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Importance of sex education in schools: literature review

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Abstract

According to the National Association for the Education of Young Children, early childhood also includes infancy, making it age 0-8 instead of age 3-8. At this stage children are learning through observing, experimenting and communicating with others. Childhood is the age span two years to adolescence. The term childhood is non-specific in its time span and can imply a varying range of years in human development. The broad stages of childhood are: Early childhood (two to six years) and Late Childhood (six to twelve years). The implementation of sex education in schools will provide teenagers with the correct information to enable them to make the right choices in life. Sex education teaches the young person what he or she should know for his or her personal conduct and relationship with others. Sex education is an awareness to understand the sex problems scientifically. It conveys all educational measures, which help the growing children to understand and face the problems of life. At the time of puberty, physical changes and emergence of sexual feelings cause a lot of problem among adolescents. It encompasses sexual development, sexual and reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sex education in high schools helps young people to be more prepared for life changes such as puberty, menopause and aging. Sex education can develop skills and self-esteem to help students enter adolescence. It helps them in knowing that the sudden few changes are okay and normal. For example, girls would not get shocked, panic and afraid at their first menstruation once they already had the knowledge about it.

Keywords: Sex Education, Schools, Literature review

Introduction

Childhood is also conceptualized as a process of development towards adulthood. In the nineteenth century, childhood began to be mapped out as a series of developmental stages that determined the character of the adult individual. Rose argues that, in making it the object of scientific inquiry, psychology constructed or invented childhood and claimed a particular expertise in categorizing children, measuring their aptitudes, managing and disciplining them and has done so ever since. Living in a society where childhood is thought of as a series of developmental stages has specific effects on children. For example, schooling is organized as a series of age-graded progressions, which means that children are not only relatively segregated from adults but also from children of different ages. Children themselves acquire ideas about what is appropriate for people of their own age and may try to negotiate specific freedoms or privileges on this basis. Ordering children's lives in this way also influences what they are capable of achieving. It has been argued that the restriction of children to age-graded institutions may help to construct the very developmental stages that are seen as universal features of childhood (Skolnick 1980) [33]. For a child to behave in the manner of someone older is often thought inappropriate, so the term precocious has become an insult. Age-grading may help to keep children childish. Historical and anthropological evidence suggests that children in other societies and in the past were far more independent and capable of taking care of themselves than Western children are today. The idea of childhood as a developmental phase means that childhood is usually seen as important largely in terms of its consequences for adulthood. This is, as a number of researchers have pointed out, a very adult-centered view. Children are thought of as incomplete adults whose experiences are not worth investigating in their own right, but only insofar as they constitute learning for adulthood. Developmental theories presuppose that children have different capacities at different ages, yet children are

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frequently characterized as the polar opposites of adults: children are dependent, adults are independent; children play, adults work; children are emotional, adults are rational. The definitions of both childhood and adulthood are, moreover, gendered. Models of ideal adulthood are frequently in effect models of manhood, so that there is often a correspondence between attributes deemed childish and those deemed feminine such as emotionality and conversely those deemed adult and masculine such as rationality.

The definition of childhood as a developmental stage and psychological state masks the fact that it is still a social status. Because childhood is defined as a stage or state of incapacity, children are thought to be incapable of exercising adult rights. There is considerable debate about whether this assumption is justified or not and about what rights are appropriate to children. Childhood is an exclusionary status in that children are neither citizens nor legal subjects and are under the jurisdiction of their parents. Their subordinate position is also evident in their interaction with adults. A child is expected to be deferential and obedient; a "naughty" child is one who defies adult authority.

Adolescence

Adolescence is the transitional period in human life between childhood and adulthood. The transition occurs physically and mentally. The changes involve biological, social and mental developments, although the changes that are easy to measure objectively are the mental and biological changes. In the past, puberty has been mostly linked with teenagers and the onset of adolescence. In the recent past, however, the beginning of puberty has increased in the preadolescence and the adolescence extending beyond the teenage years. This has made adolescence more difficult to discern. Teenage years are from 13 years to 19 years but the end of adolescence and the commencement of adulthood differ from country to country. The age also varies with function after all even in different communities there are different ages where a person is considered old enough to assume responsibilities to the community. Adolescence is usually associated with increased independence and less supervision as compared to the preadolescence age.

