

WE DON'T NEED NO EDUCATION?: THE CHALLENGES OF IMPARTING SEXUAL HEALTH EDUCATION IN INDIA

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ABSTRACT

This paper deals with the scenario of sex education in India. The social and political orthodoxy on several levels has made it difficult for the state machinery to actively impart sex education to adolescents. However, educating the teenage demographic on reproductive health has strong links with promoting awareness about sexual well-being and gender violence. The paper begins with the history of sexual health education in relation to state policies. Subsequently, it makes a case for the possibilities it provides in increasing health standards across multiple demographics and simultaneously spreading awareness about larger issues of gender violence and disparity. The next section surveys prevailing government policies on sex education, its presence, priorities and its blind spots. Then, the paper reviews the work of the NGO sector in broadening access to reproductive health education and their areas of specialisation. Finally, the paper contains policy recommendations regarding the proper formulation and implementation of sex education in India for adolescents and low income households in rural regions.

Keywords: HIV-AIDS, UNICEF, Women and Children Development, PTSD, NPEP

Introduction

Sex education is defined as the formal teaching of human sexuality from the perspectives of biology, psychology, sociology and law. This includes biological aspects such as sexual anatomy, sexual reproduction, reproductive health, methods of contraception and as well as study of social and psychological processes of consent, reproductive rights and the idea of abstinence. Historically, adolescents in many cultures have not received any form of formal sex education, primarily because of the taboo around the subject. The progressive education movement of the 19th century brought this subject to the mainstream as sex education started being adopted in schools across North America (Tupper, Kenneth). However, due to the continuance of stigma around sexuality, most information on sexual matters was circulated through informal media channels in the twentieth century. Such information tended to be inaccurate, unscientific and misleading. After World War II, increasing levels of teenage

pregnancies in the United States forced its governments to adopt state-sponsored sex education programmes, despite strong opposition from religious groups (Tupper, Kenneth). To turn to another continent, the outbreak of HIV-AIDS in countries in Africa significantly increased the value placed by society on sex education; it was seen as one of the most suitable methods to tackle the epidemic (Namibia National Policy on HIV/AIDS for the Education Sector). According to SIECUS, by the mid-1990s, every state in the United States of America had passed mandates for formal education on AIDS (sometimes tied to general sex ed and sometimes not). Therefore, for the majority of the twentieth century, the presence of state-controlled discourse on sex education has been prevalent primarily in western liberal democracies and countries facing HIV epidemics.

In the twenty-first century, sex education also occupies an important position in feminist discourse. International organizations like Planned Parenthood claim that broad sex education helps in the advancement of women's rights (Huffington Post). In fact, there are several interlinked issues that form a part of both sex education and feminist ideology such as the concept of consent and safe sex. Furthermore, the importance of sex education in feminist discourse is proven by the fact that patriarchal societies attach stigma to female sexuality. The control that a woman should have over her reproductive system has historically been thwarted by multiple institutions. Thus, when conversations on abortions and usage of birth control began in the sphere of study of sex and reproduction, they were seen as a step in the direction of gender equality. These conversations form the focal point of the feminist movement.

Religious institutions provide a significant hurdle to the project of sexual health education; the problems vary from religion to religion. For example, Christianity, most notably, takes issue with the endorsement of contraception, as it runs in contradiction with the idea of the sanctity of human life. Similarly, Islam taboos imparting sex education because it establishes a continuum between knowledge of sex and practising it, which is considered a sin before marriage. Hinduism attaches stigma to sex education because it challenges the patriarchal norms that come along with Hindu culture. This has made the fight for sex education a difficult one when viewed from a social, cultural or political lens. However, state sponsored sex education at public schools and community events have been successful in western liberal democracies. According to SIECUS, the Sexuality Information and Education Council of the United States, 93% of adults they surveyed support sexuality education in high school and 84% support it in junior high school. Other channels of sex education for adolescents include parents, caregivers and private entities such as Planned Parenthood. Thus, the issue of state-sponsored sex education is intricately tied its secular character (or lack thereof).

Need for Sex Education in India

Large-scale gender violence is one of the most significant reasons for the need for sexual health education in India. Most noticeably, the sex ratio in India stands at 943 girls for 1000 males in 2011 (The Lancet). A major reason for this disparity is the wide-scale practice of female foeticide and infanticide. MacPherson estimates that 100,000 abortions every year continue to be performed in India solely because the fetus is female. Potential mothers are socialised to believe that having a female child is detrimental to their family, either economically or socially. Patriarchy induces people to believe that female children are a burden on the family. This has led to large levels of female foeticide. Moreover, there have been several cases of female infanticide in India. Sheetal Ranjan reports that the total male and female infanticide reported cases in India were 139 in 1995, 86 in 2005 and 111 in 2010. In both scenarios, the prevalence of fallacies regarding sex in societies leads to the victimisation of the female parent; the mother is held responsible for determining the gender of the child. It is precisely the widespread belief in these fallacies about sex that makes it important to impart sex education in adolescents. A related problem is that of premature pregnancies and abortions. Pregnancy outside of wedlock carries severe social stigma in India. Medical termination of pregnancy is available to the elite and the attitude of the providers towards such women is not amicable. As a result, attempts are made to abandon the child or undertake unsafe abortions. Such high levels of social stigma and mental trauma have led to cases of suicide amongst newly married women. Thus, imparting wide-scale sex education will work toward addressing issues of societal pressure and will empower women to make more informed decisions about their sexuality.

