Female Secondary School Adolescents' Sexual Behavior and School Based HIV/AIDS Education Program

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Abstract

Most adolescents engage in indiscriminate sexual experimentations. This practice exposes them to the risk of contracting sexually transmitted infections including HIV/AIDS. Human immunodeficiency virus (HIV) and acquired immune deficiency syndromes (AIDS) are among the deadly diseases that exist globally. Twice as many girls, compared to boys engage in sexual activity before the age of 15 years (Federal Republic of Nigeria (FRON), (2012). The knowledge of HIV prevention is significantly less among girls aged (15-19 years) compared to boys of the same age range. HIV/AIDS keeps increasing in Nigeria and fewer schools provide life skills-based HIV/AIDS education. Schools are considered the primary centers for impartation and acquisition of knowledge and skills. This study investigated the sexual behavior of female secondary school adolescents and school-based HIV/AIDS education. Descriptive survey was the data collection method used. Female secondary school students (n=2010) completed the questionnaire forms on sexual behavior. Teachers (n=50) participated in in-depth interviews on school based HIV/AIDS education. Quantitative data were analyzed with descriptive statistics. Qualitative data were transcribed and analyzed. Validity of the qualitative data was established through the use of member checks. One thousand five hundred and seventy-two participants were sexually active (78.5%). Four hundred and thirty participants never had sexual intercourse (21.5%). Sexually active adolescents who used preventive measures of different types totaled 911(58.0%). Six hundred and sixty one participants (42.0%) did not use any preventive measure. Findings revealed sexually active participants were at increased risk of HIV/AIDS infections. In-depth interviews determined no significant HIV/AIDS education in the schools. A high number of sexually active adolescents suggests the need for more intervention programs on life skills-based HIV/AIDS and sexuality education.

Introduction

Adolescents are at increasing risk of contracting the deadly disease of Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). HIV/AIDS is a major global health problem (World Health Organization, (WHO), 2013). According to WHO (2013), sub-Saharan Africa is the most affected region. School-based HIV/AIDS education programs might assist in preventing the spread of this deadly disease among adolescents. Concerns related to this study include the fact that the birth rate among Nigerian adolescents is one of the highest in the world (The Joint United Nations Program on HIV/AIDS (UNAIDS) & WHO, 2000). Also, HIV/AIDS infections have no known cure (WHO, 2013). Additionally, the prevalence rate of sexually transmitted infections including HIV/AIDS among female Nigerian adolescents is on the rise (UNAIDS & WHO, 2000).

In the year, 2000, a national reproductive health policy was formulated to check risky sexual behavior during adolescence but it failed (WHO, 2001). Obsolete and incomplete information on sexual knowledge, attitudes, and behaviors of adolescents in Nigeria contributed to the failure (WHO, 2001). The picture of the future of any nation might be painted from the prevailing lifestyles of her adolescents. In Nigeria, generally, open discussion of sex is seriously frowned upon and not encouraged. Ironically, discussing sex with adolescents is disapproved even though they are sexually active. Sexual education that would have helped in reducing the vulnerability of adolescents is also opposed by some religious and cultural settings (Odutolu, Mafeni, Okonkwo, & Fajemisin, 2006). The situation is further made worse by many Nigerian parents and adults who believe that sexual health education will expose the adolescents to sexual activity.

On the contrary, Nayar (2011) posited that sexual health education to adolescents helps in preventing HIV infection. Studies globally reported by the WHO reveal that sexual health education helps in delaying initiation of sexual activity and reduces the rate of risky sexual behavior (Kirby, Laris & Rolleri, 2007). They added further that sexual health education offered at the right age and time might reduce the vulnerability of adolescents to HIV infection through the reduction in risky sexual behavior. The ignorance and unwillingness of parents and teachers to address adolescent sexual health issues including HIV and AIDS education increases the tendencies of adolescents to risky sexual behavior (Sofo, Ali-Akpajiak & Pike, 2003).

Globally, people from15-29 years of age constitute half of the new HIV infection cases (Nayar, 2011). This is due, in part, to the failure to provide sexual and HIV education, which is part of the proven strategy for the prevention of HIV (Nayar, 2011). There is a need to provide sexual health education in schools, homes and communities. Schools stand out as an important setting because of the large collection of adolescents present (Nayar, 2011).The right information will help in arming and sensitizing adolescents against risky sexual behavior. Failure to provide this sexual health information therefore predisposes adolescents to psycho- social health problems, satisfying their curiosities based on the wrong information from wrong sources and wrong interpretations of sexual anatomy and physiology (Nayar, 2011).

