

Perceptions of students regarding the delivery of sexual and reproductive health education in schools in Fiji

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Abstract

Adolescent sexual and reproductive health (SRH) remains a challenge globally. High school youths without comprehensive sexuality education (CSE) are more likely to engage in high risk sexual behaviors than their peers in schools with CSE. Fiji continues to have very poor adolescents SRH indicators. This study aimed to gauge the perceptions of students towards the delivery of SRH education in schools in Fiji. A qualitative study design was used to collect data from students in year 11-13 in public secondary schools in Suva, Fiji in 2018. Schools with equal ethnic mix were selected. A semi-structured open-ended questionnaire was used to guide Focus Group Discussions (FGDs). A male research facilitator conducted FGD with males while a female research facilitator facilitated that amongst the females. Data collected was analyzed thematically. Seven FGDs were conducted. A total of 46 students (29 males) participated with the age range from 17-19 years old. Eight themes emerged: current SRH education; students' knowledge on adverse consequences of SRH; sources of SRH information; need for sex education; provision of SRH education in schools; characteristics of teachers of SRH education; age-appropriate incremental sex education; and ideal version of SRH. The study shows that Fijian students desired a lot more from sex education than what is currently offered for sexual decision-making. There is a need for mandatory and comprehensive sex education for young people.

Keywords: Sexual and reproductive health, school-based sex education, qualitative study, students, Fiji

Introduction

Worldwide, adolescent sexual and reproductive health (SRH) remains a challenge (1). Sixteen million births worldwide, 111 million cases of sexually transmitted infections (STIs) and 15% of new human immunodeficiency virus (HIV) cases, occur among adolescents (2). Worldwide, maternal health issues are a leading cause of death among adolescent

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women. In 2015, the adolescent fertility rate (AFR) for 15 to 19-year-old women was 44 per 1,000 births, with much higher rates in low-income countries (97 per 1,000), compared to high-income countries (19 per 1,000) (3).

In the Pacific, although HIV prevalence has not exceeded 1% in the general population it is increasing amongst women and there are high rates of other STIs. Prevalence rates for physical or sexual violence among Pacific Island women (15-49 years of age), is extremely high at approximately 60-77% (4). In terms of the SRH Indicators, Fiji's AFR has been relatively constant at 36/1,000 births has remained relatively constant, however, an alarming increase was seen in 2013 which was an increase by 95% and another drastic increase in 2015 (4-6). In terms of HIV, although Fiji is estimated to have a low prevalence of HIV, the number of people diagnosed with HIV is increasing every year in contrast to decreasing new infections worldwide (7). Additionally, in Fiji, people as young as 12 years are sexually active evidenced from high rates of teenage pregnancy and the Intimate partner violence stands at 66%, which is extremely high (4, 8).

High school youths in years 9-13, who are in public schools without comprehensive sexuality education (CSE), are more likely to engage in high-risk sexual behaviors than their peers in schools with CSE (9). By the age of 20 years, majority of the adolescents are sexually active, whether they are married or not. Among them, unprotected sexual intercourse with multiple or casual partners is rife. They do not use contraceptives and many of them lack the basic information about sexual matters and STIs, including HIV infection (10). The key SRH issues that affect young people are puberty, pregnancy, access to modern contraceptives, unsafe abortions, and violence including gender-based violence (4, 11, 12).

Generally, studies have shown that students/young people are always inclined to receive education/information on SRH as they are at a transition period from children to adults and experiencing the onset of puberty and are keen to learn what is going on, what is normal and what is not. Along with parents and teachers, students had a favorable attitude towards the importance of sex education (13). In Fiji, SRH was first institutionalized

in 1985 to deal with the problem of a high percentage of illegitimate births among teenage girls and a high incidence of sexually transmitted illnesses. Fiji continues to have very poor adolescents SRH indicators. This study is designed to gauge the perceptions of students regarding the delivery of SRH education to students in years 11 to 13 (aged 16-18) and suggest solutions and strategies for improvement in Fiji.

Methods

This study utilized qualitative research methods to collect data using focus group discussions (FGDs) in Suva between July and August 2018. The target population was students from years 11-13 in selected mainstream public secondary schools in Suva, Fiji irrespective of gender. The study excluded students from other levels.

To recruit the study participants, a list of schools was obtained from the Ministry of Education (MOE) and schools with equal ethnic mix were selected to ensure equal representation from the two ethnicities. The school principal's permission was sought first, after which the SRH subject coordinator who facilitated a meeting with students. A short oral presentation was done to the students on the rationale of the study. Those willing to participate were provided with an information sheet, a consent form for parental consent, and an assent form.

