

**PERSPECTIVES OF STAKEHOLDERS ON THE
INTRODUCTION OF SEX EDUCATION IN MALDIVIAN
SCHOOLS**

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ABSTRACT

Sexually transmitted infections and unplanned pregnancy among adolescents are important public health issues that can be tackled through the implementation of effective education strategies. This research study examined the views of students, parents and expertise on the introduction of sex education in Maldivian Schools. An exploratory research design was used and both qualitative and quantitative methods was used to collect data. 110 students whose ages ranged from 15 to 19 years from 4 schools of Male' was given the self-administered questionnaire and other expertise were interviewed to find their attitudes towards sex education inclusion in schools. The findings of this study indicated that almost all the study participants had favorable attitude towards the importance of school sex education except for religious scholars. Students indicated that their preferable place for sex education provision is school compared to other places with a percentage of 54.5. It was found that gender and preferable place for sex education and source had a significant association with a P-value < 0.05 . Parents and teachers agreed that the content of school sex education should include abstinence-only and it must be based on the principles of Islam only. Moreover, parents and teachers also said that the age for introduction time for school sex education should be between 12 and 15 years of age. Teacher teaching experiences and field of studies have a supportive idea about the starting of school sex education. Therefore, it is evident that there is support for sex education and future research is important for giving a more brief idea about perspectives from a bigger sample group.

KEYWORDS: Sex education, Attitude, Knowledge, Perception, Adolescents

DECLARATION

Name: Mariyam Ifa

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I hereby declare that this Project is the result of my own work, except for quotations and summaries which have been duly acknowledged.

Signature:

Date:

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Abbreviations and Acronyms

AHS – Ahmadhiyya School

AIDS – Acquired Immuno-Deficiency Syndrome

AO – Abstinence Only

APE – Abstinence Plus Education

CHSE – Centre for Higher Secondary Education

CSE – Comprehensive Sex Education

HIV – Human Immuno-Deficiency Virus

IS – Iskandhar School

MoHG – Mininstry of Health and Gender

ME – Ministry of Education

RH – Reproductive Health

SE – Sex Education

SHE – Sexual Health Education

STD – Sexually Transmitted Diseases

SRE – Sexual and Reproductive Education

SRH – Sexual and Reproductive Health

STI – Sexually Transmitted Infections

UNESCO – United Nations Educational Scientific and Cultural Organization

UNFPA – United Nations Population Fund

VIHS – Villa International High School

WHO – World Health Organization

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

The sexual change that began along with the evolution of world, altered the attitudes of almost everyone and changed the society. Nowadays, any topic could be discussed openly and freely among the families and in classrooms of schools with teachers. Most of the people no longer feel that sex is a topic to be overlooked or not to be brought up in “polite society,” but one that should be freely and openly discussed (Villar & Concha, 2012). Thus, as Maldives is considered to be a 100% Islamic country, talking about sex is still considered a taboo (UNFPA, 2011).

Sex education (SE) is a setting which can be used to deliver information that could shape the attitudes and beliefs about the self-identity, relationships and intimacy in a person’s life. The topics which are included in SE ranges from sexual development, to reproductive health (RH), affection, and gender roles (Villar & Concha, 2012).

This preliminary study to find the views and opinions of the stakeholders for the introduction of SE was inspired by the facts that young peoples or adolescents demographic are considered to be the highest in the global population. As a result, they have the susceptibility of simultaneously being exposed to the vulnerability of sexually transmitted infections (STIs), including HIV (Human Immunodeficiency Virus)

infection (Walcott, Chenneville, & Tarquini, 2011). SE/family life education is valuable in its capability to truthfully educate young people about their sexuality and its risks, to provide them with the appropriate knowledge to protect themselves from unwanted pregnancy and STIs, including HIV infection (Phelps & Charles, 2014). They should have the appropriate, correct and adequate information to make responsible choices and to become responsible adults in future. As a result, providing them with the correct and age appropriate information about sexuality, puberty, STIs, in school does not prevent any parent from teaching and modeling values and expectations in the home, rather it should support parents in providing opportunities for family communication (Phelps & Charles, 2014).

According to Goldman (2012), children and adolescents must be provided with sexual and reproductive health (SRH) information before their sexual development at puberty, which mostly happens at about age 12 years for girls and age 13 years for boys. Moreover, he states that, SE given to children by most of the parents are inexpert, rare and insufficient puberty and sexuality education. Schools, then, become the reasonable site for culturally relevant and clear, evidential, age-specific knowledge about puberty, sexuality, relationships, reproductive health, and issues of child safety and protection, based on values of respect and rights. A unified and complete puberty/sexuality education curriculum is compulsory to address these needs and rights, and to meet schools' duty of care and protection for children and adolescents (Goldman, 2012).

The need to focus on young generation to provide and promote sexual health is clear as approximately half of the global population is below 25 years of age. In all countries, adolescents and young people have been identified as the most vulnerable group to sexual ill-health. Half of all new HIV infection cases occur in people aged 15–24 years

(WHO, 2010). They are more probable to get an STI or a HIV infection, they involve in high levels of sexual activities, have high numbers of unwanted pregnancy and unsafe abortions, and lacks adequate and suitable access to health services and information (WHO, 2010). In Maldives, the adolescent and youth demographic is also the highest and according to the 2006 census, 31.9 percent of the population was young people between the ages 15-24 (UNFPA, 2011).

According to the UNFPA report (2011), abortion was found more among unmarried youth than married couples. It also highlighted the alarming perception towards abortion which was identified among them to be a ‘risk free procedure’ rather than a risky procedure. Moreover, the importance of providing safe sexual messages were underlined as the youth would persist risky behaviors regardless of the societal disapproval. Hence, this shows the importance of sexual health knowledge for these age groups.

The following table shows the percentages of first sexual experience among the age groups outside marriage. This statistics is from 20th January to 11th December 2010.

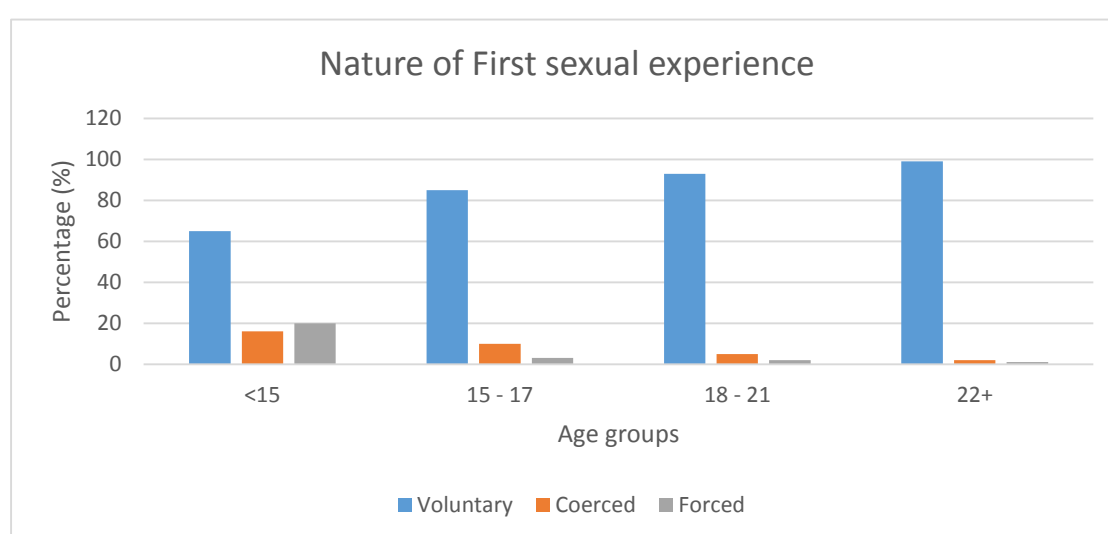


FIGURE 1.1 1 NATURE OF FIRST SEXUAL EXPERIENCE AMONG THESE AGE GROUPS

Source: UNFPA Report 2011, pg. 9

From the above figure 1.1.1 shows the worrying rate of the young aged groups being involved in sexual activities outside marriage. Also, it is quite unbelievable that most of the cases are identified to be as voluntary.

The following figure 1.1.2 shows the Medico Legal Records (MLR) of IGMH (Indhira Gandhi Memorial Hospital) for suspected and recognized cases of pregnancy outside marriage from the date 20th January to 11th December 2010.

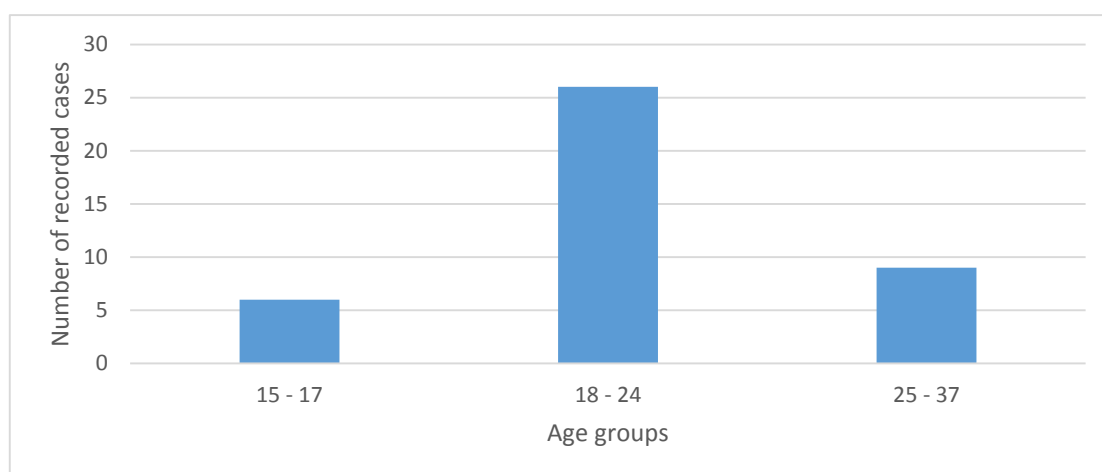


FIGURE 1.1 2 MEDICO LEGAL RECORDS OF IGMH

Source: UNFPA Report 2011, pg. 11.

