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Research Paper

Attitude and Knowledge Towards Sexual or Reproductive Health among Young Adults

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ABSTRACT

This study was planned to study and compare the attitude and knowledge towards sexual and reproductive health between males and female. It was a cross sectional study where a group of young adults, males and females, were selected, ranging from age 18 to 25 year, for participation and correlation was studied between the two measures i.e., attitude and knowledge towards sexual and reproductive health. Brief Sexual Attitude Scale, and Knowledge questionnaire was provided to participants and data was collected. According to the results, there was no significant relationship between attitude towards sexual and reproductive health, and knowledge towards sexual and reproductive health, also, it was found that females show significantly positive attitude in the domain of permissiveness, birth control, and communion and not in instrumentality as compared to males. It was also found that there is no significant difference between males and females in the domain of knowledge towards sexual and reproductive health.

Keywords: *Attitude, Knowledge, Sexual or Reproductive Health, Young Adults*

Attitude refers to a set of emotions, beliefs, and behaviours toward a particular object, person, thing, or event. Attitudes are often the result of experience or upbringing, and they can have a powerful influence over behaviour.

According to SOCIAL PSYCHOLOGY, an attitude can be a positive or negative evaluation of people, objects, events, activities, and ideas. It could be concrete, abstract or just about anything in your environment. Attitude may influence the attention to attitude objects, the use of categories for encoding information and the interpretation, judgement and recall of attitude-relevant information.

According to CARL JUNG, attitude is a "readiness of the psyche to act or react in a certain way".
The main attitude dualities that Jung defines are the following:

- Consciousness and the unconscious.
- Extraversion and introversion.
- Rational and irrational attitudes

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Factors Affecting Attitude

- **Psychological**: The attitude of a person is determined by psychological factors like ideas, values, beliefs, perception, etc. All these have a complex role in determining a person's attitude.
- **Family:** Family plays a significant role in the primary stage of attitudes held by individuals. Initially, a person develops certain attitudes from his parents, brothers, sister, and elders in the family. There is a high degree of relationship between parent and children in attitudes found in them.
- **Society:** Societies play an important role in formatting the attitudes of an individual. The culture, the tradition, the language, etc., influence a person's attitudes. Society, tradition, and the culture teach individuals what is and what is not acceptable.
- **Economic:** A person's attitude also depends on issues such as his salary, status, work environment, work as such, etc.

Components Of Attitude

a) The cognitive component of a social attitude consists of a person's system of beliefs, perceptions and stereotypes about the attitudinal object. In other words, it refers to his ideas about the object. The term opinion is often used as a substitute for the cognitive component of an attitude particularly when it is relevant to some issue or problem.
b) The affective component of social attitude refers to the emotional aspect of the attitude which is very often a deep rooted component and resists most to change. In other words, it indicates the direction and intensity of an individual's evaluation.
c) The behavioural component of social attitudes indicates the tendency to react towards the object of attitude in certain specific ways. In other words, it is a predisposition to act in a certain manner towards the attitude object. This is known by observing the behaviour of the individual i.e., what he says he will do or actually how he behaves, does or reacts.

Characteristics Of Attitude

- Attitudes give a direction to one's behaviour and actions.
- Attitudes are not innate but learned, acquired and conditioned.
- Attitude is never neutral. It can be either positive or negative, favourable or unfavourable, palatable or unpalatable.

Knowledge

- Knowledge is a familiarity, awareness, or understanding of something such as facts, information, description, skills which is acquired through experience or education by learning, perceiving, or discovering
- Knowledge refers to a theoretical and practical understanding of something. It can be implicit (as with practical skill or expertise) or explicit (as with the theoretical understanding of a subject), it can be more or less formal or systematic.

Characteristics of Knowledge

- An understanding of physiological, emotional, cognitive, and social determinants of behaviour.
- Basic understanding of the various disciplines in psychology as well as major theories and history of psychology.

- Familiarity and experience with psychological research methods, including data collection and analysis.
- Specific knowledge and abilities related to your concentration (e.g., Cognitive, Neuroscience, Developmental, etc.)

