



When Knowledge is Power To Prevent

School Based Sexuality Education Programme



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Contents

List of Tables and Figures	i
Foreword	iii
Acknowledgments	v
Executive Summary	vii

CHAPTER I: INTRODUCTION

1.1: Background	1
1.1.1: Programmes to raise awareness about reproductive and sexual health issues	3
1.1.2: Stakeholders' view about school based Adolescence Education Programme	4
1.2: Rationale for the study	4
1.3: Objectives of the study	6
1.4: Organization of the report	6

CHAPTER II: METHODOLOGY

2.1: Study area and population	7
2.2: Study design	9
2.2.1: Selection of intervention schools	11
2.3: Data collection tools	11
2.4: Ethical considerations	11
2.5: Primary data collection & quality control	11
2.6: Data analysis	12
2.7: Limitations of the study	14

CHAPTER III: PROCESS OF DEVELOPING A CULTURALLY SENSITIVE CURRICULUM

3.1: Needs assessment	15
3.1.1: Literature and existing curriculum review	15
3.1.2: Review of existing school curricula in Science & Biology	15
3.1.3: KAP survey of students	16
3.1.3.1: Physical and mental changes during adolescence	16
3.1.3.2: Perceptions about masturbation	17
3.1.3.3: Attitude regarding premarital sex	17
3.1.3.4: Protection against HIV	17
3.1.3.5: Gender related issues	17
3.1.4: Stakeholders' survey	17
3.1.4.1: Stakeholders' perspective on sexuality education in school	18
3.1.4.2: Stakeholders' perspective on possible outcome of this education	18
3.1.4.3: Stakeholders' perspective on the question of who should deliver this education	18
3.1.4.4: Stakeholders' perspective on possible content for sexuality education	19

3.2: Curriculum development	20
3.2.1: Stakeholders of the curriculum	20
3.2.1.1: Schools	20
3.2.1.2: Students	21
3.2.1.3: Trainers	22
3.2.1.3.1: Training for the trainers	23
3.2.1.3.2: Transaction of the curriculum	24
3.2.1.3.3: Frequency of sessions	24
3.2.1.3.4: Processes followed in the school	25
3.2.1.3.5: Constraints and challenges faced by trainers	26
3.2.1.4: School authorities	27
3.2.2: Developing an incremental curriculum	28
3.3: Challenges faced during implementation	31

CHAPTER IV: AWARENESS & EXPERIENCE OF REPRODUCTIVE AND SEXUAL HEALTH ISSUES

4.1: Awareness about changes during puberty	33
4.2: Awareness about sex determination	37
4.3: Awareness about risk associated with adolescent pregnancy	37
4.4: Awareness about contraceptives and safer sex	39
4.5: Awareness about STIs	40
4.6: Awareness about transmission/prevention of HIV/AIDS	41
4.7: Awareness about sexual harassment and sexual abuse	42
4.8: Perception about premarital sex	45
4.9: Sexual experience and condom use	46

CHAPTER V: COMMUNICATION, AWARENESS ABOUT LAWS AND ATTITUDE TOWARDS GENDER ISSUES

5.1: Communication with peers and parents	49
5.2: Awareness about laws, legislations	49
5.3: Attitude on gender issues	49
5.4: Substance use	52

CHAPTER VI: PERCEPTION ABOUT THE CURRICULUM & ITS IMPACT

6.1: Stakeholders' view on the programme	55
6.2: Trainers' perception about students' response to the program and impact of the curriculum	57
6.2.1: Students' response to the programme: Trainers' perceptions	58
6.2.2: Impact of the curriculum: Trainers' perceptions	58
6.3: Students' opinion about the program	58
6.3.1: Students' opinion about course curriculum	58
6.3.2: Students' suggestions regarding curriculum delivery	59

6.3.3: Perceived changes in peers	61
6.3.4: Changes perceived by students in their own self	61
6.3.5: Students' perception on challenges facing youth today	62

CHAPTER-VII: SUMMARY AND CONCLUSION

7.1: Summary	65
7.2: Sustainability	67
7.3: Future steps	67

References	71
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Annexures

Annexure I: Knowledge, attitude and practices of class VIII students on selected sexual and reproductive health issues, Rewari, 2004	73
Annexure II: Framework for the curriculum-Seven steps to an informed adolescence	74

Abbreviations	81
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List of tables and figures

Table 2.1: Selected demographic and SRH indicators of India, Haryana and Rewari	7
Table 2.2: Health facilities and educational institutions in Rewari, Haryana	8
Table 2.3: Percentage of de facto household population age 6-17 years attending school in the 2005-06 school-years by sex, residence and age, Haryana	8
Table 2.4: Sample size	12
Table 2.5: Number of students exposed to the programme over three years, among respondents in Post Test Class X	13
Table 2.6: Exposure to sessions in classes IX and X	14
Table 3.1: Number of students in each year of intervention	21
Table 3.2: Mean age of students in classes, during each intervention year	22
Table 3.3: Number of contacts, sessions and time period during which sessions were conducted in each year	24
Table 3.4: Number of contacts and sessions conducted during each academic year	30
Table 4.1: Awareness about body and changes during puberty	34
Table 4.2: Awareness/ perception about Menstruation, Nightfall and Masturbation	35
Table 4.3: Awareness about sex determination	37
Table 4.4: Awareness about risk associated with adolescent pregnancy	38
Table 4.5: Awareness about contraceptives and safer sex	39
Table 4.6: Awareness about RTI/STI	41
Table 4.7: Awareness about transmission & prevention of HIV	43
Table 4.8: Awareness/perception about eve teasing	45
Table 4.9: Perception about Premarital sex	46
Table 4.10: Sexual experience	46
Table 4.11: Condom use	47
Table 5.1: Communication with peers and parents	50
Table 5.2: Awareness about laws, legislations	50
Table 5.3: Awareness/perception about gender difference in the society	51
Table 5.4: Decision to have a baby should be made by both partners	51
Table 5.5: Awareness about substance use	52
Table 5.6: Substance use	53
Table 6.1: Source to avail the SRH knowledge	60
Figure 2.1: Number of students attending each session over three years	14

Foreword

Young people have the right to knowledge and information about sexuality and sexual and reproductive health, in order to understand the process of growing up, with particular reference to their sexual and reproductive health needs. This is true in Sweden, in India and all over the world.

Sexuality education and information is a way to support and prepare young people for living a responsible and positive sexual life. It should enable each and every individual to work towards learning how he/she wants to live and towards discovering what is right or wrong for him/her.

Guiding stars are knowledge instead of ignorance, openness and facts instead of mysteries, and acceptance of young people's sexuality, relationships and love – with or without a partner.

The Swedish Association of Sexuality Education (RFSU) regards the right to sexuality education and information as a cornerstone in the prevention of HIV, sexually transmitted diseases, unwanted pregnancies and sexual and gender-based violence.

To understand the differences between Sweden and India it is important to know two things. First, in Sweden sexuality education is compulsory in schools and has been since 1955. Second, there is hardly any opposition to sexuality education in Sweden. It is included as a part of the general health objectives for public health work and often referred to as an important part of prevention and promotion of sexual health.

In India there is no compulsory sexuality education and it is controversial to include the issues in the school curriculum. Despite this, MAMTA Health Institute for Mother and Child implemented a study on school based sexuality education programme in Haryana between 2004 – 2008. This study aimed at developing an appropriate sexuality education curriculum in consultation with stakeholders, implementing the curriculum in schools, and evaluating its effects in urban and rural settings.

The content of the sexuality education covered three main themes, adolescent growth and development, sexual and reproductive health, and development of life skills, where issues of gender, sexuality and rights were integrated.

One significant result from the study is that both boys and girls from intervention schools are able to identify and reject common misconceptions on masturbation. Another is that students respond at endline that they “know how to use condoms properly”. These results are incredibly important, and show that the implementation has been effective in supporting the students to “live a responsible and positive life”. Apart from these specific results MAMTA also received insights in the processes that can facilitate this type of programmes in schools, and an evidence base for advocacy for expanding sexuality education into the school system.

Future challenges are, to meet the opposition, and to fight such moral and traditional values and attitudes that are likely to cause a backlash in the development towards improved rights to young people, in a changing world.

Finally, to develop a comprehensive sexuality education incorporated in the school curriculum, involves hard advocacy work on all levels in the society, but will eventually result in increased sexual and reproductive health for India's millions of young women and men.

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RFSU

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We wish to acknowledge the unstinting support provided by the District Education Officers in Rewari, DIET in Haryana and the school authorities of the Boys' and Girls' Senior Secondary Schools in Rewari and Bawal. It is their conviction in the Adolescence Education Programme that helped us to carry out this study over a period of four years.

We cannot thank enough the students in the four intervention schools who embraced our programme with such zeal and fervour and were ever willing to share their feedback and suggestions about various aspects of the programme. Without their participation, this programme would not have evolved into its present form.

Executive summary

As young people stand on the threshold of adulthood, they need authentic knowledge that helps them to understand the process of growing up, with particular reference to their sexual and reproductive health needs. In India the entire issue of 'sexuality education' has been mired in controversy and has been a topic for much political debate and media discussion over the past few years. Rather than discussing the most promising and relevant approaches to provide sexuality education, the debate is still centered on whether sexuality education should even be included as part of the school education. At the same time there is a growing body of evidence from across the country that establishes the fact that a small but significant proportion of adolescent boys and girls are sexually active, most often in circumstances where they are unable to use 'protection' either due to lack of information or means to do so.

Presently there is very little robust evidence about the most appropriate and effective ways to educate school-based adolescents in India about sexual and reproductive health issues. The urgency of this research gap is apparent not only in the context of India's HIV threat, but also in the growing recognition that there are risks and limitations in simply adopting educational models from other countries because of cultural and social differences, as well as disparities in available funds and materials for implementation. This study aims to respond to the gap in the evidence base on effective school-based sexuality education programs in Indian settings.

As the terms sexuality education often evokes strong reactions from various quarters, a more acceptable term, '*Adolescence Education*' has been used. The study was conducted in the period 2004-2008, in a total of four schools: two schools each (one boys' and one girls' school) in urban (Rewari) and rural (Bawal) settings in the state of Haryana, with total cohort strength of about 500.

Important steps in the initial phase were to seek permission from the relevant authorities in the district education department and the school (Principals, and School In-Charge) and wide based consultation with stakeholders. This led to the programme being largely endorsed by various stakeholders -District Education Officer, DIET representatives, parents, teachers and students. Regular feedback and consultation, over a period of three years, helped the intervention team to address various challenges including opposition from some of the school teachers.

During the first phase (September 2004 – August 2005), Adolescence Education Framework for Classes VIII, IX and X was developed, based on consultation with stakeholders and Needs Assessment that also served as the baseline. In the second phase (September 2005 – January 2008), specific curriculum was developed and then delivered incrementally to the same cohort, year by year, as they have progressed from class VIII to class X, by a group of trainers from outside the school system. A pre - post test quantitative questionnaire based on each year's curriculum and Year End Review (FGDs and IDIs) was used to assess the change in KAP in each academic session and making incremental changes in the curriculum. During the last phase, (February-December 2008), the impact of this study was assessed through an endline survey, process evaluation, class evaluation and feedback from students and stakeholders on perceived acceptability.

A comparison was made between students in Class X (students who were part of the intervention) and Class XI (students in same school but not part of the intervention), in four intervention schools. The

results from baseline (2004) and endline (2008) carried out in the four intervention schools plus other schools in the area were also included in the final analysis.

Amongst the respondents, a significantly larger number of girls were exposed to the programme over three years as compared to boys. Overall among class X students, 54 % had been exposed to the programme over a period of three years and 90 % over 2 years.

An analysis of the data shows significant change in knowledge and attitude among students who received the intervention, but more so in case of girls. Change of similar magnitude is not visible amongst male students and may be linked to the level of exposure to the programme as well as the academic performance and school environment in general.

Some of the **key findings** are as follows:

1. Change in knowledge

- Comparison of data from baseline and endline study, reveals that irrespective of the location of school, boys and girls from intervention schools are able to identify (and reject) common misconceptions about masturbation (such as masturbation leads to impotency, causes sexual dysfunction, deformity of the sexual organs, causes weakness) and nocturnal emission. The difference in knowledge is statistically significant in all the four intervention schools as compared to their counterparts.
- Irrespective of location of school and sex of the students, higher percentages of the students from class X correctly identify all 4 or at least 3 symptoms of STI (redness/ itching in genital area, foul smelling discharge from vagina/ penis, burning sensation during urination, pain abdomen in females) compared to students from class XI.
- One of the most interesting findings in context of HIV is that statistically significant percentages of students in Class X are able to reject all myths related to HIV transmission when compared to Class XI, which did not receive the intervention.
- Statistically significant difference is observed among Class X girls (compared to girls in Class XI) in terms of the understanding that oral pills cannot provide protection against STIs/HIV.

2. Attitude on gender issues

- Statistically significant numbers of girls in class X (92 percent RG and 95 percent UG) feel that the decision to have a baby should be made by both the partners when compared to girls in Class XI.
- Less percentage of boys in urban (47 percent versus 57percent) and rural schools (53 percent versus 64 percent) and girls in urban school (35 percent versus 47 percent) agree to the statement that 'men make better decisions than women' when compared to students in the non intervention class. The difference is statistically significant in all three schools.

3. Attitude towards condom use

- Statistically significant numbers of Class X students respond at endline that they 'know how to use condom properly'.
- A statistically significant percentage of girls in the intervention schools (78 and 33 percent in rural and urban school respectively) compared to girls in control schools (5 and 10 percent in rural and urban respectively) would reportedly 'decline to have sex without a condom'.
- At the endline, 80 percent of boys and 89 percent of girls in the rural schools, 69 percent of boys and 32 percent girls in the urban schools agree that a girl can suggest the use of condom to her boyfriend. This result is statistically significant in all the four groups when compared to the control groups.
- 67 percent of boys in rural school, 84 percent of boys in urban school, 69 percent of girls in rural school and 27 percent of girls in urban school agree that a boy can suggest the use of condom to his girlfriend. When compared to students in the control group, this finding is statistically significant in all groups, except rural boys.

4. Dealing with sexual abuse and violence

- When asked about possible actions that can be taken when faced with sexual abuse, a higher percentage of girls from Class X (intervention group) responded that they would 'oppose it then and there'. Statistically significant numbers of class X students in urban schools responded that when faced with sexual abuse they would 'oppose it then and there' and also 'confide in an elder trusted person'.

5. Attitude on premarital sex and reported sexual activity

- Interestingly, when asked at the endline if 'it was alright to have premarital sex', more girls in the intervention group agreed with the statement as compared to girls in the control group. However the opposite was true for boys- more boys in intervention schools when compared to boys in the control groups disagreed with it.
- 47 percent (n=21) of boys in rural school and 40 percent (n= 18) in urban school have reportedly had a sexual experience (sexual intercourse) as compared to 14 percent (n=12) and 15 percent (n=7) respectively by boys in rural and urban control groups. At the same time, 7 percent (n=6) and 10 percent (n=22) of girls in rural and urban schools respectively report a similar experience compared to 3 percent (n=3) girls in rural and 5 percent (n=12) urban control groups.

6. 'Educators' for Adolescence Education Programme

- 41 percent of class X boys from rural school and 68 percent from urban schools would reportedly like adolescence education to be imparted by the class teacher while 52 and 64 percent prefer to receive it from the teacher from the same school (but not the Class teacher).

- The school authorities unanimously endorsed the need for a school- based 'Adolescence Education Programme', albeit with some scepticism about the capacity of teachers to undertake such a programme and expressing reservations about issues (like condoms, abstinence vs. safe sex) that should be discussed.

Conclusions

The review of Sex and HIV education programmes from many developing and developed countries has shown that programmes that impact on mediating factors like knowledge, perception of HIV risk, personal values about sex and abstinence , perception of peer norms and others have a positive effect on sexual behaviour and on condom and contraceptive use. The results from this study demonstrate a significant impact on many of the mediating factors, which is likely to have a positive effect in preventing unwanted pregnancies, STIs and HIV among the students in the future.

It is apparent from the study that for any 'Adolescence Education Programme' to be effective, it has to be delivered over a period time, at least 3 or more years, so as to ensure optimum exposure of all students to the content and an opportunity to discuss related issues as they gain in trust and confidence. Since such programmes are currently not part of the regular school curriculum and total number of contacts and the number of hours over which it is delivered are limited, this becomes even more important. Secondly, the sustainability of the programme will depend, to a great extent, on the interest and ownership shown by the teachers. While students are open to receiving this education through teachers, most of the teachers interacted as part of this study, have for various reasons expressed their inability to deliver such a curriculum. Given that teachers also have strong views on the topics that can or should be discussed in classroom settings, books or manuals with basic non negotiable curriculum content along with very clear key messages should also be made available to the students.

Considering that this programme was delivered over a period of three years in school settings and its contents closely match with the revised curriculum for Adolescence Education Programme (by NACO , MHRD), it provides useful evidence about the likely effectiveness of AEP and insights into the processes that can facilitate the delivery of the programme in schools. In this context the results from the present study can be used as an evidence base for advocacy for expanding Adolescence Education in school settings and to further expand understanding of different approaches to sexuality education in India and the South Asia region.

Chapter One

Introduction

1.1: Background

The need for addressing the sexual and reproductive health concerns of young people has grown over time. Several landmark events have highlighted these needs, most notably the International Conference on Population and Development (ICPD) and its Program of Action. At the international level, the ICPD and ICPD 5-year review (ICPD+5) reiterated the importance of providing information, counselling and services for youth, and more generally, respecting the reproductive rights of adolescents and youth. By 1999, the recommendations of ICPD+5 included the direct recognition of young people's vulnerability to HIV and suggested that attention had to be focused on how to reduce prevalence in this age group. Other notable conventions ratified by India that have implications for the reproductive and sexual rights of young people include the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

In accordance with the ICPD Program of Action 7.47 and in collaboration with non-governmental organisations, all governments have been urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in specific areas, such as: gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice and family life, reproductive health and sexually transmitted diseases, HIV infection and AIDS prevention. Furthermore, ICPD Program of Action 7.46 declares that all countries “should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.”¹

There are an estimated 314 million young people (aged 10 to 24 years) in India today, representing almost one-third (31 %) of the population, i.e. adolescents (10 to 19 years) and youth (15 to 24 years). To be exact, 22 percent of the population falls into the adolescent age group of 10 to 19 years. The Census of India (2001) shows that in the age group of 15-19 years, 27 percent of girls and 15 percent of boys are illiterate.² It is generally acknowledged that significant proportions of young people in India experience risky or unwanted sexual activity, do not receive prompt or appropriate care, and experience adverse reproductive health outcomes.³ This is due to lack authentic knowledge on physiological, emotional and social developments that take place during the process of growing from childhood to adulthood. At the same time, an overwhelming number of adolescent girls experience sexual relationship within the context of marriage.⁴ Despite the rising age at marriage and laws prohibiting early marriage (Child Marriage Prohibition Act 2008), 47 percent of all women aged 20 to 24 years were married by the time they were 18 years old and 18 percent by 15 years of age.⁵

The prevailing family system in India emphasises premarital chastity and monogamous marital sex, particularly for women. However, a number of small-scale studies, despite limitations in their designs and methodologies, have found a higher-than-expected level of premarital sexual activity. Studies of sexual behaviour among unmarried urban school and college students reported sexual activity that ranged across different studies from 8 percent to 39 percent in the case of male students and 1-20 percent for female students. Studies in the general population in both rural and urban areas have reported premarital

sexual activity that ranged from 7 – 48 percent for male respondents and 3-10 percent for female students.⁶ Premarital sexual activity is clearly more common among men than women, although some of the differences may reflect over-reporting among males and under-reporting among females.

At the national level, eight percent of the youth (15-24 years) reported sex with non-regular partners during preceding 12 months.⁷ Of all male respondents aged 15-24 years who have heard of male to male sexual behaviour, three percent reported that they themselves have been involved in such behaviour.⁸ Similar results have emerged from the NFHS-III which shows that among the never married youth aged 15-24 years, 0.5 percent of women and 7 percent men have experienced intercourse in the 12 months preceding the survey. Nearly 37 percent of never married young men reporting recent sexual activity used a condom the last time they had sex, compared with less than 18 percent of young women.⁹ Reports (often from qualitative studies) of premarital sexual contacts of men have found a wide variety of partners: sex workers, friends, relatives and future spouses.¹⁰ Among girls, reported premarital sexual contact is mainly with future spouses, friends and relatives.¹¹

Another study shows that in Maharashtra only 33 percent unmarried women aged 15-24 years know they can get pregnant with their first sexual encounter, as compared to 46 percent unmarried men. In Rajasthan, this figure is 27 percent and 28 percent respectively for unmarried women and men. Again, only 61 percent unmarried women, as against 92 percent men, have heard about condoms in Rajasthan. But even among those unmarried women who know about condoms, only 18 percent have correct knowledge in Maharashtra and 25 percent in Rajasthan.¹² This evidence is applicable to all young people; those in and out of school, those living in rural and urban areas and those from different socio economic groups. Nonetheless, it clearly suggests the need to equip adolescents with the information and skills to practice responsible sexual behaviour, to manage peer pressure, to make informed decisions and to say 'no' to risky behaviour.

