# Sexuality education: perception of secondary school teachers in an urban community in Southern Nigeria

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**Abstract**

The school is one of the avenues to reach adolescents with accurate comprehensive sexuality education (SE). As important stakeholders in the school system, this study aims to determine the perception of teachers on school-based sexuality education. Methodology: This was a descriptive cross sectional study carried out among 408 teachers selected by means of simple random sampling technique from 10 secondary schools in Oredo LGA, Edo State, Nigeria. The tool for data collection was a self-administered semi-structured questionnaire. Data collected were analysed with SPSS version 16.0 software. Results: Most of the teachers (98.0%) were aware of sexuality education but only 44.1% had correct knowledge of issues discussed in it. Fifty percent (50.9%) of the teachers indicated having had training in sexuality education. The mean age suggested by the respondents for introduction of sexuality education was 10.6 (range 3-18 years). Most of the teachers (90.7%) indicated the mother as being the one who should introduce the child to SE. A greater proportion, 61.3%, said sexuality education should be taught at all levels in the secondary schools, while 28.9% and 9.8% suggested junior secondary and senior secondary schools respectively. The sex of the teacher, religion, cultural beliefs and communication, were identified factors that could hinder the implementation of sexuality education in schools. There is need for all teachers to undergo a course in sexuality education as part of their training. The respective tiers of government, through the ministries of education should ensure the implementation of the approved national sexuality education curriculum in all schools in Nigeria.

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**Key words:** Sexuality education, teachers, perception, family life

## Introduction

Sexuality refers to a core dimension of human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction.[1] It is experienced or expressed in thoughts, fantasies, desires, belief, attitudes, values, activities, practices, roles and relationships. Sexuality is the result of the interplay of biological, socio-economic, cultural, ethical, and religious/spiritual factors.[1,2] Sexuality education is the lifelong process of building a strong foundation for sexual health. It takes place on a daily basis in homes, schools, faith-based institutions, and through the media.[1,2] Sexuality education is a lifelong process of acquiring information and forming attitudes, belief and values.[2,3] It addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from the cognitive domain (information), the affective domain (feelings, values, and attitudes) and the behavioural domain (communication and decision-making skills).[4]

Sexuality education begins at home. Parents and caregivers are and ought to be the primary sexuality educators of their children. Teachable moments such as opportunities to discuss sexuality issues occur on a daily basis

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at home.[5] From moment of birth, children learn about love, touch, and relationships. Infants and toddlers learn about sexuality when their parents talk to them, dress them, show affection, play with them and teach them the names of the parts of their bodies.[5] As children grow into adolescence, they continue to receive messages about sexual behaviours, attitude and values from their families and within their social environment.[3,5]

Some parents and care givers are uncomfortable discussing sexuality issues with their kids, others feel anxious about providing too much information or embarrassed about not knowing answers to questions that are asked.[1] Honest, open communication between parents and children, through childhood, the pre-teen years, adolescence, and young adulthood can help lay the foundation for young people to mature into sexually healthy adults.[1,4]

Young people also learn about sexuality from other sources. These include friends, teachers, neighbours, television, music, books, advertisements, toys and the internet. They also frequently learn through planned opportunities in faith communities, community-based agencies and schools.[6,7]