Adolescence is the stage of rapid physical and psychological changes. The course of speedy physical changes in adolescence is known as puberty. For girls puberty comes earlier than boys. The process starts gradually mostly at 11 years for girls and 13 years for boys. The age at which puberty starts has been reducing probably due to the changes in nutrition. The hormone changes that cause the changes in adolescence begin sometime earlier before the physical changes take effect. The hormones might lead to periods of low moods and restlessness. Girls start experiencing the changes earlier than boys and mostly appear to be maturing faster than boys. At the puberty stage, girls start getting their menstrual periods and there is growth of hair under-arm and pubic parts. Boys break their voice, that is, their voice becomes deeper and they grow body, pubic and facial hair and start experiencing erections and wet dreams. Both girls and boys go through rapid physical growth. At the age of seventeen, they are young men and women who may be bigger than their parents. At this stage, most adolescents begin getting concerned with their appearance. Weight is a problem with the adolescents. If an adolescent is overweight and the others make fun of it, they are likely to get depressed. This can cause inactivity and discomfort in feeding which can aggravate the situation. There are some who result to dieting

causing a bigger health problem.

At the adolescence stage, people start to feel and think differently. They start being independent of the immediate family members, starting to establish friendships and relationships with their peers. They stop relying on parents for the psychological support, their parents become less significant in their eyes as their associations outside the family build up. They start arguing with their parents more often. This is because they have come up with their own views that often conflict with those of their parents. The adolescents spend most of the time with each other, or having telephone conversations with each other. They also start selecting their own clothes and develop different modes of dressing. They are still more likely to retain their values from their families especially those that respect their families. All the same, clothes and appearance become a way of articulating solidarity with friends.

As they become more independent from their parents, the adolescent tend to experiment new things. This stage is the time when people begin in a hurry to learn about the world and trying to establish their place in it. To establish their place involves attempting new experiences several of which might turn out to be unsafe or even dangerous. They often realize that they have very little experience to fall back to when things go wrong. This may give rise to speedy changes in self-confidence and behaviour. They may feel mature one minute, very immature and inexperienced the next minute.

Importance of sex education in schools

Sex education should be implemented in schools due to its many benefits to teenagers. The implementation of sex education in schools will provide teenagers with the correct information to enable them to make the right choices in life.

On the other hand, some have claimed that implementing sex education in schools actually promotes the risk of sex and is ineffective. However, based on various research findings, it is shown that sex education is effective by reducing the rate of teen pregnancy, providing correct information and also decreasing the number of HIV, AIDS and STDs cases among teenagers. Hence, sex education encourages healthy teen sexuality.

Young people have the right to lead healthy lives. Providing youth with honest, age appropriate sexual health education is a key part in helping them take personal responsibility for their health and well-being. Our children and youth grow up in a rapidly changing world where globalisation and technological advancements expose them to a wide range of influences from around the world. They need to acquire the knowledge, skills, values and attitudes which will allow them to develop healthy and responsible relationships and make informed and responsible decisions. While parents play the primary role, schools have a complementary role in providing sexuality education as part of a holistic education.

With accurate, current and age-appropriate knowledge, and social and emotional skills, our children and youth will be equipped to protect themselves from sexual advances and abuse, and avoid sexual experimentation and activities that lead to problems related to teenage pregnancies and STIs/HIV.

Sex education is the instruction of issues relating to human sexuality, including emotional relations and responsibilities, human sexual anatomy, sexual activity, sexual reproduction, age of consent, reproductive health, reproductive rights, safe sex, birth control and sexual abstinence. Sex education that covers all of these aspects is

known as comprehensive sex education. Common avenues for sex education are parents or caregivers, formal school programs, and public health campaigns.

