Sexual & Reproductive Healthcare 6 (2015) 3–8

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Sexual and reproductive knowledge, attitudes and behaviours in a school going population of Sri Lankan adolescents

Neelamani Rajapaksa-Hewageegana [a], Hilary Piercy [b,*], Sarah Salway [c], Sarath Samarage [d]

[a] Health Education Bureau, Colombo, Sri Lanka
[b] Centre for Health and Social Care Research, Sheffield Hallam University, Sheffield, UK
[c] Centre for Health and Related Research, University of Sheffield, UK
[d] WHO Country Office, Colombo, Sri Lanka

ARTICLE INFO

Article history:
Received 31 January 2014
Revised 31 July 2014
Accepted 15 August 2014

Keywords:
Adolescence
Sexual health
Sexual knowledge
Sexual behaviour
Sri Lanka

ABSTRACT

The reproductive and sexual health of adolescents is an important health concern and a focus of global attention. In Sri Lanka, a lack of understanding about adolescent reproductive and sexual health needs is a matter of national concern.

A survey was undertaken to examine the sexual knowledge, attitudes and behaviours of school going adolescents in Sri Lanka. A random sample of schools was selected from one district. Data were collected by a self-completion questionnaire and analysed using SPSS. Response rate was 90%.

2020 pupils (26% boys, 74% girls) aged 16–19 years (mean = 16.9) participated, the majority Sinhalese (97%).

Most reported a good parent–child relationship (88%). A minority (34%) discussed sexual issues with parents. Health professionals were the preferred source of sexual information (32%) rather than parents (12.5%) or friends (5.6%). Less than 1% demonstrated satisfactory sexual and reproductive knowledge levels. 1.7% were sexually active (30 boys vs 5 girls), the majority with same age partners. 57% used contraception at first intercourse.

There is an imperative to address the lack of sexual and reproductive knowledge. A minority of school going adolescents become sexually active. These individuals are potentially vulnerable and services need to be developed to meet their needs.

Introduction

The reproductive and sexual health of adolescents has been recognised as an important health concern and has been the focus of considerable global attention for many years. In the twenty years since adolescent reproductive health was identified as an area for specific action at the International Conference on Population and Development in 1994, substantial efforts have been directed towards understanding and addressing the specific needs of this population. Notwithstanding this, in many parts of the world, the reproductive health needs of adolescents are often poorly understood or neglected [1] especially in South Asian countries such as Sri Lanka [2,3] where the current paucity of information has been identified as an area of concern at national policy level [4].

The adolescents of Sri Lanka are required to negotiate their sexual development and transition to adulthood within the context of complex and often competing traditional social and cultural values and attitudes and those espoused by an increasingly globalised society. There is little public awareness about adolescent reproductive health in the country. Cultural taboos that preclude discussion of sexual matters within and between generations are common in South Asia [5–7]. In India, a desire to adhere to traditional values uncorrupted by knowledge of sexual matters creates reluctance for any explicit communication about matters associated with sex [8]. In this environment, it is difficult for parents, teachers and community leaders to openly discuss key issues among themselves or with adolescents. Nair et al. [9] found very low levels of communication about sexuality: in their study only 5% of teachers and 1% of parents reported that they had discussed sexual issues with adolescents. The indications are that channels of communication, such as mother–daughter discussions, teacher–student discussions or peer-to-peer programmes through which adolescents might receive information on safe sex, relationships, reproductive health and related issues are not widely available to South Asian adolescents [7].

School based sex education programmes play an essential role in equipping adolescents with the knowledge they require to make informed sexual and reproductive decisions and to protect their

* Corresponding author. Centre for Health and Social Care Research. 34 Collegiate Crescent, Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield S10 2BP, UK. Tel.: +44 114 2255603.
E-mail address: h.piercy@shu.c.uk (H. Piercy).

http://dx.doi.org/10.1016/j.srhc.2014.08.001
1877-5756/

health [10]. A substantial body of evidence indicates the effectiveness of curriculum based interventions in improving sexual knowledge and reducing sexual risk among adolescents in developed and developing countries [11,12]. The effectiveness of any school based programme is dependent on access to education. Sri Lanka, which has very high levels of schooling, is well placed to benefit from such an approach: the country has a 92% literacy level and nine years compulsory schooling. Upper secondary school enrolment rates are 55% for boys and girls aged 15–19 years, greater than that in other South Asian countries [13,14].

A school based adolescent sexual and reproductive health (ASRH) education programme has been provided in Sri Lanka for forty years. The first programme was introduced by the Department of Education in 1973 and development over subsequent years resulted in an expanded programme which was introduced in secondary schools in 1996 [15]. However, the indications are that these initiatives have had limited effect to date. A national adolescent survey conducted almost 10 years ago with 15–19 year olds reported very low levels of knowledge about reproductive processes, contraception and sexual health in their groups of school going and out of school adolescents [3]. Knowledge levels in all three areas were higher in those out of school, though in both groups knowledge levels increased with age and socio-economic status. De Silva et al. [15] similarly reported low knowledge levels in their population of 10–24 year olds with extremely low levels among the younger age groups.

