

Adolescent sex education in India: Current perspectives

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Sex education is defined as a broad program that aims to build a strong foundation for lifelong sexual health by acquiring information and attitudes, beliefs and values about one's identity, relationships, and intimacy. Sexual health is considered to be a state of physical, emotional, mental, and social well-being in relation to sexuality and not merely the absence of disease or infirmity as defined by the WHO.^[1] Psychological and sociocultural influences in the delivery of this education can increase the likelihood of effectiveness. Primarily, during adolescence (10–19 years) its provision is a crucial preventative tool, as it is the opportune time when young people experience developmental changes in their physiology and behavior as they enter adulthood.^[2] The complex emotional state in which youth find themselves in, stigma surrounding matters of a sexual nature in the Indian society and widespread gender inequality faced makes it increasingly challenging for adolescents to attain the knowledge they need. Through what is termed “family life education” (FLE), we can hope to teach the roles and responsibilities of males and females toward each other in all relationships in familial and social contexts, thus endowing the knowledge necessary to maintain sexual health as they navigate through the vulnerabilities of life.^[2] However, the existence of strong stigma and controversy handicaps any existing adolescent health programs, with them being incomprehensive and failing to fully address the main health issues adolescents are vulnerable to. These include several negative sexual and reproductive health outcomes,^[3] such as early and closely spaced pregnancy, unsafe abortions, sexually transmitted infection (STI), HIV/AIDS, and sexual violence, the rates of which are already increasing at a disturbing rate.

NEED FOR SEXUAL EDUCATION FOR INDIAN ADOLESCENTS

The importance of delivery of sex education in a timely fashion to this significant demographic is emphasized by current statistics that show that almost one in every fifth person on the globe is an adolescent.^[4] They comprise

18% (1.2 billion) of world's population in 2009, with 88% living in developing countries. India has the largest adolescent population (243 million with more than 50% of the adolescent population living in urban areas). These figures indicate the importance of specifically addressing the healthcare needs of this considerable demographic, particularly for the developing countries such as India.^[5] Recent literature suggests that at this time they are highly likely to experiment and engage in the types of risky behaviors that have the potential to influence the quality of health and probability of survival in both short- and long-term over their lifetime. Therefore, meeting the needs of such a vulnerable group and overcoming existing shortcomings in the delivery of tailored primary preventative measures would significantly improve the survival and general health conditions, nutritional status, and sexual and reproductive health of the future Indian adult population.^[6] This encompasses issues such as early pregnancy, unsafe abortions, STIs including HIV, and sexual abuse and violence.

THE CURRENT SCENARIO IN CLINICAL SETTINGS

The sexual and reproductive health needs of adolescents^[7-10] in India are currently overlooked or are not understood by the Indian healthcare system. This could be owing to the lack of knowledge of scientific evidence along with the gross unpreparedness of the public health system. Healthcare professionals often lack the knowledge themselves that impacts upon imparting information to the adolescent population who seek it. Often comprehensive sexual histories are not taken, and sexual health is not openly discussed due to cultural and traditional norms in society. Incorrect information has the potential to create misunderstanding in the youth making them less likely to adopt healthy practices and attitudes toward sex enabling them to maintain lifelong sexual health.

A HOLISTIC PERSPECTIVE

In addition, the skills, adolescents develop from sexuality education are linked to more general life-skills, such as communication, listening, decision-making, negotiation and learning to ask for, and identify sources of help and advice

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such as parents, care givers, and professionals through the family, community, and health and welfare services.^[11] These useful life-skills are not only applicable to sexual relationships but also in other aspects of life. They are taught to recognize situations in which they are pressurized by others and how to resist and deal with these, along with challenging long-standing prejudices they are faced in day to day life.

A CULTURAL CHALLENGE

Public discussion of topics of a sexual nature are widely considered as taboo in the Indian society, therefore acting as a barrier to delivery of adequate and effective sexual education to Indian adolescents. Sex education at school level has attracted strong objections and apprehension from all areas of the society, including parents, teachers, and politicians, with its provision banned in six states which include Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Chhattisgarh, and Karnataka. Legislators contend that it corrupts the youth and offends “Indian values,” leading to promiscuity, experimentation, and irresponsible sexual behavior. Some opponents argue that sex education has no place in a country such as India with its rich cultural traditions and ethos. These views lie at the heart of the traditional Indian psyche and will need to be approached tentatively with psychological insight when challenged. Expertise from healthcare professionals along with patience and time will be required in order to bring about what is likely to be a gradual change in the existing conservative attitudes.^[12]

A CHANGING CLIMATE AND THE ROLE OF THE MEDIA

Proponents argue that these conservative views are outdated in a fast modernizing society such as India, with an ever-growing adolescent population adopting rapidly evolving attitudes toward sex. Mass media has had a highly influential, yet mixed impact, on the Indian way of life. By helping bring sexual topics into discussions through the powerful mediums of television, radio, and the internet, it has allowed recognition of the urgent need to address the misinformed or uninformed youth. With studies showing that the majority of parents do not accept the responsibility for providing sex education, with 88% of the male and 58% of the female students in colleges in Mumbai reporting that they had received no sex education from parents. They were left to resort to information they gather from books, magazines, youth counselors, and through pornography, with its increasing accessibility in recent times. Those exposed to sexually implicit content on the television and internet is more likely to initiate early/premarital sex, which comes with a host of negative implications which they often find themselves unequipped to deal with. This applies to a quarter of India's young people who indulge in premarital sex.^[13]

