CHAPTER – II

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2.1 Introduction

This chapter deals with the review of related literatures and materials on the subject of this study. Review of related literature is an important step in the development of a research project. The review was done after a thorough exposition and exploration of avenues to identify literature related to the topic of investigation. It helps to determine the gaps, consistencies and inconsistencies the literature about the particular subject under the study. Review literature guides the investigator to design the proposed study in the scientific manner so as to achieve the desired result. With changing times it has become necessary that we impart sex education to our teenagers. In teenage the physical changes particularly so in the sex organs and hormonal changes taking place in the body makes them curious to explore these changes.

A persons knowledge and attitude have a strong influence on his or her sexual attitude an behavior.

2.2 Review of Related Studies

Selwyn and Powell (2006) investigated how young people are using school based sources of Sex and Relationship Education (SRE) to obtain information and advice. Anonymous self completion questionnaires were administered to young people aged between 12 and 19 years in three secondary schools and 6 out of school youth settings. Follow-up focus group interviews were conducted on 12 groups of the young people from the school and out of school settings. The major findings were:

- The results of the study suggest that school lessons were the most frequent source of sex and relationship information for many young people.
- Lessons were reported to be the most useful for students who were male, younger and more educationally engaged.
- School lessons were widely criticized by young people as predominantly focusing on biological aspects of sex and relationships and lacking participatory element.
- Young people perceived a diminishing commitment to sex and relationship education by teachers as they progressed into later years.
S. L. Escobar-Chaves; S. R. Tortolero; C. M. Markham; B. J. Low; P. Eitel and P. Thickstun conducted a study to determine of what is and is not known on a scientific basis of the effects of mass media on adolescent sexual attitudes and behaviors. The major findings were:

- Although television is subject to ongoing tracking of its sexual content, other media are terra incognita.
- Data regarding adolescent exposure to various media are, for the most part, severely dated.
- Few studies have examined the effects of mass media on adolescent sexual attitudes and behaviors: only 12 of 2522 research-related documents (< 1%) involving media and youth addressed effects, 10 of which were peer reviewed.
- None can serve as the grounding for evidence-based public policy. These studies are limited in their generalizability by their cross-sectional study designs, limited sampling designs, and small sample sizes.

In addition, we do not know the long-term effectiveness of various social-cultural, technologic, and media approaches to minimizing that exposure (e.g., V-Chips on television, Internet-filtering-software, parental supervision, rating systems) or minimizing the effects of that exposure (e.g. media-literacy programs).

P. N. Aniebue (2007) conducted a study to assess the knowledge and attitude to sex education among secondary school teachers in Enugu. The major findings were:

- Three hundred teachers, 215 females and 85 males were interviewed. The mean age of the teachers was 38.1 +/- 7.5 years. Sixty-nine (23.0%) had adequate knowledge of sex education and 282 (94.0%) approved the inclusion of sex education into the school curriculum.
- The commonest reason for disapproval of sex education was fear that it would lead to promiscuity amongst the students.
- Educational status and marital status of the teachers were significant determinants of positive attitude to sex education p < 0.05.
- The most appropriate age to introduce sex education according to the teachers is 11–15 years.
• Two hundred and thirty eight (79.3%) respondents were of the opinion that teachers needed to be trained to provide sex education to students and 244 (81.3%) admitted that sex education was not in the school curriculum.

• Secondary school teachers are in support of provision of sex education to students. However they need training and skills on how to present sex information in a positive manner to achieve the desired goal. There is need to include sex education in the school curriculum.

A study entitled “Safe motherhood : when to begin” conducted by M. Verma; J. Chhatwal and E. Mathew. Two thousand five hundred college girls were assessed for their knowledge and attitudes regarding sex, pregnancy and child rearing with the help of a pretested questionnaire. The major findings were:

• The site of menstruation was known to only 35.3% of the girls.

• The knowledge about the time and site of conception was 25.3% and 58.2%, respectively.

• Only 16.3% of the respondents knew the normal route of delivery although the duration of normal pregnancy was known to majority (87.7%).

• The girls were aware of the ideal timing of abortion (67.5%) but the safe method and legality were poorly known facts.

• Only 5% of the girls believed in pre-marital sex.

• More than half (54.9%) of the girls knew about some form of contraceptive, Copper-T being the best known.

• Nearly one fifth of the girls were either undecided or wished family members to decide about antenatal check-ups.

• The need for better diet and injections during pregnancy was well known although few (15.2%) were aware of the injections being tetanus toxoid.

• Only about 10% wanted a home delivery but one fourth felt that a Dai or a relative was suitable for conducting the delivery.

• An overwhelming majority of the students stated that knowledge about above facts was important and they would like to learn about them preferably during college education.
It is recommended that ‘Family life education’ be provided during pre-adolescent and adolescent years to ensure a safe motherhood and a healthy child.

W. Liu and E. Carolyn (2003) to examine Chinese parents’ knowledge, attitudes, and practices about sexuality education for adolescents in the family. The major findings were:

- **Total Knowledge of Parents**: The mean of total knowledge score for fathers was 9.51 (SD = 2.81), for mothers was 8.97 (SD = 2.82). In the regression analysis, the overall model was significant, F (2, 806) = 31.60; p < .001, accounting for 7.3% of the variance. Both parental education (t = 7.47; p < .001) and parent gender (t = 2.16; p < .001) were significant predictors of knowledge about sexuality. Fathers had more sexual knowledge than did mothers.

- **The Sources of Parental Knowledge about Sexuality**: Parents’ own knowledge about sexuality came from magazines (43.5%), newspapers (18.9%), friends (11.9%), schools (8.9%), radio (4.7%), television (3.9%), parents (2.6%), books (2.1%), colleagues (1.6%), self (0.8%), spouse (0.7%), and movies (0.4%). Thus, media were the main source of sexual knowledge, and schools and their own parents were not seen as an important source of information by the respondents.

- **Participants’ Sexuality Education from Their Own Parents**: Among 706 participants, 30.7% of them said that they had long ago once asked their parents, “Where did I come from?” Most of them (68.4%) had asked their parents this question prior to age 10. Mean of the age was 7.50. Fathers (mean = 6.61; SD = 2.52) had asked this question earlier than had mothers (mean = 8.38; SD = 3.63), and significant difference existed between fathers and mothers (t = 3.41; p < .01).

- **Appropriate Age to Begin Sexuality Education for Children from Parents**: Almost half of the parents (47.3%) believed that the appropriate age to begin sexuality education for children from parents should be 13-15 years old. Some of them (23.9%) thought 16-18 should be the appropriate age. (Note that this is almost 10 years beyond the point that our participants had asked their parents “Where did I come from?”). Just 2.2% of parents thought the appropriate age...
should be 7-9 years old. Only 0.6% of parents said the appropriate age should be 1-3 years old.

- **Attitudes toward Sexuality**: Many participants (44.4%) thought sexuality to be an embarrassing topic, but most (60.3%) also believed that sex is a basic appetite like hunger. The majority (67.2%) had negative attitudes toward masturbation but positive attitudes toward old people (55.5%) and handicapped people (86.4%) engaging in sex. In the regression analysis, the overall model was significant, $F(4, 828) = 11.61; p < .001$, accounting for 5.3% of the variance. Parent gender ($t = 4.22; p < .001$) and parental education ($t = 4.68; p < .001$) were significant predictors of attitude toward sexuality; child gender ($t = .57; p = .57$) and child age ($t = .26; p = .79$) were not significant. T-tests showed that more fathers (69.0%; mean = 3.56; SD = .97) than mothers (54.3%; mean = 3.25; SD = 1.02) agreed that sex is a basic appetite like hunger ($t = 4.33; p < .001$). More mothers (73.4%; mean = 2.17; SD = 1.03) than fathers (58.4%; mean = 2.54; SD = 1.14) had negative attitudes toward masturbation ($t = 4.85; p < .001$). More fathers (63.9%; mean = 3.62; SD = .78) than mothers (49.5%; mean = 3.43; SD = .72) believed that old people should have sex ($t = 3.52; p < .001$).

- **Attitudes toward Sexuality Education in General**: Most participants (66.8%) thought sexuality education is too conservative in modern China. The majority (72.2%) agreed that children do need sexuality education as they are growing up, and disagreed (55.3%) with the idea that sexuality education should be delivered only when children are grown up and ready for marriage. Most parents (87.9%) believed that more sexuality education would help teach children to be more responsible in their sexual behavior, and most (72.8%) did not think sexuality education would result in more sexual activity for children. However, most (72.6%) parents agreed that the best way to reduce the rate of teenager pregnancy is to tell the teenager, “Don’t have sex before marriage.” In the regression analysis, the overall model was significant, $F(4, 825) = 2.69; p < .05$, accounting for 1.3% of the variance. Parental education ($t = 2.26; p < .05$) and child age ($t = -2.07; p < .05$) were significant predictors of attitude toward sexuality education in general; but parent gender ($t = .04; p = .97$) and child gender ($t = .40;
p = .69) were not significant.

- **Attitudes toward Sexuality Education in the Family**: Most participants (80.3%) agreed that parents should be the first teachers about sexuality education for their children. The majority (73.8%) thought parents should be more responsible than schools in providing sexuality education for their children. More than half of them (55.3%) thought parents should tell children about intercourse and contraception only when children are ready for marriage. In the regression analysis, the overall model was significant, $F(4, 827) = 4.21; p < .005$, accounting for 2.0% of the variance. Parental education ($t = 3.54; p < .001$) was a significant predictor of attitude toward sexuality education in the family; but parent gender ($t = 1.59; p = .11$), child gender ($t = .30; p = .76$), and child age ($t = -.96; p = .34$) were not significant.

- **Attitudes toward Sexuality Education in School**: The majority of the participants (62.7%) thought that teaching information about sexuality in school is as important as teaching reading, writing, and arithmetic. Most (86.2%) believed that if children were given a good sexuality education in school, they would make wiser decisions in sexual behaviors when they grow up, and 85.6% of them agreed that children should learn about how to prevent AIDS in school. However, only 37.5% of parents agreed that children should get information about contraception in school, and only 37.6% agreed that boys and girls should be combined together in classes during sex education. Fathers and mothers had different attitudes toward some items. In the regression analysis, the overall model was significant, $F(4, 827) = 6.62; p < .001$, accounting for 3.1% of the variance. Parent gender ($t = 3.11; p < .005$) and child gender ($t = 2.37; p < .05$) were significant predictors of attitude toward sexuality education in school; but parental education ($t = .93; p = .36$) and child age ($t = 1.83; p = .07$) were not significant. T-tests showed that more mothers (47.6%; mean = 2.83; SD = .99) than fathers (30.5%; mean = 3.21, SD = .96) disagreed that boys and girls should be together in classes where the knowledge about sexuality is taught. More mothers (45.0%; mean = 2.82; SD = 1.00) than fathers (30.3%; mean = 3.17; SD = .98) disagreed that children should learn knowledge about contraception in school. The findings showed
fathers’ attitudes were more positive than mothers’ toward contraception education for children in school (t = 4.97; p < .001) and boys and girls being together in sex education classes (t = 5.45; p < .001). Parents with sons had more positive attitude toward sexuality education in school than did parents with daughters.

- **Attitudes toward Sexuality in the Media**: The majority of the parents (74.2%) agreed that there is too much sex on television and movies. Only 21.7% agreed that parents should not allow children to access the internet at home because of how easy it is for children to find sexual material on the worldwide web. In the regression analysis, the overall model was significant, F (4, 822) = 5.11; p < .001, accounting for 2.4% of the variance. Parent gender (t = 3.35; p < .005) was a significant predictor of attitude toward sexual media; but parental education (t = 1.52; p = .13), child gender (t = .55; p = .58), and child age (t = 1.79; p = .07) were not significant. T-tests showed that more mothers (79.5%; mean = 2.14; SD = .85) than fathers (67.1%; mean = 2.42; SD = .98) thought there is too much sex on television and in movies (t = 4.32; p < .001).

- **Total Attitudes**: The mean of attitudes was 76.36 for fathers (SD = 8.79), 74.10 for mothers (SD = 8.73). In the regression analysis, the overall model was significant, F (4, 828) = 6.86; p < .001, accounting for 3.2% of the variance. Parent gender (t = 2.61; p < .005) and parental education (t = 3.78; p < .001) were significant predictors of total attitudes; but child gender (t = 1.25; p = .21) and child age (t = .18; p = .86) were not significant. Fathers had more positive attitudes than did mothers toward sexuality and sexuality education.

Key Components of Effective Interventions are adapted from Kirby (2007) Set measurable health outcomes with specific behaviors attached.

- Discuss behaviors through a public health model of prevention and give accurate statements regarding effects of those behaviors (Meyers, Meyers, & Grogg, 2004).
- Give information regarding knowledge, risks, peer influence, and other factors associated with sexual health.
- Try to include service-learning components with voluntary/paid work in the community.
• Increase parental communication through a family systems model (Bersamin et al., 2008).
• Create an environment in which students feel comfortable discussing personal issues.
• Consider the characteristics of the target group when developing activities.
• Introduce activities and topics, in a sequential order, that focus on specific health behaviors identified and that have relevance to students in class.
• Make sure that teaching methods employed will not only catch the attention of the students, but will also help change their health behaviors.

Poobalan et al. (2009) also reviewed sexual health education programs that were implemented in both the schools and communities for youth 10 to 18 years old. The researchers noted that across 30 different review studies, successful sexual education programs considered the biological and cognitive aspects of the youth who were targeted for the program. Interventions that consisted of active involvement of participants, such as practicing negotiation skills, showed higher rates of success. Further, this review noted that programs that taught abstinence were effective only when also emphasizing other values as well as skills in contraception use.

Many studies do not have an underlying theory used to support a sexual education program; most use practical knowledge or common sense. The problem with understanding how theory is applied to sexual health education curricula is that publications often just mention the theory (if at all), and do not provide a description of how the theory was used to guide the development and implementation of the programs. Poobalan et al. (2009) noted that Bandura's social learning theory, which provides behavioral modeling skills to help the teen negotiate challenges of social and peer pressure, appears more successful in creating behavioral changes in contrast to the theory of reasoned action (Fisher, Fisher, & Rye, 1995) and the Health Belief Model (Glantz & Bishop, 2010).

Although it can be time consuming to maintain, service learning components have been shown to have long-term benefits when combined with sexual health instruction in delaying sexual initiation by youth (Kirby, 2007). Service learning
involves students being placed in community organizations or businesses to gain practical experience. Students benefit not only from working at the site, but also from reflecting about the work they have performed. Further, programs should be altered based on the needs of the population that is to be targeted. For instance, students who are already sexually active should learn about contraceptives as well as positive behavioral skills regarding their sexual practices (Fisher, Fisher, Bryan, & Misovich, 2002; Kirby, 2007). Often, contraceptive knowledge and STI prevention programs show only short-term gains among those who are already sexually active (Coyle et al., 2006; Fisher et al., 2002). It is much more difficult to change sexual behaviors once they have begun than to delay the onset of those behaviors. Even so, it has been shown that older teens respond to the intervention by reporting increased condom usage for sex (Poobalan et al., 2009). In addition, there is little known about the moderating effect of culture and ethnicity on teens' response to these programs. This is an area of needed research vis-à-vis program effectiveness.

