

RESEARCH BRIEF

# Teachers' Perspective on Sexual Health and Relationship Education in Northern Prefecture in Japan: A Qualitative Study

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Sexuality education is a lifelong process that begins at birth. Parents, family, peers, partners, schools, religion, and the media influence the messages people receive about sexuality at all stages of life (Reis & Seidl 1989; Ansuini, Fiddler-Woite, & Woite 1996; Walker & Milton, 2006). Therefore, in today's world, comprehensive school-based sexuality education that is appropriate to students' age, developmental level, and cultural background should be an important part of the education program at every grade. A comprehensive sexuality education program will respect the diversity of values and beliefs represented in the community and will complement and augment the sexuality education children receive from their families, religious and community groups, and health care professionals (Milton, 2000). Thus, the main goal of sexuality education is the promotion of sexual health by providing learners with the opportunities to develop a positive and factual view of sexuality and sexual health (Breuner & Mattson, 2016). Borawski et al. (2015) identified the effectiveness of school-based health education offered by both classroom teachers and nurses. However, educational programs at schools

for preventing STIs have often been implemented in many different ways (Mason-Jones et al., 2016).

In Japan, sexual health and relationships education (SHRE) was adapted in 1948 as part of health and physical education. Young people in the period of secondary or high schools will need adequate and appropriate information and assurance about their physical and mental changes since young people are exposed to information related to sexuality from mass media which have much stronger influence (Escobar-Chaves et al., 2005; Landry, Turner, Vyas, & Wood, 2017). In Akita Prefecture in Japan, for example, the effectiveness of school-based SHRE is reported in the context of teenage abortions (Someya, 2015). However, the current school-based SHRE in many places in Japan has been unsuccessful given the steady high cases of teenage abortions and STIs among young people. According to the Ministry of Health, Labour and Welfare, STDs have remained relatively steady in the past 10 years from 2007 to 2016 in Japan (Figure 1). The most common are chlamydia, gonorrhea, herpes, and condyloma acuminata. The prevalence by age for genital chlamydia is the third highest for women aged

15–19 indicating that the infection rate in the teens is relatively high (“Number of sexually transmitted diseases,” 2017). Japanese Foundation for Sexual Health Medicine reported that the number of young people who have had their first sexual experience in their teens had been decreasing since 2005 (“Sexual behaviours and contraceptive use,” 2017). However, the abortion rate (the number of abortions per 100 pregnancies) is the highest for women younger than 20 years of age. Some 60% of teenage pregnancies end in abortion in Japan (Ishiwata, 2011).

Although the reasons for such negative impacts of the school-based SHRE are not fully known, several barriers and issues have been discussed: teachers' variables such as age, gender, levels of knowledge, attitudes, skills, local social norms, religious beliefs, and cultural traditions (Iwu, Onoja, Ijioma, Ngumah, & Egeruoh, 2011). Therefore, this study aimed to assess issues of current school-based SHRE and challenges, difficulties, and barriers of teachers delivering SHRE.

**Methods**

A randomly selected 22 teachers drawn from 13 schools in the K Sub-prefecture, Northern Japan were requested to complete a survey, with response rate being 81.8%.

Semi-structured in-depth interviews were conducted in June 2012. Two interviewers from study members were trained to respect the confidentiality of the participants. At the beginning of an interview, study objectives and procedures were explained to the participants. The interview is comprised of five parts: 1) demographic information such as age, gender, marital status, and teaching experiences; 2) current situations of SHRE; 3) their perceived barriers to teaching SHRE; 4) their learning/training experiences and its influence on their current teaching strategies; and 5) future needs using the interview note shown in Table 1. The interviews were held in Japanese and lasted for 1.5–2.0 hours. The discussions were tape-recorded and transcribed.

The transcript of the interview was analyzed by means of inductive formation of categories from the texts. The core categories were created in agreement with constant comparison method. Story lines were molded by the extracted categories, with analysts ensuring that these categories and storylines did not distort the participants' meanings.

Informed consent was obtained from all of the participants. The survey was approved by each school's top officials. Ethical clearance was granted by the Ethical Review Committees of the Hokkaido University Graduate School of Medicine.

