research brief |

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School-Based Sexuality Education in Rewari, Haryana

Adolescents in India face an extraordinary lack of information about sexuality. 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 reproductive health needs. It is important to equip them to assist them in coping with the needs during the transitional phase – from adoloscence to adulthood. Unfortunately, sexuality education is denied to adolescents because the subject is considered to be culturally sensitive and controversial for discussion in the classrooms of Indian schools.

BACKGROUND AND RATIONALE

Many parents and adults have misconceptions that providing "sex education" would embolden adolescents and encourage sexual activity. The reality appears to be the opposite. Numerous studies from various countries show that providing appropriate sexual health education typically delays the initiation of sexual activity amongst youth and helps them avoid risky behaviour whenever they indulge in sexual activity. The provision of right content and skills at an appropriate age and time works as a protective factor that reduces the vulnerability of adolescents to HIV, sexually-transmitted infections and unwanted pregnancies.

Unfortunately, there is very little conclusive evidence to pin-point the most appropriate and effective method to educate school-based adolescents in India about sexuality. 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 very different sociocultural settings.

In the year 1971, **Population Education** syllabus, developed by NCERT [1], was introduced in schools. The theme areas were population growth and family life. In the wake of International Conference on Population Development, 1994, Adolescent Sexual 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 **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). **Adolescence Education Programme,** introduced in 2005-06, focuses on developing life skills to cope with negative peer pressure, improving sexual health and preventing new HIV infections.

The present study has been designed to enable the development, implementation and evaluation of a sustainable sexuality education program that responds to the needs and demands of school–based adolescents in both urban and rural settings of North India, while reflecting National and International understandings of sexual and reproductive health needs and concerns.

1 National Council of Educational Research and Training

This project aims to respond to the gap in the evidence base on effective school-based sexuality education programs in Indian settings.

Firstly, it uses an approach of consultation and feedback with stakeholders – parents, teachers and secondary school students. By doing so, it is presumed that these stakeholders will endorse the curriculum that is being developed and implemented with their active involvement.

Secondly, it uses triangulation of methods (quantitative, qualitative, document review) to identify needs, gaps and opportunities.

And finally, the study design enables evaluation of changes in knowledge, attitudes and practices, as well as comprehensive process evaluation (monitoring) to permit modification of the program during implementation.

The project's aim is not merely to exchange knowledge and change attitudes of students, but also to develop a sustainable program based upon consensus and consultation with stakeholders. The program will be found successful if the curriculum has been implemented and largely accepted and endorsed by all the stakeholders, and if there is evidence of changing knowledge and attitudes among the students.

STUDY AREA/POPULATION

The location for intervention is 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 in North India.

A purposive selection strategy was used to identify intervention schools based upon (a) obtaining permission from relevant authorities for the program to be implemented in the schools, and (b) Boys' and Girls' Government Higher Secondary Schools which cater to the education needs of adolescents largely living in villages and semi urban areas.

METHODOLOGY

The study utilizes a single-group, time series design and has two major parts, Intervention & Research.

Research includes four components, namely:

i Needs assessment (consultation, desk review, primary data collection – qualitative and quantitative) for baseline data and curriculum design.

ii Annual pre & post assessment of knowledge and needs of adolescents.

iii Periodic process evaluation of intervention, based upon indicators related to content, delivery and stakeholder's perspective to enable modification.

iv Impact evaluation of program to determine program effectiveness over its lifetime.

Intervention includes two components, namely:

i Development and implementation of age-specific sexuality education sessions by trained facilitators starting with Class VIII in the first year, with annual increments in content to subsequent years (Classes IX and X) for the same cohort based upon age-specific needs, assessment and feedback.

ii Modification of the program within each year where required (based on Process monitoring).

The study was initiated in September 2004 and will be completed by December 2008.The study comprises three phases, described below.

PHASE I: CURRICULUM DEVELOPMENT BASED ON NEEDS ASSESSMENT AND REVIEW, SEPTEMBER 2004 – AUGUST 2005 (COMPLETED)

During this phase, consultation was undertaken with parents and teachers to identify their perspectives and concerns about the proposed program. A mixed-method needs assessment was conducted with students of different

ages to establish the baseline and identify gaps in knowledge and attitudes. Also, available and planned National curricula and models from International settings were reviewed in order to document existing efforts and expertise and identify specific content and modalities most likely to be suitable to the cultural context of this intervention. These various sources of information were used to draft the Sexuality Education Framework for Classes VIII, X and XI curriculum. The program was endorsed by parents, teachers, students and education department authorities.

