Journal of Experimental Research

June 2015, Vol 3 No 1
www.er.journal.com
Email: editor-in-chief@er-journal.com

Received: March 2015
Accepted for publication: May, 2015

Factors And Attitudes Affecting Sexual behaviour And Sex Practices among Secondary School Students in Enugu.

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Abstract

The study aimed to evaluate factors and attitudes affecting sexual behaviour and sex practices of secondary school students, and to suggest changes necessary for preventing and/or reducing HIV transmission among them. 1009 multi-staged sampled secondary school students aged 10-20 years completed the anonymous interviews. 973(96.4%) were Christians and 711(70.5%) day students. Premarital sex was approved of by185(18.3%) of the respondents while 596(59.1%) claimed they would continue to abstain till they get married; 252(25.0%) will abstain for some years while 136(13.5%) will abstain for months. 181(17.9%) believed that abstaining from sex is an abnormal behavior, that HIV/AIDS was a hoax. 573(56.8%) agreed that HIV/AIDs is a disease from which they could protect themselves while 387(38.4%) thought otherwise. Only 581(57.6%) of the respondents would seek advice if they found they were HIV positive. 797(79%) of the respondents were afraid of HIV infection while 520(351.5%) said that someone in their family might become infected. Attitudinal factors showed statistically significant variation with gender, age, school and class of the respondents. A good number also practice homosexuality and lesbianism. Appropriate information about sexuality education and the negative consequences of early sexual exposure, STIs/HIV/AIDS and teenage pregnancy should be provided in public schools.

KEY WORDS: Factors, attitude, sexual behavior, sex practice, secondary school, students, STI/HIV/AIDS.

INTRODUCTION

Childhood and youth are both periods of accelerated learning, and a time during which young people can acquire the necessary knowledge, attitude, values, and skills that can help them to maintain healthy behaviour, and avoid behaviours that put them or others at risk. (UNESCO, 1995, WHO, 1992a). WHO 1992b. McCauley and Slater 1995, Liskin, et al 1989). Secondary school students represent a sexually active group (WHO, 1992a). Their sexual attitude and sexual behaviour will influence the spread of HIV to others at risk. They are also at a vantage stage of development in which they are receptive to information and intervention. Furthermore, schools represent strategic institutions where STI/HIV/AIDS prevention and health promotion education should begin, (WHO, 1992, WHO AIDS series 10, 1992. McCauley and Slater 1995. The prevalence of adolescent STI's including HIV/AIDS, pregnancy and school dropout rates are high in Nigeria (Slap et al 2003). In response to this, Nigeria's reproductive health policy focuses on preventing risky sexual behaviours during adolescence. Part of the obstacles to the programme is inadequate and incomplete information on the sexual knowledge, attitudes and behaviours of adolescents, (McCauley and Slater, 1995) and partly because it is not taught in a formal setting. Given the early age at which many young people become sexually active, there should therefore be special emphasis on early information and education of pre adolescents and adolescent boys and girls, both in school and out of school. As adolescents mature and become sexually active, they face serious health risks with regard to STI's. Most

face these risks with too many sexuality myths, too little factual information, guidance about sexual responsibility and access to health care (McCauley and Slater 1995).In the early days of HIV/AIDS epidemic, national AIDS programmes and community groups seeking to stem the tide of HIV spread had no choice but to experiment with prevention programmes. The was no way of knowing with certainty what prevention strategies would work best, especially for convincing people to change their attitudes, sexual or other risk behaviours. After more than a decade and half of experience, what does work is to create a supportive social environment in which people can be informed about the whole range of options for promoting positive HIV/AIDS attitude and safe sexual behaviour. The aim is to encourage them to assume responsibility for their own behavior, imbued positive attitudes and give the necessary social and health services support. What is more, these have been found to work in a matter of months, not the years or even decades once believed necessary to change human attitude and behavior (WHO 1992a).With these in mind, the study was embarked on in the hope that the findings from the study will provide useful data that can help in the fight against STI's/HIV infection and AIDS.

