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Sex Education in the Mosque: An HIV Prevention Initiative for Muslim Adolescents

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Premarital sex among American adolescents is common (Centers for Disease Control and Prevention [CDC], 2019b). An estimated 55% of male and female US teens have had penile–vaginal intercourse by age 18 years (Abma & Martinez, 2017). Developmentally, adolescents lack maturity to navigate through the potential physical, psychological, emotional, and spiritual consequences of sex (Suleiman et al., 2015). Teenagers frequently place their social status and peer acceptance above their safety, leading to risky behaviors, particularly with sex (Wesche et al., 2019). In 2017, the Centers for Disease Control and Prevention found that adolescents "between ages 13 to 24 made up 21% (8,164) of the 38,739 new HIV diagnoses in the United States" (CDC, 2019a, p. 1). To reduce the spread of HIV and sexually transmitted illnesses (STIs), it is imperative to focus on sex education with adolescents.

Adolescent Muslim Americans have been found to have risky sexual behaviors similar to their non-Muslim peers (Ali-Faisal, 2014). Sex is often perceived as a dirty word in many Islamic communities. The taboo nature of romantic relationships often impedes communication around sex and leaves youth misinformed (Bennett, 2007). American Muslim adolescents also face challenges navigating through a society that is not accepting of their religious values, although internally struggling with adolescent development (Seward & Khan, 2016). There is no evidence-based sex education program to meet their unique needs (Seward & Khan, 2016). This article focuses on efforts to increase HIV and sex education among this marginalized community.

Background

Adolescent neurological development associated with puberty leads to increased sensation-seeking and risk-taking behaviors (Suleiman et al., 2015). The frontal cortex region of the brain controls reasoning and helps us think before we act (American Academy of Child and Adolescent Psychiatry, 2016). The neurological development of the frontal cortex continues to mature well into young adulthood (Suleiman et al., 2015). Therefore, an adolescent's ability to think about the consequences of an action, solve problems, and control impulses is limited and increases their sexual risk-taking behaviors (American Academy of Child and Adolescent Psychiatry, 2016), which includes higher rates of unprotected sex, unplanned pregnancy, and sexually transmitted infections, including HIV.

The religion of Islam constitutes a way of life governed by morals, values, and submission to God. Muslims, followers of Islam, are expected to diligently strive to please God through worship, exemplifying good character, and abiding by His rules. Islam teaches that engaging in actions that may lead to sex (dating, flirtatiously conversing with the opposite sex alone) and having sex before marriage are forbidden. The Qur'an, the Islamic sacred text, states "Do not even go close to unlawful sexual intercourse. It is indeed a shameful act, and an evil way to follow" (The Qur'an, 17:32). With teachings greatly focused on the virtue of chastity, many Muslims believe sex should only be discussed discretely and privately, if discussed at all. Many Muslim parents do not talk about sex with their children, leaving them unaware and uninformed (Ali-Faisal, 2014). Refraining from discussing issues of sexuality in the home in an effort to prevent promiscuity often backfires and leads adolescents to learn from unreliable sources and engage in risky behaviors, potentially exposing themselves to HIV/STIs or teen pregnancy.

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Despite the stigma and taboo nature of sex within this community, in one study, two thirds of Muslim youth residing in the United States and Canada reported having sex before marriage (Ali-Faisal, 2014). The study explored issues of sexual health education and experience among 403 Muslims ages 17–35 years, who were primarily raised in North America. Further, participants in this study reported that their greatest source of sex education was equally received from media and friends, and least likely from their parents (Ali-Faisal, 2014). In an exploratory study in Indonesia, a heavily Muslim populated country, Bennett (2007) recommended that comprehensive sex education should be offered through the framework of Islamic teachings for Muslim youth and adolescents. "For young Muslims, Islam can best provide a theoretical and moral framework for the provision for such education under the umbrella of Islamic education, which applies a holistic approach to physical, moral, and spiritual development of the person" (Bennett, 2007, p. 383).