Due to the alarming rates of sexual ill activities identified above, it shows the necessity to establish such a program which could provide the essential information to make responsible choices for adolescents.

1.2 PROBLEM STATEMENT AND JUSTIFICATION

Many countries have implemented SE in schools and they have identified it to be effective in giving information to students about their puberty, sexual health knowledge etc. Some have mentioned that these programs have decreased the sexual activities

among adolescents, as well as the early initiation of sexual activities. Thus in Maldives, till date such a program have not been established targeting to this vulnerable age group in schools. Although, there are health education sessions taken in schools as life skill programs which focuses on different topics regarding to health but, does not focus on SE in particular.

1.3 PURPOSE OF THE STUDY

The purpose of the study is to find the views of students, parents, teachers and religious scholars to introduce sex education along with health education in the curriculum of Maldivian Schools.

1.4 OBJECTIVES OF THE STUDY

1.4.1 GENERAL OBJECTIVES

- To find the views of students, parents and expertise opinion to introduce sex education in Maldivian Schools.

1.4.2 SPECIFIC OBJECTIVES

- To find the views of students to introduce sex education in Maldivian Schools.
- To determine the opinions of parents to introduce sex education in Maldivian Schools.
- To identify the expertise opinion about the introduction of sex education in Maldivian Schools.

1.5 RESEARCH QUESTION

What are the opinions or views of students, parents and experts (teachers and religious scholars), to introduce sex education in the curriculum of Maldivian Schools?

1.6 SIGNIFICANCE

The findings of this study would determine the views and opinions of stakeholders, which would benefit the Ministry of Education (MoE) and as well as Ministry of Health and Gender (MoHG) to create and implement a SE policy in the curriculum of Maldivian schools. Moreover, it would identify the proportion of the respected people involved in the sample of the research, who supports the idea of introducing SE as a part of health education in schools.

1.7 DELIMITATIONS / SCOPE OF THE STUDY

The scope of the study is limited, being geographically confined only to Male' the capital city of Maldives. Due to self-funding and limited time to carry out the research, this study would be concluded using a limited sample from the target population. However, the results of this study can be applied to the whole country, as the study sample would be from different locations of Maldives.

Regardless of the relevance of the adolescent age group to this enquiry, the focus of the study is limited to a sample students of adolescents between the ages 15-19. As this age group would have been exposed to sexual talks and would be among the highest vulnerable age groups. Above 19 adolescents were not taken as this study is based on the introduction of SE to schools, the opinions taken are from adolescents who are currently studying.

1.8 DEFINITION OF TERMS

Abstinence Only: this approach teaches students that abstinence is the only way to prevent teen pregnancy.

Abstinence-Plus Education: this program promotes abstinence as the ideal option for youth and recognizes that they should practice protected sex. It also focuses on reducing one or more sex behaviors that lead to sex.

AIDS: The most advanced stage of HIV infection is acquired immunodeficiency syndrome. It can take 10-15 years for an HIV-infected person to develop AIDS.

Comprehensive Sex Education: teaches students about contraceptives and practicing safe sex. This approach also teaches students about goal setting and allowing them to explore their values.

The human immunodeficiency virus (HIV): is a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections.

Sex education: It is a broad term used to describe education about human sexual anatomy, sexual reproduction, sexual intercourse, and other aspects of human sexual behavior.

Sexual health education: is a lifelong process of acquiring information and forming attitudes, beliefs, and values about such important topics as identity, relationships, and intimacy.

CHAPTER 2

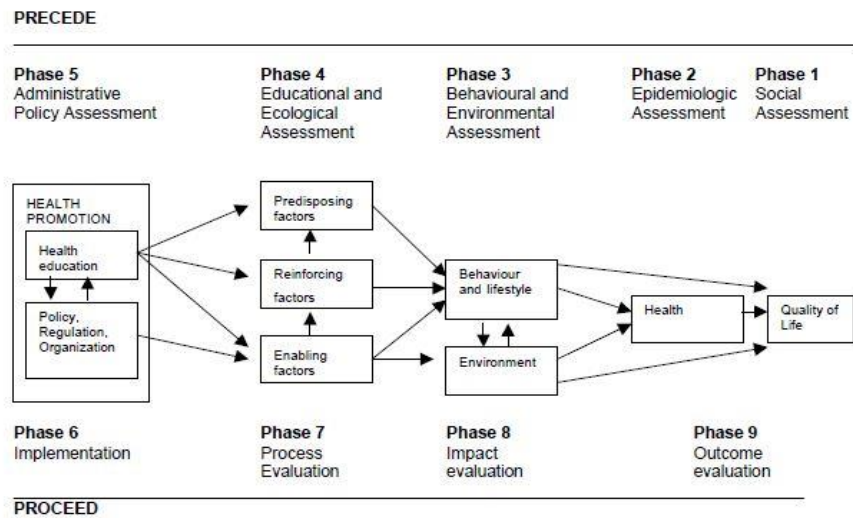
LITERATURE REVIEW

This chapter is focused mainly on four areas. To begin with, it would cover the theoretical framework chose for this study and conceptual framework made based on this theory. Secondly, it would cover the study area in a perspective from worldwide. Thirdly, it would contain the literature review done on specific variables of the study subject and finally, it would overlook for the situation of Maldives.

2.1 THEORETICAL FRAMEWORK

The theoretical framework that will be used for this study is Lawrence Green's PRECEDE-PROCEED model. It was developed by L.Green over a 20 year period starting from 1968. The phase 1-2 of this model has been taken for the study, as it involves social assessment which articulates the community's requirements and wishes while considering the communities problem solving capability, strengths, and resources, and the willingness to change (Matlo, 2012). Similarly, it reflects the subjects of the study as the primary objective is to find the perspectives of the stakeholders for introduction of SE.

PRECEDE-PROCEED Framework (L. Green)

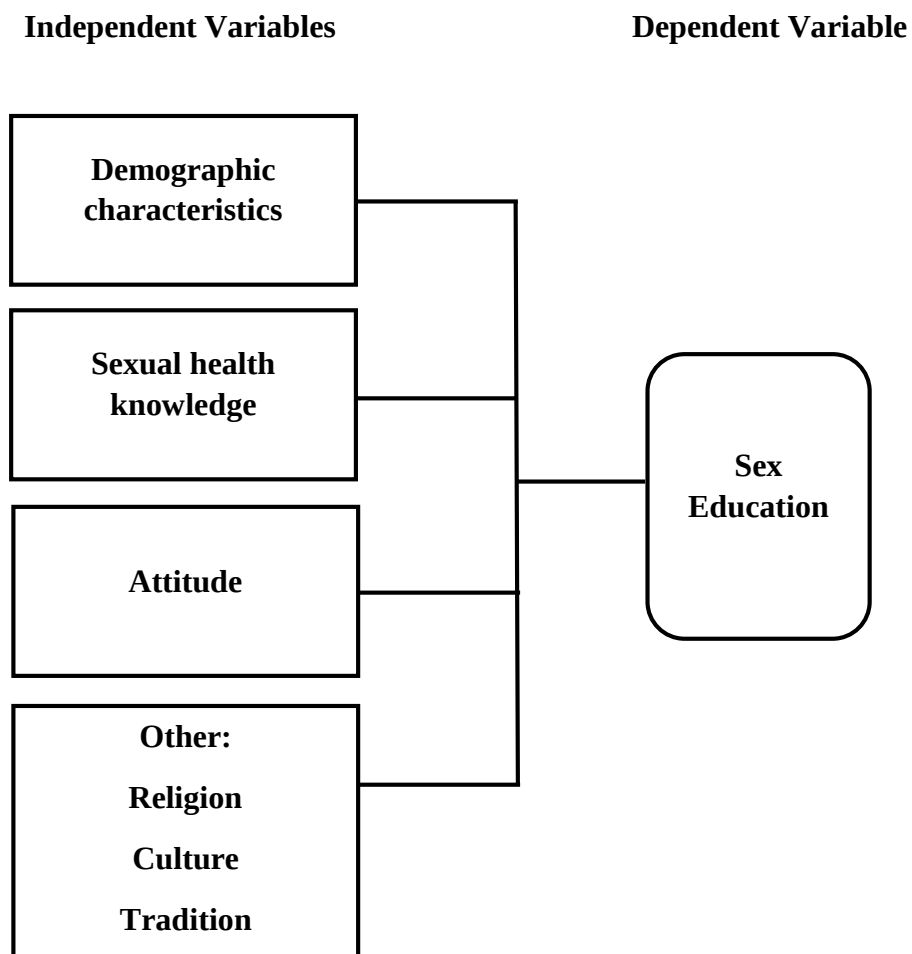


Source taken from: www.google.com/image

Based on this theory, a conceptual framework has been designed for this study.

2.1.1 CONCEPTUAL FRAMEWORK AND MEASUREMENT OF VARIABLES

Conceptual framework reflects the title of the study, by evaluating the relationship between the dependent and independent variables the outcome would be derived. Moreover, the independent variables (beliefs of stakeholders, culture, tradition, religion and policy) of the study would be measured by conducting the research and based on the findings, the effects on the dependent variable (sex education) would be justified.



