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Knowledge of Academic Leaders (Teachers) Regarding the Protection of Children From Sexual Offenses (POCSO) Act: Power to Enhance Change in School Children

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ABSTRACT

Introduction: The Protection of Children from Sexual Offences Act (POCSO Act) 2012 was enacted by government of India to protect children from offenses of sexual assault, sexual harassment and pornography by incorporating child friendly mechanism. Academic leaders being the back bone of the child development in the school plays an important role in disseminating the law of child .A better understanding of teachers' knowledge about POSCO act will allow us to establish key starting points from which to utilize the system for prevention. A cross sectional study was conducted to assess the Awareness of academic leader regarding POCSO act. **Objectives:** 1.To assesses the level of Knowledge regarding POCSO act among academic leaders. 2. To associate the level of knowledge of academic leader with selected socio demographic variables. **Methodology:** A descriptive survey design was used to conduct the study. .Purposive sampling technique was used to collect the data from 50 academic leaders in school. Pre tested, validated self-administered tool was used to collect the data. **Results:** Majority of the academic leader had average level of knowledge regarding POCSO act (52%). **Conclusion:** Academic leaders being a back bone in the school have to be enhanced with awareness programme to empower young generation. Nursing profession is an as essential stakeholders in extending services to impart knowledge to school stakeholders

Keywords: *POCSO act, Knowledge, academic leader*

INTRODUCTION

The Protection of Children from Sexual Offences Act (POCSO Act) 2012 was enacted by government of India to protect children from offenses of sexual assault, sexual harassment and pornography by incorporating child friendly mechanism. This provides a comphrensive definition and recognition of crime which covers all possible sexual crimes and sexual exploitation against children. Under POCSO act a person below the age of 18 years is a child [1].

What are the Salient features of POCSO act?

The Protection of Children from Sexual Offences (POCSO) Act 2012 is applicable to the whole of India.

Protects the child through all stages of judicial process and gives paramount importance to the principle of "best interest of the child".

Penetrative and aggravated penetrative sexual assault, sexual and aggravated sexual assault, sexual harassment, and using a child for pornographic purposes are the five offences against children that are covered by this Act.

This Act suggests that any person, who has an apprehension that an offence is likely to be committed or has knowledge that an offence has been committed, has a mandatory obligation to report the matter i.e. media personnel, staff of hotel/ lodges, hospitals, clubs, studios, or photographic facilities.

Failure to report attracts punishment with imprisonment of up to six months or fine or both.

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It is now mandatory for police to register an FIR in all cases of child abuse.

A child's statement can be recorded even at the child's residence or a place of his choice and should be preferably done by a female police officer not below the rank of sub inspector.

As per this Act, the child's medical examination can be conducted even prior to registration of an FIR.

The Act casts duty on state to spread awareness among general public, about the provisions of this Act through media, i.e., television, radio and print at regular intervals.

Why Children Don't Speak Up About Abuse?

Children are afraid that they may be disbelieved.

Children feel a sense of guilt.

Children are afraid that the person who groomed and abused them

The child may have been manipulated by the offender into believing that their relationship is normal.

Sometimes the child does not realize that it is being abused.

Fear of retaliation and further abuse also forces a child to keep silent.

Generally, children are not encouraged to talk about their feelings and when they do… adults do not listen or believe.

How to Prevent Child Sexual Abuse?

• School-based prevention programs

• Training of medical providers, school staff, clergy, child protection caseworkers, forensic interviewers, and law enforcement officials can increase the willingness of youth to disclose child sexual abuse as well as the willingness of adults to report suspected abuse.

•Training parents to refute common myths around "stranger danger" can help to increase their awareness of far more common (and preventable) sexual abuse risk factors in the household.

What are the services available to children?

(a) 1098: The Childline Helpline helps to get guidance and information for the children

(b) Police FIR: Inform the child before reporting to the police. Ensure that the child is comfortable with the idea and prepared for meeting with the police. Reassure the child that you will be with them every step of the way but also inform them that they will have to be prepared to recount the incident. Once the child is prepared, do not take the child to the police station. Instead, the child may choose the place they find most comfortable to meet the police who will come in plain clothes and not in uniform.[2]

Problem Statement:

Descriptive study to assess the level of Knowledge of academic leaders regarding POCSO act in selected schools of Moradadbad, Uttar Pradesh

Objectives:

1. To assess the level of Knowledge regarding POCSO act among academic leaders.

2. To associate the level of knowledge of academic leaders with selected socio demographic variables.

Hypothesis:

H_1: There will be a significant association between level of Knowledge of academic leaders regarding POCSO act with their selected demographic variables.

MATERIAL AND METHOD

Research Approach and Design: A descriptive cross sectional survey was used to conduct the study.

Sample size: The sample consisted of 50 academic leaders in selected schools

Setting of the study: academic leaders working in selected schools of Moradabad district, Uttar Pradesh.

Sampling technique: Purposive sampling was used to select the subjects.

Data collection instruments: The instruments used were developed by the researcher. The researcher used the following instruments for collecting the data. Data were collected by the primary investigator in the schools.

Part 1: Demographic proforma was developed by the investigator for the purpose of collecting back ground information of the samples .It consisted of items

namely age in years, gender, religion, qualification and year of experience.

Part 2:Self-administered awareness questionnaire was used to collect the data. Total items in the questionnaire were 20. There were four opinions for each question and maximum score possible was 20. Correct response for each item was given score of 1 and for the wrong or unanswered items, it was scored 0.The Knowledge score was arbitrarily categorized as low knowledge, average knowledge and high knowledge.

Content Validity of the tool: For ensuring the content validity, the instruments were given to five experts from fields of psychiatry, Obstetrics and gynecology nursing, forensic medicine, community health nursing, and School teacher's .Modifications were made according to the opinion and suggestion of the experts.

Reliability of the tool : The reliability of knowledge questionnaire was determined by using split-half method and Spearman-Brown prophecy formula and found to be reliable (r= .89)

Procedure for data collection: Ethical clearance was obtained from selected schools authorities. The purpose of the study was explained to the participants through participant information sheet and the informed consent was taken from all the subjects before administering the research instruments.

FINDINGS

The analysis of the data was done as per objectives.

Sample characteristics:

The sample of present study consisted of 50 academic leaders. Majority of academic leaders (38%) belonged to the age group of 31 to 40years. Maximum (78%) were female. More than half of the academic leaders belonged to hindu religion (74%) and most were with B.Ed. qualification (54 %).Majority of academic leaders were with 0to 5 years of experience .(Table 1)

Table 1: Sample characteristics of academic leaders

Sample Characteristics	**(f)**	**(%)**
Age in years		
21-30	18	36
31-40	19	38
41-50	8	16
51 and above	5	10
Gender		
Male	12	22
Female	38	78
Religion		
Hindu	37	74
Muslim	8	16
Christian	5	10
Qualification		
B.Ed	27	54
MA/M.Ed	9	18
Any other	14	28
Total years of experience in teaching		
0-5	18	36
6-10	12	24
11-15	8	16
16 and above	12	24

Level of Awareness of Academic leaders regarding POCSO act

Out of 50 academic leaders , 26 (52%) had average knowledge score and about 17(34%) had high knowledge score whereas only 7(14%) had low knowledge score regarding POCSO act abuse (Table 2).The mean knowledge score was 13.82 and standard deviation was 3.2. Hynniewta, B., Jose, T. T., & Anjali, K. G assessed the Knowledge and attitude on child abuse among school teachers in selected urban English medium schools of Udupi District. Majority of the school teachers (84%) had average knowledge on child abuse whereas, all the teachers had favourable attitude towards identification and reporting of child abuse. With regard to association between knowledge and selected demographic variables, there was no significant association found except for previous knowledge on child abuse ($p < .05$)[3].

