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Research Article

Risky Sexual Behaviour and Experience of Sexual Coercion Among University Students in Ibadan, Nigeria

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ABSTRACT

Risky sexual behaviours increase the likelihood of contracting sexually transmitted diseases. Undergraduates are peculiarly at a high risk of exposure to risky sexual behaviours because many are becoming free from parental influences and monitoring for the first time in life as well as peer pressures. This study examined the prevalence of risky sexual behaviour and the experience of sexual coercion among clinical students of the College of Medicine, University of Ibadan, Nigeria. This was a descriptive cross-sectional study carried out among 300 level to 600 level clinical students of the College of Medicine, University of Ibadan using a self-administered questionnaire. There were 399 participants. The male-female distribution was 52.1% and 47.9% respectively. 84.4% fell within the 20 to 24 age range (mean age of 22.88±2.2). 18% were sexually active, 65% have had at least two sexual partners. Less than half (47%) reported inconsistent condom use while 77% had ever had unprotected sex; 41.9% of females had experienced at least one form of sexual coercion. Gender [p = <0.001, OR (95% CI) = 0.40 (0.26, 0.63)] and department [p=0.003, OR (95% CI) =0.41 (0.23, 0.75)] were found to be significant in predicting experience of sexual coercion. There was a high prevalence of risky sexual behaviour among the sexually active students. In addition, about one-third of all the students who responded to the questionnaire reported an experience of sexual coercion. Hence there is a need to implement sexual and reproductive health interventions in this and similar populations.

Keywords: *Sexual coercion, risky sexual behaviour, prevalence, help-seeking behaviour*

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INTRODUCTION

According to the 2004 Report of the Global AIDS Epidemic nearly half of the world's population is below 25 years old and by the year 2050 it is projected that Sub-Saharan Africa would have more adolescents than any other region in the world (Steinbrook, 2004). The reproductive health of adolescents and young adults is increasingly of public health interest globally (Ajuwon *et al*., 2011). Many adolescents and young adults face several reproductive health challenges such as unplanned pregnancies, unsafe abortions and sexually transmitted diseases including HIV/AIDS (Barnet, 1998). Of all new infections of HIV in Sub-Saharan Africa in 2012, one third occurred in persons between the ages of 15-24 years (approximately 780,000 persons) (Liu *et al*., 2015). Many of the adolescents who have any of these reproductive health challenges probably got involved in risky sexual behaviours through coercion by relatively more empowered or informed persons (Fawole *et al*., 2005).

Sexual coercion is a major public health challenge with numerous social, mental, and psychological consequences (Moore *et al*., 2007). Several population based studies (Moore *et al*., 2007; Dingeta *et al*., 2012, , Imaledo *et al*., 2012) have shown that the experience of sexual coercion leads to a greater likelihood of risky sexual behaviours such as multiple sexual partners, early sexual debut, exchange of sex for drugs or money and inconsistent condom use. Such behaviours are the target of prevention efforts against HIV/AIDS especially in communities where the disease continues at epidemic proportions (Agardh *et al*., 2011).

Undergraduates are a peculiar population who are at high risk of exposure to risky sexual behaviours by virtue of the fact that many are free from parental control for the first time in life and are susceptible to peer pressures. A study done in Ethiopia amongst undergraduate students found that about 60% of the students engaged in risky sexual behaviours such as unprotected sexual intercourse while 50% of males had paid for sex (Dingeta *et al*., 2012). Another study among young people in Kenya reported a sexual coercion prevalence of 21% and 11% among females and males respectively with an association between sexual coercion and multiple sexual partners (Erulkar, 2004). In Nigeria, a survey of male and

female adolescent students and apprentices aged 15-19 years found that about 55% of 1025 respondents had been victims of at least one sexually coercive behaviour, the most common being unwanted kiss and touch of the breast. Four per cent of the same population had experienced rape which was perpetrated mainly by boyfriends and other persons well known to the victims (Ajuwon *et al*., 2001, Fawole *et al*., 2005).

Although studies have been carried out on risky sexual behaviour and the experience of sexual coercion amongst secondary school students (Ajuwon *et al*., 2006) and undergraduates in tertiary institutions in Nigeria (Olaleye and Ajuwon, 2012) none has been directed specifically at students in the medical sciences. Secondly, the relationship between risky sexual behaviour and sexual coercion among this group has not been fully explored. A knowledge gap therefore exists regarding the association between risky sexual behaviour and experience of sexual coercion among students of this subset who as future health workers are expected to educate their clients on sexual risk prevention. Therefore, this study was aimed at determining the prevalence of risky sexual behaviour and sexual coercion among students of the College of Medicine, University of Ibadan, Ibadan. It also sought to find out if participants who had experienced a form of sexual coercion sought any help as well as the relationship between the experience of sexual coercion and risky sexual practices.

