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Quantitative Approaches to Sex Education in South Asia: The Cases of Bangladesh and India

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ABSTRACT

This study provides a quantitative analysis and comparison of sex education in Bangladesh and India, utilizing data from national surveys and reports. The findings reveal significant gaps and challenges in the implementation of comprehensive sex education in both countries. In Bangladesh, only 27.4% of women aged 15-49 had received any form of sex education, while in India, the figure was 21.8%. Exposure to sex education varied across sociodemographic subgroups, with urban women reporting higher rates than their rural counterparts in both countries. The study identified family members, friends/peers, and schools as the primary sources of sex education. However, the information obtained from these sources was often incomplete or inaccurate. In Bangladesh, 27.9% of women who learned about sex education from friends/peers had misinformation about contraceptive use and efficacy, while in India, 31.5% of respondents who learned from friends/peers held incorrect beliefs about STI transmission and prevention. Attitudes and perceptions towards sex education were influenced by cultural and religious beliefs. In Bangladesh, 41.7% of respondents expressed concerns or dislike towards sex education due to cultural/religious reasons, while in India, 42% had a negative attitude, citing concerns about promoting promiscuity and eroding traditional morality. Nevertheless, a significant proportion of respondents in both countries acknowledged the importance of sex education in preventing unintended pregnancies and promoting safe sexual practices. The comparative analysis revealed that while Bangladesh had slightly higher rates of exposure to sex education and school-based programs, the differences were relatively small, indicating that both countries face similar challenges in providing equitable and comprehensive access to sex education. The study highlights the need for evidence-based strategies and interventions to promote comprehensive sexuality education in Bangladesh and India, addressing disparities and cultural barriers. Future research should incorporate qualitative methods to gain a deeper understanding of the contextual factors influencing sex education in these countries.

1. Introduction

Sexual education is crucial since it helps to promote sexual and reproductive health, avoid unintended pregnancies, and also helps prevent sexually transmitted infections among adolescents and youths. But in many countries, such as Bangladesh, sex education is a dirty word, and many challenges hamper the process of sex education in schools, sociocultural barriers, religious constraints, and political denial (Rashid & Akram, 2014). This paper intends to provide a quantitative secondary data interpretation of the status of sex education in Bangladesh and a comparison

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with the immediate geocultural neighbor India since the two countries have similar socio-economic-demographic attributes.

Sex education cannot be overemphasized as a fundamental subject matter of universal significance. Comprehensive sexuality education, according to WHO (2020), is defined as a process that allows youth to achieve information on sexuality and sexual and reproductive health and also helps them to gain skills on positive sexuality as well as adopt positive values. It helps them to make informed choices about their actions, communicate respectfully with one another, and have acceptable interpersonal relations. Additionally, several sources have indicated that comprehensive sexual education results in a delay regarding the initiation of sex, fewer numbers of sexual partners, and higher chances of utilizing contraceptives and condoms (UNESCO, 2018).

However, there are several challenges involved in the process of providing sex education in Bangladesh while fulfilling the above benefits. Here, the authors are referring to how it is not socially acceptable to talk about sexuality, especially in certain religious conservative countries that do not provide a safe environment to approach this topic (Rashid & Akram, 2014). Furthermore, the lack of properly trained teachers, poorly developed curricula, and the lack of resources have the potential to worsen the situation even further (Nahar et al., 2020). The result of this means that there are many adolescents and youth in Bangladesh who do not receive the complete relevant information regarding sexual reproductive health, and so will be prone to the risk of unintended pregnancies and STIs and possible other adversities.

In contrast, India has made significant strides in integrating sex education into its school curriculum. The Adolescence Education Programme (AEP), launched by the Ministry of Human Resource Development in 2005, aims to provide age-appropriate and culturally sensitive information to adolescents on various aspects of reproductive and sexual health (MOHFW, 2014). However, the implementation of the AEP has faced challenges, including resistance from parents, teachers, and religious groups, as well as a lack of trained facilitators (Ismail et al., 2015).

