

American University in Cairo

AUC Knowledge Fountain

Theses and Dissertations

6-1-2019

Assessment of needs and barriers to sex and gender education among social workers in Egypt

Germeen Riad

Follow this and additional works at: <https://fount.aucegypt.edu/etds>

Recommended Citation

APA Citation

Riad, G. (2019). *Assessment of needs and barriers to sex and gender education among social workers in Egypt* [Master's thesis, the American University in Cairo]. AUC Knowledge Fountain.

<https://fount.aucegypt.edu/etds/763>

MLA Citation

Riad, Germeen. *Assessment of needs and barriers to sex and gender education among social workers in Egypt*. 2019. American University in Cairo, Master's thesis. *AUC Knowledge Fountain*.

<https://fount.aucegypt.edu/etds/763>

This Thesis is brought to you for free and open access by AUC Knowledge Fountain. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of AUC Knowledge Fountain. For more information, please contact mark.muehlhaeusler@aucegypt.edu.

The American University in Cairo
School of Humanities and Social Sciences

Assessment of Needs and Barriers to Sex and Gender Education among Social Workers in
Egypt

Thesis Submitted to
Department of Psychology
In partial fulfillment of the requirements for
the degree of Master of Arts in Community Psychology

By Germeen Riad

Under the supervision of Dr. Carie Forden

January/2019

Table of Contents

Acknowledgment	5
Abstract	6
Issues Impacting Sexuality and Sex Education in Egypt	8
The Culture of Silence	8
Media and Sex Education	11
Family, Sexuality and Patriarchy.....	13
Gender-Based Violence	15
Sex Education	19
The Need for Sex Education.....	19
Sex Education Initiatives in Egypt	21
Sex Education Approaches.....	24
The Role of Social Workers in Sex Education	25
Research Question	26
Methodology	27
Survey.....	27
Semi-Structured Interviews	29
Ethical Considerations	31
Results	31
Survey	31
Misconceptions and Knowledge.....	31
Gender Equality.....	33
Gender Roles.....	34
Double Standard.....	35
Gender-Based Violence.....	36
Beliefs about Sex Education and Comfort with Talking about Sex.....	37
Barriers to Sex Education.....	38
Sources of Sex education.....	39
When and What to Teach.....	40
Interviews	40
Theme 1: Importance of Sex Education.....	40
Theme 2. Barriers to Sex Education.....	42
Theme 3: Common Problems Encountered and Misconceptions.....	44
Theme 4. Gender, Sex and Sexuality.....	49
Theme 5. Gender-Based Violence.....	51
Theme 6. Recommendations for Sex Education Curriculum.....	57
Discussion	58
Misconceptions About Sexuality	58
Menstrual Blood and Stigma Around Women's Bodies.....	60
Poor Knowledge about anatomy, female sexuality and FGM/C.....	60

Attitudes toward Gender and Gender-Based Violence.....	62
Gender Ideology, Inequality and Violence.....	65
Religion's Role in Sex Education.....	66
Importance of Sex Education.....	67
Barriers to Sex Education.....	68
Recommendations for the Sex Education Curriculum.....	69
Limitations and Suggestions for Future Research.....	71
Conclusion	72
References.....	73
Appendices	82
Appendix A – English consent form.....	88
Appendix B- Arabic consent form.....	89
Appendix C- Interview questions	90
Appendix D- Survey in English.....	91
Appendix F- Interview questions in Arabic.....	94
Appendix E- Survey in Arabic.....	95

List of Tables

Table 1: Survey participants sample demographic data	28
Table 2 : Interview participants sample demographic data	30
Table 3: Results of the Survey about misconceptions about sex	32
Table 4: Survey results gender, marital status and misconceptions about sex	33
Table 5: Results of the Survey about Gender equality	33
Table 6: Survey results gender, marital status and gender equality.....	34
Table 7: Survey results attitudes towards gender roles.....	34
Table 8: Results of the Survey gender, marital status, and attitudes towards gender roles	35
Table 9: Results of the Survey about gender double standards	37
Table 10: Results of the Survey about gender-based violence	38
Table 11: Results of the Survey about gender-based violence	38
Table 12: Results of the Survey about Beliefs and comfort about sex education.....	38
Table 13: Results of the Survey barriers to sex education.....	38
Table 14: Frequency table on the educational source for sex education	39
Table 15: Results of the Survey frequency of the selected topics that a social worker needs to be knoweldgeable about	41

Acknowledgment

I would like to express my very great appreciation to Dr. Carie Forden for her valuable and constructive suggestions during the planning and development of this research work. Her willingness to give her time so generously has been very much appreciated.

I would like to express my deep gratitude to Dr. Yasmine Salah for her enthusiastic encouragement and useful critiques of this research work.

I wish to thank my family and friends for their support and encouragement throughout my study.

Finally, for all the alienated, oppressed and tormented souls by violence, dogma and ignorance, I dedicate this research.

Abstract

Despite governmental and legislative efforts (Hassanin, 2008), societal tolerance of sexual and gender-based violence is widespread in Egypt, even among health professionals (Rasheed, 2011). Moreover, there is a lack of understanding and misconceptions regarding human sexuality. Such misconceptions often lead to harmful practices such as female genital mutilation/cutting, childhood marriage, and child sexual abuse (WHO, 2010). Child protection social workers must be equipped to deal with children who have been victims of such practices and must be able to provide the sex education that is necessary for its prevention. A survey of 86 child protection social workers and eleven in-depth interviews was conducted in order to better understand how they viewed and dealt with sexuality, gender roles and sexual and gender-based violence. It was found that they had a number of misconceptions about sexuality as well as a tendency to gender stereotype. Female social workers were overall less tolerant of gender-based violence, more supportive of gender equality and had fewer misconceptions related to sex compared to male social workers. Male social workers who were married were more likely to hold attitudes supportive of women facing sexual and gender-based violence, had more flexible views of gender roles and lower double standards, and were more open to gender equality, than male social workers who were single. Based on these results, recommendations are made for culturally appropriate training to build social workers' capacity for addressing sex and gender issues in their child protection practice.

Key words: sex education, sexuality, FGM/C, SGBV, gender, violence, social worker, child protection, Egypt.

Assessment of Needs and Barriers to Sex and Gender Education Among Social Workers in Egypt

Gender-based violence (GBV) is still a prevalent and serious problem worldwide. One in every three women has experienced at least one form of violence in her life (UN Women, 2016). Despite a number of national initiatives during the past two decades, rates of GBV in Egypt remain high (Rousdy, 2013). GBV is violence that occurs due to rigid and normalized gender roles, in addition to unequal power relationships between men and women, within each societal context (Bloom, 2008). While these unequal power relationships are often expressed interpersonally, they are also deeply integrated into the social structure (WAVE and UNFPA, 2014).

Sexual harassment, female genital mutilation/cutting, and domestic violence are forms of GBV, and all are experienced at high levels in Egypt. Egypt ranks second in the world after Afghanistan in sexual harassment. A study carried out by UN Women in 2013 indicated that more than 99.3 % of Egyptian girls and women experience a form of sexual harassment in their life (UN, 2013). The same study concluded that 82.6% did not feel safe in the street and 86.5% didn't feel safe in public transportation. According to the data of the 2015 Egyptian Demographic Health Survey (EDHS, 2015), 87% of girls and women (15-49 years) are circumcised, and more than half the population supports the continuation of the practice. For domestic violence, the most recent data available shows that 36% of ever-married women between age (15-49) have suffered physical violence from the age of 15 (EDHS, 2015).

Compared to other countries, Egypt ranks low in gender equity at 136 out of 145 on the 2015 Global Gender Gap Index (USAID, 2017), an indication that the issue is deeply rooted in the Egyptian culture. Gender based violence and sexual abuse have major long-term consequences on the majority of Egyptian women and children; it is a serious problem that needs to be addressed in a way that incorporates the social context of gender inequality,

sexual violence, and reinforcing cultural norms.

One way to address GBV and gender inequality is through sex education. According to The Egyptian Initiative for Personal Rights report (Rousdy, 2013), there is a need for comprehensive sexuality education programs among youth in Egypt. The report argues that sexual and reproductive health are greatly affected by ignorance, poverty, discriminatory gender norms, and gender-based violence. It concludes that FGM/C, sexual violence, early marriage, sexually transmitted infections (STIs) and unwanted pregnancies are a few of the most significant threats due to a lack of sex education among Egyptian youth.

Comprehensive sexuality education is a basic right for every individual as it is fundamental to sexual health and bodily integrity.

Issues Impacting Sexuality and Sex Education in Egypt

Reluctance to discuss issues related to sex, the use of pornography, a patriarchal culture that includes rigid notions of male honor, and socialization into highly gendered roles for men and women, all contribute to unhealthy sexual practices and challenges around sex education in Egypt.

The Culture of Silence

"In the Arab world, sex is the opposite of sport. Everyone talks about football, but hardly anyone plays it. But sex – everyone is doing it, but barely anybody wants to talk about it." So, declares one interviewee at the beginning of Shereen El Feki's book *Sex and Citadel*, (2013). The culture of silence that surrounds sexuality and intimate relationships in Egypt includes an inclination to deny any sexual behavior or sexual abuse among children and youth. This may prevent children and adolescents from talking about sex with grownups. Consequently, youth do not obtain solid, correct and structured knowledge about the psychological and physical effects of unprotected sex, contraception or health services available to victims of sexual violence, which leaves them unprepared for the physical and

emotional changes and the numerous societal challenges of the 21st century world (El Feki, 2014).

In Egypt, when adolescents were given the opportunity to ask anonymous questions in a public lecture on reproductive health, they asked about masturbation, the elasticity of the hymen, wet dreams and homosexual behavior. Their questions reflected an unmet need for information about sexual behavior that is not limited to sexual activities that individuals engage in with a partner, but also comprising masturbation, safe and risky sexual behavior, consensual and forced sexual behavior and sexual dysfunction (Roushdy, 2013). Youth in the region do not get to have enough information about their bodies, maturation, and other aspects of sexual and reproductive health to help prepare them for future safe and autonomous adulthood. Sex education is rare in the Arab region due to religious and political opposition. Sexual and reproductive health topics are often ignored because the teachers themselves are even embarrassed or unprepared to teach them (DeJong et al, 2007).

Worldwide, sex education is a controversial issue with conflicting ideologies. Some argue that it constitutes a very important component in empowering youth to have secure, consensual, and pleasant sex lives and others argue that it is ethically threatening and stimulates unsafe sexual activities (Hampshire & Lewis, 2004). These fears endure even though strong evidence supports the view that sexuality education is empowering and protective (Kirby, 2006; Kirby, Laris, & Rolleri, 2007; Shepherd et al., 2010). Avoiding talk about sex will only add to feelings of discomfort and leaves youth at risk (Rousdy, 2013).

According to Ragab and Mahmoud (2006), boys and girls in Egypt are usually given little information if any about their sexuality and reproductive well-being when they reach adolescence. However, they continuously pick up sexual messages from unreliable resources, such as commercially driven media, or their peers, which in most cases does not promote healthy sexuality. In Egypt, most families do not share fundamental information about human

sexuality with their children. Parents usually avoid talking to their children about sexually related matters either because it is uncomfortable or because they themselves lack the information that teenagers need to know in a rapidly changing world (Rousdy, 2013).

According to a study on a nationally representative sample of Egyptian youth, 73% never talked to their parents about changes accompanying puberty and 67% of the girls felt shock and fear when they had their first period (Population Council, 2009).

This lack of information could be due to avoidance of sex education in school systems as well. Sex and reproduction chapters are often ignored in the biology curriculum, as teachers tell their students to read “this chapter” on their own (DeJong, 2005). A study by the Cabinet Information and Decision Support Center in Egypt found that less than five percent of its participants received their education about sexual and reproductive health from academic curricula, and family health centers (Rabie, 2010). In the Egyptian context, there is also a tendency for sex educators to provide wrong information. For instance, the science curriculum for the second year of the preparatory level teaches that HIV/AIDS is “a disease transmitted through sinful and homosexual relations,” ignoring the various other means through which the virus could be transferred (Rousdy, 2013).

A study conducted by Farag and Hayter (2014) on attitudes and experiences of Egyptian nurses towards sex and relationship education found four themes: personal issues, cultural and political dimensions, parental issues, and skills and confidence. These themes showed how individual and social forces affected practice and views on sex education. The nurses feared being blamed for creating a permissive culture. The conviction that sex education is ethically challenging affected the nurses’ ability to provide effective sex education. They were concerned that their participation in sex education would ruin their reputation. This is related to conventional women's role in the Islamic culture (Charrad,

2011) that women are often expected to be sexually naive (DeJong et al., 2005). And finally, the nurses were concerned about their lack of overall knowledge in the area of sex education.

Media and Sex Education

Due to the critical knowledge void as indicated by numerous studies surrounding sexuality (Ibrahim, 2010), Egyptian youth often resort to the media to fulfill their need for information. The exposure to media is often misleading and damaging without equipping young people with the necessary information and principles to offset the lack of knowledge. As Dr. Hind Khattab, chairperson of the Egyptian Society for Population Studies and Reproductive Health stated, “Media images and portrayals of sexuality fill a void created by silence about sexuality in their families and communities. The ignorance of young people leaves them vulnerable to negative health consequences” (Khattab, 2007).

One source of incorrect knowledge about sex is pornography. Given the pornography consumption rates available online, we can conclude that a significant part of the region interacts with pornographic material on a regular, if not customary, basis especially with the widespread access to technology and mobile phones. According to the 2008 Google Trends, Egypt-based searches for the keyword “sex” far outnumbered other countries (Google Trends 2008) and has since remained one of the top search words. According to SimilarWeb’s analysis, the top two countries with the highest share of adult websites are Iraq and Egypt (Hussey, 2015). In an anthropological study done by Kasemy (2016) on pornography among Egyptian youth living in Cairo, participants considered pornography as a tool to learn about sex and sexual relations. They saw their pornography consumption as a normal manly activity, which constituted an important component of their identity. What they viewed provided them with a judgment-free learning space, in contrast to their friends or families.

Some research concludes that pornography plays an important role in normalization of sexual behavior and empowerment (Weinberg, 2010). However, there are concerns about

pornography as a business-driven industry that encourages misogyny and sexism; leading to the objectification of women, loss of respect and violence (Paul, 2006). In the 1970s, the earliest feminist critiques led by authors such as Andrea Dworkin and Catherine McKinnon were mainly concerned with the negative “effects” of pornographic consumption on men. Male consumption of pornography alarmed some feminist critics who argued that pornography strengthened cultural attitudes that objectified and demeaned women (Dworkin and McKinnon, 1988).

Gender Roles and Socialization.

Violence against women is found to be most widespread when gender roles are strictly expressed and imposed (Heise, 1998). Moreover, adopting a concept of masculinity that is associated with male honor, dominance, toughness, and/or the recognition that men have ownership of women increases GBV (Heise, 1998). According to WHO, social norms that shape gender roles and cultural ideologies of male sexual privilege legitimize the use of sexual violence against women and decrease their ability to make independent choices about participating in sex (WHO/LSHTM 2010).

According to Connell (1987), gender is probably the cultural category most prone to being misunderstood as natural due to its close association with anatomical sex disparities. The naturalization of this social category occurs through the socialization process at the family level, followed by media messages that reinforce gender stereotypical notions. It is characterized by exposing children to messages of dos and don'ts according to a stereotypical binary of masculinity and femininity. It emphasizes anticipated roles for women to be homemakers and for men to be bread winners at a young age. For example, for girls, the tradition of purchasing “Gehaz” which is the Arabic word for preparation, starts at a very young age. It includes kitchen equipment and other items that are needed for setting up a house.

Social construction of masculinity and femininity is very strong in Egypt and gender double standards prevail. Compared to boys, there are more rules to constrain girls' mobility and access to resources, and the overall censorship of girls' behavior is much higher, limiting individual choice. A good girl is socialized to be obedient, submissive, and a pleaser (DeJong et al., 2005). The prevailing gender role belief for girls in Islamic cultures is to be shy and sexually gullible (DeJong et al., 2005). Egyptian society considers getting married and childrearing as the ultimate accomplishment of a "good woman." According to Fernea (2003), motherhood in Egypt is idealized. Fertility and chastity are the woman's primary obligation along with all the responsibilities of the household and childcare. She must protect men from her own seductive powers and keep her sexuality for her husband alone.

According to Fernea (2003), male domination also starts very early when young boys guide their sister's behavior. In the Arab context, boys are considered to be the caretakers of their sister's virtue and their mother's as well, particularly in the absence of their father. From early infancy, the son is trusted with the duty of protecting the family's honor. A recent study of masculinity in the region found that people in Egypt have a rooted conviction that women should execute tasks like cooking and cleaning in the household, while it is the position of men to have the final word in the family decisions. This study indicated that 86.8 % of men and 76.7 % of women think that a woman's most essential role is to take care of the household and cook for the family, while 90.3 % of men and 58.5 % of women reported that the man should have the final decision in his household (ElFeki, 2017).

Family, Sexuality and Patriarchy.

For Nawal El Saadawi (2007), the family composes the core of patriarchal power relationships in Egypt. Egypt's culture is patriarchal with regard to the centralization of power, responsibility and privilege in the father figure. According to Sylvia Walby (1990), patriarchy is a social framework and a set of practices, dominated by men, and in which

women are exploited and oppressed. It is comprised of six main structures including: male violence, gendered modes of production, gendered relations in paid work, a gendered state, patriarchal relations in sexuality, and gendered cultural institutions. Control of sexuality is one of the powerful tools of this patriarchal system and Nawal El Saadawi (2007) argues that there is a fear of women's sexuality because it challenges the patriarchal system. For men sex is a right, sanctioned by religion. Even the Islamic paradise offers men constant sexual satisfaction but the same is not true for women. Therefore, sex is centered around men's satisfaction (Sharabi, 1988) and it can be argued that even religion is patriarchal in that sense (Mernissi, 1975).

Honor. Honor is not an individual value in the Egyptian culture, specific to each person's behavior, but rather a male issue connected to a women's virginity. Engaging in premarital sex for men is not considered a matter that threatens the family's honor at all; on the contrary, many would consider male engagement in premarital sex to be a sign of manhood and a source of pride. In her book, *The Hidden Face of Eve*, Nawal El Saadawi (2007), says the hymen: "is the very fine membrane called honor". She recounts the evenings spent by the side of young women, treating them for hemorrhages suffered on their wedding night, the result of a ritual ceremony in which the *Daya* (a midwife) cuts through the hymen with her fingernails to prove the woman's honor to her husband and both families. At the opposite end of the spectrum, she talks about privileged women who have the ability to pay for plastic surgery to reconstruct their hymen, trying to persuade their new spouses that they are virgins. This belief is not only inaccurate but harmful at its core as it considers women should be owned by men. In addition, this cultural fallacy around honor and the hymen and its wrong association with virginity has led to honor crimes (van Moorst, 2012).

