Module 2: Evidence based approaches to sexuality education for adolescents - Adolescent health and development with a particular focus on sexual and reproductive health - Assignment

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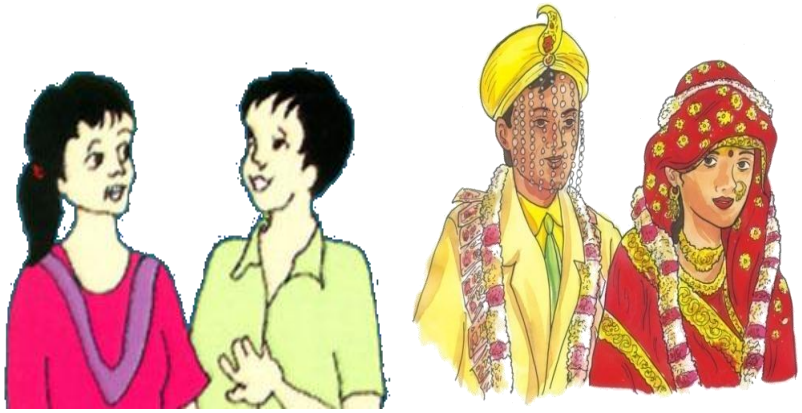
Task: List and describe Country specific barriers to expanding or improving sexuality education for adolescents and based on resource material provided, suggest ways to overcome the existing barriers.



## Introductory Comments

India is the second most populous country in the world with total population of over 1081 million. Adolescents (10-19 years) form a large section of population – about 22.5 percent, i.e. 225 million. They are living in diverse circumstances and have varied health needs. The total population of young people (10 – 24 Years) is approximately 331 million comprising nearly 30 percent of the total population of India (Census 2001).

Most young people become sexually active during adolescence. In the absence of right guidance and information at this key stage, they are more likely to have multi-partner unprotected sex with high-risk behaviour groups. They are also less likely to have information on contraception and the risks of contracting HIV and means of protecting themselves from the infection. Such youth may face repeated risk of HIV infection through sexual exposure due to coercion or other compulsions and unwanted pregnancies.

Physiologically, young people are more vulnerable to STIs than adults; girls more than boys. Gender imbalances, societal norms and economic dependence contribute to this risk. Lack of access to correct information (almost 73 percent of young people have misconceptions about modes of HIV transmission), tendency to experiment and an environment which makes discussing issues around sexuality taboo, adds to their vulnerability. Sexually transmitted infections (STIs) present a large burden of disease and debility. As per a recent STI prevalence study (NACO 2003), over five percent of adult population in the country (India) suffers from STIs.

## Existing Policy and Program Scenario

In recent years, given the concerns about population stabilization, improving maternal and child health and the emerging HIV/AIDS epidemic in India, the Government of India's National Rural Health Mission (NRHM) and National AIDS Control Organization (NACO) have identified adolescents and youth as a specially vulnerable group. It has been recognized that they need to be equipped with knowledge, changed attitudes as well as skills that will enable them to adopt responsible behavior and protect them from both unwanted infections and unwanted or too early pregnancy. Comprehensive reproductive health (RH) education will help them understand the need for adopting responsible reproductive and sexual behavior as they mature into adulthood and marriage.

The Tenth Five Year Plan recognizes adolescents as a distinct group for policy and program attention. The National Population Policy 2000 identifies adolescents as an underserved group for which health, specifically reproductive and sexual health interventions are to be designed. The National Youth Policy 2003 recognizes 13-19 years as a distinct age group, which is to be covered in programs of all sectors, including health, education, science and technology, etc. In this regard, the Youth Ministry has devised special programs for adolescent health and empowerment. The National Curriculum Framework 2005 for School Education explicitly highlights the need for integrating age appropriate adolescent reproductive and sexual health, including HIV/AIDS messages into the school curriculum. This framework is translated into the National Adolescence Education Program of the Ministry of Human Resource Development-NACO, which proposes 100 per cent coverage of all secondary and higher secondary schools with HIV/AIDS prevention and Adolescent Reproductive Sexual Health messages. In keeping with the spirit of convergence under the MoHFW's NRHM, 2005, the RCH II ARSH strategy emphasizes the need for inter-sectoral linkages with other departments at the policy and program levels.