Evidence reveals that 12 percent of women aged 15-19 years have become mothers and 4 percent of women aged 15-19 years are currently pregnant with their first child. This means that one in six women aged 15-19 years have begun childbearing. The percentage of women, who have begun childbearing, shows a sharp increase with age, from 3 percent at age 15 years to 36 percent at the age of 19.¹³ The adverse health consequences of early childbearing in these circumstances are well known, including damage to the reproductive tract, maternal mortality, pregnancy complications, prenatal and neonatal mortality and low birth weight.¹⁴ Some 15 percent of births to adolescents aged 15 - 19 years in India were reportedly unplanned.¹⁵ The available evidence suggests that this in part is because of the fact that contraceptive use is infrequent and irregular. An analysis of data from NFHS 1998–99 shows a lifetime induced abortion ratio of 1.1 among married adolescents nationally.¹⁶ Among unmarried abortion-seekers, adolescents constitute a disproportionately large percentage in studies addressing this topic. At least one-half of unmarried women seeking abortions at facilities are adolescents, many of who are below 15 years of age.¹⁷

Additionally, 5 percent of the respondents aged 15-24 years reported any self-reported STD symptom in last 12 months.¹⁸ Government statistics indicate that 40 percent of all new sexually transmitted infections are among young people in the age group of 15 to 29 years. Over 31 percent of AIDS burden of all reported AIDS cases in India occur among 15-29 years indicating that many of them are at high risk of contracting HIV

infection. Majority of these young people acquire HIV through unprotected sex. However, only 33 percent (males- 35%, females- 21%) received interpersonal communication on STD/HIV/AIDS in past one year.¹⁹

Abuse, exploitation and violence are unfortunately common for both male and female children, adolescents and young people have a nationwide study conducted by the Department of Women and Child Development, 53 percent children reported having faced one or more forms of sexual abuse and 50 percent abusers are persons known to the child or in a position of trust and responsibility.²⁰ In 2006, 8 percent (1,593) of the total victims of rape were girls under 15 years of age, while 17 percent (3,364) were teenaged girls (15-18 years).²¹

A recent article that reviewed the global literature on youth mental health has found that youth is the stage in which most mental disorders have their onset.²² A high rate of self-harm and suicide is a leading cause of death in young people. Mental health can be strongly correlated with many other health and development concerns for young people, notably with educational achievements, substance use, violence, reproductive and sexual health outcomes. Important behavioural disorders, particularly in young men in India, are alcohol abuse and tobacco abuse. Recent National level data indicates that 4 percent of 15-19 years girls chew and 0.1 percent smoke tobacco while 29 percent of 15-19 years boys chew and 12 percent smoke tobacco. 11 percent of boys of the same age group drink alcohol.²³

1.1.1: Programmes to raise awareness about reproductive and sexual health issues

A number of national and state-specific programmes have been implemented to raise awareness about sexual and reproductive health among young people. While some of these programmes have targeted young people in school, others have focused on those out of school. Some programmes have targeted the population more generally, but have acknowledged young people as a group required special attention. The review suggests that on balance, communication programmes appear to stress HIV and safe sex over other aspects of sexual and reproductive health. Such information delivery mechanisms are far more numerous with regard to HIV, safe sex and condom promotion than other aspects of sexual and reproductive health.

Programmes to build awareness on sexual and reproductive health matters tend to focus on school and college-going youth rather than those out of school. Under the broad heading Adolescent Education Programmes fall two key programmes, namely the National Population Education Programme and the School AIDS Education Programme.²⁴ The earliest and most well known programme to be initiated in the country was the National Population Education Programme, currently known as the Population and Development Education Programme. Launched in the early 1980s, the National Population Education Programme originally aimed to sensitise young people with regard to population and development issues. With the paradigm shift in the 1990s, the National Population Education Programme shifted its focus from demographic issues to reproductive and sexual health and gender issues.²⁵ To further national efforts to promote family life and population education among adolescents, the National Centre for Educational Research and Training, which is responsible for developing national curriculum standards, has incorporated sex education with information on the growth and development of adolescents, life skills and HIV/AIDS into the national curriculum since the mid 1990s.

With the emergence of the HIV epidemic, the Ministry of Human Resource Development, Department of Education and the National AIDS Control Organisation launched a number of HIV/AIDS education programmes in schools and colleges. The School AIDS Education Programme was introduced for students of Classes IX–XII. Sessions were generally conducted in the biology or science class, and included such topics as human anatomy and modes of HIV transmission, prevention and testing. Additionally, the “Youth Unite for Victory on AIDS” campaign, launched in June 2006 by the Ministry of Youth Affairs and Sports and NACO in collaboration with seven National Youth Organisations, also intends to strengthen ongoing efforts to raise sexual and reproductive health awareness among school and college-going students.²⁶

1.1.2: Stakeholders' view about school based adolescence education

NFHS-3 has reported on acceptability of providing information in schools on HIV/AIDS and related family-life topics. Virtually all Indian adults agree that children should be taught moral values in school, and most adults think that children should learn about the changes that occur in their bodies during puberty. Men and women, however, differ somewhat on whether children should be taught in school about contraception. About half of women and two-thirds of men think that girls should learn about contraception in school.²⁷

While youth are ever curious, however they are unlikely to approach their parents for information as young people fear that their parents will become suspicious and misunderstand their curiosity for sexual experience. Parents themselves are unwilling, uncomfortable or simply not well informed to communicate with their children on these matters. The 'Youth in India: Situation and Needs study in Maharashtra' shows that less than 1 percent of unmarried young men and 5 percent of unmarried young women reported that one or both parents had ever talked to them about reproduction or how pregnancy happens.

At the same time, about nine in ten unmarried youth – female and male – believe it is important for young people to have sex education. Most believe that this education should be imparted to youth by the time they are 15-17 years old and about half of them believe that it should be imparted by teachers or others who are considered to be experts. Of those who received sex education, more than eight in ten reported that it had answered many of their concerns, while nine in ten reported that teachers explained things comprehensively. About one quarter of males and two fifths of females reported that they were embarrassed during these sex education sessions.

Findings from several studies show that even where parents and schools do not provide young people information on sexual matters, youth are resourceful and seek to satisfy their curiosity through other channels. Peers are a significant source of information, especially among young men. Unfortunately peers are also likely to be as poorly informed as those who seek information from them, thereby perpetuating the cycle of misinformation.

1.2: Rationale for the study

The widespread nature of sexual and reproductive health concerns including HIV, especially among young people, calls for urgent need to address the same for the development of the society in general

and young people in particular. The above discussion focusing on young people's reproductive and sexual health clearly shows the need for action oriented programmes that focus on the following areas:

- sexual and reproductive health needs of adolescent girls and boys
- gender roles and life skills that affect young people's health
- ways to equip young people with knowledge and information on diverse, interrelated issues
- build self-efficacy, life, communication and negotiation skills amongst them
- sensitise parents and other trusted adults to provide a more supportive environment for them

Information about sexual and reproductive health and safe sexual behaviour can help young people to develop a value system they need to face any eventuality with courage and understanding. In India, we are still debating about the content and the appropriate age for sexuality education. The discussion still centres on whether or not sexuality education should be a part of the school curriculum, and this topic has been the cause for ambivalent reactions across the social spectrum. Young people thus often have to face the challenge of understanding sexual behaviour unequipped and the result is an increased vulnerability to unplanned pregnancies, sexual abuse and HIV. This needs to change, with education at the forefront. Since most of the reproductive and sexual health concerns including HIV transmission are preventable, education for young people in India has the potential to be one of the most effective methods for minimizing the SRH concerns.

Education programmes need to address not only sexuality, but also an understanding of age appropriateness, content and a methodology for implementation that respects the socio-cultural context. The World Health Organisation reports that numerous studies carried out all over the world show that providing sexual health education typically delays the initiation of sexual activity among youth and helps them avoid risky behaviour whenever sexual activity begins. Therefore, the provision of appropriate content and skills at an appropriate age and time works as a protective factor and reduces the vulnerability of adolescents to HIV. If offered in an appropriate manner, sex and HIV education help youth to clarify their values, avoid risky behaviour and improve their negotiation skills. This reduces their overall vulnerability, increases their capacity to perceive risk and increases the options available to them for leading a safe and disease-free life. This is the best means to impart sex and HIV education in a graded fashion and in measured doses, providing the right information at the right age.

The most effective sexual health programmes are those that include more than basic information on reproductive health and HIV. These programmes help youth to enhance their thinking, communication, social and negotiation skills (Life Skills), as well as helping to clarify their values and to re-examine their attitudes towards risky behaviour. Talking about responsible lifestyles and their attendant benefits at the outset of adolescence can inculcate sexual values, appropriate behaviours and good sexual health. For this to happen, it is critical to elicit opinions from a wide range of community representatives, including parents, teachers, religious leaders and other community leaders. An acceptable strategy has to be developed so that programmes for adolescents avoid controversy. Too often, such attempts to provide the pertinent information fail because of conflict over what type of curriculum to actually institute. The research outlined below is designed to address some of these issues.

1.3: Objectives of the study

Specifically, the objectives of the study are:

1. To conduct an analysis of needs and demands for sexuality education.
2. To develop an appropriate sexuality education curriculum based on consultation with stakeholders.
3. To implement an age-specific sexuality education curriculum.
4. To evaluate processes and effects of the sexuality education program.
5. To use findings to advocate introduction of sexuality education with stakeholders within the educational system.
6. To disseminate findings and lessons learned among network partners, and in national and international forums and publications.

1.4: Organization of the report

The present report consists of 7 chapters as described below:

Chapter I: Introduction

Chapter II: Methodology

Chapter III: Process of developing a culturally sensitive curriculum

Chapter IV: Awareness & experience of reproductive and sexual health issues

Chapter V: Communication, awareness about laws, and attitude towards gender issues

Chapter VI: Perception about the curriculum & its impact

Chapter-VII: Summary and conclusion

Chapter Two

Methodology

2.1: Study area and population

The study that was initiated in September 2004 and completed by March 2008 was carried out in a total of four schools: two schools each (one boy's and one girls' school) in urban (Rewari) and rural (Bawal) settings in the state of Haryana. Haryana is a state in northern India and surrounds New Delhi on three sides. Consequently, a large area of Haryana is included in the National Capital Region. Rewari is one of the 20 districts of Haryana state, located in its southern part. It is around 80 km away from the capital city of India, New Delhi. This district is spread over 1559 Sq. km area with a total population of 765,351 (2001 census). Bawal is one of the blocks in Rewari district.¹ The Child sex ratio (0-6 years) in Haryana is 798 as compared to 918 for India and reflects a strong preference for a male child. Women and men aged 20-24 years marrying below the age of 18 is 41 percent and 10 percent respectively (compared to national average of 47.4% for women and 9.5% for men). 12 percent of women are in the age group 15-19 years who have begun childbearing (compared to national average of 16%). 52.7 percent women and 74.2 percent men know that HIV can be transmitted from mother and to her baby (national average is 46.7% and 63.3% respectively)². Table 2.1 presents selected demographic and sexual and reproductive health (SRH) indicators of the study district as compared to the state and the country.

Table 2.1 : Selected demographic and SRH indicators of India, Haryana and Rewari

Indicators	NFHS-3, 2005-06		DLHS-2, 2004
	INDIA	HARYANA	REWARI ³
Sex ratio (Females per 1,000 males)	933	897	899*
Sex ratio 0-6 (Females per 1,000 males)	918	798	811*
Percentage literate-Male	78.1	81.0	88.4*
Percentage literate-Female	58.5	59.8	60.8*
Total fertility rate (TFR)	2.7	2.7	
Percentage of women aged 15-19 years who have begun childbearing	16.0	12.1	59.2**
Current use of Condom	5.2	11.2	10.2
Unmet need for family planning	12.8	8.3	11.4
Percentage of women aged 20-24 years who had first sexual intercourse before the age of 18	43.0	36.1	----
Percentage of men aged 20-24 years who had first sexual intercourse before the age of 18	11.2	9.2	----
Percentage of women who know that HIV/AIDS can be transmitted from a mother to her baby	46.7	52.7	22.4
Percentage of men who know that HIV/AIDS can be transmitted from a mother to her baby	63.3	74.2	18.6

Source: International Institute for Population Sciences (IIPS) and Macro International 2007, National Family Health Survey (NFHS-3), 2005-2006, India, MEASURE DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA.

³ International Institute for Population Sciences (IIPS), 2006, District level Household Survey (DLHS-2), 2002-04: Rewari, Mumbai: IIPS.

* Primary Census Abstract, Series 1, Census of India, 2001, Office of the Registrar General of India, New Delhi.; **Based on women age 17-19 years.

¹<http://www.rewari.nic.in/location.htm>

² International Institute for Population Sciences (IIPS) and Macro International 2007. National Family Health Survey (NFHS-3), 2005-2006, India, MEASURE DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA.

Table 2.2 reveals that there are 195 senior/high schools in Rewari, in which 36,093 boys and 30,006 girls are enrolled. There are only two Senior Secondary Schools in Bawal town; one for boys and one for girls.

Table 2.2: Health facilities and educational institutions in Rewari, Haryana

Serial No.	Type of health facilities	Total
1.	Hospitals (tertiary level)	2
2.	Primary Health Centre	14
3.	Dispensary	5
4.	Community Health Centre (first referral unit)	4
5.	Sub Centre	102
TOTAL		127

Serial No.	Type of educational institutions	No. of institutions	No. of students		
			Male	Female	Total
1.	Colleges	10	5510	3756	9266
2.	Sr. Schools / High Schools	195	36093	30006	66099
3.	Middle Schools	117	4719	5208	9927
4.	Primary Schools	534	35027	33951	68978

Source: <http://www.rewari.nic.in/district%20profile.htm>

Table 2.3: Percentage of de facto household population age 6-17 years attending school in the 2005-06 school year by sex, residence and age, Haryana, 2005-06

Age	Male			Female			Total		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
6-10 yrs.	90.4	88.9	89.3	91.7	83.6	85.4	91.0	86.5	87.5
10-14 yrs.	83.0	84.0	84.5	83.9	76.2	78.0	83.4	80.9	81.5
11-14 yrs.	81.0	84.0	83.2	82.2	74.9	76.6	81.5	79.7	80.1
15-17 yrs.	53.4	51.9	52.4	62.2	34.4	42.5	57.5	43.7	47.8
6-14 yrs.	85.9	86.7	86.5	87.0	79.6	81.3	86.4	83.4	84.1
6-17 yrs.	77.3	79.0	78.5	79.8	69.6	72.0	78.4	74.6	75.5

Note: In this table, children's age refers to their age at the start of the 2005-06 school year (assumed here to be April 2005). Source: International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005-2006. India, MEASURE DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA.

Both Rewari and Bawal have a number of schools run by individuals, private trusts, or business houses. They are perceived as providing quality education through English as the medium for transacting the curriculum. Many of these schools are co-educational i.e. enrol both boys and girls, unlike most Government schools which usually have separate boys' and girls' schools. Reasonably 'well to do' families prefer to send their children to Private schools. In case the resources are limited, it is often seen that boys get a preference over their sisters in terms of being enrolled into Private schools. Table 2.3 reveals that about 84 percent of the population aged 6-14 years in Haryana were attending school in 2005-06. The same figure is 76 percent among those aged 6-17 years.

2.2: Study design

This project was designed to enable the development, implementation and evaluation of a sexuality education program that responds to the needs and demands of school-based adolescents in both urban and rural settings, and reflects national and international understanding of sexual and reproductive health needs and concerns.

At present, most of the evidence about programmatic responses and their effectiveness is generated by western, mainly English-speaking countries. It cannot be assumed that these models will meet needs in other settings because of cultural and social differences, as well as disparities in available funds and materials for implementation.

Given that sexuality is a sensitive issue in most societies, it was particularly important that the program be grounded in the realities of rural and urban setting to offer the greatest opportunity for success and sustainability. It was also critically important that the process of development of programmes be documented, that programme effectiveness be measured using robust designs to build the evidence base, and that findings and lessons learned be disseminated and shared more widely on national and global level.

This project aimed at responding to the gap in the evidence base on effective school-based sexuality education programmes in non-western settings in several ways:

At first, it utilised an approach of consultation and feedback with stakeholders: parents, teachers and secondary school students so that these stakeholders did not obstruct, rather be actively involved in the process. Secondly, it was a study design that enabled evaluation of change in knowledge, attitudes and practices, as well as comprehensive process evaluation (monitoring) to permit modification of the Programme during implementation.

This present project on sexuality education had two major parts i.e. Research and Intervention. The Research part has four components, namely:

1. Needs assessment (consultation, document review, primary data collection) for baseline data and for curriculum design.
2. Annual pre-post assessment of knowledge and needs of adolescents.

3. Periodic (process) evaluation of whole intervention based upon indicators related to content, delivery and stakeholder perspectives to enable modification.
4. Impact evaluation at conclusion of programme to determine programme effectiveness over its lifetime.

The Intervention part had two components, namely:

1. Development and implementation of age-specific sexuality education sessions by trained trainers starting with Class VIII in the first year, with expansion annually to subsequent years for the same cohort (Classes IX and X) based upon age-specific needs, assessment and feedback.
2. Modification of the programme for each year (and revision of existing curricula) wherever required (based on Process Evaluation, i.e. monitoring) to address weaknesses.

The study was initiated in September 2004 and completed in December 2008. The study was planned and carried out in three phases: first phase (September 2004 – August 2005), second phase (September 2005- January 2008), and third phase (February - December 2008), details of which are given below.

Phase I: Curriculum development based on needs assessment and review - September 2004– August 2005

During this phase, available and planned national curricula and models from international settings was reviewed in order to (a) benefit from existing efforts and expertise and (b) identify specific content, modalities and teaching methods most likely to be suitable to the cultural context in which this Programme is to be implemented. This was followed by Needs Assessment with Target Community and Stakeholders to understand the prevailing perspectives and concerns of stakeholders and the needs of young people. National and international reviews, consultation with parents, teachers and students, and the needs assessment from students were used as guiding frame work to develop a comprehensive sexuality education curriculum. This sexuality education framework was shared with and agreed upon by parents, teachers, students and education department authority.

Phase II: Intervention and modification (process evaluation) - September 2005-January 2008

In this phase the curriculum was being delivered in schools incrementally; with an additional class level each year, and the Program's content and acceptability being monitored while making changes wherever needed, through feedback from students and stakeholders. The curriculum was delivered to the cohort in Classes VIII, IX, and X in academic sessions 2005-2006, 2006-2007 and 2007-2008 respectively.

Phase III: Impact evaluation- February 2008-December 2008

During this phase the impact of this study was assessed through an endline survey, process evaluation, class evaluation, and feedback from students and stakeholders on perceived acceptability.

2.2.1: Selection of intervention schools

A purposeful selection strategy was used to identify intervention schools based upon (a) obtaining permission from relevant authorities for the programme implemented in the schools, and (b) Boys' and Girls' Government Senior Secondary Schools (that offer education beyond 10th grade) catering to the education needs of adolescents largely living in urban (small towns) and rural (villages) areas. All these schools are affiliated to Haryana Board of Secondary Education. The sample schools that were selected are: 1 Rural Boys' school (RBS), 1 Rural Girls' school (RGS), 1 Urban Boys' school (UBS), and 1 Urban Girls' school (UGS).

2.3: Data collection tools

Both qualitative (focus group discussion and in-depth interview) and quantitative (self-administered questionnaire) data collection tools have been applied for collecting information from the respondents. Focus Group Discussion (FGD) with the help of pre-decided guidelines had been conducted among the students, teachers and parents. Like wise, in-depth interviews of some of the teachers had also been conducted. Focus group discussions were conducted by trained community workers. The interview guides were translated from English into Hindi, the local language, which is widely spoken and understood by all groups. The volunteered responses/ opinions were recorded by a note-taker in form of notes while discussions were moderated by a facilitator. Along with that, self-administered questionnaire had been administered among the students to gather quantitative information on required issues.

2.4: Ethical considerations

Ethical approval was obtained prior to commencing each FGD and IDI. All the participants were:

- Informed of the background and purpose of the research.
- Reminded that participation was voluntary.
- Assured that data from the discussion and questionnaire would be kept strictly private and confidential for use only by the research team.
- Explained that the response of the participants during IDI and FGD will be noted down and will be used for project purpose.
- Explained that there were no correct or incorrect answers and that each had the right not to respond or discuss issues with which they were not comfortable.

Along with that, the study did not collect the names of the students participating in the self-administered questionnaire so as to ensure privacy and confidentiality of the students.

2.5: Primary data collection and quality control

The primary data in the form of self administered questionnaire, FGD, and IDI were collected with the

help of trained facilitators. It is worth mentioning that the following measures were adopted in order to ensure good quality of data.

1. Comprehensive training of trainers with an emphasis on qualitative and quantitative techniques through training workshops.
2. Monitoring and supervision of field operations by coordinators.
3. The guidelines for FGD and IDI were pre-tested before being administered among the respondents.
4. Yearly feedback from the facilitators was obtained to finalise the module for the classes.

2.6: Data analysis

Quantitative data collected through self administered questionnaire has been edited on the very same day to avoid any information lapse. Un-coded sections of the schedule have been coded initially and the data has been entered and analyzed using the Statistical Package for Social Science (SPSS) 13.0. Our analytical approach includes both uni-variate and bi-variate analysis. Chi square test has been applied to see the significant differences in the certain indicators in different phases of the study. The content analysis of the qualitative data gathered through FGDs and IDIs has been carried out after finalizing a detailed code list covering all the issues of the interviews. FGD analysis was performed based on group-reported consensus and/or divergence of opinions, both between and within groups and reported on with reference to specific themes of investigation. The unit of observation is individual participant while that of analysis was the group level. The qualitative findings have been presented in various chapters to substantiate the quantitative results and as explanations to some issues besides independently describing certain issues.

Table 2.4: Sample size

Phases of the Studies	Class	Test	Male	Female	Total
PHASE-I Needs Assessment (September 2004 - August 2005)	VIII		109	251	360
	IX		85	81	166
	X		168	324	492
	XI		76	53	129
	XII		527	515	1042
PHASE-II Implementation in Schools (September 2005 - January 2008)	VIII	Pre-Test	245	325	570
		Post-Test	93	258	351
	IX	Pre-Test	79	315	394
		Post-Test	53	289	342
X	Pre-Test	89	314	403	
	Post-Test	77	279	356	
PHASE-III Endline (February 2008 - December 2008)	X	Control	132	353	485
		Intervention	90	321	411

The findings of the present study are based on the information collected from 27 FGDs, 12 IDIs and quantitative data from students of different classes. Table 2.4 presents the total number of students from different classes covered in the study.

