

VARIATIONS IN SEXUAL HEALTH KNOWLEDGE AS A FUNCTION OF GENDER AMONG NIGERIAN UNIVERSITY STUDENTS

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Abstract

This study was conducted to examine variations in sexual health knowledge (SHK) as a function of gender (differences in sexual health knowledge of male and female students) among Nigerian University Students. A total of 2,507 male and female students from eleven (11) Nigerian universities were selected through convenience sampling. They were both male (1204,54.3%) and female (1013,45.7%) respondents, a total of 2217 (88.4%) male and female subjects responded to the questionnaire. Most of the subjects who responded to the questionnaire (1336,60.3%) were aged 20 – 24 years. The data, thus, collected was analysed using descriptive statistics to describe the demographic variables and t – test to determine variations in SHK of the male and female subjects. The results showed significant variations between Nigerian University male and female students in the different components of SHK at a significant level of .05. It was concluded that appropriate and adequate steps be taken to eliminate gender inequality to prevent sexually transmitted infections, (STIs) human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS) transmission and females be given the power to freely negotiate their sexual safety in their communities and societies.

Sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) represent a major public health problem in developing countries (Dworkin and Ehrardt, 2007). STIs have been reported to account for 15% of the total disease burden worldwide and affect both men and women.

It has also been reported that reproductive tract infections (RTIs) and STIs are a significant cause of morbidity and mortality in both men and women, particularly in women of reproductive age (UNAIDS, 2005).

Africa's population is currently growing faster than any other major region and is projected that it will account for 21% of world population by 2050 as against 9% in 1950. Sub-Saharan Africa continues to suffer disproportionately from the global HIV/AIDS epidemic, suggesting that Southern African has the highest prevalence of HIV. Recent estimates suggest that the epidemic has stabilized but often at very high levels in much of sub-Saharan Africa where an estimated 22 million people are living with HIV/AIDS, thus, accounting for 67% of all people living with HIV worldwide (UNAIDS/WHO, 2008). The research evidence revealed that more than half of Africans with HIV live in four countries of African Nigeria comes second with 2.9 million people, Zimbabwe, 1.7 million, Tanzania, 1.4 million, South Africa comes first with 5.5 million people living with HIV/AIDS (UNAIDS, 2008).

Improved treatment and care have reduced the number of new cases of HIV/AIDS among children and increased the number and proportion of infected children surviving to and through youth. But the number of newly acquired cases among youth continues to rise in these African countries (Lawrence, Angelo; Sample; Roger; Peralta; and Fredman; 2006).

There is a growing crisis especially in the developing world, as approximately 50% of new HIV infections worldwide are found among youths between the ages of 15 and 24, thus about 6,000 new infections occur daily, and there are 12.4 million teens and youth living with HIV/AIDS worldwide, with at least half of them being females (UNAIDS, 2003).

This growing crisis of HIV infections among the youths may be attributed to unsafe sexual practices, and failure to see themselves at risk for infection (Uwakwe; Agofure; Ogundiran; and Okamgba; 1998).

The poor economic conditions in Nigeria have created a serious pressure on young adults to engage in unsafe sexual practices. Quite a number of youths, particularly university female students engage in commercial sex to substitute their merger income. These female adults are enticed by older men with money to have unsafe or unprotected sex. This type of practice may have contributed to the transmission of HIV/AIDS among young adults (Eke-Huber, 2000). As regards gender differences, Van Rossem; Meekers; and Akinyemi, (2001) reported the existence of gender differences particularly in condom use; revealing that men significantly used condoms more than women. However, this study (Van Rossem, 2001) did not consider the variations in the different components of sexual health knowledge among their sample population. The purpose of this study, on the other hand, was to assess variations in sexual health knowledge as function of gender among Nigerian University Students.

Methodology

Research Design

As this study was a non-experimental research in which information was already available and no independent variable was manipulated by the researcher, ex-post facto research design was used. In this design, the sexual health knowledge of Nigerian university male students was compared with Nigerian University female students.