. Adolescents have needs with regards to their sexual and reproductive health. These needs differ from those of adults. These needs are poorly understood and are therefore not adequately served by society. Neglecting such needs has serious implication for the future of these adolescents. Such health problems in adolescence include, early sexual intercourse, unprotected sexual intercourse with multiple and casual partners, lack of basic information about sexual matters and sexually transmitted infections (STI) and early marriage.[8-10] Contraceptive use is low for both married and unmarried youth, resulting in high rates of early and unwanted pregnancy.[8,11,12] Other youth reproductive health problems include sexual abuse, female genital cutting, and HIV/AIDS and other sexually transmitted infections.[7,13,14] These have contributed to the poor health indices in Nigeria. Adolescents therefore need appropriate information and skills to help them take the right sexual decisions. The school is one of the avenues to reach adolescents with reproductive health information especially in a country like Nigeria. This has the advantage of a captive audience with wide coverage. In many communities, teachers are perceived by young people as the most credible and trustworthy source of information about sexuality and stand high in the list of young people's preferences of sexuality education deliverers.[12,15] A study in Tanzania examined teachers' attitudes towards and comfort in teaching sexuality education in rural and urban communities.[15] The result showed that, though teachers expressed commitment to teaching sexuality education in schools, they expressed difficulty and discomfort in teaching most of the key sexuality education topics. The study then recommended the need for facilitating teachers with knowledge, skills and confidence to teach various sexuality education topics. Another research was done in Calabar, Nigeria to determine the perception of students, teachers and parents towards sexuality education in schools.[16] In the result, most of the students (35.0%) identified teachers as their main source of information on sexual health issues. Virtually all the teachers (100.0%) supported the idea that sex education should be introduced into the school curriculum; eighty-five percent of the teachers strongly disagreed to the statement that sex education in schools will corrupt our children and expose them to early sexual intercourse.[16] Sexuality education has been recognized as a key tool to solve sexual health problems of adolescents. This is because most pupils and students spend significant amount of their time in school.[15,16] Also, they see their teachers as role models and tend to emulate their lifestyles and listen to what they say. As important stake holders in

the school system it would therefore be important to view the perception of teachers on sexuality education of students.

This study was aimed at determining the perception of secondary school teachers in Oredo LGA about sexuality education of adolescents. Specifically, it aimed at assessing their knowledge on sexuality education, ascertain from them when best to introduce sexuality education to the child, as well as determine the content of such sexuality education. It also sought to know if there are merits and demerits of sexuality education, and possible hindrances to implementing sexuality education in schools.

## Methodology

This study was carried out in Oredo Local Government Area (LGA) of Edo State, located in the Southern Niger Delta area of Nigeria. Oredo is one of the three LGAs in Benin City, the capital of Edo State. It is bounded in the south by Egor, in the north and west by Ikpoba-Okha. Politically, Oredo is one of the 7 LGAs under Edo South senatorial district. It is an urban LGA consisting of cultural mix of various ethnic groups with Bini as the predominant ethnic group. Its language is Edo. The local indigenes are predominantly farmers. This LGA owns a total of 4 first level health facilities and 2 secondary health care facilities, the Central Hospital Benin, and Stella Obasanjo Hospital, Benin. There were thirty-eight (38) government-owned secondary schools in Oredo LGA when this study was carried out.

The study population was made up of all teachers in the selected government owned secondary schools in Oredo LGA. A descriptive cross sectional study design was used for this study which was carried out in the months of January and February 2005. A community survey on maternal attitudes to youth sexuality-related activities in Delta State showed that 50% of the women studied felt they had enough knowledge to discuss sexual matters with their adolescents.[17] Based on this 50% prevalence rate, 95% confidence level (Z=1.96) and 5% tolerable error margin, the minimum sample size for the study was determined using the Fischer's formula.[18] The minimum sample size obtained was 384. However, 408 questionnaires were used for the analysis. A simple random sampling method was used to recruit the respondents. Ten secondary schools were selected among the thirty-eight government owned secondary schools in Oredo LGA through simple random sampling using the balloting method. In the chosen schools, all the teachers present at the time of the survey were studied. Only permanent teachers in the selected schools were studied. All non-teaching staff and teachers on teaching practices were excluded from this study. The data were collected using semi-structured questionnaire administered by trained research assistants. The questionnaire sought for information on the socio-demographic characteristics of the respondents, awareness and knowledge of sexuality education, appropriate time and persons to introduce sex education, possible hindrance to sex education in schools and status of respondents on assertions based on sexuality education. Data were analysed using SPSS version 16.0 software and presented as simple percentages, ratios, proportions, and frequency and contingency tables. Chi-square test of significance was used to draw association between categorical variables. A written permission was issued from the Department of Community Health, University of Benin, for this study. In the chosen school, after consent was obtained from the principals or their representatives, the teachers were met as groups or as individuals and the objectives and benefit of the study were explained to them and their cooperation and consent sought for participation in the study.