Guidelines for the Sexual Health Education Component of Comprehensive Health Education (CT Guidelines) is to provide a framework to promote the sexual health and wellbeing of Connecticut’s children and youth within a comprehensive health education program. The CT Guidelines offer guidance to local school districts for the development and implementation of sexual health education that reflects the values and norms of the local community. Sexual health education programs include age-appropriate, medically accurate information on a broad set of topics related to sexuality, including human development, relationships, decision-making, abstinence, contraception, and disease prevention (SIECUS, 2010). These developmentally appropriate programs start in prekindergarten and continue through Grade 12. The overall goal of sexual health education is to provide young people with the knowledge and skills to promote their health and well-being as they mature into sexually healthy adults (SIECUS, Guidelines, 2004).

The CT Guidelines contain information and resources to assist administrators, teachers and parents / guardians in:

- making the connection between sexual health and student health and education outcomes;
implementing district and school policies that support medically accurate sexual health education programs that address the health needs of all students;

• identifying desired curriculum goals, objectives and student outcomes;

• developing an effective PK-12 sexual health education program using developmentally appropriate, medically-accurate and evidence-informed curricula and resources;

• implementing a sexual health education program using evidence-informed curricula, effective teaching strategies, and student assessments delivered by certified health education teachers appropriately trained in sexual health education;

and evaluating the implementation of program goals, objectives and student outcomes.

Oladepo and Akintayo (1991) view sex education as a process of acquiring sex knowledge, positive attitude towards sexual acts, male and female relationship and the role of parents. Sex is not limited in fact to genital activities. In reality, sex describes a huge range of activities. On this basis, the concept of sex education can be outlined as followed:

i) Knowledge of human reproduction.

ii) Misuse and abuse of sex.

iii) The spread and prevention of sexually transmitted diseases (STD).

iv) Dangers of adolescent pregnancy.

v) Importance of inter-personal relationship.

vi) Choosing a partner.

vii) Family planning, importance and methods.

In the opinion of Mba (2006) the following should constitute the content of sexuality education:

• Human growth and development.

• Relationships.

• Life skills.

• Sexual attitude and behaviour.
• Sexual health.
• Society and culture.

School-based Sexuality Education:

UNESCO (2009) argues that sexuality education has a number of mutually reinforcing objectives:
• increase knowledge and understanding (such as about sex and the law, the nature of sexual abuse and what to do about it);
• explore and clarify feelings, values and attitudes (developing self-esteem and feeling proud of one's body);
• develop or reinforce skills (saying “no”, resisting pressure);
• promote and sustain risk-reducing behaviour (seeking help).

Commitment to using human rights (WHO, 2006a). Rights that are enshrined in laws and policies at international and national levels include:
• the rights to life, liberty, autonomy and security of the person;
• the right to education and access to information (including on sexual and reproductive health issues);
• the right to privacy;
• the right to non-discrimination;
• the right to be free from torture or cruel, inhumane or degrading treatment or punishment;
• the right to self-determination within sexual relationships;
• the right to the highest attainable standard of health, including sexual health.

The recent surveys conducted by the ICDDR, Centre for Health and Population.
• Research and other organizations in Bangladesh among adolescents have consistently documented their generally poor knowledge of sexual and reproductive health. Furthermore, what is "known" is often incorrect and derived through communication with friends who are equally not knowledgeable. A needs assessment study carried out by ICDDR,B has also documented that adolescents
in Bangladesh rarely discuss sexual and reproductive issues neither with their parents nor with their teachers. This study explored whether adolescents desired to have reproductive health information and from what source they preferred to have this information. Findings of the study showed that easy-to-read information materials were the most preferred sources. This study also found that there exist widely-varied opinions among parents, teachers, and decision-makers about the desirability of providing adolescents with sexual and reproductive health information (UNICEF, 2010).

- A recent survey in Nigeria by the Ministry of Health stated that through purposive sampling technique, 41 volunteers (respondents) participated in the study. Through in-depth interview during focused group discussions, it was revealed that 87% of the respondents were aware of gonorrhea and AIDS but majority were not aware of other STIs. Another recent survey by the Action Health incorporated (1995) on sexual behaviour, STIs awareness showed that among some sexually active persons interviewed, 17.43% women could not resist having sex with their boyfriends, while 40.4% of the men had sex with girl-friends or concubines within the two immediately preceding months. The most sexually active groups are 18-24 years. The result of the survey also showed that 3.1% of the respondents experienced some symptoms of sexually transmitted infections (STIs) within two months of relationship (Susan, 2001).

Kirby, Laris and Rolleri (2006) have carried out a detailed analysis of the different elements in the development, content and implementation of effective programmed in an effort to capture the features that make them successful. They have concluded that the large majority of effective sex education programmed include a core set of characteristics that are not always part of programmed that had only a limited impact on sexual behaviour. The characteristics of effective sex education programmed are summarized below. During the development of the curriculum, the development team should:

- involve experts in research on human sexuality, behaviour change and related pedagogical theory.
• consult with young people.
• assess young people’s reproductive health needs, their behaviours, their beliefs and perceptions of risk, their attitudes and skills, and their intentions regarding sexual behaviour, condoms and contraception.
• use a logic model approach that specifies the reproductive health goals the programme wants to achieve, the specific sexual behaviours that would lead to those goals, the cognitive risk and protective factors affecting those behaviours, and activities involved in changing those cognitive factors.
• design activities that are sensitive to community values and consistent with available resources including staff time, staff skills, the space available for group activities and access to supplies.
• test the programme using a pilot programme and obtain on-going feedback from the learners about whether and how the programme meets their needs.

Wenli Liu and Carolyn Edwards, 2003 conducted a study on Chinese parents’ knowledge, attitudes, and practices about sexuality education for adolescents in the family to examine Chinese parents’ knowledge, attitudes, and practices in the area of sexuality education for adolescents.

Social Problem related to Sexuality:

• **Teenage pregnancy**: In developed countries, teenage pregnancies are associated with many social issues, including lower educational levels, higher rates of poverty, and other poorer life outcomes in children of teenage mothers. Teenage pregnancy in developed countries is usually outside of marriage, and carries a social stigma in many communities and cultures. Many studies and campaigns have attempted to uncover the causes and limit the numbers of teenage pregnancies.

• **Infertility**: A woman is usually blamed and looked down upon for not being able to give birth to a child. The cause of infertility could be in the males as much as in the females; or could be in both. Many infertile couples resort to religious rituals only to experience disappointments. Adopting a child is the surest way to become parents.
• **Gender discrimination**: The birth of a female child is not so welcome as that of a male. The female child receives a second grade treatment throughout her life in matters such as education, nutrition, job opportunities, pay and health care facilities. She is conditioned to be submissive, non-decisive and dependent.

• **Amniocentesis and female foeticide**: Examination of amniotic fluid from pregnant mother to detect the sex of the foetus (Amniocentesis) and aborting the same if female, is a criminal act.

• **Horoscope matching for marriage**: There is no scientific evidence proving the credibility of horoscope-matching for marriage. Such marriages may or may not be happy. Though there are no perfect methods for selection of a partner, the horoscope-matching should not be entirely relied upon.

• **HIV/AIDS**: The highest price man has to pay for his sexual lust is death through HIV/AIDS. There is no cure for this disease. Education and prevention are the only ways out.

• **Sexual Abuse**: Sexual abuse mostly of women and children are ghastly, cruel and inhuman acts. All individuals are equal and everyone should be treated with dignity and respect. The culprits of sexual abuse should be strictly dealt with.

• **Pornography**: Pornography and blue films depict pervasive sexual behaviour and may bias the minds of adolescents leading to false beliefs and wrong attitudes in them.

• **Child Marriage**: In some parts of India the child marriages are still in vogue. Teenage parenthood is harmful for the parents as well as to the child.

• **Dowry**: Many young women fall victims to the social evil of dowry. They are tortured, deserted or killed.

• **Devdasees**: In some cultures the female child is “married” to God or given to Goddess to fulfill the vow by the parents. The female when grown up finds no way out other than prostitution.

    Sex education helps the adolescent in following ways:

• The transition from the childhood to the adulthood is smooth so as adults the right attitude will be there before marriage and after marriage.
• Reproductive organs, process of birth, taking care of reproductive organs especially for the girls during the periods can be handled.
• The issues like teenage pregnancy, abortion and death during abortion, unwanted pregnancy after and before marriage, gap between children etc. can be handled
• Avoids or decreases the incidence of teenage pregnancies.
• Stresses on self-restraint.
• To decrease the incidence of sexually transmitted diseases.
• Prevent or decrease the rate of sexually transmitted diseases such as gonorrhea, non-gonococcus urethritis, pelvic inflammatory disease and syphilis
• Control or decrease the teenage pregnancies.

The Role of Parents regarding Sex Education:

The role of parents in the lives and decision-making processes of youths is often underestimated. Although the transition to greater independence is the hallmark of this developmental phase, parents clearly have a role and exert significant influence in the choices young people make about sex.

• Teenagers are most likely to seek sexual information from their friends (61 percent). Although they are least likely to seek information from their parents (32 percent), a significant number of teenagers (43 percent) express a strong desire to have more information on how to talk to their parents about sex and relationships (Kaiser Family Foundation, 2000a).
• Nearly 80 percent of teenagers indicate that what their parents have told them and what their parents might think influence their decisions about sex and relationships (Kaiser Family Foundation, 2000b).
• The more that teenagers are satisfied with the mother–child relationship, the less likely they are to be sexually experienced (Advocates for Youth, 1997). Conversely, poor communication with parents about sex and safe sex practices, and parental substance abuse are also linked with risky sexual behaviors (Fraser, 1997).
• Poor parent–child relationships are associated with depression in adolescents. For young men, this may lead to more frequent use of alcohol, which is strongly linked
with early sexual activity.

- For young women, estrangement at home often leads them to seek and establish intimate relationships outside the family, seeking the warmth and support they lack at home. Also, girls experiencing sexual abuse in the family are linked to increased risk of teenage pregnancy (U.S. Public Health Service, 2001).

**The Role of Peers regarding Sex Education:**

The peer group is an important factor in adolescent development and has some bearing on teenagers' decisions about sex.

- Adolescents (ages 13 to 18) report that they are most likely to get information about sexual health issues from their peers (Kaiser Family Foundation, 2000a).
- Pressure to engage in sex increases during middle adolescence (Fraser, 1997). Peer group attitudes about sex influence the attitudes and behaviors of teenagers.
- Youths who resist engaging in sexual activity tend to have friends who are abstinent as well. They also tend to have strong personal beliefs in abstinence and the perception of negative parental reactions. Youths who are sexually active tend to believe that most of their friends are sexually active as well, that rewards outweigh the costs of sexual involvement, that sex overall is rewarding, and that it is all right for unmarried adolescents over age 16 to engage in intercourse (Advocates for Youth, 1997).

**The Role of Media Regarding Sex Education:**

The images that pervade the media (television, music videos, the Internet, and the like), are increasingly more explicit in sexual content.

- More than half (56 percent) of all television shows contain sexual content averaging more than three scenes with sex per hour. For shows with sexual content, just 9 percent include any mention of the possible risks of sexual activity, or any reference to contraception, protection, or safer sex (Kaiser Family Foundation, 1999).
- Among young people 10 to 17 years of age who regularly use the Internet, one-quarter had been exposed to unwanted pornography in the past year, and one-fifth
had been exposed to unwanted sexual solicitations or approaches (U.S. Public Health Service, 2001).

- Although media images of sex and sexuality may be socially defined as a negative influence on teenage sexual decision-making, there is considerable potential for the use of media in conveying messages about responsible sexual behavior. For example, more than one-half of high school boys and girls indicate learning about birth control and pregnancy prevention from television (U.S. Public Health Service, 2001).

**The Role of Communities Regarding Sex Education:**

The circle of influence on sexual decision-making extends beyond the individual and family system. Key considerations of these extended influences include:

- Impoverished communities that lack sufficient employment and educational opportunities, access to providers and medical services, and overall social disintegration are associated with higher sexual risk taking (Fraser, 1997).
- Schools have unique opportunities to provide education and information, as well as structured activities that discourage unhealthy risk taking. Greater involvement in schools is related to decreased sexual risk taking and later initiation of sex, pregnancy, and childbearing (U.S. Public Health Service, 2001).
- Young women who were the least successful in high school are the most likely to become pregnant (National Association of Social Workers [NASW], 2000). Substance use and abuse are also factors in sexual decision making. One-quarter of sexually active high school youths reported using alcohol or drugs during their most recent sexual encounter (Kaiser Family Foundation, 2000c).
- Youths often encounter barriers in obtaining needed information and services regarding their sexual health. Policies on medical confidentiality, parental involvement and consent, as well as the nature of sex education available to youths are important considerations in sexual health outcomes.
- The political focus abstinence-only sexuality education has greatly impacted the nature and scope of information and services available to youth. This focus on
abstinence-only until marriage however, contradicts the beliefs of the majority of Americans who favor comprehensive sexuality education that includes abstinence as well as information on contraception, pregnancy prevention, STDs, and HIV/AIDS (Advocates for Youth & SIECUS, 1999).

**Role of School regarding Sex Education**

In the current scenario sex education to the teens should be considered as the responsibility of every parent and teacher. It is better for the children get the right information from parents, peers or teachers than from books, magazines, pornographic websites and various other sources. This leads to misconceptions and does more harm than actually good. Right information can enlighten a teenager regarding the hazards of sexual issues and related health problems. Sex education to the teens is important and should be considered as the responsibility of every parent and teacher. Studies have shown that effective sex education to adolescence in school can increase the age at which they experiment with sex.

However in India sex education in school has not yet become an accepted part of the curriculum and comprehensive sex education in schools still remains a subject of intense debate. Certain schools have introduced novel health and hygiene workshops that handle issues like health foods, usage of sanitary napkins, human anatomy and human reproduction. But the education system in India is still has disagreement about conducting workshops and programs within the school premises on sex education.

WHO considers that sex education should be given to all children who are 12 and above. The increasing incidence of teenage pregnancies and HIV in India makes it important that we give our children sex education so that they get the right information rather than misconception.