Traditionally, adolescents in many cultures were not given any information on sexual matters, with the discussion of these issues being considered a taboo. Such instruction, as was given, was traditionally left to a child's parents, and often this was put off until just before a child's marriage. The progressive education movement of the late 19th century, however, led to the introduction of "social hygiene" in North American school curricula and the advent of school-based sex education. Despite early inroads of school-based sex education, most of the information on sexual matters in the mid-20th century was obtained informally from friends and the media, and much of this information was deficient or of dubious value, especially during the period following puberty, when curiosity about sexual matters was the most acute. This deficiency was heightened by the increasing incidence of teenage pregnancies, particularly in Western countries after the 1960s. As part of each country's efforts to reduce such pregnancies, programs of sex education were introduced, initially over strong opposition from parent and religious groups.

The outbreak of AIDS has given a new sense of urgency to sex education. In many countries, where AIDS is at epidemic levels, sex education is seen by most scientists as a vital public health strategy. Some international organizations such as Planned Parenthood consider that broad sex education programs have global benefits, such as controlling the risk of overpopulation and the advancement of women's rights. The use of mass media campaigns has sometimes resulted in high levels of "awareness" coupled with essentially superficial knowledge of HIV transmission.

Rationale

Sex education is defined as a broad program that aims to build a strong foundation for lifelong sexual health by acquiring information and attitudes, beliefs and values about one's identity, relationships, and intimacy. Sexual health is considered to be a state of physical, emotional, mental, and social well-being in relation to sexuality and not merely the absence of disease or infirmity as defined by the WHO. There is a need to impart sex education among students in schools because sex education aims to appraise, protect, and promote health. Sex education develops skills and self esteem to help students enter adolescence. Health education is very important for school children. It creates awareness, makes them knowledgeable regarding health matter, develops motivation and promotes change in health behaviour and health attitudes in them.

Objectives

- To study the research papers related to importance of sex education in schools.
- To review the available literature related to importance of sex education in schools.

Review of related literature

UNESCO (2009) ^[36] stated that effective sexuality education can provide young people with age-appropriate, culturally relevant and scientifically accurate information. It includes structured opportunities for young people to explore their attitudes and values, and to practice the decision-making and other life skills they will need to be able to make informed choices about their sexual lives

Collins (2008) ^[8] stated 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. Nedham (2004) ^[27] focused on health problems as a risk factor for academic failure and on school context as a source of protective effects. They tried to identify among others potential protective factors that may counterbalance the academic risk status of health problems. They examined three aspects of the school environment that might protect physically or mentally ill students from academic course failure: the presence of health services may be related to students' health; schools with more positive, protective climate often serve as a "safety net" catching at risk students which may extend to the risk associated with physical and mental health problems. In schools with positive student teacher relationship, teachers may be more likely to help physically and mentally ill students avoid academic course failure by offering extra support, encouragement etc.

Basavanthappa *et al.* (2003) ^[4] stated that health Education is very important for school children. It creates awareness makes them knowledgeable regarding health matter, develops motivation and promotes change in health behavior and health attitudes in them. Health education content areas include personal hygiene, environmental health, nutrition, prevention and control of communicable and non -communicable diseases, first aid and emergency care, home nursing, family life and reproductive health, prevention and control of Sexually Transmitted Diseases and HIV/AIDS etc.

Adegoke (2003) ^[1] stated that sex education is the acquisition of knowledge that deals with human sexuality. It consists of instruction on the development of an understanding of the physical, mental, emotional, social, economic and psychological phases of human relations as they are affected by sex. In other words, sex education involves providing children with knowledge and concept that will enable them make informed and responsible decisions about sexual behaviors at all stages of their lives.