The mosque, a Muslim place of worship, has historically played an integral role in education. Muslims gathered at mosques to not only obtain religious knowledge but also to seek counseling and guidance through life's journey (Uluhanli & Khan, 2017). Mosques are known as significant places of learning, which led to their being central sites for recruitment and the setting to facilitate this program.

New Jersey is home to the second largest Muslim population in the United States (World Population Review, 2019). New Jersey is also home to more than 37,000 people living with HIV (New Jersey Department of Health, 2019). The state has historically had one of the highest proportions of HIV incidence in females in the United States (New Jersey Department of Health and Senior Services, 2017). Although Black non-Hispanic and Latinx females accounted for 28% of the state's female population in 2014, minority women accounted for more than 83% of HIV cases among all adult and adolescent female cases (New Jersey Department of Health and Senior Services, 2017). Essex County, the setting for this program, has the state's highest number ($n = 3{,}700$) of adult and teenage women living with HIV among New Jersey counties (New Jersey Department of Health and Senior Services, 2017).

Program Description

Islamic communities lack access to comprehensive sex education consistent with their beliefs and values. The *Sex Education in the Mosque* program adapted evidence-based curriculum of Jemmott et al. (1998), *Making a Difference*, which uses social and behavior theories to educate participants about their sexuality, STIs, and HIV, although instilling high self-esteem and confidence. The curriculum was adapted, with permission, by incorporating Islamic beliefs from the Qur'an and Prophetic teachings to be sensitive and specific to the Muslim population.

In the United States, abstinence-only-until-marriage education programs have historically received billions of dollars in support but are notoriously known as being highly ineffective (Lemon, 2019). These programs are often conducted in public spaces where a specific faith is not a common denominator (Yarber & Sayad, 2019). Although it was abstinence-based, *Sex Education in the Mosque* was a comprehensive curriculum grounded in an Islamic framework. The program distinguished itself from typical abstinence-based programs because it portrayed sex as a pleasurable and natural experience. Rather than instilling feelings of shame and fear, typical of abstinence-only-until-marriage education programs, themes of empowerment, identity, and confidence to make healthier decisions were maintained.

One of the program facilitators (S.A.), who is of Islamic faith, worked directly with the developer of the original curriculum (L. Jemmott) to revise it. For example, the curriculum initially encouraged participants to engage in physical acts such as deep kissing, intimate touch, and mutual masturbation with partners, instead of penetrative sex. Although such actions would safeguard against HIV/STIs and pregnancy, in Islam these acts are prohibited, because they commonly lead to penile–vaginal intercourse. The curriculum was modified to alternatively encourage Prophetic teachings such as fasting from food and drink twice a week to ease sexual urges until one is ready for marriage (The Hadith, n.d.). The curriculum also promoted regular exercise to release endorphins for potential feelings of bodily pleasure (Heinrich et al., 2020). The modified curriculum was reviewed by an Islamic scholar and three supporting Imams of the recruiting mosques to ensure adherence to religious rulings.

Integrating Muslim values reinforced the importance of having a strong Islamic identity to further strengthen adolescent confidence and propel them to make healthier decisions. The main objectives for this program were to increase knowledge about prevention of HIV/STIs and pregnancy, help participants gain positive attitudes and stronger intentions to make healthier relationship decisions, and ultimately decrease incidence of premarital sex among participants. This project also examined relationships between the participants' religious practices and religiosity and their actual sexual intentions and behaviors to further understand the impact of the program.

The program consisted of eight modules (please refer to Table 1) implemented over two 5-hr weekend days. It

