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Research Paper

Sexual Health Awareness Scale (S.H.A.S)

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ABSTRACT

The understanding people have of sexual health is quiet outdated. This can lead to unsafe sexual practices and unsatisfactory sexual experiences. The Sexual Health Awareness Scale can help in analysisng the level of awareness an individual has about sexual health, thereby providing a reference for sex educators and therapists. The scale explores three main domains belies about sexual, attitude towards sexual health and sexual practices. The scale uses a Likert scale. The scale is a self-inventory. Once the participants complete answering the questions they are scored, interpreted and taken for further analysis. The validity of the scale was done by the evaluation of subject matter experts. The questions in the scale were tested for their reliability using SPSS.

Keywords: *Sexual Health, Awareness, Scale*

Humans have always aimed at improving their health. Though it is an important component of our lives, the term "health" is frequently used to refer just to physical well-being. Due to various current public awareness efforts and people discussing their psychological well-being, the term "health" has been broadened to include mental health as well. Physical and mental health are extremely significant for our well-being, but there is a third component to consider when determining physical and mental health: sexual wellness.

Sexual health has been defined as, "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

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(WHO, 2006a). It is a broad understanding and education of sexuality, sexual rights, and experiencing sexual closeness and pleasure, not just awareness of safe sex practices and pregnancy. Sexual health entails being aware of your own and your partner's sexual needs and boundaries.

Because sex and sexuality are taboo topics in many parts of India, most teenagers still lack access to proper sex education. Only a few educational institutions provide pupils with sex education. The general majority's lack of understanding might lead to hazardous sexual habits. Sexual health is vital because it has an impact on other aspects of your health, such as your physical and emotional well-being. It is critical to educate adolescents on these topics in order for them to live a healthy lifestyle.

Certain factors help to identify whether or not a person is sexually healthy. Communication is one of the most crucial factors. To set boundaries, an individual must be able to communicate effectively with their relationship. They should also be able to accept their spouses' refusals without becoming upset or hostile. Communication also necessitates attentiveness to the partner's nonverbal clues. Knowing about the many types of contraception and deciding with your partner which contraception best suits you based on your body and other needs is also part of being sexually healthy. An individual should be able to experience pleasure, enjoy the entire process leading up to sexual intercourse, and not experience any bodily pain during sexual coitus. Apart from that, a person should be able to maintain non-sexual interactions. Negative emotions should not be associated with pleasurable activities that do not include a spouse.

The Government of India has included Adolescent Reproductive and Sexual Health (ARSH) services in the school curriculum to help teenagers make educated decisions. However, there are other challenges to raising awareness among adolescents, including the patriarchal society and social barriers to speaking with teachers, parents, and elders. Even parents, who are mainly unskilled and uneducated, limit their conversation with daughters to the topic of menstruation and are hesitant to discuss problems of safe sex or reproductive health. Furthermore, they believe that addressing these issues will dilute authoritative parenting and promote sexual promiscuity.

This scale is used to determine or assess a person's level of sexual awareness. The scale's findings can be utilised for counselling or any other type of intervention. The scale was also created for those between the ages of 18 and 25. This can assist people in developing better sex behaviours at a young age.

REVIEW OF LITERATURE

By the year 2014, the number of young adults contracting sexually transmitted diseases had seen a rise and survey by the Centres for Disease Control and Prevention on Latinos and African-Americans proved that many of the young adults between the ages of 13-24 years did not use protection while having sexual intercourse. According to a study conducted by researchers from the Penn University, most of young adults use social media as the main source of information for sex-education. The study also found that participants who had access to sexual risk reduction information were more prone to the use of birth-control or protection (Berger, 2017). The above study sheds light on the fact that social media can be a great tool that can be used by young adults to get information related to sexual health. Moreover, teens self-socialize, that is, they learn behaviors, values, and their roles through their interaction with the society. In this new era of digitalization, therefore young adults

resort to social media as the source for information. It is also a platform for them to explore their identity and sexual experience anonymously (Nikkelen et al., 2020).

Gamble & Nelson (2016) conducted a study to understand the influence of television watching and its effect on sexual relationship in young adults. The study indicated that women were more prone to have higher sexual expectations after watching movies on television and men generally had a consistent take on this. This result could be attributed to the fact the movies and television shows indicate the unsatiable sexual nature of males. Another aspect that could have caused these results would be the 'the ceiling effect' which means that men generally have higher sexual expectations in their relationships so the relationship television viewing may not have added anything substantially to their expectations.

Young adult women have also reported having more issues relating to body and sexual performance than a lot of young adult men. A study has also indicated that men have more sexual performance expectations from their female partner than women had. This also implies that viewing of visual pornographic content has caused dissatisfaction with the partner's physical appearance, therefore, creating an unrealistic sexual performance expectation (Goldsmith et al., 2017). A survey report suggests that around 20% of young adults between the ages of 13-19years have engaged in sending nude images or semi-nude images or videos of themselves with another teenager. 'Sexting', which means sending, receiving or forwarding sexually explicit messages on text through the use of technology and internet, has also been reported to be common amongst teenagers (Cookingham & Ryan, 2015).

