CONTESTATION AND CONSENSUS ON SEX EDUCATION IN INDIA

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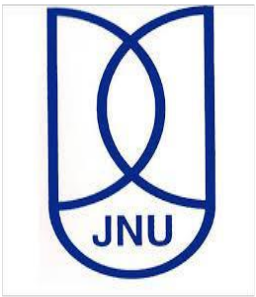

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DECLARATION

I declare that the dissertation entitled "**CONTESTATION AND CONSENSUS ON SEX EDUCATION IN INDIA**" submitted by me in partial fulfillment of the requirements for the award of **MASTER OF PHILOSOPHY** is my original work. It has not been previously submitted for any other degree of this University or any other university.

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Doiphode Pradnya Ramesh

TABLE OF CONTENTS

ABBREVIATIONS

AEP	-	Adolescence Education Programme
AEP+	-	Adolescence Education programme plus
AIDS	-	Acquired Immunodeficiency Syndrome
AJWS	-	American Jewish World Service
BJP	-	Bhartiya Janata Party
CINI	-	Child in Need Institute
CSE	-	Comprehensive Sexuality Education
FPAI	-	Family Planning Association of India
GMHC	-	Gay Men's Health Crisis
HCF	-	Human Capability Foundation
HIV	-	Human Immunodeficiency Virus
ICDS	-	Integrated Child Development Scheme
ICPD	-	International Conference on Population and Development
IPPF	-	International Planned parenthood Federation
IWHC	-	International Women's Health Coalition
KVS	-	Kendriya Vidyalaya Sangathan
MHRD	-	Ministry of Human Resource Development
NACO	-	National AIDS Control Organization
NCERT	-	National Council of Educational Research and Training
NDA	-	National Democratic Alliance
NGO	-	Non-governmental Organization
NIOS	-	National Institute of Open School
NPEP	-	National Population Education Programme
NVS	-	Navodaya Vidyalaya Samiti

RCH	-	Reproductive and Child Health
RFSU	-	The Swedish Association for Sex Education
RSS	-	Rashtriya Swayamsevak Sangh
SCERT	-	State Council of Educational Research and Training
SIECUS	-	Sexuality Information and Education Council of the United States
SRHR	-	Sexual and Reproductive Health and Rights
STI	-	Sexually Transmitted Disease
TARSHI	-	Talking About Reproductive and Sexual Health and Issues
UN	-	United Nations
UNFPA	-	United Nations Population Fund
UPA	-	United Progressive Alliance
WHO	-	World Health Organization

INTRODUCTION

This dissertation is about illustrating the trajectory of the discourse and practice of sex education in India. The purpose of this study is to understand how the discourse and practice of sex education has evolved since its inception by locating it in a general history of sex education, what has been the rationale of the discourse and practice of sex education on part of the Indian State and how have non-governmental organizations contributed differently in the discourse and practice of sex education in India. The Indian State's role in the addressing sex education will be juxtaposed against a general history of sex education. A crucial element of this study is to simply layout the different application of sex education over the course of twentieth century.

RATIONALE

The understanding of sex has evolved. In the academic world sex was understood as a biological identity and now has been recognized as a 'cultural object'. But given the popular meaning of sex as intercourse then sex education as an idea has emerged to enable young people with the information and knowledge to responsibly engage in it. The immediate reason that drove the demand for sex education was the spread of venereal diseases (presently understood as sexually transmitted diseases). Over the decades the purpose of sex education has evolved with the changes unleashed by developments in technology, new insights by various disciplines on child sexuality and sexuality in general and difficulties in combating dire threats (AIDS crisis).

Unlike sexuality that has now become a field in itself, sex education per se is still treated as a topic. Sex education has a very limited literature base of its own. Also, the history of sexuality has relatively neglected sex education within its broader field. This is because there is no 'nuanced and interrogated narrative (Hall, 2009) that exists for sex education so far. The discourse and practice of sex education has borrowed concepts from various disciplines like sexology, psychology, behavioral science, education, anthropology and social sciences. Its status as a subject of study is almost like that which falls on the margins of so many disciplines.

Does sex education then belong to the history of education and pedagogy? Or given the close connection between concerns over sexual health of the population and arguments

for better and relevant sex education is it associated with the history of health? As sex education focuses on the age group of adolescents and young people does it have its place in the history of childhood? This ambiguity on where exactly sex education belongs or should be positioned has remained a troublesome issue for policy makers.

Sex education in this dissertation is treated in its broadest sense that incorporates many aspects of both formal and informal avenues that shaped sexual knowledge. The formal avenue includes the officially sanctioned and regulated sex education in the schools by the State. This also include the educational programmes and alternative curriculum designed by non-governmental organizations. The informal avenue includes sex education imparted within the private sphere of the family, peer-group interactions and the media. Both the formal and informal avenues of sex education have contributed in changing and shaping our sexual knowledge from time to time proving to be a multi-layered process.

What has remained more or less central to the idea of sex education is health/sexual health. Hence, this study positions sex education primarily within the concept of health/sexual health. In the initial duration, sex education was almost framed as a strategy for damage limitation whether it be with regard to venereal disease or loss of reputation. Sex education was almost exclusively about preventing sexually transmitted diseases embedded in an implicit decision on part of the authorities to not touch the pleasure aspect of sex.

Over the course of twentieth century sexual health came to be recognized as a crucial but least understood part of health. The World Health Organization (WHO) had defined sexual health as "the integration of the somatic, emotional intellectual and social aspects of social being in ways that are positively enriching and that enhance personality, communication and love" (WHO F. C., 2010). The growing attention that sexual health received as a result of concerns over sexual hygiene and political mobilization of the health cause in the 1950s by feminists have allowed new concepts to emerged and revision of old ones. The revised definition of sexual health by WHO is- "Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (WHO, accessed 2018).

Post 1990s a significant concept that emerged in relation to sexual health has been-reproductive and sexual health and rights. The demand of feminists in the Cairo Conference of 1993 and the recognition of Reproductive and sexual health as important to macro goals of population stabilization of the globe and micro goal of prioritizing women's health have resulted in crucial developments within the arena of sexual health. The efforts to ensure sexual health for all within the framework of rights began post 1950s and have crystallized after Cairo Conference. Both reproductive and sexual health has radically changed the way the discourse and practice of sex education by framing reproductive and sexual health within the framework of human rights and extending that framework to claim sex education as a human right. This has provided impetus to non-governmental organizations to move sex education on the policy agenda in India.

Without social acceptance and provision of finance taking up any research is difficult. Research in the field of sex education lacks both. Hence, research in arenas such as family planning, HIV/AIDS prevention and reproductive and sexual health have mentioned the need for sex education in schools in India. Other than articles on sex education or CSE research on sex education is hardly present. Also, research on HIV/AIDS prevention have increasingly moved towards proposing a comprehensive approach to imparting sexual information driven by the fact that HIV transmission mainly happens through sexual intercourse.

The existing literature that have studied sexual behavior of men and women in India are mostly quantitative in nature. Quantitative researches lack the understanding of the inability to capture sexuality or sexual behavior in terms of number. Moreover, there are hardly researches that have explored and understood 'how gender and power operate in affecting people's, particularly women's sexuality' (Chandiramani, Kapadia, & Khanna, 2002).

The significance of the transition that the idea of sex education has gone from its inception to its contemporary understanding reflects the transition that sexuality and sexual health as concepts has undergone too. The understanding of sexuality has changed from being understood as a limiting factor within the earlier framework of sexual health to an enabling factor that has the potential to experience pleasure and wellbeing. Ongoing research continue to change the ability of humans to exercise and

determine their sexuality. This ability to exercise sexual agency also demands on the part of the individual to self-regulate his/her sexual behavior so as to adopt safe sex practices. The State has always regulated sexuality in the public domain but in the contemporary times it has the responsibility to provide not only sexual health facilities but also knowledge that enables individuals to ensure their sexual health and agency.

This study has focused on the examination of the discourse and practice of sex education in India. Firstly, the study begins with tracing of the origin and evolution of sex education from the literature on historiography of sex education in Europe. Followed by using this general history of sex education as a background to study the Indian context.

It is not within the scope of this study to evaluate or pass a value judgement on the work of the Indian State and the non-governmental organization with regard to the kind of sex education programmes it has formulated. Nor has this study interpreted which formulation is correct. This study only lays out the different sex education programmes existing and their limitations.

As sex education has been placed within the sexual health framework the study has used secondary and primary resources coming from mainly scholars within the area of health (sexologists, psychologists, health academicians). Sex education can also be studied from the perspective of education. Within the framework of education focus will fall on the pedagogy of sex education.

HYPOTHESES

1. Sexuality Education enables adolescents especially girls to have an agency over their body.
2. Sexuality Education has an affirmative impact on the sexual health and behavior of young people.

RESEARCH METHODOLOGY

This study looks into the ideational evolution and relevance of sex education within the limited historical developments from late 19th century to its present-day concept of Comprehensive Sexuality Education (CSE). Against a general history of sex education, I am juxtaposing the Indian State's experience of struggling with the acceptance and provision of sex education to its young population. Secondary literature has been used in drawing out a general history of sex education and in illustrating the role of Indian State in addressing and conceptualizing its version of sex education.

I have interviewed Amita Dahanu and Shivrudra Lupane from Family Planning Association of India (FPAI) on the contribution of FPAI in the field of sexual health and imparting sex education and the organizations' stand on CSE and its advocacy. Shivrudra Lupane interviewed on 6th July 2017 gave an overview of CSE as an emerging concept and FPAI designed CSE curriculum. On the other hand, Amita Dahanu interviewed on 11th March 2018 narrated the transition of FPAI's population education to its present efforts to impart Comprehensive Sexuality Education to adolescent. FPAI factsheets and annual reports that are available on its websites have also been used. As sex is a sensitive and controversial topic it took time for me to pursue and gain trust of people in FPAI to make them understand my genuine interest in doing this research and the reason to choose the organization as a case. I made used of the youtube videos that TARSHI has uploaded on the internet. One video is on the discussion on CSE with parents and another is about Radhika Chandiramani's views on adolescence education programme and CSE in India. I have also used publications and online resources from the TARSHI website.

CHAPTERIZATION

This study has three main chapters connected by the central argument that there has been a significant shift in the discourse and practice of sex education over the course of 20th century.

Chapter 1 attempts to bring out a brief history of sex education particularly borrowing from the instances of countries in Europe. The discourse on sex and sexuality has been molded by three models namely religious or moral, biological and social that emerged successively. The parts within the chapter intends to bring out how these three models

have influenced the discourse and practice of sex education in countries like Sweden and Germany in the early half of the twentieth century; Scotland and Italy in the second half of the twentieth century. Further the chapter illustrates the significant developments that resulted in the second half of the twentieth century in the emergence of the discourse on sexuality, sexuality education and consequently Comprehensive Sexuality Education by the end of 20th century.

Chapter 2 attempts to illustrate the progression of the discourse and practice of sex education in India in the second half of the twentieth century and the stand of the Indian State on it. As sex was a taboo subject the pioneering initiatives to introduce the idea of imparting sex education to young people were taken up by individuals. The Indian State's overarching concern in the second half of the twentieth century was population control. Population education that aimed at promoting family planning programmes and philosophy of planned family had sex education as the much neglected and least comprehended part. Though population control remains an important concern, the arrival of AIDS crisis in 1980s, its proliferation in 1990s among adolescent population and other significant developments that happened in the 1990s gain the State's attention and response in the form of Adolescence Education. Consequently, the Adolescent Education Programme that aimed at providing necessary information about the body and the process of growing up during adolescence was introduced in the early 21st century.

Chapter 3 primarily focuses on the contribution of two not-for-profit organizations namely the Family Planning Association of India (FPAI) and Talking About Reproductive and Sexual Health (TARSHI) in the course of sex education in India. The significance of this chapter is in bringing out the limitations of the Adolescence Education programme of the State and the stand of FPAI and TARSHI on advocating Comprehensive Sexuality Education in India using the framework of human rights.

The concluding chapter summaries the findings and observations drawing from the three chapters. The concluding chapter also point out the gaps in the existing literature that provide future possibilities of research.

CHAPTER ONE

THE HISTORY OF SEX EDUCATION

Sex Education has been recognized globally as the key to make young people aware of their sexual health. But what were the reasons that led to the demand of sex education in the first place? When did we start imparting sex education and how and why has its content and understanding changed in the contemporary times?

The purpose for which sex education was introduced has not remained the same today. In the late 19th century Europe sex education began in order to reduce the spread of venereal diseases. It began with the intention to teach the young importance of particularly sexual hygiene and reproduction. Today we have Comprehensive Sexuality Education (CSE) that has moved beyond the intention of merely providing information to young on sexual and reproductive health. It has now encompassed aspects such as sexual and reproductive rights, developing knowledge base and skills that enables one to take charge of one's sexual health and to determine one's sexuality. This chapter is about the trajectory of the discourse and practice of sex education from its inception to its transformation to CSE.

The understanding of sex and sexuality in the West has been molded by three models: the 'moral/religious model, the biological model, and the social model' (Mottier, 2008). Although they have emerged successively they cannot be sharply restricted to a time period and hence these models continue to coexist even today. They had important implications not only on the kind of sex education models that were formulate and imparted in different countries in Europe but also on the ways in which we conceptualize our sexual behaviors, identities, and the possibilities for personal and political transformation.

In this regard the chapter has been divided in three parts. The first part examines the religious understanding of sex and its influence on the way sex education was imparted in the late 19th century and 20th century Europe. The second part illustrate how biological understanding of sex came into being and its influence on the ways sex education was imparted in 20th century. The third part examines the challenges to biological model of sex that resulted in the development of the social model of sex.

This part also illustrates the impact of these changes on the ways sex education has come to be understood in the contemporary times.

PART I

1.1 RELIGIOUS/MORAL MODEL OF SEX AND SEX EDUCATION

Christianity being a wide spread religion in the European context produced a highly influential normative model of sex. By declaring sex as, the original sin, Christianity positioned sex decisively at the core of Christian morality. The characteristics of a moral/religious model of sex during this time was that it raised virginity and celibacy to the position of chief spiritual ideals and a fundamental mean to free the self from material obligations both for men and women. Secondly it looked at marriage as an acceptable compromise with the material world and encouraged sex only for procreation. It therefore emphasized monogamy and fidelity. Sex outside marriage and even for reasons other than procreation was seen as immoral and an obstacle to spiritual salvation.

As sex was seen as an important and powerful distraction from spirituality Christian ideas and practices were very hostile in handling sex issues. A key influence in this sort of means to check on sex was Augustine (354-430 AD). The doctrine of 'original sin' held sex as the main cause of removal of Adam and Eve from the Garden of Eden as described in Genesis. The founding fathers of Western Christianity Augustine being one of them placed this doctrine at the center of religious preaching. According to Augustine sex is the original sin because divinity or God is averse to bodily desire and lustful sex. Hence, sex is what keeps men attached to the materialistic world by weakening the moral determination to attain spirituality.

The taint of sin was thought to pollute humans from the moment of birth. A new born baby was described as the seedbed of sin. Regulation of sex thus would begin from the birth onwards. Even if sex was seen as a sin, consummation within marriage was important and non-consummation was declared as legitimate ground for divorce. This was because the Church father realized that firstly majority of believers would not prefer to adopt the Christian ideal of celibate life. Secondly, the act of procreation was vital for the continuity of human race. Marriage was thus seen as an acceptable

compromise, a mode of preventing polygamy and was praised as a building block of the society. Christianity took over 1000 years to firmly establish itself in Europe and regulated very closely the most instinctual and irresistible force-sex. it further created institutional mechanisms such as confession of personal sexual truths and rigorous examination of one's own conscience fostered by the Reformation. However not all religions looked at sex with such stern hostility. Judaism disapproved of complete sexual abstinence which it saw as an obvious impediment against God's directive to be fruitful and multiply.

1.1. (A) THE DEMAND FOR SEXUAL KNOWLEDGE

The rigid and dogmatic Christian ideas, ethics and religious practices came to be challenged during the Age of Reason -17th century onwards. The Scientific Revolution that lasted throughout 16th and 17th centuries led by ideas and works of mainly Galileo, Copernicus and Isaac Newton resulted in science becoming a distinct and separate discipline from philosophy. The following 18th century further saw ideas like freedom and reason challenging the superstitions and arbitrary powers of the State led by Church authorities. The consistent attack that the Catholic Church and State faced from 17th century onwards coupled up with scientific discoveries encouraged development of an ethos of sexual libertinism in Europe. This is evident from the use of condom that began in the 17th century by the aristocratic elites first and was made up of sheep intestines then. Rubber condoms became available from the 1850s onwards. Rubber condoms were primarily used as protection against venereal diseases by men who had sex with prostitutes (Mottier, 2008). Abortion was disapproved by the Church but was largely acceptable across Europe if done before the fourth month of pregnancy. The abortion industry was flourishing from the 19th century press that allowed public advertisement of methods of abortion. However soon abortion came under State regulation and was criminalized in the course of the century.

Industrial modernization unleashed rapid social, economic and political changes that intensified cultural concerns about sex resulting from the linked processes of industrialization, urbanization and secularization. The urban industrial spaces attracted increasing number of population leading to crowding of cities. The transition from an agrarian to an industrial society marked by decreasing importance and control of religion created large urban masses of atomized individuals, living in difficult working

conditions and crowded spaces. The industrial society was marked by stress resulting from the difficult working conditions and crowded spaces which encouraged an underworld of dance halls, drastic rise in the accessibility of pornographic material intensified by print technology and prostitution. The thriving of such an environment raised concerns over the declining public and private morality that religious reforms groups claimed resulted from sexual libertinism and the medical literature warned of spread of sexually transmissible diseases as harmful to personal and public health.

By the late 19th century a significant transition became evident. Men and women were increasingly turning towards medicine for seeking advice and explanations on sexual matters. Sexual behavior and concerns which were dictated by religious morality was losing its influence and clergies were slowly getting substituted by medical experts as the source of information on sex. The industrial market found its new niche in the form of sexual hygiene goods and services. Crowding of the cities and close interaction amongst the people was increasingly making precaution from venereal diseases a need rather than choice for maintaining public health. The State's urge to increase its power against that of the Church meant promoting scientific ways of dealing with personal and intimate issues like sex over which the Church since long had the sole authority. Medical experts arguing that sexual repression cannot be the answer for increasing instances of spread of venereal diseases suggested initiatives such as sex education to make people aware of about sexual hygiene and ways to prevent venereal diseases.