Marriage. Marriage, as an institution, is led by males with the husband having the final word in the household. Therefore, marriage enhances patriarchal authority at the family

level. In various parts of the world marriage is considered as an unconditional grant to sexual access for men to their wives and the legitimacy to coerce this accessibility by force if needed. Lack of sexual autonomy often puts women at risk of different sorts of GBV (Heise, 2002). Marriage in Egypt is less a matter of individual choice than of family arrangement, especially for women. Nearly 90% of men but less than 50% of women thought the final decision to marry should rest with the couple themselves. While more than three-quarters of men made their own decisions about whom and how to marry, almost 90% of women reported that, for them, marriage decision was made by other family members – mainly their fathers (El Feki, 2017).

Gender-Based Violence

According to the United Nations, violence against women is defined as any act of violence that “results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life” (quoted in Somach and AbouZeid, 2009, p.3).

In Egypt, GBV takes many forms and includes verbal, physical, and psychological abuse in public and private venues. According to Wasef (2018), GBV can be categorized into two main categories. First, social violence that is associated with sexual harassment, social norms and gender roles. Second, domestic violence that includes any physical harm among family members against women and domestic practices like early marriage and female circumcision FGM/C and child marriage. This widespread prevalent forms of GBV in Egypt, constitutes a violation of child protection standards and women’s human rights.

Child protection social workers are often called upon to intervene in cases of gender-based violence. It is therefore important that they correctly understand the issues surrounding GBV and that they are able to educate others on it. As it has been found that violence against

women is exacerbated by lack of awareness of the women exposed to it and not knowing it is their right to be free from violence (Kalmuss & Straus, 1982).

With regard to domestic violence in Egypt, a study on understanding masculinities (El Feki, 2017) concluded that more than half of its male respondents believed that women deserve to be beaten on occasion, and 90 per cent asserted that women should accept such treatment in order to preserve the family. While women strongly disagreed, they were far more willing to tolerate violence for the sake of family unity.

Sex education that includes a gender component has been shown to reduce incidences of GBV. For example, according to a study conducted in India, addressing gender in HIV and violence reduction programs was found to be an important and successful strategy. The intervention is designed to stimulate critical thinking about gender norms that promote risky behavior and to create support for gender norms that promote care and communication. Evaluation of the intervention by qualitative and quantitative methods indicated that interactive group education activities led to positive shifts in gender norms, HIV and gender-based violence among young men (Verma, 2008).

Sexual harassment. Sexual harassment constitutes a major problem in Egypt. It takes diverse forms including unwanted touching, catcalling, stalking, and indecent exposure (Fahmy, 2014). According to the UN's (1993) definition, it is a form of gender-based violence and is considered a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.

Therefore, sexual harassment should be viewed as one aspect of GBV and gender inequality (Heise, 1994) and be addressed accordingly. Social workers need to be educated about the different aspects of sexual harassment and the criminalization of Egyptian law for it

that was established in 2014 for the first time (The National Council for Women, 2015) as they are one of the stakeholders who educates others on their legal rights.

Female Genital Mutilation/Cutting. FGM/C is one of the most compelling pieces of evidence that many Egyptians suffer from a lack of understanding of human sexuality.

According to the World Health Organization, FGM/C includes any intentional procedure that alters or cause injury to the female genital organs for non-medical purposes. This includes partial or total removal of external female sex organs. It is most commonly carried out on girls between infancy and age 15. Despite Egypt having passed a law in 2000 that criminalizes FGM/C practices and the involvement of any physician or other healthcare provider, (Hassanin et al., 2008) FGM/C rates are still high. The practice of female circumcision according to the 2015 Egyptian Demographic and Health Survey EDHS, is widespread in Egypt as 87% of ever-married women age 15-49 have been circumcised. FGM/C is acknowledged internationally as a violation of the human rights of girls and women. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death (UNIFEM, 2003; WHO, 2018).

Women and girls are subjected to FGM/C for social, cultural and religious reasons. One of the main motivations to the practice is the belief that FGM/C guarantees women's honor as the women's sexual desire resides in the clitoris; by cutting it, the women's sexual desire decreases, ensuring premarital virginity and marital faithfulness (WHO, 2010). A study by Fahmy & Ragab (2010) focused on the role of female sexuality by examining women's and men's support for FGM/C, and their impressions of its sexual consequences. The research was constructed in two rural areas in a large slum in Cairo and in Upper Egypt in 2008-09. A total of 102 women and 99 men participated in focus group discussions. Many participants felt that the purpose of FGM/C was to reduce the sexual desire of women and

increase their chastity, but not to reduce women's sexual pleasure; a misconception. The authors concluded that a collective effort and commitment, especially from the government and educators is necessary to eliminate the practice of FGM/C and to change the misconceptions about FGM/C.

The 2015 Ministry of Health and Population survey concluded that an estimated 82% of FGM/C cases were conducted by doctors or other medical personnel, and there is the belief that FGM/C is "medically necessary or beneficial" (WHO, 2010). In Egypt, this includes concern over the size of the clitoris, as it is believed that a large clitoris stimulates sexual desire (WHO, 2010). It is also believed that FGM/C restrains sexual desire, thereby ensuring marital fidelity and preventing sexual behavior that is considered deviant and immoral (Gruenbaum, 2006). Although FGM/C is officially repudiated by both Islam and Christianity in Egypt, local religious leaders often hold power on FGM/C practice (OHCHR, U., & UNDP 2008) and believe it is a religious mandate (Abdi, 2007; Johnson, 2007). Even though the practice can be found among Christians, Jews and Muslims, none of the holy texts of any of these religions prescribes female genital mutilation and the practice pre-dates both Christianity and Islam (WHO and UNFPA, 2006). Fear of stigmatization (Behrendt, 2005; UNICEF, 2005a), marriageability (Hernlund, 2003; Dellenborg, 2004), and purity (Talle, 1993; Johansen, 2007) have often been cited as the reason for FGM/C as well.

The majority of Egyptian women undergo FGM/C and it is a traumatic experience for girls with potential long-term consequences for female sexuality. Medicalization of this harmful practice is very alarming and reflects the dominance of culture and tradition over reason. Therefore, there is a need for a sexuality education program that addresses the relationship of FGM/C to gender-based discrimination, sexual violence, and reproductive health (Rousdy, 2013).

Domestic Violence. Intimate partner violence (IPV) happens more frequently in communities where men have more decision making and financial power in the family, where women are not able to access divorce, and violence is the usual resort to resolve any conflict (WHO, 2010). According to Holden's (2003) definition, IPV includes physical, emotional, and sexual assault or coercion by a spouse or adult intimate partner. A recent study concluded that 53.4 percent of Egyptian men and 32.8 percent of Egyptian women think that sometimes women deserve to be beaten, while 90% of men and 70.9% of women reported women should bear violence for the sake of the family (IMAGE, 2017).

Early Marriage. Childhood marriage constitutes another risky reproductive health practice. According to UNICEF (2017), 17% of girls in Egypt marry before the age of 18 and are at risk of violence and abuse, and under constant pressure to get pregnant as soon as they marry to prove their fertility. Once married, only 8% of women in Egypt and 10% of men believe it is appropriate to use family planning before having their first child. This leaves younger brides vulnerable to adolescent pregnancy, which carries elevated risks such as iron deficiency 'anemia', obstructed labor, and miscarriage complications compared to older women (Fraser, 1995). Young women often lack information about family planning, sexually transmitted infections (STIs) and other sexual and reproductive health matters (Ashford, 2008).

Sex Education

The Need for Sex Education

Ignorance around sex is widespread in the Middle East and North Africa. For example, researchers found that 50% of Tunisian males age 17-24 and 70% of female think that contraception usage could be harmful (Soweid, and Manayan, 2004). A study from Iran, on 1,385 males aged 15-18, found that 28% reported having engaged in extramarital sexual activity. Substantial proportions of participants held misconceptions regarding condoms, STIs

and reproductive physiology. Respondents were only able to answer 3 of 10 questions on naming contraceptive methods and 4 out of 9 questions about HIV/AIDS, STDs and their symptoms. The authors concluded that there was a need for adolescent sex education programs to provide them with the needed information and skills to make safe and informed sexual decisions (Mohammadi et al, 2006).

According to UNFPA (2009), sexuality education should develop both knowledge and values. It is

“a long-lasting process of attaining information and establishing positions, convictions and values about identity, relations and intimacy. It incorporates sexual development, reproductive health, intimate relationships, gender roles, and body image. Sexuality education tackles the biological, psychological, sociocultural, and spiritual scopes of sexuality.”

Sexuality education should encompass all the needed information, skills and values to empower young people to make decisions about their health and sexuality (IPPF, 2009).

Sexuality education also should take into account the link between gender relations and reproductive health and the social and cultural context of these relations (ICPD, 1994).

Recognizing the importance of sexuality as an important aspect of being human (WHO, 2012), and life-threatening consequences that result from misinformation and ignorance of matters related to human sexuality (UNESCO, 2009), sexuality education is a vital area for political intervention as a matter of public health that concerns children, youth and adults and is affected by ignorance, poverty, discriminatory gender norms, disease, and gender- based violence (Roushdy, 2013). Lack of sex, gender and relationship education also leaves many children vulnerable to anxieties that come with changes of puberty (Population Council, 2009). It is a powerful prevention tool that can protect future generations from the incorrect beliefs and harmful practices that we are fighting today (Roushdy, 2013). Through

educating social workers on the long-term consequences of FGM/C and other GBV on the women's health and well-being, we help prevent the problem before happening.

Sex Education Initiatives in Egypt

History. In the first half of the 20th century, Salama Musa was the first Arab intellectual in modern history to seriously argue that sexuality education is a matter of public concern (Massad, 2007). In his book *Ahadith al-Shabab*, published in 1957, Salama Musa initiated an open debate on sexuality. He called for a societal revision of youth education on matters related to relationships, health and sexual behavior (Musa, 1969). In 1972, Nawal El-Saadawi published her book, *Women and Sex*, which was banned in Egypt for almost two decades when it was first published. The book focused on female sexuality, and the various misconceptions around virginity especially in rural areas that had led to honor crimes. It caused El-Saadawi to lose her position as Director of Public Health at the Ministry of Health, a reflection of political resistance to the topic. Since the late 1970s, with the rise of Islamic conservatism, sex education was seen as a Western attempt to undermine traditional and Islamic values. In fact, Islamic heritage is full of sexually explicit writings, making sexual conservatism a relatively new thing (El Feki, 2013).

The widespread incidence of HIV/AIDS constituted a turning point in constructing a new understanding of the connection between a health crisis and a wide range of cultural, social, political and economic issues (Parker, et. al., 2007). The international climate of increased awareness and advocacy for sexual and reproductive health and rights led to the reemergence of a public discourse on sexuality in Egypt in the 1980s, through public engagement with a number of cross-cutting issues on the global concerns to the regulation and practice of sexuality (EPIR, 2013). In 1994, The International Conference for Population and Development (ICPD) met in Cairo and endorsed individual rights in sexuality and reproduction (DeJong, 2000). UNFPA (1994) adopted a holistic approach to sexuality that

went beyond the traditional focus on women and female sexuality to integrate masculine and youth sexuality. It also created the space to address concerns related to sexual violence, HIV/AIDS and sexual and reproductive health and rights. The ICPD included an international agreement among the represented 180 countries, on the importance of sexuality education as a component of “reproductive health and responsible parenthood” that countries should provide for all citizens of appropriate ages.

In the media in 2007, a show on sex education, Kalaam Kibeer (Big Talk) by Heba Kotb was introduced. It is a popular show that uses Islamic scriptures as a method of reason and justification to provide sex education and to encourage spouses to be more aware of their partners' desires. It adopts Kotb's principle that “being a good Muslim means having good sex” (Swank, 2007). Yet even within this space where sexuality was openly discussed, various non-heterosexual practices and premarital sexuality were excluded from the discussion and Kotb proposed that FGM/C had no effect on women's sexual pleasure. The media platform, in this case as in many cases, was a method for reproducing fallacies and nurturing ignorance.

The most recent emergence of a sex education platform is Al-Hubb Thaqaafa (Love is Culture) in March 2014. It is an Arabic social media stage, offering correct and unbiased information on sexuality, relationship and love, providing youth with the information needed to have healthy, safer and happy sex. Al-Hubb Thaqaafa is part of the platform Love Matters and offers advice columns, testimonials, and thought-provoking articles, allowing its visitors an unprecedented opportunity for interacting, exchanging opinions and ideas not only with experts but also with other fellow users with the objective of achieving a greater space for freedom of expression (Feki, 2014). Given that such spaces remain rare, in the politic as well as personal life, in most countries of the Arab world, Al-Hubb Thaqaafa has attracted a great

number of Arabic-speaking visitors from around the world reaching more than nine million visitors since its launch in ? year? (Feki, 2014).

Challenges related to past Sex Education Initiatives in Egypt. As indicated by EPIR report (2013), challenges in the implementation of available sexuality education include negative connotations of the term, social resistance, and limited accessibility of sexuality education initiatives coordinated by local and international NGOs due to the lack of support of the Ministry of Education and other stakeholders. Additionally, there is a lack of readiness of teachers to discuss the topic of sexuality in school (Roushdy, 2013).

Generally, comprehensive sexuality education programs are met with apprehension as people incorrectly deem that open discourse on matters related to human sexuality with teens will support extra-marital sexual relations and eventually lead to promiscuity (Baldo, 1993). However, research proves that sex education is likely to delay initiation of sex (Baldo, 1993) and reduce the number of sexual partners (Kim, 1997). Moreover, opponents of sex education in Egypt assume that comprehensive sexuality education programs are ready-made universal programs that are not culture specific (Roushdy, 2013). However, sexuality education is takes in consideration the cultural context. Moreover, it doesn't focus on how to have sex as widely assumed by opponents, but rather concentrates on values, decision-making, biology, emotions, gender identity, and sexual feelings. It also offers support for delaying first sex, abstinence, limiting the number of partners and safer sex (Roushdy, 2013). Since using the label "sexuality education" might cause a problem in Egypt, it was proposed by the Population Council and the Cairo Family Planning and Development Association to use "reproductive health" as an acceptable alternative (Hassan, 2009). In addition, a focus on the need to deal with rising STIs and unwanted pregnancy rates in youth can be used to persuade those who are reluctant of the need to sex education even in Islamic countries (Shepherd et al. 2010; El-Feki, 2006).

Sex Education Approaches

There are two main approaches regarding sex education. First is the abstinence-based approach which concentrates on teaching young people that refraining from sex until marriage is the best way of avoiding sexually transmitted infections and unwanted pregnancy. Second is the comprehensive approach which is an interdisciplinary approach that aims to increase knowledge, reduce misinformation, strengthen positive values and attitudes, and enhance skills to make informed decisions (UNESCO, 2009). The principal social value of comprehensive sexuality education is that it adopts a climate for the discussion of problems affecting the sexual and reproductive health and bodily integrity of individuals in the process of their development, aspiring to support gender equality and respect. It tries to explain to young people the potential benefits of delaying having sex until they are emotionally and physically ready. It also teaches them how to protect themselves from infections and pregnancy when they do decide to have sex (Roushdy, 2013).

The abstinence-only approach is especially supported by religious fundamentalist groups. Recent studies, however, show that abstinence-only education is not only less effective than comprehensive sexual education, it is altogether ineffective (Hamilton, 2007). Various studies confirm a positive correlation between exposure to comprehensive sexuality education programs and reduced unsafe behavior among youth (Gruseit, 1997). There is no support for the argument that sex education encourages experimentation or increases sexual activity. If any impact is witnessed, almost without exception it is postponed initiation of sexual intercourse and/or effective use of contraceptives (Gruseit, 1993). A study that examined the impact of sexuality education on youth sexual risk-taking for teens ages 15-19 found that adolescents who received comprehensive sex education were 50% less likely to experience unwanted pregnancy than those who received abstinence only programs. It also showed that discussing contraception with youth was not associated with an increase in

sexual activity or STIs and that withholding information only increased the probability of unsafe sexual initiation (Kirby, 2001). An assessment of 66 comprehensive sexual risk reduction programs in the USA concluded that those programs were effective in reducing teen pregnancy, HIV, and STIs (Chin et. al, 2012).

Though there are opponents of sexuality education in Western cultures, it is widely considered to be an essential part of education and is embedded in educational policy and practice across curricula for all ages (Denny & Young, 2006). The debate is on the exact nature of sex education, age-specific issues, and the expansion of sexual health care into schools (Ingham & Hirst, 2010). Numerous studies have concluded that sex education programs that give precise, comprehensive, and age appropriate information on human sexuality, comprising risk-reduction strategies and contraception, assists youth in taking steps to insure their wellbeing, including postponing sex, using contraception, and being monogamous (Alford, 2008).

The Role of Social Workers in Sex Education

In Egypt, different political ideologies embraced by governments have led to different realities for the field of social work. From the 1950's through the 1970's, the government was adopting a socialist ideology and was responsible for providing the basic needs of the citizens including health care, employment, education, and housing (Soliman & Abdelmegied, 2010; Walton & Abo El Nasr, 1988). However, from the 1970's onwards and the embrace of liberalization and free market economy under Anwar El Sadat's policies, the situation in Egypt shifted. This shift was accompanied by an increase in poverty which caused the need in the formation of NGOs and charity organizations (Abouzahr, 2006; Ethnasios, 2012) to compensate for the services that might otherwise should be offered by the government (Abouzahr, 2006). Currently, voluntary associations and NGOs have been offering much of social work practice.

According to Soliman (2007) the current social work curricula still embraces traditional methods last updated 25 years ago. This failure to update curricula created a gap between the quality of education and the needs of the society. Social services were, and still are, rooted in religious practices and largely based on volunteerism and charity (Abouzahr, 2006). NGOs have existed in the same general form that they do today since at least the nineteenth century (Walton & Abo El Nasr, 1988). The voluntary nature of NGOs combined with the outdated social work curriculum means that there is a need to invest in educating social workers so that they can utilize new models of social work practice in order to adequately address the new changes in societies (Alphonse et al., 2008) with models and approaches sensitive to the cultural context (Gray, 2004). In particular, there is a need to support social workers in providing correct information and helpful support in issues related to sexuality.