2.2 WORLDWIDE PERSPECTIVE

Sex education (SE) would guide the adolescents to place the sexual aspects of life in their honest viewpoint and would provide factual information that would help lessen many misconceptions. Recent several studies show that the majority in North America supports SE in schools and believe that adolescents should be provided with information to protect themselves from unwanted pregnancies and sexually transmitted diseases (STDs) and infections. Thus, some people are still against SE, as they believe the lesser adolescent children know, the lesser the probability for them to involve in sexual activity. They think that by implementing SE, it would increase the curiosity of adolescents and lead them towards the experimentation of sexual activities (Al-Dien, 2010).

In the United States of America, there are two main approaches which mainly lead the curricular of SE which is abstinence only (AO) and comprehensive sexuality education (CSE) (Lesko, 2010). “Abstinence approaches are generally associated with tradition, backwardness, and conservative religion-infused public policy, while comprehensive sex education (CSE) is linked with modernity, scientific accuracy, and freedom to talk about and enact sexuality” (Lesko, 2010, p. 281). These two approaches intention is to police adolescent’s access to sexual knowledge and discourage sexual contact, instead of acknowledging the sex with which many youngsters are undoubtedly already engaging (Lesko, 2010).

2.2 VARIABLES

Discussing, teaching and as well as learning about sex, sexuality and sexual health, are not forbidden or disapproved in Islam. In fact, given the importance of sexuality in human affairs, in both the public and private sectors, sexuality has a significant place in the teachings from the Qur'an, the Hadith and the sira (life history) of Prophet Muhammad (peace be upon him). "Rules concerning sexual health govern many Islamic practices such as prayer (salat in Arabic), fasting (sawm), bathing (ghusl), marriage (ziwaj), divorce (talaq), performing the pilgrimage (hajj), as well as the entire spectrum of human behavior, including justice and equality" (Sanjakdar, 2009, p. 264).

Education about sexual health in Islam is reflected as a part of the religious upbringing of a child. Therefore, to ensure an Islamic perception to the sexual health education (SHE) curriculum, it is suggested that knowledge be 'Islamicised'; which means to unify the teachings of the Qur'an and the Hadith. As well as aspects of Islamic Law (Sharia), such as what is halal (allowed) and what is haram (prohibited), should also be highlighted. By doing this, SHE could turn out to be a means for spiritual development and an opportunity for Muslim students to discover the Islamic beliefs and perception (Sanjakdar, 2009; Al-Dien, 2010).

The lack of structured efforts to educate adolescents for sexual experiences increased the possibility that they would learn through experimentation. Therefore, educational efforts, become the choice for a limited number of schools around the world. "School-based- sex education programs are often limited in scope and duration, typically focusing on anatomy and physiology. Most students receive just five hours of instruction on birth control and six hours on STD prevention and education from grades 7 through 12" (Al-Dien, 2010, p. 396). Moreover, all discussions about sexuality with

Muslim students should be within the framework of modesty and to conserve this modesty, single sex classes for SE programs are desired, as are classes that would be taught by a teacher of the same sex (Al-Dien, 2010).

Cultural influences, including religious decrees and cultural gendered norms can affect the way individuals obtain information about sexual issues. The inadequate knowledge about safe sexual practices could lead to sexual ill health. Thus, still in some societies and cultures, sex is considered as a topic which should not be discussed among families and in respectful places. Similarly, in Vietnamese, Asia and Cambodian culture it is identified that the lesser the youngsters know, the fewer are the chances that they would engage in sexual activities. Nevertheless, there is no evidence about this belief that SE could lead to an increase in sexual activity. Hence, there is some evidence that lack of knowledge about sex could increase the chances of pregnancy (Rawson & Liamputtong, 2010).

“In order for SRE to reach the classroom, it must not only survive the academic scrutiny for it to be justified, but it must also successfully overcome the stark criticism from gatekeepers, including parents” (Mkumbo & Ingham, 2010, p. 68). Research done specially on developed countries, discovered the constant strong support for school-based SRE (Sexual and Reproductive Education) among parents. Likewise, surveys carried out in the USA, the United Kingdom and Canada, for example, have revealed that more than 90% of parents had the desire for SRE to be introduced in schools and supported a wide range of topics to be comprised in the SRE curriculum (Mkumbo & Ingham, 2010). Studies conducted in sub-Saharan African countries about attitudes towards school-based SRE have also shown vast parental support for teaching SRE in the curriculum of schools (Mkumbo & Ingham, 2010).

Muslim parents seek for an education that builds and enhances Islamic principles, manners, character and actions. Contemporary sex education is likely to present certain behaviors, which Muslims consider sinful, abnormal or improper. Topics like ‘free sex’, ‘safe sex’ and ‘boyfriend/girlfriend relationships’, are terms and concepts devoid of any responsibility and accountability and therefore are in direct abuse of proper Islamic manners and Islamic law (Sanjakdar, 2009; Al-Dien, 2010).

2.3 SITUATION OF MALDIVES

The adolescent youth demographic is considered highest in Maldives, as one in four Maldivian is between the age group of 15-24. In Maldives, unsafe sexual relations between adolescents are at a peak. Ibrahim, Sermsri & Thepthien (2012), identifies that 14% of males and 5% of females below the age of 18 years confessed of being sexually active and a lot of them admitted that they did not use condoms. Such situations exposes the youth to unwanted pregnancies, induced unsafe abortions and STDs. The statistics for abortions are difficult to be gained as people are not ready to talk about this issue openly and freely. As well as religious and societal constraints plays a vital role in this (Ibrahim, Sermsri, & Thepthien, 2012). Thus, “the results found from the Reproductive Health Survey (2004) and Biological and Behavioral Survey (2008) have pointed that unwanted pregnancies and voluntary abortions do happen in the Maldives” (Ibrahim, Sermsri, & Thepthien, 2012, p. 33).

According to Ibrahim, Sermsri, & Thepthien’s (2012) study, it revealed that among the 285 participants, 50% had poor knowledge about sexual health. It also discovered that 44% of 285 participants had negative attitudes towards sexual health, which makes this group more prone to high risk behavior than those with positive attitudes. Moreover,

findings showed that 42% of the participants had high risk behavior in consideration to sexual health and male students were at high risk compared to females.

Most of the cultural and traditional communities in the Maldives consider grown-ups talking about sexual health with young adolescents as a taboo. Since, most of them feel uncomfortable talking about such issues with adolescents (Ibrahim, Sermsri, & Thepthien, 2012). Similarly, the society is structured in a way that contraceptive methods availability is confined to married couples. “The underlying assumption here is that sexual intimacy does not or should not occur until marriage, which is consistent with socially held views, underpinned by long held religious beliefs” (UNFPA, 2011, pg. 8).

According to the UNFPA report (2011), abortion was found more among unmarried youth than married couples. It also highlighted the alarming perception towards abortion which was identified among them to be a ‘risk free procedure’ rather than a risky procedure. Moreover, the importance of providing safe sexual messages were underlined as the youth would persist risky behaviors regardless of the societal disapproval. “Among the 15-19 year male cohort, only 8 percent had correct knowledge of a woman’s fertile period” (UNFPA, 2011, pg. 20, 21). Hence, this shows that there is a clear gap of knowledge of sexual health among these age groups.

In the MoE’s curriculum of Maldives, reproductive health (RH) information is available only in the Islam and Biology syllabi. The primary grades for which this information is provided are 4, 5, 6 and 7 on Science, thus it neither contains the anatomy and physiology of the human reproductive system nor topics related for adolescent sexual and reproductive health (ASRH). Secondary grades (8, 9, and 10) and higher secondary grades (11 and 12) gain this knowledge from the Islam and Biology subjects only

(UNFPA, 2011). As a result, students who study biology can gain some knowledge about RH. However, only a minority of the population studies science stream. Hence, in Islam subject it does not give any information about scientific knowledge about SRH, but specifies about what is allowed (halaal) and what is forbidden (haram) in Islam.

One of the objectives of the School Health Policy 2011, is “to empower students with skills and competencies that enable them to make healthy choices to prevent health problems, maintain and improve their health, and adopt healthy behaviors” (Ministry of Education, 2011, pg. 15). This objective itself states that it is important to invest skills in students, so that they could make healthy choices in present and at future as well. Additionally, health education and health promotion activities should be directed regarding to the concerns of students in order to improve health issues such as reproductive health issues.

There were few knowledge gaps found while literature were reviewed. One of the knowledge gap identified was the teacher’s perspective on SE. Many of the articles reviewed stated that teacher’s felt uncomfortable while talking about the topic ‘sex’ thus, none of the articles reviewed had the information about their opinion on SE for adolescents. In addition, in Maldives there has not been a research conducted specifically to find the perspectives of stake holders on the introduction of SE, there were very few literature on this topic and most came from behavioral health surveys.

CHAPTER 3

METHODOLOGY

3.1 RESEARCH DESIGN

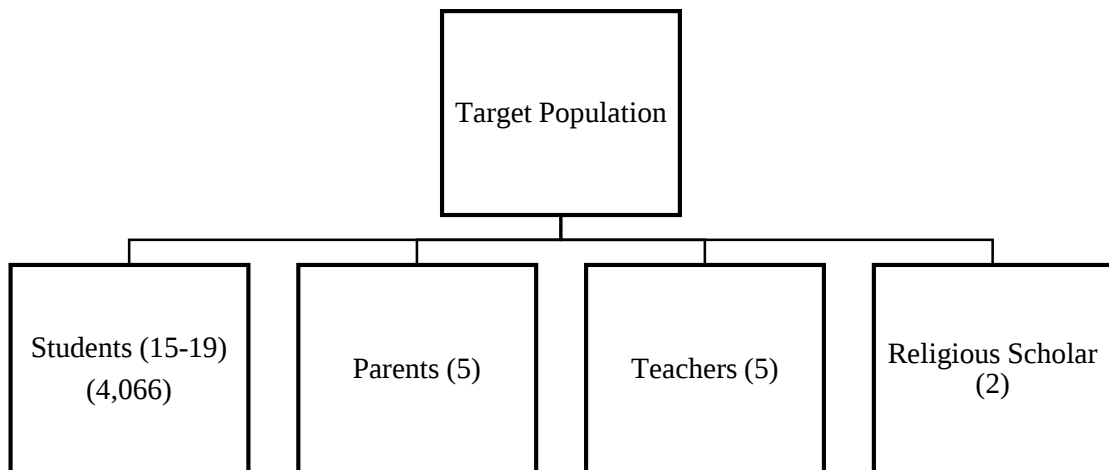
An exploratory research design was used for this study as this is a preliminary study and the subject area is new.