Participants

The population for this study was made up of all Nigerian University male and female students within the six (6) geo-political zones. The following zones constituted six (6) strata: North-central, North East, North-West, South-East, South-West and South-South.

Sample Size and Sampling Technique

A convenience sampling technique was used to select a total of 2,507 undergraduate students. Two States from each stratum (geo-political zone) were randomly selected hence, a total of 12 States randomly selected were used. As the number of complexes varies from university to university, only three complexes which were found in all the selected universities were used. These complexes were Sciences / Medicine/Applied Sciences, Social / Management Sciences and Arts/Humanities. From each university, 5% of the student strength of each of the randomly selected complexes was used for this study. This 5% of each of male and female students was selected using convenience sampling.

Research Instrument

The instrument (questionnaire) used for data collection was vetted and pilot tested on a sample of 140 subjects of a university in order to find out its internal consistency reliability. Cronbach's Alpha of correlation coefficient of .86, Spearman Brown's equal and unequal length correlation coefficient of .65 and Guttman-Split Half Correlation Coefficient of .65 were revealed which indicated that the instrument was consistent and reliable to be used for this study.

A total of 2,507 copies of the vetted and pilot tested questionnaire were distributed and collected by the first researcher and four (4) trained research assistants. Out of these, 1,204 (54.3%) were for male and 1,013 (45.7%) for female students.

Results

Table 1: Frequencies of Respondents according to their Demographic Characteristics

S/No.	Characteristic	Frequency	Percentage (%)
1.	Age		
	(a) 15 – 19	421	18.9
	(b) 20 – 24	1336	60.3
	(c) 25 – 29	414	18.7
	(d) 30+	46	2.1
		2217	100
2.	Sex		
	(a) Male (b) Female	1,204	54.3
		1,013	45.7
		2217	100
3.	Ethnicity		
	(a) Yoruba	719	32.4
	(b) Ibo	531	24.0
	(c) Hausa	510	23.0
	(d) Others	457	20.6
		2217	100
4.	Area of Study		
	(a) Sciences/ Medical/Applied Sciences	1163	52.2
	(b) Social/ Management Sciences	5180	23.4
	(c) Arts/ Humanities	536	24.1
		2217	100

5. Level of Study		
(a) 100 Level	491	22.1
(b) 200 Level	560	25.3
(c) 300 Level	521	23.5
(d) 400 Level	458	20.6
(e) 500 Level	179	8.1
(f) 600 Level	8	.4
	2217	100
6. Religious Affiliation		
(a) Christianity	1323	59.5
(b) Islam	875	39.5
(c) Indigenous Traditionalist	14	.6
(d) Others	5	.2
	2217	100
7. Martial Status		
(a) Never Married	2,119	95.6
(b) Married and Living with Spouse	84	3.8
(c) Divorced	8	.4
(d) Widowed	1	.0
(e) Separated	5	.2
	2217	100

Out of the 2,507 questionnaires distributed, 2217 (88.4%) were successfully completed, returned and analysed. Table 1 shows that majority of the respondents (1336, 60.3%) were in the age group of 20 – 24 years. They were both male (1,204, 54.3%) and female (1013, 45.7%) respondents. They were almost equally distributed among Yoruba (719, 32.4%), Ibo (531, 24%), Hausa (510, 23%) and others (457, 20.6%) ethnic groups. Furthermore, table 1 reveals that majority of the respondents (1,163, 52.3%) were from the Sciences/Medicine/Applied Sciences and others were from the Social/Management Sciences (518, 23.4%) and Arts /Humanities (536, 24.1%). A careful look at table 1 shows that most of the subjects were from 100 (491, 20.6%). 200 (560, 25.3%), 300 (521, 23.5%)

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and 400 (458, 20.6%) levels. Most of them were either Christians (1,323, 59.7%) or Moslems (875, 39.5%). Most of the respondents (2,119.96.5%) were never married.

