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Adolescents' Knowledge and Attitudes towards Sex Education: A Study in Government Higher Secondary Schools in Thrissur, India

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Abstract

Adolescents require accurate information and supportive environments to understand bodily changes, relationships and personal safety, yet sexuality education in India remains shaped by cultural sensitivities and limited communication. This study assessed adolescents' knowledge of sex education and examined their attitudes towards it in selected government higher secondary schools in Thrissur, Kerala. The study adopted a quantitative, descriptive design. Using proportionate stratified random sampling, 96 students aged 15–18 years were selected from four schools, and data were collected in January 2025 through a structured, self-developed questionnaire. Responses were analysed using SPSS and summarised as frequencies and percentages. Moderate knowledge (37.5%) and moderate attitudes (39.6%) were most common, while 28.1% showed high knowledge. More than half (54.1%) did not report receiving formal sex education at school, and 56.2% lacked knowledge of where to access reproductive health services. Although 69.8% were aware of child-protection laws, 68.7% were uncomfortable discussing sex education with their parents. The findings highlight uneven knowledge, limited service awareness and family communication barriers, underscoring the need for structured school programmes, teacher training, parent orientation and adolescent-friendly referral mechanisms involving social workers.

Keywords: Adolescents, sex education, knowledge, attitudes, parent–adolescent communication

Introduction

Adolescence, conventionally defined as the period between 10 and 19 years of age, is characterised by interrelated physical, cognitive, emotional and social transitions. Pubertal development, evolving peer relationships, identity formation and growing autonomy generate distinct learning needs. Adolescents therefore need accurate information and supportive environments that help them understand bodily changes, build respectful relationships, recognise personal boundaries, and identify credible sources of health information and support. Sex education extends well beyond the transmission of biological knowledge about reproduction. It encompasses age-appropriate instruction on puberty, anatomy, reproductive health, personal hygiene, sexually transmitted infections (STIs), consent, bodily autonomy, gender, relationships, safety and available support services. When delivered in a developmentally appropriate and scientifically accurate manner, sexuality education equips young people to evaluate information critically and to make informed

decisions. It should not be reduced to a discussion of sexual activity; rather, it constitutes an integral component of health education, life-skills development and child and youth protection.

In the Indian context, discourse on sexuality is shaped by familial expectations, cultural and religious norms, gendered socialisation and the perceived sensitivity of the subject. These factors may determine whether adolescents feel able to approach parents, teachers or health professionals with their questions. Simultaneously, young people encounter information through peers, television, social media and the internet, sources that vary considerably in accuracy and reliability. Where formal education and trusted adult communication are limited, adolescents may struggle to distinguish evidence-based information from myths and misleading claims. Schools offer a structured and equitable setting for reaching adolescents. However, the availability and quality of sexuality education vary with institutional resources, educator preparedness and local attitudes. Families likewise play a significant role in supporting adolescents, yet discomfort in discussing sexuality can constrain parent–adolescent communication. Social workers can contribute by facilitating age-appropriate awareness activities, strengthening referral pathways, supporting families and advocating for accessible, adolescent-friendly services.

Existing research in India has consistently identified gaps in adolescents' knowledge of reproductive health, contraception and STIs, as well as the influence of family, school and peer environments. McManus and Dhar (2008), in a survey of urban schoolgirls in South Delhi, documented misconceptions and limited knowledge concerning STIs, HIV prevention and contraception. Their findings further indicated that many participants relied on friends and the media for information and that a substantial proportion found it difficult to discuss sexual health with their parents. Studies from other Indian settings underscore the importance of school-based provision and educator preparedness. Anilkumar et al. (2022), in a cross-sectional study in Central Kerala, found that some adolescents had inadequate knowledge and that knowledge and attitudes differed across selected socio-demographic characteristics; the authors recommended regular, well-delivered sessions and capacity-building for teachers. Halder (2021) similarly reported generally supportive views among several stakeholder groups, while noting parental discomfort and the perceived need for specialised teacher training.