In India, many factors such as culture, lack of scientific evidence and lack of knowledge among health care professionals have contributed to the lack of good sex-education (Ismail et al., 2015). A good sex-education can also develop life-skills required by the individual to face life and its challenges. Many of the schools and teachers just focus on only the biological aspect of it, for example some teachers in Nepal but most of the students reported that they want a sex-education that is more skill based therefore, it is important to shift the focus from biology alone to skill-based sex education (Netsanet et al., 2012). In a video released by Netflix in 2020 as a part of their promotions for sex-education series, an interview was done with many youngsters and their parents on sex-education. There was a certain discomfort associated with the topic that was evident on the faces of both the children and their parents while discussing the topics. In the second part of the same video, the parents and their children were asked to name all the reproductive as well as private parts by looking at the images. Most of the participants and their parents weren't able to name the parts correctly indicating the lack knowledge related to sex (Channa & et.al, 2020).

Higgins, J. A., Mullinax, M., Trussell, J., Davidson Sr, J. K., & Moore, N. B. (2011) conducted a study to investigate sexual satisfaction and sexual health among university students in the United States. They surveyed 2168 university students in the United States and asked them to rate their physiological and psychological satisfaction with their current sexual lives. Many respondents reported that they were either satisfied (approximately half) or very satisfied (approximately one third). In multivariate analyses, significant ($P < .05$) correlates of both physiological and psychological satisfaction included sexual guilt, sexual self-comfort, self-esteem (especially among men), relationship status, and sexual frequency. They concluded that to enhance sexual well-being, public health practitioners should work to improve sexual self-comfort, alleviate sexual guilt, and promote longer term relationships.

Hogarth, H., & Ingham, R. (2009) conducted an exploratory study to understand masturbation among young women and associations with sexual health. Thematic analysis of interview transcripts was employed to identify the range of reported experiences across participants, as well as the relations between various aspects of sexual development and experiences within participants. The findings revealed a broad continuum of views and opinions on female masturbation, which had strong links with parent and partner communication and the young women's beliefs and values concerning their sexual selves. The article concludes by drawing attention to the apparent relation between positive early childhood communication, young women's positive views of their sexual self, and their subsequent sexual activity.

Birhan, Z., Tushune, K., & Jebena, M. G. (2018) conducted a study to explore Sexual and reproductive health services use, perceptions, and barriers among young people in southwest Oromia, Ethiopia. A cross sectional study was employed to collect data from 1,262 in-school youths. Simple random sampling technique was used to select schools and study participants.

Fifteen focus group discussions and 22 key informant interviews were conducted. Results indicated that four hundred sixty (36.5%) of the respondents had utilized sexual and reproductive health services. Advice on sexual and reproductive health was the major (67.2%) service sought followed by seeking-treatments (23.3%). Health centers were the major (65.0%) source of SRH services. Being married, being sexually active, father-child communication, religion and place of residence were significantly associated with use of sexual and reproductive health services ($p<0.05$). Lack of information about SRH, poor perceptions about SRH, feeling of shame, fear of being seen by others, restrictive cultural norms, lack of privacy, confidentiality and unavailability of services were deterring use of sexual and reproductive health services.

Hayter, M., & Harrison, C. (2008) have done an investigation to study gendered attitudes towards sexual relationships among adolescents attending nurse led sexual health clinics in England. Ten focus groups (five male and five female) involving sexual health clinic attendees aged between 14–16 years were conducted. Focus groups were asked to comment on four sexual relationships ‘case studies’. Group discussions were recorded and transcribed. Data were subject to thematic analysis. Three themes emerged from the data analysis. ‘Empathy’ reflected how young women were more likely to try to see their partner’s point of view. ‘Complexity’ also reflected that young women were more aware of the complex nature of relationships than were the male participants. ‘Language’ related to how young males used aggressive language in the context of relationships

– a feature absent from female participants’ discourse.

Weinstein, R. B., Walsh, J. L., & Ward, L. M. (2008) conducted a study to test a new measure of sexual health knowledge and its connections to students' sex education, communication, confidence, and condom use. They created a new, comprehensive sexual health knowledge measure to assess 347 undergraduates' knowledge of reproductive health, contraception, condom use, sexually transmitted diseases (STDs), and HIV/AIDS. Overall, students demonstrated a fairly poor understanding of sexual health issues. Women were more knowledgeable than men, specifically on the topics of contraception and STDs. Prior exposure to sex education covering mainstream reproductive health issues or newer contraception methods was correlated with greater knowledge across all domains,

particularly for men. Greater knowledge was also correlated with greater sexual assertiveness and confidence with condoms among women.

Matsick, J. L., Conley, T. D., Ziegler, A., Moors, A. C., & Rubin, J. D. (2014) conducted a study to examine whether individuals were more likely to stigmatise relationships that: (i) focus on loving more than one person (which is characteristic of polyamory), (ii) focus on having sex without love (which is characteristic of swinging lifestyles), or (iii) involve having sex without love without a partner's participation (which is characteristic of open relationships). Participants were assigned to read a definition of one of the three CNM relationship types (i.e., a swinging, polyamorous or open relationship) and to indicate their attitudes towards individuals who participate in those relationships. Results show that swingers were overwhelmingly perceived more negatively (e.g., less responsible) than individuals in polyamorous relationships and that people in open relationships were sometimes perceived more negatively (e.g., less moral) than people in polyamorous relationships. Overall, findings suggest that people are more uncomfortable with the idea of strictly sexual relationships (i.e., swinging relationships) than relationships involving multiple romantic/emotional attachments (i.e., polyamorous relationships).

