

Perception of Students' Teachers' and Parents' towards Sexuality Education in Calabar South Local Government Area of Cross River State, Nigeria

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ABSTRACT: This study was aimed at assessing the perception of students, teachers and perception in Calabar south local government area of Cross River State, Nigeria. A cross sectional survey was employed and a structured questionnaire was used to generate both qualitative and quantitative data from 850 respondents using the multi-stage stratified sampling technique. Most students were within the age bracket of 13-18 476 (95.2%), teachers were mostly within 25-29 years 54 (27.0%) and parents were mostly 40-44 years of age 22 (22.0%). Most study participants shared similar opinion that sex education should cover areas such as abstinence, HIV/AIDS, sexually transmitted diseases, basis of reproduction etc. Masturbation, abortion and contraceptives were unanimously agreed not to be included in sex education content. A substantial proportion of the respondents agreed that abstinence-plus should be the main message of sex education in schools. Training for both parents and teachers should be provided by government and NGOs for accessibility of appropriate resources to develop capacity and confidence to deliver effective sexuality education to school adolescent. Policy makers need to formulate a definite, explicit, and workable sexuality education policy.

Keywords: Sexuality education, Perception, Parents, Students, Teachers.

1. Introduction

The need for sexuality education in schools has become indispensable in today's

contemporary society. While many societies and cultures around the world are yet to consent to the introduction of sex education in schools mostly because of their socio-cultural background, belief system, political system, religion, etc, some countries see sex education as a gateway to deal with issues related to reproductive health and sexual preference among teenagers. Sexual health is one of five core aspects of the WHO global Reproductive health strategy approved by the World Health Assembly in 2004 (WHO, 2004). According to WHO, **Sexuality** is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, ethical, legal, historical, religious and spiritual factors (WHO, 2006). Collins (2008), argued that sexuality education encompasses education about all aspects of sexuality including information about family planning, reproduction, body image, sexual orientation, sexual pleasure, values, decision making, communication, dating, relationships, sexually transmitted infections and how to avoid them, and birth control methods

According to the UN Population Report, today's generation of young people (15 to 24 years) is the largest in history. Additionally, there has been increasing rates of HIV infection among young people (about half of new cases), which can escalate a global concern of reproductive sexual health. In Europe, sexuality education is in the first place personal-growth-oriented, whereas in the United States of America it is primarily problem-solving, or prevention-oriented. There are a wide variety of historical, social and cultural reasons for this fundamental difference that cannot be discussed in this context, but it is important to note it here. In Western Europe, sexuality, as it emerges and develops during adolescence, is not primarily perceived as a problem and a threat, but as a valuable source of personal enrichment. In Sweden sex education has been a mandatory part of school education since 1956. The subject usually started between the ages of 7 and 10 and continues through the grades, incorporated into different subjects such as biology and history. On the other hand, in England sex education is not compulsory in schools as parents refused to let their children take part in the lessons. The curriculum focuses on the reproductive system, fetal development and safe sex is discretionary and discussion about relationships is often neglected. Britain has one of the highest teenage pregnancy rates in Europe and sex education is a heated issue in government and media reports (Huffstutter, 2007). In Germany, sex education has been part of school curriculum since 1970. Since 1992, sex education is by law a governmental duty. It normally covers all subjects concerning the growing-up process, body changes, puberty, emotions, the biological process of reproduction, sexual activity, partnership, homosexuality, unwanted pregnancies and the implication of abortion, the danger of sexual abuse and violence, child abuse, and sex transmitted diseases (http://www.cdc.gov/healthy_youths/YRBS/pdf/trends). In Japan, sex education is mandatory from age 10 or 11 years, mainly covering biological topics such as menstruation and ejaculation. In China and Sri

Lanka, sex education traditionally consists in reading the production sections of the biology textbooks.

In most Africa context especially in Nigeria, sex education is seen as a taboo to be talked about. Generally, adolescents are not allowed to have access to sexual health information because the society have the perception that such exposure will corrupt the child and he or she may likely be a victim of early sexual intercourse. In 2002 when the Nigerian Educational Research and Development Council (NERDC) in conjunction with the Federal Ministry of Education, civil societies and many other International Development Partners drafted and proposed a curriculum on Sexuality Education for both primary and secondary schools, it was received with mixed feelings and generated raging controversy especially in Northern Nigeria. Within a very short time, the discussion on its acceptability or otherwise was hijacked by religious leaders and other gatekeepers and was given different connotations and coloration. A recent study carried out in Kano state in Northern Nigeria revealed that parents have a negative perception of sexuality education in schools probably because of their religious belief and socio-cultural norms and values. In contrast, teachers had positive attitude towards teaching sex education in schools (Ayyuba, 2011). Nevertheless, several studies in Nigeria have validated the introduction of sex education in schools. A cross-sectional study carried out in kwara state, Nigeria reported that 78% of the respondents suggested that sex education should be made compulsory in schools (Akande and Akande, 2007).

School is a privileged setting for formal, articulate sex education as children and adolescents spent a considerable amount of their time at school and other agents of sex education like the internet and other media can often provide non-structured education. First love experiences occur at school age, and school has human and material resources for providing education. Sex education at school also contributes to its promotion in the home environment. Sex education programs have been shown to delay sexual initiation or increase condom use among those who are already sexually active. A recent Portuguese study reported that nearly 90% of those surveyed said sex education at school was very important and 87% believed it should be mandatory.