In assessing teachers on the knowledge of sexuality educations, some questions were asked on issues about reproduction, reproductive anatomy, physiology; values, self esteem and communication; friendship, love, dating and parenting. Ten questions were asked in all and the maximum score obtainable was ten (10). Teachers who scored 7-10 marks were graded as having good knowledge. Fair knowledge was for teachers that had 4-6 marks, while 1-3 marks were regarded as poor. Those with zero score were taken as having no knowledge.

Table i: Demographic Features of Teachers

| VARIABLE | FREQUENCY | PERCENTAGE (%) |
|---|---|---|
| **Age group (years)** | N=408 | |
| 25-29 | 90 | 22.1 |
| 30-34 | 64 | 15.7 |
| 35-39 | 92 | 22.5 |
| 40-44 | 60 | 14.7 |
| 45-49 | 60 | 14.7 |
| >50 | 42 | 10.3 |
| **Sex** | | |
| Male | 90 | 22.1 |
| Female | 318 | 77.9 |
| **Marital status** | | |
| Single | 114 | 27.9 |
| Married | 278 | 68.1 |
| Separated/widow | 16 | 4.0 |
| **Tribe** | | |
| Bini | 228 | 55.9 |
| Esan | 68 | 16.7 |
| Owan | 28 | 6.9 |
| Igbo | 14 | 3.4 |
| Yoruba | 12 | 2.9 |
| Igara | 8 | 1.9 |
| Others | 50 | 12.3 |
| **Educational qualification** | | |
| University first degree | 262 | 64.2 |
| National certificate examination | 122 | 29.9 |
| Masters degree | 10 | 2.4 |
| Higher National Diploma | 8 | 2.0 |
| Postgraduate diploma | 6 | 1.5 |
| **Duration of Teaching (years)** | | |
| 1-5 | 168 | 41.2 |
| 6-10 | 64 | 15.7 |
| 11-15 | 54 | 13.2 |
| 16-20 | 80 | 19.6 |
| 21-25 | 26 | 6.4 |
| 26-30 | 16 | 3.9 |

Table ii: Distribution of teachers by knowledge of sexuality education

| Level of knowledge | Frequency | Percent |
|---|---|---|
| No knowledge | 20 | 4.9 |
| Poor Knowledge | 106 | 25.9 |
| Fair knowledge | 102 | 25.0 |
| Good knowledge | 180 | 44.1 |
| TOTAL | 408 | 100.0 |

