



Health Risk Behaviours among In-School Adolescents in Enugu East Local Government Area, Enugu State, Nigeria

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Abstract

This study determined health risk behaviours among in-school adolescents in Enugu East Local Government Area of Enugu State. Four objectives, four corresponding research questions and three null hypotheses were posed to guide the study. The descriptive survey design was adopted for the study. The population for the study was secondary school students in Enugu east local Government Area. Multi-stage sampling techniques were used to draw the sample of 540 in-school adolescents for the study. A researcher designed Health risk Behaviours Questionnaire- HRBQ was the instrument used for data collection. Face validity of the instrument was established by three experts from the department of Human Kinetics and Health Education, Enugu State University of Science and Technology. The percentages and frequencies were used to answer the research questions. The null hypothesis was tested using chi-square at .05 level of significance. The study revealed that (418.5%) in-school adolescents had health risk behaviours. (59.8%) in-school adolescents had Health risk Behaviours based on gender higher than that of females (70.1%). The overall in-school adolescents in different classes are JSS1 (52.5%) JSS2 (54.8%), SSI (52.2%), SS2 (68.8%). The overall of in-school adolescents aged 13-17 years (51.3%) had health risk behaviours, less than those aged 18-22 years (59.2%). The study recommended that peer education programme should be introduced where students in-school encourage each other on adopting good health behaviours and discourage risky ones. Also health education programme should be organized by schools to educate in-school Adolescence on health risk behaviours

Keywords: Health Risky behaviors, students, Adolescent, in-school.

Introduction

Health risky behaviours contribute to the leading causes of death and disability among adults and youths, and contribute to educational and social problems. It can also cause alcohol and other drug abuse, unintentional injuries, property damage violence including suicide, tobacco use, unhealthy dietary behaviours, physical inactivity, sexual behaviours that contribute to unintended teen pregnancy, sexually transmitted diseases, HIV, diminished lifespan, and treatment. Secondary school students are in adolescence which is typically a time when young people begin to challenge parental controls and values and to be influenced by their peers. The family is known to be an essential source of support and agent of intervention and health promotion through the school years, so relationship with parents are very important during the period (John, Matthew, Rashed, 2012). During this period, schools become more important where the support of teachers and peers may have more influence than their home environment (John, 2017). Also schools play a critical role in promoting the health and safety of young people and help them establish lifelong healthy behaviours (Adeleye, 2018).

Health behaviours is an action taken by a person to maintain, attain, or regain good health and to prevent illness. It also reflects a persons health beliefs. Some common health behaviours are exercising regularly, eating a balance diet, wearing seat belts, practicing safe sex, seeking information about health matters and obtaining necessary inoculation (Adriana, 2017). Health – risk behaviours can be defined as any activities undertaken by people with a frequency or intensity that increase risk of disease or injury (Aghaji & Omotow, 2010). The six priority health risk- behaviours according to (Anderson & Mueller 2016) are alcohol and drug abuse, behaviours that contribute to unintentional injuries and violence including suicide, tobacco and sexual behaviours that contribute to unintended teen pregnancy and sexually transmitted infections, including HIV (Martin, 2014).

Health risky behaviours are mostly acquired during adolescent and their results are reflected on to adulthood, and influence cognitive performance, emotions, and overall quality of life (Supa 2017). Changing health risk- behaviours has been shown to decrease morbidity and mortality and enhance quality of life (Collins & Steinberg, 2016). It was reported that in the Philippines four out of ten important causes of deaths among secondary school students are attributable to health risk behaviours (Eaton & Harris, 2018). Some studies done in African include Nigeria reported that adult behavioral pattern such as drinking, smoking and pre-marital sexual activities started from secondary schools, and they constituted major health problems of secondary school students (Ekanem & Asuzu, 2014). Behavioral problems that occur during in-school adolescence such as substance use and violence behaviours may continue throughout adulthood, associated with social non-adaptation, substance abuse and conflicts (John & Matthew, 2012). The peer group may serve as a model and influence behaviours and attitudes, it may provide easy access, encouragement and an appropriate social setting for consumption (Miller, 2017). Peers may strongly determine preference in the way of dressing, speaking, using illicit substances, sexual behaviours, adopting and accepting violence, adopting criminal and anti-social behaviours and in many other areas of the adolescents life (Raji, 2013). An example of this is that motives alcohol consumption given by adolescents are related to social events, which usually take place in the company of friends.

