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Effects of sexual health education on adolescence in Saint Patrick's, secondary school, Awka, Anambra state

Josephat Chukwudi Akabuike[1], Ifeanyi Gabriel Eyisi[2], Ifeoma Anne Njelita[2], Chioma Silvia Eyisi[3], Akabuike Chioma[2], Chinyerem Cynthia Nwachukwu[2]

[1]Department of Obstetrics and Gynaecology, Chukwuemeka Odumegwu Ojukwu University and Teaching Hospital, Awka, Nigeria.

[2]Department of Community Medicine and Primary Healthcare, Chukwuemeka Odumegwu Ojukwu University and Teaching Hospital, Awka, Nigeria.

[3]Department of Medicine, University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu, Nigeria.

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Abstract: **Introduction: Sexuality education can improve adolescents' knowledge and shape healthier attitudes and practices. This study assessed knowledge, attitudes/practices, and information sources regarding sexual and reproductive health (SRH) among students of St. Patrick's Catholic Secondary School, Awka, Anambra State, Nigeria.**

Methods: A cross-sectional descriptive survey was conducted among secondary school students (SS1–SS3). Data were collected using a semi-structured self-administered questionnaire. Descriptive statistics were summarized using frequencies and percentages. The study report also included linear regression analyses to examine whether sexual health education predicted attitudes/practices and whether information sources predicted SRH knowledge; statistical significance was reported using p-values.

Results: One hundred students participated (mean age 16.08 years); 57% were female. SRH concept awareness was high: 97% reported knowing what SRH means and 97% understood puberty changes. However, only 45% could identify sexually transmitted infections (STIs). Awareness of contraceptives was 60%, and 90% reported knowing how to prevent unwanted pregnancy. Attitudes were generally favorable: 94% agreed abstinence prevents STIs and pregnancy, and 83% reported that sexual health education helped delay sexual activity. Nonetheless, only 39% would consider contraceptive use if sexually active. Teachers (91%) and school seminars/workshops (90%) were the most common SRH information sources, followed by parents/guardians (84%) and the internet (64%). The study report indicated that sexual health education significantly influenced attitudes/practices (p=0.000) and that information sources significantly influenced knowledge (p=0.002).

Conclusion: School-based sexual health education was associated with positive attitudes and self-reported practices, but specific knowledge gaps (STIs) and low willingness to use contraception persisted. Strengthening comprehensive sexuality education, improving STI-specific content, engaging parents, and linking students to youth-friendly services are recommended.

Keywords: **sexuality education; adolescents; sexual and reproductive health; knowledge; attitudes; information sources; Nigeria.**

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1. INTRODUCTION

Comprehensive sexuality education (CSE) is defined as a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality, aimed at equipping children and young people with knowledge, skills, attitudes, and values that empower them to realize health, well-being, and dignity, develop respectful relationships, and understand rights. CSE is widely recognized as an important public health and education strategy for reducing adolescent sexual risk, delaying sexual debut, and improving protective behaviors.

Adolescence is a period of rapid development when sexual exploration may begin, creating vulnerability to unintended pregnancy and sexually transmitted infections (STIs), including HIV. In Nigeria and similar contexts, adolescent fertility remains a major concern and underscores the need for effective school-based programs and access to youth-friendly services.

This study assessed the effects of sexual health education on adolescents in St. Patrick's Secondary School, Awka, focusing on SRH knowledge, attitudes/practices, and information sources.

2. METHODS

Study design and setting

A cross-sectional descriptive study was conducted among students of St. Patrick's Secondary School, Awka South Local Government Area, Anambra State, Nigeria.

Study population and sampling

The study report describes a multistage sampling approach across class levels (SS1–SS3) with random selection procedures. The analyzed dataset included 100 students (SS1=25, SS2=59, SS3=16).

Note on sample size: Your methods section states a target minimum sample size of ~109 using Taro Yamane's approach; however, the computation uses e = 0.005 (0.5%), which is unusually strict for social/health surveys (commonly 0.05). Additionally, the final analyzed sample reported is n=100. Because I cannot verify the intended design choice from the information provided, I report the achieved sample (n=100) and treat this as a limitation.

Data collection tool and variables

A semi-structured questionnaire assessed:

• Knowledge: SRH meaning, puberty changes, STI identification/symptoms, HIV awareness, STI prevention, safe sex, abstinence, contraceptives, pregnancy, teenage pregnancy consequences, prevention of unwanted pregnancy.

• Attitudes/practices: perceived effect of sex education on delaying sexual activity; attitudes to abstinence, condoms, contraception; confidence to refuse unwanted sex; seeking care for suspected STI; comfort discussing issues with adults/health professionals.

• Information sources and trust: parents/guardians, teachers, seminars/workshops, internet/social media, religious leaders, peers, reading materials, TV; perceptions of reliability and desire for youth-friendly services.

3. DATA ANALYSIS

Descriptive statistics were presented as frequencies and percentages. The report states that linear regression was used to evaluate:

1. whether sexual health education influenced attitudes and practices (reported p=0.000), and

2. whether information sources influenced knowledge (reported p=0.002).