The paper 'The sound of silence: talking about sexual orientation and schooling' by Renee DePalma and Elizabeth Atkinson is based on a Nuffield Foundation-funded online discussion project in the United Kingdom, in which higher education students and faculty were asked to reply to a series of assertions about sexual orientation in the context of schooling. This research proposes that other degrees of silence functioning inside the project's larger social, political, and educational environment may have exacerbated the relative nonparticipation quiet. Data from web forums revealed that infants are viewed as asexual individuals, that homosexuality is sexualized, and that there is a trend to segregate the public and private worlds. They also discovered some political correctness, which reflected the university's legitimized diversity discourses without necessarily addressing the more uncomfortable questions that accompanied them. Participants also imagined parental, teacher, or student concerns and shifted the conversation to other areas of concern, which may have served to shield them from direct involvement with the issues at hand. It was observed that when these elements are combined, they produce many levels of silence that aid in the formation and maintenance of heteronormativity while also revealing the heterosexual matrix's power in action, thereby asserting a need to provide sex education concerning different sexual orientations.

The paper 'Sexual and Reproductive Health Information: Disparities Across Sexual Orientation Groups in Two Cohorts of US Women' (Tabaac R et al., 2020), was primarily aimed at discovering the difference in seeking and receiving sexual health information with respect to a difference in the sexual orientation. The study was done on a sample of US women with different sexual orientations. Most sexual minority populations were more likely than the baseline to receive/seek knowledge from peers, the media, and other sources (e.g., community centres). Sexual minority categories were more likely to receive/seek information about contraception, with the exception of lesbians, while primarily straight and bisexual women were more likely to receive information on sexually transmitted infections. According to the findings, women of various sexual orientations require SRH knowledge from a variety of sources, including schools, peers, and the media. Many SRH subjects are received/sought by sexual minority women, indicating that changes to adapt instructional resources within and outside of schools are needed to optimize SRH benefits to these communities.

The role of external professionals in education about sexual orientation−towards good practice (Douglas et al., 2001): As part of their Personal, Social, and Health Education, young people in England are entitled to a thorough sex education program (PSHE). New government recommendations on sex and relationship education, as well as pre-existing concerns about homophobic bullying, sexual health, and mental health, are informing current debates regarding the content of such a program. An externally sponsored Young Gay and Bisexual Men's Development Worker in an English local authority delivered educational activities to four schools to address sexual orientation and identity concerns. The goal of an evaluation was to determine whether or not success had been achieved and, if so, why. Another goal was to uncover helpful knowledge on the role of outside specialists in providing successful sexual orientation education to young people in schools. The evaluation was created with a number of 'real-world' constraints in mind. Despite this, a large number of project accomplishments (as well as opportunities for improvement) were reported. Raising awareness of important topics among students and assisting teachers who are involved in PSHE were examples of successes. A considered approach to building partnerships with schools and working with young people were key factors contributing to success. Other factors include adequate preparation of teachers and pupils in schools, an appropriately skilled and experienced project worker, and a considered approach to building partnerships with schools and working with young people. The research, therefore, points out the importance of the role of teachers and coworkers in improving the efficiency of sex education programs.

Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S: (Stanger-Hall & Hall, 2011)

In terms of teen pregnancies and sexually transmitted diseases, the United States leads the developed world. For more than a decade, the US government had supported abstinence-only sex education programmes in an effort to lower these rates. However, there was still debate among the public over whether this investment was worthwhile and whether these programmes should be sustained. This study shows that increased emphasis on abstinence education is positively connected with teenage pregnancy and birth rates using the most recent national data (2005) from all U.S. states with information on sex education laws or policies. After controlling for socioeconomic level, teen educational attainment, the ethnic composition of the teen population, and the availability of Medicaid waivers for family planning services in each state, this trend remains substantial. The findings clearly demonstrate that abstinence-only education as a state policy is unsuccessful in avoiding teen pregnancy and may even be contributing to the country's high teenage pregnancy rates. The study, therefore, proposes integrating comprehensive sex and STD education into the biology curriculum in middle and high school science classes, as well as a parallel social studies curriculum that addresses risk-aversion behaviours and planning for the future, in accordance with the new evidence-based Teen Pregnancy Prevention Initiative and the Precaution Adoption Process Model advocated by the National Institutes of Health.

