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The Impact of Sexual Health Education Course on University Students' Sexual Myths and Sexual Health Knowledge

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Research Article

ABSTRACT

This research was conducted to determine the impact of sexual health education course on university students' sexual myths and sexual health knowledge. The intervention group of the experimental study, using a pre-test post-test control group design, consisted of 149 university students who had a sexual health education course in their curriculum. The control group, on the other hand, consisted of 156 participants who did not have a sexual health education course in their curriculum. Participants in the intervention group received 2 hours of sexual health education per week for 15 weeks as part of the course curriculum, while no intervention was provided to the control group. Pre-tests and post-tests were administered simultaneously to both the intervention and control groups. Data collection instruments included a Personal Information Form, Sexual Myths Scale (SMS), and Sexual Health Knowledge Test (SHKT). The study data were analyzed using SPSS 24.0 software. In addition to descriptive statistical methods, Pearson Chi-Square test, Pearson Product-Moment Correlation analysis, and tests for the significance of differences between two means for dependent and independent groups were used to test intergroup differences. The results were evaluated at a significance level of $p<0.05$ within a 95% confidence interval. It was found that the mean SMS total score for students in the intervention group, who attended the Sexual Health Course, was 92.10±12.56 in the pre-test, while it was 98.84±11.40 for students in the control group, and the difference between the groups was statistically significant ($p<0.05$). In the post-test, the students in the intervention group had an mean SMS total score of 48.16±13.48, while the students in the control group had an mean score of 91.48±10.62, and the difference between the groups was statistically significant ($p<0.05$). The mean SMS total score for students in the intervention group decreased from 92.10±12.56 in the pre-test to 48.16±13.48 in the post-test, and the difference was statistically significant ($p<0.05$). The mean SMS score for students in the control group decreased from 98.84±11.40 in the pre-test to 91.48±10.62 in the post-test, and the difference was statistically significant ($p<0.05$). The decrease in mean SMS total and sub-dimension scores was higher for students in the intervention group compared to the control group ($p<0.05$). It can be concluded that sexual health education is effective in reducing participants' sexual myths and increasing their sexual health knowledge.

Keywords: Sexual health education, sexual myths, sexual knowledge

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Introduction

Sexual education is defined as providing individuals with scientifically accurate, age-appropriate, and non-judgmental information about sexuality and relationships (SIECUS, 2009). In this regard, it encompasses not only human sexual behaviors but also various topics such as sexual anatomy, reproductive and reproductive health, sexual response, emotional relationships, sexual pleasure, reproductive rights and responsibilities, sexual abuse, sexual orientations, sexually transmitted infections, and pregnancy prevention (UNFPA, 2015). The American Academy of Pediatrics supports the continuation of comprehensive sexual education programs to enable individuals to maintain satisfying and safe sexual lives, prevent risky sexual behaviors, and make informed and accurate decisions regarding matters related to sexuality (AAP, 2001). Properly delivered sexual education, through correct methods, in the right settings, and by the right individuals, has been shown to increase knowledge levels

on topics related to sexuality, reduce the likelihood of holding sexual myths, and promote sexual health (SIECUS, 2009). Comprehensive sexual education programs are reported to reduce the risk of unplanned pregnancies and sexually transmitted infections, decrease the tendency to engage in risky sexual behaviors, lower the number of sexual partners, and reduce gender-based violence. Additionally, they delay the age of sexual initiation, increase condom use, and promote perceptions of gender equality (UNFPA, 2015).

The adolescent/young adult period is considered a particularly sensitive stage across all age groups due to the completion of physical, psychological, and social maturity, increased interest in sexuality-related topics, and the experience of first sexual feelings and experiences. Preparation for sexuality, curiosity, and trial-and-error behaviors are often encountered during this period. It is essential for young people to access accurate and