It is worth mentioning that the current report presents findings on the basis of the data from Needs Assessment, Class X post test, Class XI pre test, and Endline survey. Again, for comparison purpose the data from the needs assessment has been considered and used as baseline data in the present report. The study followed a group of students over three classes 8th, 9th and 10th and a comparison group was selected from the same school maintaining the equal socio-economic backgrounds. The quantitative data in the following chapters are triangulated with qualitative data from classes (9th, 10th and 11th) to highlight the evolution of perception and acceptance of the curriculum among the students.

It has also been considered that findings are to some extent influenced by the level of exposure of students to the curriculum, details of which are as follows.

Table 2.5: Number of students exposed to the programme over three years, among respondents in post test class X

Post Test Class X		Attended the program in class VIII (2005-2006)	Attended the program in class IX (2006-2007)	Attended the program in both classes VIII and IX
BOYS	Rural (44) Urban (33)	12 18	35 33	11 18
GIRLS	Rural (83) Urban (196)	48 124	74 179	43 120

The data from Class X post test shows that the level of exposure to the intervention varied among boys and girls, and in urban and rural settings. Clearly a larger number of girls, and especially those in urban location, were exposed to this curriculum over a period of three years as compared to the boys in the intervention group as a whole. One of the reasons was a major dropout of students in boys' schools at the end of Class VIII when they failed to clear the board examinations. New students admitted to Class IX in the two boys' intervention schools are the ones represented in higher numbers at the post test. Out of 470 students enrolled in Class X of the four intervention schools, 356 students appeared for the post test towards the end of the academic session. Among those who appeared for the post test, 54 percent had been exposed to the programme over a period of three years. 90 percent students had received the adolescence education programme for 2 years. This left about 10 percent students who had received it only for a year. Boys in general were less exposed to the programme with boys in rural school being least exposed when compared to other groups. This has a significant bearing on the results as is borne out by the data in the following sections.

Figure 2.1 shows the total number of students (figures from all four schools combined) attending each of the session delivered over three academic years.

It is apparent from figure 2.1 and table 2.6 that even during an academic year, the exposure to the curriculum varied among different groups. While 75 percent of girls attended 6-7 sessions in class IX, only

Figure 2.1

39 percent of boys were present in 6-7 sessions. Again in Class X, 66 percent girls were exposed to 6-7 sessions while majority of the boys attended only 4-5 sessions. This again had a bearing on the change in knowledge and attitudes demonstrated by the students at the end of three years.

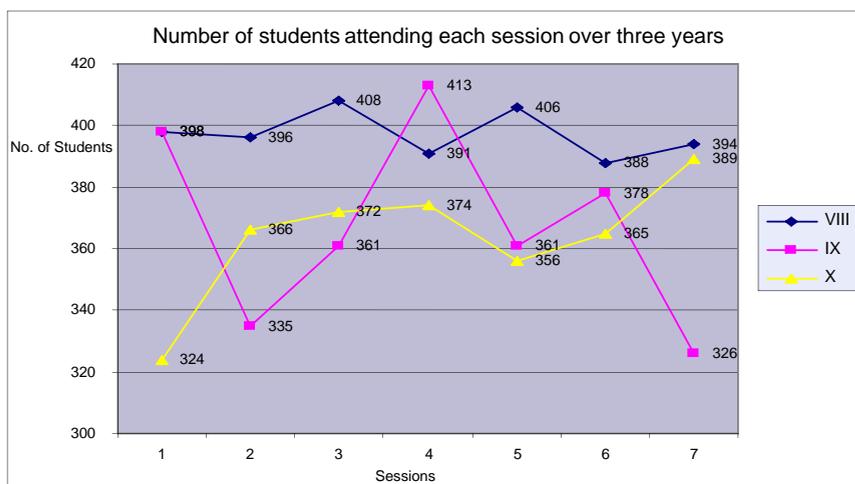


Table 2.6: Exposure to sessions in classes IX and X

Session Attended	Class IX			Class X		
	Total	Boys	Girls	Total	Boys	Girls
6-7 Sessions	66.60	39.13	74.87	57.23	28.83	66.02
5-7 Sessions	25.35	37.39	21.73	34.04	41.44	31.75
3 and less	7.44	20.87	3.40	7.87	26.13	2.23

2.7: Limitations of the Study

Study design: The study design is limited by not having a control group, which creates a greater need to identify and account for co-founders, in particular external sources of information that overlap with (or contradict) content of the curriculum. This limitation is of most relevance to student knowledge. To mitigate this potential limitation annual pre and post-tests (KAP) were administered to the cohort which included questions designed to document the range of sources of information on program content areas in addition to the curriculum itself, e.g. television, media campaigns, friends, Internet, etc.

Sample size: Timelines, budgetary and human resource limitations made it impossible to recruit a larger sample of schools that might have enabled us to generalise findings to the wider population. However, it was also felt, on balance, that a systematic, comprehensive, staged introduction of an experimental programme is best managed in a small number of schools. Therefore a decision was taken to recruit schools from lower-income (i.e., majority) populations, but which reflect diversity in terms of sex and geographic location in order to gain maximum benefit within existing constraints.

Chapter Three

Curriculum Development

3.1: Needs assessment

The main purpose of this needs assessment study was the identification of key issues and concerns, and the assessment of various experiences and evidence, intended to provide a reference for sexuality education programme and helps in developing systematic, comprehensive and culturally sensitive curricula on sexual and reproductive health. The methods applied for needs assessment have been presented below.

3.1.1: Literature and existing curriculum review

A review of the biology and science courses taught in grades VIII through XI was undertaken as these were the grades proposed for the research project. Textbooks for grade levels Grades VIII through X are general education grades in India where all students take the same course, and during these years most study of biology, reproduction and disease is included under science and technology. Grades XI and XII students take individual courses in topics such as biology, arts and commerce.

Some of the Existing Life Skills or HIV Prevention Education Curricula in country were also included in the review. These included:

- AIDS Education in Schools: A Training Package - National Council of Educational Research and Training & National AIDS Control Program (NACO), 1994.
- School Health Education to Prevent AIDS and STD - United Nations Education, Scientific and Cultural Organization (UNESCO) & World Health Organization (WHO), 1994.
- Life skills Education - UNICEF, 1998/1999.
- Life Skills Education in Schools - World Health Organization (WHO), 2000.
- Life Skills for Adolescent Girls - Institute of Health Management Pachod, 2000.
- Life Skills Education for Out of School Adolescents - IAWG Supported Project: New Delhi, 2000-2001.

3.1.2: Review of existing school curricula in Science & Biology

Currently, issues of sexual reproductive health for the most part are addressed within biology and science courses taught in grades VIII through XI. This of course has little to do with life skills in the broader sense, but since this is where many young people get basic knowledge about reproduction and safe sex practices, a brief review of what is covered in the most common texts used by government schools is useful. For this study, only the books prescribed by the Haryana Board of Secondary Education for grades for VIII through X were reviewed for the content.

A review of the text books shows that the books in Class VIII and IX do not make any reference to the period of adolescence, reproduction, STIs, HIV or any of the related issues. Class X Science and Technology book devotes three and half pages to 'Reproduction'. The topics covered here are:

- Male and female reproductive organs (with diagrams of internal reproductive organs)
- Menstruation
- Fertilisation
- Population control (that mentions a few contraceptives)
- STDs and HIV (“AIDS is a STD that can lead to death. It is not curable. It is caused by HIV virus”)

The chapter on 'Heredity and Development' describes the basis for sex determination using a simple flow diagram.

3.1.3: KAP survey of students

As part of the needs assessment, KAP survey of students of Class VIII to Class XII was undertaken in four schools of Rewari district in 2004. Both Quantitative and Qualitative tools were used. A total of 2189 students (965 boys and 1224 girls) were administered a questionnaire. The key findings of the KAP survey especially those from class VIII (total of 360 students) are described below (Refer to table, Annexure I) .

3.1.3.1: Physical and mental changes during adolescence

The students were asked about the various physical changes that take place during puberty. The results from Class VIII showed that:

1. 87.2 percent of boys and 95.6 percent girls reportedly were aware of gain in body weight and height during adolescence.
2. 37.6 percent of boys and 72.1 percent of girls were aware that breasts enlarge during adolescence.
3. 24.8 percent boys and 20.7 percent girls were aware about enlargement of testes during adolescence
4. 8.3 percent of Boys and 58.6 percent of girls knew about the onset of menstruation during adolescence.
5. 60.6 percent boys and 63.7 percent girls were aware about appearance of hair in genital area.
6. 41.7 percent of boys and 38.6 percent of girls were worried about the changes taking place in their bodies.
7. 20.8 percent of boys and 38.1 percent of girl students were embarrassed by these changes.
8. 26.6 percent of boys and 52.6 percent of girls did not know about the phenomenon of 'nocturnal emission' among boys. Only 13.8 percent of boys and 8.4 percent of girls said that it is a sign of sexual maturation among boys.

3.1.3.2: Perception about masturbation

1. 17.4 percent of boys and 23.9 percent of girls considered masturbation a 'natural practice'.
2. 35.8 percent of boys and 26.3 percent of girls reported that it causes weakness.
3. 9.2 percent boys and 10.8 percent girls thought masturbation lead to impotency.
4. 26.6 percent boys and 14.3 percent girls thought masturbation affected the structure /function of the male sexual organ.
5. 9.2 percent boys and 12 percent girls thought of masturbation as an 'immoral' act.

3.1.3.3: Attitude regarding premarital sex

1. 31.2 percent of boys and 2.4 percent of girls said that it was OK to have pre marital sex while 29.4 percent of boys and 15.5 percent of girls thought it was 'wrong'.
2. However, 34.9 percent of boys and 56.2 percent of girls said they 'didn't know' if it was alright to have sex before marriage or not.

When asked about various situations when it is alright to have sex, the responses were as follows:

1. 56.9 percent of boys and 18.3 percent of girls were of the opinion that it is alright to have sex if one is in love.
2. 45.9 percent of boys and 27.5 percent girls were of the opinion that it is alright to have sex before marriage if the partner agrees to it.

3.1.3.4: Protection against HIV

1. 74.2 percent of boys and 65.8 percent of girls knew that it is possible to protect oneself from contracting HIV.
2. 42.2 percent of boys and 17.1 percent of girls reported that condom can be used as protection against HIV.
3. 19.3 percent of boys and 13.5 percent of girls shared that a person can protect himself/herself from HIV by abstaining from sex.

3.1.3.5: Gender related issues

1. 71.1 percent of boys and 51.7 percent of girls felt that use of contraceptive is a girl's responsibility.
2. 58.1 percent of boys and 71.3 percent of girls were of the opinion that it is the responsibility of both the partners to decide when to have a child.
3. 48.4 percent of boys and 36.8 percent of girls felt that girls do not have the right to decide when and whom to marry. Surprisingly more students felt that boys also do not have this right (59.3 percent of boys and 32.4 % of girls).

3.1.4: Stakeholders' survey

The Focus Group Discussions (FGDs) were used as exploratory qualitative investigations to provide parents, school teachers, and principals with an opportunity to discuss about the educational program on sexuality in relation to their concerns. FGDs were also conducted among the students to understand their needs and concerns. FGDs were conducted in both urban and rural areas of Rewari district. In total, twenty four FGDs were conducted with the youth, twelve with parents (six each with mothers and fathers) and one each with teachers in each of the four schools.

3.1.4.1: Stakeholders' perspective on sexuality education in school

All participants, students and teachers alike, agreed that there is a strong need for sexual and reproductive health education in schools, and it should be mandatory. The teachers were unanimous in their opinion that the content should be implemented across the curriculum, integrated in teaching subjects such as biology, and additionally organized in the form of lectures by experts as visiting faculties.

Students, on the other hand, differed in their views on implementation of such a plan. Whereas some of them tended to see a separate time-tabled subject without marks, the others suggested that it should be within various subjects such as biology. But some adolescents viewed that certain streams do not have biology in later classes of XI and XII when they need this information the most. Thus, sexuality education must be separate from the subjects. Almost all the parents agreed on providing sexuality education in schools mentioning that it is important in the context of changing socio-cultural environment. Mothers felt that girls should be provided with SRH information in schools, as there are lots of restrictions imposed on them in villages. The parents were unanimous on the point that this education must be taught separately to boys and girls. All three groups of participants also agreed that sexual and reproductive health should be implemented from class VIII and above in schools and adjusted accordingly with increasing age of the students.

3.1.4.2: Stakeholders' perspective on possible outcome of this education

All the stakeholders held the opinion that this education would have a good impact on the students. But some parents also expressed their scepticism about the outcomes of this particular programme as they felt that more the students are told about these issues, the more they will open up, and those children who didn't know about all these issues would also come to know and will start talking about it in the open.

Other parents and teachers showed a positive attitude for such kind of programme. They were of the opinion that this would prevent students from undertaking risky behaviour. Students in all four schools stated that this education would have a positive impact on their lives. They mentioned range of possible benefits such as protection from various infections/diseases, good health, improved personality, reduction in eve teasing, capacity to tackle personal problems and leading a healthy married life.

All the three stakeholders were of the opinion that sexual intercourse and related behaviour should be discussed within the context of marriage. Parents and teachers considered pre marital sex and friendship with opposite sex 'unacceptable'. Parents expected that education must talk about respect for elders and family values.

3.1.4.3: Stakeholders' perspective on the question of who should deliver this education

In discussions about who should be teaching sexual and reproductive health, the participant teachers suggested that they should be individuals who are comfortable with discussing the issues with students. However, they also indicated that educators should also have sufficient knowledge and skills. The teachers also indicated that they should be well prepared and have good IEC material. The students and teachers proposed that various experts (medical doctors, gynaecologists, psychologists) should be invited from outside the school to conduct lectures. They also argued that it is easier for students to confide in someone from outside the school, someone whom they did not encounter on a day to day basis.

Moreover they said that students hold great respect for their teachers and would feel uncomfortable in talking to them on sexual health issues. They added that teachers would also face difficulty while teaching on these issues.

3.1.4.4: Stakeholders' perspective on possible content for sexuality education

Teachers suggested that in lower classes the focus should be more on bodily changes, and then gradually shift to introducing relationship and sexuality issues in order to achieve a comprehensive and systematic coverage of all topics. The parents pointed out the following topics which should be taught to students:

1. Learn to respect their parents
2. Should not tease girls
3. Sex only after marriage
4. About HIV/AIDS
5. Advantage of continuing education
6. Physical changes

Amongst parents, mothers were of the opinion that girls in class XI and XII should know about contraceptives. Parents also shared their opinion on what should not be taught. All the groups mentioned that there should be no discussion on topics like commercial sex, how to have sex (sexual intercourse), love affairs, condom use (especially not with girls, though this can be discussed with boys) and masturbation.

On the other hand, students shared that they would like the following topics to be included:

1. Substance use (alcoholism and tobacco)
2. Love and relationship
3. Sexual intercourse (to be included only for boys)
4. Responsibilities after marriage
5. Contraceptives
6. Menstruation
7. Physical changes
8. Night fall

All the students were of the opinion that details about sexual intercourse should be taught to students above 15-16 years of age. While it is evident that no general conclusions can be stated on the basis of this focus group discussion, the contribution from each of these stakeholders provided their perspective, and additionally emphasized some of the major points and considerations that would have to be addressed in any future development of curriculum in the area of school-based sexual and reproductive health education.

Findings from focus group discussions and KAP of students along with the review of existing school curriculum formed the basis for development of a framework for the curriculum, which was used to draft the curriculum over three years.

3.2: Curriculum development

Based on the key findings from the Needs Assessment, a framework (Annexure II) for the module was drawn. Additionally, a workshop for this purpose was facilitated by Dr. Martha Morrow, representing the Nossal Institute (previously the Australian Institute of International Health) and included members of the project team (Advisor, Programme Managers and Field Officers). Some of the members in this team had in the recent past worked in Rewari and Bawal as part of MAMTA's other projects and understood the local context well. During this workshop, the broad content areas and methodologies for conducting the sessions were decided. The objectives for each session were then clearly defined as were the key messages. This was to ensure that there was uniformity in the given messages being conveyed to the students by different teams that were working simultaneously across the four schools as well as different 'sections'³ within the same school.

The first step was to develop a curriculum for students of Class VIII based on the findings of the needs assessment and then piloting it in a smaller representative samples. The curriculum for Class VIII was developed through participation of educators, along with the curriculum specialists to put together the content, identifying suitable/appropriate methodologies and tools for delivery of the content. Draft curriculum was field tested with students, both boys and girls, in a different set of rural and urban schools and the feedback incorporated. The curriculum was available both in Hindi and English, but the medium of delivery in the schools was Hindi.

A 5 day workshop was organised in Rewari in July 2005 with the objective of preparing a draft of the training manual for Class VIII. The participants included 9 community workers who were to facilitate sessions in schools and three resource persons from MAMTA head office in New Delhi. MAMTA as an organisation has been working on sexual and reproductive health issues since the year 2000 when it entered into partnership with RFSU (Swedish Association for Sexuality Education). Capacity building on sexuality, gender and rights has been an integral part of the larger programme under which this research study was being carried out. As a result, a core group existed within MAMTA that had the expertise to plan out and draft a curriculum on related issues. Combining this knowledge of participatory training methods and field experience of working with young people, a draft was prepared.

The curriculum was pilot tested in non- intervention schools in similar settings. One urban and one rural school in Dharuhera were selected for this purpose. Out of these two schools, one was a boys' school and other a girl's school. All the sessions were not being pilot tested in both the schools; rather three were held in one and three in the other. The pre and post test questionnaires and various methods of obtaining feedback from the students were also pilot tested in the same schools.

3.2.1: Stakeholders of the curriculum

3.2.1.1: Schools

To initiate the project in the four schools, the permission from the relevant authorities was sought. In October 2004, senior-level staff of the organization contacted the District Educational Officer (DEO) for

³Since there are large numbers of students enrolled for each class, they are assigned to different 'sections'. For example, Class X can have up to 6 sections –XA ,XB,XC,XD and so on, with each section having 50-60 students depending on the total number of students and the staff strength.

discussing the rationale and design of this study. The DEO was requested to allot the schools based on the requirement of two schools each in urban and rural locations, with a boys' and a girl's school in each area. Subsequently DEO issued a letter to the Principals of the identified schools to take necessary action and cooperate with MAMTA in this initiative. By the time the intervention in schools started in July 2005, the DEO had been transferred and a new person had taken up the position. Another meeting was held and the curriculum that was to be delivered in class VIII was shared. Following this another letter was sent to the schools and the project took off in the new academic year.⁴

The intervention schools chosen purposively run in two shifts; first shift in the morning and second shift in the afternoon. The Principal usually assigns the key administrative responsibilities to the Shift In-charge (usually a senior teacher) as the Principal cannot be present in the school during both the shifts and is often participating in meetings or events outside the school/town. Thus, the decision making authorities in the school include the Principal and the Shift In-charge. During the three years of intervention in the four schools, the Principal and the Shift In-charge were transferred at least once during the three year period. This necessitated a continuous dialogue, advocacy and sensitisation on the programme being implemented in these schools.

3.2.1.2: Students

The numbers of students, on an average, in intervention schools was about 2000 in urban boys' and 800 in rural boys'. In girls' schools the numbers were much larger; 4000 in urban girls' school and 1050 in rural girls'. The standard Teacher: Students ratio for Government schools is 1:40,⁵ but in the intervention schools the ratio was 1:53 on an average. These schools also had various positions for teachers that were lying vacant as is true for many other government schools that were not part of the intervention.

The study focussed on students from Classes VIII, IX, X (age group 13 - 17 years). All sections from each class were included as the study population.

Table 3.1: Number of students in each year of intervention

Name of Schools	Class VIII		Class IX		Class X	
	No. of Students	Sections	No. of Students	Sections	No. of students	Sections
Rural Boys	58	2 (for the session, combined into 1 group)	54	1	51	1
Urban Boys	84	2	61	2	60	2
Rural Girls	104	2	116	2	98	2
Urban Girls	260	6 (combined to to form 3 groups during the session)	266	5 (combined to to form 3 groups)	251	5 (combined to to form 3 groups during the session)
TOTAL	506		497		470	

⁴The new academic year starts in many states of India in the month of July. Some schools start the new session from April but most of the curriculum transaction starts in July, after the two month summer break.

⁵<http://www.tribuneindia.com/2005/20050330/haryana.htm#4>

Table 3.2: Mean age of students in classes, during each intervention year

School	Class VIII		Class IX		Class X	
	Age Group	Mean	Age Group	Mean	Age Group	Mean
Rural Boys	13-16	14.23	13-18	15.01	14-19	16.25
Urban Boys	12-18	14.34	12-17	14.68	13-19	15.88
Rural Girls	11-16	13.26	13-16	14.23	13-19	15.14
Urban Girls	11-17	13.61	12-18	14.26	12-18	15.07

Note: The mean age is calculated on the basis of the age mentioned by the students in the Pre test questionnaire that was administered in July-August each year. Most of the boys in Class VIII did not make it to Class IX as they failed to clear the state board examinations. Mean age for boys in Rewari School reflects the mean age of the new cohort in Class IX (that included only a few students from Class VIII).

3.2.1.3: Trainers

The AEP was delivered by a set of trained trainers. The criteria for selection of trainers were:

- Sensitized to gender and sexuality issues
- Previously trained on SRH issues
- Previous experience of working in this field, locally
- Equal numbers of men and women
- Able to speak and write Hindi and the local dialect
- Aged 25-35 years
- Willing to commit to the program for one-year minimum

Four male and four female trainers were selected. These trainers were working with MAMTA for 5 years and more when the study was initiated and were employed as full time staff (Community Workers) into the project. All the trainers had completed Senior Secondary School, two of them were graduates and another two had post graduate degrees. This study was part of the larger project 'Young People's Health and Development: A Reproductive And Sexual Health Centred Action Approach' wherein capacity building of all the team members on issues of sexuality, gender, Rights and HIV was one of the key strategies. This was carried out in partnership with RFSU (Swedish Association for Sexuality Education). RFSU was focusing on similar effort in another intervention site (Varanasi) where it organised a week long training programme focusing on sexuality education for the staff/trainers of Varanasi and Bawal. This training mainly focussed on attitudes regarding sexuality and gender through participatory exercises. As the 'Community workers' (referred to as 'trainers' in this study) were also responsible for 'Pilot Intervention' programme in the local community (in Bawal), they understood the issues of young people well and frequently addressed the common queries and concerns through the Youth Information Centres established in some of the villages in the adjoining area.