Table 2: Level of Knowledge of academic leaders regarding POCSO act

Level of knowledge	Frequency	Percentage
High	17	34%
Average	26	52%
Low	7	14%

Association of Level of awareness with selected demographic variables

Chi square reveals that there is no significant relationship between level of knowledge with demographic variables such as age in years, gender, religion, qualification and year of experience

CONCLUSION

The present study assessed the level of knowledge regarding POCSO act among academic leaders and it is found that 34 % had high knowledge. The achievement of objectives POCSO requires a coordinated response of all the key players, specially the Counsellors, Social Workers and Special Educators such as nursing profession Naregal PM, Mohite VR, Hiremath P, Chendake M, Karale RB, Pawar S conducted study to assess the effectiveness of Planned Teaching Programme on Knowledge Regarding Prevention of Child Abuse and Neglect Among Primary School Teachers and found in pre-test majority 18 (60%) teachers had poor and 6 (20%) had average and good knowledge regarding child abuse and neglect respectively. Where as in post-test majority 19(63%) teachers had average knowledge, 6(20%) had good knowledge and 5(17%) teachers had poor knowledge regarding knowledge of child abuse and neglect[4].

Conflict of Interest: Nil

Source of Funding: Self

Ethical Clearance: The ethical clearance was taken from committee and School authorities before conducting the study

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A Descriptive Study to Assess the Level of Knowledge on Behavioral Patterns among School Children

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ABSTRACT

Social stigma is the extreme disapproval of a person or group on society that is perceived, and serves to distinguish them, from other members of a society.[2] According to community based study under the WHO mental health Gap action program, in India the life time prevalence of mental disorders range from 12.2% - 48.6%. Lack of social support combined with the absolute lack of care, street have become home to the mentally ill in India[13]. The prejudice and fear caused by stigma may even prevent people from coming forward and seeking the help they need.[16]

Method: A Pre experimental one group pre-test post-test design was adopted to carry out the present study. Based on the geographic proximity, feasibility to conduct the study and familiarity with the setting, this study will be conducted at selected tertiary care hospital of Belagavi. i.e. K.L.E.S.'s Dr. Prabhakar Kore Charitable hospital, Belagavi, Karnataka. The sample consisted of 80 caregivers of the patient with psychiatric disorders at selected tertiary care hospital of Belagavi. Samples were selected by *Non probability convenient sampling technique.* After the pre-test a PTP was administered to the subjects and on the seventh day post-test was conducted with the same structured knowledge questionnaire. The collected data was analyzed by using descriptive and inferential statistics

Result: The mean post test knowledge score obtained (O2=20) was higher than the mean pre-test knowledge score (O1=14) and similarly the mean post test attitude score obtained (O2=128) was higher than the mean pre-test attitude score (O1=108). Testing of hypothesis for evaluation of effectiveness of planned teaching program for care givers of mentally ill patients on knowledge (t_{cal} = 14.6, t_{tab} = 1.99, P < 0.05) and attitude (t_{cal} = 13.3, t_{tab} = 1.99, P < 0.05) regarding social stigma of mental illness proved that Planned Teaching Programme was effective teaching method for creating awareness regarding mental health and mental illness. There was no significant association found between the pre-test knowledge scores of knowledge (p>0.05) and attitude (p>0.05) regarding social stigma towards people with psychiatric disorders with selected demographic variables.

Keywords: *Knowledge, Attitude, Social stigma, Psychiatric disorders and People*

INTRODUCTION

"*Mental illness is nothing to be ashamed of, but stigma and bias shame us all."*

-Bill Clinton

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When we make assumptions about how mental health problems will affect someone's behavior, this makes it more likely that they will be singled out, or labeled as different, dangerous or strange. This is what we call **stigma.** Treating someone differently from how we treat others because of their mental health, whether consciously or subconsciously, is what we call **discrimination[1]**.

Stigma

The word Stigma is derived from Greek origins referred to a type of marking or tattoo which was cut or burned into the skin of traitors, criminals, slaves in order to visibly identify them as blemished or morally polluted persons and these individuals were to be avoided or kept away, particularly in public places.[2]

Psychiatric disorder

Psychiatric disorder is mall adjustment in living. It produces a disharmony in the person's ability to meet the human needs comfortably or effectively and function within a culture. A person with psychiatric disorder loses his ability to respond according to the expectations he has for himself and the demands that the society has for him.[4]

Stigma brings the experience and feelings of

- Shame
- Blame
- Hopelessness
- Distress
- Misinterpretation in the media
- Reduce to seek and/or accept necessary help.[1]

Need for the study

In India 90% of patients admitted to experiencing stigma.[1] 86% of patients had experienced discrimination. According to community based study under the WHO Mental Health Gap Action Program, in India the life time prevalence of mental disorders range from 12.2%-48.6%. Lack of social support combined with the absolute lack of care, street have become home to the mentally ill in India. Statistics suggest that 25% of the mentally ill in India are homeless.[10]

Family members experience the effects of stigma in many ways:

- Their social support network may shrink and they may face negative attitudes if they reveal the disorder.
- They may be disappointed by reactions from mental health care professionals and feel alienated from the treatment process.
- They often have to endure the effects of labeling and the visibility of the disorders.
- They may delay getting treatment due to fears of stigma.[14]

STATEMENT OF THE PROBLEM

A study to evaluate the effectiveness of planned teaching program on knowledge and attitude regarding social stigma towards people with psychiatric disorders among care givers at selected tertiary care hospital of Belagavi, Karnataka.

OBJECTIVES OF THE STUDY

- To assess the knowledge regarding social stigma towards people with psychiatric disorders among care givers at selected tertiary care hospital of Belagavi.
- To assess the attitude regarding social stigma towards people with psychiatric disorders among care givers at selected tertiary care hospital of Belagavi.
- To find out the effectiveness of planned teaching program on knowledge regarding social stigma towards people with psychiatric disorders among care givers at selected tertiary care hospital of Belagavi.
- To find out the effectiveness of planned teaching program on attitude regarding social stigma towards people with psychiatric disorders among care givers at selected tertiary care hospital of Belagavi.
- To find out the association between the pre-test knowledge scores of knowledge and attitude regarding social stigma towards people with psychiatric disorders with selected demographic variables at selected tertiary care hospital of Belagavi.