School is a setting where interpersonal relations are promoted, which are important for youngsters personal and social development (Ravert, 2018). It is responsible for the transmission of behavioral norms and standards and it represents an essential role in the adolescents socialization process. The school is able to gather different peer communities and to promote self-esteem and a harmonious development between adolescents, which makes it a privileged space for meetings and interactions (Nelson & Patience, 2018). Adolescent spends a great part of their time at school, which also makes it a privileged involvement in or protection from risk behaviours (Adeleye & Oluwatosin, 2014). Fahlen & Janson (2018) despite the positive influence of the peer groups during adolescence, the higher the adolescents autonomy from the peer group, the higher his/her resilience against its influence. (Fahlenb & Janson, 2018). This resilience seems to increase with age, which may mean that it is associated with in-school adolescents' maturity. And girls emerge in several studies as more resilient than boys (Rohan, 2017). Weinhardt (2013) assert that influence of the peer group is the type of friendship, which adolescents maintain with their peer group, if friends are close they have a greater influence on the others behaviours. When the friendship is perceived as reciprocal and of quality, is exerts greater influence (Akande, 2010). Adolescent that is able to maintain an assertive refusal are less susceptible to the groups influence (Boriffice, 2014). The relationship with parents may be a mitigating factor of the negative influence by peers. Communicating family rules and parental style have been inversely associated with substance, alcohol and tobacco consumption during adolescents development up to adulthood. Communication between parents and adolescents emerges as a protective factor for alcohol, tobacco and substance use (W.H.O, 2015). Albolfotouh, Bossiouni, (2017) observed that family meals could lead to creating a closer relationship between parents and adolescents, by strengthening a positive relationship and avoiding certain health risk behaviours, such as substance use among girls and alcohol consumption, physical violence and robberies among boys. These differences between genders may be due to a greater importance that girls attribute to family activities, but they do not reveal that boys are indifferent to them, only that the relationship between genders may differ. Mc carty, Ebel, (2013) asserted that parental monitoring and communication with parents protected adolescents of both genders from being involved in health risk behaviours. Parental monitoring can be defined as parent's knowledge about their children's activities, who they hang out with and what they do. It has been associated to protect various risk behaviours throughout adolescence such as substance use or sexual behaviours. It may vary according to age, gender or ethnicity and it decreases with age. Isaiah & Ola (2016) reported that the greater the parental monitoring the lower the adolescents' involvement in risk behaviours. The peer group was found to influence all risk behaviours assessed by the authors. The in-school adolescents that had the perception of the involvement of peers in certain behaviours were more involved in similar behaviours. This study therefore seeks to find out Health Risk behaviours of in-school adolescents in Enugu East Local Government Area, Enugu State.

Purpose of the study

The purpose of this study was to determine the health risk behaviours among in-school adolescent in Enugu East Local Government Area Enugu State. Specifically, the study sought to determine:

1. Health risk behaviours among in-school adolescent in Enugu east local Government Enugu State.
2. Health risk behaviours among in-school adolescents in Enugu East local Government Enugu state based on age.
3. Health risk behaviours among in-school adolescents in Enugu East local Government Enugu state based on class of study

4. Health risk behaviours among in-school adolescents in Enugu East local Government Enugu state based on gender

Research questions

The following research questions guided the study

1. What are the Health risk behaviours among in-school adolescents secondary school in Enugu East local Government Enugu state?
2. What are the Health risk behaviours among in-school adolescents secondary school in Enugu East local Government Enugu state according to age?
3. What are the Health risk behaviours among in-school adolescents secondary school in Enugu East local Government Enugu state according to class of study?
4. What are the Health risk behaviours among in-school adolescents secondary school in Enugu East local Government Enugu state based on gender?

Hypotheses

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

1. There is no significant difference in the health risk behaviours among in-school adolescent in Enugu east local Government area Enugu state based on age
2. There is no significant difference in the Health risk behaviours among in-school adolescents in Enugu East local Government Enugu state based on class of study
3. There is no significant difference in Health risk behaviours among in-school adolescents in Enugu East local Government Enugu state according to gender.