1.1 Statement of the Problem

About 50% of the world's population is under the age of 20 years and are at the highest risk of sexual and reproductive health problem; thus making sexuality the root of most sexual and reproductive health problems (Briggs, 1999). According to a United Nation report, 56% and 15% of females within the age cohort of 15-19 years and 20-24 years respectively are unmarried out of which a total of 18 million people within the age group 15-24 years make 19% of Nigeria's population (Ayangade, 1984). About one million teenage girls annually get pregnant with resultant 44% births, 50% of these drop out of school and 50% are unmarried and young mothers placing infants at enormous health risk (Ayangade, 1984). A study carried out in Benin City, Nigeria revealed that 55% of secondary school girls have had sexual intercourse by age 16 years and 40% admitted to at least one previous pregnancy (Ezimokhai, 2001). Adolescence indulgence in high risk sexual behavior consciously or unconsciously often results in unwanted pregnancy, unsafe abortion, HIV/STDs infection, single/early parenthood and school dropout. This has contributed to the

poor health indices in Nigeria. Obviously, these sexual health problems are insuperable without adequate sexuality education. For this to be possible, parents and teachers must give their consent for sex education to be inculcated into the school curriculum and taught as a subject in schools. This is because, most in-school adolescents spend most of their time either in school with their teachers or at home with their parents. Secondly, adolescents see teachers and parents as role models and tend to emulate their life styles and listen to what they say. However, several studies in Nigeria have reported conflicting interests of parents and teachers toward sexuality education in schools. In the context of Calabar south local government area of Cross River State, Nigeria, no document on Perception of students, teachers and parents towards sexuality education in schools have been found. Hence, it is with this context that this study was necessitated.

1.2 Objective of the Study

The objective of this study is to determine the perception of students, teachers and parents towards sexuality education in Calabar South local government area of Cross River State, Nigeria.

1.3 Significance of the Study

Throughout human history, sexuality has also been perceived as a threat to people's health: untreatable STIs and unintended pregnancies were almost always grave risks associated with sexual encounters. Sexuality education thus fulfils this highly needed function of sexual health promotion. This study will primarily serve as a baseline survey for further research on sexual education and health. This study is also imperative for adolescent boys and girls as it will aid them to have access to sexual health information, make informed decision that will guarantee them a reputable future and acquire life skills to deal with sexuality and relationships in a satisfactory and responsible manner. Religious organizations, policy makers, educators, parents and community/opinion leaders will find recommendations from this study useful as it will guide them in formulating effective policies in favour of sex education in schools, intensify campaigns on the need to include sex education in school curriculums, debunk any myths and misconceptions concerning sex education in schools in African societies and facilitate equitable access to sexual and reproductive health education. Sexual and reproductive health are nowadays also highly valued at the global level. Three of the eight internationally accepted Millennium Development Goals (**MDG 3 on gender equality, MDG 5 on maternal health, and MDG 6 which includes HIV/AIDS**) are directly related to it. Hence, this study will also serve as a panacea to the attainment of these universal development goals. Data generated from this study will be informative to the government, non-government and the public health system in planning and implementation of sustainable sexuality education programs in schools.

1.4 Theoretical Framework

Social Learning Theory, developed by Albert Bandura (Bandura, Ross, & Ross, 1961), hypothesizes that learning is obtained through people observation, imitation, and modeling. His original Bobo Doll Experiment (Bandura, Ross, & Ross, 1961) studied

modeled aggressive behavior in preschool children. The results concluded that aggressive behavior may be learned through observation. Four characteristics must be present in order for social learning to take place; the person must be attending to the stimuli, they need to retain the information of which they were paying attention to, mental reproduction of the image should take place, and lastly, the individual needs to have motivation and a good reason to imitate or demonstrate what they have learned (Bandura, Ross, & Ross, 1961). Reciprocal determinism, also developed by Bandura (1977), theorizes that a person's behavior is conditioned by one's personal factors, like their cognition, in conjunction with their environment. In addition he stressed television acted as a persuader for modeling violent behavior. Therefore it is possible that promiscuous sexual behavior in adolescents may be instigated through representations they interpret from the media.

Social Learning Theory (SLT) has been applied to sexuality education as well as many other areas of health education, including tobacco use prevention, substance abuse prevention and violence prevention. Since SLT aims to change behavior in participants, it is a good fit for prevention-based sexuality programs — for example, those that aim to prevent pregnancy by preventing sexual involvement or increasing condom use — as opposed to more comprehensive family life programs. SLT is a particularly good fit for pregnancy, STI and HIV prevention programs because sexual behavior is influenced by personal knowledge, skills, attitudes, interpersonal relationships, and environmental influences. All of these factors are addressed in SLT.

Secondly, teens receive few, if any, positive models for healthy sexual behavior. Modeling positive and healthy sexuality-related behavior to youth is extremely important. Because sexual behaviors often happen in private settings, much of what youth observe modeled about sex takes place on TV and in movies, popular music and magazines. The majority of this modeled behavior — early sexual activity, violence combined with sex, no mention of protection, no discussions about risks — is counter to what family life educators are trying to teach youths. Thirdly, it provides youth with behavioral skills practice. Youth actually practice the skills — for example, saying "no" to pressure to have sex, or putting on a condom — that they will use in their real lives. In the area of sexuality, teens often do not get a chance to "practice" these prevention skills before they are in the actual situations where they need them. Teaching youth specific behavioral skills is crucial in an effective prevention program. Unfortunately, many sexuality programs over emphasize cognitive learning and fail to address the behavioral aspects of becoming and staying sexually healthy.