Types of Knowledge

- Declarative knowledge (substantive knowledge) focuses on beliefs about relationships among variables
- Procedural knowledge focuses on beliefs relating sequences of steps or actions to desired (or undesired) outcomes
- Tacit knowledge includes insights, intuitions, and hunches
- Explicit knowledge refers to knowledge that has been expressed into words and numbers. We can convert explicit knowledge to tacit knowledge
- General knowledge is possessed by a large number of individuals and can be transferred easily across individuals
- Specific knowledge, or "idiosyncratic knowledge," is possessed by a very limited number of individuals, and is expensive to transfer
- Technically specific knowledge is deep knowledge about a specific area
- Contextually specific knowledge refers to the knowledge of particular circumstances of time and place in which work is to be performed.

Sexual And Reproductive Health

Sexual or reproductive health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. It is not merely the absence of reproductive disease or infirmity. It deals with the reproductive processes, functions and system at all stages of life.

Sexual knowledge refers to the knowledge about sexuality, myths and misconceptions. The studies in this area cover knowledge about reproduction, pregnancy, fertility, methods of contraceptive use and sexually transmitted diseases (STDs) and also gender differences in sexual knowledge. Sexual attitude refers to the attitude one has toward sexuality or sexual behaviours, which could be either liberal or conservative. Sexual knowledge and attitudes are often studied together.

Health Problems of Young Adults

Although young adulthood are generally considered healthy times of life, several important public health and social behaviours and problems either start or peak during these years. Most of these problems are linked with social determinants and lifestyles operating and interacting in complex environments that precipitate or trigger these conditions or behaviours. Developmental transition of young people makes them vulnerable particularly to environmental, contextual or surrounding influence. Environmental factors, including family, peer group, school, neighborhood, policies, and societal cues, can both support or challenge young people's health and well-being.

Evidence indicates that young people are prone to a number of health impacting conditions due to personal choices, environmental influences and lifestyle changes including both communicable and non-communicable disorders and injuries. Others include substance use

disorders (tobacco, alcohol and others), road traffic injuries (RTIs), suicides (completed and attempted), sexually transmitted infections (STI) including human immunodeficiency virus (HIV) infection, teen and unplanned pregnancies, homelessness, violence and several others. In all countries, whether developing, transitional or developed, disabilities and acute and chronic illnesses are often induced or compounded by economic hardship, unemployment, sanctions, restrictions, poverty or poorly distributed wealth at both individual and country level.

Early pregnancy and childbirth: Complications linked to pregnancy and childbirth are the second cause of death for 15-19-year-old girls globally. Some 11% of all births worldwide are to girls aged 15 to 19 years, and the vast majority are in low- and middle-income countries. The 2014 World Health Statistics put the global adolescent birth rate at 49 per 1000 girls this age – country rates range from 1 to 229 births per 1000 girls. This indicates a marked decrease since 1990. This decrease is reflected in a similar decline in maternal mortality rates among 15-19 year olds.

HIV: More than 2 million adolescents are living with HIV. Although the overall number of HIV-related deaths is down 30% since the peak 8 years ago, estimates suggest that HIV deaths among adolescents are rising. This increase, which has been predominantly in the WHO Africa Region, may reflect the fact that although more children with HIV survive into adolescence, they do not all then get the care and support they need to remain in good health and prevent transmission. In sub-Saharan Africa only 10% of young men and 15% of young women aged 15 to 24 are aware of their HIV status.

Mental health: Depression is the top cause of illness and disability among adolescents and suicide is the third cause of death. Violence, poverty, humiliation and feeling devalued can increase the risk of developing mental health problems.

Malnutrition and obesity: Many boys and girls in developing countries enter adolescence undernourished, making them more vulnerable to disease and early death. The number of adolescents who are overweight or obese is increasing in both low- and high-income countries.

Age-appropriate knowledge among youth about the changes during puberty, sexuality, modes of transmission and prevention of sexually transmitted infections, HIV, and to maintain a healthy and safe sexual life is important for the health and welfare and aware them to prevent unwanted pregnancies and of HIV/AIDS.

