Leading Article

The place of sexuality education in preventing child pregnancies in Sri Lanka

***Darshani Hettiarachchi**[1]
Sri Lanka Journal of Child Health, 2022; **51**(1): 4-7
DOI: http://dx.doi.org/10.4038/sljch.v51i1.9985
(Key words: Sexuality education, Child pregnancy, Sri Lanka)

Background
Sri Lanka is a lower-middle-income country in the South Asian region with a total population of 21.8 million. According to the national statistics in 2019, about 24% of the total population was of age zero to 14 years. Sri Lanka was assessed to have 92% of adult literacy rate (% of people aged 15 and above) in 2018 as per World Bank data[1]. This is above average by world and regional standards. In the Sri Lankan society, education plays a major role in the life and culture of the country. According to the World Bank data, Adjusted Net Enrolment Rate to primary school was 99.1% in 2016[2].

In spite of the high literacy rate, lack of awareness about reproductive and sexual health needs among children is a matter of national concern in Sri Lanka. In a study done among Sri Lankan adolescents to assess their sexual knowledge, attitudes and behaviours, only less than 1% was assessed to have satisfactory sexual and reproductive knowledge levels[3]. Child pregnancies are a global phenomenon. It can be considered as a national tragedy with multiple physical, psychological, social, educational and economic adversities. According to the statistics of the Family Health Bureau of Sri Lanka, registered teenage mothers were 4.1% of the total pregnancies in 2020 which was slightly lower than the 2015 data (5.3%). Even though these rates are lower than in other South Asian countries like Bangladesh (35%), Nepal (21%) and India (21%)[4], considering the significant morbidity and mortality, it is vital to take every step to prevent or minimize child pregnancies in Sri Lanka.

[1]*Consultant Child and Adolescent Psychiatrist, Teaching Hospital Karapitiya, Sri Lanka*
**Correspondence:*
darshani.hettiarachchi@gmail.com
https//orcid.org/ 0000-0001-5381-6116

The author declares that there are no conflicts of interest
Personal funding was used for the project.

Risk factors for child and adolescent pregnancies
Risk factors for child and adolescent pregnancies are multiple and can vary between populations. Low socio-economic family background, living in disorganized neighbourhoods, low educational level, living with a single parent, victimization of sexual abuse, poor child-parent relationships and poor parental supervision, are identified as the main risk factors in many developed countries[5]. In South Asian countries like India, Bangladesh and Nepal, low educational level, low socio-economic background, disrupted family setting and poor sexual health practices are identified as common risk factors[5]. In Sri Lanka, low educational attainment, low socio-economic status (SES) and poor parental supervision are also identified as major risk factors for teenage pregnancies[4]. The same studies reported that 59.4% of teenage girls who were on contraceptive pills have conceived, indicating method failure and lack of proper knowledge on contraceptive methods[4].

Sexuality education for children and adolescents
According to the World Health Organization (WHO), sexuality education aims to develop and strengthen the ability of children and young people to make conscious, satisfying, healthy and respectful choices regarding relationships, sexuality as well as emotional and physical health. Sexuality education is not just giving information about anatomy and physiology of biological sex and reproduction. It does not encourage children and young people to have sex. This includes providing accurate and developmentally appropriate information to children and adolescents about the biological, psychological, socio-cultural, relational and spiritual aspects of sexuality[6]. Healthy sexuality can be influenced by multiple factors such as racial, ethnic, religious, cultural, moral and personal concerns. It is also vital to consider healthy sexuality development as a key developmental milestone in all children and adolescents. All children and adolescents should receive adequate knowledge about healthy sexuality and healthy sexual behaviours. This will prevent risky sexual activities which can lead to health and social problems such as sexually-transmitted diseases and unplanned pregnancies. Sexuality education can be done in schools, home environments, community settings and health

scenarios. It should be commenced from a very young age in an age-appropriate manner.

Current situation in Sri Lanka

In the Sri Lankan setting, children get sexuality education through teachers, parents, caregivers, colleagues and healthcare workers. It is a well-known fact that Sri Lankan children are not getting adequate sexuality education via any of these resources. Our education system has given the least possible priority to healthy sexuality education due to multiple religious, cultural, moral and practical reasons. Inherently, our parents and caregivers are reluctant to talk with children about sexuality-related factors. Sexuality education and public discussions about sexuality are highly discouraged in our society. This has resulted in children and adolescents seeking information through unhealthy resources, such as social media, internet and social groups, which lead them to have access to unhealthy and potentially harmful information. Eventually, many adolescents reach adulthood with confusing, conflicting and negative knowledge about sexuality which is often exacerbated by silence and embarrassment of adults, including parents and teachers. School medical education programmes conducted by primary healthcare workers, including the Medical Officer of Health, Public Health Inspectors and Public Health Midwives is one of the main sources of sexuality education received by children and adolescents in Sri Lanka. However, in the clinical setting, it is evident that lack of knowledge about sexual health is one of the main reasons for victimization of child sexual abuse and child pregnancies. Here are a few clinical cases in favour of these contentions.