## Barriers to expanding or improving sexuality education in India

Despite having many policies and programs in place, there are many practical hurdles to executing and expanding sexuality education in India. Some of the most salient barriers are as follows:

- Lack of uniform and comprehensive reproductive health and sexuality education: The reproductive and sexual health needs of youth have long been ignored by decision-makers. Whilst there is a lot of awareness generated on the need to address youth related issues no concrete steps have been taken by the Government to equip them with knowledge, changed attitudes and skills that will enable them to adopt responsible behavior and protect them from early marriage, unwanted infections and unwanted or too early pregnancy. They need to be given reproductive health education that helps them make informed choices to facilitate responsible reproductive and sexual behavior as they mature into adulthood and marriage. Access to youth friendly services is also an important dimension, which needs to be addressed.
- Orthodox beliefs and traditional practices: Women aged 15-19 account for almost one-fifth India's total fertility. Studies have shown that health and mortality risks increase

both for the woman and for her child when women give birth at such young ages. Reproductive health and family planning programs avoid working with this age group, however, for fear of going against deeply ingrained traditional, social, cultural and gender norms. Most Indian families still promote early marriage and childbirth as a means for establishing the women's capacity for fertility. Societal conditioning and pressure to prove fertility, combined with a lack of knowledge and access to contraceptive and reproductive health services, tend to overwhelm young couples' fledging interest in spacing or delaying childbearing.

- Gaps in Inter-sectoral collaboration and convergence: Due to the tendency to have vertical programming, very little convergence is seen between departments to judiciously plan and utilize funds to avoid replication and to ensure effective comprehensive sexuality education. Different mandates and lack of collaboration leads to problems in expanding and sustaining existing programs and spending the earmarked funds for specific programs/activities. Hence, interventions seem sporadic and one-off rather than holistic.
- Lack of political and bureaucratic Will: While the above-mentioned policies do show that the need for sexuality education for adolescents/youth is clearly recognized, political whims and fancies disrupt the smooth implementation of the programs and the bureaucrats too tend to tow the line rather than trying to keep such programs a-political. A recent example was the Adolescent health curriculum developed by NACO for schools------ some political parties banned it in their States because of which there was a setback in the roll out which hampered effective implementation. No specific logical explanations and pro-activeness was undertaken by the political leaders to rectify the situation and ensure that the program is suitably re-modeled. Unfortunately, the holistic adolescent health program was dubbed as 'sex-education' and was also hyped by the media. This then brought in many religious groups/leaders into the foray wherein it was debated that it is against the culture and ethos of the country and western influence was the cause for such programming.
- Non-availability of adequate and appropriately trained personnel: Capacity building is a herculean task for a country as large as India. Since this kind of education is very sensitive, it is imperative that the people involved in imparting this education are adequately involved. In addition, schoolteachers are ill equipped and over burdened and hence find this education as an extra-curricular activity and an additional task for which they are not receiving any remuneration. Teachers themselves have negative attitudes vis-à-vis this education and feel that it is the role of others/NGOs to conduct such programs and that if they were involved in this education they would lose respect among their peers and students (especially when it comes to condom demonstrations, contraceptive knowledge etc.) In fact it is commonly seen that biology teachers hardly ever even teach the chapter on 'human reproduction' to students due to embarrassment and lack of appropriate vocabulary to handle this chapter sensitively. This in itself leads to a huge gap since students could benefit a lot from understanding this crucial topic itself.
- Lack of resources to reach the last mile: Most sexuality education programs undertaken by the Govt. are school based. In India a large number of adolescents, especially girls drop out from school. Hence, it is imperative to have community-based programs (both

urban and rural) to reach out to the out-of school population. While NGOs do try to bridge this gap by having community-based programs, the outreach is limited and not what the Govt. programs can achieve. Currently the Govt. does not have community based adolescent RH and sexuality education programs that reach all adolescents.