Social workers play an important role in the promotion of sexual health and child protection. They are key actors in identification of who are at the risk of FGM/C, early marriage, sexual abuse or any other issue related to child protection or gender-based violence since they work on one-on-one basis with children, youth and parents. Social workers cannot do their jobs well unless they understand how violence and powerlessness affect the psychological and physical health of individuals and the community at large. They need to be trained to identify victims of violence and connect them with other community support services and gain the needed compassion to reassure clients that violence is unacceptable.

Research Question

Child protection social workers must be equipped to deal with children who have been victims of GBV and be able to provide the sex education that is necessary for prevention of GBV and the promotion of sexual health. However, there is no research on what Egyptian social workers think and feel about sex education and what they understand

about sex. This research aimed to address this gap. Surveys and interviews were used to identify what child protection social workers know about sex, their views related to gender roles, and their attitudes toward and experiences with sex education. It was hypothesized that 1) Women would have less misconceptions and hold more progressive views than men concerning GBV, gender equality, and double standards. 2) Married individual would have less misconception and more awareness of the consequences of GBV and therefore, less likely to support it. Based on the research results, recommendations will be made for training and support to build social workers' capacity for addressing sex and gender issues in their child protection practice.

Methodology

In order to achieve both breadth and depth of data (Mertens, 2014), a mixed-methods approach using a qualitative measure (semi-structured interviews) and a quantitative measure (questionnaire) were used. These measures were utilized to assess child protection social workers' misconceptions, attitudes, beliefs, and experiences related to sexuality and gender roles.

Survey

Participants. The participants for the survey and interviews were 86 social workers and psychologists working at NGOs located in Cairo and Assiut. The rationale of conducting data collection in Cairo and Assiut was to explore if there was a difference in attitudes between urban and rural areas in regard to sex education and gender-based violence. However, the comparison was made complicated by the fact that the Assiut participants had received previous education on sexual and reproductive health unlike Cairo participants, and so was dropped from the analysis. All participants from Cairo ($n = 40$) worked for a large NGO that works with children, primarily orphans. Assiut participants ($n = 46$) were social workers and psychologists partnering with an independent international development and

humanitarian organization that advances children's rights and equality for girls. The NGO has branches in several communities in Upper Egypt. A breakdown of the research participant's demographic data is summarized below in Table 1.

Sample	Gender		Govern		Marital status		Age		
N=86	Females	Males	Cairo	Assiut	Single	Married	Below 30	30 to 40	Above 40
	N=46	N=38	N=40	N=46	N=42	N=42	61%	24%	15%

Table 1: Survey participants sample demographic data

Instrument. The researcher designed an original survey based on the following resources: 1) literature review on different sorts and attitudes towards GBV 2) personal observations and experiences as a researcher. The survey was developed originally in English and then was translated into Arabic. Attitudes were measured with 5 items on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). The survey (see Appendix D) was divided into five sections with 42 questions in total. The first section included 35 questions divided across six components measuring various attitudes on: personal beliefs about sex education, gender equality misconceptions about sex, gender-based violence, attitudes about gender and gender roles and gender double standards. The second section included five questions measuring attitudes about sex education and assessing general information including sexually transmitted diseases.

Procedures. The researcher went to the participants either at their place of work. A brief introduction about the research was given. Participants were reassured that their participation is strictly voluntary and given an informed consent form to sign (see Appendices A & B). They were reassured about the confidentiality of their input. After signing the consent form, participants were given the survey which took on average about 15 minutes to complete.

Data analysis. Descriptive statistical analysis was utilized to summarize the quantitative questions. A two-ANOVA was conducted using SPSS to test hypothesis to

examine gender and marital status significance on attitudes regarding GBV, double standards, gender roles, gender equality and misconception about sex. In addition to thematic analysis to analyze qualitative questions. Answers were arranged together based on similar commonalities. Then, they categorized based on themes or patterns of each qualitative questions.

Cronbach's alpha was used to assess reliability. The scaled items on the survey appeared to have good internal consistency overall ($a = 0.84$). Reliability for the five main sections was also good: misconceptions about sex ($a = 0.87$), attitudes regarding gender roles ($a = 0.95$), double standards ($a = 0.96$), gender-based violence ($a = 0.94$), and gender equality ($a = 0.95$).

Semi-Structured Interviews

A qualitative approach enables the researcher to conduct a detailed and rich exploration and analysis of participants' narratives (Denzin & Lincoln, 2005). Qualitative research also allows for the exploration of individuals within a social and cultural environment (Lincoln & Guba, 2000), providing a detailed description of their experiences and attitudes. Furthermore, it enables participants to tell their own "story" and is well suited to exploring topics that are sensitive and complex such as sex education and culture.

Participants. Eleven in-depth interviews were held with seven male and four female participants. Interview participants were Egyptian social workers working on one-on-one basis with children and youth in non-governmental institutions. The study used a convenience sampling strategy in the selection of the most reachable social workers. They were from the same institutions the survey was conducted in. All participants interviewed were Sunni Muslims. A breakdown of the interviewed participants' demographic data is summarized in Table 2.

Sample	Gender		Govern		Marital status		Age
	Females	Males	Cairo	Assiut	Single	Married	
N=11	N=4	N=7	N=5	N=6	N=6	N=5	25 to 58 years old

Table 2 : Interview participants sample demographic data

Instrument. A set of open-ended questions was used to explore the social workers experiences and views toward sex education. The questions were divided into four topical sections and each section has several questions (see Appendix C). The four sections aimed to assess attitudes towards sex education, common challenges faced, common intervention strategies, attitudes towards gender roles, gender-based violence and LGBTI. Finally, recommendations were sought for a sex education curriculum. The interviews were conducted in colloquial Arabic.

Procedures. Interviews were conducted in person by using a semi-structured set in which preliminary questions are set and further follow up questions emerged during the interviews to allow flexibility. The interviews were audio-recorded and hand-written notes were taken during the interviews to ensure accuracy and to be used as a reference for more access to more details later in the process of analysis.

Data analysis. The researcher used a “general framework coding” for thematic analysis (Lacey & Luff, 2007, 2009, pp. 6-14). First, the interviews were transcribed in the original language Arabic. Second, identification of thematic framework based on the emerging issues during the reviewing process of participants’ responses to each question. The thematic analysis (Braun & Clarke, 2006) was guided by six phases. First codes were identified, then grouped under different sub-themes to create established, meaningful patterns. Finally, themes and codes were translated from Arabic language to English. Interrater reliability was assessed by asking another researcher to sort parts of the interviews into the established themes. There was 92% agreement.

Ethical Considerations

Given the research topic, discussing ethical considerations is a significant element. Several precautionary steps were taken to ensure the safety of research participants. First, an approval letter from the university's Institutional Review Board (IRB) was obtained before contacting potential participants in both study phases, the interview and survey. Secondly, the participants were asked to sign an informed consent form per established IRB procedure. The informed consent included brief information about the study, such as its purpose, and time required for participation. Potential benefits and risks involved in participation in the study was also outlined. Additionally, the form included a clear statement explaining that participation in this study is voluntary and that participants have the right to ask questions and withdraw from the study at any time with no penalty. Likewise, the form includes a statement about confidentiality, emphasizing that the information provided by the participants would be protected and the answers from the survey would be aggregated into general results without linking any personal information of the key person. Finally, the methods for information gathering/dissemination were in a culturally sensitive manner. In addition, basic counseling skills have been generally utilized especially in the interviews, such as, active listening, empathy, and reassurance. In addition to avoiding the usage of harsh language that may alienate participants.

Results

Survey

The survey examined five areas of beliefs and knowledge regarding sexuality and gender.

Misconceptions and Knowledge. The first set of questions was designed to assess common misconceptions about sex. The most prominent misconceptions in Egypt include beliefs about masturbation, menstruation, men's ability to control sexual desire, virginity and

sensitivity of female reproductive organs. Most of the social workers and psychologists who took the survey, 79%, believed that masturbation causes serious damage to health ($M=4.21$, $SD=1.2$), and 66% believed that menstrual blood was dirty ($M= 3.8$, $SD =1.3$). Fifty-four percent thought that after a certain point of arousal a man cannot control himself ($M= 3.6$, $SD =0.9$), and 64% thought that the vagina was the most sensitive organ of the woman's reproductive system ($M= 3.6$, $SD =1.42$).

Most of the respondents, 61%, believed that virginity was the women's honor ($M= 3.6$, $SD =1.4$) and about third 32% believed that women should bleed the first time of having sex (intercourse) ($M=2.86$, $SD= 1.44$). Most of the respondents disagreed when asked if they think that contraceptive use is against God's will ($M = 2.23$, $SD = 1.2$). Almost half of the participants 47% believe that it is the women's responsibility to ensure contraception is used regularly. See Table 3 for a summary of the data on these items.

Misconceptions About Sex	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD
Masturbation causes serious damage to health	3	11	4	14	53	4.21	1.2
Contraceptive use is against God's will	30	29	12	7	8	2.23	1.2
A woman should bleed at the first time of having sex (intercourse)	17	25	15	9	19	2.86	1.4
Most women don't desire sex	11	28	37	6	1	2.49	0.8
The vagina is the most sensitive organ of the woman's reproductive system	8	7	17	30	25	3.66	1.2
After a certain point of arousal, a man cannot control himself	2	6	28	35	12	3.6	0.9
Menstruation blood is dirty	8	8	10	24	33	3.8	1.3
Virginity is the woman's honor	10	12	9	21	32	3.6	1.4

Table 3: Results of the Survey about misconceptions about sex

To see if there were differences in misconceptions about sex based on gender and marital status, a two-way ANOVA was conducted using SPSS. The five questions in this section were summed in order to reduce the number of variables. Women had a more

accurate understanding than men ($F(1,87) = 4.1, p = 0.047$), and there was an interaction between gender and marriage, with married and single women and married men having a more accurate understanding than single men ($F(1,3.9) = 0.264, p = 0.047$). See Table 4 for a summary of the data on these items.

Misconceptions	Marital	Gender	Mean	SD	N
	Single	Women	20.13	5.5	22
		Men	24.46	4.05	13
		Total	21.7	5.3	35
	Married	Women	21.3	2.4	15
		Men	21.6	5	16
		Total	21.5	3.9	31

Table 4: Survey results gender, marital status and misconceptions about sex

Basic Knowledge about STIs. Participants were able to identify 4 out of more than 30 sexually transmitted infections according to WHO (2016). The majority (78%) correctly mentioned AIDS, (14%) mentioned Syphilis, Gonorrhoea Hepatitis C and B. Only four percent mistakenly included cancer and tuberculosis.

Gender Equality. Forty percent of the survey respondents believed that women should be subordinate to men, 22% believe that men and women are not equal and 29% believe that men should have the final word in the household. Table 5 provides a summary of the data on these items.

Gender Equality	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD
Women should be subordinate to men	18	16	16	18	16	2.98	1.4
Men and women are equal	8	11	17	17	32	3.64	1.35
Men should have the final word in the household and have guardianship over his female relatives	15	25	20	15	10	2.76	1.2

Table 5: Results of the Survey about Gender equality

To see if there were differences in attitudes towards gender equality based on gender and marital status, a two-way ANOVA was conducted using SPSS. The three questions in this section were summed in order to reduce the number of variables. Results indicated that women are supportive of gender equality compared to men ($F(1,75) = 10.4, p = 0.002$). Single men believe less in gender equality compared to married men ($F(1,48.2) = 6.671, p = 0.012$). See Table 6 for a summary of the data on these items.

Gender Equality	Marital	Gender	Mean	SD	N
	Single	Women	7.17	2.5	23
		Men	10.9	4.05	13
		Total	8.5	2.9	36
	Married	Women	7.0	2.4	15
		Men	8.08	5	16
		Total	7.5	3.2	33

Table 6: Survey results gender, marital status and gender equality

Gender roles. Upon asking participants if there were specific and different roles for men and women, 73% agreed that men and women should have different roles ($M=4.0, SD = 1.3$). Moreover, 45% disagreed that unmarried women should have the same right to live on their own as unmarried men ($M=4.0, SD = 1.3$). See Table 7 for a summary of the data on these items.

To see if there were differences in attitudes towards gender roles based on gender and marital status, a two-way ANOVA was conducted using SPSS. The six questions in this section were summed in order to reduce the number of variables. There was no significance of gender and marital status on attitudes towards gender roles. See Table 8 for a summary of the data on these items.

Attitudes towards gender roles	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	M	SD
It is mainly the woman's responsibility to ensure that contraception is used regularly.	11	13	22	17	24	3.34	1.3
There are specific and different roles for men and women.	4	7	9	27	36	4.0	1.1
A woman's most important role is to take care of the home and cook for the family	24	20	19	14	8	2.55	1.3
I think it is shameful when men engage in caring for children or other domestic work	41	22	6	8	8	2.06	1.33
It is the wife's responsibility to satisfy her husband's sexual desire	12	17	23	25	8	3.0	1.2
Unmarried women should have the same right to live on their own as unmarried men	21	18	15	14	17	2.86	1.4

Table 7: Results of the Survey attitudes towards gender role

Gender Roles	Marital	Gender	Mean	SD	N
	Single	Women	17.4	3.6	23
		Men	19.2	4.05	13
		Total	18.0	3.8	36
	Married	Women	17.1	4.1	15
		Men	18.5	4.3	18
		Total	17.8	4.2	33

Table 8: Results of the Survey gender, marital status, and attitudes towards gender roles

Double standard. Eighty-one percent believe it is important for a woman to have pleasure during sex ($M=4.24$, $SD = 0.9$). Forty-six percent agree that it is okay for men to have some sort of sexual experience before marriage ($M=3.05$, $SD = 1.4$). However, the percent dropped to 31% when asked if it is okay for women to have the same experience ($M=2.67$, $SD = 1.4$).

To see if there were differences in double standard based on gender and marital status, a two-way ANOVA was conducted using SPSS. The five questions in this section were summed in order to reduce the number of variables. Married individuals were found to have less biased view on issues related to gender double standard than single ($F(1,60) = 4.7, p = 0.034$). However, there was no significance of gender. See Table 9 for a summary of the data on these items.

Double standard	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD
It is sad for a woman not to get married	13	22	25	11	13	2.87	1.2
It is sad for a man not to get married	11	22	22	12	14	2.95	1.2
It is important for a woman to have pleasure during sex	3	2	9	28	42	4.24	0.9
It is fine for a man to have some type of sexual experience before marriage	19	13	13	25	15	3.05	1.4
It is fine for women to have some type of sexual experience before marriage	27	11	20	17	10	2.67	1.4

Table 9: Results of the Survey about Gender Double Standard

Gender-based violence. Thirty percent of the respondents believe that a man has the right to ask for sex anytime from his wife ($M=2.68, SD = 1.4$). Twenty-four percent agreed early marriage can prevent adultery ($M=2.6, SD = 1.4$). Twenty percent of the respondents believe that women are usually responsible for being harassed ($M=2.49, SD = 1.3$). Eighty-one percent ($M=1.8, SD = 1.4$) disagreed that woman should tolerate violence to keep the family together. Sixty-six percent disagreed that circumcision is good as it makes women less sexually demanding. See Table 10 for a summary of the data on these items.

To see if there were differences in attitudes towards GBV on gender and marital status, a two-way ANOVA was conducted using SPSS. The seven questions in this section were summed in order to reduce the number of variables. Women were less tolerant to GBV than men ($F(1,588) = 31, p = 0.000$). Married individuals are less tolerant to GBV compared

to single individuals ($F(1,106) = 5.6, p = 0.021$). See Table 11 for a summary of the data on these items.

Attitudes about GBV	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	M	SD
A woman should tolerate violence to keep the family together	40	30	9	4	2	1.8	0.9
Female circumcision is good as it makes women less sexually demanding	33	24	14	10	3	2.12	1.1
There are times when a woman deserves to be beaten	41	23	9	7	4	1.93	1.17
A man has the right to ask for sex anytime from his wife	18	22	19	21	5	2.68	1.2
Most men prefer their wives to be circumcised	15	20	35	10	4	2.62	1.06
Early marriage can prevent adultery	26	17	20	7	14	2.6	1.4
Women are usually responsible for being harassed.	27	14	24	10	8	2.49	1.3

Table 10: Results of the Survey about gender-based violence

Gender-Based violence	Marital	Gender	Mean	SD	N
	Single	Women	14.0	4.5	23
		Men	21.5	5.07	13
		Total	16.7	5.8	36
	Married	Women	12.8	2.6	15
		Men	18.2	5.17	18
		Total	15.7	4.9	31

Table 11: Results of the Survey about gender, marital status and gender-based violence

Beliefs about Sex Education and Comfort with Talking about Sex. Under beliefs about sex education and comfort with talking about sex, six questions were explored. The first set of questions asked about the importance of sex education. Most of the respondents, 80%, thought that sex education was important ($M = 4.14, SD = 1.09$), but 19% believed that

providing sex education to adolescents might increase their sexual activities ($M= 2.37$, $SD = 1.1$), and 11% believed that sex education went against their religious beliefs ($M= 2.05$, $SD = 1.08$).

The second set of three questions aimed to assess the comfort and readiness of the participants in terms of comfort with talking about sex-related issues with their clients. Thirty-five percent ($M= 2.93$, $SD= 1.2$) said that they did not feel comfortable talking about sex with their clients. When the participants were asked about their level of confidence and knowledge, 32% believe that they don't have enough information to talk confidently about sex with their clients ($M= 2.86$, $SD= 1.2$). As for the language used (33%) say that they feel more comfortable using English words to express matters related to sex education and (33%) were neutral to the language type ($M= 3.08$, $SD= 1.1$). See Table 12 for a summary of the data on these items.

Personal beliefs about sex education	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD
I believe Sex Education is important	3	7	7	27	42	4.14	1.09
I believe that providing Sex education to adolescents might increase their sexual activities	22	33	15	12	5	2.37	1.173
Sex education goes against my religious belief	32	31	13	7	3	2.05	1.08
Comfort and readiness to talk about sex	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD
I don't feel comfortable talking to my clients about their sexual issues	14	15	27	23	7	2.93	1.196
I don't have enough information to talk confidently about sex with my clients	10	29	20	19	9	2.86	1.193
I feel more comfortable using English words to express matters related to sex education.	6	21	29	18	11	3.08	1.126

Table 12: Results of the Survey about Beliefs and comfort about sex education

Barriers to Sex Education. Upon asking respondent to check all the answers applied about the common barriers they face in talking about sex education, 64% marked due to

client embarrassment and 50% is due to their own embarrassment, followed by the lack of knowledge which is consistent with the earlier finding that 40% said that another barrier is that they don't know enough. See Table 13 for a summary of the data on these items.