PHASE II: INTERVENTION AND MODIFICATION (PROCESS EVALUATION), AUGUST 2005 – MARCH 2008

During Phase II the curriculum has been delivered incrementally to the same cohort, year by year, as they have progressed from Class VIII; currently the cohort is receiving the curriculum in Class X (session 2007 – 08). The Program content, reach, cultural sensitivity and acceptability are being monitored through feedback from students, stakeholders and facilitators, to enable modification as needed.

IMPLEMENTATION IN SCHOOLS:

Based on Phase I, and in accordance with availability of time within the yearly academic session, the curriculum was devised in a framework of seven sessions of 90 mins each (total 10.5 hours) conducted fortnightly. It has been delivered entirely by trained facilitators, most of them have worked for many years in Haryana within a larger 'MAMTA' capacity building program that focuses on community development, sexuality and gender.

The initial Class VIII curriculum was developed in partnership between the educators and curriculum specialists (part of the research team), who identified appropriate methodologies and tools for delivery. The draft curriculum each year is field tested with both male and female students in a different set of rural and urban schools, and the feedback is incorporated. The final version is available both in Hindi and English. The medium of delivery in the schools is Hindi. The facilitators are trained each year on the use of participatory methods and delivering the curriculum content in 5 days training at the beginning of each session. In addition, a reorientation on the session content takes place a day prior to the session.

A pre and post test quantitative questionnaire based on each year's curriculum is used to assess the change in KAP in each academic session. Facilitators prepare a report to record feedbacks from each session. This report contains details on questions raised by students. At the end of the year, focus group discussions (FGDs) and in-depth interviews (IDIs) captured feedback from students and teachers regarding implementation across schools and perceived quality (i.e., acceptability, cultural sensitivity, user friendliness) of the curriculum. Feedback from these data sources forms the basis for making incremental changes in the curriculum for the next year and for refining the existing curriculum.

PHASE III: IMPACT EVALUATION, APRIL 2008-DECEMBER 2008

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

INITIAL RESULTS

The key findings from needs assessment carried out at the beginning of the study are as follows:

SUMMARY OF STAKEHOLDERS PERSPECTIVES

On sexuality education in school

Students and teachers alike agreed about the strong need for sexual and reproductive health education in schools, and that it should be mandatory. The teachers uniformly felt the content should be implemented across

the curriculum, integrated in teaching subjects such as biology, and additionally organized in the form of lectures by external experts.

In contrast, students had varying views about when and how to implement this education. Some argued that a separate subject was preferable over its inclusion in biology as some students do not study biology in older years, when they need the information most.

Students, teachers and parents all agreed that this education should commence from class VIII and be adjusted accordingly with increasing age of students. However, parents were unanimous that this education must be taught separately to boys and girls. Many also wanted the curriculum to cover issues like respect for elders and family values. All stakeholders agreed that sexual intercourse should be discussed within the context of marriage. Parents and teachers also considered friendship with the opposite sex "unacceptable".

On possible outcome of this education

All stakeholders felt this education would be beneficial for students. However, some parents added the concern that this knowledge would create a momentum of its own, as students gained in confidence and were comfortable discussing topics formerly not widely shared.

On the question of who should deliver this education

Teacher participants suggested that only individuals who are comfortable with discussing the issues with students should be educators. However, they emphasised the importance of educators having sufficient knowledge and skills and access to well prepared educational materials. Both students and teachers proposed that various experts from the outside of school (medical doctors, gynaecologists, psychologists) should be invited to conduct lectures because, they argued, it is easier for students to confide in someone they do not encounter on a daily basis. The great 'respect' students hold for teachers was seen as linked to students' discomfort in discussing personal, sensitive issues with teachers.

On possible content of sexuality education

Teachers suggested lower classes should focus on bodily changes, and then gradually introduce relationship and sexuality issues to achieve a comprehensive and systematic coverage of all topics. A number of mothers felt girls in classes XI and XII should know about contraceptives. During FGDs, few parents in some groups specifically stated they did not want adolescents to be told about 'sex', 'love affairs', 'condom use' (for girls only), and 'masturbation'. However, different viewpoints were expressed and the strength and similarity of opinions among parents was not determined through methods used at this stage.