Sweden by the end of the 19th century was characterized by poor health, wretched living conditions and social problems. The labor and feminist movements were newly emergent social forces. Public health was in an alarming situation because of the rising incidence and moral panic surrounding venereal diseases that triggered an increasing call for educational initiatives (Lennerhed, 2009). The issue of sex education was first introduced in Sweden in the year 1897 by Karoline Widerström. Widerström started to educate girls in their upper teens particularly about sexual hygiene and also on the anatomy, physiology and reproductive aspects of the body (Lennerhed, 2009, pp. 55-70). Widerström was Sweden's first woman physician, gynecologist and a member of the women's liberation movement. She was of the view that sex education belonged primarily to the arena of biology but her social ideas and ethics were influenced by her vague belief in Christianity. The religious model of sex viewed female body and

biological constitution as weaker than men and hence more prone to venereal diseases and sexual deviancy. Hence initially sex education was thought to be more important for girls rather than for boys. And so, a call for educational initiative in the arena of sexual hygiene was taken by girl's schools. It was believed that sex education would help to protect girls from unwanted pregnancies that was very much a woman's problem. Furthermore, since girls' sex drive was held to be virtually non-existent, sex education for girls was considered 'safe'. Sex education for boys, on the other hand, was viewed as a more problematic undertaking that might 'awaken the sleeping bear'. Consequently, boys received little or no sex education and were correspondingly largely absolved of responsibility for their sexual behavior. The sex education through private initiatives offered in early twentieth-century Sweden through private initiatives was therefore very limited as a consequence of the gendered perception of the educational needs of girls and boys.

PART II

1.2 THE BIOLOGICAL MODEL OF SEX AND SEX EDUCATION

1.2.(A) SEXOLOGY

Developments in medical science gave impetus to modern ways of looking and understanding sex driven by science and rationality. A new discipline was born around the turn of 20th century that being- the science of sex (sexology). A major impetus to sex research came from growing concerns of public health particularly prostitution, sexual hygiene and venereal diseases. Medical science had only looked at the objective side of sex that being venereal diseases. Sexology on the other hand started scientific studying of not only sex but also the subjective realm of sexuality. In the process of constituting and exploring a new continent of knowledge (Weeks, 2014, p. 184) sexology was radically changing the ways in which social meanings attached to sex were understood. Sexology significantly contributed in developing the biological model/understanding of sexuality.

According to the biological model the subjective real of sexuality stemmed from the objective realm of the material existence of a sexed body. The sexual behavior and

instinct to reproduce resulted from the existence of sexual organs that every reproductive being has as a part of its biological setup. Hence this model conceptualized the human reproductive instinct as the norm and a variety of sexual behavior came to be looked at from the stand point of this norm. Nevertheless, sex was still considered an instinctual and hence irrational force powerful enough to cause social disorder.

Having assumed and declared normal sexual behavior the early sexologists and pioneers such as Krafft-Ebing, Hirschfeld, the Austrian Stekel, the Swiss Forel, the French Fere and Thoinot and the English Ellis began with the study and detail description of sexually abnormal behaviors. They came up with a variety of labelling, classification of the deviant behaviors from the norm and invented new exotic taxonomies some of these being fetishism, transvestism, hermaphrodism, sadomasochism (Garton, 2004) and many others.

1.2 (B) GENDER AND SEXUALITY

An important characteristic of this biological model was its biologization of gender difference. The traditional idea of body was hierarchical (often referred as one-sexed body) considering the male body to be superior and the female body to be the inferior version of male body (with female genitals understood as under evolved version of male genitals). However, the biological model claimed that bodies of men and women are biologically different because the function of female body is different to that of male. The biologically difference was used to argue for firstly women's inferior intellectual capacities by some like the 19th century English evolutionist Herbert Spencer which was further validated by the claim of basic difference in cell metabolism and sex hormones by biologist Patrick Geddes (Laqueur, 1992, p. 6). Secondly, women were continued to be excluded from entering the public sphere and politics by using the argument of biological inferiority of women to legitimize the exclusion. Third the biological difference justified the different social roles assigned to men and women and the difference in their sexual needs and behavior. Hence, the biologization of gender did not challenge the gender hierarchy. But it in turn gave a scientific legitimacy to the gender hierarchy. Consequently, men's sexuality was seen as naturally violent, promiscuous and powerful and women's sexuality was understood in relation and as a response to men's sexuality. The prevalent public opinion of the time saw masculinity as men being actively sexual and femininity as women being passive or asexual. This

was backed by sexologists who would reiterate the double sexual morality of the time. Sexology did not constitute as a homogeneous field and hence there were sexologists like Havelock Ellis who differed from the popular opinion on sexuality. This reorganized experts in the field with different institutional and political agendas and often led to tensions and controversies within and in response to sexology with mixed public reactions (Mottier, 2008).

Another assumption of the 'biological model of sexuality was that 'natural' sexual behavior included only heterosexual practice and desires' (R) for procreative rather than recreational reasons. Homosexuality was conceptualized to be an abnormal deviation from the norm also because it had no association to procreation and hence was considered to promote promiscuous behavior (Mot08). Homosexuals were seen as threat to the moral and social order of the society because they engaged in deviant sexual practices. The religious model of sex saw homosexuals as sinners whereas sexologists argued that homosexuals were deviant people in need of a treatment. Among the early sexologists, some saw homosexuality as inborn rather than a disease. Anything falling in the category of abnormal was problematized and investigated with the intention of thinking about ways either therapy, chemical or surgical including castration to correct these abnormalities.

1.2. (C) CHILD SEXUALITY

Prior to eighteenth century children were considered naturally wicked and corrupt. Driven by the fear of child masturbation emphasis was laid on surveillance and regulation by the state and civil society. However, during enlightenment the belief grew in the sexual innocence of children which shifted the emphasis from surveillance to raising of the age of consent for sexual relations (Sauerteig, 2009). This is when the intellectual reshaping of the modern concepts of child sexuality, childhood and adolescence began and fully emerged at the start of the twentieth century with the works of Sigmund Freud. In the second essay among the Three Essays on the Theory of Sexuality (1905) Freud for the first time had voiced his claim that children are born with the seed of sexual urge (Lennerhed, 2009, p. 2). In detail he discussed that babies start developing sexual feeling with acts like thumb-sucking, touching or exhibiting their genitalia, or showing interest in watching other people's genitalia. But he

explained such a behavior of children as part of a normal childhood that rarely a child escape (Lennerhed, 2009, p. 2).

As reflected in the anti-masturbation campaigns of the period, official discourses still tended to portray the child as ideally asexual and innocent and any sexual feelings as deviant and pathological. Christianity was anyways obsessed with child masturbation and ways of civilizing the sexual appetite of children. Children's sexuality now received increasing attention not only from psychologists but also from range of other experts like biologist such as Alfred Kinsey, behavioral scientists and educationalists such as Ronald and Juliette Goldman and sociologists such as Stevi Jackson. When different disciplines started to study sexual feelings and sexual behavior of the young it subsequently changed what was formerly considered as immoral or sin and was explained as phases in a child's 'normal' development.

1.2. (D) SEX EDUCATION: DISCOURSE AND PRACTICE (in the first half of the twentieth century)

This section focuses on the debate, discussion and state's participation in molding and imparting sex education in Sweden and Germany. Sweden and Germany are highlighted in this section as the discourse of sex education was initiated and imparted at the earliest.

- SEX EDUCATION AND SEXUAL POLITICS IN SWEDEN

Sex education debate received an official response only after the Social Democratic Party came to power in 1932. The Swedish State governed by the Social Democratic Party intended to bring about extensive social reforms and form a society based on the principle of equality. The Population Commission initiated to reform social attitudes towards sexuality through its report of 1936- The Sexual Issue. Driven by the leadership of socio-democratic couple Gunnar Myrdal (1898-1987) the economist and his wife Alva Myrdal (1902-86) the behavioral scientist, the Population Commission suggested an unbiased and open discussion on sexuality leading to a sex education policy and practice that is based on a modern and scientific mindset. Both Karolina Widerstrom and the Population Commission shared the Enlightenment driven idea of a child being unspoiled and full of curiosity and also that sex education belonged primarily within the biology curriculum. The Myrdals also intended to address the gender issue and the

double standard morality of the time by proposing an equal sexual partnership that engaged in sex not only for procreation but also for pleasure (Lennerhed, 2009, p. 59).

In 1932, the Socialist Physician Association was established which had a pronounced social and political perspective on sex education. In 1933, the Swedish Association for Sex Education (RFSU) was founded by Ellis Ottensen-Jensen (1886-1973) together with some socialist physicians and representatives of trade union. The political spectrum on the issue of imparting sex education in schools had on the radical side the Socialist Physician Association. The RFSU held scientific perspective on sex education guided by medicine, psychology and sociology. The Population Commission held secular view on sex education trying to balance both traditional and modern values. The influence of the biological model of sexuality was clearly apparent in Widerstrom's views who looked at female sexuality from the biologized gender prism. The Church looked at sex education purely from the point of view of marriage, family and procreation. The Socialist Physician Association had the Popular Journal for Sexual Education which linked sex education closely with political consciousness. The physician Gunnar Inghe in the journal of the Association had argued that sex education serves as a weapon in the hands of the working class for a better social order. Further expanding that sexual knowledge of the body has a liberating effect that would allow young to better understand their identity and develop into a critical youth. By this time there was a larger consensus on having sex education. The Church strongly pushed for the moral aspect as a norm that should rule the content and delivery of sex education. On the other hand, feminists, socialists and physicians largely pressed for scientific and biological aspect to be the norm.

In 1940 fifteen women's organizations collectively organized a campaign demanding school classes on sexual hygiene and training teachers in the subject matter to the National Agency for Education. As the National Agency would train only fifty teachers per year the RFSU came forward and instituted courses to train teachers. At the backdrop of early 1940s was World War II during which Sweden was governed by a coalition government. The position of the Minister of Education and Ecclesiastical Affairs was held by a leader from the conservative party. Following this in 1942 the government proclaimed provision of sex education in elementary schools and in this regard a committee was formed. The highlights of the committee were- firstly the

classes would be conducted by regular teachers who were trained, secondly the guiding principle of sex education instructions was to be marriage, family and procreation and thirdly biological facts on certain issues to be imparted separately to boys and girls. The Committee's proposal was criticized by RFSU and Population Commission as lacking scientific narration, being too moralizing and excluding discussion of issues like sexual intercourse and premarital relationships thereby reinstating silence and stigma about them. Despite criticism hardly any changes were made and the government went ahead with the committee's proposal. In 1949, talks for imparting sex education to students aged 15-17 also emerged. Overall in maintaining the balance between moral and biological approaches what resulted was a sex education that largely had a moral edifying tone to it as mere teaching of sexual anatomy and physiology was deemed inappropriate and potentially encouraging promiscuity. Sex education in schools finally began but continued to be the focus of agitated debates. Over the years, the Swedish Church lost much of its influence in the debate surrounding sex education in schools following which significant changes took place in the discourse and practice of sex education.

- SEX EDUCATION IN GERMANY

The common reasons that initiated the discourse on sex education in most of the European countries were concerns over spread of venereal diseases and declining sexual morality of the young. But in case of (West) Germany the racial, eugenic and anti- Semitic agendas gave a different turn to the way debates and books on sex education looked at sexual knowledge and its application. Unlike Sweden, (West) Germany's sex education discourse's central focus was not just reproduction but also the 'pregnant body' of the woman. The German State was closely concerned about the pregnant body of the woman and the role of mothers in producing and molding the future Aryan generation. Hence, the pregnant body (not so much the woman) was brought into the public domain that received constant medical surveillance. It was not so much 'the individual' that mattered but the community and the body of the people (Sauerteig L. D., 2009).

In (West) Germany the central question was – who should impart the sexual knowledge- parents, teachers, physicians or experts or clergy. In the first half of the twentieth century (West) Germany sex education books were main source for parents to impart

sexual knowledge to their children. The official decision to provide sex education in schools came only after 1960s. West German sex education books written during the first half of the twentieth century presented the young with literature and visual images on gender roles recreating the active-passive divide with little use of biological facts and terminologies. This is evident from works of authors such as Hans Wegener, a protestant cleric's book -*We Young Men: The Sexual Problem of the Educated Young Man before Marriage* (1906) and Emanuele Meyer, a physician's book- *In Front of the Holy Gates* (1913). Albert Wolff, a physician wrote *Sexual Education: Enlightenment Hygiene* in 1938, exclusively for mothers to educate their young children on sexual matters. His work focused on biological facts but narrated heavily using medical terminologies with a religious undertone and keeping in line with the Nazi ideology. Another author Rose Woldsted-Lauth's book *Girl Today-Mother Tomorrow* of 1940 too focused on motherhood rather than explaining the sexual activity with a central message being- 'motherhood was the ultimate destiny of every woman' (Sauerteig L. D., 2009). The highlight of most of these books on sex education was that they employed a frightening narration of the childbirth moment which has often been argued as a strategy used to discourage young girls from involving themselves in premarital sex.

Socialist authors such as Max Hodann's books on sex education were regarded as contentious. He wrote books from a socialist perspective using medical and scientific language designed to be studied by children (particularly working class) themselves. Hodann was the first one to provide anatomical drawings to help children understand the medical narration. However, in 1933 Hodann was forced to flee Germany because of his contentious work. In the first half of the twentieth century the German State endorsed availability of sex education books that were conducive with its ideology. It was only in 1969 that the Federal Centre for Health Education brought out its Sex Education Atlas to be used by teachers for imparting sex education in schools for children above 14 years old (Sauerteig L. D., 2009).

One can find how mostly all books on sex education laid emphasis on the aspect of mother and motherhood. A woman's identity and her contribution to the State or community at large was seen possible only through her ability to reproduce. By

eulogizing the aspect of reproduction in women and the identity of mother, the choice on the part of the woman to not get pregnant was literally non-existent. The medico-moral understanding of sex was clearly by and large dominant and evident from the sex education books of this time. Anthropologists like Emily Martin illustrated how the scientific language of biology had gender stereotypes hidden in it (Martin, 1991 Vol 16, No 3).

Emily Martin sheds light on how biological scientist's way of describing their research have relied on the stereotypes central to culture (Martin, 1991 Vol 16, No 3). One can find significant biological insights about the human body particularly sex shaped by the cultural definitions of male and female. As the biological model of sexuality hardly posed a challenge to the biased and stereotypical social and cultural gender roles it was easily accepted by the larger public. Challenges to the biological model developed from within and with newer sex research revising the earlier conclusions.

Austria is a different case as compared to Sweden and Germany. Although Austria also initiated sex education in the first half of the twentieth century, particularly after 1930 however the model it followed was different. Firstly, because of the dominance of the catholic church the religious/moral understanding of sexuality was paramount. Secondly, the reading material on sex education particularly books mostly written by priest and theologians aimed at imparting sexual knowledge to the parents, who were to transmit it to their children.

PART III

1.3 SOCIAL MODEL OF SEX AND SEX EDUCATION

Freud and Freudian left, the study of normative sexuality and feminist critique of biological model of sex gave impetus to the formation of social model of sex. Thus, this section explores the trajectory of social model of sex. This model started to develop in the second half of the twentieth century. However, unlike the biological model of sexuality, social model did not receive popular acceptance which is brought out in the latter part of the section.

1.3. (A) FREUD AND FREUDIAN LEFT

In 1905 Freud's 'Three Essays on the Theory of Sexuality' contextualized sexuality in the social and cultural fabric. Moving away from the biological understanding of sex and sexuality as natural and synonymous to one another Freud argued that sexuality is not a natural instinct but influenced and driven by culture. Sexuality is that drive or force that is constructed for the psychological development of a child in accordance to the socially acceptable norms and is crucial in the child's development into an adult.

Within this framework, he portrayed female hysteria as a sign of the unnatural suppression of female sexual instincts and feelings. While placing central importance upon sexuality by seeing human agency as driven by unconscious desire, Freud's analyses of individual cases of hysteria and neurosis moved away from biological accounts, linking civilization and sexual repression (Hellen, 2005).

In 1936, Wilhem Reich came up with his work 'The Sexual Revolution' borrowing from Freud the importance of libido (sexual energy) but proposing a correction of his theory of the unconscious. Reich suggested that the sexual energy can be redirected into other areas of life by the subject in order to achieve normal adult identity as against Freud's claim that the libido is suppressed by the social and cultural norms for the subject to attain normal adulthood. Reich argued that sex is a positive force repressed by the authoritative norms of the society (which according to Reich was the bourgeois capitalist society) which is the cause of all neurosis. Reich also saw the family as a central agent in the social repression of childhood and adolescent sexual exploration. He saw the family model as the state at micro-level which reproduces the authoritative

and patriarchal structures at the micro-level that ensured sexual oppression of women and repression of child sexuality. Reich thus called for a sexual revolution which would liberate sexuality from its suppression by society which according to him was not possible until the social and political capitalist order is overthrown.

The Leftist and feminists' movements that emerged were to borrow heavily from 'the call of sexual liberation from the capitalist and patriarchal repression' (Mottier, 2008) that Reich and other Freudian Left called for.

1.3. (B) STUDY OF NORMATIVE SEXUALITY

The early sexologists mainly explored the peripheral sexualities that were termed as abnormal. Havelock Ellis (1859- 1939) was the one who also studied 'normal' (heterosexual) behavior. The study of normative sexuality brought out the difficulty in clearly and sharply demarcating normal and abnormal sexual practices and suggested a continuum between the two. It also questioned the understanding of biological naturalness and suggested that what we have till now understood as natural sexual instinct are varied and diverse. Later mostly after 1950s this shifted sex research from studying the peripheral sexualities to that of surveying and analyzing the normative sexualities. The known examples of such a research is the study conducted by Kinsey in 1950s of the sexual behavior of 12000 American men and women and the Hite report that surveyed sexual experiences of 15000 American men and women from 1970s onwards. These surveys reiterated the claim that normal and abnormal sexual practices are not as clear-cut as had been thought before. The Kinsey report's findings created a public uproar because it revealed that 37% of male sample had sex to orgasm with another man and most of these men considered themselves as heterosexuals. This questioned the deviant behavior of homosexuals as a minority activity of some diseased people. The biological model of sexuality was thus challenged not only from its own discourse but also from those it studied and described- the peripheral sexualities.