Research on adolescents' perceptions further demonstrates that acceptance of sex education does not necessarily translate into adequate knowledge or comfort in discussing sensitive subjects. Thakor and Kumar (1998) reported strong student support for sex education alongside deficiencies in knowledge of STIs, contraception and reproductive health. More recently, Preethi and Anandan (2024), studying older adolescent girls, point to persistent gaps in sexual and reproductive health knowledge and to the influence of social and informational contexts.

Taken together, the literature suggests that adolescent sexuality education requires a coordinated approach involving schools, families, health professionals and community organisations. Against this background, the present study examines adolescents' knowledge of and attitudes towards sex education in selected government higher secondary schools in Thrissur, Kerala. It additionally considers reported exposure to school-based sex education, awareness of child-protection laws and reproductive health services, and comfort in discussing sex education with parents. By offering a local descriptive account, the study contributes to the evidence base on knowledge levels, attitudes, school exposure and parent–adolescent communication. Specifically, it aims to assess adolescents' knowledge of sex education and examine their attitudes toward it.

Materials and Methods

The study adopted a quantitative approach with a descriptive research design. The study was conducted in four government higher secondary schools within the jurisdiction of the Thrissur Municipal Corporation, Kerala. The universe comprised all students enrolled in government higher secondary schools under the Corporation, and the unit of analysis was the individual student. The operational age range was 15–18 years, and students enrolled in the selected schools were eligible. The study used proportionate stratified random sampling, with Plus One and Plus Two classes as the strata across the four schools. The study selected 96 students, 24 from each school. Data were obtained from all 96 respondents, and all frequencies and percentages reported in the Results section are based on this sample. Data were collected using a structured, self-developed questionnaire comprising socio-demographic items and Likert-type statements on knowledge and attitudes.

The knowledge section addressed puberty, reproductive systems, personal hygiene, contraception, consequences of unprotected sex, STIs, consent, child-protection laws, help-seeking, reproductive health services, credible online information and the role of counsellors. The attitude section examined the perceived importance of sex education, its inclusion in school curricula, preferred learning methods, the roles of teachers and health professionals, gender equality, cultural influences, parental involvement and the media. Data were collected between 18 and 20 January 2025. We analysed responses using SPSS and summarised them as frequencies and percentages, presented in tables and graphs. The study obtained necessary consent and permission, respected participants' views, and conducted the research with regard to confidentiality, objectivity, and the avoidance of harm.

Results and Discussions

The findings are presented in the following order: the socio-demographic profile of respondents, levels of knowledge and attitudes, and selected indicators of school-based exposure, legal awareness and parent–adolescent communication. All results are based on the total sample (N = 96). Percentages may not sum exactly to 100 owing to rounding.

In terms of age, respondents were concentrated in two groups: 47 (49.0%) were 16 years old, and 44 (45.8%) were 17 years old. Only a small proportion fell at either end of the range, with 2 respondents (2.1%) aged 15 years and 3 (3.1%) aged 18 years. The sample was nearly balanced by gender, comprising 51 males (53.1%) and 45 females (46.9%). It was also equally divided by class, with 48 students (50.0%) each from Plus One and Plus Two. In terms of family structure, a slight majority of respondents (54; 56.3%) belonged to nuclear families, while 42 (43.8%) belonged to joint families. For religion, Hindus formed the largest group, with 54 respondents (56.3%), followed by Christians (23; 24.0%) and Muslims (19; 19.8%).