To find accurate results for this study, mixed method approach was chosen. Quantitative method (survey questionnaire) was used to collect data from the students and qualitative method (face to face interviews) was held for parents, teachers and religious scholars to collect data for the study. For this study many focus groups instead of one was chosen as this study broadly focuses on determining the perspectives of stakeholders on the introduction of SE to Maldivian schools. Which means that everybody involved in this study has a say on this issue or study which is being done and all plays an important role.

3.2 STUDY AREA

Due to self-funding and limited time to conduct the research, the study area has been limited only to Male'.

3.3 TARGET POPULATION



3.4 SAMPLING TECHNIQUES

The four schools for this study was chosen conveniently and students were selected using simple random sampling. Every 6th student from the class register was chosen to participate in this study.

Other expertise sample was chosen using convenience method of sampling.

3.5 SAMPLE SIZE

The formulae given to calculate sample size is:

$$n = \frac{Z^2 pq}{d^2}$$

Thus, the sample size for this study was calculated using an online sample size calculator which was available in www.raosoft.com.

The sample size of students were 110, and this total sample size was used in the study. This sample size was distributed evenly among the four schools, which gave a sample of 25 students for each school.

3.6 RESEARCH INSTRUMENTS

For this study, a self-administered questionnaire set was made.

The questionnaire has four sections. Section A is for their personal information which includes their age, gender and the grade they are currently studying in. From section B to D there are total 10 questions. The section B of the questionnaire has 5 questions, which is targeted to obtain their current knowledge of reproductive health. These questions are dichotomous and multiple option based. Furthermore, section C contains 3 likert scale questions, which would be used to find their knowledge on sexual health and views on the introduction of SE. Additionally, 2 multiple option based questions are included in section D, which identifies the students views on from whom and from where they would prefer the provision of SE.

The research instrument would be attached to appendix 7.2

Likert scale questions have a scaling of 5 values, with 5 being strongly agree, 4 being agree, 3 being undecided, 2 being disagree and 1 as strongly disagree. While analyzing likert scales would be categorized in to high and low knowledge and positive and negative attitude. If students chose 1 to 3 it would either be low knowledge or negative attitudes. If students chose 4 and 5 it would either be high knowledge and positive attitude.

The interview questions for other focus groups (parents, teachers and religious scholars) would be attached to appendix 7.2

3.7 PRE-TESTING

The pretesting of the questionnaires was done by distributing 10 sample questionnaires conveniently to 10 students. It was checked whether they understood the terms in the questionnaire and the questions which were asked in it. Some problems arose regarding the questionnaire, however, it was considered and changed accordingly.

3.8 VALIDITY AND RELIABILITY

This research was conducted in order to obtain the perspectives of different stakeholders about introduction of SE in Maldivian Schools. Therefore, the questionnaire's main focus was to gather their views on this issue. The questions provided in the questionnaire were very much directed towards the topic and would make it easier for the participant to answer efficiently. The pretesting of the questionnaire was done and issues regarding the questionnaire was considered and changed accordingly. Moreover, two Expertise review was done in order to increase the validity and reliability of the questionnaire. Hence, even if the study is conducted for another sample group, the outcome of the results would be relatively the same.

3.9 DATA COLLECTION TECHNIQUES

Letters for permission for data collection were sent to schools and as soon as feedback from them were received, consent forms were given to the teacher who was responsible person to deal with from the particular school. Before giving the questionnaire participants were given information on the purpose of the research.

Quantitative: Data collection was done by filling a self-administered questionnaire by students. During the school hours students were given the questionnaire to be filled in their classrooms. Before filling the questionnaire consent forms were given to them and students who brought the consent forms filled were only taken for this study.

Qualitative: Face to face interviews were held for parents, teachers and religious scholars. Parents were chosen conveniently and was visited to conduct the interviews at their houses. For religious scholar's interviews, an appointment was made and visited for their place of work. Teachers were visited to their schools during the school hours and the interviews were conducted at the schools.

3.10 ETHICAL CONSIDERATIONS

Participants would be given information about why the study is being carried out. Every participant would be given a consent form to be filled and they would be assured that confidentiality of the information given would only be used for the purpose of the research. If a participant wishes to withdraw from the study, he/she would have the right to do so. Likewise, parental consent would be taken for students below 18 years of age.

The consent form would be attached to the appendix 7.3

3.11 FRAMEWORK OF DATA ANALYSIS

TABLE 3.1 1: DATA ANALYSIS FRAMEWORK

Objective	Question	Types of data	Technique of analysis
To find the views of students on introducing sex education in Maldivian schools	Demographics	Quantitative	Frequency and percentages
	Do you receive sexual knowledge from school?	Quantitative	Frequency and percentages
	Age when first sexual knowledge was received?	Quantitative	Frequency and percentages
	Sexual health topics covered in school	Quantitative	Frequency and percentages
	Who was the first source of informant you received sexual health knowledge from?	Quantitative	Frequency and percentages
	Who would you like to receive sexual health information from?	Quantitative	Frequency and percentages
	From where would you like to get sexual health information from?	Quantitative	Frequency and percentages
	Attitude towards sex education and current knowledge on sexual health	Quantitative	Frequency and percentages Mean, Standard deviation
	Knowledge and attitude level	Quantitative	Frequency and percentages Mean attitude score
	The association between variables	Quantitative	Chi square P-value Crude OR Percentages

CHAPTER 4

DATA ANALYSIS AND RESULTS

Data analysis of quantitative results was done using the SPSS (Statistical Package for Social Science) software version 20.0. Descriptive statistics like frequency, mean, mode, median, standard deviations of independent variables was calculated and also graphs, charts etc, was generated using this software. The inferential statistics between variables were calculated and certain tests like chi-square was originated.

4.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

Table 4.1 shows the participant's distribution of age and gender. The table reveals that most participants were between 16 to 18 years old, whilst a small number were 15 and 19 years of age. The mean age of the participants is 16.80. Moreover, the number of females who participated in this study are more compared to the number of males.

Characteristics	Frequency (n = 110)	Percent (%)
Gender		
Male	51	46.4
Female	59	53.6
Mean = 16.8		
Age Group		
15	17	15.5
16	21	19.1
17	40	36.4
18	31	28.2
19	1	0.9
Total	110	100

TABLE 4. 1: FREQUENCY AND PERCENTAGES OF RESPONDENTS BY SOCIO-DEMOGRAPHIC CHARACTERISTICS

4.2 PAST SEXUAL KNOWLEDGE EXPERIENCE

4.2.1 SEXUAL HEALTH KNOWLEDGE RECEIVED FROM SCHOOL

Table 4.2.1 shows the percentage and frequency of children who has received some sort of sexual health information from school. It shows that more than 82.7% of students has received this information, while 17.3% said that they have not.

Sexual knowledge received	Frequency (n = 110)	Percent (%)
Yes	91	82.7
No	19	17.3
Total	110	100.0

TABLE 4.2. 1: FREQUENCY AND PERCENTAGES OF STUDENTS WHO RECEIVED SEXUAL HEALTH INFORMATION FROM SCHOOL

4.2.2 SEXUAL HEALTH TOPICS COVERAGE FROM SCHOOL

Table 4.2.2 shows frequency and percentage of sexual health topics which has been covered in schools. Students have chosen puberty, STD, HIV/AIDS and bullying as the most covered topics. 61.8% students has stated that HIV/AIDS and bullying has been covered in their schools. 60% students chose STD while 50.9% students chose puberty. The least covered topics among this sample was identified as relationships and dating, peer pressure and sexual violence.

4.2 1: FREQUENCY AND PERCENTAGES OF SEXUAL HEALTH TOPICS COVERED IN SCHOOLS

Sexual Health Topics	Responses					
	Yes	Percent	No	Percent	Total	Total (%)
Puberty	56	50.9%	54	49.1%	110	100.0%
Relationships and Dating	29	26.4%	81	73.6%	110	100.0%
STD	66	60.0%	44	40.0%	110	100.0%
Peer pressure	22	20.0%	88	80.0%	110	100.0%
HIV/AIDS prevention	68	61.8%	42	38.2%	110	100.0%
Sexual Violence Prevention	29	26.4%	81	73.6%	110	100.0%
Bullying	68	61.8%	42	38.2%	110	100.0%
Decision Making	53	48.2%	57	51.8%	110	100.0%
Self Confidence	52	47.3%	58	52.7%	110	100.0%

4.2.3 FIRST SOURCE OF SEXUAL KNOWLEDGE INFORMANT

Table 4.2.3 shows the source of informant from which their first sexual information was received from. 40.9% of students has received this information from their teachers, while 30% of children got this knowledge from their peers. 10% of children identified parents as their source of informant.

