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SEXUAL BEHAVIOURS AND CONTRACEPTIVE USE AMONG ADOLESCENTS WITH LEARNING DISABILITIES IN IBADAN NORTH LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA

Ademokoya, Julius Abiodun[1], Igbeneghu, Patience Ehimhen[2i]
[1,2]Phd, Department of Special Education and Rehabilitation Sciences,
University of Ibadan, Ibadan, Nigeria

Abstract:
The study investigated knowledge of sexual behaviours and contraceptive use among Adolescents with Learning Disabilities (ALDs) in a Nigerian city. A purposive sampling was used to select 210 participants. Findings showed that the most utilised method of contraception was abstinence (51.0%) though 21.0% had had sexual intercourse and 23.3% had been sexually abused. Age is significantly a determinant of ALDs' knowledge of sexual behaviour ($\chi^2_{cal} = 278.09$, df = 4, $p < 0.05$) and use of contraceptives ($\chi^2_{cal} = 92.51$, df = 4, $p < 0.05$) while gender is not significantly a determinant factor. Suggestions are made for sexuality education to be intensified in schools for ALDs especially for early adolescents to minimise sexual abuses, unwanted pregnancies and STIs.

Keywords: sexual behaviour, contraceptive use, adolescents, learning disabilities

Introduction

Adolescents with learning disabilities (ALDs) have more difficulties in understanding and communicating, concomitant with increased level of vulnerability. As they are unable to understand tasks as well as other normal children of the same age, they are often brought up with low self-esteem as their caregivers perform more of the task for them than they would for other children. This also leads to more vulnerability and increased risk of sexual abuse than what is seen in children of the same age and normal development (Public Health Agency, 2005). ALDs are therefore at increased risk of sexual and physical abuse and neglect. ALDs will almost certainly show gaps in knowledge and erroneous beliefs

[i] Correspondent author: Igbeneghu, Patience Ehimhen patienceigbeneghu@gmail.com

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when compared with more able peers of the same age, and the degree of these problems will correspond to the extent and nature of their learning disability. They will also reflect the child's history of exposure to comprehensible family and school-based education about personal relationships, privacy, safe touching, sexual expression, dating as well as choosing partners. These gaps in knowledge and understanding will probably reflect the general belief that ALDs are best excluded from sexual education and expression, lest they get into trouble or pose a danger to themselves or others (Allington-Smith, Ball and Haytor, 2002).

Sexual behaviour may be expressed in a variety of ways including language; touch; exploring one's own body or another's sexual activity, games and interactions. All people have the right to express their sexuality but when adolescents display sexual behaviour which increases their vulnerability or causes harm to another, adults have a responsibility to take action to provide support and protection. According to Katchadourian (1990), most adolescents' first experience with sex falls into the category of autoerotic behaviour- sexual behaviour that is experienced alone. The most common autoerotic activities reported by adolescents are having erotic fantasies (about three quarters of all teenagers report having sexual fantasies mainly about television figures or movie stars) and masturbation (reported by about half of all adolescent boys and one-fourth of all adolescent girls) (Koch, 1993). By the time most adolescents have reached high school, they have crossed the line from autoerotic to "socio-sexual behaviour" – sexual behaviours involving another person (Katchadourian, 1990).

Youth Embassy (2004), opined that all human beings are sexual beings. Sexuality is not an optional extra. Everyone has sexual needs, feelings and drives including adolescents with learning disabilities. Learning about sexual behaviour is a lifelong and often haphazard process. Babies learn from birth onwards about the bodily pleasure of being warm, being cuddled, being tickled and interacted with. Others learn from watching the ways in which parents show affection to each other and from spoken and unspoken messages about private parts; also from films, advertisements and soap operas on television (Outsiders, 2009). Sadly, it is often the case that adolescents with learning disabilities only get a very negative form of sex education. Not giving them any positive formal or sensible sex education does not mean that they do not pick up many enticing ideas. They need to be protected from people who seek them out in order to exploit their ingenuity. Also to Outsiders (2009), adolescents with learning disabilities grow up although puberty may be slightly delayed for those with profound or multiple disabilities. They go through the same process as any other child. Voices start to break, body hair starts to grow, girls begin their periods, boys start to have wet dreams, and mood swings

become more extreme. All that is the biological process of puberty which cannot be stopped, even sometimes parents would want it to.