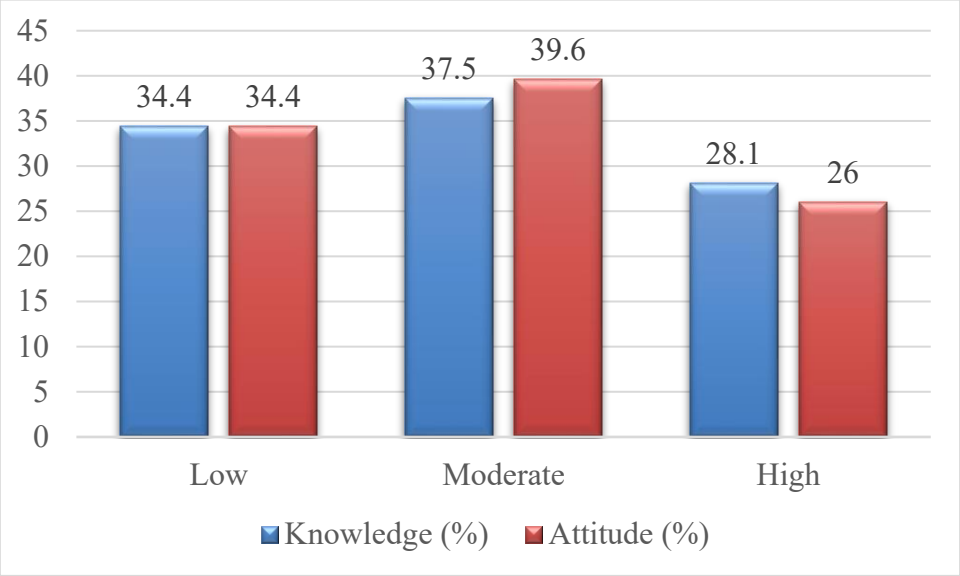

Figure 1- Level of knowledge and attitude towards sex education (N = 96)

Moderate knowledge was the most common category (37.5%), followed by low (34.4%) and high (28.1%). Thus, 71.9% of respondents demonstrated only low or moderate knowledge. Awareness of support services was particularly limited: 56.2% disagreed or strongly disagreed that they knew where to access reproductive health services and counselling, whereas 26.0% agreed or strongly agreed. This suggests that awareness of available support systems may lag behind general recognition of the importance of sex education. As shown in Figure 1, moderate attitudes predominated (39.6%), followed by low (34.4%) and high (26.0%) attitudes. These results indicate that although some adolescents recognise the value of sex education, a substantial proportion remain hesitant or uncomfortable with its content or discussion. The attitude items covered support for school-based education, interactive learning methods, the role of trained teachers and health professionals, gender-equitable provision, parental participation, and the influence of culture and media.

Table 1. Responses to selected items (N = 96, %)

Item	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I have received formal sex education at school	13.5	40.6	–	37.5	8.3
I am aware of laws relating to child sexual abuse	–	15.6	14.6	49.0	20.8
I feel comfortable discussing sex education with my parents	35.4	33.3	18.8	11.5	1.0

Note. A dash indicates that no responses were recorded in that category.

More than half of the respondents (54.1%) disagreed or strongly disagreed that they had received formal sex education at school, while 45.8% agreed or strongly agreed. Reported exposure was

therefore not universal, suggesting uneven provision or recall of school-based instruction. Awareness of child-protection legislation was comparatively high, with 69.8% agreeing or strongly agreeing that they knew of laws on child sexual abuse. Nevertheless, 30.2% were neutral or disagreed, indicating that a notable minority may lack adequate knowledge of legal protections. The most pronounced finding concerned family communication: 68.7% disagreed or strongly disagreed that they felt comfortable discussing sex education with their parents, and only 12.5% agreed or strongly agreed. This points to a substantial communication barrier within the family context.

The present findings indicate that adolescents' knowledge of sex education was uneven. Although moderate knowledge was the most common category, only 28.1% of respondents attained a high level. This pattern is consistent with earlier Indian studies documenting gaps in adolescents' understanding of reproductive health, STIs and contraception (McManus & Dhar, 2008; Anilkumar et al., 2022), and supports the view that general exposure to information does not guarantee comprehensive understanding. The lack of universal school-based exposure is noteworthy, since schools offer a structured setting where all students can access age-appropriate information. That 54.1% of respondents did not affirm having received formal sex education suggests a need to examine how sexuality-related content is incorporated into school learning, and whether students find it comprehensive, accessible and comprehensible. Teacher preparedness and the availability of suitable learning materials are likely to be important implementation factors, as highlighted in the literature reviewed (Anilkumar et al., 2022; Halder, 2021).