The main purpose of this study was to determine the sexual behavior of female secondary school adolescents, and the place of HIV/AIDS-based school education programs in meeting their sexual health needs. The outcome of this study will provide practical information for policy makers in designing informed intervention programs that will meet the sexual health needs of female secondary school adolescents.

Secondary School Adolescents' Sexual Behavior

According to the Federal Republic of Nigeria (FRON), (2012), twice as many girls than boys engage in sexual activity before the

age of 15 years. They added that HIV awareness and prevention knowledge is significantly less among girls 15-19 years of age. FRON (2012) further emphasized on the need to improve the knowledge of HIV among females (both married and unmarried).

Adolescents are exposed to high risk of HIV/AIDS infections (Ergene, Cok, Tumer & Unal 2000). The situation becomes worse in a country like Nigeria where the concept of sex cannot be openly discussed even while the young people are clearly sexually active. This situation in Nigeria is in line with researchers who attributed the rise in HIV infection to lack of preventive knowledge (Wu, Liu, Wang, Wu & Wang, 2010). It is important to educate adolescents on wholesome attitudes and behaviors that are capable of preventing sexually transmitted infections (Liao, Jiang, Yang, Zeng & Liao, 2010).Wholesome attitudes, behavior and opinions of adolescents on sexual issues are capable of contributing to the transformation of any social environment (Cheng, et al., 2008).

Adolescents are the future of any nation, thus, guiding them against experimentations with certain life style practices capable of ruining their lives such as with premarital sex is very important. Whatever affects the adolescents is capable of extending to adult life. The period of adolescence is one of the most intriguing and difficult transitions in the life span of a mankind (Adegoke, 2003). Adolescence is defined as a period characterized by anseries of challenges and confusion both to the adolescents and the adults who are supposed to show understanding (Moronkola, 2003). This affirms the assertion of Fakunle (1996) and Falaye (1998) that adolescence is a critical period that signals the end of tranquility of childhood and heralds the onset of frustration of early adulthood.

According to Krost, Forrest and Harlap (2001), the period of adolescence is the most controversial of all the three developmental stages due to experimental risky behaviors associated with it. Most people begin their sexual relationship during adolescence and some get involved in risky life threatening behaviors such as unwanted pregnancies, abortions and sexually transmitted infections (Action Health Incorporated (AHI), 2003). This can be attributed to ignorance in interpreting and managing self in response to the upsurge of hormones during this period. Contributory factors also include lack of information on sexual health and HIV, low levels of condom use, and high levels of sexually transmitted infections (United Nations General Assembly Special Session (UNGASS), 2010).

Female adolescents form a very important numerical component of a rapidly growing number of adolescents in Africa (Adegoke, 2003). The growth rate of female secondary school adolescents keep increasing rapidly and this has serious social implications for Africa and the entire world (Adegoke, 2003). Women are particularly affected by HIV and in the year 2009, women accounted for 56% of all adults aged 15 years and above living with the virus (UNGASS, 2010). According to the Staying Alive Foundation (2011), 76% of people infected with HIV/AIDS are females within the age range of 15-19 years old. Adolescence is a difficult period for girls and even for those with a strong safety net of support at home and school. The physical changes of puberty coincide with enormous emotional and psychological challenges (Brooks-Gunn & Reiter, 1990). Female adolescents have sexual and reproductive health needs that remain poorly understood or adequately attended to worldwide (WHO, 2004). It can be seen from the foregoing that neglecting this population has serious implications on the future of any nation.

Sexual activities of female adolescents predispose them to adverse effects including unwanted pregnancies, unsafe abortions and sexually transmitted diseases including HIV/AIDS. In Nigeria, both the brothel and non-brothel female sex workers rank first on the most at risk to HIV infections group (Federal Republic of Nigeria, 2012). According to Wellings, et al. (2006), the use of condoms has increased among adolescents but levels of use are still not sufficient to substantially reduce the spread of HIV (Central Intelligence Agency (CIA) World Fact book, 2010). According to the CIA World Fact book (2010), the prevalence rate of HIV/AIDS in 2008 was 5.4% of people within the age range of 15-49 years old. Young females have been more at risk than their male counterparts (Country Profile, 2008).