Lewis and Knijn (2002) ^[24] compared strategies around sex education in Britain with those of the Netherlands, where there is no public debate about teenage sexuality. They also argued that the Dutch were relatively more successful through programmes of sex education in both primary and secondary schools. Van Loon (2003) has, however, tried to 'deconstruct' these arguments and demonstrate a more complex pattern of associations, including how schools in the Netherlands are not so centrally controlled as in Britain. He argues that the reduction in rates of teenage conceptions in the Netherlands are not due to the efficacy of its liberal sex education programmes, instead associating the lower rates with a less stratified society and less poverty. He argues that the high levels of teenage pregnancy in Britain are related to wider changes in family life and processes. Indeed, he also seems to concur with the American argument for sex education programmes that are relatively illiberal and promote abstinence before marriage

Buston and Jozep (2002) suggest that teachers need to be approachable, that students should be able to ask explicit questions, including those about the physical aspects of sex. Furthermore, students should be able to make comments that are not dismissed by the teacher. Buston (1993) identified four interrelated processes that work to reduce students' discomfort in the classroom setting. These include the teacher

as protector and friend, that there should be a climate of trust fostered between students and that the program should be seen as fun. Wight (1993) argues that students should receive sex education in familiar class groupings, that the teacher should, ideally, attempt to minimize disruptions, and that they should work towards eliminating hurtful humour while maintaining an approachable manner.

Wuchu *et al.* (2002) ^[38] grounded the transformative role of education in improving the health in this way “through education, one develops capacities on many levels that increase one’s sense of personal control, mastery, and self-direction: the habits and skills of communication and analytic skills. Because education develops one’s ability to gather and interpret information and to solve problems on many levels, it increases one’s potential to control events and outcomes in life. People with high personal control are more knowledgeable about health, are more likely to initiate preventive behavioral and report better-rated health and fewer illnesses than those with a low sense of control.

Huberman (2001) discussed policies and practices in Europe, specifically the Netherlands, Germany, and France, that have contributed to more effective sexuality education and lower rates of teen pregnancy and STD’S. In these nations, adolescent sexual development is seen both normally and healthy. The education provided to these students involves instruction in making informed choices and engaging in sexual behaviour in a responsible manner. In the united states, sex education frequently involves conflicts between schools, parents and the community regarding moral issues such as premarital sex and sexual orientation. These three governments work with the media, rather than viewing it as a source of the problem, as often happens in the United states. Radio and television advertisements, billboards and health care professionals all are a part of network committed to providing long term education regarding safe sexual practices to the public.

Darroch *et al.* (2001) ^[12] examined that societal attitudes toward sexuality appear to be a bit more relaxed in Europe, and adults appear to be much more accepting of teenage sexuality. However, attitudes toward teenage pregnancy are much more negative in Europe than in the United States, which may account for lower pregnancy rates.

Siecus (2001) ^[32] defined sex education as a lifelong process of acquiring information and forming attitudes, beliefs, and values. It encompasses sexual development, sexual and reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles.

Corcoran and Michael (2000) ^[9] stated that there is an overwhelming array of factors associated with adolescent sexuality and HIV/AIDS prevention. HIV/AIDS and sexual risk behaviour among adolescents is multi-dimensional and includes both individual and environmental factors. Clear delineation of these factors and soliciting the cooperation and participation of the young people with their parents as well as other socio-political, and/or religious networks is essential in developing HIV/AIDS prevention programs for adolescents.

Smith *et al.* (2000) ^[34] argued that school-based programs and activities need to go beyond infection transmission and knowledge about reproduction to focus on sexual health in its social context. They suggest that this may include such areas as assertiveness development, values clarification and negotiation skills. Furthermore, programs must be appropriate and comprehensive and cater to the diversity of students. This suggests that teachers should be aware that not all students will be heterosexual, that some will already be sexually active

and others will have decided to delay becoming sexually active, that a range of cultural backgrounds will be represented and that sexuality is constructed differently for young women and young men.