Table 1. Curriculum Revisions

Modules	Original *Making a Difference* Content	Modified *Sex Education in the Mosque* Content
1: Getting to know you and making your dreams come true	Informs participants about program	No modifications
	Participants identify meanings of responsible behaviors and reasons why teens have sex	Added Prophetic teachings that encourage delaying sex until marriage to earn Paradise; beauty of sex and how God created it
	Participants examine own goals and potential obstacles to reaching them	
2: Understanding adolescent sexuality and abstinence	Reviews physical and emotional changes occurring during puberty	Incorporated Quranic text to discuss meaning of abstinence and what God says about sex outside of marriage versus within marriage
	Explores pressures to engage in sex	Modified alternative ways to express sexual feelings to instead review permissible methods to overcome sexual urges until marriage (fasting, exercise, etc.)
	Explores alternative ways to express sexual feelings (hugging, kissing, etc.)	
3: The consequences of sex: pregnancy	Examines myths and facts of pregnancy	Modified partner pressure skit to be between an engaged couple
	Reviews partner pressure skit in boyfriend/girlfriend relationship	
	Illustrates how pregnancy can affect lives	
4: The consequences of sex: STI	Helps participants realize they are vulnerable to STIs and HIV	Modified problem-solving strategy to additionally include thoughts about pleasing God when faced with immediate, difficult decisions
	Participants identify personal level of risk for HIV infection	Case study modified with Muslim characters
	Provides participants with problem-solving strategy	
5: The consequences of sex: HIV infection	Clarifies myths of HIV	No modifications
	Helps participants understand how pressures from peers can affect decisions	
6: Attitudes, beliefs and giving advice about HIV/STIs and abstinence	Encourages participants to think about their choices and how their self-esteem might affect those choices	Modified values-voting-attitude statements to additionally include remembrance of God and religious rulings in Islam
	Reviews group's attitudes toward abstinence	Removed statements encouraging expression of physical acts between partners before marriage (hugging, kissing, etc.)
	Provides opportunities for participants to develop skills in giving correct information on HIV/AIDS to friends	
7: Responding to peer and partner pressure	Provides practice to participants in responding to peer pressure	Incorporated lesson to review differences between love and lust from an Islamic perspective
	Helps participants identify and practice necessary skills	Modified scripted role play to include realistic scenarios for Muslim adolescents

(*continued on next page*)

Table 1. (*continued*)

Modules	Original *Making a Difference* Content	Modified *Sex Education in the Mosque* Content
8: Role plays: refusal and negotiation skills	Increases participants' motivation to practice abstinence	Modified role plays to include realistic scenarios for Muslim adolescents
	Builds skills to negotiate abstinence	Emphasized mistakes may or have already happened, yet it is not too late to change behaviors to please God and become a better Muslim. Practical tips shared. Personal challenges with sex and relationships as a Muslim adolescent also shared by one facilitator (S.A.).
	Allows participants to rehearse negotiation skills and receive feedback	
	Reinforces participants' sense of confidence in choosing abstinence	

Note. STI = sexually transmitted illness.

included interactive activities and discussions facilitated by three nurse guides. Active and experiential learning activities were designed to increase participation and help youth understand the reasoning and decision making that puts them at risk for HIV/STIs and pregnancy. Activities aimed to increase comfort, address concerns, and provide strategies for overcoming challenges with delaying sex until marriage. The activities incorporated social cognitive–behavioral skill-building strategies such as presentation, modeling, and practicing negotiation skills. The curriculum involved culturally sensitive video clips and small-group discussions that built group cohesion and enhanced learning. Activities were short (20–30 min) with most being active exercises in which participants moved from their seats and interacted with each other. In this way, the program sustained interest and attention that otherwise might have faded during a lecture or lengthy group discussion.

The program began with participants identifying qualities they loved about themselves and sharing them with the group to boost confidence and acknowledge self-worth. Participants created goals and dream timelines for the next 5–10 years and developed strategies to avoid potential obstacles or challenges to reaching those goals. During the activities, the group recognized physical and emotional changes that occur during puberty and the normality of sexual feelings during this time. Participants learned the importance of getting to know themselves and not feeling obligated to act on emotions in sexual acts. After information sharing, games were used to debunk myths and teach facts about pregnancy and HIV/STIs; these were reinforced through realistic "what would you do" scenarios to combat peer and partner pressure with negotiation and refusal skills. Participants were asked to brainstorm on the benefits of having sex versus delaying sex to heighten awareness of different pressures and enhance decision-making skills. During the last segments of the curriculum, participants put what they learned into practice by participating in multiple role-play skits that mimicked situations they would most likely face in the future.