School can play a role in the development of sexual attitudes and behaviors for adolescents is sex education within schools. In a review of over 60 studies, Kirby (2002) found that some school programs effectively decreased school dropout rates, increased attachment to schools and school performance, and reduced liberal sexual attitudes as well as actual sexual risk taking behaviors. Conversely, other studies have
indicated that sex education courses did not change the frequency of intercourse, masturbation, oral-genital sex, petting, or pre-marital sex among adolescents (Ashcraft, 2008; Dailard, 2003). It is, therefore, important to continue to study this topic in an effort to distinguish which features of programs are effective in reducing risk behavior and associated outcomes. Schools can be effective in fostering healthy adolescent sexual development, whether by delaying onset of sexual behaviors or by promoting safe behaviors for those adolescents who are already sexually active.

Sex education in school is important because many parents are shy about talking or teaching their children on this subject. However, schools can only be effective if they can ensure the protection and well-being of their learners and staff, if they provide relevant learning and teaching interventions, and if they link up to psychosocial, social and health services. Evidence from UNESCO, WHO, UNICEF and the World Bank (WHO and UNICEF, 2003) point to a core set of cost-effective legislative, structural, behavioural and biomedical measures that can contribute to making schools healthy for children. It is a fact that more and more teens these days are engaging into premarital sex. This further underscores the need for sex education to students. This will help them make better informed decisions about their personal sexual activities. Modern time is the time of internet and powerful media. Teenagers are exposed to Hollywood, TV and internet. These sources offer demonstration of sex which is highly thoughtless and casual; in this situation it is almost illogical to leave the teenagers on their sexual choices. They are young and fully excited; therefore they can not make a favorable choice. Sex education in school offers the information and knowledge they need to understand to know the responsibility that is accompanied by sexual relationships. The teacher in school helps the students to know the difference between a thoughtless and thoughtful sex. Having an urge for sex is not a problem; it is a natural process showing that the young people are developing to become adults; however the problem is having unsafe sex and hurting people through sexual choices.

Sex education in schools is being given increasing importance to inform students about issues related to sex. It is considered important for societies that its individuals are well informed about sex, sexual practices, child sexual abuse and sexually transmitted diseases. It can help children understand the impact of sex in their lives.
Indian Adolescents:

Post 2005, in the wake of the controversy around sex education; the program was restructured as the Adolescence Education Program (AEP) that focused on enhancing life skills among adolescents to enable them to respond to real life situations effectively. Positioning AEP in the wider context of an educational approach to develop life skills to empower young people proved to be a useful strategy with a clear focus on age/ experience appropriate and culturally sensitive information. Furthermore, National Curriculum Framework (2005) that guides the school curriculum across the country recognized Adolescence Education as an important area in school education.

With National Council of Educational Research and Training (NCERT) as the co-ordinating agency; the program works through both co-curricular and curricular formats. The co-curricular approach works through the three national school systems – Central Board of Secondary Education (CBSE), Navodaya Vidyalaya Samiti (NVS) and Kendriya Vidyalaya Sangathan (KVS). The 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 2010, at least two nodal teachers from 3500 CBSE schools, all the 919 KV schools, and all the 583 NVS schools have received orientation on adolescence education issues.

In 2010, the conceptual framework that guides the program design and implementation has been updated to recognize adolescents as a positive resource and focus on transformational potential of education in a rights framework. The training / resource materials have been updated and address the themes of making healthy transitions to adulthood (being comfortable with changes during adolescence), understanding and challenging stereotypes and discrimination (including abuse and violation) related to gender and sexuality, prevention of HIV/AIDS and substance abuse. For better impact and quality, the program has been consolidated in 5 UNFPA
priority states (rather than across 32 states in the country) to achieve a goal of one trained teacher for every 150 secondary school students.

More robust and regular monitoring mechanisms have been introduced and a total of 4 consultants have been placed in different implementing agencies to ensure regularity and quality in reporting.

Concurrent evaluation of the program was fielded across 200 schools to assess the program’s achievements and identify gaps for improved programming. The quantitative and qualitative data from students, teachers and school principals is being analyzed and the report should be available in April, 2011.

Kalinga Institute of Social Sciences (KISS) in the state of Orissa reaches out to 12,000 tribal girls and boys at different stages of schooling. Since 2009, UNFPA’s Orissa office is partnering with KISS to provide the adolescents with accurate age appropriate and culturally relevant education and build skills on issues related to their health. Relevant resource materials have been developed and the program is working on enhancing capacities of teachers to transact the curriculum in classroom settings. The institute has introduced life skills focused adolescence education in its secondary classes and is also working towards building a strong research base on issues related to adolescent health and well-being.

In the state of Bihar, UNFPA has entered a partnership with the Department of Human Resources Development, Govt. Of Bihar to reach out to young people in approximately 1000 secondary schools (across 9 districts) in Bihar with information and skills for improved health and well being. Center for Development and Population Activities (CEDPA) is the lead technical agency responsible for providing technical assistance and ensuring that adolescent concerns get institutionalized in the government system.

**Curricular Approach** : The NCF 2005 clearly outlines that rather than a stand-alone program the AEP should become an integral part of school education. It is noteworthy that although UNFPA’s current work at the national level with the MHRD has a large co-curricular component, our larger goal is to mainstream the components of adolescence education in the larger context of education and curricular formats. In this
regard, the content analysis exercise undertaken by NCERT shows that textbooks in different parts of the country have integrated adolescent education issues in various scholastic subjects. Efforts are underway for more comprehensive inclusion of adolescent concerns in the curriculum. The Council of Boards for School Education (COBSE) is involved in advocacy efforts for curricular integration of life skills in selected state education boards in India with relevant stakeholders. *Curricular interventions* also include UNFPA’s ongoing support for integration of life skills in the secondary curriculum of National Institute of Open Schooling (NIOS) that enrolls approximately 400,000 learners each year. In order to maximize the reach of the integrated lessons, the most popular subjects of Home Science, Social Science, Science and Languages (Hindi and English) were identified for integration.

In 2005, life skills focused adolescence education was introduced as a separate subject in the senior secondary curriculum across approximately 4500 government schools in the state of Rajasthan and the subject is now institutionalized within the government schools.

**Reaching Out-of-school Adolescents**: UNFPA and the Ministry of Youth Affairs and Sports (MOYAS) have been collaborating since 2003 and have been supporting the adolescent health and Development (AHD) project with the overall objective of ensuring a healthy and safe growing up process for out-of-school adolescents. The support has also been in keeping with the focus of the National Youth Policy (currently under revision) on the “need for youth to be equipped with requisite knowledge, skills and capabilities”. The partners involved in implementation of the project have been the Nehru Yuva Kendra Sangathan (NYKS), the National Service Scheme (NSS), and the Rajiv Gandhi National Institute of Youth & Development (RGNIYD).

In 2011, the collaboration with the Ministry of Youth Affairs and Sports has been re-strategized with the objective of consolidating teen clubs in the 5 UNFPA priority states of Orissa, Madhya Pradesh, Bihar, Rajasthan and Maharashtra for better quality and enhanced impact.

The revised strategy that will be implemented by the Nehru Yuva Kendra
Sangathan (NYKS) proposes to provide (unmarried) adolescents with life skills focused experiential learning on reproductive and sexual health issues in a gender-sensitive manner, provide them with information on education and skills building for better employability and to improve access to youth friendly and gender sensitive services in the public and private sector.

In order to achieve these objectives, UNFPA has engaged an NGO ‘Restless Development’ that will provide technical support to the Teen Clubs. Restless Development will facilitate capacity building of NYKS functionaries, including the District Project Officers (DPOs) placed at the district level and the Adolescent Peer Volunteers (APVs) placed at the block level and help institutionalize accountability in the system through establishment of clear monitoring protocols.

Given that teen clubs are village-based institutions, stratified plans are being proposed to reach out-of-school adolescents [in a village of approximately 1000 population, there are likely to be 25% adolescents (250). Based on recent data, nearly 60% (150) are likely to be out-of-school, hence potential target for the project] through different levels of engagement. One level of engagement is with members of the Teen Clubs, around 30 young people. It is proposed to identify 4 enthusiastic members of the Teen Clubs who will be trained to facilitate activities at the teen clubs under the close supervision of Adolescent Peer Volunteers. In order to motivate peer educators, they will be preferentially linked to education and skill building opportunities for better employability. Certificate courses to train and accredit them offered through the Indira Gandhi National Open University could also serve as an important value addition to the Curriculum Vitae of peer educators that will be explored.

The second level of engagement will be with the remaining 120 young people in the village who will be reached through mass media activities like village-based fairs that could be organized twice a year around themes related to adolescent issues. The fairs could include enter-educate activities like films, games, chat shows and stalls for youth friendly services, including health, and linkages with education and livelihood opportunities available in geographic proximity. These fairs could serve as opportunities to sensitize adolescents as well as enrol new members to the teen clubs.
It is not possible to reach out to adolescents, particularly girls without sensitizing the larger community of adults who interact with them, for example their parents, teachers, opinion leaders and others. In this context, the entire village community has been recognized as the third level for engagement. They could be sensitized through special stalls set up during the village fairs. Other existing village-based fair should be identified for sensitizing the community members at regular intervals.

In order to ensure continuing long term engagement with young people, UNFPA will explore setting up of youth centres at district or block level as a dedicated space for organizing youth friendly activities. It is proposed to involve National Service Scheme (NSS) volunteers and Peer Educators to lead these youth centres. These NSS and PEs would be trained to manage the youth centres. UNFPA is particularly interested in energizing the link between young people enrolled in colleges and those in out-of-school situations (drop outs and/or never been to school). This particular link has immense potential in terms of creating an ongoing link between young people in urban colleges and those in rural settings so that both are able to better understand each other’s realities. It is proposed that NSS volunteers may be involved in organizing the community mobilization campaign as well as jointly coordinating the functioning of youth centres along with the peer educators. UNFPA will explore the feasibility of this strategy.

The above strategy will be implemented in 1860 Teen Clubs in 10 districts of the 5 UNFPA states. Thus there will be 1500 teen clubs that will be directly implemented and monitored by NYKS. UNFPA will set up 360 additional model teen clubs (120 clubs each in the states of Rajasthan, Madhya Pradesh and Orissa) through Restless Development.

The Rajiv Gandhi National Institute for Youth Development is being supported for its Masters Programme on Life Skills Development. Focus will be on building the capacities of faculty and development of a robust methodology for research in life skills. A Community Radio program, the first of its kind in the country that is being run by young people is also being supported by the CO.

In four blocks of four districts each in the state of Rajasthan, support is being
provided to an initiative for out of school adolescents that reaches out to approximately 20,000 adolescent girls with the objective of empowering them with knowledge and life skills for improved reproductive and sexual health. Adolescent girls clubs have been established in these blocks and awareness sessions are held every week through a village level animator. The programme also focuses on connecting these out of school adolescent girls to formal or non-formal education and aims to address the larger issue of early age at marriage. The programme’s learning’s have been utilised for the approval of the national level out of school adolescents programme (SABLA) by the Government of India. The resource material developed under the UNFPA supported programme has been nationally disseminated to all the states where the SABLA programme is being implemented.

In Sehore district of Madhya Pradesh, UNFPA is supporting a pilot (with the NGO Samarthan as the implementing partner) for empowering out of school adolescents and youth with knowledge and life skills for improved reproductive and sexual health. The pilot is being implemented from 2009 and attempts to develop the capacity of youth to better understand reproductive health (RH) issues, to engage them in demand generation of RH services and in planning and monitoring of utilization of key RH services by the clients. The pilot also aims to create a platform for youth to raise their issues and concerns during gram sabhas and at block headquarters through public dialogue. Initial results of the pilot are quite encouraging and there is marked improvement in regular organization of village health and nutrition days and uptake of RH services through demand generation.

Population stabilization is one of the major development challenges for India today. What happens in the future depends, to a large extent, on the decisions taken by adolescents as they enter their reproductive years. Adolescents in the age group 10-19 years constitute 21.4 percent of India’s population. Within this paradigm of population and development related issues, the role of adolescents cannot be overlooked. ‘Adolescents in India : A Profile’ is a publication of the UN Inter Agency Working Group on Population and Development (IAWG-P&D). With UNFPA as the lead agency of the group, the other member organizations are FAO, ILO, UNICEF, UNIFEM, UNAIDS, WB,UNDCP, WHO, UNDP, UNESCO and UNHCR.
In keeping with its commitment to the International Conference on Population and Development, 1994, Cairo, the group aims at linking population concerns with development issues. It stresses a people-centred approach to development and a holistic vision of people’s lives. In attempting to understand population and development related issues, it emphasizes multi sectoral linkages and coordinated interventions. Its focus is on sustainable human development. These guiding principles provide the background canvas for the analytical framework of the Profile.

The working group’s selected theme for the year 1999-2000 is ‘Adolescents’. In view of the group’s current priority, the Profile aims at securing a niche for adolescents and adequate visibility for them in policy and programmatic efforts of the Government, the UN System and non-governmental organizations. The Profile is divided into four sections. The first section outlines the status of adolescents in India focusing on certain indicators such as demographic status, nutrition and health needs, education and literacy levels, vulnerability to HIV/AIDS and drug abuse, economic and employment requirements. This section of the Profile raises some pertinent issues with regard to adolescents.

It provides certain pointers to possible interventions and programming activities. Section Two proceeds to map out the various activities being carried out in relation to adolescents in the UN System. Section Three provides a brief description of government policies and programmes on adolescents. Section Four presents snapshots of selected NGO activities and programmes on adolescents. As far as the definition of the category ‘adolescents’ is concerned, the importance of achieving a conceptual clarity is emphasized throughout the Profile. The Profile does not claim to produce either a comprehensive or an exhaustive account of the status of adolescents or of the policies and programmes, directly or indirectly, oriented towards them. It is, instead, an overview which aims at providing a background to adolescents in India, highlighting their major concerns, identifying gaps in current policies and programmes and suggesting indicators for future initiatives and interventions. The guiding framework in compiling the Profile has been the South Asia Conference on the Adolescent, New Delhi, 1998. The idea behind conducting a UN mapping exercise and presenting an overview of the status, policies and programmes on adolescents, has
been to elucidate possible areas for joint interventions on adolescents. The Profile presents an all-India perspective not aim at detailing state-level data regarding the status of adolescents, policies and programmes on them. The Profile draws largely on available secondary literature, besides drawing on some interviews conducted with focal persons of various UN. Excerpts of the Profile will be a part of the IAWG-P&D website whereby the information provided in the Profile can be constantly updated.

It is thus expected to be an evolving document organizations, some Government officials and some NGO experts. ‘Adolescents in India : A Profile’ aims at sensitizing readers to the importance of recognizing adolescents as a distinct group with their own unique needs and concerns. It is indicative of the urgency to make adolescents and issues related to them the focus of government policies and programmes, the UN System’s interventions and the initiatives nongovernmental Organizations.