Operational Definitions

- **Social stigma:-** Social stigma is the extreme disapproval of a person or group on society that are perceived, and serve to distinguish them, from other members of a society.[1]
- **Psychiatric disorders:-** Psychiatric disorders

are clinically diagnosed mental health problems which leads to mall-adjustment in activities of daily living.[2]

- **People:-** A people is a plurality of persons considered as a whole, as in an ethnic group.[17]
- **Care givers***: -* First degree relatives of mentally ill patients those who are taking care of patient during the time of hospital admission. Example: Mother or father or siblings and spouse of mentally ill patient.[18]

HYPOTHESIS OF THE STUDY

- **H_1:** There will be significant increase in post-test knowledge and attitude scores than pre test knowledge and attitude scores among care givers of patient with psychiatric disorders at selected tertiary care hospitals of Belagavi, Karnataka at 0.05 level of significance.
- **H_2:** There will be significant association between the pre test knowledge and attitude scores with selected demographic variables at selected tertiary care hospitals of Belagavi, Karnataka at 0.05 level of significance.

RESEARCH METHODOLOGY

Research Approach:

An Evaluative approach was adopted in this study.

Research Design:

Pre experimental one group pre-test post-test design was adopted research design was adopted to carry out the present study.

Research Setting:

Based on the geographic proximity, feasibility to conduct the study and familiarity with the setting, the investigator selected tertiary care hospital of Belagavi i.e. K.L.E.S.'s Dr. Prabhakar Kore Charitable hospital, Belagavi, Karnataka.

Population:

The population of the present study comprised care givers of the mentally ill patients at selected tertiary care hospital of Belagavi.

Sample and Sample Size:

Sample size of the present study consists of 80 caregivers of the mentally ill patients at selected tertiary care hospital of Belagavi, who were able to read and write Kannada, and English.

Sampling Technique:

The sampling technique used for the present study is Purposive sampling technique approach which is a type of Non-Probability sampling technique which was considered appropriate for the study.

DATA COLLECTION INSTRUMENTS

The data collection tool for this study consisted of three parts.

Section I: Demographic variables

Section II: Knowledge rating scale for assessing the knowledge of the care givers of mentally ill patients regarding social stigma of mental illness.

Section III: Attitude rating scale for assessing the attitude of the care givers of mentally ill patients regarding social stigma of mental illness.

The reliability of the tool was found to be **0.73** for knowledge questionnaire and **0.86** for attitude questionnaire, which indicated that the tool was reliable.

PILOT STUDY

The pilot study was conducted in psychiatry O.P.D. of K.L.E.S.'s Dr. Prabhakar Kore charitable Hospital from 17/12/15 to 26/12/15 with selected 8 samples by Non probability convenient sampling technique.

PROCEDURE FOR DATA COLLECTION

The main study was conducted at KLES's Dr. Prabhakar Kore charitable Hospital's Psychiatry ward, Belagavi from 21/01/2016 to 22/02/2016.

RESULTS

Section I: Findings related to socio demographic variables of care givers of mentally ill patients at selected tertiary care hospital of Belagavi.

Table 1: Frequency and percentage of distribution of the sample characteristics.

				n=80
Sl. No	**Socio Demographic Variables**		**Frequency**	**percentage**
1	Age in Years			
		18-28	22	27.5
		29-38	18	22.5
		39-48	18	22.5
		49-above	22	27.5
2	Gender			
		Male	48	60
		Female	32	40
3	Education			
		No Formal Education	18	22.5
		Primary education	19	23.75
		Secondary Education	26	32.5
		Graduation-Above	17	21.25
4	Occupation			
		Government Job	24	30
		Private job	19	23.75
		Farmer	18	22.5
		House Wife	19	23.75
5	Area Of Resident			
		Urban	38	47.5
		Rural	42	52.5
6	Type Of Family			
		Nuclear	39	48.75
		Joint	23	28.75
		Extended	18	22.5
7	Number of Mentally ill in the family			
		1	80	100
		2	0	0
		3	0	0
		above 4	0	0

Cont... **Table 1: Frequency and percentage of distribution of the sample characteristics.**

8	Duration of illness			
		1-2 Yrs	9	11.25
		3-4 Yrs	33	41.25
		5Yrs and above	38	47.5

Section II

Analysis and Interpretation of knowledge scores

Analysis and Interpretation of **attitude scores**

Table 2: Mean, Median, Standard deviation and range of knowledge scores of care givers of mentally ill patients at selected tertiary care hospital of Belagavi. **n=80**

Area of Analysis	Mean	Median	Mode	Deviation(SD)	Range
Pre test	14	14	7	4.96	17
Post test	20	21	9	2.6	12
Difference	6	7	2	2.3	5

Table 3: Frequency (f) and Percentage (%) distribution of knowledge scores of care givers of mentally ill patients at selected tertiary care hospital of Belagavi. **n=80**

Knowledge Scores	Score range	Pre test		Post test	
		f	%	f	%
Good	17-24	27	28.75	71	88.7
Average	9-16	30	37.5	9	11.2
Poor	0-8	23	33.75	0	0

Table 4: Evaluation of effectiveness of planned teaching program for care givers of mentally ill patients on knowledge regarding social stigma of mental illness. **n=80**

Mean Difference (d)	Standard Error Difference (SED)	Paired 't'test values	
		Calculated	Tabulated value at 79 degrees of freedom
6.4	0.41	14.6	1.9904
*(P<0.05)			

Table 5: Evaluation of effectiveness of planned teaching program for care givers of mentally ill patients on Attitude regarding social stigma of mental illness. **n=80**

Mean Difference (d)	Standard Error Difference (SED)	Paired 't'test values	
		Calculated	Tabulated value at 79 degrees of freedom
19.8	1.5	13.3	1.9904
*(P<0.05)			

Table 6: Association between the pre-test knowledge scores of care givers of mentally ill patients and demographic variables. **n=80**

Socio Demographic Variables		Good	Average	Poor	χ2 cal val	χ2 tab	DF
Age in Years							
	18-28	6	5	11	5.091	12.59	6 NS
	29-38	6	7	5			
	39-48	5	7	6			
	49-above	6	11	5			
Gender							
	Male	9	20	19	5.93	5.99	2 NS
	Female	14	10	8			
Education							
	No Formal Education	7	6	5	2.83	12.59	6 NS
	Primary education	5	9	5			
	Secondary Education	6	10	10			
	Graduation-Above	5	5	7			
Occupation							
	Government Job	5	10	9	1.79	12.59	6 NS
	Private job	5	7	7			
	Farmer	6	7	5			
	House Wife	7	6	6			
Area Of Resident							
	Urban	9	13	16	2.32	5.99	2 NS
	Rural	14	17	11			

Table: 7: Association between the pre-test attitude scores of care givers of mentally ill patients and demographic variables. **n=80**

	Socio Demographic Variables	Un Favorable attitude	Neutral Attitude	Favorable Attitude	χ^2 cal val	χ^2 tab	DF
Age in Years							
	18-28	2	14	6	8.78	12.59	6 NS
	29-38	1	12	5			
	39-48	5	10	3			
	49-above	8	9	5			
Gender							
	Male	9	20	19	3.24	5.99	2 NS
	Female	14	10	8			
Education							
	No Formal Education	7	6	5	2.81	12.59	6 NS
	Primary education	5	9	5			
	Secondary education	6	10	10			
	Graduation-Above	5	5	7			

