POPULATION MATTERS

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COMPREHENSIVE SEXUALITY EDUCATION IN SRI LANKA

The Issue

During adolescence, young people face physical, emotional, and behavioural changes and often make choices relating to their sexual and reproductive health. Many young people approach adulthood faced with conflicting, negative and confusing messages about sexuality that are often exacerbated by embarrassment and silence from adults, including parents and teachers. In many societies, attitudes and laws discourage public discussion of sexuality and sexual behaviour. These social norms may perpetuate harmful conditions, such as gender inequality in relation to sexual relationships, family planning and modern contraceptive use.

One fifth of the population of Sri Lanka is comprised of adolescents. The National Survey on Emerging Issues among Adolescents in Sri Lanka (2004) revealed that 6% of 14–19 year olds in school and 22% of out- of-school adolescents had sexual experiences with heterosexual partners. The study also revealed that 10% of in school and 9% out of school adolescents had homosexual relationships. Further, it disclosed that the age of sexual initiation was 15.3 years for males and 14.4 years for females, and that adolescents had low knowledge of contraception and STI/HIV, teenage pregnancy and risk of sexual abuse.[1]

The Youth Health Survey (2012) conducted by the Ministry of Health, UNFPA and UNICEF, revealed the gaps in schools in providing sexual and reproductive health information to students, where only 59% of respondents said they received reproductive health education in school. It also highlighted that such information is not readily available for adolescents who are out-of-school, and that nearly 50% of youth are unaware of basic sexual and reproductive health issues.

According to the Demographic Health Survey (2016), 35% of currently married women do not use any modern contraceptive methods. Furthermore, in year 2000, it was estimated that over 650 unsafe abortions are carried out every day in Sri Lanka despite the legal restrictions, and over 80% of them are accessed by married women over the age of 30.[2]

These findings clearly reflect the need and importance of ensuring Comprehensive Sexuality Education is effectively delivered to adolescents and young people in and out of school.

4.6%

of pregnancies in Sri Lanka are **teenage pregnancies** with subnational disparities of 5–8%

Source: Demographic Health Survey, 2016

66%

of girls in Sri Lanka are **not aware of menstruation** until their first occurrence

Source: Menstrual Hygiene Management in Schools in South Asia, UNICEF, WaterAID, 2018

1 Rajapakse T.N.I. 2004 National Survey on Emerging Issues among Adolescents in Sri Lanka. Colombo, UNICEF
2 Rajapakse L.C. 2000. Estimates of Induced Abortion using RRT technique. Colombo.

What is Comprehensive Sexuality Education?

Comprehensive Sexuality Education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality, reproductive health and rights. It aims to equip children and young people with knowledge and skills that encourage positive attitudes, values and behaviours that will empower them to realize their health, well-being and dignity; develop respectful choices about sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.[2]

Curriculum-based sexuality education programmes contribute to the following outcomes:

- Delayed initiation of sexual intercourse
- Decreased frequency of sexual intercourse
- Decreased number of sexual partners
- Reduced risk taking behaviours
- Increased use of condoms
- Increased use of contraception
- Increased practice of protected sex at first sexual intercourse

Source: UNESCO, 2016

Key components of CSE

01 Relationships and Intimacy

02 Values, Rights, Culture

03 Understanding Gender

04 Violence and Staying Safe

05 Skills for Health and Well-being

06 The Human Body and Development

07 Sexuality and Sexual Behaviour

Effective delivery of CSE is incremental, which means that it is a continuing educational process that starts at an early age and is built upon. It is also age and developmentally-appropriate, responding to the changing needs and capabilities of the child. As a curriculum-based teaching, it is comprehensive, scientifically accurate, and is culturally relevant and context appropriate. CSE is also based on human rights and gender equality to ensure that it is transformative and able to develop the life skills needed to support healthy choices of children and young people.[4]

The adoption of learner-centred approaches in health education programmes have been shown to promote critical thinking and a sense of personal growth among students.[5] Further, teachers who teach CSE who are motivated, have appropriate attitudes, and are skilled in using participatory approaches have been shown to positively impact student knowledge and attitudes.[6] Research has also shown that CSE has resulted in increased knowledge among young people about different aspects of sexuality, behaviours, pregnancy risks and HIV.