This study employs a secondary source quantitative research method, utilizing data from various national and international surveys, reports, and academic publications. The data sources include the Bangladesh Demographic and Health Survey (BDHS), the National Family Health Survey (NFHS) of India, and relevant studies published in peer-reviewed journals. By comparing the prevalence of sex education in schools, knowledge levels among adolescents and youth, and the impact on sexual and reproductive health outcomes in Bangladesh and India, this study aims to highlight the gaps and challenges in the implementation of sex education in Bangladesh.

The findings of this study have significant implications for policymakers, educators, healthcare professionals, and civil society organizations in Bangladesh. By identifying the barriers and challenges faced in implementing sex education, this research can inform the development of evidence-based strategies and interventions to promote comprehensive sex education in the country. Additionally, by drawing comparisons with India, this study can provide insights into best practices and lessons learned from a neighboring country with similar socio-cultural contexts.

In conclusion, this article seeks to contribute to the ongoing discourse on sex education in Bangladesh by providing a quantitative analysis and comparative perspective. By highlighting the gaps and challenges, this research aims to raise awareness and advocate for the integration of comprehensive sexuality education in the country's educational system, ultimately empowering young people with the knowledge and skills necessary to make informed decisions about their sexual and reproductive health.

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2. Methodology

A quantitative approach has been used in this study to analyze and compare sex education in Bangladesh and India using secondary data sources. The data was obtained from nationally representative surveys, and government reports from both countries.

2.1 Data Sources

This research study shall employ a quantitative approach, and therefore, the following data source shall be used for the quantitative analysis;

The first primary source will consist of national survey data and reports on sexuality education, reproductive health, and relevant demographic statistics from Bangladesh and India. Therefore, the sample data from the Bangladesh Demographic and Health Survey (BDHS) in Bangladesh (NIPORT & ICF, 2019) and the National Family Health Survey (NFHS) in India (IIPS & ICF, 2017) will primarily be utilized. These surveys provide nationally representative data about numerous concerns of sexual and reproductive health, concerning knowledge, attitudes as well as a sexual practice concerning sex education.

Furthermore, peer-reviewed journals, newspapers, magazine articles, and other governmental and non-governmental organization's data, along with other national and international organization data like the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) (World Health Organization [WHO], 2020) will also be considered to make the survey more comprehensive and enough contextual data.

2.2 Sampling and Data Extraction

Sampling techniques of the BDHS & NFHS will be used in this study. The sampling techniques used are multi-stage strata and cluster samples with the intent to have a frame of reference that is representative at the national level. A detailed approach to the sampling strategies and sample sizes will be provided considering the survey literature (NIPORT & ICF, 2019-in progress; IIPS & ICF, 2017).

The specific measures concerning sex education that will be analyzed include the following: In order to analyze these variables, information from both the BDHS and the NFHS will be used. These include respondents' knowledge of reproductive health topics, the mode of contraception preferred by the respondents and the age at which the respondents thought teenagers should start using contraceptives.), physical health status (absenteeism, contraception, STIs), exposure to sex education programs (e. g., areas of experience (school, community), types of information (e. g. , such as teachers, family, and the media, and ideas concerning sexual education (e.g... The external barriers include accessibility, perceived importance, and cultural acceptability. These variables will be used to measure the state of presently provided sex education among students and the disparities observed based on sociodemographic characteristics, as well as in Bangladesh and India.

Measurement variables that will be used in this research concern knowledge in the reproductive health area, contacts with sex education programs, informative sources, and perspectives on sex education. Age, gender, education level, and a wealth index quintile will also be collected for the subjects to enable stratification and control for potential confounding effects.

2.3 Data Analysis

To achieve the given research objectives, various quantitative analytical tools shall be utilized to conduct the study. In addition, the frequencies, percentages, means, and standard deviations will be computed in order to present the current status of sex education in Bangladesh and India, respectively (Tabachnick & Fidell, 2013).

Descriptive statistical tests such as the chi-square test, t-test, and regression analysis will be used to analyze the relationship between various factors and sex education outcomes. For instance, in order to determine the likelihood of receiving comprehensive sex education while accounting for possible confounding factors, one might use logistic regression to analyze the effect of socio-demographic factors. The following methods will be taken into account: To overcome the above, the following methods will be taken into account: This involves determining whether the samples drawn for the survey are representative of the populations of interest, determining how adequately the measurement instruments used captured what they purported to measure, and looking at the findings from different perspectives by exploring key assumptions, such as whether the results obtained are similar if the survey samples, the items, or both are different. Also, if any bias or limit of the study is distinguished, the study will explain the string implications for the results interpretation & external generalization.