Because regression coefficients, confidence intervals, and model specifications are not provided, interpretation is restricted to the presence of statistically significant associations as reported.

Ethics

Permission was obtained from school leadership. Participation was voluntary with confidentiality and anonymity assured, per your report.

4. RESULTS

Participant characteristics

A total of 100 students participated, mean age 16.08 years. Females were 57% and males 43%. Class distribution was SS1 25%, SS2 59%, SS3 16%.

Data inconsistency note: Your narrative states "All (100%) are Christians," but the religion table lists Christianity 85%, Islam 3%, Traditional 8%, Others 4%. I cannot confirm which is correct; the results below do not rely on religion percentages except where explicitly noted.

Knowledge of SRH

• SRH definition known: 97%

• Puberty body changes understood: 97%

• Could identify STIs: 45%

• Knew STI symptoms: 52%

• Aware HIV/AIDS is an STI: 97%

• Knew how to protect self from STIs: 76%

• Understood safe sex: 74%

• Aware of different contraceptives: 60%

• Understood pregnancy occurrence: 87%

• Knew consequences of teenage pregnancy: 96%

• Reported receiving formal SRH education: 85%

• Reported knowing how to prevent unwanted pregnancy: 90%

Attitudes and self-reported practices

• Sex education helped delay sexual activity: 83%

• Abstinence prevents STIs and pregnancy: 94%

• Confident saying "no" to unwanted advances: 82%

• Condoms important for safe sex: 60%

• Would consider contraceptives if sexually active: 39%

• Sex education encourages responsible behavior: 90%

• Would seek medical help if suspected STI: 88%

• Decided to abstain until older: 94%

Information sources and trust

• Parents/guardians as SRH source: 84%

• Teachers as SRH source: 91%

• School seminars/workshops: 90%

• Internet: 64%; following sexual health social media pages: 32%

• Religious leaders discussed SRH: 75%

• Trust parents more than friends: 91%

• School-based education more helpful than online: 84%

• Social media often misleading: 90%

• Desire for more youth-friendly clinics/programs: 82%

Regression findings (as reported)

The study report indicates:

• Sexual health education significantly influenced attitudes/practices (p=0.000).

• Information sources significantly influenced knowledge (p=0.002).

Because regression outputs are not included, effect size and direction cannot be confirmed.

5. DISCUSSION

This study found high general SRH awareness (97% reporting understanding SRH and puberty) alongside important specific knowledge gaps, notably STI identification (45%) and STI symptom knowledge (52%). This pattern, broad awareness with weaker detailed STI knowledge, matters because prevention behaviors depend on accurate recognition of risk and disease concepts.

Attitudes were largely favorable toward abstinence and responsible behavior (94% endorsing abstinence for prevention; 90% endorsing responsible behavior), and most students reported that sex education helped delay sexual activity (83%). Evidence syntheses indicate that well-implemented school-based sexuality education can reduce sexual risk behaviors and improve HIV-related outcomes.

However, willingness to use contraception if sexually active was low (39%) despite 60% contraceptive awareness and 90% reporting knowledge of preventing unwanted pregnancy. This gap suggests that beyond factual knowledge, norms, perceived stigma, and acceptability may strongly influence behavioral intentions, particularly in settings where religious and cultural framing can shape adolescent sexuality perceptions. The data support this possibility indirectly: 98% reported that religious teachings shape views on sexuality (though, as noted, religion distribution in the dataset is inconsistent and cannot be confirmed).

Teachers and school programs were the dominant sources, which aligns with global guidance emphasizing schools as structured platforms for CSE delivery. The reported regression findings also suggest that both education exposure and information sources are statistically associated with better attitudes/practices and knowledge, respectively; nevertheless, without regression coefficients and model details, the strength and direction of these relationships cannot be confirmed from the provided materials.

6. CONCLUSION

Among students surveyed in St. Patrick's Secondary School, Awka, SRH awareness and supportive attitudes toward abstinence and responsible behavior were high. Nonetheless, STI-specific knowledge and willingness to consider contraception were comparatively low. The study report indicates statistically significant associations between sexual health education and improved attitudes/practices and between information sources and SRH knowledge.

7. RECOMMENDATIONS

1. Strengthen comprehensive sexuality education content with emphasis on STI identification, symptoms, and prevention, and ensure age-appropriate sequencing consistent with international technical guidance.

2. Improve contraception education by addressing myths, stigma, and decision-making skills (not only listing methods). Evidence highlights the importance of quality and rights-based approaches.

3. Enhance teacher capacity through standardized training and supportive materials to improve fidelity and comfort in delivery.

4. Strengthen parent engagement (communication skills, discussion guides), since parents were a major information source and are trusted more than peers in this sample.

5. Link schools to youth-friendly services (referral pathways, periodic school health talks with clinicians), in line with adolescent pregnancy prevention priorities and broader adolescent health strategies.

6. Digital literacy modules should be included because many students access the internet, while most perceive social media as misleading—teach how to identify credible SRH sources.

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