There is a need to acknowledge the sexual activity of adolescents in Nigeria as evidenced in other developed countries. It is also important to provide for their sexual health needs with targeted education and preventive care services to help in reducing risky sexual behavior and the negative consequences (Allan Guttmacher Institute 2001; Kirby, 2001).

HIV/AIDS Epidemic in Nigeria

Nigeria is one of the countries with the highest burden of HIV infections in the world, next only to India and South Africa (UNAIDS, 2012). Approximately 3.5 million people were living with HIV in Nigeria in 2011(UNAIDS Global Report 2012). Nigeria has the third largest number of people living with HIV (Country Profile, 2008). The HIV epidemic in Nigeria is complex and varies widely by region. It concentrates more in some states than others. The epidemic can be attributed to high-risk behaviors such as having multiple sexual partners (Country Profile, 2008).

The vulnerable groups to HIV in Nigeria are the youth and young adults. UNAIDS report indicates that Nigeria has the second highest number of new HIV infections in the world and lacks the necessary HIV related investments to combat the disease (Diamond, Kirk-Greene, & Oyediran, 2011). According to statistics of the National Agency for the Control of AIDS (NACA), in 2008, the annual death rate in Nigeria was 192,000 but has risen to 217,148 deaths which may not be unconnected with the lack of access to treatment. Out of 3.5 million Nigerians confirmed to be HIV positive, only 500,000 have access to antiretroviral drugs, which is key to managing the disease (NACA, 2012).

Secondary School Based HIV/AIDS Education

Sexually transmitted and HIV infections are common among young people within the age range of 15-24 years old (Urmil, Dutt, Sharma & Ganguly, 1999). In a study conducted by Gao, et al. (2012) in China, it was found that most of the study participants who were students lacked the basic knowledge of HIV/AIDS and the mode of transmission. Significant improvement in knowledge and attitude only followed after intervention. Obviously, this ignorance might be responsible for the rapid proliferation of this deadly infection among secondary school students. This needs to be addressed through well-designed, intervention programs.

Schools are seen by program and policy makers as strong centers for dissemination of HIV/AIDS information and education.

This is because schools have a large collection of young people and their mandate is to educate. This is why school-based HIV education is seen as a 'social vaccine' that can serve as an effective preventive tool (Lal, Nath, Badhath & Ingle, 2008). Unfortunately in Nigeria, only 23% of schools were providing life skills-based HIV education. Only about 25% of men and women between the ages of 15 and 24years could correctly identify ways to prevent sexual transmission of HIV and rejected major misconceptions about HIV transmission (UNGASS, 2010; Federal Republic of Nigeria (FRON), 2012). According to FRON (2012), twice as many girls than boys engage in sexual activity before the age of 15 years old. Data from the Nigerian government revealed that about 10% of the global population of people with HIV live in Nigeria (UNAIDS, 2010).

The importance of clarifying needs before intervention can never be over-emphasized. The Niger-Delta area where the research took place still lacks adequate research data on this subject matter (Inyang, 2009). Okpani (2000) earlier noted the paucity of data on aspects of adolescents' sexual activity in Rivers State. In other nations like China, schools are the basic arena for the introdcution of HIV/AIDS education (Liao, et al., 2010). School- based HIV/AIDS education can be likened to the community control of disease approach, which has to do with a change in behavior. This can be primarily achieved through increasing awareness and knowledge (WHO & Family and Reproductive Health, 1996).

Methods

Participants

The research participants totaled 2,010 female secondary school adolescents from public schools of the Niger Delta Region of Nigeria. Senior Secondary1 (SS1) to Senior Secondary 3 (SS3) students participated in the study. Participants were only female adolescents within the age range of 10 to 19 years old. A multistage sampling technique (3stages) was used in selecting the participants for the study. In the first stage, a purposive sampling technique was used in selecting 20 public schools from the total number of schools in the study area. Secondly, a proportional sampling technique was used to determine the number of participants to be selected from each school. In the third stage, a simple random sampling technique was used in selecting the earlier determined number of participants from each school. The demographic characteristics of the participants are represented in Table 1.