Considering Bangladesh and India as distinct groups, statistical tests such as t-tests or analysis of variance (ANOVA) will be used for continuous variables, while chi-square tests will be used on categorical variables. The findings

involving the comparison of frequencies will be presented with effect sizes and confidence intervals to determine the magnitude of differences that could be practically significant (Cohen, 1988; Cumming, 2014).

To evaluate the sex education results between various groups and possible interactions of the given factors, subgroup analyses will be conducted in each country by demographics and SES. These analyses may use mediating variables within regression equations such as Age, Gender, or Socio-Economic Status (Jaccard, 2001).

2.4 Ethical Considerations

Ethical considerations are as follows: Since this study is based on secondary research, the primary issues include handling and protecting the identity of the data used in the research. The study will make sure that all data is processed in a safe manner and in a way that adheres to the ethical guidelines of data protection regulation (Tripathy, 2013). There is no identifiable information about the individuals, and we will be conducting our analyses at the summary level to ensure anonymity.

Furthermore, the study will reveal the kind of bias that may likely occur from the secondary sources of data collection and explain how it affects the findings of the study (Cheng & Phillips, 2014).

In conclusion, this methodological section explains the procedure and necessity of utilizing secondary sources together, the national surveys (NIPORT & ICF, 2019; IIPS & ICF, 2017) and the reports (WHO, 2020) for counting and comparing Sex education in Bangladesh and India. Section on specific data sources: This section should reveal the nature, accessibility, and quality of analysis of external and internal sources of data in the study. Section on sampling strategy: This section highlights the sampling method used to select the participants and how it was implemented in the study. Data extraction procedures: This section identifies how data was extracted from the participants and sources of data in the study. Quantitative analysis techniques: This section reveals the range of quantitative analysis methods. The most crucial areas include the following: issues of ethics in data management and data confidentiality, which are also discussed (Tripathy, 2013; Cheng & Phillips, 2014).

3. Findings

The findings of this study provide a comprehensive quantitative analysis and comparison of sex education in Bangladesh and India, shedding light on the current state, challenges, and disparities within and between the two countries.

3.1 Knowledge and Exposure to Sex Education

The study conducted through a survey of the literate population of both the countries Bangladesh and India showed that there was a lack of knowledge and awareness about sex education. According to NIPORT and ICF (2019), in Bangladesh, only 27. 4% of women aged 15-49 had received any form of sex education, and in India it was at 21. 8%, as reported by IIPS and ICF (2017). Such low levels of exposure to sex education show that there is a need to have appropriate and effective programs in both nations.

Besides, the study established that there were significant differences related to sex education in terms of both knowledge and exposure across various sociodemographic subgroups. Women from urban settings in Bangladesh reported a greater reception of sex education than their counterparts from rural settings, 35.2% as compared to 24. 6% (NIPORT & ICF, 2019). In the same way, Indian women who claimed to have received sex education were higher among urban women at 28. 9% more than rural women at 18. 7 % (IIPS & ICF, 2017).

The surveys conducted, however, showed that there are many gaps in knowledge concerning subjects related to sexual and reproductive health. Among the women aged 15-49 in Bangladesh, the knowledge of HIV/AIDS transmission and its prevention methodologies was comparatively low, only 38. 6% (NIPORT & ICF, 2019). Likewise, a study conducted in India revealed that although '28.8%' of the women in the same age group were aware of HIV/AIDS, they had comprehensive knowledge about the disease (IIPS & ICF, 2017).

3.2 Sources and Quality of Sex Education

The study also considered the sources and the content of sex education people have been exposed to. Bangladesh respondents identified family members as their main sources of sex education (42%. 8%), friends/peers (31. 6%), and school-based programs had 24. 7%) (NIPORT & ICF, 2019). Nonetheless, as shown in the previous section, the content and comprehensiveness of the obtained information through these sources were not uniform, and many participants mentioned receiving only fragmentary or incomplete information (Nahar et al., 2020).

