionally stable(Kerr, Johnson, Gans and Krumrineet, 2004).

Sexual attitude is another affective factor that may determine the risky sexual behaviour of adolescents with visual impairment. According to Okoli, Nwazuoke, Olisaemeka and Ogike (2016), attitude is a state of mind or a feeling or disposition or the way a person views something or tends to behave towards it, often in an evaluative way. In other words, they opine that attitude is a demonstration of favour or disfavour towards an individual, thing, place or event. Similarly, in the view of Akinade (2005), attitude is an individual's predisposition to respond positively or negatively towards anything, people, objects, places, school and family planning. Attitude has also been regarded as the general feeling of a person or opinion about something (Encarta, 2009). From a psychological perspective, Akintayo (2006) opines that attitude is a learned inclination to react either covertly or overtly in a way that express some degree of favourability or unavoidability in relation to certain objects, persons, ideas or circumstances in the environment. From these definitions, it is inferred that one's attitude in a particular direction can be a consequence of one's behaviour in situations involving that particular thing. It is acknowledged that sexual attitude may also be affected or influenced by some of the factors found to be responsible for the risky sexual behaviour of adolescents such as parents, teachers, peers and media sources (Abrahamson, Baker and Capsi, 2002).

Research reports show discrepant findings of personal view on the sexuality of young people and factors that preempt such attitudinal roles (Adamu, Mulatu and Si, 2003; Idoko, Muyiwa and Agoha, 2015). For instance, a study conducted by Toyin, Aderemi, Pillay, Tonya and Esterhuizen, (2013) among the disabled and non-disabled individuals on attitude towards safe sex revealed that young people with disabilities reported non-consistent use of condom with their constant and occasional sexual partners compared to non-disabled individuals. Other study revealed that age, gender, religiosity, family type, parental care or protection and maternal career/protection jointly predicted sexual depression and sexual preoccupation negatively while maternal protection independently predicted sexual preoccupation negatively. Also, family type jointly predicted sexual depression positively (Idoko *et al.*, 2015). Furthermore, Kindi, Mweru

and Kinai (2009) as well as Toyin *et al.* (2013) contend that adolescents with visual impairment are most likely to have wrong notions about adolescent sexuality and risky sexual behaviour because they have less access than their sighted peers to information on sexual reproductive health, risky sexual behaviour and its attendant consequences. As a result, their negative attitude towards their sexual reproductive health maybe as a result of wrong notions and lack of information. However, this observation will be unswerving if it is empirically evinced by this study.

Certain factors have also been linked to risky sexual behaviour among adolescents apart from those discussed above. Gender is one of such factors. Gender can be described as an array of physical, biological, mental and behavioural features pertaining to and distinguishing between the feminine and masculine (female and male) population (Filgona and Sababa, 2017). Gender also represents a cultural value system that distinguishes the roles, behaviour, mental and emotional characteristics between females and males developed by society (Udousoro, 2011). Umoh (2003) describes gender as a psychological term used in defining behaviour and characteristics expected of individuals on the basis of being born as either male or female. Gender was selected as a moderating variable to elucidate the inconsistent and discrepant findings of the involvement of male and female adolescents in risky sexual behaviour.

Gender inequality remains a critical issue of concern around the globe particularly to teachers and researchers (Awodun, Oni and Oyeniyi, 2015). Hansman, Tyson and Zahidi (2009) explain that no nation around the universe has attained the same status between female and male in relation to crucial areas such as sustainable development and behavioural-related issues. This fact has prompted quite a number of researchers to unravel the gender gap (inequality) in the students' academic performance (Awodun *et al.*, 2015; Hudson, 2005; Longe and Adedeji, 2003; Yoloye, 2004; Ezirim, 2006; Francis, 2007; Igboke 2004; Ma, 2007; Ogunkola and Fayombo, 2009; Coley, 2010).

Beyond students' academic performance, quite a lot of researchers have also delved into gender difference in sexually related activities among the adolescents. Yoona, Voithb, and Kobulskyc (2018) note that significant gender difference exists in the regular

form of risk sequence of reactions resulting from earliest years of physical abuse. They maintained that sexual maltreatment significantly correlates with hazardous sexual activities in boys than in girls. In the same vein, Bensley, Van Eenwyk, and Simmons (2000) observe that earliest years of sexual maltreatment is related to a three-fold increase in HIV-risk behaviour in male rather than females in adulthood. This observation implies that adolescent male with a background of earliest years of sexual maltreatment may be extremely susceptible to participation in risky sexual activities during the teenage years.

The outcome of physical abuse on risky sexual behaviour in boys appear to suggest that physically abused boys are likely to be exposed to hyper-sexual models of masculinity that leads to risky sexual behaviour, or may use sex as a compensatory strategy to create a masculine identity as a response to earlier abuse and vulnerability. Studies have also established significant gender moderation in the path from marijuana use to risky sexual behaviour, with a significant link between these variables found in girls, but not in boys (Yoona *et al*., 2018). These findings are similar to Walsh, Latzman, and Latzman's (2014) report of gender moderation effects on the association between alcohol problems and intent to engage in risky sexual intercourse, with the association being significantly stronger for girls than for boys.

Several studies have revealed that conduct disorder is more prevalent among male youth than among female youth (American Psychiatric Association, 2013; Berkout et al., 2011). Conduct disorder refers to a disorder of childhood and adolescence characterized by a pattern of behaviour that violates social norms or the rights of others. Youth with conduct disorder engage in an array of antisocial behaviours such as aggression, destruction of property, deceit, stealing, and other serious violation of rules (for example, absconding from home) (American Psychiatric Association, 2013). Also, Holliday, Ewing, Storholm, Parast, and D'Amico (2017) note that the association with conduct disorder symptoms is stronger or only present among females. However, these findings do not absolutely support the broader category of "sexual risk behaviour" because a female-specific manifestation of conduct disorder as the association between conduct disorder indications and specific outcomes, for example, numerous partners in the past few months according to report on the use of alcohol or other drugs (AOD) before sex, is also

significant among males. Findings indicate that females with conduct disorder maybe at increased risk for participating in most of the risky behaviour.

Looking at all the past related studies, it is worrisome that none of them have actually focused on students with special needs and adolescents with visual impairment in particular. It is, therefore, on this basis that this study examined environmental and affective factors as determinants of risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

1.2 Statement of the problem

Risky sexual behaviour as well as its attendant negative consequences has been an issue of urgent concern around the world due to its high social, economic and emotional costs. Despite the introduction of a wide range of preventive measures including sexual education to track down its further development, it is disturbing to note that the incidence of risky sexual behaviour has continued to rise in alarming proportions with the increased involvement of teenagers and adolescents. It is worth stressing the fact that, through risky sexual behaviour, the youth are daily exposed to the deadly HIV/AIDS scourge and other sexual-borne diseases with far-reaching negative health implications and fatal social consequences.

The challenge becomes even more daunting when it is realised that adolescents with visual impairment who, in spite of their malicious social label as ‘asexual’, have been engaging in risky sexual activities just like their typically developing counterparts. In sub-Saharan Africa, most especially Nigeria, where HIV prevalence is very high among adolescents, the involvement of adolescents with visual impairment in risky sexual activities carries with it even more unpleasant consequences. Once infected with any of the by-products of risky sexual behaviour such as gonorrhoea, syphilis, Chlamydia, HIV, AIDS and other sexually transmitted diseases, adolescents with visual impairment may be secretly spreading it unless the government and civil societies intervene.

Faced with the intractable challenges of risky sexual behaviour, adolescents with visual impairment are yet to receive appropriate attention from the relevant authorities.

Thus, risky sexual behaviour remains a problem among this group of individuals and it accounts for their loss of interest in school tasks resulting in their poor academic performance and their increased rates of school drop-out. Besides, it leads to the rising cases of street begging, poverty, depression, social stigma, sexual coercion, unplanned pregnancy, maternal health risk, clandestine and unsafe abortions, and a host of other problems among them. The trend in research being conducted today on knowledge of and attitudes towards sexual practices among adolescents with visual impairment in Nigeria is now tilted in favour of determining effective interventions.

It is, thus, logical to opine that adequate education/information on sexuality for adolescents living with visual impairment at home and also at school will not only increase their knowledge, but it will also enlighten them on their vulnerability to sexual harassment and victimization. However, there are insufficient educational packages available in Nigeria regarding environmental and affective factors that could shape sexual behaviour among adolescents with visual impairment.

Worse still, the usefulness of the available data is undermined by the fact that the few studies that have been carried out so far on the sexual behaviour of adolescents with visual impairment among secondary school students in Nigeria were limited in geographical scope as some prominent areas including the Southwestern Nigeria were left out. It is against this background that this present study examined the influence of peer pressure, parenting style, school climate, emotional intelligence and sexual attitudes on risky sexual behaviour among adolescents with visual impairment in secondary school in Southwestern Nigeria. The study also examined the moderating influence of gender on risky sexual behaviour.

1.3 Purpose of the study

The broad purpose of this study is to investigate the extent to which independent variables of environmental factors (peer pressure, parenting style and school climate) and affective factors (sexual attitude and emotional intelligence) predict dependent variable(risky sexual behaviour) of adolescents with visual impairmentin secondary schools in Southwestern Nigeria. The specific objectives of the study are to determine:

i. The pattern of the relationship among the independent variables of environmental factors (peer pressure, school climate and parenting style), affective factors (emotional intelligence and sexual attitude) and dependent variable(risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

ii. If the independent variables ofenvironmental factors (peer pressure, school climate and parenting style) and affective factors (emotional intelligence and sexual attitude) jointly predict dependent variable risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

iii. The relative contributions of the independent variables of environmental factors (peer pressure, school climate and parenting style) and affective factors (emotional intelligence and sexual attitude) in predicting risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

1.4 Research questions

The following research questions were raised and answered:

i. Is there any significant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria?

ii. How significant is the relationship between school climate and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria?

iii. What is the nature of the relationship between parenting style and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria?

iv. Does emotional intelligence significantly correlate with risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria?

v. Are there any significant relationships between sexual attitudes and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria?

1.5 Hypotheses

The following null hypotheses were tested at 0.05 level of significance.

Ho_1 There is no significant joint contribution of the independent variables (peer pressure, school climate, parenting styles, emotional intelligence and sexual attitude) to the prediction of the dependent variable (risky sexual behaviour) of adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Ho_2 There is no significant relative contribution of the independent variables (peer pressure, school climate, parenting style, emotional intelligence and sexual attitude) to the dependent variable (risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Ho_3 There is no significant gender difference in risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

1.6 Significance of the study

There is no gainsaying the fact that adolescents with visual impairment would benefit immensely from this study because it will provide them with the knowledge and understanding of human sexuality and reproductive health, which would not only help them to avoid risky sexual behaviour and prevent its unbearable adverse consequences but which would also make them more conscious of their vulnerability to sexual harassment. Similarly, through the instrumentality of this study, parents, guardians and caregivers would be better enlightened on the effective measures of guiding and protecting their wards with visual impairment from sexual misadventure.

Furthermore, the study would raise the consciousness level of teachers and parents of adolescents with visual impairment on issues of risky sexual behaviour. Besides, the parents would be helped to create a serene home environment for their wards with visual

impairment to occupy them with productive ventures that will make them stay away from harmful sexual practices. Apart from that, the parents would have an insight into the appropriate time and decent way to discuss the sensitive sexual and reproductive health issues with their wards.

In addition, the outcome of this study would enlighten the parents, the special educators, the counsellors, the religious bodies and the entire society on the need to go back to the roots to inculcate the almost forgotten societal ethos of chastity in the lives of young people. The findings of the study would assist both parents and teachers to monitor the type of peers their wards with visual impairment keep, so as to control their activities. The important information from this study would go a long way in instilling a sense of responsibility in the general public to care for persons with visual impairment in their environment and to see their safety, particularly from sexual harassment, as a collective duty. The outcome of this study would prove valuable to policymakers to consider more sophisticated and effective ways of protecting the sexual rights of adolescents with visual impairment. The study would also help the counselling psychologists to surmount interventions to eradicate factors or situations that precipitate young people, especially adolescents with visual impairment to risky sexual behaviour.

More importantly, the results of this study will provide empirical information and serve as a reference point for students, scholars and researchers, thereby contributing to the existing body of knowledge in the discipline of special needs education. The findings of the study would also help the curriculum planners and programme designers in the area of special needs education to be flexible in designing useful curricula to reduce risky sexual behaviour among adolescents with visual impairment. Lastly, the outcome of this study would assist school administrators and special educators to enhance a positive school climate so as to reduce aggression, violence, bullying behaviour and sexual harassment regardless of sexual orientation.

1.7 Scope of the study

This study investigated environmental factors (peer pressure, parenting style and school climate) and affective factors (sexual attitude and emotional intelligence) as

determinants of risky sexual behaviour among adolescents with visual impairment in secondary schools. The study was restricted to only Southwestern zone out of the six geographical zones in Nigeria while only students from selected integrated schools for the visually impaired in Ekiti, Lagos, Ogun, Ondo, Osun and Oyo states participated in the study.

1.8 Operational definition of terms

In order to avoid ambiguity in this research, it is considered necessary to define certain words operationally. Thus, the following recurrent terms used in the study are hereby operationally defined.

Visual impairment: This is a condition that results in a restriction or a complete loss of sense of sight in an individual.

Adolescents with visual impairment: These are the young people between the age of nine to twenty-three years who experience visual limitations or total loss of vision at birth or due to other circumstances of life.

Totally blind: These are adolescents who cannot differentiate light from darkness or who experience total inability to see

Low vision: These are adolescents who are neither sighted nor blind. They can functionally make use of their vision with the assistance of a strong and powerful lens.

Risky sexual behaviour: This refers to the conducts of the adolescents with visual impairment which increase the probability of adverse health consequences such as early sexual debut, promiscuous behaviour, transactional sex and soon.

Environmental factors: These are the factors within the immediate surroundings with which adolescents with visual impairment interact consciously or unconsciously. In this study, the environmental factors are peer pressure, school climate and parenting styles.

Peer pressure: This refers to the force exerted by friends, mates, colleagues, counterparts and other groups on adolescents with visual impairment to make them conform to the standard of the group.

School climate: School climate refers to the quality and character of school safety, support and peer relationships experienced by adolescents with visual impairment which influence their behaviour positively or negatively.

Parenting styles: These refer to the standard strategies that parents of adolescents with visual impairment use in their child-rearing practices.

Affective factors: These are emotional factors that influence the attitudes of adolescents with visual impairment. Affective factors considered in this study are sexual attitude and emotional intelligence of adolescents with visual impairment towards risky sexual behaviour.

Emotional intelligence: This is the capacity of adolescents with visual impairment to be aware of their own feelings and those of others in order to cultivate a socially acceptable behaviour.

Sexual attitude: This refers to feelings, beliefs or opinions of adolescents with visual impairment about sexuality based on cultural views and previous sexual experience which are manifested in their behaviour**.**

CHAPTER TWO

LITERATUREREVIEW

This chapter presents the review of related literature under the following subheadings: conceptual review, theoretical review and empirical review.

2.1 Conceptual review

2.1.1 Concept of adolescence

Adolescence is generally considered as the age or the interval between childhood and adulthood. It is often referred to as the second phase of life. The World Health Organisation (2002) group adolescence into early adolescence (10 -13 years), traditional or mid-adolescence(14-18 years) and late adolescence (19-23 years) while Falaye (2001) categorizes adolescence into the early adolescence (13 -18years) and late adolescence(18-21years).

There are several definitions and description of adolescence. For instance, Owuamanam (2003) sees adolescence as an unstable time during which a child needs structures as well as opportunities to become more independent. Oriade (2005) stipulates that the adolescence period begins after childhood and ends once adulthood begins. This period is fondly characterized by the children seeking freedom from the parents, guardians and other adults who care for them. It is worthy of note at this point that the adolescence period varies from individual to individual. At the stage of adolescence, there is a considerable acceleration in growth, where children are naturally transformed in physique, emotions, cognitive and social interactions (Falaye, 2001). Adolescents make up about 20percentof the total population of the world of which 85percent of them live in the developing countries.

Fieldman (2000) describes adolescence as a trying period associated with psychological stress and storm. The children experience stress and untold tension in a bid

to establish personal identity in the journey of migration from dependence to independence. In the course of this adventure, they stumble on the knowledge of their sexuality. The adolescents at this level develop some peculiar emotions and feelings of desire to be touched, loved, and cared for, and to be given good attention by persons of the opposite sex (Asuzu, 1994). At this stage, they develop more tendency to seek information about their sexual life from the peers. The age of adolescence is a very sensitive stage and any form of exposure to erroneous information or lifestyle during this period can be very costly because it largely has a negative impact on the decision making of the adolescents. However, adolescents bred in a serene sub-urban environment have a lesser tendency of being exposed to negative exposure; they have greater tendency to engage in positive activities that are directly advantageous to them and their community (Carlson and Heth, 2010). In a nutshell, the concept of adolescence is the notion of transition, a period of change, growth and disequilibrium.

The biological changes experienced during adolescence like puberty which overwhelms the individual at an early stage is a source of stress to the individual because the interaction and the combination of these changes often result in a complex life experience for the individual. The changes during puberty have been grouped into four broad categories namely: inner-biological, psychological, cultural-social and outer-physical changes (Riegel, 1975). According to Kimmel and Weiner (1988), each of these changes is accompanied by instability, problems, complex questions and sudden transition in the life cycle, and if not properly managed can result in formidable problems for the adolescents and society at large. From a dialectal interpretation of these changes or developments, the major events in the life of individuals are arbitrarily imposed upon them by social and legal regulations such as departure from school, recruitment into military services, job appointments and dismissals and ultimately retirements. Other changes are brought about by cultural-social and outer-physical progressions such as depressions, inflations, revolutions, wars, droughts, floods, fires, and earthquakes (Riegel, 1975). Only the inner-biological progression seem to follow some predictable order, first revealing the individual's maturation, the birth of children, proneness to incapacitation, illness and death. It should be understood that most of these changes appear as crises tothe

individual and as catastrophes to society at large. They show a discrepancy or disharmony or to put it better, lack of synchronization between the biological, psychological, cultural and physical events sequences. Crises are brought about by the discordance between inner-biological order and individual's psychological development while catastrophes are brought about by discordance between the cultural-sociological and the outer-physical progressions. The fatalistic viewpoint is, in turn, generated by the failure to consider these progressions simultaneously and thus, to reach a more comprehensive understanding in order to programme and co-ordinate them more effectively (Riegel, 1975).

In the same vein, Arnett (2007) defines adolescence from biological, cognitive and social perspectives. From a biological point of view, adolescence is seen as a physical modification characterized by the beginning of puberty and the end of physical development. From the perspective of cognition, adolescence is the development in the capability to reason abstractly and vastly; socially, it is a preparatory stage for adulthood. Some of the main pubertal changes include development in sex organs; in height, weight and muscle mass together with marked development in brain structure and organization (Larson and Wilson, 2004; Christie and Viner, 2005; Dorn and Biro, 2011).

Adolescent developmental tasks

This section is devoted to the various developmental tasks that influence adolescents' exposure to risky sexual activities as established in developmental theories.

a. Physical development

Apart from fast physical development, adolescence is also marked by sexual maturity. While menarche (first menstruation) and ovulation are some of the manifestations of sexual maturation in girls, sexual growth in boys is signalled by the first seminal emission (Berger, 1994). According to Dreyer (1975), teenagers become more acquainted and fascinated with their bodies, leading them to experiment with interactions of physical intimacy in search of a sense of sexual identity. As an outcome of sexual maturation, both sexes start getting strong physical attraction towards each other, a situation that predisposes adolescents precarious sexual behaviour if not adequately met with awareness of the associated dangers of high-risk sexual behaviour.

b. Psychosocial development

Havighurt (1953) identifies the development of self -one's holistic identity-as a developmental task that an adolescent strives to realize. This psychosocial stage spurs in adolescents the quest for self-discovery: who they are; what they value and stand for; and what their future aspirations are. This stage involves the integration of physical, sexual, social, cognitive and moral tasks of development to construct a holistic self. Since sexual identity occupies a focal point in one's self, a healthy psychosocial development requires sexual experimentation and gratification. These sexual wants, if not appropriately coordinated, may birth biological problems like the transmission of sexually transmitted diseases and other infections; and socio-economic problems such as unwanted pregnancies which may in turn negatively impact on the development of a healthy psyche.

c. Cognitive development

According to Havighurst (1953), specific cognitive skills are developed during the period of adolescence. Cognitive changes that take place during adolescence stage can be defined as a more comprehensive and advanced ability to reason logically about concrete as well as abstract concepts and the ability to analyse situations (Inhelder and Piaget, 1958). On the other hand, Elkind (1967) believes that though adolescents are cognitively able to take others' thoughts and feelings into account, they often fail when they attempt to do so, as they end-up believing that others share their thoughts and feelings about specific concepts or situations. Lapsley and Murphy (1985) describe this concept as adolescents' perception of themselves as special and unique. They also tend to believe that they are invulnerable and indestructible. Research conducted by Arnett (1990) corroborates this theoretical belief as it has been proved that adolescent girls with a high level of egocentrism tend to believe that there is almost no possibility that they will fall pregnant if they are to have sexual intercourse without the use of contraceptives. Research conducted by Moore and Rosenthal (1991) showed that adolescents tend to believe that they are immune to the negative consequences of risky behaviour and this false thinking places them in a vulnerable position amongst the general population with regards to contraction of HIV/AIDS. Although adolescents maybe biologically prepared to engage in sexual behaviour, they are often not psychologically ready to make responsible decisions or

realise the negative consequences of sexual behaviour (Louw*etal,* 1998). It is evident from the literature that adolescents' physical, psychosocial and cognitive development places them in a vulnerable position regarding risky sexual behaviour. However, what is not clear is whether self-efficacy and future time perspectives are factors that make them resilient in the face of risky sexual behaviour.

2.1.2 Concept of visual impairment

Visual impairment can simply be described as the physical damage, malformation or malfunctioning of the organ of vision (Dala, 2005). This disability can affect any person at any given stage in life. Consequently, persons with visual impairment are individuals who suffer a reduced function of the eyes or a total blindness. The functionality of the eye is measured by specific visual tests such as visual acuity, visual field, and colour or near vision (Dala, 2005). On the other hand, Abang (2005) refers to visually impaired persons as individuals with some degrees of visual problem which could be remedied either by surgical operation or by optical correction. In the definition of Mba (1995), visually impaired persons are those who are short-sighted, long-sighted or those who suffer from astigmatism.

Sisan, Connie, Karen and Valarie (2003) note that visual impairment ranges from a visual acuity of 20/200 in the better eye after correction to having no usable vision or a field of vision reduced to an angle of 20 degrees. Visual acuity of 20/200 means that the individual sees at 20 feet what is normally seen at 200 feet. A reduced field of vision means that the individual has tunnel vision with limited peripheral vision. Blindness ranges from being totally without sight to unreliable vision and primary reliance on other senses. A person with blindness usually uses braille as a reading and writing medium. Visual impairment refers to a significant loss of vision, even though the person may wear corrective lenses. The nature and degree of visual impairment may vary significantly, so each person may require individual adaptations to instructional practices and materials in order to learn effectively. Visual impairment includes two main categories: blindness and low vision. Blindness means no useable vision while low vision means a reduced central acuity of 20/70 or less in the better eye after correction.

`Furthermore, visual impairment has also been given legal and educational categorizations (Abang 2005; Heward 2000, 2006; Smith 2007). From the legal viewpoint, students with visual impairment have clinically measured visual acuity of 20/200 or 6/60 in the better eye with best correction or a visual field of 20 degrees or less (Kaufmanand Hallahan, 2011; Abang, 1992). A person may also be considered legally blind if his field of vision is extremely restricted when looking straight ahead (Heward, 2000). Ordinarily, a normal eye should be able to see an object with a range of 180 degrees. Thus a field of vision is the area of coverage of the eye when an individual focuses straight ahead. A person who has a field of vision of 20 degrees or less instead of the normal 180 degrees is legally blind. It should be noted that this legal definition is simply an eligible standard; however, it is not concerned with the way in which a person with blindness experiences and learns about the world (Huebner, 2000). The way a person with blindness experiences and learns about the world is at the core of the functional definition of visual impairment. Hallahan and Kaufman (1991) and Turnbul and Turnbul (2004) assert that functional definition of visual impairment was provided by Individual with Disabilities Education Act(IDEA) for educational purpose which defines visual disability as an impairment in vision that even with correction adversely affects a child's educational performance. The key to this definition is that students have some kind of disorder of the visual system that interferes withlearning (Turnbul and Turnbul, 2004). The functional definition of visual impairment classified visual loss based on the extent the individual use his vision and/or auditory/tactile means for learning.

Visual impairment is a significant limitation of visual capability resulting from disease, trauma, or congenital or degenerative conditions that cannot be corrected by conventional means, such as refractive correction or medication. This functional loss of vision tends to manifest with the bestcorrected visual acuity of less than 20/60, or significant central field defect, significant peripheral field defect including homonymous or heteronymous bilateral visual field defector generalized contraction or constriction of the field, or reduced peak contrast sensitivity with either of the above conditions. Although the report of Nwazuoke and Obiajunwa (1996) in Nwazuoke (2000) on the performance level of some visually impaired and sighted pupilsin an intelligence test

showed that sighted pupils performed better than their counterparts with a visual handicap, it was pointed out that visual impairment does not necessarily lower an individual's intelligence. Nwazuoke (2000) attributes the disparity in academic performance between pupils with visual impairment and their sighted peers to lack of access to bibliographic materials and a significant disadvantage in teaching strategy rather than a function of any significant intelligence discrepancy. Ayoku (2006) submits that visual impairment is potentially handicapping as it adversely affects physical, motor skills, intellectual, emotional and psychological development as well as the ability to interact with the social and physical environment. For the handling of the potential handicap, suggested intervention strategies include human attachment, meaningful auditory stimulation, opportunities for various adaptations, experiences and appropriate and timely interventions in order to overcome these negative consequences.

Persons with visual impairment, therefore, exhibit a spectrum of special needs as a result of their sensory limitations. The ranges of such needs are manifested in the series of differences demonstrated by the person's abilities, aptitudes, learning styles, learning readiness and motivation. The needs of this group are further compounded by society's nonchalant attitude about their interest (Ayoku, 2006). One of the challenges confronting exceptional persons and persons with visual impairment in particular in Nigeria is the persistent denial of their fundamental rights (Osinuga, Adebisi and Ajobiewe, 2004). The State of Queensland points out that visual impairment is any diagnosed condition of the eye or visual system that cannot be corrected within normal limits. Disease, damage or injury causing vision impairment can occur in any part of the visual system such as the eye, the visual pathways to the brain and the visual centre of the brain. Normal visual acuity is recorded as 6/6. The first number refers to the testing distance while the second number refers to the size of the letter being viewed.

Category	Presenting distance visual acuity	
	Worse than:	**Equal to or better than:**
Mild or no vision impairment		6/18
Moderate vision impairment	6/18	6/60
Severe vision impairment	6/60	3/60
Blindness	3/60	1/60*
Blindness	1/60*	light perception
Blindness	No light perception	
	* Or counts fingers (CF) at 1 metre.	

Visual acuity

Classification of visual impairment

Various professionals in the discipline of education for learners with visual impairment have classified persons with visual impairment based on the level of their visual functioning and educational needs. For many years children with visual impairment have been classified into two categories; the blind and the partially sighted (Abosi and Ozoji, 1985). However, the World Health Organization (2000) omitted the term 'partially sighted' in its own classification system. Baraga in her study found out that 80percent of children termed blind in special schools for the blind have some vision useful for mobility and she also found another group called low vision children. Iregbu, (2007) notes that the World Health Organization in 1992 categorized visual impairment into total blindness, low vision and partial vision. This categorization has culminated in the classification of children with visual impairment into three broad categories. In the same vein, Eniola (1993), Mba (1995) and Chukuka (2010) group visual impairment into partial sightedness, low vision and total blindness. Abang (1992) asserts that vision can be impaired in three ways; the visual acuity may be reduced, the field of vision may be restricted and the colour vision may be defective. Partially sighted children are those whose vision is distorted due to some error of refraction (Mba, 1995; Chukuka, 2010). Adeyemi (2005) also identifies an error of refraction to include myopia, hyperopia, astigmatism and presbyopia.

Panda (2007) asserts that a person is said to be partially sighted if defined in terms of distance from Snellenchart while low vision is defined in terms of clarity reduction. Sykes and Ozoji (1992) opine that low vision children are those children with a severe or profound level of visual impairment but have the residual vision to function primarily in a sighted way. They are those children whose visual acuity falls between 20/70 and above (Hallahan and Kaufman 2011). This fact means that the low vision child stands at 20 feet to see what a normal vision can see at a distance of seventy. Turnbul and Turnbul (2004) describe low vision individuals as those who can generally read print, although they may depend on optical aids, such as magnifying lenses to see well. They further observe that only a few in this category can read both print and Braille. Heward (2000) affirms that a low vision child has little vision that he uses to supplement the information received primarily through other senses. Chukuka (2010) notes that low vision children only function in their environment with minimal sight. Porter (2005) points out that low vision can restrict visual and motoric inspection of the environment.

Totally blind persons refer to individuals who cannot read and write print after all optical corrective measures have been taken. They use Braille as a medium for reading and writing. Lowenfeild (1973), however, states that a child is blind if he has a central visual acuity of 20/200 or less in the better eye with correcting glasses. This implies that the affected child can see at a distance of 20 feet what normal eyes can see at 200 feet. The blind individual has visual acuity worse than 20/400, with the best possible correction or a visual field of 10 degrees or less (Smith, 2007). The totally blind receive no useful information through the sense of vision and must use tactile and auditory senses for all learning (Heward, 2000; Chukuka, 2010; Smith 2007).

The World Health Organization groups children with total vision loss into near blind and blind (Hallahan and Kauffman 1991). Heinze (1986) in Awoniyi (2011) observes that many people assumed that individuals who are blind have no vision and thus live in the world of total darkness. He further affirms that only about 10percent of all persons labelled as blind are totally without sight. Basharu (2002) adds that most persons considered blind do respond to some objects and do not live in a world of total darkness. Baraga and Erin (2001) assert that a child with blindness refers to one whose vision loss

interferes with his optimal learning and achievement unless adaption is made in the method of presenting learning experiences, the nature of the materials used and the type of learning environment. Jernigan (2002) eventually adds that a person is blind if he must devise an alternative technique to do efficiently many things in the environment he would do if he had a normal vision.