Methods

The descriptive survey design was adopted for the study. The population for the study comprised of 10, 125 senior in-school adolescents in Enugu east L.G.A of Enugu state. Multi-stage sampling technique was used to select the sample size of 540 respondents. The first stage involved stratification of 40 secondary schools in Enugu East L.G.A of Enugu state into boys, girls and co-educational secondary schools. The second stage involved the use of simple random sampling technique of balloting without replacement to draw 20 (5boys, 4 girls' and 11 co-educational) secondary schools out of the 40 secondary school in Enugu East L.G.A. the third stage involved simple random sampling technique of balloting without replacement to draw 48 in-school adolescents (6 boys and 6 girls in each of Jss1, Jss2 ss1 & ss2 classes) from each of the 20 selected secondary schools. The instrument for data collection was the researcher-designed Health Risk Behaviours Questionnaire (HRBQ). The instrument was validated by three experts from the department of Human Kinetics and Health Education, Enugu State University of Science and Technology, Enugu. A letter of introduction duly signed by the Head, Department of Human Kinetics and Health Education, Enugu State University of Science and technology, Enugu, seeking permission to carry out the study on Health risk behaviours among in-school adolescents in Enugu East L.G.A was presented to each principal of the selected secondary schools that was used for the study. The copies of the questionnaire were administered to the respondents in the secondary schools by the researcher and with the help of the form teachers who assisted in the distribution and collection of the instruments were collected from the respondents at the spot. The information from copies of the questionnaire were coded and analyzed using statistical package for social science (SPSS) batch system. Frequencies and percentages were used to answer the research questions chi-square statistics were used to test the null hypothesis.



Results

Table 1: Socio- demographic characteristic of Respondents (n=540).

S/N	Variables	F	%
1.	Gender		
	Male	28	51.9
	Female	26	48.1
2.	Class of study		
	J.S.S 1	140	25.9
	J.S.S 2	133	24.6
	S.S 1	146	27.0
	S.S 2	121	22.4
3.	Age		
	13-17 Yrs	275	50.9
	18-22 Yrs	265	49.1

Table 1 shows the social demographic characteristic of respondents. The result shows the percentage of males respondents (51.9%) is greater than that of females (48.1%). The percentage of respondents in S.S1 (27.0%) is greater than those in other classes J.S.S1 (25.9%), J.S.S2 (24.6%), SS2 (22.4%). The aged range of 13-17 years had a higher percentage (50.9%) than those in the age range 18-12 years (49.1%). The result further shows that those between the ages of 13-17 years were the major respondents.

Table 2: Respondents of the in-school adolescents in Enugu East L.G.A that involved in Health Risk Behaviours (N=540)

S/N Health risk behaviours	Yes		No	
	F	%	F	%
1. alcohol	412	76.3	128	23.7
2. tobacco	356	65.9	184	34.1
3. risky sexual behaviours	287	53.1	253	46.9
4. Physical Violence	386	71.5	154	28.5
5. Eating disorders	253	46.9	287	53.1
6. Sports and other unsafe exercise	194	35.9	346	64.1
7. Drug use	372	68.9	168	31.1
Overall Percentage	59.8		70.1	

Table 2 shows the overall percentage of secondary school students that involved in Health risk of those who do not involved in Health risk behaviours. The majority of the respondents indicated that health risk behaviours on taken alcohol was (76.3%) and the least involved in health risk behaviours on sport and others unsafe exercise (35.9%). The table further shows outer most health risk behaviours; smoked tobacco (65.9%) risky sexual behaviours (53.1%); physical violence (71.5%); Eating disorders (46.9%); and drug use (68.9%).

**Table 3
Health risk behaviours among in-school adolescents in Enugu L.G.A based on gender (n=540) 28**

S/N Health risk behaviours	Male				Female			
	Yes		No		Yes		No	
	f	%	f	%	f	%	f	%
1. alcohol	192	68.6	88	31.4	192	73.8	68	26.2
2. smoked tobacco	169	60.4	111	39.6	77	29.6	183	70.4
3. risky sexual behaviours	128	45.7	152	54.2	168	64.6	92	35.4
4. Physical Violence	171	61.1	109	38.9	101	38.8	159	61.2
5. Eating disorders	128	45.7	152	54.3	179	68.8	81	31.2
6. Sports and other unsafe exercise	195	69.6	85	30.4	151	58.1	109	41.9
7. Drug use	189	67.5	91	32.5	209	80.4	51	19.6
Overall percentage	59.8		40.2		59.2		40.8	

Table 3 show the overall percentage of males (59.8%) and females (59.2%) that involved in health risk behaviours while the percentage of secondary school students that do not involved in health risk behaviour was, males 40.2%) and females (40.8%). The table further show that (68.6%) of males and 29.6% females had smoked

tobacco; 45.7% males and 38.8% females involved in physical violence; 45.7% males and 58.1% females involved in sports and other unsafety exercise, 67.5 males and 80.4% females involved in drug used while 31.4% males and 26.2% females do not involved in taken alcohol, 39.6% males and 70.4% females do not involved in smoked tobacco, 54.2% males and 35.4% females do not had risky sexual behaviours, 38.9% males and 61.2% females do not involved in physical violence, 54.3% males and 31.2% females do not eating disorders, 30.4% males and 41.9 females do not involved in sports and other unsafe exercise, 32.5% males and 19.6 females do not involved in drug use.