Barriers to sex education	Percent	Frequency
My clients are embarrassed and that makes it difficult	64%	54
I find talking about sex embarrassing	50%	42
I don't know where to find the information needed	28%	33
I was taught that sex is not something to talk about	25%	24
I don't see myself as someone who knows enough to discuss sex with clients	24%	21
It's not considered part of my job to discuss sex	14%	12
Talking about sex goes against my religious beliefs	3%	3

Table 13: Results of the Survey barriers to sex education

Sources of sex education. The most common source of information on sex was media at 40%, followed by 33% who got knowledge from their friends and 15% who said that they had received some education about sex from their families while 15% did not receive sex education at all. Twelve percent said that they have received education through trainings on sexual and reproductive health and relevant books. See Table 14 for a summary of the data on these items.

Source of sex education knowledge	Family	School	Media	Friends	No education
Frequency	13	15	33	28	13
Percentage	15%	17%	38%	32%	15%

Table 14: Frequency table on the educational source for sex education

When and What to Teach. When participants were asked about how early they thought children should be taught about sex, the majority (40%) thought it was better to start at preparatory level (12 to 15) years old, (27%) believed it should start at the primary level, while (15%) believe that sex education should start just before marriage. Upon asking to mark all that applies to what a social worker should be knowledgeable about in order to deal with sexual issues among children and youth, the majority of the respondents want to learn about healthy relationships, decision-making, STIs, sexual abuse and commitment in marriage. Table 15 shows the arranged topics according to the frequency of their selection.

Healthy relation-ships	Decision making	STIs	Sexual abuse	Marriage commit-ments	Anatomy	Sexual assaults	Friend-ships	Gender	Love	Birth control	Homo sexuality
55	52	50	48	47	45	45	26	26	25	21	5

Table 15: Results of the Survey about gender, marital status and gender-based violence

Interviews

The qualitative analysis using inductive coding revealed six main themes: “importance of sex education”; “barriers to sex education”; “common problems encountered, misconceptions and interventions”; “gender, sex and sexuality”; “gender-based violence”; and finally, “recommendation for the sex education curriculum”.

Theme 1: Importance of sex education.

The analysis showed that all participants ($n = 11$) believed that sex education was very important. Three of them mentioned that sex education is especially important nowadays due to the unprecedented widespread access to the internet, pornography and social media, which contains many unreliable resources that could be potentially harmful and lead to undesirable behaviors. Therefore, if there is sex education, there will be less room for false and

misleading information, and this will enhance their professional competence as social workers and psychologists. As Ms. Hoda¹ in Cairo said:

I see it as very important now due to the increased openness. Children are not as they used to be. Now, they have access to internet, social media, and their friends have more information. So, it is better to provide them with the correct information than to leave them exposed to any sort of knowledge they may come across. Giving them the sufficient information will fulfill their curiosity so that they would not search for it further. We urgently need that training. That will create a huge impact in our way of dealing with children. Because some kids come and ask me questions that I don't know the answer to, and I ignore it which could potentially put him in danger.

Concerns about Masturbation. Four of the participants stated that sex education is especially important for teenagers because this when they usually start masturbating. Mr. Maged from Assiut said “sex education has special benefit in rural areas because it will aid in decreasing social embarrassment around the topic”.

Concerns about pornography. There seemed to be a concern about the nature of the sexual dynamics presented in the pornographic materials. Mr. Moustafa from Cairo said:

Sex education is very important because during the past 10 years the internet usage became very widespread, access to pornography websites and increased practice of masturbation among boys and girl. Therefore, sex education became more important than before due to the availability of wrong resources, such as: school friends and the internet. I believe that there is no male youth who have never been exposed to pornographic materials. There are sadistic practices in those materials, so boys may learn that torturing women is a fun thing to do.

¹ The names used are pseudonyms in order to protect the confidentiality of participants

Child protection. One of the social workers in Assiut Ms. Zeina, considered sex education as a method for child protection. She said:” Sex education is important because it helps the girl to protect herself so that she can protect her children later on so that they none of them get abused or harassed”.

On asking about the negative outcomes that may arise with sex education, only Mr. Ahmed, one of the social workers in Assiut, mentioned that sex education might have a negative effect but only on a minority of people. He said, "Sex education might encourage youth towards masturbation, lesbianism and adultery. However, these problems can only happen due to poor religious upbringing, because sex education is in itself religious education." Meaning that religion includes sex education

Theme 2. Barriers to sex education.

Two subthemes emerged in terms of barriers to sex education: lack of resources and social stigmatization.

Lack of resources. Five participants mentioned that they had not received any structured education on the matter. One of the social workers, Ms. Reham, in Cairo said, “The problem mainly is the lack of information and reliable resources. We didn't receive any sex education growing up.” Ms. Hoda from Cairo as well said, “Even though I am married and have children, I don't have any knowledge on the topic of sex education.” Mr. Maged in Assiut stated, "99% of his local community in Assiut did not receive any education about sex.

Social stigmatization. Most of the participants interviewed ($n=10$) expressed openness and a welcoming attitude to answering sex related question from clients. However, two showed concern about the social stigma they would encounter from other colleagues if they heard them addressing such topics. For instance, one of the male social workers in Assiut, Mr. Maged said, “I will answer the best I can. Because that means the person, who asked wants to learn, which is good. The problem is that most of them will not ask. They will

only be encouraged to ask if the topic was brought up publicly from a person who can deliver information without being offensive or without making anyone feel embarrassed.” However, two participants mentioned that they were concerned about the social stigmatization from other colleagues or family members if they heard them discuss such matters. For example, Reham, a female psychologist in Cairo said,

Personally, I have no problem talking about sex, but other colleagues who don't share my stand and adopt the same culture might constitute an obstacle. They will consider me as impolite and disrespectful person. They will never think of what I am saying from a scientific perspective. They will be like: ‘if you are my sister, I will make you stay home instead of being involved in these disrespectful acts.’

A male social worker in Assiut, Mr. Mohamed, said, “I have no problem myself. I want to fully answer any question I am asked. However, I find other people’s looks and opinions constraining. Because I don’t want to offend them by saying words that they might not want to hear. If I did, they will think of me as a deviant.”

Some of the participants shed light on the cultural context of the topic. They mentioned that a lot of people do not get educated on the matter because it is still considered a taboo despite its growing importance. Mr. Maged from Assiut stated that the problem is not only that parents ignore their children's sex related questions, but also sometimes, they can be treated violently. He said, "The issue starts very early on when parents discourage their children from asking sex related questions. Most of the messages that the children receive when they ask sex related questions are violent. Such as "this is a dangerous territory" and "Don't ever talk about this." "It is a disgrace; don't ever bring up such a topic." "You are not well behaved." He added, "Children get reprimanded and humiliated to the point of getting kicked out of the house if they look at his neighbor or his relative. Since children are forbidden by force, they become violence perpetrators. Therefore, children get more curious

on the matter. And they become aggressors because of their parent's violent attitude.”

Another female social worker from Assiut, Ms. Zeina mentioned that the main reason why there is lack of knowledge around the topic is because of the social norms governing people's behavior. She said, “It is considered a taboo in our community despite its importance. The fact that it is a taboo, leads to other problems. If we didn't talk, we would be like ostriches burying our heads in the sand.”

Theme 3: Common problems encountered and misconceptions.

On asking the participants on the common problems they usually encounter due to lack of sex education, six subthemes emerged related to masturbation ($n = 10$), considering homosexuality as perversion "shezoz" ($n = 7$), child abuse, religion and gender along with pornography ($n=4$). A few of the participants ($n= 4$) also mentioned sexual harassment and child abuse.

Masturbation. All of the social workers and psychologists interviewed except one ($n=10$) thought that masturbation is unethical, religiously unacceptable or "haram" and medically harmful in the short and long-term. For the short term, they think it reduces sperm count before marriage, leads to prostate problems, muscle weakening, appetite loss, low productivity and morals, loss of self-confidence, mental abilities, weakening of erection, concentration and memory. As for the long-term effects, issues such as sterilization, losing eyesight, memory, and overall natural sexual instincts were mentioned. For example, Mr. Mohamed from Assiut said, “It is religiously haram (unacceptable). It is animal behavior.” Mr. Hamed from Assiut thought that the excessive practice of masturbation could affect someone's muscles and nerves to the point that he will not be able to carry or hold a chair. Ms. Zeina from Assiut also thought that masturbation had medical and ethical consequences. She stated, “Masturbation causes medical problems such as pelvic congestion syndrome for women and muscle relaxation and premature ejaculation in men. Therefore, nobody should

masturbate because it also encourages girls to promiscuity, making her more eager to get married early, in addition of being haram.”

Only Mr. Maged from Assiut considered masturbation to be a normal behavior. He said, “It is a normal practice and if the teenager didn't experience this, he will not be considered normal.”

When participants were asked what they do in cases where they deal with issues related to masturbation, the majority said they would advise them on the potential medical drawbacks. For example, Ms. Hoda from Cairo said, “I will tell him its disadvantages.

Because when he knows, he will be able to control himself.” Mr. Moustafa from Cairo,

I teach them that it is haram, although it is controversial among Muslim scholars.

However, I will not talk about the religious part. Let us talk medically; most of

ophthalmologists say that masturbation weakens eyesight on the long run. I have read about this and this is why I am quite certain that it also affects memory. There is another study conducted on students who practice masturbation in England that concluded that it reduces academic achievements.

Many also showed concerns about the effect of masturbation within the marital context. Mr. Hamed in Assiut mentioned a personal experience with his son. He said, “I took my son to the doctor and he told me he masturbates. He advised him to stop because that practice will affect his fertility later when he gets married.” Mr. Abdelhamid also said, “Masturbation leads to losing the natural sexual desire. The person becomes abnormal. He will not be able to engage in normal sexual behavior when he gets married, which might lead to his wife's infidelity, which will ultimately lead to divorce.”

Many of the participants interviewed attributed masturbation and other sexual activity before marriage to having too much free time. Therefore, they constructed their intervention approach based on this understanding by keeping them busy through sports and engaging

them in energy consuming activities. One said, "I will advise him to participate in sport to vent out his energy." Another reported that "We teach them how to control their lust and drain their energy in a positive way through sports, handcrafts and subscribing to sports clubs. So that they can follow a different path other than perversion."

Considering homosexuality as perversion. The interviews showed that all of the social workers saw homosexuality as a disease or a perversion. Some social workers believed that homosexuality was very common and occurred because of sex segregation and the wide spread portrayal of homosexual sex in pornographic materials. All of them used the word perversion "shezoz" rather than the less derogatory term for homosexuality "mithleya" to describe it. Moreover, it seems that the word perversion is used to describe any non-heterosexual behavior (pedophilia, incest, homosexuality, non-consensual sex, etc.) Seven of them mentioned that their intervention would include violence whether physical or verbal. For instance, Mr. Bassam from Cairo said, "My reaction will be violent. I might beat them both."

Others described homosexuality as a disease. One of them said: "Perversion is a disease that the child can't get rid of." In addition, others mentioned AIDS as a direct consequence of homosexuality: "AIDS came as a result of homosexuality", along with prostate cancer, internal bleeding and anal fracture. Ms. Hoda, a social worker in Cairo, said "perversion became very prominent the last couple of years, because I work with children in street situations, children are frequently exploited as they are the most vulnerable target group." Bassam, a social worker from Cairo said: "The most common problem I encounter as a social worker is "perversion" for sure. That happens among children. We also catch a lot of perversion incidents among teenagers."

When the participants were asked about their intervention approach in those cases, most of them said that they try to talk to them out of it by using religion and religious

scripture ($n=7$) such as Lot's story to frighten them. Mr. Bassem said: "I will use Lot's story and God's punishment. I will intimidate them by those stories." Another intervention strategy was to use disparaging words such as "You will be like the animal." "This is disgraceful, this is only permitted in marriage contexts, you have to love yourself, nobody should touch you and neither should you. And advise him to take a shower and pray." As one participant stated "Homosexuality destroys families. God is the one who ordained this. Marriage has to be for procreation." Others stated that they will explain to them the nature of love that it has to be between different sexes like Mr. Hamed from Assiut. Mr. Bassam from Cairo thought that a homosexual boy might have a bad influence on the rest of the group and thought that the best intervention is segregating that boy.

Unfortunately, three of them said that they would resort to physical violence. A male social worker from Assiut, Mr. Mohamed said "I will advise him first but if I have the physical ability, I will beat him. Or if beating will back fire, I will just talk to him and will escalate the matter to his parents and see if they agree on this. I will try to convert this relationship to a normal friendship away from deviations."

Religion's role in sex education. Upon asking the participants about their intervention approaches with sexual problems, it seems that religion is utilized heavily. Many of the social workers and psychologists interviewed said that they used religious teaching to reprimand, coach and restrain unwanted behavior, whether it was homosexuality, masturbation or sexual harassment. As mentioned previously, four social workers said that they would use specific scriptures to deal with homosexual behaviors.

Attitudes about gender identities. When participants were asked about their initial reaction if they saw a boy wearing a dress or found out that two adolescent boys or girls are in a romantic relationship, stereotypical exclusivity of masculine or feminine binary identity was very prominent. Any gender expression that did not fit the stereotype was looked down

upon in Cairo and non-existent in Assiut. Mr. Bassam in Cairo said, “I despise any man wearing a chain around his neck.” Moreover, a male social worker in Assiut, Mr. Abdelhamid said, “God cursed men who imitate women, and women who imitate men. This is *haram* and will lead to diseases. Like Lot’s people ... etc.” Others denied its existence totally saying “That is not possible in rural areas.” One of them said that this is an abnormality and should be referred to a psychiatrist.

Child abuse. There is a clear difference between the child abuse rates in Cairo and Assiut according to the interviews. Participants from Cairo agreed that the child abuse rate in Cairo is high given that they work with children in street situations. Mr. Tarek from Cairo said, “In homes, the percent is much lower.” The perpetrators could be colleagues, friends, schoolteachers, neighbors, drug dealers, a stranger and sometimes the father. According to participants, children on the street suffer a great deal from oppressive and violent homosexual and heterosexual acts. According to Ms. Hoda in Cairo:

We have seen a lot of perversion acts among children, when we investigate in the matter, we find out that the father for example makes him watch pornography to get him excited to replicate what he saw with him. Saying that this our secret so don’t tell your mother. Sexual abuse is very common in this target group because it is done to break the boy's ego and humiliate him (yakser 3eno). The gang leader does that to have control over his followers and makes him want him. The leader holds the dominant position in the homosexual practice to ensure that the boy stays in his circle and under his command. It is one of their mechanisms to keep boys on the street, so we try our best to get him off the street before this happens. That gang leader has many followers. He makes them sell tissues, Tramadol (addictive drugs), etc. and later in the night they all sleep in the same place. So, an older boy can easily abuse a younger boy and so on.

Ms. Hoda also reported that "Another very common incident is in the street. This is where the phrase 'I will take you to garbage ... behind the chair factory' comes from. The practice includes leaving a mark on his private parts as proof that he saw his private parts (the mark could be a bite, sting, wound, etc.)" There is a great stigma around homosexual behavior that parent or family members take extensive efforts to monitor the boy's behavior. One of the female social workers in Cairo said, "Some families do that to their children to make sure that they do these practices and if they did, they will be told upon. However, Assiut respondents agreed that it is very rare and constitutes psychological illness. "Very uncommon in our village and is considered an illness.

Theme 4. Gender, Sex and Sexuality

Gender Stereotypes. Gender stereotypes of masculinity and femininity were widespread among participants. Many participants mentioned that the most important virtue in a man is chivalry (Elshahama), showing jealousy over his wife and sister, and being an independent, family provider. Mr. Bassam from Cairo said, "Not every male is a man. A man has to be courageous, jealous. I get very surprised when I see a girl smoking shisha and wearing a mini skirt in front of her father. Where is his protection as a man and a father? How come you see this and do nothing?! I don't think that this is an example of a man." Others added "my wife is my possession; my sister is my possession. How can I allow people to see them not wearing modestly in public." "The most important thing in a man is having a strong character."

Religious roots to gender roles. Mr. Mohamed thought that the privilege/preference of one gender over the other has religious roots that might be wrongly understood. He said, "The preference of male to female is common in society. This is supported by the verse in the Quran in Surat AlNisa (4:34) Men are overseers over women, by reason of that wherewith Allah hath made one of them excel over her, and by reason of that which

they expend of their substance. This is a wrong interpretation of religious scripture. It means that the public representation of men in public spaces is higher. Then he will come home and tell her so that she intellectually grows.

Five of the respondents stated that the most important quality in a girl/woman is (Hayaa') which doesn't have a direct translation to Arabic but means "a bad and uneasy feeling accompanied by embarrassment, caused by one's fear of being exposed or censured for some unworthy or indecent conduct" helpfulness, obedience and feminine. Mr. Tarek in Cairo said, "Hayaa is the girl's corner stone. In addition to modest clothing and talking." "The most important qualities in a girl is religiosity and ethics, politeness. This will be enough to protect her from anything." And "woman's greatest strength is her weakness." Careers were seen as secondary to women's home duties. As Mr. Bassam stated, "women can achieve an academic or career success but her role in the household should be number one."

Female sexuality. Two of the social workers thought that women's sexual desire was higher than men. Ms. Amira, a female social worker in Assiut said, "Women have 99 spots of pleasure." Mr. Mahmoud, a male social worker in Cairo said, "perversion and watching pornography is more common among girls because it is medically known that women's lust (sexual desire) is higher."

Gender socialization. Participants also described gender differences in decision-making powers that impacted their ability to intervene with girls and women. A social worker in Assiut, Ms. Zeina said, "Even at schools we have been taught from a very early stage that girls sweep the floor. "I am as a girl in a village, I feel like I don't have the right to speak out my opinion or take a decision. My brother, who is younger than me, has the right to take fateful decisions in the household but not me." She continued,

When I give awareness sessions to the girls about FGM or Early marriage, one girl said to me "I am convinced that FGM is a harmful practice, but I can't take the

decision not to have my little sister circumcised or not to marry early. I am not the decision maker. Gender or sex puts her in a very limited position and that starts from a very young age. Some women cannot take very important personal decisions like how many children she will have. What birth control method she will use? The woman is looked upon from a sexual physical perspective that limits her in certain roles and prevents her from taking certain decisions. One of the most common problems that face girls here is oppression. I am not achieving my status as a girl or a woman. And that has to do with gender.”