Blindness has been viewed by various people based on their perceptions, disciplines and the effects it imposes on them. Millais (2010) asserted that visual impairment is the condition of lacking visual perception due to physiological or neurological factors. In other words, it is a lack or loss of ability to see –lack of perception of visual stimuli. Often, people who are diagnosed with legal blindness still have some useable vision. Eniola (2008) categorizes students with visual impairment as those who are totally blind, those with low vision and those with partial sightedness. The term "Visual Impairment" is now generally accepted as referring to people within the visual range of no sight at all to useful but defective vision rather than the more strictly categorical terms of "blind", "low vision" or "partially sighted" (Nkangwung, 2011). Although Jernigan (1999) sees blindness as a characteristic; it is nothing more special, or more peculiar, or more terrible than that suggested. It is pointed out that with the understanding of the nature of blindness as a characteristic, a normal characteristic like hundreds of others with which every individual must live, one will better understand the real need to be met. It is stressed further that any characteristic is a limitation. Thus, every characteristic regarded as strengths as well as weaknesses is a limitation.

2.1.3 Adolescents with visual impairment

Adolescence is a transitional stage of physical and psychological human development that generally occurs during childhood. The period of adolescence is most closely associated with the teenage years, though its physical, psychological and cultural expression may begin earlier and end later. Puberty is commonly seen as one of the characteristics of the adolescence age. It is the period between childhood and adulthood, a period in which children naturally prepare for adulthood. Okeke (2001) asserts that adolescents with visual impairment are those who have difficulty in vision which

necessitates the use of special educational methods or adaptations to materials and who need to use special aids and materials for learning.

Heward (2000) states that children with visual loss are those who, as a result of their limited or total loss of vision, are deficit in one or more skills requiring vision. As a result, they need special equipment and adaptations to function effectively at school and at home. Iruegbu (2007) posits that persons with visual impairment are those whose sense of vision is defective with the corresponding limitation in orientation and mobility skills, daily living activities and visual tasks, resulting from their defective visual condition. Abang (2005) asserts that students with visual impairment are those whose defective vision interferes with their optimal learning and achievement unless adaptations are made in terms of methods of presenting learning experiences, the nature of the materials used and the type of the learning environment. When objects in the environment cannot be perceived or understood as a result of vision damage or obstruction, visual impairment has occurred (Smith, 2007).

Maccsohusett (2012) opines that students with visual impairment have limited ability to learn incidentally. This situation affects how they form concepts and develop schema or frameworks for understanding new ideas and vocabulary that provide essential foundation skills for comprehension and abstract reasoning. Learning social skills, play skills and adaptive living skills are likewise affected. Interpreting non-verbal, social interactions especially body language, understanding another person's point of view, and working in cooperative learning groups are markedly enhanced by "seeing" other's responses to these interactive activities. Mastering these skills may require explicit instruction for students with vision loss. Limited incidental learning also affects performance on standardized assessments, especially cognitive and achievement tests, where questions are based on assumptions about the kinds of information that should be known by certain chronological ages.

Tests that have not been standardized on students with visual impairments may underestimate students' true abilities and the results should be interpreted with caution. Students with visual impairment differ from one another and from day to day. Two

students with the same levels of vision and cognition may “see” differently due to the aetiology of their vision loss and environmental factors related to the nature of the task they are viewing, such as the lighting or the visual complexity of the task. Moreover, the same student may “see” differently from day to day because of internal, personal factors including fatigue, motivation, attention, and other considerations.

Texas Education Agency (2014) submits that students with visual impairment may be totally blind or may have varying degrees of low vision. They may be born with a visual impairment or may have acquired a visual impairment at a later time in their life. They may or may not be learners on the academic level of their sighted age peers or they may have hearing impairments (deaf/blindness).They may have any number of other disabilities (mild to severe intellectual disability, physical disability, other sensory loss, emotional or behavioural problems, autism and/or specific learning disabilities).They may have impaired vision originating in a part of the structure of the eye or due to neurological causes such as cortical visual impairment.They may have additional medical needs and considerations.

Characteristics of adolescents with visual impairment

Adolescents with visual impairment are found in all parts of society. They are as gifted and talented as their sighted peers, though some of them may be on the average, which is not a function of their disability. This category of adolescents has some features in common which can be identified more easily than any other form of disability. Apart from the physical observable behaviour associated with the disability, Zimmerman and Zebehazy (2011) identify other characteristics as follows:

Motor development: They note that depending on the severity of the impairment, children with visual impairment may not be motivated to move and explore. Celeste (2007) reports that infants and toddlers in her study demonstrated delays in all gross motor milestones. The participants lack visually driven initiative behaviour and the restrictions of an environment may retard the development of some motor skills. Heward (2006) observes that children who are blind may put their natural energy into rocking, poking or

flapping which would have been useful in motor development. Stone (1997) emphasizes that poor motor development affect their learning and social acceptability.

Academic/cognitive skills: Hallahan and Kauffman (2006) opine that there is a minor difference regarding the acquisition and development of the major component of language between the children with visual impairment and the sighted ones. They maintain that children with visual impairment may have difficulties because of their impairment and corresponding lack of linguistic experiences that are related to their limited interaction with their environment. Heward (2006) asserts that the sense of sight provides steady detailed information of experience of environment and the relationship between things in the environment for the seeing children but children with visual impairment do not have access to most of such incidental learning or relating different items of information. Other researchers such as Skellengers and Hill (1997) reveal that students with visual impairment have difficulty with concept development because their construction of concepts from hearing and touch is not only less efficient, but it is also more prone to error and misunderstanding.

Orientation and mobility: Orientation and mobility are not the same skill but they complement each other (Hilland Snock-Hill, 1996). Orientation implies knowing where one is going and how to get there by interpreting information from the environment while mobility involves moving safely and efficiently from one point to another (Heward, 2006). Orientation and mobility jointly is the ability of an individual to move safely, independently, efficiently and gracefully from one position to another desired position in the environment. Heward, (2006) stresses that it is extremely important that individuals with visual impairment should be taught the basic concept in orientation and mobility to familiarize them with their bodies and surroundings, Hill and ponder (1980) posit that the blind person who has a functional knowledge of mobility relates to his environment in a more meaningful and realistic fashion as he moves can exercise control over his environment for possible adjustment.

Listening skills: Listening involves being aware of sounds, discriminating differences in sounds, identifying the source of sounds, and attracting meaning to sound (Heinze, 1986).

Students with visual impairment especially the totally blind obtain most information by listening (Heward, 2006). Normal vision is thought to be the coordinating sense. It has been estimated that 80 percent of information comes through the visual channel (Arter, 1997; Best 1992). However, students who are blind use other senses, mostly sense of hearing to contact and comprehend their environment (Heward, 2006). Learners who are blind do not automatically develop a better sense of hearing but rather it is through proper instructions and experience that they learn to use their hearing more efficiently (Koenig, 1996). Heward (2006) adds that systematic development of listening skills is an important component in the educational programme of every child with visual impairment. Students with visual impairment make use of recorded materials to listen to texts, lectures and class discussions. Olukotun (2003) notes that listening skillis very crucial during orientation and mobility training and independent travel which would enable one to interact with one's social environment.

Daily living skills: Daily living skills involve learning of the functional skills. Miller (1993) indicates that academic achievement has traditionally been overemphasized at the expense of basic living skills. Dala (2005) asserts that most of the daily living skills that are normally acquired incidentally by visual imitation should be systematically taught to students with visual impairment to acquire them. Panda (2007) lists these skills to include the following: eating, toileting, taking baths, dressing, washing clothes, body hygiene-cleanliness, food preparation, using medicine, using electrical appliances, using telephones, shaving, handling money and shopping. Corn and Sack (1994) and Rosenblum (2000) add that transportation and recreational activities are requisites for an independent and enjoyable social adult life.

Speech and language characteristics: Eniola (1993) identifies children with visual impairment as exhibiting the following language and speech characteristics: they tend to speak more slowly and louder than their sighted peers, they modulate and project their voices less appropriately, they have less voice variety, they use fewer bodily movement, facial expressions and gestures in talking, they use less lip movement in articulation, they often refuse to respond to a question or to speak spontaneously at a level usually characteristic of their peers. They also find it difficult to follow directions or description.

Hearing characteristics: The blind have a low tolerance for noise or changes in the usual pattern or sound. They behave like the deaf at times by requesting the repetition of information. Usually, they have to turn up the volume of radio or television set beyond a reasonable level.

Mobility characteristics: Turnbul and Turnbul (2004) assert that individuals with visual impairment are limited in their spontaneous ability to move safely in and through their environment. This situation affects the visually impaired child's early motor development and exploration of the world. Corn and Sacks (1994) observe that the inability to move around is a continuous source of frustration for many adults with visual impairment. Barraga and Erin (2001) opine that the inability to move around through space affects their opportunities for experiences. Trunbul and Turnbul (2004) further observe that the limited mobility makes children with visual impairment to become passive and to have fewer opportunities for intellectual and social stimulation. Their ability to get along with others is limited because of restricted mobility. Panda (2007) asserts that reduced vision correlates with poor motivation to move through the environment which limits the sense of competency and mastery. Zimmerman and Zebehazy (2011) assert that a lack of social skills is the area in which students with visual impairment tend to differ most from their peers. Tuttle (1981) observes that young as well as older people with visual impairment are often characterized as socially immature, self-conscious, isolated, passive, withdrawn and dependent. Turnbul and Turnbul (2004) note that children with visual impairment find it difficult to acquire certain social skills which others may acquire automatically. Students with visual impairment, when compared with the sighted students tend to ask too many questions or engage in inappropriate acts of affection to hold sighted mates interest (Perez-Pereira and Conti-Ramsden 1999; Maccuspie 1992). Children with visual impairment also tend to display a delay in the development of social skills (Erin Dignan and Brown 1991). Bullock (2004) and Dennison (2008) observe that deficiencies in social skill competence have been found to be associated with social maladjustment.

2.1.4 Sexuality among adolescents with visual impairment

Sexuality is a central aspect of being a human throughout life and it encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. The field of sexuality is largely under-studied in sub-Saharan Africa despite its undisputed importance for reproduction and health (Vance, 1999; WHO, 2004; Undie and Benaya, 2006). Sexuality encompasses physical capacity for arousal and pleasure (libido) as well as personalized and shared social meanings attached both to sexual behaviour and the formation of sexual and gender identities (Dixon Mueller, 1993).

Moronkola (1995) describes sexuality as the act of reproduction, an avenue or a process of sharing love between two lovers in communication, pleasure or enjoyment. Gognon and Simons (1973) also define sexuality as a concept that is made up of social interaction, social environment, culture and learned behaviour. For any individual, sexuality involves a certain self-concept, a particular view of the body and its relationship to others; and acceptability of a specific masculine or feminine gender role as well as the expression of a physical need.

Human sexuality is more than just whether you are male or female, and it is more than just the act of sex. It is a complex idea that involves physical make-up, how one thinks about oneself, and how one feels about others and society in which one lives (Benson, Middleman and Torchia, 2010). Some of the things that contribute to sexuality include:

- **Anatomic Sex:** Anatomic sex refers to the sex organs with which one is born. That is, one is either a boy (with a penis and testicles) or a girl (with breasts, uterus, vagina, and ovaries). Occasionally, a baby is born with malformed sex organs and may have reproductive organs of both sexes. However, anatomic sex is only one component of sexuality.
- **Gender identity:** Gender identity relates to how one feels inside, and whether one "feels" like a boy or a girl. Most people have a combination of feelings, including some that are thought of as "male" or "masculine" and some that are thought of as "female" or "feminine." In most cases, someone feels mostly like a boy or mostly

like a girl. Gender identity and anatomic sex sometimes do not match. In other words, a person can be born a boy but feels like a girl. This is sometimes referred to as transgender.

- **Sexual orientation:** Once students begin puberty, they are likely to begin to have strong physical and emotional attractions to others. Sexual orientation refers to whether one is primarily attracted to people of the opposite sex (heterosexual), the same sex as one (homosexual, gay, or lesbian), or both (bisexual). Sexual orientation is influenced by many factors including anatomic sex, gender identity, society in which one lives, and other factors some of which are not completely understood. Sexual orientation is believed to exist in a continuum. That is, one may feel attracted to people of the same sex but still have some feelings for people of the opposite sex or vice versa. These feelings are normal and may fluctuate throughout life (Benson, Middleman and Torchia, 2010).

Sexual thoughts, feelingsand behaviour present throughout life are often accentuated during the time of studentship. Puberty provides visible, undeniable evidence of physical maturity, obvious maleness or femaleness, and the ability to reproduce. The magnitude of students' sexual behaviour is growing and fast emerging as a public health concern across the country. It is necessary to put into perspective the sexual behaviour of students since it is central to the prevention of transmission of Human Immunodeficiency Virus (HIV) and other sexually transmitted diseases (STDs) in the country (Orubuloye, Caldwell and Caldwell, 1991).

Makinwa-Adebusoye (1991) defines sexual behaviour as a product of society, culture as well as the biological structure and function. Most students are aware of sexuality because it influences their personality and way of life. Some students view sexuality as something to laugh at, to joke about or to attract others to themselves, but the philosophers, scholars, psycholinguists and religious leaders havea serious thought about sexuality and its importance to individuals and society at large.

The rising rates of pre-marital sexual activity in developing countries have drawn attention to the process by which students make decisions about various aspects of reproductive behaviour. Gathering this information is crucial because of the increased

vulnerability of students to the risk of early STDs, including AIDS, the potential risk of early pregnancy to the female students' health and the negative consequences of an early and extra-marital childbearing (Kishor and Neitzel, 1996). Several studies have reported high rates of premarital sexual activity among Nigerian students (Feyisetan and Pebley, 1989). Several factors have also been offered to explain the high rates of sexual activity among Nigerian students such as Nigerian's deteriorating socioeconomic situation, the erosion of traditional African values, the early onset of menarche, a widening gap between age at menarche and age at marriage, infrequent and ineffective use of barrier contraceptives and the decreased value placed on virginity (Senderowitz and Paxman, 1985; Nicholas, Ladipo, Paxmen and Otolorin, 1986; Feyisetan and Pebley, 1989; Orubuloye, Caldwell and Caldwell, 1991; Renne, 1993)

Brook-Gunn and Paikoff (1993) and Steinberg (1996) are of the opinion that because of the controversies surrounding premarital intercourse, much of the research conducted into the sexual behaviour of students has focused on this single activity. It is also wise to remember that a good deal of the sexual activity of students even sexually experienced students involve activities other than sexual intercourse, such as necking and petting. Moreover, because most students do not begin their sexual experiences with intercourse but progress toward it through stages of gradually increasing intimacy, it is important to view intercourse as one activity in a long progression, rather than as an isolated behaviour.

According to Katchadourian (1990), most students' first experience of sex falls into the category of autoerotic behaviour-sexual behaviour that is experienced alone. The most common autoerotic activities reported by students are having erotic fantasies (about three-quarters of all teenagers reported having sexual fantasies mainly about television figures or movie stars) and masturbation (reported by about half of all male students and one-fourth of all female students) (Koch, 1993). By the time most adolescents have reached high school, they have crossed the line from autoerotic to "socio-sexual behaviour" – sexual behaviour involving a real person (Katchadourian, 1990).

Dixon-Mueller (1993) and Cho (1995) opine that although there is a clear trend among young men and women to marry later in their lives, sexual relations prior to marriage are on the rise. The period of exposure to sexual activities also becomes longer because the average age of menarche continues to decline. Social and economic changes including urbanization, industrialization and education have eliminated many of the traditional restraints on early sexual activity outside marriage and have exposed many adolescents and young people, especially adolescent girls, to the risk of unwanted pregnancy and abortion which in turn increase the risk of their health and well-being.

2.1.5 Risky sexual behaviour among adolescents with visual impairment

Risky sexual behaviour is any sexual activity that increases the risk of contracting sexually transmitted infections or becoming pregnant. It includes early sexual debut, unprotected sexual activity, inconsistent use of condoms, sexual intercourse with an infectious drug user, transactional sex (sex in exchange for money, food, drugs or shelter) or sex with a promiscuous partner (Aral and Haffner, 1995). Adolescent sexual risk-taking, defined for the purpose of this study as a history of sexual intercourse involving either multiple partners or no contraceptive or condom use contributes to the staggering number of sexually transmitted diseases and unwanted pregnancies in Africa (Rodgers, 1999). Sexual risk for adolescents has changed dramatically over the past decades. Among sexually active teenagers, about 1 in 4 acquires a sexually transmitted disease every year (SIECUS, 2000)

Risk refers to a chance of loss and engaging in risky behaviour is defined as risk-taking (Beyth-Marom and Fischhoff, 1997). Particular to adolescent sexual risk-taking, Brooks-Gunn and Paikoff (1997) state that almost nothing is known about how teenagers make choices to engage or not to engage in sexual experience, or how the choice to use contraceptives is made. Often researchers assert that, for adolescents, engaging in sexual intercourse is sexual risk-taking. For instance, Blum et al. (2000) considered any history of sexual intercourse as a category of risk. It may be difficult for clinicians to discern that these activities are occurring, especially since adolescents are unlikely to volunteer this information. Instead, this behaviour is often identified through the diagnosis of an STI, HIV or pregnancy.

Risky sexual behaviour, such as unprotected vaginal, oral, or anal intercourse, sex with multiple partners, and sex with high-risk partners (that is, intravenous drug users) can result in substantial negative outcomes. The cost of this behaviour to both the individual and society can be staggering. Individuals who engage in risky sexual behaviour run the risk of becoming pregnant (or getting someone else pregnant) and having an unplanned child or an abortion. An unplanned, early birth can make academic success, school completion, and employment extremely difficult, if not impossible, for the mother (Hayes, 1987). Furthermore, children born to teenage mothers without adequate prenatal care are at an increased risk of being born prematurely with a variety of physical and psychological deficits, such as mental retardation (Aber, Brooks-Gunn and Maynard, 1995).

A sexual relationship will be considered risky for adolescents when the outcome is capable of causing biological, social, economic and emotional problems. These various problems include teenage pregnancy, abortion, sexual coercion, sexual exploitations, STI's, HIV/AIDS, keeping of multiple sexual partners, premarital sexual relationships, indulgence in casual sexual relationships and unwanted touching, incest, assault, threats and seductions.

Factors that influence adolescents into risky sexual behaviour

Adolescents engage in risky sexual behaviour due to some factors that are of significant influence in their lives. Some of such factors include the following;

- **Socio-economic factor**:

Socioeconomic status is related to the outcome of risky sexual behaviour. Among the socioeconomic indicators that significantly predict risky sexual behaviour and pregnancy is parental low educational attainment. An adolescent own level of academic achievement is also positively related to age at sexual debut. Most adolescents subject themselves to a sexual relationship as a means of meeting their material needs. Some engage themselves in a relationship with wealthy old men, due to economic hardship. It can also lead young ones into early marriages. Adolescents are exposed to hawking to meet with personal and family demands. This leads them to meet different kinds of people who may entice them into risky sexual activities.

- **Cultural factor**:

In most cultures, the young adolescents do not have the right to decide when to marry and bear children, or whom to marry and under what conditions. Such decisions are made by parents when the girls are too young to understand the implications. While most cultures frown at a premarital sexual relationship, there are those that encourage premarital sexual relationship (Busari and Danesy, 2004).

- **Cognitive bias / personal belief**:

Cognitive bias can be defined as a way of thinking that distorts incoming information, such as information about personal risk or anticipated consequences. Formally known as "unrealistic optimism," this cognitive bias has been demonstrated in ages ranging from early adolescence through adulthood. The pervasive nature of this bias may partially explain why the risky sexual behaviour is distressingly prevalent among adolescents, even in the presence of knowledge about the potentially devastating consequences of the behaviour. High rates of risky sexual behaviour may be an indication of deficits in perceptions of personal vulnerability. Adolescents may consider unprotected sexual intercourse as dangerous in general, but not for them in particular. This false reasoning exists because they, like adults, underestimate their own risk for adverse consequences. They may be strongly influenced by the more immediate, anticipated positive consequences of engaging in unprotected intercourse, such as enhanced physical sensation and feeling of spontaneity. In short, immediate consequences of engaging in risky sexual behaviour may momentarily outweigh negative long-term consequences of doing so, and this may lead adolescents to choose risky behaviour based on anticipated immediate consequences, even in the presence of negative long-term consequences. Thus, the tendency to focus on immediate consequences of actions may be a recipe for risky sexual behaviour.

In addition, it may be the case that adolescents simply value the more immediate consequences of unprotected sexual intercourse more than the long-term consequences. Thus, adolescents may fully appreciate the fact that their continued engagement in unprotected sexual intercourse may result in eventual contraction of an STI, but they place so much value in the aesthetic experience of engaging in the act (for example, pleasurable

sensations, feelings of self-worth) that its positive valence far outweighs the negative valence of the future consequence (for example, risk of STI contraction or unwanted pregnancy).

This set of values, biased toward the appreciation of the here-and-now to the exclusion of all else is likely to enable risky sexual behaviour. Moreover, such behaviour is only "risky" with respect to the long-term negative consequences (death, as in the case of HIV); they are a virtual "sure thing" with respect to the positive immediate consequences (sexual gratification).

- **Psychosocial factor**:

Consistent linkages have been found between early sexual activity and other forms of misconduct, including delinquent activities and substance use (Ketterlinus et al., 1992; Costa et al., 1995; Halpern-Felsher, Millstein, and Ellen, 1996). Adolescents' sexual activity may also be linked to a general propensity to engage in potentially risky activities. Risk-proneness and involvement in problem behaviour predicted non-virginity in both genders (Kowaleski-Jones and Mott, 1998). Among boys, self-restraint at ages 10-11 was inversely associated with a number of sexual partners and level of misconduct four years later (Feldman and Brown, 1993). Finally, in a clinic sample, girls terminating a pregnancy were found to be more impulsive than those seeking contraceptive advice (Rawlings, Boldero and Wiseman, 1995).

- **Lack of information**:

There is a dearth of sound information from parents on sexuality issues to the young ones, but the abundance of wrong information from their peers. Parents fail to educate their children on sexuality issues for several reasons. Lack of knowledge on the part of parents is one of such, and the sensitive nature of sexual issues is another.

- **Social pressure** and **gender power imbalance**:

Risky sexual behaviour may emanate from social pressure from the males in the process of wanting to prove their manhood. Most culture frown at premarital sex by girls, but encourage the boys. Consequently, this results in the same thing because the boys must

relate to the girls. In most settings, women are expected to be innocent about sexual issues. This promotes ignorance and unassertiveness, involving an inability to say “no” to sexual advances by males.

- **Curiosity and experimentation**:

  Boys want to experiment with a number of girls, through a process referred to as “conquest”in order to demonstrate their sexual prowess (Action Health Incorporated, 2003). There is the desire to experience the functions of their reproductive organs and satisfy their sexual desires. The first experience leads to the craving for a second chance, regardless of the risks (AHI, 2003).

2.1.6 Peer pressure among adolescents with visual impairment

Peers are a pervasive aspect of one’s social life. They entail a broad range of people who surround one in one’s everyday lives from early childhood until old age. In younger life phases, peer groups tend to be homogeneous concerning individual characteristics such as gender, age, socioeconomic status, and ethnicity. For instance, children and adolescents tend to segregate into groups of their own gender and age (Maccoby, 1990). This homogeneity decreases from middle adolescence (Lempers and Clark-Lempers, 1993). In adulthood, peer networks become much more gender-integrated than in adolescence (Marsden, 1987). Similarly, age homogeneity decreases with the decreasing influence of institutions that create opportunities for contact with peers of the same age, such as school (Feld, 1982).

In 1890, James argued that there is an association between the social environment and the behaviour, feelings, and thought of individuals. Their dynamic interplay has been considered to play a key role in personality maturation, because identities are not construed by individuals alone but negotiated in social interaction processes between individuals (Hogan and Roberts, 2004; Swann, 1987).Hence, it is essential to account for the social context in which one is embedded to understand personality development (Leary and Baumeister, 2000; Neyer and Lehnart, 2007). To this end, considering the omnipresence of peers in one’s life, it is likely that they influence who one is. One of the few approaches that explicitly considered the role of peers in personality development is

Group Socialization Theory (Harris, 1995). The Theory posits that with children's advancing age, outside-the-home socialization that takes place in peer groups becomes an increasingly important determinant of adolescents' personality development. The period of adolescence is marked by the establishment of close, intimate relationships with same and opposite-sex peers. It is during this developmental period that teens start relying more on friends for advice, support and companionship, as well as learning experience in cooperation and role taking, as they slowly individuate from parents. Peers may, therefore, replace parents as an important social influence (Brown, 2011). Thus, in ways similar to the community, the peer group becomes an agency of acculturation and learning.

Furthermore, group socialization theory proposes that siblings who grow up in the same family become different from each other not only because 50 percent of their genes differ, but also because they belong to different peer groups (Harris, 1995). In view of this contention, it implies that peer pressure accounts for a substantial share of the variance in lifespan character or personality development. In other words, peer group processes of within-group assimilation lead to peer group members' personalities or character becoming more similar over time; at the same time, between-group differences increase (Reitz1, Zimmermann, Hutteman, Specht, and Neyer, 2014). Nevertheless, peer group members also differ in their personality development, which is driven by unique dyadic relationship experiences.

In addition, it is pertinent to note that, the directionality of peer pressure on an individual's behaviour is unclear. Podhisita, Xenos and Varangrat (2001) point out that it is not clear whether adolescents are mimicking the actual or imagined behaviour of their peers or whether once they initiate behaviour, they tend to associate with others whom they perceive to also exhibit the same behaviour. A general online dictionary defines peer relationships as being characterized by "equal standing with another" (Merriam-Webster.com, 2011). Interestingly, these contentions correspond with social exchange theory which refers to resource-based exchanges (Blau, 1964). According to one of Fiske's (1992) four elementary forms of social relationships, peer relationships often function predominantly according to the principle of equality matching. This assertion implies that resource exchanges in peer relationships are equivalent as peers are entitled to the same amount of giving and receiving, for instance, in terms of affection and support.

Hence, peer relationships are reciprocal and peers expect and keep track of an even balance (Clarks and Mills, 1979).

2.1.7 Parenting styles among the families of adolescents with visual impairment

Parenting has been recognized as a major agent in socialization of adolescents and it is the act of parenthood, the child's upbringing, training, rearing and child's education (Okapko, 2004; Ofoegbu, 2002, Utti, 2006). Parenting can also be viewed as a set of behaviour involved across life in relations among organisms who are usually non-specific, and typically members of different generations or, at the least, of different birth cohorts. Parenting interactions provide resources across the generational groups and functions in regard to domains of transactional, reproduction, nurturance, and socialization.

According to Inman, Howard, and Walker (2007), parents are often faced with the complex task of parenting their children. Parenting is much more than being a mother or a father providing food, safety, and succour to an infant or a child. It involves bidirectional relationships between members of two (or more) generations; it can extend through all or major parts of the respective life spans of these groups; it may engage all institutions within a culture including educational, economic, political, and social ones; and it is embedded in the history of a people especially, as that history occurs within the natural and designed settings within which the group lives (Ford and Lerner 1992). Parenting practices are known to be closely related to many aspects of adolescents and parents are regularly found to be a critical socializing influence on the development of adolescents as well as the younger children.

Noller (1995) notes that families that provide close, supportive environments for adolescents while encouraging independence at the same time, seem to produce adolescents who can cope with the transition to adulthood. In addition, children whose parents encourage autonomous thinking and self-discovery are more likely to develop psychological and social competence. Meanwhile, excessive control and lack of autonomy may stifle the processes of social and psychological maturation that are necessary for adolescents to make responsible choices about their behaviour (Rodgers, 1999). Researchers have further refined the concept of parenting to differentiate between parenting styles and parenting practices. Parenting styles have been defined as a stable

complex of attitudes and beliefs based on Baumrind's classification while parenting practices focus on the specific components of parenting such as monitoring or awareness and involvement (Darling and Steinberg, 1993). Although most studies of parenting do not focus on sexual behaviour, a limited number of studies do so. For example, an expanding research literature has found that parent-teen relationships, communication and parental awareness are associated with delayed sexual activity and sometimes with contraceptive use (Miller, 1998).

Research reports found that adolescents whose parents exhibited warmth and control while permitting their children to express their own views are likely to express pride and positive feelings about their ethnicity. Darling (2007) reports that parenting style predicts a child's well-being in the domains of social competence, academic performance, psychosocial development and risk sexual behaviour. Children and adolescents whose parents are authoritative rate themselves and are rated by objective measures as more socially and instrumentally competent than those whose parents are non-authoritative. This competency will enhance and promote proper growth and development of adolescents in their environment.

However, factors which constitute negative parenting (poor parenting) were equally identified as parental harshness, aggression, lack of love, lack of affection, lack of care, adequate monitoring and supervision, and lack of control to mention but a few. These and a host of other conditions may predispose the adolescents to sexual risk behaviour and increase in sexual transmission diseases. Besides, poor parenting is linked to an increased number of adolescents' health challenges. For instance, Kring et al (2007) report a clinical case of a 19-year-old girl with irregular breathing, a rapid pulse and dilated pupils. Diagnosed symptoms began after excessive drugs use resulting from poor and parental disharmony. Apart from addiction, she was also into sexual risk activities such as promiscuous behaviour, disengagement from family activities, abortion and commercial prostitution. Darling (2007) also observes that children and adolescents whose parents are uninvolved perform most poorly in all domains. Nonetheless, the persistence aspects of parental child-rearing styles such as strong discipline, parental disharmony, rejection of the child and inadequate involvement in the child's activities are potential factors for sexual risk behaviour among adolescents (Okorodudu and Okorodudu, 2003).

Some studies have shown that a large percentage of all sexual risk-taking adolescents come from homes that lack normal parental love and care. Attention, love and warmth go a long way in assisting adolescents' emotional development and adjustment (Odebumi 2007). Adolescents require parental love, care, warmth and serious attention to be able to adjust adequately in the environment in which they find themselves. Parents have major roles to play in the adjustment process of adolescents. The behavioural problems of most deviants are rooted in their homes (Atkinson, 2004). Evidence suggests that when the communication on sexual issues between the parents and the adolescent is warm, it creates a healthy environment for the development of the adolescent. Adolescents exhibiting traits of friendliness, cheerfulness, positive emotions and good maturity traits show that they come from homes where they are accepted and loved (Otuadah, 2006).

Okpako (2004) notes that adolescents who are well-enlighten on sexual behavioural issues will always remain a source of joy and happiness to their families. On the other hand, the neglected adolescents gradually become sex addicts, aggressive, restive, rapist and the like. The required parental monitoring and control for adolescents' development may be hindered due to parents' serious involvement in economic activities to meet up with family financial commitments (Angand Goh, 2006). Such parents spend little or no time at home to communicate with their children on sexual risk issues. Adolescents are likely to have a lower efficacy in negotiating contraceptive use or refusing sex with their partners, thus, increasing their exposure to pregnancy and sexually transmitted diseases. DiClemente, et al.(2001) and Loromeke (1997) are of the view that parents' communication on sexual risk issues with their children occur according to the training they received from their own parents. For instance, the majority of parents who grew up in a strict environment end up creating such for their own offspring.