4.2 2: FREQUENCY AND PERCENTAGES OF STUDENT’S FIRST SOURCE OF INFORMANT FROM WHICH SEXUAL KNOWLEDGE WAS RECEIVED

Source of informant	Frequency (n = 110)	Percent (%)
Peer	33	30.0
Parents	11	10.0
Family member	6	5.5
Teacher	45	40.9
School health officer	2	1.8
Doctor	1	.9
Nurse	1	.9
Religious scholar	1	.9
Internet	10	9.1
Total	110	100.0

4.3 PREFERABLE SOURCE OF INFORMANT AND PLACE FOR SEX EDUCATION PROVISION

4.3.1 PREFERABLE SOURCE TO PROVIDE SEX EDUCATION

Table 4.3.1 shows the preferable source of informant which students chose. 36.4% students chose teachers, while 28.2% students chose parents. 16.4% students selected doctor as their preferred source of informant, whereas 14.5% chose school health officer.

4.3 1: FREQUENCY AND PERCENTAGES OF PREFERABLE SOURCE TO PROVIDE SEX EDUCATION

Preferable source	Frequency	
	(n = 110)	Percent (%)
Parents	31	28.2
Teacher	40	36.4
School health officer	16	14.5
Doctor	18	16.4
Nurse	3	2.7
Religious Scholar	2	1.8
Total	110	100.0

4.3.2 PREFERABLE PLACE FOR SEX EDUCATION PROVISION

Table 4.3.2 highlights the frequency and percentages of the preferable place from which students would like to obtain sex education from. School leads the table by being selected by 54.5% students. 19.1% students chose hospital, while 14.5% students selected home as their preferable place.

4.3 2: FREQUENCY AND PERCENTAGES OF PREFERABLE PLACE FOR SEX EDUCATION PROVISION

Preferable place	Frequency (n = 110)	Percent (%)
School	60	54.5
Clinics	3	2.7
Hospital	21	19.1
Home	16	14.5
Internet	10	9.1
Total	110	100.0

4.4 ATTITUDES TOWARDS SEX EDUCATION AND CURRENT KNOWLEDGE OF SEXUAL HEALTH

4.4.1 ATTITUDE AND KNOWLEDGE STATUS

Table 4.4.1 indicates the attitude and knowledge which students have about sexual health and sex education. According to this table the average score for attitude is 2.118 and standard deviation is 0.675.

TABLE 4.4 1: ATTITUDES TOWARDS SEX EDUCATION AND CURRENT KNOWLEDGE OF SEXUAL HEALTH

Statement	5	4	3	2	1	Mean	SD
n = 110	%	%	%	%	%		
Do you think the information you have about sexual health is enough?	14.5	20.9	27.3	27.3	10.0	2.97	1.22
Do you think it is important to obtain knowledge about sexual health?	59.1	33.6	7.3	0	0	1.48	0.63
Do you think it would be beneficial to have reproductive health education instilled in the curriculum of your school?	49.1	26.4	18.2	3.6	2.7	1.85	1.02
Average Score for Attitude: Mean = 2.118 SD = 0.675 Min = 1 Max = 5							
Score: 5 = Strongly Agree, 4 = Agree, 3 = Undecided, 2 = Disagree, 1 = Strongly Disagree							

4.4.2 KNOWLEDGE AND ATTITUDE LEVEL OF STUDENTS ON SEX EDUCATION

Table 4.4.2 illustrates the level of knowledge and attitude of students towards the above statements. Attitude is categorized in to positive and negative attitudes, while knowledge is categorized into high and low knowledge. The first statement was to assess whether participants sexual health information was adequate or not. Most of the participants had low knowledge on sexual health information with a percentage of 64.5. The second statement was to check student's attitude towards sex education provision. 92.7% students had a positive attitude towards this. Third statement was to identify their attitudes towards inclusion of sex education in the school curriculum. Most of the students (75.5%) had a positive attitude towards this as well.

4.4 2: KNOWLEDGE AND ATTITUDE LEVEL OF STUDENTS

Statements	Level of knowledge and attitude	Frequency (n = 110)	(%)
Do you think the information you have about sexual health is enough?	High knowledge	39	35.5
	Low knowledge	71	64.5
Do you think it is important to obtain knowledge about sexual health?	Positive attitude	102	92.7
	Negative attitude	8	7.3
Do you think it would be beneficial to have reproductive health education instilled in the curriculum of your school?	Positive attitude	83	75.5
	Negative attitude	27	24.5

High knowledge > 4, Low knowledge < 3, Positive attitude > 4, Negative attitude < 3

4.5 ASSOCIATION BETWEEN VARIABLES (CROSS TABULATIONS)

4.5.1 ASSOCIATION BETWEEN PREFERABLE PLACE FOR SEX EDUCATION PROVISION AND GENDER

Table 4.5.1 verifies the association between independent variables (gender and preferable place for sex education provision). It can be seen that gender and preferable place for sex education provision has a P value <0.05. This indicates that there is a significant association between these two variables.

4.5.2 ASSOCIATION BETWEEN PREFERABLE SOURCE TO PROVIDE SEX EDUCATION AND GENDER

Table 4.5.2 verifies the association between independent variables (gender and preferable source to provide sex education). It can be seen that gender and preferable source to provide sex education has a P value <0.05. This indicates that there is a significant association between these two variables.

Table 4.5 1: association between preferable place for sex education and gender

Variable	Preferable place for sex education provision			Crude OR	95% CI		X ²	P-value
	n	School	Other places		Lower	Upper		
		(%)	(%)					
Gender							3.959	0.036*
Male	51	27.8	23.2	1				
Female	59	32.2	26.8	1.414	1.003	1.994		

*P-value = <0.05

Table 4.5 2: association between preferable source to provide sex education and gender

Variable	Preferable source to provide sex education			Crude OR	95% CI		X^2	P-value
	n	Teachers (%)	Other informants (%)		Lower	Upper		
Gender							6.582	0.009*
Male	51	18.5	32.5	1				
Female	59	21.5	37.5	1.928	1.147	3.24		

*P-value = <0.05

4.5.3 ASSOCIATION BETWEEN KNOWLEDGE ON SEXUAL HEALTH AND GENDER

Table 4.5.3 indicates the association between independent variables (gender and knowledge on sexual health). It can be seen that gender and preferable source to provide sex education has a P value > 0.05 . This indicates that there is no significant association between these two variables.

4.5.4 ASSOCIATION BETWEEN ATTITUDE TOWARDS SEX EDUCATION (DEPENDENT VARIABLE) AND GENDER (INDEPENDENT VARIABLE)

Table 4.5.4 indicates the association between dependent and independent variable (attitude towards sex education and gender). It can be seen that attitude towards sex education and gender has a P value > 0.05 . This indicates that there is no significant association between these two variables.

4.5.5 ASSOCIATION BETWEEN ATTITUDE TOWARDS SEX EDUCATION INCLUSION IN THE SCHOOL CURRICULUM AND GENDER

Table 4.5.5 verifies the association between two variables (attitude towards sex education inclusion in school curriculum and gender). It can be seen that attitude towards sex education inclusion in school curriculum and gender has a P value > 0.05 . This indicates that there is no significant association between these two variables.

TABLE 4.5 3: ASSOCIATION BETWEEN KNOWLEDGE ON SEXUAL HEALTH AND GENDER

Variable	Knowledge on sexual health			Crude OR	95% CI		P-value
	n	High knowledge (%)	Low knowledge (%)		Lower	Upper	
Gender							1.360 0.167
Male	51	18.1	32.9	1			
Female	59	20.9	38.1	1.251	0.845	1.854	

*P-value = <0.05

4.5 4: ASSOCIATION BETWEEN ATTITUDE TOWARDS SEX EDUCATION AND GENDER

Variable	Attitude towards sex education			Crude OR	95% CI		X ²	P-value
	n	Positive attitude	Negative attitude		Lower	Upper		
		(%)	(%)					
Gender							0.046	0.557
Male	51	47.3	3.7	1.085	0.526	2.238		
Female	59	54.7	4.3	1				

*P-value = <0.05

TABLE

TABLE 4.5 5: ASSOCIATION BETWEEN ATTITUDE TOWARDS SEX EDUCATION INCLUSION IN SCHOOL CURRICULUM

Variable	Attitude towards sex education inclusion in school curriculum			Crude OR	95% CI		X ²	P-value
	n	Positive attitude	Negative attitude		Lower	Upper		
		(%)	(%)					
Gender							0.455	0.327
Male	51	38.5	12.5	1				
Female	59	44.5	14.5	1.144	0.786	1.665		

*P-value = <0.05

4.6 QUALITATIVE RESULTS ANALYSIS

4.6.1 TEACHER'S PERCEPTION

4.6.1.1 OPINION ABOUT INTRODUCING SEX EDUCATION

In response to the question about opinion on introducing sex education in schools, among the five teachers interviewed, a percentage of 80% of teachers highlighted that it is important to introduce sex education in schools. They stated that it is important to provide the children with the appropriate and right information regarding sexual health. They also noted that it is significant to make students aware about their sexual health as it would help them to make informed decisions regarding this matter. Teacher 2 said that:

“As the children reaches the peak age, they try to know about this... but they feel reluctant to ask their parents or teachers. They share this with their friends and get this information from them. The main concern which I have is that they chose the wrong person to share or gain information from”

Teacher 4 highlighted that by introducing this it could excite the students in a negative way rather than in a positive way. She stated that:

“I don't think that introducing sex education is a right thing to do in schools...when I teach reproduction in biology, students get more excited in the other components rather than the information portion in it”

4.6.1.2 TYPE OF PROGRAM WHICH SHOULD BE INTRODUCED IN MALDIVIAN SCHOOLS

All the teachers agreed that if a sex education program is to be introduced in Maldivian schools it must be religiously appropriate and within the morality of Islam and our Maldivian culture. It is important to provide the information which is within the Islamic

principles. 80% of the teachers stated that abstinence only programs must be introduced to Maldivian schools, while 20% of the teachers stated that comprehensive sex education would be essential. Teacher 1 stated that:

“we know students get involved in these type of sexual relationships..it is important to guide them to a safer behavior, so I think comprehensive sex education would be beneficial in that way..”

