Sex Education: Role of Mental Health Professionals in India

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Abstract

Sex education in India is a victim of competing interests. On the one hand, there exist deep societal taboos against public discussions on sexuality and on the other, a young and rapidly growing population creates unprecedented requirements for new thinking on sexual health. Placed in the interface of this conflict, mental health professionals need to carefully consider the context and aims of sex education. Here, we present an overview of the key debates surrounding the development of an appropriate curriculum for sex education, and the role of the mental health professionals in relation to other key stakeholders (e.g., educationists, parents and peers, and civil society members).

Introduction

India represents a particular paradox in the field of sex education. There has been a historical policy push towards regulating sexual activity, with India being the first developing country to formulate a family planning policy as early as 1951 [1,2]. The motivation varied from a need to control a burgeoning population, to the more recent need to control sexually transmitted infections, including HIV. At the same time, India remains a deeply conservative society, where discussions of sexual activity have been considered a taboo [3,4]. Health professionals must negotiate this conflict frequently in their practice, since it is one that is intimately connected with health outcomes. It is also one in which the transmission of appropriate information demands expertise, and skills to engage with the prior beliefs of the audience.

What Is Sex Education?

Literature abounds in terms that are roughly equivalent to sex education-'Family Life Education', 'Lifestyle Education', 'Adolescent Education', 'Family Planning Education', and so on. Apart from reflecting societal needs to use euphemisms while talking about sexual activity, they also represent differences in the scope and curriculum of sex education [5]. Knowledge about sex is conveyed either informally or formally by peers, by parents or other adult caregivers, by teachers, or by health professionals; and the expected outcome of this education naturally varies with this context [5–8]. Here, we shall restrict ourselves to the aspects that are related directly to the WHO's definition of sexuality:

"Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thought, fantasies, desire, beliefs, attitudes, values, behaviours, practices, roles and relationships [9]."

The above definition makes it clear that discussions of sexuality cannot easily be separated from their relational context. We will discuss the general issues relating to providing information about sexuality and sexual relationships to groups, as this is the context in which the term 'sex education' is most often used. Therefore, this article will not discuss individualized information that might need to be conveyed in a clinical context, which are more often part of mental health professionals' daily practice. It is within this framework that we would strive to define a role for mental health professionals.

What is the Purpose of Sex Education ?

Sex education has several purposes, which will be dealt here in detail.

The importance of sex education cannot be over-emphasized. First and foremost, sexuality in all its dimensions comprises an important aspect of human behavior, and being able to regulate one's own sexual urges and behavior is part of living a healthy life. As is the case with other complex behavior, there is an intricate interplay of sociological, psychological and physiological factors that are involved, and need to be accounted for in discussions of sexuality. At the same time, misconceptions about sexuality are highly prevalent, as demonstrated by surveys [3,10,11]. The rates of unplanned and early pregnancies remain high [12], and are associated with high rates of morbidity and mortality [13].

Adolescence is a particularly risky period, with studies showing that women are at the highest risk for intimate partner violence and sexual violence between the ages of 15 and 17 [14]. A considerable proportion of the AIDS burden in India lies amongst the adolescent population. Studies conducted by the Department of Child Welfare have come up with a disturbing finding that a majority of children have experienced some form of sexual abuse [15]. Sex education remains an important component of the efforts to tackle all these health-related problems, and is therefore, a priority for educators and health professionals.
While doing so, educators must be aware of certain issues.

- **The social construction of gender, and the prevalence of gender stereotypes:** That might be unintentionally reinforced by the educator (that women do not initiate sex or explore

sexual relationships; that women must dress modestly to avoid sexual assault; that sexual victimization affects only women; and other issues related to consent for sexual activity).

- **A life course perspective:** The information that needs to be conveyed depends on the age and gender of the recipients. Some advocates for sex education have argued that sex education is best initiated at an early age, in order to cover all aspects including identification and protection against childhood sexual abuse. This has shaped the sex education curriculum in a number of countries [9,16]. Others have suggested that discussions on sexuality are best restricted to those who are married, as being more representative of sexual expression in Indian culture [17]. Another school suggests that no general discussions of sexuality should take place.
- **The cultural context:** Surveys have demonstrated that sexual activity quite commonly occurs outside the marital context and in adolescence, both in urban and rural India, and this information must be considered in shaping institutional stances. A recent meta-analysis concluded that sex education aiming at abstinence performed poorly when compared to comprehensive sex education on a number of parameters, including knowledge of sexually transmitted infections, and age at initiation of sexual contact [18].
- **The social realities of the subject:** Examples from the west may not be appropriate while discussing the relationship between sexual experimentation and parties, drinking or dating, which are often used in manuals of sex education when they are transposed directly from the western context [4]. Differentiated opinions on sexual activity, ranging from strong support for abstinence and a heterosexual orientation, to more liberal views, the entire gamut of sexual experiences may be discussed during the sex education course.