Ellis proposed that there might be a continuum rather than a sharp distinction between normal and abnormal sexual practices. He also pointed at that the influence of social understanding of the body on the biological assumptions of what constituted normal and abnormal in sex and sexuality. The empirical sex researches that reiterated this opened up the path for social understandings of sexuality. In short, according to the

social model, sexuality is not so much about bodily urges but about what particular societies allow to be sexually expressed or not.

1.3. (C) FEMINIST CRITIQUE OF THE BIOLOGICAL MODEL OF SEX

The first wave feminist argued that women needed protection from the dreadful repercussions of male lust deriving from both the moral and biological models of sexuality. They reproduced the predominant social perception of femininity of the time by placing the woman in the role of guardianship of public and private morality. The public -private morality of the time based female respectability on virginity or married chastity while naming the sexually active or promiscuous women as whore literally or metaphorically.

For the second wave feminist movements that emerged in 1960s and 1970s sexuality was at the heart of their agenda. However, these movements emerged in societies where the detraditionalization processes had transformed the institutions of marriage, the family and gender. Women's control over their life options increased significantly when they entered the workforce post-war that gave them greater economic independence and the emerging alternative support mechanisms of the state for the welfare purposes. Another major social change took place with the introduction of new technology in the area of reproductive control. Margaret Sanger the American birth control campaigner and eugenicist along with Katherine McCormick the philanthropist funded the scientific research and development of reliable birth control pill. The result was the invention of the modern contraceptive pill by Karl Djerassi that now became available to the Western world. Further came the IVF (In Vitro Fertilization) that allowed women to get pregnant by fertilizing an egg outside the body in a laboratory dish and then implanting it in the uterus. These new technologies not only allowed prevention of conception but also to artificially produce it if needed. Though these new technologies meant sexual freedom for women it was also criticized as another medical means of control over female bodies as there were side effects of the new product involved too. The introduction of these new reproductive technologies had the scope to radically change the conception of sexuality and sex education in the times ahead.

As sexuality became the central issue of the second wave feminist movements the slogan 'personal is political' came to be adopted. With this they argued that 'women's

‘personal’ life experiences are in fact rooted in the subordinate position that women as a group have within the gendered power structure’ (Mottier, 2008) and practices. The need for collective political action was felt to tackle the structural inequalities that led to sexual oppression at the level of women’s personal experiences. The personal/private realm was politicized because of which sexuality came to be intensely problematized and intensely discussed. Within the arena of sexuality activism since 1970s included majority of the private realm concerns like right to sexual pleasure, political lesbianism, right to say ‘no’, right to access contraceptive methods and make them more reliable, rape, abortion, sexual abuse, sexual harassment, prostitution, pornography. This introduced the politics of sex in the political domain linking the private issues to the public issues. Feminist who problematized sexuality were still a minority and had not stood as a unified whole. However, research on female sexuality increased tremendously.

Anne Koedt in her essay ‘The Myth of the Vaginal Orgasm’ argued that even the biological model of sexuality has understood and analyzed women’s body in relation and response to man’s biological need. She controversially argued that vaginal orgasm was fake and attacked the normative emphasis on vaginal orgasm. Shere Hite was another feminist sexologist that brought out the gendered politics of orgasm whose work became internationally known particularly ‘The Hite Report on Female Sexuality’ (1976) and ‘The Hite Report on Male Sexuality’ (1981).

The finding that “only approximately 30 percent of the women in the study could orgasm regularly from intercourse” (Hite, 1981) was hotly debated not because it was new but because Hite used it to challenge the way in which sexual science had used this finding to describe female sexuality as naturally frigid. Earlier surveys by Kinsey, Masters and Johnson had already found that majority of women don’t orgasm from intercourse and hence have a lack of enthusiasm for intercourse. In Hite’s view women’s problem was not what Masters and Johnson termed as female ‘coital orgasmic inadequacy’ but the way in which sexologists interpreted the findings reiterating the societal gendered way of defining sexual norms. Society is too used to defining anything related to women in a subordinate manner to the extent that it finds it difficult to accept the fact women can orgasm easily and pleasurably whenever they want (many women several times in a row) showing beyond a doubt that women *knows* how to

enjoy their bodies. According to Hite the problem was never in female sexuality but with the way society defined sex and subordinated women's role to the state of sexual slavery. Equating the patriarchal oppression of women with the biological model of sexuality Hite further argued that sexual slavery has been an almost unconscious way of life for majority of the women. Sex (biological identity) has been defined culturally and hence can be undefined and redefined. Hite tried legitimizing her claims by referring to the scientific methods and data of her work for which she was bitterly attack by other sexologists.

One of the reasons for such a tension and differing standpoints amongst sexologists and feminists was the different ways of thinking/interpreting sexuality and its links to relations of power between the genders. The situation was further complicated when in 1980s the post-structural, postmodern and postcolonial theories of gender challenged the simplistic binary opposition between the man as the oppressor and the woman as the passive victim arguing that such a strategy might be politically helpful in mobilizing but not so helpful conceptually.

Nevertheless, the separation of intercourse and reproduction brought a radical transformation in the conditions that had till then determined female sexuality and consequently male sexuality. This sexual revolution that technology had brought critics suggest primarily benefitted men more than women and largely reproduced the unequal power relations. This is because as Sheila Jeffreys's *Anticlimax: A Feminist Perspective on the Sexual Revolution* (1990) argues that, in retrospect, the revolution was less an increase in sexual freedom for women than the fulfilment of male fantasies about female availability.

The Marxist theorists like Marcuse and Reich had suggested subversion of capitalism by the free reign of pleasure principle. However, what materialized was commodification of sex as a result of lifting of obscenity and other moral laws. The national and international sex industry flourished extensively becoming a major player in global capitalist economy. The concept of sexual liberation had predicted that sexual freedom would render prostitution needless, since women would now be willing to meet all male sexual needs for free, commercial sex in reality greatly increased as well as pornography. Prostitution and pornography both became major issues for women's movements.

The final and possibly most decisive challenge to the biological model of sexuality has resulted from the emergence of anti-essentialist perspectives across a range of disciplines in the social sciences and the humanities from the 1970s onwards. The new theoretical models look at sexuality as a social construct and emphasize the social nature of sexual experience. There are still others like Foucault, David Halperin, Stephen Heath, Jeffrey Weeks, Ken Plummer and other sociologists who have argued for the need to comprehend sexuality by contextualizing it in history, culture and social relations of power.

1.3. (D) SEX EDUCATION: THE DISCOURSE AND THE PRACTICE (second half of the twentieth century)

Countries like Scotland, Italy, England and Poland overcame initial reluctance and introduced sex education in schools in the late 1950s and early 1960s. Different European countries took different approaches towards sex education depending upon mainly the history, culture and politics of the time. However, this section illustrates sex education in countries such as Scotland and Italy where the churches remained very powerful agencies in imparting sex education to the young far into the twentieth century. Furthermore, where the Catholic Church did continue to dominate the process of sex education, the outcome was by no means uniform.

By the second half of the twentieth century, biological model had rose to prominence, even then in countries such as Scotland and Italy, the religious/moral model of sex drove sex education. This was due to the paramountcy of the Catholic Church.

- SEX EDUCATION IN SCOTLAND

In Scotland the social disruption caused by the Second World War in many ways fueled the quest for the reinstatement of traditional moral values. The policy followed was based on the earlier assumptions of the biological model of sexuality that considered abstinence until marriage as the best prevention approach from getting sexually transmitted infections and diseases. The delegation of school sex education primarily to a religious organization such as the Alliance-Scottish Council (ASC) (Davidson, 2009) was symptomatic of this agenda. Moreover, it is arguable that the discourse of Christian purity continued to inform sex education policy long after the demise of the ASC. As a result, there was very little sex education in Scottish schools beyond a scatter

of ad hoc local initiatives, predominantly involving girls. Some school medical officers gave incidental instruction in sex to older pupils on an informal basis. Some talks were also given in a few schools on hygiene, including anatomy and physiology, as part of the physical training lessons.

The Alliance's talks and literature reflected its focus of imparting a sex education aimed at reinstating Christian morality. At the forefront of its objectives was the dissemination of 'Christian standards' so as to arm the young against the manifold temptations of post-war society and the 'new permissiveness'. The Alliance adopted medical language to impart moral ideas of sexual experience. For instance, it discussed sexual experience as fundamentally pathological and polluting and advised to keep sexual intercourse limited to reproductive goals. The developments of sex glands in boys was looked at as a crucial moment in structuring the moral character rather than building sexual self-awareness. While nocturnal emissions were biologically normal, the Alliance was clearly uncomfortable with their implications. It warned boys on the loss of fluid as loss of vitality. They were, the literature claimed, often 'accompanied by rather unpleasant dreams' and 'the loss of this fluid' should not 'as a rule, be more often than once a week'. If it was more frequent, the child was advised 'to speak to your father or mother, as you may need a tonic'. Deliberate masturbation, or in the terminology of the Alliance's literature, 'self-abuse', was strongly discouraged as a 'waste of vital energy', an indication of abnormal development, and a denial of 'the opportunities of Christian manhood', possibly requiring medical advice. Thus, although the direr warnings of early purity literature surrounding masturbation had been excised, a clear message was still conveyed that future health, happiness and self-esteem were contingent on abstinence and self-control during adolescence. For physiological reasons and the gender perception of sex education of the time girls received more explicit information on sexual intercourse and reproduction. The sexual knowledge was conveyed as precautionary information necessary to inculcate 'chastity' and 'self-control' within marriage, family and motherhood. The social hygiene literature of the inter-war period points out at the gendered assumption that boys and girls have different sexual appetite which is evident from the instruction given to girls stating them not to excite the sexual impulses of boys. Again, the rhetoric of hygiene and pollution informed much of the detailed advice, with menstruation conveyed as essentially a cleansing process keeping 'the nest as fresh and pure as possible'.

Annabelle Duncan, a health educator that closely worked with the Alliance had routinely collected feedback from pupils on her sex education talks. The main responses were firstly many of the pupils confirmed that they viewed the talks as dissipating their ignorance and or anxieties about sexual knowledge. Secondly many girls viewed the talk as having liberating effect on their relationships, both with their peer group and their parents (and especially their mothers). Thirdly the impact of the talks mainly on girls was not so much increase in moral awareness but more general enhancement of social confidence and self-esteem.

Even if ASC's moralistic approach to sex education was proving to be inadequate, the Scottish Educational Department chose to continue its traditional policy in the 1970s of encouraging local authority initiatives, and of devolving responsibility for more general provisions to nongovernmental agencies, such as the Scottish Marriage Guidance Council and Family Planning Association.

The narratives on reproduction played a central role in defining and naturalizing gender roles of femaleness and maleness. Throughout the period, women's role remained confined to the private sphere of the house, the family and childcare, whereas men were represented as acting in public and being the breadwinner and protector of the family. Significantly, it was only towards the end of the 1970s that these gendered images became less distinct. This was when the social model of sex had begun to challenge the 'essentialist' idea of sexuality which saw biology or presence of a sexual organ as the driving force of sexual behavior.

- SEX EDUCATION IN ITALY

In twentieth century Italy the two hegemonic groups – the Catholic Church and its antagonist communism both looked at sex with negative connotation. And so even if the discourse on sex education was welcomed by progressive sections of Italian society it was reduced to assertion of rules of behavior by the Church and the proposal to introduce it in schools was abandoned in the first half of the century. The influence and power of the Church increased further after 1948 when the Christian Democracy Party came to power (Wanrooij, 2009). The Courts were the only liberal institution on matters of sex. Women of the Communist Part in 1963 did campaign for sex education as a survey conducted in 1962 found majority of Italians in favor of some sort of sex

education. The conservative sections of the society saw sex as something natural that need not be taught and that imparting sex education would only arise curiosities in young encouraging them to sexually experiment. The Catholic Church on the other hand used sex education to reinforce Christian ideas on sex and counter the processes of secularization and modernization. This is evident from the fact that in 1975 the General Assembly of the Italian Bishops Conference made courses on sexual, religious and moral aspects of matrimony mandatory (Wanrooij, 2009).

However, there were some Catholic priest and pedagogue who approved the idea of sex education in schools. But the strong influence of the Catholics on the school system ensured that sex education in the 1970s adhered to the conservative and religious ideas. In 1974-75, students of a Technical School in Ciampino near Rome organized their own course of sex education choosing to discuss Catholic and Marxist interpretations of the role of sexuality using newspapers, official Catholic documents and Communist Party publications (Wanrooij, 2009). Even in the contemporary times a liberal form of sex education depends on individual teachers' initiatives. The Kinsey report was used as an evidence to argue for the declining sexual morality unleashed by modernizing forces. The call for sexual liberation of the 1960s and 70s was vehemently opposed by the Catholic Church but on the other hand made the demand for sex education more widespread.

1.3. (E) ADOLESCENCE AND SEXUALITY EDUCATION

Sex education driven by the biological model laid emphasis on communicating information about the anatomy and physiology of the sexual organ. It assumed that that mere biological facts and explanation of the body would change the risk behavior of the individuals. The idea that sexuality constitutes more than just the bodily urges emerged thereby contesting biological model of sexuality.

On the other hand, the category of adolescents that was present even before but was considered part of childhood started expressing itself distinctively. Adolescence as a distinct age group from childhood and adulthood emerged when it became apparent that young people in Europe would experience their first sexual contact by the age of 16-18 on average but would marry by the age of 25 on an average and have their first kid around the age of 28-30 on an average. The recognition of this age group as having its

own culture, behavior and needs meant new responses from the State and society. This coincided with the sexual revolution of the 1970s. The reproductive technologies like the Pill and modern methods of contraception separated sex and sexuality from reproduction thereby broadening the scope of sexual liberties as well as the understanding of sexual health. Sexuality by this time became a subject that was open to public discussion.

Adolescents sexual health and behavior were distinct from adults. In the area of sexual health this required new sorts of health services or adaptation of existing ones along with new education efforts. A shift from sex education to sexuality education through schools has been considered as 'an essential component of this adaptation process' (WHO, 2010). Unlike sex education sexuality education also proposed that parents should come ahead in imparting sexual knowledge to their children. It also proposed imparting sexual knowledge to young before they reach adolescence. The immediate reason for introducing sexuality education in schools differ between countries in Europe ranging from prevention of sexually transmitted diseases to that of unwanted pregnancies. Unlike sex education that was based on the assumption that children are inherently vulnerable sexuality education was driven by the conviction that young people can be strengthened and enabled to handle sexuality in responsible and safe ways.

Sexuality education has been defined as "learning about the cognitive, emotional, social, interactive and physical aspects of sexuality" (WHO, 2010). With the coming of the broad concept of sexuality education some countries started imparted it at an early age of 5 whereas some countries at the age of 14 depending upon the way sexuality education was framed in a particular country. By broadening its horizon sexuality education became a multidisciplinary curriculum subject. Sexuality education officially started in Sweden in 1955. However, in practice it took years to assimilate the subject into the curriculum because it demanded integration of new set guidelines, manuals and training teachers.

Developments that took place in the 1980s (the AIDS crisis) posed newer challenges and brought back old concerns. Both sex and sexuality education models driven by the biological understanding of sexuality came under criticism after the AIDS crisis (more

so in the 1990s) that problematized the gender and power inequalities that exist between sexes and within the very act-sex.

1.3. (F) AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME) CRISIS

The first case of AIDS was reported in 1981 in the US Centre for Disease Control and Prevention, Los Angeles. Aids was considered to be the most dangerous epidemic in the human history because nearly 25 million deaths were reported since its first detection. Thereafter it spread vicariously throughout the world. Globalization and technological development allowed fast spread of the disease and hence fast national and international level of intervention was needed. Even so most governments did not respond quickly because HIV/AIDS was identified as a disease that affected mostly the minority deviant sexualities and not the larger public that were heterosexual.

The response to Aids particularly in western countries like US and UK saw the rise of the Right-wing politics (Reagan and Thatcher governments respectively) claiming the moral regeneration of the state and the society through state intervention. If 1960s saw sexual liberation and a call for sexual revolution then the emergence of HIV/AIDS (acquired immunodeficiency syndrome) in the 1980s was seen as a consequence of sexual liberation. The AIDS crisis was quickly able to revive the traditional association of sex with risks and anxieties and female bodies with that of disease particularly that of prostitutes and the ethnic or racial other. This invited the religious models of sexuality in the politics of sexuality.

HIV/AIDS in its initial period was regarded as a gay disease. Hence, most of the initial prevention efforts in UK and USA did not come from the state but from the grassroot organizations that had developed out of gay liberation and feminist's movements. In this regard gay activists who founded voluntary organizations such as the Gay Men's Health Crisis (GMHC) 1981, or the Terrence Higgins Trust in the UK, developed the concept of 'safe sex' and pioneered preventative sex education as well as support groups for people living with AIDS, with minimal state support. With governments paying less attention to the programmes for prevention of the spread of HIV/AIDS the plague of AIDS further aggravated by 1990s. The emerging recognition that the majority of infections occur through unprotected heterosexual/ reproductive intercourse led to what has been described as a 'de-gaying' of AIDS in the 1990s. With this the

scope of intervention to control the spread of AIDS had to be broadened to sexual and reproductive health of both homosexuals and heterosexual. The state had now entered the bedroom primarily through the prevention mode to promote safe sex practices of either sexual abstinence or use of condoms.

The issue of heterosexual infections with Aids also triggered further feminist critiques of sexuality. Building on the argument that AIDS risk was not attached to certain types of people, as the focus on 'risk groups' had implicitly assumed, but to certain types of (unprotected) sexual practices, such as anal sex, feminist research such as the series of studies carried out in the early 1990s by Janet Holland and others explored the consequences of male sexual domination for risk-taking sexual behavior. The research revealed that both heterosexual men and women tend to define and experience sexuality in relation to the primacy of male sexual 'needs'. Most partners adopt a biological understanding of male sexuality as the expression of natural, uncontrollable urges which should not be intruded; a view which puts obvious constraints on women's possibilities for negotiating safer sex. Furthermore, normative female identity creates the dilemma for women that, on the one hand, contraception and AIDS protection are seen as female responsibilities, while, on the other hand, women feel they should refrain from asking for anything that might spoil their partners' sexual pleasure. Intruding the sexual act of the male partner and being assertive about safety can run counter to being feminine, as Holland's team pointed out. The non-adoption of safer sex practices such as condom use does not, however, result from an external imposition of male power (at least not within the consensual relationships). As Holland's study demonstrates, male preferences are instead interiorized and actively reproduced by women, a mechanism the team describes as 'the male in the head'. Various feminist analyses emerging from the area of AIDS risk and prevention have thus been concerned with issues of women's power and powerlessness in heterosexual interactions, usually stressing the relative lack of power of women in sexual encounters with men. The reasons given for this powerlessness vary, however: different socialization for UK sociologist Janet Holland, economic dependency on men for Australian social psychologist Susan Kippax, or wider dominant definitions of heterosexuality for US anthropologist Carole Vance. Despite such divergent diagnostics, feminist research demonstrates the need to take gender identity into account when conceptualizing risk in sexual practices. Normative gender identities and gendered relations of power have clear implications for people's

ability to prevent the sexual transmission of AIDS; implications that government policies have in recent years attempted to try to build into their preventative strategies. Thus the AIDS crisis ironically provided the opportunity to challenge the power inequalities that inherently exist in performing sexual intercourse.