Cont... **Table: 7 Association between the pre-test attitude scores of care givers of mentally ill patients and demographic variables.**

Occupation							
	Government Job	1	14	9	11.3	12.59	6 NS
	Private job	3	11	5			
	Farmer	5	9	4			
	House Wife	7	11	1			
Area Of Resident							
	Urban	5	21	12	3.57	5.99	2 NS
	Rural	11	24	7			

DISCUSSION

Assessing the level of knowledge and Effectiveness of planned teaching programme in terms of gain in knowledge regarding social stigma of mental illness:

Data analysis for level of knowledge revealed that Pre-test score of caregivers of people with psychiatric disorder. The mean pre-test knowledge scores were 14, with standard deviation 4.9, median 14, mode 7 and range 17. Among the total sample (n=80), 30 (37.5%) had average knowledge, where as 23(33.75%) had poor knowledge and 27(28.75%) had good knowledge. Testing of hypothesis for evaluation of effectiveness of planned teaching program for care givers of mentally ill patients on knowledge(t_{cal} = 14.6, t_{tab} = 1.99, P<0.05) regarding social stigma of mental illness proved that Planned Teaching Programme was effective teaching method for creating awareness regarding mental health and mental illness.

The findings of the study are supported by the study of Farid F Youssef, Raecho Bachew, Glenderia Sherma et al. "To assess Knowledge and attitudes towards mental illness among college students". 673 subjects participated in this study. In this study, knowledge was higher among those persons who knew someone with a mental illness. This study results suggested that widespread educational campaigns need to be implemented across the region, designed to both increase knowledge about mental illness and reduce discrimination towards persons suffering with mental illness.[11]

Association of knowledge and attitude of caregivers of people with psychiatric disorder with selected demographic variables:

Chi square test was computed to find out the association between knowledge of caregivers of people with psychiatric disorder with selected demographic variables. Test results were, the computed chi-square at df (6) for age in years was (5.09), gender at df(2) was (5.90), education status at df(6) was (2.3), occupation at df(6) was (1.79), area of residence at df (2) was (2.32). Chi-square calculated value is less than chi-square table value so there is no significant association between demographic variables and pre-test knowledge scores of caregivers of people with psychiatric disorder at 0.05 level of significance. Hence **H2** is rejected.

Chi square test was computed to find out the association between attitudes of caregivers of people with psychiatric disorder with selected demographic variables. Test results were, the computed chi-square at df (6) for age in years was (8.78), gender at df(2) was (3.24), education status at df(6) was (2.81), occupation at df(6) was (11.3), area of residence at df (2) was (3.57). Chi-square calculated value is less than chi-square table value so there is no significant association between demographic variables and pre-test attitude scores of caregivers of people with psychiatric disorder at 0.05 level of significance. Hence **H2** is rejected.

This study supported by the study of Imlisongla Longkumer, Indranee Phookan Borooah to assesss the Knowledge about and attitudes toward mental disorders among Nagas in North East India. 500 adults who are above 21 years of age both males (n = 226) and females (n = 272) are taken as study samples. In this study The findings of this study suggested that need of educational programs aimed at providing information about mental disorders and the mentally ill may be organized in educational institutions like Schools and Colleges, and also in the Church.[10]

CONCLUSION

The study assumed that the social stigma is acts like barrier in between psychiatric patients and society. Due to lack of knowledge and the negative perception about mental illness, people hesitate to receive treatment from psychiatric hospitals and they hesitate to tell about psychiatric disorder if they or their relatives or family members suffering. As the caregivers of patient with psychiatric disorder knowledge increases, more favorable attitude develops. Care givers of patient with psychiatric disorder have some knowledge regarding social stigma of mental illness.

The result of the study proved that caregivers of patient with psychiatric disorder lacking in the knowledge and attitude on social stigma of mental illness. Majority of the caregivers of patient with psychiatric disorder had poor to average knowledge and unfavorable to neutral attitude regarding social stigma of mental illness.

Acknowledgement: Nil

Conflict of Intrest: Nil

Source of Funding: Self

Ethical Clearance: The Ethical Clearance is obtained from "The Ethical Committee (Human) for M.Sc (N) Research Project, K.L.E. University's Institute of Nursing Sciences Belagavi."

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Impact of Sexual and Reproductive Health Education Programme in Improving their Knowledge among School Going Adolescents : A Pre Experimental Pilot Study

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ABSTRACT

Aim: This study explores the effectiveness on knowledge regarding sexual and reproductive health among school going adolescents. **Method:** The research design was pre experimental one group pre test post test design. Reliability and validity of the tool were established. evaluated by test-retest method and the Chronbach alpha was found to be 0.99 Data were collected through resarcher-developed questionnaire through probability sampling .The study was conducted in at St.Joseph's High School Andhra Pradesh, India among 30 sample after obtaining ethical permission. The data were analyzed using descriptive and inferential statistics **Results:** The analysis showed that prior to administering structured teaching programme the adolescents knowledge level is between poor and good knowledge level. After implementing educational programme it was reported that the level of knowledge was increased from poor to good and excellent.The present study revealed the effectiveness of structured teaching programme on sexual and reproductive health awareness among adolescents through pre and post test. Study revealed that pre test mean was 18.47 with standard deviation 2.27 however post test mean was 31.6 with standard deviation 1.83 which signified the effectiveness of structured teaching programme, As the table t value (2.045) is less than the calculated t value (28.14) at degree of freedom 29, at 0.05 level of significance. So there is a significant difference between the pre & the post test level of knowledge regarding sex awareness.

Keywords: *Sexual and reproductive health, awareness & adolescence*

INTRODUCTION

"Adolescence is perhaps nature's way of preparing parents to welcome empty nest."

-Karen Savage & Patricia Adam

In a broader canvas, sexuality is the most sensitive subject and intimate feature of human life. According to Glasier et al. (2006) sexuality encompasses gender identity, male and female roles, eroticism, sexual orientation, pleasure, intimacy, and reproduction. Sexuality is associated with bio-psychosocial, economic, political, religious, and cultural factors. The term 'reproductive health' is coined by Peters and Wolper (1995) that explains it as complete attainment of well-being in terms of mental, physical, and social conditions. Scarce knowledge or lack of awareness in reproductive health enhances the chance of vulnerability for adolescents to engage in unintended pregnancies, STD's, STI's, and HIV[1]. The World Health Organization (WHO) defines "adolescent" as an individual between 10 to 19 years of age. According to UNICEF, there are 243 million adolescents comprising 20% of the total population of India.[2] Twenty seven percent of adolescent mothers have reported an unmet need for contraception. Nearly 35% of HIV infections occur among the young people in the age group of 15-34 years.[3] Majority of adolescents still do not have access to information and education on sexuality, reproduction, and sexual and reproductive health and rights, nor do they have access to preventive and curative service.[4]

The current study was under taken to assess the knowledge on sexual and reproductive health programme and to provide education to the school going adolescence.