One such solution to these problems is Sex Education. Sex education is the instruction of issues relating to human sexuality, including emotional relations and responsibilities human sexual anatomy, sexual activity, age of consent, Reproductive health reproductive rights, birth control, and sexual behaviour. Sex education that covers all of these aspects is known as comprehensive sex education. Common source for sex education are parents or caregivers, formal school programs, and public health campaigns. Evidence shows that a combination of comprehensive sex education and access to birth control appears to decrease the rates of unintended pregnancies among teenagers. Numerous studies show that curricula providing accurate information about condoms and contraception can lead to reductions in the risky behaviours reported by young people as well as reductions in unintended pregnancies and STIs. Programs that teach only abstinence have not been shown to be effective.

Sex education should be an integral part of the learning process beginning in childhood and continuing into adult life and its lifelong learning process. It should be for all children, young people and adults, including those with physical learning or emotional difficulties. It should encourage exploration of values and morale values, consideration of sexuality and personnel relationships and the development of communication and decision making skills. It should foster self-esteem, self-awareness, a sense of moral responsibility and the skills to avoid and resist sexual experience.

Health education also plays important roles in human life and it is also a fundamental right. It can help to increase self-esteem, develop effective communication skills and encourage awareness about health and disease related knowledge. The mixture of myths/stigma secrecy, lack of knowledge, social disparity and negative media messages confuses young people and encourages poor self-esteem resulting in uninformed choices being made and it may lead to incorrect knowledge about sex, unprotected sex, unplanned pregnancy; STI'S including HIV/AIDS or deeply unhappy and damaging relationship.

Because of lack of clear protocol for sex education, like content, way of approaches, rules and regulation etc., for educational services and how these services should be fulfilled in different socioeconomic and cultural environments is not clear. So, this study was done to identify the knowledge attitude and perception of sex education among school going adolescents.

Importance of Health Psychology

Health psychology is a rapidly growing field. As increasing numbers of people seek to take control of their own health, more and more people are seeking health-related information and resources. Health psychologists are focused on educating people about their own health and well-being, so they are perfectly suited to fill this rising demand.

Healthy psychology can benefit individuals in a number of different ways. Many professionals in this field work specifically in the areas of prevention and focus on helping people prevent health problems before they start. This may include helping people maintain a healthy weight, avoid risky or unhealthy behaviours and maintain a positive outlook that can combat stress, depression, and anxiety.

Another way that health psychologists can help is by educating and training other health professionals. By incorporating things that have been discovered in the field of health psychology, physicians, nurses, nutritionists, and other health practitioners can better incorporate psychological approaches into how they treat patients.

Affects Of Casual Sex on Mental Health

Examining the mental health associations of casual sex also report that participants who were not depressed before showed more depressive symptoms and loneliness after engaging in casual sex.

In addition to the known risks of contracting STDs, developing unwanted pregnancies, and being raped or otherwise assaulted, people who engage in casual sex may suffer emotional consequences.

Motivation also plays an important role in sexual or reproductive health. Extensive research guided by self-determination theory, a well-established theory of human motivation

and personality, shows that when we do things for the "right" reasons, our well-being flourishes. When we do those *exact same* things for the "wrong" reasons, our well-being suffers.

Here are some examples of autonomous (right) and nonautonomous (wrong) motives for casual sex:

Autonomous ("Right") motives:

- Wanting the fun and enjoyment.
- Wanting to explore and learn about your sexuality.
- Believing it is an important experience to have.

Nonautonomous ("Wrong") Motives:

- Wanting to feel better about yourself or to avoid other unpleasant feelings.
- Wanting to please someone else (e.g., your partner or friends).
- Wanting to get a favour, material reward, or revenge.
- Hoping it would lead to a long-term relationship.

Those who engaged in casual sex for the wrong reasons (High Nonautonomy group) had lower self-esteem, higher depression and anxiety, and more physical health symptoms compared to those who engaged in casual sex but not for the wrong reasons (Low Nonautonomy group) had higher self-esteem and similar levels of depression, anxiety, and physical symptoms.