Case 1

B was a 14-year-old girl transferred to a teaching hospital from a peripheral hospital with suspected acute abdomen and she delivered a baby after a few hours following admission. Until the delivery she was not aware about her pregnancy. The alleged perpetrator was her 17-year-old biological brother who used to live in the same house. According to the history, they have had multiple sexual encounters without proper knowledge about the consequences. As a final outcome the baby was handed over to the probation authorities, B was kept with the family and the 17-year-old brother was sent to a certified school by courts. The entire family structure was disrupted and the family had to move to another area due to social stigma. In this scenario, parents have failed to provide adequate adult supervision mainly due to poor knowledge. If the 17-year-old boy had reasonable sexuality education, his behaviour would have been controlled. If B was aware about age-appropriate sexual health she would have asked for adult support.

Case 2

C was a 15-year and 11-month-old girl who had eloped with her 18-year-old boy-friend 2 months back. She was found by the police after parental complaint and brought to the hospital for assessment for alleged child sexual abuse. On child and adolescent psychiatric assessment it was found that she has had multiple sexual encounters with her boy-friend. On assessment, it was revealed that she was aware that she could get pregnant by having unsafe sexual practices. When inquired about the safety measures, she reported that her boy-friend was taking contraceptive pills. Unfortunately, she was not aware that there are no male contraceptive pills in practice. This shows how easily they can get trapped by fake information due to lack of knowledge and the importance of giving accurate information about safe sexual practices.

Case 3

D was a 13-year-old girl who used to live with her biological father and older sister. Her mother had gone abroad as a domestic helper one year back. She was brought to the hospital by the school teacher after she got a fainting attack at school. At the hospital, it was found that she was pregnant with a period of amenorrhea of 4 months. She reported repeated victimization of sexual assault by her grandmother's partner at home. Since she was not aware that girls should get their menstruation monthly, she had not informed anyone about her missing menstrual cycles.

Case 4

E was a 12-year-old very intelligent girl who lived with her biological parents. She had got 168 marks for the scholarship examination in grade 5. After watching a movie where a Nun was explaining to a journalist about victimization of sexual abuse at a young age, C had asked the mother about the meaning of 'athawaraya' (the Sinhala word for rape). After explanation by the mother about the meaning of rape, she has revealed repeated victimization of sexual abuse by her biological father for years.

Case 5

F was a 14-year-old girl who used to live with her grandmother after the death of her parents a few years ago. She had stopped attending school one year back due to financial difficulties. She had started living together with her 19-year-old boy-friend at his house after that. She had not revealed about her missing periods to anyone due to fear of getting scolded. Her boy-friend's mother had noticed her enlarging tummy and referred her to the Public Health Midwife. By that time she was 6 months pregnant. She was assessed to be a very thin, weak and medically compromised girl whose life was at risk by continuation of the pregnancy. If the

girl, her boy-friend or boy-friend's mother, had any knowledge on sexual health, this incident would have been prevented.

These clinical examples clearly show the knowledge gap in sexuality education in Sri Lanka and the importance of healthy sexuality education in preventing child pregnancies and repeated victimization of child sexual abuse.

The place of comprehensive sexuality education in Sri Lanka

Comprehensive Sexuality Education (CSE) is a curriculum-based process of teaching and learning about the physical, emotional, cognitive and social aspects of sexuality, reproductive health and rights[7]. The key components of CSE include understanding about the human body and its development, understanding gender, sexuality and sexualized behaviours, skills for health and wellbeing, relationships and intimacy, values, rights, culture, violence related to sexuality and how to be safe[7]. CSE is the education delivered in formal and informal settings, which is scientifically accurate, comprehensive, age and developmentally appropriate, based on gender equality, human rights and also culturally appropriate[8]. According to the available evidence, sexuality education has shown positive effects on young people's knowledge, attitudes and behaviours related to sexual and reproductive health[8]. Formal or informal sexuality education does not increase sexual activity, sexual risk-taking behaviour or sexually-transmitted disease rates[9].

The Youth Health Survey, conducted in 2012 by the Ministry of Health, Sri Lanka, United Nations Children's Fund (UNICEF) and United Nations Fund for Population Activities (UNFPA) showed the gaps in providing reproductive and sexual health information to students in schools. In the survey, only 59% of students had received reproductive health education from school. It also found that such information is not available for youth who are out-of-school. Only 50% of the youth have the basic knowledge on sexual and reproductive health issues[7]. Nearly 66% of girls in Sri Lanka are not aware of menstruation until menarche[10]. The National Survey on Emerging Issues among Adolescents in Sri Lanka (2004) reported that adolescents had poor knowledge on contraception, teenage pregnancy, risk factors of sexual abuse and sexually-transmitted diseases[11].