Research Design

A mixed methods research design was used for the study. Descriptive survey research (quantitative research) involved the use of a questionnaire, which was administered on students who were the research participants. The title of the questionnaire was Questionnaire on Female Secondary School Adolescents' Sexual Behavior (QFSSASB). The questions were partially self -structured and partially adapted from a questionnaire on young people's sexual behavior. In-depth interviews were conducted on the teachers of the schools that participated in the study to find out the place of HIV/AIDS school-based education programs in their schools.

Procedure

Informed consent and assent were obtained accordingly from the heads of schools and the study participants. The study participants were assured of confidentiality and anonymity. They were given the right to withdraw at any point. While completing the questionnaire they were encouraged to stay apart from their peers to further assure confidentiality, thus enhancing accuracy of responses. They were made to complete the questionnaires on the spot to also enhance a high return rate. The study started with the collection of data on sexual behavior of female secondary school adolescents. Due to the sensitive nature of the study additional steps were taken further to enhance anonymity and confidentiality. Study participants were spaced out to enhance privacy. Participants were also encouraged to submit their questionnaire forms by themselves in to a basket provided when they were through with the completion. This were necessary to elicit correct and unbiased responses.

The in-depth interview is a type of qualitative research and was carried out on 50 teachers on the provision of HIV-based education programs in their schools. It was not as rigidly structured as the survey questions. It involved asking open-ended questions orally by the researcher while the participants' responses were recorded. The participants did most of the talking while the researcher listened, took notes and guided the conversation through the use of a question guide.

Instrumentation

Sexual behavior. The questionnaire on sexual behavior was divided into two sections, A and B respectively. Section A was on demographic characteristics of the study participants. Section B was on sexual activity. Questionnaire items were extracted from those previously used in a similar study on female secondary school adolescents' sexual behavior (Adamchak,et al., 2000). Sample items on the questionnaire were: (a) Do you have a boy friend? (b) Have you ever had sex with your boyfriend? (c) Did sex take place willingly or was it pressurized? (d) Are you having sex for the first time? In a previous study (Inyang 2009), the reliability of the instrument was (r=0.89) and the validity was acceptable. To ensure that the research measured what it intended to measure, the questionnaire instrument was subjected to face validity for judgment at face value. Content validity was done to ensure the coverage of the necessary areas addressed by the study. Construct validation was done to ensure the instrument aligned with all the concepts. These were carried out by the consulted experts in the field and related fields. Corrections and suggestions made were effected accordingly.

School-based HIV education program. In-depth interviews were conducted on the research participants who were teachers from secondary schools. A ten-question interview guide was used. All the participants were interviewed in their schools.

The purpose of qualitative research is to describe the phenomena of interest through the eyes of the research participants. Participants being the only ones to judge legitimately the credibility of the results were used to establish internal validity. Transferability assessed the extent the results could be generalized. This was done to establish the external validity and it was the sole duty of the researcher. Sample questions on the interview guide included (a)

HIV/AIDS is taught in this school as a separate subject including the transmission and non-transmission modes, preventive and self-protective measures. (b) HIV/AIDS is only mentioned in passing without much deliberation when teaching other subjects like biology or integrated science. (c) This school has once witnessed a training program on HIV awareness and teaching techniques for teachers. (d) Teachers have supplementary HIV/AIDS promotional materials such as visual aids, videos, posters and pamphlets to help in teaching the topic. (e) High risk behaviors are clearly explained to the students and this school has a HIV/AIDS club. The tape recordings were transcribed for data analyses at the end of the interview.

Data Analyses

Descriptive statistical analysis was done on the quantitative data to describe the characteristics of the sample and participants 'sexual behavior. Qualitative data were transcribed. Analysis of the transcribed text was done with a framework for qualitative data analysis (Miles & Huberman,1994). Conclusions were drawn from deductions made from participant's responses.

Results

Descriptive statistics. Descriptive statistics on demographic characteristics of research participants revealed that most of the research participants were within the age bracket of 14-17 years old. The next largest sample resided in the 10-13 years old bracket. Those within the age bracket of 18-19 years contributed the least to the total number of participants. Christians totaled the highest number of participants when it came to religious affiliation.