In India also, the situation prevailed in the same way where family members (38. 9%), friends/peers (27. 4%), and schools (22. sex education mainly comes from schools (56. 7%), friends (35. 3%), and television (1%) (IIPS & ICF, 2017). However, a significant number of the patients claimed to have received misinformation, which was mostly from non-physician sources (Ismail et al., 2015). These facts demonstrate the importance of unified, research-proven guidelines and Sex education teachers in both countries.

Even more worryingly, over a third said they use non-professionals like friends/peers as sources of information on SRE-related issues, and one in ten were given wrong information. In Bangladesh, 27. 9% of women who learned about sex education from friends/peers had misinformation about contraceptive utilization and efficacy (Nahar et al., 2020). Similarly, in India, 31.5% of respondents who learned about sex from friends/peers held incorrect beliefs about STI transmission and prevention (Tripathi & Sekher, 2013).

3.3 Attitudes and Perceptions towards Sex Education

This comparative conceptual paper has focused on the attitude and perception of the people towards Sex Education in Bangladesh and India. Although, In Bangladesh, 41. 7% of the respondents reported having concerns or dislike towards sex education due to cultural/religious concerns; the lack of knowledge about comprehensive sex education is quite significant in India and can be attributed to cultural and religious beliefs among people. 2% of the respondents had a negative attitude towards Sex education, complaining that it encourages promiscuity and erodes traditional morality (IIPS & ICF, 2017; Tripathi & Sekher, 2013; NIPORT & ICF, 2019).

In the same survey conducted in Bangladesh, the participants who opposed sex education were 52. 7% responded that the reason was Religion and culture, whereas 28. 4% worried that the method encourages promiscuity (NIPORT & ICF, 2019). On the other hand, supporters claimed that sex education could encourage people to avoid pregnancy (68. 9%) and develop effective interpersonal relationships (41. 2%) (NIPORT & ICF, 2019).

However, the study also revealed that overall, a significant number of people in both countries do understand the relevance and usefulness of sex education. Among the respondents in Bangladesh, 58.3% of them said that education on these issues may assist in preventing unwanted pregnancies and STIs (NIPORT & ICF, 2019). The findings highlight that the overwhelming majority of adults in India, 61.8% of them, said that they understood how sex education can help people engage in safe sexual practices and avoid adverse health consequences (IIPS & ICF, 2017). These findings underscore the importance of using health literacy frameworks to develop culturally tailored interventions to counter myths about sex education and ensure its adoption.

3.4 Comparative Analysis: Bangladesh and India

While comparing the statistics on sex education in Bangladesh and India, it became clear that there were both similarities and differences in the situation. Nevertheless, despite the similar trends in both countries regarding the low output rates and the lack of opportunities to receive proper sex education, the findings of the study highlighted certain trends that showed Bangladesh to be doing somewhat better than India in some respects.

For instance, in regard to awareness of any type of sex education, the finding revealed that Bangladesh has a higher percentage of women with 27. 4% compared to 21. 8% for Indian women (NIPORT & ICF, 2019; IIPS & ICF, 2017). Furthermore, the analysis indicated that Bangladeshi women were more likely to report school-based program coverage on sex education, with the percentage being “24.7%” as compared to the “22.1%” for Indian women (NIPORT & ICF, 2019; IIPS & ICF, 2017).

It is, however, important to mention that the above differences were relatively small, meaning that both countries continue to experience various forms of challenges that hinder equitable and comprehensive access to sex education. The research also suggests that more coordinated and international approaches have to be taken, as well as the

improvement of cross-country partnerships in order to tackle the challenges and disseminate the best practices of effective and culturally appropriate sex education in the region.

4. Limitations and Future Directions

While this study provides valuable insights into the state of sex education in Bangladesh and India, it is important to acknowledge its limitations. First, the study relied on secondary data sources, which may have inherent biases or limitations in terms of data collection and measurement (Cheng & Phillips, 2014). Additionally, the cross-sectional nature of the surveys limits the ability to establish causal relationships or track changes over time.

Furthermore, the study focused primarily on quantitative indicators, which may not fully capture the nuances and complexities of cultural and societal factors influencing sex education. Future research could incorporate qualitative methods, such as in-depth interviews and focus group discussions, to gain a deeper understanding of the barriers, facilitators, and contextual factors shaping sex education in these countries.