The health emergency created by Aids has constituted a major area for state intervention in citizens' sex lives, with sex education campaigns spelling out to them, in sometimes graphic detail, how they can avoid risk of infection with HIV. Initial government campaigns focused primarily on providing information as to how to prevent HIV infection, implicitly assuming that citizens were rational individuals who would abandon their risk-taking practices once they had been informed of their dangers. However, continuing new infections rapidly demonstrated that the provision of information, while crucial, did not suffice. Indeed, sexual interactions do not constitute the most rational area of most individuals' lives. In addition, we generally do not engage in sex as individuals, but in interactions with others, which again underlines issues of power and communication. The Aids crisis has thus demonstrated the importance for government prevention campaigns to take into account the social, psychological and political aspects of sex (Mottier, 2008) that encouraged States to consider substituting sex education with a broader and comprehensive sexuality education.

The AIDS crisis demanded change in the sexual behavior of both men and women and not just the availability of information to preventing and control the proliferation of sexually transmitted disease. This provided an impetus to shift from sexuality education to a broader and comprehensive understanding of sex and sexuality that could alter the sexual behavior of young individuals to protect them from adverse effects of risk of sexually transmitted disease. This would enable them to view sex in the domain of pleasure however using safe sex methods.

This broader understanding of sex and sexuality was conceptualized in the form of Comprehensive Sexuality Education, known as CSE in the 1990s. CSE was distinct from sexuality education because firstly it incorporated the reproductive and sexual health demand that arose out of the Cairo Conference of 1993. Secondly, it outlined the demand for sexual knowledge within the framework of human rights. and thirdly, CSE explicitly adopted a positive approach to sexuality education by incorporating the

much-neglected pleasure aspect of sex in its program. This ignited fresh debates and discussions on the discourse of sexuality education and how to impart it.

With this the chapter has thus illustrated how the models of sexuality have influenced the content and practice of sex education in the European countries over the course of twentieth century. But what are the factors that have influenced the discourse and practice of sex education in India? Has the models of sexuality, the discourse and practice of sex education in Europe influenced the narrative on sex education in India? These are the questions that will be dealt in the following chapter.

CHAPTER TWO

THE INDIAN STATE AND SEX EDUCATION

The previous chapter looked into the three models of sexuality and their correlation with the sort of sex education frameworks countries in Europe chose to adopt. This chapter will look into the relevance of the models of sexuality in the Indian context. Cognizant of the fact that India is a post-colonial developing country the chapter will also look into how different or similar has the trajectory of the discourse and practice on sex education been in India.

The trajectory of sex education in India has been population education from the 1970s, adolescence education programme introduced in 2005 and contemporary discussion on Comprehensive Sexuality Education. In this regard this chapter has been divided into three parts. The first part deals with the pioneering initiatives taken up by individuals to introduce the discourse and practice of sex education in India. The second part deals with the Indian State and population education. The third part deals with significant developments that led to the introduction of Adolescence Education Programme which is the Indian version of sex education to be imparted in schools.

PART I

2.1 PIONEERING INITIATIVE

Avabai Wadia mentions in her memoirs about the first clinic, the Kutumb Sudhar Kendra established in 1950 that not only provided advice and assistance in family planning but also counselling on sex and marriage problems (Wadia, 2001). Wadia was the then president of the Family Planning Association of India (FPAI) a non-governmental organization which was established in 1949. FPAI in consonance with the Family Planning Programmes of the Indian government was largely about providing facilities and services regarding birth control, contraception, advocating the idea of a planned family, abortion and imparting information on sexual transmitted diseases and infections. Within FPAI there were few people who then believed that the silence on the subject of sex and sex education should be broken. Sex being a taboo subject public discussion on it was practically unknown in India and a risky task to undertake. Wadia's visit to Sweden and Denmark where sex education activities in schools and other

settings had greatly advanced further moved her in the direction of promoting sex education. She relentlessly worked in this field as a catalyst and facilitator ensuring availability of opportunities, funds and other resources. Wadia was accompanied by people with similar vision particularly Dr. Mahindra Watsa an expert counsellor on sex who assembled a professional team of doctors and counsellors to work in this field. Risky though Dr Watsa accompanied by Mrs Sarla Mukhi opened up the discussion on a wide range of topics including that of sexual orientation in a workshop organized in Pune 1977 leaving many participants shocked (Wadia, 2001).

The idea to impart sex education as a formalized subject in schools, colleges and other institutions was suggested in the first Asian Conference of sexology that was organized by Dr. M. Watsa, Dr Prakash Kothari, the FPAI and the Indian Association of Sex Educators, Counsellors and Therapists in December 1981 (Wadia, 2001, pp. 567-644). Sex being a taboo subject in India the recommendation had to go through a lot of ifs and buts even within the doctor community.

2.1. (A) PERSPECTIVES ON SEX EDUCATION

The issue of sex education was dealt in detail by Dhun Panthaki and Anthony D'Souza who addressed the what, how when and why aspects of sex education in 1960s and 1970s. Anthony D' Souza, was the director of the Indian Social Institute and chairman of its Family Life Centre. Dhun Panthaki was a biology teacher in a girl's school who was influenced by the initiative that few people in FPAI had taken in the direction of sex education.

In 1967, Dhun Panthaki a biology teacher in a school then in Mumbai initiated the programme called 'Sex Education' for students of Class IX (about 16 years old) (Panthaki, 1997, p. 1). She had participated in the Family Life Education Programme that was conducted by Family Planning and Research Centre in 1967 that moved her interest in this field. She could blend sex education well with the biology curriculum and so this experimental programme was repeated for the next year for Class IX and X. The pilot programme of two years brought out some very interesting findings. From the observation, evaluation and response of the students to the pilot it was evident that students were not only ready to receive information on sex but wanted it earlier. This is because it was known that by the age of 15 many students had acquired information

on sex though not all of it was correct. To correct this situation the same topics which were dealt in Class IX were taken up again in Class X. However, the response from Class X student was condescending. The same students who had engaged in a lively participation in Class IX showed a cold indifference by remaining silent and even disgust at times by not willing to cooperate. A questionnaire was prepared to understand the loss of interest of the students. The findings of the questionnaire revealed the source of information on sex, the average age of receiving information and the topics that would interest them.

The source of information were largely magazines and books like Kama Sutra, Love and the Facts of Life, Teach yourself Sex, The Doctor Talks his Mind about Sex, The Naked Ape, The French Art of Love, The Erotic Travellers and The Cradle of Erotica (Panthaki, 1997, pp. 2-3). By the ages of 7 and 11 years the student on an average had got some information on sex. Unlike the previous year in Class IX, same students in Class X wanted discussion on topics such as the emotional development of teenagers, venereal diseases, masturbation and its effects, conception, childbirth, moral codes of society, social prejudices, prostitution and homosexuality. On the basis of the findings the content and methodology of Sex Education for Class X was revised. The atmosphere in the classroom changed. Initially students were hesitant and embarrassed to use sexual terminology and ask personal questions. Gradually with the supportive environment and respect accorded to every student's feelings and differences helped them to open up. Rules that guided the discussions were firstly no judgmental comments should be passed that would shun the speaker and secondly nothing would be particularly labeled as 'right' or 'wrong'. Within this framework it was observed that students in the process of drawing conclusions were learning to reason on sound basis.

The evaluation of the programme revealed that students had a lot of information and misinformation on sex before they reached their teens and so the programme was further extended to include Class IX. The Sex Education programme was welcomed by the parents of Class IX and Class X many commenting that they feel relieved as the school is taking up the task that they find difficult. Many other parents requested for a similar programme for Class VI (11year old). Cooperation was sought from the parents through the parents-teachers meeting. Accordingly, Sex Education was imparted to

Class IV, VI, IX and X whereas Class V, VII and VIII did not receive any formal instruction on the subject but individual queries were welcomed.

On the other hand, D'Souza was of the opinion that 'sex education is not a separate subject to be learnt like arithmetic or geography rather it is a part of the whole process of learning to live' (D'Souza, 1979, pp. vii-x). He wrote the book 'Sex Education and Personality Development' in 1979 in which he illustrates the importance of sex education and its varied aspects, trying to clarify the confusion and dispel the fears that have shrouded the entire question of sex education in the country. D'Souza make the connection between sex education and personality development of a child arguing that for a healthy development of a child from adolescent to an adult sex education is of chief importance. Hence, he extensively writes on what adolescence means and how 'a child' is different from an 'adolescent'.

D'Souza addressed the most basic questions about sex education in his work such as why to impart sex education? What does one mean by sex education? Who should talk to adolescents about sex? and when to start the talk on sex? D'Souza's work is important in understanding the social awareness and conditions that prevailed during 1960s and 70s. Talking about sex education then was a radical move as the larger political and social conditions that prevailed indicated an authoritative and patriarchal mindset. This is evident from D'Souza's reference of the peculiar features of the Indian society illustrated by the Association for Social Health in India memorandum on sex education that makes it difficult/ almost impossible for parents to impart sex education. Firstly, it is the level of education of the parents particularly of the mother that is so low that they neither have the knowledge nor the skill to take up the task. Secondly, the traditional family values emphasize on following the authoritarian pattern that entails restricted communication between parents particularly the father and children. This creates the generation gap. Third is the language barrier. There are no standard terminologies in most of the regional languages on the basis of which instructions can be given (D'Souza, 1979, p. 21). Though ideally parents should allow attentive and active listening to the adolescents to understand and then guide them what often happens in the Indian case is that the parent retreat to the authoritative pattern of making the adolescent submit to the authority.

D'Souza thus had emphasized on the education of the parents rather than that of their children. Parents in India are so poorly informed on the subject of sex. They are so culturally made to believe that sex is not a subject of communication that their natural response to anything related to sex education is abstinence. D'Souza therefore recommends that sex education should form a part of the adult education[1] in India. He also recommends brief courses or conferences, seminars, programmes for personal development through sex education for teachers and parents.

Panthaki differentiates between sex education and education in human sexuality. Sex education as she explains is a narrow concept as it deals with only physical aspects of sex such as reproduction, contraception, sexually transmitted diseases and HIV/AIDS. Such a biomedical centric approach to sex has not and does not result in a responsible sexual reproductive behavior (Panthaki, 1997, p. 8). D'Souza too was of the opinion that knowing merely, the physical aspects of sex in itself will not lead to responsible sex behavior. On the other hand, education in human sexuality as she puts it, includes not just the physiology and anatomy of sex organs but also the psychological reactions associated to being a 'male' and 'female', the behavioral responses to sex (biological identity) that is conditioned by social norms and religion. In short, education in human sexuality looks at the individual as a whole whereas sex education reduces the individual to his/her sex organ.

Drawing this differentiation Panthaki further brings out the reaction of parents to sex education and education to human sexuality. Firstly, most parents not knowing the difference between the two usually agree to 'sex education' given to their daughters but not so much to their sons. Such parents are of the opinion that girls should know about such things so that they can avoid being deceived or become victims of ignorance. Secondly, post 1980s because of the threat of AIDS sex education got accepted more like a disaster management education (Panthaki, 1997, p. 9) and hence many a times the only aspect of sex that is talked about is the AIDS prevention measures. This clearly shows that parents in particular and people in general fail to understand that lack of

[1] Adult Education aims at extending educational options to those adults, who have lost the opportunity and have crossed the age of formal education, but now feel a need for learning of any type, including literacy, basic education, skill development (Vocational Education) and equivalency. It was included in the First Five-year Plan of 1951-56. Accordingly, the National Adult Education Programme (NAEP) was launched on 2nd October, 1978. The programme aims at eradicating illiteracy among adults of the age group 15-35.

knowledge about the facts of life or sex and sexuality causes anxieties not just in girls but also boys and a silence on these issues further hinders the development of a responsible behavior towards each other.

Unlike D'Souza, Panthaki was of the opinion that besides parents and teachers trained educators should come forward in imparting education in human sexuality. However, educators are not substitutes for counsellors or therapists and that counsellors and therapists should be referred to in case of major problems related to sex and sexuality. Panthaki was also of the opinion that education in human sexuality should be imparted not only in schools but also in colleges. The proposed content of the programme on human sexuality included the physical aspects of biological facts and functions; emotional aspects of sexual attraction, fantasies, feelings; social aspects of friendship, love, peer pressure; myths and misconceptions about masturbation, size of the penis and breast, hymen, virginity etc; preventive aspects such as facts of HIV/AIDS, unplanned pregnancies, safe sex, sexual health, usage of drugs; variant sexual behavior aspect such as pedophilia and the addiction to pornography; future life preparation that includes marriage, conception and childbirth, family welfare, parenting; attitudes and values wherein attitudes and value defined as opportunity to question, explore and assess existing values and their relevance (Panthaki, 1997, pp. 16-18). As Panthaki was associated with FPAI her views did reflect the emphasis on encouraging young people about the use of contraception.

D'Souza's perspective towards sex education and the ways in which it should be imparted reflects the traditional medico-moral approach with more emphasis laid on the aspect of morality. This is evident from the emphasis he puts on the aim of sex education which is different for boys and girls. According to D'Souza boys need sex education for the full development of their personality and in inculcating the values of monogamy whereas girls need sex education so that they can prevent themselves from being alluded by strangers (understood as sexual predators) and become good wives in future. On the other hand, Panthaki imparted sex education from her biological understanding of sex and sexuality. Hence, her stake on the subject matter reflected bio-psychological approach to sex. Nevertheless, Panthaki in the third edition of her book 'Education in Human Sexuality' brings in the social and economic barriers that particularly girls/women face in India that make sex education even more important for

them. Panthaki sees sex education as a medium to address the social and gender inequalities that exist in the Indian society. She has tried to point out the gap that exist between the fundamental rights that the Constitution guarantees to women and the social and gender inequalities that they have to face on a daily basis.

Imparting sex education in the 1960s and 70s was rare. Dhun Panthaki's initiative in this field itself was an exceptional case and it had to face lots of hurdles. Panthaki in an interview mentions the criticisms and reactions of parents, doctors and men towards her work and herself being a female sex educator. She describes that once when she was presenting her work a man questioned- how can an unmarried woman like Panthaki talk about sex (Preksha, 2017). There were parents who would get offended with the idea of their children knowing about child birth, HIV/AIDS and homosexuality and doctors who loath homosexuals (Preksha, 2017). D'Souza too mentions the difficulty in making parents understand the need of sex education as parents would argue that they didn't have one in their times and were able to live without knowing about sex.

As illustrated in the first chapter by 1960s and 70s sex education became widely acceptable and the State became an agent in providing funds and training to teachers to impart sex education in many countries of Europe. In case of Italy, Austria and England the State and the Church reluctantly accepted the need of sex education and provided funds and resources to impart sex education that had sex abstinence approach. But in India the State gave more importance to Population Education and hence sex education largely remained dependent on initiatives taken on the part of individuals like Panthaki.

The following section will highlight as to how and why sex education by the Indian State was conceptualized only in terms of contraception and population control measures unlike the pioneers who also looked at the inherent need for sexual knowledge.

PART II

2.2 INDIAN STATE AND POPULATION EDUCATION

A government influences the size, growth and composition of its population through a conscious, deliberate and explicitly charted out population policy (Goel, 2005, p. 37). For the Indian State population has been a paramount issue since independence. In regard with this the government's population policy in the form of family planning programmes and services focused on population control measures. The first two five-year plans (1951-61) took a clinical approach towards the provision of family planning services. Understanding that a mere clinical approach is proving to be inadequate the third five-year plan brought in the educational approach to motivate people in the acceptance of small family norm and family planning services. The fourth five-year plan further broaden the concept of family planning by integrating it with welfare programmes like availability of food, safe drinking water, shelter, employment and particularly the health of women and children resulting in the Family Welfare Programme that was more comprehensive in nature. Improvements in the availability of health services reduced the death rate and even assisted in the rise of birth rate. Population was hence becoming an alarming concern as it was overshadowing the growth and development that the country was making.

2.2 (A) POPULATION EDUCATION

In August 1969 the National Seminar on Population Education was organized in Bombay (presently Mumbai) to conceptualize population education in India. In this seminar sex education too received official attention as a way of complementing population education and hence population control goal of the State. Hence the way sex education was thought of then was-

> "if sex education is imparted by dedicated personnel through careful planning and methodology, it can sublimate the energy of youth which can be utilized for national reconstruction and socio-economic development like the water of Bhakra Dam which was causing floods and havoc earlier but is being used now to generate electricity and irrigate the barren lands" (Goel, 2005).

Unlike countries in Europe where sex education received official attention with regard to concerns over spread of venereal diseases, in India sex education received official attention as illustrated above within population control framework. And so, the youth population who were to be future adult citizens were seen from the macro perspective of being resource to the State rather than from the micro perspective of being individuals with needs and rights.

In 1971, a Population Education Syllabus was developed by NCERT in accordance with the recommendations of the National Seminar. The syllabus had six major areas- 'population growth; population and economic development; population and social development; population health and nutrition; population, biological factors and family life and ecological considerations and population' (Yadav & Mallik, March 2014). It was decided that population education will be imparted through formal schooling system to grade IV to XII class students. The underlined assumption of the population education was that it will make the target groups (students) firstly aware of the inter-relationship of the multi-faceted population phenomenon and development and secondly this awareness will eventually produce a generation of adults capable of making informed and responsible decisions regarding population and development. The implicit intention of population education being convincing the young minds the importance of family planning and making it acceptable. In order to support basic training for teachers on population policy governmental institutions on family planning/welfare like Gandhinagar institute of Health and FW trust, Tamil Nadu; Family Welfare Training and Research Centre, Mumbai; National Institute of Health and Family Welfare; Rural Health Training Centre, Najafgarh; International Institute for Population Sciences (Goel, 2005) were geared up. With this population education was now imparted in schools by NCERT at the national level and SCERT at state/UTs levels.