2. Methodology

2.1 Study Setting

The study area is **Calabar South local government area**. It is situated in the southern part of Cross River State. Its headquarters are in the town of Anantigha. It has an area of 264 km² with an estimated population of 191,630 (NPC, 2006). Calabar south has 12 political wards and lies at the coastal area empty into the Atlantic ocean and located between latitude 4⁰55 and 8⁰30 East of the Green Meridian. It is bounded by Calabar river to the west, Akpabuyo local government area to the east, Odukpani local government area to the north and

Atlantic ocean to the south. The three dominant ethnic groups are the Efiks, Quas and the Efuts which share common culture and religion. English and Efik are the languages widely spoken. Christians are predominantly across the area with few Muslims and traditional religious groups. Most occupants of the area are civil servants, businessmen and traders. Infrastructure such as schools, market, health facilities, etc is built across the area.

2.2 Study Population

The study population comprised of senior secondary school students, teacher and parents in Calabar South local government area of Cross River State, Nigeria.

2.3 Study Design

A descriptive cross-sectional survey was employed to determine the perception of secondary school students, teachers and parents towards sexuality education in Calabar South local government area of Cross River State, Nigeria. This study took place from April 15-26, 2013 and both quantitative and qualitative data was generated.

2.4 Sampling Procedure

A multi-stage sampling technique was employed to select respondents for this study and is described as follows;

1. Of the 12 wards in Calabar South local government area, 5 wards were selected using systematic random sampling technique.
2. In each ward, two secondary schools were selected using simple random sampling technique giving a total of $2 \times 5 = 10$ secondary schools (i.e. 5 public schools and 5 private schools).
3. In each school, the class register was obtained from class teachers which constitute the sampling frame of all the students in each class and systematic random sampling technique was employed in the selection of 50 senior secondary students with even number across the three arms; giving a total of $50 \times 10 = 500$ students.
4. In each selected school, 20 teachers who gave their consent to participate in the study were randomly selected giving a total of $20 \times 10 = 200$ teachers.
5. In each selected school, 10 parents who came to take their wards/children home and gave their consent to participate in the study were randomly selected giving a total of $10 \times 10 = 100$ parents.
6. Therefore this study constituted a total sample size of **800 respondents** (i.e. 400 students, 200 teachers & 100 parents).
7. However, to make room for non-response and attrition bias the sample size was increased to **850** which became the actual sample size for the study.

2.5 Instrument for Data Collection

A structured questionnaire with both open and close ended questions was designed to generate data from consented respondents. The questionnaire was self-administered to

students and teachers and interviewer-administered to parents. It comprised of questions on socio-demographic data of respondents, content of sex education, attitude of respondents towards sex education and starting age/level of sex education.

2.6 Data Analysis

The questionnaires were manually sorted out and analyze using Statistical Package for Social Science (SPSS, version 13.0). Data was summarized using frequency tables, graphs, means and standard deviations.

2.7 Ethical Consideration

Approval was duly sought and obtained from school management board/principals of selected schools used in the study. Verbal consent was also sought from respondents that participated in the study. Participation in this study was strictly voluntary and respondents were assured of confidentiality and anonymity of information elicited.

3. Results

Out of the 850 questionnaires that was administered to respondents, about 800 questionnaires were returned and analyzed representing a response rate of 94%.

3.1 Socio-demographic data

Students

Most of the students who participated were within the ages of 13-18 476 (95.2%). Twelve of the respondents were less than 13 years (2.4%) and twelve were above 18 years of age (2.4%). Majority of the respondents were Christians 266 (98.6%), females 290 (58.0%), SS1 students 309 (61.8%) and currently staying with both parents 362 (72.4%).

Teachers

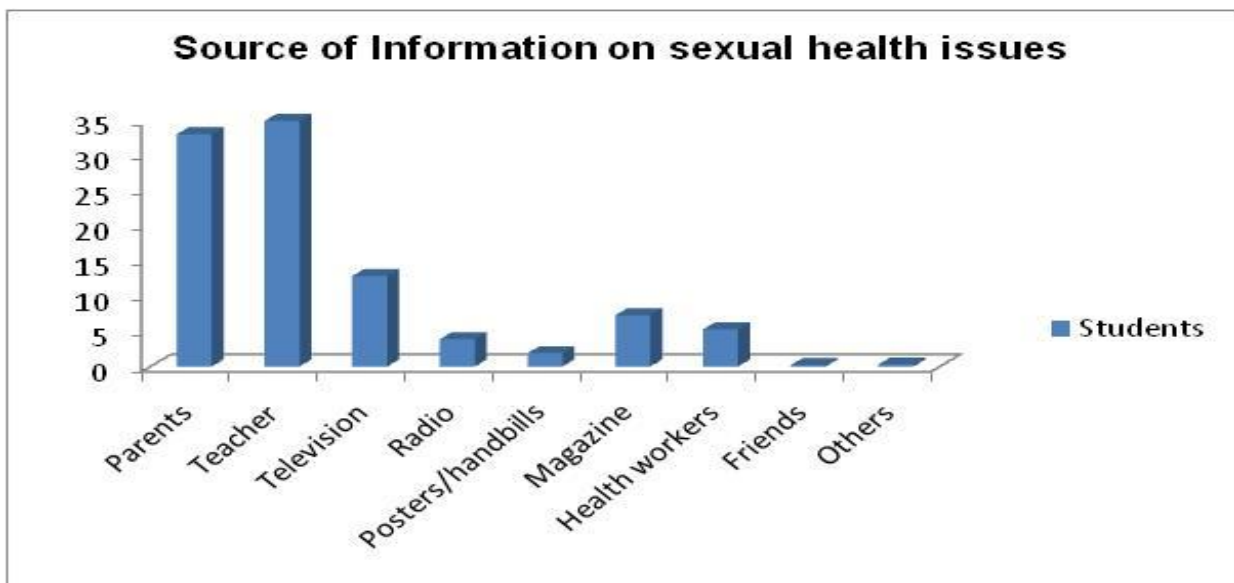
More than half of the respondents 112 (56.0%) were females within the age bracket of 25-29 (27.0%). Most respondents were predominantly Christians 177 (88.5%), single 121 (60.5%) and were teachers who were currently teaching SS classes 95 (47.5%). Virtually all respondents had tertiary level of education 200 (100%). About 77 (38.5%) teachers reported having 1-3 years of working experience while 45 (22.5%) of teachers reported to have worked for less than a year.