Practicing safe sex by using condoms, spermicides, birth control, or any other physical barrier method were not ridiculed or neglected in *Sex Education in the Mosque*. Instead, facilitators reviewed such practices in open discussions and highlighted the pros and cons of each. Participants were able to visualize how although these practices may protect them physically against HIV/STIs and pregnancy, they would not protect them against the potential emotional, psychological, and spiritual effects of sex outside of marriage. Overall, Muslim female participants had access to a curriculum that taught HIV prevention in a manner that was respectful of their beliefs and their right to honest and complete information, thus enhancing their holistic health.

Evaluation of the Program

The intervention site of the project was a mosque located in Newark, New Jersey. Participants were 18 adolescent, self-identified Muslim females who were single and had never been married. Due to presumed differences in maturity and life experiences, participants were divided into two age groups: 13–15 years of age ($n = 8$) and 16–19 years of age ($n = 10$).

Recruitment occurred at three different mosques located in New Jersey. In recognition of the importance of

securing buy-in and assistance of key stakeholders, including Imams and administrative boards of the mosques, the facilitators requested and obtained full support from each of the three mosques' Imams and administrative personnel. Overwhelming support by stakeholders highlighted the relevance and seriousness of the program. To facilitate participation, project organizers also advertised with posted flyers on the communication boards of each mosque and via the mosque's social media pages. The project was conducted by three female facilitators who were between 25 and 35 years old. Although one of the facilitators was of Islamic faith, the others were not. All program organizers were accepted as nursing professionals and welcomed into the mosque to conduct the course. Questions respective of Islamic faith and the teachings of the Qur'an were directed to the Muslim facilitator. All facilitators were present during the entire project. All facilitators were trained by organizers of the original *Making a Difference* curriculum to ensure consistency of content.

Program participants were asked to complete a preintervention questionnaire and postintervention questionnaire at the end of the 2-day program and again 3 months later. Questionnaires were adapted from the original study of Jemmott et al. (1998) with the *Making a Difference* curriculum. Questionnaires included a total of 98 multiple-choice, free text, and true/false questions. Eighteen questions asked about participant demographics; 10 questions reviewed history of sexual activity; 18 true/false questions assessed knowledge about HIV, STIs, and pregnancy; and 37 beliefs/attitudes questions regarding sexual activity and abstinence were measured with 5-point Likert scales. There were also five multiple-choice and free-text questions asking about the participants' Islamic behaviors and practices, such as how often they prayed salat (daily ritual prayers), if they wore hijab (head covering worn by Muslim women) in public and/or at school, how often they attended the masjid, and how much Qur'an they had memorized.

The Hoge Intrinsic Religiosity (IR) Scale, a 10-question reliable and valid measure of religiosity, was used with the pre-, post-, and 3-month postquestionnaires (Hafizi et al., 2015). The Cronbach alpha coefficient for this version of the Hoge IR Scale was 0.88. The intraclass correlation coefficient was 0.83 (95% confidence interval 0.47–0.95, $p = .001$; Hafizi et al., 2015). The Hoge IR was validated with Muslim youth and reviewed how participants felt Islam influenced their everyday life and decisions (Hafizi et al., 2015). Written informed consent was obtained from all participants and parents. The study was reviewed and approved (#Pro20160000633) by the Rutgers University Institutional Review Board in 2017.

Program Results

Data were analyzed using IBM SPSS Statistics version 24 (IBM, Inc., Armonk, NY). Frequency and descriptive analysis were used to analyze demographic data and assess sexual behavior at baseline and 3 months after the intervention. *T*-tests were used to examine the changes between the participants' baseline knowledge regarding STIs, HIV, and pregnancy and knowledge immediately after the intervention and at the 3-month follow-up. Chi-square tests were used to assess changes in participants' attitudes and intentions to abstain from sex. One-way analysis of variance was used to examine associations between the Hoge IR scale scores and actual sexual behavior as well as intentions and attitudes about abstinence.