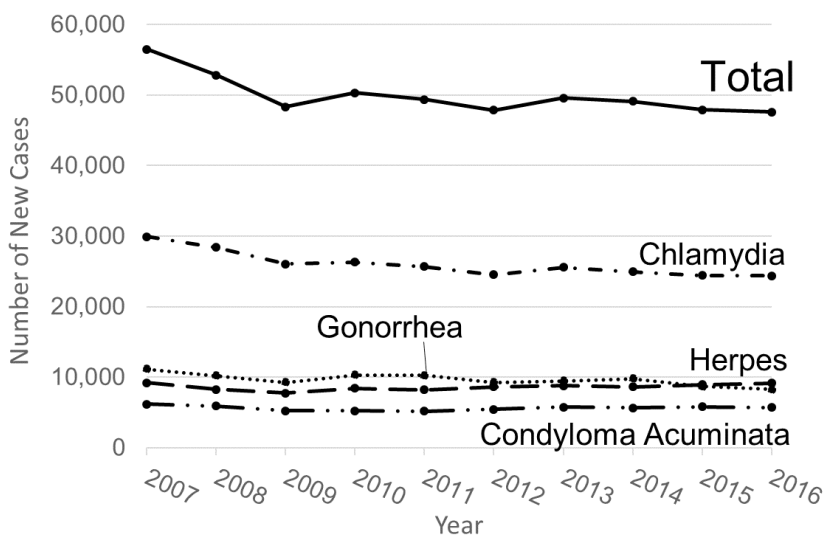


Figure 1. Trends of yearly cases of sexually transmitted diseases in Japan, 2007–2016.

**Table 1**  
*Interview Guide*

1. How important is SHRE in Health education (at school)?
✓ What is the main theme/goal of SHRE at your school (or from the point of your view)?
2. What are the most and least difficult topics to be handled?
✓ Why do you feel so?
▪ Personally? Environmentally?
✓ What are your efforts on them?
3. What kind of supports do you need in the future to improve your SHRE?
✓ What do you think makes teachers and future teachers more comfortable and easier to deliver SHRE?

**Table 2**  
*Respondents' Characteristics*

ID	Gender	Age Category	Marital Status	Teacher's Temure (years)*	Teacher's SHRE (years)*	Main Subject Area**	Working Experiment †	Currently Working †
T1	male	40–49	Married	19	19	HP	E, J & H	H
T2	female	50–59	Married	36	30	SN	H only	H
T3	male	30–39	Married	15	15	HP	H only	H
T4	female	40–49	Married	26	26	HE	J only	J
T5	male	40–49	Married	20	20	HP	H only	H
T6	male	30–39	Married	16	16	HP	J & H	H
T7	male	40–49	Married	25	16	HP	E & J	E
T8	male	40–49	Married	20	20	HP	H only	H
T9	male	30–39	Married	15	15	HP	H only	H
T10	male	20–29	Unmarried	4	0	HP	CT	CT
T11	male	40–49	Married	21	21	HP	J & CT	CT
T12	male	30–39	Married	10	10	HP	J & H	J
T13	male	30–39	Married	15	10	HP	E & J	J
T14	male	50–59	Married	28	18	HP	J only	J
T15	male	40–49	Married	18	3	HP	J only	J
T16	female	40–49	Married	24	24	SN	E & J†	J†
T17	female	40–49	Married	18	10	M	J only	J
T18	female	20–29	Unmarried	5	1	SN & HP	J & H	U

Note. \* As of March 2012.

\*\* HE: Home Economics, HP: HP Education, M: M, SN: SN.

†E: Elementary School, J: Junior High School, H: High School, CT: College of Technology, U: University.

†† Elementary through Junior high school.

## Results

### *Socio-Demographic Characteristics*

Table 2 summarizes the socio-demographic and work characteristics of the participants. The mean age category of participants was 40–49, with 50% of teachers making this selection. More males ( $n=13$ , 72.2%) participated than females ( $n=5$ , 27.8%). The range of teaching experience and teaching SHRE at schools in years were 4–36 (minimum to maximum) and 0–30 respectively. Most of the participants have been teaching SHRE less than their teaching experiences and about a half were teaching it for less than 15 years.

### *Current School-Based SHRE*

Current situations of SHRE were summarized in the contexts of who teaches, what are taught, and how it is implemented at schools.