**Impacts of Sex Education:**

Sex education is broadly defined as any instruction in the processes and consequences of sexual activity, ordinarily given to children and adolescents. Today the term usually refers to classroom lessons about sex taught in primary and secondary school, usually as part of biology class (Microsoft Corporation, 2003). Historically, the task of educating adolescents about sex has been seen as the responsibility of the parents. However, parent-child communication in sexual matters may be hindered by parental inhibitions or by various inter-generational tensions. Moreover, studies have shown that children’s rarely receive their first information on sexual matters from their parents (Microsoft Corporation, 1993). In the late 19th century, attempts by educators and social workers to supplement parental sex instruction concentrated on what was then known as “social hygiene” basically, biological and medical information about human reproduction and venereal disease (Microsoft Corporation, 2003).

In the post World War II era, however, the relaxation of traditional social norms governing sexual activity, as well as the torment of sex related information available to children via mass media, made a mere sophisticated and Comprehensive
program me of sex education seem desirable to many. The subjects explained and
discussed as part of sex education include the physical processes of human
reproduction, the working of male and female organs, the origin, dissemination and
effect of sexually transmitted infections, family roles structures, the ethics of
relationships, and the emotional and psychological causes and consequences of
sex(including under-age sex), marriage and parenting. Safe sexual practice is being
increasingly focused on with the advent of the Acquired Immune Deficiency
Syndrome (AIDS).

Frequently, however, the larger societal and ethical question stemming from
sexual behaviour, being highly subjective in nature, is not regarded as appropriate to a
strictly factual approach. At all levels of instruction, teaching methods may include
visual aids, lectures and moderated discussions.

Although many parents approve of some type of sex education in schools, in
practice there has always been some opposition to such classes. In many schools in
Britain the policy is to send a letter of consent to the parents of each child before the
study is embarked upon to enable the parents to remove their children from classes
should they so wish. Some parents object to sex education on the grounds of religion
and morality (Microsoft Corporation, 1993 and 2003).

According to World’s Youth (2001) sexuality education for youth as long been
hampered by adults who are concerned that such knowledge will promote promiscuity
among the youths. Schools are a key location for reaching large numbers of youths.
However, because many youths are not in school, community based approaches are
also needed in many areas.

Elements for a Successful Sex:

• Give a clear message on risky sexual acts. Focus on reducing a few key acts that
  lead to unintended pregnancy or STI infection.
• Use a behaviour change framework to define and evaluate activities.
• Provide basic accurate information about the risks of unprotected intercourse and
  ways to avoid unprotected intercourse.
• Include activities that address social pressures on sexual act.
• Provide modelling and practice of communication, negotiation and refusal skills.
• Employ variety for teaching methods designed to involve participants and have them personalize the information.
• Use teachers and peers who believe in the program they are implementing and provide training for them.
• Incorporate behavioural goals, teaching methods, and materials that are appropriate to the age, sexual experience and culture of the students.

Guidelines for Comprehensive Sexuality Education in Nigeria (1995) explains that sexuality education is a life long process of acquiring information and forming attitude, beliefs, and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. Sexuality education addresses the biological and socio-cultural, psychological and spiritual dimensions of sexuality from:
1. The cognitive domain.
2. The affective domain.
3. The behavioural domain.

It also includes the skills to communicate effectively and make responsible decision. The primary goal of sexuality education is the promotion of sexual health. The World Health Organization (1975) defines sexual health as “the integration of the physical, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love”. Every person has a right to receive sexual information and to consider accepting sexual relationships for pleasure as well as for procreation.

Sex education as shown by Ariba (2000) may be regarded as a method of achieving appropriate and safe sexual behaviour by a given population through systematic persuasion. An elaborate definition of sex education is given in a paper written by Emenike (1981) who argues that it is education for effective living with an understanding of human sexuality is an integral, inseparable part of it. The creation of satisfying interpersonal relationships rather than simply the exercise of sex would be the goal, and it would involve the whole population and the total life span, going far
beyond genital behaviour to include roles and inter sex expression of love and affection. Shuyler, (1976) defines it as education which teaches the young person what he or she should know for his or her personal conduct and relationship with others.

**Problems related to Teenage Pregnancy:**

Adolescent pregnancy is not just a health issue; it is a development issue as well. It is rooted in poverty, gender inequality, child marriage and lack of education. It often means an abrupt end to childhood, curtailed education and lost opportunities, the experts said. They are shaping humanity’s present and future. With the right skills and opportunities during adolescence, girls can invest in themselves, their families and communities, the report said.

Frederika Meijer, UNFPA Representative of India and Bhutan said: ‘The greatest returns on investment come from investing in adolescent girls. Educated and healthy girls have the opportunity to reach their full potential and claim their human rights. They are also more likely to marry later, delay childbearing, have healthier children, and earn higher incomes.’

Breaking the cycle of adolescent pregnancy requires commitment from nations, communities and individuals in both developed and developing countries to invest in adolescent girls. Governments should accelerate efforts to prevent child marriage and its consequences, and promote policies that support girls’ rights, she said.

Adolescents and youth must be provided with age-appropriate comprehensive sexuality education to develop the knowledge and skills they need to protect their health throughout their lives. Babatunde Osotimehin, UNFPA executive director said: ‘Every young girl, regardless of where she lives, or her economic circumstances, has the right to fulfill her human potential. Today, too many girls are denied that right. We can change that, and we must.’

In developing countries early marriage is the cause of the teenage pregnancy. Child marriages end in teenage pregnancy making life difficult for mothers. Several factors such as peer pressure, drug addiction, interplay of hormones during puberty can lead teenagers to develop early sexual relationships. Following are the consequences faced by teenage mothers.
• Teenage mothers are most likely to drop out of the high schools or colleges without completing their education.
• Children of teenage mothers get minimum health care.
• In countries like India, a girl and her family are ridiculed in society.
• Getting financial security and raising their children becomes difficult for teenage mothers.
• Teenage pregnancy results in poor economic conditions and single parenting.
• Usually teenage fathers are not ready for and deny to take responsibility of their children.
• Children of teenagers are subject to abuse and neglect.
• Teenage mothers have to depend on their parents for financial and emotional support.
• Sexually transmitted infection (STIs)/Types and Symptoms.
• Sexually transmitted Infections (STI) formerly called venereal diseases, but now called STIs are spread by sexual contact. Some are also transmitted not by sexual contact alone, but blood transfusion.

These are group of infections in which the principle was of transmissions by casual contact. They were previously called venereal diseases (V. D.) (Obinu, 2001). Several kinds of STIs are epidemic including gonorrhoea, infections of urethra, not caused by gonorrhoea (nongonococcalurethritis); non specific urethritis (NSV); genital herpes virus; genital warts (Candy Loma Accumineta); scabies (mites) and urethraland vaginal infections caused by the bacterium, chlamydiatrahomatis, the protozoan trichomoas, and the yeast monillia. AIDS and hepatitis are also transmitted by unprotected sexual contact. Large numbers of infections are transmitted largely or exclusively by sexual contact. In addition to those epidemic diseases already mentioned, such diseases include syphilis, crablike (pediculosis pubis), vaginal infection caused by the haemophilus bacterium; molluscumcontagious, chanchroid (soft sore); lymphogranulema venereum and grand Loma inguiraler.

These and so many others are transmitted only by intimate contact with an infected person. A few of these diseases notably cancroids and scabies can be spread
by the infected person from one area of skin to another. Scabies, lice, genital herpes and vaginitis caused by trichomones and monilla may also be acquired by means other than sexual contact (Obinu, 2001). The epidemic nature of STIs makes it difficult to control them. Some public health officials attribute the increase in many of these diseases to increasing sexual activity. Preventing these ugly situations require among other measures of investigating the causative factors, education of the populace and specifically too, the teaching of re-education at the grassroots which includes schools, market places, organizing workshops and seminars for the people at the work place and even the parents themselves.

- Michael (1981) states that sexually transmitted infections (STIs) are simply those diseases which can be contacted from an infected person by means of sexual intercourse. Again sexually transmitted infections (STIs) are human infections that are transmissible by sexual intercourse which may be vaginal, anal or oral.

- Initially it was believed that gonorrhea and syphilis were the only infections which could be transmitted by sex hence the name venereal disease (V. D.) was given to them. As time went on, it became clear that there are more than 20 other conditions which are sexually transmissible (Michael, 1981). Although the size of the problem is unknown, particularly in Nigeria, STIs are very common and are among the top five infections for which people seek care.

STIs remain a public health problem of major significance in most parts of the work and their consequences can be devastating: these include adolescent female suffering chronic abdominal pain, entopic pregnancy, infertility or cervical cancer. Male could develop urethral stricture and infertility and infants could die from congenital syphilis or be born with severe eye infections or life threatening pneumonia.

Evidence of the manifestation of STIs in published history is poor and indeed specific general diseases were not identified in the middle ages and earlier amongst the famous people known to have suffered from STIs. According to the World Health Organization (WHO 1992), STIs are the most common diseases and the prevalence rates are particularly high in developing countries like Nigeria. Every year, there are
250 million new cases and some of these are complicated by the above mentioned complications of young women. Some STIs account for major tragedy for young women in Africa because they promote the transmission of Human Immune Deficiency Virus/Acquired Immune deficiency Syndrome (HIV/AIDS). Many STIs and in particular HIV can be vertically transmitted in pregnancy with devastating effect on the unborn child.

The “UNAIDS 2011 World Aids Day” report shows that the rate of HIV infection has fallen by 56% in India, the country still has the third largest number of people with HIV/AIDS in the world. The National AIDS Control Organization (NACO)'s 2011 annual report shows that young people in the age group of 15-24 account for 31% of the HIV/AIDS burden. An older study, UNICEF's 2003-08 analysis, found that only 20% of adolescent girls and 36% of adolescent boys in India had any knowledge of the disease. This is unfortunate for two reasons – first, because a large percentage of those infected with HIV in India are between the ages of 15 and 24 and second, 80% of HIV infection among Indians is transmitted through heterosexual contact, not through men having sex with men or through the use of contaminated needles, as is often popularly assumed.

Women’s Health Journal (2000) states that the best prevention of sexually transmitted infections is to avoid multiple sex partners. Another method of preventing sexually transmitted pathogen is healthy living (hygiene). It is further argued that women can help protect themselves by seeking prompt treatment for all reproductive tract infections. Scientists have now shown conclusively that the risk of contracting (and transmitting) HIV increases in the presence of a reproductive tract infection. This includes a wide range of STIs such as gonorrhea, Chlamydia, cancroids’, bacterial gAGINOSIS AND trichomoniasis.

**Importance of Sexuality Education:**

Ariba (2000) and Emenike, (1981) show that there are many reasons why sexuality education should be taken seriously since our world today has become just a global village. Events occurring in parts of the world that were previously remote are now becoming instant influences on patterns of behaviour in other parts. When these
influences are negative, their impact on the recipient population could be catastrophic unless such population are well informed and have involved appropriate behaviour to cope with such information. Through the media (both print and electronic and most recently the internet), and direct interaction with foreigners and visitors to other countries, the citizenry are becoming exposed to many sexuality problems.

Adebajo (1997) and Ariba (2000) have shown that the increasing incidents of teenage pregnancies, STIs, HIV/AIDS, induced-abortions, sexual violence, harmful traditional practices (i.e. early marriage, female genital mutilation) divorce and teenage prostitution have drawn the attention of health policy makers towards the need for more education in the area of adolescent reproductive health. It has been revealed by research conducted by the Association for Reproductive and Family Health (ARFH), Ibadan that a lot of sexual behaviour patterns and high risk reproductive practices are due to ignorance.

The research further reveals that many people, particularly youths had inadequate information regarding reproductive health, human sexuality and safe sexual practices.

- Disorders of pregnancy are more common in adolescent pregnancy than in adult.
- Psychological, social and educational problems include illegitimacy and its accompanying mental malfunctioning.
- All these predicaments could lead a girl to indulge in prostitution etc.

**Sexual Abuse and Exploitation:**

According to Suleiman and Dominic (2006) the vulnerable mostly become victims of sexual abuse and sexual exploitation; and once sexually abused or exploited, such victims, whether children or athletes, become even more vulnerable as they have been stripped of their self esteem, are faced with threats to their person and humiliated by the exploiters. This is a common phenomenon all over the world. According to the Federal Government’s plan of action for the protection of young children and youths (athletes inclusive) from sexual violence and exploitation (FGN, 2003). The subject of sexual abuse and sexually exploitation of children has become a far stronger focus of public interest since the mid 1980s. Various governments and
non governmental organizations have done some trend-setting work. But there is still a need for action in various sectors for the protection of youth from sexual abuse and exploitation (Ibrahim and Ogunsanwo, 2005 in Suleiman & Dominic (2006)).

The debate over teenage pregnancy and STIs has spurred some research into the effectiveness of different sex education approaches. In a meta-analysis, DiCenso (2000) have compared comprehensive sex education programs with abstinence-only programs. His review of several studies shows that abstinence-only programs did not reduce the likelihood of pregnancy of women who participated in the programs, but that abstinence-only actually increased it. The researchers conclude that four abstinence programs and one school program were associated with a pooled increase of 54% in the partners of men and 46% in women (confidence interval 95% 0.95 to 2.25 and 0.98 to 2.26 respectively).

The results of the study revealed that male adolescents had some knowledge of sexual maturity and sexual behaviour while most of the female students lacked basic and essential knowledge on these matters. About 45% – 60% of the males had some knowledge about wet dreams, masturbation and homosexuality, while most of the females did not have any knowledge, and this could be attributed to cultural factors.

It was also noted that the vast majority of both males and females knew about AIDS. This probably reflects the mass media interest in this subject. On the other hand, the vast majority of them knew nothing about other sexually transmitted infections. This highlights the need for education in this area and the role the mass media and school seminars can play.

Children and young people are affected by abuse and neglect in various ways. Outcomes of abuse may range from mild symptoms to debilitating and life-threatening conditions (Runyon & Kenny, 2002). Factors that may affect the way in which abuse and neglect affects children and adolescents include:

- the age and developmental status of the child when abuse occurred;
- the severity of maltreatment;
- the frequency and duration of maltreatment;
- the relationship between the child and the perpetrator; and
- the type(s) of abuse / neglect.
Adolescent Sexuality and Media:

Along with the examination of media usage, several researchers have attempted to explain the relationship between adolescent sexuality and media. Correlational studies indicate that exposure to sexually suggestive materials is associated with premarital sex, although whether sexually active teens seek out sexual content or whether sexual content increases sexual activity remains uncertain (Brown et al., 1990; Brown & Newcomer, 1991; Donnerstein & Smith, 2001; Lackey & Moberg, 1998; Malamuth & Impett, 2001; Strouse & Buerkel-Rothfuss, 1987). Other researchers have found sexual content in the media to have a minimal, if any, impact on sexual activity of adolescents (Peterson, Moore, & Furstenberg, 1991; Roberts, 1993).