Baumrind's classify parenting styles into four categories of authoritative or demanding, authoritarian, permissive and uninvolved parenting. This classification represents a critical research tradition for researchers who have studied parenting and child outcomes ranging from school performance, delinquency and psychosocial functioning among others (Brenner and Fox, 1999).

i. Authoritarian parenting style: Authoritarian parents display little warmth and are highly controlling. They are strict disciplinarians who use a restrictive, punitive style and insist that their children follow outlined directions. Authoritarian parents invoke phrases such as, "you will do this because I said it," and "because I am the parent and you are not." Authoritarian parents do not engage in discussion with their children, and the family rules and standards are not debated. Authoritarian parents believe that their children should accept, without question, the rules and practices that they have established. Research reveals that children of authoritarian parents learn that following parental rules and adherence to strict discipline are valued over independent behaviour. As a result, adolescents may either become rebellious or dependent. Parents with this style are highly controlling in the use of authority and rely on punishment but are not responsive. They value obedience and do not tolerate give and take relationships with their children. Authoritarian parents do not expect their children to express disagreement with them on their decisions and rules and do expect them to obey without explanation (Maccoby and Martin, 1983).

ii. Demanding or authoritative parenting style: Demanding and responsive parents are classified as authoritative parents whose children are expected to perform better in social competence than those whose parents are authoritarian but not demanding (Ang et al 2006). On the other hand, authoritative parenting styles tend to create a collaborative environment that fosters productive communication between parents and their children (Noller and Bagi, 1985). Authoritative or demanding parents require their children to be responsive to parental rules and requests while also assuming the parental responsibility of responsiveness to their children's needs and points of view (Maccoby and Martin, 1983). Moreover, authoritative parenting has positive effects on adolescents' behaviour while authoritarian has negative effects. Authoritative parenting is characterized by a child-centred approach that holds high expectations of maturity. Authoritative parents can understand how their children are feeling and teach them how to regulate feelings. They often help their children to find appropriate outlets to solve problems. Authoritative parents encourage children to be independent but still place controls and limits on their actions (Furedi, 2001). Extensive verbal give-and-take is not refused, and parents try to be warm and loving towards their children (Furedi, 2001). Authoritative parents are not

usually as controlling as authoritarian parents, allowing the child to explore more freely, thus having them make their own decisions based upon their own reasoning. Often, authoritative parents produce children who are more independent and self-reliant (Chan and Koo, 2011). An authoritative parenting style mainly results when there are high parental responsiveness and high parental demands. Authoritative parents will set clear standards for their children, monitor the limits that they set, and also allow children to develop autonomy. They also expect mature, independent, and age-appropriate behaviour of children. Punishments for misbehaviour are measured and consistent, not arbitrary or violent. Authoritative parents set limits and demand maturity, but when punishing a child, the parents will explain their motives for the punishment. Children are more likely to respond to authoritative parenting punishment because it is reasonable and fair. Children know why they are being punished because an authoritative parent makes the reasons known. They are attentive to their children's needs and concerns, and will typically forgive and teach instead of punishing if the children fall short (White, Hayes and Livesey, 2005).

iii. Permissive Parents: Permissive parents are very warm but undemanding. They are indulgent and passive in their parenting and believe that the way to demonstrate their love is to give in to their adolescent's wishes. They are accepting but their main concern is not to interfere with their children's independence; these parents are more responsive than demanding. They demand little in terms of obedience and respect for authority. They are non-traditional and lenient, do not require mature behaviour, allow considerable self-regulation, and avoid confrontations (Maccoby and Martin, 1983). Permissive parents invoke such phrases as, "sure, you can stay up late if you want to," and "you do not need to do any chores if you do not feel like it." Permissive parents do not like to say no or disappoint their children. As a result, the children are allowed to make many important decisions without parental input. Parents do not view themselves as active participants in shaping their children's actions; instead, they view themselves as a resource, whom their children should look up to for advice. Research findings show that adolescents of permissive parents learn that there are very few boundaries and rules and that the consequence is not likely to be very serious (Steinberg and Silk, 2002). As a result, they

may have difficulty with self-control and demonstrate egocentric tendencies that can interfere with proper development of peer relationships (Maccoby and Martin, 1983).

2.1.8 School climate among adolescents with visual impairment

School climate is a multi-faceted concept that describes the extent to which a school community creates and maintains a safe school campus, a supportive academic, disciplinary, and physical environment, and respectful, trusting, and caring relationships throughout the school community (Steinberg, Allensworth, and Johnson, 2011). Research has shown that a positive school climate can help schools and teachers to meet key goals including boosting students' achievement and closing achievement gaps, increasing high school graduation rates, decreasing teacher turnover and increasing teacher satisfaction and turning around low-performing schools (Fenzel, and O'Brennan, 2007). Positive school climate also enhances safety in the school and community by increasing communication among students, families, and faculty, and reducing violence and bullying (Safe Supportive Learning, 2013).

School climate encompasses the level of task difficulty, individual values and interpersonal relationships (Wang, Haertel, and Walberg, 1993). Review of the literature suggested that individual values and level of task difficulty were important determinants of student motivation to achieve (Wigfield, 1994; Osterman, 2000). According to Cohen, McCabe, Michelli, and Pickeral, (2009), school climate is associated with safety, healthy relationships, engaged learning and teaching and school improvement efforts. School climate is based on patterns of people's experiences of school life and reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures. A sustainable, positive school climate fosters students' development and learning necessary for a productive, contributory and satisfying life in a democratic society. This climate includes norms, values, and expectations that support people feeling socially, emotionally and physically. Early educational reformers such as Perry (1908), Dewey (1916), and Durkheim (1961) recognize that the distinctive culture of a school affects the life and learning of its students. Marzano (2003) defines school climate as a factor that contributes to the tone in schools and the attitudes of staff and students towards their schools. Positive school climate is associated with well-managed

classrooms and common areas, high and clearly stated expectations concerning individual responsibility, feeling of safety at school, and teachers and staff that consistently acknowledge all students and fairly address their behaviour (Cohen and Geier, 2010).

Generally, school climate is said to reflect the schools' life experience of the students, the school personnel and the parents socially, emotionally, civically, and ethically as well as academically. Over the past two decades, research studies from a range of historically disparate fields (for example, risk prevention, health promotion, moral education, character education, mental health, and social-emotional learning) have identified research-based school improvement guidelines that converge predictably to promote safe, caring, responsive and participatory schools (Centres for Disease Control and Prevention, 2009). Positive and sustained school climate is associated with positive child and youth development, effective risk prevention and health promotion efforts, student learning and academic achievement, increased student graduation rates, and teacher retention. Recent research suggests that positive school climate is associated with reduced aggression and reduced violence as well as reduced bullying behaviour and sexual harassment regardless of sexual orientation (Attar-Schwartz, 2009).

2.1.9 Emotional intelligence among adolescents with visual impairment

Emotional intelligence and its study as a concept have raised considerable interest over the past few decades (Day, 2004). The term "Emotional Intelligence" became popular in 1995 when Daniel Goleman wrote a book titled "Emotional Intelligence". Before then, Gardner opened the eyes of many to see that multiple intelligence illuminates the fact that humans exist in a multitude of context and that these contexts both call for and nourish different arrays and assemblies of intelligence.

Sternberg (1985) on his own devoted much of his career to the study of various conceptions of human intelligence which he started with his Triarchic Theory of human intelligence. He later expanded upon his view of human ability and success. He stated that successful intelligence is that set of mental abilities used to achieve one's goals. In 1998, he claimed that successful intelligence involves three aspects which are interrelated but distinct and they include analytical, creative and practical thinking. Practical intelligence is the ability to size up a situation well, to be able to determine how to achieve goals, to

display an awareness of the world around one and to display an interest in the world at large (Sternberg, 1990; Sternberg, Forsythe, Hedlund, Horvath, Wagner, Williams, Snook and Grigorenko, 2000; Wagner, 2000).

Emotional intelligence concept argues that Intelligence Quotient is too narrow to determine success but there are other areas of emotional intelligence that dictate and enable an individual to be successful. Although emotional intelligence has received much attention, it has been difficult for researchers to agree on a consensual definition.

Mayer and Salovey (1990) attempt to clarify the definition of emotional intelligence by categorizing it into five (5) domains as follows:

(i) Self-awareness-observing oneself and recognizing feelings as it happens.

(ii) Managing emotions – handling feelings so that they are appropriate, realizing what is behind the feelings and finding ways to handle it.

(iii) Motivating oneself in the service of a goal.

(iv) Empathy – understanding others' feelings and appreciating the difference in feelings.

(v) Handling relationships, managing others' emotions, social skills and competence.

Mayer and Salovey (1993) define emotional intelligence as a type of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them and to use the information to guide one's thinking and actions. In some other research, Mayer, Salovey and Caruso (2000) define emotional intelligence as the ability to perceive and express emotion, assimilate emotion in thought, understand and reason with emotion, and regulate emotion in the self and others.

Goleman (1995) sees emotional intelligence as the skills that help people harmonize and which should be valued as a workplace asset in the years to come. He confirmed that emotional intelligence consists of five (5) components: knowing one's emotions (self-awareness), managing them, motivating oneself, recognizing emotions in others (empathy) and handling relationships.

Goleman (1998) mixes competency with the personal trait. He considers EI as the capacity for recognizing one's own feelings well in oneself and in one's relationships. He suggested four dimensions of application of EI as follows:

"Self-awareness – capacity for understanding one's emotions, one's strengths, and one's weaknesses."

"Self-management – capacity for effectively managing one's motives and regulating one's behaviour."

"Social-awareness – capacity for understanding what others are saying and feeling and why they feel and act as they do."

"Social-skills – capacity for acting in such a way that one is able to get desired results from others and reach the desired goals."

Cooper and Ayman (1997) define EI as the ability to sense, understand and effectively apply the power and acumen of emotions as a source of human energy, information, connection and influence. It was confirmed by studies that EI actually meet the standard for intelligent mental performance, rather than just preferred ways of behaviour.

Cooper and Ayman (1997) based their definitions of EI on the ability to navigate life towards ever-increasing degrees of freedom of accessing innate skills and to integrate emotions and awareness, to align feelings and reason, to direct actions with vision, to solve problems, to resolve conflicts and to enhance interpersonal and intrapersonal relationships.

Their competency definition suggested four areas of emotional intelligence application which include the following:

Listen – This involves an individual's ability to be open to emotional intelligence and social communication.

Love – This involves the ability to sense the true meaning of compassion.

Choose – This involves the ability to redirect thoughts, feelings and actions based on values and beliefs.

Be free – This involves the ability to reinvent a vision and live according to purpose.

Also, in Akinboye (2003) a competency-based definition of EI was suggested by Q-metrics as the ability to sense, understand and effectively apply the power and acumen of emotions as a source of human energy, information, trust, creativity and influence.

The Q-metrics application of EI is divided into three:

"Awareness – involves emotional self-awareness, emotional expression and emotional awareness of others.

Competency – involves intentionality, creativity and resilience, interpersonal, connected and constructive discontent.

Values and attitudes – involve outlook, compassion, intuition, trust, radius, personal power and integrated self."

Bar-On (1997,2000,2003) states that emotional intelligence includes one's emotional, personal and social dimensions of general intelligence and he describes it as a concept involving abilities and skills related to understanding oneself and others, relating to peers and family members and adapting to changing environmental situations and demands. Emotional intelligence has also been confirmed to increase with age and it has been established that older people display higher levels of emotional intelligence than younger people (Kafetsios, 2004; Wei, 2004; Van Rooy, Alonso and Viswesvaran, 2005; Adeyemo, 2004).

2.1.10. Sexual attitude among adolescents with visual impairment

Attitude can be considered as a favourable or unfavourable evaluative response towards happenings in one's environment and it is usually rooted in one's beliefs, feelings, or intended behaviour. It is a product of social orientation and an underlying inclination to react to situations either favourably or unfavourably. However, in the context of sexual attitude, it can be described as an innate drive to react either covertly or overtly in a manner that betrays a certain level of favourability or unavoidability. Psychologists perceive attitudes as enduring features that may change in the course of time but are at the same time assumed to be rather stable unless external influences which may incur change are entertained. Researchers have carried out numerous studies to learn what factors may affect one's sexual attitudes (Straut and Stank, 2001; Adamu, Mulatu and Si, 2003; Idoko, Muyiwa and Agoha, 2015). For instance, Wiederman (2010) notes that one's genetic contexture bordering on personality, experiences, cognitive processes and culture plays an important role in shaping one's sexual attitudes and behaviour.

According to Wiederman (2010), individuals are genetically composed of different traits and as such, it is impossible to compare individuals' sexual beliefs, values, and

attitudes. One's genetic makeup appears to influence how one thinks and behaves. Research findings indicate that one is born with a level of temperament or personality by virtue of the unique combination of genes inherited from one's parents (Smith, Nezlek, Webster and Paddock, 2007). Consequently, the inherent temperament or personality enables certain sexual beliefs, values, and attitudes easier to acquire for some individuals than for others. With regards to cultural influence, the author also contended that individuals are exposed to formal and informal teachings within their cultures, which they most likely conform to or act in ways contrary to these teachings or cultural beliefs. Moreover, cultures influence and somewhat dictate certain beliefs and attitudes informally by modelling for others what belief and attitude should be retained or rejected. This modelling is better explained through the principles of social learning. When one sees someone who is successful in demonstrating a certain belief or reacting in a particular manner, onetends to imbibe such a belief or reaction.

Just as the influencing factors on sexual beliefs and attitudes vary, people differ in their sexual attitudes. Extant works revealed that there are various valid and reliable measurements of sexual attitudes. Hendrick, Hendrick and Reich's (2006) reliable and valid 23-item Brief Sexual Attitudes Scale identifies four types of sexual attitude and they include the following;

- Permissiveness: Being permissive towards an *open* relationship
- Birth control: *Being alive to the responsibility* in birth control
- Communion: Attitude towards the importance of *meeting together* with a sex partner
- Instrumentality: Attitudinal disposition towards *enjoying the physical sex*

In addition to the aforementioned measures, several other measures are designed to account for more specific sexual attitudes. For example, the Sexual Opinion Survey is an empirical survey which derived 21-item scale developed to explore the emotional dimension of sexuality (Fisher, 1998), the Reiss Premarital Permissiveness Scale (Reiss, 1967) investigates premarital permissiveness and the Premarital Sexual Attitude Scale (Treboux and Busch-Rossnagel, 1995) considers the impact of peers and parents on adolescent's sexual behaviour. Similarly, the Trueblood Sexual Attitudes Questionnaire explores the dynamics in attitudes after completing a human sexuality exercise (Harmon,

Hall, Gonzalez and Cacciapaglia, 1999), while the Cross-Cultural Attitudes Scale examines conservative and liberal sexual attitudes (Leiblum, Wiegel and Brickle, 2003).

Generally, a critical perception of the study of human sexuality maintains that sexual experience has a mutual relationship with sexual attitudes and a small to medium effect size (Fischer, 1986; Kilman, Wanlass, Sabalis and Sullivan, 1981; Michael, Gagnon, Laumann and Kolata, 1994; Serdahely and Ziemba, 1984; Taylor, 1982). Aside from the field of sexuality, evidence exists noting the often weak relationship between attitude and behaviour (Ajzen and Fishbein, 1980). The bond between attitude and behaviour can be strengthened when the two are measured closely in time, when multiple behaviour is aggregated, when highly specific attitudes are measured, and when behavioural intentions are measured (Ajzen and Fishbein, 1980). In a situation where inconsistency is noticed in the sexual attitude-behaviour relationship, questions have been raised about attitudes changing as an effect of gender and age (Taylor, 1982) resulting in a problem of measuring attitude change over a relatively short time in early adulthood (Stevenson, 1990). In addition, several measurement issues have been raised such as a lack of comparable scales used when measuring attitudes and experiences (Carterand Frankel, 1983; Fisher, 1986; Smith, Flaherty, Webb and Mumford, 1984; Taylor, 1982).

As regards the relationship existing between sexual attitudes and experiences in college students, Robinson and Jedlicka (1982) find that college students' attitudes towards sexual experiences fluctuated; however, the levels and numbers of sexual experiences had not changed. While many college-age students are engaging in sexual intercourse with an increasing number of partners, the report of attitudes more readily reflects changes in cultural mores. For instance, research indicates teenagers who opt to wear "purity rings" or wear or cite other pledges not to engage in intercourse until marriage, are just as likely to engage in premarital sex as teens who do not, and less likely to take sexually transmitted infection or disease precautions (Rosenbaum, 2009). Tucker-Ladd (2006) indicates that it is not unusual for experience to differ from stated attitudes, especially when the issue is emotional and confusing. In addition, attitudes have been found to often change over time as a "catch-up" with behaviour and experience (Tucker-Ladd, 2006).

Despite the complexities characterizing sexual relation as a web of emotions, attitudes, and behaviour, members of society with various forms of visual, auditory, or physical challenges are often ignored in sexuality-related studies (Hendrick, Hendrick, and Reich, 2006; Maart and Jelsma, 2010; Enwereji and Enwereji, 2008). Disabilities, nevertheless, do not essentially prevent potentials for sexual attraction, whether heterosexual or homosexual (Esmail, Walter and Knuppe, 2010). Sexual attitude or expression is an essential feature of both challenged and able-bodied people. What remains unclear is whether there are differences between the able-bodied and the challenged people in sexual attitude. Furthermore, the role of psychological factors in such possible differences has been largely misconceived.

2.2 Theoretical review

2.2.1 The health belief model

In health education and promotion, The Health Belief Model (HBM) remains the most commonly used theory (Glanz, Rimer and Lewis, 2002; National Cancer Institute (NCI), 2003). The theory was developed in the 1950s to explain why medical screening programmes organised by the U.S Public Health Service, particularly for tuberculosis, were not very successful (Hochbaum, 1958). The underlying concept of the original HBM is that health behaviour is measured by personal beliefs or perception about a disease and the strategies available to decrease its occurrence (Hochbaum, 1958). Personal perception is influenced by the whole range of intrapersonal factors affecting health behaviour. Four perceptions drive the main constructs of the model: perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers. Each of these perceptions, individually or collectively, can be used to explain health behaviour. More recently, other constructs have been added to the HBM; thus, the model allows an expansive frame that accommodates cues to action, motivating factors and self-efficacy.

Perceived seriousness

Perceived seriousness, as a construct, refers to an individual's belief about the seriousness or severity of a disease. While the perception of seriousness is often based on medical information or knowledge, it may also emanate from the beliefs one holds about the

difficulties a disease would create or the effects it would have on one's life in general (McCormick-Brown, 1999).

Perceived susceptibility

Personal risk or susceptibility remains one of the more powerful perceptions in prompting people to adopt healthier behaviour, in that, the greater the perceived risk, the greater the likelihood of engaging in behaviour to decrease the risk. Naturally, when people believe they are at risk for a disease, they tend to be more likely to yield to measures in preventing it from happening. Unfortunately, the opposite also occurs. When people believe they are not at risk or have a low risk of susceptibility, unhealthy behaviour tends to result. This is exactly what has been found with adolescents and risky sexual behaviour. When the perception of susceptibility is combined with seriousness, it results ina perceived threat (Stretcher and Ronstock, 1997). If the perception of threat is a serious disease for which there is a real risk, behaviour often changes.

Perceived benefits

The construct of perceived benefits concerns a person's perception of the value or usefulness of a new behaviour in decreasing the risk of developing a disease. There is the tendency for people to adopt healthier behaviour when they believe the new behaviour will decrease their chances of developing a disease. Perceived benefits play an important role in the adoption of secondary prevention behaviour such as screenings.

Perceived barriers

The nature of change is that it does not easily come to most people. With respect to this fact, the last construct of the HBM addresses the issue of perceived barriers to change. This is one's evaluation of the obstacles that confront one in adopting a new behaviour. Of all the constructs, perceived barriers are the most significant in determining the behavioural change (Janz and Becker, 1984). For a new behaviour to be adopted, one needs to believe that the benefits of the new behaviour outweigh the consequences of continuing the old behaviour (Centres for Disease Control and Prevention. 2004). By this, it makes it easier for barriers to be overcome and new behaviour to be adopted.

Modifying variables

The four constructs of perception are modified by other variables involving culture, education level, past experiences, skills and motivation, and several other factors. These are individual characteristics that influence personal perceptions.

Cues to action

Apart from the four beliefs or perceptions and modifying variables, the HBM also suggests that behaviour is influenced by cues to action. Cues to action are events, people, or things that constrain people's behaviour. Practical examples include illness of a family member, media reports, mass media campaigns, advice from others, reminder postcards from a health care provider or health warning labels on a product (Graham, 2002; Ali. 2002).

Self-Efficacy

HBM, in 1988, added Self-efficacy to the existing original four beliefs (Rosenstock, Stretcher and Becker, 1988). Self-efficacy is defined as the belief in one's own ability to do something (Bandura, 1977). People generally do not try to do something new unless they think they can do it. If someone believes a new behaviour is useful (perceived benefit), but does not think he is capable of doing it (perceived barrier), chances are that it will not be tried.

In summary, according to the Health Belief Model, modifying variables, cues to action and self-efficacy affect one's perception of susceptibility, seriousness, benefits and barriers and therefore one's behaviour. The HBM focuses on two aspects of individual representations of health and health behaviour: threat perception and behavioural evaluation (Abraham and Sheeran, 2005). Threat perception is construed as two key beliefs: (a) perceived susceptibility to diseases and health problems and, (b) the anticipated severity of the consequences of the disease. The behavioural evaluation also consists of two sets of beliefs: (a) those concerning the benefits or efficacy of a recommended health behaviour and, (b) those concerning the costs of enacting the behaviour. In addition, the model proposes that cues to actions such as individual

perceptions or social influence can activate behaviour when appropriate beliefs are held (Abraham and Sheeran, 2005).

In relation to adolescents' sexual behaviour, this theory illuminates how adolescents view or perceive sex-related matters. Adolescents generally view sex-related matters in diverse ways. Many factors have been identified to contribute to adolescent sexual behaviour. Factors such as upbringing and peer pressure play a principal role. It is obvious that there are modifying factors (such as age, sex, ethnicity, personality, disabilities) which determine perceptions of adolescents about sex. However, adolescents including those with visual impairment perceive the seriousness of risky sexual behaviour as a factor of awareness on the consequences of this behaviour. Any sex-related disease is a factor of those modifying factors. The cues to action which include media information and education have a direct link with the perceived threat of disease and this invariably determines the likelihood of behavioural change. It is also important to appreciate those barriers to behavioural change, hence adolescent sexual attitudes and behaviour can neither be modified nor change in isolation. In sum, according to HBM, the demographic characteristics have a greater influence on the perceived susceptibility and perceived seriousness, so also perceived barriers and perceived benefit. This invariably influences the perceived threat and likelihood of taking action. The cues to action also have a direct effect on the likelihood of taking action.

2.2.2 Reasoned action and optimistic bias theories

The theory of Reasoned Action was developed by Martin Fishbein and Icek Ajzen in 1980 and later revised by Ajzen (1985). The main assumption in the theory is that people are usually rational and make predictable use of information available to them. In this case, the visually impaired equipped with knowledge of HIV/AIDS transmission and prevention would consider the consequences or risks of health-related behaviour before engaging in them. The assumption is that individuals' reason determines human action involving indulgence or restraint when faced with a threat to their health.

The action taken depends on the belief that one can fall prey to a disease, the severity of the disease, the degree of exposure to information about the disease and the

extent to which one believes that a preventive action has more rewards than costs. This theory suggests that if students with visual impairment are knowledgeable and consider themselves at risk, then they are likely to have a positive attitude toward safer sex (prevention) practices which will reduce their risk of infection with HIV/AIDS. With inadequate knowledge and perception of invulnerability, one is likely to have a negative attitude toward safer sex practices thus likely to engage in risky sexual behaviour. Adoption of safer sex practices against HIV/AIDS is likely to be effective when the students have comprehensive HIV/AIDS knowledge and when they perceive their risks of infection to be great.

The theory of Optimistic Bias by Weinstein (1984), on the other hand, argues that individuals generally think that they are less likely than the average person to experience health problems. When people who hold this kind of orientation are asked to evaluate their own chances of developing certain diseases compared to others of the same sex, they usually evaluate their own risks to be significantly lower than that of others. The bias appears to emerge from limitations of the cognitive processing of risk factors by the individuals and it occurs for those risks which are perceived to be preventable and are infrequent with the individuals having little experience. This theory is useful in determining students' perceptions of risk of infection with HIV/AIDS.

2.2.3 Theory of Planned Behaviour

This theory proposes that adolescents act in some ways based on their knowledge of a particular problem and of a potential behavioural solution to the identified problem. Behavioural intention is considered as a product of the adolescents' attitudes towards the behaviour, perceived subjective norms, and self-efficacy in performing the particular behaviour. In the presence of these predictors of sexual behaviour, behavioural intention is highly predictive of actual behaviour if the adolescent has the necessary skills to perform the behaviour in the absence of any environmental constraints (Hargreaves, 2002).

According to the Theory of Planned Behaviour (TPB), three kinds of considerations guide human behaviour. These encompass beliefs about the likely outcomes of the behaviour and the evaluations of these outcomes (behavioural beliefs),

beliefs about the normative expectations of others and motivation to comply with these expectations (normative beliefs), and beliefs about the presence of factors that may facilitate or impede performance of the behaviour and the perceived power of these factors (control beliefs). In their respective aggregates, behavioural beliefs produce a favourable or unfavourable attitude towards the behaviour, normative beliefs result in perceived social pressure or subjective norm, and control beliefs give rise to perceived behavioural control. In combination, attitude towards the behaviour, subjective norm, and perception of behavioural control lead to the formation of a behavioural intention. As a general rule, the more favourable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behaviour in question. Lastly, given a sufficient degree of actual control over the behaviour, people are expected to carry out their intentions when the opportunity arises. The intention is thus assumed to be the immediate antecedent of behaviour.

The TPB was developed in 1985 as an extension of the Theory of Reasoned Action (TRA) to overcome the main criticism that the TRA model did not consider intentions and behaviour that are not completely under volitional control (Albarracin, Johnson, Fishbein and Muellerleile, 2001). This expanded model is appropriate for both volitional and non-volitional behaviour. In both theories, the central variable is an intention to perform a behaviour and it is the immediate determinant of the behaviour (Ajzen and Fishbein, 1980). In the TRA, the intention is viewed as a function of two other determinants; attitude towards the behaviour and subjective norms. Subjective norms are a function of one's beliefs that the specific social referents (for example parents, friends, peers and others) think one should or should not perform the behaviour as well as his motivation to comply with those referents. The TPB adds perceived control over the behaviour as a third determinant of intention (Ajzen, 1985). The following terms are described below as stated by Ajzen in his theory of planned behaviour;

Attitude: attitude refers to a favourable or unfavourable degree of one's feeling and predisposition towards certain behaviour (Ajzen, 1991). It cannot be observed directly but has to be inferred from observed consistency in behaviour (Ajzen and Fishbein, 1980). In

this dissertation, attitude is defined as one's feeling and predisposition toward premarital sex and condom use. It influences the intention of sexual abstinence and condom use.

Subjective norms: Subjective norms are expectations of the referent people and motivations complying with their expectations. They can be defined as the perceived social pressure to comply with a specific behaviour which is accepted as a standard and considered normal in a particular society (Ajzen, 1991). In this study, the subjective norms with respect to premarital sex and condom use consist of parental expectations and friend (peer) norms toward premarital sex and condom use when adolescents engage in premarital sex.

Perceived behavioural control: The third determining factor of behavioural intention is perceived behavioural control. The definition of this term is perceived ease or difficulty in performing a specific behaviour. It is often compared to self-efficacy and locus of control (Werner, 2004). Nonetheless, the locus of control and perceived behavioural control show a great difference with respect to whether the concepts are directly linked to a particular behaviour (Ajzen, 1991).

There is a suggestion to conceptualize perceived behaviour control as only an external control factor, and include self-efficacy as an internal factor (Werner, 2004). However, Ajzen who developed the theory of planned behaviour explained that perceived behavioural control consists of two components, self-efficacy and controllability, both of which reflect internal and external factors. Ajzen explained that perceived behavioural control is most compatible with Bandura's self-efficacy belief and is a stronger path to intention than behaviour (Ajzen, 1991, 2004). Controllability is a belief about the extent to which performing the behaviour is up to the actor. Controllability has a stronger path with actual behaviour than intention.

Intention: Intention is an immediate antecedent to engaging in a specific behaviour (Werner, 2004). Each intention is viewed as being related to the corresponding behaviour**.**

Overall, the magnitude and consequences of risky sexual behaviours appear to merit a larger body of literature. This research would benefit greatly from theories already applied to risky sexual behaviour and fill the gap in the literature by assessing the fit of

theories to the investigated phenomenon. Below are two theories that provide credible explanations of risky sexual behaviour among adolescents.

2.2.4 Social Learning Theory

This study leans on the resources of the Social Learning Theory propounded by Albert Bandura in (1977) in achieving its aim. The Social Learning Theory centres on the learning that occurs within a social environment. The belief here is that people learn from one another, through such concepts as observational learning, imitation and modelling. This Theory is based on three principles of learning. Children learn new behaviour mainly through observation and imitating what others do by modelling. Behaviour is strengthened by reinforcement, so a child who relates to the father in a particular way and is rewarded either by a gift or a comment such as "thank you" or "well done" or freedom from punishment is likely to continue behaving in the same way. In other words, an individual learns through past experience and that certain satisfaction is more likely in some situations than in others. In addition, learned behaviour may be modified or changed with new experiences or input. Behaviour is learned from other people, and individuals' needs are sometimes met with the assistance of other people (Rotter, 1954).According to this theory, one's behaviour is determined by one's goals. With past experiences, a set of differentiated needs develop in each individual. The more specific the category of behaviour and goals included in the need, the greater the possibility of predicting the strength of one from the other. In SLT a need may be viewed as having three essential components: need potentials, expectancies, and values.

Need potential deals with the set of behaviour geared towards the same goal and their potential strength, which is the likelihood that they will be used in a given situation (Rotter, 1971). For example, Johnson, Mccaue and Klein (2002) submit that adolescents who consider the rewards of sex as outweighing the costs had a higher frequency of sex than other adolescents. Sexual intercourse would be seen as the "set of behaviour" used to achieve the goal of the "rewards" of sex.

The second major component is expectancies, or beliefs and knowledge, that certain behaviour will lead to satisfaction or goals that a person values. For example, an

individual may know that past experiences of having sexual intercourse brought excitement and pleasure. The individual believes and expects that the same act of sexual intercourse will bring excitement and pleasure again. Thus, such an individual participates in sexual activity continually. Another individual may know that sexual intercourse can lead to the transmission of HIV and genital herpes, therefore does not participate in a sexual activity because such a person values personal health.

The third major component examines the value attached to the goals themselves. In it, values set apart the degree to which one set of satisfaction is preferred over another (Rotter, 1971). The value of an exciting life is found to correlate more highly with risky adolescent behaviour than are other values (Rozmus and Edgil, 1993). For adolescents who valued excitement, the satisfaction of sexual intercourse is preferred in comparison to abstinence, which could be considered unexciting (Johnson Bachman and O'Malley 1999).