**Who teaches.** In most junior and high schools, physical and health educators are teaching SHRE in a classroom. School nurses, called *Yogo* teacher in Japan, who possess a teacher's license but not registered nurses, are also involved when they had a special lecture and merely deliver SHRE in a classroom. In contrast, persons in charge varied at elementary schools. Class teachers in different majors have the responsibility to give SHRE especially at small schools in rural areas, where such schools tended to have no physical and health educators and school nurses.

**How it is implemented.** In this study, all of the schools use the co-education model rather than single-sex education. A participant noted the biggest advantage of co-education—it allowed them to communicate with the opposite gender on a frequent basis where everything in this world involved girls and boys.

At elementary schools, SHRE was taught during the time of either morality, homemaking (home economics), comprehensive education, or special activities. Junior and high school students spend very little time during physical and health education at junior high schools, and health education which is a core once a week in high schools: a median total of three hours. Especially at high schools, SHRE was taught only in

the first grade. Among all the participants, their schools were also involved in a special lecture presented by public health nurses once a year.

**What are taught.** The primary goals of school-based SHRE were either 1) to help students respect others, 2) to delay the onset of sexual activity, and 3) reduce the frequency of sexual activity and number of STIs, not just the promotion of sexual health, the participants noted. More than a half of the participants answered that the contents that should be taught were curriculum-based, whereas about half of them were not directly referring it. In addition, the teaching contents were left entirely to each teacher and the coverage also varied, which may have great impacts on later students' knowledge levels.

### *Teachers' Perceived Barriers*

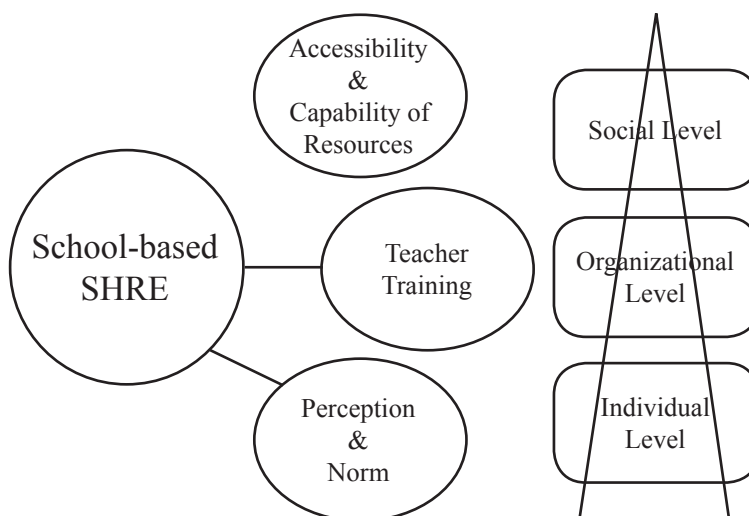
There were three main issues found on the school-based SHRE: accessibility and capability of resources, communication barriers, and inadequate teacher training toward SHRE (Figure 2). Additionally, some of important quotes from interviewees were listed in boxes.

**Accessibility and capability of resources: Time and Material (Table 3).** First of all, the most reported were time-related issues. Almost all of the participants claimed that they lack the time for 1) preparation, 2) lifelong learning, and 3) fulfillment of the curriculum. Half of the participants also claimed a lack of teaching materials. There is a limitation what teachers themselves can find resources: reference materials, textbooks, and visual aids. Comprehensive SHRE teaching kits will provide resources to help gain accurate information about safer sex and contraceptive methods; to discuss safer sex in their relationships; to see and handle contraceptives; and to learn about how STIs are spread, how to avoid them, and how to treat them. Thus, the previous study showed that students strongly favored a presentation style that was open, honest, comfortable, and nonjudgmental, and they believed teachers should be specially trained in this area.

**Communication barriers (Table 4).** An increase of open communication between the students and teachers on a daily basis helped teachers be more comfortable in talking about sensitive topics, a participant noted.

Most of the participants emphasized the importance of parents' involvements, especially the mother. Almost all of the participants expressed that they received enough understandings and supports from their colleagues; however, they merely cooperated with the teachers in different subject areas. Furthermore, teachers with the same area discussed about their progress but hardly shared their teaching methods and materials, which sometimes led a lack of information.

**Inadequate teacher training (Table 5).** Some of the teachers neglected that they might not have enough knowledge on sexuality as well as techniques to express such sensitive messages to students. Most of the participants had a slight memory what they have learned how to deliver SHRE in the past. Thus, even after becoming a teacher, they have less opportunity to take such kinds of training for SHRE.