The male trainers conducted sessions in boys' school and worked as two teams (with two trainers in each team). On the other hand the female trainers formed three teams, where each trainer was paired with a

Co-facilitator whose role was to support the trainer during the session. This mechanism had to be adopted since the number of girls was much more than the boys. Over the three academic years, there was a conscious effort in ensuring that the same trainers delivered the curriculum in a particular school and worked with the same group of students (UB, RB, UG, and RG). Few changes in the team of trainers were however inevitable, given a span of three years over which the intervention took place. The team of female trainers remained the same during the Classes VIII and IX but two of these trainers were replaced in Class X. Both these trainers were working in another Adolescent Health project in the same area (Rewari) in the capacity of the Programme Officer and Community worker respectively. In this respect they had experience of working with adolescent and have a good understanding of issues relating to adolescent health and development as a result of the capacity building initiatives under that project. The only change that took place in the male team was the replacement of one of the trainers in Class IX by a trained peer educator who then worked as part of this team till the end of the study period.

3.2.1.3.1: Training for the trainers

The trainers were involved right from the development of the first draft of the curriculum. In the first year, there was active participation of the trainers in preparing the draft of the curriculum based on the agreed framework in a 5 day workshop facilitated by senior level team members. Following this, they pilot tested the curriculum, which provided them an opportunity to practice some of these sessions in the class settings. The curriculum eventually required modification in terms of re-sequencing of some of the objectives, toning down the language and limiting the level of information on sensitive issues so as to make it more acceptable to the education department and local school authorities. Before each session the team of male and female trainers sat together to prepare the relevant tools for the sessions. Mock sessions were conducted. The trainers also organised Practise Question Answer sessions so that they were prepared to handle queries from the students. They were provided additional reading material, articles and documents related to the major themes. They were supported in the process by the Project Officer posted locally.

In the second year the draft curriculum was prepared by the team of experts located within the New Delhi office, incorporating all the feedback and suggestions received at the end of first year. This draft was then shared with the trainers during three days of workshop facilitated by the Programme Manager. During this work shop the trainers went through each session carefully and suggested modifications based on their experience of working with the students. Most of these are related to the 'words'/terms' in Hindi which required to be simplified. This was followed by pilot-testing as in the previous year – two sessions being tested on each day, one with the boys' section and other with the girls'. The pilot testing was completed over three days. In the third year all the trainers were invited to the office in New Delhi where the curriculum experts along with the trainers reviewed the curriculum. After incorporating the feedback, the final curriculum was sent back and the trainers held practice session (in presence of the Project officer) a day before the session was conducted. With each year of intervention, the trainers grew in confidence and became more adept at conducting sessions and handling queries. To quote some of the trainers,

“Confidence has increased so much... The main thing we learned is time management, because we had limited time to complete the session and we had to deliver the curriculum within a time limit and it was very good learning for all of us...”

Male Trainer, Urban Boys' School

“Earlier, in our previous project with UNFPA, when we demonstrated condoms in the schools then teachers had strong objection and we had to stop the demonstrations...Now in this project, we felt so much more confident.....Students and teachers also respected us..”

Male Trainer, Urban Boys' School

3.2.1.3.2: Transaction of the curriculum

Considering that this programme would be implemented as a co-curricular activity in the identified schools, it was important to clearly define and limit the number of sessions so that it did not consume too much time out of the school curriculum. Each session was limited to 90 minutes. This was keeping in view the fact that each subject teacher is assigned 45 minutes in a day (defined as the 'class period') and permission could be sought for allocating two periods in a given week for this programme.

3.2.1.3.3: Frequency of sessions

The intervention was carried out in four schools with total cohort strength of about 500 (ranging from 506 in class VIII to 470 in Class X), by a team of eight trainers available as part of the project team. The sessions were conducted in the morning shift (8.00 AM-2.00 PM) in Bawal schools (rural setting) and in the afternoon shift (12.40-6.10 PM) in Rewari schools (urban setting) on Saturdays. The plan was to deliver the seven sessions, one each fortnight, so as to spread it over a period of 3-4 months in each year. In addition to the sessions, few more contacts were essential at the end of the year to conduct the Year End Review with various stakeholders. Though only 7-9 contacts (7 in class VIII, 8 in Class IX and 9 in Class X) were required during the academic year, even this proved to be challenging. The schools reopened in the beginning of July and the process of enrolment of new students in the class continued almost till the end of the month. The students were then engaged in practice sessions for the Independence Day Function (15th August) and again in January for the Republic Day (26th January). Extended holidays during the festival season (Dussehra and Diwali), winter breaks, examinations and 'preparation leave' made it somewhat difficult to maintain continuity between sessions. The experience over three years shows that the sessions were delivered over a period of 3-5 months on an average in each year.

Table 3.3: No. of contacts, sessions and time period during which sessions were conducted in each year

Class	No. of Sessions	Total No. of Contacts	Duration in which the sessions were delivered
VII	7	7 (pre and post test combined with 1 st and 7 th session)	September 17, 2005 - December 3, 2005
IX	7	8 (one additional contact for Pre-Test)	October 27, 2006 - February 3, 2007
X	7	9 (one additional contact each for Pre and Post-Test)	August 18, 2007 - November 23, 2007

3.2.1.3.4: Processes followed in the school

On the day that the session was to be conducted, facilitators hired a vehicle for the day and first travelled to the schools in Bawal. There the male trainers split into two teams while the female trainers formed three teams by pairing with a Co facilitator. On reaching the school they informed the Principal (or the School In-charge if the principal was not available) about their arrival and were mostly accompanied by the Principal or the In-Charge to the respective classes (to inform the teachers) in the two girls' schools. In the boys' school, the students were often outside the class and the trainers directly went to classrooms. The students were usually waiting for them to arrive or gathered in the class on seeing them.

The largest number of students was in Rewari Girls' school. They were divided into five sections. The trainers organised them into three groups for the sessions. On certain occasions, trainers shared that girl students from other classes also sneaked into the group during the sessions. They had heard about the sessions from their peers in Class X and were keen to be part of it. Attendance for the students was marked against the roll numbers by the Co facilitator or by the Class Monitor. Then the session began with the recap of the previous session.

Each year the facilitators were invited to participate in the Focus Group Discussion, so as to receive their feedback on the curriculum in terms of content and methods used and to bring on record the experiences while conducting sessions in different schools and the challenges faced. The schools faced a constraint in terms of the space available within classrooms, facilities (like availability of audiovisual aids, continuous electricity supply) and resources (like training tools and materials). A conscious effort was made to opt for methods that could be adapted for use in the given environment.

The most useful methodologies (according to the feedback from facilitators) were: brainstorming, role plays and case studies. One of the most popular tools was the apron⁶ that was used to discuss the male and the female sexual anatomy, reproductive organs, and the process of menstruation. The handouts that provided concise information on some of the issues were distributed in Class VIII and were appreciated by the students. They said that it helped them to share information with peers and they were able to refer back to them in case they wanted to recollect the information shared during the sessions. The trainers had some degree of flexibility in terms of using the methodologies though they had been instructed to generally follow the session plan and not miss out on any of the key messages. Sometimes trainers made their own innovations, when the situation demanded a change.

“In Reproductive Organs session, we had to do one activity. We had to make different charts and students had to mark the organs and name them. But in one section students are more (in number) so it was very difficult to do it. So we used the apron, even though the method in our curriculum was different.”

Female trainer, Girls' school sharing her feedback on the teaching methodologies

The methodologies that did not work well as envisaged were the exercises/activities that required students to move actively in the classroom. Given that the size of the classrooms was small, and the

⁶An apron that can be tied at the waist was used to depict male and female external and internal sexual and reproductive organs and menstrual cycle. The apron has many layers, so that each layer can be lifted up to depict the organs that lie beneath.

number of students was large (especially in the girls' schools), the activities could not be conducted as planned. The experiences with using the Question Box were varied. Some of the trainers shared that the students did not hesitate in asking questions directly in the classroom. One of the challenges in using the question box was that the answers could only be provided at the beginning of the next session. This often took long and diverted the discussions away from the topic or theme to be covered on that day or during that particular session.

3.2.1.3.5: Constraints and challenges faced by the trainers

Some of the constraints faced by the facilitators in delivering this program were (based on the FGD at end of Class IX):

1. Getting permission from the Principal or the 'In-charge' at the beginning of the academic session.
2. Non availability of classroom on certain days.
3. Conducting sessions in two different schools (one urban and one rural) on the same day.
4. Conducting sessions at the end of the day (last two periods), especially in the afternoon shift (students would lose focus and interest).

Qualitative data further validates the above discussed challenges. In the words of some of the trainers/ facilitators:

“When we went to take session in Rewari School, principal said without permission from District Education Officer, I can't give permission to take sessions.”

Male Trainer, Boys' school, Rewari

“Due to B. ED exam and Open school examinations, we didn't get a classroom; we had to take one session in open field. We faced lot of disturbance. Secondly, last two periods had been allocated to us for conducting the sessions, so sometime students didn't take much interest.”

Female Trainer, Girls' school, Bawal

“To take two sessions in one day is very difficult; we take session in Rewari and Bawal on the same day. And another thing is that we have to stick to the time given (committed) to school authority.”

Male Trainer, Boys' school, Rewari

“At last (towards the end of the academic session) teachers said you know it's time for exams. Complete the session quickly. One teacher also said why you are late, it's your problem, I will take my class.”

Male Trainer, Urban Boys' school

3.2.1.4: School authorities

In the schools, principals and School In-charges played a very significant role in terms of providing support to the programme. The entry into the schools was facilitated by the order passed by higher authorities but the implementation would not have been possible where the principals and teachers were not committed to the programme and convinced about its objectives. Many teachers in different schools (and especially girls' schools) had apprehensions about the curriculum. However the unstinting support from the Principals did not allow this programme to get stalled. The project team, as a strategy, held a meeting with all the teachers in the school before the programme was initiated in Class VIII. They had continuous 'one to one' interaction with the concerned teachers as well.

“The teacher used to come into the class during our session and see what we were writing on the blackboard and she also asked the students. She told us you should not talk about condom, what you tell them may be correct but they will use it in a wrong way.”

Female Trainer, Rural Girls' school

“When we were taking session on contraception, the School Head went to all classes and sat there for few minutes. We were talking about Mala-D (oral contraceptive pills) and condom. Afterwards she said that don't give this knowledge very openly. But when we asked the girls they said it is Head Madam's duty to say something, but this knowledge is useful for us.”

Programme Officer, Sexuality Education programme, Bawal

“Teacher told us to give information which is necessary, and not give them (students) much information so that they start doing it in practical.”

Female Trainer, Urban Girls' school

Continued dialogue with the teachers help assuage some of their doubts and eventually some of them even turned into allies. Much of the credit of achieving this change goes to the trainers who had to play the dual role as advocates and trainers at the same time.

“Friendship between boys and girls is not right and even teachers do not support it because students don't know the results, girls can get carried away by emotions and this will result in love marriage and love marriage is not successful”.

Principal Government Girls' Senior Secondary School, Rewari

“Last time most negative teacher was Madam Sushma (name changed) of Bawal girls' school, but we have seen changes in her, this year she is the one who supported us most and took care of us. When we went to say thanks, she used to say no need of saying thanks; you give information that is good. She said the school's door is always open for you people.”

Programme Officer, Sexuality Education Programme, Bawal

“If we talk about Bawal boys (school), we got full support; principal told us that MAMTA people can come any time, teacher also left the class and period when we reached to take sessions. Many times Principal took us to the classroom.”

Male Trainer, Rural Boys' school

“Likewise in Bawal girls (school), we had no problem, Principal and In-charge also supported. She said that it is a good thing that you are talking about issues which we can't discuss with the girls.”

Female Trainer, Rural Girls' school

“In Rewari too, Madam Shobha (name changed) used to take us till the classroom, she made all student sit properly and told the girls that no body will make noise or be undisciplined. She was very busy in school management, despite that she always gave us enough time.”

Female Trainer, Urban Girls' School

“Whenever Principals are in a meeting we had to go into the room to take permission (for conducting the session). Principal used to introduce us and our work to others in the school.”

Male trainer, Rural boys' school, Bawal

“Many teachers asked us what will you tell the students today? They appreciated our work and said it is useful information.”

Female Trainer, Urban Girls' school

“Teachers told us to organise a workshop on issues that were being discussed with students, so that they can answer questions related to those issues.”

Female Trainer, Rural Girls' school

3.2.2: Developing an incremental curriculum

During the year, consultation with School principals/ 'In-charge' and teachers was undertaken as a strategy to build trust. These interactions were documented and the overall process documentation was used as the basis for modifying the curriculum and the programme. The facilitators also maintained a detailed record of the processes followed during each session. At the end of each session, each trainer submitted a report that included details about:

- The number of students attending a particular session,
 - Overall response from the students (on contents and methods),
 - Questions raised by the students related to the theme of the session or otherwise,
 - Challenges faced during the delivery of the sessions, and
 - Trainers' suggestions, if any, for modifying a particular session in next year's curriculum.
- These reports were compiled by the programme officer/manager and a consolidated report was prepared for each session that provided an overview in terms of (i) the response on a particular topic/theme from students in urban and rural settings, by boys and girls, (ii) total attendance across the schools for this session and (iii) questions that were brought up in the course of the session.

A 'Debriefing Meeting' was also held by the Programme Officer (stationed at the local office) after each session had been delivered in all schools. All the trainers participated in the meeting to provide an overall feedback on the session and to discuss feasible solution in case they had faced any challenges.

A Pre-Post test was developed based upon each year's curriculum. The Pre test was administered in the first contact /session in each academic year. The post test was conducted at the end of the year after all sessions had been delivered in a particular school. The test papers did not ask for names (but asked for the roll numbers in class IX and X), and the students were explained that the results from these test papers would not be included in the academic assessment. The analysis of the Pre test provided an understanding about the areas which would require emphasis during the year and also if this was to be particularly reinforced in a subset of the cohort (e.g., boys in rural school).

A comparison of the post and pre test was made at the end of each academic year. The analysis revealed the general trend over each year and the basis for identifying issues/areas in which the students did not demonstrate the expected levels of change in knowledge or attitude. The possible reasons for low percentages on an identified issue were discussed. These were to be taken into account while planning the curriculum for the next year and for orienting the trainers on the key issues / messages to be reinforced in the classroom. A 'Year-end review' was carried out after delivering all the sessions, usually towards the end of each academic year. This included Focus Group discussion with students and facilitators and interviews with principals/In-charge/Teachers from all the four schools. Students were invited to contribute ideas and feedback on both content and delivery methods. This process was conducted separately for boys and girls in the urban and the rural setting; and repeated annually with the same cohort as they advanced through the school.

The curriculum was modified at the beginning of the new academic session based on the feedback from students, facilitators and teachers and with the inclusion of additional content for each New Year of intervention. In this way an incremental curriculum was developed for classes IX and X, to cover basic sexuality education needs for this age level, with the addition of topics of special interest at this stage, e.g., stress management and goal setting for students appearing for Board Examinations. Considering that new students join at the commencement of class levels and not exposed to the program to the same degree as the original cohort, the curricula for each year consolidated previous learning while introducing new, age-specific material. The implementation of a basic curriculum in Class VIII provided most important feedback for revision of content and methodologies as well as strategies to address most common constraints (time, class size, skills of the facilitators etc.) and challenges (student's interest, capacity to grasp the content, attendance, presence of new students in class etc.). The trainers also brought valuable feedback to the table while developing the curriculum. These were taken into consideration and changes incorporated accordingly in the curriculum. Some of the verbatim reflecting the trainer's observation about the curriculum development and implementation are as follows.

“Handouts given on nutrition showed the requirement in calories; they asked what a calorie is?”

Female Trainer, Rural Girls' school

“They don't know how to measure, they should be told quantity of chapatti (flat Indian bread) and vegetable. It's written in measurement (calories), which was not good enough.”

Female Trainer, Rural Girls' school

“Question box didn't work, they asked directly. In next session it takes long time (to answer the queries from the question box) and topic also gets diverted.”

Male Trainer, Rural Boys' school

“We should give separate time for question and answers because their eagerness to know more will keep increasing otherwise. We should include at least 15 to 20 minutes for question answer session. We faced problems in finishing our session first and giving answers to their questions. If we don't give proper time to answer (their queries) they don't listen to us during our sessions.”

Male Trainer, Rural Boys' school

“We should distribute handouts with main heading after each session.”

Female Trainer, Rural Girls' school

“We should share our curriculum with teachers before starting of session. They will be clear about what we are conveying to the students. So they will be able to observe and share any changes in the students.”

Female Trainer, Urban Girls' school

The number of contacts and sessions conducted during each academic year has been presented in table 3.4.

Table 3.4: Number of contacts and sessions conducted during each academic year

Session Name	Class VIII 2005-06	Class IX 2006-07	Class X 2007-08
Additional contact			Pre test
Session 1	Who am I? (Pre-Test)	Who am I? (Pre-Test)	Stepping towards future
Session 2	Changes during adolescence	How to be happy	How to think positive and cope with stress
Session 3	How to be happy	Peer pressure	Peer pressure
Session 4	Peer pressure	Understanding the changes during puberty	Understanding the changes during adolescence
Session 5	Early marriage, Early pregnancy	Changes during adolescence	Gender and health
Session 6	HIV and AIDS	Early marriage and early pregnancy & contraceptive	Early marriage and early pregnancy & contraceptive
Session 7	Sexually transmitted infections	Knowledge of STIs and HIV	STI and HIV transmission and prevention
Additional contact		Post test	Post test

3.3: Challenges faced during implementation

The proposal took cognisance of the many challenges that could be faced in the implementation of this curriculum. However, many unforeseen challenges cropped up, some 'out of control' of the intervention team.

New students in the cohort: The government schools are obliged to admit all students seeking admission at the beginning of the academic year. New students that joined during the year or at the commencement of other Class levels were not exposed to the program to the same degree as the original cohort. This may have diluted the effect of the program for the cohort overall. To minimise this potential confounder, the curricula for each year consolidated previous learning while introducing new, age-specific material.

Unexpected dropouts from the cohort: An unexpected turn of events took place at the end of the first year of intervention. The Government of Haryana decided to introduce the Board Examinations⁷ for Class VIII in the same year in which the intervention took place. Almost all the male students who were part of the cohort (Class VIII students in boys' schools) did not pass the examinations and as a result could not move on to Class IX. This meant that most of the boys who reached Class X and participated in the Post Test at the end of the year (Class X) received only two years of intervention, compared to three years received by most of the girls in the cohort.

Shifting of students to another school or drop-outs leading to difficulty in tracking roll numbers: At the end of the first year of intervention it was decided that each student will be asked to mention their roll Numbers (but not the names) on the Pre and Post test sheets so that it is possible to track the number of sessions attended by the students and if they had appeared for the Pre-Post Test. However, during the academic year few students moved to other schools or dropped out. During the third year of intervention a new branch was opened (in one of the girls' school) to overcome the constraint of space and some of the students in the cohort were moved to the new school building. As a result the roll numbers changed during the year and it became difficult to track them.

Availability of students to finish the curriculum in time: Absenteeism, especially in boys' school was a constant issue. It was the observation of the trainers that the overall environment in terms of discipline, and commitment of the teachers and the students varied in girls' and boys' schools. Both the boys' school lacked in this department. The boys' cohort was already small to begin with and this was compounded by the high rate of absenteeism or the trend to 'cut'/'bunk' classes.

Pilot testing of curriculum: Each year the incremental curriculum was developed based on the feedback received from the Year-end Review (towards the close of the academic year) and the analysis of the Pre and Post test. The curriculum however had to be field tested in non intervention schools which opened at the same time as the intervention schools. This meant that some time was required to carry out

⁷A common examination is held for all students in a particular class across the state and the students are evaluated by independent examiners.

the pilot testing and incorporating the suggestions into the curriculum and then making available the final curriculum to the trainers in time for them to start the sessions in identified schools.

Continuity of sessions: Though only 7 contacts (8 in Class IX and 9 in Class X) were required during the academic year, even this proved to be challenging. The schools reopened in the beginning of July and the process of enrolment of new students in the class continued almost till the end of the month. The students were then engaged in practice sessions for the Independence Day Function/Celebration (and again in January for the Republic Day). Extended holidays during the festival season (Dussehra and Diwali), winter breaks, examinations and 'preparation leave' (for board examination) made it somewhat difficult to maintain continuity between sessions.

Chapter Four

Awareness and Experience of Reproductive and Sexual Health Issues

This section describes the significant changes observed among Class X students (in the four schools where the intervention was carried out over a period of three years through classes VIII, IX and X) as compared to students in Class XI in the same schools who served as the control group. The data was collected through Pre-test administered to Class X and XI students at the beginning of the academic session 2007-08 and Post test administered to Class X at the end of the session 2007-08. This is based on the premise that students who will pass out of Class X at the end of the academic year are at the same level (in terms of exposure to regular school curriculum) as Class XI students at the beginning of an academic year. Also included here are results from the need assessment (which has also been considered as baseline) and endline study carried out in the four intervention schools as well as in other schools in the same geographical setting that served as control.

4.1: Awareness about changes during puberty

One of the key theme areas in curriculum was about the pubertal changes in boys and girls that included information on the reproductive system. The sessions also included information related to physiological events like menstruation and nocturnal emission and addressed some of the common myths and misconceptions. From the data in table 4.1 it is evident that students in Class X have a better understanding compared to Class XI students about the fact that final height of an adolescent girl or boy depends on the height of the parents. This difference is statistically significant (1% level of significance) among the girls in class X compared to Class XI. While more students in class X are aware that pimples are caused by hormonal changes in the body (and not by fried food, sexual fantasies) there is no statistical difference in comparison to Class XI.

More students of Class X in all four schools can correctly identify the female reproductive organs from a set of terms that refer to various structures in the body. This knowledge is statistically significant in three groups (except rural boys) when compared to Class XI students. At the same time statistically significant number of girls in Class X (compared to girls in Class XI) identified that 'uterus' is the reproductive organ where the foetus develops.