Students provided the following list of what should be taught:

1. Substance abuse (alcoholism and tobacco)
2. Love and relationships
3. Sexual intercourse (boys)
4. Responsibilities after marriage
5. Contraceptives
6. Menstruation
7. Nightfall (nocturnal emission)

Many students thought 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 contributions from each of these stakeholders provide their perspective and additionally stress some of the considerations that need to be addressed in any future development of curriculum.

RESULTS FROM INTERVENTION IN CLASS IX

Students in Class IX were asked to complete a knowledge, attitudes and practices questionnaire (or "test") based on that year's curriculum, at the beginning and again at the

end of the delivery of the curriculum. In this way some evidence of continued gaps as well as improvements could be identified.

CLASS IX PRE-TEST AND POST-TEST

Analysis of data showed that the mean age of students of class IX was higher for boys: 15.1 years for rural areas (range 13-17 years) and 14.8 years for urban areas (range 13-17 years), while it was 14.4 years (range 13-16 years) and 14.3 years (range 12-18 years) for female students from rural and urban areas, respectively.

The results overall, show significant change in knowledge and attitudes of female students, especially those in rural settings. Change of similar magnitude however is not visible amongst male students. The Pre-Post test comparison on selected variables is presented here (see Table 1).

The male students in urban areas and female students (both urban and rural) show a statistically significant difference in the pre- post test result that 'no treatment is required for nightfall'. The difference in urban males is not statistically significant.

Only the rural female students have a statistically significant difference in the opinion that 'it is males' duty to ensure a protective environment for females in public places.' Male students from rural areas and female

Table 1 : Pre-post Test Comparison of Selected Parameters by Place of Residence and Sex

Sex	Place	Pre test	Post test	χ^2value	Significance level
Sperm is produced regularly in the body					
Male	Rural	51.3	70	2.464	0.116
	Urban	57.5	73.9	1.697	0.193
Female	Rural	14	25.3	4.018*	0.045
	Urban	6.7	23.2	21.932*	0.000
Nightfall does not result in weakness					
Male	Rural	5.1	50.0	18.388*	0.000
	Urban	50.0	78.3	4.873*	0.027
Female	Rural	14.0	52.7	34.000*	0.000
	Urban	14.9	18.2	0.791	0.374
No medical treatment is required for 'nightfall'					
Male	Rural	10.3	30.0	4.323*	0.038
	Urban	72.5	78.3	0.256	0.613
Female	Rural	22.4	56.0	23.614*	0.000
	Urban	20.7	39.9	17.838*	0.000
Men can help to provide a protective environment for women in public places					
Male	Rural	79.5	80.0	0.003	0.958
	Urban	72.5	69.6€	0.062	0.804
Female	Rural	71.0	89.0	9.686*	0.002
	Urban	68.3	71.7	0.574	0.449
Girls should never be teased					
Male	Rural	71.8	36.7€	8.515*	0.004
	Urban	37.5	39.1	0.016	0.898
Female	Rural	83.2	92.3	3.716	0.054
	Urban	88.9	84.3€	1.860	0.173
Both husband and wife should make the decision about when to have a child					
Male	Rural	74.4	73.3€	0.009	0.923
	Urban	52.5	52.2	0.001	0.980
Female	Rural	75.7	95.7	15.832*	0.000
	Urban	65.9	83.3	16.244*	0.000
Making sexual remarks, following somebody with a wrong intention, and writing obscene letters are all elements of sexual harassment					
Male	Rural	5.1	23.3	4.955*	0.026
	Urban	17.5	26.1	0.657	0.417
Female	Rural	29.0	54.3	13.244*	0.000
	Urban	20.2	48.5	36.190*	0.000
In case of sexual abuse , one should confide in a trusted elder person and oppose the action then and there					
Male	Rural	38.5	43.3	0.167	0.683
	Urban	75.0	82.6	0.489	0.484
Female	Rural	80.4	98.9	17.689*	0.000
	Urban	71.6	88.4	17.656*	0.000

Note: * Statistically significant difference in post test compared to pretest.

€ Regression in post test compared to pretest

students from urban areas show a positive change in the post test compared to pre test; the difference, however, is not statistically significant. The urban males actually regressed between pre- and post-test. Also, rural boys were less likely to agree that boys should never 'eve tease' a girl at the post-test than the pre-test.

Female students from both urban and rural areas showed a statistically significant difference in pre- post test knowledge that 'both husband and wife should decide when a child should be born'. However the males from both the areas show a minor shift towards the negative.

