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Students' Health Behavior and Course Completion in Public and Private Universities in Uganda

Asingwire Richard, Prof. Ijeoma Amunaka B. and Dr. Sofia Sol Gaite T.

e-mail: richard.asingwire45186@stud.kiu.ac.ug
Affiliated university: Kampala International University

Abstract: *The study was on Students' health behavior and course completion in public and private universities in Uganda. It was conducted in 9 public and private universities in Uganda while balancing 3 regions: Central, Western and Eastern. The study was of Qualitative in nature and used a Positivism philosophy backed with Health Belief Model (HBM) by Rosen stock, supported by the Theory of Reasoned Action (TRA) which was proposed in 1975 by Martin Fishbein. Students perform health behavior having reasoned about the positive and negative consequences. Health Belief Model terms like Susceptibility, Perceived benefits, Perceived barriers, Self efficacy and Clue to barriers were borrowed from HBM. Preventive, Illness and Sick-role behaviors that were pathways to the risky health behavior were borrowed from HBM. These pathways were used in studying related literature, designing research instruments, collecting data, analyzing and interpreting it. Findings: A new culture has come up - students have created their own new life where there are no outsiders like elders. Students don't care about the future. They have lost hopes. There is an increasing rate of cross-age risky sexual behavior. Cross gender risky sexual behavior is rampant among students either willingly, lured or forcefully. Love for money, materials plus job promising are becoming the order of the day. Students accept their risky sexual behaviors is concerned publicaly. HIV is being transmitted at a very high rate among students. A big number of students don't know their HIV status. The majority of students don't their HIV status and are doing nothing as far as preventing themselves from being infected by HIV. Almost all the students don't know anything about Prep. Some few students who are HIV positive stopped from taking their ARVS. The majority of students don't use condoms. So many students are suffering from Sexual Transmitted Diseases. Recommendations: There should be enough programs of Health behavior awareness starting from national lever to students as individuals. Social media should be the pathways of educating, guiding and controlling students. Religious leaders should go to come down to where students are to give hope. Health institutions should come down to find students where they are. Students should develop a habit of health seeking behavior. Though out of restriction and free from the 'eye' of the parents or teachers, students should learn how to control themselves using laws of nature.*

Keywords: health behavior, risky sexual behavior, course completion

Background of the study

Historical Perspective

Globally, 1 out of 10 (20%) of the young people in University is likely to encounter at least one health behavior challenge (WHO, 2017). These behavior challenges are likely to pose a significant threat to academic performance and completion. Half-lifetime people experience psychosocial disorders such as disorders, for example, anxiety, panic, adjustment, and depression among others that may start by the age of fourteen, and 75percent by the age of twenty-four (WHO, 2017). Studies done in Canada and the USA have shown that student health behaviors in universities are increasing (Jellinek et al., 2015).

Continental wise, in most of the African Countries, the scenario of student's health behavior is still a heavy challenge compared to developed nations as Africa's health-care system and education system is inadequate (Manjual, 2016). Indeed, there is evidence that undergraduate students facing unique academic challenges that render them more vulnerable to anxiety (Samaha, 2016).

First year university students are particularly prone to stress due to the transitional nature of college life (Elzubeir, 2017). In addition to academic requirements, relations with faculty members and time pressures are yet further sources of health behavior challenge amongst private and public universities in Africa (Schneiderman, 2005) cited in Yaribeygi, (2017).

On top of all, tests, grades, competition, time demands, professional class environment, and concern about future careers are found to be major source of students behavior health challenge. Consequently, these challenges pose a considerable threat to academic performance, relationships, job performance and general decline in course completion (Sanchez, et. al 2016)

Uganda's case, there are 46 Universities (EduRank, 2021). Despite such recent expansion of higher education in Uganda, there is still much cause for concern. The transition rate at this level is about 35%, implying that only about 35,000 who are able to join university education, are they only ones who graduate (Kasozi, 2003) cited in Abdeyazdan, (2017).

University students have high rates of poor diet, physical inactivity, long sitting hours, inadequate sleep, excess alcohol consumption, and smoking (substance use) in the end, poor performance that brings low course completion (Patterson M, 2021). The challenge was that course completion was low. What caused all that? Was it family background, government policies or students' health behavior? Therefore, the researcher came in to find out what causes the low course completions in public and private Universities in Uganda.