Table 1. *Descriptive Statistics on Demographic Characteristics of Research Participants' by Frequency and Percentiles*

Variables	n	%
Age Range		
10-13 years	460	22.9
14-17 years	1256	62.5
18-19 years	294	14.6
Total	2010	100
Ethnicity		
Ikwere	928	46.2
Ogoni	424	21.1
Ijaw	112	5.6
Kalabari	59	2.9
Others	487	25.2
Total	2010	100
Class		
SS1	1050	52.2
SS2	615	30.6
SS3	345	17.2
Total	2010	100
Religion		
Christianity	1946	96.8
Islam	38	1.8
Traditional	26	1.4
Total	2010	100

Descriptive statistics were done on the variables used in determining the sexual behavior of research participants. The majority of research participants had boyfriends, and were sexually active and experienced. Lesser numbers had boyfriends, but did not engage in sexual intercourse. Very few research participants were without a boyfriend. Some research participants did not respond to this item (Table 2). Considering the participants that experienced sexual intercourse as at the time of data collection, the majority had sex willingly, while fewer participants were persuaded in different ways into having sex (Table 2).

Table 2. *Descriptive Statistics on Sexual Behavior of Research Participants*

Sexual Behaviour	n	%
Participants' boyfriend/sexual experience		
Had boyfriends and sexually experienced	1789	89
Had boyfriend without sexual experience	35	1.7
Had no boyfriend at all	43	2.1
No response	143	7.1
Total	2010	100
Experienced sexual intercourse willingly		
Sexual experience took place willingly	1517	84.8
Sexual experience did not happen willingly	156	8.7
No response	116	6.5
Total	1789	100

Statistical analysis on the age of sexual debut showed that some participants had sexual intercourse as early as the age of 10. Most of the participants had sex by the age of 16 years old (Table 3).

Table 3. *Ages of Sexual Debut of Research Participants*

Ages (yrs)	Frequency	%
10	17	0.9
11	8	0.4
13	24	1.2
14	25	3.8
15	150	7.5
16	1045	52.0
17	104	5.3
18	98	4.9
19	45	2.2
No sex	400	20.0
No response	38	1.8
Total	2010	100

Data analysis determined that condoms were the contraceptive method used the most by participants. Most of the participants reported not using any form of contraception, however (Table 4). Generally, the choice and use of contraception varied among schools. The same observation was made on the different age groups.

Qualitative Data Analysis

Qualitative research participants were made up of 50 male and female teachers purposively selected. Ten public secondary schools in Niger Delta Region of Nigeria participated in the study and five teachers were selected from each school. Teachers of

Table 4. ***Descriptive Statistics on Use of Contraception by Research Participants***

Contraception	n	%
Use of Contraception		
Used contraception during sexual intercourse	436	24.4
Did not use any contraception	1256	70.2
No answer	97	5.4
Total	1789	100
Types of Contraception Used		
Condoms	201	46.1
Withdrawal method	78	17.9
Pills	52	11.9
Safe period	63	14.5
Others	42	9.6
Total	436	100

different subjects were preferred as participants to rule out bias. In-depth interviews with all the teachers revealed that HIV/AIDS was not taught in detail as a separate topic. Teaching did not delve into transmission and modes of transmission of HIV/AIDS. The teaching of HIV/AIDS only came up in passing during the teaching of subjects such as biology and integrated sciences. This situation was attributed to the absence of qualified health educators in the secondary schools. The responses were similar from the teachers in the various schools.

The method of word repetition was used in establishing the emerging themes from the data. In-depth interview data review revealed that participants repeatedly referred to ideas associated with a lack of specialists and professionals, inadequate information on HIV/AIDS, non-specialists, students not well informed, no health education in the curriculum, health education, not an independent subject, poorly understood, secondary school students and HIV/AIDS only mentioned in passing. A typical teacher response was:

> The unfortunate situation might be attributed to non-existence of Health Education as a separate subject in our schools. Those that attempt to handle this topic of HIV/AIDs cannot handle it with passion since it is not exclusively their responsibility. Those that also attempt to provide HIV/AIDS education lack adequate knowledge to do so effectively (male teacher).

On the use of promotional materials to teach HIV/AIDS, a typical response was:

> It is not possible to use promotional materials when the topic is not handled by those qualified to do so. It is only when qualified health educators are handling the topic that they can apply other innovations to enhance students' understanding. That is only when the promotional videos, posters and pamphlets could be introduced. Qualified health educators would be able to address it adequately since it is their area of specialty. We only mention it in passing in our schools. We do not see the teaching of HIV/AIDS as a priority (female teacher).