“They were not serious in first two sessions, but when we talked about reproductive parts, they started taking interest. They laughed at first, and then they realised that this knowledge is very useful for their future life.”

A male trainer sharing experience from the rural boys' school in Bawal

“In reproductive and adolescence session, girls listened very carefully and there was pin drop silence in class during these sessions. They asked many questions even after the end of sessions. We observed that they need more information and time for these sessions. They feel good about receiving this information.”

A female trainer sharing experience from the urban girls' school in Rewari

Table 4.1: Awareness about body and changes during puberty

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Is of the opinion that height of an adolescent boy or girl depends on height of the parents					
Boys	Rural	38.6	23.1	2.327	.127
	Urban	42.4	31.4		
Girls	Rural	55.4	35.0	8.205***	.004
	Urban	66.8	37.9		
Aware that pimples are caused by: Hormonal changes in the body, especially during adolescence					
Boys	Rural	63.6	76.9	1.734	.188
	Urban	78.8	78.4		
Girls	Rural	71.1	65.0	0.831	.362
	Urban	69.9	62.1		
Aware that Uterus and Vagina are female reproductive organs					
Boys	Rural	63.6	46.2	2.558	.110
	Urban	78.8	49.0		
Girls	Rural	59.0	29.9	16.904***	.000
	Urban	58.2	44.2		
Aware about part of the female body where the baby develop					
Boys	Rural	88.6	89.7	0.026	.871
	Urban	78.8	90.2		
Girls	Rural	92.8	73.5	11.954***	.001
	Urban	90.8	83.2		

“When we went to take session after Reproductive Organs session, some students told us to show the apron with diagrams of reproductive parts, they asked us to draw diagram of penis and vagina on the blackboard.”

Female Trainer, Rural Girls' School

While the students generally fared well when asked about the significance of menstruation, statistically significant number of girls in class X of the rural school are aware that menstruation signifies physical ability to become pregnant. Girls in class X have better awareness about the interval between two

menstrual cycles (that it is usually 21-35 days) which is statistically significant. However it is boys in Class XI (non intervention class) who are better informed about it, a difference that is statistically significant in comparison to boys in class X. The most significant findings are in relation to the phenomenon of Night fall (or nocturnal emission) and Masturbation. Considering that various myths and misconceptions among school students in the adolescent age group, the curriculum has been successful in changing some of these perceptions.

Table 4.2: Awareness/perception about menstruation, nightfall and masturbation

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Aware that menstruation signifies a girl's physical ability to become pregnant					
Boys	Rural Urban	70.5 81.8	74.4 66.7	0.157 2.313	.692 .128
Girls	Rural Urban	89.2 81.6	74.4 75.8	6.773** 1.969	.009 .161
Aware that interval between one menstrual period and the next is usually 21-35 days					
Boys	Rural Urban	50.0 27.3	74.4 54.9	5.178*** 6.206**	.023 .013
Girls	Rural Urban	89.2 80.1	65.0 64.2	15.165*** 12.160***	.000 .000
Agreed that Nightfall signifies that a boy has reached puberty					
Boys	Rural Urban	65.9 78.8	69.2 60.8	0.104 2.977*	.747 .084
Girls	Rural Urban	92.8 77.6	41.9 48.4	53.947*** 35.205***	.000 .000
Does not think that if a boy has nightfall then he requires medical help					
Boys	Rural Urban	50.0 36.4	10.3 7.8	15.180*** 10.569***	.000 .001
Girls	Rural Urban	75.9 52.6	20.5 10.5	60.614*** 78.478***	.000 .000
Agreed that semen lost though masturbation or nightfall is always replaced by the body					
Boys	Rural Urban	84.1 87.9	48.7 56.9	11.787*** 9.019***	.001 .003
Girls	Rural Urban	92.8 54.1	30.8 27.4	75.946*** 28.475***	.000 .000
Disagreed that frequent masturbation leads to impotence in men					
Boys	Rural Urban	25.0 39.4	5.1 9.8	6.181*** 10.419***	.013 .001
Girls	Rural Urban	38.6 30.1	23.1 8.9	5.593** 27.305***	.018 .000

Most students in the intervention classes identify that nocturnal emissions signify that a boy has reached puberty. This difference is statistically significant, except for boys in rural school. A much larger percentage of students in Class X think that a boy who has nightfall does not require medical help. The difference is statistically significant in all four schools (at 1% level of significance). This is an important finding since the most common reason for which adolescent boys seek help from Quacks (unqualified, self-proclaimed doctors) is for the concerns relating to nocturnal emission. Again, class X students in all four schools have the knowledge that semen lost through masturbation or nocturnal emission is always replaced by the body. When compared to students in Class XI, this difference is statistically significant (at 1% level of significance in all four schools). This knowledge is significant in light of the fact that most common myths perpetuated locally are about semen being precious and correlating semen loss to weakness.

“When I explained about the nightfall that it does not have any harmful effect on the body, none of the students asked any questions on the same day, but next day some other students, who were not present in the session asked if I had really said this. I asked the other students to clarify, and then some of the students told their peers very confidently that Nightfall is not harmful ...”

Male trainer, rural boys' school, Bawal

The feedback received from adult stakeholders, during the Needs Assessment, emphasized that issues like masturbation and sexual intercourse be kept out of the curriculum. However the opportunity to ask questions directly in the class and through the question box inevitably brought up the issue of masturbation. The trainers had been prepared to handle these questions and the Pre-Post questionnaire included questions on these issues to assess students' knowledge.

Students in Class X in all four schools have the knowledge that masturbation does not lead to impotence. The difference in knowledge about this issue is statistically significant in all four schools (at 1% level of significance in girls' schools and at 5% level of significance in boys' schools). Data from comparison of the baseline and endline study, reveals that irrespective of the location of school, boys and girls from intervention schools are able to identify (and reject) common misconceptions about masturbation (such as masturbation leads to impotency, causes sexual dysfunction, deformity of the sexual organs, causes weakness) and accept that masturbation is a 'natural practice'. The difference in knowledge on this issue is statistically significant ('masturbation is a natural practice') in all the four intervention schools as compared to their counterparts at baseline and endline.

Statistically significant numbers of boys in control group (at endline) consider masturbation to be an 'immoral act' when compared to the intervention group. Such an attitude is important to change since this can lead to a feeling of guilt or depression among boys who practise masturbation. Masturbation was not included as a topic within the curriculum because of the reservations expressed by stakeholders (parents and teachers) about this issue being discussed in the classroom setting. However this topic emerged frequently during the Question Answer session and it is apparent that students who were part of this programme benefited in terms of information on this issue.

4.2: Awareness about sex determination

In the state of Haryana, the adverse sex ratio is highly concerning. In this context, the curriculum includes a section on how the sex of the foetus is determined; highlighting the fact that this process cannot be controlled or influenced by either of the two partners. Irrespective of the intervention, sex of the students and location of the school, between 68-72 percent of students are aware that the sex is determined by the chromosomes on the egg and sperm. However among the boys in rural school, higher percentages (84%) of boys in non intervention classes have this knowledge, which is statistically significant. The reason for high level of knowledge on this issue can be due to the fact that this is a topic that is also included in the Science and Technology curriculum of Class X in Haryana Board.

Table 4.3: Awareness about sex determination

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Aware that sex of a child is determined by the chromosomes on the egg and the sperm					
Boys	Rural	52.3 (23)	84.6 (33)	9.854***	.002
	Urban	72.7 (24)	72.5 (37)	0.000	.986
Girls	Rural	68.7 (57)	70.9 (83)	0.119	.730
	Urban	69.4 (136)	71.1 (135)	0.128	.721

4.3: Awareness about risk associated with adolescent pregnancy

Early marriage is another issue that demands attention in the state of Haryana. Though girls in school are less likely to get married early compared to their counterparts who are out of school, yet there are chances that some of them may still get married below the age of 18 years. Additionally there are chances that peers or young girls in the extended family face this risk. In this context the curriculum emphasizes on the age of marriage and delaying birth of the child beyond 19 years. The curriculum also conveys the message that pregnancy can be planned, thus replacing the notion that pregnancy just occurs and one cannot do anything to prevent it.

Table 4.4: Awareness about risk associated with adolescent pregnancy

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
If one is married before 18 years of age, it would be best to plan a baby: Delay pregnancy till one is older than 19 years					
Boys	Rural Urban	50.0 81.8	89.7 90.2	15.180*** 1.236	.000 .266
Girls	Rural Urban	74.7 82.1	67.5 74.7	1.203 3.135	.273 .077
Pregnancy during adolescent years (less than 19 years of age) can be Risky for both the Mother and the Child					
Boys	Rural Urban	81.8 93.9	87.2 90.2	0.450 0.368	.502 .544
Girls	Rural Urban	96.4 92.3	86.3 84.7	5.716** 5.532**	.017 .019

Most students, except boys in Class X in rural school, recognize that it is best to delay pregnancy till the girl is 19 years or older (Table 4.4). The difference is statistically significant among Class X and XI girls in urban school (82% compared to 75%). However 90 percent Bawal boys (RB) in Class XI (non intervention class) as compared to 50 percent in Class X have chosen this option. 'It would be best to delay the pregnancy till one is older than 19 years in case one is married before 18 years' has been reported by higher percentage of the boys from class XI than those from class X. However, the reverse is true for the girls. The difference is statistically significant for urban girls. Again, higher percentage of the girls from class X than their counterparts from class XI have awareness that pregnancy during adolescent years (less than 19 years of age) can be risky for both the mother and the child. The difference is statistically significant.

“In the beginning boys were joking and saying that if marriage will take place early then definitely pregnancy will also occur and we will get some sweets...when we told them what could be the consequences (of early marriage and pregnancy) then they accepted and said that we were just joking, we know it is very harmful...”

A Male Trainer, about the FGD

“Sometimes it is dangerous for both the girl and the child she is bearing. If marriage takes place before the age of 18 years then girl should not become a mother before 19 years of age. Girls should know how to keep the child healthy, how to have safe sex and whether condom should be used or not. These things she must learn before she gets married.”

Class IX Student, Government Boys Senior Secondary School, Bawal

4.4: Awareness about contraceptives and safer sex

The curriculum focused on providing information regarding the oral contraceptive pills, condoms and 'Safer Sex'. While the overall knowledge that oral pills prevent pregnancy was high, most of the students did not know that it does not provide protection against STIs or HIV (table 4.5). Similarly for condoms, a higher percentage of students know that it prevents transmission of STIs and HIV than those who know that it also prevents pregnancy.

Table 4.5: Awareness about contraceptives and safer sex

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Aware that Oral pills can prevent pregnancy					
Boys	Rural Urban	81.8 87.9	97.4 86.3	5.216** 0.045	.022 .831
Girls	Rural Urban	79.5 86.7	74.4 60.5	0.719 34.301***	.397 .000
Aware that Oral pills can not prevent transmission of HIV and STIs					
Boys	Rural Urban	20.5 24.2	17.9 29.4	0.083 0.269	.763 .604
Girls	Rural Urban	45.8 36.2	29.1 15.3	5.894** 22.084***	.015 .000
Correct knowledge about contraceptive pills & condom (Includes those who know Oral pills can prevent pregnancy but can not prevent transmission of HIV/STI, and know that condom can prevent pregnancy as well as HIV/STI)					
Boys	Rural Urban	6.8 12.1	15.4 13.7	1.569 0.045	.210 .831
Girls	Rural Urban	16.9 6.1	0.9 2.1	17.946*** 3.918***	.000 .048
Aware that Condoms can prevent pregnancy					
Boys	Rural Urban	63.6 51.5	48.7 68.6	1.873 2.488	.171 .115
Girls	Rural Urban	61.4 41.8	45.3 44.7	5.072** 0.331	.024 .565
Aware that Condoms can prevent HIV & STIs					
Boys	Rural Urban	75.0 90.9	82.1 48.4	0.605 2.246	.437 .134
Girls	Rural Urban	61.4 50.5	41.9 46.8	7.435*** 0.520	.006 .471

“We can use Mala-D and condom to prevent birth of a child. Because by using condom semen does not enter inside, it remains in the condom.”

Class IX Student, Government Boys senior Secondary School, Bawal

“We can use condom to protect ourselves from AIDS and also for protecting against unwanted pregnancy.”

Class IX Student, Government Boys senior Secondary School, Rewari

Statistically significant difference is observed among Class X girls in urban and rural schools (compared to Class XI girls) in terms of the understanding that oral pills cannot provide protection against STIs/HIV. 61.5 percent of Class X girls in Bawal (RG) are aware that condoms can prevent pregnancy and HIV, which is statistically significant in comparison to Class XI girls. The results have also been analyzed to find the percentages of students that have complete and correct information (that oral pills prevent pregnancy but not STI/HIV and that condom prevents both). Bawal girls (17%) in Class X demonstrate a statistically significant difference in knowledge when compared to all other groups in this regard even though the overall percentage is low.

4.5: Awareness about STIs

Students from class X seem to have better awareness about STIs. As is seen from the results (table 4.6), irrespective of location of school and sex of the students, higher percentages of the students from class X correctly identify all 4 or at least 3 symptoms of STI (redness/ itching in genital area, foul smelling discharge from vagina/ penis, burning sensation during urination, pain abdomen in females) compared to students from class XI. The difference is statistically significant in all groups except for boys in urban school.

While a high percentage of students across Class X and XI know that STIs are curable, a higher percentage of students in the Intervention class (X) know that HIV is not curable. This is statistically significant among girls in rural school. Most students in both class X and XI are aware of the fact that in case a person has a STI, treatment should be sought from a qualified doctor at a recognized hospital or clinic. Whether this knowledge translates into practice will depend on the availability of the services in the locality as well as other factors (e.g. friendliness of services, availability of male and female doctors, drugs etc.).

Table 4.6: Awareness about RTI/STI

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Have knowledge about all 4 symptoms of RTI					
Boys	Rural Urban	13.6 6.1	0.0 5.9	5.733*** 0.001	.017 .973
Girls	Rural Urban	66.3 18.4	20.5 9.5	42.531*** 6.432**	.000 .012
Have knowledge about at least 3 symptoms of RTI					
Boys	Rural Urban	25.0 30.3	0.0 13.7	11.240*** 3.411*	.001 .065
Girls	Rural Urban	68.7 42.9	28.2 13.2	32.130*** 41.993***	.000 .000
Think sexually transmitted infections are curable					
Boys	Rural Urban	65.9 87.9	76.2 62.7	1.220 6.365**	.269 .012
Girls	Rural Urban	80.7 70.4	59.8 71.6	9.824*** 0.520	.002 .800
Complete knowledge on management of STI/STD (who knows that STI are curable and HIV/AIDS is not curable)					
Boys	Rural Urban	27.3 45.5	38.5 31.4	1.179 1.706	.278 .191
Girls	Rural Urban	28.9 26.5	8.5 16.3	14.277*** 5.964**	.000 .015
Aware of the place for treatment of STIs: Hospital/clinic with qualified doctor					
Boys	Rural Urban	86.4 93.3	100.0 88.2	5.733 0.757	.017 .384
Girls	Rural Urban	92.8 95.4	93.2 92.1	0.011 1.805	.915 .179

4.6: Awareness about transmission/prevention of HIV/AIDS

HIV was one of the main themes addressed through the curriculum. From the results it is clear that a large percentage of students in both Class X and XI are aware of the fact that women are more vulnerable to HIV (table 4.7). However it is the girls in intervention classes (Class X) who correctly

recognize the reasons (biological and social) for this vulnerability and this is statistically significant in context of girls in rural school. At the same time boys in Class X of the urban school also show a statistical difference in this regard, when compared to boys in Class XI. Overall higher percentage of students who were part of this programme (Class X) is aware of the difference between HIV and AIDS. This difference is statistically significant among girls in both urban and rural schools.

When it comes to knowledge about modes of transmission, the data was analyzed to find the percentage of students who could correctly identify all the four routes of HIV transmission (sex without condoms, sharing needles or syringes, from HIV positive mother to child, and through blood transfusion). It can be seen that more girls in Class X had this information compared to Class XI girls and it was statistically significant in case of girls in urban school. On the other hand, boys in class XI demonstrated better awareness on this issue but the difference is not significant. One of the most interesting findings in context of HIV is that statistically significant percentages of students in Class X who are able to reject all myths related to HIV transmission when compared to Class XI, which did not receive the intervention. It is clear from the results that more students at endline are aware that 'one can protect against HIV infection'. This may be attributed to overall increase in general awareness on HIV and AIDS that is being created through various mechanisms including media campaigns, newspapers and various activities organized in the school. Surprisingly students in urban areas had low awareness about this issue at baseline (3 years ago) as compared to those in rural locations.

“AIDS... We did not know about this... we feared what this was and how it spreads...”

Class X Student, Government Boys senior Secondary School, Bawal

“If everybody will know correctly about HIV-AIDS, then it will automatically stop spreading.”

Class IX Student, Government Boys senior Secondary School, Bawal

The students in Class X were asked in the endline study if they know how to use condom properly. More students in all the four intervention schools (including girls and boys) responded in positive, and the difference was statistically significant as compared to students in intervention schools (table not shown). This difference was more marked among girls, both rural and urban as well as boys in urban school. The students were asked if they would have sex with someone who declined to use a condom. The results show that a significant percentage of girls in the intervention schools (77.5% and 32.8 % in rural and urban school respectively) compared to girls in control schools (5.4% and 9.9% in rural and urban respectively) reportedly would decline to have sex without a condom. This difference was statistically significant.

4.7: Awareness about sexual harassment and sexual abuse

Sexual harassment in the form of eve teasing was an issue that was highlighted through the curriculum. While higher percentages of girls in Class X were of the opinion that boys should never tease girls, it was higher percentage of boys in the non intervention class (XI) who held the same opinion (table 4.8). The result was statistically significant among Bawal girls (96.4% of Class X compared to 78.6% of Class XI). In Bawal boys' school, more students from Class XI were of the opinion that girls should never be teased (36.4% of Class X compared to 77% of Class XI).

Table 4.7: Awareness about transmission/prevention of HIV/AIDS

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Aware that women are more likely to get HIV due to biological and social reasons, as compared to men					
Boys	Rural Urban	34.1 57.6	51.3 35.3	2.506 4.036	.113 .045
Girls	Rural Urban	83.8 58.2	59.8 52.1	4.036** 1.432	.000 .231
Aware that HIV is a virus and AIDS is the illness caused by it					
Boys	Rural Urban	65.9 84.8	66.7 78.4	0.005 0.535	.942 .464
Girls	Rural Urban	91.6 77.0	62.4 57.4	21.752*** 16.981***	.000 .000
Aware about all the 4 modes of HIV transmission					
Boys	Rural Urban	38.6 54.5	43.6 56.9	0.210 0.044	.647 .834
Girls	Rural Urban	32.5 49.5	27.4 31.6	0.626 12.826***	.429 .000
Have at least one misconception about modes of HIV transmission (Kissing, Sneezing, Touching, Sharing food, Mosquito bite)					
Boys	Rural Urban	56.8 72.7	82.1 51.0	6.119** 3.933**	.013 .047
Girls	Rural Urban	53.0 47.4	66.7 65.3	3.805* 12.439***	.015 .000
Percentage of young people who know that HIV/AIDS is not transmitted by kissing, sneezing, touching, sharing foods and mosquitoes					
Boys	Rural Urban	31.8 27.3	7.9 39.2	2.105 1.264	.147 .261
Girls	Rural Urban	41.0 44.4	19.7 23.2	10.816*** 19.395***	.001 .000
Percentage of young people who have rejected at least 4 out of the 5 misconceptions about HIV/AIDS transmission (kissing, sneezing, touching, sharing foods and mosquitoes)					
Boys	Rural Urban	45.5 54.5	61.5 70.6	2.147 2.246	.143 .134
Girls	Rural Urban	66.3 70.9	42.7 50.0	10.780*** 17.685***	.001 .000

Table 4.7: Awareness about transmission/prevention of HIV/AIDS (contd...)

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Percentage of young people who have rejected at least 3 out of the 5 misconceptions about HIV/AIDS transmission					
Boys	Rural Urban	54.5 66.7	82.1 84.3	7.127*** 3.565*	.008 .059
Girls	Rural Urban	77.1 79.6	63.2 67.9	4.361** 6.833***	.037 .009
Agreed that It's possible to know if a person has HIV by his/her physical appearance					
Boys	Rural Urban	18.2 21.2	5.1 11.8	3.325* 1.367	.068 .242
Girls	Rural Urban	16.9 12.9	16.2 11.1	0.014 0.266	.906 .606
Think AIDS is not curable					
Boys	Rural Urban	54.5 54.5	61.5 64.7	0.415 0.867	.520 .352
Girls	Rural Urban	57.8 62.8	36.8 37.9	8.700*** 23.853***	.003 .000

The students were asked to identify acts that would amount to sexual harassment (making sexual remarks, following somebody with a wrong intention, writing obscene letter, making obscene phone calls). Girls from Class X correctly identified all these acts to be different forms of sexual harassment and the difference between Class X and XI girls was statistically significant. On the other hand, boys from Class XI showed a better knowledge on these issues than the boys who were part of the intervention.

When asked about what possible actions can be taken when faced with sexual abuse, a higher percentage of girls from Class X (intervention group) responded that they would 'oppose it then and there' while more boys in the control group (Class XI) opted for this response. A higher percentage of girls and boys (statistically significant) in urban locations chose the option of 'confiding in a trusted elder person' as compared to the control group (Class XI). Also the same group (Class X in urban schools) chose both these options ('opposing then and there' and 'confiding in an elder trusted person') together, and this difference was statistically significant when compared to the Class XI students.