**Results**

This result is based on 408 questionnaires that were filled and returned out of the 430 that were distributed. The response rate was 94.8%.The demographic characteristics of the teachers are shown on table i. The age range of the teachers was 25-60 years. Their mean age was 37.7±8.1 years. Ninety (22.1%) of the teachers were males and 318 (77.9%) were females. Educational level of the teachers revealed that 262 (64.2%) of them had university first degree, while 122 (29.9%) had National Certificate of Education. One hundred and sixty-eight of them (41.2%) had taught for 1-5 years. This was followed by those who had been teaching for 16-20 years (19.6%). Only 16 (3.9%) teachers had 26-30 years teaching experience. Most of the teachers 278 (68.1%) were married while 114 (27.9%) were single. Majority of the teachers were Christians 390 (95.6%) while a few were African traditional worshippers 14 (3.5%), and only 4 (1.0%) were Muslims. Most of the teachers, 228(55.9%) were Binis, while 68 (16.7%) and 28 (6.9%) were Esan and Owan respectively. Fifty (12.3%) of the teachers belonged to other ethnic groups. An analysis of the teachers knowledge on sexuality education shows that, four hundred (98.0%) of the teachers had heard about sexuality education whereas 8 of them (2.0%) had not. To assess whether the teachers had any form of training in SE they were asked to indicate their status and place of training. Two hundred and eight (50.9%) indicated having had some form of training, while 200 (49.0%) did not have any form of training. Of the 208 teachers that admitted having a form of training, 102 (49.0%) were trained in seminar/workshop, while 47(22.5%) were trained in school, and 22 (10.6%) were trained in other places such as churches, marriage course, at home by parents, books and the media. Thirty seven of them (17.8%) did not indicate where they had their training. Table ii shows the distribution of the teachers by their knowledge of SE. Almost half of them 180 (44.1%) of the teachers had good knowledge, 102 (25.0%) had fair knowledge, while 106 (25.9%) and 20 (4.9%) had poor knowledge and no knowledge, respectively. The mean age proffered for introduction of SE to the child was 10.6±3.2 years (range of 3-18 years). Modal age proffered was 10 years. The response on who to introduce and educate the child to SE was varied, with 370(90.7%) recommended the mother, 30 (7.4%) chose the father, while only 8 of them (1.9%) mentioned the teachers. Response to whether boys and girls should be taught in same setting showed that, 334 (81.8%) of the teachers approved both sexes should be taught together, while 74 (18.2%) felt the boys should be separated from the girls. The reasons given for disapproving both sexes be taught together were to make them feel free 49 (66.2%), both sexes have different anatomy 10 (13.5%), the fear of experimenting what they are taught 9 (12.4%), to prevent them making fun of the process 4 (5.4%). Two of them (2.7%) gave no response even though they disapproved combining both sexes. When the teachers were asked to indicate whether SE was included in the school curriculum, 132

(32.4%) of the teachers said it was included, 186 (45.5%) dissented, while 90 (22.1%) gave no response. The topics listed by the teachers to be included in sexuality education included: puberty 380(93.1%), adolescence 350(85.8%), sexual relationships 344 (84.3%), sexually transmitted diseases/HIV/AIDS 340(83.3%), contraceptives 250 (61.3%), abortion 115 (28.2%), abstinence 95 (23.3%)), lesbianism 88 (21.6%), masturbation 39 (9.6%), and drug abuse 33 (8.0%). Most of the teachers (64.7%) were of the opinion that SE has no disadvantage what so ever, whereas 35.3% said there were disadvantages such as, fear of experimenting what is being taught (50.3%), increase immorality in the society(10.2%), early sexual experimentation (15.0%) and increase rate of abortion and STI (24.5%).

A greater proportion of the female teachers (42.7%) than the males (35.6 %) were of the opinion that SE should begin at most 10 years of age (table iii). However this relationship was not statistically significant (p=0.21).

## Discussion

It was noted that majority of the teachers were females. This was not surprising since the teaching profession like the nursing profession is predominated by the females. More than four fifth of the teachers were Christians. This is expected since the study was done in Benin where majority of the populations are Christians.

Awareness of sexuality education was quite high among the teachers, but not up to half of them (44.1%) had good knowledge of issues discussed in it. This finding is higher than that obtained by Aniebue where 23.0% of the teachers had adequate knowledge of the subject.[19] This brings the need to empower the teachers so that they can play the role of providing sexuality education to young people. School-based sexuality education may be the only opportunity of providing accurate information to young people about reproductive health.