A sizeable minority of adolescents experience unintended pregnancies and sexually transmitted infections (STIs) (Datta, Sternberg and Johnson, 2007; Finer, 2010). Unintended pregnancy rates are the highest among individuals less than 20 years of age, despite availability of effective contraceptive methods (Brown, Hennessy, Sales, DiClemente, Salazar, Vanable, Carey, Romer, Valois, Brown and Stanton, 2011). Reported contraceptive use by adolescents has increased over the years. From 1991 to 2005, the percentage of sexually active secondary school students who reported using a condom the last time, they had sexual intercourse increased from 46.2% to 62.8% in 2005. Despite this increase, consistent use of any contraceptive method remains a challenge for most adolescents (American Academy of Pediatrics, 2007). Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse or a greater number of partners (Kirby, Laris and Rolleri, 2007). In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to experience negative outcomes related to sexual activity (Guttmacher, Lieberman, Ward, Freudenberg, Radosh and Des Jarlais, 1997).

The issue of contraception for adolescents with learning disabilities is often forgotten. Data from the National Longitudinal Study of Adolescent Health has shown that adolescents with learning disabilities are as sexually experienced as adolescents without disabilities. Attitudes about contraceptives as well as sexuality education and counselling needs within this population should not be overlooked (Cheng and Udry, 2002). Factors that contribute to lack of contraceptive use or inconsistent use include issues related to adolescent development such as reluctance to acknowledge one's sexual activity, belief that one is immune from the problems or consequences surrounding sexual intercourse or pregnancy, denial of the possibility of pregnancy together with lack of education and misconceptions regarding use or appropriateness of contraception. But an adolescent's level of knowledge about how to use contraception effectively does not necessarily correlate with consistent use (American Academy of Pediatrics, 2007). Some of the reasons why adolescents may not use or may delay use of contraception include lack of parental monitoring, fear that their parents will find out, ambivalence and the perception that birth control is dangerous or causes unwanted adverse effect such as increase in weight.

For adolescents with learning disabilities, there is high use of injectable contraceptives and intrauterine contraceptive devices (IUCDs). Management of contraceptive needs among adolescents with learning disabilities is similar in most cases to the management of non-disabled ones (Arscott, Dagnan, and Kroese, 1999). However, a

person with learning disabilities may still be competent to make an informed choice regarding method of contraception and be able to use any method reliably (Grover, 2002). It is therefore essential to consider the adolescents' circumstances and wishes of the adolescents with learning disabilities and not necessarily opt for those methods that do not require the understanding and involvement of the user.

Research Questions

1. *Which method of contraceptive is readily available and used among ALDs?*
2. *What are the sexual behaviour trends among ALDs?*
3. *What is the level of knowledge and use of contraceptive among ALDs?*

Hypotheses

1. Gender will not significantly be a determinant of ALDs knowledge of sexual behaviour.
2. Gender will not significantly be a determinant of ALDs knowledge and use of contraceptive.
3. Age will not significantly be a determinant of ALDs knowledge of sexual behaviour.
4. Age will not significantly be a determinant of ALDs knowledge and use of contraceptive

Methodology

This study adopted a descriptive survey design to investigate sexual behaviours and contraceptive use among ALDs in Ibadan North LGA of Oyo State. A simple random sampling was employed to select seven public secondary schools in Ibadan North LGA of Oyo State. In each of the selected schools, class teachers nominated adolescents with record of poor academic performance based on their past examination records. After which there was a further screening of the selected students for learning disabilities using Pupils Rating Scale. Finally, 30 students identified as having learning disabilities from each of the selected schools making a total of 210 participants were used in the study. Two research instruments were used for this study; namely The Pupil Rating Scale (Myklebust, 1981) Revised with reliability coefficient of 0.62 (Lazarus, 2009) and Adolescents with Learning Disabilities' Reproductive, Sexual and Contraceptive Behaviour Inventory with a reliability coefficient of 0.89.

Data Analysis

Data collected for the study was analysed through a qualitative scale, whereby alternate responses were allotted to the items in the Adolescents with Learning Disabilities' Reproductive, Sexual and contraceptive Behaviour Inventory in order to make it uniform in decision-making. Frequencies and percentages were used generally for the demographic data and research questions while chi square was used for the test of hypotheses.

Results

Research question 1:

Which method of contraceptive is readily available and used by ALDs?