MATERIALS AND METHODS

The study was undertaken in secondary schools in Enugu metropolis the capital of Enugu State of Nigeria. Institutional approvals were obtained from the schools and the students were adequately briefed. The study was conducted from October - December 1997. The subjects were students in Junior Secondary 2 (JS2) classes through Senior Secondary 3 (SS3). They were selected by multi staged simple random sampling. From each class 20-25 students were selected by simple random ratio until the required sample size was obtained. Volunteers were used to administer the questionnaires anonymously and to ensure confidentiality. The questionnaire used was a modification of the 'Model' KABP instrument proposed by WHO's Global programme on AIDS with specific concerns of African researchers in mind (Anastesia et al, 1993). The data was entered into a portable computer using EPIINFO 6 software. Descriptive and analytical methods were used. Data is presented in tables and charts for clarity and chi squared test applied where necessary.

RESULT

1009 Students age 10 – 20yrs completed the questionnaire, 221(21.9%) of the respondent indicated they had sexual intercourse before the interview. One hundred and forty one (63.8%) of these were males and 80(36.2%) were females; the difference was statistically significant ($p<0.001$). Table 1: show the responses of the students about HIV prevention and control. Increasing age ($p<0.001$) and female gender ($p<0.02$) correlated with more correct responses. The older students did not perform better than the younger ones when asked if condom prevented transmission of HIV/AIDS ($p>0.1$). Misconceptions were greater among girls than boys with regard to routes of transmission ($p<0.01$). Table 2 show the responses of the students regarding HIV infection and health stratified by type of school (correct responses for HIV infected persons remaining well for up to 10 years). Knowledge about HIV/AIDS varied between the schools (boys/girls/mixed) with the girls' schools consistently performing better than the other type of schools. However, the students of girls' schools were less able to identify breast milk and casual sex as modalities of HIV transmission ($p<0.001$). The students of girls' schools identified risk behaviours for HIV/AIDS more often than students of boys' and mixed schools ($p<0.001$). Students in Senior secondary schools performed significantly better than students in junior secondary schools ($p<0.001$), but in the case of casual sex as risk factor for HIV transmission the performance of JSS and SSS students were comparable $p>/=0.2$. Seven hundred and ninety seven (79.0%) were afraid of HIV infection. A significant finding was that as many as 520 (51.5%) said that they were afraid that some members of their family might become infected with HIV/AIDS. Premarital sex was approved of by 185(18.3%) respondents. On the contrary, 252 (25.0%) will abstain for some years, 136(13.5%) will abstain for some months, while 596(59.1%) claimed they would continue

Table 1: Student's responses on attitude/actions to prevent contracting HIV infection

Actions to avoid HIV infection	No of responses	Pattern of responses		
		Yes (%)	No(%)	Nil (%)
Abstinence	946	650(64.4)	296(29.3)	63(6.2)
Unprotected sex	964	224(22.2)	740(73.3)	45(4.5)
Condom use	941	391(38.8)	550(57.4)	68(6.7)
One sex partner	942	363(36.0)	579(57.4)	67(6.6)
HIV free partner	928	486(48.2)	442(43.8)	81(8.0)
Faithfulness	924	514(50.9)	410(40.6)	85(8.4)

Table 2: HIV infection and health stratified by type of school of the respondents. (Correct responses for HIV infected persons remaining well for up to 10 years).

CORRECT RESPONSE	TYPE OF SCHOOLS		
REMAINS WELL	BOYS	GIRLS	MIXED
FOR UP TO 10YRS	60(48.8)	74(62.2)	91(73.4)
	36(40.0)	59(37.5)	68(58.7)
	50(45.9)	52(46.8)	45(48.4)
	P=0.04	P=0.04	P=0.001

Comparing all schools p<0.001 (3 boys, 3girls and 3 mixed schools).