3 International Technical Guidance on Sexuality Education. UNESCO. Revised edition 2013.
4 Ibid 2.
5 Ibid 2.
6 Kontula, O. 2010. The evolution of sex education and students' sexual knowledge in Finland in the 2000s. *"DOI:10.1080/14681811.2010.515095"*

About the Study

In 2016, UNFPA supported the Ministry of Education to commission a national study on Comprehensive Sexuality Education in Sri Lanka. This study, titled 'An analysis of Knowledge and Attitudes of School Children's Sexual and Reproductive Health Education', was conducted by Prof. K. Karunathilake. The study provides recommendations based on the key findings, to further strengthen delivery of curriculum-based comprehensive sexuality education in Sri Lanka.

Study Objectives

To determine:

- Current level of knowledge and attitudes on CSE among in -school adolescents.
- Level of preparedness among teachers delivering the curriculum based CSE programme.
- Current physical environment of the classroom for teaching CSE.
- Role of school principals in the delivery of CSE.
- Parental attitudes to school based CSE delivery.

Study Sample

- Island-wide Random Sampling
- 294 schools
- 2,776 students: 1,069 boys and 1,707 girls from Grades 10,11 and 12 (Arts & Commerce stream)
- 176 School Principals
- 261 Health Science & Physical Education teachers
- 276 Teachers in charge of Discipline
- 990 Parents

Key Findings

Students

- **82%** considered sexual and reproductive health as important for a successful life and more girls than boys considered it essential.
- **78%** identified sexual and reproductive health as a teaching priority in the school curriculum.

72% identified **teachers** as the preferred source **to obtain sexual and reproductive health information**

- Only **one third** considered current teaching as adequate for satisfactory knowledge about the physical changes in adolescence, pregnancy and the reproductive systems.
- Nearly **one third of boys** and **two fifths of girls** were unaware of spontaneous (uncontrolled) ejaculation.
- **85%** of girls believed that a girl cannot get pregnant before her first menstruation.

Only **35%** of girls and **60%** of boys were aware that using a **condom may prevent a pregnancy**

75% of girls thought that **menstrual blood was 'polluted'**

40% of boys believed that **wet dreams were abnormal**

- Over **2/3** of the students believed that immunization could prevent STIs.
- Only **2/3** of students had appropriate attitudes with no stigma and discrimination around HIV.
- Over **79%** thought that decisions related to sexual relationships should be a mutual responsibility of both partners.

There were 10,162 government schools in the country in 2016. According to the functional grade, there are four categories of schools, namely

- **1AB** - Schools having A/L science stream
- **1C**- Schools having A/L arts and/or commerce streams only
- **Type 2** - Schools having classes only up to Grade 11
- **Type 3** - Schools having classes only up to Grade 8

Health Science & Physical Education Teachers

- **85% (Type AB & C) and 100% (Type 2) failed to respond to the question on whether sexual and reproductive health information is part of the school curriculum, whether it is essential for adolescents, and to give reasons for their response, as they do not have a clear understanding on the subject.**
- Respondents (<10%) identified the impact of culture, disciplinary challenges and lack of information on sexual and reproductive health in childhood as reasons for why CSE is essential for adolescents.
- Teachers preferred external resource persons to teach CSE although students preferred teachers to do so.
- Most teachers were unable to identify the integral components of a CSE curriculum.
- 53% identified hard and soft infrastructure barriers to teaching CSE but half of them failed to identify the problem by type (A few respondents identified lack of confidence, backwardness and feeling shy, knowledge inadequacy, poor attitudes & opinions, lack of access to modern technology, lack of separate classrooms and negative parental attitudes).
- Only 50% of teachers who identified that they lacked confidence to teach CSE had sought support. The preferred sources of support included Medical Officers, Public Health Staff, Education Instructors on Health Science and School Counselors.

More than

50%

of teachers had not participated in any sexual and reproductive health training programmes

- Trained teachers admitted to lacking sufficient knowledge to discuss sexual and reproductive health issues with students.