Adolescent sexual behaviour has received limited attention in Sri Lanka although two national surveys provide some insights. In a study conducted by UNICEF, 6% of school-going 14–19 years olds reported having engaged in heterosexual intercourse whilst 20% reported of knowing friends who were sexually active. Boys were substantially more likely to report heterosexual activity than girls for themselves (14% vs 2%) and their friends (40% vs 11%). The mean age of first intercourse was 15.3 years for boys and 14.4 years for girls [3]. De Silva et al. [15] confined themselves to indirect questions of sexual activity in their study because they considered it inappropriate to ask the adolescents in their study about their own sexual behaviour. In their sample of 15–17 year olds, 27% of males and 11% of females reported knowledge of unmarried peers with experience of sexual intercourse. The extent to which any of these findings might accurately reflect actual sexual activity levels in this population is difficult to determine. The sensitivity of the topic may result in substantial under-reporting of own sexual behaviour, however knowledge of others' behaviour is likely to be a poor proxy indicator in this context because it relies on the adolescents having an accurate knowledge of their peers' sexual behaviour.

The indications are that contraceptive usage is low among those who do become sexually active. In the school going group in the UNICEF study [3], 24% of those who were sexually active had ever used condoms and 17% had used condoms at last sexual intercourse. Two hospital based studies involving pregnant adolescents similarly reported low contraceptive awareness and lack of contraceptive usage largely attributable to lack of knowledge and fear of side effects [16,17]. These difficulties are compounded by problems of access: in common with many other developing countries, unmarried adolescents in Sri Lanka face considerable difficulties accessing family planning or reproductive health services because they are only available to, or perceived to be only available to those who are married [4,18].

The literature identifies substantial areas of concern and suggests that Sri Lankan adolescents are ill equipped to make informed decisions about sexual activity and protect themselves from the unwanted consequences. However, ten years have elapsed since the UNICEF study and further work is indicated to determine the extent to which progress has been made. Additionally, a more detailed understanding of those adolescents who do become sexually active and the surrounding circumstances is required in order to identify the needs of this population and inform development of reproductive health policy and practice. This paper presents the findings of a survey examining the sexual and reproductive knowledge, attitudes and behaviours of school going adolescents in Sri Lanka which was conducted as part of a larger study exploring adolescent sexuality.

Methods

Recruitment of study participants

The study was undertaken in Badulla District in the central hill country. The district has around 860,000 residents and socioeconomic characteristics comparable with those in other parts of the country [19]. The study population comprised all those adolescents aged 16–19 years who were studying in classes from Grade 11 to 13 in government schools within the district in the study period 01/01/2010 to 30/06/2010. The proportion of boys and girls registered in Grades 11–13 at the time were roughly equal. The sample frame used for recruitment of respondents was the "Register of schools" of the Department of Education. Schools are organised into five geographical zones in the district and sampling occurred across all five zones.

The study population comprised all those aged 16–19 years who were registered in state schools in the two year period July 2007–June 2009. Based on a desire to estimate the proportion of sexually active adolescents (estimated to be 30%) with an accuracy of ±5% and an anticipated non-response rate of 15% and using standard methods for sample size calculation [20], a target sample size was set at 404 for each school zone giving a total sample size of 2020.

The sampling approach was as follows. One school was randomly selected from each school zone and visited for data collection. At an initial visit one of the research team explained the study in detail to all those eligible to participate including issues of confidentiality and anonymity. The adolescents were then given an information letter and consent form for their parents to sign. The researcher returned one week later to collect data. Only those pupils returning signed consent forms participated in the study. Following completion of data collection at the first school, a subsequent school was randomly selected and visited, and the process was repeated until the sample size was achieved. Within each zone, schools were visited until a minimum of 400 students completed the questionnaire. The number of respondents recruited per school ranged from a minimum of 80 to a maximum of 110. The recruitment rate was 90%.

Data collection

Data were collected by means of a self completion questionnaire covering a range of topics including: socio-economic background, social circumstances, attitudes towards premarital sex, sexual and reproductive knowledge and sexual practice. The content of the questionnaire was informed by prior empirical and conceptual work and developed in collaboration with key stakeholders including adolescents, medical officers, parents, teachers, youth workers and sociologists to ensure that it was acceptable for use in an educational setting. Terms deemed too explicit were replaced by less explicit terms and some closed questions were replaced by open questions to address concerns about promotion of sexual activity. The questionnaire was developed in Sinhala and the final version was translated to English and Tamil using a rigorous back and forward translation approach. Subsequently a pilot study was conducted with a small group of volunteer students (male and female) outside the study area to test comprehensibility and acceptability. This involved some re-ordering of the questions and the process for administering the questionnaire.