Table 2: t-test for variations between male and female respondents in their sexual health knowledge relating to STIs/HIV/AIDS

Variation	N	Mean	Std. deviation	t	Omega squared (ω^2)
Awareness of STIs/ HIV/AIDS					
Male	1204	3.9785	.56046		
Female	1013	4.0160	.50839	1.66	
Signs and symptoms					
Male	1204	3.6484	.51364		
Female	1013	3.7759	.49142	6.013*	.02
Modes of Transmission					
Male	1204	3.9608	.47656		
Female	1013	4.0291	.43517	354*	.01
Prevention					
Male	1204	3.4909	.56322		
Female	1013	3.4456	.55740	1.92	
Treatment					
Male	1204	3.7227	.62569		
Female	1013	3.9299	.61789	7.91*	0.03
Sources and relevance of information					
Male	1204	3.6381	.55097		
Female	1013	3.7105	.55626	3.11*	0.004

t (2215) = 1.960 < 0.05

* = significant

The results show some significant variations between male and female respondents in the different components of sexual health knowledge, except in general awareness of STIs/HIV/AIDS (mean = 0.04) and knowledge of prevention (mean = 0.05). However, to make any sense from these variations the meaningfulness of the variations is calculated by estimating Omega Squared (ω^2).

The differences, thus, found between male and female subjects in their knowledge of signs and symptoms, modes of transmission, treatment and sources and relevance of information relating to sexual health could explain only from 3% to 4% of variance in sexual health knowledge due to gender differences. In other words, although, these differences exist between male and female subjects, they could not explain more than 3% of the variance of sexual health knowledge.

Discussion

The results of this study revealed that female Nigerian university students had better knowledge of signs and symptoms, modes of transmission and treatment of STIs/HIV/AIDS and also better access to the sources and relevance of information relating to STIs/HIV/AIDS than their male counterparts. In general, the female respondents had better sexual health knowledge. However, these differences should be interpreted cautiously because none of them explains more than 3% of the variance in components of sexual health knowledge. Previous studies were concerned with condom use by young men and women and also with age differences in condom use. Some young males used condom frequently than young females. The findings of this study supported the findings of Van Rossem *et al.*, (2001), Demographic and Health Survey, (2008) and Collins (2005) that female students are at greater risk because of their lower self-efficacy for condom use.

Consistent with the results of those previous studies (Harding *et al.*, 1999; Van Rossem *et al.*, 2001, and Collins, 2005), the findings of this study suggest that belief and knowledge of signs and symptoms, modes of transmission and treatment do not actually translate to applying such knowledge to practice. This explanation is substantiated by the fact that although, the oral incidence of AIDS is declining, it is not declining in young females, in whom the incidence of AIDS is more than it is in young males (Bryan *et al.*, 2002; and Lawrence *et al.*, 2006). In addition, very few young females were reported to encourage their sexual partners to use condom (Imonde, Aluede, and Imhonde, 2005; Collins, 2005), which suggest that females are more at risk than the males.

Whatever may be the reason for this elsewhere, in Nigeria it is attributed to the lower perception of risk by females than males and that the use of condoms is a prerogative of males (Imhonde, *et al.*, 2005; Van Rossem, *et al.*, 2001). These suggest that self-perception of risk is not a sufficient condition for a change in this risky sexual behaviour. This gender disparity can be addressed by considering the social processes in most societies (Van Rossem, *et al.*, 2001; Harding; Anadu; Gray; and Champeau; 1999).

Conclusion / Recommendations

This study suggests that female Nigerian university students are more knowledgeable about sexual health issues relating to signs and symptoms, modes of transmission, and treatment of STIs/HIV/AIDS than their male counterparts. Because of this gender disparity, it is, therefore, suggested that appropriate and adequate steps be taken to eliminate gender inequality to prevent STIs/HIV/AIDS transmission, giving power to females to freely negotiate their sexual safety in communities and societies. Based on the findings of this study, it is recommended that relevant, adequate and accurate information relating to sexual health be made available to the Nigerian university students, particularly the male students. In addition, it is recommended that intervention models for prevention of STIs/HIV/AIDS should highlight the preventive aspects of these infections.

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