Another female social worker from Cairo, Ms. Reham felt that, "There is a great difference between how men and women are treated and socialized. Men can stay out as long as they want and have many relationships and he will eventually get married and settle down. However, if a girl did anything wrong or didn't but was suspected, she gets judged and disgraced. This means that they will be sentenced to death while she is alive.”

In marital contexts, three participants felt that the good wife should not behave in an assertive and on an equal basis with her husband and that it is her responsibility to calm him down if any conflict aroused because of her brain anatomy as a woman. Mr. Tarek from Cairo said, “The woman should not talk to her husband as if they are equal especially if he is in a bad mood.” Ms. Hoda from Cairo, "Women have a higher ability to calm and contain their husbands to avoid any conflict from escalating. A man's brain is like a box, he gets angry if anyone interrupted him unlike women who are multitaskers.”

Theme 5. Gender-based Violence.

Participants described concerns related to female genital mutilation/cutting, sexual harassment and early marriage.

FGM/C. Religion plays an important factor in perpetuating or hindering FGM/C. All the research participants in the qualitative data set were Sunni Muslims and there appeared to

be confusion about the religious basis for FGM/C. Different interpretations or understanding of Sharia law was prominent indicating significant confusion. The variation of attitudes included agreement, disagreement and indecisiveness.

Compared to men, women showed more disagreement with and sensitivity towards the practice. Some of them shared their painful personal experiences on the matter. Although all of the women ($n=4$) said that they disagreed with the practice for issues related to the humiliation, pain, and harmful medical, and psychological consequences, two of them showed confusion about clitoris size and the necessity of the medical intervention in that case. Reham from Cairo felt that "It is wrong. I don't know if some girls are born with parts that need/should be cut or not. I don't have enough info." For male participants, only one disagreed with the practice, while the majority ($n=6$) agreed either because they saw it as a religious mandate ($n=2$) for all girls, or that it should be done only in the case of a large clitoris ($n = 4$).

Medicalization of FGM/C. Although FGM/C as a procedure is not a surgery that medical students learn about in schools of medicine, it seems that there is great authority given to medical personnel in determining whether FGM/C is needed or not. The majority ($n = 8$) mentioned the need of consulting a medical person on the issue because it seems that some of them think it is dependent on the clitoris size. However, there was no mention about the exact limit of how big it should be to be removed.

Mr. Mohamed from Assiut said, "For male circumcision, it is a confirmed Suna. However, for females it depends on the medical consultation of the clitoris size. Because if it is large it will produce fungus and a bad smell. And for males too, there will be worms under the foreskin." And Mr. Maged from Assiut stated "Although FGM is not beneficial especially to girls. If there is certain disfiguration, the doctor is the one who has to decide if a surgical

intervention is needed or not. For example, if the clitoris size is larger than it should be, then it needs to be trimmed. Other than that, it is not allowed."

Religious sanction for FGM/C. Some respondents believed that FGM/C is sanctioned by Islam, but others reported that it was against it and others seemed ambivalent or confused; showing concern that FGM/C might reduce women's pleasure in sex, thus hindering their own pleasure, and on the other hand worried that uncircumcised women will be too sexually demanding, endangering their control. For instance, Mr. Bassam from Cairo said,

I agree that FGM/C is beneficial for the girls. Because first, FGM/C is supported by prophet Mohamed. Second, because it decreases women's lust. I am very convinced by those two reasons." "I don't know what the religious point of view is on this topic. Our culture and traditions usually take a higher rank than religion. I don't know why. My point of view is that it is okay as long as it protects (prevents) girls, then there is no problem. But I am also not sure. I am not concerned about the topic. Don't know if it has drawbacks on the long run. I have heard that it might cause frigidity/lack of sexual desire, like being married to a wooden piece (senseless body). I don't know. Could you tell me more?

An example of religion as the main reason for opposing the practice comes from Ms. Hoda in Cairo, "I don't believe that I need to look further into the matter. The matter is settled (definitive) for me because it is in opposition with sharia law." Mr. Tarek, also from Cairo said "FGM is not beneficial. This is the religious point of view. It has nothing to do with decreasing lust."

Chastity and decreasing women's lust. The desire to control women's sexuality came up as a reason for FGM/C ($n = 2$). Mr. Moustafa in Cairo said, "There is a useless extra skin that has to be cut by a doctor in a medical procedure and is not considered circumcision.

It is disgraceful for the girls to experience those emotions/desires. That way she will be respectful. It lessens the women's lust. If the clitoris is large, it should be removed. This is the religious sharia law."

Hygiene. One additional factor reported in the qualitative data included health benefits cleanliness and hygiene ($n = 1$). "I recommend consulting a specialized doctor before proceeding. It has nothing to do with chastity and girl's honor. It could be related however to hygiene. Some fungus could accumulate. In that case, it is better to be removed." Mr. Mohamed from Assiut.

Reasons for opposing FGM/C. Some participants opposed FGM/C due to potential problems including death due to infection or bleeding, mutilation of reproductive organs, and elimination of sexual desire. For example, Ms. Tasneem from Cairo argued that "FGM should not happen because it results in frigidity. Women should enjoy completely with their spouses so that they wouldn't seek outside relationships." Ms. Amira from Assiut opposed the practice because of her own experience, saying "I had a very bad experience with FGM. I bled and suffered. I had daughters. I will never do that to them." "No girl forgets the day that it happened. It is very painful and humiliating and unfortunately a lot of women support it." And Ms. Zeina from Assiut felt that "FGM is not beneficial. It has significant medical, psychological and social drawbacks including humiliation, which makes the girls very introverted and shy from a very young age. From a medical perspective: the girl could bleed, and get an inflammation Why do we do it? Do we do it for chastity? Chastity is acquired by education and religious education. The sexual stimulus exists in the brain."

Sexual Harassment. Most of the female social workers and psychologists interviewed ($n = 7$) had a good understanding of the roots of sexual harassment. Two shared some personal sexual harassment incidents that reflected strength and proactivity. Ms. Reham said, "I used to be afraid. But the last time that happened, I took the harasser to the police

station.” And when asked about the explanation that women’s clothing leads to harassment, she said:

I don’t think that women’s clothes are the reason for sexual harassment. Because if we compared the current percentage of harassment to the old days, now it is much higher, even though they used to wear more open than now. Currently the number of women wearing hijab is much higher as well as sexual harassment. Women dress more modestly and harassment is higher. So, there is no correlation. They choose to harass the quiet girl that will do nothing to defend herself.

Ms. Zeina stated that sexual harassment can happen due to lack of sex education because sex education includes teaching about rights and boundaries and sexual harassment is invading someone's privacy.

Sometimes a man harasses and he doesn’t know that this action constitutes sexual harassment. Like standing very closely to a girl in a bus or something. This is a problem that is also common between married couples because the husband thinks that he has ownership over his wife's body. Therefore, the teenager should be taught that he/she has ownership over his/her body. Sometimes religion doesn't prevent harassment or traditions or even the legal penalties. One should be taught that her/his body is her own. And nobody has the right to touch it.

She added that harassment became widespread due to the lack of morals and family dissociation (lack of familial cohesion). “Nowadays, parents care about getting their kids to the faculty of medicine or pharmacy more than raising a well-mannered person. They care about guaranteeing him a financially secure future than raising a good person.”

However, the men who were interviewed tended to repeat the widespread justification of harassment and victim blaming. For example, Mr. Tarek from Cairo said

The main reason sexual harassment exists is the high cost of marriage arrangements. The second reason, which is very important, is the girl's clothes. If she is wearing provocative clothes, she will encourage harassment because he is a human being. The problem of sexual harassment in Egypt is increasing due to the delay in the age of marriage. The perpetrator no longer has control over his desires. Another male social worker from Assiut, Mr. Hamed, said that "a woman is supposed to know her boundaries and that of the other. Men and women share the responsibility in any sexual harassment incident. Also, excessive freedom. Like wearing transparent and tight clothes could encourage sexual harassment because men are psychologically weak."

In Assiut, most of the participants, males and females, agreed that sexual harassment incidents are very rare due to the different nature of the rural community where they all know each other compared to the urban ones, which acts a protective factor. One of the social workers Mr. Ahmed said: "There is no sexual harassment in rural areas. Because we know this girl's father and she knows I am whose son. So, her father might shoot me if something like this happened. Fear, because we know each other. Unlike Cairo, where people don't know each other. Ms. Amira from Assiut said, "It is very uncommon here. But whenever that happens women hide this matter from men to avoid violence. So, they beat whoever does this and let him go to keep things from escalating. It is possible for a sexual harassment incident in such villages to reach retaliation between families."

Attitudes towards Early marriage. On asking participants about the earliest age the girl could be married, most of the respondents (n = 9) agreed with the legal age specified by the law which is 18. Two male social workers in Cairo said that the girl's marriage age should be in accordance with Sharia law. Mr. Moustafa in Cairo said, "When the girl reaches puberty according to sharia law. But also depending on the context. In the desert, the girl can

get married at 12 years old." And Mr. Tarek from Cairo added, "The girl can get married as early as 16 years old."

Theme 6. Recommendations for a sex education curriculum.

Comprehensive. Five participants recommended that a sex education curriculum should be comprehensive. As Mr. Maged from Assiut said, "It should be holistic and comprehensive in nature; discussing the matter from a psychological, social and medical perspective." It was suggested by Ms. Zeina from Assiut that "Sex education is not only about the body but it is mainly about gender roles. The girls get marginalized from a very young age. Even the school teacher asks the young girls to sweep the classroom floor and those school teachers are highly educated but gender is social, and people reproduce the same societal values." Mr. Moustafa from Cairo suggested a thorough medical training excluding religion because there are different schools in the same religion. "I recommend a thorough medical training excluding religion because there are different schools in the same religion".

Trainers skills and personality. Two of the participants mentioned that the trainer has to be very confident and skilled due to the nature of the topic. As Ms. Zeina said, "The trainer has to have good communication skills, be knowledgeable, spontaneous, confident, culturally sensitive, use simple and clear language and present ideas and knowledge instead of forcefully imposing them." It was suggested that the approach be interactive and practical including real examples and best intervention practices. The recommendations included providing the social workers with an age-specific guide on what children need to know and when they need to know it. In addition, participants recommended that information regarding the human's anatomy, STIs, sexual harassment and child abuse be included. Finally, they highlighted the necessity of the training in schools and for all social workers. As Mr. Bassam said, "It should be mandatory for all social workers."

Discussion

A survey of 86 social workers and eleven in-depth interviews were conducted in order to better understand how they viewed and dealt with sexuality, gender roles and sexual and gender-based violence. Analysis of both the quantitative and qualitative data showed that most of the social workers strongly believed in the importance of sex education. However, they also held various misconceptions about normal body functions such as masturbation, menstruation, men's ability to control sexual desire, virginity and sensitivity of female reproductive organs, as well as gender stereotypes that support gender-based violence and gender inequality. It was found that women were less tolerant of gender-based violence, more supportive of gender equality and had fewer misconceptions related to sex compared to men. Married men held less tolerant views of GBV, were less likely to hold stereotypical gender roles and double standards and were more supportive of gender equality than single men.

Misconceptions About Sexuality

It was found that the social workers and psychologists in the current study had a number of misconceptions about sex, including misconceptions about masturbation, menstruation blood, men's ability to control sexual desire, virginity and the sensitivity of female reproductive organs.

Masturbation. The majority of participants saw masturbation as unhealthy and a sin. Many cited common false claims around masturbation that were listed by Nichols (2017), such as going blind, impotence later in life, erectile dysfunction, penis shrinkage, low sperm count, infertility, and physical weakness. Research on masturbation has indicated that, contrary to these traditional beliefs, masturbation is a common sexual behavior and is actually linked to indicators of sexual health. According to Coleman (2003), there are a number of benefits to masturbation, including reducing stress, releasing tension, enhancing sleep quality, boosting concentration, elevating mood, relieving menstrual cramps and

preventing STIs and pregnancy. Masturbation can have positive impact on early sexual development and on one's capacity for healthy sexual relationships later in life (Hogarth & Ingham, 2009). Masturbation may lead not only to a person learning about their own sexual response and pleasure, but also to a sense of autonomy and bodily integrity that may improve a person's self-esteem and sense of identity. In this way, masturbation might contribute to positive intimacy experiences and improved sexual satisfaction and health (Coleman, 2003). Also, masturbation is commonly recommended for treating premature ejaculation among men (Tiefer, 1998).

Masturbation in Egypt is a very sensitive topic. It is often publicly referred to as the 'secret habit.' It may be viewed in opposition with religious and cultural beliefs and those who practice it may experience feelings of guilt. According to a study done on 484 male medical students in Tanta, 70.5% reported feelings of guilt as a side effect of masturbation (Kabbash, 2017). Social workers need to be informed about the lack of harm and actual benefits associated with masturbation and taught how to communicate in a way that will address concerns about religious and cultural taboos that are associated with self-pleasure. Moreover, social work professionals need to understand that sexual activities are not exclusive to reproduction. A distinction between recreational and reproductive sex should be addressed. In his classic book, *The Psychology of Sex*, Havelock Ellis (1933) argued that masturbation is an important part of the development of human sexuality. Moreover, sex is essential for both mental and physical well-being not just for the functionality of reproduction.

Homosexuality and Perversion. Although in the qualitative data, the majority of the interviewees stated that perversion (meaning homosexuality) was a common problem they faced, it was the least chosen topic to learn about in the quantitative analysis. This might be due to incorrect knowledge regarding homosexuality as was seen in the interviews. All

except one participant used the word perversion “Shezoz” which is associated with very negative cultural connotation rather than “Mithleya” to describe homosexual behavior. All saw homosexuality as going against religious beliefs and some saw it as a disease. Many of them mentioned that their intervention would be through violence whether physical or verbal.

Menstrual Blood and Stigma Around Women’s Bodies. Most of the social workers believed that menstrual blood is dirty. Such socio-cultural, religious or traditional beliefs contribute to restrictive practices either self-imposed or imposed by others on menstruating girls and women. These restrictions may include reduced mobility, seclusion, and isolation them from fully participating in community (Mohamed, 2018). The stigma, embarrassment and silence around menstruation can contribute to gender inequality that discriminates against women and girls (Winkler, 2014). Menstruation stigmatization is rooted in some religions, in Judaism, Christianity, Islam and the Hindu faith, (House, 2013). Lack of participation in religious activities due to menstruation reinforces adverse gender norms in which women are perceived as lesser. Therefore, it is crucial that social workers and psychologists learn correct information about menstruation so that they are more sensitive in dealing with it as a normal bodily function and be able to avoid perpetrating this harmful culture.

Another misconception that emerged from the qualitative analysis was that menstruation signifies girl's readiness for marriage. Two of the social workers mentioned that the earliest age of marriage corresponds to the onset of menstruation according to Sharia law. This interpretation of Sharia law may not be accurate because it disregards the social, historical, economic and political context in which those verses emerged. It would be beneficial to the social workers to learn more about the readiness of an individual to enter into marriage, healthy relationships and commitment.

Poor knowledge about anatomy, female sexuality and FGM/C. Most of the participants thought that the vagina was the most sensitive organ of the woman’s

reproductive system. However, according to the literature, the clitoris is the primary source of female sexual pleasure, as it is the most sensitive erogenous zone of a female body (O'Connell, 2005). A study around FGM/C and sexuality in Egypt concluded that the clitoris was perceived to be the source of sexual desire rather than sexual pleasure and FGM/C was intended to reduce women's sexual appetite and increase women's chastity but was generally not believed to reduce women's sexual pleasure (Fahmy, 2010). This finding signifies confusion and poor understanding of female reproductive organs.

Religion has been utilized to support and oppose views on FGM/C indicating the powerful nature of religion in guiding people's behavior and the different interpretations of religious scriptures. In Islam, some argue that while it might not be mandatory, it is still part of the *sunna*, a recommended practice. Others see it as a violation (Johnsdotter, 2003). In a recent study, a variety of cultural myths, religious, and hygienic concerns were behind the FGM/C. Overall, a large proportion of the participants supported the continuation of FGM/C in spite of adverse effect and sexual dysfunction associated with FGM/C (Mohammed, 2014).

Confusion is not only restricted to different schools of religious thought but also included the size and role of the clitoris. Confusion about the clitoris size was repeated many times during the interviews and the majority mentioned the need to consult a medical person on the issue. This procedure is not a surgery that medical students learn about in schools of medicine, but it seems that there is great authority given to medical personnel in determining whether FGM/C is needed or not. According to the 2015 Ministry of Health and Population survey, an estimated 82 % of FGM/C cases were conducted by doctors or other medical personnel. The justification provided is the clitoris size which is unethical, vague, and unscientific criteria. Social workers have a paramount role in combating FGM/C and other types of GBV through education, enforcing law and providing counseling to women and girls

who have undergone the procedure. Hence, it is important for social workers and psychologists to gain knowledge about the practice itself and the reasons for its continuation, as well as experience with interventions that can more effectively lead to its abandonment. Application of this knowledge through a common, coordinated approach that promotes positive social change at community could lead to female genital mutilation being abandoned. A rights-based approach should be embraced; every woman has the right to have sexual health and to feel sexual pleasure for full psychophysical well-being (Mackie, 2009).

Virginity and Hymen Bleeding. Most of the respondents believed that virginity is the women's honor and about a third believed that women should bleed the first time having sexual intercourse. Poor understanding of the nature of the hymen has caused too much harm and led to many honor crimes and stigmatization (Bekker, 1996; van Moorst 2012). It is widely believed that the hymen corresponds to virginity. If a bride does not bleed from a ruptured hymen on her wedding night, this means that she has had sex and is not a "virgin" (Frank et al 1999). Many People wrongly believe that the vaginal corona is a thick membrane that entirely covers a woman's vaginal opening and ruptures the first time you have intercourse, which is not true. It may be insignificant or even completely absent at birth; around 30% of women are not born with it and a significant percentage of women do not bleed during first intercourse, with figures ranging from 40% and 80% according to several studies (Bekker et al 1996; Loeber 2008; van Moorst et al 2012). Knowledge of the hymen anatomy and its abnormalities is essential to eliminate misconceptions about it.

Attitudes toward Gender and Gender-Based Violence.