Explanations for the varied impact of the media include the differing characteristics of adolescents discussed earlier in this paper and additional factors such as the perceived reality of the content viewed, the media's portrayal of consequences (or lack of) associated with sexual behavior, and the influence of other role models. Studies of peer group interaction suggest that learning from the media is not only an individual process, but that messages received during peer group interactions may also contribute to how adolescents learn from and interpret media messages (Durham, 1999; Milkie, 1994). According to Donnerstein and Smith (2001), research shows that parents who openly communicate and actively co-view television may help "inoculate adolescents from potentially detrimental effects of exposure" (p. 298). Frequency of viewing (Malamuth & Impett, 2001) appear important as well. Although the majority of research regarding the impact of the media on sexuality has focused on harmful effects, the media do appear to have some positive effect on the education of adolescents regarding sexuality, sexual behavior, and safe sex. While media campaigns that specifically target the sexual behavior of adolescents can be effective (Berne & Huberman, 2000; Strasburger, 1995), learning also takes place indirectly. Kehily (1999), through participant observation, discovered that young girls read magazines to learn about sex. Milkie (1994) conducted a study with a middle-school aged male peer group and concluded that in this group, movies were the source of learning and sharing about male sexuality. In addition to television, print media, and music, the Internet has now become a viable way for adolescents to gain
information about sexuality (Flowers-Coulson, Kushner, & Bankowski, 2000).

**STDs Prevention among Adolescents:**

The term ‘sexually transmitted diseases’ denotes disorders that are principally spread by intimate contact. These diseases are not merely acute illnesses, but may lead to serious complications such as infertility, ectopic pregnancy, cervical cancer, fatal wastage, and even death. Many STDs are curable, but they can be cured only if the patients are correctly diagnosed and treated in time. Furthermore, there is no known cure for some STDs such as HIV/AIDS. The prevention of STDs is therefore of the utmost importance. In addition, the risk of contracting and spreading HIV/AIDS is reduced by the prevention and cure of other STDs. Prevention through lifestyle and behavioural modification is currently recommended as the primary protection against these diseases.

The impact of HIV/AIDS on people in Sub-Saharan African countries is more serious than in any other region of the world. This region with only 10% of the global population is where over 60% of all HIV-infected people live. In 2005, approximately 4.6% of females aged 15-24 years and 1.7% of males of the same age group in this region were HIV-infected. In terms of STDs other than HIV/AIDS, the 2004 national survey of adolescents between 12 and 19 years of age in Ghana showed that 3.6% of girls and 1.4% of boys reported infections (5). The real percentage of infected adolescents might be higher because of reluctance to report infection or seek diagnostic tests. Today, various sources provide adolescents with information on sexual and reproductive health issues, including STDs. These sources include family, teachers, friends, health professionals, and the mass media (3, 5, 7-10, 17, 19, 27). However, the majority of adolescents have yet to obtain sufficient accurate information on STDs. Information about HIV/AIDS quickly gained global currency due to the rapid spread of the pandemic and widespread media coverage and public information programmes. A recent national survey in Ghana found that nearly all adolescents heard about HIV/AIDS, yet a significant percentage of adolescents could not list all transmission mechanisms of the disease. They even believed that HIV/AIDS was spread by mosquito bites, witchcraft, and toilets. Nearly 10% of
adolescents thought that HIV/AIDS could be cured by having sex with a virgin (5). Insufficient and incorrect information on HIV/AIDS persists in other African countries such as Tanzania as well (6). In a national study in South Africa, where 10% of young people aged 15-24 years were living with HIV, 1% of boys aged 15-19 years were not aware of HIV/AIDS and 9% thought that there were no preventive methods for the disease (7).

Less than 50% of Ghanaian adolescents have heard about STDs other than HIV/AIDS. A qualitative study conducted in Ghana and three other African countries showed that many adolescents could not list STDs other than HIV/AIDS correctly. Although the increased risk of acquiring and spreading HIV if infected with other STDs has been demonstrated, Nigerian adolescents seemed not to appreciate this link between HIV/AIDS and other STDs. An incorrect understanding of STDs other than HIV/AIDS appears in developed countries as well. A study in Canada showed that 28% of urban high school students identified HPV as a cause of HIV/AIDS (9).

Lack of knowledge causes low self-perception of risk of acquiring STDs (5). In South Africa, 62% of HIV-infected young people considered themselves at no or little risk of contracting HIV/AIDS (7). When adolescents do not know their own risk level, they tend not to feel that it is necessary for them to take preventive actions.

Adolescents engage in sexual activities in pursuit of pleasure, under peer pressure, in order to maintain love relations, and even for financial reasons. Nowadays, early sexual debut tends to be linked to high risk-taking behaviours (11). Sexual contact among adolescents often occurs with multiple short-term partners, or high-risk partners combined with inconsistent, incorrect, or non-use of condoms. The 2004 national survey of adolescents in Ghana found that only 22% of sexually experienced girls and 40% of sexually experienced boys reported only one lifetime sexual partner.

Adequate and accurate sex education programmes enable adolescents not only to protect themselves from STDs but also to motivate others to make safe choices. The primary goals of sex education for young people are: (i) to provide them with relevant and accurate information; (ii) to provide them with the skills to abstain from sex until they are mature; (iii) to ensure that they know how to avoid unsafe sex in order to
protect themselves from STDs and pregnancy and (iv) to enable them to achieve sexual well being in adulthood. The first sex education lessons must be given to adolescents before their first sexual encounter. For sex education programmes to be effective, the content and approach must take into account differences between different groups of adolescents – boys and girls, rural and urban adolescents, younger and older adolescents.

**Family Planning Recommendation :**

Family Planning recommends the following components are included in sexuality and relationships programmed for primary and intermediate and secondary years, when age and stage appropriate, and spiraling through the years.

**Primary and Intermediate Years :**

**Attitudes and Values :**

- Clarification of family and own attitudes and values.
- Equality.
- Identifying that love and sex are not the same.
- Identifying stigma.
- Non-judgmental.
- Open-mindedness.
- Positive attitude toward their health.
- Positive self-esteem.
- Recognising discrimination .
- Respect for self and others.
- Sense of responsibility.

**Skills :**

- Ability to ask questions and seek help.
- Ability to take responsibility.
- Assertiveness.
- Being a good friend.
- Communication and negotiation including boundary setting, giving and getting
• Consent.
• Confidence.
• Decision making.
• Developing critical thinking.
• Recognising myths and stereotypes.
• Empathy.
• Hygiene.
• Recognising peer pressure.
• Recognising yes and no feelings.

Knowledge:
• Basics of reproduction, including pregnancy and birth.
• Biological differences between sexes.
• Difference between gender and sex.
• Different types of love, friendships.
• Different types of relationships, families.
• Names of body parts.
• Pubertal changes (physical, emotional and social).
• Qualities of a good friend.
• Recognising and managing range of emotions.
• Yes and no feelings; privacy.
• Older years.
• Contraception.
• Impact of alcohol and drugs.
• Relationship violence.
• Sexual orientation.
• Sexually transmissible infections and prevention.
• Society’s changing norms and values.
• Stages of intimate relationships.
• Support services.
Secondary Years:

**Attitudes & Values:**
- Clarification of own attitudes and values.
- Equality.
- Gender roles.
- Identifying stigma.
- Identifying that love, lust and sex are not the same.
- Non-judgmental.
- Open-mindedness.
- Positive attitude toward their health.
- Positive self-esteem.
- Respect for self & others sense of responsibility.
- Recognising discrimination.

**Skills:**
- Ability to ask questions and seek help ability to take responsibility.
- Assertiveness.
- Condom use.
- Confidence.
- Critical thinking.
- Critiquing the media.
- Communication and negotiation including giving and getting consent, delay and abstaining, boundary setting.
- Decision making.
- Recognizing myths and stereotypes.
- Empathy.
- Ethical by standing.
- Recognizing peer pressure.
- Recognizing unhealthy behaviours, coercion and violence.
Knowledge:
- Cultural norms and social rules.
- Contraceptive options including emergency contraception.
- Gender diversity.
- Impact of alcohol and drugs.
- Pregnancy options including abortion.
- Qualities of a good friend.
- Recognising and managing range of emotions.
- Relationship violence.
- Reproduction.
- Rights and laws, e.g. Relating to sexual diversity, consent, service access, abortion, safety and protection.
- Sexual orientation.
- Sexually transmissible infections and prevention.
- Stages of intimacy, sexual response and pleasure.
- Support services.

2.3 Healthy Society and Sex Education

There is always a wide gap between the children and the parents when it comes to sexuality. Though parents are well aware of the sexual activity but it becomes very difficult for them to realize that it is quite a normal activity of every adult and the children and youths do have some queries regarding this. Unless the children and the youths get their queries answered properly, it becomes very difficult for them to have a proper mental development and it would be tough for them to handle various sex-related incidents and crimes which are increasing day by day. All these have made the society understand the important of sex education for youths and the government along with various NGOs are is taking various measures to incorporate sex education in schools so the sex education in India and other countries could start at early stage and help the children to have a proper development both physically and mentally.

Sex education in India has given rise to various arguments and people have different views on this topic. According to some, sex education in schools will
unnecessarily make a forbidden world open in front of the children and teenagers which they will not be able to handle properly. There is another group which thinks that sex education in schools will actually help the children and youths to know various aspects of sex, improve their attitudes especially towards the opposite sex, having fair idea about their sex preferences, relationship formation etc. Sex education for youths which are imparted by the professionals will actually help in the formation of a healthy society.

Sex Education in India is done through the class lectures, banners, campaigns, television, radio and workshops. Most of the programs of sex education in schools are given in the local or the most-used language so that it becomes easier for the children to grasp and implement the knowledge.

2.4 Development of Proper Sex Attitude

The transition from the childhood to the adulthood is smooth so as adults the right attitude will be there before marriage and after marriage. The issues like teenage pregnancy, abortion and death during abortion, unwanted pregnancy after and before marriage, gap between children etc. can be handled. Reproductive organs, process of birth, taking care of reproductive organs especially for the girls during the adolescent periods can be handled.

*Year 5 - 6 Sexuality Education Programme (2013)*

**MOE (Ministry of Education) and Sexual Issues**

Sexuality Education helps students understand the physiological, social and emotional changes they experience as they mature, develop healthy and rewarding relationships, and make wise, informed and responsible decisions on sexuality matters. Sexuality Education covers the following dimensions of a person’s sexuality:

**Physical**: Physical sexual maturation and intimacy, the physiology of sex and human reproduction;

**Emotional**: Sexual attitudes and feelings towards self and others;

**Social**: Sexual norms and behaviour and their legal, cultural and societal implications; and

**Ethical**: Values and moral systems related to sexuality.
Issues of sexuality would involve value judgments. Parents as the primary caregivers, are responsible for the health and moral values of their children. Hence, parents may choose to opt their children out of a school’s sexuality education programme, talks and workshops. Parents may refer to the Roles of Stakeholders webpage for more information on the role of parents in the sexuality education of their children.

Children need to acquire the knowledge, values and habits which will allow them to develop healthy and responsible relationships as they grow up. While parents play the primary role in their children’s sexuality education, schools have a complementary role to play in providing students with objective and reliable information on sexuality as part of a holistic education.

Our youth are growing up in a rapidly changing world, where globalisation and technological advancements expose them to a wide range of influences from around the world.

**Greater Access to Information**:  
Our youth have access to many sources of information, such as the internet, cable TV and their friends. They are exposed to social norms of other societies and interest groups. Hence, it is important that our youth are able to receive objective and reliable information in schools, as well as guidance from their parents.

**Problems related to Teenage Pregnancies**:  
Each year, there are about 2,000 teenage pregnancies in Singapore (statistical age group used is 10-19 years). Some abort their pregnancies while others go on to give birth and become teenage mothers. Both groups suffer negative consequences, either from the trauma of abortion or as a single young mother, for which they are ill-equipped.

**Sexual Activity, STIs / HIV among Teenagers**:  
Teenage pregnancies and the rates of STIs / HIV indicate that some youths are sexually active and are having unprotected sex.
SIECUS Guideline Regarding Sex Education

The Sexuality Information and Education Council of the United States (SIECUS Guidelines, 2004) cites the following principles as fundamental to guide the development of sexual health education programs:

**Parent and Community Involvement**: School-based programs must be carefully developed to respect the diversity of values and beliefs represented in the community. Parents, family members, teachers, administrators, community and faith-based leaders, and students should have an opportunity to provide input into sexual health education programs.

**Being a Component of a Comprehensive School Health Education Program**: Sexual health education should be offered as part of an overall health education program and can best address the broadest range of issues in the context of health promotion, social and gender equity, and disease prevention. Communities and schools should seek to integrate the concepts and messages in the *Guidelines for a Coordinated Approach to School Health* (CSH Guidelines) into their overall health education initiatives.

**A Focus on All Youth**: All children and youth will benefit from sexual health education regardless of gender, sexual orientation, gender identity, ethnicity, race, socioeconomic status, or disability. Programs and materials should be adapted to reflect the specific issues and concerns of the community as well as any special needs of the learners. In addition, curricula and material should reflect the cultural diversity represented in the classroom.

**Well-Trained Teachers**: Sexual health education should be taught by specially trained teachers. Professionals responsible for sexual health education must receive training in teaching human sexuality, including the philosophy and methodology of sexuality education. While ideally teachers should attend academic courses or programs in schools of higher education, in-service courses, continuing education classes, and intensive seminars can also help prepare sexuality educators.
A Variety of Teaching Methods: Sexual health education is most effective when young people not only receive information but also are also given the opportunity to examine their own and society’s attitudes and values and to develop or strengthen social skills. A wide variety of teaching methods and activities can foster learning, such as interactive discussions, role playing, individual and group research, group exercises, and homework assignments (SIECUS Guidelines, 2004).

A more in-depth explanation of these fundamental principles is offered in Section 2 of the CT Guidelines.

UNESCO’s Sex-ed Guidelines:
10th September, 2009:

The United Nations Educational Scientific and Cultural Organization (UNESCO) recently proposed “International Guidelines on Sexuality Education.” These guidelines provide educators with information on how to teach children about reproductive and sexual matters including STIs and unintended pregnancy.

The reason for these guidelines lies in the astonishing HIV/AIDS figures from UNAIDS and the WHO, which states that more than five million young people are living with HIV worldwide and 45 percent of all new infections occur among those aged 15 to 24 years old. International Planned Parenthood Federation shows that 111 million new cases of curable sexually transmitted infections occur among young people aged 10 to 24 and 4.4 million girls aged 15 to 19 seek abortions, most of which are unsafe.