Parents

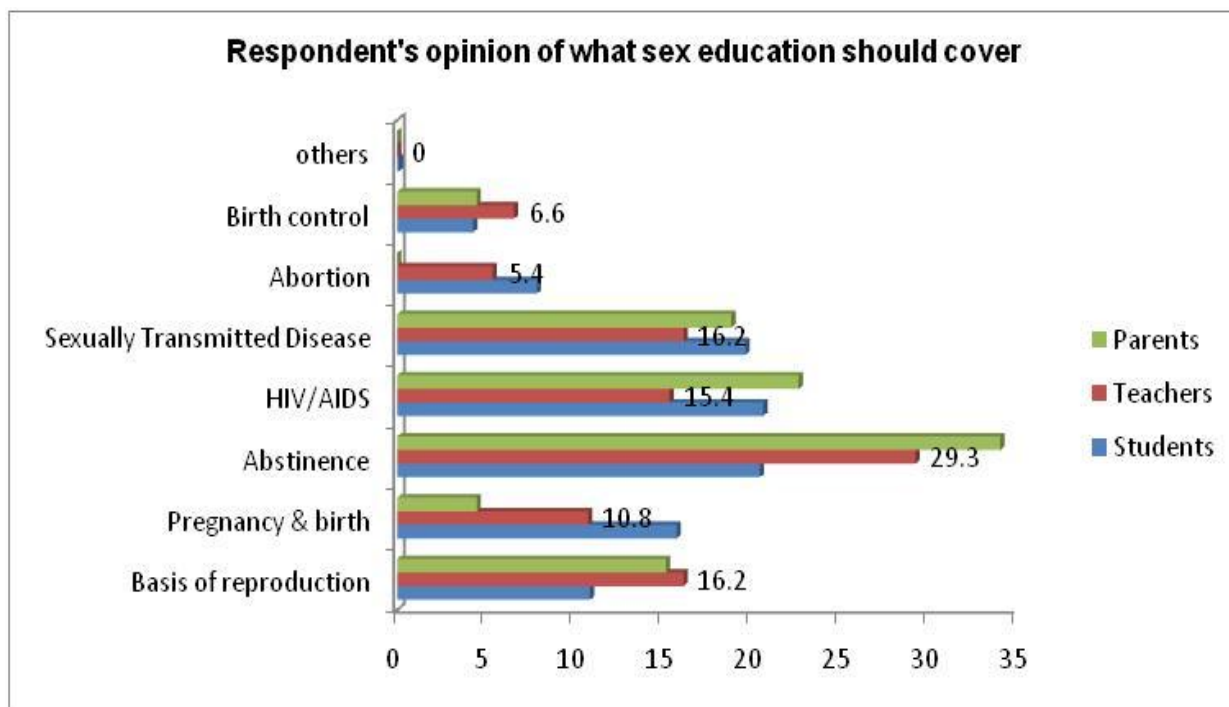
Parents in this study were mostly males (59.0%) within the age bracket of 40-44 (22.0%). Two-third of the respondents were Christians (92.0%), married (85.0%) and had tertiary level of education (72.0%). Slightly more than half were civil servants (52%) earning monthly income (65.9%) within the range of 50,000-60,000 naira (37.0%). About seventy-two respondents reported having just two children in secondary school while 25 respondents said they have only one child in secondary school.