sufficient information about sexuality at the right time to make informed decisions about their sexual lives. However, numerous studies indicate that young people have low levels of knowledge about fundamental sexual and reproductive health topics such as reproductive physiology, pregnancy prevention, and sexually transmitted infections (STIs), including Acquired Immune Deficiency Syndrome (AIDS). These studies also reveal that young people struggle to access information sources and that the sources they rely on are not always reliable (Sohbet and Geçici, 2013; Al-Quaiz et al., 2013; Oljira et al., 2013; Thanavanh et al., 2013; Nyoni and Ross, 2013). In fact, many studies suggest that university students, despite being considered part of an educated segment of society, also have insufficient knowledge about sexuality (Bulduk and Erdoğan, 2012; Dağ et al., 2012; Polat et al., 2012; Yazıcı et al., 2012 Ekşi and Kömürcü, 2014) and harbor common sexual myths (Eşsizoğlu et al., 2011; Apay et al., 2013; Gürsoy and Özkan, 2014). Studies conducted abroad show similarities to our country (Ganczak et al., 2007; Hong, 2011; He et al., 2012; Adinew et al., 2013; El Gelany and Moussa, 2013; Farih et al., 2014; Sahile et al., 2015). In many conservative societies, discussions about sexuality are often not comfortable within families, and comprehensive sexual education programs are not commonly integrated into school curricula. This leads young people to fill the gap in sexual education from various sources of information (Pai et al., 2010; Malek et al., 2010; Al-Quaiz et al., 2013; Nyoni and Ross, 2013). Receiving sexual education from a reliable source and based on evidence helps individuals take responsibility for their sexual behaviors, avoid risky sexual behaviors, and increase their risk perception (SIECUS, 2009; UNFPA 2015).

In this context, integrating age-appropriate sexual education courses into curricula from early childhood through all stages of education is of great importance. Information acquired through accurate and reliable sources and the skills gained can contribute to increasing knowledge about sexual health, dispelling sexual myths, and improving sexual health. This study aims to determine the impact of sexual health education courses on university students' sexual myths and sexual health knowledge.

Material and Methods

This research, which employed a pre-test post-test control group experimental design, was conducted at a state university between 2021-2022 and 2022-2023 academic years. The study aimed to determine the impact of sexual health education courses on university students' sexual myths and sexual health knowledge. The research was conducted in two different units of the university, one with a mandatory sexual health education course in the curriculum and the other without such a course. The intervention group consisted of 158 participants, and the control group included 170 participants, making up the entire population of the study. The entire population was included in the sample. The sample for the study consisted of a total of 305 students, with 149 students from the intervention group and 156 students from the control group participating in both the pre-test and post-test assessments.

Data Collection Tools

The data for this study were collected using the Personal Information Form, Sexual Myths Scale, and Sexual Health Knowledge Test.

Personal Information Questionnaire: The questionnaire included items questioning the participants' sociodemographic characteristics such as age, sex, maternal education, paternal education.

Sexual Myths Scale (SMS): SMS was developed to measure the extent of the sexual myths the respondents had. It was proved to be valid and reliable. The total Cronbach's α coefficient of the tool was 0.91. The tool consists of 28 items and 8 subscales. The lowest and highest possible scores to be obtained from the scale are 28 and 140, respectively. The scale has no cutoff point. The higher the score obtained from the scale is the greater the number of sexual myths the person has (Golbasi et al., 2016).

Sexual Health Knowledge Test (SHKT): SHKT aimed at objectively measuring the knowledge levels of individuals about sexual health was developed by Evcili and Golbasi. Correlation of item difficulty and item discrimination values were calculated in the statistical analysis. The validity and reliability of the test were methodologically confirmed, resulting in 40 items addressing sexuality and all its dimensions. The α coefficient of the test which has 40 multiple choice questions is 0.88. The results suggest that the test is a valid and reliable tool to measure an individual's knowledge level of sexual health issues. The respondents are asked to carefully read each question. The scores are calculated as follows: While the participant gets a score of "1" from any question he/she correctly answers, he/she gets a score of "0" from any question he/she incorrectly answers or does not answer. The minimum and maximum possible scores to be obtained from the scale are 0 and 40, respectively. The test has no cutoff point. As the total score obtained from the scale increases so does the individual's sexual health knowledge (Evcili and Golbasi, 2017).