Table 4: Health Risk Behaviour among in-school Adolescents in Enugu East L.G.A based on class of study (n=540)

S/N Health risk behaviours	F	JSS1 N=140		JSS2 N=133				SS1 N=146				SS2 N=121				
		Yes %	No %	Yes f	No %	Yes f	No %	Yes f	No %	Yes f	No %	Yes f	No %			
1. Alcohol	85	60.7	55	39.6	78	58.6	55	41.4	28	19.2	118	80.8	108	89.3	13	10.7
2. Smoked tobacco	73	52.1	67	47.9	59	44.4	74	55.6	125	85.6	21	14.4	89	73.6	32	26.4
3. Risky sexual behaviours	38	27.1	102	72.9	86	64.7	47	35.3	108	74.0	38	26.0	102	84.3	19	15.7
4. Physical Violence	64	45.7	76	54.3	68	51.1	65	48.9	48	36.1	98	67.1	79	65.3	42	34.7
5. Eating disorders	102	72.9	38	27.1	38	28.6	95	71.4	118	80.8	28	19.2	85	70.2	39	32.2
6. Sports and other unsafe exercise	29	20.7	111	79.3	38	69.2	41	30.8	39	26.7	107	73.3	23	19.0	98	81.0
7. Drug use	124	88.6	16	11.4	92	66.9	44	33.1	63	43.2	83	56.8	97	80.1	24	19.8
Overall		52.5		47.5	89	54.5		45.2		52.2		48.2		68.8		31.5

Table4 Shows the secondary school students who involved in health risk behaviours based on class of study J.S.S1 (52.5%), J.S.S2 (54.8%), SS1 (52.2), SS 2 (68.8%), while those that do not involved in health risk behaviours J.S.S1 (47.5%), JSS2 (54.8%), SS1 (52.2%), SS2 (31.5%). The table further shows that SS2 (68.8%) involved in health risk behaviours more, followed by SS1 (52.2%) then JSS2 (54.8%) and JSS1 (52.5%) therefore Health risk behaviours increased with class of study among secondary school students

Table 5: Health Risk behaviour among in-school adolescents in Enugu East Local Government Area Enugu based on age (n=540)

S/N Health risk behaviour	F ^s	13-17 yrs N=275				18-22 yrs N=265			
		Ye %	No %	Ye f	No %	Ye f	No %	Ye f	No %
1. alcohol	165	60.4	109	39.6	168	63.4	97	36.6	
2. smoked tobacco	186	67.6	89	32.4	197	74.3	68	25.7	
3. risky sexual behaviours	95	34.5	180	65.5	87	32.8	178	67.2	
4. Physical Violence	164	59.6	111	40.4	208	78.5	57	21.5	
5. Eating disorders	108	39.3	111	60.7	95	35.8	170	64.2	
6. Sports and other unsafe exercise	189	68.7	167	31.3	158	59.6	107	40.4	
7. Drug use	80	29.1	86	70.9	186	70.2	70	29.8	
Overall percentage		51.3		48.7		59.2		40.8	

Table 5 shows that the overall percentages of age brackets of the respondents that involved in Health risk behaviours; 13-17 years (51.3%) and 18-22years (59.2%). Those that do not involved in Health risk behaviours: 13-17 years (48.7%) and 18-22years (40.8%)- the table further shows that the secondary school students who involved in health risk behaviours was more among 18-22 years old 59.2%. the response showed that older students in school influence or predisposes students in health risk behaviour.



Table 6: Chi-square Analysis of no significant difference in-school Adolescents in Enugu East L.G.A that involved in health Risk behaviour based on gender.

Variable	N	0(E)	0(E)	X ²	df	p-value
Male	280	200(208.4)	80(71.6)	2.7513	1	.841
Female	260	202(193.6)	58(66.4)			

Table 6 shows the chi-square ($x^2=2.7513$) value with the responding p-value of .841 since are p-value was less than .05 level of significance, the null hypothesis was therefore rejected. This implies that there was a statistically significant difference in secondary school student in Enugu East L.G.A that involved in health risk behaviour based on gender. Therefore, the secondary school students in Enugu East L.G.A that involved in health risk behaviour is not the same for males and females.

