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Awareness and attitude towards sex health education and sexual health services among youngsters in rural and urban settings of Sindh, Pakistan

Ashfaque Ahmed Talpur,[1] Asif Raza Khowaja[2]

School of Health and Related Research (ScHARR), University Of Sheffield, England, United Kingdom,[1]

Department of Paediatrics and Child Health, Aga Khan University, Karachi, Pakistan.[2]

Corresponding Author: Ashfaque Ahmed Talpur. Email: ash_sindhu@hotmail.com

Abstract

Objectives: To assess attitudes and awareness regarding sexual health education and services among young individuals in Pakistan.

Methods: A cross-sectional survey was conducted in urban and semi-urban districts of Sindh, Pakistan, in 2010. A self-administered questionnaire was distributed in-hand among 200 young people aged 16-25 years; who were selected on the basis of convenience sampling. Of the questionnaires distributed, 165 (82%) were returned. After checking for quality and consistency, 150 (75%) forms were found good enough to be used for categorical analysis, using PASW Statistics 18 for Mac 2008 version.

Results: Of the 150 participants, 94 (63%) were males and 56 (37%) were females. A quarter of them (n=38; 25.3%) said sexual health services were available too far away from their area. Besides, they also found the staff to be 'not competent.' Almost one-third (n=49; 32.7%) reported of not having matching gender choice (male or female) of professionals with whom they could feel comfortable sharing their sexual health concerns. Majority of the participants (n=101; 67.3%) considered trained health professionals as the primary source of sexual health education, whereas, 90 (60%), 75 (50%), and 59 (39.3%) also reported to have secondary sources, including internet, parents and telephone helpline respectively.

Conclusion: Sexual health education and services for the young are barely enough or satisfactory in terms of quantity and quality in Pakistan, suggesting a case for having curriculum-based sex education implemented in academic institutions.

Keywords: Sex health education; Sexual health services; Perceptions towards Sexual Health Education. (JPMA 62:708; 2012).

Introduction

The proportion of young persons is growing faster in the world.[1] Risky sexual behaviours, such as early sexual debut, premarital sex, multiple partners and bisexual orientation, are also increasingly becoming common among young people.[2,3] Sex education for the young has remained a limited and controversial issue in many countries across the world.[1] According to the World Health Organisation bulletin 2007, many nations worldwide pledged that by 2007, more than 90% of young people in their countries would be able to correctly recognise the modes of HIV transmission and its prevention. However, available evidence shows that only 40% of young males and 36% of females have appropriate knowledge of HIV/AIDS.[4] Health education is a basic right of young people. It improves their knowledge about their bodies, gives them the opportunity to understand their responsibility in society, and helps them develop negotiating skills.[5] However, sexual and reproductive health is entangled in complex societal stigmas, fears, misconceptions and misinformation.[1]

Limited access to information and services for young people decreases their self-confidence and the ability to make informed choices.[6] For example, a study in Sri Lanka revealed lack of knowledge among youngsters aged 17-19 years to result in low self-confidence and psychological distress, especially with regard to masturbation practices and menstruation periods.[7]

Demographically high proportion of youth, low literacy rate, low knowledge about Sexually Transmitted Infections (STIs), delayed marriages, and poor health indicators are few major risk factors in raising the susceptibility of young people contacting sexually transmitted infections in Pakistan.[8]

Literature about sexual and reproductive health for young people is scarce in Pakistan.[9] Young people in Pakistan have very limited knowledge about sexual and reproductive health, and majority of them have different misconceptions.[10] For example, a study conducted on young boys and girls aged

10-19 years in Karachi found that 54% participants had no information on any STI.[11] A qualitative study on adolescents reported that girls perceived menstruation as the ability to give birth; and that having a shower during menstruation periods is harmful for their health.[12] Another study representing young men aged 18-21 years reported having fears of detrimental effects as a result of masturbation, varying from erectile dysfunction (30.4%) to physical (76.4%) and sexual weakness (10.9%). Feelings of guilt associated with masturbation were also reported by 76% of the participants. Young people experience many negative psychological effects due to their lack of knowledge about sexuality.[10] They want to learn about their bodies[9,11] as 88% participants, in a study, maintained that sexual health should be included in school curriculum.[13]

Young persons' perceptions about need of sex education, satisfaction with sexual health services, and knowledge about STIs has attracted very little space from research point of view in Pakistan.[11] Therefore, this study was aimed to assess youngsters' awareness and attitude towards the availability of sexual health education and sexual health services in the country.