3.2 Content of Sexuality Education

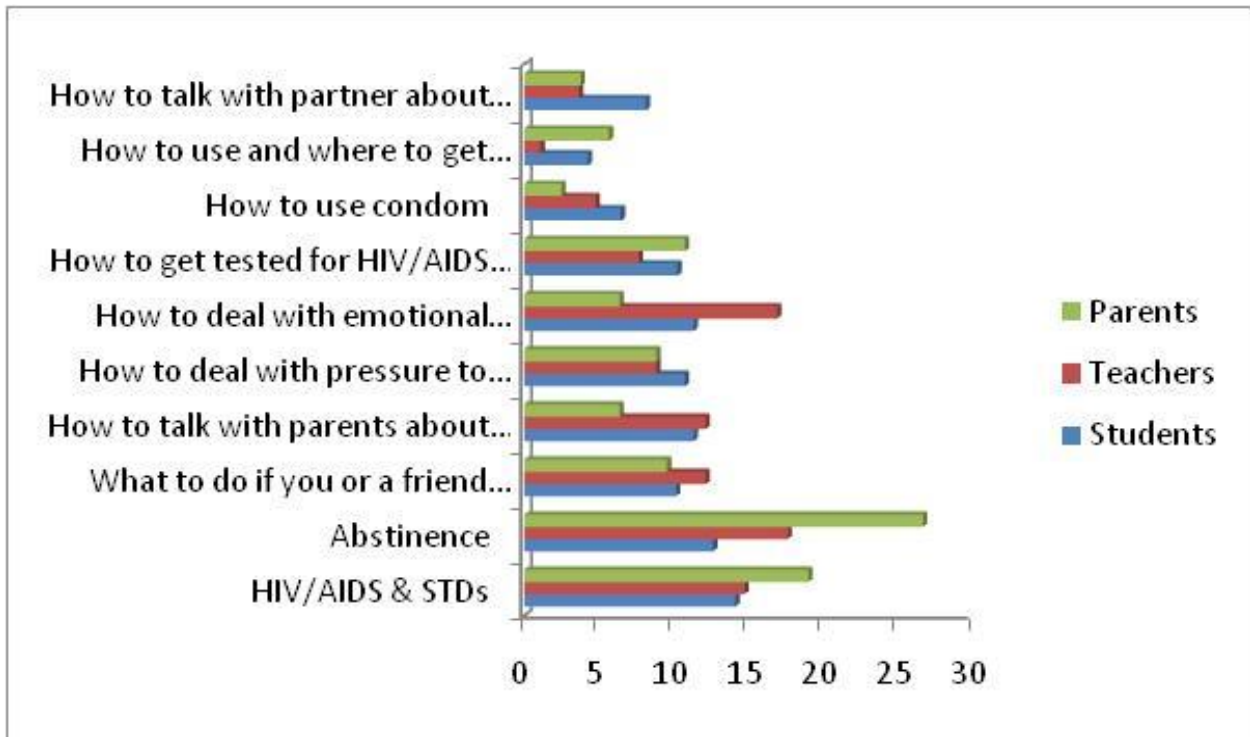
About 353 (70.6%) of students said they have had sex education in school while 147 (29.4%) said sex education is yet to be introduced in school. However, while 324 (86.9%) of students actually welcomed the idea of sex education in schools, only 49 (13.1%) of the students oppose the idea of sex education in schools. On the other hand, most teachers 119 (59.5%) said they have started sex education in schools predominantly five times and above 81 (40.5%). About 61 (30.5%) of the teachers said they have had sex education just once. Virtually all teachers 200 (100%) and parents 100 (100%) supported the idea that sex education should be introduced into the school curriculum. Most students reported that teachers 212 (35.0%) were their main source of information on sexual health issues. Other sources of information on sexual health issues among students are parents 200 (33.1%), Television 78 (12.9%) and magazine 44 (7.3%).



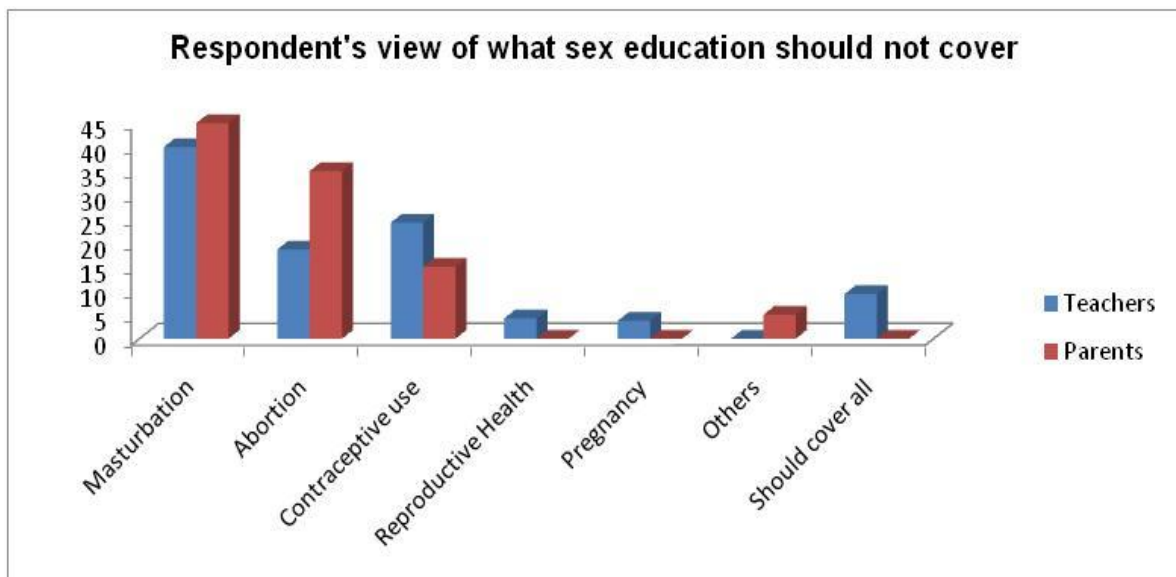
Almost half of the students 230 (46.0%) subscribed to the fact that health education teachers should be responsible for teaching sex education in class. Also, 217 (43.4%) students rather said that any qualified teacher should be responsible for teaching sex education in class. Only 39 (7.8%) preferred science teachers. According to most students, sex education should mostly cover, HIV/AIDS (20.7%), Abstinence 292 (20.5%), Sexually transmitted diseases 280 (19.7%), and pregnancy and birth 226 (15.8%). Teachers in their opinion believed that sex education should cover mostly abstinence 76 (29.3%), sexually transmitted disease 42 (16.2%), basis of reproduction 42 (16.2%) and HIV/AIDS 40 (15.4%). Parents view of what sex education should be made up of includes; abstinence 45 (34.1%), HIV/AIDS 30 (22.7%), sexually transmitted diseases 25 (18.9%) and basis of reproduction 20 (15.2%).