The mean age of the participants was 15.9 years. Eighty-three percent identified as African American, 11% Caribbean, 4% Hispanic, and 2% White. The program found an increase in mean scores on the "HIV/STI/Pregnancy true–false" items portion of the immediate posttest and after 3 months, which demonstrates enhanced participant knowledge of such topics. The total range for scoring was zero for no correct answers to 18 having all 18 items correct. There was a statistically significant difference in the 18 HIV/STI/Pregnancy true–false item scores between the pretest ($M = 15.1$, $SD = 1.96$) and immediate posttest ($M = 17$, $SD = 0.93$); $t(7) = -3.91$, $p = .006$. There was also a statistically significant difference in HIV/STI/Pregnancy true–false item scores between the pretest ($M = 15.12$, $SD = 1.96$) and the 3-month posttest ($M = 17.13$, $SD = 0.99$); $t(7) = -3.74$, $p = .007$. However, the difference in scores between the immediate posttest ($M = 16.7$, $SD = 1.07$) and after 3 months ($M = 16.91$, $SD = 0.99$) was not statistically significant; $t(11) = -0.76$, $p = .463$ (Table 2).

There was also an increase in positive attitudes and intentions to abstain from sex before marriage on the posttests. In the pretest versus posttest, a significant association was found with whether the participants planned to have sex before marriage ($\chi^2(4) = 10.02$, $p = .04$). One participant (5.9%) changed their response from "in the middle" to "disagree" and three participants (17.6%) changed their response from "disagree" to "strongly disagree." In the 3-month postintervention survey, all participants reported they did not have sex after the program.

Slightly more than one quarter (27%; $n = 5$) of participants were sexually active at baseline; 60% of those ($n = 3$) who were sexually active stated they had had penile–vaginal intercourse with 5–10 partners. Of those who were sexually active, 80% ($n = 4$ out of 5) reported they wore hijab and prayed five times a day on a daily basis, as practicing Muslims. However, there was no

Table 2. *T*-test Comparing Scores of the HIV/Sexually Transmitted Illness/Pregnancy True–False Questions

Tests Being Compared	Test (*M*, *SD*)	Test (*M*, *SD*)	*T*	*p*-Value
Pretest scores versus posttest scores	Pretest (15.1, 1.96)	Posttest (17, 0.93)	−3.91	0.006
Posttest scores versus 3-mo follow-up scores	Posttest (16.7, 1.07)	3-mo follow-up (16.91, 0.99)	−0.761	0.463
Pretest scores versus 3-mo follow-up scores	Pretest (15.12, 1.96)	3-mo follow-up (17.13, 0.99)	−3.742	0.007

statistically significant association found between the total Hoge IR score and whether the participant would delay sex until marriage ($F(13,3) = 0.475$, $p = .851$) or would find it easy to not have sex before marriage ($F(13,3) = 0.216$, $p = .979$) in the immediate and 3-month posttest periods.

The program was positively received by participants. At the end of the 2-day workshop, participants were given the opportunity to answer the question: "How did you feel about the overall program?" One participant wrote: "The program was great, and it definitely raised more awareness in my life, and changes I needed to make personally for myself." Another wrote, "I like that we spoke about such a touchy subject so easily, and learned many methods on how to be true to ourselves and cool at the same time!" and "…the discussions really helped voice our opinions out." There were no negative comments to this question from the 18 participants.

Discussion

Sex Education in the Mosque addressed sex education and HIV prevention with a primary focus on abstinence and making self-empowered choices. The information provided in this program is rarely spoken about in Muslim homes. This program is the first of this nature to be addressed in the mosque and has the potential to shape the future of sex education among Muslim youth by influencing the way they are taught about HIV on an institutional, local, state, and national level. This curriculum fills a gap, because there is no current evidence-based curriculum to address sexual education in the Muslim community. This curriculum, built on the evidenced-based *Making a Difference* curriculum (Jemmott et al., 1998), addressed the unique needs of Muslims while educating them about HIV, STIs, and pregnancy prevention. It is important for nurses and other health care professionals to be equipped to maintain the safety of Muslim youth while upholding their religious principles and cultural values. Mosques and Islamic schools can serve as sites for future implementations to reach the vast majority of Muslim youth.