In this study, teachers who said they have had training in sexuality education were 50.9%. This result is slightly higher than that obtained from a study in western Nigeria where 47.1% of the study population of teachers was known to be family life educators.[20] A similar study done in Nyanza, Kenya, found that less than half of the interviewed teachers had received any form of training in family life education.[21] There is need to train more teachers in adolescent reproductive health. Studies have shown that most adolescents have their first sexual intercourse in the age range 10-16 years.[14,22-24] In this study, the average recommended age for commencement of sexuality education was 10.6±3.2 years. This recommendation is justifiable considering the decreasing age at sexual debut. The first recorded case of HIV/AIDS in Nigeria was reported in a sexually active 13 years old girl. Therefore, children should be given correct and appropriate sexuality education even before they become sexually mature to guide them make informed decisions. Barely half (50.9%) of the teachers admitted having been trained in SE and less than half of this number were trained in school in their course of study. This underlies the need to include SE in the curriculum of teachers in training, and also offer periodic retraining of teachers. In 2002, the Federal Ministry of Education authorized the implementation of a national sexuality education curriculum in its educational system.[25] Many teachers in southern Nigeria have been trained to give sexual health information to adolescents and some of these programmes have encountered resistance from teachers who are to implement it. Mothers (90.7%), fathers (7.4%) and teachers (1.9%) were identified as the appropriate individuals to educate the young ones about sexuality health, according to this study. This finding corroborates with results obtained from other studies.[19,26] Parents and family members, particularly mothers, are influential sources of knowledge, attitudes and values for children and young people.

However, it has been found that many parents do not and are unable to provide their children with adequate reproductive health information.[5,7,17] Many feel uncomfortable talking with children about the subject because they do not wish to expose their own lack of knowledge. Some also believe that the provision of sexuality information leads to more promiscuity.[17] Thus teachers remain an important agent in this regard. In all, school-based sexuality education complements and augments the sexuality education children receive from their families, religious and community groups.[1,7] Few but significant proportions of the teachers (10.6%) said they received sexuality education from other sources such as the church. This is quite encouraging. The church has long been a safe environment that organizes and sponsors activities for young people. In the public health field, research has found that a connection to religion is a protective factor for youth in terms of healthy behavior in the future.[9,14,27] Christian institutions are places where moral values are formed and strengthened, and life's lessons are taught using the bible.[27] Almost two thirds (64.7%) of the teachers were of the opinion that sexuality education had no demerit, whereas others said there were problems associated with it. Among the problems identified were, the fear of experimenting what is being taught (50.3%), increase immorality in the society (10.2%) and increase rate of abortion and STIs (24.5%). Some of these fears have been expressed by teachers in other studies.[19,20,26] Aniebue reported that, teachers who opposed to sex education in school did so out of the belief that it encourages promiscuity, is indecent and unwholesome.[19] However, several studies have found that the fear that sex education programmes encourage or increase sexual activity appear to be unfounded.[7,21] In this study, more than three quarters of the teachers (81.8%) were of the opinion that both boys and girls be taught together while 18.2% felt they should be separated. A similar pattern was reported by Aniebue.[19] However, Sattler recommended that the decision on this should be dependent on the topic under consideration. While a number of topics can be taken together, some sensitive topics would require that the sexes be separated.[28] Concerning the themes they wanted addressed in sexuality education, most of the teachers mentioned changes in puberty, sexual relationships and STIs including HIV/AIDS, while a few mentioned abstinence and lesbianism. The number of teachers who mentioned abstinence in this study is lower than other studies where most of the teachers usually opt for abstinence-only sexuality programmes.[3,20] Teachers that indicated lesbianism were relatively quite few probably because this issue is not common or it is under reported. Never-the-less, health educators need to be conscious of lesbianism with the upsurge of gay marriage.

## Conclusion

Most of the teachers were aware of sexuality education but not up to half of them knew issues it contained. Barely half of them had training in sexuality education while in school. Not up to half of the teachers admitted that the school children were being educated on sexuality. The teachers were able to mention common reproductive health problems seen in adolescence. Most of the teacher wanted the children to be taught at all levels, and some were not comfortable that both sexes be taught together.

It is therefore recommended, there should be training and retraining of teachers in schools on sexuality education of the young adults. The government should implement strategies to ensure monitoring of the school to ensure the approved sexuality education curriculum is being implemented. Identified barriers to implementation should be addressed.

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