Table 3: Factors Affecting Attitude To Premarital Sex, stratified by age

Age Groups	Factors	True(%)	False	Nil	P value
years	**Fear of Pregnancy**				**p=0.001**
10 11		13(58.5)	9(39.1)	1(4.3)	
12-13		110(45.3)	118(48.8)	15(6.2)	
14-15		175(49.3)	152(42.8)	28(7.9)	
16-17		165(57.5)	99(34.5)	23(8.0)	
18>		33(35.9)	47(51.1)	12(13.0)	
	Fear of God				p<0.001
10-11		13(58.5)	9(39.1)	1(4.3)	
12-13		178(72.4)	54(22.2)	13(5.3)	
14-15		266(74.9)	68(19.2)	21(5.9)	
16-17		214(84.0)	35(12.2)	11(3.8)	
18>		73(79.3)	15(16.3)	4(4.3)	
	Fear of Infection				p<0.001
10-11		14(60.9)	9)39.1)	0(0.0)	
12-13		141(58.0)	89(36.6)	13(5.3)	
14-15		217(61.1)	107(30.1)	31(8.7)	
16-17		215(74.4)	50(17.4)	2(7.7)	
18>		53(57.6)	30(32.6)	9(9.8)	
	Fear of Parents				p>0.02
10-11		11(47.8)	11(47.8)	1(4.3)	
12-13		115(47.3)	108(44.4)	20(8.2)	
14-15		157(16.1)	162(83.9)	36(10.1)	
16-17		149(51.9)	113(39.4)	25(8.7)	
18>		33(35.9)	46(50.0)	13(14.1)	
	No reason				p=0.1
10-11		2(9.7)	18(78.3)	3(13.0)	
12-13		49(20.2)	167(68.7)	27(11.1	
14-15		66(18.6)	246(69.0)	44(12.4)	
16-17		48(16.7)	200(69.7)	39(13.6)	
18>		16(17.4)	61(66.3)	15(16.3)	

Table 4:Factors affecting student's attitude to pre-marital sex stratified by class

Class of students	Factors	True(%)	False(%)	Nil(%)	P value
	Fear of Pregnancy				**p=0.001**
JS2		89(41.6)	111(51.9)	14 (6.5)	
JS3		93 (46.3)	98 (48.8)	10 (5.0)	
SS1		94 (47.7)	67 (34.0)	36 (18.3)	
SS2		94 (47.7)	67 (34.0)	36 (18.3)	
SS3		122(61.0)	75 (37.5)	3 (1.5)	
	Fear of God				p<0.001
JS2		148(69.2)	54(25.2)	12(5.6)	
JS3		133(66.2)	58(28.9)	10(5.0)	
SS1		156(79.2)	30(15.2)	11(5.6)	
SS2		180(81.2)	20(10.2)	17(8.6)	
SS3		181(90.5)	19(9.5)	0(0.0)	
	Fear of Infection				P<0.001
JS2		110(51.4)	91(42.5)	13(6.1)	
JS3		117(58.2)	74(36.8)	10(5.0)	
SS1		130(66.0)	49(24.9)	18(9.1)	
SS2		129(65.5)	35(17.8)	33(16.8)	
SS3		157(78.5)	40(20.0)	3(1.5)	
	Fear of Parents				P<0.001
JS2		88(41.1)	110(51.4)	18(7.5)	
JS3		88(41.1)	101(50.2)	12(6.0)	
SS1		94(47.7)	81(41.1)	22(11.2)	
SS2		88(44.7)	66(33.5)	43(21.8)	
SS3		110(55.0)	88(43.0)	4(2.0)	
	No reason				
JS2		49(22.9)	143(66.8)	22(10.3)	
JS3		48(23.9)	136(67.7)	17(8.5)	
SS1		36(18.3)	132(67.0)	29(14.7)	
SS2		24(12.2)	125(63.5)	48(24.4)	
SS3		24(12.0)	162(81.0)	14(7.0)	

Table 5: Responses of sexually active students in relation to type of school and class.