Predictably, the UNESCO guidelines have stirred a strong reaction from social conservatives, who argue that the guidelines are exposing kids to sex far too early, by drawing attention to masturbation and abortion. But according to Time, masturbation is only mentioned 5 times in the 102 page document, “twice to explain to 5 to 8 year olds what the term means” noting that “it is not harmful, but should be done in private.” The other three times it is mentioned is to 9 to 15 year olds explaining that “it does not cause physical or emotional harm and is often a person’s first experience of sexual pleasure.” This is hardly teaching 5 year olds how to perform such a task.

UNESCO recommends that students are provided with sex education starting at
five years old, with more detailed information as they get older. According to UNESCO, sex education at an early age helps delay sexual activity and reduces the amount of sexual partners and unprotected sex. The guidelines also provide a section entirely devoted to justifying why they have been written, drawing on information from 87 different studies from around the world reviewing curricula from 12 countries.

It is clear that UNESCO understands the importance of education. With no AIDS vaccine, UNESCO recognizes that education is the only way to prevent the spread of the deadly virus. Fortunately, the United Nations Population Fund (UNFPA) has responded by reaffirming its support for comprehensive sexuality education. UNFPA’s Executive Director, Thoraya Ahmed Obaid spoke out this week, saying that, “We are mandated by the Programmed of Action of the International Conference on Population and Development (ICPD) to provide support to governments to protect and promote the rights of adolescents to reproductive health education, information and care”.

**Some Strategies to reduce STIs according to UNAIDS (2008):**

Provide teens with the information, skills, and support they need to practice safe sexual behaviour. This programme should be tailored to youths’ needs and age appropriate, culturally sensitive and teach sexual and reproductive options. Build on current knowledge of best practices by emphasizing communication, skill-building activities, and role-playing.

Educate adolescents and young people about the risks of sexually transmitted diseases, including HIV/AIDS. Incorporate promising strategies into comprehensive STIs prevention programs including: individual and peer education, counselling, case management, after school activities, and building support systems and relationships with caring adults. Increase access to reproductive health care. Encourage all health care providers who provide care to youth to include comprehensive, age-appropriate information on sexual health issues, including prevention of STIs. Make confidential STI screening and treatment services easily accessible to teenagers along with culturally sensitive understand the knowledge and attitude among students for
introducing sexuality education in secondary schools counselling and education regarding the use of available protective measures.

The SAFE Project:

The European Commission Directorate General for Health and Consumer Protection, as part of ‘The SAFE Project: A European partnership to promote the sexual and reproductive health and rights of young people’. The project is a partnership between IPPF European Network, WHO Regional Office for Europe and Lund University. They stated, “All young people have the right to comprehensive sexual and reproductive health information, education and services, to be active citizens, to have pleasure and confidence in their sexuality, and to be able to make their own informed choices.” In order to meet these rights, we seek to promote a model of sexuality education that considers the various inter-related dynamics that influence sexual choices and the resulting emotional, mental, physical and social impacts on each person's development. This positive approach to sexuality education includes an emphasis on sexual expression and sexual full filament, representing a shift away from methodologies that focus exclusively on the reproductive aspects of adolescent sexuality. They also suggest, sexuality education must help young people to

• acquire accurate information: On sexual and reproductive rights; information to dispel myths; references to resources and services,

• develop life skills: Such as critical thinking, communication and negotiation skills, self-development skills, decision making skills; sense of self; confidence; assertiveness; ability to take responsibility; ability to ask questions and seek help; empathy,

• nurture positive attitudes and values: Open-mindedness; respect for self and others; positive self-worth/esteem; comfort; non-judgmental attitude; sense of responsibility; positive attitude toward their sexual and reproductive health,

• sex education covers a broad range of issues relating to both the physical and biological aspects of sexuality, and the emotional and social aspects. It recognizes and accepts all people as sexual beings and is concerned with more than just the
prevention of disease or pregnancy. CSE programmes should be adapted to the age and stage of development of the target group.

**Sexual Rights (Canadian Guideline for Sexual Health Education):**

“Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children;
- and pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

**Policy Statement – Sex Education:**

**Guidelines:**

The Governors of the school will take the responsibility for deciding its Sex Education policy and the quality of its programme of study. They will ensure its content is appropriate to the needs and ages of students it is targeted for and that it is linked to moral values.

Our Sex Education Policy will be available for all parents to view on request. A parent may also, view lesson materials and discuss methods of presentation with the relevant Head of Year. If a parent decides to withdraw their child from the programme or any part of the programme advance notice must be given to the school by contacting the Head Teacher, so that suitable alternatives and arrangements can be
made. Parents will be notified of such opportunities and their rights to withdraw their children through the future school prospectus or various correspondence. By law, parents, may not withdraw their children from material of a National Curriculum nature.

Appropriate outside speakers may be used to speak on particular topics such as menstruation, contraception and S. T. D. The suitability of such speakers will be vetted by the relevant Head of Year.

The school will review the adequacy of its training for those teachers who have the major responsibility for providing sex education.

The Head of Year will ensure that all staff, but especially those staff that have the major responsibility for providing sex education, are aware of the School Sex Education Policy by way of the Handbook.

Parents and Governors will be informed of our Sex Education Policy (by way of our future prospectus). Parents will be made aware of their rights to view in detail the School’s Sex Education Policy, lesson content, method of presentation and withdrawal of their children from such teaching if desired. Interested parents will be invited to appropriate meetings in which they can contribute their views of future review of policy and practice in this area. Appropriate training opportunities will be provided for the staff who are teaching a major part of the Sex Education programme.

**Parental Attitude Toward Teaching of Sex Education**

The attitude of parents towards teaching of sex education is emotional response that expresses different degrees of acceptance and rejection. In sum total, the attitude of parents determines the success of the teaching of sex education. Attitude are formed from membership of groups. Teachers, family, peer groups, religious or voluntary organizations and the mass media are some of the sources which impart sex education to the youth.

The type of attitude formed by parents can be negative or positive. A positive attitude towards the teaching of sex education will lead to the avoidance of premarital sexual intercourse while on the other hand negative attitude will lead to unwanted pregnancies and their complications. Bobak & Jenson (1989) also state that some
youths become promiscuous as a result of the negative effects of sex education.

Sexual attitude, like other attitude which generally result from frustration, are derived from unspoken and often unconscious premises and creative thoughts, which are always articulate and precise. Most of what we consider our mental activity consists of sub-articulate, half conscious semantic reflexive reactions. Study of sex education has usually been either in terms of the extent to which it is approved or disapproved of as an abstract proposition. The reason for parent’s attitude towards teaching of sex education in schools is the fear of pregnancy. The traditional norms have tended to condemn sex education in schools. Variation in the findings of research into the reasons for abstaining from premarital coitus suggests that even though different techniques of investigation produce different results there may have been as actual shift in the attitude of parents in recent years. For example fear of pregnancy was cited as a much more important reason than parental influence for children not having premarital intercourse (Bromleu & Britten, 1938). For example, Caldwell et al., (1989) assert that “A pragmatic attitude exists in Africa toward sex education with a fair degree of permissiveness toward premarital relations, are not the high point of sin and usually should not be severely punished, substantial educational efforts are needed to improve societal attitude towards sex education. Adeyemo’s (1995) writes-up on attitude towards sex education. He explained that the attitude of parents towards sex education can be influence by the knowledge. The attitude of parents will depend on the personality of parent-attitude. Activity creates problem because the most active information obtain will help to have either negative or positive attitude towards sex education. Nass & Fisher (1988) described public attitude towards sex education swinging back and forth between valuing free domain sexual choices and valuing restriction on sexual expression which also affect the attitude of parents towards sex education. Inadequate information about sex has led to the parents forming a negative attitude towards sex education.

International Planned Parenthood Federation (IPPF) (1997) states that over 70% youths (girls) in Africa become pregnant between the ages of 15-19 years. In Nigeria so many youths (girls) aborted in schools.

Ciray (1993) described attitude as relating stable judgments of values which
pass certain objects of experience in things heard or found.

The IMB Model for Behaviorally Effective Sexual Health Education:

Elements of Effective Sexuality Education Programs:

The following structural elements need to be included in an effective sexual health education program:

• mandatory, comprehensive curriculum with appropriate learning knowledge, skills, beliefs/attitudes, social support, preventive health services and behavioural outcomes organized in an well-designed scope and sequence from the early primary years to senior school graduation.

• sexuality education program is part of a comprehensive health education program, which in turn, is part of a personal and social development program.

• high quality teaching/learning materials, including print, media and technology based alternatives.

• active learning and teaching methods.

• effective pre-service education for teachers.

• good in service education for teachers.

• parent involvement in instruction through good communications with the home and through take home learning activities.

• active student involvement in adapting the program to local needs and peer leadership and education in the classroom and the school.

• the instructional program is situated within a comprehensive school-community approach to promoting sexual health that includes accessible and convenient adolescent preventive health services, social support from parents and others in the community, a safe healthy physical environment in the school, convenient access to condoms by youth, etc.

Sex Education in Schools:

The importance of sex education for preventing teen pregnancy cannot be overemphasized. Somers and Surmann (2005) have found that early and comprehensive sex education is correlated with less risky sexual behavior among
teens. Specifically, those who receive sex education in school at a young age report having sex less frequently than those who received sex education post-puberty (Somers & Surmann, 2005). There are two major types of sex education currently used in schools: abstinence only and comprehensive sex education. This section describes both types in relation to teenage pregnancy prevention. Currently, states are not required to provide sex education to teens (Collins, Alagiri, Summers & Morin, 2002). However, the federal government does decide which programs will receive federal funding, and after eight years of abstinence-only sex education being the only recipient of federal funds during the Bush administration, the Obama administration has made a change in policy only to provide funds to evidence-based sex education programs (Collins et al., 2002; Guttmacher, 2009).

Abstinence-only sex education teaches students that the only sure way to avoid unplanned pregnancy and sexually transmitted diseases (STDs) is to abstain from sexual activity until marriage (Collins et al., 2002). Teens are not educated about contraception and condoms, and discussions of abortion are avoided (Collins, et al., 2002). Students are taught refusal skills and discuss values, and they are also told that sex before marriage will likely result in negative consequences for themselves, their partners, and a baby if they were to get pregnant (Collins et al., 2002).

Studies have shown that teens who have taken a pledge to be abstinent until marriage are just as likely to become sexually active as teens who have not received abstinence-only sex education, and are less likely to use protection than their peers who have received comprehensive sex education (Thomas, 2009). This is likely a result of the teens not learning the effectiveness of condoms and contraception (Collins et al., 2002).

The other type of sex education is comprehensive sex education, which can be described as “abstinence plus” (Collins et al., 2002), where abstinence is promoted, but students are also educated about contraception and condoms. Students may have discussions about such topics as STDs, HIV, and abortion (Collins et al., 2002). Comprehensive sex education recognizes that students may become sexually active at some point, and aims to equip teens with accurate knowledge about disease and pregnancy prevention options (Collins et al., 2002).
Currently, schools have the option of providing abstinence-only or comprehensive sex education, which is determined by policy. Some schools that teach abstinence only use programs such as The Postponing Sexual Involvement Program (PSIP) and the Youth Asset Development Program (YADP) (Yampolskaya, Brown & Vargo, 2004). Both of these programs are aimed at improving academic outcomes, assisting teens in making education and career goals, and educating at-risk youth about the consequences of sexual activity. The idea is that teens who have long-term plans will be less likely to engage in risky sexual behaviours. Yampolskaya et al. (2004) found that students who participated in these programs did have better academic outcomes, particularly with the YADP. However, these were preliminary data, and the researchers did note some limitations. For instance, Yampolskaya et al. (2004) did not find that these programs changed students’ attitudes toward teen parenting.

Monahan (2001) examined a federally-funded Adolescent Pregnancy Prevention program, which was abstinence-only based. Treatment and control groups were compared on their knowledge, dating behaviours, and attitudes (control groups did not receive the Adolescent Pregnancy Prevention program) (Monahan, 2001). No significant differences emerged regarding 12 knowledge about sex and reproduction, and dating behaviours (Monahan, 2001).

**Knowledge of Reproductive and Sexual Rights:**

Participants were asked 24 questions to assess their knowledge on reproductive and sexual rights, and they were categorized into two groups based on their score in relation to the mean. The mean score was 15.7. More than half (54.5%) of the respondents were found to be knowledgeable, while a substantial proportion (45.5%) of the respondents was not. Students were asked whether a married woman should have the right to limit the number of her children according to her desire and without her husband’s consent. The majority (63.7%) of them showed their disagreement with this idea. One hundred fifty-seven (24.5%) of the study participants said that a husband should get sex whenever he wants irrespective of his wife’s wish. Around half (53.7%) disagreed with the question that reflected the right of girls to autonomous
reproductive choices without their partners’ consent. Four hundred nine (63.7%) agreed that parents have the right to decide on sexual and RH issues of their children. Among all, 270 (42.1%) of the respondents disagreed with the statement which said students should have the right to freedom of assembly and political participation to influence the Government to place sexual and reproductive health issues on the priority list during planning and interventions. Three hundred sixty-four (56.7%) agreed with the statement that unmarried couples have no right to use.

**Sexual Content in Media**

There is much sexual content in media, and this amount is increasing. According to a research study done by A. Deborah, Fisher, L. Douglas L. Hill, Joel W. Grube and E. L. Gruber (2004) on television programming in America from 2001-2002, 82.1% of television shows viewed during primetime had some form of sexually suggestive behaviour or speech, and “66.8% contained some form of sexual behaviour in at least one 2-minute interval” (pp. 538-539). This would suggest that in watching television, one will be Sex in the Media bombarded with some form of sexual content, as mild as sexual dialogue, references, or innuendo, in approximately four out of five shows watched. Approximately two out of three shows will have a visual depiction of sexuality. Hopefully those adolescents who are uncomfortable talking to their parents about sex are not watching television with them.

The sexual content in media is not only increasing in quantity, but it is also increasing in severity; it is shifting from milder forms such as passionate kissing, touching, or perhaps implied sex to more explicit content such as nudity and graphic scenes depicting sexual intercourse. Pardun, L’Engle, and Brown (2005) did a study on the effect of sexual content in media on adolescents. During their study, they found that about 41% of what they considered to be sexual content in media consisted of either partial or full nudity. Something as shocking as nudity or graphic sex in media is hard to remove from the mind, and it may linger in a young person’s thoughts for a long time. The more one thinks about such things, the more likely one is to be influenced by them.

