GENDER, CIVIL SOCIETY, AND THE STATE IN CONTEMPORARY SOUTH ASIA: PREVENTIVE APPROACHES TO GENDER BASED VIOLENCE

A Radcliffe Institute Exploratory Seminar
Harvard University - August 26-27, 2014

Session I: Current Policy Landscape Relating to Gender and Education in India

India is home to the largest youth population in the world. Efforts to implement an adolescent education program that addresses sexual and reproductive health, life skills and other matters relevant to these young persons' healthy development have been ongoing for decades. However, due to large scale controversy a comprehensive nationwide program has yet to be implemented.

The first attempts to implement a life skills and adolescent development program into mainstream education began in 1980 through a partnership between UNFPA and the Department of Education (Ministry of Human Resource Development)[1]. After almost two decades of negotiation and revisions, in 1999 the Indian government began the process of launching a sex education program, the Adolescent Education Program (AEP). Over the following years experts and policy makers further deliberated over which topics to include and whether these would offend any "prevailing inhibitions" in society. In 2005 a new iteration of the Adolescence Education program emerged as part of the National Population Education Project. The Central Government developed the AEP in association with National AIDS Control Organization (NACO) and UNICEF for implementation in all secondary and higher secondary schools with Indian National Council of Educational Research and Training (NCERT) as the implementing body. The objectives of the AEP were:

a. To ensure the integration of AE elements into the school curriculum and in teacher education courses,

b. To organize activities for life skills development,

c. To help students acquire authentic knowledge about Adolescent Reproductive and Sexual Health (ARSH) including HIV/AIDS and substance abuse, especially drugs, and

[1] http://ncert.nic.in/ncert/aerc/UNFPA_MHRD.html

d. To inculcate in students essential life skills to develop healthy attitudes and responsible behaviour towards ARSH issues, including HIV/AIDS and substance abuse.

More debate ensued. Liberals lamented the program's emphasis on abstinence as the best strategy for the promotion of sexual and reproductive health[2]. Conservative opponents argued for a ban on sex education in schools altogether on the ground that it corrupted the youth and offended 'Indian values'. They contended that it may lead to promiscuity, experimentation and irresponsible sexual behavior. In 2007, several Indian states including Gujarat, Madhya Pradesh, Maharashtra, Karnataka, Kerala, Rajasthan, Chhattisgarh and Goa declared that the course content as suggested by MHRD was unacceptable and thus banned the program.

Thereafter NCERT launched a scaled down version of the program, in a limited number of states namely Bihar, Madhya Pradesh, Maharashtra, Odisha and Rajasthan, and institutions, through the three national school systems - Central Board of Secondary Education (CBSE), Navodaya Vidyalaya Samiti (NVS) and Kendriya Vidyalaya Sangathan (KVS). According to NCERT the current program:

> …works on a cascade training approach that has created a pool of master trainers who orient nodal teachers who are entrusted with the responsibility of transacting life skills based education (16 hours module) to secondary school students through interactive methodologies. Nodal teachers are provided guidelines and materials to facilitate the transaction process. Advocacy sessions are organized with principals of participating schools and sensitization sessions are held with parents. By end 201 2, approximately 500 master trainers had oriented 3400 nodal teachers on adolescence education issues. For

[2] Trivedi , A. 2013. World Population Focus on India, Part 1: Sex Education " http://world.time.com/2013/07/10/world-population-focus-on-india-part-1-sex-education/

better impact and quality, the program has been consolidated in 5 UNFPA priority states, to achieve a goal of one trained teacher for every 150 secondary school students.

Progress in furthering the adolescent education agenda is also being made on various other fronts. NCERT and UNFPA have now renewed emphasis on evaluating the efficacy of the current life skills education programs[3]. In addition, the International Center for Research on Women (ICRW), with support from DFID are carrying out a number of impact evaluations on the effectiveness of such smaller scale adolescent education. This focus on evaluation will no doubt prove and improve the efficacy of such programs. Life skills focused adolescence education was introduced as a separate subject across 4500 government schools in Rajasthan in 2005 and the subject is now institutionalised within the government schools[4]. UNFPA's Rajasthan state office's project to integrate life skills and adolescent concerns in the pre-service teacher training curricula across seven universities in the state is a significant strategy to ensure long term effectiveness and sustainability of school based programmes. UNFPA India is also working on integrating and evaluating life skills into the adolescent curriculum of independent schools, the enrollment of which is over 400,000.