To enhance safe sex practice and negotiation skills among school adolescents, students believed that sex education should extensively include; HIV/AIDS and other sexually transmitted disease 345 (14.2%), abstinence 309 (12.7%), how to talk with parents about sex and relationship 278 (11.4%), how to deal with emotional issues and consequences of sex 277 (11.4%), how to deal with pressure to have sex 262 (10.8%), how to get tested for HIV/AIDS and other STDs 252 (10.3%) and what to do if you or a friend has been raped or assaulted 249 (10.2%). Teachers also supported that sex education should extensively cover mostly abstinence 48 (17.7%), how to deal with emotional issues and consequences of sex 46 (17.0%), HIV/AIDS and other sexually transmitted disease 40 (14.8%), what to do if you or a friend has been raped or assaulted 33 (12.2%), how to talk with parents about sex and relationship 33 (12.2%) and how to deal with pressure to have sex 24 (8.9%). Parents also expressed their opinion that sex education should also majorly involve abstinence 42 (26.8%), HIV/AIDS and other sexually transmitted diseases 30 (19.1%), how to get tested for HIV/AIDS and other STDs 17 (10.8%), what to do if you or a friend has been raped or assaulted 15 (9.6%) and how to deal with pressure to have sex 14 (8.9%).



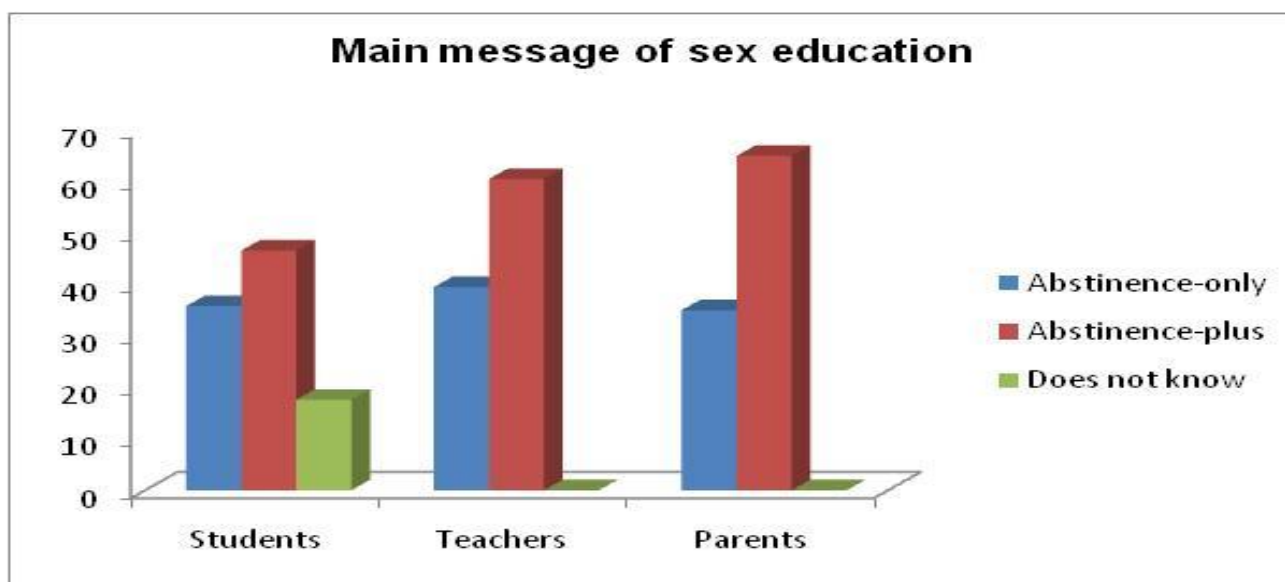
Contrarily, most teachers agitated that sex education should not cover masturbation 86 (40.0%), contraceptive use 52 (24.2%) and abortion 40 (18.6%), but 20 (9.3%) of the teachers said they should be included in sex education class. Similarly, parents also said sex education should not include masturbation (45.0%), abortion (35.0%) and contraceptive use (15.0%).



3.3 Structure of Sexuality Education

Virtually 63 (31.5%) of teachers and 45 (45%) of parents share similar opinion that the government are the sole deciders of what should be taught on sex education in schools.