The Indian Context

Surveys on sexual activity

A number of surveys have shown an early age of sexual activity, particularly in metropolitan areas. The average age of first intercourse in two surveys in Mumbai, for example, was found to be between 13 and 14 years of age and other surveys amongst school-going and college-going adolescents have data to suggest that anywhere between 14% and 40% of young men, and between 5% and 40% of school-going and college-going adolescents are sexually active [11,19]. These surveys are likely to represent only the populations in which the studies were conducted (the educated urban on the one hand and the under-privileged urban on the other) and may not be universal to the entire population. Researchers have also had to negotiate cultural sensitivities while surveying minors, including taking consent from parents and teachers (this may have introduced a selection bias). However, they do run against the general impression of India being naturally conservative, and suggest that it would be wrong to conflate sexual activity and marriage, even in the Indian context.

This data may also be supplemented by the data which suggests that under-age marriage, particularly for women, is still a reality in India, and that for a number of Indian women, the first pregnancy still occurs in the adolescent period.

Knowledge about sex

The above mentioned studies as well

as others have also delved into the respondents' knowledge and attitudes towards contraception, safe sex, and HIV/AIDS. These studies indicate that a vast majority of adolescents do not have access to knowledge that would be essential for them to avoid high-risk sexual intercourse and the consequences there of [20].

Curricula

The National Council for Educational Research and Training (NCERT) has brainstormed including sex education in schools since 1993. However, a curriculum for sex education was finally introduced in 2006/2007 under 'Adolescent Education Programme' which was produced in collaboration with the National AIDS Control Organization (NACO) and UNICEF [21]. This programme was withdrawn after several states protested against including sex education in the school curriculum [22,23]. Some states have gone on to produce their own sex education curriculum, and these texts have been subjected to criticism [4]. This troubled course probably reflects difficulties in achieving a consensus that satisfies the competing requirements—scientific, political and social. Interestingly, a survey of teachers in Delhi demonstrated overwhelming support for giving some kind of sex education to school children, although it was met with opposition on including topics related to pre-marital sex, masturbation or abortions [24].

How Mental Health Professionals Get Involved ?

Mental health professionals may have to deal with discussions on sexuality as part of their daily clinical practice. Traumatic sexual incidents such as childhood sexual abuses are well documented risk factors for development of depression, personality disorders and schizophrenia in later life and may be linked with depression, adjustment disorders, anxiety disorders or post-traumatic stress disorder. Alternatively, alterations in sexual activity may be part of a mental illness.

In addition to these clinical presentations in which mental health professionals may encounter persons in need for accurate information about sexuality, a number of other situations must be borne in mind which may require additional questioning, and may be incidental to the presentation, but may carry great relevance.

- Those with alternate sexualities and gender incongruence, which are associated with difficulties in adjusting to these differences
- Children or adolescents who are in need of support while adjusting with sexual development and sexual relationships

What is the Role of Mental Health Professional ?

The first and most important role for mental health professionals is to serve as advocates for appropriate sex education. Professional associations particularly must recognize that this is an important area where mental health professionals need to formulate their position, making use of the best available evidence. Such a position must recognize the importance of sex education as mentioned above, and should be culturally appropriate. In our view, this must be based on an understanding of sexuality and its contributions to a healthy life.

As discussed previously, sex education is disseminated through a number of outlets, and the quality of this information varies considerably

with the source. It would be difficult to single out one section as being primarily responsible for sex education responsibilities. Mental health professionals' roles, therefore, would necessarily be collaborative with the other stakeholders such as parents, educators and civil societies and government bodies. At each level, it would be necessary to recognize the relative strengths of each contributor. Mental health professionals may be able to contribute in various ways, but particularly in assisting with the development and dissemination of a curriculum that integrates physiological and biological information with an understanding of the psychological and developmental elements that are part of adolescent sexual activity. Another possible role for mental health professionals is to collate data on the current status and population needs for sex education, and to evaluate intervention programmes by designing appropriate studies.

Conclusion

Although sex education has been recognized as an important tool for encouraging adolescents towards healthy relationships, they have not been successfully implemented so far in India. A curriculum that is backed by scientific evidence, pragmatic about adolescent sexual experimentation, while accounting for cultural sensitivities, needs to be developed after wide consultation. Mental health professionals have a duty to collaborate with other health professionals, educators and civil society groups, to assist in developing and implementing such a curriculum.

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