A semi-structured open-ended questionnaire adapted from a similar study (14) was used to guide the FGD. As the guides have been slightly amended, it was piloted again and revised accordingly.

A suitable time was agreed with the SRH education coordinator for the FGD. The focus group was made up of 5 to 7 individuals and there were seven FGDs. A male research facilitator conducted FGD with males while a female research facilitator facilitated that amongst the females. One iTaukei female trained research assistant assisted with facilitating FGDs among the female groups. The researcher strived to ensure that the room was a quiet, cool, and non-threatening environment conducive for discussion with the group. The issues about SRH are sensitive, given which the privacy of the respondents was given serious consideration. In this connection,

the FGDs were thus stratified by gender to encourage openness and gendered-specific sensitive responses from the participants. Each FGD lasted approximately 40 minutes. FGD for each of the groups was terminated once there was data saturation. Data was in the form of recorded notes taken during the FGD and digital audio recordings of FGD.

Data analysis

Audio-recorded FGDs were first transcribed into English verbatim. The transcribed data was read and re-read multiple times to immerse in the data. In doing so, the key categories/theme was identified and

data were summarized under appropriate categories (15).

Ethic approvals

Ethical approval was sought and granted by Fiji National University's College Health Research & Ethics Committee; the Fiji National Research Ethics Committee of the Ministry of Health (2018.108.CEN) and from the Fiji Ministry of Education, Fiji (RA 41/18). Study participants were provided consent forms to obtain parental consent and were also requested to sign the assent form for participation in the study.

Table 1. Demographic characteristics of participants of the FGD

Focus Group Number	Gender & Ethnicity	Level	No. of participants
Focus group 1	Males & Mixed ethnicity	Year 12	7
Focus group 2	Males & mixed ethnicity	Year 13	6
Focus group 3	Males & mixed ethnicity	Year 11	9
Focus group 4	Males & mixed ethnicity	Year 12	7
Focus group 5	Females & mixed ethnicity	Year 12	5
Focus group 6	Females & mixed ethnicity	Year 13	5
Focus group 7	Females & mixed ethnicity	Year 11	7
Total			46

Results

Seven FGDs were conducted in the mainstream public secondary schools in Suva, Fiji. A total of 46 students (29 males) participated. The student's ages ranged from 17-19 (Year 11-13) with the majority being from Year 12. A breakdown of the demographic characteristic is shown in Table 1.

The findings are organized in thematic areas that are the subheadings with key messages of the respondents quoted. In this study, eight themes merged as students' main concerns of SRH in Fiji as explained below:

Current SRH education

Of all the schools that participated, only one school offered family life education (FLE) separately to male

and female students. This was because of the religious nature of the school. This was a Muslim school and the principal mentioned that due to the sensitive nature of the subject in Islamic society, FLE classes were segregated for the two genders.

Where classes were held together for both genders, students preferred that sensitive topics such as those that dealt with reproduction and the reproductive system, conception, and contraception be conducted separately. Additionally, male and female students preferred that those sensitive topics be delivered by a teacher of their own gender as they did not feel more comfortable discussing matters related to SRH with teachers whose gender was opposite to the students. One student expressed that:

“It will be good if we have a male teacher for FLE so that we can discuss certain things more openly. It is difficult to ask questions when we have a female teacher.” [Year 11 iTaukei Male student]

Students' knowledge on adverse consequences of SRH

All students knew what teenage pregnancy was and appeared to be well aware of the problems associated with teenage pregnancy. The majority of the students viewed teenage pregnancy statistics to be alarming and cause of concern for Fiji. The majority of the students could not easily correctly spell out the term HIV/AIDS as human immunodeficiency virus/acquired immune deficiency syndrome but knew it as "human virus" or as some sort of syndrome. All students recognized it as an STD or STIs. Gonorrhoea appeared to be the second and only other well-known STI after HIV. Science students appeared to understand the basic terms associated with SRH health better compared to their non-science peers. For instance, science students understood the term "contraception"; however, this needed simplifying (as saying "methods of pregnancy prevention") when used amongst students of commerce background. The majority of the students did not know various methods of preventing pregnancy; however, all knew that condoms could be used to prevent both unplanned pregnancy and STIs. The second most common method of preventing pregnancy mentioned by students was the withdrawal method. The majority did not know any other method apart from these two.