This shows the importance of formulating and implementing CSE programmes in Sri Lanka. Effective delivery of CSE is incremental, which is a continuing educational process which starts at an early age and is built upon progressively. It also should be age and developmentally appropriate, responding to the changing needs and capabilities of the child. This should start from the home environment. It is also important to emphasise that a single party cannot take the whole responsibility in this matter. It should be a collaborative approach of the education sector, health sector, child protection services, legal system, parents, community services and social services in formulating a multilevel expanded and integrative sexuality education system in Sri Lanka.

Importantly, parents and caregivers can be their children's primary sexuality educators. However, lack of knowledge and skills or discomfort may prevent their role and responsibility. Therefore, it is important to educate, encourage and empower parents and caregivers which can primarily be done through healthcare workers. Children should receive this education age appropriately. For toddlers, it is vital to teach them about how to name body parts including sex organs and help them to identify them as private parts. It is also important to teach them about good touch and bad touch of their body by adults. Parents should also be educated about self-stimulatory behaviours in this age group and how to handle them at the home environment without giving undue attention.

There is no doubt that CSE should be integrated to the education curriculum. In Sri Lanka, more than 50% of teachers have not participated in any sexual and reproductive health training programmes and even trained teachers admitted to lacking sufficient knowledge to discuss sexual and reproductive health issues with students[7]. Therefore, it is vital to educate, train, encourage and empower teachers in this regard. Healthcare workers are in a better position to provide and support sexuality education to all children, adolescents and young adults in a longitudinal manner. If sexuality is discussed routinely and openly during clinic visits and home visits, participants will be more comfortable and conversations will be easier to initiate and continue in a more effective and informative manner.

Conclusion

Sri Lanka is reported to have 4-5% of teenage pregnancies per year despite a 92% adult literacy rate. It is quite evident that Sri Lankan children get very limited information and education about sexuality and sexual health which results in repeated victimization of child sexual abuse and child pregnancies. Therefore, it is a timely requirement to formulate and introduce a CSE programme for children in Sri Lanka with the collaboration of all responsible authorities.

References

1. UNESCO Institute for Statistics (uis.unesco.org). Data as of September 2020. Available from: https://data.worldbank.org/indicator/SE.ADT.LITR.ZS?locations=LK

2. Sri Lanka Education Statistics Sri Lanka LK: Adjusted Net Enrolment Rate: Primary: % of Primary School Age Children 1977 - 2016 | YEARLY | % | WORLD BANK Available from: https://www.ceicdata.com/en/srilanka/education-statistics

3. Hewageegana N R, Piercy H, Salway S, Samarage S. Sexual and reproductive knowledge, attitudes and behaviours in a school going population of Sri Lankan adolescents. *Sexual and Reproductive Healthcare* 2015; **6**(1): 3-8. https://doi.org/10.1016/j.srhc.2014.08.001 PMid: 25637417

4. Fernando D, Gunawardena N, Senarath U, Weerasinghe MC, Senevirathne RDA, Senanayake H, *et al.* Risk factors for teenage pregnancies in Sri Lanka: perspective of a community based study. *Health Science Journal* 2013; **7**(3): 269-84.

5. Papri FH, Khanam Z, Ara S, Panna MB. Adolescent pregnancy: Risk factors, outcome and prevention. *Chattagram Maa-O-Shishu Hospital Medical College Journal* 2016; **15**(1): 53-6. https://doi.org/10.3329/cmoshmcj.v15i1.28764

6. Breuner CC, Mattson G. Sexuality education for children and adolescents. *Pediatrics* 2016; **138**(2): e20161348. https://doi.org/10.1542/peds.2016-1348 PMid: 27432844

7. Karunathilaka K. Policy Brief 8 - Comprehensive Sexuality Education in Sri Lanka. UNFPA Sri Lanka 2019. Available from: https://srilanka.unfpa.org/en/publications/policy-brief-8-comprehensive-sexuality-education-sri-lanka

8. International technical guidance on sexuality education: An evidence-informed approach commissioned by the United Nations Educational, Scientific and Cultural Organization (UNESCO), 2018. Available from: https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf

9. Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD. School based sex education and HIV prevention in low- and middle-income countries: A systematic review and meta-analysis. *PLOS ONE* 2014; **9**(3): e89692 https://doi.org/10.1371/journal.pone.0089692 PMid: 24594648 PMCid: PMC3942389

10. Menstrual hygiene management in schools in South Asia, Asia and Pacific, Menstrual hygiene, Education. UNICEF, Water AID, 2018. Available from: https://washmatters.wateraid.org/publications/menstrual-hygiene-management-in-schools-south-asia

11. Rajapakse TNI. National Survey on Emerging Issues among Adolescents in Sri Lanka. Colombo, UNICEF. 2014.