MATERIALS AND METHODS

The Setting and Study Population: The study was a descriptive cross-sectional study. The research was carried out among students of the College of Medicine (medical, dental, and physiotherapy students), University of Ibadan, Ibadan, Nigeria who resided at Alexander Brown Hall, University College Hospital, Ibadan between 2015-2016 when the study was conducted. Established in 1948, University of Ibadan is the oldest Nigerian tertiary institution situated 8 kilometres from the centre of Ibadan metropolis, in South West, Nigeria.

Sample Size and Recruitment procedures: The sample size for the study was determined using Leslie Kish sample size formula [p=31.1% (Agardh *et al*., 2011)]. Simple proportion was used to estimate the number of students needed from each level and department. The first author attended a class for each category of students; immediately after a class was completed, she adopted a simple random sampling technique to select the number of students required for each level. Prior to selection, the students were informed about the objectives of the study and that participation was voluntary.

Procedures for data collection: Data were collected using a questionnaire, which consisted of four sections including the demographic information such as age, sex; sexual behaviour such as age at sexual debut; experience of sexual coercion such as force at first sexual activity; help seeking behaviour after sexual coercion such HIV counselling and testing. The students completed the questionnaire which were collected immediately after.

Ethical Considerations: The University of Ibadan/University College Hospital Ethics Review Committee approved the study protocol prior to data collection. Informed consent was obtained from each study participant. Prior to their selection the students were informed about the purpose of the study, that participation was voluntary, and that information collected will be kept confidential. Due to the sensitive nature of the subject of investigation, the questionnaire was anonymous, and no names or other identifiers were mentioned in it.

Data analysis: Each of the questionnaire administered was checked for completeness. The data were entered into a computer and analysis was performed using Statistical Package for the Social Sciences (SPSS) version 21 The analysis was done using both descriptive and inferential statistics.

RESULTS

Demographic Profile of the Respondents: A total of 399 students were recruited into the study; of these about half were females. Almost all the students belonged to a religious faith and 84.4% fell within the 20 to 24 age range (mean age of 22.88±2.2). Three-quarter were students of Medicine and Surgery while the rest were dental and physiotherapy students (Table 1). Majority of the students (61.4%) had ever worked for money while fifteen percent were working at the time of the survey.

Table 1: Socio-demographic Profile of Study Participants.

		All		Male		Female	
		N	%	n	%	n	%
Sex	Male	208	52.1				
	Female	191	47.9				
Age	10-19	2	0.5	1	0.5	1	0.6
	20-24	322	84.2	160	78.8	162	90.5
	25-29	50	13.1	34	16.7	16	8.9
	30-34	7	1.8	7	3.4	0	0
	35-40	1	0.6	1	0.5	0	0
	Missing	17					
Levels of Respondents	400L	159	39.8	97	46.6	62	32.5
	500L	130	32.6	57	27.4	73	38.2
	600L	110	27.6	54	26	56	29.3
Department of Respondents	Medicine	316	79.2	178	85.6	138	72.3
	Dentistry	52	13.0	16	7.7	36	18.8
	Physiotherapy	31	7.8	14	6.7	17	8.9

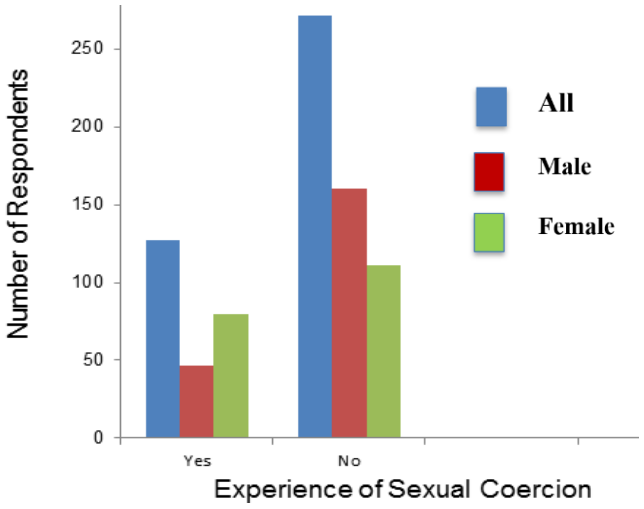
Table 2:
Socio-Demographic Factors and Risky Sexual Behaviour among Medical Students.