While these programs will provide much needed information for a subset of the large adolescent population, what is still lacking is a nationwide coordinated program, one that also targets the millions of adolescents outside the schooling system. With 225 million Indians now aged between

[3] Concurrent evaluation of the program was fielded across 200 schools to assess the program's achievements and identify gaps for improved programming. Both quantitative and qualitative tools were used. In the 14-18 age group, 20,000 adolescent students (11,500 boys and 8,200 girls) who were exposed to the program and 2300 adolescent students (1400 boys and 900 girls) who were not been exposed to the program participated in the concurrent evaluation. Some of the preliminary findings show modest program effects e.g Sixty seven percent adolescents exposed to the program knew that male condoms can prevent both HIV transmission and pregnancy compared to 58% who were not exposed to the program. See http://ncert.nic.in/ncert/aerc/Concurrent_%20evaluation.html

[4] http://www.unic.org.in/display.php?E=12870&K=

10 and 19[5]— 22% of the overall population, the demand for adolescent life education is intensifying. A 2013 report on adolescent attitudes to family life education revealed that most unmarried young people—80%— believe that such education is important, but less than half of young people actually receive it.[6] The increasing awareness that this massive unmet need of young people in understanding interpersonal relationships and sexual health is linked to devastatingly high incidences of gender based violence has led to a tempering of resistance in social and political spheres. Teachers, many of whom were against the implementation of life skills education, are increasingly turning to civil society organizations for training on how to broach issues of sexual health, substance abuse and other traditionally taboo subjects with their students[7]. The recently appointed Minister for Health Minister Harsh Vardhan came under large-scale media scrutiny over his call for banning sex education in government schools. He later clarified that "Sex education is necessary, but without vulgarization"[8]. The critique and subsequent clarifications of the minister's comments mark a departure from the previous more rigid stance of the now ruling BJP party on sex education[9].

There is some movement in the social and political climate, with stakeholders from all sides of the political spectrum calling for a large scale, two prong, top down and bottom up strategy to urgently address the educational deficit in adolescent education.

[5] Population in Different Age Groups and their Proportions to the Total Population. Office of the Registrar General and Census Commissioner.
[6] Tripathi, N. 2013. Youth in India Ready for Sex Education? Emerging Evidence from National Surveys. PLoS ONE, 8(8).
[7] Thurau, N. 2013."Teachers in India to Attend Sex Education Workshop as Taboo Wanes" http://www.openequalfree.org/ed-news/sex-no-longer-a-taboo-in-india-teachers-will-attend-sex-education-workshop
[8] http://www.ndtv.com/article/india/sex-ed-that-is-not-vulgar-is-ok-clarifies-health-minister-harsh-vardhan-549077
[9] For example in 2009, a panel led by BJP leader M Venkaiah Naidu condemned plans to introduce sexual education into schools. The panel criticized the petition seeking introduction of appropriate chapters on HIV/AIDS incorporated in biology syllabuses in higher classes. See Parliamentary Panel says no to sex education in schoolshttp://articles.timesofindia.indiatimes.com/2009-04-16/india/28052929_1_new-syllabus-schools-adolescence-education-programme

Session II: Best Practice Examples: Gender and Education and India

1: An Innovative Government Approach

NCERT 2010 Conceptual Framework—Adolescence Education Programme[10]

In 2010 NCERT launched a new conceptual framework on adolescent education. The framework was widely applauded for its human rights based approach to adolescent health and wellbeing. The framework emphasized the need for an open and participatory pedagogical approach and a curriculum that conceptualized adolescence as a "positive stage of life: a phase full of possibilities and potential". The far reaching framework includes the following core principles:

Adolescence Education should enable adolescents to:

- Understand changes they are undergoing, and address any fears and anxieties related to these changes.
- Become aware of rights and how these can be protected.
- Take decisions and negotiate with others, based on own interests and rights of others.
- Recognize sexual abuse, violence and discrimination and break the silence related to these.
- Be healthy and able to protect themselves from diseases and infections.
- Counter shame about their bodies and sexuality, feel confident and positive about themselves, experience greater well being.