Implementation of the Research

Prior to commencing the research, the Personal Information Form, Sexual Myths Scale, and Sexual Health Knowledge Test were administered to the intervention group. There were no students in the intervention group who refused to participate in the pre-application of the data collection tools; thus, a 100% response rate was achieved (n=158). In the control group, a response rate of 98% was reached to the data collection tools (n=166). No interventions were conducted with the control group until the post-test application. During the intervention phase of the research, participants received a 2-hour sexual health

education course each week for a duration of 15 weeks. The course covered fundamental concepts related to sexuality, sexual health and reproductive health, universal values related to reproductive rights and sexuality, sexual identity development, sexual orientations, gender and gender roles, anatomy of the reproductive system, sexual response cycle, physiology of reproduction, contraception, sexually transmitted infections, sexual violence, and safe sexual behaviors. The course content was structured to provide accurate, up-to-date, evidence-based information on topics related to sexuality and sexual health, promote the ability to make informed decisions regarding matters related to sexuality, establish healthy relationships, foster a positive perception of sexuality, develop universal sexual values, build effective communication skills, and enable participants to share their acquired knowledge using effective communication techniques. Throughout the lessons, various interactive educational activities (such as weekly assessments, group discussions, brainstorming sessions, video presentations, imaginative exercises, and question-answer sessions) were used to support the learning process. At the end of the semester, the data collection tools were re-administered to the students in the intervention group. During the post-test application, a response rate of 94% was achieved among the intervention group (n=149). Simultaneously, the data collection tools were also re-administered to the students in the control group. Among the control group students who had received the pre-test, 92% were reached during the post-test (n=156). On the day of the pre-test application, students who were absent or had forgotten their assigned pseudonyms could not be matched with their data collection tools and were consequently excluded from the research.

Data Analysis

The study data were transferred to the SPSS 24.0 Windows package program for analysis. In the evaluation of the study data, descriptive statistical methods (count, percentage, mean, standard deviation) were used. Additionally, to test for differences within and between groups, the Pearson Chi-Square test, Pearson Product-Moment Correlation analysis, and tests for the significance of differences between two means (t-test) for dependent and independent groups were employed. The results were evaluated at a significance level of $p<0.05$ within a 95% confidence interval.

Ethical Approval

To conduct the research, ethical approval was obtained (September 09, 2022). All participants were provided with a voluntary informed consent form, and verbal consent was obtained. It was explained to the participants that the data collected would be used for scientific purposes and would be published without using their names.

Results

The participants have an mean age of 20.48 ± 1.16, with 52% of them being female. 97.6% of them are single, and 73.2% live in urban areas. It was observed that 58.3% of the participants' mothers and 82.6% of their fathers have a high school education or higher. Regarding participant characteristics such as age, gender distribution, marital status, place of residence, and parental education level, there were no statistically significant differences between the intervention and control groups ($p>0.05$), indicating that the groups had a homogeneous distribution. Approximately 48.8% of the participants considered their knowledge about sexual topics to be sufficient, and there was no significant difference in this regard between the intervention and control groups ($p>0.05$). The participants primarily reported getting information about sexual topics from the internet (80.5%), peers/friends (72.6%), and television (48.6%).

Table 1 displays the mean scores and difference scores for the SMS total and sub-dimensions of students before and after sexual health education. According to the table, it was found that the mean SMS total score of the students in the intervention group was 92.10 ± 12.56 in the pre-test, whereas it was 98.84 ± 11.40 for the students in the control group, with a statistically significant difference between the groups ($p<0.05$). The students in the intervention group had an mean SMS total score of 48.16 ± 13.48 in the post-test, while the students in the control group had a score of 91.48 ± 10.62, and this difference was found to be statistically significant ($p<0.05$). It was also determined that the decrease in the SMS total score mean between pre and post-program was statistically significant for the students in the intervention group ($p<0.05$). The control group students had an initial SMS score mean of 98.84 ± 11.40, which decreased to 91.48 ± 10.62 in the post-test, and this decrease was statistically significant ($p<0.05$). The reduction in the SMS total and sub-dimension score means for the students in the intervention group was found to be higher compared to the control group students ($p<0.05$).

Table 2 presents the mean scores and difference scores for the SHKT total and sub-dimensions of students before and after sexual health education. According to the table, it was found that the mean SHKT total score of the students in the intervention group was 19.85 ± 5.93 in the pre-test, whereas it was 16.28 ± 4.50 for the students in the control group, with a statistically significant difference between the groups ($p<0.05$). The students in the intervention group had an mean SHKT total score of 32.40 ± 6.16 in the post-test, while the students in the control group had a score of 22.62 ± 5.38, and this difference was found to be statistically significant ($p<0.05$). It was also determined that the increase in the SHKT total score mean between pre and post-program was statistically significant for the students in the intervention group ($p<0.05$). The control group students had an initial SHKT score mean of 16.28 ± 4.50, which increased to 22.62 ± 5.38 in the post-test. The increase in the SHKT total and sub-dimension score means for the students in the intervention group was found to be higher compared to the control group students ($p<0.05$).