Adolescent sex education in India: Current perspectives (Sathyanarayana Rao et al., 2015): Adolescent sexual and reproductive health needs in India are currently ignored or misunderstood by India's healthcare system. This could be due to a lack of scientific knowledge as well as the public health system's complete lack of preparedness. Healthcare personnel frequently lack knowledge, which has an impact on their ability to provide information to the adolescent population. Due to cultural and traditional norms in society, thorough sexual histories are frequently not taken, and sexual health is seldom freely

discussed. Incorrect information can lead to misunderstanding among youth, making them less likely to adopt healthy sexual behaviours and attitudes that will help them maintain their sexual health throughout their lives. After an exploration of information through these pre-existing data, the paper arrived at certain important conclusions. The provision of appropriate sex education to adolescent boys and girls may result in a variety of benefits, including a delay in sexual activity, a reduction in unplanned and early pregnancies and their associated complications, fewer unwanted children, reduced risks of sexual abuse, greater completion of education and later marriages, reduced recourse to abortion and the consequences of unsafe abortion, and a reduction in the spread of sexually transmitted diseases, such as HIV. To ensure that the process of imparting sex education to stakeholders is adequately measured and less controversial, a balance between the eagerness and ambitious plans of NGO's to implement different sexuality education in schools and the restrictive approach of legislators must be achieved. Incorporating the expertise of healthcare professionals such as psychologists, social workers, psychiatrists, obstetricians and gynaecologists, and genito-urinary physicians can help tailor the existing programme so that it is more likely to be effective in the medium to long term in changing the attitudes and behaviour of Indian adolescents in a way that benefits their overall and sexual health.

METHODOLOGY

Instructions

“The Sexual Health Awareness Scale consists of 48 statements. Five options are corresponding to each statement, ranging from Strongly Agree to Strongly Disagree. Read each statement carefully and choose the most appropriate option that represents you. None of the answers are right or wrong, therefore please feel free to choose any option. Try not to use the ‘neutral’ option unless or until it's necessary. There is no time limit to answering the questionnaire. If you have any doubts regarding the statements, please feel free to clear them at any point while answering. Please make sure that you have answered all the 48 items before submitting”.

Precautions/Control

- Make sure the room is properly lit and the environment is noise free.
- The items required for administration of the test (writing material, Sexual Health Awareness Scale, scoring key and norms) should be arranged before the subject.
- It is made sure that the subject has understood all the instructions clearly.

Scoring

The Sexual Health Awareness Scale uses a five point likert scale ranging from Strongly Agree, Agree, Neutral, Disagree to Strongly Disagree. The scoring procedure in Sexual Health.

Awareness Scale is quite objective. The scoring of the 48 items is divided into positive and negative scoring.
The items3, 4, 5, 6, 7, 8, 9, 10, 13, 14, 15, 16,17, 18, 19, 26, 28, 34, 36, 37, 39, 42, 43, 45, and 47 are positively scored. These items are scored as mentioned below.

Strongly agree - 5 Agree - 4
Neutral - 3
Disagree - 2
Strongly Disagree - 1

Sexual Health Awareness Scale (S.H.A.S)

The items 1, 2, 11, 12, 19, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 32, 33, 35, 38, 40, 41, 44, 46 and 48 are negatively scored. These items are scored as mentioned below.

Strongly agree - 1 Agree - 2
Neutral - 3
Disagree - 4
Strongly Disagree - 5

Negatively scored items are added to remove aspects such as participant inattention and satisficing. In the case of this scale, negative items indicate a lack of sexual health awareness whereas positive items indicate awareness about sexual health practices.

Example of positively scored items:
Q3. "At the beginning of my teenage I was given appropriate sex education" - A person who 'strongly agrees with this statement is well educated in terms of sexual health, therefore showing heightened sexual health awareness. Therefore, the statement is positively scored, where strongly agree = 5.

Example of negatively scored items:
Q1. "I expect my partner to imitate the same behaviour that I see in pornography" - A person who 'Strongly agrees' to this statement does not understand that human sexual behaviour is unique and are therefore unaware of various aspects of sexual health practices in the domain of sexual intercourse. Therefore, the item is negatively scored, where strongly disagree = 5

Analysis of scores
After the scores are obtained for each item, add up the scores for the positive and negative items together. The score thus obtained will be your Sexual Health Awareness score. The range of the scores can be from 40-240. The 192 points are further divided into three equal sections with 64 points each (48-112, 113-176, 177-240). The scores thus obtained can be interpreted according to the range mentioned below.
48 - 112 = Low level of Sexual Health Awareness
113 - 176 = Average level of Sexual Health Awareness
177 - 240 = High level of Sexual Health Awareness

Scale Items
1. I expect my partner to imitate the same behaviour that I see in pornography.
2. I feel that I need to use a different gender on social media than what I generally identify myself with.
3. At the beginning of my teenage I was given appropriate sex education.
4. I am fully aware of the various risks of teenage pregnancy.
5. I believe that teenage pregnancy results from a lack of sex education.
6. I know all the different methods of contraception
7. I am comfortable speaking about sexual health with friends of the opposite sex.
8. I understand the concept of consent in sexual relationships.
9. Appropriate communication with my partner can improve our sexual relationship.
10. I feel comfortable addressing sexual concerns with my parents
11. I feel masturbation is an act of shame.
12. I believe that in a sexual relationship, both partners should be equally concerned with each other's pleasure as they are with their own.