Population Control had become such a big concern that in 1976-77 the then Congress government prioritized the family planning programmes to the extent that coercion was used to mobilize people for sterilization. The Janata Party politicized the coercive sterilization measures to control the family size into a major political issue over which elections were fought and won against the Congress. The coercive measures did yield the necessary result that the State wanted in terms of controlling the growing population

but political parties soon realized that implementing coercive family planning services were detrimental to winning elections and coming to power. The new 'Cafeteria Approach' under the Janata government eliminated the coercive measures and continued the family planning programme through the earlier clinical and educational approach. The Cafeteria approach made accessing family planning services and programmes a matter of choice rather than an obligation.

In 1980 the National Population Education Programme (NPEP) was launched and was supported by the United Nations Population Fund (UNFPA). By 1986 the NPEP got extended to higher education sector and non-formal adult education sector (Chakrabarti, 2003). The scale of the programme increased significantly but the necessity to reconceptualize population education was felt. The then existing (1971) population education syllabus was a demographic laden concept. The approach of population education was changed to a value-laden concept that brought out the interrelationship between population, development, environment. resources and quality of life.

The population education programme was criticized for its moralistic approach in conveying information that needed a fact based scientific approach. The failure of population education in achieving any significant change in reproductive behavior of individuals that should have resulted in decreased fertility has been attributed to many aspects of the programme. Firstly, population education has been accepted as a critical curricular area in the national policy but it has not been treated as a separate subject in the school curriculum. Secondly, researchers have often critiqued the authors of school textbooks for not looking beyond the traditional structures of concerned subjects. For instance, a lesson on reproductive system in biology textbook lays more emphasizes on reproduction and reproductive organs of plants and animals than exploring the reproductive system of humans and the socio-cultural implications of reproductive behavior. Thirdly, the educational system in India has been criticized heavily for following an outdated textbook approach to learning that does not encourage critical thinking and raising questions.

Existing research had suggested certain essential issues such as the process of growing up and reproductive behavior to be added to the reconceptualized population education that would better influence the fertility behavior of individuals. Recognizing that future adults were present day's adolescent boys and girls, suggestion was made that

population education should add topics such as anatomy and physiology, changes during puberty, conception, infections, contraception and sexually transmitted infections. However, these suggestions did not find any place in the reconceptualized population education until the AIDS crisis made it unavoidable to notice.

In 1986 April the first cluster of HIV positive individuals who were sex workers was detected in India at Madras (Chennai) and in the following month of May the first person with AIDS in India was detected in Mumbai (Bhonsle, 2016). Soon after reporting of the first HIV/AIDS case in the country, the Government recognized the seriousness of the problem and took a series of important measures to tackle the epidemic. In 1987 National AIDS Control Programme was launched. The target group of this programme were sex workers (NACO, 2015). The popular opinion about AIDS in the 1980s (brought out in the first chapter) was that it affected homosexuals and sex workers. Hence, an educational response to AIDS came much later.

In the 1990s when India became the second largest population of HIV infected persons the issue gained priority. It was reported that over 35% of all reported AIDS cases occurs among 15-24 years old. The adolescent's ignorance of the body now became a threat for the country's future growth and development and the State had to take stringent measures to cope up with the dire situation of rising numbers of sexually transmitted diseases among the youth population. The Population Education Framework started considering revision of the existing curriculum to add topics on HIV/AIDS prevention.

The 1990s awaited significant changes. The 1993-94 Cairo Conference on Population and Development gave the necessary push to the much-awaited change.

2.2. (B) REPRODUCTIVE HEALTH AND RIGHTS AND THE CAIRO CONFERENCE

The concept of reproductive health and rights emerged from the developments that began in the health sector post 1970s and got impetus after the AIDS crisis. By the late 1970s the second wave of feminism politicized health and health care facilities arguing that health is not merely about availability of medicines and value-neutral technology but its understanding is derived from the way the society is structured. Having learned their lesson from the sexual revolution of 1960s that attack the patriarchal structure but

assumed that the new technology of contraceptives and 'the Pill' would liberate the women made the women's group in the West wary and critical of the medicalization of the women's body and health. The Black women's group too came ahead and criticized the white women of being color blind and pointed out at the deeply racist approach of population control programmes. In the Third World countries different women's groups accompanied by health groups critiqued the family planning programme that had unleashed the wrath of sterilization as anti-poor, anti-women and anti-human rights (Rao, 2004). The establishment of the medical industry had started to erase the health histories of the First World countries who forgot that public health resulted not merely from medical advances but from the availability of a comprehensive primary health care system. It was forgotten that similar to resources health and disease too gets unevenly distributed. This shifted the approach towards public health from the one that addressed the broader factors of health to a technological- medicine centric one. Such an approach was over-emphasizing the biological factors of disease and ill-health by ascribing it solely to the individual's failures and undermining the social and economic factors of disease and ill-health.

In the 1980s, the return of religious model of sexuality post aids crisis meant that the religious and conservative groups promoted the abstinence-until marriage approach to sexuality. The overbearing position of the religious model of sexuality remained for a brief period of time and soon it was comprehended that such an approach has failed to yield the desired results of decline in the spread of HIV/AIDS cases. The increasing number of deaths due to HIV/AIDS (the figures produced by WHO and UNAIDS estimate it to be more than 25 million) and its fast proliferation in not only India but all over the world gave it the stature of one of the most destructive disease in the human history.

On the other hand, the 1990s witnessed the International Conference on Population and Development (ICPD) that emphasized another significant concern of the time (particularly for India) - population stabilization. In the ICPD of 1993, it was realized that the 'demographic goal of reducing fertility could not be attained without taking into account women's ability to make decisions regarding reproduction and fertility' (Rao, 2004). The Population Control concern driven by the family planning programmes and services had become very unpopular and were heavily criticized of

being anti-poor, anti- racist and anti-women making it unacceptable. It was in dire need of revision. The Cairo Conference witnessed heated debate and discussions on issues such as family planning programmes, technology driven health concept and the demand for reproductive health and rights.

The feminists were of the opinion that as it has been realized that even for purely instrumental reasons, there had to be a change in the approach to the population issue women's reproductive health and rights should become the priority over population control agendas. Feminists argued that women's ability to make reproductive decisions is mediated by multiple and complex processes by which class, caste, religion, the family, the institutions of patriarchy interact with and are acted upon by the state and international structures. That is to say there is a need to integrate the politics of the body into a larger framework that emphasizes the transformation of the state, social, demographic and economic development policies.

Thus, women's control over their bodies, over reproduction is an issue of power both between the sexes and among various layers of society. Differentiation among women also has a profound implication for the ability to exercise such control. A range of practices, laws, values and institutions provide the hegemonic basis for patriarchy. From the feminist's perspective reproductive health and rights meant challenging both the ideology and practices which allow others to control women's bodies.

However, the concept of Reproductive Health and Right got limited to safe abortions, availability of contraception, and the treatment of contraceptive side effects backed by national and international funding institutions like the World Bank, Population Control establishments and financial institutions looking for new investment areas. Availability of international funding meant a plethora of NGOs moving into research on reproductive health. In the era of reproductive technologies that flourish within a capitalist system that is always in search of new markets the concept of choice got reduced to consumption and found a private enterprise in women's bodies (Rao, 2004).

Another global event that put women's health and sexuality squarely on agenda was the Fourth World Conference of Women that was held in Beijing in 1995. In the conference seven all-India women's organizations prepared an alternative document wherein the ICPD came in for stringent criticism. They argued that in the Cairo Conference the

issue of abortion dominated the proceedings. The issue of right to abortion led by Western feminists was backed by the representatives of Third World women in Cairo assuming that some consideration would be paid to the Third World women's issues, concerns and experiences too. But they did not get the support of women representatives of the First World.

Acknowledging that issues of development of poor countries in the new global order did not receive enough attention at the ICDP, it was also argued that the ICDP did not take adequate note of processes that governed health in Third World countries, which in the current global scenario were working fundamentally against the interest of the Third World (Rao, 2004). The alternative document commented that: "women's health should not be subordinated to population goals nor restricted to reproductive matters" (Rao, 2004).

Feminists were critical of the understanding of reproductive health that resulted from the Cairo consensus because even though it talk about women empowerment and gender equality its over emphasis on biology meant that the economic, social and political aspects of reproductive health will be overlooked.

On the other hand, Cairo consensus was celebrated as a paradigm shift as it shifted the focus from firstly numbers to conditions for population stabilization, secondly on individual needs instead of demographic targets and thirdly to integrate population concerns into development strategies rather than pursuing and providing sustenance to population control approach narrowly.

Even though feminists from the Third World countries were apprehensive and critical over the outcomes of Cairo Conference it was almost inevitable for India like other developing and underdeveloped countries to reject what was been proposed in the ICPD because of the international politics of the time. The definition of security in the Post-Cold war world dominated by US intensified the concern over population growth of particularly Third World countries as imperative for achieving the goal of population stability across the globe. In this regard family planning programmes were considered as the least costly, time-bound and pragmatic means of ensuring population control. This approach was also backed by the World Bank that funded the family planning programmes in the Third World countries. It was argued that population control

problem has become too grave to wait for results from the over-all development approach to health become fruitful.

Following the ICPD three significant changes were introduced by the Indian State. Firstly, the population education programme's focus was shifted to gender equity, women's empowerment, reproductive health and rights, adolescent sexual behavior, health education, family life education, drug addiction, HIV/AIDS and sustainable development and a separate Reproductive and Child Health (RCH) policy was proposed. Secondly, the concept of Adolescence Education that focused on imparting accurate and authentic information on adolescents and their reproductive and sexual health, HIV/AIDS prevention and substance abuse was proposed. Thirdly, sexuality was brought in the public domain of discussion.

2.2. (C) ADOLESCENCE EDUCATION

The concept of Adolescence Education was introduced in a national seminar organized by the National Council of Educational Research and Training (NCERT) in 1994 and endorsed by the National Population Education Project (NPEP). The seminar recommended introduction of adolescence education in school curriculum. Sex education needed urgent attention now and a definite educational response because of the arrival of the pandemic of AIDS and the growing problems related to sexual behavior and drug abuse among adolescents (Ed. Muley, Yadav, Pandey, & Sadhu, 1994). Since then Adolescence Education presumed as a form of sex education was under official consideration.

A general framework of adolescence education was developed under the last phase (1998-2001) of the NPEP. The limited attention that adolescent education received was in the form of being crucial to the changed perception of population issues resulting from the ICPD Programme of Action. Addressing adolescent reproductive and sexual health was seen as crucial to the new method of approaching population issues. This also got reflected in the National Population Policy of 2000 adopted by the Government of India that described adolescent as an underserved group in need of reproductive health and services that would enable them to become a positive and valuable resource.

With this in South Asia, by the end of the 1990s, both researchers and governments had begun to shed their traditional doubts and unwillingness towards young people's

reproductive and sexual health, and a growing body of empirical statistics and evidence and government attention provided an opportunity to take notice of the sexual and reproductive health situation of youth in the region. In response to this the HRP[2], ISRRF[3] and IRR[4] collectively organized an international conference in November 2000 entitled: "Adolescent Reproductive health: evidence and programme implications for south Asia", held in Mumbai, India to discuss and come up with ways to address the reproductive health concerns of adolescents.

Never before were adolescents as a group and their sexual and reproductive health talked about. It was childhood and the adulthood that were understood to have health concerns. The World Health Organization defines adolescents as the age group 10-19 and describes it as "a time of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood" (Bott, 2003). Like any other group adolescents as a group is not homogeneous and the nature of adolescence varies tremendously by age, sex, marital status, class, region and cultural context. Adolescents sexual and reproductive health needs differ from those of adults in important ways and which remain poorly understood or served in not only South Asia but in much of the world.

2.2. (D) SEXUALITY AND SEXUAL RIGHTS: SOUTH ASIA

The AIDS pandemic and its spread among adolescent population not only gave the necessary push to research on reproductive and sexual health but also on sexuality, sexual health and sexual rights as a human right in the South Asian region. This arose parallel to the State's effort to conceptualize adolescence education/sex education. However, the non-governmental organizations such as FPAI and TARSHI were the one who took cognizance of these developments which will be dealt in the next chapter.

Sexuality was not thought out as a respectable field in the academic discipline for study except in sexology and medicine until the 1980s (Misra, 2005, pp. 11-28). The research in the field was marginalized as in many cultures sex and sexuality was a taboo subject.

[2] HPR stands for the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction.
[3] ISRRF stands for the Indian Society for Research on Reproduction and Fertility.
[4] IRR stands for the Institute for Research in Reproduction.

Sexuality has been for a long time regarded as a reserve of medical science because its visible manifestations are most often expressed through the body. Medical science and sexology did provide us with important insights about sexuality (Radhika, 2008). But as many feminists and social construction theorists would argue medical science and sexology also often reduced sexuality to its more biological status which eulogized the theme 'biology is destiny'. The challenges that biological model of sexuality received from within sexology and the eventual development of the social model of sexuality initiated the necessary shifts in the theoretical assumptions made by medical science and sexology of the early 20th century.

The global success of various groups including feminists, child right activists, workers, prisoners of war and others in using the language and structures of international human rights has led the world of rights to expand to comprise many more aspects of a person-including sexuality. Movements that advocated measures like the provision of contraception, equality within marriage, and protection from domestic and sexual violence took sexuality out of the realm of the private. Even though the feminists group intended to make the personal as the political by bringing issues that belonged to the private realm into the public discourse the attempts were met with confrontations.

Sexual rights as a concept started developing within the larger rubric of human rights. Human rights were designed to check the abuse by the nation of its inhabitants and includes obligations to set up social conditions through which all people can enjoy rights through common standards and structures of accountability and participation. The state has an obligation to protect its inhabitants from violations of their human rights by others as well as to ensure that state actors themselves do not violate human rights. Sexual rights are evolving as a claim to address the many violations and barriers to access services and information of sexual nature - on abortion, contraception, sex work and many others issues related to sexuality for the betterment of the larger social and material conditions of people's lives. It is an individual's right that is meant to check violations and abuse perpetrated by not only the state bodies but also the family members, teachers, religious leaders, partners and work colleagues. The concept of 'sexual rights', which links different aspects of sexuality to a range of specific rights claims (e.g. for equality, non-discrimination, freedom from violence and the right to

sexual health) is being increasingly used to build the conditions for new claims of inclusion (Misra, 2005).

In order to claim one's right one should be educated or aware about it. A part of sexual rights was brought to focus by the International Conference on Population and Development held in Cairo in 1994 in the form of reproductive health rights. It was here that for the first-time development was concretely linked to rights rather than a population control paradigm. The debate on reproductive health and rights provided the impetus to taking further the issue of sexuality. This became apparent with the 1995 Fourth World Conference on Women held in Beijing, China that placed sexuality directly on the human rights framework. The current and burning debate on reproductive health and rights gave impetus to sexual rights. Reproductive health and rights coupled with sexual rights stimulated Comprehensive Sexuality Education around late 20th century. Organizations advocating Comprehensive Sexuality Education are increasing framing it as a sexual right.

2.2. (E) SEXUALITY, CULTURE AND POLITICS (late 1990s)

The liberalization of the Indian economy in the early 1990s subsequently catalyzed wide ranging cultural changes by the late 20th century. These cultural changes were greeted with both affirmative engagement and anxieties around loss of Indian cultural values and ethos. The late 1990s witnessed three important events. Firstly, the debate on censorship (particularly TV) that primarily focused on dilemma around sex and sexuality which gave impetus to the second debate around the impact of TV violence on audiences, particularly children. And thirdly the rise of Hindu Right led by their political front the BJP (Indian Nationalist Party) and eventually coming to power in 1998 through coalition politics. The rise of the Hindu right has been accompanied by an aggressive cultural nationalism that has sought to project a pure Hindu culture by harking back to a glorious past, 'uncorrupted' by either Islam or colonialism (Ghosh, 2005).

Censorship demands are made on the assumption that the concerned speech or representation will impact on people in particular ways. Through the 1990s the popular

press and media was replete with news and articles that simply linked media violence[5] to real violence without analyzing the linkage. Children were considered as the most vulnerable TV audience section, given their youth and inexperience. Findings were presented indicating that media impacts every aspect of children's lives ranging from their hopes, ambitions for the future, their attitudes to relationships-familial, parental, romantic, sexual etc. Feminists like many other groups are divided about this because some feminists support the repression of sexual imagery as it is seen to demean and commodify women. Frequent reminders that the Indian culture and tradition were under threat by various marauding force gave impetus to the rise of the Hindu Right during this time. The cultural interventions of the Hindu Right riding on public anxieties around the loss of 'Indian Cultural values', included the enactment of laws restricting speech and expression. Restriction were imposed by the amendment in the Cable Television Networks (Regulation) Act, 1995. In addition to imposing a highly censorious Programme and Advertising Code, the BJP government introduced pre-exhibition scrutiny and censorship for all TV programmes by bringing them under the Cinematograph Act of 1952. Censorship has been central to the Hindu right's campaigns and to this end it has used both legal and extra-legal measures. But it is also important to remember that the demand for bans did not come from the Hindu right alone but also from different women's groups and political parties ideologically opposed to the Hindu right.

Regulation increased to the extent that the children's TV show Shaktimaan launched in September 1997, discontinued it telecast on the state-owned channel Doordarshan after March 1998. The reason being the United News of India alleged that the serial was responsible for the death and injury of several children who either to imitate the superhero or endangered themselves to be rescued by him. The Delhi High Court appointed a committee in this regard. According to the popular account copycat children are unable to differentiate between fact and fiction. However, the Committee did question the popular account calling it absurd as films and television serials of the time were full of superhero/superhuman antics. Further, it also pointed out at the two most popular television serials of the time- the Ramayana and the Mahabharata that depicted unusual and psychic power to reiterate its point. The debate around censorship

[5] Media violence has been understood as the correlation between themes of violence in media sources such as videos, television serials and films with the real-world aggression and violence.

and media impact on children continued to increase in the 21st century and the way this has impacted the debate on sex education has been dealt in the next chapter.