Table 1. SMS total and sub-dimensions mean scores before and after sexual health education course

Sexual Myths Scale Sub-dimensions	Intervention Group (n=149)			Control Group (n=156)			t/p
	Pre-test m (sd)	Post-test m (sd)	Difference	Pre-test m (sd)	Post-test m (sd)	Difference	
Gender	18.42±3.12	15.18±3.46	-1.96±1.40	17.82±4.12	17.26±2.40	-0.94±1.42	*4.12/0.052 **6.46/0.001 ***4.70/0.001
Scale Score (min-max): 6-30	**t= 11.05 p=0.001**			t= 6.18 p=0.068			
Sexual Orientation	20.12±2.40	12.04±3.86	-1.82±1.02	19.50±3.12	16.18±3.82	-1.18±0.56	*4.82/0.056 **6.08/0.001 ***-7.20/0.001
Scale Score (min-max): 5-25	**t= 12.42 p=0.001**			**t=8.16 p=0.001**			
Age and Sexuality	14.10±3.20	9.12±2.16	-1.56±1.40	13.38±2.18	12.80±2.48	-0.83±0.42	*2.16/0.058 **3.10/0.001 ***-5.42/0.001
Scale Score (min-max): 4-20	**t=11.48 p=0.001**			t=5.11 p=0.086			
Sexual Behaviour	9.82±2.48	5.13±3.40	-1.14±1.20	10.20±2.14	9.48±3.14	-0.76±0.18	*3.48/0.062 **3.78/0.001 ***-4.10/0.001
Scale Score (min-max): 3-15	**t=6.52 p=0.001**			t=7.42 p=0.123			
Masturbation	7.00±2.12	5.06±1.48	-1.62±1.02	7.86±3.40	6.56±1.82	-0.52±0.18	*0.96/0.126 **6.42/0.001 ***-4.48/0.001
Scale Score (min-max): 2-10	**t=10.02 p=0.001**			t=6.10 p=0.079			
Sexual Violence	11.62±2.02	7.23±2.40	-1.86±1.04	10.52±2.46	10.12±3.10	-0.10±0.52	*4.40/0.001 **5.86/0.001 ***-3.80/0.001
Scale Score (min-max): 4-20	**t=9.48 p=0.001**			t=7.16 p=0.156			
Sexual Intercourse	7.46±1.28	5.60±2.12	-2.90±1.40	6.06±1.10	6.86±2.42	0.16±0.82	*1.48/0.003 **4.62/0.001 ***-5.40/0.001
Scale Score (min-max): 2-10	**t=10.72 p=0.001**			t=4.12 p=0.121			
Sexual Satisfaction	7.10±1.46	4.12±1.10	-2.86±1.16	7.86±1.10	5.48±2.12	-1.02±176	*2.12/0.140 **3.20/0.001 ***-5.18/0.001
Scale Score (min-max): 2-10	**t=11.22 p=0.001**			**t=10.02 p=0.048**			
Total SMS Score	92.10±12.56	48.16±13.48	-10.75±5.10	98.84±11.40	91.48±10.62	-6.16±3.80	*6.86/0.001 **6.18/0.001 ***-10.40/0.001
Scale Score (min-max): 28-140	**t=15.43 p=0.001**			**t=10.06 p=0.001**			

* This is the result of the statistical analysis between the pre-test SMS total and sub-dimension scores of the ıntervention and control groups. ** This is the result of the statistical analysis between the post-test SMS total and sub-dimension scores of the ıntervention and control groups. *** This is the result of the statistical analysis between the intervention and control groups' SMS total and sub-dimension difference means.
***Abbreviations:** SMS, Sexual Myths Scale; sd, standard deviation; m, mean;*
Bold values indicate p < 0.05

Table 2. SHKT total and sub-dimensions mean scores before and after sexual health education