Socio-demographics	Risky sexual behaviour				p	OR (95% CI)
	Yes		No			
	N	%	N	%		
Gender						
Male	49	94.2	3	5.8	1.000	0.86 (0.08,8.79)
Female [a]	19	95.0	1	5.0		
Age						
≤25 years	58	96.7	2	3.3	0.347	3.63 (0.29,44.68)
>25 years [a]	8	88.9	1	11.1		
Department[1]						
Medicine	55	96.5	2	3.5	0.087	7.86 (0.95,64.93)
Dentistry [a]	7	77.8	2	22.2		

[a] Reference category
[1]Physiotherapy students were not included in this table due to their very few positive responses (1 response)

Table 3:
Prevalence of Sexual Practice and Experience of Sexual Coercion

		All		Male		Female	
		n	%	n	%	n	%
Do you have a boyfriend/girlfriend	Yes	130	32.6	52	25	78	40.8
	No	269	67.4	156	75	113	59.2
Ever had sex	Yes	72	18.0	52	25	20	10.5
	No	327	82.0	156	75	171	89.5
Age at sexual debut	Less than 18	20	30.3	18	37.5	2	11.1
	Greater than 18	46	69.7	30	62.5	16	88.9
	Missing	6					
Number of lifetime sexual partner	One to two	41	63.1	25	54.3	16	84.2
	More than two	24	36.9	21	45.7	3	15.8
	Missing	7					
Condom use	Inconsistent	56	77.8	40	76.9	16	80
	Consistent	16	22,2	12	23.1	4	20
Alcohol use before last sexual intercourse	Yes	8	11.1	7	13.5	1	5
	No	64	88.9	45	86.5	19	95
Experience of sexual coercion	Yes	127	31.9	47	22.7	80	63
	No	271	68.1	160	77.3	111	37
Risky sexual behaviour	Yes	68	94.4	49	96.1	19	95
	No	4	5.6	3	3.9	1	5



Sexual Practices: Thirty-three percent had a boyfriend or girlfriend. About thirteen per cent of the students felt pressure to have sex and most of the pressure was from friends (54.9%). Eighteen per cent had debuted sexually, seventy percent of which occurred after the age of eighteen and 65% had at least two sexual partners. Forty-seven per cent reported inconsistent condom use while 77% had ever had unprotected sex. Fewer females than males had debuted sexually; increasing age and gender were statistically significant to having had first sexual intercourse; however, age and sex were not statistically significant with regards to involvement in risky sexual behaviour (Table 2). Students below the age of 26 years were three times more likely to have had risky sexual behaviour compared to those above 26 years (OR=3.63; CI=0.29,44.68). Ninety per cent of the students who had debuted sexually did not use alcohol before their last sexual intercourse (Table 3).

Experience of Sexual Coercion: Overall, 31.9% had experienced at least one form of sexual coercion (Table 3). More females than male students reported experience of sexual coercion (Figure 1). Majority of those who reported current experience of coercion were within the age range of 20-24 years. Gender [p = <0.001, OR (95% CI) = 0.40 (0.26, 0.63)] and Department [p=0.003, OR (95% CI) =0.41 (0.23,

0.75)] were found to be significant in respect to experience of sexual coercion (Table 4). The most common form of coercion reported was being kissed against the wish of the participant (18.3%). Other forms included unwanted touches of breast or backside (17%) and person insisting on having sex (7.5%) (Table 5). There was no relationship between risky sexual behaviour and the experience of sexual coercion (Table 6). Of those that experienced at least one form of coercion (127) only 15.7% sought help, mostly from friends.

Table 4:
Socio-Demographic Factors and Experience of Sexual Coercion among Medical Students

Socio-demographics	Experience of Sexual Coercion				p	OR (95% CI)
	Yes		No			
	n	%	N	%		
Gender						
Male	47	22.7	160	77.3	<0.001	0.40 (0.26,0.63)
Female [a]	80	41.9	111	58.1		
Age						
≤25 years	115	32.4	240	67.6	0.16	2.01 (0.74,5.47)
>25 years [a]	5	19.2	21	80.8		
Department[1]						
Medicine	92	29.1	224	70.9	0.003	0.41 (0.23,0.75)
Dentistry	26	50.0	26	50		

Table 5:
Frequencies of Forms of Sexual Coercion Experienced among the Students of the College of Medicine, University of Ibadan.