Kirby (2000) ^[22] provided an overview of different methods of sexuality education and endorsed an abstinence-plus approach. In his own examination of over 30 programs, it was found that abstinence-plus programs do not increase rates of sexual activity in adolescents who participate, and also do not increase the number of sexual partners or lead to adolescents engaging in sexual activity sooner. Kirby listed ten key characteristics of effective sexuality education programs. The first is that effective programs focus narrowly on one or more sexual behaviors to reduce unintended pregnancy and sexually transmitted diseases (STDs). Effective programs also are grounded in theoretical approaches that have shown success in reducing other risk behaviors. The third listed characteristic is that such programs have a clear stance on sexual behaviors, rather than discussing both sides and letting students choose what is right for them. The fourth characteristic states that students are provided with accurate information regarding the risks involved in unprotected sexual activity and how to stay away from unprotected intercourse. For a program to be effective, it must also include instruction for dealing with social pressures related to sexual activity. Related to this topic, programs should also provide modeling and practice in these social skills. Students need to practice skills such as negotiation, refusal, and communication issues. Personalizing the information is also an important aspect of reaching adolescents in sexuality education programs. Developmentally and culturally appropriate goals and materials are also important aspects in providing an effective sexuality education program. In order to be effective, sexuality education programs also need to last long enough to adequately cover information and complete activities.

Snegroff (2000) ^[35] indicated the difficulty parents have discussing sexuality comfortably with their children, even when they recognize the importance of such communication. Even parents who do not discuss sexuality with their children still project their feelings about sexuality to them through their behaviour. If the message young children get about sexuality from their parents is negative, then they are less likely to discuss sexuality issues with parents when they are older. As the title of Snegroff’s article states, “No sexuality education is sexuality education”

Coyle *et al.* (1999) ^[10] examined the effectiveness of a school-based sexuality education program called Safer Choices. Safer Choices is a two-year program, with the main goal being to reduce the number of students having sexual intercourse in their high school years and increase condom use among those who already were engaging in sexual activity. The theoretical basis for Safer Choices is rooted in social cognitive and influence theories, and it incorporates models of school change. The main components of the program are “school organization, curriculum and staff development, peer resources and school environment, parent education, and school-community linkages”. In the Safer Choices program, students participated in ten lessons and school-wide events that were organized and sponsored by peers. Safer Choices has many of the characteristics previously identified as part of an effective sexuality education program, such as focusing on specific behaviors, a theoretical basis, covering a long enough span of time, and involving trained staff and peers who believe in the program. The study involved ten schools in California and ten schools in Southeast Texas during the

1993-1994 and 1994-1995 school years. Five schools in each state were randomly selected to have the Safer Choices program implemented. The five schools in each state not selected received a comparison program.

The following are some of the results of the evaluation of Safer Choices done by Coyle *et al.* (1999) ^[10]. The study first examined the change in students' knowledge after being exposed to the two programs. While both programs increased students' knowledge regarding HIV and other STDs, the increase among the Safer Choices students was significantly greater, with the difference between the two groups greater in Texas. Students in the Safer Choices program also had significantly more positive attitudes and expressed more positive normative beliefs about condom use than those in the comparison program. The Safer Choices participants also reported slightly higher levels of communication with parents than the comparison groups about how to prevent STDs. Neither program was shown to significantly reduce initiation of sexual behaviour, but the Safer Choices program was shown to reduce unprotected intercourse.

Fawole *et al.*, (1999) ^[14] reported knowledge, attitude and sexual risk behaviors of 223 students who received a comprehensive health education intervention were compared with 217 controls. Nigerian secondary school students are becoming sexually active at an increasing earlier age. Sexually active students are at risk of contacting STDs, including HIV infection. As a result education initiatives to increase level of knowledge. Studies concluded that students can benefit from specific education programmes that transmit important information necessary to prevent risky behaviour, and improve knowledge and attitudes on HIV/AIDS