13. Sex is a basic human physical need like every other basic human needs of hunger, thirst, safety and security, etc.
14. I believe sex education and talking about sex openly should be normalized
15. I understand that inability to release the built up sexual energies may lead to sexual frustration which in turn can affect mental health
16. Sex education is essential for preventing sexually transmitted diseases in youth
17. I know about the different types of sexually transmitted diseases.(STD's)
18. I am comfortable with the sex assigned to me at birth and know the difference between sex and gender.
19. Sex education is unethical and unnecessary.
20. Parents and teachers are the only ones responsible for teaching kids about sex education
21. I feel guilty after engaging in any sexually arousing activities or fantasizing about those.
22. I watch pornographic content often.
23. I learnt about sex by watching pornographic content.
24. I follow social media handles/contents related to sex.
25. I am comfortable sharing photos of my private parts with strangers
26. I accept follow/friend requests from strangers who post explicit photos of themselves.
27. A man and a woman both should share the responsibility of birth control.
28. I do not hesitate to involve in unprotected sex.
29. I engage in sexually pleasurable activities (like masturbation) independent of any partner.
30. I believe porn always shows the truth about sex.
31. I believe that actors in pornographic films always enjoy the act of sex.
32. I believe the sexual enhancement pills that are often shown in advertisements work.
33. I believe media (movies/videos/songs) that degrade sexual intercourse are good.
34. At the beginning of my teenage, I was given appropriate sex education.
35. I believe it is inappropriate to engage in sex during adolescence.
36. Masturbation has no side effects to health
37. I believe a partner is not necessary to experience sexual stimulation
38. The ultimate goal of any sexual activity/engagement with a partner must be an orgasm.
39. I think pleasure is not equivalent to orgasm but it's about the entire journey of sexual experience.
40. I believe sex can be solely defined in terms of sexual intercourse.
41. I believe sex education can escalate engaging in sexual activities.
42. I am aware of the different sexual identities, orientation
43. I am aware of the LGBTQ community.
44. Learning about sexual education may lead to more sexual assaults.
45. I am familiar with the various biological terminology for private parts
46. I believe sexual intercourse should only be done after marriage
47. Society looks down on talking about sexual education
48. I prefer searching for my doubts on sexual education online rather than asking a person

Psychometric properties

The original sample for which the scale was developed in 2022 consisted of 252 young adults (between 18-25 years of age) in India. The scale generally has high reliability and

good content validity. To obtain norms for a sample similar to your own, you must search the academic literature to find research using similar samples.

Reliability

- Internal consistency is in the range of .805 to .824, and Cronbach's alpha for various samples are in the range of .795 to .812
- The Sexual Health Awareness Scale presented high ratings in reliability areas; internal consistency was 0.805.

Validity

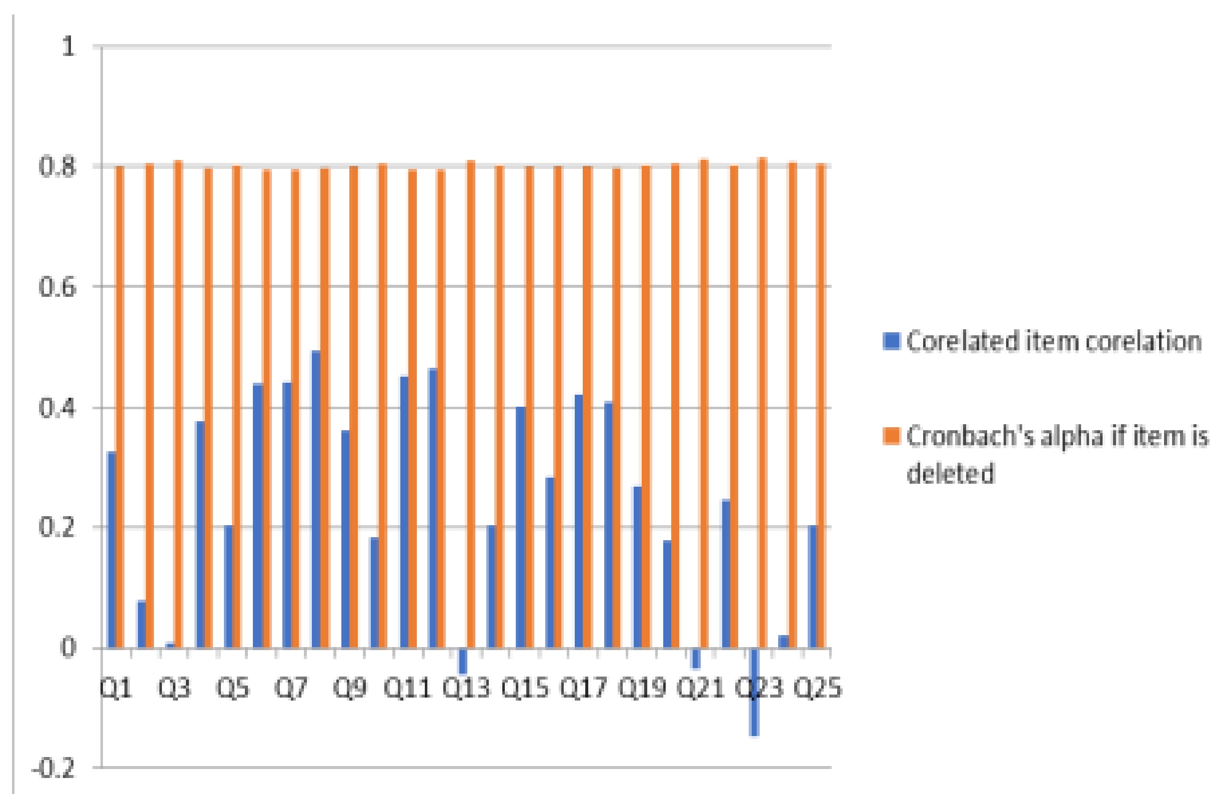
This scale has good content validity as the mental health professional's expertise in this field. These include