Sources of SRH information for students

All students mentioned that they get their SRH information mostly from the schools during the FLE classes through the FLE teacher with the second most common source being the internet and social media. The majority of students mentioned having access to the internet and they mostly accessed it on their phones at home. Friends or peers were also mentioned as a source of SRH information. The least common source of SRH information was at home from parents or siblings as one student stated:

"Parents usually don't share sex-related information with us. For example, fathers usually give us a hint, as I am more comfortable with my father than my mother. He tells me to be careful of this stuff (engaging in sex) and what the consequences of it will be at an early age and what they

[parents] will be affected and consequences from dropping out of school if found engaging in those behaviors." [Year 12 Indo-Fijian male student]

All students trusted the information obtained from the school the most compared to the information obtained from the internet. Some students said that the information from internet/on websites might be altered and may promote unsafe sex (such as pornography). They also trusted information from peers. Students also said that parents and siblings could also be trusted with the information; however, such exchanges of information were rare. Only a few students mentioned discussing SRH issues with parents and siblings.

One female student, who begged to differ from her *iTaukei* counterparts, noted that:

"Although my classmates are saying that everything should start at home but there are some parents who don't share with the children...so in schools, we can learn on sex education with our friends and teachers so it would be more open and like we cannot share things at home so school will be the best place to learn it, including HIV and all other stuff." [Year 13 Indo-Fijian female student]

In terms of preference for obtaining SRH education/information, students preferred teachers, internet, and peers to parents. Those who mentioned peers were because they said that they had a teacher of different gender and they said they felt shy. For instance, one Indo-Fijian female stated that:

"I would not talk to my teachers because I would feel awkward because the teacher is a male". [Indo-Fijian female]

Need for sex education

All students believed that it was vital to have SRH education for several reasons. These included preparing them for life; for family planning; to learn about preventing unwanted pregnancy; to save oneself from STIs, to learn about the changes that are taking place in their bodies, their reproductive systems; how to take care of themselves; how to make the right choices and to practice safe sex. One student mentioned that:

“For me, I am schooling in this school since Year 9 and we have sex education. It should be taught everywhere in Fiji. It is an important subject so that young people know about sexual health the consequences of unsafe sex.” [Year 12 Indo-Fijian Male student]

Amongst the girl’s groups, one of the female students noted:

“I think sex education is important so that young people can take actions and precautions on how they can prevent diseases and educate themselves on the prevention of such diseases.” [Year 12 Indo-Fijian Student]

The majority of the male students mentioned that they would prefer to learn SRH in schools and mentioned that they would like regular teachers (such as form teachers/counselors/specialist FLE teachers) to teach them. Students mentioned regular teachers because they said that since sex education is a sensitive issue, students need to be comfortable with the person who is imparting SRH knowledge and they said regular teachers understood the students’ emotional state. Additionally, students mentioned that they saw these (regular) teachers daily, spent most of the time around them every day, these teachers knew students and parents general background and it was these teachers who provided feedback to the parents on children’s academic progress and well-being, particularly on teacher-parent’s day. Students also mentioned that it would be good to include/invite speakers from various agencies who have greater knowledge in specific areas. For instance, doctors and nurses were identified as people who could talk on sexual health, sexuality and reproductive health, pregnancy, contraception, STIs whilst police officers could speak on topics such as misuse of drugs and addiction.

As opposed to the male students, some of the girls said that they would like to get their SRH education from their family, particularly their mothers. One iTaukei female stated:

“I would like to learn from family members like my mother because they know better and they have gone through this stage of life. She tells me what is wrong and right.” [Year 13 iTaukei female student]

Provision of SRH education in schools

Across all FGDs, all participants were in favor of the provision of SRH education in schools and said that it was crucial to have sex education in schools. Participants said issues around SRH were not discussed openly in the majority of the homes as it is still considered a taboo, thus they felt school was a good avenue to teach young people SRH.

Some students were aware of the possibility that teachers might feel uncomfortable or shy to talk about SRH issues. Majority of the students mentioned that teachers did not teach SRH during its designated session but were an opportunity for teachers to relax while students engaged them in some sort of work as male student stated that:

“Some teachers do not teach during our family life classes..... they just come and sit or do their work. It is more like a relaxation time for the teachers while we do our work...so we do not learn much” [Year 12 Indo-Fijian male student]

Characteristics of teachers of SRH education

Students said that they would like teachers who are friendly, approachable, open-minded, caring, and understand their situation. Some students wanted a teacher whom they can confide in and teachers who are comfortable in discussing SRH matters with them. They did not want teachers who breached student’s confidentiality or those who shared student’s information or gossiped about their students with other teachers. They disapproved of teachers who were judgmental and liked to spread rumors. Some students were clear of the criteria for an ideal FLE teacher. One Year 13 female student stated:

“I prefer married teachers because they have more experience. They can tell us the right and the wrong. They should be friendly, so students can share their problems with them, someone we can trust, and we share with them openly and those who can give good advice to us.” [Year 13 iTaukei female student]

Another student shared that:

“I want teachers who can teach in detail and attract student interest by really being engrossed in the subject while teaching or providing information. In our school teachers just stand, relax, teach what drugs are for example, and go away, so we want teachers who get into the details of the subject and not teach in a superficial way.” [Year 12 Indo-Fijian male student]

None of the students likes teachers who only wrote notes and explained only occasionally. To this regard, a male student stated that:

“To be very honest, when we are having family life class, we are only writing notes. Our teacher explains once in a while, the whole year has almost gone, and we've been just writing notes.” [Year 12 Indo-Fijian male student]

Age-appropriate incremental sex education

There was a consensus across all groups that sex education content should be incremental. Everyone agreed that it should begin at the primary school level with some basic health education and that as the students move up the levels, the content should be more in-depth (age-relevant) and gender-sensitive. Students felt that sensitive components of sex education should start at year 7 (12 years old) or the onset of puberty so that these concepts will become clearer to the children as they grow and will be able to notice the changes in their bodies.

An ideal version of SRH

Most students mentioned that they would like the class to cover subjects related to the use of contraceptives to prevent unplanned pregnancies, symptoms, and prevention of STIs including HIV/AIDS and skills to negotiate for safe sex practices. Some students said that it would be good to have a textbook or a workbook, just like any other subject, which will be useful for those who do not write notes during the class and can read the book in their own time. Students said that currently they did

not have any textbook to refer to when they needed some information.

Some students also mentioned that teachers should discuss courtship and youth intimate relationships, including stress and how to deal/ manage it. They mentioned that once students know how to handle relationships or broken relationships they will not resort to suicide. This is currently not well covered as one male student stated:

“Teachers should discuss more on relationships and how to handle a breakup. We are not taught what we will go through after a break-up and that is a reason some people to commit suicide.” [Year 12 Indo-Fijian male student]

When asked how a student wanted the classes to be improved, one Indo-Fijian male student shared:

“In my previous school, we had a specialist female teacher. She was a doctor from America. She came and taught us about preventing pregnancy and the use of condoms and other things and showed us a condom as well. I need someone like her to teach.” [Year 12 Indo-Fijian male student]

Most students expressed that teachers should be able to generate student interest and make students realize the importance of SRH so that students do not take these subjects lightly and see it as a free period.

Students said that they needed teachers to provide real-life examples to the concepts they teach so that it makes more sense to them. Such examples may include the real consequences for people who use drugs or engage in unsafe sex. Some students mentioned that teachers should make the lessons more interactive and creatively use multi-media (animation, projectors, and videos) to deliver their subjects to make it more interesting. Students mentioned that there should be less of note-taking but more of explanation and interactive discussion. One Indo-Fijian male shared:

“More topics need to be included or taught properly like on drugs and the consequences of its use and relationships. Teachers should include real-life examples for student's better understanding.” [Year 13 Indo-Fijian male student]

Discussion

The study reveals that sex education is not offered comprehensively and students have a great concern concerning the manner of its implementation. There was a consistent emphasis from students of both genders to segregate sex education sessions into male and female groups particularly on sensitive topics i.e. those that dealt with conception, contraception, and STIs. This is because these topics referred to the anatomy of the male and female reproductive organs and opposite genders find it uncomfortable. This can be explained by the fact that discussion related to sex is considered taboo in both iTaukei and Indo-Fijian culture thus students find it comfortable. The view of segregating class emerges from the fact that in Fijian societies are a closely-knit society where people mostly have communal lifestyles and are related to each other and such discussion makes people uncomfortable depending on the types of relationships they share. For instance, in a classroom, a girl maybe an aunt to another male classmate, and these can make the situation embarrassing/uneasy for both. Therefore, adolescents feel more comfortable with teachers of their own gender. The issue of community dynamics coming into play whilst delivering sex education is not reported elsewhere and can be tied to the Fijian culture. A study among English secondary schools also found that all girls and one-third of the boys preferred some or all of the sex education classes to be delivered in single-sex groups (16). However, the rationale for such segregation is not explained whilst in the current study the sensitive nature of topics and cultural and community dynamics are the reasons behind segregating the classes base on gender.