Teacher 5 noted:

“As we are an Islamic nation, sex education must be taught within the Islamic principles only..”

Moreover, teachers said that it is important to formulate this program as gender based. As teachers even they find it difficult to answer some of the questions when the opposite gender of students are present. They also noted that some students feel shy to ask questions as the opposite sex is present in the class. 80% of the teachers thought that it would be more suitable when teachers of the same gender would provide this information, however 20% of teachers said that they do not find any difference when providing information to students, as male or female students would be students for them.

4.6.1.3 CONSEQUENCES FACED DUE TO NOT HAVING A SEX EDUCATION PROGRAM IN THE SCHOOL

In response to the consequences of not having a sex education program in schools, teachers noted that students does not get the right information from the right source. At a critical age, for example at puberty, they are exposed to many different sex related matters which makes them curious to know about it. However, due to parent’s hesitancy

to provide their children with the right information, they start exploring on their own at a very young age. Teacher 3 stated that:

“students nowadays are always in a relationship.. without knowing even they engage in sexual matters.. it is important to guide them and tell them that relationships are not always being physical..”

Teacher 1 retorted;

“they get exposed to these things through media.. parents tend to keep the sex related matters as secrets to them.. which makes them hide these issues from parents..”

4.6.1.4 EFFECTS OF INTRODUCING SEX EDUCATION IN SCHOOLS

All the teachers highlighted that there can be positive and negative effects of introducing sex education in the curriculum of schools. They stated that there is a chance to change the negative sexual behavior of students and to make them aware of the sexual health problems which could arise due to a negative sexual behavior. Whereas, when students are provided with this type of critical information some students might take the advantage of it and misuse the information they have. Age appropriate sex education must be introduced to make sure that these types of issues would be fewer. Teachers noted that:

Teacher 1:

“these information are very sensitive..if children knew more than they should they are tend to experience it.. all these things must be put in to consideration when the program is made..”

Teacher 5:

“if methods are taught for example, they would know that they would not get pregnant if they use a condom..”

Teacher’s main concern was that if students are exposed to these type of things at an inappropriate age it might have negative effects on them. Teachers noted that the most appropriate age to start this program for students are between the ages 12 to 14. They said that these are the critical ages when most of the children enter their puberty. Specific topics must be covered when they reach a particular age group. Teacher 2 retorted that:

“I think that topics of sexual information should be categorized according to their age..like firstly when they enter their age of puberty, they can be given information about puberty..as they reach different age groups according to their age, appropriate information can be given..so that when they finish their school they would have all this information..”

4.6.1.5 OPINION ABOUT STUDENT’S SEXUAL HEALTH INFORMATION STATUS AND PREFERABLE PERSON TO PROVIDE THIS INFORMATION TO STUDENTS

When teachers were asked about their opinion on students sexual health knowledge status they noted that the information students have about sexual health is not right at all. Teacher 5 stated that:

“students think that it is a must to have a boyfriend/girlfriend..they think that to maintain that relationship it is important to be physical..”

Teacher 1 said:

“they don’t have right information.. parents are also shy to give them this information..”

When teachers were asked about the most appropriate person to provide this information to students, they indicated that it should be a responsibility of parents and teachers to provide them with the right information. They highlighted that even though parents might not have the most in depth information about specific topics, it is important to provide their children with the basic information they have. Moreover, as students spend most of their time in schools with teachers, they are tend to believe their teachers perspective more than their parents, which ultimately makes teachers as the most appropriate person to provide sex education to students.

4.6.1.6 TEACHERS KNOWLEDGE AND ATTITUDE TOWARDS SEX EDUCATION PROVISION

When teachers were asked about the knowledge they have about sex education, almost all of the teachers said that they do not think they have enough information to provide to students. Teachers stated that the information they have about sexual health is very general. Due to this they can only provide to students the general information only. Additionally, in response to the question “is it important to get yourself trained in sex education”, teachers noted that it is very important to get trained specifically in this topic if they are to provide this information to students. Teachers highlighted that:

Teacher 2:

“as teachers we should be answerable to any question the student asks...”

Teacher 4:

“all the teachers must be trained generally so that they could provide these type of information to their students..”

Teacher 5:

“we received health education training when we did the teaching course...but specifically never on sex education topics..”

4.6.1.7 IMPORTANT TOPICS TO BE CONSIDERED IN SEX EDUCATION PROGRAM

All the participants were given a list of topics which are covered in sex education. They were asked to choose the most important topics amongst these. All of them chose puberty, dealing with peer pressure to be sexually active, sexual decision making, sexually transmitted diseases, personal safety, effects of drugs, alcohol and tobacco use and sexual coercion and assault. When they were asked why these topics were important to be covered, they said that, it is important to guide students at a younger age, as at the beginning of the program, these topics should be covered which would give them a general idea about the changes which occur with their body. Moreover, it is important to lead them towards a better decision making attitude and keep them informed of the diseases, abusive behaviors and effects of substance use also. Peer pressure is a very high turning point for students as they tend to fit in to a group at this age. As a result, they tend to act as their friends in many ways adopting to their lifestyle. Many teachers noted that:

“if a student is said by their friend “you can’t get involved with that guy/girl” they tend to do that to show their guts..”

“the society we live in is very dangerous..children are abused almost every day..someone has to give them information on what to do and how to avoid these things..”

Most of the teachers dropped the topics of family planning methods, family types and roles and relationships and dating, as they thought that these topics must be known when the student is almost ready for marriage. They noted that these topics could be covered in higher secondary grades rather than lower ones.

4.6.2 RELIGIOUS SCHOLARS PERCEPTION

Two of the religious scholars interviewed responded to introducing sex education to schools in a negative manner. They expressed the belief that it is a very sensitive information and they firmly believed that these type of information should be provided to people who are getting ready for marriage or about to get married. Hence, they also believed that it is not ‘haram’ in Islam to provide this information according to the child’s age, following the context of Islam. Religious Scholar 1 stated that:

“I don’t support to introduce sex education in the school curriculum..different children would take it positively and negatively..in a class if these things are taught, the child who wasn’t interested might get excited and might want to experience these things which is totally haram in our religion..”

Religious scholar 2 highlighted:

“in school it is okay to provide education about bullying and effects of drug abuse and so on..but I don’t think things related to sexual health should be taught..it is okay to provide this information only when they are about to start a married life..”

Both the religious scholars noted that these critical information must be provided by parents. Different children face the age of puberty differently, so it is the responsibility of parents to guide them in a concise manner rather than the government or school. However, they believed that if the children who are involved in sexual behavior are identified in schools by teachers, they can be redirected by teachers or management of

staff with the collaboration of their parents rather than the provision of these information in classrooms or seminars to the whole school.

4.6.3 PARENT’S PERCEPTION

4.6.3.1 OPINION ABOUT INTRODUCING SEX EDUCATION

The overall response of the five parents interviewed about the question of introducing sex education in schools were very positive. They said that it is very important to provide sex education and make their children aware of these sexual health related matters. They also highlighted that it should be provided to this new generation of children as they are more exposed to new relationships more than the generations which came before. Parent 2 noted that:

“I think it is very important for the kids to know the acceptable behaviors and limits within the Islamic principles...”

4.6.3.2 TYPE OF PROGRAM WHICH SHOULD BE INTRODUCED IN MALDIVIAN SCHOOLS

All the parents agreed that if a sex education program is to be introduced in Maldivian schools it must be religiously appropriate and within the morality of Islam and our Maldivian culture. It is important to provide the information which is within the Islamic principles only. All the parents stated that abstinence only programs must be introduced to Maldivian schools as they would want to guide their children towards abstinence only.

4.6.3.3 CONSEQUENCES FACED DUE TO NOT HAVING A SEX EDUCATION PROGRAM IN THE SCHOOL

In response to the consequences of not having a sex education program in schools, parents noted that students do not get the right information from the right source.

Almost all the parents (80%) highlighted that they try their level best to provide these information to their children, however, they even lack the knowledge of these things.

Parent 2 said that:

“I have two boys..the elder one is in his teens..as a mother sometimes I feel shy to talk about these things with him but still I try..so I guess it should be school which steps in..”

The above statement from parent highlights that sometimes they even feel reluctant to talk about these with their child, which makes them choose internet or some other source such as peers to get this information from. This ultimately would lead to negative sexual behavior among this age group. Moreover, they said that as today's generation are more close to the technologies and social media they tend to get these information through that. They expose their so called 'love life' in social media without knowing that these things are not right in our culture.

Parent 5 stated that:

“Schools even lack in providing this information in the most appropriate way...as a result students don't believe what we say most of the times...they accept the things which are taught in schools more than what we say...”

Parent 4 highlighted that:

“they expose their love life to the general public...sometimes there are things that our muslim community doesn't accept...some kids are so much into their love life that we feel difficult to control them and guide them...”

4.6.3.4 EFFECTS OF INTRODUCING SEX EDUCATION IN SCHOOLS

All the parents noted that there can be positive and negative effects of introducing sex education in the curriculum of schools. They stated that there is a chance to change the negative sexual behavior of students and to make them aware of the sexual health problems which could arise due to a negative sexual behavior. Whereas, when students are provided with this type of critical information some students might take the advantage of it and misuse the information they have. Age appropriate sex education must be introduced to make sure that these types of issues would be fewer.