The stigma surrounding sex as a raunchy and degrading act was ultimately a barrier to obtain more youth participation. Many community members were unaware of the high prevalence of premarital sex occurring among Muslim youth and felt sex education was not necessary for their children. For example, one parent blatantly crossed out the word "sex" from program flyers believing it was inappropriate to be displayed in the mosque. Of interest, the Imam of the congregation identified sex as a beautiful gift from God and encouraged facilitators to design an educational program for parents who may be misinformed.

After talking with mosque administrators after the program, they conveyed that some members of their communities misunderstood the language used on recruitment materials. For example, "Sex education" printed on posters was at times misleading as many parents believed the program would be teaching sexual positions, tips, and techniques. Despite a great deal of stakeholder and community support, many parents still felt uncomfortable with allowing their daughters to participate in the project. Use of the word "abstinence" on posters may have been better received. Future implementations of the program should include a segment dedicated to parental education to remove any misconceptions that may prevent parents from enrolling their children.

This program showed participants' low level of baseline knowledge regarding HIV/STIs and pregnancy prevention. Interactive educational methods captured participants' attention and led to their ability to retain knowledge, as shown with increased mean knowledge scores. Participants were able to sustain their high scores on the true–false items post intervention and at the 3-month follow-up. Participants' Hoge IR scores indicated Islam's strong influential nature in their lives. However, these adolescent Muslim females showed difficulty connecting their religious beliefs to real-life circumstances, like sex and relationships. High scores on the religiosity scale, meaning greater religiosity, had no association with

stronger intentions to abstain from sex until marriage and finding it easier to abstain from sex in the immediate and 3-month follow-up posttest. This shows that in addition to educating adolescents about their religion, interventions are needed to help put those beliefs into everyday practice, especially in regard to sex and relationships.

Limitations of the program included its reliability on participants' self-reported actions and behaviors, which could have been intentionally or unintentionally inaccurate. Even though unlikely, related to facilitators maintaining a confidential and comfortable environment and motivating participants to respond honestly, this possibility cannot be totally dismissed. Furthermore, participants conveyed their frustration with surveys being too lengthy with 98 questions. Due to this program being replicated from a prior federally funded study, questionnaires incorporated more questions than needed for this particular program. Inconsistent results may be related to participants' short attention spans and rush to complete questionnaires versus taking their time to report sincere answers.

Facilitators were well aware of the potential of participants already being sexually active before initiating this program. Therefore, program organizers carefully selected language to promote optimism in changing harmful behaviors and actual skills to do so, as opposed to shaming and embarrassing participants and leading them to feel hopeless. The concept of forgiveness was also reinforced. All participants reported successfully practicing abstinence for 3 months postintervention, further demonstrating this program's effectiveness. Further education programs are needed to ensure similar results remain with long-term follow-ups. Additionally, participant inclusion criteria should be expanded to include both males and females of diverse backgrounds to best depict the Muslim population.

Conclusion

The Muslim community is lacking sex education programs that incorporate and are culturally congruent with their beliefs while teaching their youth HIV, STI, and pregnancy prevention. This project laid the groundwork for creating an effective curriculum that can address Muslim youth's unique needs. *Sex Education in the Mosque* has attracted attention from various Muslim leaders, professionals, and youth in the United States, Canada, and the United Kingdom. Many Muslims have recognized the universal lack of sex education and HIV prevention programs within their communities as a concern that needs to be addressed. Based on this need and multiple requests from communities to replicate the program, a nonprofit organization called *Love beyond Love* was initiated by one of the authors. The organization aims to strengthen the modified curriculum through replication and data collection among numerous diverse Muslim male and female youth. Muslim youth have the power and potential to hold themselves to a higher standard when given the opportunity to access knowledge, confidence, and skills needed to meet today's challenges.

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