Table 4.8: Awareness/perception about eve teasing

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Is of the opinion that Boys should never tease girls					
Boys	Rural Urban	36.4 39.4	76.9 58.8	13.766*** 3.027*	.000 .082
Girls	Rural Urban	96.4 90.3	78.6 93.2	12.710*** 1.032	.000 .310
Have complete knowledge about sexual harassment (Making sexual remarks, Following somebody with a wrong intention, writing obscene letter, Making obscene phone calls)					
Boys	Rural Urban	50.0 48.5	87.2 62.7	13.021*** 1.664	.000 .197
Girls	Rural Urban	71.1 63.3	49.6 41.1	9.255*** 19.082***	.002 .000
Opine that they will oppose sexual abuse then and there					
Boys	Rural Urban	59.1 69.7	79.5 72.5	3.998** 0.080	.046 .777
Girls	Rural Urban	78.3 78.6	71.8 74.2	1.086 1.018	.297 .313
Opine that they will tell a trusted elder person in case of any sexual abuse					
Boys	Rural Urban	40.9 66.7	46.2 31.4	0.232 10.075***	.630 .002
Girls	Rural Urban	37.3 50.0	39.3 37.9	0.079 5.736**	.778 .017
Opine that they will oppose sexual abuse then and there, and tell a trusted elder person					
Boys	Rural Urban	22.7 45.5	35.9 13.7	1.745 10.434***	.187 .001
Girls	Rural Urban	20.5 37.2	23.1 21.6	.191 11.377***	.662 .001

4.8: Perception about premarital sex

When asked at the endline if 'it was alright to have premarital sex', statistically significant number of girls in the intervention group agreed with the statement as compared to girls in the control group (endline study). However the opposite was true for boys; more boys in intervention schools compared to boys in the control schools (statistically significant) disagreed with it and did not support the idea of premarital sex.

Table 4.9: Perception about premarital sex

Indicators by the sex of the student	Location	Baseline Class X	Endline Class X		Endline Intervention v/s Control		Baseline v/s Endline (Intervention)		Baseline v/s Endline (Control)	
			Intervention	Control	χ^2 Value	Sig. Level	χ^2 Value	Sig. Level	χ^2 Value	Sig. Level
		N	N	N						
		RB-113 UB-55 RG-74 UG-250	RB-145 UB-45 RG-89 UG-232	RB-86 UB-46 RG-111 UG-242						
It is OK to have premarital sexual relationship										
Boys	Rural Urban	44.2 21.8	15.6 37.8	53.5 56.5	17.646*** 3.206*	.000 .073	0.610 8.083**	.435 .004	19.155** 0.309	.000 .578
Girls	Rural Urban	6.8 1.2	37.1 47.8	32.4 31.4	0.472 13.402***	.492 .000	49.131*** 40.619***	.000 .000	0.559 16.941***	.455 .000

4.9: Sexual experience and condom use

46.7 percent (N=21) of boys in rural school and 40 percent (N= 18) in urban school have reportedly had a sexual experience (sexual intercourse). Only 6.7 percent (N=6) and 9.5 percent (N=22) of girls in rural and urban schools respectively reported a similar experience. However this number is higher than that reported by the boys and girls in the control group [14 % (N=12) by RB, 15 % (N=7) by UB, 2.7 % (N=3) by RG and 5 %(N=12) by UG] and statistically significant in all three groups except the rural girls' school (table 4.10).

Table 4.10: Sexual experience

Indicators by sex of the students	Location	Endline Class X		Endline Intervention v/s Control	
		Intervention	Control	χ^2 Value	Sig. Level
		N	N		
		RB-45 UB-45 RG-89 UG-232	RB-86 UB-46 RG-111 UG-242		
Did you ever have a sexual relationship?					
Boys	Rural Urban	46.7 40.0	14.0 15.2	16.776 7.012	.000 .008
Girls	Rural Urban	6.7 9.5	2.7 5.0	1.875 3.641	.171 .056
Did that intercourse happen with your consent?					
Boys	Rural Urban	71.4 61.1	58.3 NC 57.1 NC	NC NC	
Girls	Rural Urban	33.3 40.9	33.3 NC 25.0 NC	NC NC	
Below 15 years when had sexual intercourse					
Boys	Rural Urban	33.3 22.2	25.0 NC 28.6 NC	NC NC	
Girls	Rural Urban	16.7 18.2	33.3 NC 8.3	NC NC	NC

Of the total number of boys (N=39, RB 21, UB 18) who reported having had a sexual experience, 71 percent of RB and 61 percent of UB reported that this was consensual as against 58 and 57 percent of boys in control schools in rural and urban settings, respectively. 33 percent of RB and 22 percent of UB reported having the sexual experience below the age of 15 years. However the numbers are too small to establish the statistical significance of this result.

Table 4.11: Condom use

Indicators by sex of the students	Location	Endline Class X		Endline Intervention v/s Control	
		Intervention	Control	χ^2 Value	Sig. Level
		N	N		
		RB-45 UB-45 RG-89 UG-232	RB-86 UB-46 RG-111 UG-242		
A girl can suggest her boyfriend to use condom					
Boys	Rural	80.0	59.3	5.674	.017
	Urban	68.9	47.8	4.149	.042
Girls	Rural	88.8	19.8	93.925	.000
	Urban	31.5	11.2	29.347	.000
A boy can suggest her girlfriend to use condom					
Boys	Rural	66.7	64.0	0.095	.757
	Urban	84.4	50.0	12.212	.000
Girls	Rural	68.5	16.2	56.587	.000
	Urban	27.2	7.9	30.851	.000

In the endline study, 80 percent of boys and 89 percent of girls in the rural schools agree that a girl can suggest the use of condom to her boyfriend (table 4.11). 69 percent of boys in the urban school also felt so, but only 31.5 percent girls in urban schools agreed to this statement. This however is statistically significant in all the four groups when compared to the responses from students in control schools. 66.7 percent of boys in rural school, 84.4 percent of boys in urban school, 68.5 percent of girls in rural school and 27.2 percent of girls in urban school agreed that a boy can suggest the use of condom to his girlfriend. This finding is statistically significant in all groups except the rural boys, when compared to students in the control group (64 percent in RB, 50 percent in UB, 16 percent in RG and 8 percent in UG).

Chapter Five

Communication, Awareness about Laws & Legislations and Attitude towards Gender Issues

Over the three years, various issues that have been addressed through the curriculum included skills on communicating with peers and parents, creating awareness about laws and legislations related to problems like early marriage and female foeticide. Discussion on gender and its influence on young people were included each year with an objective to increase awareness and bring about change in attitude towards gender related issues. Some of the results from the study are quite encouraging and show that change has begun to take place.

5.1: Communicating with peers, parents

The data in table 5.1 shows that compared to class XI, higher percentage of class X students, especially those from rural schools, chose the option of 'reasoning it out' in a situation when they are angry with someone. Also higher percentages of the boys from class X think that 'understanding other people's feeling makes the relationship stronger'. Further, irrespective of sex, higher percentages of the urban students from class X held the view that 'understanding other people's feelings helps in decreasing arguments & fighting', when compared to the responses from class XI students. On a similar line, higher percentage of the boys from class X (compared to class XI boys) are of the view that understanding other people's feelings not only makes the relationships stronger but also helps in decreasing arguments & fighting.

5.2: Awareness about laws, legislations

The curriculum included information regarding existing legislations in context of 'age at marriage' and 'female foeticide'. Students in all three schools (except for boys in rural school) have correct knowledge about the legal age at marriage for both boys and girls, in India, and the difference is statistically significant when compared to students in Class XI (table 5.2). A high level of awareness exists about the Preconception Prenatal Diagnostics Technique Act (Prohibition of Sex Selection) among students in general and there is no difference observed between the intervention and non intervention classes.

5.3: Attitude on gender issues

Higher percentage of boys in urban (55% compared to 26%) school, girls in urban school (54% compared to 40%) and girls in rural school (45% compared to 32%) disagreed to the statement that 'men usually make better decisions than women' when compared to students in the non intervention class (table 5.3). It is statistically significant in all three schools. Only 22 per cent of UB, 32 percent of RG and 39 percent of UG from class X agreed with the statement that 'women should concentrate on maters in the home only.' These percentages are significantly less than the percentage of students in class XI who agreed with this statement.

Table 5.1: Communication with peers and parents

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190				
If you get angry with another person, the first thing you would do is: try to reason out	Rural	61.4	59.0	0.049	.824
	Urban	57.6	68.6	1.066	.302
Boys	Rural	75.9	61.5	4.567**	.033
	Urban	67.9	71.6	0.633	.426
Think that understanding other peoples feelings: Makes the relationships stronger	Rural	61.4	59.0	0.049	.824
	Urban	75.8	49.0	5.945**	.015
Boys	Rural	56.6	53.0	0.259	.611
	Urban	72.4	78.4	1.855	.173
Understanding other peoples feelings: Helps in decreasing arguments & fighting	Rural	47.7	51.3	0.105	.746
	Urban	69.7	43.3	5.682**	.017
Boys	Rural	55.4	70.1	4.532**	.033
	Urban	55.1	50.0	1.007	.316
Understanding other peoples feelings: Makes the relationships stronger and helps in decreasing arguments & fighting	Rural	38.6	25.6	1.591	.207
	Urban	51.5	23.5	6.942***	.008
Boys	Rural	25.3	33.3	1.492	.222
	Urban	41.3	35.8	1.248	.264

Table 5.2: Awareness about laws, legislations

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190				
Aware about the legal age of marriage for girls and boys in India	Rural	70.5	94.9	8.325***	.004
	Urban	97.0	76.5	6.436**	.011
Boys	Rural	96.4	86.3	5.716**	.017
	Urban	86.7	77.9	5.195**	.023
Aware that it is legally a crime to abort female fetuses	Rural	97.7	100.0	0.897	.344
	Urban	90.9	98.0	2.246	.134
Boys	Rural	92.8	91.5	0.115	.735
	Urban	95.4	96.3	0.200	.655

5.3: Awareness/perception about gender difference in the society

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Disagreed that men usually make better decisions than women					
Boys	Rural Urban	30.0 54.5	17.9 25.5	1.651** 9.175**	.438 .027
Girls	Rural Urban	45.1 54.1	31.6 40.0	17.791*** 12.013***	.000 .007
Disagreed that women should concentrate on matters in the home only					
Boys	Rural Urban	37.5 77.4	59.0 35.3	7.673* 14.119***	.053 .003
Girls	Rural Urban	68.3 60.7	52.1 61.1	6.654* 11.683***	.084 .009

Higher percentage of the girls in class X (92% RG and 95% UG) felt that the decision to have a baby should be made by both the partners (table 5.4). The corresponding figures in class XI are 74 percent and 88 percent. This difference between the two classes in the above indicator is statistically significant. The response by the boys is almost similar in both classes X and XI but less number of boys compared to girls thinks that the decision should be made jointly.

5.4: Awareness/perception about gender difference in the society

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
The decision to have a baby should be made by both the partners					
Boys	Rural Urban	84.1 84.8	89.7 80.4	0.575 0.271	.448 .602
Girls	Rural Urban	91.6 94.9	73.5 88.4	10.293*** 5.323**	.001 .021

Some of the views that emerged from the focus group discussion with girls are as follows:

“In Haryana there is more respect for the boys and you can see the numbers (sex ratio)”.

Class X, Student, Govt Girls Senior Secondary School, Rewari

“There is a lot of discrimination between boys and girls like boys can go to schools and get education easily and girls do not--- girls get married early ---they cannot go out alone whereas boys can---boys get better food in comparison to girls.”

Class X, Student, Government Girls Senior Secondary School, Rewari

Some of the views that emerged from the FGD conducted with the boys are presented here:

“Parents love male child more than the girl child, they give more facilities to sons than to daughters, we should not do this and we should treat both equally.”

Class IX Student, Government Boys senior Secondary School, Rewari

“Girls face 'dropping out' from school. Their parents stop sending them to school due to eve teasing.”

Class IX Student, Government Boys senior Secondary School, Rewari

5.4: Substance use

Chewing of Gutkha⁸ is a common practice among boys and is more common than smoking. Available evidence shows that this can become addictive and long term chewing of Gutkha leads to unhealthy consequences for the teeth (staining, decay) and oral cavity (Cancer). The aim of the curriculum was to create awareness about this issue. It is seen that irrespective of locations of the school, higher percentage of the boys from class XI than boys in class X know that chewing Gutkha can lead to cancer of the oral cavity (statistically significant in UB). Between 77-81 percent girls in both classes have this knowledge and the differences are not significant (table 5.5).

Table 5.5: Awareness about substance use

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Chewing Gutkha can lead to Mouth cancer					
Boys	Rural	68.2	71.8	0.128 10.419***	.720 .001
	Urban	60.6	90.2		
Girls	Rural	80.7	77.8	0.254 0.335	.614 .563
	Urban	77.0	79.5		

⁸Gutkha is a preparation of crushed betel nut, catechu, lime and sweet or savoury flavour, with or without tobacco. It acts as a mild stimulant and is consumed much like 'chewing tobacco'.

At the baseline and endline study, the students were asked whether they have ever smoked or drank alcohol. More students (both boys and girls) in the intervention endline schools reported 'having ever smoked or taken alcohol' as compared to students at endline control school (table 5.6). The reason for such a result is difficult to explain unless there is a tendency for under reporting among students in the control schools as compared to intervention schools. An assumption is that students who were part of the intervention have been exposed to an environment in which they have had an opportunity to discuss these issues in a more open and non judgmental manner and therefore do not hesitate to report these behaviours.

Table 5.6: Substance use

Indicators by the sex of the student	Location	Baseline Class X		Endline Class X		Endline Intervention v/s Control		Baseline v/s Endline (Intervention)		Baseline v/s Endline (Control)	
			Intervention	Control	χ^2 Value	Sig. Level	χ^2 Value	Sig. Level	χ^2 Value	Sig. Level	
		N	N	N							
		RB-113 UB-55 RG-74 UG-250	RB-145 UB-45 RG-89 UG-232	RB-86 UB-46 RG-111 UG-242							
Ever drink alcohol											
Boys	Rural	42.5	26.7	9.3	6.886**	.009	3.416*	.065	26.579***	.000	
	Urban	12.7	28.9	0.0	15.504***	.000	4.040**	.044	6.291**	.012	
Girls	Rural	1.4	11.2	0.9	10.151***	.001	6.273**	.012	0.084	.772	
	Urban	8.8	9.9	0.0	25.115***	.000	0.176	.675	22.393***	.000	
Ever smoked											
Boys	Rural	22.1	31.1	3.5	19.960***	.000	1.398	.237	14.027***	.000	
	Urban	3.6	22.2	2.2	8.604***	.003	8.096***	.004	0.186	.666	
Girls	Rural	0.0	3.4	0.0	3.799*	.051	2.541	.111	NA	---	
	Urban	2.0	5.2	0.4	10.058***	.002	3.559*	.059	2.570	.190	

There are no clues in the qualitative data to show that this trend has been on the rise in the intervention school or any possible reason/s for students having recently adopted such behaviours. On the contrary, some of the responses from the students at the end of the programme were:

"I smoked earlier but when facilitators told us this leads to cancer then I quit smoking..."

Class X Student, Government Boys senior Secondary School, Bawal

"I refused my friends who were forcing me to chew pan masala."

Class IX Student, Government Boys senior Secondary School, Rewari

Chapter Six

Perception about the Curriculum and its Impact

Focus Group Discussions and In-depth Interviews were conducted with teachers and students. The purpose was to discuss various aspects of the programme as well as to understand their perception about the impact and relevance of the programme and to collect their feedback on the content and teaching pedagogy.

6.1: Stakeholders' view on the programme

In-depth interviews were conducted with the principal and/or the School In-charge in the four schools where the intervention was carried out.

The In-charge in Government girls' school in Rewari expressed her reservations about a number of issues. She was sceptical about issues like menstruation and masturbation being addressed through the curriculum. She felt that if the girls were given the opportunity to discuss openly about these issues, they would get 'excited'. However she said the programme was good but did not feel confident about the school teachers being able to conduct similar sessions. She thought that they would not be 'as effective' as the trainers in this programme. She was of the opinion that if we 'hide' information from students, then they may take the 'wrong path'. However they should be told not to have sexual relationships rather than talking to them about the correct way to use condoms.

When asked what she would recommend in case some one plans to introduce this curriculum in another school/setting, she said:

“The first thing you will have to do is to take permission from higher authorities and this is a very big task. Once you get the permission to introduce this curriculum there will not be any major difficulty. All other issues can be sorted out internally”.

In-charge, Government girls' school in Rewari

The In-charge, Bawal Girls' school, shared her views on the curriculum. She said that it was a good curriculum, especially for girls and should be delivered in all schools, specially the girls' school. However she felt that the students were like 'daughters' to the teachers and it would not be fair that they be asked to address these issues in the classroom. She was also not in favour of these subjects being included in the course books. She supported the idea of an external female trainer to facilitate these sessions. She was against the idea of male facilitators and the girls and boys being taught together. According to her it would be appropriate to have this programme for students in classes IX-XII, as younger girls would not be able to understand.

The school In-charge, Rewari boys' school felt that overall the programme was good. However she was of the opinion that this programme should not include Class VIII students as they are too young and the content may even have a negative impact on them. According to her, group discussion, case studies and

use of IEC materials are useful methods for transaction. She however felt that teachers would not be able to deliver this curriculum because they themselves would be embarrassed talking about these issues. In her words,

“It was good program. Students need somebody to guide them at this stage of their life. There covered relevant issues. They can not change in only 3 years, so this course should be for the class 8th to class 12th students. In my opinion, there was less time given to the students. There should be one month for this and all the students should be taught.”

In-charge, Government Boys' senior secondary school, Rewari

The Principal of the Boys' school in Bawal expressed his satisfaction with the programme. He said that the students were improving and he personally talked to the students and they were happy about the sessions. He had attended one of the Dissemination meetings organised by MAMTA to share the details of the programme with all the Principals of the schools in the district. During this meeting some of the Principals opposed the programme but he thought that 'if you hide something, it will remain hidden forever, it is better to discuss it openly; it opens the minds of the people'.

On the perceived changes in students, he said that earlier if some boys were following girls and teasing them, the students also joined them. Students don't do it now since they have realized the demerit of such behaviour. He felt that the programme had created a good environment in the school and recommended that more students be covered through this programme.

“Earlier they used to write some thing on the toilet walls and walls of the school building, but I think they have stoped it, they have become mature now. And as I said now they seem to be very serious about their studies.”

Principal, Govt boys' senior secondary school, Bawal

About the likely challenges in implementing this programme in other schools, he said that many people are not in favour of such an education while some may accept it. The main problem is to get the approvals to carry this programme and then it is the availability of time (for this programme) during the school hours. When asked if this programme had in any way affected the school attendance, the Principal said that the interest increased, and there was no negative impact of the programme. A lot of students did come to the classes.

Asked if the programme had any influence on the academic performance, the Principal said that there had been no negative impact of the programme, since the sessions were conducted only once a week and so it did not disturb the schedule. .The students have already been working hard round the year for the Board examinations.

“Timings should be decided with mutual consent. Like last year you (trainers) and we adjusted well by mutual consent. There should be no disturbance in the studies; we should take it as an additional activity besides the academic curriculum”.

Principal, Govt boys' senior secondary school, Bawal

About teachers' involvement in the programme he said:

“You can involve them, it will take some days, may be there will be some disturbance in the studies but it will be ok in a few days. For example, in villages women hide their face with their sari and it takes some time to open the veil and show their faces. But once it opens, there is no problem .In the same way teachers here will open up in a few days”.

6.2: Trainers' perception about students' response to the program and impact of the curriculum

6.2.1: Students' response to the programme: Trainers' perceptions

The curriculum generated a lot of interest among students in the four schools who appreciated this opportunity to receive information on the issues which were otherwise unaddressed through the school curriculum or other interactions in the school setting. Some of the interesting observations in this regard were shared by the trainers.

“When we went to take session, students themselves collected in class, those who were not coming on Saturdays, started coming. They don't stay absent on Saturdays.”

Male trainer sharing experiences from urban boys' school in Rewari

“In the beginning students were quite undisciplined, they were not taking much interest, but during recap we realised that they had complete information from the last sessions, and then we came to know that they are receiving the information well and our method was good.”

Male trainer sharing experiences from rural boys' school in Bawal

“When we were taking sessions, students used to visit our project office to read the book, they asked questions, so we realize that they are taking interest in this.”

Programme Officer, Bawal

“Teachers told us that all girls used to wait for facilitators on Saturdays. Girls also asked us about the next session when they met us outside the school.”

Female trainer sharing experiences from rural girls' school in Bawal

“At the end of every session, they didn't give us chance to ask them to write question, they were ready with question.”

Female trainer sharing experiences from urban girls' school in Rewari

“I had interaction with teachers and one of them said ' when you people teach the students, they sit there for 2 hrs and in our class they do not want to sit for 45 minutes'...”

Male trainer, rural boys' school in Bawal

“They listened well, because in recap they asked questions regarding problems of their sisters and sisters-in-law, so we knew that they were discussing the things at home also.”

Co-facilitator, Government Girls' school, Rewari

“Because they are experiencing same situation at this age, their participation was more and they heard the session very carefully. They said that they face pressure from peers as a daily routine; they were asking us how do you knew about our real situation.”

A male trainer sharing the feedback from the session on Peer Pressure

6.2.2: Impact of the curriculum: Trainers' perceptions

The curriculum had an impact on students in many different ways. Not only did it increase their knowledge, it motivated the students to seek more information.

“I would like to share an experience... We went to Rasiyawas village for field testing of questionnaire of IR3 (Intervention research Round 3) ... There was a girl with whom I did the survey and I did not know her... She replied correctly to most of the questions and then I asked her from where did you get all this information and she replied that Indra madam (one of the trainers in rural girls' school Bawal) told us in the session...”

Female trainer sharing experiences from the intervention area

“The other thing happened in the Bawal boys' school, a lot of boys came to Bawal office and they read books and other materials... In December, schools observe World AIDS day and for the preparation, students came to us seeking our support... We feel that students have gained much confidence...”

Programme Officer stationed in project office, Bawal

6.3: Students' perception about the curriculum

6.3.1: Students' opinion about course curriculum

From the focused group discussions with girls it clearly emerges that they were interested in the programme and enjoyed being part of it. They shared that in Class VIII there was little comprehension of the issues being discussed but over a period of three years they acquired clarity on various issues and understood its relevance in their growth and development. Many girls had not attained menarche in Class VIII and so could not relate to this issue. However this changed in Class IX and girls started to take more interest in these issues. The trainers established a rapport with the students and created an environment that helped the girls overcome their inhibitions and shyness in the initial period.