This progressive approach to adolescent education, if translated into a well monitored nationally coordinated program for adolescent education, would leave India poised to move from laggard to leader in addressing this critical issue.

[10] Relevant Websites: http://ncert.nic.in/ncert/aerc/pdfs/CONCEPTUAL_%20FRAMEWORK.pdf

2. Civil Society and Curriculum Development

Similar to India, many countries around the world, particularly in the global south, are facing a cultural clash where the evolving needs of a large youth population for a comprehensive life and sex education program interface with conservative traditions. In India and beyond many civil society organizations have stepped in and developed culturally sensitive tools such as adolescent education curricula and pedagogical guides to education to inform their youth population about critical issues and empower them to live healthy and productive lives. Some best practice materials include:

a) Population Foundation of India- *A Facilitator's Manual on Adolescent Health & Life Skills for NCC Cadets*
http://populationfoundation.in/resource-center/publication/facilitator%E2%80%99s-manual-adolescent-health-life-skills-ncc-cadets

b) UNESCO -*International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators* Volume I- 2009
http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

c) Population Council - *Guidelines For A Unified Approach To Sexuality, Gender, HIV, And Human Rights Education.* These comprehensive guidelines integrate the concept of human rights and particularly sexual and reproductive rights in a very accessible way.
http://www.popcouncil.org/pdfs/2011PGY_ItsAllOneGuidelines_en.pdf

d) PROMUNDO – Program H manual –The guide includes approximately 70 activities to carry out group work with young men (ages 15 to 24) on gender, sexuality, reproductive

health, fatherhood and care-giving, violence prevention, emotional health, drug use, and preventing and living with HIV and AIDS.

http://www.promundo.org.br/en/sem-categoria/engaging-men-and-boys-in-gender-equality-and-health-download/

The plethora of resources available means that when a critical mass demand for a national program implementation is reached, those charged with the development / amendment of the existing curriculum will have a wealth of resources from which to draw.

3. Civil Society Engaging with Men and Boys

Case Study**:** *Promoting Gender Equity as a Strategy to Reduce HIV Risk and Gender-based Violence Among Young Men in India supported by USAID, Population Council Horizons Program, CORO, MAMTA, DAUD and Instituto Promundo*

Implementers: The Horizons Program, CORO for Literacy, MAMTA, and Instituto Promundo developed, piloted, and scaled-up a behavior-change intervention, Yaari-Dosti. The interventions were based on a successful program that addressed gender norms in Brazil. The team conducted operations research to examine the effectiveness of the interventions to improve young men's attitudes toward gender roles and sexual relationships, and to reduce HIV risk behaviors and partner violence.

Program: Set in urban slums of Mumbai and in rural villages in Gorakhpur (Uttar Pradesh), the action research project used a quasi-experimental design to test the impact of different combinations of intervention activities on young men's support for inequitable gender norms, HIV/STI risk behaviors, and partner violence. The program targeted married and unmarried young men aged 16–29 years in urban settings and aged 15–24 years in rural settings. The intervention

included group education sessions and lifestyle social marketing (LSSM) campaign. The major objective of the LSSM campaign was to reinforce the messages from the group educational sessions, which focused on more gender-equitable lifestyles and versions of manhood through community-based activities conducted in spaces where young men normally congregate. The program was designed to stimulate critical thinking about gender norms that promote risky behavior and to create support for gender norms that promote care and communication.