Table 1: The Most Readily Available Method of Contraceptive for ALDs

The most readily available method of contraceptives		**Sex**		**Total**
		Male	**Female**	
Abstinence	Count	59	48	107
	% of Total	28.1%	22.9%	51.0%
Male and Female Condom	Count	23	9	32
	% of Total	10.9%	4.2%	15.1%
Vaginal Spermicides	Count	4	6	10
	% of Total	1.9%	2.9%	4.8%
Oral Contraceptive Pills	Count	6	22	28
	% of Total	2.9%	10.5%	13.4%
Injectable hormonal Contraception	Count	2	6	8
	% of Total	1.0%	2.9%	3.8%
Progestin Implants	Count	0	2	2
	% of Total	0%	1.0%	1.0%
Withdrawal	Count	6	6	12
	% of Total	2.9%	2.9%	5.7%
Fertility awareness	Count	5	6	11
	% of Total	2.3%	2.9%	5.2%
Total	**Count**	**105**	**105**	**210**
	% of Total	**50.0%**	**50.0%**	**100.0%**

Table 1 showed that the most readily available method of contraceptive used by ALDs was abstinence with 51.0% (28.1% males and 22.9% females) of the total respondents. This was followed by the use of condom (15.1%) and oral contraceptive pills (13.4%).

Research question 2: *What are the sexual behaviour trends among ALDs?*

Table 2: Sexual Behaviour Trends among Adolescents with Learning Disabilities

	Male						Female						Total					
	Agree		Disagree		Undecided		Agree		Disagree		Undecided		Agree		Disagree		Undecided	
KNOWLEDGE OF SEXUAL BEHAVIOUR	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
I have a girl/boyfriend	50	23.8	50	23.8	5	2.4	47	22.4	57	27.1	1	0.5	97	46.2	107	51.7	6	2.9
I have had sexual experience(s) before now	24	11.4	80	38.1	1	0.5	20	9.5	85	40.5	0	0	44	21	165	78.6	1	0.5
I have more than one sexual partner	10	4.8	91	43.3	4	1.9	9	4.3	89	42.4	7	3.3	19	9	180	85.7	11	5.2
I have sex regularly	9	4.3	94	44.8	2	1	10	4.8	91	43.3	4	1.9	19	9	185	88.1	6	2.9
I have been sexually abused before	9	4.3	70	33.3	2	1	40	19	85	40.6	4	1.9	49	23.3	155	73.8	6	2.9
I have attempted abortion before	7	3.3	94	44.8	4	1.9	10	4.8	94	44.8	1	0.5	17	8.1	188	89.5	5	2.4
It is difficult to obtain information about sexual behaviour	34	16.2	59	28.1	12	5.7	33	15.7	64	30.5	8	3.8	67	31.9	123	58.6	20	9.5
I have visited a health facility to get sexuality education services	15	7.1	77	36.7	13	6.2	16	7.6	82	39	7	3.3	31	14.8	159	75.7	20	9.5
Peer pressure has a great influence on my sexual life	30	14.3	62	29.5	13	6.2	34	16.2	65	31	6	2.9	64	30.5	127	60.5	19	9
I am always attracted to the opposite sex	32	15.2	71	33.8	2	1	21	10	77	36.7	7	3.3	53	25.2	148	70.5	9	4.3
I have never heard about homosexuality	23	11	76	36.2	6	2.9	23	11	74	35.2	8	3.8	46	21.9	150	71.4	14	6.7
I believe that masturbation is a kind of sexual behaviour	42	20	45	21.4	18	8.6	49	23.3	44	21	12	5.7	91	43.3	89	42.4	30	14.3

Table 2 showed the responses of the ALDs based on their sexual behaviours. The result indicated that 46.2% (23.8% males and 22.4% females) of the respondents had a girl/boyfriend. 21.0% (11.4% males and 9.5% females) had had sexual experience before now. 9.0% (4.8% males and 4.3% females) had more than one sexual partner while another 9.0% (4.3% males and 4.8% females) had sex regularly. 23.3% (4.3% males and 19.0% females) had been sexually abused while 8.1% had attempted abortion. 75.7% (36.7 % males and 39.0% females) had never visited a health facility for sex education. 30.5% (14.3% males and 16.2% females) agreed that peer pressure had more influence on their

sexual life. 71.4% (36.2% males and 35.2% females) disagreed that they had never heard about homosexuality.

Research question 3: *What is the level of knowledge and use of contraception among ALDs?*

Table 3: Knowledge and Use of Contraception among Adolescents with Learning Disabilities