On the other hand, the issues of censorship remain a hurdle for those attempting to move sexual rights forward on the policy agenda as censorship of books, films, internet websites would help in reinforcing the stigma associated with sexuality. The experience and processes of spectatorship transformed with larger cultural transformation in times ahead. The Indian mediascape of the 1990s saw the friction between the new and old media to coexist and spread as multiple channels, images and media platforms were emerging.

PART III

2.3 ADOLESCENCE EDUCATION PROGRAMME

It was in 2005 that the Adolescence Education Programme was developed by the National Council of Educational Research and Training (NCERT[6]) in collaboration with the UNFPA and launched by the Ministry of Human Resource Development (MHRD), Government of India. The Adolescence Education Programme (AEP) aims to 'empower young people with accurate, age appropriate and culturally relevant information, promote healthy attitudes and develop skills to enable them to respond to real life situations in positive and responsible ways' (Yadav, 2014). The (NCERT) is the coordinating agency of AEP. AEP also works through national agencies such as - Kendriya Vidyalaya Sangathan (KVS)[7], Navodaya Vidyalaya Samiti (NVS)[8], National Institute of Open School (NIOS)[9] and the State Council of Educational Research and Training (SCERTs) that caters to schools run by State Governments under the National Population Education Project (NPEP) (Yadav, 2014). The state did not take into account the emerging concept of sexual rights to advocate sex education as a result the

[6] NCERT is an autonomous body under the Ministry of Human Resource Development.
[7] KVS also known as Kendriya Vidyalayas are affiliated to the Central Board of Secondary Education. These schools cater to the educational needs of children of transferable central government employees including defense and paramilitary personnel.
[8] NVS is an autonomous body under the Ministry of Human Resource Development, Department of Secondary & Higher Education, Government of India. Navodaya Vidyalayas are unique experiment intended to provide high-quality education to talented young people from marginalized sections of society.
[9] NIOS also known as National Open School was established in 1989 as an autonomous organization by the Ministry of Human Resource Development. NIOS provides general and academic courses at secondary and senior secondary level along with a number of vocational courses.

adolescent education programme of the state has not been framed within the human rights discourse.

At the initial level, Odisha (Orissa then), Gujarat, Madhya Pradesh, Maharashtra, Rajasthan and Kerala were chosen as pilot states to implement the AEP. It met with outrage from the different sections of the society from the religious leaders to that of political parties, parents, teachers and many others. In this regard 11 states put a ban on AEP/sex education. It was only in Odisha (Orissa then) that Adolescent Reproductive and Sexual Health (ARSH) curriculum (known at national level as the Adolescence Education Programme) was implemented by the state government, as intra-curricular and was made compulsory (Samuels, et al., 2013).

The pilot programme in the four districts in Orissa included a 'compulsory curriculum comprising of three components namely – on growing up and sexuality, HIV/AIDS and drug abuse. The target population decided was adolescent aged 13–16 years, with classes every week for four hours for the duration of 4-year. It was also decided that at least one female teacher be there in each pilot school. The pilot was to be regularly monitored and assessed (by the Project Directorate and Project Officer) with an end-of-pilot evaluation (Samuels, et al., 2013). However, the pilot project was disrupted and stopped by socio-cultural and political opposition. It was evaluated later that the programme and the pilot project lacked advocacy and addressing concerns of the State and district level stakeholders with the curriculum.

Unlike the countries in Europe where the content of sex education was debated and decided, in case of India this did not follow. Hence the major issue of contestation remained the nature and content of the curriculum. The opponents argued that the content of the curriculum were too explicit targeting children who were too young and therefore potentially encouraging promiscuity. Such responses mostly came from the conservative groups but even the liberals and the secular Left did not present a clear stake on the proposal to have a sex education programme in India. As oppose to countries in Europe, who adopted sex abstinence approach to sex education, the conservative group in India on the other hand argued that sex education is a foreign concept and that it is against Indian cultural values. The Hindu right wing group argued that India need imposition of its traditional norms rather than any kind of sex education. Fears were expressed that it would sexualize Indian children and cause early sexual

experimentation as in the West. Some ‘even labelled HIV and AIDS as a ‘western’ disease and felt that international pharmaceutical companies were manufacturing statistics about its incidence in India merely to push up drugs and condom sales in Indian markets and that we should not buckle to this pressure’ (Chakravarti, 2011).

2.2.(A) STATE’S PERSPECTIVE ON AEP

The AEP advocacy manual (CBSE Portal, accessed in 2018) mentions adolescents as an underserved population group that requires urgent attention for meeting their health needs. The rapidly changing globalized world needs new strategies to be developed that enables the young population to adapt to the changes. It was noted that growing numbers of adolescents were adopting irresponsible health and sexual practices under peer pressure and substance-abuse. Adolescents adopt risky behavior mainly because they are unformed on crucial issues appropriately, lack the skills to manage their emotions and life-situations and do not have youth friendly services available to them. AEP has been conceptualized as knowledge of the process of growing up during adolescence, HIV/AIDS and substance abuse. Its objectives are to improve necessary knowledge base and life-skills in adolescence so that they can manage risky situations completely and develop a positive attitude towards people living with HIV/AIDS. Adolescents are looked at as a large human resource (22% according to the 2001 Census). Their behavior has an impact on the National Health Indicators like maternal and infant mortality that are directly linked to population stabilization goal of the state. The manual talks about India having a large percentage of its population in the working age group of 15-59 years, but the situation will change with the fertility rates declining slowly. India presently has the demographic bonus of high young population and window of opportunity[10]. Sexually responsible adolescents are the window of opportunity as a qualitative human resource. Adolescents as a population group is like an economic and political opportunity that has implications for the future scenario of the country. The State clearly has a resource approach in addressing the reproductive and sexual health and knowledge needs of adolescents.

Hence, after the public and political uproar that followed pilot project of AEP, the curriculum was revised and developed by numerous agencies both governmental and

[10] Window of opportunity means that there is an opportunity to do something but that this opportunity will only last for a short time and so it needs to be taken advantage of quickly.

non-governmental. One such revised teachers' curriculum version was developed by the NCERT with support from the UNFPA in 2009-10. Another revised version of the AEP has been developed by NACO[11] (Das, 2014). Cognizant of the political opposition the AEP received in 2005, efforts are made to create an enabling atmosphere for the implementation of AEP. Advocacy sessions and workshops are being organized with principals and parents of participating schools.

The discourse on sex education in India thus began with it been looked at as one of the population control measures. Though adolescence education programme of the State tries to directly impart sex education in schools but its approach is that of HIV/AIDS prevention rather than providing a comprehensive knowledge on the subject matter of sex and sexuality to adolescents for the wholesome development of their individuality. On the other hand, there have been progressive individuals and non-governmental organizations who have come to realize the importance of imparting sex education to adolescents and are advocating for the same. How has their contribution in terms of research and practice changed the way issues on sex and sexuality gets treated in contemporary India will help us to understand the future of sex education in India.

[11] NACO established in 1992 is under the Ministry of Health and Family Welfare. It implements policies and programmes meant for prevention and control of HIV/AIDS in India.

CHAPTER THREE

NON-GOVERNMENTAL ORGANIZATIONS AND SEX EDUCATION IN INDIA

The previous chapter dealt with the trajectory of sex education in India and the way in which the state responded to the issue. This chapter looks into the different approach that NGOs in India took in addressing the issue of sex education and the extent to which their contribution has brought change in the perception on sex education. The two non-governmental organizations I have chosen are Family Planning Association of India (1949) and TARSHI (1997).

The reason to choose FPAI has been firstly as an organization that was established in 1949 it has an experience base of 68 years during the course of which it shifted and revised its approach in providing reproductive and sexual health facilities and educational programmes according to lessons learnt. Secondly, FPAI has a broad base throughout the country as it's a national NGO and provides broad range of provisions as will be brought out in the chapter. TARSHI on the other hand is squarely focused on dealing with reproductive and sexual health issues through its helpline, counselling and online publications. In this regard this chapter has been divided into three parts. The first part deals with the work of Family Planning Association of India in the field of population education and sex education. The second part deals with adolescent reproductive and sexual health, TARSHI's work in this field and critical evaluation of AEP by academicians and NGOs. The third part deals with the discourse on CSE in India.

PART I

3.1. FAMILY PLANNING ASSOCIATION OF INDIA

The Family Planning Association of India (FPA India) is a national level not-for profit organization established in 1949, India. The organization is a founder member of the International Planned parenthood Federation (IPPF) (International, 2018). In 1952, the IPPF was founded at the Third International Conference on Planned Parenthood in Bombay (presently Mumbai), India by Margaret Sanger from America, Dhanvanti

Rama Rau from India accompanied by Elise Ottensen -Jensen from Sweden (International, International Planned Parenthood Federation, history, 2018). IPPF resulted from the consistent campaigning and firm belief of women like Margaret Sanger, Rama Rau and Elise Ottensen-Jensen in women's right to control their fertility. In view of the wide range of programmes, services and educational initiatives that FPAI provides in the area of sexual health since 1950s its donors range from philanthropists and private charitable trust to Government of India (respective state governments), United Nations Population Fund, European Union, India HIV/AIDS alliance, Population Foundation of India and many others.

The organization now has over 40 local branches spread all over the country. FPAI closely works with many other non-governmental organizations, private practitioners/ experts from various backgrounds and the government. The organization employs a community-centered approach aiming to encourage people from the community to form local community groups in collaboration with the FPAI team in providing health and particularly reproductive and sexual health related services. In consonance with the government's decision to promote family planning programmes and service through educational mode, FPAI too has developed a wide-range of educational programmes from time to time.

3.1. (A) FPAI: FROM POPULATION EDUCATION TO SEX EDUCATION (1950s to 1980s)

FPAI from 1950s till 1980s exclusively promoted and implemented family planning programmes and services thereby complementing the State's efforts of population control. But FPAI's orientation to implement population control measures were different from that of the then government in power. This section is thus, about FPAI's community centric approach to promote and implement family planning programmes.

In the late 1960s, FPAI began educating young people in school, colleges and non-formal educational institutions on issues related to population and family life reflecting the demographic concerns of the time. As Amita Dahanu (Dahanu, 2018) from FPAI narrates- the organization with its community centered approach soon realized that working with community is a different ball game altogether. The common people found it difficult to relate to ideas such as population explosion and its impact on the economy,

scarcity of resources, environmental impact and so on. Because these were the people who were concerned with ‘mujhe kaal ka roti milega ki nahi milega’ (will I be able to avail food tomorrow or not). Dahanu explains how convincing people to use condoms and contraception was difficult at that time. Firstly, the child mortality rate was high and secondly the social mindset of having a male child meant every family tried having at least one male child which meant pressurizing the woman to reproduce multiple children. Joint family system existed back then which meant the authority and the power to decide on familial matters lay with the eldest male (grandfather) of the family. Women had no say in the decision making of when and how many children she wants. Decisions related to health, nutrition and work were taken by mothers-in-law. The only way a woman could gain some power and say in the family was after giving birth to a male child. In such a scenario FPAI started community programmes for women that taught them crafts that they wanted to learn like mehendi, making designs on pots and clothes and similar crafts that they would practice at home. Having learned these craft the women would earn little bit of money from selling it and that eventually started changing their perspective about self and self-health.

FPAI also had programmes on encouraging spousal communication. The spousal relationship of the time was such that it was a given that a woman cannot question her husband’s rights or conjugal rights of having sex whenever the husband demanded. The social and sexual practices were driven by the gendered perception of the time that men are aggressive and sexual whereas women are supposed to be passive and concerned about satisfying her husband. The question of a woman saying no to sex by her husband just didn’t exist. As the concept of family planning also endorsed by the State was all about shifting the decision-making power on reproduction of the next generation from the head of the joint family (which would in most cases be the grandfather) to the couple the spousal communication oriented programmes were essential. The level of ignorance about the body was so high that most men and women didn’t know the difference between the urinal opening and the vaginal opening and also on the very act of sex or conception. The dominant idea of the time was that sex should take place within marriage and for the purpose of reproduction.

Another programmes that Dahanu mentions is the Saas- Bahu Milava. Such a programme was important as the mother-in-law would take the health decisions of the

daughter-in-law. Hence, it was important to educate the mother-in-laws to prioritize the health of the pregnant daughter-in-laws during and post pregnancy because only a healthy mother would deliver a healthy baby that would have high chances of surviving post birth.

These were some of the important FPAI's community based educational programmes. On the other hand, FPAI also had clinics across the country that provided services like abortion, offered sterilization and termination methods, provided condoms and other contraception. The services that the organization provided through clinics were paid ones whereas the educational programmes were be mostly funded.

Having learned from the experience that most of the men and women lacked knowledge of the sexual organs and how conception happens, FPAI in 1980s decided to impart sex education to young people. Amita Dahanu (Dahanu, 2018) acknowledges that FPAI's sex education programme focused on educating the young only on the anatomy and physiology of the body and hence covered topics like puberty, menstruation, conception, contraception. Sex education was thus driven by the biological understanding of sex and had a bio-medical narration to it. The purpose of sex education was encouraging young people in delaying the age of marriage and opting for planned conception. But it was difficult to convince parents about the importance of sex education. Most parents found this concept strange, unnecessary and unacceptable.

3.1. (B) NGOs AND SEX EDUCATION

The Cairo Conference of 1994 was so influential that FPAI, Chennai branch started their sex education programme in schools in the very year 1994 as funds were flowing from international and governmental sources. But on ground the response of the principals and teachers was more of passive willingness. Sex education was unpopular among the school authorities, teachers and communities. It was a top-down approach that lacked effective communication channeled to its main stakeholders -the school authorities and parents. The 1990s seems like a decade of budding sex education initiatives even though there was strong resistance from parents and conservative political groups like the Rashtriya Swayamsevak Sangh (RSS). But nevertheless, the initiatives existed because HIV cases were increasing in India and its impact was being felt more so around the mid-nineties.

A largely grudging acceptance of sex education was also accompanied by some rare instances of active welcome. In a rare case, communities in the Dakshinbagi village of West Bengal readily send their adolescent girls and boys for a sex education training camp which was conducted by the Child in Need Institute (CINI[1]), an NGO in 1997 (Swati, 2004). Mostly women showed signs of enthusiasm on the issue of sex education. Women who attended the CARE[2] training programme with their adolescent girls in a slum in Jabalpur, Madhya Pradesh signed that the present generation of adolescent girls should not make the same mistakes that they made out of ignorance. "When girls know about their bodies, they are more careful and take better care of themselves" signed a group of women of Dakshinbagi of West Bengal.

An unexpected result of these small sex education initiatives taken up by NGOs like CINI and CARE was that the mother-daughter relation improved significantly. Girls after attending sex education training programmes started teaching their mothers menstrual hygiene. It was observed that sex education acts as a catalyst for profound changes in the outlook and behavior of adolescents as information about the body led to not only better hygiene and nutritional practices by teenagers but also to a radical change in their concepts of dignity, relationships and aspirations. The way adolescent girls internalized sex education was different from that of adolescent boys. Girls tended to link sex education with lifting the veil of abuse, freedom of movement and career aspirations. For them talking about the body is the platform where they can talk about the repression, deprivation, shame and fear that they have grown up with. It was observed that information of the body and sex would stir thought process in adolescent girls. The point to be aware of here is that all these sex education initiatives were usually catered under the name of family life education or adolescent health education and not explicitly using the term 'sex education'. Preetam Pal from the Women's Development Project, Rajasthan, conducted a two-year action research project under the title "Empowering girls through health education" in five slums of Jaipur. Pal argues that providing adolescent girls with information on nutrition and menstrual hygiene will have little effect if a girl's self-worth is low. This is because girls usually accept the

[1] CINI is a not-for-profit organization in India established in the year 1974 by the pediatrician Dr. Sameer Chaudhuri. The organization is located in Kolkata, West Bengal, India and extends its operation to adjoining states Jharkhand and Odhisha.

[2] CARE is a not-for-profit organization working in India for over 65 years, focusing on alleviating poverty and social injustice. Their overall goal is the empowerment of women and girls from poor and marginalized communities leading to improvement in their lives and livelihoods.

family values and attach them to their bodies. She will not think it is necessary to take care of her health until and unless she understands the relationship between firstly her health to that of her family, secondly her future husband and their marital life, and thirdly to her own mobility. Patriarchal codes are perpetuated through women's bodies and until and unless the conflict between gender perception and self-evaluation which is acute in adolescents is resolved mere information on nutrition and hygiene will have little effect. Hence, programmes on sex education should encompass a range of social, economic and political issues that are connected to health to have an overarching effect.

During this time FPAI was able to promote and impart sexual health and sex education throughout the country through its branches. From the response that FPAI's sex education programme received and in consultation with Dr. Mahindra Watsa and Dhun Panthaki FPAI initiated to shift its focus to sexuality education.

PART II

3.2. ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH AND SEXUAL KNOWLEDGE

Adolescent as a category and age group have come to receive attention not just in India but all over the world. Adolescence is now regarded as a crucial process as a lot of research suggests that attitudes and values formed during this period stay long ahead in adulthood. The debate on reproductive and sexual health stirred up by the Cairo Conference and the growing incidences of STIs and diseases among adolescents gave impetus to the research on adolescent reproductive and sexual health issues in India. This section thus maps out the adolescent reproductive and sexual health status, the cultural and social barriers in imparting sexual knowledge to adolescents and FPAI's contribution in this regard.

Bott and Jejeebhoy points out that in South Asia the sexual debut of adolescents particularly girls happen within marriage because of the existence of traditions such as child marriage (Bott, 2003, pp. 3-28). On the other hand, the international scenario is different because what is problematic for them is premarital sex or sex outside marriage that adolescents get into. This is not to claim that premarital sex amongst adolescents does not exist in India at all. But to bring out the aspect of married adolescent sex that

exist in India because of the child marriage tradition still practiced in some parts of the country. Surveys conducted in India have found out that by the age of 15 nearly 24 percent of adolescent girls were married which is not the case with boys with only 6 percent of adolescent boys getting married by then (Bott, 2003, p. 8). The sexual activity of adolescent girls within marriage in the Indian context expose them to teen pregnancy which puts them at a higher risk of dying during childbirth or further exacerbates their reproductive health. The situation is worsened by social seclusion norm that discourage even married adolescents to access information and contraception services on safe and protected sex.