While overall, survey respondents disagreed with statements supporting GBV, women were more strongly disapproving of GBV than men, and married men and women were more strongly disapproving than single men and women. This may be because both gender and marriage appeared to impact beliefs about gender roles, the double standard, and

misconceptions regarding sex. Studies have shown that gender role attitudes and endorsement of a double standard can impact sexual behavior and attitudes toward sex (e.g., Lefkowitz, Shearer, Gillen, and Espinosa-Hernandez, 2014), and that women are less likely to endorse gender role stereotypes, gender inequality, and the double standard (e.g., Ali et.al, 2017; El Feki, 2017; Kagesten et. al, 2016; Zuo et. al, 2018). This finding is consistent with another study conducted in Pakistan which concluded that boys usually endorse more patriarchal gender beliefs compared to girls (Saeed Ali, 2017). These types of gender double standards beliefs are closely linked to poor sexual and reproductive health-related (Kågesten, 2016). The same outcome was confirmed by another study in the United States which concluded that a sexual double standard was associated with more conventionally gender-stereotyped sexual behaviors such as more sexual partners and women who were more conventional about men's and women's sexual roles perceived more barriers to using condoms (Lefkowitz, 2014).

It was interesting to also find that marriage impacted attitudes toward GBV, gender stereotyping and double standards. This could be because married participants are more exposed to the consequences of GBV such as FGM/C and its implication on marital satisfaction. Previous research has found that younger Arab men have more traditional views about gender than older Arab men (El Feki, 2017). Another possibility is perhaps marriage in a highly gender-segregated culture like Egypt's, challenges gender stereotypes as it brings men and women into more intimate contact (El Feki, 2017).

Men's Sexual Desire. A small majority of the survey respondents (54%) thought that after a certain point of arousal a man cannot control himself. This stereotype about men also came up two times in the qualitative analysis. For instance, one of the male social workers in Assiut said while talking about sexual harassment "Men are psychologically weak and have no control over their desires. Therefore, it is the women's responsibility to cover up and have overall control of the situation." This view of the male sex drive is fundamental to normative

heterosexuality (Messerschmidt, 1986), and is connected to justification and tolerance of different sorts of gender-based violence. If male sexuality is naturally aggressive and women are expected to be gatekeepers of male desire (Fine 1988; Tolman 1991), then men cannot be held accountable for sexual harassment and sexual assault and other forms of criminal sexual behavior (Connell 1987; French 2003; Messerschmidt 2012).

Sexual Harassment. Only 20% of survey respondents agreed or strongly agreed that women were to blame for sexual harassment, and female participants were less likely to blame victims of sexual harassment than male participants. This relatively low rate of agreement is in contrast to a survey of young people in Egypt which found that 60% agreed that women who dress provocatively deserve harassment; however, similar to the present study, young men were more likely to agree than young women (Sieverding & Hassan, 2016).

Interestingly, in Assiut it was suggested that there may be a protective factor that doesn't exist in urban Cairo, which is the fact that all of the people in the village know each other, and sexual harassment can lead to familial revenge (*Tar*). The study conducted by UN women confirmed that harassment is more widely spread in urban than in rural areas (UN Women, 2013).

It is critical for social workers to understand the concept of sexual harassment as a form of social violence restraining women's participation in the public sphere and threatening their overall feeling of security. For the minority who blame the victim for harassment, it must be made clear that harassment is not caused by what the victim wears or does. A distinction between experiencing sexual arousal and harassment needs to be clear. Moreover, understanding social workers need to be aware of the relational dynamics between gender, sexuality and violence that reproduces inequality. According to Stein et al. (2002), sex education must include gender equity education. By investing and treating social workers as

agents and decision makers, we could create spaces where they can work together with different layers of the community to create social change.

Gender Ideology, Inequality and Violence. The majority of participants believed that women and men should have different roles, with many believing women should be subordinate to men. Masculinity was associated with dominance, toughness, chivalry and ownership of females, and femininity was associated with having ‘Hayaa’, modesty, submissiveness and obedience; as one of the participants said, “A women’s strength lies in her weakness.” Unfortunately, this type of gender ideology induces, legitimates and invokes sexist stereotypes, sustains gender inequality and disarms women’s decision-making power, autonomy and self-protection (Mitra, 2007; Paxton, 2007). Adoption of patriarchal attitudes was found to be closely related to violence inflection (Kågesten, 2016). Consequently, improving women's status is not just a worthy goal in terms of gender equality, but also has important implications for combating GBV as it is strongly linked to power (Paxton, 2007). According to WHO (2010), gender inequality is a key determinant that underpins violence against women in most societies.

Gender Double Standard. Survey respondents disagreed that it was fine for a woman to have some type of sexual experience before marriage but were neutral about men’s extramarital sexual activities. That inconsistency indicates a double standard based on gender. Although culture and religion require that both men and women marry as virgins (Moorst, 2012), in practice the virginity rule and its consequences are enforced on girls and young women only, and not on boys and young men (Bekker 1996; Saharso 2003). Whereas promiscuity is generally accepted for boys and may even gain them prestige (Bhugra 1998; Gürsoy & Vural 2003), girls are scorned and and/or punished if they engage in the same sort of behavior. This finding is also supported by the qualitative analysis and is consistent with another study on perceptions of gender roles in sexual relations in Egypt. It was found that

more males than females agreed that men should have experience to teach their women (72.5% males vs. 52.9% females) and that having extramarital sexual relations was worse for women than men (18.1% vs. 4.6%), (Kabbash, 2018).

Social workers need to be provided with a safe space to examine their own gender biases to avoid reproducing them. Being aware of their own biases will positively influence the quality of their interventions and will assist, on the long run, in creating a healthy culture that supports gender equity and reduces GBV. They also need to be aware that adhering to conventional social norms may have negative consequences for both women and men.

Religion's Role in Sex Education.

Religion did not constitute a barrier to sex education either in the qualitative or in the quantitative analysis to the respondents. In fact, it was very prominent in the interviews that religion was utilized frequently as an intervention method to commonly encountered problems. This could be due to the lack of scientific resources or to the importance of religion to the Egyptian society. One male social worker in Assiut said that religious teaching includes sex education. This attitude is confirmed by the literature. According to Ashraf (1998), Islam has a positive vision of sexual life and considers sexual urges as a natural quality in human beings. Sex education has been recognized as a crucial part of a child's religious upbringing (Sarwar, 1996). Symbolic of this positive attitude, sex has an important place in paradise (Sanjakdar, 2013). However, dominant Islamic discourse on sexuality focuses on gender differences and expects men and women to conform to 'masculine' and 'feminine' gender-role norms prescribed in Islamic traditions (Mabud, 1998) and is intolerant of any expression of sexuality outside the heterosexual marital framework, including premarital sex (Yip, 2016).

Among interviewees, there was some confusion between what was religious and what was scientific, and a tendency to misuse religion. For instance, it appeared that the primary

intervention in cases of masturbation and homosexuality was done primarily through religious threats and intimidation by recalling Lot's story and God's punishment from the Quran. In addition, interviewees mentioned pseudoscientific information and incorrectly claimed that it had a religious basis, such as losing eyesight and memory from masturbation. Social workers need to learn that intentional or unintentional use of religion to coerce, threaten, reject, condemn, or manipulate an individual into following "religious" views about sexuality constitutes a form of religious abuse. This abuse may result in great harm to the victim by causing low self-esteem, guilt, shame, spirituality loss, substance abuse, or thoughts of suicide (Super & Jacobson, 2011). Therefore, social workers need to develop awareness of what it means to properly help clients to navigate any divide between religious, cultural or spiritual beliefs and healthy expression of sexuality.

Importance of Sex Education.

Both the quantitative and qualitative data were consistent with literature on the importance and the need for sex education in general and specifically for social work professionals. The majority of participants agreed that the importance of sex education is currently unprecedented due to the uncontrolled widespread access to pornography across different socioeconomic classes. When participants in the current study were asked about sex education resources, media and friends came on the top of the list. The culture of silence around sexual matters has contributed to driving youth to often less accurate sources, like friends, the internet, and pornography (Leonard, 2010; Ibrahim, 2010). Information from these sources is often misleading and damaging without equipping young people with the necessary information and principles they need to make healthy sexual choices. Pornography in particular has the potential to perpetuate cultural attitudes that objectify and demean women (Dworkin & McKinnon, 1988).

Child Protection. One of the most important themes that emerged from the qualitative analysis is the utilization of sex education programs as a prevention tool against child sexual abuse. According to (Wurtele, 2009), sex education programs that teach children to recognize potentially abusive situations or perpetrators, to resist by saying 'no' and to remove themselves to a safe situation and report previous or continuing abuse to a trusted person are successful in teaching children sexual abuse concepts and self-protection skills. Another study concluded that the completion of the Safer, Smarter Kids curriculum, a curriculum that teaches kids prevention concepts, concluded a significant increase in students' knowledge of key prevention concepts with a 77 % increase in the post-test score (Brown, 2017). In the Egyptian context, sex education is still a challenge, however, there are promising initiatives that have been adopted by UNICEF, Save the Children and Plan International. They introduce sex education to children in a creative, interactive and age appropriate methods through songs and games. Hopefully these kinds of initiatives will help change the culture on the long term.

Barriers to Sex Education.

Three themes emerged from the qualitative analysis as barriers to sex education: “lack of resources”, “sex is a taboo” and “social stigmatization” whereas “personal and client embarrassment”, “lack of information”, “social stigma” were also selected as the main barriers to sex education in the questionnaire. While personal and client embarrassment were at the top of the list in the quantitative analysis as barriers to sex education, they were not as prominent in the qualitative analysis. This may be due the social desirability effect with interviewees not wishing to admit to embarrassment in the interview setting. Both the qualitative and quantitative analysis concluded that there was a lack of reliable resources; supporting the claim that there is a lack of correct information available in Arabic (El Feki, 2014).

Sex as a Taboo. As in other Middle Eastern countries, in Egypt sex is a taboo and it is shameful to speak about openly with others (El Feki, 2014; Majumdar 2018). This is one of the major barriers to social workers' ability to discuss sexual issues with their clients. For example, one of the female psychologists mentioned that others would think of her an immoral person if she talked about sex with her clients. This issue was also found in a study on Egyptian school nurses who were fearful about their reputation if they discussed sexual issues with clients (Farrag, 2014). Because this topic is very sensitive in the Egyptian community, it must be handled with care. A great effort should be invested in making social workers more comfortable talking about sex by normalizing sex, empowering them with knowledge and skills, and encouraging them to contribute to social change by promoting healthy sexuality and gender roles.

Recommendations for the Sex Education Curriculum.

Even though there were some barriers and misconceptions, there was a great desire and openness for change, and the vast majority of participants were interested in participating in sex education. Many of the participants recommended that the curriculum should be comprehensive; tackling the topic from different perspectives and focusing on gender, decision making, healthy relationships, child abuse and marriage.

Efforts towards reducing SGBV should not focus on responses to victimization but it should rather focus on promoting healthy sexuality and prevention because SGBV is rooted in discriminatory social norms and gender stereotypes that perpetuate violence. Therefore, the best way to end violence against women and girls is to prevent it from happening in the first place by addressing its root and structural causes but in the meantime, a training should give social workers the tools to act in light of these structural causes. That can be done through:

- 1- Mapping existing initiatives, programs and available human and material resources, in order to accumulate the best tools to provide social workers with a comprehensive

manual in Arabic that serves as a reference with FAQ to help them address common concerns and questions. The topics should include Sex, Gender, SGBV, how to deal with SGBV survivors, best intervention practices and advocacy strategies to combat SGBV. They could also be offered illustrating flyers to assist them in delivering information to beneficiaries.

- 2- The curriculum should include a discussion of human development including the physical, emotional, social and intellectual aspects. It should cover reproductive and sexual anatomy and physiology, and the physical and emotional changes accompanying the transition to adulthood. The concept of gender can be easily incorporated into a discussion about the formation of male and female reproductive organs. Also, there should be an entire section dedicated to tackling common misconceptions about sex, masturbation, menstruation blood, men's ability to control sexual desire, virginity and the sensitivity of female reproductive organs.
- 3- Given the complexity of the topic, the training manual should be done through collaborative efforts between psychologists, sexologists, health practitioners, anthropologists and religious scholars.
- 4- The training would help in normalizing sexual behavior and erase the stigma, and shame around sex so that social workers can be comfortable in handling sex related issues in healthy way.
- 5- Social workers need to be educated on the negative drawbacks of using religion as a tool of oppression and intimidation to restrain behavior. They also need to adopt science and human rights as a reliable reference to guide behavior and decision, and be more able to make clear distinction between what is religious and what is scientific.

- 6- Social workers need to learn about the best therapeutic interventions in cases of child abuse, homosexuality and various sorts of SGBV. They need to be equipped with the necessary information on how to respond to consultation regarding FGM/C and how to deal with victims of SGBV. They should be adequately informed about the legal stand point of FGM/C and how to use the legislative tools effectively for child protection.
- 7- The training should be interactive, culturally sensitive, and help in creating a safe space for discussions and dialogues that prompt trainees to think about their gender biases and stereotypes. Sex education is not only about being informed, but it should build the analytical and critical mindset that is able to be scientifically skeptical. The analytical skills are the source of validating data or any piece of information whether in religion or science.
- 8- The training should embrace a human rights-based approach that is not limited to religious, legislative and medical education but extends to rights to a healthy life and bodily integrity through promoting values on healthy relationships, gender equality and increase awareness of the cultural attitudes that favor men over women and how those gender social constructions play an important role in driving SGBV. Through this perspective, it will be clear that the process of FGM/C is unethical at its core, constituting violation not only to the integrity of the human body but freedom, trust, protection and autonomy of the child and adult.
- 9- A great emphasis should be made on the social workers role for advocating for culture change and encouraging positive deviance among the people they serve.

Limitations and Suggestions for Future Research.

Research limitations include a small sample size and limited geographic representation, making it difficult to generalize beyond Cairo and Assiut. Future research

could be done on a larger sample and include other rural and urban areas. It would also be interesting to look beyond social workers to see if others responsible for sex education, such as teachers, have similar misconceptions and attitudes. A lack of previous studies in the research area on social workers in Egypt constituted a challenge in the literature review and made it difficult to contextualize the results. If a sex education curriculum is developed based on this research, future research could include an evaluation of the training outcomes on the attendees.

Conclusion

Although the research showed that there is a lack of resources on sex education, various misconceptions about body functions and biased gendered values and norms that justify sexual and gender-based violence, social workers showed significant interest, readiness, and need for sex education. Given the importance of their preventive role in reduction of gender-based violence, in child protection and their sensitive position as agents of change, it is of crucial importance to invest in increasing their competencies, awareness and education on gender issues and its short and long-term consequences, and by utilizing best practices in developing comprehensive sex education approaches that are adapted to fit the cultural context.

References

- Abdi, M. S. (2007). A religious oriented approach to addressing FGM/C among the Somali community of Wajir Kenya. Retrieved from <http://wajir.org/rapporten/MaryamSheikh-Rapport over relatieKoran enFGM.pdf>
- Abouzahr, M. (2006). Egyptian social services, *Senior Honors Theses*. Paper 39. Available at: <http://commons.emich.edu/honors/39>
- Ashraf, S. A. (1998). The concept of sex in Islam and sex education. *Muslim Education Quarterly*, 15, 37-43.
- Assembly, U. G. (1993). Declaration on the Elimination of Violence against Women. *UN General Assembly*.
- Alphonse, M., George, P., & Moffatt, K. (2008). Redefining social work standards in the context of globalization: Lessons from India. *International Social Work*, 51(2), 145-158.
- Baldo, M., Aggleton, P., & Slutkin, G. (1993). Does sex education lead to earlier or increased sexual activity in youth? [Unpublished]. Presented at the Ninth International Conference on AIDS Berlin Germany 1993.
- Bekker, M. H., Rademakers, J., Mouthaan, I., De Neef, M., Huisman, W. M., Van Zandvoort, H., & Emans, A. (1996). Reconstructing hymens or constructing sexual inequality? Service provision to Islamic young women coping with the demand to be a virgin. *Journal of Community & Applied Social Psychology*, 6(5), 329-334.
- Behrendt, A., & Moritz, S. (2005). Posttraumatic stress disorder and memory problems after female genital mutilation. *American Journal of Psychiatry*, 162(5), 1000-1002.
- Bloom, S. S. (2008). Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators. Retrieved from <https://www.measureevaluation.org/resources/publications/ms-08-30>

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Charrad, M. M. (2011). Gender in the Middle East: Islam, state, agency. *Annual Review of Sociology*, 37, 417-437.
- Chin, H. B., Sipe, T. A., Elder, R., Mercer, S. L., Chattopadhyay, S. K., Jacob, V., ... & Chuke, S. O. (2012). The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: two systematic reviews for the Guide to Community Preventive Services. *American Journal of Preventive Medicine*, 42(3), 272-294.
- Coleman, E. (2003). Masturbation as a means of achieving sexual health. *Journal of Psychology & Human Sexuality*, 14(2-3), 5-16.
- Connell, R. (1987). *Gender and power: Society, the person and sexual politics*. Cambridge: Polity.
- WHO (2016). Sexually transmitted infections (STIs). Retrieved from [https://www.who.int/en/news-room/fact-sheets/detail/sexually-transmitted-infections-\(stis\)](https://www.who.int/en/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis))
- DeJong, J, Shepard, B, Farzaneh Roudi-Fahimi and Lori Ashford. "Young People's Sexual and Reproductive Health in the Middle East and North Africa." *Reproductive Health Matters*, 14(78). Retrieved from <http://www.prb.org/Publications/PolicyBriefs/MENAYouthReproductiveHealth.aspx>
- Roudi-Fahimi, F., & Ashford, L. (2008). Sexual and reproductive health in the Middle East and North Africa: A guide for reporters.