When asked, the students could recall most of the topics that were covered during the year. The students appreciated the methods used for transaction of curriculum and found it was easier to comprehend since

the trainers did not use technical terms like their Science teacher. The students also shared that their teacher skipped most of the details and just touched upon the issue briefly.

“Most of the time we receive incomplete information but we received complete, accurate and adequate information from you (trainers)”

Class X, Student Government Girls senior secondary school, Rewari

“Earlier we were shy...you removed our inhibitions during the sessions...The method of answering questions was very good and one thing I like most is the Question box, through it we got all the answers in a very interesting way...”

Class X, Student Government Girls senior secondary school, Bawal

“Facilitators taught us through stories; this was very good for us.”

Class X Student, Government Boys senior Secondary School, Bawal

“We can learn better through plays, films about HIV/AIDS and female foeticide.”

Class X Student, Government Boys senior Secondary School, Rewari

Some of the suggestions that the students made about the programme are as follows:

“Sexuality education should be included in the curriculum in Haryana, many people oppose it while others are supporting it, but it should be included.”

“The Science books should have one or more chapters providing details on these issues.”

“This should be included as a subject in Board Examinations.”

“The teachers should also receive this curriculum along with the students.”

“Books should be given so that we can read ourselves.”

6.3.2: Students' suggestions regarding curriculum delivery

The students were asked about the preferred source of information regarding sexual and reproductive health issues. Peers were chosen as the most common answer by more than 60 percent of male and female students in the intervention classes, irrespective of the location of school. 41 percent of class X boys from rural school and 67 percent from urban schools would reportedly like to get this information from the class teacher while 52 percent and 64 percent preferred to get it from the teacher from the same school (but not the Class teacher). The girls in rural schools had similar response. However girls in urban school showed less preference for teachers and ranked friends (61%), mother (58%) and books and magazines (53%) as the preferred sources of information.

Table 6.1: Source to avail the SRH knowledge

Indicators by sex of the students	Location	Class			
		Post Test Class X	Pre Test Class XI	χ^2 Value	Sig. level
		N	N		
		RB-44 UB-33 RG-83 UG-196	RB-39 UB-51 RG-117 UG-190		
Preferred source to avail the SRH knowledge: class teacher					
Boys	Rural	40.9	64.1	4.454**	.035
	Urban	66.7	58.8	0.523	.470
Girls	Rural	45.8	43.6	0.095	.758
	Urban	55.6	54.2	0.077	.782
Preferred source to avail the SRH knowledge: any other teacher from the same school					
Boys	Rural	52.3	74.4	4.310**	.038
	Urban	63.6	72.5	0.745	.388
Girls	Rural	50.6	35.9	4.310**	.068
	Urban	46.9	34.2	6.477**	.011
Preferred source to avail the SRH knowledge: a person trained from outside the school					
Boys	Rural	50.0	61.5	1.114	.291
	Urban	66.7	60.8	0.298	.585
Girls	Rural	48.2	28.2	8.369***	.004
	Urban	46.4	31.6	8.933***	.003
Preferred source to avail the SRH knowledge: mother					
Boys	Rural	22.7	38.5	2.432	.119
	Urban	51.5	29.4	4.151**	.042
Girls	Rural	53.0	72.6	8.177***	.004
	Urban	58.2	80.5	22.626***	.000
Preferred source to avail the SRH knowledge: father					
Boys	Rural	18.2	35.9	3.331**	.068
	Urban	39.4	25.5	1.812	.178
Girls	Rural	16.9	26.5	2.581	.108
	Urban	14.3	22.6	4.477**	.034
Preferred source to avail the SRH knowledge: older sister/brother/relative					
Boys	Rural	9.1	43.6	13.019**	.000
	Urban	45.5	29.4	2.246	.134
Girls	Rural	42.2	42.7	0.006	.936
	Urban	27.0	38.9	6.195**	.013
Preferred source to avail the SRH knowledge: friend					
Boys	Rural	63.6	71.8	0.627	.428
	Urban	60.6	72.5	1.310	.252
Girls	Rural	69.9	56.4	3.739*	.053
	Urban	61.2	63.2	0.153	.695
Preferred source to avail the SRH knowledge: None of the above but through books and magazines					
Boys	Rural	50.0	84.6	11.082**	.001
	Urban	54.5	68.6	1.706*	.191
Girls	Rural	39.8	54.7	4.340**	.037
	Urban	53.1	68.9	10.223***	.001

When it comes to the non intervention class (Class XI), a significant number of students preferred to receive this information from the teacher who is from the school but not the Class teacher. A 'trained person from outside the school' taking on this role is preferred by the 50 percent (RB) and 67 percent (UB) of boys in the intervention class, 62 percent (RB) and 61 percent (UB) boys in the non intervention class. In contrast less than 50 percent girls chose this as an option in the intervention school, the percentage being even lower in the non intervention classes. During the FGD, almost all boys strongly expressed the view that these sessions should be taken by the teachers or facilitators, who are not from their school because the relationship between students and teachers does not permit the students to be comfortable talking about these issues with them. Some of the boys thought that their school teachers are not competent enough to handle these issues as facilitators from other agencies are.

“Students are more open with you (facilitators). School teachers may take the sessions but that will not be as effective as you will be in taking the sessions”.

Class X, Student Government Girls senior secondary school, Rewari

“We feel shy listening to these issues from our teachers because we take them as our 'GURU'.”

Class IX, student Government Girls Senior Secondary School, Bawal

“Though we have information in our syllabus but it is difficult for us to understand the terminology. You have given information in a very easy language. Even our science teacher cannot teach on these issues in detail.”

IX Class, student Government Girls Senior Secondary School, Bawal

6.3.3: Perceived changes in peers

When asked if they perceive any changes in their peers, this is what the female respondent from the urban school had to say:

“Earlier we were weak in studies, we did not make much effort to cover the subjects but after taking the sessions, we do...Now we do not fear boys...We do not pressurize our peers...If our friend is going to do some thing wrong then we do not follow them”

Class IX, student Government Girls Senior Secondary School, Bawal

6.3.4: Changes perceived by students in their own self

Many of the students believe that this programme helped them change their attitude towards a number of issues (taboos related to menstruation, eve teasing and masturbation). They now feel more confident discussing various issues with their parents and friends and are less hesitant discussing issues related to sexuality. They were now able talk to their parents about consequences of marriage at an early age.

“Our confidence has increased ... We have information on HIV/AIDS...Early marriage...Sexual relationships...Menstruation...Sexually transmitted diseases...And we have knowledge on rest of the subjects...”

Class IX, student Government Girls Senior Secondary School, Bawal

"We don't get pressurized by our friends. We are also having some conflict with our mothers about the myths related to menstruation, which they force us to follow and we don't want to follow it.

Class X, Student Government Girls senior secondary school, Rewari

"Earlier I got very angry, but now I control myself, and go outside".

Class X, Student Government Girls senior secondary school, Bawal

The boys said that they now have more information about HIV, female foeticide, and early marriages and are sharing the information with others. Reportedly their attitude and behaviour has changed in many ways:

"Earlier I dreamt in the night and nightfall occurred...I was worried. But after attending these sessions I did not think like that...It is not a disease..."

Class X Student, Government Boys senior Secondary School, Rewari

"I smoked earlier but when facilitators told us this leads to cancer then I quit smoking..."

Class X Student, Government Boys senior Secondary School, Bawal

"Earlier I could not take any decision but after the session (on decision making) now I take some decisions...I have left eve teasing..."

Class X Student, Government Boys senior Secondary School, Bawal

"Earlier we used to quarrelinstantly got angry...but now I have patience...if somebody's involved in a dispute I tell him not to do so....."

Class X Student, Government Boys senior Secondary School, Rewari

"My fear about the possibility of getting infected with HIV has decreased."

FGD with class X boys in Government Boys senior Secondary School, Rewari

"Earlier we talked rudely to girls, but now we talk politely, we respect them more."

FGD with class X boys in Government Boys senior Secondary School, Rewari

6.3.5: Students' perception on challenges facing youth today

The students were asked about their perception on what are the main dangers facing youth today. The response varied across the four schools but there were some common issues highlighted by the students. The girls in Rewari School (UG) said that HIV and sexual harassment (eve teasing) were important issues. In addition to HIV and sexual harassment, girls in Bawal felt that gender discrimination is a challenge that the girls face, especially the humiliation and disrespect that they face in their husbands home (though their in-laws) and more so if the girl is 'unable to become a mother'.

“In our society there is much sexual abuse”

“Environment is not good for girls”

“Girls are safe only in their homes and so parents don't allow them to go out”

Class X, Student, Government Girls Senior Secondary School, Rewari

The boys in Rewari School (UB) again mentioned HIV as one of the dangers facing youth today and brought up premarital sexual relationships as another important issue. The boys in Bawal again mentioned HIV but added that Substance use was another challenge facing young people.

The students were asked to suggest possible solutions to these problems. The responses included-creating awareness about HIV, eve teasing and sexual harassment, banning the sale of 'Gutkha', 'cigarettes' near the schools, and shopkeepers should not be allowed to sell these items to underage children, protesting against sexual harassment and ill-treatment (from in-laws), girls getting married only after the age of 18 years, and the girls should be given more knowledge so that they can feel confident about themselves. The students should be helped to acquire skills to cope with their problems. Girls feel that it is important that they be guided at this important stage in life.

The girls said that if they come to know about an incident where female foeticide or early marriage has taken place, they should file an FIR (first information report, filed at the Police station). In case someone faces sexual abuse, they should take an elder person into confidence or oppose it and take a strong stand. In case a girl's family is being asked for dowry, an FIR should be filed.

“But to start making a change we must start from our own homes!”

Class X student, from girls' school in Bawal during FGD

Chapter Seven

Summary & Conclusion

7.1: Summary

The review of data on young people in India clearly shows the growing incidence of sexual relationships among adolescents and the increasing number of premarital pregnancies, STIs and HIV and adolescents who are sexually abused, raises the question of how to provide education on relationships and sexuality to young people. Young peoples' need for sexuality education is evidenced by their typically early initiation of sexual activity. The extent of knowledge and accuracy of knowledge about risks to sexual health and means of preventing unhealthy or undesired outcomes are important indicators of their need for information to help them make choices and to engage in safe and healthy behaviours.

This need is particularly felt in India, because the school curriculum does not include the crucial elements of reproductive health, including related topics such as sexual development during the period of adolescence, relationships and substance use. Many curricula contain lessons on the biological aspects of the reproduction system, but education is never complete by simply offering biological information. There is a need to focus holistically on physiological, emotional and socio-cultural dimensions of adolescent reproductive health. This study aimed at developing an appropriate sexuality education curriculum in consultation with stakeholders, implementing the curriculum in schools, and evaluating its effects in urban and rural settings.

The curriculum was developed by a team of experts from MAMTA and Nossal Institute representing diverse backgrounds and experiences and with the involvement of trainers who had been working in the local area for at least 5 years before this study was carried out. Taking the findings of the needs assessment into consideration, a framework for the curriculum was developed that specified the main theme areas, key messages and details pertaining to methods and reference materials. The curriculum was revised each year and new information was added based on the feedback from the students, trainers and the teachers. Thus, an age appropriate, incremental curriculum was developed for students of Class VIII, IX and X in the government schools, that was pilot tested before being delivered in the classrooms. This curriculum was delivered, as planned, over three consecutive academic sessions in two boys and two girls schools in urban (Rewari town) and rural (Bawal) settings in Rewari District from 2005-2008.

The content covered three main themes; (i) adolescent growth and development, (ii) sexual reproductive health issues (early marriage and adolescent pregnancy, STIs, HIV transmission and prevention), and (iii) developing life skills. Issues of gender, sexuality and Rights were integrated within these theme areas. The programme was implemented with support of a team of trainers who were young and belonged to the intervention area. They had received formal training on using innovative methods for conducting training on various sexual reproductive health issues and were also experienced in programme implementation at grass-root levels in the local community. Thus they had a good understanding of the context of the young people and could develop good linkages with the education department and the school authorities. The support from the District Education department and school principals was one of the key factors that facilitated the implementation of the programme.

The results from the comparison of Class X (post test) with Class XI students (pre test) and baseline compared to endline (intervention and control groups) show that the curriculum was successful in bringing about some of the desired changes among students who were part of the intervention. The students who received the curriculum over two or three consecutive years demonstrated a change in knowledge and attitude on many issues when compared to students who were not part of this intervention.

On issues like HIV transmission, laws and legislations related to age at marriage and female foeticide, a high level of knowledge exists among all students, irrespective of the groups they belong to (intervention or control group). This may be attributed to information being disseminated widely through various channels that includes the mass media (radio and television spots, serials), billboards, and print media and at times even through interpersonal communication. A few topics that include the male and female reproductive organs, menstruation and sex determination of the foetus are covered in the Class X's Science and Technology curriculum and thus all students had adequate knowledge on these issues as would be expected.

In this context a significant finding is that students in the intervention group were able to reject myths and misconceptions more often than students who have not received the intervention. This is true for issues like nocturnal emission, masturbation and HIV transmission. This may be due to the fact that these students benefited from the opportunity to clarify their doubts and bring up for discussion various myths and misconceptions that existed within the group. Other students (in non intervention classes/schools) did not show a similar response on these issues.

When the boys and girls in the intervention schools are compared, it is obvious that girls have shown more significant change over baseline and at the post test in class X. There are many reasons ascribed to this finding. First, the girls in the intervention group have had a higher exposure to the programme as compared to boys. Only 38 percent of boys as compared to 59 percent of girls were part of the intervention for three years while 88 percent boys and 91 percent girls received the curriculum for two years.

Secondly, in terms of attendance during the sessions, girls scored a better record and were more likely to be present in the class as compared to the boys. It was the experience of the facilitators that the overall environment in the girls' school was more conducive as compared to boys' school. There was more discipline in girls' school and the classes were held regularly. On the other hand, in boys' school, the students were often found outside the class (and even the school). Neither were the teachers very inclined to take classes nor the students keen to attend them. The male facilitators reported that many students turned up in class only when they saw them coming to the class rooms.

Thirdly, the overall academic performance of the girls has been better than that of the boys. The results of Class X board examinations (held by the Haryana Board Of Education) shows that 88 percent of girls in urban location and 84 percent in the rural location, passed the examination as against 92 percent of boys in the urban school and 69 percent in rural school. The boys in the rural school (in Bawal) seem to be at the lowest level in terms of school performance (academic) in comparison to other three schools. The results from the study show that this is one intervention school that has shown the least change over baseline at the end of the intervention. On many issues, boys in the urban school have shown a more significant change as compared to rural school but were still bettered by the girls.

Another area that is of significance is the difference in knowledge, values and attitude among girls who were part of the intervention towards safer sex and condom use. Significant percentages of girls, both in rural and urban setting, reportedly are more supportive of condom use and recognise the value of practising 'safer sex'. This intervention shows that it is possible to empower young girls with knowledge and bring about a change in values and attitudes towards sexual health issues.

Amongst the girls in the two locations, the girls in rural school have shown a higher degree of change as compared to girls in urban settings. This trend has been clearly visible in the pre-post test comparison carried out each year. The girls in urban school were generally at a higher level to start with so that the change that was visible was less than that shown by girls in the rural school who started at a lower level of knowledge on various issues.

The review of Sex and HIV education programmes in a study by Douglas Kirby (2005) describes that "those programmes that has a positive effect on sexual behaviour and on condom and contraceptive use had an impact on eight mediating factors including knowledge, perception of HIV risk, personal values about sex and abstinence, perception of peer norms and others."⁹ If this is the case, then this programme which has been successful in effecting most of the mediating factors should have a positive effect in preventing unwanted pregnancies, STIs and HIV among the students in the future.

7.2: Sustainability

To sustain this programme in the schools, it is clear that it has to be carried forward by the school teachers. Engaging with the students on a regular basis is human resource intensive activity and cannot be sustained in long term through external resources given the huge number of schools and tens of thousands of students who need to be covered by such a programme over a long period of time. The need of the hour is not only to involve teachers but also to work with them to reduce inhibitions and barriers to initiate meaningful discussion on sexuality and sexual health issues in the classroom setting. Unless the trainer/facilitator (teacher) can create a safe, open and non judgmental environment in the classroom, the curriculum will fail to have its desired impact. A beginning has been made towards achieving this mandate through the Sexuality Education Programme.

7.3: Future steps

In the wake of International Conference on Population Development, 1994, Adolescent Sexual and Reproductive Health emerged as one of the key areas. Adolescence Education was then introduced in schools in 1998, to address issues of physical growth and development, socio cultural development and adolescence, gender roles, HIV, STD and drug abuse. School AIDS Education Programme launched in

⁹Douglas Kirby, B.A. Laris, and Lori Rolleri. Youth Research Working Paper No.2: Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries. Family Health International, 2005.

1999-2004 by Department of Education and National AIDS Control Organization (NACO) aimed at providing accurate age appropriate information to young people (14-18 yrs). The School AIDS Education Programme (SAEP), National Population Education Programme (NPEP) and Adolescence Reproductive and Sexual Health Programme (ARSH) were linked together as Adolescence Education Programme, introduced in 2005-06. This programme focuses on developing life skills to cope with negative peer pressure, improving sexual health and preventing new HIV infections.

“Adolescence education is defined as an educational intervention to help learners acquire accurate and adequate knowledge about reproductive and sexual health with a focus on the process of growing up during adolescence, in its biological, psychological, socio-cultural and moral dimensions”. The nomenclature of 'Adolescence Education Programme' (AEP) is more acceptable to various constituencies who seem to have a lot of reservations about the word of 'sexuality or sex education'. Also it is a more appropriate description of the programme which falls short of addressing issues like sexual relationships, pleasure or intercourse (except in its reproductive context).

Adolescence Education Programme (AEP) is a joint initiative of the Department of Education, National AIDS Control Organisation in partnership with UNICEF, UNESCO and UNFPA. It is to be implemented in all states across the country for students in class IX-XI with the objective of empowering adolescents to deal with risky situations, preventing new HIV infections, reducing vulnerability to the infection and substance dependence and fostering positive behaviour development.

Since the programme was launched, there has been intense debate in many states regarding the content and appropriate age for initiating the Adolescence Education Programme. Following objections from several states including Gujarat, Madhya Pradesh, Maharashtra, Kerala and Karnataka, the programme was reviewed by a task force and consequently the curriculum has been revised taking into consideration the reservations and objections raised by various stakeholders (parents, teachers and public representatives).

The new package is now available to the state governments who have the flexibility to modify the content and devise their own teaching aid keeping in view the local needs and sentiments. At the same time NACO is making all efforts to work with key resource persons in each state so as to support the process of adaptation and translation, and ensure quick roll out of the programme in schools.

In this context the results from the present study will be used as an evidence base for advocacy for expanded sexuality education in other school settings in India and to further expand understanding of different approaches to this challenging but crucial aspect of youth well-being in developing countries.

The present study focuses on students in the age group of 13- 18 years, which is same as the target group for AEP (14-18 years). The curriculum content delivered in this study matches closely with the AEP (MAMTA was involved in the revision of the AEP modules and training materials). This study provides significant evidence about the likely effectiveness of AEP which is also planned to be delivered over a period of three years in school settings. Considering that most of the evidences on benefits of Sexuality education programmes are from other countries, the evidences from this study can be used to strengthen the advocacy for AEP in the country. The results will be relevant to many states in North India which share common cultural and traditional values. The fact that the programme was implemented in government

schools, in both urban and rural settings, and included both boys and girls, will make the results relevant to a majority of schools.

The plan is to share the final set of modules (curriculum) and results from this study with stakeholders in Haryana (Department of Education, State AIDS Control Society, DIET) and advocate for adaptation of the AEP curriculum for the state of Haryana. As MAMTA also works closely with the government departments in the state of UP, Bihar and Rajasthan, the report and the curriculum will be shared with the relevant stakeholders.

The findings will be reported and shared in public settings and used for the purpose of advocacy for policy /programme initiatives/responses within the education system. The results will be widely disseminated within the country and in South Asia. The feedback from the students, teachers, school principals and trainers should serve as a testimony to the fact that there is an urgent need to bridge the information and communication gap on sexuality and health related issues. Contrary to what the detractors of sexuality education would like to believe, this study shows that it is possible to address adolescent health issues in a respectful and participatory way in the school setting.