Female students from urban and rural areas and male students from rural areas recognize that 'making sexual remarks, following somebody with a wrong intention and writing obscene letters, all constitute sexual harassment', a change that is statistically significant. Although it started at a high base, at post-test female students from rural and urban areas were even more likely to identify the options that in case of sexual abuse, one should 'oppose the action then and there' and also 'confide in a trusted elder person.' The males of both areas indicate a positive change in this regard; however, the difference is not significant.

> We were laughing [when facilitators discussed reproductive organs], because we were attending this type of session for the first time, because all of it was very different, for the first time ... we thought that [the educators] were telling very bad things, that time we did not know that it will be so good.
>
> Male student, class IXth of Govt. Senior Secondary School, Rewari

Self-esteem is one component of self-concept, which Rosenberg defines as "totality of the individual's thoughts and feelings with reference to himself as an object." During the one year of intervention at Class IX, the female students in the rural school show enhanced self esteem, an increase that is significant (Table 2).

Table 2 : Percentage Distribution of Score of Rosenberg Scale

Sex of student	Place of Residence	Rosenberg scale classification	Pre Test Data	Post Test Data	χ^2 value
Male	Urban	Lowest Self Esteem	42.4	20.0	5.47
		Low Self Esteem	24.2	13.3	
		Mid Self Esteem	21.2	53.3	
		High Self Esteem	12.1	13.3	
	Rural	Lowest Self Esteem	43.3	45.8	0.84
		Low Self Esteem	26.7	33.3	
		Mid Self Esteem	26.7	16.7	
		High Self Esteem	3.3	4.2	
Female	Urban	Lowest Self Esteem	27.3	32.3	5.30
		Low Self Esteem	35.3	35.3	
		Mid Self Esteem	22.3	25.1	
		High Self Esteem	15.1	7.2	
	Rural	Lowest Self Esteem	41.9	28.2	17.01**
		Low Self Esteem	16.1	42.3	
		Mid Self Esteem	14.5	21.1	
		High Self Esteem	27.4	8.5	

THE WAY FORWARD:

By the end of December 2008, the delivery of curriculum to the cohort (for the third consecutive year) will be completed. Students will be evaluated (by post-test, questionnaires, FGDs, IDIs) in relation to changes in knowledge-attitudes-intended practices and the Rosenberg self-esteem Scale. Individual student will be followed up to see the change in Rosenberg Scale and the overall results will be correlated with the number of sessions attended. The results will be compared with that of the students of Class XI who have not been exposed to the curriculum, and will serve as a 'Control Group.' Class XI students were administered the same test at the beginning of the session.

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Education in Rewari, Haryana

> I liked (the sessions) because what we could not ask from our teachers and parents, we asked and came to know .... because in future we can use it, ...we can prevent sexual infections, we came to know how HIV spreads and how we can be safe from HIV.
>
> Male student, class IXth of Govt. Senior Secondary School, Rewari

The initial results from this intervention study show that the curriculum is making an impact, but this is most obvious in one group i.e., the girls in rural school. The reason for differences in performance of males and females in the cohort will be further explored.

The third phase of this study – the Impact Evaluation and documentation of key processes and results – will be initiated in January 2008. This is expected to contribute to the evidence base in relation to effective, appropriate sexuality education programs for national and international audiences, and to national-level decision-making by educational authorities.

The evaluation 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 final evaluation will be used as an evidence base for advocacy for expanded sexuality education in other school settings in India and to further understanding of different approaches to this challenging but crucial aspect of youth well-being in developing countries.

> On TV they do inform about HIV/AIDS, but from you [facilitators] we can ask our queries.
>
> Male student, class IXth of Govt. Senior Secondary School, Rewari

RESEARCH TEAM:

Dr. Sunil Mehra (Mamta)
Dr. Deepti Agrawal (Mamta)
Dr. Martha Morrow (University of Melbourne, Australia)
Dr. Subha Sankar Das (Mamta)
Mr. Kailash C. Lakhara (Mamta)

INTERVENTION TEAM:

Mr. Jayant Kumar
Ms. Sunita Pawar
Ms. Madhu
Ms. Indira
Mr. Mange Ram
Mr. Rinkan
Mr. Rajesh Ranga
Mr. Pawan

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CONTACT DETAILS:

MAMTA- HEALTH INSTITUTE FOR MOTHER AND CHILD

B-5, Greater Kailash Enclave-II, New Delhi 110048 (India)
Tel: + 91- 11- 29220210 / 29220220 / 29220230 Fax: + 91- 11- 29220575
E-mail: mamta@ndf.vsnl.net.in URL: www.mamta-himc.org & www.yrshr.org