The objectives of the study was to

1. To assess the pre-test level of knowledge regarding sexual and reproductive health awareness education among adolescents

2. To evaluate the effectiveness regarding sexual and reproductive health awareness education programme among adolescents

3. To find out the significant association between pre-test levels of knowledge among adolescents regarding sexual and reproductive health awareness with selected demographic variables

Research Hypothesis

H_1:There will be an significant difference between the pre-test and post-test level of knowledge among adolescents regarding sexual and reproductive health at $P \leq 0.05$.

H_2:There will be an significant association between pre test level of knowledge regarding sexual and reproductive health with selected demographic variables at $P \leq 0.05$.

Research Methodology

Research approach was quantitative cross-sectional survey with a research design of one test pre-test -post-test .The study was conducted among 30 adolescents studying at St.Joseph's High School, Nizamabad ,Andhra Pradesh after obtaining ethical clearance. The study was conducted on adolescent boys and girls between the age group 13-15 years using random sampling technique.

Criteria for sample selection

The sample was selected based on the following inclusion and exclusion criteria.

Inclusion Criteria

Adolescents those who are between the age group of 13-15years.

Adolescents both male and female.

Adolescents those who are available at the time of data collection

Exclusive criteria

Adolescents those who are not willing to participate in the study.

Adolescents those who are not available during the data collection period.

DESCRIPTION OF THE TOOL

A structured questionnaire was developed to assess the impact of teaching programme on knowledge regarding sex awareness among adolescents.

The tool for the data collection consists of two sections:

Section A:

Demographic Variables consists of Age, Sex, Religion, Education of father, Education of mother, Occupation of father, Occupation of mother, Type of family, knowledge about sex awareness.

Section B: Consists of structured questionnaire to assess the knowledge of the adolescents regarding sex awareness, totally 40 questions were formulated under separate sub-headings.

Correct answers carried 1 mark and incorrect marks carried 0 marks.

The questions were related to,

Section I deals with knowledge regarding reproductive system

Section II deals with knowledge regarding teenage pregnancy and sexual assault

Section III deals with HIV/AIDS.

The knowledge score were categorized into four groups:

0-10: Poor, 11-20: Average, 21-30: Good, 31-40: Excellent. To ensure the content validity of the tools, the tool was submitted to 5 experts from which two experts from mental health nursing and three psychiatrists. The reliability of the tool was elicited by using the test re test method and findings were compared. Karl Pearson r was computed for finding out the reliability of the tool. The reliability of the tool was tested and r=0.93.

Intervention

Sexual and reproductive health awareness education programme was given after the pretest which constitutes

knowledge regarding reproductive system, teenage pregnancy and sexual assaultand HIV/AIDS using different pedagogues like lecture, role play and video assisted teaching. Subjects were clarified their doubts. The session was for one day and after the intervention post test was done .

DATA ANALYSIS

The data were analysed using statistical package SPSS17.0 and appropriate descriptive and inferential statistics were used. Inferential statistics i.e.Paired t-test (to find out mean difference of pretest and post knowledge score) and chi-square test to test the relationship between categorical variables)

RESULTS

Table No:1-Socio-demographic variables

Sl.No:	Demographic Variables	Freq-uency	Percen-tage
1	**Age in years**		
	a)13 yrs	11	36.7
	b)14 yrs	11	36.7
	c)15 yrs	8	26.7
2	**Sex**	14	46.7
	a)Male	16	53.3
	b)Female		
3	**Education of father**		
	a)Non-literate	7	23.3
	b)Primary	6	20.0
	c)Secondary	4	13.3
	d)Intermediate	9	30.0
	e)Degree	4	13.3
4	**Education of mother**	8	26.7
	a)Non-literate	11	36.7
	b)Primary	5	16.7
	c)Secondary	4	13.3
	d)Intermediate	2	6.7
	e)Degree		
5	**Occupation of father**	3	10.0
	a)Public	10	33.3
	b)Private	11	36.7
	c)Business	6	20.0
	d)Coolie		

Cont... **Table no: 1-Socio-demographic variables**

6	**Occupation of mother**	7	23.3
	a)Private	7	23.3
	b)Beedi worker	13	43.3
	c)House wife	3	10.0
	d)Business		
7	**Type of family**		
	a)Nuclear	14	46.7
	b)Joint	15	50.0
	c)Single parent	Nil	Nil
	d)Extended	1	3.3
8	**Previous knowledge**		
	a)Yes	6	20.0
	b)No	24	80.0

As per the table N0:1 Majority were in the age group 13 and 14 years, more than half (53%) were females with majority (30%)of their fathers had intermediate as their educational qualifications where as Majority(36.7) of mothers had primary education , mostly male genders worked in private firm whereas Majority(36.7)% of female counter parts were housewives. Almost half (50%) belong to joint family. Majority (80%) had not have knowledge regarding sexual and reproductive health.

Table no:2 elucidates frequency and percentage distribution to assess the pre and post test level of knowledge regarding sex awareness among adolescents.

Sl. no	Level of knowledge	Pre-test F(%)		Post-Test F(%)	
1	VERY POOR	0	0%	0	0%
2	POOR	5	17%	0	0%
3	GOOD	25	83%	8	27%
4	EXCELLENT	0	0%	22	73%
5	MEAN & STANDARD DEVIATION	18.47±2.27		31.60± 1.83	
6	T-VALUE	2.045			
7	CALCULATED T-VALUE	28.143			
8	df	29			
9	P -value	0.05			

Test used:Paired –T test

As it can be seen from the table no:2 that pre test mean was 18.47 with standard deviation 2.27, post test mean was 31.60 with standard deviation 1.83 which shows the effectiveness of structured teaching programme. As the table t value (2.04) is less than the calculated t value (28.143) at degree of freedom 29.

There is a significant statistical difference between the pretest mean score and post test mean score at 0.05 level of significance. Hence research hypothesis is accepted.