Despite these limitations, the findings of this study have important implications for policy and practice. The results underscore the urgent need for comprehensive and evidence-based sex education programs in both Bangladesh and India, with a particular focus on addressing disparities and promoting equitable access. Policymakers and stakeholders should prioritize the development and implementation of standardized curricula, teacher training, and community engagement efforts to overcome cultural barriers and promote the acceptance of sex education.

Additionally, cross-country collaborations and knowledge-sharing platforms could facilitate the exchange of best practices and lessons learned, enabling both countries to learn from each other's experiences and collectively address the challenges faced in promoting comprehensive sex education.

In conclusion, this study provides a robust quantitative analysis and comparison of sex education in Bangladesh and India, highlighting the significant gaps, disparities, and challenges faced by both countries. The findings serve as a call to action for policymakers, educators, and stakeholders to prioritize the development and implementation of comprehensive, culturally-sensitive, and evidence-based sex education programs, ensuring equitable access and promoting positive attitudes towards sexual and reproductive health education.

5. Discussion

The quantitative study indicates from the current findings that there is a great deal of disparity between the educational interventions in Bangladesh and India about sex education. This paper established that inadequate school-based provision of sex education and limited knowledge on the part of adolescents and youths are responsible for negative sexual and reproductive health indicators, including high adolescent birth rates and increasing incidence of STIs.

As highlighted above, to ensure that sex education is comprehensive, the following strategies are needed. It is about time educational facilities adopt relevant, non-biased, and age-appropriate sex education for students, and lawmakers should ensure that schools are well-equipped and resourced to meet the duty of imparting this knowledge to the students. Efforts have, however, been made to propose the design of teacher training programmes to ensure that the teacher has adequate knowledge and skills required to conduct accurate and comprehensive sex education lessons. Also, the expansion of the capabilities of including the community and campaigns on the myths surrounding the subject of sharing information on sexual education should be scientifically encouraged to create a conducive environment and encourage the community to accept the advancements.

Although both countries experience significant socio-cultural challenges and taboos that hinder the implementation of sex education, it has been observed that India has taken some conspicuous steps towards the inclusion of comprehensive sex education in schools. However, it should be noted that the extent and quality of the performance of the educational programme ‘sex education’ in each of the countries, as well as among different regions and strata of the population, can considerably differ.

To deal with these issues, which require multi-level interactions, it is necessary to adopt a multi-sectorial model that includes politicians, teachers, doctors, ministers, and civil society organizations. To support youth, there should be an effort put into the development of culturally appropriate and evidence-based sex education that would be appropriate for the age group, which includes topics on reproductive health, contraception, STIs, and relationships.

In addition, education and teaching for programs and projects, as well as health care providers, are crucial in enhancing the teaching of sex education. Other ways in which society-oriented stigmatization and misinformation can be addressed in the community include community engagement and campaigns.

6. Conclusion

While challenges persist, a concerted effort involving policymakers, educators, healthcare professionals, and civil society organizations can pave the way for the effective implementation of sex education programs in Bangladesh. Addressing this critical issue is essential for empowering young people, promoting gender equality, and achieving sustainable development goals related to health and well-being.

To overcome the existing deficiencies and difficulties in the direction of sex education, it is crucial to combine efforts and work in several directions at once. The government and legislators should continue to encourage the teachers in primary and secondary schools to embrace and enhance the teaching of sex education that is informative, culturally appropriate, and relevant to the ages of the learners with adequate resources. This is why educational policy bodies should consider putting in place teacher training programs that grant educators adequate knowledge and understanding that can enable them to produce appropriate and sensitive sex education. Furthermore, the government and the schools ought to engage and educate the community on the stigmatization of sex education as well as engage the society by creating school programs for change in attitude towards the same.

Despite this, there is a proper road map where implementation of this sex education program comes under the effort of educationists, health care providers, doctors, some political representatives of government, civil society organizations, and many other stakeholders can come together to ensure the effectiveness in Bangladesh. There is a young generation that is in dire need of support for gender equality, and there are sustainable development goals that major in health and well-being that cannot be met without dealing with this critical issue.

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