A recent study states cable television is associated with a significant decrease in the reported acceptability of domestic violence toward women and a general increase in women's autonomy, potentially through increased participation of women in household decision-making.^[14] Such ideas can be supplemented and reiterated through FLE in schools, involving medical staff, teachers, and peers by correcting the attitudes toward inequalities arising from the traditional perception of gender roles in India. Reports of United Nations Children's Fund, UNAIDS, and the United Nations Population Fund support the effectiveness of sexuality education program in the USA and other parts of the world in recent decades. India can also stand to reap such benefits from wide-spread implementation of the similar program, especially with data to suggest a strong willingness and receptiveness of adolescents, particularly females to being properly educated in this area.

GENDER ISSUES

The long-standing tradition in which girls are married very early, especially in rural areas, often to men much older gives rise to many pregnancy-related problems. Complications arising from the pregnancy and unsafe abortions are a leading cause of death among women aged 15–19 years, with 20% of the group experiencing childbearing before 17 years of age, with pregnancies often closely spaced. The risk of maternal mortality among adolescent mothers stands twice as high that of mothers aged 25–39 years. Education about family planning, conception, and contraception could ameliorate the situation and give the young women the opportunity to make their own informed decisions.^[15] However, in rural areas socioeconomic barriers such as lack of literacy and school attendance can stand as barriers to the primary level at which sex education acts as a preventive measure. For instance, data from major household surveys suggest that the prevalence of perceived importance of FLE was relatively high among the youth (81%) in India. However, only 49% of women actually received FLE due to vast demographic and socioeconomic differentials within the population. Only the relatively mature unmarried women (20–24 years) residing in urban areas with more than 10 years of education, engaged in nonmanual occupation, and coming from better-off families had higher prevalence of perceived importance of and receiving FLE than others.

THE HIV EPIDEMIC

More importantly, adolescents in the age group of 15–24 years contribute to a disproportional 31% of AIDS burden in India, despite the whole demographic comprising about 25% of the country's population. According to the last UNAIDS report,^[16] there were 2300,000 people of 15 years and above, living with HIV in India, with one youth infected with HIV/AIDS almost every 15 s (Population Foundation of India, 2003). In India, 19% of girls and 35%

of boys have comprehensive knowledge of both HIV and AIDS. Evidence suggests that early diagnosis and treatment of STIs/reproductive tract infections (RTIs), which include behavior change through education among the target groups, has the potential to reduce considerably the transmission of STIs/RTIs. This includes information about the spread of the disease, contraception, and sexual health screening tests. In this way, well-designed school sex education can help combat the culture of ignorance, hesitation, shame, and fear associated with the disease in the community, from which the disease is born. This can only be achieved by scrapping away deep rooted and widely accepted misconceptions and speculations.

A TOOL TO COMBAT RISING SEXUAL ABUSE AND VIOLENCE

Prevalence of sexual abuse, violence, and physical abuse are increasing among the adolescence and are increasingly co-occurring with substance abuse. A study on child abuse in India, conducted by the Ministry of Women and Child Development, reports that 53% of boys and 47% of girls surveyed faced some form of sexual abuse.^[17] Therefore, FLE might help the vulnerable young population to be aware about their sexual rights and empower them to protect themselves from any undesired act of violence, sexual abuse, and molestation. The nongovernmental organization (NGO), Nari Raksha Samiti, had submitted that sexuality education in school curricula could play a role in addressing the rise of rape cases in India.

Adolescents find themselves at a vulnerable stage of their lives where influences of peer pressure can be conducive to socially unacceptable and perhaps even criminal group behavior. The rapidly emerging rape culture among youth needs to be addressed and stopped at the earliest possible instance. This requires concentrated efforts not only from institutions and organizations, but also from individuals as members of that society, as sexual offenders often have mental health and psychosocial risk factors that incite, maintain, and perpetuate the offence. This can be achieved through education about sex and drugs and teaching the use of ethical and moral principles to govern their actions, in order to discourage ambiguity and the development of careless, unhealthy, and potentially dangerous attitudes. The Committee on the Rights of the Child (CRC, WHO), published guidelines in 2013 on the rights of children and adolescents and issued guidelines on states' obligations to recognize the special health and development needs and rights of adolescents and young people. This has been further envisaged in WHO Report in 2014 titled "health for the world's adolescents." In order to adhere to these guidelines when providing sex education, the expertise of healthcare professionals becomes indispensable in educating not only the students but also the teachers educating them.^[10,18] Psychiatrists and psychologists have a key leadership role

in constructing focused FLE program which introduce these potentially emotionally challenging issues to the youth of India with consideration of psychosocial and cultural factors.