Type of school	Boys (only)			Girls (only)			Mixed (boys & girls)		
	(2)	(6)	(9)	(1)	(4)	(5)	(3)	(7)	(8)
No (%)	37 (16.7)	17 (7.7)	32 (14.5)	1 (0.5)	21 (9.5)	17 (7.7)	23 (10.4)	47 (21.3)	26 (11.6)
Class of students	Js2	Js3		SS1			SS2		SS3
No (%)	32 (14.5)	42 (19.9)		44 (20.0)			53 (24.0)		50 (22.6)

*All schools compared for affirmative response to "ever had sex" $p<0.01$
#Jss Vs SSS for the respondents knowing that their sex partner have other sex partners $p<0.01$

to abstain until they get married. Table 3 and 4 show the responses of the students to suggested factors affecting their attitude to premarital sex in relation to their ages and classes respectively.

DISCUSSION

The findings confirm that the respondents in this study population are sexually active 221(21.9%) and engaged in high-risk sexual behaviours as can be deduced from Table 5 and Table 1. Only 22.2%, 38.8%, 36.8%, 48.2% and 50% responded affirmatively that unprotected sex, condom use, one sex partner, HIV free partner and faithfulness could prevent HIV infection respectively. This may imply urgent sexual health needs of these adolescents. Abstinence identified by 64.4% of the respondent as preventive for HIV infection, is the main safe sex practice being promoted for young people. In as much as it is prime and practicable for HIV prevention, it is often not an agreeable alternative practice to many young people. This is especially so, since quest for education ensures many years in school and possibly away from parental guidance and delays marriage. Offering young people good options to choose from have had positive impact in HIV prevention in situation where sexual networking is common (Anastesia et al 1993, Bullough and Bollough 1991). young people are unable to freely obtain a condom. Either because of prejudiced attitudes of the larger community, or they are unable to afford them or do not know where to get them. Young people are further embarrassed should condom be found in their possession. Young people are not socially equipped to negotiate condom use or safe sex practice in the context of social networking. Promotions of safe sex practice become urgent and have an important place in the promotion and control of HIV prevention. Of the respondents in this study, 18.3% approved of premarital sex while another 38.4%believe that AIDS is a disease they could not protect themselves from. These findings support the need for development of educational strategies which directly address prejudiced attitudes towards HIV/AIDS. These strategies should include remedies towards such attitudes, generally directed against minority and marginal groups girls, women and children, homosexuals, and intravenous drug users who are at higher risks for HIV/AIDS (Alvarez-Gracia et al 1996; Well et al 1995; Diclemente et al 1986. Modification of sexual behaviour is a prime focus of action for HIV/AIDS prevention. Premarital sex is common among students of this study population (22%). This is consistent with the reported figure of 24%-46% by the National task force on sexuality Education in Nigeria

(National Guidelines Task Force 1996).These figures are lower than 61%-85% reported from Uganda and Tanzania (Agyei and Epema 1992) and 95% reported in out of school youths in Nigeria (Orubuloye et al 1991). Cultural, social and economic issues may be responsible for this high level of premarital sex on the part of the general public as in East Africa (Hudson 1996).This high level of sexual activity among adolescents may result from insufficient, confusing or wrong messages they receive from peers, parents and society. Premarital sex can have severe consequences (Orubuloye et el 1991, Orubuloye et al 1993, Meniru, 1996) notably STDs, early and unwanted pregnancies with 150 out of every 1000 women who give birth being 19 years and under, as well as reports of 80% of adolescent girls presenting with abortion complications, accounting for 72% of all deaths in this age group (National Guidelines Task Force 1996). (Barnett, 1993).This is consistent with the finding in this study as fear of pregnancy and infection were major factors affecting their attitude to premarital sex. Other risk behaviours include 54.3% of respondents not being familiar with their sex partner, male sexual partner of young females are older, have other sex partners and are more sexually experienced. They are also in the position to offer and lure young inexperienced adolescents with money and other advantages. In traditional African societies, young people were taught that having sex was healthy but that it was saved for marriage and also that there is a difference between coital and non coital relations (Aggleton 1996). Some factors may have led to breakdown in moral norms and socio-cultural inhibitions to premarital sex. These include urbanization and unemployment, increased school enrolment, rising age at marriage, overall increase of aspiration in life and exposure to modern and western culture against the background of lack of appropriate information about sexuality issues and relevant coping mechanisms in a fast changing world. The norms that prevented extra-marital sex have also been weakened and the resources and commensurate services to counteract these weaknesses have not been adopted and or provided (Nancy, 1993).