2.2.5 Ecological Systems Theory

Several adaptations have evolved from the social ecological model; however, the initial and most utilized version is Urie Bronfenbrenner's (1977, 1979) Ecological Systems Theory**.** According to Bronfenbrenner, the ecology of human development entails the process by which the developing individual and the immediate environment mutually influence each other across time. This relation is further affected by the relationships among individuals in the immediate setting as well as in the larger societal context. That is, according to Bronfenbrenner, all levels of the environment in which adolescents develop influence their development; while at the same time, the adolescents influence their environment. Bronfenbrenner further proposed five levels of the environment: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. Each of these levels is defined in terms of how directly it impinges on the individuals.

The *microsystem* is the immediate setting, in which the adolescents find themselves, and it includes the *activities, roles* and *interpersonal relationships* between and among the developing persons and the people in their*microsystems* (Bronfebrenner, 1977, 1979). The term activities refer to what one or more persons are doing or saying.

Roles refer to what is expected of people who occupy specific positions in the setting such as parents, siblings, teachers, and boyfriends or girlfriends. The term interpersonal relations refer to the ways people treat one another within the setting. That is how the parent treats the adolescents; how the boyfriend treats the girlfriend, how the teacher treats students and so forth.

Within the microsystem, there is space for reciprocity. For example, one of the adolescents' microsystems is their home environment. In it, their parents, siblings, and other people in their homes actively influence them, while they (the adolescents) reciprocate the influence. Other microsystems of the adolescents include the schools they attend and their peer groups. In these settings, the relationships between adolescents and their teachers and classmates are considered to be part of the microsystems. The microsystems, therefore, are the settings that have the most direct influence on the individuals. In the context of risky sexual behaviour, adolescents' individual risk factors include biological, psychological, cognitive or emotional, and behavioural factors.

The second system, *mesosystem* consists of the interrelations between the major microsystems and the developing persons (Bronfenbrenner, 1977, 1979). The mesosystem constitutes the linkages and processes that operate between two or more of the developing persons' behavioural settings. For example, the mesosystem of the adolescents includes the relationships between the people in their home environment and the people in the school environment. If there is congruence between the beliefs of their parents and their peers in the schools, the mesosystem of the adolescent positively impacts the adolescents and vice versa; if there is no congruence, the effect may be negative. In the case of sexual activity, the adolescents' sexual activities on any given day would be influenced by how they perceive their parents' and peers' reactions to their sexual behaviour. If they perceive that the parents and peers would disapprove of being sexually active, then they are less likely to engage in sex. If there is incongruence, the adolescents will find themselves in conflict and will behave according to which microsystem has the strongest influence at the time.

The third system, e*xosystem,* includes the social structures that are imposing upon the immediate settings of the developing persons and their influence on what occurs

(Bronfenbrenner, 1977, 1979). The participants are not actively participating and the events are not directly affecting the participants in the setting. That is, the exosystem has an indirect effect on adolescents. An example of the adolescents' exosystem is their parents' workplaces. If their parents work long hours, then they arrive home from school to empty houses each day. Being alone at home may put adolescents at risk of engaging in sexual activities.

Similarly, the fourth system, *macrosystem,* represents the cultural milieu in which adolescents live. That is, the macrosystem is the broad cultural or subcultural context in which adolescents develop. The macrosystem also has an indirect but more remote effect on adolescents, because this system includes the values, beliefs, laws and policies of the larger community. The macrosystem can be the city in which adolescents live or the cultural background of their families.

Finally, the *chronosystem* is the era or epoch in which the adolescents are developing. Society's norms and value systems are dynamic and ever-changing. For example, an adolescent who grew up in the 1950s and the one growing up in the twenty-first century would find themselves in a very different world. The norms, opportunities, values and beliefs regarding the sexuality of the 1950's are very different from those of the current decade. An adolescent growing up now will face greater sexual pressures than in the past.

A central tenet in Bronfenbrenner's framework is that it is the developing person's interpretation of the activities, roles, and interpersonal relations within the settings that influence behaviour, not the setting itself. In spite of the divergence position of the theories, the ecological systems theory constitutes the overarching theoretical orientation on which this research is anchored.

2.3 Empirical review

2.3.1 Peer pressure and risky sexual behaviour among adolescents with visual impairment

Peer pressure is often used to describe the force or the influence exerted by one's peer group on oneself in encouraging one to change one's attitude, behaviour, morals and

values to conform to the group's actions, taste, fashion sense or general outlook in life. Thus, peer pressure can be defined as peers' encouragement and constant urge to make one to do something (Santor, Messervey and Kusumakar, 2000).Research has evinced two types of peer pressure namely positive and negative peer pressure. The positive attributes of peer pressure involve peers motivating themselves to engage in positive behaviour such as volunteering in community service, social works and excelling in academics athletics, music, and various other types of extracurricular activities. In a way, this can be considered a channel for adolescents to become better rounded, exploring positive domains beyond academics. Also, peers can be protective; when an adolescent's peers support protective behaviour and exhibit responsible conducts, members of such peer group are more likely to engage in this behaviour as well (Ellickson, McCaffrey and Klein, 2009; Elkington et al., 2011; IOM and NRC, 2011). Essentially, negative peer pressure is the opposite and the most common attribute is risk-taking behaviour (Marshal and Chassin, 2000; Kıran-Esen, 2003).

It is apt to stress that some studies have been conducted on the association between peer pressure and risk-taking among adolescents. For example, Gardner and Steinberg (2005) carried out an experimental study titled "Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood". In this study, 306 individuals in 3 age groups (in years) namely: adolescents (13–16), youths (18–22), and adults (24 and older) all completed two questionnaire measures assessing risk preference and risky decision making, and one behavioural task measuring risk-taking. Analyses indicated that (a) risk-taking and risky decision making decreased with age; (b) participants took more risks, focused more on the benefits than the costs of risky behaviour, and made riskier decisions when in peer groups than alone; and (c) peer effects on risk-taking and risky decision making were stronger among adolescents and youths than adults. These findings support the idea that adolescents are more inclined towards risky behaviour and risky decision making than adults and that peer pressure plays an important role in explaining risky behaviour during adolescence (Gardner and Steinberg, 2005).

Peer group membership is a very powerful socializing agent and can have a strong influence on the perceptions, opinions and behaviour of adolescents. Peers have a significant influence on young people's behaviour. Studies on alcohol use, smoking, drug use and delinquent behaviour have shown that adolescents tend to socialize with people who share similar behavioural traits (Lansford, Dodge, Fontaine, Bates and Pettit, 2014). These types of selection patterns tend to give rise to an amalgamation of risky behaviour among adolescents of various groups (Haye, Green, Pollard, Kennedy and Tucker; 2014). In a study conducted by Prinstein, Boergers and Spirito (2001), it was found that adolescents who engage in behaviour like substance use, violent behaviour, and suicide attempts also reported having pressurized their friends to engage in similar behaviour.

During adolescence, peer factor like the perception of risky sexual behaviour is linked to adolescents' risky sexual behaviour as adolescents tend to take up similar behaviour (Cavanagh 2004; Prinstein, Meade and Cohen, 2003). Although large evidence suggests a positive relationship between adolescents' perception of peer's sexual behaviour and their own sexual experience, it is not known whether adolescents are projecting either their own behaviour onto their peers or whether, once they are initiated into sexual activity, they tend to associate with others whom they perceive to be sexually active (Podhisita, Xenos and Varangrat, 2001).However, peer pressure has been shown to reinforce or change individual attitudes and behaviour regarding sexual activity that leads adolescents to engage in risky sexual behaviour (Albarracin, Kumkale and Johnson, 2004, Stanton, Li, Feigelman and Baldwin 1998). For example, Blum and Mmari (2005) note that ten studies that examined the relationship between perception of peers' sexual behaviour and their own sexual experiences found a positive relationship between the two factors. Evidence was also found for an increase in pregnancy risk when an adolescent has a friend who has been pregnant (Blum and Mmari, 2005).

Similarly, a dissertation by Low (2005) used structural equation modelling to examine whether friends' characteristics were related to participants' sexual behaviour concurrently and over a one-year period and whether participants' sexual behaviours predictive of changes in friendship characteristics over time. Low (2005) found that characteristics of close friends were associated with the participants' current sexual

behaviour, but not with changes in sexual behaviour over time. Additionally, having friends with more dating involvement and having friends with more social approval for sexual involvement was predictive of more frequent sexual behaviour over time (Low, 2005). Accordingly, a cross-sectional study by Amsale and Yemane (2012), using a logistic regression analysis to examine factors related to sexual behaviour using an ecological framework, found that risky sexual behaviour was significantly and very strongly associated with the perception of peers' involvement in sexual intercourse.

Lashbrook (2000) provided one plausible explanation of how peers exert their impacts on adolescent risk-taking. Specifically, he demonstrated that older adolescents may attempt to avoid negative emotions, such as feelings of isolation and inadequacy, by participating in risky behaviour with peers. Recent findings suggested that the answer is not straightforward. Brady, Dolcini, Harper, and Pollack (2009) found that adolescents with low social support from peers maybe prone to engaging in sexual risk-taking as a response to stress, whereas adolescents with high peer support may engage in sexual risk-taking due to peer socialization of risk. Adimora, Akaneme and Aye (2018) explored predictors of risky sexual behaviour among secondary school adolescents in Enugu state, Nigeria. while employing a cross sectional survey of correlational study carried out on 285 secondary schools, the study indicated that adolescents who show a heightened sensitivity to positive peer pressure demonstrated compliant and no or lowered risky sexual behaviour whilst, those that are engaged with negative peer pressure strongly exhibit disruptive and risky sexual behaviour. This is what gives the peer group the predictive strength often found in research today.

2.3.2 School climate and risky sexual behaviour among adolescents with visual impairment

Manning and Saddlemire (2004) described elements of school climate, to include respect, trust, mutual obligation and concern for others' welfare all of which exert a powerful influence on interpersonal relationships between and among educators' and learners' as well as on learners' academic achievement and overall school progress. Similarly, the knowledge that children acquire in school through interactions is equally

important as the academic knowledge they receive. School climate, if positive, can provide an enriching environment, both for personal growth and academic success. Rutter, Felner, Seitsinger, Burns and Bolton (2009) have demonstrated intricate relationships between school climate and student self-concept. Various studies have also shown a positive correlation between school climate and student absenteeism (Rumberger, 2007; Sommmer, 2005). According to Crain and Moles (2002), school climate is a predictor of student suspension. A growing body of research suggests that positive school climate is a related to effective risk prevention and health promotion efforts as well as effective teaching and learning (Rand Corporation, 2004; Wang, et. al., 2003;Najaka, et. al., 2002; Cohen, 2001). Recent research reviews have shown that effective risk prevention and health promotion efforts are correlated with safe, caring, participatory and responsive school climate (Catalano, et. al. 2002; Greenberg, et. al. 2003; Berkowitz and Bier, 2005).

Empirical evidence suggests an association between positive perceptions of school climate and a range of positive teacher and student outcomes, including outcomes directly related to school safety. O'Malley et al. (2012) summarise the findings from studies which show that students who perceive their school climate to be positive are also less likely to engage in high-risk behaviour. Recent research further indicates an association between positive school climate, reduced aggression and violence, decreased bullying behaviour and sexual harassment (Brookmeyer, Fanti, and Henrich, 2006; Goldstein, Young, and Boyd, 2008; Gregory, et al., 2010; Meraviglia, Becker, Rosenbluth, Sanchez and Robertson, 2003; Kosciw and Elizabeth, 2006; Yoneyama and Rigby, 2006; Meyer-Adams and Conner, 2008; Birkett et al., 2009; Attar-Schwartz, 2009). However, these relationships have not been fully elucidated. One study revealed that the association between school climate and level of aggression and victimization is dependent upon each student's feelings of connectedness to the school (Wilson, 2004).

Using hierarchical linear modelling with a state-wide sample of over 7,300 ninth-grade students and 2,900 teachers randomly selected from 290 high schools, Gregory et al. (2010) in another study, showed that consistent enforcement of school discipline (structure) and availability of caring adults (support) was associated with school safety. Klein, Cornell and Konold (2013), using a sample of 3,687 high school students who

completed the school climate bullying survey and questions about risk behaviour from the youth risk behaviour surveillance survey (YRBS) found that positive school climate is associated with lower student risk behaviour.

The social-emotional climate of schools is predictive of mother's reports of their school-age children's alcohol use and psychiatric problems (Kasen, Johnson and Cohen, 2000). Furthermore, researchers have found that positive school climate is a protective factor for boys and may supply high-risk students with a supportive learning environment, yielding healthy development, as well as preventing antisocial behaviour (Haynes, 2000; Kuperminc et al., 2001). School climate research suggests that positive interpersonal relationships and optimal learning opportunities for students in all demographic environments can increase achievement levels and reduce maladaptive behaviour (McEvoy and Welker, 2000). Regarding the roles of teachers and administrators, the study by Taylor and Tashakkori (1995) revealed that positive school climate promotes job satisfaction for school human resources. Attending a new school can be frightening for students and this apprehension can adversely affect students' perceptions of their schools' climate and learning outcomes. Hence, the students' interest is critical to their transitioning from one school level to another. Consequently, providing a supportive school climate for students is important for a smooth and easy transition to a new school (Freiberg, 2000). Previous school climate research supports the conclusion that many factors comprise this complex concept.

Research has also shown that teachers' work environment, peer relationships and feeling of inclusion and respect are important aspects too. In a study of 12 middle schools, Guo (2012) found that the teachers' work environment, which may be considered as an indicator of teachers' relationships with each other and school administrators, fully mediated the path from a whole school character intervention to school climate change. This finding indicates the critical foundational role of positive adult relationships for a positive school climate. In the same vein, Higgins-D'Alessandro and Sakwarawich (2011) demonstrated that students with special needs, those who had Individual Education Plans (IEPs) only were able to benefit from the positive school climate if they felt included and

respected by other students, indicating the critical role of peer relationships in the well-being of students with differences.

School climate has a significant influence on the work of both teachers and students; it reflects the reality in schools. In a Longitudinal study Henderson, Butcher, Wight, Williamson and Raab, (2008), analysed survey data from 4,926 pupils in 24 Scottish schools to determine the school effect on rates of sexual experience of in-school adolescents. The study concluded that school-level socio-economic factors wider socio-economic environment influence young people's sexual experience. In the same vein, Kim (2015) while using two waves of data from a school-based longitudinal survey found school's socioeconomic contexts may be more relevant to male adolescents' initiation of sexual activity. However, Kirby (2002) concluded that research on the impact of schools upon adolescent sexual behaviour is uneven. He maintained that there is relatively little research on the impact upon sexual behaviour of school structure and non-sexuality-focused school programs.

In conclusion, school climate plays a significant role in providing a healthy and positive school atmosphere. As noted by Freiberg (2000), the interaction between the various school and classroom climate factors creates fabrics of support that enables all actors in a school system to teach and learn at optimum levels. Positive school climate yields positive educational and psychological outcomes for students and teachers. Impliedly, a negative climate can prevent optimal learning and development (Freiberg, 2000; Kuperminc, Leadbeater and Blatt, 2001; Manning and Saddlemire, 2004).

2.3.3 Parenting style and risky sexual behaviour among adolescents with visual impairment

According to Grigorenko and Sternberg (2000), parenting style encompasses both contextual and individual dimensions to child rearing. Some researchers have categorized parents into three categories, based on parenting styles: authoritarian, authoritative and permissive/indulgent (Baumrind, 1991; Patock-Peckham, Cheong, Balhorn and Nagoshi, 2001). The authoritarian parenting style constitutes parents who are often strict and harsh. Authoritative parents are flexible and responsive to the child's needs but still enforce

reasonable standards of conduct while permissive or laissez-faire parents are those who impose few restrictions, rules or limits on their children. Some have added a fourth category of neglectful parenting style (low control and low acceptance (Adalbjarnardottir, and Hafsteinsson, 2001).

Research has shown that parenting style has positive and negative implications based on behavioural outcomes of adolescents and children (Ang and Groh, 2006; Utti, 2006). For example, authoritative parents are high in responsiveness and demandingness and exhibit more supportive than harsh behaviour. Authoritative parenthood encourages verbal interaction, convey the reasoning behind the rules, and use reason, power, and shaping to reinforce objectives. Authoritative parenthood is often associated with positive adolescent outcomes and has been found to be the most effective and beneficial for most families. Steinberg and Silk (2002) and Gonzalez, Holbein, and Quilter (2002) are in agreement that the authoritative parenting style fosters adolescents' positive well-being. Adolescents with authoritative parents are less prone to externalizing behaviour, and specifically are less likely to engage in drug use than those with uninvolved parents (Steinberg and Silk, 2002; Gonzalez, Holbein and Quilter, 2002).

Recent findings suggest that the positive effects of authoritative parenting are amplified when both parents engage in an authoritative parenting style (Simons and Conger, 2007). The study by Simons and Conger (2007) further indicated that having at least one authoritative parent fosters better outcomes than family parenting styles that do not include an authoritative parent. Adolescents whose parents are both authoritative or whose mother alone is authoritative report higher well-being, such as higher self-esteem and life-satisfaction, than participants with no authoritative parent (Milevsky, Schlechter, Klem, andKehl, 2008). These research findings suggest that regardless of the gender of the parent, the presence of even one authoritative parent is beneficial for adolescent outcomes (Bronte-Tinkew, Moore and Carrano, 2006).

Authoritarianism is characterized by low responsiveness and high demand. The authoritarian parenting style is associated with parents who emphasize obedience and conformity while expecting obedience to rules without explanation in a less warm

environment (Baumrind, Larzelere and Owens, 2010). Authoritarian parents exhibit a low level of trust and engagement towards their children, discourage open communication, and engage in strict control (Maccoby and Martin, 1983). Verbal hostility and psychological control were found to be the most detrimental of the authoritarian-distinctive, coercive power-assertive behaviour (Baumrind, Larzelere, and Owens, 2010). Adolescents from most Caucasian authoritarian families have been found to exhibit poor social skills, low levels of self-esteem, and high levels of depression (Milevsky, Schlechter, Netter and Keehn, 2007). However, the effects of authoritarianism vary depending on communities in which the adolescent lives. For example, Okorodudu (2010) investigated the influence of parenting style on adolescents' delinquency in Nigeria. Regression statistics was used for the analyses of the study. Irrespective of gender, location and age, the study revealed that the authoritarian parenting style did not effectively predict adolescents' delinquency. The study further indicated that parents who exerted control and monitored adolescent activities were found to have the most positive effects on adolescents' behaviour (Okorodudu, 2010).

According to Baumrind, Larzelere and Owens (2010), permissive parenting is characterized by high levels of responsiveness and low levels of demandingness. Permissive parents behave in an affirmative manner toward the adolescent's impulses, desires, and actions while consulting with the adolescent about family decisions (Baumrind, andOwens, 2010).Parents who are permissive do not set rules; they avoid engaging in behavioural control while setting but few behavioural expectations for adolescents (Baumrind et, al, 2010). They show a steep decrease in monitoring once their children attain adolescence with increased levels of externalizing behaviour (Luyckx et al., 2011). Researchers have reported that adolescents from permissive families are more prone to substance use, school misconduct with less exposure to positively oriented school behaviour compared to adolescents from authoritative or authoritarian families (Querido, Warner and Eyberg, 2002). Permissive parenting also contributes to low self-esteem and extrinsic motivational orientation among adolescents (Ginsburg and Bronstein, 1993). Recent findings also revealed that permissive parenting style effectively predicts adolescents' delinquency (Okorududu, 2010).

Lastly, uninvolved parenting style has been found to have the most negative effect on adolescent outcomes when compared to the other three parenting styles. Uninvolved parents often fail to monitor or supervise their children's behaviour and do not support or encourage their children's self-regulation (Baumrind, et. al, 2010).The uninvolved parenting style is described as low in responsiveness and low in demandingness. In general, these parents often show disengagement from the responsibilities of child-rearing and are often seen as being uninvolved regarding the needs of their offspring (Baumrind, et.al, 2010).Uninvolved parents do not engage in structure or control with their children and often there is a lack of closeness in the parent-child dyad; therefore, adolescents of uninvolved parents often engage in more externalizing behaviour (Hoeve, Dubas, Eichelsheim, van der Laan, Smeenk and Gerris, 2009).

Studies have established a positive association between uninvolved parenthood and delinquent acts like from vandalism and petty theft to assault and rape (Hoeve et al., 2009). Further, the researchers found that by grade 12, adolescents with uninvolved parents drank alcohol almost twice as much and smoked twice as much as their peers that lived in authoritative households (Luyckx, et al., 2011). In another study, adolescents who perceived their parents as uninvolved used more drugs compared to adolescents who perceived their parents as authoritative (Adalbjarnardottir and Hafsteinsson, 2001). In addition to increased externalizing behaviour among adolescents who have uninvolved parents, findings show that participants with either an uninvolved parent or two uninvolved parents scored lower on self-esteem than participants without an uninvolved parent (Milevsky, Schlechter, Klem and Kehl, 2008). Similarly, in another study, the effects of uninvolved parenting were associated with higher levels of child-reported depressive symptoms during adolescence (Simons, Lin, Gordon, Brody, Murry and Conger, 2002).In sum, research consistently indicates that individuals whose parents are uninvolved perform most poorly in all emotional and behavioural outcomes.

In addition, findings from studies suggest that the gender of the parent may influence the effects of parenting style on adolescent outcomes. For example, in a study looking at the relationships between maternal parenting style and adolescent sexual behaviour in a sample of 253 British adolescent-mother dyads, parenting style was found

to be directly associated with the delay of the first sexual experience for the adolescents between the age of 15-16 years. For the older adolescents, this was not true (Taris and Semin, 1998).Similarly, researchers controlled for several mother-related variables and found that having an authoritative father was associated with positive outcomes among adolescents (Bronte-Tinkew, Moore and Carrano, 2006). In another study, researchers found that having an uninvolved mother was associated with significantly worse outcomes than families with an uninvolved father (Simons and Conger, 2007).

Interestingly, researchers found that monitoring varies across parenting styles. A study conducted by Luyckx, et al. (2011) found that authoritative parents exhibit higher levels of parental monitoring during their child's childhood and a slight decrease across adolescence. These findings suggested that authoritative parents somewhat relinquish their monitoring in response to adolescents' increasing demands for independent decision-making. In corroboration, Taris and Semin's (1998) findings also suggested that parental styles have a greater influence in the adolescents' sexual attitudes and behaviour in the early teen years versus the later years and that parental influence decreases for the older adolescents.

Moussa (2016) utilized retrospective reports from a sample of college students and their primary caregiver during childhood to examine the interplay among parent and adolescent personality, parent psychopathology, parenting behaviour, and adolescent outcomes, specifically substance use and risky sexual behaviour. The study found that parenting variables, specifically parenting style and internalizing psychopathology, are better at predicting risky sexual behaviour. In the same vein, Yimer and Ashebir (2019) employed a cross-sectional study on 406 randomly selected 14–19 years old high school adolescents in Legehida District, Northeast Ethiopia. They found that authoritative parenting and high adolescent-parent relationships quality reduce sexual risk behaviours among adolescents. Huebner and Howell, (2003) examined the relationship between adolescent sexual risk-taking and perceptions of parental monitoring, frequency of parent–adolescent communication, and parenting style. It was obtained that parental monitoring, parental monitoring by parents–adolescent communication and parenting style by ethnicity were significant predictors of sexual risk-taking.

In a review of factors on adolescents' risky sexual behaviour, Ondrej (2013) submits that a number of studies indicated that both a high level of parental monitoring and support are associated with a later age of first sexual intercourse and with a more consistent contraceptive use. He however, underscored that most studies explored parental monitoring and parental support without differentiation between the mother and father. Moreover, parental monitoring and support were mostly explored as single variables. Therefore, information about which of the parents is more/less likely to influence a child's sexual behaviour is rather unclear.

2.3.4 Emotional intelligence and risky sexual behaviour among adolescents with visual impairment

Emotional intelligence is one's ability to use emotions adaptively (Salovey and Mayer, 1990; Goleman, 1995). According to Bar-On and Parker (2000), emotional intelligence includes non-cognitive intelligence such as sensational, personal, social abilities as well as skills that influence one's capacity to effectively negotiate environmental pressure. Although emotional intelligence is a relatively new empirical construct, the role of emotions and their impact on the lives of humans has been debated for centuries. The ancient Greeks viewed logic and reason as being superior to emotions (Payne, 1986) while the Romantic Movement embraced emotions and promoted emotional expression through the arts (Solomon, 2000). Various studies have been conducted to investigate how emotion affects thinking and behaviour. Emotional intelligence as a concept is important because it provides an understanding of how emotional states affect social functioning and related processes variables (Mayer and Salovey, 1997). As noted by Schulze, Roberts, Zeidner, and Matthews (2005), emotional intelligence has predictive value above and beyond cognitive intelligence regarding real-life outcomes.

Literature is replete with evidence of the nexus between emotions and behaviour (Smith, 2002). Adolescents with lower emotional intelligence tend to have poorer peer relations, suggesting that individuals with low emotional intelligence may have trouble establishing meaningful social interactions (Bracket, Warner and Mayer, 2004). Furthermore, adolescents with lower emotional intelligence demonstrated significantly

more involvement in potentially harmful behaviour such as illegal drug use, excessive alcohol consumption and delinquent or deviant conduct. A study by Bracket et al. (2004) supports observable patterns of correlation among lower emotional intelligence and larger amounts of alcohol consumption, illegal drug use and involvement in deviant behaviour. Corroborating this, Smith (2001) posits that isolated children or those rejected by peers suffer the loss of self-esteem and other emotional distresses, tend to dislike school and are at risk of a wide range of destructive personal and interpersonal outcomes, including substance abuse, gang involvement, teen pregnancy, violence at school and risky sexual behaviour.

There is evidence of an association between negative self-perception on the duo of truancy and classroom disruption at secondary school (Petrides, Frederickson and Furnham 2004). A low level of emotional self-efficacy, in combination with increased impulsivity and poor social skills, are likely to be implicated in various forms of antisocial behaviour (Bohnert, Crnic and Lim 2003; Trinidad, Unger, Choud, Azen and Johnson 2004). High emotional intelligent adolescents have a greater propensity to smoke in the future if they had previously experimented with smoking. Low emotional intelligent adolescents have a higher penchant for smoking if their perceived ability to refuse a cigarette offer from a person they just met was low or hostility level was high. Bracket et al. (2004) reported a condition called “alexithymia”, which can be defined as a self-reported difficulty in identifying and expressing emotions. According to them, adolescents with high scores on alexithymia measures reported increased alcohol consumption, drug use and dependence on psychoactive substances.

Recent research on emotional intelligence also shows that emotional skills, as assessed by performance-based assessments, are positively related to a healthy personal and social functioning as well as students’ academic success (Mayer, Roberts and Barsade, 2008). Empirical evidence abounds to show that students with limited skills related to understanding and recognizing emotions had a higher challenge adjusting at school compared topeers with a wide spectrum of emotional skills (Kerr, Johnson, Gans and Krumrineet, 2004). Emotional intelligence, therefore, assumes a buffer against risk-taking. In a study by Ogunsanwo, Mojisola, Ayodele and Kolawole (2014), it was

revealed that the sexual attitude and behaviour of adolescents is strongly affected by psychological factors like locus of control and emotional intelligence. This finding corroborates an earlier study by Ogunleye and Oke (2012) which demonstrated poor psychological well-being as a predictor of early onset of sexual activity and unprotected sex, while a good psychological well-being is positively associated with less sexual risk behaviour.

Wozniak (2013) examined the relationship between social-emotional intelligence and risky sexual behaviours in adolescence. The study collected data for 49 high school students in New York State using the Bar-On Emotional Quotient Inventory Youth Version and a researcher-designed questionnaire. It was established that a significant relationship exists between risk-sexual behaviour and emotional intelligence. Ortiz (2012) examined the relationship between emotional intelligence, and sexual other health risk behaviours among young adults. While using an online questionnaire to draw responses from undergraduate college students, the study found no significant difference in emotional intelligence between college students engaging in risk behaviour and college students not engaging in risk behaviours, for the risk behaviours assessed. He however found strong no significant relationship between emotional intelligence and health risk behaviour.

Rivers, Brackett, Omori and Sickler (2013) examined the hypothesis that emotional intelligence may serve to protect college students from involvement in risky behaviour. Their findings suggested that emotion skills may be a more relevant intervention target than self-esteem with regard to college students' engagement in risky behaviour. They however cautioned that further studies are needed to examine the causal relationship between emotional intelligence and risk taking among college students, and that future research studies should both test the mechanisms by which emotion skills serve as a buffer against engaging in risky behaviour among students.

Even with the unclear causal explanation, some earlier studies demonstrate that emotional intelligence is associated with the perceived parental warmth and perceived parental social support (Ciarrochi, Chan and Caputi, 2000; Mayer, Caruso and Salovey, 1999; Lopes, Salovey and Straus, 2003). For example, a study by Panithee (2012) found

that adolescents with higher emotional intelligence also reported significantly higher perception of parenting care style, whereas there was a significant negative association between emotional intelligence and overprotective parenting style. Furthermore, in Panithee's (2012) study, a significant positive association between parents' quality of life and adolescents' emotional intelligence was observed. Additionally, it was found that, as emotional intelligence was positively associated with parenting care style, overprotective parenting style was also negatively correlated with emotional intelligence.

2.3.5 Sexual attitude and risky sexual behaviour among adolescents with visual impairment

Attitude is an acquired overt or covert tendency to react either in a manner that is expressive of a certain degree of favourability or unavoidability in relation to certain objects, persons, ideas or environmental factors (Akintayo, 2006). This definition emphasizes that one's attitude towards anything can be a consequence of one's behaviour in situations involving that particular thing. Similarly, the definition acknowledges the fact that human attitude is affected by some of the factors identified as responsible for the risky sexual behaviour of adolescents such as parental, teacher, peer and media factors (Abrahamson, Baker and Capsi, 2002; Olson, Straut and Stank, 2001).

A study by Cross and Morgan (2003) found that college students exhibited varied sexual attitudes and behaviour in different generations. Cross and Morgan (2003) also blamed the media for the changing sexual attitudes and behaviour of students. Today, students receive more sex education through life orientation, peer education and the media. Cross and Morgan (2003) contend that sex education has not been able to change sexual attitudes and behaviour of college students in recent history. As a matter of fact, successive student generations engage in sexual experimentation earlier than ever before, with an increasingly dangerous mix of alcohol and sex, leveraging on wider sex information through the media and ICT (Cross and Morgan 2003).