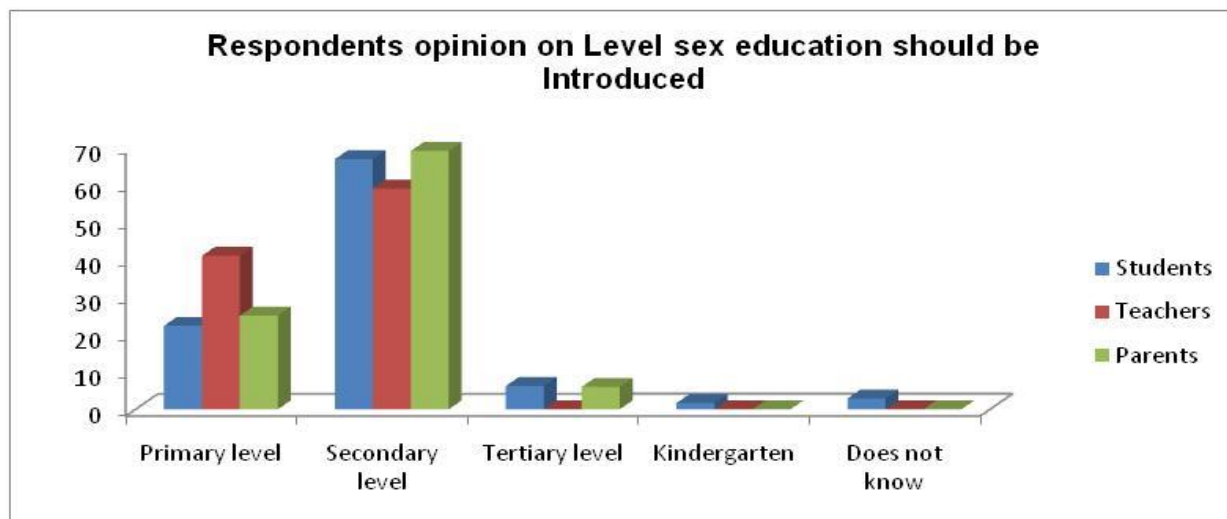
While some teachers felt that health workers 59 (29.5%), parents 34 (17.0%) and teachers 33 (16.5%) can influence what should be taught in a sex education class, some parents also stated that health workers 30 (30%) and teachers 20 (20%) should influence the content and structure of sex education class. Most teachers said that sex education class should be a combination of boys and girls in one class 123 (61.5%) and a combination of lectures and student's participation 125 (62.5%). Parents gave their view that sex education should be a combination of boys and girls in one class 72 (72%) and a combination of lectures and student's participation 65 (65%). Only 28% of parents and 38.5% of teachers said that boys and girls should be taught sex education separately. Most teachers stated that sex education should be packaged with other subjects 102 (51.0%) rather than being an independent subject 98 (49.0%). Parents in their opinion also stated that sex education should be packaged with other subject 65 (65%) rather than being an independent subject 35 (35%). Both teachers 121 (60.5%) and parents 65% said that the main message of sex education should be abstinence-plus. Most students 233 (46.6%) also supported that the main message of sex education should be abstinence-plus.



3.4 Attitude towards Sexuality Education

Most students strongly agreed that sex education be made a compulsory subject in school 319 (63.8%), males and females should be jointly taught sex education in one class 317 (63.4%) and prevention of sexual vices is believed to be through sex education 226 (45.2%). About 199 students strongly disagreed to the fact that sex education will corrupt and encourage them to keep sexual partners. Teacher in their view strongly agreed that sex education be made a compulsory subject in school 106 (53%), males and females should be jointly taught sex education in one class 102 (51%) and prevention of sexual vices is believed to be through sex education 83 (41.5%). Eighty five percent of teachers strongly disagreed to the statement that sex education in schools will corrupt our children and expose them to early sexual intercourse. Parents should similar attitude by strongly agreeing to statements such as sex education be made a compulsory subject in school (60%) and prevention of sexual vices

is believed to be through sex education (80%). About 45% of parents just agreed that males and females should be jointly taught sex education in one class and 55% disagreed that sex education in schools will corrupt their children and expose them to early sexual intercourse.



3.5 Starting Age of Sexuality Education

Majority of the students 314 (66.8%) felt that sex education should be introduced at the secondary level of education whereas 105 (22.3%) said it should be at the primary level. Teachers 118 (59.0%) and parents (69%) also felt that sex education should be introduced at the secondary level of education.

Starting age for sex education according to most students 122 (26.5%) should be from 12 years and above. While teachers said the starting age should be from 10 years and above, parents said 14 years and above should be the ideal starting age.

4. Discussion

The World Bank (2002) reported with the growing recognition that attitudes and beliefs are formed early in life, more reproductive health programs are being implemented in primary schools with the aim of reaching students before they become sexually active and in many cases, drop out of school (because of becoming pregnant, contracting an infection, caring for a sick relative, or being orphaned). An impact on children and young people before they become sexually active can be made by comprehensive sexuality education to be part of the formal school curriculum, delivered by well-trained and supported teachers (UNESCO, 2009).

Majority of the students who participated in the study were females (58.0%) within the age bracket of 13-18 years (95.2%). Twelve of the respondents were less than 13 years (2.4%) and twelve were above 18 years of age (2.4%). This finding disagrees with a study carried out among students in a rural secondary school in Kwara state, Nigeria (Akande & Akande, 2007). Major participants among students were Christians (98.6%), females (58.0%), SS1

students (61.8%) and students staying with both parents (72.4%). A large proportion of the teachers were females (56.0%) within the ages of 25-29 years (27.0%), Christians (88.5%), single (60.5%) and currently teaching senior secondary classes (47.5%). Virtually all the teachers in this study had attained tertiary level of education (100%) and reported to have had working experience for about 1-3 years (38.5%). This finding differs with a cross-sectional study carried out in Northwest Ethiopia (Fentahun, Assefa, Alemseged and Ambaw, 2012). Parents on the other hand were majorly males (59.0%), married (85%), civil servants (52.0%), Christians (92.0%) and were within the age bracket of 40-44 years (22.0%). More than two-third of parents who participated in this study had tertiary level of education (72.0%).