Theoretical Perspective

This study was guided by Health Belief Model (HBM) theory of health seeking behaviors by Rosen stock (as cited in Greene, 2018). The study was guided by three pathways presented in Health Belief Model. These pathways are; Preventive health behavior, Illness behavior and Sick-role behavior. The Health Belief Model (HBM) is a psychological health behavior change model, which was developed to explain and predict health-related behaviors, particularly as it relates to participating in health services. The study was also be supported by Theory of Reasoned Action which was proposed in 1975 by Martin Fishbein and by Icek Ajzen. The Theory of Reasoned Action (TRA) suggests that a person's behavior is determined by their intention to perform the behavior and that this intention is, in turn, a function of their attitude toward the behavior and subjective norms (Fishbein & Ajzen, 1975).

The Health Belief Model was developed in the 1950s by social psychologist Rosen stock (as cited in Greene, 2018) at the U.S. Public Health Service to understand the widespread failure of a screening program for tuberculosis. Rosen stock (as cited in Greene, 2018) stated that more recently, the model has applied to understand patients' responses to symptoms of disease, compliance with medical regimens, lifestyles behaviors, and behaviors related to chronic diseases.

The Health Belief Model (HBM) addresses four major components for compliance with recommended health actions: Perceived barriers of recommended health, perceived benefits of recommended health action, Perceived susceptibility of the disease, and Perceived severity of the disease. Modifying factors that can affect behavior compliance include media, health professionals, personal relationships, incentives, and self-efficacy of recommended health action Bandura (as cited in Leslie, 2019).

Therefore, the Health Belief Model (HBM) guided the researcher in studying related literature, designing the research instruments (Interview guide and Observation sheet), collecting and analyzing data in terms of pathways: preventive, illness and sick role behaviors. Terms like perceived susceptibility, perceived benefits and threats/ barriers, self-efficacy and clue to action were used in the study borrowed from the Health Belief Model (HBM).

Conceptual Perspectives

The independent variable (IV) in the study was student's health behavior. In the study, the variable was defined by Preventive health behavior, illness behavior and sick-role behavior where preventive health behavior was indicated with Perceived susceptibility and Self-efficacy, illness behavior shall be indicated with Perceived severity and Perceived benefits and also Sick-role behavior shall be indicated with Perceived barriers Clue to action.

According to the Ottawa Charter, (Flynn, 2015), Health behaviors are actions individuals take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as substance use and risky sexual behavior.

According to Farlex Medical Dictionary (as cited in Blanche, 2015), health-seeking behavior is an action taken by a person to maintain, attain or regain good health and to prevent illness. These include medication, physical exercise, eating balanced diet/nutrition and protection. Health seeking behavior is therefore defined as the act of maintaining good health and preventing illnesses. For the study, the main focus was put on risk sexual behaviors, as a construct of health behavior, through 3 pathways: Preventive, Illness and Sick-role behaviors.

The dependent variable (DV) of the study was Course completion which was indicated by Academic performance and Students' discipline. The course completion described the proportion of students who enter a university school program and completed it successfully according to their admissions. The two variables were intervened by Family background and health promotion environment, inadequate information about health behavior and Policy supporting situations.

Contextual Perspective

Uganda officially the Republic of Uganda is a landlocked country in East Africa. The country is bordered to the east by Kenya, to the north by South Sudan, to the west by the Democratic Republic of the Congo, to the south-west by Rwanda, and to the south by Tanzania. The southern part of the country includes a substantial portion of Lake Victoria, shared with Kenya and Tanzania.

Uganda is in the African Great Lakes region. Uganda also lies within the Nile basin and has a varied but generally a modified equatorial climate. It has a population of over 42 million, of which 8.5 million live in the capital and largest city of Kampala. Uganda,

the country's higher education system is represented by 46 universities with over 535 study programs. In addition, over 232 Bachelor programs at 46 universities, 229 Master programs at 37 universities and 74 PhD programs at 10 universities (UNCHE, 2017). However, the study concentrated on students on Bachelor's programs preferably education undergraduate program.