Table no:3 . depicts association between pre-test level of knowledge among adolescents regarding sex awareness with selected demographic variables

Demographic variables	LEVEL OF KNOWLEDGE				Chi-square Value	Table Value	df	P	S
	V.poor	Poor	Good	Excellent					
AGE									
13 Yrs	-	8	3	-					
14 yrs	-	9	2	-	2.50	12.59	6	0.05	**
15 yrs	-	8	0	-					
SEX									
Male	-	12	2	-	0.107	7.82	3	0.05	**
Female	-	13	3	-					
EDUCATION OF FATHER									
Non-literate	-	7	0	-					
Primary	-	5	1	-					
Secondary	-	3	1	-	4.20	21.03	12	0.05	**
Intermediate	-	6	3	-					
Degree	-	4	0	-					
EDUCATION OF MOTHER									
Non-literate	-	7	1	-					
Primary	-	9	2	-					
Secondary	-	4	1	-	0.758	21.03	12	0.05	**
Intermediate	-	3	1	-					
Degree	-	2	0	-					
OCCUPATIONOF FATHER									
Public	-	3	0	-					
Private	-	6	4	-	6.17	16.92	9	0.05	**
Business	-	10	1	-					
Coolie	-	6	0	-					
OCCUPATION OF MOTHER									
Private	-	6	1	-					
Beedi worker	-	5	2	-	**1.35**	**16.92**	**9**	**0.05**	**
House wife	-	11	2	-					
Business	-	3	0	-					

Cont... **Table no:3 . depicts association between pre-test level of knowledge among adolescents regarding sex awareness with selected demographic variables**

TYPE OF FAMILY									
Nuclear	-	11	3	-					
Joint	-	14	1	-	**6.30**	**12.59**	**6**	**0.05**	**
Extended	-	0	1	-					
PREVIOUS KNOWLEDGE									
Yes	-	5	1	-	**0.00**	**7.82**	**3**	**0.05**	**
No	-	20	4	-					

** Not significant at 0.05 level of significance

Test used: chi-square test

As it can be seen from the table no:3 that there was no statistically significant association with regard to demographic variables such as age, sex, education of father and mother, occupation of father and mother and type of family with the mean pretest knowledge score because the chi-square value is less than calculated t-value at 0.05 level of significance.

DISCUSSION

The current study is a pilot study to inculcate sexual and reproductive health awareness among adolescents. Though the research has done on small sample size the intervention was highly effective.Smaller-scale interventions appeared to be more effective than large-scale programs. The larger effects associated to small-scale trials seems worth exploring. It may be the case that in large-scale studies it becomes harder to control for confounding variables that may have an adverse impact on the outcomes (Cagampang *et al*., 1997).

While during the pre- interventional period majority (83%) of the adolescents had good knowledge however interestingly their insight regarding reproductive system, teenage pregnancy and sexual assault and HIV/AIDS had increased in to the level of excellent knowledge as (73%). This reiterated the effectiveness of the reproductive and health education programme which was statistically significant. A similar results were obtained by the study conducted by(Nair M.K.C et al 2011)[6]

Paradoxically there was no statistically significant association with the selected demographic variables. Hence Null hypothesis is accepted.

CONCLUSION

Furthermore, there is a need to develop and implement strategies for integrated primary education about puberty, gender, and fairness/rights. It will be important to translate and disseminate useful curriculum resources. Finally, robust sexual and reproductive health education programme ensures the adolescents to have a adequate level of knowledge and attitude towards sexuality and reproductive health.

Source of Funding -self.

Conflict of Interest -None

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Myths and Misconceptions about Mental Illness in Rural Area – Literature Review

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ABSTRACT

The Researcher aims to assess myths and misconceptions about mental illness in women of rural area.. Multiple databases were searched focusing on existing myths and misconceptions into the society. It was concluded through this literature review that there are many myths and misconceptions existing into the society and it need to be removed by spreading awareness into the society.

Keywords: *Standing position, sitting crossed leg position, blood pressure, faculties*

INTRODUCTION

Mental health is a emotional, psychological, and social wellbeing of a person, an adjustment of an individual plays an important role in mental health. How the people adjust with each other, how they react with each other, how they response and all depends on the mental health. An opposite to mental health, it is mental illness.[1]

Rural people are still not aware about the approaches and care for mental illness and they believed that once, mental illness occurs, it won't cured. In addition they thought like it is not a mental illness, it is all due to the supernatural power and ancestor cause. Not limited to this there are several myths and misconceptions present in our society like Mental illness only affects a few people, People with a mental illness never get better, Mental illness can be cured by black magic and so on.[2]

The literature reviewed was obtained through different database includes CINHAL (Cumulative index TO Nursing & Allied Health Literature), MEDLINE (Medical Literature Analysis & Retrieval System Online), PubMed, Science Direct, SpringerLink, ProQuest & Google scholar.

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MATERIAL METHODS AND FINDINGS

The study is headed mainly on Myths and misconceptions about mental illness among women of rural area.

FINDINGS

Study shows that myths and misconceptions about mental illness presents everywhere into the society.

Jugal Kishore,Radhika Mukharjee, Mamta Parashar, R C Jiloha and G K Ingle conducted cross-sectional study was to assess myths, beliefs and perception about mental disorder and health seeking behaviour in several population and medical professionals at Delhi in 2011. A total 436 subjects were selected (360 from urban and rural communities, 76 medical professionals) by simple random technique and the result revealed that the mental disorders were thought to be because of loss of semen or vaginal secretion (33.9% rural, 8.6% urban, 1.3% professionals), less sexual desire (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's punishments for their past sins (39.6% rural and 20.7% urban, 5.2% professionals) and polluted air (51.5% rural, 11.5% urban, 5.2 professionals).34.8% of rural and 13% of urban people believed that children

do not get mental illness so, the study concludes that myths and misconceptions are significantly more prevalent in rural areas than in urban areas and among medical professionals.[3]

Swapnil Gupta, Ajit Avasthi, R. Sureshkumar, conducted cross-sectional study to compare the psychopathology between depressed patients with low religiosity and those with high religiosity at Chandigarh in India{to correlate the level of religiosity with the psychopathology in the psychiatric clinic of a general hospital}. The study include 60 samples, 30 is low religiosity and 30 is with high religiosity and they examined the depressive symptoms, diagnosis was made using standard ICD-10 criteria, Results revealed that patients with depression, hopelessness and suicide intent correlated negativity with the level of religiosity. It concludes that religiosity has a significant effect on the psychopathology of the depressed patient, especially on hopelessness and suicide intent. This implies that the incorporation of religiosity elements in the treatment of the depressed is likely to have a useful positive impact.[4]

Deepak Goel, JS Dhanai and Alka Agarwal et al, conducted study to assess knowledge, attitude and practice of epilepsy at Uttarakhand, India in 2010. Total 219, 12th standard students were selected randomly from different six village school of Daheradun district of Uttarakhand state and results says that 98% students heard about epilepsy, 74.9% thought epilepsy as a mental disease and 48% believed that it is contagious negative attitude showed as nearly 2/3rd students that epilepsy is hindrance in marriage and occupation Nearly 41% would use onion and shoe for terminating seizure attack. It is concluded that 12th class of Uttarakhand students has poor knowledge, attitude and practice for epilepsy and needs special education Programme to dispel those misconceptions.[5]

Kurpath Radhakrishnan conducted a study on challenges in the management of epilepsy in poor resource countries and said in the 18th annual conference of the Indian Academy of neurology at Trichi, Tamilnadu. In to that nearly 80% of the 50 million people with epilepsy worldwide reside in developing countries that are least equipped to tackle the enormous medical, social and economic challenges posed by epilepsy and these include widespread poverty, illiteracy, inefficient and unevenly distributed health care system, and social stigma and misconceptions with epilepsy. Studies reported that a large proportion of patients with epilepsy in developing countries never receive appropriate treatment for their conditions, and many, though diagnosed and initiated on treatment, soon discontinue treatment. Unaffordable cost of treatment, unavailability of antiepileptic drugs, and superstitious and cultural beliefs contribute to high epilepsy treatment gap in resource poor countries. It concluded that burden of epilepsy is more in developing countries and it is untreated or undiagnosed due to cultural, social beliefs present into the society and can be minimized by educating the public about the positive aspects of life with epilepsy. [6]