Findings of the study

- It was found that effective sexuality education can provide young people with age-appropriate, culturally relevant and scientifically accurate information. (UNESCO 2009) ^[36].
- The findings revealed that sexuality education encompasses education about all aspects of sexuality including information about family planning, body image, sexually transmitted infections and how to avoid them, and birth control methods. (Collins2008) ^[8].
- The results showed that a multifaceted intervention program that provides information and skills as well as counselling and services, appears to have positive influences on contraceptive practices among unmarried young females and males in sub-urban. (Wang *et al.* 2004).
- The findings revealed that sex education involves providing children with knowledge and concept that will enable them make informed and responsible decisions about sexual behaviors at all stages of their lives. (Adegoke 2003) ^[1].
- It was found that health education is very important for school children. It creates awareness, makes them knowledgeable regarding health matter, develops motivation and promotes change in health behaviour and health attitudes in them. (Basavanthappa *et al.* 2003) ^[4].
- It was revealed that abstinence-plus programs provide students with important information, and do not lead to an increase in sexual activity. (Wiley 2002) ^[37].
- The results showed that people with high personal control are more knowledgeable about health, are more likely to initiate preventive behavioural and report better-rated health and fewer illnesses than those with a low sense of

control. (WuChu *et al.* 2002) ^[38].

- The findings indicated that students should receive sex education in familiar class groupings, that the teacher should ideally attempt to minimise disruptions, and that they should work towards eliminating hurtful humour while maintaining an approachable manner. (Buston *et al.* 2002).
- The study revealed that sex education in schools encompasses sexual development, sexual and reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. (SIECUS 2001) ^[32].
- The study revealed that radio and television advertisements, billboards and health care professionals all are a part of network committed to providing long term education regarding safe sexual practices to the public. (Hubberman 2001) ^[20].
- It was found that adolescents are more likely to discuss sexuality with their teachers than parents this means if the adolescents get message from teachers it has more benefits because they better communicate and easily understand by teachers. (Snegroff 2000) ^[35].
- It was found that different effective programmes help in the awareness to reduce untitled pregnancy and sexually transmitted diseases (STD's). Effective programmes also are grounded in theoretical approaches that have shown success in reducing other risk behaviours. (Kirby 2000) ^[22].
- The findings indicated that sex education programmes in schools, socio-political, and/or religious networks is essential in developing HIV/AIDS prevention for adolescents. (Corcoran and Michael 2000) ^[9].
- It was revealed that "Safer choice Programme" in schools helped students how to prevent themselves from STD's. Students in the Safer Choice Programme also had positive attitudes about health. (Coyle *et al.* 1999) ^[10].
- The results showed that schools can play an important role in providing youth with a knowledge base which may allow them to make informed decisions and help them shape a healthy lifestyle. (Leger 1999).

Summary

School-based sexuality education continues to be a controversial topic. School Based Sex Education is nowadays an important public health issue as it concerns not only youth AIDS prevention (and other sexually transmitted infections - STI) and adolescent pregnancy prevention but also interpersonal relationships and psychosocial issues. Sex education is the process of acquiring information and acquiring attitudes and beliefs about sex, sexual identity, sex relationships and intimacy. It is also about developing young people's skills so that they make informed choices about their behaviour, and feel confident and competent about acting on their choices. It is widely accepted that young people have the right to sex education, partly because it is a means by which they are helped to protect themselves against abuse, exploitation, unintended pregnancies and sexually transmitted diseases and HIV/AIDS. Health education builds students' knowledge, skills, and positive attitudes about health. Health education teaches about physical, mental, emotional and social health. It motivates students to improve and maintain their health, prevent disease, and reduce risky behaviors. Health education curricula and instruction help students learn skills they will use to make healthy choices throughout their

lifetime. Sex education in high schools helps young people to be more prepared for life changes such as puberty, menopause and aging. Sex education can develop skills and self esteem to help students enter adolescence. It helps them in knowing that the sudden few changes are okay and normal. For example, girls would not get shocked, panic and afraid at their first menstruation once they already had the knowledge about it. *Health education* consists of a planned, sequential curriculum taught daily in every grade (prekindergarten through twelve) that addresses the physical, mental, emotional, social, and spiritual dimensions of health and is designed to motivate and help students maintain and improve their health, prevent disease, and avoid health-related risk behaviors. A quality curriculum allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices while addressing a variety of topics, including personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.