1) **Ms. Roseline Florence Gomes:** Assistant Professor Department of psychology Jyoti Nivas College Bangalore
2) **Vasundharaa S Nair:** Senior Research Fellow - UGC Dept. of Psychiatric Social Work, NIMHANS, Bengaluru
3) **Ms. Aishwarya N:** Assistant Professor Department of psychology Christ(Deemed to be University), Bangalore

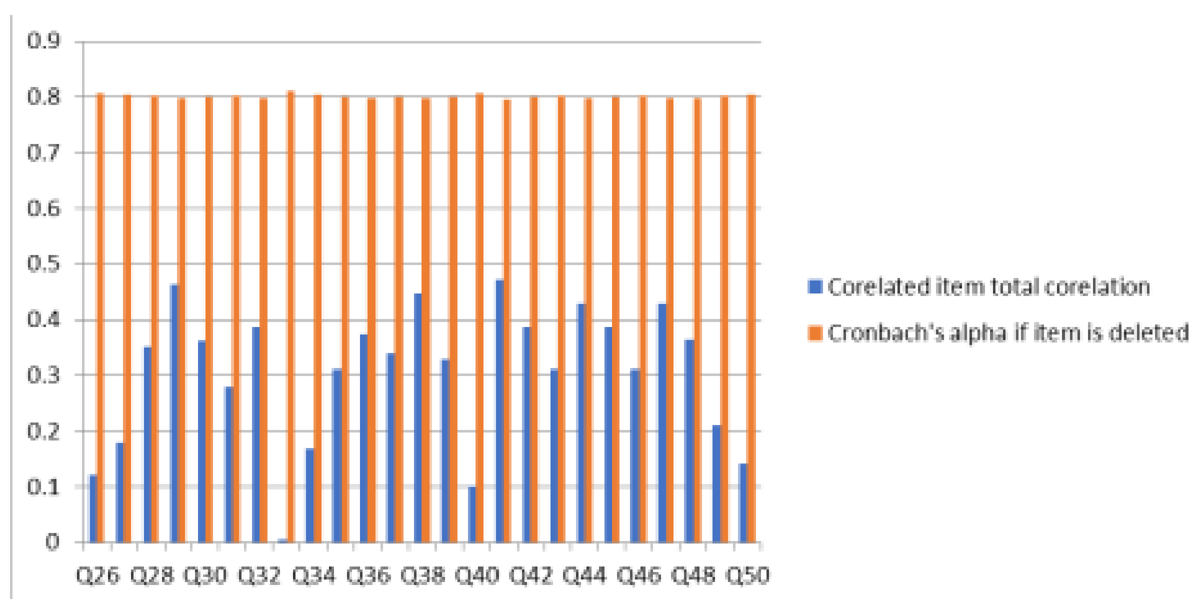
Interpretation

The aim of the present research was to develop a tool that measures sexual health awareness of the young adulthood population. The data was put into SPSS and reliability analysis was performed. The Cronbach's alpha was found to be 0.78 and after deleting 2 items, the correlation was increased to 0.804.

Diagramatic representation 1 (Analysis of questions 1-25)



Diagrmatic Representation 2(Analysis of questions 26-50)



It can be observed that the 6th question i.e., “I know all the different methods of contraception” has an item-total correlation of .439, which can be interpreted as a good correlation with other items. The item is based on awareness about sexual health which the scale is aiming to measure. Being aware of all the different methods of contraception is important before making any decision about engaging in sexual activity with a partner and it contributes to sexual well-being. Therefore, this is a good item.

It can be seen that the 7th question i.e., “I'm comfortable speaking about sexual health with friends of the opposite sex” has a corrected item correlation of 0.440, which can be interpreted as a good correlation with other items. The item is based on the topic of sexual health conversation with the opposite sex which is a true representation of what the scale aims to measure. It's important to have an open conversation about sex and topics related to it in order to promote and have sexual health awareness. Conversation with the opposite sex is focused on the item because of the boundaries and distinctions set by the society based on gender due to which people are conditioned to be ashamed of talking about these matters with the opposite sex. It's important to know about different experiences related to sex to broaden one's awareness. Hence conversation is important. This indicates that the item is a good item.

The 11th question i.e., “I feel masturbation is an act of shame” has a good correlation with other items with a corrected item-total correlation of 0.451. The item is negatively framed i.e., opposite to what scale is measuring to see the direction of the responses and ensure the item is read properly before responding. The item is good as it measures what it aims to measure. Self-stimulating activities like masturbation are prohibited in many religious and cultural beliefs (Aneja. J, Grover. S, Avasthi. A, 2015) and there is a shame attached to female masturbation in the society (Clayton. W & Humphreys. G, 2017). However, masturbation actually has no side effects to health and in fact, it can be good for health both mentally and physically, contributing to sexual and overall well being.