- Sexuality education camouflaged under life skills education: Often in many schools it has been seen that programs claim to be giving RH and sexuality based information to students under life skills education but the content is not comprehensive enough to bring about the desired behaviour change. Methodology used for such education/training is often didactic and diluted, while we know that only participatory methodology and experiential/simulation techniques (role-play, games, activities etc.) can help adolescents learn the appropriate techniques for negotiation, decision-making etc to make informed choices.

## Suggestions on overcoming above mentioned barriers

Global evidence suggests that working with adolescents and youth and equipping them with the requisite knowledge, attitudes and skills on reproductive and sexual health ensures positive behaviour and in many cases delay in sexual debut, appropriate planning of families and overall improvement of quality of life. A single most critical intervention that can make a huge difference in achieving the MDGs (goals 1,2,3,5 &6) is 'comprehensive sexuality education'. As specified in IPPF's Framework this education must address 7 essential components/elements: gender, sexual and reproductive health and rights and HIV/AIDS (including information about services and clinics), sexual citizenship, pleasure, violence, diversity and relationships. Innovation, creativity, and involvement of youth themselves in planning and execution can lead to widespread acceptance and dialogue and involvement of all stakeholders and gatekeepers is essential.

Donors like the UN agencies and INGOs and Foundations too should have uniform agendas and work collaboratively to influence the policy makers in a proactive way and help build consensus and ownership right from the outset in order to avoid instances where political fall-out can sabotage a very sound policy/program.

The evidence-based approaches mentioned in the UNESCO documents on 'International Technical guidance on Sexuality Education' provide sound strategies that can help overcome many of the above-mentioned barriers. Sharing of the evidence and data with policy makers and implementers that good programs can bring about change in sexual behaviors and delay initiation of sex, reduce unwanted pregnancies and sexual risk-taking will go a long way in trying to overcome the current crisis vis-à-vis adolescent health education in schools in India. The basic minimum package for a sexuality education program to be effective should also be standardized across all States in India and inter-sectoral collaboration should be encouraged and facilitated.

The 'Levers of Success' case-studies documented by UNESCO provides with very crucial factors that need to be adhered to in order to ensure that barriers to expansion and strengthening Govt. efforts for comprehensive and holistic sexual education is handled effectively. The most critical factors that need to be adhered to are ensuring political will at all levels and proactive participation, allies among decision-makers and implementers, adequate quality capacity

building of key personnel, support of donors, involvement of youth in the true sense, active advocacy and involvement of all key stake holders including parents and communities.

## Concluding Comments

Despite evidence-based programming and policies, in India it is seen that while currently definite resources have been earmarked for adolescent interventions under the flagship program (National Rural Health Mission), the National AIDS control program and the School Health Programs (Ministry of Human Resource development), gaps are seen in implementation and utilization of funds at the field level. Many State Governments are still grappling with the programming aspects and in actually operationalizing adolescent health education programming and services.

There is no dearth of resources in terms of funds, tools, frameworks and curriculum including global evidence that sexuality education has very positive outcomes among adolescents and youth and helps them develop as responsible and resourceful individuals who can improve the state of their families, country and the World as a whole. The challenge before us is to ensure effective rollouts and implementation which will ensure that adolescents & youth are reached till the last mile and Governments are able to effectively scale-up the evidence-based programs. The most beneficial messaging and programming is to make an economic argument to change behaviours at an individual level as compared to only health outcome messaging. Most youth want a better quality of life as compared to what they have grown up with; this desire alone can help them see the benefits of improving their lives by ensuring that they lead a risk-free life and have a family that they desire and are not encumbered with children 'by chance' instead of 'by choice'. Governments need to realize the potential that the youth have to make a difference and public health professionals should continue in their endeavours to ensure that this is achieved.

## Assignment documents


1. IPPF. From evidence to action: Advocating for comprehensive sexuality education. London: IPPF; 2009.
2. UNESCO. International Technical Guidance on Sexuality Education. Volume I. The rationale for sexuality education. Paris: UNESCO; 2009.
3. UNESCO. International Technical Guidance on Sexuality Education. Volume II. Topics and learning objectives. Paris: UNESCO; 2009.
4. UNESCO. Levers of Success. Case studies of national sexuality education programmes. Paris: UNESCO; 2010.