Forms of Sexual Coercion	**Response**	**n**	**%**
Someone touched your backside against your will	Yes	68	17
	No	331	83
Someone kissed you against your will	Yes	73	18.3
	No	326	81.7
Someone forced you to view sexually explicit material	Yes	11	2.8
	No	388	97.2
Someone attempted to have sex with you either by threats or force	Yes	3	0.8
	No	396	99.2
Someone insisted on having sex with you	Yes	30	7.5
	No	369	92.5
Someone used drugs or alcohol to make you have sex with him or her	Yes	2	0.5
	No	397	99.5
Someone made you perform a sexual act against your will	Yes	18	4.5
	No	381	95.5
Someone insisted you terminate a pregnancy	Yes	2	0.5
	No	397	99.5

Table 6:
Relationship between Risky Sexual Behaviour and Experience of Sexual Coercion

	Experience of Sexual Coercion			
	Yes	No	P value	OR
Risky Sexual Behaviour				
Yes	29 (42.6)	39 (57.4)	1	0.744 (0.10,5.59)
No	2 (50.0)	2 (50.0)		
Total	**31 (43.1)**	**41 (56.9)**		

DISCUSSION

This study set out to determine the prevalence of risky sexual behaviour and experience of sexual coercion among students of the College of Medicine, University of Ibadan. It also explored the help seeking behaviour of those who had been sexually coerced and the association between risky sexual behaviour and experience of sexual coercion among students of the College of Medicine, University of Ibadan.

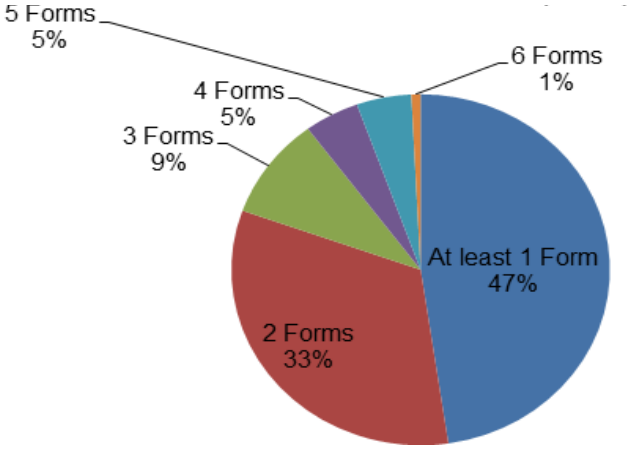


Figure. 2:
Forms of Sexual Coercion Experienced among the Students

Overall, 18% of the students had attained sexual debut. This result differs from a similar study done among students of a different faculty in the same University where a prevalence of 55.2% was found (Olley and Rotimi, 2003). A possible explanation may be the difference in faculties (Social Sciences vs. Clinical Sciences) as well as the reluctance of the students to give up their sexual details to a fellow student. The results of this study show that a higher prevalence of risky sexual behaviour exists among students aged above 30 and below 25. This was similar to what was found by Menon *et al*, 2016 among students of the University of Zambia (Menon *et al*., 2016). They found that students aged 21- 24 reported having more than two partners in the past year as compared to those in the older age groups. Similar to the study by Menon *et al*, 2016, the current study also found that inconsistent condom use was more common among female (75%) than males (36.5%) students.

In this study, the overall prevalence of sexual coercion was 32% and significantly more female than male students were affected. These findings are consistent with those of Agardh *et al*, 2011 who found a prevalence of sexual coercion among Ugandan University students of 33.2% and 29.9% in females and males respectively (Agardh *et al*., 2011). More females than males are vulnerable to sexual coercion due to low position of women and existence of gender inequity in Nigeria. Despite their potential negative impact on reproductive health, only a few of those who had experienced sexual coercion sought help. This may be due to the stigma associated with coercive sex which make survivors suffer in silence. It may also reflect lack of programs or services to meet needs of those affected.

We did not find a relationship between risky sexual behaviour and the experience of sexual coercion in the current study. This is in contrast to the findings of Agardh *et al* in Uganda and Garoma and colleagues in Ethiopia who found a positive association between early sexual debut, sex many sexual partners and the experience of sexual coercion (Garoma *et al*., 2008, Agardh *et al*., 2011). The explanation may be related to differences between the settings in Nigeria and these countries.

In conclusion, we found a high prevalence of risky sexual behaviours and experience of sexual coercion among medical students; more females than males had experienced sexual coercion. Unfortunately, only few of those affected sought help. We recommend interventions that include education on skills for prevention of sexual coercion. Such educational programs can be implemented in the hall of residence during special events like hall week. Educational materials like posters and handbills may be helpful in creating awareness about dangers of sexual coercion and how to prevent it. In addition, there is need to create a friendly service centre which should be managed by trained counsellors to provide appropriate services for those who need help. A hotline may also be created to provide confidential services for survivors.

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