Let's Talk about Sex: The Link between Sex Education and Self-poisoning in Sri Lanka

While mental illness is a leading cause of suicide in high-income countries, Grace Crowley discusses the results of a study that identified inadequate sex education as a possible risk factor for self-poisoning in Sri Lanka. She argues for a nuanced approach to suicide research, using mixed-methods to better understand the drivers of self-harm and suicidal behaviour in low- and middle-income countries.

Sri Lanka used to have one of the highest suicide rates in the world, largely driven by self-poisoning with pesticides. The dramatic reduction in suicide rates following the banning of several hazardous pesticides in 1995 is often cited as a public health success story. However, suicide and self-harm are still common in Sri Lanka; in 2019, self-harm was the 8th most common cause of death, in comparison to neighbouring India where it was the 14th. While the rates of suicide from pesticide poisoning may have fallen, a trend towards using (often less fatal) medicinal and other substances for the purposes of self-harm has led to an exponential increase in the number of hospital admissions for self-poisoning. Therefore, identifying risk factors and targets for prevention of self-poisoning is as important as ever.

Suicide and self-harm are complex, multifactorial phenomena. Currently, there exists no tool or algorithm that can accurately predict who will die by suicide and who will not. What we do know is that the "who, why, when and how" of self-harm and suicide are likely to vary by geographical location. For example, while mental illness is an important risk factor, a lower prevalence of psychiatric disorders has been found among those who self-harm or die by suicide in low- and middle-countries compared to in high-income countries.

Qualitative research in this area is key because it provides detailed narratives around acts of self-harm and suicide. In other words, speaking to people can paint a picture of the preceding events (and possible contributing factors) in a way that statistics cannot. While every person's narrative will be unique, patterns can emerge that provide clues as to specific sets of factors, characteristics, or points in the lifespan when people may be more likely to self-harm or attempt suicide.

Qualitative research in Sri Lanka has identified that self-harm often occurs in the context of interpersonal disagreements or family conflict. When researchers interviewed young women who had self-harmed, along with their mothers, they noticed the contributing role of societal norms around sex, modesty and shame, and perceptions of 'forbidden' or 'unacceptable' relationships. In some settings, pregnancy out of wedlock (or even expressing knowledge of sex before marriage) could ruin a woman's reputation, lead to removal from the family, or ostracisation from society. With this in mind, it isn't a huge leap to suggest that the way sex is perceived, discussed, and taught may be linked to self-harm and suicidal behaviour.

The opportunity to explore this area arose when Dr Duleeka Knipe (epidemiologist at the University of Bristol) met with local stakeholders in Sri Lanka to develop a research protocol. The aim was to find out whether there is an association between childhood adversity and self-poisoning. This was done by interviewing two groups of people: patients who were admitted on a hospital toxicology ward for the medical management of self-poisoning ("cases") and outpatients/visitors to the hospital ("controls"). It was during one of these research development meetings that members of a local non-governmental organisation suggested asking participants about their experience of sex education. The team developed three questions relating to

- receipt,
- quality, and
- usefulness

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of sex education, which were included in the research interview.

Once the study was completed, we decided to conduct an exploratory analysis to see if there was evidence of a link between sex education and self-poisoning in the data that had been collected.

The analysis found that roughly 1-in-3 people who had self-poisoned and 1-in-5 controls reported not receiving any sex education.

> **A key finding was that individuals who did not receive sex education were 68% more likely to have self-poisoned than individuals who had received sex education.**

We also found that the self-reported usefulness of sex education was important, with those receiving sex education they deemed "not useful" being almost twice as likely to have self-poisoned than those who received "useful" sex education.

Does this mean that receiving useful sex education is protective against suicide? We can't make that conclusion based on this study alone, for three main reasons:

- The study was not designed to answer this specific research question;
- The sex education questions had not been validated, that is, we do not know whether the choice of wording accurately captured the actual receipt, quality and usefulness of sex education the participants had received;
- It's highly likely that some participants did not feel comfortable discussing sex in this context, due to shyness or stigma.

> **Notwithstanding these limitations, the results suggest that there is an association between sex education and self-poisoning in Sri Lanka – a clue which warrants further research.**

There are myriad mechanisms through which sex education could alter the lives of young people such that they do not end up self-harming or attempting suicide in the future. The benefits of good quality sex education are considered to extend beyond preventing unwanted pregnancies and STIs – it can lead to healthier relationships, protect against domestic violence, and provide a space for open dialogue on topics such as gender and sexuality.

The point at which sex education is delivered in schools is an opportune time to intervene in the lives of young people by providing them with knowledge, which may in turn empower them, leading to population-level change in attitudes and behaviours. This type of change undoubtedly takes time and shifting societal attitudes on any topic is no easy feat. Improving sex education in Sri Lanka would require buy-in from parents, teachers and politicians, as well as religious and community leaders. As an example of the scale of the challenge, a recent attempt by the Ministry of Education and the Ministry of Health to introduce a Grade 7 sex education textbook was met with public outrage.

To those of us based in high-income countries, a possible link between sex education and self-harm may seem tenuous. But in settings where sex and relationships are not openly discussed, and where crossing the boundaries of social norms can have serious repercussions, the association makes sense. We need to work towards a nuanced, life-course approach to suicide prevention, which is both data-driven and grounded in qualitative and anthropological research. The results of this exploratory analysis suggest that, in Sri Lanka, improving access to useful sex education should be an area of focus going forward.

This research was first presented in Crowley, G., Bandara, P., Senarathna, L. *et al.* Sex education and self-poisoning in Sri Lanka: an explorative analysis. *BMC Public Health* 22, 26 (2022), https://doi.org/10.1186/s12889-021-12374-4.

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