Subjects and Methods

A cross-sectional survey was conducted, using a self-administered questionnaire. In order to have representation from both urban and rural populations, two distinct study sites (district Hyderabad, which is predominantly urban, and village Sakrand in district Nawabshah) in the Sindh province of Pakistan were selected.

The study participants were recruited from both public and private academic institutions, using the convenient sampling method. The eligibility criterion was restricted to age between 16-25 years, regardless of gender and particular subject of study at the institution. In total, 200 questionnaires were distributed in-hand along with an information sheet explaining their participation in the research. Study participants were facilitated by a trained research assistant at each study site. They were given options to either complete-and-return the questionnaire on-spot; or take it home and return it later by a set date in a sealed envelope which was provided with the questionnaire. Majority of the participants (n=158; 79%) opted to return the questionnaire later, and the envelopes were subsequently collected by the research assistant. Altogether, 165 filled questionnaires were received. The quality and consistency of the forms were checked and the responses from 150 questionnaires were found suitable for entry and further analysis.

The data-collection tool was a quantitative-structured questionnaire, which was translated into three languages: English, Urdu and Sindhi. The translated questionnaire was piloted on 05% of the total sample size, randomly selected in similar settings before the study. Statistical analysis of the data was undertaken using PASW Statistics 18 for Mac 2008 version. The data was analysed to produce descriptive statistics.

As the study did not involve any physical or emotional harm to the participants, participation was made purely on voluntary basis for which verbal consent was obtained from all the participants. Confidentiality of the participant was ensured by coding individual responses on unique participant identification codes. The study received ethical approval from the Ethical Review Committee of the School of Health and Related Research (ScHARR), University of Sheffield, England.

Results:

Of the 150 participants, 94 (63%) were male and 56 (37%) were female. Only 42 (28%) were married (Table-1).

Regarding sexual health service, 47 (31.1%) of the young people admitted to having a fear that a friend might find out that they had asked for an advice about sexual health, and this stopped them from seeking any medical help (Table-2). There were 38 (25.3%) who said sexual health services were far away for them to make use.

Of the participants 37 (24.7%) commented about the attitude of staff at such health facilities as "unwelcoming"

Table-1: Descriptive analysis of demographical indicators.

	Frequency	Percentage
Gender		
Male	94	62.7
Female	56	37.3
Age Group		
16 - 18 years	14	9.4
19 - 21 years	65	43.3
22 - 25 years	71	47.3
Marital status		
Single	80	53.3
Married	42	28.0
Engaged	20	13.3
In relationship	4	2.7
Divorced	1	0.7
Widowed	00	00
Others*	3	2.0
Location		
Town	99	66.0
Village	35	23.3
Others*	16	10.7
Education		
No formal education	5	3.3
Primary	4	2.7
Secondary	32	21.3
College or University	103	86.7
Others*	6	4.0

Other* represents the missing data in the table.

Table-2: Descriptive analysis of sexual health services.