Evaluation: Attitudes toward gender norms of the young men were assessed using a version of the Gender Equitable Men (GEM) Scale developed initially in Brazil and adapted to the Indian context. A change in GEM Scale scores, as well as in a number of behavioral indicators including condom use, violence against partners, and communication with partners, were evaluated. Further, associations between the GEM Scale and behavioral indicators were determined at baseline and follow up, and across the intervention arms.

Effect:

- At baseline, the majority of young men supported inequitable gender norms. GEM Scale scores were trichotomized into "high equity," "moderate equity," and "low equity." At baseline, less than 10 percent of the young men in all the sites were categorized as "highly equitable." The majority of young men were distributed across ''moderate" and "low" equity categories. There was not much difference between the rural and urban sites.
- After the intervention, there was a significant positive shift of young men moving from the "low gender equity" category into the "moderate gender equity" and "high gender equity" categories in the intervention sites.
- Partner communication significantly improved in the intervention sites.

- There was a significant increase in condom use at last sex with all partner types in the intervention areas.
- Self-reported violence against a partner declined in the intervention sites.
- There was a positive trend toward improvements in GEM Scale scores being associated with decreases in HIV/STI risk behaviors.
- Young men in the intervention arms showed significant improvements in their attitudes toward people living with HIV (PLHIV), while attitudes significantly worsened among the comparison groups in both Mumbai and in Gorakhpur.
- Young men participated actively in the group education sessions

Conclusion: This study showed that change in attitudes and behaviors is a complex and gradual process. Qualitative observation of those who attended the sessions suggests that changes among the young men happened in stages. In the initial stages of the intervention, young men who came into the sessions often denied the idea of gender-based inequality in their society and in their individual actions. As they progressed through the sessions, they moved their position toward accepting that gender-based inequality does exist. Further into the intervention, they acknowledged that some of their attitudes and behaviors were gender inequitable, and that it would be beneficial to change these views.

Relevant websites:

Summary adapted from:

http://www.popcouncil.org/uploads/pdfs/horizons/India_GenderNorms.pdf

For other organizations working with men and boys see also the Equal Community Foundation http://ecf.org.in/

Session III: Academic Research Relating to Adolescent Sex and Life Skills Education: What the Science Shows

In this section a select number of studies relevant to the adolescent education debate are summarized. McManus and Dhar (2008) show the deficit in basic knowledge in reproductive health amongst India's youth, which urgently needs to be addressed. Kirby et al (2006, 2009) draw on a plethora of sources, in a meta-analysis of the literature, demonstrating that sex education does not encourage young people to have sex at an earlier age or more frequently. On the contrary, studies show that sex education delays the start of sexual activity, reduces sexual activity among young people and encourages those already sexually active to have safer sex. Kivela et al. in a review of cost effectiveness of sex education programs make a compelling case for including mandatory sex education in all schools by concluding that intra-curricular sexuality education programs have, because of their compulsory nature, the most potential to be scaled up and are therefore most efficient.

1. Study of knowledge, perception and attitude of adolescent girls towards STIs/HIV, safer sex and sex education: (A cross sectional survey of urban adolescent school girls in South Delhi, India)

Authors: A McManus, L Dhar

Objective: The aim of this study was to evaluate Indian adolescent school girls' knowledge, perceptions, and attitudes towards STIs and HIV/safer sex practices/sex education and to explore their current sexual behavior.

Methods: A cross sectional study was carried out in 2007 in South Delhi, India. The self-administered questionnaire was completed by 251 female students from two senior secondary schools.

Results: More than one third of students in this study had no accurate understanding about the signs and symptoms of STIs other than HIV/AIDS. About 30% of respondents considered HIV/AIDS could be cured, 49% felt that condoms should not be available to youth, 41% were confused about whether the contraceptive pill could protect against HIV infection and 32% thought it should only be taken by married women.

Conclusion: Though controversial, there is an immense need to implement gender-based sex education regarding STIs, safe sex options and contraceptives in schools in India

Chicago Citation: McManus, Alexandra, and Lipi Dhar. "Study of knowledge, perception and attitude of adolescent girls towards STIs/HIV, safer sex and sex education:(a cross sectional survey of urban adolescent school girls in South Delhi, India)."*BMC Women's Health* 8, no. 1 (2008): 12.