Kuberan, Rushender, and Kumar (2017) conducted a cross-sectional analysis to study attitude and knowledge about sexual and reproductive health among secondary higher school in Tamil Nadu. A cross sectional descriptive study was carried out among 464 secondary school going adolescent students of Chengalpattu Taluk using a structured self-administered questionnaire comprising questions to assess the knowledge on reproduction, contraception and HIV/STD and the attitude on sexual risk behaviour. The average level of knowledge on reproduction, contraception and STD/HIV was 38.5%, 34.75% and 45.5% respectively. 18% gave correct response to questions "there is problem if a girl does not get period 14 years" and "it is dangerous to have intercourse during a girl's period". 80% knew pregnancy happens when sperm fertilizes ovum and 80.6% gave incorrect answer to question that "letting semen drip out of the female organ after sex prevents pregnancy". 50% were ignorant that it is possible to have more than one STD. 42.5% agreed about having sex with several people for their age. 52% agreed to use condom if sexually active. 56.2% disagreed to popularity of boy or girl who has sexual intercourse. The research showed that the students lack correct information about sexuality issues in general which could be due to insufficient sexual education by schools and parents.

Wang, Gong, and Hang (2013), conducted in China, surveyed male to assess levels of knowledge, attitudes and practices regarding prevention of sexually transmitted diseases (STDs). The study recruited 4000 men aged 18–59 years by cluster random sampling. Almost one-third of respondents reported that they had reproductive system symptoms. It was found that 43.0% of reproductive system diseases occurred among middle-aged (40–49 years) participants. Also, suggested that males were aware of the benefits of condom use during sexual intercourse, and therefore, did behaviour in accordance with this knowledge. Thus, 87.7% of respondents believed it was correct to use condom during sexual relationships with unfamiliar partners. Some other aspects of STD/AIDS knowledge levels were low in this study, with only 41.9% believing that breastfeeding could transmit

HIV/AIDS, only 50.3% being aware that gential warts was one type of STDs, and a number of subjects thinking that mosquito bites and kissing could transmit HIV/AIDS. This study also pointed out the lack of knowledge and misconception about several items, such as characteristics of STDs, the reason for banning consanguineous marriage, and the means of transmission of HIV/AIDS. These results indicated that the men had a certain degree of Knowledge, attitude and practices, whereas some aspects require further public health education in the general population.

Wood and Bertrand (2018), conducted a research study to assess attitude toward sexual and reproductive health among adolescents and young people in urban and rural areas. They recruited 224 participants: 112 females and 112 males. All participants were unmarried and majority (90%) had some secondary school education. Fourteen group discussions were conducted with a total of 224 adolescents and young people aged 15–24 years in urban and rural areas. The topics discussed and age groups of participants differed somewhat in the urban and rural areas. Data were analysed to identify themes in the participants' discussion of their attitudes towards Sexual or Reproductive health. It was identified that both males and females aged 15–24 from urban area were very open and forthcoming with their attitudes on multiple issues related to pregnancy and contraceptive use. For the adolescent boys, their fear of pregnancy stemmed from the financial implications, the reaction of their parents, the acquisition of a "bad" reputation in the neighbourhood, and dishonour and shame pregnancy would bring to their family especially their parents. All the adolescent boys were familiar with the condom but were far less familiar with other modern methods. Some had knowledge about natural methods (withdrawal and the calendar method). Similar to adolescent girls, adolescent males incorrectly cited pharmaceutical products- Decaris, Tetracycline and Vermox- as modern methods. The data showed that 43% of young people from rural areas of these provinces have some secondary or higher education and 63% are employed. The findings also suggest that fear of pregnancy, the judgmental attitude of health providers, and fear of side effects are major concerns among adolescents and young people in rural areas.

Devi (2017), conducted a study on sexual and reproductive behaviour among adolescent mothers in rural areas of Tamil Nadu. The study was carried out on a sample of 400 adolescent mothers aged 15-19 years living in the rural areas of two districts of Tamil Nadu. The information collected from the adolescent mothers covered a range of subjects. The analysis of data on the background characteristics of adolescent mothers showed that 85% of adolescent mothers interviewed in the survey were literates and Hindu. It was observed that adolescent mothers who were literates, Hindus, high standard of living and high family income and those living in joint family system had more knowledge on the duration of bleeding during menstruation than others. 9% of adolescent mothers were using sanitary napkins. The analysis of data indicated poor knowledge on sexually transmitted diseases, 46% of adolescent mothers had no knowledge about menstruation.