Conclusion

Hence it can be concluded that, sex education is effective by reducing the rate of teen pregnancy, providing correct information and also decreasing number of HIV/AIDS and STD's among teenagers. Hence sex education encourages healthy teen sexuality. Sex education teaches the young person what he or she should know for his or her personal conduct and relationship with others. Sex education is a lifelong process of acquiring information and forming attitudes, beliefs and values. Health education is very important for school children. It creates awareness, makes them knowledgeable regarding health matter, develops motivation and promotes change in health behaviour and health attitudes in them. Sex education involves providing children with knowledge and concept that will enable them make informed and responsible decisions about sexual behaviours at all stages of their lives. School based health education is provided for students and are designed to appraise, protect, and promote health. Health services are designed to ensure access and/or referral to primary health care services, foster appropriate use of primary health care services, prevent and control communicable diseases and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for safe school facilities and environments, and provide educational and counseling opportunities for the promotion and maintenance of individual, family, and community health. Services should be provided by qualified professionals such as physicians, nurses, dentists, and other allied health personnel. Health services via school-based clinics that are linked with enhanced academic services have been associated with reduced absenteeism, improved academic achievement,

Recommendations

- The school teachers should receive the most up-to-date, sex education research and should be able to deliver the information to the student body in a mature, fun and realistic fashion.
- Education is the only way out to vanish unhealthy practices among adolescents.
- The teacher should express an open attitude and willingness to listen and discuss any and all issues relating to sexual health.

- Direct students to reputable resources where they can find their own answers to their
- Sex education is more than just teaching about sexual behaviours. This means you should also educate yourself on issues such as abstinence, body image, gender, sexuality, sexual development, sexually transmitted diseases, sexual health, and sexual pleasure.
- Sex education should be given to dispel the unfounded belief by many that sex education would encourage "sexual experiment".
- Sex education programmes should be held for young people in secondary schools to help their self-worth, sense of responsibility, understanding and acceptance of diversity
- Sex education should also be delivered via mass media as most of the information available to youth comes largely from news, magazines, movie, etc.
- In a nutshell, young people need sex education in order to assist them to develop a positive sense of their own sexuality by creating opportunities for them to consider all aspects of sexuality, to ask questions, and to understand that there are adults who support them as they learn about this part of themselves.

References

1. Adegoke R. Enhancing school based prevention and youth development through coordinated social, emotional and academic learning. *American Psychologist*. 2003; 58:6.
2. Archad D. Sex education for adolescents and their families. *Journal of Sex and Marital Therapy*, 1993, 53.
3. Aries P. An evaluation of the acquisition of sexual information through a sex education class. *Journal of Sex Research*. 1962; 13:3.
4. Basavanthappa R, Nig J, Pitter Y. Fundamentals of Sex Education. *Journal of Innovative Research*. 2003; 5:3.
5. Berger J, Krieger N, Williams N, Moss P. Measuring Social Class in US Public Research Health. *Annual Review on Public Health*. 2007; 14:8.
6. Brock K, Beazley C. The sexual activity of young people and its implications for education. *Gender and Education*. 1995; 14(2):149-167.
7. Buston V, Jozep R. The context and practice of sex education. *British Journal of Sociology of Education*, 2001, 22.
8. Collins. Developing an Understanding of Gender Sensitive Care. *Journal of Advanced Nursing*. 2008; 40(1):69-77.
9. Corcoran C, Michael G. Tackling Socioeconomic Inequalities in Health. *The Lancet*. 2000; 362:9393.
10. Coyle D, Pawan K, Rumeey C. Learning about sex. Results from Natsal Health Education and Behavior. 1999; 33:6.
11. Currie B, John K. Socioeconomic Status, Poor Health in Childhood, and Human Capital Development. *National Bureau of Economic Research*, 2008, 48.
12. Darroch D, Chang W, Pawan N. Depressive symptoms as a longitudinal predictor of sexual risk behavior among U.S. middle and high school students. *Pediatrics*. 2001; 18:1.
13. Doyal R, Krish Y. Sex, Gender, and Health. *Medical Publication of the Year*, 2001.
14. Fawole M, Jimmy S, Saroj D, Hines D. The Connection between Academic Failure and Adolescent Health in Secondary Schools. *Sociology of Education* 2006; 79:22.