**Figure 2.** Three dimensions and levels of teachers' perceived barriers on SHRE.

**Table 3**

*Accessibility and Capability of Resources: Time and Material*

<p>(Time)</p> <p>“I want to attend a seminar... but no time since I’m a coach of...I have to develop and evaluate teaching materials.”</p> <p>“We have a syllabus but never completed...not enough time to deliver all the necessary info...”</p> <p>“SHRE is no longer priority issue...since the subjects to be covered in Health &amp; Physical Education are broader than ever...if I have more time, I would like to spend more time for it.”</p> <p>“I have a lot of things that I want to cover but the current curriculum doesn’t allow me”</p> <p>(Material)</p> <p>“I cannot find the better or best materials which fulfill students’ needs”</p> <p>“I am using materials which previous teachers left.”</p> <p>“I check TV programs as long as I can and buy DVD by myself.”</p> <p>“Teachers in the same grade level work together but use different teaching materials and methods...”</p>
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**Table 4***Communication Barriers*

<p>(Student–Teacher)</p> <p>“Educating students about this sensitive subject needs to be a balance between what they want to learn or to be interested, and to develop a good relationship because students shows refusal attitude to receive such information from the outsiders.”</p> <p>“Some students show refusal behaviors.”</p> <p>(Student–Parent) (Teacher–Parent)</p> <p>“Urgent need for ‘parental education’ which has stronger influences than my message...”</p> <p>“We distribute HOKEN DAYORI (a health bulletin) to parents but there is no collaborative activity to education both students and parents at the same time (at junior and high schools).”</p> <p>“The mother–daughter sex talk is rarely straightforward. But, parent–child communication about human papillomavirus (HPV) vaccine may provide parents with the opportunity to talk with their daughters. We should make the best use of this chance.”</p> <p>(Teacher–Teacher, School Leader, and Professional)</p> <p>“We check our progress time to time for examination. But I don’t know what kind of materials other teachers use. Please tell me more effective or comfortable ways to deliver SHRE, if any.”</p> <p>“We are well cooperating even with teachers in different fields but the most problem (at high schools) is I don’t know what students have been learnt at primary schools. In that case, it sometimes wastes of time to duplicate the contents.”</p> <p>“Most of the time, only school nurses receive info on SHRE training... not to health teachers...”</p> <p>“Senior teachers and some organizations have the concept of ‘don’t wake up sleeping babies’...”</p> <p>“If there are any organizations or professionals undertake a research or possess the latest information, I would like to share them. Where/who should I reach to?”</p> <p>“In many small rural primary schools, there is no health and physical teacher or school nurse. If there were human resource dispatch services from a local government. ”</p>
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**Table 5***Inadequate Teacher Training*

<p>“I didn’t receive any SHRE when I was in a college, so I had difficult time to develop my own way.”</p> <p>“I didn’t like to use technical terms... until I got used to it...”</p> <p>“I’m basically a physical teacher. I actually don’t like to teach health (as a whole).”</p> <p>“I always collect information by myself most of the time from the internet. Thus, my current teaching methods are all experience-based. I ask my wife.”</p> <p>“I’m sometime afraid of encouraging young people to commit too-early sexual activity...”</p> <p>“It’s even difficult to evaluate students’ study achievement and my lectures’ effectiveness”</p>
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## Discussion

Physical and health educators usually teach sexual health and relationships education (SHRE) in a classroom although many studies have been discussing that school nurses are considered as key persons for SHRE. Although co-education has been the subject of widespread discussion for some time in the past and many schools in other developed countries adapt single-sex education in recent years for this subject (Strange, Oakley, Forrest, & The Ripple Study Team, 2003; Jackson, 2010), most of the participants supported co-education model as it helps to understand and have no misunderstanding between girls and boys.

A researcher also pointed out that co-education develops much-required confidence in them, and they do not hesitate or hold back later in their lives (Robinson & Smithers, 1999). SHRE tended to consist of didactic lectures about basic anatomy and physiology when teachers felt uncomfortable in a classroom. For years, many schools have been relying on outside experts to teach sensitive subjects such as pregnancy prevention and contraceptive use. However, this study found that students learn more about such issues when taught by their regular classroom teacher because students can be more inclined to learn life-changing behaviors from someone they know and trust. Strong student-teacher relationships have been linked to many positive outcomes, including better behavior in classrooms and improvement in learning (Buston, Wight, Hart, & Scott, 2002). Therefore, teachers should also set a positive classroom climate in which students feel comfortable learning about and discussing this sensitive subject.