In a study by Chireshe et al. (2007), it was found that there were no differences in the perceived male-female attitudinal roles in intimate relationships between either party of students from two universities in Zimbabwe. However, the majority of men were

generally viewed as initiators of sexual encounters who take control and responsibility of the process of sexual intercourse. This situation puts women at greater risk of contracting HIV, a factor necessitating women's empowerment on safe sex and sexual practices. In another study by Mwaba and Naidoo (2005) to determine sexual practices and attitudes towards premarital sex and condom use among a sample of South African university students, it was found that half of the participants reported having sex within 12 months of their arrival on campus and 8percent indicated that they had been coerced into having sex by their partners. Two-thirds of the participants reported that it was not bad to have sex between 18 and 21 years, 65percent approved of sex before marriage while over 80percent of the participants reported that they would refuse to have sex if their partner was unwilling to use a condom. However, the same study found that the majority of participants practice safe sex and are aware of the consequences of having unsafe sex. It is clear from the findings of the above study that some university students engage in premarital sex.

In a study conducted among undergraduate students of two universities in Ningbo, China, Cong et al. (2006) observed that condoms were never or were rarely used by 35percent of sexually active male and female students. About 10% of sexually active female students and their male student partners had experienced pregnancy and induced abortion. The study further revealed that about 1.5percent of sexually active students of both genders were diagnosed with an STI. In the similar Nigerian-based study, Abdulraheem and Fawole (2009) discovered that students in a university were significantly sexually active (74percent) and having multiple sexual partners (66.4percent), while only 38.1percent devotedly used condoms for sexual intercourse.

The study by Alamrew et.al (2014) indicated that 90.3% of sexually debuted disabled people did not observe consistent condom use in the last 12 months. This finding contrasts with the report of an Ethiopian study by Adamu, Mulatu and Si (2003) where 48percent of sexually active people with disabilities used condoms consistently. A study by Adamu, Mulatu and Si (2003) explored factors of sexual initiation, subsequent risk behaviour and condom use among 1,102 youth students in secondary schools in some parts of Ethiopia. In that study, two-thirds of the sexual initiations were unprotected and

some occurred with casual or commercial sex partners (9.1percent). It is asserted in the same study that multi-partnered sex (52.7percent) and sex with casual (30.4percent) or commercial (25.3percent) partners were the most commonly reported lifetime risk behaviour. 56.7percent of the youths claimed to never use condoms. Even though this was the case, half of them indicated to have used them regularly and claimed to feel protected by condom use from a sexually transmitted infection. Geographical location of subjects was related to such usage of condom vis-à-vis expressed feelings of safety

A study conducted by Azuike, et.al (2015) looked into the sexual attitude and behaviour of students in senior secondary schools in South-eastern Nigerian. The descriptive, cross-sectional study employed multi-stage sampling techniques. Findings revealed that 24.1percent had sexual exposure with a mean age of 12 ± 3.6 years at sexual debut, 74.7 percent of the respondents with multiple sexual partners claimed they did not use condoms during their first sexual exposure while 83.3percent of those who had been pregnant terminated the pregnancy. A similar finding was made in a study by Toyin, Aderemi, Pillay, Tonya and Esterhuizen, (2013). According to them, disabled persons were significantly more likely to have reported inconsistent condom use with their constant or casual sexual partners compared with non-disabled individuals.

A more recent study investigated the factors influencing sexual attitude and behaviour of emerging adults. A sample of 360 respondents comprising 182 males and 178 females participated in the study. Four hypotheses were tested using regression and analysis of variance (ANOVA), and it was found that age, gender, religiosity, family type, parental care/protection and maternal career/protection jointly predicted sexual repression, sexual preoccupation negatively while maternal protection independently predicted sexual preoccupation negatively as family type jointly predicted sexual depression positively (Idoko, Muyiwa and Agoha, 2015).

In their study, Williams and Aderanti (2011) employed a descriptive survey design to investigate the influence of attending church- owned and government-owned universities on sexual attitudes and risky sexual behaviour of emerging youths. The findings indicated a social assumption as well as an empirical association between the variables and showed that religiosity was a potent gatekeeper of certain behaviour which

may include sexual attitudes and risky behaviour of individuals. A total of 200 randomly selected students were constituted into two study groups. Findings implicated religiosity as having a significant influence on sexual attitudes. However, no significant influence was revealed with respect to risky sexual behaviour in both groups. The study also showed a significant difference in religiosity, sexual attitudes and risky sexual behaviour among the two groups. It was concluded that religious participation in schools should be done in such a way that it does not infringe on the fundamental rights of the students. Promotion of academic excellence was identified as a positive strategy to divert students' attention from risky sexual behaviour.

Sufficient evidence abounds to prove that there is a correlation between attitude and self-esteem (Miller, Christensen and Olson, 1987; Tanfer and School, 1992). If attitude is incongruent with behaviour, a state of dissonance can occur and this may change the way self-esteem is affected. Miller et al. (1987) report that non-virgins whose attitudes are negative towards premarital coitus had low self-esteem. Consequently, those who had a positive attitude towards premarital coitus had higher self-esteem. These illustrate the above-mentioned concept of congruence and dissonance. Furthermore, Levinson, Jaccard, and Beamer (1995) in their study, examined adolescents' attitudes towards casual sex and their engagement in casual sex behaviour. It was revealed that adolescents tended to hinge their self-esteem on issues related to sexual attitude and behaviour, for example, by internalizing their attitudes and behaviour regarding casual sex and that they held increased positive attitudes regarding casual sex.

2.3.6 Gender and risky sexual behaviour among adolescents with visual impairment

Gender inequality constitutes a critical issue that has attracted scholarly attention in recent times (Awodun, Oni and Oyeniyi, 2015). According to Hansman, Tyson and Zahidi (2009), gender equality has been a tall order, defying attempts to realize it across the globe. Common focal areas in gender equality discourse include economic participation, education and role-related issues.

"Gender" has been ascribed various meanings and interpretations by scholars. For

instance, Filgona and Sababa (2017) describe the term ‘gender’ as including a range of physical, biological, mental as well as behavioural attributes that pertain to and differentiates between the female and male human population. Udusoro, (2011) views gender as a cultural construct that results from the distinctiveness of roles, behaviour, mental and emotional characteristics between females and males in a given society. To Umoh (2003), gender is a psychological term used for describing behaviour and traits constructed as societal expectations from individuals, which result from the biological distinction of sex. These submissions allude to the fact that gender involves categorization on the basis of masculinity and femininity.

Gender differential across the globe has prompted quite a number of researchers to look into gender difference in sexual-related activities among the adolescents. Yoona, Voithb, and Kobulskyc, (2018) investigated gender differences in pathways from child physical and sexual abuse to adolescent risky sexual behaviour among high-risk youth. Path analysis was performed with 862 adolescents drawn from longitudinal studies of child abuse and neglect. Four waves of data collected in the United States were used: childhood physical and sexual abuse experiences (from ages 0–12) were assessed by child protective services reports, internalizing and externalizing symptoms were measured at age 14, substance use was measured at age 16, and risky sexual behaviour was measured at age 18. Their results revealed that significant gender difference exists in the patterns of risk pathways resulting from childhood physical abuse. They maintained that physical abuse was directly and positively correlated with risky sexual behaviour in boys but not in girls. For girls, physical abuse had a significant indirect effect on risky sexual behaviour via externalizing symptoms.

The study by Bensley, Van Eenwyk and Simmons (2000) examined gender differences in the association between conduct disorder and risky sexual behaviour. The study recruited a total of 616 youths from four primary care clinics. Questions completed covered risky sexual behaviour, drug use and conduct disorder (CD). The study revealed that childhood physical abuse was related to a three-fold rise in the risk of HIV in males but not in females. This implies that adolescent male with a history of childhood physical abuse may be more vulnerable to risky sexual behaviour during adolescence. The result

further confirmed the association among conduct disorder (CD), having more than three-lifetime partners and having two or more partners in the last 3 months. Engaging in sex without condom use was stronger among the female youth than among the male youth. However, the association between CD and alcohol and other drug use before sex was stronger in the male youth than in the female youth.

Direct effects from physical abuse to risky sexual behaviour in boys may indicate that physically abused boys are more likely to be exposed to hyper-sexualized models of masculinity, leading to risky sexual behaviour, or may use sex as a compensatory strategy to establish a masculine identity as a response to prior abuse and vulnerability. Significant gender moderation was also found in the path from marijuana use to risky sexual behaviour, with a significant association between these variables found in girls but not in boys (Yoona, Voithb, and Kobulskyc, 2018). These findings were similar to that of Walsh, Latzman, and Latzman, R. D. (2014) who investigated the role of trauma-related intrusions and alcohol problems in the pathway from child sexual and physical abuse to risky sex among emerging adults. The study included 1,169 racially diverse college students (72.9% female, 37.6% black/African-American, and 33.6% white) who completed an anonymous questionnaire assessing child abuse, traumatic intrusions, alcohol problems, and sexual risk behaviour. The results revealed that gender moderation effects on the link between alcohol problems and intention to engage in risky sex were significantly stronger for women than for men.

Studies have demonstrated a higher prevalence of conduct disorder in males than in females (American Psychiatric Association, 2013; Berkhout et al., 2011). This includes disorders of childhood and adolescence usually characterized by a pattern of behaviour that violates social norms or the rights of other persons. Young persons with conduct disorder engage in a range of violent or deviant behaviour such as aggression, destruction of property, deceit, theft, and serious violation of rules (for example, running away from home) (American Psychiatric Association, 2013). In their recent study on gender differences in conduct disorder, Berkout et al., (2011) also report that conduct disorder is more prevalent among males than among females and that young girls with conduct disorder differ from boys in association with internalizing disorders and temperamental variables. Furthermore,

Holliday, Ewing, Storholm, Parast, and D'Amico (2017) opine that conduct disorder symptoms is stronger or is only present among females. While these results or observations do not fully support the broader category of "sexual risk behaviour" as a female-specific manifestation of conduct disorder, the association between conduct disorder symptoms and certain outcomes in number of partners in the past three months and use of alcohol or other drugs (AOD) use before sex was significant among males. Findings indicated that females with conduct disorder may be at heightened risk of participating in many of such behaviour. These conflicting findings prompted this research to include gender as one of the moderating variables that were verified in the study.

2.4 Appraisal of the literature reviewed

The literature review dwells extensively on the key concepts in the study and explains them from the perspectives of scholars and researchers. It is evident from the reviewed literature that the rate of risky sexual behaviour among adolescents generally is becoming alarming. The general belief is that adolescents with visual impairment are asexual individuals who do not participate in sexual activities and are therefore not at risk of sexually transmitted infections and other negative sexual or reproductive health outcomes. Nonetheless, it is glaring in the literature that adolescents with visual impairment experience similar rates of risky sexual activities with even greater risk of contracting any or all of the sexual-borne diseases than the typically developing adolescents. Hence, they need to be protected.

Beyond that, the literature review identifies the tenets of some prominent theories which help to explain the study better and these theories include the health belief model, the theory of planned behaviour, theory of reasoned action, theory of optimistic bias, ecological theory and social learning theory. As much as the theories are clearly and logically expounded, they are not sufficient to be used individually as conceptual frameworks for research of this nature and the reason stems from the fact that each of them either focuses on one set of variables to the exclusion of the others. The reason can also due to the fact that different factors may be influenced by different situations, producing different underpinnings for risky sexual behaviour. Moreover, there may be no

linkage between one factor predisposing adolescents to risky sexual behaviour and other factors.

In addition, the literature review reveals the paucity of studies on risky sexual behaviour among in-school adolescents with visual impairment. Many of the past studies on risky sexual behaviour had tended to focus on the typically developing adolescents and they were mostly carried out in geopolitical zones of Nigeria other than the Southwestern ern zone. Thus, this present study sought to examine the influence of environmental factors (parenting style, peer pressure and school climate) and affective factors (sexual attitude and emotional intelligence) on risky sexual behaviour among adolescents with visual impairment in Southwestern ern zone of Nigeria.

2.5 Conceptual Framework

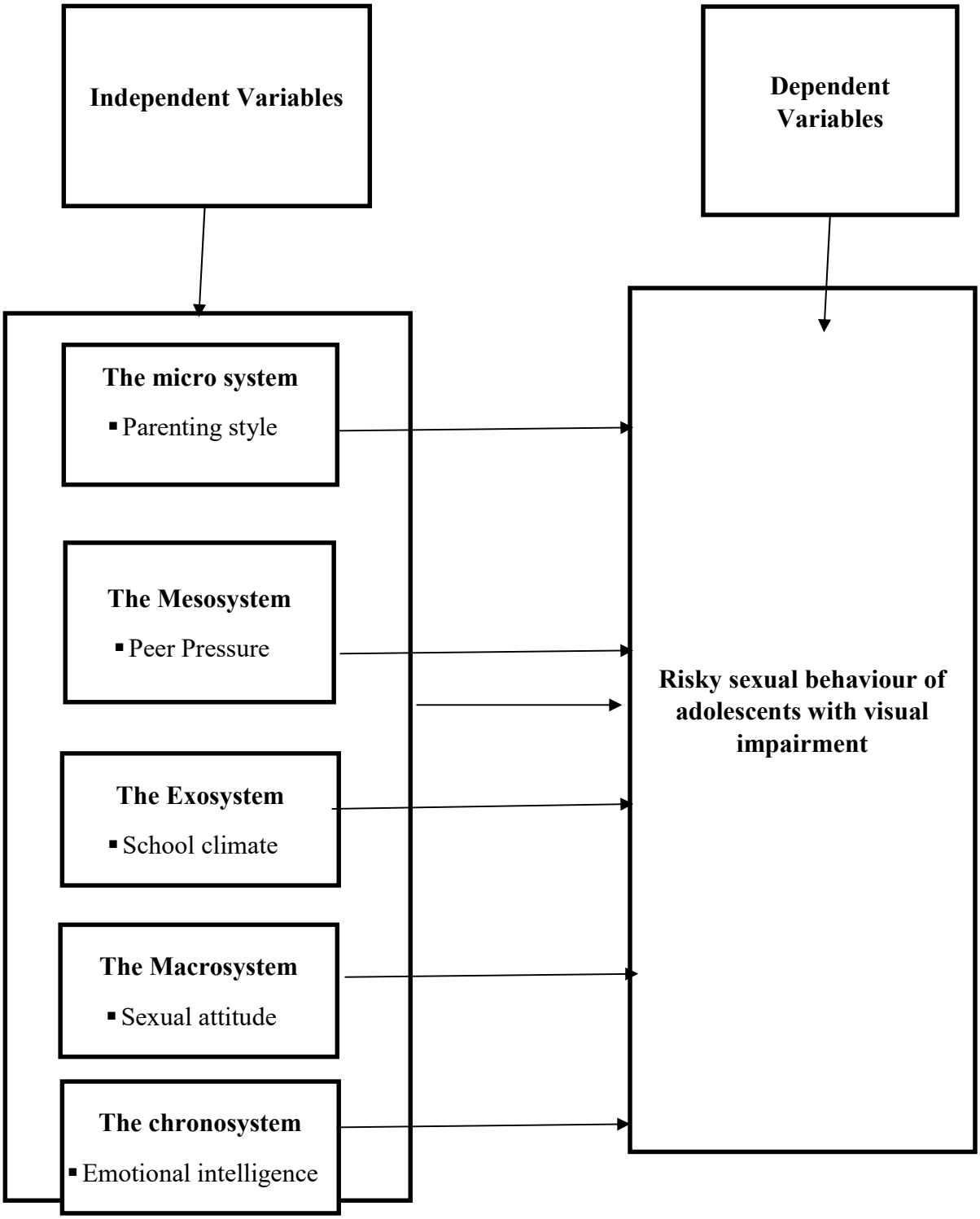

Fig 5: Conceptual framework
Source: Researcher's design

CHAPTER THREE

METHODOLOGY

This chapter focuses on the method used to carry out this study such as researchdesign, population, sample and sampling technique, instruments, validity and reliability of research instrument, procedure for data collection and method of data analysis.

3.1 Research design

This study adopted the descriptive research design of the correlational type. Correlation research is a method of quantitative research whereby a sample of a chosen population can be studied to discover the relative incidence, distribution and interrelations of sociological and psychological variables. The design was considered appropriate for this study because it is non-experimental in that no manipulation of the variables is envisaged since their manifestations are clearly apparent (Kerlinger and Lee, 2000). To this effect, this study is only an observation of an already existing phenomenon.

3.2 Population

The population of the study comprised all adolescents with visual impairment in integrated secondary schools in Southwestern Nigeria. Southwestern Nigeria is one of the six geopolitical zones in Nigeria, carved out of the defunct Western State of Nigeria. It encompasses Ekiti State, Lagos State, Ogun State, Ondo State, Osun State and Oyo State. There are several schools for adolescents with special needs situated within each state in Southwestern Nigeria, but the integration of adolescents with visual impairment has taken place in the schoolslisted below:

1. Federal Government College, Ikere-Ekiti.
2. Federal Government College, Ijanikin, Lagos State.

3. Queens College, Lagos State.

4. King's College, Lagos State
5. Lagos State Model Junior College Agbowa Ikosi.
6. Owo High School, Owo, Ondo State
7. Adetola Odutola Secondary School, Ijebu ode, Ogun State
8. Ade Okubanjo School for Visually Impaired, Ijebu-Igbo, Ogun State
9. Yewa Egbado College, Abeokuta, Ogun State
10. St. Peters Abeokuta Ogun State
11. Special Secondary School Osogbo Osun State.
12. Adeniran Memorial Grammar School Ogbomoso Oyo State

3.3. Sample and sampling technique

The sample consisted of 311 adolescents with visual impairment. The researcher adopted a purposive sampling approach in selecting secondary schools (integrated settings) in Ekiti, Lagos, Ondo, Ogun, Osun and Oyo states in Southwestern Nigeria. This sampling technique was adopted because of the peculiarity of the respondents and their characteristics. Purposive sampling relies much on the judgement of the researcher when it comes to the selection of respondents for the study.

Snellen's chart was used to screen adolescents with visual impairment to really ascertain their visual acuity in the selected secondary schools in Southwestern Nigeria. Afterwards, a total enumeration of three hundred and seventeenadolescents with visual impairment was used for the study (both low vision and total blindness).

Table 3.1: Shows the number of adolescents with visual impairment in the schools used for the study.

Table 3.1: Population and sample

State	Selected schools	Number of students
Ekiti	Federal Government College Ikere-Ekiti	32
Lagos	Federal Government College, Ijanikin, Lagos State	15
	King's College, Lagos State	29
	Lagos State Model Junior College Ijanikin Lagos	14
	Queen's College, Lagos State	16
Ondo	Owo High School, Owo	43
Ogun	Ade Okubanjo School for Visually Impaired, Ijebu-Igbo Ogun State	24
	Adeola Odutola Secondary School, Ijebu ode Ogun State	07
	St, Peters Abeokuta Ogun State	43
	Yewa College, Abeokuta, Ogun State	33
Osun	Osun State Secondary School for Persons with Special Needs	05
Oyo	Adeniran Memorial Grammar. School.Ogbomoso	50
	Total	311

Inclusion criteria

The inclusion criteria in this study are:

1. Adolescents who have been identified to have visual impairment (low vision or totally blind), screened with Snellen chart. The totally blind refers to those with no perception of light while the low vision ranges from those with no perception of light to those with visual acuity of 6/18. The respondents must be students in any of the selected schools.
2. The respondents must be within the age range of 9-23 years.
3. The respondents must be students studying in the selected schools.
4. Adolescents with visual impairment (low vision or totally blind) in junior and senior secondary schools.
5. Adolescents willing to be screened and participate without coercion

3.4 Instrumentation

The following instruments were used in the collection of data for the study:

1. Snellen chart (Snellen, 1862)
2. Peer pressure scale(Velisiwe, 2005)
3. School factors questionnaire scale (SFQS) (2007)
4. Parenting style inventory (PSI) (Darling andToyokawa,1997).
5. Emotional intelligence scale (EIS) (Schutter, Malouf, Hall, Haggerty, Cooper, Golden and Dorheim, 1998)
6. Brief sexual attitudes scale (BSAS) (Hendrick, Hendrick and Reich, 2006)
7. Youth risk behaviour questionnaire (YRBQ), (Centres for Disease Control and Prevention, 1988).

The instruments are all standardized and foreign, hence a pilot study was carried out with a population of 31 adolescents with visual impairment in Aperin Oniyere Commercial Grammar School Ibadan and Adesola Orita Aperin, School Ibadan to revalidate the instrument.

3.5. Description of instruments

3.5.1. The Snellen's chart:

The standard eye chart known as 'Snellen Chart' was developed by Hermen Snellen in the year 1862. It is a standardized eye screening test adopted by the World Health Organisation (WHO) to identify the degree of visual loss. According to Watt (2003), the Snellen eye chart has a series of letters or letters and numbers, with the largest at the top. The letters have different sizes such that the top letters should be seen clearly by an eye with normal vision at a distance of 200ft or 60metres. Each row has a figure at the side indicating the distance in metres or feet at which that row can be seen by normal eyes (Olukotun, 2003). The letter 'E' was used to screen the adolescents with visual impairment in order to ascertain their level of visual loss that is, whether it is low or total vision loss.

3.5.2Peer pressure scale

The Peer Pressure Scale is a sub-scale of Learner's Aggressive Questionnaire developed by Veliswe (2005). It contains 14 items out of the total 83 items of the original scale. The items are structured in a 5-point Likert format with response ranging from strongly disagree = 1 to strongly agree = 5. A typical example on the scale reads "*My friends think I am boring*", "*My friends like to fight each other*". The scale had reported a two-week test-re-test reliability coefficient of 0.62 with an original Cronbach's Alpha coefficient of 0.74. However, for the current research, the instrument was re-validated using test-retest method and reliability coefficient of 0.84 was obtained.

3.5.3 School climate student scale (SCSS)

School climate scale was adapted from the revised version of the Dimension of Excellence Scale (DOES) developed by Dusewicz and Beyer (2014). The DOES package is a set of survey instruments designed to be used with school staff, parents, and students to assess the quality and effectiveness of a local school or district. Each survey addresses dimensions found to be related to school effectiveness in a wide variety of educational research studies. The dimensions include school climate, leadership, teacher behaviour, curriculum, monitoring and assessment, student discipline and behaviour, staff development, and parent involvement. The present study adapted the school climate

student dimension. The scale consists of 21 items to measure school climate on a five-point Likert format of 1-strongly agree to 5- strongly disagree. A typical item on the scale reads "*My school is a safe and clean place", "Most of the students in my school don't like to cause trouble"*.The instrument had reported an adequate reliability index of (α = .96). However, further reliability was conducted through a pilot study and a Cronbach's Alpha of 0.92 was obtained.

3.5.4Parenting style inventory (PSI)

Parenting styles were assessed using the validated parenting styles inventory developed by Darling and Toyokawa, (1997). The scale contained 15 items structured on a five point Likert format of 1-strongly disagree to 5- strongly agree. A typical item on the scale reads*:" My parents give me a lot of freedom to do whatever I like", "My parents spend time just talking to me". When I do something wrong, my parents do not punish me"*. The coefficient alpha of responsiveness, autonomy granting and demandingness subscales are .74, .75 and .72 respectively. In the current study, the 15 items were subjected to validity and reliability tests in order to ascertain its suitability for the study, and it reported a Cronbach's Alpha of .84.

3.5.5 Emotional intelligence scale (EIS)

The emotional intelligence scale (EIS) developed by Schutter, Malouf, Hall, Haggerty, D.; Cooper, Golden, and Dorheim, (1998) assessed emotional intelligence based on self-report to items tapping the appraisal and expression of emotions in self and others, regulations of emotions in self and others and utilization of emotions in solving problems. It was designed to help people label their feelings rather than labelling people or situations. The instruments also help people to analyse their feelings rather than the actions of motives of other people. The scale has 33 items, which are on a 4-point scale-strongly disagree = 1, disagree = 2, agree = 3 and strongly agree = 4. Participant responds by indicating their level of agreement on the 4-point scale. A typical item on the scale reads*"When my mood changes, I see new possibilities", "Emotions are some of the things that make my life worth living".* The instrument has been properly designed in such a way so as to tap all domains of emotional intelligence so that people will be able to take responsibilities for their emotions and happiness.

The EIS has demonstrated high internal consistency with Cronbach's ranging from 0.78 to 0.98. The instrumenthas been used by various researchers in Nigeria (Salami, 2005; Adeyemo and Ogunyemi, 2005; Aremu and Lawal, 2008, Fakolade, 2014). However, for the present study, the scale was adapted and modified to consist of 29 items. Item eighteen (18) and (29)were removed due to the fact that they were not suitable for the study participants (visually impaired).Further reliability test of the 29 items was carried out through a pilot study and a Cronbach's Alpha reliability of .97 was obtained.

3.5.6 Sexual attitudes scale (SAS)

The brief sexual attitudes scale (BSAS) developed by Hendrick, Hendrick, and Reich (2006), was used to measure the attitudes of adolescents with visual impairment towards sexual activities. The BSAS was used to evaluate an individual's attitudes towards sexual permissiveness, birth control, sex as communion with another, and the instrumentality of sex. The scale has 23 items structured on a five-point Likert format of 1-strongly disagree to 5- strongly agree. Examples of items included on the scale are "*Ido not need to be committed to a person to have sex with him or her", "*I *would like to have sex with many partners"*. This scale has been shown to be reliable and valid (Alpha = .93). However, for the present study, a pilot study was used to ascertain the reliability of the instrument which reported a Cronbach's Alpha of .85.

3.5.7 Adolescent risky behaviour questionnaire (ARBQ)

It was adapted from the Youth Risk Behaviour Surveillance System (YRBSS), developed in 1988 by the Centres for Disease Control and Prevention (CDCP) to monitor health risk behaviour that contributes to the leading causes of mortality, morbidity, and social problems among youth and adults in the United States. The YRBSS monitors six categories of behaviour: (a) those that contribute to unintentional injuries and violence; (b) tobacco use;(c) alcohol and other drug use; (d) sexual behaviour that contributes to unintended pregnancy and sexually transmitted disease, including human immunodeficiency virus infection; (e) dietary behaviour; and (f) physical activity. Sexual behaviour that contributes to unintended pregnancy and sexually transmitted disease, including human immunodeficiency virus infection was the portion the scale used. Examples of items included on the scale are *(1) How many different people have you had*

sexual intercourse within the last 12 Months. (2) What kind of contraceptive(s) did you use the first time? The instrument has been extensively used by Nigerian researchers (Ofole and Agokei, 2014) who reported validity index of 0.61.

In the current study, the initial items of 13 were subjected to validity and reliability tests through a pilot study in order to ascertain its suitability for the study. Critical reliability analysis of the original 13 items brought down the number to 9. Further reliability test of the 9 items was also carried out and the results indicated that the scale has a Cronbach's Alpha reliability of 0.73.

3.6. Procedure for data collection

The researcher obtained a letter of identification from the Head of the Department of Special Education for the purpose of identification. She also sought and obtained ethical approval from the UI/UCH Ethics Committee through the Institute for Advanced Medical Research and Training (IAMRAT)with reference number 17/0199. The researcher also obtained permission from UCH APIN HIV clinic (Infectious Disease Institute) for the statistical secondary data on patients with disability treated of HIV and STIs.Approval of the school principals of the selected secondary schools was also sought to involve some of the selected students with visual impairment for the study. The consent letter given at UI/UCH was translated from English to Yoruba.

The instruments were administered to all selected respondents after their willingness to participate has been obtained. The administration of the instruments lasted six weeks.One week was spent in the administration of the instruments in each state. The researcher enlisted the help of four research assistants who were trained to facilitate the administration of the questionnaire. The respondents were informed about the study and their rights regarding participation. The researcher and the research assistants then administer the questionnaire and encouraged the respondents to fill in their response without prejudice. The copies of the questionnaire were collected on the spot.

3.7 Method of data analysis

The data collected in the study were analysed using descriptive statistics of frequency count and percentages and inferential statistics of Pearson Product Moment Correlation and Multiple Regression and t-test. Descriptive statistics was used to analyse the demographic profile of the respondents while the Pearson Product Moment Correlation was used to examine the relationship between the selected independent variables and the dependent variable. Moreover, multiple regression was used to investigate the joint and relative contributions of the independent variables to the prediction of the dependent variables while t-test was used to examine the significance of gender differences in risky sexual behaviour among adolescents with visual impairment. It is worthy to mention here that multiple regression was introduced and employed after the significant relationship had been established to exist between the dependent variable and some of the independent variables used in the study.

CHAPTER FOUR
RESULTS AND DISCUSSION OF FINDINGS

This chapter presents the results and the various findings drawn from the study. The following results presented were based on the research question raised which the study sought to answer.

4.1 Demographic profile of respondents

A total of three hundred and eleven (311) copies of the questionnaire were retrieved from a population of three hundred and seventeen (317) respondents, giving 98% response rate. A statistical product and service solution (SPSS) version 21 was used for the analysis of the demographic profile. Below are the personal characteristics of the respondents.

Table 4.1: Frequency distribution based on gender

Gender	Frequency (F)	Percentage (%)
Male	167	53.7
Female	144	46.3
Total	311	100.0

Source: Field Survey, 2017

Table 4.1 shows the ranking of the respondents according to gender and it is revealed that 167 (53.7%) of the respondents are male while 144 (46.3%) are female students. This implies that male students participated more than their female counterparts in the study. However, gender distribution is graphically represented in Figure 4.1.The pie chart reveals that male respondents are more than their female counterparts in the distribution.

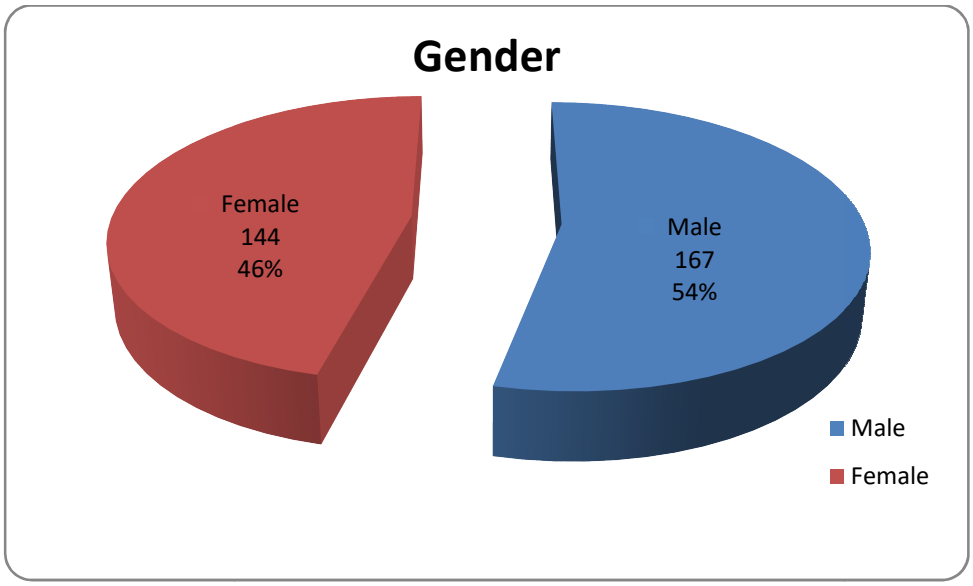

Figure 4.1: Pie chart showing gender distribution

Table 4.2: Frequency distribution based on age range

Age	Frequency (F)	Percentage (%)
9-12 years	10	3.2
13-16 years	128	41.2
17-20 years	135	43.4
21-23 years	38	12.2
Total	311	100.0

Source: Field survey, 2017

Table 4.2 showcases the respondents' age ranges in hierarchical order and it is revealed that between 9 and 12 years are 10 (3.2%) respondents; between 13 and 16 years are 128 (41.2%) respondents; between 17 and 20 years are 135 (43.4%) respondents; between 21 and 23 years are 38 (12.2%) respondents in the distribution respectively. This implies that between 17-20 years are more represented than other age groups in the study. However, age group distribution is graphically shown in Figure 4.2.The bar chart reveals that age group between 17 and 20 years of age is more represented in the distribution.