Teachers in charge of Discipline

- **44% of teachers identified that CSE is taught in schools, but 87% did not respond to the question on whether sexual and reproductive health information is part of the curriculum, essential for adolescents, and to give reasons for their response, as they do not have a clear understanding on the subject.**
- Respondents (<10%) identified the impact of culture, disciplinary challenges and lack of information on sexual and reproductive health in childhood as reasons for why CSE is essential for adolescents.

- Benefits of CSE was identified as protection from child abuse; improved sexual and reproductive health & management of motives; prevention of addiction to wrong acts (not specified); finding solutions to sexual and reproductive health problems that adolescents face.
- One third of the teachers failed to respond on identification of core topics. Others noted STIs, understanding physical changes in adolescence, preventing homosexuality; accessing sexual and reproductive health information; preventing abuse and deviance as core topics to be addressed.

93% in Type AB schools said they face barriers teaching CSE

- Only a minority identified the following problems as barriers to teaching CSE: Inadequacy of teacher's knowledge; Poor attitudes and opinions; Lack of separate classrooms; Backwardness and shyness of teachers; Parents' negative attitudes and lack of modern technology.
- When facing teaching difficulties, help was sought from Doctors, Education Instructors, Public Health Staff and Knowledgeable Health Education Teachers.

Nearly **90%** identified the need to build the following skills for CSE teaching: Ability to teach without shame; communication skills; positive attitude

- 69%-85% across the three types of schools said they had not been ashamed of teaching CSE and stated that desegregation of students by sex is not required to teach CSE.

Key Informant Interviews with School Principals

Principals appeared conflicted between the values and beliefs in traditional and contemporary Sri Lankan society, as well as the societal impact of modern information technology.

In general, Principals felt that unless the Ministry of Education provided factual knowledge through the school system, students were likely to satisfy their curiosity by accessing websites with unsuitable content using mobile phones and computers. Also, a considerable opposition to teaching CSE was expressed by some Principals.

> **"There is no need for sexual education or knowledge of reproduction health. Although there was no sexual education in the traditional society, there was great discipline among people. If students are given such an education on sexual matters, then it damages their minds."**
>
> *Principal 1 (Key Informant Interviewee)*

While culture and religion were mentioned as constraints to the delivery of school based CSE, interestingly some Principals felt that CSE and culture were aligned through the common aim of protection by not condoning wrong behaviour (not specified). Some expressed concerns that CSE was "too new a concept for students". Others considered the detection of sexual and reproductive health problems in Grades 8-11 students may require such information to be provided from Grade 6 upwards. Most felt CSE should be taught from 12 years of age, as it was essential that by age 15, adolescents should be knowledgeable and able to "protect their health".

Some children have sexual relationships, but the teachers and parents are unaware of these. Sometimes both parents are employed or their mothers are abroad. There is no protection for the children. I met a student who has engaged in a sexual relationship 12 times. We need to provide them with accurate scientific knowledge.

Principal 2 (Key Informant Interviewee)

Focus Group Discussions with Parents

The shift from the traditional model of extended family living in the same household, to a Nucleus Family living arrangement, was considered a loss of a source of sexual reproductive health information and awareness. Some parents were aware of problems of abuse and sexual and reproductive health issues among their children, but had not attempted to dig deep to identify the issue. As a result, the parent-child relationship did not seem to support discussions on their sexuality.

Most parents considered themselves inadequate to provide sexuality related information to their children and mentioned that attempts at parent-child communication on various aspects and issues of adolescence were largely unsuccessful. Similar to Principals, parents endorsed the provision of formal school-based CSE, mostly as a protective measure that would safeguard children from sexuality information accessed through Information Technology.

The tendency of adolescents to seek information from their peers was attributed to inadequacies in teaching due to the lack of well-trained teachers. Parents identified the Health Science Teacher as the most suitable conveyor of sexual and reproductive health information for school students.

Children learn everything in school. But, if there are any difficulties in their studies, they discuss with their friends and rarely seek help from teachers or parents. I think, the best way to provide them with knowledge is through the school, which is accepted.