From the onset of puberty, the seclusion norms for girls increases in number and become dominant than before. A good or ideal girl is supposed to not go out, when out cover the body especially the breast, not to laugh loudly, cover her head or not to hold the head up, not to look and talk to boys or men and so on (Swati, 2004). As a result, adolescent girls lack the experience or physical access to the outside world. Due to which they are unaware of the few services that cater to their needs for nutrition and overall health, vocational skills and economic opportunities. In case of an adolescent bride, the adolescent is unlikely to have any say in deciding whom to marry, and when married whether or not to have a sexual relation and to bear children. Adolescent married girls lack a biologically developed body to bear children and the education or awareness or agency to assert their own health needs. The social norms on the other hand places strong pressure on the girls to consummate their marriage and prove their fertility immediately after marriage. In many cases even today the only way a woman gets accepted and gains economic security in their marital homes is after giving birth to a boy. These new findings meant that a uniform sex education curriculum or programme would fail or is not enough as Indian population is diverse and multicultural. The reproductive and sexual health needs of rural adolescents were different from that of urban. The government has been working on reducing the school dropout rates but even then, a significant number of adolescent girls and boys join the workforce. This pushes these adolescents particularly girls in a vicious cycle of poverty and exploitation that will be dealt later in this section. Bott and Jejeebhoy have pointed out at the need for a sex education programme for out-of school adolescents of both rural and urban areas.

Critiquing the sex education model that narrowly focus on the physiology of the body, many of the recommendations of the international conference on adolescent reproductive health held in Mumbai (2000) pointed towards the need to have a comprehensive sex education programme for the Indian adolescents that is culturally sensitive and relevant. A comprehensive sex education programme meant challenging some of the traditional social, economic and political practices that were responsible for perpetuating risk behavior[3].

Dhun Panthaki through her research and experience in the field of sexuality brought out the connection between health, women's status and the importance of sexuality education in the third edition of her book '*Education in Human Sexuality'*. A huge gap exists between the constitutional rights that men and women both are entitled to in India and the ground realities. Arguing that women are constitutionally entitled to equal rights and opportunities for education, health care and employment they often fail in claiming them as the personal laws of the different religious groups in India have a larger stake in governing the social aspects of life than the constitutional laws. Also, the personal laws for the various religions governing marriage, divorce, property rights, child custody and so on, do not support gender equality. The body of the women is closely regulated by the social attitude, norms and behavior that derive its legitimacy from the personal laws. Though women in India do take recourse to law, 'feminists in India have been critical of an overreliance of the law' (Dutta, 2013) as the means to achieve women empowerment and gender equality.

Panthaki argues that gender inequalities and discrimination are prominently visible in the area of health from skewed child sex ratio to girl-child malnutrition and under-five mortality, to high maternal mortality and morbidity as well as the direct physical and mental effects of overt violence and underlying insecurity of life. She further argues that discrimination does not always exist in the form of overt denial of services. One needs to look at the discrimination that a woman is subject to because of her incapability in exercising her agency to access social, economic and political opportunities resulting from the orthodox and discriminatory norms of patriarchy. Panthaki proposes that sexuality education needs to teach assertiveness, negotiation skills and critical thinking

[3] Sexual initiation that are unplanned and unprotected.

to young girls in order to enable them to develop their intellectual and decision-making capacities.

Sexual violence and the fear of this violence has been a permanent constraint on women's mobility in society. It has been the main social tool by which women are subordinated to men. Physical violence such as domestic violence, marital rape, rape, sexual harassment, acid attacks and honor killing further have serious health. However, education have brought substantial change in women's ability to fight discrimination and assert her rights and imparting sexuality education would prove to be a significant move in this direction.

Taking cognizance of this findings FPAI has in its sexuality education programme incorporated biological, emotional and psychological changes that adolescent undergoes during puberty. The content of the programme also focuses on developing communication skills and understanding and handling peer pressure. The organization imparts sexuality education to both school and out-of-school adolescent. However, targeting out-of-school adolescents has its own challenges such as restricting on the duration and quantity of sexual information that can be imparted in an open space.

India is culturally, socially, economically and politically diverse and hence there are spaces that are more governed and regulated by conservative norms than others. For instance, women experience urban spaces more liberating as there are opportunities to education, jobs, socialization, interaction with opposite sex that are crucial aspects in the social development of individuality. Irrespective of conservative or liberal spaces double standard on sexuality exist that substantially hinders women ability to refuse sex and make their own reproductive health decisions especially within marriage. The absence and ignorance of the sexual body makes even negotiation difficult for women. The state has come to realize that a woman's body is of utmost concern to it in effectively implementing its population control and stabilization goals. In this regard the State has post 1994 has made policies that focus on ensuring the reproductive health of the woman for example the Reproductive and Child Health policy. However, because there is a kind of shame and stigma attached to open discussion on sex and the sexual body women are not aware of these provisions. Claiming such health and welfare schemes meant for women will only follow when the stigma attached to accessing and discussion information about sexual body is removed. This has been reiterated by

NACO in its 2015 report on the National Aids Prevention and Control Policy of 2002. NACO has urged to look at HIV/AIDS as a 'political and social challenge' (NACO, 2015) rather than a mere public health issue. Recognizing that behavioral change will not happen until gender inequalities, power relations, discrimination and stigma attach to any open discussion on sexual health matters are addressed as these significant obstacles in programmes that aim at prevention of spread of HIV. Mere availability of health facilities like contraception, medical care for dealing with STIs and HIV and factual data of the body will not automatically translate into adoption of rational and sexually responsible behavior on the part of individual. The health facilities have to be backed with the comprehensive understanding of the sexual body.

3.2. (A) TARSHI

Talking About Reproductive and Sexual Health and Issues (TARSHI) is a non-governmental organization established in 1996 by Radhika Chandiramani. TARSHI believes in enabling people with an agency over their sexual and reproductive health and sexuality. In this regard the organization disseminate information, knowledge and perspectives on sexuality, sexual and reproductive health within a human rights framework (TARSHI, 2018) through helplines/infoline, counselling, journals and online magazine. TARSHI also conducts trainings, workshops and consultancies to make counselling skills, discussion and knowledge on gender and sexuality more accessible to people. On the issue of CSE TARSHI has engaged with other organizations and individuals in understanding people's response to CSE and advocating CSE. In 2014 TARSHI conducted a talk with parents who impart sex education to their children.

TARSHI's previous funder included international donors like the Ford Foundation, RFSU[4], MacArthur Foundation, SIECUS[5], Astraea (lesbian foundation for justice), The

[4] RFSU is Swedish Confederation of Sexual Enlightenment established in 1933 by Elise Ottensen-Jensen.
[5] SIECUS is Sexuality Information and Education Council of the United States.

David and Lucile Packard Foundation and Deakin University. Its current funder includes AJWS[6], IWHC[7] and the Human Capability Foundation[8].

A study conducted by TARSHI in partnership with CREA[9] in 2002 critically reviewed some of the existing studies on sexuality and sexual behavior in India. As against the popular notion that sexual activity in India begins after marriage the study revealed that sexual activity commences on average around 10 years of age among street boys and during mid to late adolescence among boys and girls in urban and rural areas (Chandiramani, Kapadia, & Khanna, 2002). Though adolescents are aware of contraception, they find it difficult to obtain contraceptives. There is a dominant conception about condoms that it interferes with sexual pleasure. The level of knowledge about reproductive and sexual health among adolescents is low. Even if they are aware of HIV/AIDS adolescents hardly know the difference between HIV and AIDS and other STDs. A commonly held misconception about HIV/AIDS and other sexually transmitted diseases is that they are caused by kissing, deviant sexual practices, mosquito bites and sex with either a menstruating woman or homosexuals.

The study also revealed that adolescent boys and men knew more about sexual matters such as orgasm, masturbation, oral sex, anal sex and contraception as compared to adolescent girls and women. Adolescent boys and men found masturbation pleasurable but expressed the anxiety and stigma attached to it. Girls on the other hand perceived masturbation as an activity that causes weakness, infertility and disease.

Despite social disrespect attach to it pre-marital and extra marital sexual activity is prevalent in urban and rural areas. The study report that sexual coercion and violence exist even in consensual relationships and understanding of ideas like consent is almost non-existent. An alarming finding has been that both girls and boys have experienced sexual abuse but boys perceive coercive and violent sex as pleasurable and necessary

[6] AJWS is the American Jewish World Service
[7] International Women's Health Coalition
[8] HCF is a grant-making foundation based in UK founded in 2011 that support organizations that working for the rights of marginalized communities.
[9] Creating Resources for Empowerment in Action (CREA) founded in 2000, is a feminist human rights organization located in New Delhi. The organization works at the grassroot, regional, national and international level to advance the rights of women and girls, and the reproductive and sexual freedoms of all people.

for sexual satisfaction. Mass media was reported as the single most mentioned source from where sexual information and ideas are derived.

Presence of sexual myths and misconceptions and lack of knowledge about the body and reproductive health make it difficult for adolescents and women to take rational decisions on matters related to safe sex and reproductive health.

The following section is important in understanding the framework both TARSHI and FPAI are using to advocate CSE in India.

3.2. (B) SEXUAL RIGHTS AND CSE

Debates over sexual rights are still in a state of flux. Their overlap with a range of rights especially rights to equality, privacy, health, non-discrimination and freedom from violence, among others are being explored. The 'discourse on sexual rights has gained momentum in the last decade through the international space opened up by the UN world conferences as well as the work of activists across the world but it has also faced increasing resistance from traditionalist forces including religious bodies as well as governments' (Misra, 2005).

The transformation in attitudes towards sexuality in many parts of Asia for example, and the determined efforts of numerous individuals and organizations to accelerate change has not been highlighted within the international community. Improvements in reproductive and sexual health services, the mobilization of vulnerable groups to fend off HIV infection, the greater rights accorded to sex workers, and a general broadening of attitudes towards sexual diversity are just some of the outcomes of these efforts.

The right to sexual health itself is contested, but it is being strategically used to advance sexual rights as human rights. 'Although it appears politically tempting', Miller argues, 'to claim more aspects of sexual rights through this approach (as it sidesteps certain condemnations based on religion, culture or morals), one should be wary of over-medicalizing a constellation of social and biological processes that encompass domains of imagination, expression and communication, law, religion and economics as well as the body' (Miller, 2001, 91(6)). In a significant move the United Nations Special Rapporteur Paul Hunt's report on the Right to Health (2004), has been seen as

groundbreaking as it clearly links sexuality, rights and health and concludes that sexual rights must be recognized as human rights.

The International Technical Guidance on Sexuality Education acknowledged that sexuality education had been primarily a part of HIV prevention response (UNESCO, 2009). Though HIV prevention measures remain important evidence and practice has validated that sexuality education has a broader relevance to other issues too. CSE was recognized as a concept that has gone beyond HIV prevention and sexual health approach to enabling an overall wellbeing of young people. It is acknowledged that CSE has been positioned within the framework of human rights and gender equality (UNESCO, 2009). CSE has been endorsed by UNESCO, UNFPA and IPPF.

By assess the Adolescence Education Programme of the State TARSHI, FPAI and other progressive sections of people have illustrated the limitations of AEP and the need for a comprehensive model of sex education in India.

3.2. (C) ADOLESCENCE EDUCATION PROGRAMME: ASSESSMENT

Paromita Chakravarty had examined the Life Style Education Manual (Life Style 2005), a textbook on adolescent sexual and reproductive health designed by the West Bengal Board of Secondary Education (in association with NACO and the West Bengal State AIDS Prevention and Control Organization) for teachers to be used as a guide or manual. It was introduced as early as the 2006-07 session into the curriculum of all secondary schools in the state of West Bengal, India (Chakravarti, 2011).

She examines the limitations of the Life Style Education not just in its immediate context of the AEP and the Left government's approach to it but also placing it in the wider historical trajectory of Bengal. While doing so Chakravarty argues that the abstinence model of sex has more to do with the Victorian morality than to do with Indian culture and morality. She substantiates her argument by using Foucault's distinction between the two types of discourses on sexuality- the art of lovemaking connected with the Orient and the other being the science of sexual behavior connected with the West. India was introduced to the science of sex- sexology and sexual behavior by the British during colonization. As it has been brought out in the first chapter sexology of the late 19th century reiterated moralistic understand of sex in scientific language and added a prescriptive medical narration to it. Sexology thus looked at

sexuality through its restricted prism of reproduction and recommended abstinence to prevent sexually transmitted infections and diseases. The sexual abstinence norm coincided with the Hindu Brahmanical idea of brahmacharya that considered sexual abstinence as a necessary condition to attain spiritual purity and power. The Hindu nationalism discourse of the time used the ideal of brahmacharya as one of its foundation ideas. Gandhi's abjuring of sex also helped in reiterating the connection between nationalism and brahmacharya.

On the other hand, the art of love making as brought out by texts like Kamasutra[10] and other texts by Vātsyāyana[11] introducing the pleasure aspect of sex. these texts focus on enhancing intimacy by encouraging communication and practice of diverse sexual acts between the sexual partners. As any kind of discussion on sex education has not received enough attention the implications of encompassing the ancient indigenous understanding of sexuality on imparting sexual knowledge is an imperative arena yet to be explored. The Life Style Education Manual predicts the influence of the science on sex and its perception of sex education and has failed to even engage with the literature on the art of love making. Hence, sex education in the form of adolescence education has a fear based, abstinence-driven, HIV prevention approach to it.

The Life Style Education's stated aim was providing a comprehensive knowledge about the physical, emotional, psychological and intellectual changes that take place in the body and mind during puberty. However, Chakravarti argues that the manual is in no way a comprehensive text as it narrowly focuses on the body's physiology and anatomy and talks about the mind in need of a moral lens to control one's sexuality.

Swati Bhattarcharjee on the other hand describes the initiatives to introduce sex education in India as the politics of silence (Swati, 2004). Illustrating the enthusiasm with which sex education in the form of the adolescent education programme started in the 1990s and early 2000 but failed to continue, Bhattarcharjee argues that the failure is due to the lack of 'enough political clout to make a change' (Swati, 2004).

[10] Kamasutra is an ancient Hindu text written in Sanskrit language by Vātsyāyana that is widely considered as a standard work on sexual behaviors of men and women of the time. It is not exclusively a sex manual but a philosophical text that explores sex and other pleasure-oriented faculties (mind) of humans to enable a virtuous and content living.

[11] Vātsyāyana was an ancient Indian philosopher who lived roughly between second sixth to second century BC in Patliputra (presently Patna) and is known for his writing on sex and sexuality.

Bhattacharjee substantiates her argument by illustrating how different schemes and programmes on sex education in India are kept to the level of mere disposal of medical information on sexual hygiene and prevention of STDs and HIV/AIDS. There are many initiatives like the Reproductive and Child Health (RCH) policy, the Integrated Child Development Scheme (ICDS) and many other governmental policies and programmes. But all these policies and consequent schemes are discreet due to which information is available but that which is vague and incomprehensible. For instance, Ashok Kumar, Deputy Commissioner, Health and Family Welfare Department says that the RCH policy is concerned with the girl's physical development, healthy habits disciplined upbringing, healthy reproductive growth and behavior, but sexual abuse does not fall in the ambit of the RCH policy. This indicates the narrow understanding of health (which focuses only on the biological aspects of health and neglect the social, economic and political aspects) that is been used in implementing the RCH policy.

Even the 'model' adolescent programme being run by the Directorate of Social Welfare, Tamil Nadu under the Integrated Child Development Scheme, does not address issues of sexual abuse. Its two-day camp programme consists of health and hygiene awareness, legal literacy and nutrition. Like this programme, many other such programmes have a clinical approach that works on a nexus of primary health centre-counsellors-specialists. Concepts such as sexuality, sexual abuse, social norms, femininity, masculinity and many others are not brought under discussion in these schemes.

FPAI have also pointed at some of the limitations of AEP. AEP target audience is school adolescents and there has been no programme formulated for the out-of-school adolescents. AEP's curriculum resembles the old model of sex education that focused on anatomy and HIV/AIDS prevention information and has excluded topics such as alternative sexuality, masturbation, nocturnal emission etc. Also, there is no uniformity in the implementation of sex/adolescent education programmes across states and union territories as some states have banned AEP.

TARSHI has vehemently critiqued AEP and the Teacher's Workbook having known from the telephone helpline and counselling it provide the range of sexual problems and ignorance that adults and young people face. Even if AEP's approach is imparting HIV prevention information it does not explain how to use a condom and why is condom a

protection. Young people are encouraged to prevent sexually transmitted infections and diseases without explaining what sex is and how does sexual transmission happen. The language used to describe sexual intercourse is vague and referred as 'intimate physical relationship' (TARSHI, published 2008). The curriculum has all important facts related to HIV but lacks instructions and explanation to back those facts. AEP promotes abstinence until marriage approach calling it as the 'expected standard of human sexual activity' (TARSHI, published 2008).

3.2. (D) SEXUAL IGNORANCE AND SEXUAL PROBLEMS IN INDIA

Post AIDS crisis the discourse on sexuality was dominated with issues such as prevention of HIV/AIDS and other STIs, safe, importance of using contraception/safe sex and substance abuse. The 21st century India has experience diverse sexual issues coming to forefront. Beginning with challenging section 377[12] of the Indian Penal Code by Naz Foundation in 2001 that brought homosexuality in the public domain of discussion; followed by the debate sparked by the introduction of Adolescence Education Programme over sex education in 2005 and the Nirbhaya rape[13] incident of 2012 that brought out the alarming situation of increasing numbers of sexual violence against women. Sex outside of marriage, same-sex partnerships, rape, child sexual abuse and HIV/AIDS rarely stayed far from the headlines.

People in the age of internet heavily rely on various websites on google and pornography as sources of sex education. Experts like Dr. Mahindra Watsa who is associated with FPAI and clinical psychologist Radhika Chandiramani from TARSHI have written about the sexual problems that Indian adults and young people face because of lack of authentic information and knowledge on the subject matter of sex. Dr. Rajan Bhonsle and Dr. Minnu Bhonsle are counsellors who have also spoken in favor of sex education but are neither associated with TARSHI or FPAI.

[12] Section 377 of the Indian Penal Code (1860): Unnatural offences – Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years and shall be liable to fine. This section was introduced in 1860 during the British rule in India and since then not revised.

[13] The Delhi gang rape that involved brutal rape and fatal assault of a 23-year-old female. The girl was named Nirbhaya and the case came to be popularly known as the Nirbhaya rape case.