KNOWLEDGE AND USE OF CONTRACEPTIVE	Male						Female						Total					
	Agree		Disagree		Undecided		Agree		Disagree		Undecided		Agree		Disagree		Undecided	
	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
I have heard about contraceptives before	52	24.8	41	19.5	12	5.7	62	29.5	37	17.6	6	2.9	114	54.3	78	37.1	18	8.6
I have used contraceptive before	8	3.8	85	40.5	12	5.7	11	5.2	78	37.1	16	7.6	19	9	163	77.6	28	13.3
I am currently using contraceptive	12	5.7	74	35.2	19	9	9	4.3	84	40	12	5.7	21	10	158	75.2	31	14.8
I have visited family planning clinics before	13	6.2	80	38.1	12	5.7	14	6.7	80	38.1	11	5.2	27	12.9	160	76.2	23	11
I do visit family planning clinic regularly	5	2.4	87	41.4	13	6.2	4	1.9	90	42.9	11	5.2	9	4.3	177	84.3	25	11.4
I do discuss family planning with partner before sex	10	4.8	79	37.6	16	7.6	7	3.3	88	41.9	10	4.8	17	8.1	167	79.5	26	12.4
I believe that the use of contraceptive can cause abnormalities in babies	19	9	58	27.6	28	13.3	36	17.1	49	23.3	20	9.5	55	26.2	107	51	48	22.9
Birth control pills protect users against Sexually Transmitted Diseases	24	11.4	56	26.7	25	11.9	34	16.2	51	24.3	20	9.5	58	27.6	107	51	45	21.4
Condom protects users against sexually transmitted diseases /HIV/AIDS	72	34.3	25	11.9	8	3.8	67	31.9	23	11	15	7.1	139	66.2	48	22.9	23	11
Condom cannot be used more than once	59	28.1	22	10.5	24	11.4	61	29	25	11.9	19	9	120	57.1	47	22.4	43	20.5
Condoms are effective for preventing pregnancy	62	29.5	27	12.9	16	7.6	66	31.4	19	9	20	9.5	128	61	46	21.9	36	17.1
I like using condom during sexual act	29	13.8	56	26.7	20	9.5	16	7.6	70	33.3	19	9	45	21.4	126	60	39	18.6
Contraceptives are safe for adolescents	32	15.2	45	21.4	28	13.3	34	16.2	50	23.8	21	10	66	31.4	95	45.2	49	23.3
I believe abstinence is the best contraceptive method	54	25.7	28	13.3	23	11	60	28.6	31	14.8	14	6.7	114	54.3	59	28.1	37	17.6
There are no youth friendly family planning clinics around me	52	24.8	37	17.6	16	7.6	41	19.5	44	21	20	9.5	93	44.3	81	38.6	36	17.1

Table 3 showed the responses of the adolescents with learning disabilities based on their knowledge and use of contraception. The results showed that 54.3% (24.8% males and 29.5% females) of the respondents had heard about contraceptive before, 9.0% (5.7% males and 4.3% females) had used contraceptive before while 10.0% of the respondents were using contraceptives as of the time of this investigation. 12.9% (6.2% males and 6.7% females) had visited family planning clinic before. 79.5% (37.6% males and 41.9% females) did not discuss family planning with partner before sex. 66.2% (34.3% males and 31.9% females) believed that condom users were protected against sexually transmitted diseases while 61.0% (29.5% males and 31.4% females) agreed that condoms were effective for preventing pregnancy. 31.4% agreed that contraceptives were safe for adolescents while 45.2% disagreed. 54.3% (25.7% males and 28.6% females) believed that abstinence is the best contraceptive method. 44.3% (24.8% males and 19.5% females) believed that there were no youth friendly family planning clinics around them.

Hypothesis 1: Gender will not significantly be a determinant of ALDs knowledge of sexual behaviour

Table 4: Chi Square Analysis of Gender on Adolescents with Learning Disabilities' Knowledge of Sexual Behaviour

VARIABLES		AGREE	DISAGREE	UNDECIDED	TOTAL	$\chi^2_{cal.}$	Df	$\chi^2_{tab.}$	P
MALE	O	287	891	82	1260	2.15	2	5.99	NS
	E	286.50	900	73.5					
FEMALE	O	286	909	65	1260				
	E	286.50	900	73.5					
TOTAL		**573**	**1800**	**147**	**2520**				

NS = Not significant at the level of 0.05

Table 4 indicated that gender is not significantly a determinant of adolescents with learning disabilities' knowledge of sexual behaviour. The $\chi^2_{cal.}$ which is 2.15 is less than the

$\chi^2_{tab.}$ which is 5.99 and on this basis the null hypothesis (H_o) is accepted at 0.05 level of significant ($\chi^2_{cal} = 2.15$, df = 2, $p > 0.05$).