15. Gourlay Y. Reports of Reproductive Education. *Family Planning Perspectives*. 1994; 32(5):220-226.
16. Haingre G. Policies and Strategies to Promote Social Equity in Health. Background Document to WHO-Strategy Paper for Europe, 2005.
17. Harris N, George K, Nayarko K, Lopez C. A Review of the Effectiveness of Health-related Physical Education Programmes in Schools. *Health Education Journal*. 1997; 56(1):84-104.
18. Hillier B. Education and Health in 22 European Countries. *Social Science & Medicine*, 1996m, 63.
19. Hubbard R, Robert B. A replication study of Reducing the Risk, a theory based sexuality education curriculum for adolescents. *The Journal of School Health*, 68.
20. Hubberman G. The effectiveness of abstinence education programs in reducing sexual activity among youth. Heritage Foundation, 2001.
21. Jaccard P, Khanna G, James B. Maternal correlates of adolescent sexual and contraceptive behavior, *Family Planning Perspectives*. 1998; 28(4):159-165.
22. Kirby C. Do abstinence-only programs delay the initiation of sex among young people and reduce teen pregnancy? National Campaign to Prevent Teen Pregnancy, 2000.
23. Leger T. Age at First Birth, Health, and Mortality. *Journal of Health and Social Behavior*. 1999; 4(1):32-50.
24. Lewis J, Knijn T. The politics of sex education policy in England and Wales and the Netherlands. *Journal of Social Policy*. 2002; 31:4.
25. Luker. *When Sex Goes to School*. Norton and Company, 2006.
26. Menedez P, Lalit G. Inequalities in young people's health. Health behaviour in School-aged Children. International report, 1996, 32.
27. Nedham D. The Interrelated Role of Health Problems and Educational Context. *Social problems*. 2004; 51(4):369-586.
28. Panda A, Rocky L, Paul J. Factors associated with sexual risktaking behaviors among adolescents. *Journal of Marriage and Family*, 2002, 56.
29. Schonfiled M, Jores L, Martin L. The context and practice of sex education. *British Journal of Sociology of Education*. 1998; 22(3):353-368.
30. Schwartz D, Kamaluzzaman, Knijin M, Kumar R. The importance of adolescents' perceptions of parental communication about sexuality, *Journal of Adolescence*. 1999; 22(6):835-851.
31. Shahar S. Sex education on a psychiatric unit. *American Journal of Nursing*. 1990; 74:22.
32. Siecus F. Sexuality Information and Education Council of the United States, Fact sheet, 2006.
33. Skolnick P. Educating the learning disabled adolescent about sexuality. *Journal of Learning Disabilities*. 1980; 12:9.
34. Smith A, Krisgowen L, Das P, Swasthi K. Socio-economic Position, Gender and Health. *Journal of Health Psychology*. 2000; 42:315-334.
35. Snegroff S. No sexuality education is sexuality education. *Family Planning Perspectives*. 2000; 32:257-258.
36. Unesco. UNESCO. Information Series on School Health – Promoting Physical Activity in Schools. International science, technology and environmental education newsletter. 2009, 2.
37. Wiley S, Chauhan B. The ethics of abstinence-only and abstinence-plus sexuality education. *The Journal of School Health*. 2002; 72:11.
38. WuChu C, Santana P, Raj M. Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Journal of Adolescent Health*. 2002; 31:264-279.