The 12th item i.e., “I care about my partner's pleasure more than my own” has a corrected item-total correlation of -0.044 which is not indicative of a good correlation with other items. However, this item was decided to be kept because it has a good theoretical

framework. In a sexual relationship, it's important to care about each other's pleasure equally, in the same way as they care about their own for a healthy relationship as sexual satisfaction is important from both sides and influences the relationship (Rokach. A., Patel. K., 2021). It's important to know this for sexual awareness and practice this for promoting good sexual health and well being. Therefore we decided to reframe this item into "I believe that in a sexual relationship, both partners should be equally concerned with each other's pleasure as they are with their own" and keep it.

The 16th and 17th items i.e., "sex education is essential for preventing sexually transmitted diseases in youth" and "I know about the different types of sexually transmitted diseases" has a good corrected item-total correlation of 0.421 and 0.407. It's important to obtain the right sex education to prevent sexually transmitted diseases in youth (Cortínez-López. A, Cuesta-Lozano. D, and Luengo-González. R, 2021) as they are the important population who are primarily suffering from the lack of sex education and poor sexual health well being. It's also important to know different types of sexually transmitted diseases. These are the factors that together contribute to sexual health awareness and sexual well being. These are the factors indicative of a good item for the tool.

The 20th item i.e., "Parents and teachers are the only ones responsible for teaching kids about sex education" has a good correlation with other items with a corrected item-total correlation of 0.179. It's a good item as it's important to be aware of the fact that parents and teachers are not the only ones responsible for it but the media and society as a whole are responsible to promote sexual health. Knowing about this contributes to good awareness of sexual health.

The 21st item i.e., "I feel guilty after engaging in any sexually arousing activities or fantasizing about those" has a corrected item-total correlation of 0.464. The positive correlation and good theoretical framework supported preventing the item from deletion. Guilt experienced after engaging in masturbation or any such sexually arousing activities can be associated with poor mental health (Aneja. J, Grover. S, Avasthi. A, 2015), and the guilt maybe be because of a variety of factors and one of the factors might be lack of sex education leading to poor sexual awareness. Therefore, it suggests that it's a good item.

The 31st item i.e., "I believe that actors in pornographic films always enjoy the act of sex" has a good corrected item-total correlation of 0.362 indicating a good correlation with other items and that it's a good item. It's important to know that the actors do not always enjoy the act of sex as shown in those films because most of the youth of our nation lacks sex education and therefore one of the sources from where they learn about sex is a pornographic film. They tend to believe that whatever is shown is the right thing and the experience of pleasure that is shown applies to everyone. So they try to imitate what is shown in the film. But the truth is those films only set unrealistic standards and the experiences that bring pleasure are subjective and can be different for different people (Quadara. A, El- Murr. A, Latham. J, 2017). Therefore not knowing about the above factors can be attributed to low sexual awareness. The above factors indicate that it's a good item and tends to measure what it aims to measure.

The 41st item i.e., "I believe sex education can escalate engaging in sexual activities" has a good corrected item-total correlation of 0.101 which is indicative of a relatively good correlation with other items. It's a wrong interpretation of people that sex education escalates engaging in sexual activities. Studies show that sex education delays sex among

youths and increase knowledge about reproductive health and results in safe sexual activities (Barnett. B, 1997). Knowing about this fact can significantly contribute to eradicating the stigma attached to sex education and therefore improve overall sexual health awareness among youth. The item is framed in the opposite direction of what the scale aims to measure to see if the people believe in the widely accepted myth about sex education which can have an impact on the level of sexual awareness. Therefore, this item is a good one.

The 45th item i.e., "I'm familiar with the various biological terminology about private parts" has a corrected item-total correlation of 0.429 which is indicative of a good correlation with other items on the scale. Knowing the various biological terminology about private parts is important to determine sexual health awareness. Therefore, the item measures what the scale intends to measure, which is indicative of a good item.

When the questionnaire was initially designed, it comprised 50 questions. Two of these items were removed after being subject to reliability analysis. The item "I believe that my society is sexually uninformed" has a corrected item correlation of -.195. The value of Cronbach's alpha also remains close to .79 after deletion, suggesting an increase in the Cronbach's value. The item "I always use the internet to clarify my doubts whenever I am curious about subjects related to sex" has a corrected item correlation of -.053. The value of Cronbach's alpha also remains close to .792 after deletion, suggesting an increase in the Cronbach's value. It was also discovered that the aspects measured by this question were measured by a similar question. Therefore, these two questions were deleted.

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Conflict of Interest

The author declared no conflict of interest.

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Appendix

Appendix A Table A1

Item no. Corrected Item-Total Correlation Cronbach's Alpha if Item Deleted

Q1 .326 .800 Q2 .078 .806 Q3 .007 .811 Q4 .377 .798 Q5 .204 .803
Q6 .440 .796 Q7 .441 .795 Q8 .495 .797 Q9 .360 .800 Q10 .184 .805
Q11 .452 .796 Q12 .464 .795 Q13 -.044 .811 Q14 .203 .803 Q15 .402
.799 Q16 .283 .801 Q17 .422 .799 Q18 .408 .797 Q19 .268 .802 Q20
.179 .804 Q21 -.036 .812
Q22 .246 .802 Q23 -.147 .815 Q24 .012 .807 Q25 .121 .805 Q26
.204 .803 Q27 .121 .806 Q28 .180 .805 Q29 .351 .801 Q30 .462 .797
Q31 .362 .799 Q32 .279 .801 Q33 .386 .798 Q34 .006 .811 Q35 .167
.805 Q36 .310 .800 Q37 .373 .798 Q38 .339 .799 Q39 .446 .797 Q40
.329 .800 Q41 .101 .807 Q42 .472 .796 Q43 .386 .799 Q44 .311 .801
Q45 .430 .797 Q46 .364 .798 Q47 .211 .803 Q48 .142 .805