A reasonable proportion of students (70.6%) and teachers (59.5%) said they have had sex education in school. However, while 40.5% of the teachers said that sex education has been taught for five times and above, 30.5% of the teachers revealed that they have had sex education just once. This shows that school management within Calabar south, have adopted sex education as a tool to ameliorate the poor indices of adolescent health in the country. Most students (86.9%) revealed that they would like sex education to be taught sustainably in school because it will afford them the privilege to be aware of certain things that concern their sexual health and get correct answers to some questions that may border them. Virtually 100% of teachers and parents unanimously agreed that sex education should be introduced into the school curriculum. Collectively, their reasons were that sex education will be a platform to provide correct and factual information to school students as it borders on sexual health and relationship to enable them make informed decisions concerning their sexual life and debunk any misconception where necessary. This finding is consistent with a comparative study carried out in Taiwan and England where sex education was consistently recognized as a valuable part of the curriculum (Liang, 2010). About 35.0% of the students revealed that teachers were their major source of information on sexual health issues. This is because most students trust and believed what their teachers teaches them in class. Besides their parents, school students spend most of their time with their teachers and are seen as fastest available means of correct and factual information as it borders on sexuality and health. Other students said that their parents (33.1%), television (12.9%) and magazine (7.3%) were their source of information on sexual health issues. This finding differs with a study carried out by Akande et al, 2007 where students reported that the media (30.1%) were their major source of information and teachers recorded a low percentage of 15.9%. Most students felt that health education teachers should be responsible for teaching sex education in class. This may probably be that students perceive health education teachers to be more knowledgeable about sex education since sexual health forms an integral part of health education curriculum. This finding disagrees with that of Akande et al, 2007 where science teachers were seen to be responsible for teaching sex education in class. Nevertheless, about 217 out of 500 students said that any qualified teacher can teach sex education in class. Based on the content of sex education, a substantial proportion of students, teachers and parents felt that sex education class should cover vital areas like abstinence, HIV/AIDS, Sexually transmitted diseases and basis of reproduction. These areas seen by respondents as global issues of concern that affects

mostly young school adolescent in developing countries like Nigeria. To enhance safe sex practice and negotiation skills, respondents collectively agreed that sex education should include; abstinence, sexually transmitted diseases, how to deal with emotional issues and consequences of sex, how to deal with pressure to have sex and how to get tested for HIV/AIDS and other STDs. These areas also are perceived by respondents to pose challenges on sexual health of adolescent, hence, school adolescent should be guided in these areas to enable them make informed decisions when faced with such issues. Masturbation, abortion and contraceptive use were predominantly areas that respondents (parents & teachers) felt that sex education should not include probably because of their socio-cultural backgrounds and religious beliefs against the practice of such phenomena. This finding corroborated with studies carried out in Delhi, India and Osun state, Nigeria (Bhasin, Aggarwal, 1999; Asekun-Olarinmoye, Fawole, Dairo & Amusan, 2007).

About 45% of parents and 31.5% of teachers strongly share the opinion that the government is the sole deciders on what is to be taught in sex education class. This is because, the government is unarguably seen as effective policy makers that will inculcate sex education into the school curriculum. Largely, 61.5% of teachers and 72% of parents agreed that sex education class should be a combination of boys and girls in one class and about 62.5% of teachers and 65% of parents felt that a typical sex education class should be a combination of lectures and student's participation. Most teachers (51.0%) and parents (65.0%) suggested that sex education should be packaged with other subjects like biology, health science etc. Reasons given were that part of sex education content is being taught in the aforementioned subjects. Although, 49.0% of teachers and 35.0% of parents preferred sex education to be an independent subject so that adequate attention would be given to it. Virtually more than half of all respondents i.e. students (46.6%), teachers (60.5%), parents (65.0%) subscribed to the fact that abstinence-plus should be the main message of sexuality education in schools. In a qualitative study carried out in Ethiopia, almost all parents said that the content of the school sex education should include abstinence -only and abstinence - plus based on the mental maturity of the students. That means at early age (Primary school) the content of school sex education is abstinence-only and at later age (secondary school) the content of school sex education should be added abstinence-plus (Fentahun et al, 2012).

In this study, respondents show positive attitude towards sexuality education. Most students (63.8%), teachers (53.0%) and parents (60.0%) strongly agreed that sex education be made compulsory subject in school. This finding agrees with that of Akande et al, 2007. While 63.4% of students and 51.0% of teachers strongly favor the opinion that males and females be jointly taught in class, 45.0% of parents just agreed that males and females be jointly taught in class. Prevention of sexual vices is believed to be through sex education was strongly agreed by all respondents but, 39.8% of students and 42.5% of teachers strongly disagreed with the statement that sex education in schools will corrupt students and expose them to early sexual intercourse. Majority of parents (55.0%) equally disagreed with the statement.

Secondary level of education was viewed by most study participants (students 66.8%, teachers 59.0% & parents 69.0%) as the ideal stage where sex education can be introduced. This is because at this stage, adolescent have gained mental maturity to assimilate what is been taught in class and are required to make informed decisions about their sexual life.

While most students (26.5%) are of the opinion that sex education should start from 12 years of age, teachers felt it should start from 10 years. This result agrees with that of Asekun-Olarinmoye et al, 2007. Parents in their opinion felt that fourteen years of age would be more appropriate to start imparting sex education. Adolescent at these ages are usually at their pubertal stage where rapid development of their sex characteristics takes place preparing them for adulthood.

5. Conclusion and Recommendation

The findings in this study revealed that study participants have a favorable perception toward the introduction of sex education in schools. Most respondents felt that areas such as HIV/AIDS, sexually transmitted diseases, basis of reproduction, abstinence, how to deal with pressure to have sex, how to deal with emotional issues and consequences of sex and how to get tested for HIV/AIDS and other STDs should form core content of sex education in schools. Masturbation, abortion and contraceptive use were areas that were suggested by parents and teachers to be excluded from sex education content. Teachers were the major source of information for students on sexual issues. Hence, based on these findings the following recommendations are made;

1. The government should organize trainings and workshops for teachers intermittently to improve their teaching skills in sensitive areas like adolescent sexual health.
2. Syllables on subjects like biology and health science should be broaden to incorporate necessary aspects of sexuality education.
3. Policy makers need to formulate a definite, explicit, and workable sexuality education policy.
4. Parents and teachers jointly have the responsible to provide correct and factual information on sexual health to adolescent since they spend most of their time with their parents at home and teachers at schools.

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