The low level of comfort in discussing sex education with parents warrants particular attention. With nearly seven in ten respondents reporting discomfort, adolescents may have limited opportunities to seek clarification from trusted adults and may rely more heavily on peers or digital sources, a pattern also reported by McManus and Dhar (2008). However, the present study did not test a direct relationship between parental communication and reliance on such sources, so this interpretation remains tentative. The finding nonetheless supports parent-focused awareness initiatives that encourage non-judgemental, developmentally appropriate conversations. The limited awareness of reproductive health services further suggests gaps in practical health literacy. School-based programmes should therefore extend beyond classroom instruction to introduce adolescents to trustworthy counselling and health-service options, while explaining confidentiality and when safeguarding procedures apply.

Finally, the sizeable proportion of respondents with low attitudes, alongside the modal moderate category, implies that interventions must address not only knowledge deficits but also embarrassment, stigma and misconceptions about the purpose of sexuality education. A supportive, inclusive and culturally responsive approach may help students engage with the subject without regarding their questions as inappropriate.

Implications and Recommendations

The findings carry implications for social work practice at several levels. At the individual level, school social workers and counsellors can offer confidential, age-appropriate guidance, clarify misconceptions, and help adolescents identify reliable sources of health information and appropriate referral services. At the group level, facilitated peer-education sessions, small-group discussions, question boxes and other interactive activities can give adolescents structured

opportunities to explore puberty, consent, personal safety, healthy relationships and reproductive health. At the family level, parent-awareness sessions can strengthen communication skills and help caregivers respond to adolescents' questions in a factual, respectful and non-judgemental manner, which is especially relevant given the discomfort reported by most respondents in discussing sex education with their parents. At the school level, social workers can collaborate with teachers, counsellors and health professionals to develop a planned programme, strengthen referral systems and support educator training. Finally, at the community level, partnerships among schools, health services, child-protection agencies and community organisations can improve awareness of available services and legal protections while responding sensitively to local contexts.

Based on these findings, it is recommended that schools introduce a structured, age-appropriate, and scientifically accurate sexuality education programme. The programme should include practical information on puberty, reproductive health, contraception, STIs, consent, personal boundaries, online safety and help-seeking, and should use interactive methods such as group discussion, scenario-based learning, peer education and question-and-answer sessions rather than relying exclusively on textbook instruction. Capacity-building for teachers and school counsellors is also needed, covering adolescent development, sensitive communication, safeguarding and referral procedures. In addition, parent-orientation programmes should promote open and supportive parent–adolescent communication, and schools and nearby health facilities should establish or strengthen adolescent-friendly counselling and referral mechanisms. Future research should use a larger, well-documented sample, validated measurement tools, and appropriate inferential analyses to examine factors associated with adolescents' knowledge and attitudes.

The study was limited to higher secondary students from selected government schools within the Thrissur Municipal Corporation; therefore, its findings cannot be generalised to all adolescents in Kerala. The descriptive design does not permit causal inferences. The self-developed questionnaire may introduce measurement limitations, as information on its psychometric properties and the scoring thresholds used to categorise knowledge and attitudes is limited. Restricted access to schools also constrained the data collection.

Conclusion

The study suggests that a substantial proportion of adolescents have an incomplete understanding of sex education and remain hesitant about its content or discussion. Three findings merit particular attention. First, school-based exposure was not universal, as 54.1% of respondents did not affirm having received formal sex education at school, pointing to uneven provision or recall of instruction. Second, awareness of support structures was limited: 56.2% disagreed that they knew where to access reproductive health services and counselling, although awareness of child-protection laws was comparatively high (69.8%). Third, and most pronounced, 68.7% of respondents were uncomfortable discussing sex education with their parents, indicating a communication barrier within families.

These patterns are consistent with earlier Indian research documenting gaps in reproductive health knowledge and the influence of family, school and peer environments. They suggest that recognising the value of sex education does not necessarily ensure adequate knowledge or comfort in discussing sensitive subjects. Adolescents with limited access to trusted adults and structured instruction may therefore depend on peers and digital media, although the present study did not test

this relationship directly. The study underscores the need for a coordinated response involving schools, families, health services and community organisations. A structured, age-appropriate and scientifically accurate programme, supported by trained teachers and counsellors, interactive teaching methods, parent-orientation initiatives and adolescent-friendly referral mechanisms, would help address these gaps. Social workers are well placed to facilitate such efforts at the individual, group, family, school, and community levels.

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