A HUMAN RIGHT PERSPECTIVE

Sexuality education is perceived as a basic human right that falls under the broader title "reproductive rights" as emphasized by reputable NGO's such as the Family Planning Association of India and International Planned Parenthood Federation as well as the World Association for Sexual Health (WAS). The recent revision to the WAS Declaration of Sexual Rights (2014) emphasizes the need at statement 10 - The right to education and the right to comprehensive sexuality education that everyone has the right to education and to comprehensive sexuality education. Comprehensive sexuality education must be age appropriate, scientifically accurate, culturally competent, and grounded in human rights, gender equality, and a positive approach to sexuality and pleasure (www.worldsexualhealth.org), on the basis that sex education impacts general health, adaptation to the environment, quality of life, and helps to live optimally by choice.^[19] With India being one of the signatories to the 1994 United Nations International Conference on Population and Development (ICPD), it is obliged to provide free and compulsory comprehensive sexuality education for adolescents and young people as part of commitments made under the ICPD agenda. According to the United Nations Human Rights Council Report by not providing sex education, this violates the human rights of Indian adolescents and young people as recognized under international law.

THE STRUCTURE OF THE CURRENT NATIONAL PROGRAMMES IN INDIA

The current existing program of sexual education incorporate in the Indian curriculum is termed adolescent FLE and was proposed by National AIDS Control Organization and the Ministry of Human Resources and Development. The major objectives of family life/sex education (FLE) can be broadly described as follows:

- To develop emotionally stable children and adolescents who feel sufficiently secure and adequate to make decisions regarding their conduct without being carried away by their emotions
- To provide sound knowledge not only of the physical aspects of sex behavior but also its psychological and sociological aspects, so that sexual experience will be viewed as a part of the total personality of the individual
- To develop attitudes and standards of conduct that will ensure that young people and adults will determine their sexual and other behavior by considering its long-range effects on their own personal development, the good of other individuals, and welfare of society as a whole.

More specifically, the program includes but is not limited to the following topics: Human sexual anatomy, sexual reproduction, reproductive health, reproductive rights and responsibilities, emotional relations, contraception, and other aspects of human sexual and nonsexual behavior.

SHORTCOMINGS OF THE PROGRAMME

Previous backlash with regards to the provision of sex education in schools has meant that a conservative approach has been adopted. Talking about reproductive and sexual health issues (TARSHI), a NGO in New Delhi argues after review of the material covered in this new curriculum, that it is lacking components that are essential to comprehensive sexuality education.^[20] Their critique of the new curriculum stems from the 60,000 + calls they have received on the helpline they run on sexual information. People of all ages call the confidential helpline seeking information about sexual anatomy and physiology, counseling and referrals regarding sexuality and reproductive health issues.

Analysis showed that 70% of the callers were below 30 years of age, while 33% were in the age group of 15–24 years, which indicates that young people do have the need, but lack an adequate authentic source to receive appropriate and correct information in a positive manner. It suggests that the curriculum imposes beliefs and values on young people that prevent them from clarifying their own beliefs and values and discourages them from making their own decisions. The subjects which seem to be ill-addressed by the current curriculum include puberty and the body, conception and contraception, healthy relationships and communication, gender identity, body image, and HIV prevention.

Among those who received formal family life/sex education, household surveys reveal that the majority did, in fact, feel that FLE answered many of their anxieties/queries and the teacher/trainer explained the subject well. However, 21% of men and 37% of women also reported that they felt embarrassed while attending family life/sex education. This, in a way, suggests that the curriculum and the method of teaching should be context- specific and culturally sensitive.

A closer look at the demographic profile of the TARSHI helpline callers demonstrates that calls come from married individuals more so than unmarried individuals. This illustrates how queries do not only arise as a result of teenage experimentation, but sexuality information is also needed for those who are older and have spouses and careers and children. Myths regarding sexuality issues, even among the elderly and educated people, can be illustrated though looking at popular columns in the Indian newspapers, such as Dr. Mahendra Watsa's column in Mumbai Mirror. This existing lack of knowledge can also be rectified for the long-term through improving provision of sex education in

schools, youth clubs, and government programs. Another way of targeting the adult population in addition to the youth is through proactive training of general practitioners and other health professionals to impart crucial knowledge at a primary care level that evidently a considerable proportion of the Indian adult population lacks.

CONCLUSION

Provision of FLE might result in multiple benefits to the adolescent boys and girls including delayed initiation of 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 curb of the spread of sexually transmitted diseases including HIV. Balance between the eagerness and ambitious proposals of NGO's to implement varied sexuality education in schools and the restrictive approach of the politicians needs to be achieved to ensure that the process of imparting sex education to stakeholders is well measured and less controversial. Incorporation of expertise from healthcare professionals such as Psychologists, social workers, Psychiatrists, Obstetricians and Gynecologists, and Genito-Urinary Physicians can help tailor the existing program so they are more likely to be effective in the medium to long-term in impacting the attitudes and behavior of adolescents of India in such a way it reflects positively on their general and sexual health.^[5]

Financial support and sponsorship

Nil.

Conflicts of interest

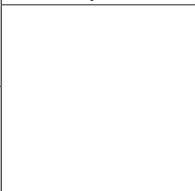
There are no conflicts of interest.

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