Dutta and Anupama (2014), conducted a study on attitude knowledge and practice of sexual and reproductive health among students and teachers of selected high schools in Assam. The study indicated that only 9.8% of the high school students have adequate knowledge regarding Sexual Health Education, 29.4% have moderate and 60.8% have inadequate knowledge. Majority of the students have shown undecided attitude towards Sexual Health Education. In relation to the opinion of the students regarding Sexual Health practice 85% are found to follow unhealthy practice and only 15% are following healthy practice. In matter of Knowledge regarding Sexual Health Education, 80.33% teachers have

moderate knowledge and 16.67 %have inadequate knowledge and only 3 percent have adequate knowledge. Regarding the Attitude of the teachers regarding Sexual Health, the majority of the teachers (78.67%) have undecided attitude. The practice level of the teachers, 48.67% are found to follow unhealthy practice while 51.33% are found to follow healthy practice.

Orji, and Esimai (2003), conducted a study on Introduction of sexual health education in to Nigeria schools. The objectives of the study was to assess the knowledge of the parents, teachers and student on their knowledge and their acceptance of the sexual health education in the school curriculum. The sample of the study 400 students,400 parents and 200 teachers. The investigator reported that majority of the parents (92%) teachers (90%) and students (78%) supported its introduction of sexual health education into the school curriculum. The parents and teachers belief that sexual health education in schools would prevent unwanted pregnancy, enhance healthy relationships between opposite sex, prevent transmission of HIV and STD infection. Only (15.4%) of the respondents opposed the introduction of sexual health education in the schools.

Gogoi, Maitrayee (2010), conducted a study was assess knowledge and attitude on reproductive health among girls high school students in urban and rural area of Dibrugarh District, Assam. The convenient random sampling was use to select the schools in rural and urban area. The 130 student were selected from stratified random sampling technique from the schools, class VII, IX, and X. The study finding was 1.5% student had adequate, 49.2% had moderate and 49.2% had inadequate knowledge regarding reproductive health. The 39.2% had favourable, 58.5% had moderate and 2.3% had unfavourable attitude. The investigator concluded that there is a need to conduct study among the boys, parents and teachers to assess the knowledge, attitude and practice to promote and implement awareness about sexual health issues.

Garcia (2012), conducted a study on college going students to see the effect of casual sex on mental health**.** The results showed that a relatively high percentage of students had engaged in casual sex within the past month (11%), with more men (18.6%) than women (7.4%). This difference is typical of those reported in casual sex research and could reflect a genuine, biologically-based sex difference. People who engaged in more casual sex had greater psychological distress. College students who recently engaged in casual sex reported lower levels of self-esteem, life-satisfaction, and happiness compared to those who had not have casual sex in the past month. And students who recently engaged in casual sex had higher distress scores as indicated by levels of depression and anxiety.

METHODS

Objective

- To study the attitude and knowledge towards sexual and reproductive health among young adults.
- To study and compare the attitude and knowledge towards sexual and reproductive health between males and females.

Hypothesis

- There would be no significant difference between males and females in the domain of knowledge towards sexual and reproductive health.
- There would be no positive attitude towards sexual and reproductive health among young adults.

Design

The research was a cross sectional study where a group of young adults including (males and females) were selected for participation and correlation between the two measures i.e. attitude towards sexual and reproductive health and knowledge towards sexual and reproductive health was studied.

Sample

The sample comprised of total sixty (N=60) young adults.

Inclusion Criteria:

- Age range of the sample is 18 to 25 years.

Exclusion Criteria:

- Subject suffering from any serious mental or physical illness.
- Subject suffered from any truma in last one year.