Regarding an infected person remaining well for 10 years, there were varied responses ($p<0.001$) from the mixed schools compared to the boys' or girls' only schools. In addition more students of mixed schools had sex than other types of schools. This may suggest inappropriate sexual information, sexual myths and that mixed schooling promoted sexual activity among adolescents. There is also a tendency for increased sexual activity as the respondents became older and progressed in class, Junior Secondary School (JSS) 74 vs. Senior secondary school (SSS) 147 ($p<0.001$). An interesting finding was that upbringing and parental influence ranked least of the factors influencing the respondent's attitude to premarital sex. The reason for this need to be further explored. Lack of, inadequate or misappropriate sex education at homes may be contributory, as may early independency of the adolescents' and early exposure to sexual myths among this study population. In general, our society appear to be very religious, it is however surprising that fear of God as a factor did not out class other factors in ranking, yet 94% of the respondents were Christians. Individual and personal affectations (fear of pregnancy and infection) of the consequences of premarital are important factors affecting the attitude of these adolescent to premarital sex $p<0.001$.

Lack of factual information about AIDS and sex education constitutes part of the problems in STI/HIV/AIDS promotion. Protected sexual intercourse, mutual faithfulness and HIV screening of intending spouses among other STI/HIV/AIDS education must be taught in a formal setting or context in schools. Sex education is yet to find a place in the schools curriculum. Yet sex practice and age at first sexual intercourse is common and dropping year by year. Safe Sex Practice means ability to express sexuality in ways that prevent the transmission of HIV infection. The best protection is to choose sexual activities that do not allow semen, vaginal fluid or blood to enter the vagina, anus, and mouth or to touch the skin where there is an open sore. (UNESCO 1995, WHO 1992). Therefore sexual abstinence and postponement is closest to the above definition

and remains of prime consideration in interrupting transmission of STI/HIV/AIDS. Safe Sex Practices including abstinence may have limited utility for many girls because sex may be corrosive or forced. This study also shows that respondents of this study are starting sex early, also shows that if appropriate intervention is mounted that more adolescents can postpone sexual debut till after the age of 20 years and this should begin early before the age of 10 years.

However for those who cannot or lack the will or want to continue sex practices, specific safe sex practices (UNESCO, 1995, WHO 1992; WHO 1992, McCauley and Slater, 1995, Liskin et al 1989), includes a monogamous relationship that is mutual and faithful, condom use at every sex act, non-penetrative sex and avoiding sex when one has a genital ulcer or wound. Early presentation and appropriate management of STD's is effective in reducing transmission of HIV. Other proven measures are patient care, expansion of testing activities for HIV and blood safety, counseling and public health surveillance.

The above considerations call for urgent action to commence Sex, STD's/HIV/AIDS education at the lowest possible grade as part of any health and hygiene programme before sexual debut. In the continued absence of a preventive vaccine or therapy to cure HIV disease, interventions for prevention remain the mainstay of HIV/AIDS related health promotion.

Limitations of the Study

1. The findings relate to urban student populations and may need modifications for application to rural student populations.
2. Because the data were self-reported, under-reporting and over-reporting may have occurred, especially as some questions dealt with intimate behavoiur.

CONCLUSION

1. High risk sexual behavior facilitating transmission of HIV is common among the students and sexual behavioral modification to avoid/interrupt acquisition of HIV infection is deficient and not practiced.
2. Age, School type, fear and prejudiced attitudes and lack/inappropriate sex education are important factors militating against HIV prevention among the student in this study population.

RECOMMENDATION

The students of this study population constitute a highly vulnerable group at risk of HIV infection and AIDS. Based on the findings from this study the following recommendations become necessary:

1. Implementation of sexuality education programme amongst secondary school students in Enugu Nigeria.
2. Design and implementation of a school HIV/AIDS education programme which should involve the school, parents, community, religious bodies NGO's and Government.

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