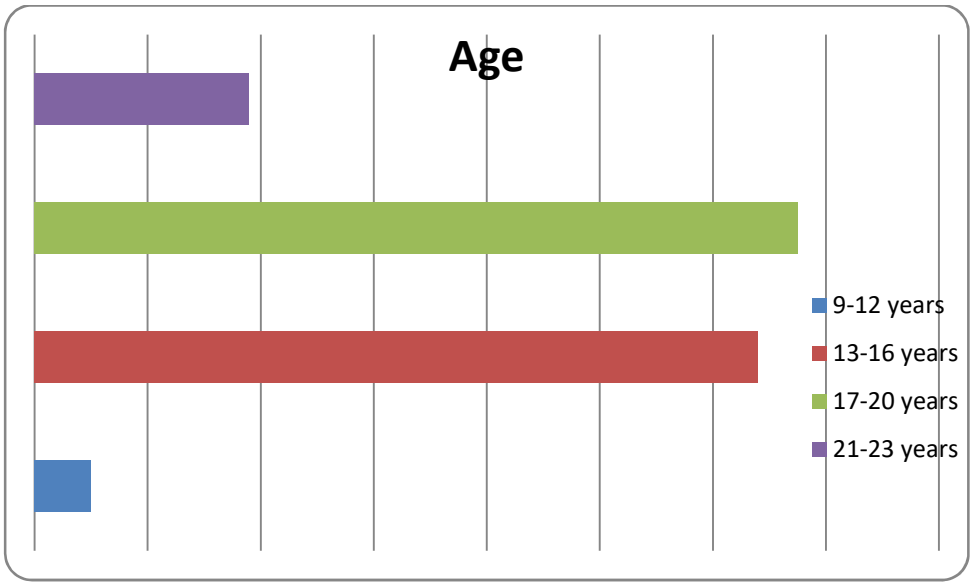

Figure 4.2: Bar chart showing the distribution of age group.

Table 4.3: Frequency distribution based on students' classes

Students Classes	Frequency (F)	Percentage (%)
JSSI	24	7.7
JSSII	35	11.3
JSSIII	40	12.9
SSSI	88	28.4
SSSII	69	22.3
SSSIII	54	17.4
Total	311	100.0

Source: Field survey, 2017

Table 4.3 shows the respondents' classes in thehierarchy and it is revealed that JSS I class has 24 (7.7%) respondents; JSS II has 35 (11.3%) respondents; JSS III has 40 (12.9%) respondents, SSS I class has 88 (28.4%) respondents; SSS II has69 (22.3%) respondents; SSS III has 54 (17.4%) respondents in the distribution. The result implies that SSS I class 88 (28.4%) are mostly represented in this study. Furthermore, classes are graphically illustrated in a Bar chart (figure 3).The bar chart reveals that SSS I class is more represented in the distribution.

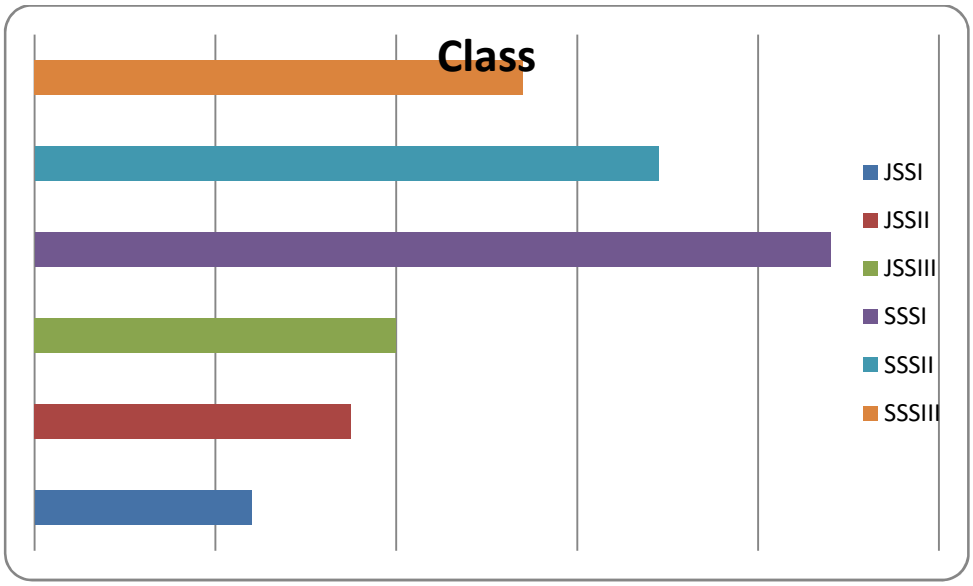

Figure 4.3: Distribution of respondents according to classes.

Table 4.4: Frequency distribution based onrespondents' category of visual impairment

Categorisation	Frequency (F)	Percentage (%)
Total blindness	138	44.4
Low vision	173	55.6
Total	311	100.0

Source: Field survey, 2017

Table 4.4 reveals the respondents' categorisation and it shows that 138 (44.4%) of the respondents experience total blindness, while 173 (55.6%) of the respondents have low vision. This implies that respondents' with low vision participated more than their counterparts with total blindness in this study. This result is further graphically represented in a pie chart (figure 4.4).The pie chart reveals that low vision is more represented in the distribution.

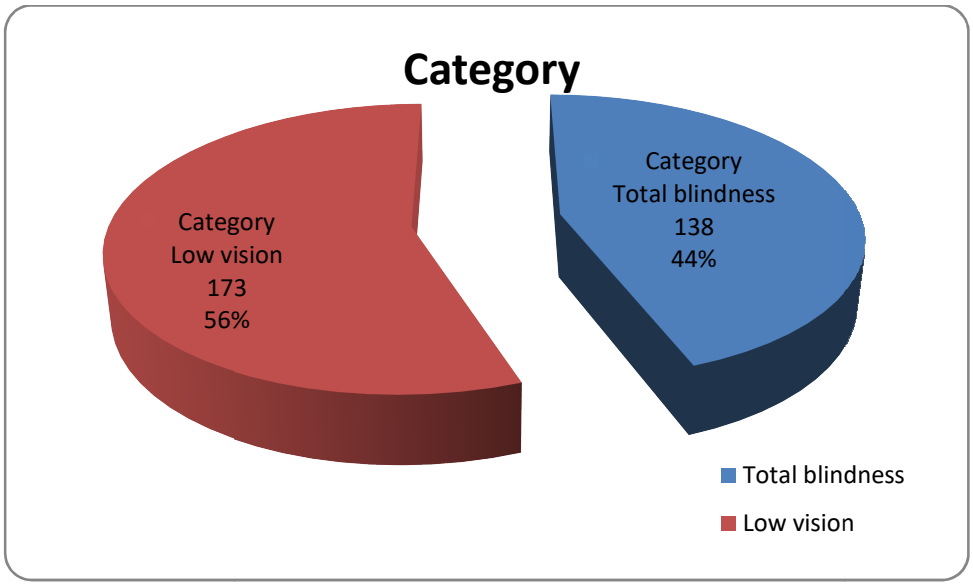

Figure 4.4: Pie chart showing categorisation of respondents according to the nature of visual impairment.

4.2 Answers to research questions

This section consists of the results from the inferential statistics on the account of the five questions raised and answered.

The relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment

Research question one: Is there anysignificant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria?

Table 4.5: PPMC; The relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Variables	N	Mean	St.Dev	Df	R	P	Sig
Risky sexual behaviour	311	16.926	4.494	309	-.094	0.678	NS
Peer pressure	306	39.474	8.996				

**Correlation is significant at 0.05(2-tailed)*

Table 4.5 reveals that there is no significant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment ($r_{(309)} = -0.094$, $p>0.05$). The mean for Risky sexual behaviour were obtained as 16.926 and Standard deviation 4.494. Further, the mean and standard deviation for peer pressure were obtained as 39.474 and 8.996 respectively. Although, the result confirms that a negative relationship exists between them, such a relationship is not a significant one. This thus implies that significant relationship does not exist between peer pressure and risky sexual behaviour among adolescents with visual impairment

The relationship between school climate and risky sexual behaviour among adolescents with visual impairment

Research question two: How significant is the relationship between school climate and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria?

Table 4.6: PPMC; The relationship between school climateand risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Variables	N	Mean	St.Dev	Df	R	P	Sig
Risky sexual behaviour	311	16.926	4.4942	309	.214**	0.032	S
School climate	306	73.977	23.7425				

**Correlation is significant at 0.05(2-tailed)*

Table 4.6 reveals that there is a significant relationship between school climate and risky sexual behaviour among adolescents with visual impairment; ($r_{(309)} = .214^{**}$, $p<0.05$). The mean generated for risky sexual behaviour were obtained as 16.926 and Standard deviation 4.494. Further, the mean and standard deviation for school climate were obtained as 73.977 and 23.7425 respectively. This implies that there is a positive linear relationship between school climate and risky sexual behaviour.

The relationship between parenting styles and risky sexual behaviour among adolescents with visual impairment

Research question three: What is the nature of the relationship between parenting styles and risky sexual behaviour among adolescents with visual impairment in secondary schools in South -western Nigeria?

Table 4.7: PPMC The relationship between parenting styleand risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Variables	N	Mean	St.Dev	Df	R	P	Sig
Risky sexual behaviour	311	16.926	4.4942	309	.084	0.067	NS
Parenting style	306	48.759	9.1404				

**Correlation is significant at 0.05(2-tailed)*

Table 4.7 reveals thatthere is no significant relationship between parenting style and risky sexual behaviour among adolescents with visual impairment; ($r_{(309)} = 0.084$, $p>0.05$). The mean for risky sexual behaviour were obtained as 16.926 and Standard deviation 4.494. The mean and standard deviation for parenting style were obtained as 48.759 and 9.1404 respectively. Althougha positive linear relationship exists between them, such a relationship is not significant enough to be reckoned with. This thus implies that there is no significant relationship between parenting style and risky sexual behaviour among adolescents with visual impairment.

The relationship between emotional intelligence and risky sexual behaviour among adolescents with visual impairment

Research question four: Does emotional intelligence significantly correlate with risky sexual behaviour among adolescents with visual impairment in South -western, Nigeria?

Table 4.8: PPMC; The relationship between emotional intelligenceand risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Variables	N	Mean	St.Dev	Df	R	P	Sig
Risky sexual behaviour	311	16.926	4.4942	309	.244**	0.001	S
Emotional intelligence	306	95.612	28.4771				

**Correlation is significant at 0.05(2-tailed)*

The table (Table 4.8) reveals that there is a significant positive relationship between emotional intelligence and risky sexual behaviour among adolescents with visual impairment; ($r_{(309)} = .244$, $p<0.05$). The mean for risky sexual behaviour were obtained as 16.926 and Standard deviation 4.494. The mean and standard deviation for emotional intelligence were obtained as 95.612 and 28.4771 respectively. This implies that there is significant positive linear association between emotional intelligence and risky sexual behaviour.

The relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment

Research question five: Is there any significant relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria?

Table 4.9: PPMC; The relationship between sexual attitudesand risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Variables	N	Mean	St.Dev	Df	R	P	Sig
Risky sexual behaviour	311	16.926	4.4942	309	.055	0.076	NS
Sexual attitudes	306	64.270	18.0946				

**Correlation is significant at 0.05(2-tailed)*

Table 4.9 reveals that there is no significant relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment; ($r_{(309)} = 0.055$, $p>0.05$). The mean for risky sexual behaviour were obtained as 16.926 and Standard deviation 4.494. The mean and standard deviation for sexual attitudes were obtained as 64.270 and 18.0946 respectively. Although the result indicates that a positive relationship exists between them, such a relationship is not significant. This implies that there is no significant relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment.

4.3 Testing of hypotheses

This section presents the testing of the hypothesesat 0.05 level of significance.

Joint contributions of the independent variables to the dependent variable

$H0_1$: There is no significant joint contribution of the independent variables (environmental factors {peer pressure, parenting style and school climate} and affective factors {sexual attitude, and emotional intelligence}) to the prediction of the dependent variable (risky sexual behaviour) of adolescents with visual impairment in secondary schools in Southwestern Nigeria**.**

Table 4.10: The joint contributions of independent variables (environmental factors {peer pressure, parenting style and school climate} and affective factors {sexual attitude, and emotional intelligence}) torisky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Model	**Sum of squares**	**Df**	**Means Square**	**F**	**Sig.**
Regression	480.996	2	96.199	5.053	.000[b]
Residual	5482.491	288	19.036		
Total	5963.486	293			
R = .284[a]					
R^2 = .081					
Adjusted R^2 = .065					
Std. Error of the Estimate = 4.36308					

*Denotes significant relationship at 0.05 significance level.

Table 4.10 shows that the joint contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitudesand emotional intelligence) to risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria is significant. The result yields a coefficient of multiple regressions R = .284; R^2 = .081and adjusted R-square = 0.065. This suggests that thesefive factors combined account for 6.5% (Adj.R^2= .065) variance in the prediction of risky sexual behaviour among adolescents with visual impairment. This implies that there are significant joint contributions of the independent variables (peer pressure, parenting style, school climate, sexual attitudeand emotional intelligence) to the dependent variable (risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria. The other factors accounting for the remaining variance are beyond the scope of this study. The ANOVA result from the regression analysis shows that there is a significant joint effect of the independent variables on risky sexual behaviour among adolescents with visual impairment, ($F_{(5,288)}$ = 5.053; P<0.05). Hence, the null hypothesis which states that there is no significant joint contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitudesand emotional intelligence) to the prediction of the dependent variable (risky sexual behaviour) of adolescents with visual impairment in secondary schools in Southwestern Nigeria is hereby rejected.

The relative contribution of the independent variables to the dependent variable

$H0_2$: There is no significant relative contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence) to the dependent variable (risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Table 4.11: Multiple regression showing the relative contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitudes and emotional intelligence)towardsrisky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	13.069	2.754		4.745	.000
Peer pressure	-.016	.054	-.019	.298	.766
Parenting style	.028	.052	.035	.549	.583
School climate	.034	.016	.175	2.101	.036
Sexual attitude	.110	.063	.103	1.744	.082
Emotional intelligence	.032	.011	.201	3.003	.003

*Dependent Variable: Risky sexual behaviour; *Denotes significant at P<0.05.*

Table 4.11 reveals the relative contributions of each of the independent variables (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence)torisky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

These independent variables constitute the potent predictors of risky sexual behaviour among adolescents in secondary schools with visual impairment. The result shows that there is asignificant relative contribution of emotional intelligence ($\beta = .201$; $t = 3.003$; $P<0.05$) and school climate($\beta = .175$; $t = 2.101$; $P<0.05$)to risky sexual behaviour among adolescents with visual impairment while the other variables are not significant. Asthis result reveals, the most potent predictor is emotional intelligence followed by the school climate. However, other predictors like peer pressure, parenting style, and sexual attitudeare not significant as predictors of risky sexual behaviour among adolescents with visual impairment.This implies that only emotional intelligence and school climate have significant relative contributions to risky sexual behaviour among adolescents with visual impairment. Thus, the null hypothesis which states that there is no significant relative contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence) to the dependent variable (risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria is hereby rejected.

Significant gender differences in risky sexual behaviour among adolescents with visual impairment

$H0_3$: There is no significant gender difference in risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Table 4.12: T-test summary showing gender differences in risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria

Variable	Sex	N	Mean	Std. Dev	Df	t-value	P	Remark
Risky sexual behaviour	Male	168	16.689	4.7465	309	6.229	.020	S
	Female	143	17.147	4.1452				

Table 4.12 reveals the difference between male and female through their mean scores onrisky sexual behaviour among adolescents with visual impairment. The result shows that a significant difference exists between male and female risky sexual behaviour (t (309) = 6.229, $p<0.05$). This implies that female adolescents (mean=17.147) display a higher tendency to engage in risky sexual behaviour than their male counterparts (mean= 16.689).Hence the null hypothesis stating that there is no significant gender difference inrisky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria is hereby rejected.

4.4: Summary of Findings

RQ1: Is there anysignificant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary schools in South-western Nigeria?

Findings: Findings showed that there was no significant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria.

RQ2: How significant is the relationship between school climate and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria?

Findings: Findings reported the existence of significant positive relationship between school climate and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria.

RQ3: What is the nature of relationship between parenting style and risky sexual behaviour among adolescents with visual impairment in secondary schools in South-western Nigeria?

Findings: Findings indicated that there was no significant relationship between parenting style and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria.

RQ4: Does emotional intelligence significantly correlate with risky sexual behaviour among adolescents with visual impairment in secondary schools in South- western Nigeria?

Findings: It was reported by the findings of the study that there was a significant positive relationship between emotional intelligence and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria.

RQ5: Is there any significant relationship between sexual attitude and risky sexual behaviour among adolescents with visual impairment in secondary schools in South-western Nigeria?

Findings: It was shown by the findings of the study that there was no significant relationship between sexual attitude and risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern, Nigeria.

$H0_1$: There is no significant joint contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence) to the prediction of the dependent variable (risky sexual behaviour) of adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Findings: Findings revealed that there was a significant joint contributing effect of the factors (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence)on risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

$H0_2$: There is no significant relative contribution of the independent variables (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence)to the dependent variable (risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Findings: Findings revealed that there was significant relative contribution of emotional intelligence and school climatetowards the risky sexual behaviours among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

$H0_3$: There is no significant gender difference to risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.

Findings: Findings revealed that there was a significant difference in male and female risky sexual behaviour among adolescents with visual impairmentin secondary schools in Southwestern Nigeria.

4.5 Discussion of findings

Research question one attempted to determine the significant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.Findings revealed that there was no significant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria. This finding contradicts the findings of Lansford, Dodge, Fontaine, Bates and Pettit, (2014) in their study which was carried out on alcohol use, smoking, drug use and delinquent behaviour and which found that peers have a significant influence on young people's behaviour.Similarly, findings revealed that peer pressure reinforces or changes individual attitudes and behaviour regarding sexual activities resulting in the tendency of adolescents to engage in risky sexual behaviour activities (Albarracin, Kumkale and Johnson, 2004).

A dissertation by Low (2005) which used structural equation modelling to examine whether friends' characteristics were related to participants' sexual behaviour concurrently and over a one-year period and whether participants' sexual behaviours predictive of changes in friendship characteristics over time. The study found that characteristics of close friends were associated with the participants' current sexual behaviour, but not with changes in sexual behaviour over time. Additionally, having friends with more dating involvement and having friends with more social approval for sexual involvement was predictive of more frequent sexual behaviour over time (Low, 2005). Accordingly, there is a confirmation of the validity of peer on sexual risky behaviour in a cross-sectional study by Amsale and Yemane (2012), employing a logistic regression analysis to examine factors related to sexual behaviour using the ecological framework. It was discovered in

the study that risky sexual behaviour was significantly and very strongly associated with the perception of peers' involvement in sexual intercourse.

Lashbrook (2000) provided one plausible explanation of how peers exert their impacts on adolescent risk-taking. Specifically, he demonstrated that older adolescents may attempt to avoid negative emotions, such as feelings of isolation and inadequacy, by participating in risky behaviour with peers. Recent findings suggested that the answer is not straightforward. Brady, Dolcini, Harper, and Pollack (2009) found that adolescents with low social support from peers maybe prone to engaging in sexual risk-taking as a response to stress, whereas adolescents with high peer support may engage in sexual risk-taking due to peer socialization of risk. This is what gives the peer group the predictive strength often found in research today.

However, the finding also negates the submission of Blum and Mmari (2005) that a positiverelationship exists between the two factors with evidence from an increase in pregnancy risk. While corroborating the finding of Blum and Mmari (2005), Lashbrook (2000) found that older adolescents most times attempt to avoid negative emotions, such as feelings of isolation and inadequacy, by participating in risky sexual behaviour with peers. Brady, Dolcini, Harper, and Pollack (2009) also found that adolescents with low social support from peers maybe prone to engaging in sexual risk-taking as a response to stress, whereas adolescents with visual impairment with high peer support may engage in sexual risk-taking due to peer socialization of risk.

However, Akaneme and Aye (2018) exerted that the influence peers can be bi-directional. Adolescents with positive peer pressure showed lowered risky sexual behaviour while, those that are engaged with negative peer pressure strongly exhibit disruptive and risky sexual behaviour. Theories have shown that the effect of peer influence can be positive or negative. Peers share a lot of information which can be influential in adolescents' adoption of behaviour. The lack of relationship between risky sexual behaviour and peer pressure may be down to the fact that visually impaired draws little friends compared to other adolescents. Having multiple friends have been linked to the odds of risky behaviours which also include sexual practices.

Research question two investigated the relationship between school climate and risky sexual behaviour among adolescents with visual impairment in Southwestern in Nigeria.The result of the study revealed a positive relationship between school climate and risky sexual behaviour among adolescents with visual impairment. This finding corroborates the submission of Gregory et al. (2010) who found that consistent enforcement of school discipline (structure) and availability of caring adults (support) was associated with school safety. Similarly, Klein, Cornell and Konold (2013) found that positive school climate was associated with lower student risk behaviour. Guo (2012) found that the teachers' work environment, which may be considered as an indicator of teachers' relationships with each other and school administrators, fully mediated the path from a whole school character intervention to school climate change.

This indicates the critical foundational role of positive adult relationships for a positive school climate. A growing body of research suggests that positive school climate is a related to effective risk prevention and health promotion efforts as well as effective teaching and learning (Rand Corporation, 2004; Wang, et. al., 2003;Najaka, et. al., 2002; Cohen, 2001). Recent research reviews have shown that effective risk prevention and health promotion efforts are correlated with safe, caring, participatory and responsive school climate (Catalano, et. al. 2002; Greenberg, et. al. 2003; Berkowitz and Bier, 2005).

Also supporting this position was McEvoy and Welker (2000) whodemonstrated that positive interpersonal relationships and optimal learning opportunities for students in all demographic environments can increase achievement levels and reduce the maladaptive behaviour. Taylor and Tashakkori (1995) also found that a positive school climate is a protective factor for boys and may supply high-risk students with a supportive learning environment, yielding a healthy development as well as preventing antisocial behaviour.As noted by Freiberg (2000), the interaction between the various school and classroom climate factors creates fabrics of support that enables all actors in a school system to teach and learn at optimum levels. Positive school climate yields positive educational and psychological outcomes for students and teachers. Impliedly, a negative climate can prevent optimal learning and development (Freiberg, 2000; Kuperminc, Leadbeater and Blatt, 2001; Manning and Saddlemire, 2004).

The finding of O'Malley et al. (2012) also supports the finding of the present study by maintaining that students who perceive their school climate to be positive are also less likely to engage in high-risk behaviour. This finding is likewise in tandem with the position of Freiberg (2000) who noted that the interaction of various school and classroom climate factors can create a fabric of support that enables all members of the school community to teach and learn at optimum levels. Generally, school climate is said to reflect the schools' life experience of the students, the school personnel and the parents socially, emotionally, civically, and ethically as well as academically. Over the past two decades, research studies from a range of historically disparate fields (for example, risk prevention, health promotion, moral education, character education, mental health, and social-emotional learning) have identified research-based school improvement guidelines that converge predictably to promote safe, caring, responsive and participatory schools (Centres for Disease Control and Prevention, 2009).

Positive and sustained school climate is associated with positive child and youth development, effective risk prevention and health promotion efforts, student learning and academic achievement, increased student graduation rates, and teacher retention. Recent research suggests that positive school climate is associated with reduced aggression and reduced violence as well as reduced bullying behaviour and sexual harassment regardless of sexual orientation (Attar-Schwartz, 2009). Taylor and Tashakkori (1995) revealed that positive school climate promotes job satisfaction for school human resources. Attending a new school can be frightening for students and this apprehension can adversely affect students' perceptions of their schools' climate and learning outcomes. Hence, the students' interest is critical to their transitioning from one school level to another. Consequently, providing a supportive school climate for students is important for a smooth and easy transition to a new school (Freiberg, 2000).

School has been underscored as an important factor for adolescents' behaviour. Apart from home, school is the closest environment for school adolescents. Most schools in Nigeria have rules and regulations guiding conducts of their students. Some schools, especially boarding school, place restriction to mingling of male and female by separating their abode. This is further strengthened by placing significant punishment on sexual harassment and bullying among others. However, Nigerian schools have not done enough

in establishing sex education into curriculum. This is the most plausible considering the need to promote moral and healthy living among teeming adolescents' populace.

Research question three examined the nature of relationship existing between parenting styles and risky sexual behaviour among adolescents with visual impairment in Southwestern Nigeria. The finding showed that there was no significant relationship between parenting styles and risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria. This finding corroborates findings from Ang and Groh (2006) and that of Utti (2006)who both maintained that parenting styles have both positive and negative connotations in the literature because of the behavioural outcomes of adolescents and children. In contrast, findings conducted by Simons and Conger (2007) showed that the positive effects of authoritative parenting are amplified when both parents engage in an authoritative parenting style. They added that the authoritative parenting style is associated with the lowest levels of depression and the highest levels of school commitment among adolescents. This implies that having at least one authoritative parent fosters better outcome than family parenting styles that do not include an authoritative parent.

Okpako (2004) notes that adolescents who are well-enlighten on sexual behavioural issues will always remain a source of joy and happiness to their families. On the other hand, the neglected adolescents gradually become sex addicts, aggressive, restive, rapist and the like. The required parental monitoring and control for adolescents' development may be hindered due to parents' serious involvement in economic activities to meet up with family financial commitments(Ang and Goh, 2006).Research reports found that adolescents whose parents exhibited warmth and control while permitting their children to express their own views are likely to express pride and positive feelings about their ethnicity. Darling (2007) reports that parenting style predicts a child's well-being in the domains of social competence, academic performance, psychosocial development and risk sexual behaviour. Children and adolescents whose parents are authoritative rate themselves and are rated by objective measures as more socially and instrumentally competent than those whose parents are non-authoritative. This competency will enhance and promote proper growth and development of adolescents in their environment.

These research findings suggest that regardless of the gender of the parent, the presence of even one authoritative parent is beneficial for adolescent outcomes (Bronte-Tinkew, Moore and Carrano, 2006). In like manner, the finding agrees with the results of Baumrind, Larzelere, and Owens (2010) who found that verbal hostility and psychological control were the most detrimental of the authoritarian-distinctive, coercive power-assertive behaviour. Adolescents from most Caucasian authoritarian families have been found to exhibit poor social skills, low levels of self-esteem, and high levels of depression (Milevsky, Schlechter, Netter and Keehn, 2007). Similarly, Luyckx, Tildeley, Soenens, Andrews, Hampson, Peterson and Duriez, (2011)found that by grade 12, adolescents with uninvolved parents drank alcohol almost twice as much and smoked twice as much as their peers that lived in authoritative households.

Odebumi (2007) established that a large percentage of all sexual risk-taking adolescents come from homes that lack normal parental love and care. Attention, love and warmth go a long way in assisting adolescents' emotional development and adjustment. Adolescents require parental love, care, warmth and serious attention to be able to adjust adequately in the environment in which they find themselves. Parents have major roles to play in the adjustment process of adolescents. The behavioural problems of most deviants are rooted in their homes (Atkinson, 2004). Evidence suggests that when the communication on sexual issues between the parents and the adolescent is warm, it creates a healthy environment for the development of the adolescent. Adolescents exhibiting traits of friendliness, cheerfulness, positive emotions and good maturity traits show that they come from homes where they are accepted and loved (Otuadah, 2006).

Adalbjarnardottir and Hafsteinsson(2001) maintained that adolescents who perceived their parents as uninvolved used more drugs compared to adolescents with visual impairment who perceived their parents as authoritative.One explanation for this phenomenon might be that sexually active adolescents who were nurtured by harsh parents may decline or disregard any information concerning the prevention of sexual activity offered by their parents (Meschke, Bartholomae and Zentall, 2002). In some cases, parents may not give any of such information.Okorodudu and Okorodudu(2003), however, affirmed that adolescents seek such information from their peers, particularly as peers turn out to be a vital part of their life.Nonetheless, the persistence aspects of

parentalchild-rearing styles such as strong discipline, parental disharmony, rejection of the child and inadequate involvement in the child's activities are potential factors for sexual risk behaviour among adolescents.

Okpako (2004) notes that adolescents who are well-enlighten on sexual behavioural issues will always remain a source of joy and happiness to their families. On the other hand, the neglected adolescents gradually become sex addicts, aggressive, restive, rapist and the like. The required parental monitoring and control for adolescents' development may be hindered due to parents' serious involvement in economic activities to meet up with family financial commitments(Ang and Goh, 2006). Such parents spend little or no time at home to communicate with their children on sexual risk issues. Adolescents are likely to have a lower efficacy in negotiating contraceptive use or refusing sex with their partners, thus, increasing their exposure to pregnancy and sexually transmitted diseases. DiClemente, et al.(2001) and Loromeke(1997) are of the view that parents' communication on sexual risk issues with their children occur according to the training they also received from their own parents. For instance, the majority of parents who grew up in a strict environment end up creating such for their own offspring.

In addition, permissive or laissez-faire parenting devoid of definite or precise goals plays docile part in the raising of children (Ang and Groh, 2006; Utti, 2006). Okorodudu (2010) observes that adolescents from permissive parenting are more vulnerable to delinquent behaviour, risky sexual behaviour and a host of other health complications than their counterparts from the homes of other parenting styles. Adolescents raised by authoritative parents are less vulnerable to externalizing behaviour and precisely, there are less likely to engage in at-risk behaviour than adolescents with permissive parents (Steinberg and Silk, 2002; Gonzalez, Holbein and Quilter, 2002). Thus, the occurrence of risky sexual behaviour among adolescents living with disabilities, especially those with visual impairment seems to relate to the styles these adolescents are being reared from home. This fact therefore implies that parenting style has the potential to influence cognitive and affective domain of adolescents living with or without disabilities.