Sexual content is not simply present in media, but it is presented in such a way
that it seems casual and even routine. It is not uncommon to see a couple have sex on their first date in a movie or television show. Sexual comments, jokes, and innuendo are common in casual dialogue. Sex is made to seem as if it not a big deal, and that it is done by everyone – married or not. Risks are rarely mentioned. A study done by Nabi & Clark (2008) revealed that only 14% of programs with sexual content in 2005 mentioned unwanted consequences such as unplanned pregnancies or sexually transmitted diseases or showed “sexual responsibility” such as using some form of protection during sex. Chia & Gunther (2006) believe that this depiction of sex in media can promote the Sex in the Media 6 misconception that everyone in real life is participating in such risky behavior, and if one does not participate in them, they are an exception to the norm. With more and more sexual content in media and increasingly explicit content, these ideas are becoming more widespread. Young people are influenced by what they see, and they see much sex in media.

Adolescents are exposed constantly to media images. Sexual content in the media is a reality in today’s arena of entertainment. Depictions of sexual content are displayed on television in various programs, music videos, computers, and lyrics of songs. Teen magazines are a source of representations of sexual attitudes and behaviours from which adolescents get skewed perceptions of what is acceptable. A finding indicated that an average of three pages per adolescent magazine incorporated some kind of sexual content. Those between the ages of eight and 18 years old had a television in their bedroom according to a national survey in 1999. Adolescents are exposed to various forms of media six to seven hours a day in the United States (Brown & Witherspoon, 2002). Studies have provided data on just how much time adolescents spend using some form of media, and there are differences between adolescent age groups when comparing the amount of time spent with various forms of media. Adolescents between 8-13 years old watched TV 44%, used audio media 17%, other non-interactive screen 15%, print 10%, computer 7% and video games 7% (Escobar-Chaves et al., 2005). Older adolescents between 14-18 years old use TV 36%, audio media 34%, other non-interactive screen 11%, print 8%, computer 7%, and video games 4%. The results indicate that mass media has seven different modes to supply adolescents with sexual content whether it be visual, auditory or combinations
of visual and auditory. The numerous modes of mass media are a clear indication of how accessible it is for adolescents to come in contact with sexual content. The data from Escobar-Chaves also provides data on the two age groups of adolescents regarding the amount of time utilizing specific modes of media. Television was the mode, which had the highest utilization rate in both adolescent age groups. The high utilization rate of television can be explained by results in the study indicating 65% of adolescents have a television in their own bedroom (Escobar-Chaves et al., 2005). A study for the Kaiser Family Foundation in 2003 indicates sexual content was “unusually high” in the television programs viewed most frequently by adolescents (Escobar-Chaves et al., 2005). The study revealed the following information regarding the sexual content viewed by adolescents, “83% of programs had any sexual content (behaviour or talk); 80% of programs had sexual references (talk about sex); 49% contained sexual behaviour, 59% of which was passionate kissing; 20% contained behaviour that was explicit or implicit intercourse” (Escobar-Chaves et al., 2005, p. 311). Further analysis of indicates the amount of sexual content in the television programs viewed by adolescents was higher than the programs on prime time television or television programming as a whole (Escobar-Chaves et al., 2005). The Internet disseminates a large amount of information due to its ability to transmit virtually any type of information across the world. It provides a forum for the exchange of nearly any type of information especially that which is of a sensitive nature, like sex. The anonymity provided by the Internet is also another huge attraction for adolescents seeking information on sexual intercourse and sexual activities.

Kanuga and Rosenfeld’s (2004) research indicated that 75% of adolescents between 15-17 years, have used the Internet, and of those, 94% believe the information online is helpful and accurate. Many use the Internet as a vehicle for friendship, information on hard to discuss subjects, and as a substitute for real life. The Internet replaces talking to a parent, clinician or school educator regarding sex. In addition to closing dialogue with parents and counsellors, the Internet exposes adolescents unknowingly to pornographic sites and chat rooms which can lead to predators seeking sexual activities with adolescents. When exploring the effects of
pornography, it is important to first note the ease with which it can be accessed. The Kaiser Family Foundation supported a telephone survey of adolescents using the Internet and found that more than half of adolescents between 15-17 years were unintentionally exposed to pornography on the Internet (Kanuaga & Rosenfeld, 2004). Various prominent organizations, such as the American Academy of Pediatrics, have joined in researching the effect media has on influencing adolescents. The results of the research advise that adolescent sexual activity may be due to the sexual content on television (Collins et al., 2004). In other words, the initiation of adolescent sexual activity has to do with the amount of sexual content viewed not the amount of media viewed overall. The reoccurring concept of a relationship between the amounts of sexual content viewed or listened to by adolescents a supposed to only reviewing time spent using media devices shows substantial findings. There is evidence from Collins et al. (2004), regarding the sexual content in Nielsen rated teen programs, but the sexual content in all TV programs needs to be investigated. A study in 2001-2002 by Collins et al. examined the amount of sexual content in television programming and the sexual activity of the participants. The study was conducted by a telephone survey of 1792 adolescents between the ages of 12 and 17 years old. The survey gathered knowledge from the adolescents on what they watched on television, their attitudes, and their knowledge of sex and sexual behaviour. A total of 23 programs were used based on Nielsen ratings for television programs aired during peak hours. These programs were the most frequently viewed by adolescents in groups of males, females, 12-14-year-olds and 15-17-year-olds. The programs appeared on major networks, such as, ABC, NBC, FOX and CBS to name a few. Only sitcoms, reality shows, drama and animated programs were among those in the study There is concern that the amount of sexual content in television viewed by adolescents is occurring at a high rate. A study by the Kaiser Family Foundation in 2001-2002 regarding sexual topics in television programs frequently watched by adolescents revealed there were 6.7 scenes per hour containing sexual issues (Brody, 2006). Another finding revealed that sexual talk occurred in 61% of television programs and 32% of obvious sexual activity occurred in television programs (Collins et al., 2004). A depiction of sexual intercourse whether it actually occurred or heavily suggested was in approximately
14% of television programs (Collins et al., 2004).

There are tools designed to examine the sexual content viewed by adolescents. Data gathered by the tools may support research establishing a firm relationship between lengths of exposure to sexual content in mass media and an adolescent’s decision to initiate sexual activity. One such tool is the Sexual Media Diet (SMD), which measures four areas of mass media, television shows, movies, music artists, and magazines. The SMD questionnaire was used in the Teen Media Study Fall 2001 through Spring 2002, which was conducted in the South-eastern United States on 3,261 seventh- and eighth grade students from three public schools. Pardon, L’Engle, and Brown (2005) stated, “The SMD measure showed a statistically significant association with adolescents’ sexual content in the media, based on the combination of media consumption and content” (2005, p. 75). The study also included two other areas of the media, Internet sites and newspapers. The demographics of the students consisted of 12-14 year olds with the majority being female 55% and among them 50% were white and 41% were black (Pardun, L’Engle & Brown, 2005).

Pardun, L’Engle, and Brown, (2005) provided information on the amount of sexual content consumed by the adolescents in general and individually in the six modes of media. When reviewing all six modes collectively, researchers determined 11% of information from the media contained sexual content. The amount of sexual content in the individual six modes of media consumed by the adolescent’s was listed as: music 40%, movies 12%, television 11%, magazines 8%, internet sites 6%, and newspapers 1%. The data reveals adolescents have multiple choices to view a significant amount of sexual content in six different modes of mass media. When specific sexual behaviours were reviewed overall from the six modes of mass media it revealed a focus on viewing body parts in a sexual manner 56% and relationships 33%. Sexual activity among consenting non-married adults overall in the six modes of mass media was at 25%. All of the data continues to reveal a large portion of information on sexual activity is disseminated to adolescents. In contrast, there is a limited amount of information for adolescents on safe sex messages or puberty. Messages on responsible sexual health, abstinence, body development and condoms were in the minority at 6% of sexual information consumed by adolescents (Pardun,
L’Engle & Brown, 2005). The results from the study by Pardun, L’Engle and Brown (2005) provided information on a link between exposure to sexual content and the adolescent’s sexual behavior. “Analyses showed strong positive associations between exposure to sexual content in the media and sexual activity and intentions” (Pardun, L’Engle & Brown, 2005). The study reported the amount of sexual content consumed has a far greater impact on the individual rather than the specific sexual behaviors observed (Pardun, L’Engle & Brown, 2005). Further analysis of the sexual content in the media and survey results propose adolescents are “enveloped” in media which is sexual in nature. The mode of media, identified as having the largest amount of sexual content, was music, which was listed at 40%. An adolescent’s decision to become sexually active or engage in sexual activity in the future may depend on the amount of sexual content viewed (Pardun, L’Engle & Brown, 2005). A substantial connection between the media and an adolescent’s intent to become sexual active was established despite other significant influences in the adolescent’s life, such as peers, family, religion and school (L’Engle, Brown & Kenneavy, 2006). The SMD indicated media influences in early adolescence as a 13% variation in the irritant to have sexual intercourse in the near future (L’Engle, Brown & Kenneavy, 2006). The influence of media also seemed to cause an 8-10% variance in different levels of sexual behavior once demographic controls were considered (Pardun, L’Engle & Brown, 2005). The study yielded some interesting findings on adolescents who are abstinent. Adolescents who are abstinent seem to be at risk for initiating sexual intercourse when they are increasingly exposed to sexual content and perceive an acceptance of adolescents engaging in sexual behaviours (Pardun, L’Engle & Brown, 2005). Another area, which may offer an explanation on the initiation of sexual behaviour is looking at various theories and models. Theories and models have been developed which explain why individuals are influenced to engage in various sexual behaviours. The theories and models are based on perceptions from an individual’s encounters with peers and social situations. Part of how adolescents learn is through socializing with peers, and from information they obtain from the media. In turn, the theories and models offer an insight into how information is perceived and processed, and eventually cause the adolescent to engage in sexual behaviour.
Sexuality Education – Human Right:

The need for sexuality education has been expressed from time to time some researchers have observed that 87.2 percent of adolescent girls from high school and junior college wanted sexuality education to be a part of the regular high school curriculum. Similarly, a survey done with 959 adolescent girls on issues of sexuality shows that regardless of age and education all the respondents expressed the need for introducing sexuality education into the academic curriculum. Easter Thamburaj et al. also found that students in public (63.06%) and private schools (48.80%) felt that sexuality education should be included in the curriculum. Sexuality education programs have been found to have beneficial impact. Thakor and Pradeep found that the sex education program resulted in knowledge in and desired change in attitudes.

The need for sex education has been perceived by various NGOs as well as international organisations working in the field of human health and education. Majority of school teachers (73%) were found to be in favour of imparting sex education to school children. The adolescents are quite inquisitive about the changes taking place in their body and want to know about sex and sexuality. Social taboos associated with the topic restrain them to ask their parents or elders. In such a situation it is difficult for them to get correct information about the anatomy of the human body and sexuality. They often depend on their peers who are equally ill-informed. The absence of proper knowledge makes them even more curious towards sexuality and the opposite sex. Many of them try to find out about sexuality through experimentation which further worsens the situation due to incorrect knowledge. If they are given proper information regarding their body, sexuality and HIV, they would be able to take care of their health and body in a better way. Their decisions would be more mature and rational. By denying sexuality education young children grow up being ashamed, confused and uninformed about themselves and their bodies. They are also rendered far more vulnerable. 16% women aged between 15-19 years are mothers. (National Family Health Survey, 2007).

Over 35% of AIDS cases reported are below 25 years of age and 50% of new infections are between 15 and 24 years old. (UNICEF, 2010). Around 2.27 million people are currently living with HIV (UNGASS, 2010). In India the rate of teenage
pregnancy is anywhere between 8% to 14% (Bhalerao et al., 1990, Mahavarkar, Madhu, Mule, 2008). Incidence of Breast Cancer, Cervical Cancer, gynaecological disorders, skin disorders are increasing among the youth. One in 22 women in India are likely to suffer from breast cancer during her lifetime. Breast cancer is the most common cancer in women in India (Khan et al 2010). A quarter to a third of India’s young people indulge in premarital sex (Sharma, R, 2001).

Myths regarding sexuality issues, even among the elderly and educated people, can be seen by going through some of the popular columns in the newspapers, such as Dr. Mahendra Watsa’s column in Mumbai Mirror. With easy access to internet resources, mobile and other telecommunication gadgets information about sex, sexuality and related topics is easily accessible without censorship. This information, in many cases, is misleading, unorganised, incomplete and unscientific leading to health issues and socio-legal problems. Hence, sexuality education is needed in such changing times. Sexuality education is a human rights issue as it impacts general health, adaptation to environment, quality of life and helps to live optimally by choice. It would not be an exaggeration to state that the right to life includes the right to sexuality education as well as reproductive rights. Hence, it is a human right which needs to be enshrined. Sexuality Education is a basic requirement as lack of information and/or knowledge related to sexual anatomy, its functioning, and other related details can endanger human life and health. Sexuality education is also needed to understand the impact of environment on human sexual health. A review study by Kumar and Kumar has pointed out the influence of environment on human sexual and reproductive health and highlighted the need to include the topic of “Environment and Sexuality” in courses on Environment Education and Sexuality Education in India.

Though the Government of India and its agencies have advocated sexuality education and prepared a program for its implementation, the inhibition associated with the word “sex” as well as preconceived irrational fears and increasing resistance from political opponents have scuttled the said programme. Twelve Indian State Governments had gone against the Adolescent Education Programme Introduced by the Central Government in association with the National AIDS Control Organization (NACO) and the United Nations Children’s Fund (UNICEF), which provoked the
Minister for Women and Child Development, Renuka Chaudhary, to term India ‘a nation of hypocrites’. One of the main reasons for banning sexuality education was that the contents of the sexuality education programme, prepared by the Government was explicit and contrary to Indian culture and morality. Critics of the programme opined that sexuality education in schools will increase risky behaviour amongst adolescents and young people. It would encourage promiscuity, experimentation, and so on.