For the past 20 years or so African higher education institutions have been experiencing explosive enrolment growth rates. For instance, according to the literature, from 1999 to 2012 enrolment shot up by 170%; that is, from 3.5 million students to 9.54 million students (UNCHE, 2018). Explosive university enrolment is a continent-wide phenomenon.

The World Bank states that since 1985, about nine African countries have led the trend in university enrolment growth. They include: Rwanda (up 55%), Namibia (46%), Uganda (37%), Tanzania (32%), Côte d'Ivoire (28%), Kenya (27%), Chad (27%), Botswana (22%) and Cameroon (22%) - (UNCHE, 20218). Overall, according to the World Bank, the African continent has attained an average annual enrolment growth rate of 15% in its higher education institutions (UNCHE, 20218).

In Uganda, the state of higher education in Uganda through the 2018/19 higher education publication, the total number of HEIs increased by four up from 233 in 2017/18 to 237 in 2018/19, Public Universities remained 9, Private Universities remained 44; Other Degree Awarding Institutions remained 10 and Other Tertiary Institutions increased by four from 172 to 176 (UNCHE, 20218). In 2018/19 total student enrolment increased from 261,087 to 275,254 representing a significant increase of 5.43%. Universities still take the highest number of registered students at 192,346. There was a slight drop in GER in Uganda from 6.85% in 2017/18 to 6.81 in 2018/19 representing 0.58%. In the year 2018/19, NCHE received a total of 1,206 programs, reviewed 1,141 and accredited 335 representing 29.4% (UNCHE, 20218).

The official school going age for Post-secondary is 19-24 years (Education Monograph Report, 2018). Overall only 11% of 3,858,753 of the population aged 22-25years completed tertiary education and higher. Dis-aggregation by gender shows that the course completions for males (11.3% of 1,749,786) was more than for the females (10.7% of 2,108,967) of the same age group (Education Monograph Report, 2018). Likewise, tertiary education course completions for urban (19% of 3,858,753) was far higher than for the rural (7% of 3,858,753) - (Education Monograph Report, 2018). By region, the rates for Kampala (24%) was the highest and for Karamoja (6.2 % 0f 3,858,753) was the lowest among all the regions.

Generally, the percentages are low. If the students' performance could be improved, the general course completion would be improved too and students would go into the field, become productive rather than staying long redundant in universities. Hence, the study intended to investigate the students' health behavior and course completion in public and private universities in Uganda.

Operating terms

Susceptibility - capable of submitting to an action or behavior.

Perceived benefits - expected positive outcomes for performing a risky health behavior.

Perceived barriers - expected negative consequences for performing a risky health behavior.

Self efficacy – beliefs in students' capacity to perform risky health behavior.

Clue to action - having enough knowledge about the risky health behavior.

Purpose of the Study

The study examined the relationship between students' health behavior and course completion in public and private Universities in Uganda.

Specific Objectives

To assess the relationship between students' preventive health behavior and course completion in public and private Universities in Uganda.

To determine the relationship between students' illness behavior and course completion in public and private Universities in Uganda.

To examine the relationship between students' sick-role behavior and course completion in public and private Universities in Uganda.

Study Scope

The study was limited to students' health behavior and course completion in education departments in 9 selected public and private Universities from 3 different regions of Uganda. Public Universities were: Makerere University – Central region, Kabale University – Western region and Kumi University – Eastern region. Private Universities were: Kampala International University, Kampala University, Cavendish University and International University of East Africa – Central region. International Metropolitan University – Western region. Islamic University in Uganda – Eastern region. The study used 2018 as the base year to account for students' enrolment in Universities for the period of 2018–2021. Empirical data from public and private universities that were in existence by 20018 was analyzed.

Methodology

Research Philosophy

The research was guided by Positivism Philosophy by Auguste Comte during early 19th century – basing on the ideology that students perform behaviors having enough knowledge about such (efficacy) and well knowing the consequences. It was supported by the theory of reasoned action and the health belief model. Health belief model terms the consequences as the perceived benefits and the perceived barriers. Students forego the perceived barriers and perform behaviors because of the perceived benefits. The researcher based on this philosophy when collecting (using interviews and observation instruments) and analyzing qualitative data.