There was no HIV/AIDS club in existence in any of the schools. Any form of HIV/AIDS education that existed in all of the schools was very shallow. Most of the teachers did not demonstrate a good understanding of the subject of HIV/AIDS and high-risk behaviors.

Discussion

The study focused on establishing the sexual behavior of female secondary school adolescents in Nigeria. The study also sought to find out if school- based HIV/AIDS health education programs were in place to cater to the sexual health needs of female adolescents. The descriptive analyses revealed that most of the respondents were sexually active. The high number of sexually active respondents affirmed the position of (UNGASS 2010) that 80-95 percent of HIV infection in Nigeria is due to heterosexual sex. There were those that started their premarital sexual activity as early as the age of 10 (Table 4). This finding corroborates the position of FRON (2012) that twice as many girls as boys engage in sexual activity before the age of 15 years old. This early sexual debut can be attributed to absence of age-appropriate sexual health education.

According to studies as reported by (WHO, 2001; 2004), sexual health education helps in delaying initiation of sexual activity and reduces risky sexual behavior. The highest number of research participants started their sexual activity at the age of 16. These findings can be attributed to the fact that open sexual discussion and age appropriate sexual health education for adolescents are seriously frowned upon in Nigeria. This is the situation even when the adolescents are sexually active.

Early sexual debut revealed by this study might be attributed to the attitude of Nigerian parents towards sexual health education. Parents should be the first age appropriate sexual health educators as they are the primary contacts of the children. The findings can also be attributed to parental encouragement (Inyang, 2009). In a focus group discussion on sexual behavior conducted by (Inyang, 2005) in Niger Delta Region of Nigeria, most participants submitted that some parents encouraged the children into premarital sexual activity as a money-making avenue. Most of those that were sexually active were not also using contraceptive measures. This finding aligned with the position of UNGASS (2010) concerning low levels of condom use among the adolescents due to lack of information on sexual health and HIV. The high number of sexually active participants in this study also attests to the height of ignorance among female adolescents. The unwillingness of parents and teachers to address adolescent sexual health issues including HIV/AIDS education increases the tendencies of adolescents to risky sexual behavior (Sofo, et al., 2003).

Qualitative analysis revealed the absence of any significant form of HIV/AIDS health education programs in the schools. This finding aligns with the 2009 situation in Nigeria where, only 23 percent of schools were providing life skills-based HIV education, and just 25 percent of men and women between the ages of 15 and 24 years correctly identified ways to prevent sexual transmission of HIV and rejected major misconceptions about HIV transmission (Federal Republic of Nigeria (FRON), 2012; UNGASS, 2010). These current findings revealed no remarkable improvement. This situation might be responsible for the high number of sexually active students and the lack of contraception use.

In summary, female secondary school adolescents in this study were highly sexually active. Most of them indulged in unprotected premarital sexual practices. Their sexual health needs were not

provided for as revealed by the study through the absence of any significant school-based HIV/AIDS health education programs in schools. Lack of providing for their sexual health needs increased their vulnerability to risky sexual behavior and HIV/AIDS infection through ignorance. This was deduced from the number of those who were sexually active.

The study revealed an obvious need for sexual and HIV/AIDS health education intervention programs. Significant improvement in knowledge and attitude will only follow after intervention. Obviously, ignorance is responsible for the rapid proliferation of this deadly infection among secondary school students. This needs to be addressed through well-designed, intervention programs. Schools are seen by program and policy-makers as a strong center for the dissemination of HIV/AIDS information and education. This is so because schools have a large number of young people. This is why school based HIV education is seen as a 'social vaccine' that can serve as an effective preventive tool (Lal, et al., 2008).

Qualified health educators with confidence should be posted to secondary schools for effective handling of issues in their area of specialization. Age-appropriate sexual health and HIV/AIDS education, which is tailored towards teaching the students how to prevent the onward transmission of HIV/AIDS infection should be made available in Nigerian secondary schools. Policy-makers as well as school teachers should take advantage of the unique position of schools to reach every young person with the education that will proffer an effective solution in preventing the spread of HIV/AIDS epidemic. Teachers, school administrators, parents, other caregivers and community partners should be well equipped with the right knowledge for effective education and promotion of healthy sexual practices.

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