Steinberg and Silk (2002) and Gonzalez, Holbein and Quilter (2002) are in agreement that the authoritative parenting style fosters adolescents' positive well-being. Adolescents with authoritative parents are less prone to externalizing behaviour, and

specifically are less likely to engage in drug use than those with uninvolved parents (Steinberg and Silk, 2002; Gonzalez, Holbein and Quilter, 2002). Recent findings suggest that the positive effects of authoritative parenting are amplified when both parents engage in an authoritative parenting style (Simons and Conger, 2007). The study by Simons and Conger (2007) further indicated that having at least one authoritative parent fosters better outcomes than family parenting styles that do not include an authoritative parent. Adolescents whose parents are both authoritative or whose mother alone is authoritative report higher well-being, such as higher self-esteem and life-satisfaction, than participants with no authoritative parent (Milevsky, Schlechter, Klemand Kehl, 2008). These research findings suggest that regardless of the gender of the parent, the presence of even one authoritative parent is beneficial for adolescent outcomes (Bronte-Tinkew, Moore and Carrano, 2006).

Permissive parents behave in an affirmative manner toward the adolescent's impulses, desires, and actions while consulting with the adolescent about family decisions (Baumrind, and Owens, 2010).Parents who are permissive do not set rules; they avoid engaging in behavioural control while setting but few behavioural expectations for adolescents (Baumrind et, al, 2010). They show a steep decrease in monitoring once their children attain adolescence with increased levels of externalizing behaviour (Luyckx et al., 2011). Researchers have reported that adolescents from permissive families are more prone to substance use, school misconduct with less exposure to positively oriented school behaviour compared to adolescents from authoritative or authoritarian families (Querido, Warner and Eyberg, 2002).

Permissive parenting also contributes to low self-esteem and extrinsic motivational orientation among adolescents (Ginsburg and Bronstein, 1993). Recent findings also revealed that permissive parenting style effectively predicts adolescents' delinquency (Okorududu, 2010). The uninvolved parents on the other hand do not engage in structure or control with their children and often there is a lack of closeness in the parent-child dyad; therefore, adolescents of uninvolved parents often engage in more externalizing behaviour (Hoeve, Dubas, Eichelsheim, van der Laan, Smeenk and Gerris, 2009). Studies have established a positive association between uninvolved parenthood and delinquent acts like from vandalism and petty theft to assault and rape (Hoeve et al., 2009).In relating

the result of the finding to Nigerian context, the insignificant relationship between parenting style and risky sexual behaviour might be indicating the cultural justification of parenting. Parents in Nigeria are custodian of moral values. Hence, styles of parenting, whether authoritative or laissez faire hold the same target the same outcome in zero tolerance for sexual practice.

Research question four examined the correlation between emotional intelligence and risky sexual behaviour among adolescents with visual impairment in Southwestern Nigeria.The results of this study found that apositive relationship existed between emotional intelligence and risky sexual behaviour among adolescents with visual impairment; therefore, there was a significant relationship between emotional intelligence and risky sexual behaviour among adolescents with visual impairment. This finding corroborates the position of Bracket, Warner and Mayer (2004) who found that adolescents with lower emotional intelligence reported having poor quality peer relations, suggesting that individuals with low emotional intelligence may have trouble establishing meaningful social interactions. Furthermore, adolescents with lower emotional intelligence demonstrated significantly more involvement in potentially harmful behaviour such as illegal drug dealing, excessive consumption of alcohol and engagement in promiscuous behaviour.

A study by Bracket et al.(2004) also supported observable patterns of correlation among lower emotional intelligence and larger amounts of alcohol consumption, illegal drug use and involvement in deviant behaviour. Corroborating this, Smith (2001) posits that isolated children or those rejected by peers suffer the loss of self-esteem and other emotional distresses, tend to dislike school and are at risk of a wide range of destructive personal and interpersonal outcomes, including substance abuse, gang involvement, teen pregnancy, violence at school and risky sexual behaviour.

In agreement, Smith (2001) opines that children who are isolated or rejected by peers suffer loss of self-esteem and other emotional distress, tend to dislike school and are at risk for a wide range of destructive personal and interpersonal outcomes including substance abuse, gang involvement, teen pregnancy, violence at school and risky sexual behaviour. Studies, as quoted by Petrides, Frederickson and Furnham (2004), have shown

that pupils with low emotional intelligence scores are significantly more likely to have been expelled from their schools and the findings further suggested that emotional intelligence is relevant to scholastic achievement and deviant behaviour at school, especially for disadvantaged and vulnerable adolescents.

Empirical evidence abounds to show that students with limited skills related to understanding and recognizing emotions had a higher challenge adjusting at school compared topeers with a wide spectrum of emotional skills (Kerr, Johnson, Gans and Krumrineet, 2004). Emotional intelligence, therefore, assumes a buffer against risk-taking. In a study by Ogunsanwo, Mojisola, Ayodele and Kolawole (2014), it was revealed that the sexual attitude and behaviour of adolescents is strongly affected by psychological factors like locus of control and emotional intelligence. This finding corroborates an earlier study by Ogunleye and Oke (2012) which demonstrated poor psychological well-being as a predictor of early onset of sexual activity and unprotected sex, while a good psychological well-being is positively associated with less sexual risk behaviour.

Moreover, the study by Ogunsanwo, Mojisola, Ayodele and Kolawole (2014) on Nigerian adolescents showed that the sexual attitude or behaviour of adolescents is strongly affected by psychological well-being factors such as locus of control and emotional intelligence. The present study is in agreement with the work of Ogunleye and Oke (2012) which claimed that poor psychological well-being predicts both early onset of sexual activity and unprotected sex, while good psychological well-being is positively associated with less sexual risk behaviour. Similarly, Panithee, (2012) found that visually impaired adolescents with higher emotional intelligence also reported significantly higher perception of parenting care style, whereas there was a significant negative association between emotional intelligence and overprotective parenting style.

Research question five sought to know if there was any significant relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment in Southwestern Nigeria.Findings revealed that there was no significant relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment. This finding contradicts the view of Cross and Morgan (2003) who established a significant difference in sexual attitudes and behaviour between the present

and the past generations. They blamed the media for the changing sexual attitudes and behaviour of students by claiming that students of nowadays receive more sex education through life orientation, peer education and through media, for example, TV programmes such as Soul Buddies, Soul City, and so on. Cross and Morgan (2003) argue that sexual attitudes and behaviour of college students have not changed in recent time despite the constant sex education.Levinson, Jaccard and Beamer (1995) in their study, examined adolescents' attitudes towards casual sex and their engagement in casual sex behaviour. It was revealed that adolescents tended to hinge their self-esteem on issues related to sexual attitude and behaviour, for example, by internalizing their attitudes and behaviour regarding casual sex and that they held increased positive attitudes regarding casual sex.

Moreover, this state of affair has resulted in a generation of youth who engages in sexual experimentation earlier than ever before, who dangerously combines alcohol with sex, and who accesses sex or sex information 24 hours a day with just the click of a mouse. Similarly, Chireshe et al. (2007) found that the majority of the respondents viewed men as initiators of the sexual encounters. This situation puts women who are visually impaired at greater risk of contracting HIV. As such, there is a need to empower women about safe sex with their sexual partners. Also, Mwaba and Naidoo (2005) found that half of the respondents used in their study reported having sex within 12 months of their arrival on campus and 8 percent indicated that they had been coerced into having sex by their partners. Cong et al. (2006) found that condoms were never or were rarely used by 35 percent of sexually active students of both genders. Pregnancy and induced abortion were each experienced by about 10 percent of sexually active female students and the female partners of male students. The same study found that about 1.5 percent of sexually active students with visually impaired of both genders was diagnosed with an STI. In a similar vein, a study in Nigeria carried out by Abdulraheem and Fawole (2009) showed that young college students were significantly sexually active (74 percent) and had multiple sexual partners (66.4 percent); and that only 38.1 percent used condoms always during sexual intercourse.

Toyin, Aderemi, Pillay, Tonya and Esterhuizen (2013) corroborated this position by maintaining that people with disabilities were significantly more likely to have reported

inconsistent condom use with their constant and casual sexual partners compared with non-disabled individuals. It is acknowledged that sexual attitude may also be affected or influenced by some of the factors found to be responsible for the risky sexual behaviour of adolescents such as parents, teachers, peers and media sources (Abrahamson, Baker and Capsi, 2002; Olson, Straut and Stank, 2001). Research reports show discrepant findings of personal view on the sexuality of young people and factors that preempt such attitudinal roles (Adamu, Mulatu and Si, 2003; Idoko, Muyiwa and Agoha, 2015). In confirmation of the relatedness of sexual attitude and risky sexual behaviour among adolescents with visual impairment,a study conducted by Toyin, Aderemi, Pillay, Tonya and Esterhuizen, (2013) among the disabled and non-disabled individuals on attitude towards safe sex revealed that young people with disabilities reported non-consistent use of condom with their constant and occasional sexual partners compared to non-disabled individuals. Other study revealed that age, gender, religiosity, family type, parental care or protection and maternal career/protection jointly predicted sexual depression and sexual preoccupation negatively while maternal protection independently predicted sexual preoccupation negatively. Also, family type jointly predicted sexual depression positively (Idoko *et al.*, 2015). Furthermore, Kindi, Mweru and Kinai (2009) as well as Toyin *et al.* (2013) contend that adolescents with visual impairment are most likely to have wrong notions about adolescent sexuality and risky sexual behaviour because they have less access than their sighted peers to information on sexual reproductive health, risky sexual behaviour and its attendant consequences. As a result, their negative attitude towards their sexual reproductive health maybe as a result of wrong notions and lack of information.

Establishing attitude and sexual risky behaviour among the visually impaired,Williams and Aderanti (2011) employed a descriptive survey design to investigate the influence of attending church- owned and government-owned universities on sexual attitude and risky sexual behaviour of emerging youths. The findings indicated a social assumption as well as an empirical association between the variables and showed that religiosity was a potent gatekeeper of certain behaviour which may include sexual attitudes and risky behaviour of individuals. A total of 200 randomly selected students were constituted into two study groups. Findings implicated religiosity as having a significant influence on sexual attitudes. However, no significant influence was revealed

with respect to riskysexual behaviour in both groups. The study also showed a significant difference in religiosity, sexual attitudes and riskysexual behaviour among the two groups. It was concluded that religious participation in schools should be done in such a way that it does not infringe on the fundamental rights of the students. Promotion of academic excellence was identified as a positive strategy to divert students' attention from riskysexual behaviour.

Corroborating evidence on the relationship between attitude and sexual risky behaviour among adolescents, Ningbo, China, Cong et al. (2006) in their study conducted among undergraduate students of two universities, observed that, condoms were never or were rarely used by 35percent of sexually active male and female students. About 10% of sexually active female students and their male student partners had experienced pregnancy and induced abortion. The study further revealed that about 1.5 percent of sexually active students of both genders were diagnosed with an STI. In the similar Nigerian-based study, Abdulraheem and Fawole (2009) discovered that students in a university were significantly sexually active (74percent) and having multiple sexual partners (66.4percent), while only 38.1percent devotedly used condoms for sexual intercourse.

Hypothesis one sought to find out if there were significant joint contributions of the independent variables (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence) to the prediction of the dependent variable (risky sexual behaviour) of adolescents with visual impairment in secondary schools in Southwestern Nigeria.Findings revealed that there was a significant joint contributing effect of the factors (peer pressure, parenting style, school climate, sexual attitude and emotional intelligence)onrisky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria. This finding supports the view of Gardner and Steinberg (2005), who carried out an experimental study titled "Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood". Their results indicated that (a) risk-taking and risky decision making decreased with age; (b) respondents took more risks, focused more on the benefits than on the costs of risky behaviour, and made riskier decisions when in peer groups than alone; and (c) peer effects

on risk-taking and risky decision making were stronger among adolescents and youth than among adults.

This finding maintained that adolescents are more inclined toward risky behaviour and risky decision making than adults and that peer pressure played an important role in explaining risky behaviour during adolescence (Gardner and Steinberg, 2005). However, findings from Lansford, Dodge, Fontaine, Bates and Pettit, (2014) in their study on alcohol use, smoking, drug use and delinquent behaviour reported that peers have a significant influence on young people's behaviour and that adolescents tend to socialize with people who have similar behavioural patterns. This position was also supported by Prinstein, Boergers and Spirito (2001) who maintained that adolescents who werereported to engage in behaviour like substance use, violence or aggressiveness and attempted suicide also pressurized their friends to engage in similar behaviour. During adolescence, peer factor like the perception of risky sexual behaviour has been found to be related to adolescents' risky sexual behaviour as adolescents tend to take up similar behaviour (Cavanagh, 2004; Prinstein, Meade and Cohen, 2003). Although large evidence suggests a positive relationship between adolescents' perception of peer's sexual behaviour and their own sexual experience, it is not known whether adolescents are projecting their own behaviour to their peers or whether once they are initiated into sexual activity, they tend to associate with others whom they perceive to be sexually active (Podhisita, Xenos and Varangrat, 2001).

Hypothesis two sought to determine the relative contributions of the independent variables (peer pressure, parenting style, school climate, sexual attitudes and emotional intelligence) to the dependent variable (risky sexual behaviour) among adolescents with visual impairment in secondary schools in Southwestern Nigeria.Findings revealed that there was significant relative contributions of emotional intelligence and school climate risky sexual behaviour among adolescents with visual impairment. This finding supports the submission of Manning and Saddlemire (2004) who described aspects of school climate to include trust, respect, mutual obligation, and concern for others' welfare have powerful effects on educators' and learners' interpersonal relationships as well as learners' academic achievement and overall school progress. They maintained that what children

learn about themselves in school through interactions is equally important as the academic knowledge they receive. They were of the view that if school climate is positive, it can provide an enriching environment both for personal growth and academic success.

This position is also in tandem with the submission of O'Malley et al. (2012) who explained that students who perceive their school climate to be positive are also less likely to engage in high-risk behaviour. Moreover, quite a number of studies have established that a positive school climate is associated with reduced aggression and violence (Brookmeyer, Fantiand Henrich, 2006; Goldstein, Young and Boyd, 2008; Gregory, et al., 2010) and that it also reduced bullying behaviour (Meraviglia, Becker, Rosenbluth, Sanchez and Robertson, 2003; Kosciw and Elizabeth, 2006) and sexual harassment, regardless of sexual orientation (Attar-Schwartz, 2009). Panithee's (2012) study found a significant positive association between parents' quality of life and adolescents' emotional intelligence was observed. Additionally, it was found that, as emotional intelligence was positively associated with parenting care style, overprotective parenting style was also negatively correlated with emotional intelligence.

Bracket, Warner and Mayer (2004) found that adolescents with lower emotional intelligence reported having poor quality peer relations, suggesting that individuals with low emotional intelligence may have trouble establishing meaningful social interactions. Furthermore, adolescents with lower emotional intelligence demonstrated significantly more involvement in potentially harmful behaviour such as illegal drug dealing, excessive consumption of alcohol and engagement in promiscuous behaviour. In agreement, Smith (2001) opines that children who are isolated or rejected by peers suffer loss of self-esteem and other emotional distress, tend to dislike school and are atrisk of a wide range of destructive personal and interpersonal outcomes, including substance abuse, gang involvement, teen pregnancy, violence at school and risky sexual behaviour.

In another study that looked at the relationships between maternal parenting style and adolescent sexual behaviour in a sample of 253 British adolescent-mother dyads, parenting style was found to be directly associated with the delay of the first sexual experience for adolescents between the age of 15-16 years. However, for the older adolescents, this was not true (Taris and Semin, 1998).Similarly, researchers controlled for several mother-related variables and found that having an authoritative father was

associated with positive outcomes among adolescents (Bronte-Tinkew, Moore and Carrano, 2006). In another study, researchers found that having an uninvolved mother was associated with significantly worse outcomes than families with an uninvolved father (Simons and Conger, 2007).

Hypothesis three sought to determine significant gender difference in risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern Nigeria.Findings revealed that there was a significant difference in male and female risky sexual behaviour among adolescents with visual impairment. This finding negates the findingof a study conducted by Chireshe et al. (2007) that there was no difference in the perceived male-female attitudinal roles in intimate relationships between either parties of students from two universities in Zimbabwe. Two-thirds of the respondents viewed the ages 18 to 21 years as an appropriate period to have sex, 65 percent approved of sex before marriage while over 80 percent of the respondents reported that they would refuse to have sex if their partner was unwilling to use a condom. Chireshe et al., (2007) study also found that a majority of respondents practice safe sex and are aware of the consequences of having unsafe sex. Similarly, Idoko Muyiwa and Agoha(2015) found that age, gender, religiosity, family type, parental care/protection and maternal career/protection jointly predicted sexual depression, sexual preoccupation negatively; maternal protection independently predicted sexual preoccupation negatively; family type jointly predicted sexual depression positively. Bensley et al. (2000) also found that childhood physicalabuse was associated with a three-fold increase in HIV-risk behaviour in men but not in women in adulthood. This implies that adolescent male with a history of childhood physical abuse may be especially vulnerable to and at heightened risk of engaging in risky sexualbehaviour during adolescence. Direct effects from physical abuse to risky sexual behaviour in boys may indicate that physically abused boys may be exposed to hyper-sexualized models of masculinity, leading to risky sexual behaviour, or may use sex as a compensatory strategy to establish a masculine identity as a response to prior abuse and vulnerability.

Studies have demonstrated a higher prevalence of conduct disorder in males than in females (American Psychiatric Association, 2013; Berkhout et al., 2011). This

includesdisorders of childhood and adolescence usually characterized by a pattern of behaviour that violates social norms or the rights of other persons. Young persons with conduct disorder engage in a range of violent or deviant behaviour such as aggression, destruction of property, deceit, theft, and serious violation of rules (for example, running away from home) (American Psychiatric Association, 2013). Holliday, Ewing, Storholm, Parast and D'Amico (2017) in their study found out that conduct disorder symptoms is stronger or is only present among females. While these results or observations do not fully support the broader category of "sexual risk behaviour" as a female-specific manifestation of conduct disorder, the association between conduct disorder symptoms and certain outcomes in number of partners in the past three months and use of alcohol or other drugs (AOD) use before sex was significant among males. Findings indicated that females with conduct disorder may be at heightened risk of participating in many of such behaviour. These conflicting findings prompted this research to include gender as one of the moderating variables that were verified in the study.Widman, Choukas-Bradley, Helms and Prinstein (2016) in their study on Adolescent Susceptibility to Peer Influence in Sexual Situations, found out that in total, 78% of youth provided more risky response in the chat room than thosein pretest. The most robust predictor of this change was gender, with boys significantly moresusceptible to peer influence than girls. Significant interactions were also noted with greatersusceptibility among boys with later pubertal development and African-American boys.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the findings, conclusion, recommendations, and limitations of the study and contributions to knowledge as well as suggestions for further studies.

5.1 Summary

The study employed the acceptable format of five chapters recommended by the University of Ibadan; beginning with the first chapter which is the general introduction up to the fifth chapters, with the first chapter highlighting the introduction of the study and its background. The study comprehensively reviewed past and recent related literature on the independent variables (peer pressure, school climate, parenting style, emotional intelligence and sexual attitude respectively) and dependent variable (risky sexual behaviour of adolescents with visual impairment). Also, detailed review of concepts such as environmental and affective factors among others was extensively undertaken. The review served as an anchor point to the study in that it exposed the researcher to critically trace the antecedent and lapses which the present study filled. Theoretical framework and empirical findings were critically reviewed. A conceptual model and appraisal of literature guiding future research like the present one were also included.

The study employed the use of descriptive survey research design of correlational type. A total of 311 students comprising adolescents with visual impairment in secondary schools in Southwestern, Nigeria made up the respondents used for the data collection and analysis. The data collected from the study were thoroughly analysed using descriptive statistics, Pearson moment correlation coefficient (PPMC), multiple regressions analysis and t-test at 0.05 level of significance. The findings of this study revealed that:

i. There was no significant relationship between peer pressure and risky sexual behaviour among adolescents with visual impairment in secondary school in Southwestern, Nigeria.

ii. A positive relationship existed between school climate and risky sexual behaviour among adolescents with visual impairment.

iii. There was no significant relationship between parenting style and risky sexual behaviour among adolescents with visual impairment in secondary school in Southwestern Nigeria.

iv. A positive relationship existed between emotional intelligence and risky sexual behaviour among adolescents with visual impairment.

v. The relationship between sexual attitudes and risky sexual behaviour among adolescents with visual impairment was not significant

vi. There was a significant joint contributing effect of the factors (school climate and emotional intelligence) on risky sexual behaviour among adolescents with visual impairment in secondary school in Southwestern Nigeria. The two factors combined accounted for 65% variance in the prediction of risky sexual behaviour among adolescents with visual impairment.

vii. There was a significant relative contribution of emotional intelligence and school climate towards risky sexual behaviours among adolescents with visual impairment. The most potent factor was emotional intelligence followed by the school climate.

viii. A significant difference existed between male and female risky sexual behaviour among adolescents with visual impairment, with female adolescents displaying ahigher tendency to engage in risky sexual behaviour than their male counterparts.

5.2 Conclusion

The study investigated the specific environmental and affective factors that predispose adolescents with visual impairment to risky sexual behaviour. It was observed that secondary school adolescents' social environment inadvertently plays a major part in

explaining the risky sexual lifestyles of students in the study. Hence, there was no bias in the effect of prevailing adverse social exposure or ideas on the status of this target population. Adolescents with visual impairments are as much susceptible as their colleagues without disabilities to harmful social or school climatic factors that increase the tendency to risky sexual behaviour. Contrary to the perceived sexual inactivity of the visually impaired, it is evident that adolescents with visual impairment may be sensitive to other sexually suggestive environmental factors communicated by other means apart from visual perception. In view of the curricular activities structured to address risky sexual behaviour, it is evident that specific attention need be given to this neglected population by adopting codes other than restraints on sexually motivating attitudes perceptible by sight only.

Emotional intelligence emerged as the most potent affective factor of risky sexual behaviour among adolescents with visual impairment, acting singly or in a joint interaction with school climatic factors. The study showed that the tendency to take risky sexual decision by adolescents with visual impairment was strongly related to low or poor emotional intelligence, which could be due to negative self-conception or poor sense of individuality, and could also imply that certain aspects of sex education may have been inadvertently neglected for adolescents with visual impairment, probably due to the sexual inactivity wrongly assumed for these individuals.

Comparison using differences in sex revealed that female adolescents with visual impairments display higher tendency to engage in risky sexual behaviour than their male counterparts. Other tested factors like parenting styles, peer pressure, sexual attitude bore no significant relationship with risky sexual behaviour among adolescents with visual impairment.

5.3 Recommendations

Based on the findings of the study, the following recommendations were hereby made:

1. It is imperative to improve the sexual health of adolescents with visual impairment through preventive strategies that emphasize the vigorous strengthening of the emotional intelligence which will enhance adolescent lifestyle. Programmes should be consciously planned and have a friendly outlook that would aid access to sexual health services at the volition of these adolescents. Several evidence-based and skill-focused programmes should be made available while relying on cognitive-behavioural principles that emphasize sexual risk reduction. This should be delivered in small groups and include multiple sessions to help increase sexual health knowledge, improve attitudes towards condoms, and reduce sexual risk-taking behaviour among adolescents.
2. Learners should be aided in developing communication, negotiation and refusal skills through the use of modelling and practice (role-playing, written practice and so on.)
3. School administrators, special educators, and counsellors must enable adolescents with visual impairment to recognise and appreciate the roles and impact of the school environment in shaping their lifestyles and dispositions towards reducing risky sexual behaviour among them. This should go beyond the cognitive level change, individual values, and group norms to include building social skills.
4. The government and policy makers should adequately address the issue of prejudice, negative attitudes and accessibility concerns confronting adolescents with visual impairment when accessing sexual and reproductive health-care and services.
5. The government should support schools and communities in formulating policies and implementing practices aimed at reducing the risky sexual behaviour, bringing back religious education in schools and addressing the problem of

poverty,especially among female adolescents with visual impairment in the communities.

6. Sexuality education should be incorporated into the school curriculum so as to enable adolescents especially those with visual impairment to acquire the required knowledge about sexuality, which will enable them to have recourse to their emotion in taking sexual-related decisions.

7. There is a need to train specialist teachers or facilitators and lecturers who are conversant with visual impairment and who can positively impact the lives of adolescents with visual impairment.

8. Parents should endeavour to regularly admonish and counsel their children with visual impairment apart from sharing their knowledge and experience with them. Constant dialogue on the need to refrain from activities revolving around risky sexual engagements is an urgent necessity. Parents have the onerous duty to make their children to be fully aware of the dangers inherent in risky sexual behaviour.

5.4 Contributions to knowledge

The contributions are as follows:

i. This study described for the first time the nature of the relationship that exists among environmental (school climate), affective factors (emotional intelligence) and risky sexual behaviour among adolescents with visual impairment. The interface of these factors, as demonstrated by the study, had a strong positive relationship with the sexual lifestyles of adolescents with visual impairment.

ii. The findings of the study showed the extent to which affective factor (emotional intelligence) contributes to shaping the attitude of adolescents with visual impairment towards taking risky sexual decisions.

iii. The findings of the study highlighted the potential aspects of environmental and affective factors that pose serious challenges to adolescents with visual impairment in relation to risky sexual behaviour which can be used as a guideline by the management of educational institutions and other stakeholders to effectively

design programmes or develop approaches to improve the emotional intelligence of adolescents with visual impairment, hence reducing the incidence of risky sexual behaviour and their consequences.

5.5 Limitations of the study

The study was limited in scope to only students with visual impairment and as such, the results cannot be generalized to students with other exceptionalities and to the broader population of adolescents. However, the research approach and factors identified provide a solid basis for a wider survey. Moreover, thoughenvironmental and affective factors portrayed a big picture of the variance in the risky sexual behaviour of adolescents with visual impairment, there are other factors that influence risky sexual behaviour among adolescents with visual impairment which were not considered in this study. In addition, the sample size was not large enough to x-ray adolescents with visual impairment in Southwestern, Nigeria. Notwithstanding the identified limitations, the results and findings of the study as well as recommendations accruing from them are not in any way invalidated.

5.6 Suggestions for further studies

Though this study has succeeded in investigating environmental and affective factors as determinants of risky sexual behaviour among adolescents with visual impairment in secondary schools in Southwestern, Nigeria, the following suggestions will be helpful for further research:

1. A study scope targeting several states with a higher sample size would help to generalize the findings in this area of research. Of course, similar studies in other geo-political zones would yield useful insight into the generalisation potential of this result across cultures.
2. The population should be broader to enhance the generalization of the result. For example, selected secondary schools in other geo-political zones of the country can be included.
3. Further studies are required to incorporate other components of environmental and affective factors to expand the model of the present study.

4. Considerable research base is needed for better understanding of social identity-related determinants of adolescents' sexual risk-taking in Nigeria. There is a need to assess the impact of ethical-oriented approaches in health support activities for adolescents.
5. There is a need for a clear assessment of internal and external factors contributing to sexual offending in adolescents. Beyond that, a research focus on adolescents' resilience to risky sexual behaviour would be a useful point to consider.

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APPENDIX I

INFORMED CONSENT FORM

IRB Research approval number: ####

This approval will elapse on dd/mm/yy

Title of the research:

ENVIRONMENTAL AND AFFECTIVE FACTORS AS DETERMINANTS OF RISKY SEXUAL BEHAVIOUR AMONG ADOLESCENTS WITH VISUAL IMPAIRMENT IN SECONDARY SCHOOLS IN SOUTHWESTERN, NIGERIA

Name(s) and affiliation(s) of researcher(s) of applicant(s):

This study will be conducted by Bibiana Ifeoma OKOLI of the Department of Special Education, under the supervision of Professor I. A. Nwazuoke

Sponsor(s) of research:

This study is self-sponsored

Purpose(s) of research:

The purpose of this research is to investigate the extent to which environmental factors (peer pressure, parenting style and school climate) and affective factors (sexual attitude, and emotional intelligence) predict risky sexual behaviours of adolescents with visual impairment.

The procedure of the research, what shall be required of each participant and the approximate total number of participants that would be involved in the research:

A total of 194 participants will be recruited into the study using a multi-stage sampling technique. You will be required to fill out a questionnaire in a short time

Expected duration of research and of the participant(s)' involvement:

In total, the study will be for six weeks. We expect you to be involved in this research for 10 to 15 minutes.

Risk(s):

The study will not pose any harm or injury to you since it does not involve any invasive procedure. Your time will only be required.

Costs to the participants, if any, of joining the research:

Your participation in this research will only cost you your time.

Benefit(s):

Findings from this study seek to identify the place of peer pressure, parenting style, school climate, emotional intelligence and sexual attitude on risky sexual behaviours among adolescents with visual impairments in secondary schools (integrated settings) in Southwestern Nigeria.

Confidentiality:

Your name will not be used at any point in the study. This confidentiality of the data obtained will be ensured by using serial numbers.As part of our responsibility to conduct this research properly, officials from NAFDAC, NHREC and ethics and food and drugs regulators from the United States of America may have access to these records.

Voluntariness:

You are free to withdraw their consent at any time.

Alternatives to participation:

If you choose not to participate, this will not affect your care in the school in any way.

Consequences of participants' decision to withdraw from research and procedure for orderly termination of participation:

You can also choose to withdraw from the research at anytime. Please note that some of the information that has been obtained from you before you chose to withdraw may have been modified or used in reports and publications. These cannot be removed anymore. However, the researcher promises to make effort in good faith to comply with your wishes as much as is practicable.

The modality of providing treatments and action(s) to be taken in case of injury or adverse event(s):

If you suffer any injury as a result of your participation in this research, you will be referred to the appropriate hospital.

What happens to research participants and communities when the research is over?

The researchers will inform you of the outcome of the research through a news bulletin. During the course of this research, you will be informed of any information that may affect your continued participation or your health.

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information, including about risks and benefits, to make an informed decision.

DATE: _____ SIGNATURE: _____

NAME: _____

Statement of the person giving consent:

I have read the description of the research and have had it translated into a language I understand. I have also discussed with the doctor to my satisfaction. I understand that my participation is voluntary. I know enough about the purpose, methods, risks and benefits of the research study to judge that I want to take part in it. I understand that I may freely stop being part of this study at any time. I have received a copy of this consent form and additional information sheet to keep for myself.

DATE: _____SIGNATURE:_____

NAME: _____

WITNESS' SIGNATURE (if applicable): _____

WITNESS' NAME (if applicable): _____

Detailed contact information including contact address, telephone, fax, e-mail and any other contact information of researcher(s), institutional HREC and head of the institution:

This research has been approved by the Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at Biode Building, Room 210, 2nd Floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, E-mail: uiuchirc@yahoo.com and uiuchec@gmail.com

In addition, if you have any question about your participation in this research, you can contact the principal investigator, Name…….....

Department……..... Phone…….. .....

Email…….....

PLEASE KEEP A COPY OF THE SIGNED INFORMED CONSENT.