Parent's main concern was that if such a program is to be established, it should be age appropriate and within the Islamic principles and values of our Maldivian culture. They noted that the most appropriate age to start this program for students are between the ages 12 to 15. They said that these are the critical ages when most of the children enter their puberty and transform from childhood to adolescence. Furthermore, they believed that in this age they undergo lots of psychological and physical changes. As a result, if they are not given the right information at this age, then there is a chance that they might deviate in a negative way.

4.6.3.5 OPINION ABOUT STUDENT'S SEXUAL HEALTH INFORMATION STATUS AND PREFERABLE PERSON TO PROVIDE THIS INFORMATION TO STUDENTS

When parents were asked about their opinion on student's sexual health knowledge status, 80% of them noted that the information students have about sexual health is not right at all. Parent 3 highlighted that:

"I don't think that schools even provide this information..so in information wise I wouldn't say that they have the right knowledge..."

Parent 4 stated that:

“I don’t know about other kids...but I think my child’s knowledge would be good...”

When parents were asked about the most appropriate person to provide this information to students, they indicated that it should not be a sole responsibility of schools but a combined responsibility of both parents and a teacher specialized in sex education to provide them with the right information. They highlighted that even though they might not have the most in depth information about specific topics, they try their best to provide this information to their children. Moreover, as parents see themselves as less knowledgeable people to deliver such critical information, they think that schools play a huge role to shape their children in better ways.

Parent 1 retorted that;

“girls are close to their mother while boys to their dad...due to this I think some of us feel shy to talk to them about sexual matters...”

4.6.3.6 IMPORTANT TOPICS TO BE CONSIDERED IN SEX EDUCATION PROGRAM

All the parents were given a list of topics which are covered in sex education. They were asked to choose the most important topics amongst these. All of them chose puberty, dealing with peer pressure to be sexually active, sexual decision making, sexually transmitted diseases, personal safety, effects of drugs, alcohol and tobacco use and sexual coercion and assault. When they were asked why these topics were important to be covered, they said that, it is important to guide students at a younger age, as at the beginning of the program, these topics should be covered which would give them an insight in to changes which occur with their body. Moreover, it is important to lead them towards a better decision making attitude and keep them

informed of the diseases, abusive behaviors and effects of substance use also. Peer pressure is a very high turning point for students as they tend to fit in to a group at this age. As a result, they tend to act as their friends in many ways adopting to their lifestyle.

Most of the parents (60%) dropped the topics of family planning methods, family types and roles and relationships and dating, as they think that in schools the sex education given are to protect them from their unhealthy sexual behaviors rather than promoting sex. They noted that these topics could be covered later in life when they are ready for marriage. 40% of the parents thought that these topics could be generally taught to students rather than giving them the most in depth information.

Parent 1 noted that:

“I don’t think we are guiding them towards family planning...rather we are trying to protect them from engaging in sex...”

Parent 2 retorted that;

“I think these topics can be highlighted in general in the program rather than going in to there in depth ways...”

CHAPTER 5

DISCUSSION

5.1 SUMMARY OF FINDINGS

This research study examined the views of students, parents and expertise on the introduction of sex education in Maldivian Schools. An exploratory research design was used and both qualitative and quantitative methods was used to collect data. 110 students whose ages ranged from 15 to 19 years from 4 schools of Male' was given the self-administered questionnaire and other expertise were interviewed to find their attitudes towards sex education inclusion in schools.

The findings of this study indicated that almost all the study participants had favorable attitude towards the importance of school sex education except for religious scholars. Students indicated that their preferable place for sex education provision is school compared to other places with a percentage of 54.5. It was found that gender and preferable place for sex education and source has a significant association with a P-value < 0.05 . Parents and teachers agreed that the content of school sex education should include abstinence-only and it must be based on the principles of Islam only. Parents noted that they find it somewhat difficult to talk about sexual health matters with children, as a result they even recommend an establishment of sex education program in schools. Moreover, they also highlighted that the age for introduction time for school sex education should be between 12 and 15 years of age. Teacher teaching

experiences and field of studies have a supportive idea about the starting of school sex education.

5.2 DISCUSSION OF FINDINGS

The majority of students who took part in this study were females compared to males. The females make up to 53.6% of participants while males are 46.4%. In this study the age group of students ranged from 15 to 19 years of age, with a mean age of participants as 16.8. The results of the study revealed that almost more than 83% of students have received some sort of sexual health information from school till now. However, the topics which were covered in the four schools and amongst students varied. The most covered topics were identified as bullying (61.8%), HIV/AIDS prevention (61.8%), STD (60.0%) and puberty with a percentage of 50.9. least covered topics were relationships and dating (26.4%), sexual violence (26.4%) and dealing with peer pressure to be sexually active (20.0%). This showed that students get some information from schools on sexual health, yet the topics which are covered were mostly based on giving them information about diseases. Topics such as peer pressure have been neglected which could cause diverse effects on children.

The findings of this study highlighted that, students first source of sexual knowledge was received from teachers despite the gender of students with a percentage of 40.9. Moreover, the most striking result that emerged from the data was that peers were the source of informant for a percentage of 30.0 students in both the genders, and only 10% of students selected parents as their first source of informant. Likewise, the findings of this study suggested that student's preferable source of informant and place for provision of sex education was found to be teachers (36.4%) and school (54.5%) respectively. It was seen that gender and preferable place for sex education provision had a P value <0.05 , which indicates that there is a significant association between

gender and preferable place for sex education provision (school). Moreover, it was found that gender and preferable source to provide sex education had a P value <0.05 , which indicates that there is a significant association between gender and preferable source to provide sex education (teacher). The present finding also supports Newby, Wallace, Dunn, & Brown's study (2012) which concluded that student's first source of informant was either school (80%), peers (53%) or parents (42%) and their preferable source and place was teachers and school with a percentage of 62%.

This study has found that generally students had a low knowledge in field of sexual health. Majority of the sample, 64.5% stated that they do not have enough sexual health knowledge, however, 35.5% of students were discovered to have high knowledge. This findings indicate that students in Maldivian schools lack in receiving appropriate and knowledgeable information from school. Moreover, it was surprising to see that, most of the participants had a positive attitude towards sex education and inclusion of this in school curriculum. This study produced results which corroborate the findings of a great deal of the previous work in this field (Yu, 2012; Newby, Wallace, Dunn, & Brown, 2012; Fentahun, Assefa, Alemseged, & Ambaw, 2012).

The overall response of parents and teachers involved in this study was found to have a positive attitude towards introducing sex education in schools. They supported the ideology of beginning this at an early age of about 12 to 15 years of age as most of the children reach their puberty during these ages. Moreover, their main concern was that if children are not provided this information through a right source, there is a greater chance that they would not have the right information about this. This was seen among all the parents and teachers despite their difference in demographics. The result can be corroborated with previous studies (Fentahun, Assefa, Alemseged, & Ambaw, 2012; Makol-Abdul, Nurullah, Imam, & Rahman, 2009; Kakavoulis, 2001). However, both

the focus groups highlighted that there can be both negative and positive consequences if age appropriate sex education is not formulated in schools. It was seen that parents and teachers understood the importance of the inclusion of sex education at schools in age appropriate manners.

All the participants of both the focus groups supports the idea of including sex education in the moral principles of Islam. As an Islamic nation, it is important that we teach our students or youngsters things which are acceptable in Islam within the context of Islam. Likewise, this preliminary study revealed that all the parents and teachers is supportive to include abstinence only programs in Maldivian school's curriculum rather than comprehensive sex education. Furthermore, it was highlighted that they support the ideology of gender based sex education to be introduced in schools. Hence, these results differ from a published study conducted in California for parents, where most of the parents support comprehensive sex education (Constantine, Jerman, & Huang, 2007).

Majority of both the groups believed that the information which students have about sexual health is not right. They identified issues like early engagement in relationships and sexual behaviors. Moreover, they highlighted that this new generation is very much exposed to mass media, where these information are easily accessible. They do not think of the right information and act accordingly to the things they are exposed to and adopt ill sexual behaviors. Unhealthy sexual behaviors among the youth of Maldives can be identified in some of the published articles (Ibrahim, Sermsri, & Thepthien, 2012; UNFPA, 2011).

Findings of this study revealed that most of the parents feel some kind of hesitancy to provide sexual related information to their children. Besides, they stated that the

information they have on this area is very general and they firmly believe that this type of sensitive information must be provided by schools with a properly trained teacher. Similar findings were found in a study conducted in Canada for muslim adolescents by Al-Dien in 2010. Additionally, teachers noted that they must be trained specifically in sex education so that they could provide better information on these topics rather than from their general knowledge. A minority of teachers noted that they feel reluctant to answer questions about sexual matters in mixed gender classes. Hence, it was known that most of the teachers did not feel any difference due to this.

Majority of the participants (both parents and teachers) agreed upon including several topics such as puberty, sexual coercion and assault, dealing with peer pressure to be sexually active, sexual decision making, STD etc. The main reason why they included these topics were because they thought that it would be beneficial to guide them in ways which would give them an insight of diseases, decision making skills and identifying ways to be away from sexual matters. Topics like family planning methods, family types and roles etc were not chosen by almost 80% of participants (parents and teachers) due to its irrelevancy. They highlighted that these topics are more advanced for the school aged children and sex education they want is for minimizing the amount of sexual involvement rather than promoting it. Nevertheless, minority of participants agreed that these topics could be taught in general rather than in an in depth way. This result can be backed up by a similar study done by Mkumbo and Ingham (2010) in Tanzania which showed similar relative findings as this study.