However, most Indian households are conservative and prohibit discussions about sex because of the stigma attached to it. In rural areas and urban slums, girls are often married early and they don't go into marriage equipped with any knowledge of sex. This manifests itself on a larger scale. According to UNICEF, about 240 million women alive in India today were married before the age of 18 (Hindustan Times). This only focuses on a part of the need for sex education in India. A study commissioned by the Indian Ministry of Women and Children Development and carried out by UNICEF. The study revealed that a shocking 53% of children between 5 -12 years of age had experienced some forms of sexual abuse in India. That is nearly more than half of the children. Such levels of abuse can often lead to PTSD, depression and anxiety amongst individuals when reach adulthood. Without sex education, children are often left in fear and vulnerable, and are consequently unable to articulate their experience and achieve any kind of physiological or psychological redressal. Sex education is formulated with the very intention of raising awareness about grievance redressal mechanisms in case of harassment or molestation. Therefore it is extremely imperative to teach children what conduct is inappropriate, not just for

ensuring civil conduct on their part, but also to increase their ability to call out problematic behavior that induces life-long mental illnesses on victims.

HIV and STI prevention is another major front at which sex education proves as the most effective artillery. More than four million people are estimated to be infected with HIV in India – the highest proportion of any country in the world (International Journal of STD and AIDS). According to National AIDS Control Organization of India, the prevalence of AIDS in India in 2015 was 0.26%, which is down from 0.41 in 2002. It estimated that 2.11 million people live with HIV/AIDS in India in 2015. HIV and other sexually transmitted diseases can be simply prevented by the use of contraception, which is the focal point of sex education. Apart from HIV, there are several other sexually transmitted infections (STIs) that can be prevented by raising the levels of awareness about these diseases and their respective contraception methods.

Government Initiatives: Past and Present

Sex education in India is dispensed through government and non-profits alike. There are three levels at which it operates: sex education for adolescents, family planning for young married couples and HIV-AIDS awareness and prevention. This section elaborates upon governmental initiatives on all these fronts, and the respective areas in which further work is required.

In recent times, there has been a shift in the state machinery's perception of sex education. While multiple governments have shied away from sex education, a few of them in the recent past have been working toward institutionalising sex education in various ways. The Ministry of Human Resource Development, for example, has adopted the National Popular Education Programme (NPEP), which is being implemented in 30 States and Union Territories according to data provided by Government agencies. The NPEP aims at imparting authentic knowledge to learners about Adolescent Reproductive and Sexual Health (ARSH) concerns, inculcating a positive attitude toward sexual health, and developing appropriate life skills for responsible behavior around reproduction and sex. Moreover, a roleplay and activity-based module called the School Health Programme, will be imparted in government schools across the country with the help of specially trained teachers and peer educators (selected school students). This was flagged by Prime Minister Narendra Modi himself under Ayushman Bharat, a national health protection scheme as reported by the Hindustan Times. The module will address various aspects of growing up including sexual and reproductive health, sexual abuse, good touch and bad touch, nutrition, mental health, sexually transmitted diseases, non-communicable diseases, injuries and violence and substance abuse in an age-appropriate manner. The 22-hour programme is a joint initiative by the Union Health Ministry and the Ministry of Human Resource Development and is expected to benefit 26 crore adolescents. Ayushman Bharat covers over 10 crore poor and vulnerable families.

India's family planning programmes are run by the government in conjunction with NGOs. Because these programs are often quota-based, they take two forms: sterilisation programmes and contraceptive programmes. Both use an incentive-based approach, where families are often given domestic rations or cash to undergo procedures of sterilization. Historically, family planning in India has been criticised because of the uneven and unfair impact of programmes to underprivileged minorities. In 2015, the Government of India introduced the National Rural Health Mission that aims at dispensing services including family planning.

HIV/AIDS has been deemed a health crisis in India. Prevention techniques have been set as a priority by the government. HIV/AIDS prevention education in India has been focused on educational materials like newspapers and pamphlets as well as conversations with educated professionals. The National AIDS Control Organisation (NACO) was established in 1992 as a division of India's Ministry of Health and Family Welfare to provide leadership to HIV/AIDS control programme in the nation through 35 HIV/AIDS Prevention and Control Societies. It is the nodal organisation for formulation of policy and implementation of programs for prevention and control of HIV/AIDS in India. In 2010, NACO approved the TeachAIDS curriculum for use in India, an innovation which represented the first time that HIV/AIDS education could be provided in a curriculum which did not need to be coupled with sex education.