SHKT Sub-dimensions	Intervention Group (n=149)			Control Group (n=156)			t/p
	Pre-test m (sd)	Post-test m (sd)	Difference	Pre-test m (sd)	Post-test m (sd)	Difference	
Sexual Universal Values Scale Score (min-max): 0-2	1.02±0.40 **t=10.60 p=0.001**	1.86±0.42	0.62±0.40	1.30±0.60 **t=4.90 p=0.001**	1.72±0.60	0.26±0.20	*1.12/0.208 **2.20/0.056 ***5.78/0.001
Sexual Identity Scale Score (min-max): 0-4	1.42±1.02 **t=16.65 p=0.001**	3.30±1.20	0.60±0.33	2.86±0.26 **t=5.14 p=0.001**	1.16±0.48	0.16±0.10	*2.16/0.001 **6.10/0.001 ***10.48/0.001
Sexual Orientation Scale Score (min-max): 0-3	1.18±0.48 **t=17.70 p=0.001**	2.36±0.92	0.58±0.04	2.42±0.10 **t=6.06 p=0.001**	1.24±0.24	0.21±0.30	*1.10/0.01 **4.16/0.001 ***11.20/0.001
Sex-Gender Scale Score (min-max): 0-3	2.10±0.80 **t=12.16 p=0.001**	2.52±0.76	0.41±0.32	1.16±0.80 **t=4.90 p=0.001**	1.98±0.72	0.22±0.18	*4.06/0.001 **4.12/0.001 ***4.861/0.001
Reproductive Anatomy Scale Score (min-max): 0-3	1.06±0.48 **t=16.51 p=0.001**	2.16±0.98	0.48±0.22	1.18±0.82 **t=6.20 p=0.001**	1.10±0.80	0.18±0.12	*1.72/0.060 **5.26/0.001 ***13.78/0.001
Sexual Relationship Scale Score (min-max): 0-4	2.51±1.14 **t=13.02 p=0.001**	3.86±1.00	0.56±0.12	2.48±1.18 **t=3.60 p=0.001**	2.18±1.14	0.18±0.14	*1.30/0.140 **5.12/0.001 ***8.42/0.001
Reproductive Physiology Scale Score (min-max): 0-3	1.10±0.70 **t=16.66 p=0.001**	2.60±0.78	0.42±0.27	1.27±0.74 **t=3.82 p=0.001**	1.02±0.52	0.26±0.32	*1.28/0.082 **6.16/0.001 ***9.08/0.001
Contraception Scale Score (min-max): 0-6	2.50±1.54 **t=18.60 p=0.001**	4.48±1.52	0.67±0.03	3.80±1.43 **t=6.42 p=0.001**	2.12±1.04	0.10±0.52	*2.64/0.001 **5.30/0.001 ***11.5/0.001
STDs Scale Score (min-max): 0-7	2.70±1.48 **t=18.82 p=0.001**	5.86±1.28	1.10±0.10	3.15±1.45 **t=6.60 p=0.001**	3.16±1.64	0.20±0.72	*3.16/0.001 **4.06/0.001 ***11.10/0.001
Sexual Violence Scale Score (min-max): 0-3	1.80±1.42 **t=10.30 p=0.001**	2.83±0.90	0.42±0.10	1.84±0.98 **t=4.15 p=0.001**	1.26±0.20	0.10±0.24	*1.20/0.817 **5.18/0.001 ***6.2880/0.001
Sexual Behavior Scale Score (min-max): 0-2	0.60±0.12 **t=16.42 p=0.001**	1.56±0.78	0.48±0.16	1.80±0.70 **t=7.48 p=0.001**	0.72±0.46	0.10±0.32	*2.26/0.001 **3.30/0.001 ***4.26/0.001
Total SHKT Score Scale Score (min-max): 0-40	19.85±5.93 **t=26.10 p=0.001**	32.40±6.16	16.02±5.60	16.28±4.50 **t=13.20 p=0.001**	22.62±5.38	4.18±2.42	*4.50/0.016 **8.86/0.001 ***13.6/0.001

* This is the result of the statistical analysis between the pre-test SHKT total and sub-dimension scores of the ıntervention and control groups. ** This is the result of the statistical analysis between the post-test SHKT total and sub-dimension scores of the ıntervention and control groups. *** This is the result of the statistical analysis between the ıntervention and control groups' SHKT total and sub-dimension difference means.