Parent 1 (Informant of Focus Group Discussion)

Additionally, doctors, other health staff, instructors and education officers were considered the most suitable to deliver CSE. Some parents disapproved of romantic relationships and feared that CSE may lure their children into sexual activity.

The parents also recognized that adolescence was a time of mental stress, and that onset of bodily changes caused concerns among children. Parents also recognized that parent-child conflicts were on many issues related to relationships and personal appearance. Further, it was mentioned that girls' concerns about personal appearance, body image, weight, and fairness of skin, were attributed to the influence of media.

Mothers can be entrusted with teaching girls about the bodily changes during adolescence, but sex-related information should be provided by teachers.

Parent 2 (Informant of Focus Group Discussion)

Parents considered it very important to provide books with sexual and reproductive health information, but emphasized that this should be "according to age". Some parents considered Grade 6 as a suitable age to start the CSE curriculum, stating that it will "reduce young people eloping". Some considered the appropriate age to be while students are pursuing their Advanced-level studies at 18 years, and some felt it would be better when they are at university at 21 years.

Analysis

The large cohort of in-school adolescents (70%) and the government decision to implement 13 years of compulsory education, provides a captive target audience for delivery of curriculum based CSE.

Parents and teachers require that CSE syllabi content is "culturally appropriate"[7] and there is wide acceptance that it should be delivered in age-appropriate increments to have the best outcomes.

In public secondary schools, CSE is primarily taught by Health Science Teachers, whom the majority of students identified as their preferred source of information. However, Health Science Teachers themselves preferred that external resource persons taught the subject, probably due to their lack of knowledge and confidence to deliver the subject matter. These deficiencies were self-identified by the teachers and corroborated by students, parents and principals.

This study provides many useful insights on measures that are necessary to strengthen and sustain the delivery of age-appropriate CSE in public secondary schools.

The failure of 85% (Type AB & C) and 100% (Type 2) to identify whether sexual and reproductive health information is part of the curriculum and essential for adolescents, raises a primary concern about teachers' interest, commitment and suitability to deliver the curriculum-based CSE content.

Only 12% of teachers identified the School Health Unit of the Ministry of Education, which is closely involved in the delivery of the Sexuality Education programme, as a preferred source of information when requiring support; however the study does not reveal why.

Clearly, intense and continuous training with review and revamping of teacher training curricula and the use of computer-based interactive teaching approaches are required to strengthen teacher capacity for effective programme delivery.

The teacher's ability to speak openly, confidently and without shame on sensitive sexuality related subject matter is vital for effectively delivery of CSE, as well as to inculcate healthy open attitudes among students.

Subject teachers considered the content of sexual and reproductive health information in textbooks of Grade 1 to 11 as insufficient. They further noted that the health and physical education curriculum textbook provides sexual and reproductive health content only from Grade 8 upwards, and that the information is limited to the physiological aspects, not including information on social, cultural, cognitive, and emotional aspects of sexual and reproductive health and rights. These gaps need to be addressed through regular revision of the CSE curriculum.

A separate guide book or recommended reading book for Grades 10, 11, and 12 containing more descriptive study materials and recommended references is indicated. The publication by the Family Health Bureau of the Ministry of Health, *'Udawu Youvanaya'*[8] addresses a range of topics including sexually transmitted diseases and family life. It was endorsed by Principals and should be revised and made widely available to older adolescents, as principals, teachers and parents are in agreement that older adolescents require quality sexual and reproductive health related reading material to counter the negative influences of information streamed through various websites and other media sites.

Over 50% of respondents in the National Youth Health Survey 2012 identified the need to reorient health service delivery to provide youth specialized health services.[9] This is likely relevant to increasing attendance at the currently underutilized youth befriending *'Yovun Piyasa'* centres in government hospitals.

7 National Strategic Plan on Adolescent Health 2013-2017 Family Health Bureau Ministry of Health.
8 Udawu Youvanaya. Family Health Bureau Ministry of Health, 2000.
9 Ibid 9.