Hypothesis 2: Gender will not significantly be a determinant of ALDs knowledge and use of contraceptive

Table 5: Chi Square Analysis of Gender on Adolescents with Learning Disabilities' Knowledge and Use of Contraceptives

VARIABLES		AGREE	DISAGREE	UNDECIDED	TOTAL	$\chi^2_{cal.}$	Df	$\chi^2_{tab.}$	P
MALE	O	503	800	272	1575	3.43	2	5.99	NS
	E	512.50	809.50	253					
FEMALE	O	522	819	234	1575				
	E	512.50	809.50	253					
TOTAL		**1025**	**1619**	**506**	**3150**				

NS = Not significant at the level of 0.05

Table 5 indicated that gender is not significantly a determinant of adolescents with learning disabilities' knowledge and use of contraceptive. The $\chi^2_{cal.}$ which is 3.43 is less than the $\chi^2_{tab.}$ which is 5.99 and on this basis the null hypothesis (H_o) is accepted at 0.05 level of significant ($\chi^2_{cal} = 3.43$, df = 2, $p > 0.05$).

Hypothesis 3: Age will not significantly be a determinant of ALDs knowledge of sexual behaviour

Table 6: Chi Square Analysis of Age on Adolescents with Learning Disabilities' Knowledge of Sexual Behaviour

VARIABLES		AGREE	DISAGREE	UNDECIDED	TOTAL	$\chi^2_{cal.}$	df	$\chi^2_{tab.}$	P
10 – 13 YEARS	O	110	674	56	840	278.09	4	9.49	S
	E	191	600	49					
14 – 16 YEARS	O	122	705	13	840				
	E	191	600	49					
17 – 19 YEARS	O	341	421	78	840				
	E	191	600	49					
TOTAL		**573**	**1800**	**147**	**2520**				

S = Significant at the level of 0.05

Table 6 indicated that age is significantly a determinant of adolescents with learning disabilities' knowledge of sexual behaviour. The $\chi^2_{cal.}$ which is 278.09 is greater than the $\chi^2_{tab.}$ which is 9.49 and on this basis the null hypothesis (H_o) is rejected at 0.05 level of significant ($\chi^2_{cal} = 278.09$, df = 4, $p < 0.05$).

Also, there were significant associations in the sexual behaviours of:

a) 10 – 13 years and 14 – 16 years age ranges ($\chi^2_{cal} = 28.11$, df = 1, $p < 0.05$).
b) 10 – 13 years and 17 – 19 years age ranges ($\chi^2_{cal} = 180.38$, df = 1, $p < 0.05$).
c) 14 – 16 years and 17 – 19 years age ranges ($\chi^2_{cal} = 221.65$, df = 1, $p < 0.05$).

Hypothesis 4: Age will not significantly be a determinant of ALDs knowledge and use of contraceptive

Table 7: Chi Square Analysis of Age on Adolescents with Learning Disabilities' Knowledge and Use of Contraceptives

VARIABLES	AGREE	DISAGREE	UNDECIDED	TOTAL	$\chi^2_{cal.}$	df	$\chi^2_{tab.}$	P
10 – 13 YEARS O	288	574	188	1050				
E	341.67	539.67	168.67					
14 – 16 YEARS O	293	647	110	1050	92.51	4	9.49	S
E	341.67	539.67	168.67					
17 – 19 YEARS O	444	398	208	1050				
E	341.67	539.67	168.67					
TOTAL	**1025**	**1619**	**506**	**3150**				

S = Significant at the level of 0.05

Table 7 indicated that age is significantly a determinant of adolescents with learning disabilities' knowledge and use of contraceptives. The $\chi^2_{cal.}$ which is 92.51 is greater than the $\chi^2_{tab.}$ which is 9.49 and on this basis the null hypothesis (H_o) is rejected at 0.05 level of significant ($\chi^2_{cal} = 92.51$, df = 4, $p < 0.05$).

Also, there are significant association in the knowledge and use of contraceptive of:

a) 10 – 13 years and 14 – 16 years age ranges ($\chi^2_{cal} = 24.82$, df = 1, $p < 0.05$).
b) 10 – 13 years and 17 – 19 years age ranges ($\chi^2_{cal} = 66.12$, df = 1, $p < 0.05$).
c) 14 – 16 years and 17 – 19 years age ranges ($\chi^2_{cal} = 120.47$, df = 1, $p < 0.05$).

Discussion

Readily Available Method of Contraceptive Use For Alds

This study revealed that both male and female adolescents with learning disabilities believed that abstinence was the best contraceptive method. Also, the male respondents identified condom as the second option while the female respondents identified oral contraceptive pills. The fact that majority of the respondents in this study chose abstinence is quite commendable. Though for some adolescents with learning disabilities abstinence may be a difficult choice. Those who choose to abstain from sexual intercourse should be encouraged and supported by their parents, peers and society including the media because abstinence is the most effective means of birth control and prevention of sexually

transmitted infections (STIs) and is a viable strategy for reducing unintended pregnancy and achieve reduction in STI rates.