Relevant Websites: http://www.biomedcentral.com/1472-6874/8/12/

2. **The effectiveness of sex education and HIV education interventions in schools in developing countries- A META analysis**

Authors: Douglas Kirby, Angela Obasi, B.A Laris

Objective: To review the impact of sex education and HIV education interventions in schools in developing countries on both risk behaviors for HIV and the psychosocial factors that affect them.

Methods: The authors conducted a systematic review. Searches identified studies in developing countries that evaluated interventions using either experimental or strong quasi-experimental

designs and measured the impact of the intervention on sexual risk behaviors. Each study was summarized and coded, and the results were tabulated by type of intervention.

Findings: Twenty-two intervention evaluations met the inclusion criteria: 17 were based on a curriculum and 5 were not, and 19 were implemented primarily by adults and 3 by peers. These 22 interventions significantly improved 21 out of 55 sexual behaviors measured. Only one of the interventions (a non-curriculum-based peer-led intervention) increased any measure of reported sexual intercourse; 7 interventions delayed the reported onset of sex; 3 reduced the reported number of sexual partners; and 1 reduced the reported frequency of sexual activity. Furthermore, 16 of the 22 interventions significantly delayed sex, reduced the frequency of sex, decreased the number of sexual partners, increased the use of condoms or contraceptives or reduced the incidence of unprotected sex. Of the 17 curriculum-based interventions, 13 had most of the characteristics believed to be important according to research in developed and developing countries and were taught by adults. Of these 13 studies, 11 significantly improved one or more reported sexual behaviors, and the remaining 2 showed non-significant improvements in reported sexual behavior. Among these 13 studies, interventions led by both teachers and other adults had strong evidence of positive impact on reported behavior. Of the 5 non-curriculum-based interventions, 2 of 4 adult-led and the 1 peer-led intervention improved one or more sexual behaviors.

Conclusions: A large majority of school-based sex education and HIV education interventions reduced reported risky sexual behaviors in developing countries. The curriculum-based interventions having the characteristics of effective interventions in the developed and developing world should be implemented more widely. All types of school-based interventions need additional rigorous evaluation, and more rigorous evaluations of peer-led and non-curriculum-based interventions are necessary before they can be widely recommended.

Chicago Citation: Kirby, Douglas, Angela Obasi, and B. A. Laris. "The effectiveness of sex education and HIV education interventions in schools in developing countries. "*TECHNICAL REPORT SERIES-WORLD HEALTH ORGANIZATION* 938 (2006): 103.

Relevant Websites:

http://www.who.int/immunization/hpv/target/preventing_hivaids_in_young_people_unaids_who_2006.pdf#page=112

3. **The Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries**

Authors: Douglas Kirby, B.A. Laris, Lori Rolleri

Objective: This paper aims to find out: 1) What are the effects, if any, of curriculum-based sex and HIV education programs on sexual risk behaviors, STI and pregnancy rates, and mediating factors such as knowledge and attitudes that affect those behaviors?; 2) What are the common characteristics of the curricula-based programs that were effective in changing sexual risk behaviors?

Methods: This review is composed of two components that follow from the two research questions identified above. The first is a review and analysis of studies evaluating the impact of various curriculum-based programs. The second is a synthesis of the common characteristics of curricula found to be effective in these studies. The methods for accomplishing both these tasks are described in this section.

Findings: Curriculum-based sex and HIV education, in developing countries, had a positive effect on delaying initiation of sex, reducing frequency of sex, reducing number of partners, increasing

condom use, and reducing pregnancy (laboratory tests). It did not have an effect on reducing pregnancy (self-reports) and reducing STIs (laboratory tests).