- DeJong, J., Jawad, R., Mortagy, I., & Shepard, B. (2005). The sexual and reproductive health of young people in the Arab countries and Iran. *Reproductive health matters*, 13(25), 49-59.
- DeJong, J. (2000). The role and limitations of the Cairo International Conference on Population and Development. *Social Science & Medicine*, 51(6), 941-953.
- Dellenborg, L. (2004). A reflection on the cultural meanings of female circumcision. *Re-thinking Sexualities in Africa*. Retrieved from <http://copyrightland.net/re-thinking-sexualities-in-africa/a-reflection-on-the-cultural-meanings-of-female-circumcision.htm>
- Denny, G., & Young, M. (2006). An evaluation of an abstinence-only sex education curriculum: An 18-month follow-up. *Journal of School Health*, 76(8), 414-422.
- Denzin, N. K., & Lincoln, Y. S. (2008). *Introduction: The discipline and practice of qualitative research*. Sage publications, Inc.
- Dworkin, A., & MacKinnon, C. A. (1988). *Pornography and Civil Rights: A new day for women's equality*. Organizing Against Pornography.
- Ellis, H. (2018). *Studies in the Psychology of Sex* (Vol. 6). BoD–Books on Demand. Retrieved from <https://www.worldofrarebooks.com/studies-in-the-psychology-of-sex-volume-vi-sex-in-relation-to-society-by-havelock-ellis.html>
- El Feki, S. (2006). Middle-Eastern AIDS efforts are starting to tackle taboos. *Lancet*, 367(9515), 975-976.
- El Feki, S. (2014). *Sex and the citadel: Intimate life in a changing Arab world*. NY: Random House.
- El Feki, S., Heilman, B., & Barker, G. (2017). *Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES)-Middle East and North Africa*. UN Women.

- Ethnasios, R. A. (2012). *Describing the care and treatment of orphans in Egypt through the perspectives of residents, caretakers and government social workers*. University of Southern California. Retrieved from <https://search.proquest.com/openview/7851cac39ca636fa0c5fc4527af6c0f2/1?pq-origsite=gscholar&cbl=18750&diss=y>
- El Saadawi, N. (2007). *The hidden face of Eve: Women in the Arab world*. Retrieved from https://books.google.com/books/about/The_Hidden_Face_of_Eve.html?id=u5n9zUZuVI8C
- Farrag, S., & Hayter, M. (2014). A qualitative study of Egyptian school nurses' attitudes and experiences toward sex and relationship education. *The Journal of School Nursing, 30*(1), 49-56.
- Fahmy, A., El-Mouelhy, M. T., & Ragab, A. R. (2010). Female genital mutilation/cutting and issues of sexuality in Egypt. *Reproductive health matters, 18*(36), 181-190.
- Feki, S. E., Aghazarian, E., & Sarras, A. (2014). Love is Culture: Al-Hubb Thaqafa and the New Frontiers of Sexual Expression in Arabic Social Media. *Anthropology of the Middle East, 9*(2).
- Fernea, R. (2003). Gender, sexuality and patriarchy in modern Egypt. *Critique: Critical Middle Eastern Studies, 12*(2), 141-153.
- Frank, M. W., Bauer, H. M., Arican, N., Fincanci, S. K., & Iacopino, V. (1999). Virginity examinations in Turkey: role of forensic physicians in controlling female sexuality. *JAMA, 282*(5), 485-490.
- French, S. L. (2003). Reflections on healing: Framing strategies utilized by acquaintance rape survivors. *Journal of Applied Communication Research, 31*(4), 209-319.

- Fraser, A. M., Brockert, J. E., & Ward, R. H. (1995). Association of young maternal age with adverse reproductive outcomes. *New England Journal of Medicine*, 332(17), 1113-1118.
- Geertz, A., Iyer, L., Kasen, P., Mazzola, F., & Peterson, K. (2016). An Opportunity to Address Menstrual Health and Gender Equity. *FSG*.
- Google Trends. (2008). "Trend History جنس".
<http://www.google.com/trends?q=%D8%AC%D9%86%D8%B3> (last accessed March 11, 2008).
- Gray, M., & Fook, J. (2004). The quest for a universal social work: Some issues and implications. *Social Work Education*, 23(5), 625-644.
- Gruenbaum, E. (2006). Sexuality issues in the movement to abolish female genital cutting in Sudan. *Medical Anthropology Quarterly*, 20(1), 121-138.
- Gürsoy, E., & Vural, G. (2003). Nurses' and midwives' views on approaches to hymen examination. *Nursing Ethics*, 10(5), 485-496.
- Hamilton, V. E. (2007). Religious v. secular ideologies and sex education: A response to Professors Cahn and Carbone. *W. Va. L. Rev.*, 110, 501.
- Hampshire, J., & Lewis, J. (2004). 'The ravages of permissiveness': sex education and the permissive society. *Twentieth Century British History*, 15(3), 290-312.
- Hassanin, I. M., Saleh, R., Bedaiwy, A. A., & Bedaiwy, M. A. (2008). Prevalence of female genital cutting in Upper Egypt: 6 years after enforcement of prohibition law. *Reproductive Biomedicine Online*, 16, 27-31. Retrieved from [https://doi.org/10.1016/S1472-6483\(10\)60396-3](https://doi.org/10.1016/S1472-6483(10)60396-3)
- Hegazy, A. A., & Al-Rukban, M. O. (2012). Hymen: facts and conceptions. *The Health*, 3(4), 109-115.

- Heise, L., Ellsberg, M., & Gottmoeller, M. (2002). A global overview of gender-based violence. *International Journal of Gynecology & Obstetrics*, 78(1), S5–S14
- Heise, L. L. (1998). Violence against women: an integrated, ecological framework. *Violence Against Women*, 4(3), 262-290.
- Hernlund, Y. K. (2003). Winnowing Culture: Negotiating female 'circumcision' in the Gambia.
- House, S., Mahon, T., & Cavill, S. (2013). Menstrual hygiene matters: A resource for improving menstrual hygiene around the world. *Reproductive Health Matters*, 21(41), 257-259.
- Hussey, M. (2015). Who Are The Biggest Consumers Of Online Porn? Retrieved from <https://thenextweb.com/market-intelligence/2015/03/24/who-are-the-biggest-consumers-of-online-porn/>
- Hussein, A. (1954) Social reform in Egypt, *Muslim World Journal*, 44 (1),12- 19.
- Ibrahim, B. (2010). Transition to Adulthood: A National survey of Egyptian adolescents, 1999. The situation has been reconfirmed by the subsequent survey of young people. Population Council.
- Ibrahim, B., Sallam, S., El Tawila, S., El Gibaly, O., El Sahn, F., Lee, S. M., Galal, O. (1999). Transitions to adulthood: a national survey of Egyptian adolescents.
- Ingham, R., & Hirst, J. (2010). Promoting sexual health. *Promoting Health and Wellbeing through Schools*, 99-118.
- Johnsdotter, S. (2003). Somali women in western exile: Reassessing female circumcision in the light of Islamic teachings. *Journal of Muslim Minority Affairs*, 23(2), 361-373.
- Johansen, R. (2007). Experiencing sex in exile—can genitals change their gender? On conceptions and experiences related to female genital cutting among Somalis in Norway.

- Johnson, M. (2007). Making Mandinga or Making Muslims? Debating Female Circumcision, Ethnicity and Islam in Guinea-Bissau and Portugal.
- Kabbash, I., Zidan, O., & Salem, S. (2018). Perceptions of Gender Roles in Sexual Relations and the Sexual Experiences of Medical Students in the Nile Delta of Egypt. *Sexuality & Culture*, 23(1), 310–324
- Kaestle, C. E., & Allen, K. R. (2011). The role of masturbation in healthy sexual development: Perceptions of young adults. *Archives of Sexual Behavior*, 40(5), 983-994.
- Kågesten, A., Gibbs, S., Blum, R. W., Moreau, C., Chandra-Mouli, V., Herbert, A., & Amin, A. (2016). Understanding factors that shape gender attitudes in early adolescence globally: A mixed-methods systematic review. *PloS one*, 11(6), e0157805.
- Kasemy, Z., Desouky, D. E. S., & Abdelrasoul, G. (2016). Sexual Fantasy, Masturbation and Pornography Among Egyptians. *Sexuality & Culture*, 20(3), 626-638.
- Kalmuss, D. S., & Straus, M. A. (1982). Wife's marital dependency and wife abuse. *Journal of Marriage and the Family*, 44(2), 277-286.
- Khaja, K., Lay, K., & Boys, S. (2010). Female circumcision: Toward an inclusive practice of care. *Health Care for Women International*, 31, 686–699.
- Khattab, H. (2007). Culture and sexuality in North Africa and the Middle East. *Human Sexuality in Africa: Beyond Reproduction. Auckland Park, S. Africa: Jaena Media*, 123-130.
- Kim, N., Stanton, B., Li, X., Dickersin, K. and Galbraith, J. (1997) 'Effectiveness of the 40 adolescent AIDS-risk reduction interventions: a quantitative review.' *Journal of Adolescent Health*, 20, 204–215
- Kirby, D. (2001). Understanding what works and what doesn't in reducing adolescent sexual risk-taking. *Family Planning Perspectives*, 33(6), 276-281.

- Kirby, D. B., Laris, B. A., & Rolleri, L. A. (2007). Sex and HIV education programs: their impact on sexual behaviors of young people throughout the world. *Journal of Adolescent Health, 40*(3), 206-217.
- Kirby, D. (2006). Comprehensive sex education: strong public support and persuasive evidence of impact, but little funding. *Archives of pediatrics & adolescent medicine, 160*(11), 1182-1184.
- Kohler, P. K., Manhart, L. E., & Lafferty, W. E. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of adolescent Health, 42*(4), 344-351.
- Edgar, A., & Sedgwick, P. (Eds.). (2007). *Cultural theory: The key concepts*. Routledge.
- Komsan, N. A. (2009). Sexual Harassment in the Arab Region: Cultural Challenges and Legal Gaps. In Findings from the Conference on “*Sexual Harassment as Social Violence, and its Effect on Women*.”
- Lacey A. & Luff D. *Qualitative Research Analysis*. The NIHR RDS for the East Midlands / Yorkshire & the Humber, 2007;2009. Retrieved from https://www.rds-yh.nihr.ac.uk/wpcontent/uploads/2013/05/9_Qualitative_Data_Analysis_Revision_2009.pdf
- Lefkowitz, E. S., Shearer, C. L., Gillen, M. M., & Espinosa-Hernandez, G. (2014). How gendered attitudes relate to women’s and men’s sexual behaviors and beliefs. *Sexuality & culture, 18*(4), 833-846.
- Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions and emerging confluences. In K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 127–152). London, England: Sage

- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage Handbook of Qualitative Research, 4*, 97-128.
- Lincoln, Y. S., & Guba, E. G. (2000). The only generalization is: There is no generalization. *Case Study Method, 27-44*.
- Loeber, O. (2008). Over het zwaard en de schede; bloedverlies en pijn bij de eerste coïtus. Een onderzoek bij vrouwen uit diverse culturen. *Tijdschrift voor Seksuologie, 32*, 129-137.
- Love Matters, Arabic. (2014). الحب ثقافة | بصراحة وبدون حرج. Retrieved from <https://lmarabic.com/>
- Mabud, S. A. (1998). An Islamic view of sex education. *Muslim Education Quarterly 15*, 69-93.
- Mackie, G., & LeJeune, J. (2009). *Social Dynamics of Abandonment of Harmful Practices: A new look at the theory*. UN.
- Majumdar, C. (2018). Attitude towards premarital sex in India: Traditional and cultural changes. *Sexuality and Culture, 22*, 614–631.
- Mernissi, Fatima (1975) *Beyond the Veil: Male—Female Dynamics in a Modern Muslim Society* (Cambridge, MA: Schenkman).
- Mertens, D. M. (2014). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods*. Sage publications.
- Messerschmidt, J. W. (1986). Capitalism, patriarchy, and crime: Toward a socialist feminist criminology. Totowa, NJ: Rowman & Littlefield.
- Messerschmidt, J. W. (2012). Gender, heterosexuality, and youth violence: The struggle for recognition. Rowman & Littlefield as a priority for achieving gender equality. *Cardozo JL & Gender, 21*, 1.

- Mitra, A., & Singh, P. (2007). Human capital attainment and gender empowerment: The Kerala paradox. *Social Science Quarterly*, 88(5), 1227-1242.
- Mohammed, G. F., Hassan, M. M., & Eyada, M. M. (2014). Female genital mutilation/cutting: Will it continue?. *The Journal of Sexual Medicine*, 11(11), 2756-2763.
- Mohamed, Y., Durrant, K., Huggett, C., Davis, J., Macintyre, A., Menu, S., McSkimming, D. (2018). A qualitative exploration of menstruation-related restrictive practices in Fiji, Solomon Islands and Papua New Guinea. *PloS one*, 13(12), e0208224.
- Nichols, H. (2017). Are there side effects to masturbation?. *Medical News Today*. Retrieved from <https://www.medicalnewstoday.com/articles/320265.php>.
- O'Connell, H. E., Sanjeevan, K. V., & Hutson, J. M. (2005). Anatomy of the clitoris. *The Journal of Urology*, 174(4), 1189-1195.
- OHCHR, U., & UNDP, U. (2008). Eliminating Female genital mutilation. *An interagency statement*. Geneva: WHO.
- Paul, P. (2006). *Pornified: How pornography is transforming our lives, our relationships, and our families*. New York, NY: Henry Holt &.
- Pauls, R. N. (2015). Anatomy of the clitoris and the female sexual response. *Clinical Anatomy*, 28(3), 376-384.
- Population Council. (2009, January). Survey of Young People in Egypt. Retrieved 2012, from Population Council: http://www.popcouncil.org/pdfs/2010PGY_SYPEFinalReport.pdf
- Quran surah An Nisa 34 (QS 4: 34) in arabic and english translation. (2009, July 01). Retrieved from <http://www.alquranenglish.com/quran-surah-an-nisa-34-q4-34-in-arabic-and-english-translation>
- Rabie, M. H. S. (2010). Assessing the Impact of Media on Reproductive

Awareness and Attitudes (in Arabic). Retrieved 2012, from Cabinet Information and Decision Support Center:

<http://www.eip.gov.eg/Upload/Documents/1214/TOC/content%20mass%20media.pdf>

Rasheed, S. M., Abd-Ellah, A. H., & Yousef, F. M. (2011). Female genital mutilation in Upper Egypt in the new millennium. *International Journal of Gynecology & Obstetrics*, 114(1), 47-50.

Roald, A. S. (2001). *Women in Islam: The Western experience*. London, England: Routledge

Rousdy, N. (2013, January). Sexuality education in Egypt: A needs assessment for a comprehensive program for Youth. Retrieved from

https://www.academia.edu/6507309/Sexuality_Education_in_Egypt_A_Needs_Assessment_for_a_Comprehensive_Program_for_Youth

Roudi-Fahimi, F., & Ashford, L. (2008). Sexual and reproductive health in the Middle East and North Africa: A guide for reporters. Retrieved from

<https://www.popline.org/node/201120>

Saharso, S. (2003). Feminist ethics, autonomy and the politics of multiculturalism. *Feminist Theory*, 4(2), 199-215.

Sanjakdar, F. (2013). Educating for sexual difference? Muslim teachers' conversations about homosexuality. *Sex Education*, 13(1), 16-29.

Sarwar, G. (1996). *Sex education: the Muslim perspective*. London: Muslim Educational Trust.

Saeed Ali, T., Karmaliani, R., Mcfarlane, J., Khuwaja, H. M., Somani, Y., Chirwa, E. D., & Jewkes, R. (2017). Attitude towards gender roles and violence against women and girls (VAWG): baseline findings from an RCT of 1752 youths in Pakistan. *Global Health Action*, 10(1), 1342454.

- Sexuality, Poverty and law Program. Sexuality and social justice: A toolkit. <http://spl.ids.ac.uk>. Accessed August 15, 2018.
- Sieverding, M., & Hassan, R. (2016). Her future is marriage?: Young people's attitudes towards gender roles and the gender gap in Egypt. *Cairo: Population Council*.
- Sharabi, H. (1992). *Neopatriarchy: A theory of distorted change in Arab society*. Oxford University Press, USA.
- Shepherd, J., Kavanagh, J., Picot, J., Cooper, K., Harden, A., Barnett-Page, E., Price, A. (2010). The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: A systematic review and economic evaluation. *Health Technology Assessment, 14(7)*, 1-230.
- Somach, S., & Abou Zeid, G. (2009). Egypt violence against women study. *Literature review of violence against women. Washington (DC): United States Agency for International Development*.
- Soliman, H. H., & Abd Elmegied, H. S. (2010). The challenges of modernization of social work education in developing countries: The case of Egypt. *International Social Work, 53(1)*, 101-114.
- Soliman, H. (2007a) 'Social Work Education in Egypt: Challenges and Search for Modernization', paper presented at the 20th Annual Social Work Conference, Helwan University, Helwan, Egypt, 11-12 March.
- Stein, N., Tolman, D. L., Porche, M. V., & Spencer, R. (2002). Gender safety: A new concept for safer and more equitable schools. *Journal of School Violence, 1(2)*, 35-49.
- Super, J. T., & Jacobson, L. (2011). Religious abuse: Implications for counseling lesbian, gay, bisexual, and transgender individuals. *Journal of LGBT Issues in Counseling, 5(3-4)*, 180-196.

- Tabatabaie, A. (2015). Childhood and adolescent sexuality, Islam, and problematics of sex education: a call for re-examination. *Sex Education, 15*(3), 276-288.
- Tan, D. A., Haththotuwa, R., & Fraser, I. S. (2017). Cultural aspects and mythologies surrounding menstruation and abnormal uterine bleeding. *Best Practice & Research Clinical Obstetrics & Gynecology, 40*, 121-133.
- Talle, A. (1993). 4. Transforming Women into 'Pure' Agnates: Aspects of Female Infibulation in Somalia. In *Carved flesh/cast selves: gendered symbols and social practices* (pp. 83-106).
- Tiefer, L. (1998). Masturbation: Beyond caution, complacency and contradiction. *Sexual and Marital Therapy, 13*, 9-14.
- Tolman, D. L. (1991). Adolescent girls, women and sexuality: Discerning dilemmas of desire. *Women & Therapy, 11*(3-4), 55-69.
- The National Council for Women. (2015). The National Strategy to Combat Violence Against Women.
- UN Women (2016). Retrieved from www.unwomen.org
- UNICEF (2005). *Female genital mutilation/cutting: a statistical exploration 2005*. Unicef.
- United Nations Children's Fund, & Gupta, G. R. (2013). Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. *Reproductive Health Matters, 18*(4), 184-190.
- UNFPA (2009). The rationale for sexuality education: International technical guidance on sexuality education-An evidence-informed approach for schools, teachers and health educators. Retrieved 2012, from the United Nations Population Fund:
http://unfpa.org/webdav/site/global/groups/youth/public/International_Guidance_Sexuality_Education_Vol_I.pdf

UNESCO (2009). International Technical Guidance on Sexuality Education: An evidence-informed approach for schools (2-3). Retrieved 2012, from United Nations

Educational, Scientific and Cultural Organization: <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>

United Nations (2014): Report of the United Nations Entity for Gender Equality.

www.ohchr.org/EN/HRBodies/HRC/.../A_HRC_29_3_ENG.doc

United Nations, General Assembly (1993): Declaration on the Elimination of Violence Against Women www.un.org/documents/ga/res/48/a48r104.htm

Women, U. N. (2013). Study on ways and methods to eliminate sexual harassment in Egypt. *New York: UN Women.*

Van Moorst, B. R., van Lunsen, R. H., van Dijken, D. K., & Salvatore, C. M. (2012).