Sexual Behaviour Trends among Alds

The study showed that about 21 per cent of ALDs had had sexual intercourse. This supports Sunmola, Dipeolu, Babalola and Adebayo (2003) that of adolescents without learning disabilities aged 11 to 25, about 33% of the population covered had already had first sexual experience but more males than females reported having experience first sexual encounter. The report from this study also showed that 23.3% of the adolescents with learning disabilities have been sexually abused. This is in agreement with the report of Allington-Smith, Ball and Hayfor (2002) that adolescents with learning disabilities are susceptible to being sexually abused. The report of Chamberlain, Rauh, Passer, McGrath and Burket, (1984) showed that 1 in 3 and 1 in 4 adolescents with learning disabilities had suffered sexual abuse in America while Baker and Duncan (1985) reported 1 in 10 adolescents with learning disabilities in Britain. These reports can be connected to the findings of this study if converted to ratio we will have 1 in 4.3 adolescents with learning disabilities used for this study reporting that they have been sexually abused. Cooke (1990) also reported that prevalence of sexual abuse among adolescents with learning disabilities is 4-5%.

Knowledge and Use of Contraception among Adolescents with Learning Disabilities

The findings from this research implied that adolescents with learning disabilities used for this study have 54.3% knowledge and 9.0% use of contraception and only 10.0% are currently using contraceptive. Sunmola *et. al.,* (2003) reported that a wide disparity was found in knowledge and use of contraceptive methods studied. To collaborate this finding, the Federal Office of Statistics (1992) reported that among adolescents aged 15-19 who were part of the survey and had 10% of births in population rarely use contraceptives as only 2% of the adolescents were then users of modern contraceptive method. Ejembi and Otu (2004) reported in their study that only 32.4% of the sexually exposed adolescents had ever used or were using a method of contraceptive use. Holschneider and Alexander (2003) reported that only 18% of sexually active adolescents from 845 youth used reported always or sometimes using condom.

Also, the result from this study indicated that 45.2% of the adolescents with learning disabilities are of the opinion that contraceptives are not safe for adolescents just as 79.5% do not believe that family planning should be discussed with partner before sex. Although 66.2% believed condom protects users against STIs and HIV/AIDS while 51.0% are aware that birth control pills do not protect users against STI and HIV/AIDS. This is

also supported by Mohammadi, Mohammad, Farahani, Alikhani, Zare, Tehrani, Ramezankhani, and Alaeddini, (2006) who reported that few adolescents used for their study had in depth knowledge of contraception. About half knew that condom are effective for preventing pregnancy, 42% knew that it can prevent STI.

Therefore the reason for the failure to use contraceptive by ALDs is the fact that most ALDs believe that using contraceptive would be tantamount to admitting that they are planfully and willingly sexually active. Going on the pills or purchasing a condom requires an adolescent with learning disability to acknowledge that she/he is having sexual relations. For many young people this as an extremely difficult admission to make. Moreso, adolescents with learning disabilities believe that there are no youth friendly clinics around them and cannot confined in most health care providers with confidentiality.

Gender Will Not Significantly Be a Determinant of Alds Knowledge of Sexual Behaviour

The finding showed that both male and female adolescents with learning disabilities exhibited the same sexual needs, feelings and drives and has similar perception towards sexual issues. This result supports the findings of Falaye and Aremu (2004) who found that there were no statistically significant differences in the male and female adolescents' sexual behaviours in terms of reaction to pubertal changes, sources of sex information and attitudes to reproductive health matters. Also, Falaye, Falaye and Ogundokun (2006) reported that gender differential were minimal in the sexual behaviours of adolescents. Jacobo, Herrera, Cota, Nunez and Guzman (2002), reported that there was no significant difference in sex based on sexual behaviour of the adolescents without learning disabilities. Therefore male and female adolescents with learning disabilities should be seen as exhibiting similar sexual behaviour and responding to the issues of sex in similar manner. They need to be educated equally on issues relating to sex and sexuality.

Gender Will Not Significantly Be a Determinant of Alds Knowledge and Use of Contraceptive

The study indicated that both male and female adolescents with learning disabilities have similar knowledge and use of contraceptives. Therefore, both male and female adolescents with learning disabilities should be educated on the various contraceptive methods available to them and should equally be allowed the right to choose which contraceptive that is suitable to them. American Academy of Pediatrics (2007) reported that male and female adolescents' level of knowledge about how to use contraception effectively does

not necessarily correlates with consistent use and the fear that their parents will find out prevents them or may delay use of contraception in addition to the believe that birth control is dangerous to adolescents.