Research Design

The research employed mixed research approaches; quantitative and qualitative. Descriptive research design was used. The researcher studied informants for a month and interviewed some informants, out of their will, about behaviors, life experiences by interacting with them. The researcher after analyzing the information got, conclusions were reached at and recommendations were made.

Sample size

A sample size of 375 participants obtained for cross-sectional studies from each of the 9 selected Universities. These will be: 306 students, 18 lecturers, 18 non teaching personnel, 15 administrators, 9 health workers and 9 university counselors. A 95% level of confidence and a 5% level of precision will be used in the sample size calculation.

Sampling strategies

The researcher selected respondents randomly and others purposely, according to need of the study. The study was also guided by lecturers to get the respondents. Random sampling was used to select public and private universities from each of the 3 Ugandan regions – Central, Eastern and Western. The research study collected data using Interview guide and Observation sheet as research instruments. A review of institutional websites allowed the researcher to identify academic officers who received research instruments by e-mail. Two individuals from each University were identified as primary and secondary contacts. An e-mail request for participation was sent to primary contacts. Follow-up were made through whatsApps, calls and physical contacts.

Research instruments

Observation sheet: the researcher got involved with the students and was more observant to the most effect. That enabled him to understand the students' behaviours in reality. When he was done, at night after the encounters, the researcher would write whatever he had observed and checked what was coming frequently on the observation sheets.

Interview guide: The researcher used interview guide to get information about students' health behavior from the rest of the informants apart from students. These were Administrators, Lecturers and Non teaching staff. That was because they were trained personnel and they were trustworthy in keeping the secrets of the students. An interview guide helped the researcher not to be astray from the research objectives. It also saved time for both the researcher and the respondents.

Instrument validity and reliability: The researcher piloted to check content validity. He piloted the study in University nearer to him – Kampala International University. That mainly tested the reliability and validity of the research instruments. The researcher got involved in the University environment while studying 15 informants and checked if the information got was consistent and valid.

Piloting

The study was piloted in the university nearer to the researcher – Kampala International University. It's from piloting that the researcher tested the validity and reliability of the research instruments with the information concerning students' behavior and course completions.

Data analysis

Data analysis involved identification and transcription of the qualitative findings into categories. The categories were then sorted and aligned to the research objectives from which lessons leaned on students' health behavior and course completions in a narrative form.

Interpretation

The researcher conducted a manual analysis of datasets and code responses into categories. He studied the categories. Basing on repetitive occurrence and consistencies, he came up with conclusions concerning health behaviors and course completion of university students.

Ethical considerations

Approval to conduct the research was obtained from the College of Higher Degrees and Research – Kampala International University. The study was also registered and cleared by the Uganda National Council for Higher Education. Permissions were obtained from the selected universities before collecting data. Written informed consent was obtained from participants before taking part in the study.

Findings

Observation

Susceptibility - A big number of students in urban universities they are always getting involved in risky sexual behaviors. They find themselves involved in risky sexual behaviors because of the environment – being free from strict world of parents and teachers. They find it difficult to resist.

Severity – Students are suffering from consequences of the risky sexual behavior. This is evidenced by most of their talks, when in their small groups where they trust each other; most of their stories were about risky behavior. They were always heard sharing of their past experience. Such consequences heard were sexual transmitted diseases, being coned by partners, being black mailed, or having different sexual partners. A few talks were individuals talking about their personal experiences while most of the talks were about other students that they were attached to. That some were on ARVs.

Self-efficacy - Most of the students believed in themselves for habits of risk sexual behaviors that they were involved in. They could be heard telling their friends how they are strongly active in bed; "Me, I can have sex with four girls in one night", "He this one, me, I can have sex with someone for 5 hours or until she/he cries and begs me to top", "Me, I can go for 4 rounds when still on one partner just". "I hear that so and so finishes quickly – beeps like a cock!", "Do you know that so and so doesn't work at all?", "So and so has a very small *dick* (penis) like the last finger", "Me, you can't satisfy me. *Tolina* worker (you are weak in sex), "Me, I like *cassava* (a very big penis). Some students could be spotted by the way they dress and walk – dressed in tights and showing off their big sexual organs. Some students' walking styles or standing postures were meant to show off to others how they are strong sexually or good in bed. Most of the girls, if not in min dresses that revealed their thighs, were putting on jagging or leggings showed how they were 'created' well by having good figures. Boys and girls had a way of walking while 'waving' their arms/hands in an attracting way. This was proved by being spotted trying to look around to see if there might be some people looking at them. All in all, students were not feeling shy at all.