However, such fears are irrational and far from reality. It has been observed that sex education does not encourage young people to have sex at an earlier age or more frequently (Grunseit & Kippax, 1993). On the contrary, the study revealed that sexuality education delays the start of sexual activity, reduces sexual activity among young people and encourages those already sexually active to have safer sex. Published reports of United Nations Children’s Fund (UNICEF), UNAIDS, United Nations Population Fund (UNFPA), support the effectiveness of sexuality education programmes in the US and other parts of the world. The Central Government in India has not taken any further action with respect to states banning sexuality education program proposed by it. Indian Constitution, Education and Health are both subjects that can be exclusively legislated upon and executed by State Legislatures and Governments. However, the Central Government has forgotten that under international law, federalism or any other such argument is not an excuse for the violation of international commitments. This rule has been codified by the 1969 Convention on the Law of Treaties and the 2001 Draft Articles on State Responsibility prepared by the International Law Commission. Further, the Indian Constitution empowers the Central Government to make any laws or take any executive action if it is in furtherance of its international commitments regardless of whether such a matter is a State subject under the federal structure. Lack of compulsory comprehensive sexuality education in schools, according to the Report of the United Nations Human Rights Council Report, violates the human rights of Indian adolescents and young people as recognized under international law. Broadly interpreted the right to sexuality education is enshrined in the Indian constitution as well as the international covenants and agreements. Article 21 which deals with right to life or personal liberty and
Article 21–A of the Constitution dealing with ‘free and compulsory’ education, as well as the Directive Principle of State Policy under Article 45 of the Constitution can be interpreted as covering the right to sexuality education. Furthermore, Article 51–A (k) imposes a ‘fundamental duty’ on parents to provide educational opportunities to their children in the age group of six to fourteen years, which can also be interpreted as including the opportunity to have sexuality education. Two case laws with regard to court judgments on sexuality education are worth noting. The first is the judgment of the Supreme Court of India which decided that sexuality education in schools cannot be brought under the ambit of fundamental rights by making it a part of the right to education, while dealing with a Public Interest Litigation, which had suggested making sexuality education in schools compulsory. The NGO, Nari Raksha Samiti, had submitted that sexuality education in school curricula could play a role in checking the rise of rape cases. Though agreeing with the suggestion, the bench said it cannot be given the status of a fundamental right on the same footing as the right to education itself. The second judgment is that of the European Court of Human Rights in the case of Kjeldsen, Busk Madsen and Pedersen v. Denmark (popularly known as the Pedersen Case, 1976). The applicants were parents of children who were going to State primary schools in Denmark. As per Danish Constitution, all children have right to Free Compulsory Education in State primary schools. The State had introduced compulsory sexuality education in State primary schools as part of the curriculum.

Parliament Bill (2011) – Guidelines and Safeguards against:

- Showing pornography.
- Teachers giving sexuality education to pupils when they were alone.
- Giving information on methods of sexual intercourse.
- Using vulgar language while imparting sexuality education.

The applicants, who were parents of school going children, gave several petitions to have their children exempted from sexuality education in concerned State schools. However, these requests were not met and all of them withdrew their children from the said schools. The applicants argued that the Denmark Government had violated Article 2 of Protocol No. 1 to the European Convention on Human Rights,
which states: “No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religions and philosophical convictions.” The State argued that Article 2 would cover only religious instruction and not all forms of instruction. The Court rejected this argument and held that any teaching should respect parents’ religious and moral convictions. However, the Court also held that Article 2 would be violated only if while imparting sexuality education, the teachers advocated sex at a particular age or particular type of sexual behaviour. Moreover, the parents still had the freedom to educate their children at home in conformity with their own religious convictions and beliefs and therefore, imparting sexuality education per se was not a violation of Article 2.

International conventions and legal instruments, to some of which India is also a signatory, have strongly advocated the right to sexuality education as one of the important human rights.

The International Conference on Population and Development (ICPD) and Programme of Action (POA), 1994 (often known as the Cairo Declaration) – The ICPD POA was the first and most comprehensive international document to embody concepts of reproductive and sexual health and rights. India is one of the signatories to the 1994 United Nations International Conference on Population and Development (ICPD). At this conference, “Five Year Review member states” of the UN, including India, affirmed the Sexual and Reproductive Rights (SRRs) of adolescents and young people. Therefore, as a part of their commitments under the ICPD agenda, governments, including India, are obliged to provide for free and compulsory comprehensive sexuality education for adolescents and young people. Article 24, 28 and 29 of the Convention on the Rights of the Child, 25 has important provisions related to education of children which can include the right to sexuality education. General Comment No.3 on HIV and AIDS of ‘The Committee on the Rights of the Child’ states that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (Article 6), State
parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality. The Committee on the Elimination of Discrimination against Women (CEDAW), has called on state parties to take steps under the right to health, in particular to “prioritize the prevention of unwanted pregnancy through family planning and sexuality education and reduce maternal mortality rates through safe motherhood services and prenatal assistance.” CEDAW further recommends that sexuality education be “widely promoted” and “targeted” at adolescent girls and boys. The Committee on Economic, Social and Cultural Rights (under the International Covenant on Economic, Social and Cultural Rights) in its General Comment No. 14 on’ the right to the highest attainable standard of health’ has specifically recognised the obligation of the government to provide sexuality education and information and have discussed the issue of sexuality education as a component of the rights to life and health. What sexuality information should be given to young people as well as to the elderly? When should sexuality education start? Who should provide sexuality education. How effective is the school-based sexuality education, are important issues that needs to be scientifically discussed and consensus on these issues should be arrived.

Appropriate balance between the eagerness and ambitious proposals of the NGOs to implement varied sexuality education in schools and restrictive approach of the politicians needs to be arrived at so that the process of imparting sexuality education to stakeholders is well regulated and less controversial.

Post-globalisation India has seen the rise of several moral panics around questions of sexuality. These moral panics, whether they are about clothing or premarital sex or something else, reflect contemporary anxieties particularly about adolescent girls and young adult women but also more generally about young people and their sexuality.

When it comes to moral panics, there is a tendency to operate in binary opposites: innocence is presumed to be the opposite of knowledge, innocence is also the opposite of wildness (which is why our children should never see us "wildly" partying-whatever that means-or even just having a good time). The quest for pleasure is often seen to be equal to hedonism and certainly irresponsible when it comes to
parenting. Since lack of knowledge equals the preservation of innocence, our children should also never be educated about sexuality, often compelling them to make uninformed choices.

Theories and Models of Sexual Behavior

Examining adolescents’ decisions to initiate sexual intercourse using models and theorem help in explaining their behaviours. There are a number of models and theories, which deal with behaviours and how external information influences the decisions of an individual (Escobar-Chaves et al., 2005). Theories and models regarding adolescent socialization practices, peer influence and the value of media to adolescents make Albert Bandura’s social learning theory, priming theory, media practice model, and super-peer theory a good choice for explaining why they engage in sexual behaviours. Although the theories and models vary on how they explain adolescent sexual behaviours and perceptions, they share a common premise that sexual content consumed will initiate a change in adolescents’ perceptions of sexuality and eventually their sexual behaviours (Escobar-Chaves et al., 2005).

Social Learning Theory

The social learning theory is based on life experiences, whether direct or indirect, processing the information and then learning and possibly modelling a behaviour from the gathered information. It is the adolescent who is processing, learning and modelling the sexual behaviors from the media. An adolescent is continually growing in the physical and psychological realm. While the adolescent is growing physically and psychologically they are receiving sexual information from the media and processing it to determine their perceptions which may influence their decision to perform sexual behaviours. Adolescents can learn various forms of socialization from the media, whether it is reality or not. Research has shown televisions a large part of adolescents’ lives and they often imitate what they observe. Bandura’s social learning theory (1986) proposes that social influences determine what behaviours adolescents will exhibit. When the behaviour is perceived as being interesting and desired in addition to being common, trouble-free, and practical, the social learning theory proposes the behaviour can occur (Brown, 2002). The social
learning theory offers an explanation for the adolescent engaging in sexual behaviours. The media is a part of the socialization process for adolescents and the sexual behaviors in the media make up part of their socialization experiences. The adolescent develops a perception of the sexual behaviors encountered in the media as a social encounter. Learning by imitation of a behavior even when the behavior has not occurred is the basis of Bandura’s social learning theory (Bandura, 1986). The theory recognizes three specific areas which occur in learning: actually performing the behaviour, watching others perform the experience without direct contact, and the last phase using cognitive functions to accumulate and assimilate complicated information (Escobar-Chaves et al., 2005). When adolescents actually perform asexual behaviour after observing it in the media they are completing the area of the theory, which states they actually perform the behaviour. The last two areas of the theory, watching others without direct contact and accumulating and assimilating information occur when the adolescents encounter sexual behaviours in the media and then compile the information to determine their perceptions of the sexual behaviours. At the time when the adolescent actually performs the behaviour, they are subjected to the possible negative consequences, such as, pregnancy, STDS, and the psychological effects. In essence, the theory leads one to believe social situations influence and can cause various behaviours to occur (Peterson, Moore & Furstenberg, 1991). Children have a tendency to learn by imitation and television is progressively influential mode of socialization (Peterson, Moore & Furstenberg, 1991). While adolescents are maturing the socialization process remains a significant part of their growth and development. The social learning theory regards sexual behaviours as social experiences which intern influence adolescents to engage in sexual activities. The social learning theory offers an explanation for sexual encounters in the media serving as a social pressure which influences adolescents to engage in sexual behaviours.

**Priming Theory:**

The priming theory operates on the premise that sexual content viewed in the media can provide the motivation for adolescents to engage in sexual activity shortly after it is viewed (Escobar-Chaves et al., 2005). Based on this theory, adolescents are
very susceptible to initiating sexual behaviours shortly after they have viewed or heard sexual content. The frequency of sexual content in the media along with an adolescent’s access to various modes of media also provides a foundation for motivating the adolescent to engage in sexual behaviours. Initially adolescents may not have any motivation for sexual behaviours, but as the theory states, exposure to the behaviours maybe catalyst for engaging in sexual activity. When the exposure to sexual content is coupled with other factors in their lives, like puberty and socialization issues, the notion of imitating sexual behaviours may seem more enticing. There is sexual content contained in almost all forms of media, and with the amount of media consumed by adolescents, it may be inevitable that exposure to sexual topics is only a matter of time. As the name of the theory suggests, “priming”, is literally preparing the individual to perform a certain behaviour.

**Media Practice Model:**

The media practice model establishes that adolescents want to view the media and seek its a valuable source of information. The purpose of this model is to clarify how media is used in thorough relative structure (Steele & Brown, 2005). The main points of the model focus on relationship between the development of an adolescent’s personality and an adolescent’s selection of media, the adolescent interfacing with media and how they use the media (Steele & Brown, 2005). In essence the model assumes that an adolescent’s selection of media is based on how he / she perceives him / herself or who they want to be at that time (Brown, Steele & Walsh-Childers, 2002). According to the theory, if adolescents feel they are sexual beings, they will be more interested in the sexual images and sexual content in the media. These feelings may influence them to seek media selections containing sexual information and determine to what level they participate in the behaviours (Brown & Witherspoon, 2002). If the adolescent chooses to engage in the behaviour it is a result of the adolescent’s intentions, past experiences, and how they identify his / herself.

**Super Peer Theory:**

When adolescents experience puberty, they are often filled with many questions and substantial changes (Brown, Halpern & L’Engle, 2005). As adolescents
begin to become sexual beings the sexual content in media may become more interesting (Pardun, L’Engle & Brown, 2005). Generally, individuals will seek the information necessary to assist with explaining ongoing changes, like those seen in puberty (Brown, Halpern & L’Engle, 2005). Research has already shown the large amount of sexual information, which can be obtained from the media.

The super-peer theory operates on the premise that adolescents choose who they want to be or who they relate to in the media. This theory supports the notion that adolescents imitate the behaviours of those individuals they want to be most like (Escobar-Chaves et al., 2005). When sexual depictions are displayed in the media, an adolescent may find the actions appealing if the adolescent favours the person in the media. In addition, adolescents may view the media as less embarrassing and critical of questions regarding their changing bodies and development. This non-threatening perception of information in the media may cause the adolescent to seek the media for sexual information, which transforms the media into a kind of “super peer” (Brown, Halpern & L’Engle, 2005). All of these theories establish that adolescents are influenced by mass media and that they believe the situations in mass media are real. The mass media seeks out adolescents as potential consumers for their products. The sheer number of adolescents and their spending power make them an ideal audience for advertisers to target. This could lead the mass media to tailor their marketing strategies to entice adolescents into purchasing or consuming their products. The theories and models which were discussed, i.e. social learning theory, priming theory, media practice model and super peer theory provide a framework for explaining how mass media influences an adolescent to engage in sexual behaviours. Each theory/model explores unique area of an adolescent’s life. The social learning theory has a focus on social encounters of sexual behaviours in the media being an influence for the adolescent to engage in sexual activity. The priming theory states adolescents are motivated to engage in sexual activity shortly after viewing sexual content in the mass media. The media practice model indicates an adolescent values the information in media, and the information influences how they perceive the information. The super peer theory maintains the position of the mass media influencing adolescents to imitate the behaviours of individuals they want to be most like in the media.
Childhood Sexual Development (9 – 12 Years) :
- Period of significant change.
- Enter puberty – Physical, social, emotional aspects.
- Increased peer contact.
- Increased experimentation.
- Inhibition may increase / decrease.
- Continue to learn society expectations about gender roles and behaviors.
- Develop sense of expectations concerning adult roles and behaviors.


Childhood Sexual Development (13 – 18 Years) :
- Developing sense of identity and values.
- Experimenting with sexual activities.
- Puberty continues.
- Separation from family, developing relationships with peers.
- Developing sense of privacy.

SIECUS, Tepper, M. (2001)

Report on Teen Pregnancies

The phenomenon of teenage pregnancy seems to be a worldwide trend with countries like the US and UK reporting high rates along with India and others in South Asia. Latest data suggests that teen pregnancy in India is high with 62 pregnant teens out of every 1,000 women. In comparison, 24 British teens get pregnant before their 19th birthday while the figure is 42 in the US.

In India, the problems are very different grappling issues like early marriage, illiteracy and high infant mortality could be possible. causes for the high number of young girls getting pregnant between the ages of 15–19. India’s neighbours Afghanistan (113), Bangladesh (125) and Nepal (115) are also plagued by similar problems with younger women getting pregnant. Interestingly, the number of pregnant teens in Pakistan is much lower at 36.

The report points out that the number of women dying as a consequence of pregnancy and childbirth are unchanged since the 1980s, at about 5,36,000. Many
times that number, between 10–15 million, suffer injury or illness. Lower maternal mortality, and avoiding injuries such as obstetric fistula, depends on better care in pregnancy and childbirth, emergency services in cases of complications and access to family planning. It adds that while some poor women do want fewer children, cultural constraints hold them back.

The report suggests accepting cultural constraints of each country and working in tandem with it. “The key to reproductive health is making motherhood safer through access to family planning to reduce unintended pregnancies and to space intended pregnancies and provide skilled care for all pregnancies and births,” it says. Teen pregnancy in India is high with 62 pregnant teens out of every 1,000 women. In comparison, 24 British teens get pregnant before their 19th birthday while the figure is 42 in the US.

In India, issues like early marriage and high infant mortality are possible causes for high number of young girls getting pregnant between the ages of 15–19 (The Times of India, New Delhi, Nov. 14, 2008, Section : Times Nation, p. 18).

**Conceptual Framework of Interplay between Explanatory and Outcome Variables Studied by Wouhabe Maria**
From background study it reveals the following aspects:

1. Real situation of sex education in West Bengal.
2. The true picture of introducing sex education in school curriculum in West Bengal school.
3. Review of literature provided adequate content area for the tool preparation.