ÀSOMỌ́ I

FOOMUIFỌWỌSI

Nọmbatí a gbà wọlé fúnisẹ́ ìwádìí

Ìgbàwọlé yìí yóò dópinnidd/mm/yy

Orí isẹ̀ ìwádìí:

ÀWỌN OHUN ÀYÍKÁ TÍ Ó NÍ IPÁ GẸ́GẸ́ BÍ I OHUN ÌMÚNIMỌ EWU ÌWÀ ÌBÁLỌ̀PỌ̀ LÁÀRIN ÀWỌN ỌDỌ́ TÍ WỌ́N NÍ ÌPÈNÍJÀ OJÚ NÍ ILÉ-ÌWE GIRAMA NÍ GÚÚSÙ ÀTI ÌWỌ̀-OÒRÙN NÀÌJÍRÍÀ.

Orúkọ àtiàwọnalabasisẹpọ fúnisẹ ìwádìí

Isẹ ìwádìí yìí yóò wáyé látọwọ́ BibianaIfeomaOkolitiẹka ẹ̀kọ́ Special Education niabẹ́ ìmójútó ọjọgbọ́n I.A. Nwazuoke

Onígbọ̀wọ́ isẹ́ ìwádìí:

Isẹ́ ìwádìí yìí jẹ àdáse.

Pàtàkì isẹ́ ìwádìí

Pàtàkì isẹ́ ìwádìí yìí niláti se ìwádìí gbèdéketí àwọn okùnfa ìsẹ̀lẹ̀ (ẹgbẹ́, ọ̀nà ìtọ́mọ àti ipò ilé-ìwe) àti àwọn ohun tí ó ní ìpalára bí i (ìwa ìbálòpọ̀, òye ìmọ̀sílára) tí ó ń sọ ewu ìwa ìbálòpọ̀ ti ọ̀dọ́ tí ó ní ìpèníjà ojú.

Ìlànà isẹ́ ìwádìí yìí, ohuntí akópakọ̀ọ̀kannilátiseàtiiyetí gbogboàwọnakópatiyóò kópanínú isẹ́ ìwádìí náà jẹ́.

Àwọnakópa 194 ni a ó gbà sí inú isẹ́ ìwádìí yìí nípalíloọgbọ́n ìsàpẹẹrẹ lópọ̀ ọ̀nà (multi-stage sampling technique). Ìwọ yóò nílò látifọwọ́ sí ìwé àtòjọ ìbéèrè láìpẹ́

Gbèdékeàkókò isẹ́ ìwádìí àtiìkópaàwọn akópa

Ni àpapọ̀, ìwádìí yìí yóò wà fún ọ̀sẹ̀ mẹ́fà.A fẹ́ kí o kópanínú ìwádìí yìí fúnìsẹ́jú mẹ́wàá sí ìsẹ́jú mẹ́ẹ̀ẹ́dógún.

Ewu:

Ìwádìí yìí kò le sokùnfaewutàbí ìjàmbá fún ọ níwọ̀n ìgbà tí kò níísepẹ̀lú ìlànà àfòmó.Àkókò rẹ nìkanni ó nílò.

Ohuntí yóó ná akópa, bí ó bá darapọ̀ mọ́ ìwádìí

Ìkópa rẹ nínú ìwádìí yóò ná ọ niàkókò rẹ nìkan.

Àǹfààní

Ìwádìí nínú isẹ́ yìí n gbìyànjú mọ ipò ẹgbẹ́, ọgbọ́n ìtójú, bí ilé ìwé se rí, ìmọ̀síláraòye, àtiìwà ìbálòpọ̀ lórí.ewu ìwà ìbálọ̀pọ̀ láàrin àwọn ọ̀dọ́ tí wọ́n ní ìpèníjà ojú ní ilé-ìwe girama (ní etílé) ní gúúsù àti ìwọ̀-oòrùn nàìjíríà**.**

Àsírí

Orúkọ rẹ kò ní jẹ́ lílò nígbà Kankan nínú ìwádìí yìí.àsírí àwọn ọ̀rọ̀ tí a gbà kalẹ̀ yoowà niìpamọ́ nípalilonọmba.Gẹ́gẹ́ bi ojúsewaláti se ìwádìí yìí bí ó se tọ́, àwọnasojú látiNAFOAC, NHRECàtiàwọnìgbìmọ̀ tó n mójú to ounjẹ́ àtiòògùnlátiorilẹ èdè Amẹrika le niànǹfàànísiàkọsílẹ̀ wọ̀nyí.

Àtinúdá:

Ààyè walátifàsẹ́yìnnígbàkùúgbà.

Àwọnohunmìíránsí kíkópa

Bí o kò bá fẹ́ látikópa, eléyìí kò le kóbá ìtọ́jú rẹ niile-ìwé tàbí ibikíbi.

Èrèdí ìpinnuakópalátifà sẹ́yìnnínú isẹ́ ìwádìí àtiìlànà tí ó tọ fun ìmúkúrò akópa.

O tún le fa sẹ́yìnnínú isẹ ìwádìí niìgbàkúùgbà. Jọ̀wọ́ mọ pegbogbo ọ̀rọ̀ ti a gbà láti ọ̀dọ̀ rẹ tẹ́lẹ̀ ni a ó lò nínú àbọ̀ isẹ ìwádìí. Eléyìí kò le se é yọ mọ́, síbẹ̀ síbẹ̀, olùwàdìí sèlérí látisaipá rẹ láti se gẹ́gẹ́ bí o tifẹ́, ní bí ó bá ti ṣe mọ.

Ìlànà fúnpípèsè ìtọ́jú àtiàwọnìgbésẹ̀ tia o gbe bí ìjànbá bawáyé tàbí ìsẹ̀lẹ̀ tí kodára:

Bí o bá niìpaláralátàrí kíkópanínú iṣẹ́ ìwádìí yìí, a o mú ọ lọ siilé ìwòsànti o dára.

Kí ni o sẹlẹ̀ siàwọnakópanínú iṣẹ́ ìwádìí àtiagbègbè olùwádìí lọ?

Olúwádìí yóò sọ àbájádeiṣẹ́ ìwádìí nípalíloìwé ìròyìn. Ni àkókò ìsẹ́wádìí yìí a ó sọ àwọnohuntí ó bá yẹ kí o mọ̀, tí ó le pa ikópa rẹ tàbí ìlera rẹ lára

Ọ̀rọ̀ ẹnití o gbaìwé ìfọwọ́sí:

Mo tisàlàyé iṣẹ́ ìwádìí yìí dáadáa fun _____ mositifúnunniìròyìn tó kún, pẹ̀lú ewuàtiànfààní, láti se ìpinnu.

DÉÈTÌ: _____ ÌFỌWỌ́SÍ: _____

ORÚKỌ: _____

Ọ̀rọ̀ ẹnití ó ń se ìfọwọ́sí

Mo tikaalayeiṣẹ́ ìwádìí yìí, mosì ti se ẹ̀dà rẹ sí èdè tí ó yémi. Mo sì tibadokita sọ̀rọ̀ nípa rẹ dé ibití o tẹ́milọ́rùn. Ó yémipewọ̀nfúnniìkopa mi.

Mo mọ̀ púpọ̀ nípapàtàki ọgbọ́n, ewuàtiànfààní ìsè ìwádìí náà láti jẹ́ kí ó di mímọ̀ pé mofẹ́ kópanínú rẹ.Ó yémipé mo le dẹ́kun Ḱíkópanínú iṣẹ́ ìwádìí yìí nígbà kúùgbà.Mo tigba ẹ̀dà fọ́ọ̀mù ìfọwọ́sí àtiàwọnìwé àlàyé mìíránláti fi pamọ́.

DÉÈTÌ: _____ ÌFỌWỌ́SÍ: _____

ORÚKỌ: _____

Ìfọwọ́sí Elérìí (bí ó bá yẹ): _____

Orúkọ Elérìí (bí ó bá ye):_____

Bí a se le kànsí ọ pẹ̀lú àdírẹ̀si, telifóònù, fasi, e-mail àtiàwọnmìíràn.

Adirẹ̀sí olùsèwádìí, àjọ HRECàtioloriàjọ náà:

Ìfọwọ́sí fúnisẹ́ ìwádìí tiwaláti ọ̀dọ̀ ìgbìmọ̀ tó ń rí siòfintifasitiÌbàdàn. A le kànsí alágaìgbìmọ̀ yìí nì Biode Building Room 210, 2nd floor, Institute for Advanced Medical Research and Training, College of Medicine, University of Ibadan, E-mail:uichire@yahoo.com and uiuchec@gmail.com

Fúnàfikún, bí o bá ní ìbéèrè nípaìkópa rẹ nínú ìwádìí yìí, o le kànsí oloriolùséwàdìí.

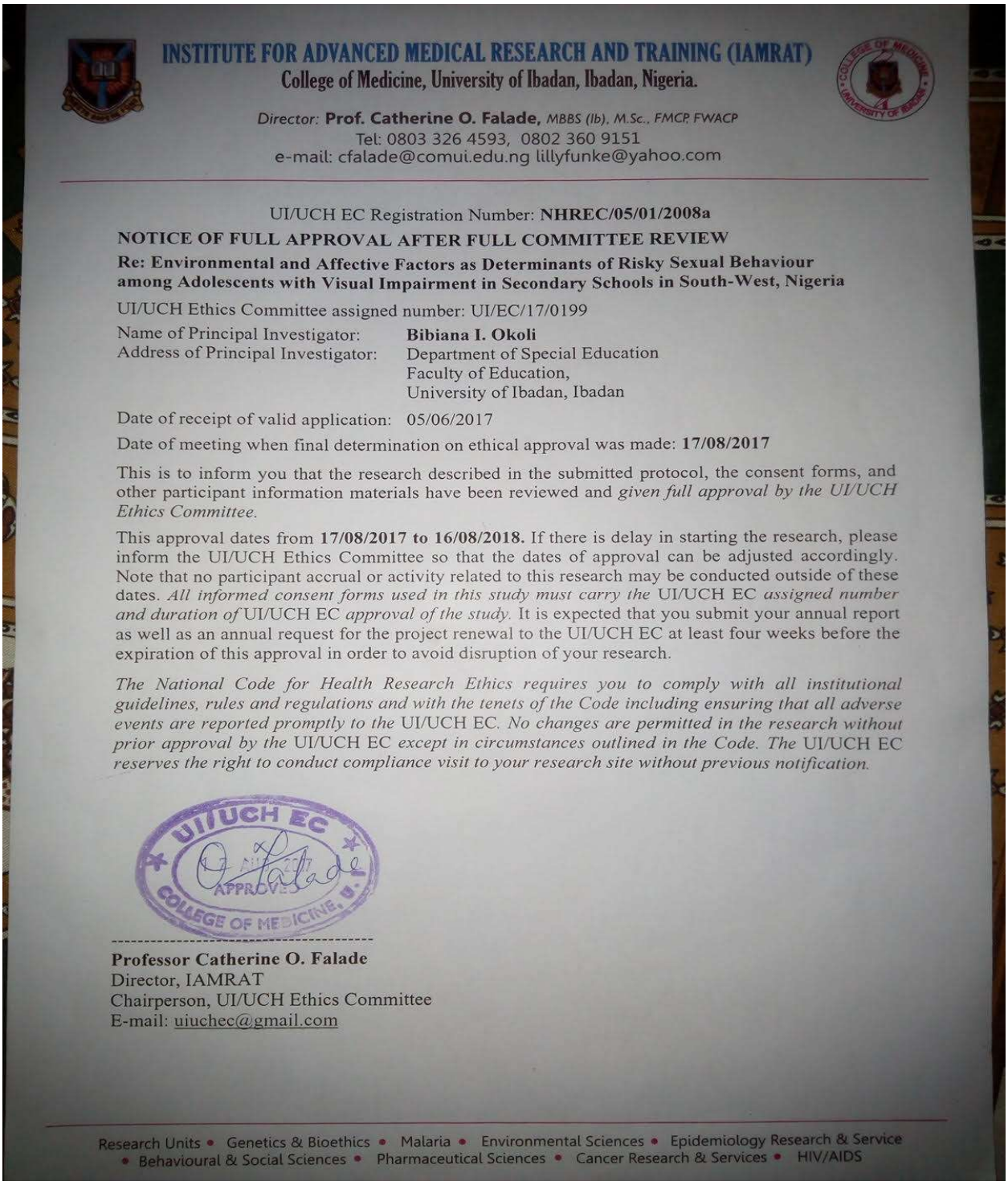
Orúkọ ……

Ẹka ẹ̀kọ́ …….. Fóònu……

Email……..

JỌWỌ́ TỌJÚ ỌKANLÁRAÌWÉ ÌFỌWỌ́SÍ TI WỌN TI BUWỌ́LÙ.

APPENDIX II



INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
College of Medicine, University of Ibadan, Ibadan, Nigeria.

Director: **Prof. Catherine O. Falade,** *MBBS (Ib), M.Sc., FMCP, FWACP*
Tel: 0803 326 4593, 0802 360 9151
e-mail: cfalade@comui.edu.ng lillyfunke@yahoo.com

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Environmental and Affective Factors as Determinants of Risky Sexual Behaviour among Adolescents with Visual Impairment in Secondary Schools in South-West, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/17/0199

Name of Principal Investigator: **Bibiana I. Okoli**
Address of Principal Investigator: Department of Special Education
Faculty of Education,
University of Ibadan, Ibadan

Date of receipt of valid application: 05/06/2017

Date of meeting when final determination on ethical approval was made: **17/08/2017**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and *given full approval by the UI/UCH Ethics Committee.*

This approval dates from **17/08/2017 to 16/08/2018.** If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC at least four weeks before the expiration of this approval in order to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

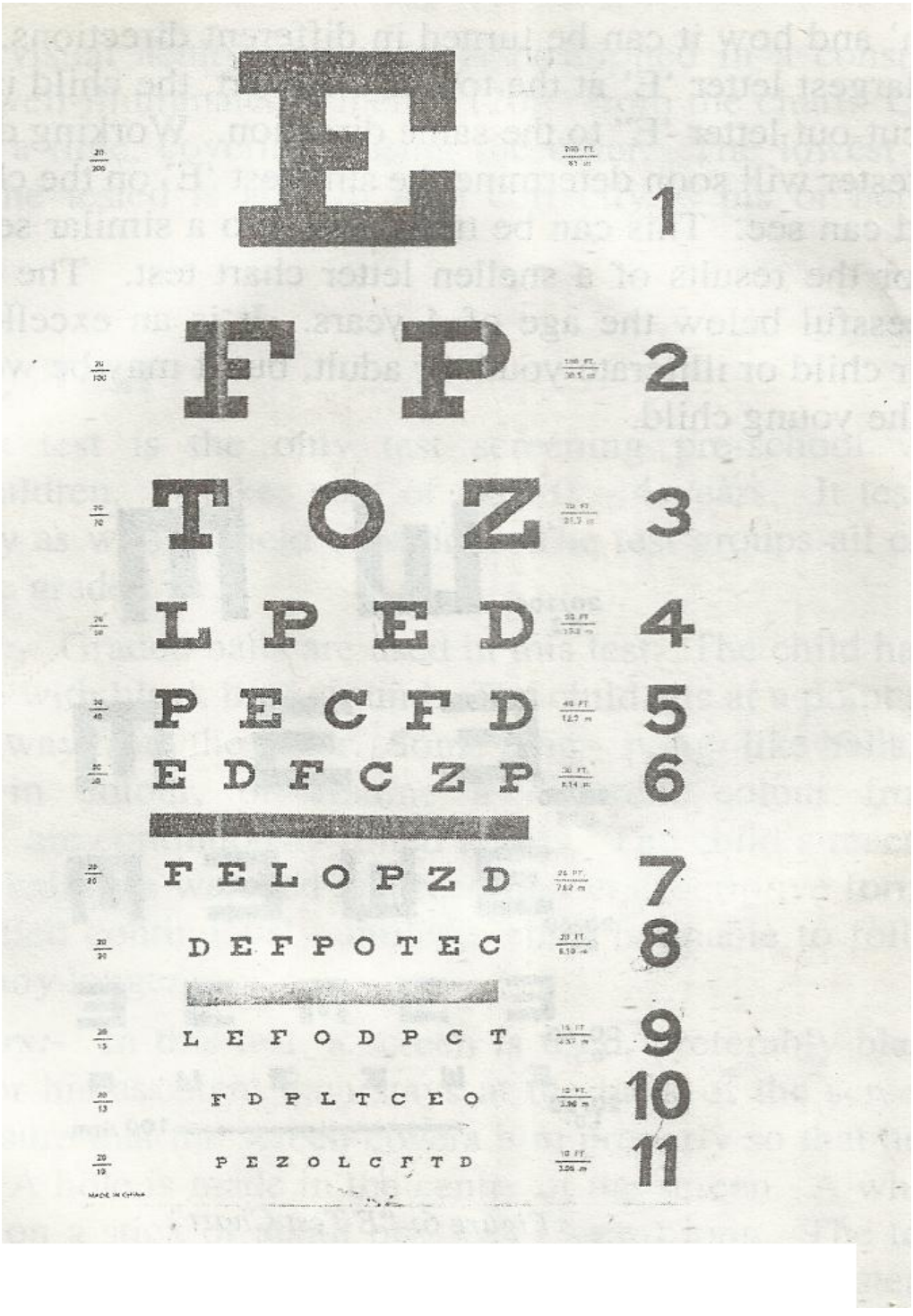
UI/UCH EC
APPROVED
COLLEGE OF MEDICINE, U.I.

Professor Catherine O. Falade
Director, IAMRAT
Chairperson, UI/UCH Ethics Committee
E-mail: uiuchec@gmail.com

Research Units • Genetics & Bioethics • Malaria • Environmental Sciences • Epidemiology Research & Service • Behavioural & Social Sciences • Pharmaceutical Sciences • Cancer Research & Services • HIV/AIDS

APPENDIX II

SNELLEN'S SCALE



APPENDIX III

UNIVERSITY OF IBADAN

FACULTY OF EDUCATION

DEPARTMENT OF SPECIAL EDUCATION

Dear Respondents,

The questionnaire is designed solely for research purpose. They are specifically to investigate **the environmental and affective factors as determinants of risky sexual behaviour of adolescents with visual impairment in secondary schools in Southwestern, Nigeria**. You are requested to kindly give frank responses to each item as you think they apply to you. All information provided would be treated confidentially**.**

Instructions:

Please fill in the needed details and tick the options that are appropriate for you in sections A, B, C, D, E and F

Section A: Bio-data

1.Sex: Male. ☐ Female ☐

2. Age: 9- 12yrs ☐ 13-16yrs ☐ 17-20yrs ☐

3. Name of school……

4. Class: J.S 1 ☐ J.S 2 ☐ J.S 3 ☐ S.S 1 ☐ S.S 2 ☐ S.S3 ☐

5. Category of Visual Impairment: Total Blindness ☐ Low Vision ☐

Section B: Peer pressure scale

In the column provided, tick SD= Strongly Disagree, D= Disagree, U = Undecided, A= Agree, SA= Strongly Agree

S/N	Items	SD	D	U	A	SA
1	My friends like to fight each other					
2	I feel uncomfortable in a group of my peers					
3	My friends encourage me to do bad things					
4	I feel I am rejected by my peers					
5	Belonging to a gang that can fight each other is cool					
6	I easily lose friends					
7	My friends think I am boring					
8	My friends often ignore me					
9	Criticisms by my friends affect me					
10	I make friends easily					
11	My peers respect me .					
12	My peers recognize me as important					
13	I have a good relationship with my friends					
14	I like to please my friends					

Section C: School climate scale

Note: 1 = Strongly Agree, 2 = Agree, 3 = Undecided, 4 = Disagree, 5=Strongly Disagree

S/N	ITEMS	SA	A	U	D	SD
1	My school is a safe and clean place.					
2	My school has plenty of room to work,					
3	Most of the students in my school don't like to cause trouble.					
4	I am treated in the same way as other students in my class.					
5	I am treated fairly by my principal and vice-principal.					

6	The supervisors visit my school and they are interested in what we do in my school					
7	The principal and vice-principal are friendly and interested in what I am doing.					
8	I like coming to school each day.					
9	I get along well with the other students in my classes.					
10	The teachers are friendly and interested in what I am doing.					
11	The teachers feel that my ideas are important.					
12	The teachers try to understand how I see things.					
13	I am not afraid to ask teachers for help					
14	I am not afraid to ask the principal and vice-principal for help.					
15	I get help from teachers when I ask for it					
16	I get help from the principal and vice-principal when I ask for it					
17	The teachers expect me to get good grades.					
18	1am proud of my school.					
19	I try to take good care of the things that belong to my school like books, desks, and lockers.					
20	I see the principal and vice-principal often in places like the hallways, cafeteria, and in my class.					
21	The principal and vice-principal often say hello to me.					

Section D: Parenting styles inventory (PSI)

Note: 1 = Strongly Agree, 2 = Agree, 3 = Undecided, 4 = Disagree, 5=Strongly Disagree

S/N	ITEMS	SA	A	U	D	SD
1	My parents do not really like me to tell them my problem					
2	My parents hardly ever praise me for doing well					
3	I can count on my parents to help me out if I have a problem					
4	My parents spend time just talking to me					
5	My parents and I do things that are fun together					

6	My parents respect my privacy					
7	My parents tell me that their ideas are correct and that I shouldn't question them					
8	Parents make most of the decisions about what I can do					
9	My parents give me a lot of freedom to do whatever I like					
10	My parents believe I have a right to my own point of view					
11	My parents really expect me to follow families rules					
12	My parents don't ask me to change my behaviour to meet the needs of other people in the family.					
13	If I do not behave myself, my parents will punish me					
14	My parents point out ways I could do better					
15	When I do something wrong, my parents do not punish me					

Section E: Emotional intelligence scale

SD= Strongly Disagree, D= Disagree, U = Undecided, A= Agree, SA= Strongly Agree

S/N	ITEM	SD	D	U	A	SA
1	I know when to speak about my personal problems to others					
2	When faced with obstacles, I remember times I faced similar obstacles and overcome them					
3	I expect that I will do well on most things I try					
4	Other people find it easy to confide in me					
5	I find it hard to understand the non-verbal messages of other people					
6	Some of the major events in my life have led me to re-evaluate what is important and not important					
7	When my mood changes, I see new possibilities					
8	Emotions are some of the things that make my life worth living					
9	I am aware of my emotions as I experience them					
10	I expect good things to happen					
11	I like to share my emotions with others					
12	When I experience a positive emotion I know how to make it last					

13	I arrange events others enjoy					
14	I seek out activities that make me happy					
15	I am aware of the non-verbal messages I send to others					
16	I present myself in a way that makes a good impression on others					
17	When I am in a positive mood, solving problems is easy for me					
18	I know why my emotions change					
19	When I am in a positive mood, I am able to come up with ideas					
20	I have control over my emotions					
21	I easily recognize my emotions as I experience them					
22	I motivate myself by imagining a good outcome to the task I take on					
23	I compliment others when they have done something well					
24	I am aware of the non-verbal messages people send					
25	When another person tells me about an important event in his or her life, I almost feel as though I have experienced this event myself					
26	When I feel a change in emotions, I tend to come up with new ideas					
27	When I am faced with a challenge, I give up because I believe I will fail					
28	I help other people feel better when they are down					
29	I use good moods to help myself keep trying in face of obstacles					
30	I can tell how people are feeling by listening to their voice					
31	It is difficult for me to understand why people act the way they do					

Section F: Sexual attitude scale

INSTRUCTION: For each statement fill in the response on the answer sheet that indicates how much you agree or disagree with that statement.1 = Strongly Agree, 2 = Agree, 3 = Undecided, 4 = Disagree, 5=Strongly Disagree

S/N	Item	SA	A	U	D	SD
1	I do not need to be committed to a person to have sex with him or her					
2	Casual sex is acceptable					
3	I would like to have sex with many partners.					
4	One-night stands are sometimes enjoyable					
5	It is okay to have ongoing sexual relationships with more than one person at a time					
6	Sex as a simple exchange of favours is okay if both people agree to it					
7	The best sex is with no strings attached.					
8	Life would have fewer problems if people could have sex freely.					
9	It is possible to enjoy sex with a person and not like that person very much					
10	It is okay for sex to be just good physical release.					
11	Birth control is part of responsible sexuality					
12	A woman should share responsibility for birth control.					
13	A man should share responsibility for birth control.					
14	Sex is the closest form of communication between two people.					
15	A sexual encounter between two people deeply in love is the ultimate human interaction.					
16	At its best, sex seems to be the merging of two souls.					
17	Sex is a very important part of life					
18	Sex is usually an intensive, almost overwhelming experience.					
19	Sex is best when you let yourself go and focus on your own pleasure.					
20	Sex is primarily the taking of pleasure from another person					
21	The main purpose of sex is to enjoy oneself.					
22	Sex is primarily physical.					
23	Sex is primarily a bodily function, like eating.					

Section G: Risky sexual behaviour

The following questions are related to your sexuality. Please choose **all that apply** to you

1. Have you ever had sexual intercourse?

a. Yes b. No

If yes, the age of the first time :

If yes, what was it? ( )

2. Who have you had sex with (please tick all of your partners)

a. My boy/girl friend b. friend(s) c. Acquaintance

d. Sex worker e. A person you 've gone out with once or twice f. Other

3. What type of sex have you had? (Please mark all that apply)

a. Vaginal sex b. Oral sex c. anal sex

4. What kind of contraceptive(s) did you use the first time? (Please mark all that apply)

a. None b. Condom c. Coitus interruptus (Withdrawal)

d. Natural family planning e. Oral pills f. Other

5. In the last three months, have you ever had sexual intercourse?

a. No b. Yes, once or twice c. Yes, once a month

d. Yes, once a week e. Yes, more than twice in a week f. Other

6. In the last three months, what kind of contraceptive(s) did you use? (Please mark all that apply)

a. None b. Condom c. Coitus interruptus (Withdrawal)

d. Natural family planning e. Oral pills f. Other

7. How many different people have you had sexual intercourse within the last 12 Months

a. No b. one c., two d. three e. more than 4

8. Have you ever been pregnant or have you ever gotten a girl pregnant?

a. No b. Yes, once c. Yes, twice d. Yes, three times e. Yes, more than 4 times

APPENDIX IV

PATIENTS WITH DISABILITY RECEIVING HIV AND STIs TREATMENTS			
VisitDate	**Sex**	**Age**	**Category**
21-01-2008	Female	39	Blind
29-01-2008	Female	45	Blind
01-02-2008	Female	50	Blind
27-03-2008	Male	40	Unable to walk
05-06-2008	Female	47	Blind
14-07-2008	Female	39	Unable to walk
04-08-2008	Male	62	Unable to walk
13-10-2008	Male	58	Blind
26-09-2008	Female	54	Unable to walk
30-12-2008	Female	44	Deaf
10-07-2009	Female	37	Unable to walk
15-09-2009	Female	53	Blind
23-09-2009	Female	57	Unable to walk
21-08-2009	Male	53	Unable to walk
28-10-2009	Female	45	Deaf
10-11-2009	Female	43	Blind
26-08-2010	Male	69	Unable to walk
27-09-2010	Male	50	Blind
25-10-2010	Male	46	Deaf
26-11-2010	Female	39	Blind
06-07-2011	Female	42	Blind
05-10-2011	Female	34	Blind
09-11-2011	Female	34	Unable to walk
21-03-2012	Female	81	Unable to walk
05-04-2012	Male	61	Deaf
05-04-2012	Male	59	Unable to walk
07-05-2012	Male	82	Unable to walk
28-06-2012	Female	43	Unable to walk
11-10-2012	Male	50	Unable to walk
19-10-2012	Female	43	Unable to walk
06-12-2012	Female	52	Unable to walk
06-08-2013	Male	41	Blind
19-11-2013	Male	73	Unable to walk
09-12-2013	Male	72	Unable to walk
11-12-2013	Female	49	Unable to walk
11-12-2013	Female	69	Blind
16-12-2013	Female	39	Deaf

Source: University College Hospital, Ibadan, Oyo State 2017

APPENDIX IVB

Patients with Disability - 2013 TILL DATE				
S/N	**Last Visit Date**	**Sex**	**Age**	**Category**
1	01-09-2016	F	53	AMPUTATED
2	03-06-2013	F	52	INABILTY TO WALK
3	08-01-2014	F	40	INABILTY TO WALK
4	02-12-2013	M	41	BLIND
5	26-07-2013	M	50	BLIND
6	28-10-2013	F	31	BLIND
7	12-10-2012	F	34	BLIND
8	16-02-2017	F	38	INABILTY TO WALK
9	10-06-2016	F	29	BLIND
10	01-05-2016	M	40	BLIND
11	22-02-2017	M	46	BLIND
12	28-09-2015	F	46	BLIND
13	11-07-2016	M	45	BLIND
14	24-09-2014	F	55	DEAF
15	20-04-2017	M	42	INABILTY TO WALK
16	15-02-2017	M	42	BLIND
17	05-03-2017	M	59	INABILTY TO WALK
18	04-08-2015	M	74	BLIND
19	14-03-2017	F	50	BLIND
20	16-06-2015	F	50	DEAF
21	12-07-2015	F	46	BLIND/DEAF
22	01-10-2017	F	39	BLIND/DEAF
23	27-06-2016	F	41	DEAF
24	13-12-2016	F	44	DEAF
25	08-12-2017	F	50	BLIND
26	12-08-2016	F	46	BLIND

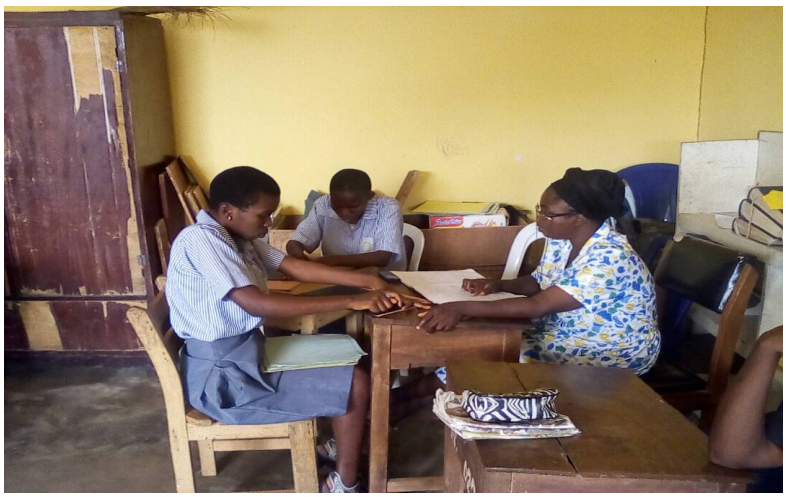
27	20-06-2016	M	44	BLIND
28	02-06-2017	F	37	BLIND
29	12-01-2016	F	53	BLIND
30	02-02-2017	F	67	DEAF
31	06-06-2017	M	65	DEFORMED LOWER LIMBS
32				

Source: University College Hospital, Ibadan, Oyo State, 2017

APPENDIX V

Kings College


ONYEABOR
VERO

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