Measures

Brief Sexual Attitude Scale (BSAS): Questionnaire to study attitude in the domain of sexual and reproductive health. It comprises of 23 questions, divided into 4 sub domains namely Permissiveness (1-10), Birth Control (11-13), Communion (14-18), and Instrumentality (19-23). Some questions refer to a specific sexual relationship, while others refer to general attitudes and beliefs about sex. For each statement participant has to fill in the response that indicates how much he/she agree or disagree with the statement. For each statement, A= strongly agree, B= moderately agree, C= neutral, D= moderately disagree, and E= strongly disagree. For analysis, A= 1, B= 2, C= 3, D= 4, and E= 5. The scoring is reversed in some questions, A= 5, and E= 1.

Knowledge about sexual and reproductive health: it is a questionnaire to study knowledge in the domain of sexual and reproductive health. It comprises of 20 questions, divided into 3 domains namely Knowledge of Sexual and Reproductive Health, knowledge of contraceptives, and knowledge of sexually transmitted diseases. For each statement participant has to fill in the response that indicates how much he/she agree or disagree with the statement. For each statement, A= strongly agree, B= neutral, and C= strongly disagree. For analysis, Likert Scale was used (3 point scale), for which, A= 1, B= 2, and C= 3.

Rationale Of the Study

Present study attempts to correlate the attitude and knowledge towards sexual or reproductive health. A group of young adults (including males and females) was selected as participants for the study in order to measure the extent of attitude and knowledge towards sexual and reproductive health in the participants. Since being aware of oneself can have a positive effect on recognition of one's own attitude and knowledge and it was hypothesised that females had a positive attitude in the domain of permissiveness, birth control and communion as compared to boys, whereas on the domain of instrumentality both groups were similar.

Procedure

The topics were selected under the guidance of the supervisor and two variables got selected that is attitude and knowledge for studying correlation between them. Then measuring tools and the type of sample was selected and approved by the supervisor. After finalisation of the topic, sample, and tools I proceeded towards data collection from young adults between the age-range of 18-25 years. I contacted individually with the participants and consent form

was given to them, I asked them to sign the consent. Then I gave them questionnaires and I gave them proper instructions to fill the questionnaire. During this procedure some information was collected from the participants such as demographical details which were relevant for the investigation. After the completion of questionnaire, they were collected back for scoring and interpretation and every participant was assured that the information provided by them will be kept confidential.

Statistical Analysis

The obtained data was analysed by using Frequency Distribution, Perason r, Correlation and Mann Whitney U Test.

RESULT AND DISCUSSION

Table No. 1 showing the sample characteristics of data (frequency and percentage):

Variable		N (Percentage)
Gender	Male	20 (23)
	Female	40 (67)
Religion	Hindu	60(100)
Residence	Rural	7(11.7)
	Urban	50(83.3)
	Semi urban	3(5)
Type of Family	Nuclear	22(36.7)
	Joint	29(48.3)
	Extended	9(15)

Table 1 indicating demographic details of data by using frequency and percentage. It shows that most of the samples consists of females (67%), Hindu (100%), belongs to urban area (50%) and residing joint family (48%).

Table No. 2 indicates the relationship between attitude and towards sexual and reproductive health, and knowledge towards sexual and reproductive health using Pearson-r.

Variable	Knowledge of sexual and reproductive health	Knowledge of contraceptives	Knowledge of STD's
Permissiveness	0.08	-0.09	-0.08
Birth control	-0.07	-0.19	0.07
Communion	0.04	-0.08	0.08
Instrumentality	-0.06	-0.08	0.08

Table 2 indicates there is no significant relationship between attitude towards sexual and reproductive health, and knowledge towards sexual and reproductive health.

Table No. 3 comparing attitude towards sexual and reproductive health between males and females (Mann Whitney U Test):

Variable	Male Mean rank	Female Mean rank	Z	P
Permissiveness	23.95	33.78	-2.05	0.04*
Birth control	22.40	34.55	-2.67	0.008**
Communion	22.13	34.69	-2.66	0.008**
Instrumentality	26.50	32.50	-1.25	0.20

$p<0.05$, $p<0.01$

Table 3 indicates that females are having significantly positive attitude in the domain of permissiveness ($p < 0.05$), birth control ($p<0.01$) and communion ($p<0.01$) as compared to males, whereas on the domain of instrumentality both groups were similar.