Conclusions: In general, the patterns of findings for all the studies were similar in both developing and developed countries. They were effective among both low- and middle-income youth and in both rural and urban areas. In general, the programs were effective with girls and boys, all age groups, and in school, clinic, and community settings. All of these findings indicate that these curriculum-based programs are quite robust; they can be effective in different countries, in different cultures, in different communities and with different types of young people. On the other hand, this robustness should not be confused with magnitude of impact. In general, these programs did not dramatically reduce sexual risk-taking, or STI or pregnancy rates. Typically, the most effective programs tended to reduce the amount of sexual risk-taking by about a third or less. Thus, these programs are not a complete solution to the problems of HIV, other STIs, or unintended pregnancy, but they can be an effective component in a larger effort.

Chicago Citation: Kirby, Douglas, and Lori Rolleri. "Impact of sex and HIV education programs on sexual behaviours of youth in developing and developed countries." (2009).

Relevant Websites:
http://dspace.cigilibrary.org/jspui/bitstream/123456789/8726/1/Impact%20of%20Sex%20and%20HIV%20Education%20Programs%20on%20Sexual%20Behaviours%20of%20Youth%20in%20Developing%20and%20Developed%20Countries%202005.pdf?1

The Process of Developing the Curriculum	The Contents of the Curriculum Itself	The Implementation of the Curriculum
1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum	***Curriculum Goals and Objectives***	1. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations
2. Assessed relevant needs and assets of target group	1. Focused on clear health goals – the prevention of STD/HIV and/or pregnancy	
3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors	2. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them	2. Selected educators with desired characteristics (whenever possible), trained them and provided monitoring, supervision and support
4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies)	3. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy)	3. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement, e.g., publicized the program, offered food, or obtained consent
5. Pilot-tested the program	***Activities and Teaching Methodologies***	
	4. Created a safe social environment for youth to participate	
	5. Included multiple activities to change each of the targeted risk and protective factors	
	6. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors	
	7. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age, and sexual experience	4. Implemented virtually all activities with reasonable fidelity
	8. Covered topics in a logical sequence	

**This chart is from "Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People throughout the World, written by Douglas B. Kirby, B.A. Larris, Lori A. Rolleri

4. Cost analysis of school-based sexuality education programs in six countries

Authors: Jari Kivela, Evert Ketting and Rob Baltussen

Background: Policy-makers who are making decisions on sexuality education programs face important economic questions: what are the costs of developing sexuality education programs; and what are the costs of implementing and scaling them up? This study responds to these questions by assessing the costs of six school-based sexuality education programs (Nigeria, Kenya, Indonesia, India, Estonia and the Netherlands).

Methods: Cost analyses were carried out in schools that were fully implementing a SE program, as this best reflects the resources needed to run an effective program. The costs were analyzed

from the program perspective, meaning that all costs borne by the governmental and (international) non-governmental organizations supporting the program were included. Cost analyses were based on financial records, interviews and school surveys. Costs were distinguished in three consecutive program phases: development, update and implementation. Recommendations on the most efficient program characteristics and scale-up pathways were drawn from results of three fully scaled up programs (Estonia, Nigeria and the Netherlands), scale-up scenarios of two pilot programs (Kenya and Indonesia), and an implementation plan (India), The costs of the programs were compared by converting cost per student reached in US dollars (US$) to international dollars (I$).

Results: Findings revealed a range of costs and coverage of sexuality education programs. Costs per student reached were: US$7 in Nigeria, US$13.50 in India, US$33 in Estonia and the Netherlands, US$50 in Kenya, andUS$160 in Indonesia.

Conclusions: Intra-curricular sexuality education programs have, because of their compulsory nature, the most potential to be scaled up and are therefore most efficient. Extra-curricular sexuality education programs have lower potential to be scaled up and are therefore less efficient. In terms of class size and number of lessons, countries need to strike a balance between the quality (demanding smaller classes and many lessons) and the costs (demanding larger classes and fewer lessons). Advocacy was a significant cost component.

Citation: Kivela et al. Cost Effectiveness and Resource Allocation 2013, 11:17

Website: http://www.resource-allocation.com/content/11/1/17