Recommendations

- Review /amend current CSE syllabi to support the delivery of age-appropriate content in every grade in a culturally appropriate and sensitive manner. Ensure inclusion of content on gender, sexual diversity, family, legal and sociocultural aspects of sexuality and sexual and reproductive health and rights is included in keeping with the multi-ethnic pluralistic society in Sri Lanka.
- Develop lesson plans and modalities that support interactive, non-judgmental youth friendly interaction with students; Explore alternative communication strategies engaging modern technology to impart information and support self-learning for older adolescents.
- Strengthen the capacity of Educational Instructors and possibly the school counselling teacher to support programme delivery, through training and development.
- Strengthen system for delivery of CSE in secondary schools through the establishment of a dedicated unit at the Ministry of Education under the supervision of the School Health & Nutrition Unit.
- Strengthen the Ministry of Education School Health & Nutrition Unit to link with all regional educational zones and to provide the necessary equipment, documentary resources, social/ community mobilizers and supporting staff to conduct special workshops, seminars, and exhibitions on sexual and reproductive health at school level in the regions.
- Designing and offering a pilot programme on parenting, to support better parent-child relationships, and to equip parents with the skills and knowledge to discuss sexual and reproductive health with their children.
- Strengthen infrastructure for sustained CSE delivery by;

  a) Updating curricula in teacher training colleges

  b) Conduct regular in-service training and skills building of teachers

  c) Instituting regular monitoring and evaluation of the teaching programme

  d) Interval revision of the CSE syllabus content

  e) Engaging and sensitizing parents at 'Parent-Teacher' meetings on age-appropriate curriculum content

  f) Allocation of sufficient funds to ensure sustainability of the programme
- Identify funds for conducting interval national-level rapid assessments of CSE programme delivery.

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International Treaties and National Actions

In 1994, 179 countries including Sri Lanka endorsed the ICPD Programme of Action that recognized the fundamental right of young people to access sexual and reproductive health information and services, and the right of countries to design sexual and reproductive health policies and programmes in keeping with their laws, values, and cultures.

Sri Lanka has adopted a multi-sectoral approach to the development of policy and programme initiatives with the support of UNFPA to provide individuals of all sexes with access to quality sexual and reproductive health information and services. Further, Sri Lanka has reiterated its ICPD commitment by endorsing other international conventions and treaties[10] that emphasize the importance of sexual and reproductive health and rights.

The Convention on the Rights of the Child (CRC) calls on states to recognize that "the best interests of the child" takes precedence in all matters pertaining to the child. It recognizes the right of minors to make decisions related to their lives based on their "evolving capacities" and the need to "respect the responsibilities, rights and duties of parents to provide appropriate direction and guidance in children's exercise of their rights".

Due consideration has been given to this concept by Sri Lanka in formulating the National Strategic Plan on Adolescent Health 2013–2017[11] and the implementation of the Adolescent Health Services Package.[12] This has been further strengthened by the issue of General Circulars[13] under the guidance of the Attorney General's Department to legally empower the provision of services to women of any age and marital status, including those less than 15 years of age if cohabiting with a man.

The recognition of the period of adolescence as a critical phase of life has been accompanied by the realization that investing in adolescent health has a wider impact beyond the health of adolescents on adult health and economic development of the country (World Health Organization, 2019).

10 Convention on the Rights of the Child, CEDAW, Universal Periodic Review, UNECOSOC.
11 Ibid 8.
12 Family Health Bureau, Ministry of Health.
13 Circular on Adolescent Health- Responsible organization within the Ministry of Health (Gen Circular No:01/07/2007 dated 18.02.2007)
Circular on Adolescent health care in the field (Gen Circular No:01-36/2010 dated 01.10.2010)
Circular on Provision of Reproductive Health Services to teenagers (Gen Circular No:02-29/2011 dated 07.03.2011)
Circular on Youth health -Responsible organization within the Ministry of Health (Gen Circular:02-93/2014 dated 19.06.2014)
General Circular [PA/DDG/PHS/IIE/QW/2007 Of 12.02.2007] reiterated in General Circular 01-25/2015

'Population Matters' is a series of analytical policy briefs on Sri Lanka's emerging social development issues.

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