Table7: chi-square Analysis of no significant difference in-school Adolescents in Enugu East L.G.A that involved in health Risk behaviour based on class of study (n=540)

Variable	N	0(E) YES	0(E) NO	X ²	df	p-value
Class of study						
J.S.S1	140	116(107.1)	24(32.9)	16.12	3	.815
J.S.S2	133	112(101.7)	21(31.3)			
SS1	146	98(111.7)	48(34.3)			
SS2	121	87(92.5)	34(28.5)			

Table 7 shows the chi-square ($x^2=16.12$) value with the responding p-value of .815 since are p-value was less than .05 level of significance; the null hypothesis was therefore rejected. This implies that there was a statistically significant difference in secondary school student in Enugu East L.G.A that involved in health risk behaviours based on gender. Therefore, the secondary school students in Enugu East L.G.A had health risk behaviours based on class of study.

Table 8: Chi-square Analysis of no significant difference in-school Adolescents in Enugu East L.G.A that involved in health Risk behaviour based on Age

Variable	N	0(E) YES	0(E) NO	X ²	df	p-value
Age						
13-17yrs	275	203(196.1)	72(78.9)	1.7238	1	.841
18-22	265	182(188.9)	83(76.1)			

Table 8 shows the chi-square ($x^2=1.7238$) value with the responding p-value = .841 since the p value was less than 0.05 level of significance, the null hypothesis was rejected. This implies that there was a statistically significant difference in secondary school students in Enugu L.G.A that involved in health risk behaviour based on Age. However age has influence on Health risk behaviour among secondary school students.

Discussion

This study considered health risk behaviours among in-school adolescents based on gender, class and age. The finding in Table 2 showed that overall of in-school adolescents who involved in health risk behaviour was 59.8%. This finding was expected because majority of the students are adults that influence through peer pressure in health risk behaviours that may cause negative consequences to their health. This is in consonant with the finding of Weinhardt, (2013) asserted that influence of the peer group is the type of friendship which adolescents maintain with their peer group if friends are close they may have a greater influence on the other's behaviours.

The findings in table 3 based on gender revealed that males in-school adolescents 59.8 percentage had involved health risk behaviours more than female 59.2%. This findings was expected because males are mostly prone to various health risk behaviour than females in-school adolescents. This is in conforms with the report of Fahlen, Janson, (2018) despite the positive influence of the peer group during adolescence, the higher the adolescent's autonomy from the peer group, the higher his/her resilience against its influence.

The findings in table 4 based on class of study showed in-school adolescents in senior secondary schools had health risk behaviours more than those in junior classes. The findings were expected because in-school

adolescents in senior class are more acquainted or prone to peer pressure with health risk behaviour because of their level of maturity in age and classes of their study. This agreed with Abolfotouh & Bossiouni, (2017), who observed that family meals could lead to creating a closer relation between parents and adolescents by strengthening a positive relationship and avoiding certain risk behaviours such as substance use among girls and alcohol consumption, physical violence, and robberies among boys.

The findings in table 5 based on age shows of in-school adolescents who were involved in health risk behaviour were more among those ages of 18-22 years old more than those 13-17years old. This was expected that older in-school adolescents involved in Health risk Behaviour more than those younger ones. This may be due to fact that older in-school adolescents are more likely to move with their peers, thereby influencing each other in health risk behaviour. This agreed with Isaiah & Ola (2106), which reported that the greater the parental monitoring, the lower the adolescent involvement in risk behaviour.

Conclusion

Based on the findings it was concluded that, greater percentage of in-school adolescents involved in health risk behaviours. 59.8% of males in-school adolescents involved in health risk behaviour more than female in-school adolescents in SS2 involved in health risk behaviours more than those in other classes. In-school adolescents within the age bracket of 18-22 years were involved in health risk behaviours more than those in other age brackets. However, gender, class of study and age were significant factors in health risk behaviours among in-school adolescents in Enugu East Local Government Area of Enugu State.

Recommendations

1. Health education teachers, school health counselors and school administrators should combine their professional experiences to promote health education interventions and health counseling programs aimed at reducing students engagement in health risk behaviours.
2. School's should organize seminars for students provide education on the health-related issues surrounding health risk behaviour.
3. Additions, counselors should also organize awareness campaigns to orient Nigerian secondary school students to the damages caused by health risk behaviour.
4. Parents should properly monitor and counsel their adolescent students on matters relating to health risk behaviour and its effect on their health.

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