Nonetheless, sex education in India still faces considerable opposition from religious and political organisations that hold significant positions of power. The government, therefore has shied away from its burden of dispensing sex education because of the fear of backlash. This fear crosses party lines and goes on to demonstrate how narratives and discourse in India are controlled by orthodox groups and have a direct impact on state policy. Parties from across the political spectrum, leftist parties like the Communist party of India, centrist parties like the Indian National Congress and right wing parties like the BJP have denounced sex education because of the fear of dilution of orthodox indian values. States like Gujarat, Madhya Pradesh, Maharashtra, Karnataka, Kerala, Rajasthan, Chhattisgarh and Goa have taken steps to ban sex education programming.

Private Non Profit Initiatives in India

Non-profit initiatives have historically played a pivotal role in the growth of sex education in India. Unlike parts of the state machinery, these NGOs are not directly accountable to the majoritarian narrative in the country. This social and political independence gives them the ability to implement programmes and policies that lead to positive societal changes. The first of these was the Family Planning Association of India, established as early as 1949. It was established with the goal of providing newly married women support and advice on reproduction and contraception. In 1952, it established its first clinic where to provide advice to family

planning, infertility, and family counseling. It is presently affiliated to the International Planned Parenthood Federation. It has branches in almost all urban centres in India.

The LPG (Liberalization, Privatization, Globalization) era policies of the Indian Government led to the growth of several progressive Non Governmental Organizations. One such example is the Society for Nutrition, Education & Health Action (SNEHA) was established in the 1990s in Mumbai. It works to promote awareness of women's autonomy, health, sexuality and sexual assault prevention. Talking About Reproductive and Sexual Health Issues (TARSHI) was established in 1996 in New Delhi. It works to expand sexual and reproductive choices by operating from an affirmative and rights-based perspective to oppressed women and counter oppressive orthodox narratives and practices. Furthermore, Nirantar Trust started in 1993 works on a similar agenda. It actively works to develop feminist leadership within its fold. The Sonagachi Project was founded in 1992, a peer education program that aims at educating sex-workers in the Sonagachi district of West Bengal (the largest red light locality in Asia) about contraception, sexual health and encouraging them to use condoms. The project has successfully increased condom usage and reduced STD levels among sex-workers in West Bengal.

Founded in 2000, CREA (Creating Resources For Empowerment in Action) works towards a theory of change through building the self-confidence, leadership, and knowledge of women and girls about their sexuality and human rights, and creating feminist platforms to challenge oppressive norms and power structures. It also provides technical assistance to the fellow NGOs, donor agencies and other institutions through strategic planning, legal training, design, planning and implementation. Their operations extend to several states in India and parts of Vietnam. CREA regularly issues publications in English and Hindi. It also allies and collaborates with other feminist and LGBTQ advocacy groups. National Aids Research Institute (NARI) organises sessions at the grassroot level on sexual health and contraception in Maharashtra. Thus, the nonprofit sector has witnessed a proliferation of several organisations that aim to impart sex education (and its allied programs) after the liberalisation of the Indian economy in 1992. While most of these organisations including the ones mentioned above work in urban sectors (as that is where they acquire most of their funding), recently, rural grassroots advocacies have also sprung up to facilitate the inclusion of rural women, children, and men in the process of sex education and reproductive health awareness.

Policy Recommendations

Sex education in India must necessarily revolve around multiple focus points. The first and most important are students. Adolescents are not only the biggest victims of a society where sex education is not the norm, they also control societal narratives in the future. There are certain prerequisites that sex education programmes in schools must have. Firstly, it must necessarily be

empirically accurate and scientifically backed up. The schools must implement an integrated strategy for making contraceptives available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases. Classroom teachers and other professionals who have shown an aptitude for working with adolescents and who have received special training are the most suitable to implement these policies and programmes. Furthermore, it is important to incorporate education on sexual consent, to both children, adolescents and adults. Lastly, ample involvement of parents, health professionals, and other concerned members of the community is required. Most importantly, sex education in publicly funded schools must be free from religious influence. Religion has co-opted sex education as an initiative that focuses only on abstinence. This is largely ineffective and leads to increase in rates of unprotected sex.

The second focal point must be the implementation of programs in rural regions which show comparatively lower levels of literacy and social development. Sex education is needed to break the hegemony of orthodox religious narratives in the field of sexuality. Sex education and family planning end up improving the lives of families with low income backgrounds. Therefore, it must carefully be implemented to ensure that people realise the benefits of something that might seem very radical to them. Consent and contraception must be specially emphasised. It is imperative that people understand the idea of consent to reduce the cases of rape and sexual assault that happen in India, especially rural regions where consent is not seen as an active choice that people make. Education about consent goes a long way in tackling the pervasive rape culture existing in the nation. Condoms must be made readily available at cheap rates in Indian villages so that sex education does not remain an abstract idea but something that can be implemented in reality to make a positive change.

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