Backgrounds of women applying for hymen reconstruction, the effects of counselling on myths and misunderstandings about virginity, and the results of hymen reconstruction. *The European Journal of Contraception & Reproductive Health Care, 17(2), 93-105.*

Verma, R., Pulerwitz, J., Mahendra, V. S., Khandekar, S., Singh, A. K., Das, S. S., ... & Barker, G. (2008). Promoting gender equity as a strategy to reduce HIV risk and gender-based violence among young men in India. *Horizons Final Report. Washington, DC: Population Council.*

Walby, S. (1990). *Theorizing patriarchy.* Basil Blackwell.

Wasef, N. H. (2018). Domestic and Social Violence against Women during the Egyptian Uprising. *Mediterranean Journal of Social Sciences, 9(1), 213-219.*

Walton, R. G., & Abo El Nasr, M. M. (1988). Indigenization and authentication in terms of social work in Egypt. *International social work, 31(2), 135-144.*

- WAVE and UNFPA (2014): Strengthening Health System Responses to GBV in Eastern Europe and Central Asia- A Resource Package. www.health-genderviolence.org/news/191
- Weinberg, M. S., Williams, C. J., Kleiner, S., & Irizarry, Y. (2010). Pornography, normalization, and empowerment. *Archives of Sexual Behavior*, 39(6), 1389-1401.
- Winkler, I. T., & Roaf, V. (2014). Taking the Bloody Linen out of the Closet: Menstrual hygiene as a priority for achieving gender equality. *Cardozo JL & Gender*, 21, 1.
- WHO (2010). Men's and women's perception of the relationship between female genital mutilation and women's sexuality in three communities in Egypt: social science policy brief.
- WHO. (2012). Working Definitions, WHO issues new guidance for the prevention and management of postpartum haemorrhage. Retrieved 2012, from World Health Organization: http://www.who.int/reproductive-health/gender/sexual_health.html#2
- WHO (2006). Towards the elimination of female genital mutilation: a training manual for the affected countries in the Eastern Mediterranean Region.
- WHO (2010). Preventing intimate partner and sexual violence against women: Taking action and generating evidence.
- Wurtele, S. K. (2009). Preventing sexual abuse of children in the twenty-first century: Preparing for challenges and opportunities. *Journal of child sexual abuse*, 18(1), 1-18.
- Yip, A. K. T., & Page, S. J. (2016). *Religious and sexual identities: A multi-faith exploration of young adults*. Country: Routledge

Appendix A – English consent form



Documentation of Informed Consent for Participation in Research Study

Project Title: Assessment of Barriers to Sex and Gender Education Among Social Workers in Egypt

Principal Investigator: Germeen Riad

You are invited to participate in a research study on assessment of educational barriers on gender and gender among social workers in Egypt.

The research procedure will be as follows: You will be asked to fill in a questionnaire or be interviewed in person or over the telephone to answer some questions to share your experience as a social worker. The duration of the questionnaire will be 30 minutes and the duration of the interview will be an hour and a half at most. In case of conducting the interview over the telephone, an oral consent will be audio recorded.

There are no risks associated with this research. Participating in research may help you by giving you a chance to think about your career. Your participation will benefit other social workers as well as social service beneficiaries by helping to develop and improve the training curriculum to increase efficiency and contribute to our understanding of the nature of the work of social workers in Egypt.

The information you provide through this research will be confidential. Your answer to questions will not be identified or linked to you and your identity will not be disclosed in any description or publication of this research.

Any questions related to this research should be directed to the Principal Investigator Ms. Germeen Riad on Tel: 01275677255

Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Signature _____

Printed Name _____

Date _____

Appendix B- Arabic consent form

الجامعة الأمريكية بالقاهرة



استمارة موافقة مسبقة للمشاركة في دراسة بحثية

عنوان البحث: تقييم العوائق التعليمية عن الجنس والنوع الاجتماعي في أوساط الأخصائيين الاجتماعيين في مصر
 الباحث الرئيسي: جرمين رياض
 البريد الإلكتروني: germeen.riad@aucegypt.edu
 الهاتف: 01275677255

انت مدعو للمشاركة في دراسة بحثية عن تقييم العوائق التعليمية عن الجنس والنوع الاجتماعي في أوساط الأخصائيين الاجتماعيين في مصر.

ستكون إجراءات البحث على النحو التالي: سيطلب منك مليء استبيان أو إجراء مقابلة شخصية أو هاتفية والاجابة على بعض الأسئلة للمشاركة بخبرتك كأخصائي اجتماعي. مدة مليء الاستبيان ستكون نصف ساعة والمقابلة سوف تكون ساعة ونصف على الأكثر. في حالة إجراء المقابلة على الهاتف، سوف يتم تسجيل صوتي للموافقة على المشاركة في البحث.

لا توجد مخاطر أو مضايقات مرتبطة بهذا البحث. المشاركة في البحث قد تفيديك من خلال إعطائك فرصة للتفكير في حياتك المهنية. مشاركتك سوف تفيد الأخصائيين الاجتماعيين الآخرين وأيضاً المستفيدين من الخدمة الاجتماعية من خلال المساعدة في تطوير وتحسين المنهج التدريبي الخاص برفع الكفاءة والمساهمة في فهمنا لطبيعة عمل الأخصائيين الاجتماعيين في مصر.

المعلومات التي ستدلى بها من خلال هذا البحث سوف تكون سرية. إجابتك على الأسئلة لن يتم تحديدها أو ربطها بك ولن يتم الإفصاح عن هويتك في أي وصف أو نشر لهذا البحث.

أي أسئلة متعلقة بهذا البحث يجب أن توجه الى الباحث الرئيسي /جرمين رياض علي الهاتف: 01275677255

ان المشاركة في هذه الدراسة ماهي الا عمل تطوعي، حيث أن الامتناع عن المشاركة لا يتضمن أي عقوبات أو فقدان أي مزايا تحقق لك. ويمكنك أيضا التوقف عن المشاركة في أي وقت من دون عقوبة أو فقدان لهذه المزايا.

الامضاء:

اسم المشارك:

التاريخ:/...../.....

Appendix C- Interview questions in English

Interview Questions

Section 1: Attitudes towards sex education:

- 1-As a social worker, how important do you think sex education is? Why?
What problems or benefits might there be from sex education?
- 2-As a social worker, how often do you have to deal with issues related to sex education?
- 3-From your experience with adolescents, what are the common problems you usually encounter? How do you deal with them? Can you please provide me with examples?
- 4-What is your initial reaction when a client comes to you with a sex related question?
- 5-What kinds of skills and knowledge do social workers need for sex education?
- 6-If a child asked you about masturbation, what would you say to him/her?

Section 2: Attitudes about gender roles:

- 7-What constitutes a good woman and a good man?
What are the hopes you have for the girls/boys you work with? Why?

Section 3: Attitudes about Gender based violence:

- 8-Most Egyptians think that FGM is beneficial for girls. What do you think? Why?
- 9-If you had a client who experienced sexual harassment, what would you tell them?
- 10- How often do you think child sexual abuse occur? Who are the most common perpetrators? Can you give me examples?
- 11- What is the most appropriate age for getting married for both genders to get married?
Why?

Section 4: Attitudes towards LGBTI:

- 12- If you had a male client who liked to wear women's clothes or youth who are in a same sex relationship, how do you deal with him/her?
- 13- We are developing a curriculum on Sex Education for social workers. What suggestions do you have for us?

Appendix D- Survey in English

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1-I don't feel comfortable talking to my clients about their sexual issues					
2-I believe that providing Sex education to adolescents might increase their sexual activities					
3-I believe Sex Education is important					
4- Sex education goes against my religious belief					
5-I don't have enough information to talk confidently about sex with my clients					
6-I feel more comfortable using English words to express matters related to sex education.					
7-Masturbation causes serious damage to health					
8-Contraceptive use is against God's will.					
9-It is mainly the woman's responsibility to ensure that contraception is used regularly.					
10-A woman should bleed at the first time of having sex (intercourse)					
11-The vagina is the most sensitive organ of the woman's reproductive system					
12- A woman should tolerate violence to keep the family together					
13-Female circumcision is good as it makes women less sexually demanding					
14- There are times when a woman deserves to be beaten					
15-A man has the right to ask for sex anytime from his wife					

16- Most men prefer their wives to be circumcised					
17-Early marriage can prevent adultery					
18-Women are usually responsible for being harassed.					
19- Most women don't desire sex					
20-After a certain point of arousal a man cannot control himself					
21- Menstruation blood is dirty					
22-Virginity is the woman's honor					
23- Women should be subordinate to men					
24- It is sad for a woman not to get married					
25- It is sad for a man not to get married					
26- It is important for a woman to have pleasure during sex					
27- It is fine for a man to have some type of sexual experience before marriage					
28- It is fine for women to have some type of sexual experience before marriage					
29-Men and women are equal					
30-There are specific and different roles for men and women.					
31-A woman's most important role is to take care of the home and cook for the family					
32- Men should have the final word in the household and have guardianship over his female relatives					
33-I think it is shameful when men engage in caring for children or other domestic work					
34-It is the wife's responsibility to satisfy her husband's sexual desire					
35- Unmarried women should have the					

same right to live on their own as unmarried men					
--	--	--	--	--	--

36- Please list any STIs you know of?**37-How have you learned about sex?**

- Parents
- School
- Media
- Friends
- I did not learn about sex
- Other methods: _____

38-A social worker should be knowledgeable about the following in order to deal with sexual issues among children and youth (Mark all that Apply):

- Reproductive Anatomy and Physiology
- Sexual abuse
- Healthy Relationships
- Friendships
- Love
- Marriage and Lifetime Commitments
- Contraceptives (Family planning)
- Communication and Assertiveness
- STD'S/Infections
- Gender roles
- Gay and Lesbian issues
- How to make healthy decisions

39-What are the barriers you may find in talking to clients?

- I find talking about sex embarrassing
- I was taught that sex is not something to talk about
- I don't know where to find the information needed
- My clients are embarrassed and that makes it difficult
- It's not considered part of my job to discuss sex
- I don't see myself as someone who knows enough to discuss sex with clients
- Talking about sex goes against my religious beliefs

40-How early do you think children should be taught about sex?

- Directly before marriage
- College
- Preparatory
- Primary
- Never

Appendix F- Interview questions in Arabic

المقابلات الشخصية

1. كأخصائي اجتماعي، في رأيك ما مدى أهمية التربية الجنسية؟ لماذا؟ ما هي مشكلات أو فوائد التربية الجنسية؟
2. كأخصائي اجتماعي، الي أي مدي تصادفك مسائل متعلقة بالتربية (الثقافة) الجنسية أو كم عدد المرات التي تعاملت فيها مع قضايا متعلقة بالثقافة الجنسية؟
3. من خبرتك وتجاربك في التعامل مع المراهقين، ما هي أكثر المشاكل التي تواجهها؟ (ما هي المشاكل الشائعة التي تواجهها عادة؟ كيف تتعامل معها؟ هل بإمكانك إعطاء امثلة؟
4. كيف تشعر عندما تتحدث عن التربية الجنسية؟ ما هو رد فعلك الأولي عندما يأتي إليك أحد العملاء (طفل أو مراهق) بسؤال يتعلق بالجنس؟
5. ما هي المهارات والمعلومات المتعلقة بالتربية الجنسية التي يجب على الاخصائي الاجتماعي اكتسابها؟
6. لو سألك طفل أو مراهق عن الاستمناء/العادة السرية، ماذا ستقول لهم؟
7. ما هي صفات المرأة الجيدة والرجل الجيد؟ ماذا تتمني (ماهي آمالك) للأولاد والفتيات الذين تتعامل معهم؟
8. أغلب المصريين يعتقدون ان الختان مفيد للفتيات، ماذا تعتقد؟ لماذا؟
9. إذا كان لديك عميل تعرض لتحرش جنسي؟ ماذا ستقول لهم؟
10. الي أي مدي تعتقد شيوع الاعتداء الجنسي على الأطفال؟ من هم أكثر الجناة؟ هل ممكن أن تعطيني امثلة من خبرتك الشخصية؟
11. ما هو السن المناسب للزواج بالنسبة للفتيات؟ والفتيان؟ لماذا؟
12. لو صادفت مراهق ذكر يحب ارتداء ملابس نسائية، أو مراهق كان شاب أو فتاة في علاقة رومانسية مع نفس النوع (الجنس) ماذا ستفعل أو كيف ستتعامل معهم؟
13. نحن الان بصدد تصميم منهج للتربية الجنسية للأخصائيين الاجتماعيين، ما هي الاقتراحات التي لديك بالنسبة لنا؟ ما هي نصيحتك لنا؟

Appendix E- Survey in Arabic

السن:

المحافظة:

الحالة الاجتماعية:

النوع:

معتراض بشدة	معتراض	محايد	موافق	موافق بشدة	
					١- لا أشعر بالراحة عند الحديث عن الجنس مع العملاء
					٢- اعتقد ان توفير التعليم عن الجنس للمراهقين سوف يزيد من نشاطهم الجنسي ويشجعهم الممارسة
					٣- اعتقد ان التعليم عن الجنس/التربية الجنسية امر مهم
					٤- التربية الجنسية تتعارض مع معتقداتي الدينية
					٥- لا املك المعلومات الكافية للحديث بثقة عن الجنس مع عملائي
					٦- اشعر براحة أكبر عند استخدام الكلمات الإنجليزية للتعبير عن الأمور المتعلقة بالجنس
					٧- الاستمناء (العادة السرية) يسبب ضررا خطيرا للصحة
					٨- استخدام وسائل منع الحمل هو ضد إرادة الله
					٩- المرأة هي المسؤولة الأساسية عن استخدام وسائل منع الحمل بشكل منتظم
					١٠- يجب أن تنزف المرأة في المرة الأولى لممارسة الجنس (الجماع)
					١١- المهبل هو العضو الأكثر حساسية في الجهاز التناسلي للمرأة
					١٢- يجب على الزوجة تحمل العنف للحفاظ على استقرار الأسرة
					١٣- ختان الإناث ممارسة جيدة حيث يجعل المرأة أقل تطلبا للجنس
					١٤- هناك أوقات تستحق فيها المرأة الضرب
					١٥- للرجل الحق في طلب الجنس في أي وقت من زوجته

					١٦- معظم الرجال يفضلون أن يكون تم ختان زوجاتهم
					١٧- الزواج المبكر يمكن أن يمنع الزنا
					١٨- النساء عادة ما تكون مسؤولة عن تعرضهم للتحرش
					١٩- معظم النساء لا يرغبن في ممارسة الجنس
					٢٠- بعد نقطة معينة من الإثارة، لا يستطيع الرجل السيطرة على نفسه
					٢١- دم الطمث غير نظيف
					٢٢- العذرية هي شرف المرأة
					٢٣- يجب أن تكون المرأة تابعة للرجل
					٢٤- من المحزن للمرأة ألا تتزوج
					٢٥- من المحزن للرجل ألا تتزوج
					٢٦- من المهم للمرأة أن تتمتع بالمتعة أثناء ممارسة الجنس
					٢٧- لا بأس في أن يكون لدى الرجال خبرة جنسية قبل الزواج
					٢٨- لا بأس في أن يكون للنساء نوع من الخبرة الجنسية قبل الزواج
					٢٩- الرجال والنساء متساوون
					٣٠- هناك أدوار محددة ومختلفة للرجال والنساء
					٣١- أهم دور للمرأة هو العناية بالمنزل والطهي للأسرة
					٣٢- ينبغي أن يكون للرجال الكلمة الأخيرة في الأسرة والوصاية على أقاربه من النساء
					٣٣- أعتقد أنه من المخجل أن يشارك الرجال في رعاية الأطفال أو أي عمل منزلي
					٣٤- تقع على عاتق الزوجة مسؤولية إشباع رغبة زوجها الجنسية

					٣٥- يجب أن تتمتع النساء غير المتزوجات بنفس الحقوق في العيش بمفردهن كالرجال الغير متزوجين
--	--	--	--	--	--

٣٦ - يرجى ذكر أي من الأمراض المنقولة بالاتصال الجنسي التي تعرف عنها؟

٣٧- كيف تعلمت عن الجنس؟

- الاهل
- المدرسة
- الاعلام
- الأصدقاء
- لم اتعلم عن الجنس
- طرق أخرى:

٣٨- يجب أن يكون الاختصاصي الاجتماعي على دراية بما يلي من أجل التعامل مع القضايا الجنسية بين الأطفال والشباب:

(يرجى اختيار الخمسة الأكثر أهمية في رأبك)

- التشريح التناسلي وعلم وظائف الأعضاء
- الإساءة الجنسية
- العلاقات الصحية
- الصداقات
- الحب
- التزامات الزواج والحياة
- وسائل منع الحمل (تنظيم النسل)
- الأمراض المنقولة بالاتصال الجنسي والعدوى
- النوع الاجتماعي
- الاعتداء الجنسي / الاغتصاب
- قضايا المثليين
- القدرة على اتخاذ القرارات

٣٩- ما هي الحواجز التي قد تجدها في التحدث مع العملاء عن الجنس؟ (إختار كل ما ينطبق)

- التحدث عن الجنس أمر محرج
- لقد تعلمت أن الجنس ليس شيئاً يمكن الحديث عنه

- لا أعرف أين يمكنني العثور على المعلومات المطلوبة
- يشعر العملاء بالحرج مما يجعل الأمر صعبًا
- لا أعتبر مناقشة الجنس جزءًا من وظيفتي
- لا أرى نفسي كشخص يعرف ما يكفي لمناقشة الجنس مع العملاء
- الحديث عن الجنس يتعارض مع معتقداتي الدينية

٤٠- ما الوقت المناسب للأطفال والشباب في بدأ التعلم عن الجنس؟

- مباشرة قبل الزواج
- الجامعة
- اعدادي
- ابتدائي
- لا يجب على الإطلاق