Sanjay Prakash (Neurologist and headache expert) was conducted a study on patients with tension-type headache at Piperia, Baroda in 2016. Consisted of 50 consecutive patients with tension type headache (TTH) visiting the outpatient neurology clinic were observed (from aug 2014 to 2015), patients were selected on basis of international classification of headache disorder (3rd edition, beta version) and results shows that first answer when they disclosed diagnosis. The reply of 32 patients (64%) with TTH was “I do not have any tension / stress.” 8 patients (16%) said “yes I have some tension / stress.” 7 patients (14%) did not reply anything and waited for next question. 3 patients (6%) asked, “What should I do?” Relative / friends of 15 patients (30%), volunteered themselves and said “ yes, he / she has tension.” But these all 15 patients denied that they had any type of tension. So, study concluded that stigma is society’s negative evaluation of particular feature or behaviour and in this circumstances, patient try to hide or conceal their illness and do not seek medical care. So, society needs awareness to find out the reality.[7]

Sandre Dietrich, Dirk Heidar, Herbet Matschinger et al, conducted a study to assess influence of newspaper reporting on adolescents attitude towards people with mental illness at Germany in 2016 among 167students aged between 13-18 years. Selected randomly and articles was assigned to them. A self administered questions was used to assess the attitude of students towards mentally ill people and results revels that students also had read the articles, had changed their attitude about mentally ill people and those who had not read they used word like violent and aggressive for mentally ill people. Thus, the study concluded that we should break the unwanted link between negative media reporting and negative attitude of people.[8]

Julio Arbolede-Florer conducted study to assess consideration on the stigma of mental illness at Canada in 2003. Researcher found that prevalence of misconception about mental illness include the belief that mental patients are dangerous and violent (88%), that they have low IQ or are developmentally handicapped (40%), that they cannot function; had a job, or have anything to contribute (32%), they are unpredictable (20%) finally that they are to be blamed for their own condition and should just shape up (20%). Thus, it concludes that successful treatment and community management of mental illness relies heavily on the involvement of people's beliefs and attitude about mental illness.[9]

Dara Roth Edney conducted a literature review about the effect of mass media and mental illness at Ontario, Canada in January 2004. The researcher found the popular sources of information about mental illness are TV's, newsmagazine show is 70% which is very highest then newspaper (58%), and lasts the radio (18%) and women's magazines (18%) and researcher found that there is a complex relationship between mass media depiction of mental illness and public's understanding. Negative media images promotes negatives attitude and gives negative perception to the people then, it concluded that an accurate information must be disseminated to the public through the media. It is vital to highlight stories of successful recovery.[10]

Wolfgang Gaebel and Anja E Baumann was conducted A study to assess the effectiveness of intervention to reduce the stigma associated with severe mental illness at Germany in 2003. Study include 200 spectators attended the event/ intervention. A self administered 182 questionnaire was distributed among the audience before the film was shown. The evaluation showed that not every public-oriented antisigma intervention obtains the desired effect exclusively 113 viewers (samples / spectators) believed that they could emphasize better with schizophrenic suffers as a result of the event and report increase understanding. It concluded that some negative stereotypes werestrengthen and social distancing increased. The study recommends organizing training programmes like open the doors, to improve the knowledge of community.[11]

O Gureje et al conducted a descriptive study on knowledge and attitude towards mental illness in Abuja. Two thousand and forty samples were selected using multistage clustered sampling technique. The result revealed that 96.5% of subjects perceived that people with mental illness were dangerous, 82.7% expressed fear to converse with mentally ill persons, and only 16.9% showed agreement regarding the marriage of mentally ill persons. Therefore, the study concluded that there was widespread stigmatization of mental illness persisting.[12]

CONCLUSION

Researcher assessed that lots of myths and misconception existing in the society, especially in the rural area in this context researcher thought of taking the task of creating awareness about mental illness and its treatment.

Conflict of Interest: None

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Ethical Clearance: The ethical clearance obtained from our institute.

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Knowledge of Adolescence Regarding Sexual Health

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ABSTRACT

Introduction: A cross sectional study was conducted to assess the knowledge of adolescence regarding sexual health. **Objectives:** To assess the level of Knowledge of adolescence regarding sexual health. **Methodology:** A descriptive survey design was used to conduct the study. Purposive sampling technique was used to collect the data from 250 adolescence in selected areas of Raichur, Karnataka. Pre tested, validated self-administered tool was used to collect the data with dimension of Concept of sexual health, sexual abuse, sexual deviation and life style of sexual health. **Results:** Majority of the adolescence had inadequate level of knowledge in all dimensions of sexual health i.e. concept of sexual health (62.8%), sexual abuse (71.6%), sexual deviation (67%) and life style of sexual health (69%). **Conclusion:** Adolescents often lack basic information, knowledge and access for affordable confidential health services. It is necessary to teach adolescent school children in their beginning of their life itself to maintain positive sexual health.

Keywords: *Sexual health, Knowledge, adolescence*

INTRODUCTION

In the journey of adolescence, the late adolescence between 15 to 18 years is the age of opportunity with major sexual development usually occurred by now, although the body is still developing towards becoming an adult. Sexual development is important part of health, similar to other measures of physical growth such as height and weight[1].

Perhaps one of the most significant sexual developmental milestones along this journey in adolescents is emerging sexuality. From Aristotle's early treatise on 'sexual desire' to Sigmund Freud's theories of 'psychosocial development', adolescent sexuality has been a controversial topic for virtually every generation. Although medical people often discuss adolescent sexuality in terms of "risks", it is important to remember that sexuality, sexual behavior and sexual relationships are an important and necessary part of human development[2].

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According to the office of the Surgeon General (2001), 'Sexuality' is an integral part of human life. It can foster intimacy and bonding as well as shared pressure in relationships. It fulfills a number of personal and social needs and people value the sexual part of being for the pleasure and benefit it affords them. Yet when exercised irresponsibly it can also have negative aspects such as sexually transmitted diseases including, HIV-AIDS, unintended pregnancy and coercive or violent behavior. To enjoy the important benefits of sexuality, while avoiding negative consequences some of which may have long term or even lifetime implications, knowledge regarding 'sex' is necessary for adolescents to be sexually healthy, to behave responsibly and to have a supportive environment to protect their own sexual health as well as that of others[3].

Globally adolescent sexual health issues have become increasingly prominent and have aroused wide spread international concern. Adolescents find themselves sandwiched between a glamorous western influence and stern conservatism at home; it strictly forbids discussion on sex. Today the media revolution has thrown them into turmoil of confusion and conflicts. Adolescents enter the home of risky behavior at an early age. Ignorance about sexual and reproductive health

among adolescents makes them particularly vulnerable to reproductive and sexual health problems. Early intervention by targeting adolescents with sex education as well as programs to improve their self-confidence and social status may be an effective way to safeguard their future health status.