Although parents, teachers and students had a positive attitude towards sex education inclusion in the schools, religious scholars who were involved in this study had a negative attitude towards this. Both the religious scholars interviewed had a general idea that students must be given age appropriate information about sexual matters by

their parents rather than from schools. However, they did not say that it was ‘haram’ in Islam to learn about sexual matters. Additionally, it was highlighted that sex education should not be openly given to students in classrooms as it was very sensitive information. If these information are given in a promoting way, it could make children who never thought of these matters wanting to explore and experience sexual intimacy or sex related things. Findings from this study stated that, sex related matters must be discussed when the child is ready for marriage only. Other things can be taught but only by parents at their home in the context of Islam. However, according to Akbarshah (2013), teaching sex education is very important in schools, as they could be able to change the negative behaviors of children and shape them in a way that Islamic morals and values are met. Moreover, he highlighted that by giving this information in schools, students can be given information about the risk of STD, unwanted pregnancies, respect the body and spirit which Allah has given to worship him and also understand the values of family in Islamic ways as well.

5.3 CONCLUSION

The findings of this study determines the views and opinions of stakeholders on introducing sex education in the curriculum of Maldivian schools. This study has found that generally stakeholders except for religious scholars involved in the study had a positive attitude towards the inclusion of sex education in schools. It was seen that 92.7% of students had a positive attitude towards sex education provision and a percentage of 54.5 students noted school as their preferable place for sex education provision. Furthermore, if a SE program is to be designed, it must be within the Islamic principles and Maldivian culture only. It can be seen that risky sexual behaviors are present in the Maldivian society, therefore to overcome this, it is important to formulate and establish a SE program for adolescents and youth. The evidence from this

preliminary study could benefit the Ministry of Education (MoE) and as well as Ministry of Health (MoH) to create and implement a SE policy in the curriculum of Maldivian schools.

5.4 LIMITATIONS OF THE STUDY

A limitation of this study is that a representative sample was not feasible due to limited time and self-funding. It cannot be concluded that the results obtained are representative of the students, parents, teachers and religious scholars in Maldives and thus generalization of the present findings is limited. This study is also limited by its use of self-administered sexuality education questionnaire, which means that students might select answers according to the researcher's expectations. Since there were only female parents included in this study, it could be a limitation for this study as inclusion of both male and female parents could have produced more effective findings. Likewise, if a focus group discussion of religious scholars with diverse views were used in this study, it might have produced more interesting results.

5.5 RECOMMENDATIONS AND DIRECTIONS FOR FUTURE RESEARCH

In light of this research it is evident that students, parents and teachers are supportive of inclusion of SE in schools. However, we do not know the type of program which would be essential for Maldivian schools. In order to indicate this, it is important to carry out researches which would give us an idea of adolescent sexual behaviors and attitudes of school aged children. Only after this, policy makers would be able to formulate an effective sex education program according to the needs of adolescents. In addition, as this study has created a platform for dialogue and interest towards attitudes held by learners and other stakeholders regarding SE, a larger scale research would have a much better impact in identifying this.

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APPENDICES

7.1 INFORMATION SHEET

Introduction

My name is Mariyam Ifa, a student from faculty of health sciences /Maldives National University, doing bachelor of primary health care, and this is my last semester. This study is a part of my final year work for my degree course.

Study Title

Perspectives of stakeholders on the introduction of sex education in Maldivian Schools.

You are invited to participate in this study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please read the following information carefully. You can ask questions if anything that you read is not clear or would like more information. Take the time to decide whether or not to participate.

Purpose of the study

The purpose of the study is to find the views of students, parents, teachers and religious scholars to introduce sex education along with health education in the curriculum of Maldivian Schools.

Do you have to join in?

No, it is voluntary. If you don't want to participate, you do not have to give a reason, and there would not be any pressure to you. You can draw out of the discussion at any time.

If you agree to take part what happens?

All the information that you provide will be confidential and used for the purposes of this study only. The data will be collected and stored in a secure manner. The information will be used in a way that will not allow you to be identified individually.

Think about the information given on this sheet, and can ask me if you are not sure about anything. If you agree to participate, please sign the consent form. The consent form will not be used to identify you. It will be filed separately from other information.

If you want any more information about the study, please contact me.

The contact details are:

Name: Mariyam Ifa

Contact no: 7668696

Email: mari.ifa@live.com

7.2 RESEARCH INSTRUMENT

Questionnaire for students to obtain their views on introducing sex education

Section A

Personal Information

Age:

Gender: Male ☐ Female ☐

Grade:

Section B

Please choose the most appropriate answer:

1. Do you/have you ever received any knowledge about sexual health from school?

Yes ☐

No ☐

2. If yes, could you tick the topics you have received information on

Puberty	☐
Relationships and dating	☐
Sexually Transmitted diseases	☐
Peer Pressure on sexual decision making	☐
HIV/AIDS prevention	☐
Sexual violence prevention	☐
Bullying	☐
Decision making	☐
Self confidence	☐

if any other than the above topics, please specify

.....
.....

Note: please refer to the last page for definition of any terms!

3. What was your age when you first received knowledge about sexual health?

>10	☐
10	☐
11	☐
12	☐
13	☐
14	☐

15	☐
16	☐
17	☐
18	☐
<18	☐

4. Who was the source to provide this information to you?

Peer	☐
Parents	☐
Family member	☐
Teachers	☐
School Health Officer	☐
Doctor	☐
Nurse	☐
Religious Scholar	☐
Internet	☐

5. Do you think the information was provided to you in the most appropriate way?

Yes	☐
No	☐

Section C

Please choose the most appropriate number:

	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
6. Do you think the information you have about sexual health is enough?	5	4	3	2	1
7. Do you think it is important to obtain knowledge about sexual health?	5	4	3	2	1
8. Do you think it would be beneficial to have reproductive health education instilled in the curriculum of your school?	5	4	3	2	1

Section D

Please tick the most appropriate answer below:

9. In your opinion, who is the most appropriate person to provide sexual health education?

Parents	☐
Teachers	☐
School Health Officer	☐
Doctor	☐
Nurse	☐
Religious scholar	☐

10. What is the most preferable place which you would consider to gain this knowledge from?

School	☐
Clinics	☐
Hospitals	☐
Home	☐
Internet	☐

Thank you for your precious time!

Terms used in the questionnaire:

AIDS: The most advanced stage of HIV infection is acquired immunodeficiency syndrome. It can take 10-15 years for an HIV-infected person to develop AIDS.

The human immunodeficiency virus (HIV): is a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections.

Puberty: is the process of physical changes through which a child's body matures into an adult body capable of sexual reproduction to enable fertilization. It is initiated by hormonal signals from the brain to the gonads: the ovaries in a girl, the testes in a boy.

Sexual health education: is a lifelong process of acquiring information and forming attitudes, beliefs, and values about such important topics as identity, relationships, and intimacy.

Sexually transmitted diseases: diseases that are transmitted through sexual contact with an infected individual.

Sexual violence: is defined as a sexual act committed against someone without that person's freely given consent.

This questionnaire is used to identify the opinions about introducing sex education

in Maldives Schools (for researcher's purpose only)

Section A

Demographics:

Age:

Gender:

Education Level:

Occupation:

Years of experience:

Monthly income

Marital Status:

Number of children:

Section B

1. What is your opinion about sex education?
2. What is your view about introducing sex education in the school curriculum?
3. What type of program do you think should be introduced in Maldivian schools?
4. Since it is not included in the school curriculum, what do you think are the issues of this?
5. What do you think would be the effects of introducing this in to the school curriculum?
6. Do you think the information children have about sexual health is right?
7. As a parent, is it easy to give sexual information to your child? Or does school has to be the source to provide this information? (for parents only)
8. Who do you think would be the most appropriate person to provide sexual health information to students?

For Teachers Only:

9. As a teacher, is it easy to give sexual information to the children?
10. Do you think you have knowledge about sexual health information?
11. Do you think teachers should be trained to give this information to students?

Section C

Please choose the most appropriate answers:

11. In your view what is the most appropriate name for this program?

Sex Education

Family Life Education

Adolescents Health Education

Life Skills Program

Sexual Health Education

12. What would be most appropriate age to start this program for?

13. In your opinion, what type of reproductive health education would be preferable for schools to target adolescents?

Abstinence only programs

Comprehensive sex education

Section D

Please choose the topics you think which should be covered in sex education

Puberty

Relationships and dating

Reproduction and birth

Family planning methods

Sexual Decision Making

Personal Safety

Sexually Transmitted Diseases/ HIV AIDS

Sexual problems and concerns

Family types and roles

Dealing with peer pressure to be sexually active

Effects of drugs, alcohol and tobacco abuse

sexual coercion and assault

14. Why do you think the topics you have chosen are important to be covered in sex education? Similarly, why do you think the other topics are less important?

Thank you for taking part in this survey!

Terms used in the questionnaire:

Abstinence-only sex education is a form of sex education that teaches not having sex outside of marriage. It often excludes other types of sexual and reproductive health education, such as birth control and safe sex.

Comprehensive Sex Education: teaches students about contraceptives and practicing safe sex. This approach also teaches students about goal setting and allowing them to explore their values.

7.3 CONSENT FORM

Consent Form

I have read the consent form and recognize that my participation in this study is entirely voluntary and that I am free to withdraw at any time during the course of the study without consequence. I understand that any information resulting from this study will be strictly confidential and used only for the purpose of this study.

I have received a copy of this consent form for my own records and I agree to participate in this study.

Signature of the Participant:

Date:

Name of the Participant:

Mobile Number:

Consent Form

I have read the consent form and recognize that my child's participation in this study is entirely voluntary and that I am free to withdraw my child at any time during the course of the study without consequence. I understand that any information resulting from this study will be strictly confidential and used only for the purpose of this study.

I have received a copy of this consent form for my own records and I have no objection for my child to participate in this study.

Name of parent:

Signature of Parent:

Signature of the Participant

Date:

Name of the Participant

Mobile Number:

7.4 WORK PLAN

[illegible]