Age Will Not Significantly Be a Determinant of Alds Knowledge of Sexual Behaviour

The study showed that the responses ALDs gave in respect of their sexual behaviours were significantly difference according to their age groups. The knowledge of sexual behaviour among 10-13 years, 14-16 years and 17-19 years were quite different from each other. This supports the reports of Falaye, Falaye and Ogundokun (2006) that age of adolescents greatly influenced sexual behaviours of adolescents. Finer and Philbin (2013) reported that middle adolescents were more sexually active than early adolescents. Therefore adolescents with learning disabilities at their early adolescence period should also be targeted with sexuality education as regarding the issues of sex and sexual behaviours, this will help to reduce the incidences of increased risky sexual behaviour, increased risk of sexually transmitted infections, HIV/AIDS, unintended pregnancies and other health consequences which are common among adolescents aged 15-19 years as reported by Population Reference Bureau (2000).

Age Will Not Significantly Be a Determinant of Alds Knowledge and Use of Contraceptive

The study showed that the pattern of knowledge and use of contraceptive among adolescents with learning disabilities varied according to their grouped age range. The late adolescents with learning disabilities (aged 17-19 years old) exhibited more understanding in the knowledge and use of contraceptives compared to 10-13 years and 14-16 years old. This finding corroborates with the submission of Miller and Moore (1990) that it comes as no surprise to learn that one of the best predictors of contraceptive use is the adolescent's age, that late adolescents are better informed, less guilty about having sex and better able to see and understand the potentially negative consequences of an unwanted pregnancy. Therefore, providing information to adolescents with learning disabilities about contraception especially at the early adolescence period does not result in increased rates of sexual activities, earlier age of first intercourse or greater number of partner as reported by Kirby, Laris and Rolleri (2007).

Conclusions

Adolescents with learning disabilities (ALDs) are as sexually experienced as the regular counterpart and they exhibit almost the same pattern of reproductive health and sexual

behaviour with those without learning disabilities. Therefore, attitude about contraception as well as sexuality education and counselling needs of ALDs should not be overlooked. Proper attention should be given to them as regards sexual behaviours and use of contraception.

Recommendations

Premised on this study, the following recommendations are made:

- Sexuality education should be incorporated into the school curriculum for ALDs
- Special educators should be properly placed and be encouraged to help ALDs in solving their sex-related problems.
- Early ALDs should be targeted with sex education to reduce te incidences of unplanned pregnancy, STIs, HIV/AIDS and sexual abuses.
- Youth friendly health care facilities should be made available and easily accessible for ALDs.
- Health care providers should be encouraged to educate ALDs on appropriate contraception for them and also help to assure them of adequate confidentiality and protection.
- Parents should be enlightened, educated and encouraged to be involved in sexuality education of their ALDs at home.

References

1. Allington-Smith, P., Ball, R., & Haytor, R. (2002) Management of sexually abused children with learning disabilities. *Adv Psychiat Treat*., 8, 67-72
2. American Academy of Pediatrics (2007) *Contraception and Adolescents committee on Adolescence*, doi: 10.1542/Peds 2007-2535
3. Arscott, K, Dagnan, D, & Kroese, B. S. (1999) Assessing the ability of people with a learning disability to give informed consent to treatment. *Psychol Med*. 29(6): 1367-1375
4. Baker, A. W. & Duncan, S. P. (1985) Child sex abuse: a study of prevalence in Great Britain. *Child Abuse Negl,* 1985; 9:457-67.
5. Brown, Y. L., Hennessy, M., Sales, J. M., Di Clemente, R. J., Salazar, L. F.,
6. Vanable, P. A., Carey, M. P., Romer, D., Valois, R. F., Brown, L. K., & Stanton, B. (2011) Multiple Method Contraception Use among African American Adolescents in four US cities. *Infectious Diseases in Obstetrics and Gynaecology.* Article ID 765917, doi: 10.1155/2011/765917.