However addressing the need of adolescents is a huge challenge in countries like India due to various cultural and social barriers. It is also commonly assumed that family and educational institutions exercise great control over sexual behavior of unmarried youth in India than the west.

REVIEW OF LITERATURE

Hewageegana N Rajapaksa and others have undertaken a survey to examine the sexual knowledge, attitudes and behaviors of school going adolescents in Sri Lanka. Data were collected randomly by a self-completion questionnaire and analyzed using SPSS. 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. The study concluded that there is an imperative to address the lack of sexual and reproductive knowledge[4].

LiaquatRoopesh Johnson etal conducted a cross sectional study to assess the sexual health awareness among school girls (10-19 years) in Kanyakumari District. Systematic random sampling was employed to select 100 study subjects. Data collection was done using self-administered questionnaire. The study results showed that 52% of the study subjects had mother as the source of information. Awareness has better with the nuclear family and higher grade students were significantly associated with the awareness of sexual health. The study concluded for sexual health awareness programme for adolescent[5].

Sahay S etal conducted a cross sectional study to identify the correlates of sex initiation among school going adolescents in Pune, India. Case control analysis (n=205) was performed among 41 cases who reported ever having sex and 164 controls matched for gender, location and type of school. Correlates of sex initiation were identified using conditional logistic regression. The study concluded that the adolescents who reported sexual abuse, Sexually Transmitted Diseases (STDs) symptoms, smoking habit and those who had not read scientific literature on reproductive and sexual health were more likely to have initiated sex early[6].

Elissa c Kennedy etal conducted a qualitative study to assess the sexual and reproductive health information preferences of adolescents in Vanuatu .Sixty six focus group discussions were conducted with 341 male and female adolescents aged 15- 19 years. Data were analyzed thematically using an inductive approach. The result showed that much of SRH information targeting adolescents focused on sexually transmitted infections and HIV. Schools had underutilized source of information. The study concluded that there is need to strengthen information provision through multiple channels to reach in and out of school adolescents[7]

Problem Statement:

Descriptive study to assess the level of Knowledge of adolescence regarding sexual health in selected areas of Raichur, Karnataka

Objectives:

To assess the level of Knowledge of adolescence regarding sexual health

MATERIAL AND METHOD

Research Approach and Design:A descriptive cross sectional survey was used to conduct the study.

Sample size: The sample consisted of 250 adolescence in selected areas of Raichur, Karnataka

Setting of the study: Adolescence in selected areas of raichur

Sampling technique: Purposive sampling was used to select the subjects.

Data collection instruments:The instruments used were developed by the researcher. The researcher used the following instruments for collecting the data. Data were collected by the primary investigator.

Part 1: Demographic proforma was developed by the investigator for the purpose of collecting back ground information of the samples .It consisted of items namely age in years, gender, order of birth and sources of information. Part 2:Self-administered questionnaire was used to collect the data. Total items in the questionnaire were 40 with dimensions of concept

of health, sexualabuse, sexual deviation and life style of sexual health. Correct response for each item was given score of 1 and for the wrong or unanswered items, it was scored 0.The Knowledge score was categorized as inadequate knowledge, moderately adequate knowledge and adequate knowledge.

Content Validity of the tool:For ensuring the content validity, the instruments were given to five experts from fields of psychiatry, Obstetrics and gynecology nursing, child health nursing, community health nursing, and Biostatistician.

Reliability of the tool: The reliability of knowledge questionnaire was determined by using split-half method found to be reliable (r= 0.88)

FINDINGS

Sample characteristics:

The sample of present study consisted of 250 adolescence.

Majority of adolescence (53%) belonged to the age group of 16 years. Kalkute Jayant Ramchandraetal studied the knowledge about sexual health of junior college students, on their study, it was found that majority of them were between the age group of 15 and 20 years[8].

Half of the adolescence (54%) was male. Amit S. Muthuetal surveyed the knowledge regarding sex among 500 college students in Mumbai and found that majority of them (54%) were boys[9].

Majority of adolescence were born as 2nd child. Argys Lawa M etal investigated the association between birth order and adolescent sexual behavior and found that middle born and last born are much more likely to use substances and be sexually active than their first born counterparts. The result provided the strongest evidence to date that birth order is related to substance abuse and pro sex[10].

More than half of the adolesence(68%) have got information about sexual health from parents .Liaquat Roopesh Johnson and etal conducted a cross sectional study among schoolgirls (10-19 years) in Kanyakumari district and found that mothers were the source of information[11].

Level of knowledge of adolescent regarding sexual health

Out of 250 adolescence 172 (68.8%) had inadequate knowledge, 78(31.2%) had moderately adequate knowledge whereas not even one had adequate knowledge regarding sexual health

Dimensions wise knowledge score of adolescence regarding on sexual health

Among 250 adolescence,157(62.8%) regarding concept of sexual health, 179 (71.6%) regarding sexual abuse, 168 (67%) regarding sexual deviation and 173(69%) regarding life style for sexual health were having inadequate knowledge. The mean score for concept of health, sexual abuse, sexual deviation and life style for sexual health is 4.7, 4.1, 4.3 and 3.9 (Table 1)

AlQuaiz A M AmbreenKazi and Maha Al Muneef conducted a cross sectional study to determine the sexual health knowledge in adolescent girls in schools of Riyah Saudi Arabia. Data was collected randomly from 419 students by using self-administered structured questionnaire. The results showed that 70.7% had poor sexual health knowledge[12].

Table 1: Dimension wise knowledge on sexual health

Dimensions wise knowledge	Mean /SD	Level of knowledge					
		Inadequate knowledge		Moderately adequate knowledge		Adequate knowledge	
		f	%	f	%	f	%
Concept of Sexual health	4.7/2.4	157	62.8	79	31.6	14	5.6
Sexual abuse	4.1/2.6	179	71.6	62	24.8	9	3.6
Sexual deviation	4.3/2.7	168	67	65	26	17	7
Life style for sexual health	3.9/2.5	173	69	72	29	5	2

RECOMMENDATION

Similar study can be replicated on a larger sample in different settings.

Similar study can be conducted by observing attitude towards sexual health among higher secondary school children.

Similar study can be conducted by taking sample from two different settings like government high schools and private high schools and compare their knowledge on sex .

Similar study can be conducted on the school teachers.

Comparative study can be done between rural and urban high schools children.

Effectiveness of awareness programme on sexual health can be done for enhancement of knowledge among adolescence

CONCLUSION

The present study assessed the adolescence knowledge regarding sexual health and it was found that not even a single subjects is having adequate knowledge regarding sexual health.Focusing on adolescent sexual health is both challenges and opportunity for health care providers. While adolescent is generally a healthy period of life, many adolescents are less informed and less comfortable in accessing health services for sexual and reproductive health, than adults. Adolescents often lack basic information, knowledge and access to affordable confidential health services. It is necessary to teach adolescent in their beginning of their life itself to maintain positive sexual health

Conflict of Interest: Nil

Source of Funding: Self

Ethical Clearance: The ethical clearance was taken from committee and concern authorities before conducting the study

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