Overall, the study shows a low level of knowledge about SRH amongst the students. Students could not spell out HIV/AIDS but gonorrhea too which is the most common STI in Fiji and students had difficulty explaining how such disease was transmitted. Additionally, students had limited knowledge about fertility control methods which was limited to condom and withdrawal method. This poor knowledge of SRH issues can be linked to several constraints such as teachers not fully utilizing the time provided to teach, arriving at classes unprepared, and not using a variety of teaching methods, resource

constraints and lack of effort, as the subject is not examinable. Furthermore, students may not have adequate access to relevant resources such as the internet and reference textbooks. The finding of this study does not augur well with those from other developing countries. For instance study in Ghana show that in-school adolescence was knowledgeable on SRH and exhibited in-depth knowledge about contraceptive methods (17). This difference may be explained by the implementation of SRH programs in their schools and teachers taking up classes effectively.

The study shows that all students favored school-based sex education as discussion surrounding the topic was none or limited at home due to cultural taboo. Wherever discussion took place, it was limited to topics such as courtship during teenage years and pre-marital sex thus favoring school-based sex education. School-based sex education has also been favored in other conservative societies where such discussion is found to be a cultural taboo as demonstrated by a survey in Lebanon, a more conservative society in the Arab world where 59% of the school students showed support for school-based sex education as SRH topics were not spoken about with their parents/guardians (18).

The study showed that students valued sex education as it would help them in sexual decision-making, avoiding teenage pregnancy, and in the prevention of STIs and as such looked forward to such classes. Students emphasized that they needed more information on topics such as contraception, STIs, and negotiating safe sex. Student's desire for sex education for their well-being is consistent with those found in other settings, for instance, college students in Hawaii who either missed sex education because it was not offered in their schools, as well as those that received it, mentioned that the most useful topics are birth control methods, STIs and healthy relationships (19). Similarly, secondary school students in Zambia agreed that sex education helped them acquired skills in dealing with their sexuality and knowledge about how human bodies function, dealing with t sexuality, and helped prevent teenage pregnancy and transmission of STIs. Sex education helped learners to make informed and responsible decisions about their sexuality and helped them to become responsible adults (20).

The findings of this study regarding sources of SRH information for students are in agreement with one study (21) but not with other studies (22-25). While in this study, student's main source of information was school and teachers although not comprehensively taught in a similar study in Marshall Island student's main source of information was friends or peers or parents. A possible reason students in this study would not consider friends as the main source of sexual knowledge because of the risk of being misinformed and would consider trust teachers for scientific knowledge on the subject. With a good penetration of over 47%, there is potential for using the internet as a source of SRH information in Fiji. Whilst individuals can be exposed to pornographic sites, the internet can also promote sex depending on the availability of such content that promotes safe sex or a sexual health application on a mobile phone (17).

There is a paucity of literature on the desirable characteristics of teachers from the students' perspective, however, the closest study is on English boys preferred of sex education teachers lists similar characteristics as elucidated by the current study which is students prefer teachers everywhere who are friendly, approachable, and open-minded teachers who could keep student's problem confidential. This is because of the sensitive nature of the subject and as students are transitioning from children to adolescents. Additionally, two other aspects that are different between the two studies is that in the current study students preferred a teacher from a science background and needs to be of their own gender particularly for sensitive topics whilst the UK study (26) found that boys preferred a social science teacher regardless of the gender of the teacher. The reason a teacher's gender is particularly important in the Fijian context is that discussion surrounding SRH is a taboo particularly with the opposite sex, so they need a teacher of the same sex (14) whilst it is not the case in western societies.

There was consensus amongst all study participants for SRH education to commence early, both at home and in schools. In the elementary grades, for instance, good hygiene education, "good and bad touches" could be taught, and as the year's progress by more sensitive topics could be added, such as from the onset of puberty. This was because students acknowledged an increase in teenage pregnancy, as

well as rape, and it was felt that early education was needed to reduce the vulnerability of children, particularly females as discussed above. This view is consistent with a Ghanaian study where students expressed the need to start early as they felt that school programs began too late (27).

Conclusion

The study shows that Fijian students desired a lot more from sex education than what is currently offered for sexual decision-making. Therefore, sex education must be made mandatory and comprehensive ensuring it is culture and gender-sensitive. In terms of the status of SRH education, it can be said that it is far from being universal and comprehensive for a myriad of reasons. Under the current scenario, unless rigorous efforts are made to offer a truly CSE program, it will remain difficult to arrest teenage pregnancy and high STI rates.

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