Abbreviations: SHKT, Sexual Health Knowledge Test; STDs, Sexually Transmitted Infections sd, standard deviation; m, mean; Bold values indicate p < 0.05

Table 3. The correlation between SMS and SHKT scores before and after sexual health education

SMS		SHKT			
		Intervention Group (n=149)		Control Group (n=156)	
		r	p	r	p
	Before Education	-0.540	**0.001**	-0.580	**0.001**
	After Education	-0.862	**0.001**	-0.546	**0.001**

Abbreviations: SHKT, Sexual Health Knowledge Test; SMS, Sexual Myths Scale; r, Pearson Correlation Coefficient; Bold values indicate p < 0.05

Table 3 provides the results of Pearson Product-Moment Correlation Analysis conducted to determine the relationship between students' scores from the Sexual Myths Scale (SMS) and the Sexual Health Knowledge Test (SHKT) before and after Sexual Health Education. According to the table, a statistically significant negative correlation was found between the scores obtained by students in the intervention and control groups from the Sexual Myths Scale (SMS) and the scores obtained from the Sexual Health Knowledge Test (SHKT) before and after Sexual Health Education (p<0.05).

Discussion

In this study, the impact of sexual health education on university students' sexual myths and sexual health knowledge levels was examined. The data obtained were discussed in accordance with the relevant literature. In our study, it was found that students in the intervention group who took sexual health education had a statistically significant decrease in sexual myths and an increase in sexual health knowledge compared to those in the control group (Table 1, Table 2). These findings demonstrate the effectiveness of Sexual Health Education. Courses related to sexuality and sexual health should be included in curricula, especially to protect young people from sexually transmitted diseases and unwanted pregnancies, raise awareness of sexual and reproductive health, increase knowledge levels, promote positive attitudes and behavioral changes (SIECUS, 2009; UNFPA 2015). Sexual health education provided by an expert educator has been shown to have a positive impact on young people's knowledge and attitudes towards sexual health/reproductive health, delay the age of first sexual intercourse, reduce the number of sexual partners, increase condom use, encourage at-risk groups to use health services, and contribute to the development of social norms related to sexuality (Mahat et al., 2008; Medley et al., 2009; Adamchak, 2006; Rabieipoor, 2011; Tolli, 2012; Yan et al., 2014).

In this study, it was determined that both the intervention and control groups had a decrease in sexual myths and an increase in sexual health knowledge in the post-test. A decrease in sexual myths and an increase in sexual health knowledge are expected outcomes for students who have taken the Sexual Health Education course. However, it is noteworthy that students who did not participate in peer education activities also showed a decrease in sexual myths and an increase in sexual health knowledge. Measurement tools (scales, tests, questionnaires, etc.) consist of a series of statements/questions aimed at determining individuals' living conditions, behaviors, knowledge, beliefs, and attitudes. It is possible that the measurement tools applied to the control group (Sexual Myths Scale, Sexual Health Knowledge Test) may have aroused interest/curiosity in young people, prompted them to seek learning, and contributed to their awareness of their current knowledge levels and existing myths.

Conclusions and Recommendations

According to the data obtained from this study, it is evident that sexual health education courses are effective in reducing sexual myths and increasing sexual health knowledge among participants. Based on these findings, it is recommended that university administration collaborates with all academic departments to incorporate elective/mandatory sexual health education courses into their curricula. These courses should be structured to meet the informational needs of young people and should be delivered by experts in the field. Furthermore, various communication and promotion strategies should be developed to ensure that sexual health education programs reach a wider student audience. These programs should aim to raise greater awareness among young people and encourage their participation. Finally, the content of sexual health education courses should encompass up-to-date and accurate information on sexual health and provide students with an opportunity to develop a positive attitude towards sexuality. These courses should also encourage young people to protect their sexual health by discussing responsibilities and risks associated with sexual health.

Limitations of the Research

In the research, students in both the intervention and control groups were asked to write their names on the data collection forms, or if they preferred not to use their names, they were asked to use a memorable pseudonym. However, during the final administration of the data collection tools, some students forgot their pseudonyms. The data collection tools could not be matched to the students who had forgotten their pseudonyms. These unmatched data collection tools were subsequently excluded from the scope of the research.

Declaration of Conflicting Interests
The authors declare that there is no conflict of interest.

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