The Ministry of Education, Culture, Sports, Science and Technology (MEXT) currently emphasizes that SHRE should be taught as a part of life skill education which is among the topics the yearlong health course addresses; however, not all students at schools in the K sub-prefecture receive that wide scope in SHRE. Relating material to students' lives and using a discussion format were also considered essential to effective sexuality education (Eisenberg, Wagenaar, & Neumark-Sztainer, 1997). It is already known that the most interactive conversations take place between mothers and daughters (Lefkowitz, Sigman, & Au,

2000); however, a previous study among American teens revealed that only half (50%) of them have this type of conversation with their parents (Jaccard, Dodge, & Dittus 2002; Noone & Young, 2010). Administrators and school leaders used to perceive parents as a major barrier to the introduction of more formalized SHRE (Reis & Seidl, 1989); however, all of the participants agreed that responsibility for SHRE should be shared by the school and the home. Since school and community values toward SHRE differ, SHRE also begin at home.

Lack of time is an important barrier to full implementation (Buston et al., 2002). Since SHRE covers the broad topic areas especially at junior and high schools with its sensitiveness, teachers are spending more time criticizing which materials and information should be delivered in a classroom. Furthermore, curriculum reform both in general and in specific areas of health and physical education required teachers more lifelong learning in sports training methods and sports health with a certificate system, which resulted in reducing time spend for learning on SHRE.

Even the contents to be covered in health and physical education were broader than ever. Teachers feel they do not have the training or confidence to deliver the information properly. Poorly trained teachers are often too shy to teach sex education and they often lack a strong, long-term commitment to teach the topics (Haignere, Culhane, Balsley, & Legos, 1996; Helleve et al., 2009; Mkumbo, 2012).

Currently, teachers are not required specialized training on this subject; however, when teachers are well-trained in SHRE and the specifics of how to teach some of the very sensitive topics, it may also increase teachers' confidence.

## Conclusion

This study reviewed the current school-based SHRE and teachers' perspectives in the K sub-prefecture through the semi-structured interview study. The results show that most of the schools are implementing SHRE in different ways with different perceptions. Some teachers have clear goals and student achievements in terms of acquiring necessary knowledge. Some still

have unclear objective on each topic. In conclusion, a number of issues and reflections which needs urgent actions from school leaders, health professionals, and the teachers currently and in near future working in this area:

### Overall

How can these findings be further used to strengthen the approach to SHRE, particularly in small schools with many limitations which still have to make further progress? Since only 18 teachers from the small district participated in this study, there is a limitation of generalization. With other schools, prefectures or countries making more headway than others, what are the common barriers or challenges in implementing SHRE that could be addressed through cross-school, nation, or country collaboration? Where should it be started: personal level, organization level, or national level?

### Resources

How can we manage limited time? Access to a wide range of resources is essential for teaching a sexuality and relationships education program. At a minimum, resources and support material should be provided to key organizations and institutions while education kits should be designed to simplify the task of teaching students. What resources do teachers require? Which organization can take such responsibilities? It also has to consider the students' development and level of knowledge and should be aware of teachers' comfortableness and views on these resources, thus, successful SHRE programs should have common elements that can be adapted to various cultural situations. For example, a variety of information and teaching materials are available on the web nowadays which are without critical reviews and inspections by professionals.

### Network

Student–teacher, student–parent, parent–teacher, and teacher–community interactions are vital elements of successful SHRE. These ensure that students feel comfortable to express ideas, ask questions, and explore topics in an atmosphere of respect. Only a

very small number of the participants highlighted the importance of research on students' behaviors and teaching methods in this particular subject. Is there a need for a priority research agenda for them? How could they be put in place? Who can be involved?

### Teacher Training

This study identified a number of areas that do not get much attention in teacher training at a college. This includes monitoring and evaluation, mainstreaming of college curricula across education systems, advocacy, strengthening of policy and legislation, and the promotion of teacher training. Does the lack of attention to these issues reflect overall weaknesses in education systems? What can be done to strengthen education policies and plans to ensure that these areas get sufficient attention?

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