References

1. International Conference on Population and Development (ICPD) Programme of Action 7.46
<http://www.unfpa.org/icpd/icpd.htm>
2. Registrar General of India. Census of India 2001. Socio-cultural Tables
3. KG Santhya and Shireen J Jejeebhoy, Young people's sexual and reproductive health in India: Policies, programmes and realities, Population Council of India, Regional working papers, 2007, No. 19
4. Pelto, P.J., A. Joshi & R. Verma. (2000). Development of Sexuality and Sexual Behaviour among Indian Males: Implications for Reproductive Health Programmes. New Delhi: Population Council.
5. International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.
6. Sarah Hawkes & K. G. Santhya. (2001). Diverse Realities: Understanding Sexually Transmitted Infections and HIV in India. New Delhi: Population Council
7. National AIDS Control Organization 2006. National Behavioural Surveillance Survey (BSS) 2006
8. National AIDS Control Organization 2006. National Behavioural Surveillance Survey (BSS) 2006
9. International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.
10. Sarah Hawkes & K. G. Santhya. (2001). Diverse Realities: Understanding Sexually Transmitted Infections and HIV in India. New Delhi: Population Council
11. Ibid.
12. IIPS and Population Council 2007, Youth in India, situation and needs 2006-2007: Fact sheets Maharashtra, Rajasthan, Mumbai, IIPS.
13. International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.
14. Kulkarni, S. (2003). "The reproductive health status of married adolescents as assessed by NFHS–2, India." Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia, ed. S. Bott et al. Geneva: World Health Organisation, pp. 55–58
15. Pachauri, S. and K.G. Santhya. (2003). "Contraceptive behaviours of adolescents in Asia: Issues and challenges." Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia, ed. S. Bott et al., pp. 108–113. Geneva: World Health Organisation
16. Pachauri, S. and K.G. Santhya. (2002). "Socio-demographic and reproductive health profile of adolescents in India: A review." Demography India, Vol. 31, No. 2
17. Jejeebhoy, S. (2000). "Adolescent sexual and reproductive behaviour: A review of the evidence from India." Women's Reproductive Health in India, ed. R. Ramasubban and S. Jejeebhoy, pp. 40–101. Jaipur: Rawat Publications
18. National AIDS Control Organization 2006. National Behavioural Surveillance Survey (BSS) 2006
19. National AIDS Control Organization 2006. National Behavioural Surveillance Survey (BSS) 2006
20. Government of India. 2007. Study on Child Abuse INDIA 2007. Ministry of Women and Child Development, Government of India
21. <http://ncrb.nic.in/cii2006/cii-2006/CHAP5.pdf>
22. Patel V, Flisher A, Hetrick S, McGorry P, the mental health of young people: a global public health challenge. The Lancet 2007; 365:1302 – 1313

23. International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS¹
24. Ministry of Human Resource Development (MOHRD), National AIDS Control Organisation (NACO) and United Nation Children's Fund (UNICEF). 2005. Adolescence Education: National Framework and State Action Plan (2005–06). New Delhi: MOHRD, NACO and UNICEF.
25. Chakrabarti, V. 2003. Population education in formal and non-formal sectors in India. In S. Bott et al., eds., *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*: 165-67. Geneva: World Health Organisation.
26. www.yuva.nic.in
27. International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005-06, India: Key Findings. Mumbai: IIPS.

Annexures

Annexure I**Knowledge, Attitude and Practices of Class VIII students on Selected Sexual and Reproductive Health Issues, Rewari, 2004**

Issues	Boys	Girls
Physical and mental changes during adolescence		
% aware about gain in body weight and height during adolescence	87.2	95.6
% aware about breasts enlargement during adolescence	37.6	72.1
% aware about enlargement of testes during adolescence	24.8	20.7
% knew about the onset of menstruation during adolescence	8.3	58.6
% aware about appearance of hair in genital area during adolescence	60.6	63.7
% worried about the physical changes taking place in their bodies during adolescence	41.7	38.6
% felt embarrassed by the physical changes taking place in their bodies during adolescence	20.8	38.1
% did not know about the phenomenon of 'nocturnal emission' among boys	26.6	52.6
% reported that 'nocturnal emission' is a sign of sexual maturation among boys	13.8	08.4
Perception about masturbation		
% considered masturbation a 'natural practice'	17.4	23.9
% reported that it causes weakness	35.8	26.3
% thought masturbation lead to impotency	9.2	10.8
% thought masturbation affected the structure /function of the male sexual organ	26.6	14.3
% thought of masturbation as an 'immoral' act	9.2	12.0
Attitude regarding premarital sex		
% think pre marital sex is OK	31.2	02.4
% think pre marital sex is 'wrong'	29.4	15.5
% do not know whether sex before marriage is right or not	34.9	56.2
% opine that it is alright to have premarital sex if one is in love	56.9	18.3
% opine that it is alright to have premarital sex if the partner agrees to it	45.9	27.5
Protection against HIV		
% knew that it is possible to protect oneself from contracting HIV	74.2	65.8
% reported that condom can be used as protection against HIV	42.2	17.1
% reported that a person can protect himself/herself from HIV by abstaining from sex	19.3	13.5
Gender related issues		
% felt that use of contraceptive is a girl's responsibility	71.1	51.7
% opine that it is the responsibility of both the partners to decide when to have a child	58.1	71.3
% felt that girls do not have the right to decide when and whom to marry	48.4	36.8
% felt that boys do not have the right to decide when and whom to marry	59.3	32.4

Framework for the curriculum-Seven Steps to an Informed Adolescence

<p>1. Who am I?</p> <p>AIMS: Establishing an atmosphere conducive to mutual trust and open exchange to assist learning; clarifying program content; identifying a baseline KAP for process and impact evaluation</p> <p>OBJECTIVES</p> <ul style="list-style-type: none"> ? Introduce overall Aims and Content of the 7 sessions ? Make students more willing to communicate through exercises and ice breakers ? Clarify expectations on both sides ? Set rules for class interaction to enable more active participation, open communication and mutual trust, and discuss ethical considerations (eg, confidentiality) ? Identify baseline KAP for the target population in year 1 for: program modification, documentation, end –of–year comparison <p>KEY MESSAGES: Everyone has the right to information. In this class we should feel comfortable about sharing our ideas and asking questions. We should respect other people’s views, and give everyone a chance to speak. We should not repeat things after class that may cause someone embarrassment.</p>			
CONTENT	METHODS	MATERIALS	COMMENTS
Introduction of facilitator and the program content Covers: <i>right to information</i>	Presentation and hand–out	Blackboard, chalk and hand–outs on program (with some detail, to be given at end of session)	Hand–outs need to be parent–friendly 10 mins
Pre test (total program content)	Structured survey	To be developed after finalizing content	Facilitator to explain this is not a marked exam 20–30 mins
Ice breaking and self-introduction	Pairs discuss own names & meanings; individuals present their partner to whole group	Chart paper or cards	30 mins
Ground rules	Facilitated brainstorming, discussion and poster	Blackboard and chalk; facilitator calls for suggestions to write on board (to be transferred to poster — may ask student to assist by recording)	10 mins
Expectations of students and clarification of program	Facilitated Brainstorming	Blackboard (to be recorded for later comparison — may ask student to assist by recording)	10 mins

2. Understanding Changes During Teenage Years

AIMS: Provide students with knowledge about adolescent developmental changes in order to increase self-awareness, reduce anxieties, and increase understanding about the opposite sex; raise awareness of gender and its impact; provide girls with practical information about menstruation in order to improve hygiene, challenge myths, and increase understanding of nutritional needs.

OBJECTIVES

- ? Increase understanding and acceptance of physical, psychological and emotional changes typical of adolescence, understand variations in pace of growth and development, and recognize potential risks of experimentation
- ? Decrease anxieties about self-image
- ? Introduce the concept of gender norms (and discrimination) and the negative impact on boys and girls, men and women
- ? Increase knowledge and skills for better menstrual management and health (girls)
- ? Debate various concepts / interpretations of menstruation and nightfall (different level of details for boys and girls)

KEY MESSAGES:

Menstruation is a sign of maturity/fertility.

Night fall is natural and not harmful and does not cause weakness.

There are variations in normal growth and development.

If you are concerned whether you are normal, you can come to the facilitator.

Difference between sex and gender. Gap between legal equality and the reality in society.

Most types of work can be done by men or women.

'Women's work' is valuable.

The most important qualities are not physical beauty.

CONTENT	METHODS	MATERIALS	COMMENTS
Re-cap	Facilitator summary		5 mins
Adolescent growth and development (<i>includes brief reference to menstruation and night fall – what and why</i>) <i>Covers changes in emotions and moods, curiosity / experimentation, variations in normal physical development</i>	Presentation with pictorials; question and answer	Pictures, charts, diagrams showing transition from infant to adult; MAMTA Adolescent Growth and Development Module in library on changes; NCERT module on emotions; Advocates for Youth website for general content	Cover myths and misconceptions; risks of experimentation; reassurance about shared experiences and/or range of pace of development and potential of each person 20 mins
Gender introduction: biology vs social roles Gender discrimination, multiple pregnancies and feticide <i>Covers: right to equality</i>	Exercise, eg, names for boys and girls; role perceptions of students	Blackboard; choose from among existing materials, eg IPAS: Gender or Sex; Adverts showing traditional norms; Fact Sheets on inequalities	20 mins
Menstruation hygiene and discomfort; nutrition during menstruation; delayed menarche Covers ways to manage hygiene in different settings / family budgets; beliefs about being unclean and food restrictions; managing pain and discomfort; sharing problems with mothers; when to seek medical attention	Presentation with pictorials and hand-outs; facilitated brainstorming; question and answer	Charts; examples of cloths, belts, sanitary napkins; Nutrition charts; Blackboard; referral address for medical consultation	15 mins (girls)
Night fall	Presentation; Q & A	None	10 mins (boys)
Body image Introduction to cover concepts that 'beauty' alone does not bring happiness or success; that we value people for qualities other than physical; that advertising promotes obsession with physical	Free-listing or brainstorming about qualities we value in others to challenge idea that 'beauty' is everything; beauty in eye of the beholder	Possibly some adverts; stories about unhappy film stars; blackboard	Important to validate their feelings and not to use empty clichés or moralistic tales which can not reassure 15 mins
Evaluation (feedback) Distribute hand-outs with key points to keep	Written	Develop format	10 mins

3. How to be Happy

AIMS: Reassure students that emotions and feelings are normal while providing skills for better self-awareness and control over emotions through responsible attitudes towards others; provide skills to improve relationships with friends, parents and teachers through more effective communication.

OBJECTIVES

- ? Improve understanding of emotional changes and feelings, and ways of managing these
- ? Increase awareness of self and others (empathy) and role of mutual respect in healthy relationships
- ? Increase self-esteem
- ? Introduce and practice Life Skills (empathy, listening, communication)

KEY MESSAGES

Everyone experiences a range of feelings.

Negative feelings can sometimes be managed or reduced.

We should try to understand the feelings of others.

Good listening, and knowing how to express your feelings are very important to get along with others.

Each person has a lot of potential, and everyone has strengths.

CONTENT	METHODS	MATERIALS	COMMENTS
Re-cap	Facilitator		5 mins
Emotions: ups and downs and handling these	Presentation and facilitated discussion about what emotions are, where they come from, which are positive or not. Their experience of emotions, responses to these. Case studies?	Case studies in small groups on selected emotions — <i>materials need to be sourced</i>	15 mins
Listening and communicating (including mutual respect) <i>Covers: right to dignity for all</i>	Presentation; Self-assessment; Case study	Materials need to be found; list possible sources	Covers communication between peers, with teachers and family 20 mins
Our feelings and responsible behaviour (risks of acting out) <i>Covers: right to dignity and freedom from coercion</i>	Presentation and facilitated discussion		Covers feelings of attraction, & responsible behaviour through consideration of others' feelings and rights 15 mins
Self esteem	Exercise/case studies		15 mins
Evaluation (feedback) Distribute hand-outs with key points to keep			10 mins

4. Peer Pressure, Teasing and Abuse			
<p>AIMS: To raise awareness about the influence of peer (and media?) pressure on decision –making, the damage caused by teasing and abuse, the role of traditional gender norms (both sexes); to provide practice in skills for resisting or responding to such situations.</p>			
<p>OBJECTIVES</p> <ul style="list-style-type: none"> ? Increase awareness of what sexual harassment is, why it is harmful, and methods of responding (for girls and boys) ? Develop understanding of sexual abuse (what it is and where it may happen), why it is wrong, and where victims can go for help ? Develop understanding of manipulation by peers, and how to resist such pressures 			
<p>KEY MESSAGES</p> <ul style="list-style-type: none"> o Eye teasing is wrong and harmful for both boys and girls. o If someone has been abused, it is important to report it. o It is all right to say no to something you feel is wrong or risky. o You have a right to be free from harassment, assault or abuse. o Boys and men have a responsibility for creating a safer environment. 			
CONTENT	METHODS	MATERIALS	COMMENTS
Re–cap	Facilitator		5 mins
Eve–teasing Reinforces concept of gender equality and gender norms Covers: <i>right to be free of harassment</i>	Presentation of definitions and real examples using Fact Sheet with facilitated discussion; individual experiences of girls and discussion of the way they managed; Role play	Fact sheet on crimes against women; examples of effective responses to teasing from media; Blackboard	Facilitated discussion of range of possible responses (girls) and role play; 20 mins
Keeping safe: sexual abuse and sexual assault and ways to prevent or respond Covers where to seek help; <i>right to dignity, abuse and assault are illegal</i>	Presentation by facilitator: “good touch, bad touch” (may be demonstrated by pair of facilitators) and rape or sexual assault; information and suggestions on responses and prevention	Hand–out referral sheet	Caution needed because individuals may have been abused or assaulted. Facilitators need to understand what should or should not be said. 15 mins
Peer pressure; Communication and negotiation skills. Our need to be accepted or part of a group is normal, but can lead us to deny our values. Used to reinforce issues of substance abuse, teasing, risky behaviour. Values and sense of self–awareness	Facilitator introduces examples and invites contributions from students; Role plays with group feedback to identify more effective responses	Prepare role plays for facilitators or scenarios for student role plays	Role plays might be different for girls and boys Key role of assertiveness in resisting peer pressure 25 mins

<p>5. Marriage and reproduction AIMS: To raise awareness of, and gain skills to address, pressures for early marriage / pregnancy, and to improve understanding of reproduction, contraception, and the risks of early pregnancy.</p> <p>OBJECTIVES</p> <ul style="list-style-type: none"> ? Gain understanding of legal age of marriage for girls and boys ? Raise awareness of physical, psychological and social consequences of early marriage, early pregnancy and early childbearing for girls and boys, and advantages of staying in school ? Increase understanding of reproduction, reproductive systems and contraception ? Increase skills in communication and negotiation in relation to early marriage and/or early pregnancy <p>KEY MESSAGES</p> <p>Early marriage is illegal, and has negative consequences for individual and society. The legal age of marriage is 18 for girls and 21 for boys. Staying in school longer is better for individuals for their own lives, and for future generations. Early pregnancy is dangerous for mother and baby, and reduces future opportunities for both. Girls who marry early should try to delay the first pregnancy until 18+. Both husbands and wives have equal responsibility in deciding when to have a baby.</p>			
CONTENT	METHODS	MATERIALS	COMMENTS
Re-cap	Facilitator		5 mins
<p>Early marriage and social consequences (covers legal age of marriage)</p> <p>Early pregnancy and its biological risks; Advantages of staying in school;</p> <p>Gender discrimination, multiple pregnancies and feticide (reinforcement of earlier session)</p> <p>Covers: <i>right to decide when to marry; right to education</i></p>	Facilitator presentation with facts and figures; guided discussion, if possible with flipchart OR case study; OR free-listing or debate about pros and cons of early marriage or pregnancy	<p>MacArthur flipchart</p> <p>Prepare hand-out</p>	<p>Caution is necessary as some may be married or will be married soon (harm reduction, ie, avoidance of early pregnancy, can also be mentioned)</p> <p>25 mins</p>
<p>Fertility, pregnancy and birth (reproductive systems and conception); deal with myths or misconceptions; reinforces information about bodily changes and reasons for menstruation</p> <p>Introduce idea that contraceptives exist to delay early pregnancy</p>	Facilitator presentation (eg facilitators would wear aprons, one male and one female)	Aprons or paper dolls in layers showing external and internal organs and systems	<p>Conception covered but limited to basic biological information (information on both sexes provided for all classes)</p> <p>25 mins</p>
<p>Contraceptives</p> <p>Covers: right to information; right to choose timing of birth. Covers: importance of shared decision-making about pregnancy</p>	Facilitator presented with simple charts or illustrations	Pictures of contraceptives for both classes but actual condoms for boys	<p>Male responsibility stressed in both, especially in boys' schools</p> <p>10 mins</p>
<p>Life Skills (assertiveness, negotiation, communication)</p> <p>Context of pressure for early marriage (own family) and pressure to bear children early (husband's mother)</p> <p>Context / Issues of rights to education, to delay marriage; to delay childbirth; male responsibility for contraception</p>	Use same story (flipchart) to identify skills and responses that could help delay marriage or pregnancy; facilitator needs to ask leading questions to elicit responses (actions and words) for class to consider (write these on blackboard)	Flipchart and blackboard	20 mins
Evaluation (feedback)			10 mins

6. STI/HIV Transmission and Knowledge			
<p>AIMS: To provide knowledge and clarify misunderstandings for the purposes of HIV and STI prevention</p> <p>OBJECTIVES</p> <ul style="list-style-type: none"> ? Gain clear understanding of what causes, and what does not cause, these diseases and conditions, and current scientific understanding of prevention, treatment and care ? Gain awareness of the links between STIs and vulnerability to HIV ? Gain awareness that anyone at any age can be vulnerable ? Gain clear understanding of symptomatology and testing ? Learn where further information, testing and treatment can be obtained locally (and where this should not be obtained) <p>KEY MESSAGES</p> <p>Some infections and diseases are caused by sexual intercourse without a condom. STIs can be cured by a qualified medical practitioner. 'Unsafe sexual contact' means not using a condom for intercourse. People with STIs are more likely to catch HIV if they continue to have 'unsafe sex'. HIV is spread by unprotected sexual contact, untested blood, needle sharing and from pregnant women to infants HIV is not contagious (not spread by sharing food or clothing, shaking hands, etc). You cannot tell if someone has HIV by looking at them, only by testing. HIV cannot be cured, but many PLWHA live a healthy life for many years.</p>			
CONTENT	METHODS	MATERIALS	COMMENTS
Re-cap	Facilitator		5 mins
STIs and RTIs: Basic fact that infections can be spread by sexual activity <i>but specific infections are not named</i> . Possible symptoms and consequences (eg, HIV transmission; infertility). Simple facts about diagnosis and cure. Covers where diagnosis and treatment can be obtained and should not be obtained. For girls, covers discharge, and what is normal or not	Facilitator presentation; Q & A; hand-out with name/s of treatment centres	Hand-out	STIs are not to be named and introduction is brief, ie, that infections can come from sexual intercourse without condoms, and that these infections can lead to serious consequences. Important to cover physiological discharge for girls. 15+ mins
HIV and AIDS Covers definitions of each and modes of transmission; myths about transmission and cure; testing and diagnosis (including where testing can be obtained); currently available treatment; who is 'at risk'? <i>Covers: right to information and to be free of disease</i>	Knowledge quiz; Facilitator presentation with visuals; Q & A; hand-out	Knowledge quiz; Transmission game? Attractive posters or charts to show effects on body; Posters or charts on means of transmission and now it is NOT transmitted	25+ mins
Gender and HIV transmission: Reinforces right to equality and impact of gender discrimination on vulnerability	Facilitator presentation; case studies and discussion		25 mins
Evaluation (feedback)			10 mins

7. STI/HIV: Issues of Prevention and Stigma

AIMS: To contribute to HIV /STI prevention through increasing knowledge and skills, and to reduce stigma against PLWHA

OBJECTIVES

- ? Develop understanding of the most effective methods of HIV/STI prevention
- ? Gain practical skills in assertiveness and negotiation for HIV/STI prevention, especially to say 'no' to pressure to have sex
- ? Develop awareness of the individual and social impact of stigma and discrimination against PLWHA

KEY MESSAGES

HIV can be prevented, but not cured.

Abstinence is the best way to prevent HIV and STIs.

Having sex without a condom makes men and women vulnerable to HIV and STIs.

You have a right to say no to sex.

You have a right to say no to taking drugs or sharing needles.

PLWHA have the same rights as other people, including the right to employment, support and health care.

CONTENT	METHODS	MATERIALS	COMMENTS
Re-cap	Facilitator		5 mins
Methods of preventions (myths) Reinforces correct understanding from last session	Facilitator and guided discussion	Actual condoms for boys	10 mins
Life skills (assertion and negotiation) Covers <i>right to say no to sexual relationships</i> . Reinforces concepts of gender issues, and peer pressure leading to risky situations	Case studies and role plays		20 mins
Stigma and discrimination Covers: right to dignity and care; right to be free from discrimination. Reinforces correct knowledge about transmission	Street corner play staged in school		10 mins
Evaluation (feedback)	Verbal and written		15 mins
Post-test (repeat of Pre-test)	Structured survey		30 mins

Abbreviations

AEP	Adolescence Education Programme
AIDS	Acquired Immune Deficiency Syndrome
ARSH	Adolescence Reproductive and Sexual Health
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
DEO	District Education Officer
DIET	District Institute of Education Training
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IEC	Information Education and Communication
KAP	Knowledge Attitude and Practices
NACO	National AIDS Control Organization
NPEP	National Population Education Programme
RB	Rural Boy
RBS	Rural Boys' School
RFSU	Swedish Association for Sexuality Education
RG	Rural Girl
RGS	Rural Girls' School
SAEP	School AIDS Education Programme
SPSS	Statistical Package for Social Science
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
UB	Urban Boy
UBS	Urban Boys' School
UG	Urban Girl
UGS	Urban Girls' School



MAMTA Health Institute for Mother and Child is a non-profit, non-government organisation aiming to improve Sexual and Reproductive Health of current and future generations through Rights-based approach. Through its various interventions the organisation constantly strives to bring about an equitable and sustainable change in the lives of young people in India and in South Asia. In addition to Sexual and Reproductive Health and Rights, MAMTA has a significant focus on Maternal and Child Health, and HIV Prevention, Care & Support programmes. Working in the context of poverty and addressing gender and Rights issues is a common mandate within all areas of work.

Established in 1991, MAMTA presently has interventions located in three countries (India, Nepal and Bangladesh) and 12 states in India. Its headquarters are located in New Delhi, with state offices in Lucknow, Chandigarh and Jaipur. MAMTA's interventions are made possible through partnerships with more than 150 organisations across India and South Asia.



RFSU (the Swedish Association for Sexuality Education) was founded in 1933. Today it is the leading organisation in Sweden in the field of Sexual and Reproductive Health and Rights (SRHR). RFSU sees openness on sexuality as the point of entry of health promotion and prevention. Rights to sexual and health services, and sexuality education are key tools in the struggle for a healthier and more equitable society.

RFSU's five international programmes on Sex Education and the right to information about sexuality, STI and HIV/AIDS, Right to sexual and reproductive health care, Health and rights of lesbians, gays, bisexuals and transsexuals, Women's right to safe abortion and reduced maternal mortality, Right to freedom from sexual violence and violence based on gender covers Tanzania, Zambia, Uganda, Kenya, China, Mongolia, Vietnam, Bangladesh, Russia, Estonia, Latvia and Lithuania.

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