Table No. 4 comparing knowledge towards sexual and reproductive health between males and females (Mann Whitney U Test):

Variable	Male Mean rank	Female Mean rank	Z	P
Knowledge of sexual and reproductive health	32.88	29.31	-0.77	0.44
Knowledge of contraceptives	32.93	29.29	-0.76	0.44
Knowledge of STD's	32.43	29.54	0.61	0.50

Table 4 indicates that there is no significant relationship between males and females in the domain of knowledge towards sexual and reproductive health.

Sexual health is a state of physical, mental, and social well being in relation to sexuality which requires a positive and respectful approach to sexuality and sexual relationships. It is also about pleasurable and safe sexual experience free of coercion, discrimination, and violence. In most of the Indian houses the discussion about sex is prohibited and is considered as a taboo. In rural areas and urban slums, girls are often married early and they don't go into marriage, they equipped with any knowledge of sex.

Sexual attitude refers to the attitude one has toward sexuality or sexual behaviours, which could be either liberal or conservative. Sexual knowledge and attitudes are often studied together.

Therefore, this study was planned to study and compare the attitude towards sexual and reproductive health, and knowledge towards sexual and reproductive health between males and females. It was a cross sectional study where a group of young adults (males and females) were selected for participation and correlation between the two measures i.e. attitude towards sexual and reproductive health and knowledge towards sexual and reproductive health was studied. Brief Sexual Attitude Scale and Knowledge questionnaire was provided to the samples and data was collected from young adults between the age-range of 18-25 years.

According to results, Table no. 1 shows the demographic details of data by using frequency and percentage. It shows that most of the samples consists of females (67%), Hindu (100%), belongs to urban area (50%), and residing joint family (48%).

Table no. 2 there is no significant relationship between attitude towards sexual and reproductive health, and knowledge towards sexual and reproductive health.

Table no. 3 shows that females are having significantly positive attitude in the domain of permissiveness ($p < 0.05$), birth control ($p<0.01$) and communion ($p<0.01$) as compared to

males, whereas on the domain of instrumentality both groups were similar. It was seen in the earlier research by Wood, and Bertrand, that females show significantly positive attitude towards sexual health as compared to males.

Table no. 4 shows that there is no significant relationship between females and males in the domain of knowledge towards sexual and reproductive health.

Sexual knowledge refers to the knowledge about sexuality, myths and misconceptions. The studies in this area covered knowledge about reproduction, pregnancy, fertility, methods of contraceptive use and sexually transmitted diseases (STDs) and also gender differences in sexual knowledge. Sexual attitude refers to the attitude one has toward sexuality or sexual behaviours, which could be either liberal or conservative.

This study concluded that female have significantly positive attitude in the domain of permissiveness, birth control, and communion as compared to males.

SUMMARY AND CONCLUSION

This study was planned to study and compare the attitude and knowledge towards sexual and reproductive health between males and female. It was a cross sectional study where a group of young adults, males and females, were selected, ranging from age 18 to 25 year, for participation and correlation was studied between the two measures i.e., attitude and knowledge towards sexual and reproductive health. Brief Sexual Attitude Scale, and Knowledge questionnaire was provided to participants and data was collected. According to the results, there was no significant relationship between attitude towards sexual and reproductive health, and knowledge towards sexual and reproductive health, also, it was found that females show significantly positive attitude in the domain of permissiveness, birth control, and communion and not in instrumentality as compared to males. It was also found that there is no significant difference between males and females in the domain of knowledge towards sexual and reproductive health.

Sexuality is still a topic which is considered as a taboo in this era. Whereas it is the most required part of the human existence. Lot of participants denied to participate in this study as they were not comfortable discussing their thoughts related to this particular topic. Therefore, it is very important that sex education is provided to the young generation through a proper channel. Family members, teachers and elders should discuss these points in detail to make youth understand the importance of sexual health.

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Conflict of Interest
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