Using sexual health services	Very often		Often		Sometimes		Rarely		Never	
	n	%	n	%	n	%	n	%	n	%
Friends might find out that I have asked for advice about sexual health and this stops me seeking medical help	47	31.3	12	8.0	21	14.0	12	8.0	51	34.0
Family members might find out that I have asked for advice about sexual health and this stops me seeking medical help	20	13.3	19	12.7	18	12.0	13	8.7	74	49.3
My religious beliefs mean that I would not have sex outside marriage	62	41.3	16	10.7	7	4.7	11	7.3	46	30.7
Existing sexual health services are too far away for me to use them	38	25.3	18	12.0	27	18.0	24	16.0	33	22.0
Existing sexual health services are designed to make access easy for young people	31	20.7	20	13.3	19	12.7	29	19.3	37	24.7
Staff are welcoming at existing Sexual Health Services	32	21.3	23	15.3	17	11.3	29	19.3	37	24.7
There are no sexual health advice and treatment services in my local area	18	12.0	15	10.0	24	16.0	40	26.7	40	26.7
Staff are competent at existing sexual health services	25	16.7	14	9.3	31	20.7	28	18.7	41	27.3
STI testing is free of cost at Sexual Health Services	19	12.7	9	6.0	15	10.0	20	13.3	76	51.7
There is interesting and informative material on sex, contraception and relationship at Sexual Health Services	30	20.0	6	4.0	21	14.0	29	19.3	49	32.7
There is a choice of male and female staff at existing sexual health services	21	14.0	20	13.3	23	15.3	25	16.7	49	32.7
I would rather not know if I have a sexually transmitted infection, including HIV/AIDS	41	27.3	15	10.0	15	10.0	19	12.7	48	32.0
I fear discussing sexual matters with anyone	51	34.0	7	4.7	15	10.0	31	20.7	36	24.0

Table-3: Descriptive analysis of views about sexual health education.

Where is the best place for education about relationships and sexual health to be provided for young people?	Yes		No		Not sure	
	n	%	n	%	n	%
Sexual health education should start from primary school	30	20.0	102	68.0	12	8.0
Sexual health education should start from secondary school	59	39.3	73	48.7	12	8.0
Sexual health education should start from college or university	95	63.3	36	24.0	12	8.0
There should be no sex education at all in schools and colleges	43	28.7	80	53.3	19	12.7
Sexual health education should be taught by parents at home	75	50.0	42	28.0	19	12.7
Sexual health education should be taught at youth centers by trained health professionals	101	67.3	19	12.7	22	14.7
Sexual health education should be taught in religious schools or centersby religious/ spiritual leaders or healers	57	38.0	58	38.7	26	17.3
Advice and information about sex should be available to young people through telephone help lines	59	39.3	60	40.0	24	16.0
Advice and information about sex should be available to young people through the internet	90	60.0	38	25.3	13	8.7
Sexual Health Education should be provided in booklet form for students	97	64.7	30	20.0	14	9.3
Sexual health education should be integrated into other science subjects and taught by teachers of that subject	82	54.7	31	20.7	28	18.7
Sexual Health Education should include discussing family values such as the responsibilities of parenting	89	59.3	33	22.0	19	12.7
Sexual health education should include physical and emotional changes at puberty and how to deal with them in positive ways	86	57.3	29	19.3	25	16.7
Sexual Health Education should include the biology of sex and human reproduction, contraception, sexuality-transmitted infections including HIV/AIDS.	97	64.7	27	18.0	18	12.0
Sexual Health Education should include advice about difficult issues such as preventing abuse and violence	98	65.3	21	14.0	24	16.0
Sexual health education should take students' views on board	70	46.7	40	26.7	33	22.0

about sexual health concerns. It was observed that 41 (27.3%) of the participants perceived health facility staff as "not competent", whereas, 49 (32.7%) reported of not having gender choice (male and female) in terms of professionals with whom they could feel comfortable sharing their sexual health concerns. Besides, 51 (34%) young people acknowledged that very often they feared discussing sexual matters with anyone, while 41 (27.3%) would rather not know if they had an STI, including HIV/AIDS.