Table A2

Cronbach's Alpha Cronbach'
Alpha Based on Standardized Items
N of items
.805 .824 48

Appendix B

S. H. A. S: Sexual Health Awareness Scale

Stuti Parasha Kashyap
Ashwathy A N
Shalini Pai
Serena Ajith
Akhila Asokan

Please fill up the following information:
Name:
Age:
Gender:
Education:
Date:

Instructions:
There are some statements given in the following pages, read each statement carefully and choose the option you think is the most appropriate. There are five alternatives for each statement- Strongly Agree (SA), Agree (A), Neutral (N), Disagree (D) and Strongly Disagree (SD). Put a cross mark (X) against the option you choose. **However, choose the Neutral (N) option only if you absolutely do not agree with the other options.**
SA- Strongly Agree
A- Agree
N- Neutral
D- Disagree
SD- Strongly Disagree

Sexual Health Awareness Scale (S.H.A.S)

SN	Questions SA A N	D	SD
1	I expect my partner to imitate the same behaviour that I see in pornography.		
2	I feel that I need to use a different gender on social media than what I generally identify myself with.		
3	At the beginning of my teenage I was given appropriate sex education.		
4	I am fully aware of the various risks of teenage pregnancy.		
5 6 7	I believe that teenage pregnancy results from a lack of sex education. I know all the different methods of contraception I am comfortable speaking about sexual health with friends of the opposite sex		
8 9 10 11	I understand the concept of consent in sexual relationships. Appropriate communication with my partner can improve our sexual relationship. I feel comfortable addressing sexual concerns with my parents I feel masturbation is an act of shame.		
12	I feel guilty after engaging in any sexually arousing activities or fantasizing about those.		
13	I care about my partner's pleasure more than my own		
14	Sex is a basic human physical need like every other basic need of hunger, thirst, safety, security, etc.		
15	I believe sex education and talking about sex openly should be normalized		
16	I understand that inability to release the built-up sexual energies may lead to sexual frustration which in turn can affect mental health		
17	Sex education is essential for preventing sexually transmitted diseases in youth		
18	I know about the different types of sexually transmitted diseases.(STD's)		
19	I am comfortable with the sex assigned to me at birth and know the difference between sex and gender.		
20	Parents and teachers are the only ones responsible for teaching kids about sex education		
21	I watch pornographic content often.		
22	I learnt about sex by watching pornographic content.		
23	I follow social media handles/content related to sex.		
24	I am comfortable sharing photos of my private parts with strangers		
25	I accept follow/friend requests from strangers who post explicit photos of themselves.		
26	A man and a woman both should share the responsibility of birth control.		
27	I do not hesitate to involve in unprotected sex.		
28	I engage in sexually pleasurable activities (like masturbation) independent of any partner.		
29	Sex Education is unethical and unnecessary.		
30	I believe porn always shows the truth about sex.		
31	I believe that actors in pornographic films always enjoy the act of sex.		
32	I believe the sexual enhancement pills that are often shown in advertisements work.		
33	I believe media (movies/videos/songs) that degrade sexual intercourse are good.		

34	At the beginning of my teenage, I was given appropriate sex education.		
35	I believe it is inappropriate to engage in sex during adolescence.		
36	Masturbation has no side effects on health		
37	I believe a partner is not necessary to experience sexual stimulation		
38	The ultimate goal of any sexual activity/engagement with a partner must be an orgasm.		
39	I think pleasure is not equivalent to orgasm but it's about the entire journey of sexual experience.		
40	I believe sex can be solely defined in terms of sexual intercourse.		
41	I believe sex education can escalate engaging in sexual activities.		
42	I am aware of the different sexual identities, orientation		
43	I am aware of the LGBTQ community.		
44	Learning about sexual education may lead to more sexual assaults.		
45	I am familiar with the various biological terminology for private parts		
46	I believe sexual intercourse should only be done after marriage		
47	Society looks down on talking about sexual education		
48	I prefer searching for my doubts on sexual education online rather than asking a person		

S. H. A. S

Scoring manual for Sexual Health Awareness Scale

Question Number Scoring
3, 4, 5, 6, 7, 8, 9, 10, 13, 14, 15, 16,17, 18, 19, 26, 28, 34, 36, 37, 39, 42, 43, 45, 47 **SA A N D SD** 5 4 3 2 1
1, 2, 11, 12, 20, 21, 22, 23, 24, 25, 27, 29, 30, 31, 32, 33, 35, 38, 40, 41, 44, 46, 48

SA A N D SD
1 2 3 4 5

Calculate the Total score and interpret using the following table.

Total Score Interpretation.
177 - 240 High level of Sexual Health Awareness
113 - 176 Average level of Sexual Health Awareness
48 - 112 Low level of Sexual Health Awareness