Perceived benefits – Most of the students get involved in risky sexual behaviors expecting to enjoy life and experience what they have been foregoing when still under strict environment of parents and teachers.

Perceived barriers – A big number of students don't think about negative consequences of being involved in risky sexual behaviors.

Clue to action – Most of the pretended to know everything about any risky behavior involved in. they thought that there is nothing they don't know concerning risky sexual behavior.

Generally, as for course completion, a big number of students don't mind about their course completion. To them, they have already achieved their dreams by being at campus. Living a university life – being free from the outside of elders, is living a heavenly world. Enjoying life, as they term it.

Interviews – Interview were based on pathways as portrayed in Health Belief Model – Preventive health behavior, Illness behavior and Sick role behavior. From the interviews conducted between lecturers and non-teaching staff, some students get involved in risky sexual behaviors not for preventive purposes. Just a few students get involved in risky sexual behavior following the ongoing say, "If you don't play sex, you become ill" (Preventive health behavior). Some few students get involved in risky health behaviors because they are ill in that, it makes them heal (Sick role health behavior). A few students get involved in risky sexual behavior to, intentionally, infect others of Sexual Transmitted Diseases or even HIV. Yet, a big number of students play the Sick role health behavior in that, they think that they are sick without going for medical checkups or being confirmed by any doctor. As for that, they don't care about the consequences they may result from such a risky sexual behavior. From interviews with administrators, lecturers and non-teaching staff, students care less about studies. After S.6 (Advanced Level) stress, they relax from reading a lot. Some negligently miss lectures or even exams. At the end of the semester of the year, the majority of students get retakes. By the time of graduation, almost a half of the intended students to graduate that year don't qualify to graduate. An average number of students are the ones who graduate according to the year admitted for.

Conclusion

A new culture has come up - students have created their own new life where there are no outsiders like elders. Students don't care about the future – they mind about day to day life. They have lost hopes. There is an increasing rate of cross-age risky sexual behavior – the old mingling with the young and vice versa. Cross gender risky sexual behavior is rampant among students either willingly, lured or forcefully. Love for money, materials plus job promising are becoming the order of the day. Whether temporally positive or permanent negative consequences, students are accepting their live publically as far as risky sexual behaviors is concerned. HIV is being transmitted at a very high rate among students. A big number of students don't know their HIV status. The majority of students are doing nothing as far as preventing themselves from being infected by HIV. The majority of students don't use condoms. Almost all the students don't know anything about Prep. Some few students who are HIV positive stopped from taking their ARVS. So many students are suffering from Sexual Transmitted Diseases, not treating such and are transmitting such to their sexual partners.

Recommendations

There should be enough programs of Health behavior awareness starting from national lever to students as individuals. Students should have enough knowledge about risky health behaviors in their true colors. Perceived barriers of risky health behavior should be inculcated into students' mind. Social media should be the pathways of educating, guiding and controlling students. Social media like TVS, Facebooks, whatsApps and You-tube are where students can be tapped from. Religious leaders should go to come down to where students are to give hope. They (Religious leaders) should not remain in church buildings while blaming and judging students/youth as "rotten" society. Health institutions should come down to find students where they are; in universities and places around universities. The ideology of health seeking behaviors has lost value. The trend has turned out the opposite. Nowadays, health service providers should be the ones to seek persons at risk of being affected by health challenges. University administrators should put themselves in the shoes of their students such that they can see what students are seeing clearly. If not, students will keep on hiding all their health endeavors from those who can help them. Students should develop a habit of health seeking behavior. They should always go for their medical checkups whenever they suspect something wrong with their health especially sexual challenges – their lives are in their hands. Though out of restriction and free from the 'eye' of the parents or teachers, students should control themselves. Though no rules and regulations abiding them, students should be aware that there are laws of nature wherever one goes. A very good example is; "Too much of everything is always bad."

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