7. Chamberlain, A., Rauh, J., Passer, A., McGrath, M. & Burket, R. (1984) Issues in fertility control for mentally retarded female adolescents: 1. Sexual activity, sexual abuse, and contraception. *Pediatrics*, 73:445-50.
8. Cheng, M. M, & Udry, J. R. (2002) Sexual behaviours of physically disabled adolescents in the United States. *J Adols Health*, 31: 48-58.
9. Cooke, L. B. (1990) Abuse of mentally handicapped adults. *British Medical Journal,* 300: 193
10. Datta, S. D., Sternberg, M. & Johnson, R.E. (2007) Gonorrhea and Chlamydia in the United Sates among persons 14 to 39 years of age, 1999 to 2002. *Annals of Internal Medicine,* 147(2): 89-96.
11. Ejembi, C. L., Otu, A. (2004) Sexual behaviour, contraceptive practice and reproductive health outcomes among Nigerian university students. *J Comm Med Prim Hlth Care*, 16(2): 8-16.
12. Falaye, A. O. & Aremu, A.O. (2004) Gender differences in the sexual behaviours of selected adolescents in Southern Nigeria. *Nigerian Journal of Guidance and Counselling,* 9(1) 240-254
13. Falaye, A. O., Falaye, T. A. & Ogundokun, M. O. (2006) Age, gender, religion and physical location as predictors of social interaction of some Nigerian adolescents during puberty. *African Journal for the Psychological Study of Social Issues.* Vol. 9(2) 217-232
14. Federal Office of Statistics. (1992) *Nigeria demography and health Survey of 1990*, Lagos Finer, L. B. (2010) Unintended pregnancy among us adolescents: according for sexual activity. *The Journal of Adolescent Health*, 47(3): 312-314.
15. Finer, L. B. & Philbin, J. M. (2012) Sexual Initiation, Contraceptive Use and Pregnancy among Young Adolescents. *Journal of American Academy of paediatrics*, doi:10. 1542/Peds. 2012-3495
16. Grover, S. R. (2002) Menstrual and contraceptive management in women with an intellectual disability. *Med J*, 176(3): 108-110.
17. Guttmacher, S., Lieberman, L., Ward, D., Freudenberg, N., Radosh, A. & Des Jarlais, D. (1997) Condom availability in New York City Public high Schools: Relationshps and Condom use and Sexual behaviour. *American Journal of Public Health,* 87: 1427-1433.
18. Holschneider, S. O. & Alexander, C. S. (2003) Social and psychological influences on HIV preventive behaviours of youth in Haiti. *Journal of Adolescent Health,* 33 (1): 31-40.

19. Jacobo, Y. D., Herrera, C. M., Cota, C. F., Nunez, M. M. & Guzman, O. R. (2002) Sexual and reproductive health in rural adolescents. Effectiveness of training. *Revista Medicadel Instituto Mexicano del Seguro Social*. 40 (2): 137-142.
20. Koch, P. (1996) Promoting Healthy Sexual Development during early Adolescent. 1993. In: L. Steinberg; *Adolescence*. Fourth edition. Bouston, McGraw Hill. Pp 293-307
21. Katchadourian, H. (1990) Sexuality. In S. Feldman and G. Elliott (Eds). *At the threshold the developing adolescent*. Cambridge mass: Harvard University press. Pp 330-351.
22. Kirby, D. B., Laris, B. A. & Rolleri, L. A. (2007) Sex and HIV education programs: their impact on sexual behaviours of young people throughout the world. *J Adoles Health*, 40: 206-217.
23. Lazarus, K. U. (2009) *Two instructional strategies as intervention for enhancing reading comprehension of students with learning disabilities in Lagos state, Nigeria*. Unpublished Ph.D thesis. University of Ibadan, 2009.
24. Miller, B. & Moore, K. (1990) Adolescent sexual behaviour, pregnancy and parenting, research through the 1980s. *Journal of marriage and family.* 52, 1025-1040.
25. Mohammadi, M. R., Mohammad, K., Farahani, F. K. A., Alikhani, S., Zare, M., Tehrani, F. R., Ramezankhani, A. & Alaeddini, F. (2006) Reproductive Knowledge, Attitude and Behaviour among Adolescent Males in Tehran. *Iran International Family Planning Perspectives*, Volume 32, Number 1,
26. Myklebust, H. R. (1981) *The Pupil Rating Scale, Revised: Screening for Learning Disabilities.* W. B. Saunders Company, New York.
27. Outsiders. (2009) Sex and learning disabilities. http://www.outsiders.org.uk/leaflets/pld-Leaflet
28. Population Reference Bureau. (2000) The World's Youth. Washington DC www.prb.org/template.cfm?section+PRB&template=/contentmanagement/contentDisplay. Cfm & Content ID=3313
29. Public Health Agency. (2005) *Abuse of children with disabilities*. NCFV Canada. *Threshold the developing adolescent.* Cambridge mass: Harvard University press, Pp 330-351.
30. Sunmola, A. M., Dipeolu, M., Babalola, S., & Adebayo, O. D. (2003) Reproductive knowledge, sexual behaviour and contraceptive use among adolescents in Niger State of Nigeria. *Afr J Reprod Hlth*, 7(1): 37-48.
31. Youth Embassy. (2004) Sexuality: Your child as a sexual being. http://www.youthembassy.com/parents_sexuality.asp

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