In terms of sexual health education, a majority of respondents favoured the concept of initiating the subject at some level of the academic process: primary (n-30; 20%); secondary (n=51; 39.3%); or college/university (n=95; 63.3%). However, 80 (53.3%) disagreed with the basic

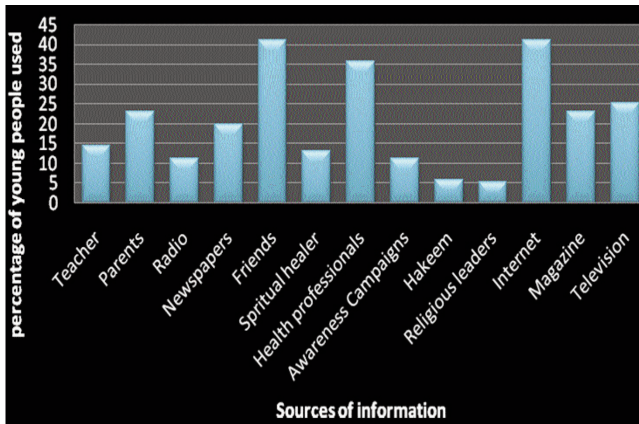

Figure: Source of Information for sexual health.

concept. With regard to the primary source of sexual health education, 101 (67.3%) participants favoured trained health professionals, while 90 (60%), 75 (50%), and 59 (39.3%) thought of secondary sources like the internet, parents, and telephone helplines, respectively. These observations were compared with global trends (Figure).

Discussion

The study underscored increased level of dissatisfaction among the young with the available sexual health services in Pakistan and highlighted the need to have curriculum-based sexual education in academic institutions.

The study also showed that existing sexual health services are inaccessible, that many staff are incompetent and unwelcoming, and that the services are not young-people-friendly. It is well known that stigmas associated with STIs deter many people from seeking sexual health services, the attitude and knowledge of staff play a vital role in building confidence and trust among healthcare seekers.[14,15] The review of the literature showed that unfavourable attitude results into under-reporting of unwanted pregnancies, and abortions in Pakistan.[16] This study showed that one-third of the young people feared discussing their sexual health problems with anyone. This indicates that they have less trust and more fear of breaking confidentiality about their sexual health. It is well discussed that if the confidentiality is compromised, young people will be less likely to use the services or will be less than honest about their sexual health conditions.[15]

The findings of this study implied that the government should re-evaluate the existing sexual health services and should make them more young-people-friendly.

The findings of the study are consistent with many other studies, in suggesting that young people want to learn about their sexual health.[9,11,13] Throughout the world, schools have been recognised as an important place for sex and STI/HIV education.[17] Strategies based on a written curriculum in school on HIV/STI education are promising interventions in terms of a reduction of unsafe sexual risk behaviours among the young.[18] Several studies and reviews have concluded that school-based sexual health education for young people improves their understanding on sexually transmitted infections, including HIV/AIDS, reduces risky behaviour like unsafe and unprotected sexual intercourse, and develops skills to communicate effectively and make healthy relationships.[18,19]

This study adds to the literature that suggests that young people want sexual health education to be taught in academic institutions of Pakistan. Young people said that the content of sex education should include family values such as responsibility of parenting; physical and emotional changes at puberty; biology of sex; human reproduction; contraception; and information about STIs including HIV/AIDS.

The study had many methodological limitations that may have influenced its results. Since the participants were recruited from academic institutions and the majority had higher secondary education level, therefore, it is difficult to generalise the findings on common young people in the local context. The quantitative nature of the questionnaire might have prevented participants from sharing their views that might have been different from the statements and options available in the questionnaire. Besides, because of the standardised nature of the questionnaire, participants who misunderstood any point might not have had an explanation of the questions concerned. Moreover, there is always doubt about the honesty of the participants' responses when self-administered questionnaires are used. Inclination of socially acceptable responses might be possible due to the sensitive nature of the topic.

Conclusion

Low level of knowledge among youngsters and their dissatisfaction with the available sexual health services are the impeding factors undermining the scope of current reproductive health services in Pakistan. Nevertheless, the knowledge sources were largely perceived to exist either in the form of media and internet, and making them formal through academia was largely recommended.

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