Watsa and Chandiramani both answer to sexual queries asked to them by people of all age- adolescent, adults and adults in the old age in Mumbai Mirror and The Asian Age respectively. A compilation of these queries has been brought out in the form of books- '*Good Times for Everyone*' (2008) by Radhika Chandiramani and '*It's Normal'* (2015) by Mahindra Watsa. The counsellor couple Rajan and Minnu Bhonsle's book '*The Complete Book of Sex Education'* highlights the cultural and social factors that have supported sexual ignorance to persist in India.

Watsa and Chandiramani have received queries and curiosities on mainly three sets of sexual problems namely the biological physical, social and emotional aspects of sex and sexuality. The biological/physical aspect of sex and sexuality illustrated concerns on the size of penis, breasts, buttock, testicles, menstruation, circumcision, hymen/ (virginity restoring microsurgery), erectile dysfunction, sperm production, pubic hair and contraception. The social aspects of sex and sexuality illustrated reflected the social biases and stereotypes associated with hymen/ virginity (virginity restoring microsurgery), semen quantity, cross dressing, unsuccessful sex or first time sexual trouble, sex in old age, oral sex, sexual desires (whether its right to have them and when is it right to have them), LGBTQ sexual attraction. The queries on the emotional/psychological aspects of sex and sexuality included asking the difference between sex and love, teenage crush, teenage sex, how to handle breakups. There are sexual curiosities such as sexual foreplay, orgasm, sexual accessories (toys, lubes and imagination), kegel exercises, G-spot that were asked.

Watsa mentions how being a sex counsellor for years and having answered to hundreds of people he still gets one question very often that being- 'Am I normal?' (Watsa, 2015). Watsa illustrates in his book how there is not only a lot of sexual ignorance about the body (the anatomy and physiology) but also gendered stereotypes about sexuality. For instance, Watsa writes about a query he received from a young man who acknowledged that he does not like and does not watch X-rated video and his friends comment that he is not normal and if that is true. In response to concerns about sexual normality Watsa explains from where this concern originates. Children receive negative and moralistic messages from people like their parents, teachers and priest like don't touch your sexual parts, sex and sexual desires is a sin, masturbation is harmful without explaining why which initiates doubts in young minds. This is further compounded by lack of sex

education from parents or in schools regarding how to deal with erotic feelings, sexual attraction that are aroused after puberty through advertisements, movies, television serials and internet porn.

Sex counsellors like Watsa and Bhonsle acknowledge that sexology has revised some of its earlier assumptions. The dominant one being that homosexuality is not a disease or abnormality. There are no universal sexual practices that are categorized as abnormal but different cultures and societies have their understanding of normal and abnormal sexual activities.

Bhonsle and Bhonsle on the other hand explains why sexual ignorance exist in not just the uneducated but also educated people in India. They call the attitude of silence on sex in India as a learned attitude made to develop since childhood through the socialization that take place within the family. This attitude is so entrenched Bhonsles exclaims that in the many counselling cases they came across they found that even couples don't communication to each other their sexual needs and desires and live an unsatisfied sex life.

The work of Bhonsle and Bhonsle is significant in evaluating the institution of family in perpetuating this attitude of silence on sex and gender inequality. The counsellors firstly dismiss the popular perception that a sexual abuser is mostly a stranger. Secondly, they argue that according to statistics a child sexual abuser in most cases around 75 to 80 percent is someone the child knows and trusts. Within this around '45 percent are relatives such as uncles, cousins, brothers and even fathers. Another 30 to 40 percent are acquaintances such as friends, neighbors, servants, teachers, drivers and even doctors' (Bhonsle, 2016). Explaining that sexual abuse is confusing for kids firstly because sex education or discussion on even sexual safety don't exist in most Indian families. Secondly, children are taught on one hand to respect and obey their elder and on the other hand not to question them. The parents are often completely unaware that their child is being sexually abused. Even if either of the parent comes to know of the sexual abuse of the child most cases go unreported as parents are shameful of acknowledging that sexual abuse has happened with their child. Such a hypocritical mindset of parents and social attitude of silence on sex gives the abuser opportunity to continue to abuse. Research have showed that childhood abuse creates many mental

and psychological problem in adulthood. A lot of stigma is attached to mental health problems in India and hence its diagnosis and treatment are largely ignored.

Bhonsle and Bhonsle have also problematized the difference between good and bad touch that parents these days teach their kids. Good touch means a pleasurable touch whereas bad touch is understood as touch that is violent or causing pain. From their counselling session they have found that most child sexual abuse cases go unreported because the abused often find the abuse pleasurable. Most of the people come to know that they have been abused in their childhood very late in their life when they start having mental problems in the adulthood when they get married or get in a sexual relationship. Arguing that such loose form of sex education is more harmful Bhonsle stress the need to impart sex education only by trained sex educators who have a comprehensive knowledge of sex and sexuality.

In another bold move Bhonsle and Bhonsle bust the myths related to masturbation by providing a causal explanation to it. They have argued that masturbation has both advantages and disadvantages. They describe that masturbation is 'a natural form of release for pent up sexual tension in the absence of a sexual partner' (Bhonsle, 2016, pp. 106-107). As masturbation does not carry the risk of unwanted pregnancy or sexually transmitted infections it can prevent irresponsible sexual experimentation. On knowing the correct technique masturbation allows men to improve their ejaculatory control. Masturbation is considered abnormal or harmful problem only when it is done in front of others, proper hygiene is not maintained before and after the act and on it becoming an obsession that has started affecting other relationships of the concerned individual.

PART III

3.3. COMPREHENSIVE SEXUALITY EDUCATION IN INDIA

The advice that young people in India receive from their parents during puberty (particularly girls) related to their body and behavior has a prescriptive and moralistic tone to it. Sex education that the young receive in schools has a medical narration to it. There is enough research to prove that young people gain most of their sexual information from their peer, internet, films and pornography than their parents and

schools. Clearly a gap exists between what the parents and schools are willing to teach about sex and what the young is interested in knowing. FPAI looks at CSE as a concept that enables in filling this gap so that the young receive sexual knowledge that is authentic and scientific from a reliable source; in an age appropriate and culturally sensitive manner in India. IPPF has defined CSE as:

> "seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views 'sexuality' holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values" (IPPF, 2010, p. 6).

CSE curriculum designed by FPAI encompasses factual and comprehensive information to young people on diverse issues such as 'human rights and values, gender norms, sexuality and sexual behavior, consent, decision making, sexual coercion and sexual diversity, the body- puberty and reproduction, relationships- with family and peers, romantic and long term, communication- decision making skills for refusing unwanted sex, negotiating, correct usage of condoms/contraception, seeking guidance and support from parents and regarding substance abuse and sexual risk, sexual health especially STIs/ HIV and AIDS, unintended pregnancy, condoms and contraception and guidance on how to access health and support' (FPAI, accessed 2018). Since 2014 FPAI have started imparting its CSE curriculum in schools and out-of-schools. CSE is imparted in those schools that approach FPA India to provide information and guidance to school children of class IX and X. The seven aspects covered by CSE are reproductive system, responsible and irresponsible behavior, communication and decision-making skills, negotiation skills to handle peer pressure, how to say 'no', pleasure, measures to protect themselves. These aspects lay emphasis on developing sexual health and communication skills. The schools that have approached FPA India for CSE are mainly private schools. However, the complete CSE curriculum demands two-hour session but in case of schools only those instructions and information are provided that gets the approval of the principals of respective schools. As sex education has not been made mandatory teachers and principals have not yet shed their traditional attitude to sex education.

In order to promote CSE model of sexuality education in public schools that has the State endorsed AEP, FPAI in 2016 developed AEP+ by adding few more topics to the existing AEP curriculum. AEP+ curriculum was advocated to the Education Minister of Gujarat who expressed his inclination to support the curriculum. The 2016 annual report of FPAI mentions that 90,356 young people were provided FPAI's AEP+ package but does not provide details of the package.

On the other hand, TARSHI has tried to open up discussion on CSE with parents (TARSHI :. T., 2017) with the intention to create spaces that will allow parents to share their views and experience on sexual issues that young people in India face in the age of internet.

Anthony D'Souza had rightly pointed out three peculiar features of Indian culture that does not make parents fit to impart sex education to their children (see ch 2). The discussion held by TARSHI with parents is indicative of the social and cultural transformation that the Indian family system is undergoing. The three peculiar features that has undergone changes and continues to are namely the education level of the parents, the authoritarian pattern that restricts communication between parents and children and language of communication (that which has standard terminologies to communicate on matters related to sex and sexuality).

In order to understand what this process of transformation is let's look into the narration of the parents. The three parents who participated in the discussion were- Kaveri Ahuja, Satindra Sen and Reema Ahmed. Kaveri Ahuja is a mother to two teenage daughters. Satindra Sen has a 12-year-old daughter and Reema Ahmed is a single parent to a 9-year-old son and a child sexual abuse educator.

Education level of parents: Anthony D'Souza had recommended that Indian parents should be educated on the topic of sex as a part of adult education or through conducting educative seminar in order to equip them with the knowledge and confidence to impart sex education to their children. Though the adult education programme of the State has not included sex education in its curriculum the three parents in the discussion unanimously agree that parents today need to educate themselves on sex education. Reema Ahmed particularly narrates the efforts she had taken to educate herself. She mentions the two major challenges she faced while doing so. First was the complete

lack of any kind of ground work on sexuality education from the community, school and her family. Second was overcoming what she has termed as the 'ho' factor. By 'ho' factor Ahmed is trying to point out the innate tendency of Indians to react to any situation or conversation on sex with disdain, shock or bafflement and outrage. Such a behavior of parents immediately shuts off children and fills them with a sense of shame and guilt. Dr. Watsa has also pointed out such a behavior on the part of most Indian parents as the reason why an attitude of silence on matters of sex exists in India even today. Reema acknowledges that she had a similar behavior and attitude towards sex before and narrates an incident in this regard. The incident goes as- when her son was around three or four years old Reema saw him fiddling with this penis. This freaked her out. Instead of reacting immediately she decided to observe and learn from the situation. Reema realized that for her son fiddling with his penis was a normal activity and a way of exploring his body. Reema decided to unlearn her traditional behavior to react to such a situation.

Indian parents are yet to open up on discussing sex and sexuality with their children. The generalization that all educated Indian parents are equipped to impart sex education is false. Amita Dahanu from FPAI has rightly pointed out that most parents are starting to realize that sex education is the need of the hour but they themselves lack knowledge on topics such as drug and substance abuse, sexuality, anatomy and physiology of sexual organs, reproduction and many others. Hence, parents want somebody else either the school or any other organization to take up the responsibility of imparting sex education (Dahanu, 2018).

Communication between parents and children: According to the traditional authoritative pattern of communication a father would never talk or communicate directly to his children. The mother had the sole responsibility in upbringing the children whereas father was responsible for earning. Today with women stepping out to work the responsibility of upbringing the children have to be shared by both father and mother. Democratization of the communication pattern followed within a family has since long been at the core of family planning's philosophy to create the modern small size planned families. Today this trait is also enabling parents to communicate and connect with their children better on matters that were traditionally considered as shunned.

Satindra Sen narrates how creating a space that allows open communication to exist has helped his daughter to be comfortable with him on personal issues. His daughter had once asked him to buy a measuring tape. On asking why she needs it the daughter replied saying that "baba trainer bras are very important in life". Sen was astonished by the level of awareness her daughter had about bras even when she had not yet reached puberty. Traditionally daughter would never share a conversation on bras with their fathers. Kaveri Ahuja agrees with Sen that parents today need to be their children's friend rather than an authority. Ahuja narrates the ease and comfort with which her daughters who studies in boarding school share with their mother their life at school openly. Ahuja is also an example of how an educated mother is way more equipped to deal with understanding the generation gap that exist and change her approach accordingly towards her children. Ahuja mentions the incident when one of her daughter had written a letter to her from the boarding school asking if she knew what porn (the daughter spelled it as pon) is because the boys in her class asked the girls about it. Ahuja was shocked with the kind of information boys are receiving at such an early age from whatever source they have access to. But she was happy to see that her daughter had the confidence to ask such a query to her rather than look for answer elsewhere. Ahuja took this as a moment of opportunity to explain to her daughter what porn meant in an age appropriate manner.

Language: Anthony D'Souza had pointed out how regional languages lacked standard terminologies to communicate information and knowledge on sexual matters. Sen too acknowledges that his parents did not communicate to him any sexual knowledge as languages like Hindi or Bengali lack the power to articulate anything on sex with a sense of neutrality or ease. English on the other hand has the standard terminologies or vocabulary on sex and sexuality. Sen's daughter studies in an English medium school and as he mentions has the skill to articulate her queries well enough to ask anything related to body and personal needs. Language carry a lot of power and is political. Different languages have been popular and predominant throughout the span of history. A language that is dynamic and enables intellectual knowledge creation and creativity is usually the one in official use and constitutes power in comparison to other languages of the time. Hence, there was a time when Sanskrit language was dominant in the Indian history as it was the language of the intelligentsia which was later replaced by English when British colonized India. Since then English as a language remains dominant not

only in India but has spread wide enough in the world in terms of a language that is dynamic and powerful.

Apart from the transformation in the three traditional features of Indian culture the discussion on CSE also brought out other important observations of the present Indian society.

Media and censorship: In the late 1990s as brought out in chapter 2 the BJP government used the cultural changes unleashed by liberalization to mobilize people particularly referring to them as parents on the negative impact media has on children's mindset and the resulting loss of cultural values. Today parents are aware of the impact of media on children and unlike 1990s are not taking recourse to censorship. Kaveri Ahuja, Satindra Sen and Reema Ahmed unanimously agreed that censorship in the age of internet is futile because it might make access to a particular information difficult but not impossible. Hence, the practical way of dealing with issues like loss of Indian values or family values is to start openly discussion issues and concerns that were traditionally shunned. These parents have realized that television and media is a biased and stereotyped medium of information on sex and sexuality. But the authority and conviction with which media uses sexual connotation and television serials narrates sexual information is scary as it is loaded with misinformation. Hence, times have come when young people need authentic source and channels of information on sex and sexuality.

Gender and Sexuality: Kaveri Ahuja mentions how it is easier to understand when to start talking to girls because of the obvious puberty trait they have of menstruating. With boys it is difficult to understand as there are no obvious indications. Though beginning of the menstruation can become a teachable moment in case of girls. The actually teaching needs to begin much early to mentally prepare girls for a process like menstruation that comes as a scary experience for most girls. Most sex education findings have shown a better mother-daughter relationship post sex education. However, similar findings have not come for a father-son relationship which is intriguing. Not that boys don't face any physical and emotional difficulties during puberty but sex education since long had this gender perception that girls need it more that still continue to persist. Hence, most sex education sessions and programmes whether that be conducted by government or NGOs have focused on girl's sexual

hygiene and reproductive needs. Boys have easy access to money and technology than girls within family system. Boys are allowed to go for gathering and parties with their friends whereas girls have time restriction which restricts their socialization with the external world. Also, men are seemed as promiscuous and interested in sex and sexual information whereas girls who show such an interest are either named as cheap or slut. Reema Ahmed express the need to address gender inequalities and have conversations with boys on issues such as what consent means in a relationship and how to behave with girls.

The discussion also mentioned how children these days hear a lot of information from media that leaves them confused. For instance, section 377 of the Indian Penal Code became a big controversy in the first decade of 21st century. This brought homosexuality in the domain of public discussion. Mainstream media was filled with debates on section 377. Hence, young people today need CSE to not only understand their own sexuality but also understand alternative sexuality and sexual identities that exist.

Pornography as a source of sex education: As mentioned before in this section availability of porn has become easy for adolescents who often use it to satisfy their curiosities related to body and sex. The general content of pornography supports abuse and the rape myth (that women enjoy forceful sex). Though there are therapists and psychologists that consider watching porn as a form of sexual addiction men watching porn has been popularly accepted. Lupane from FPAI reiterates the view that watching porn can have certain negative impact or lead to developing misconceptions especially among adolescents. Pornographic movies usually show a male partner having big penis and long endurance. This raises expectations in both girls and boys that can lead to them having self-esteem issues further in life. When parents are consulted to participate in sex education of their children, they think that their children are unaware of anything related to sex. In case of girls their mother informs them about the hygiene, the does and the don't to follow during their menstruation once they have reached puberty. But in case of boys, they are never informed by their fathers about the changes that will happen in them after they have reached puberty. This means girls at the minimum for at least menstruation have their mothers as a sexual guide or support, whereas boys are left with no guide or support from their elders and hence they seek such a guidance

from their peers. Peers gather information regarding sex from porn, internet websites, movies etc that are most of the times biased (Lupane, 2017). As a creative mode of answering queries on sex many a time sex education programmes conducted by FPAI in schools encourage adolescents to write their queries on paper and drop it in a box. And it was found that queries on porn are among the most frequently asked questions (Lupane, 2017).

Viewing of pornography/blue films can in no way truly enhance the quality of sexual relating argues Bhonsle. Some therapists say that pornography or any form of sexual addiction is simply an excuse to justify lack of control and unwillingness to conform to acceptable norms. Other psychologists and psychiatrists maintain that it is a compulsive behavior that has its roots in early childhood and can afflict both males and females. It is believed that people who suffer from this disorder come from dysfunctional families that failed to provide security and to reinforce the child's self-concept and self-esteem and in which there was an absence of trust. Researches have shown that pornography and its messages are involved in shaping attitudes and encouraging behavior that can harm individuals and their families. As it has come to notice that porn is used as an important source of sex education by adolescents, experts and NGOs have argued the need to include topics like porn and masturbation in sex education.

Schools and CSE: There are some private schools that impart sexuality education either through a school counsellor or some teacher but such cases are exceptions across the country (TARSHIdelhi, 2015). Teachers don't have anything that prepares them during their training on sexuality education yet. The attitude in most of the schools even today is that sex education is the responsibility of the biology teacher. In many school sex education sessions is limited to providing information on biological details of puberty, HIV prevention and substance abuse. Satindra Sen narrates his experience with a teacher who caught his daughter with a book (pink book for girls on their body). Sen explains how the teacher (who uses to teach Hindi) saw Sen's daughter sharing a book with her friend which according to the teacher was not a book that children should read. The teacher asked Sen's daughter to call her father and said what kind of parents allow their kids to carry such a book.

The social stigma attach to open discussion on sexuality has proved to be an obstacle for not only HIV/AIDS prevention measures but also in imparting any kind of sex education (whether AEP or CSE) in schools.

FPAI and TARSHI are working on advocating CSE with other NGOs, civil society organizations and state governments and creating spaces to debate and discuss the design of sex education that is culturally relevant and scientific. Future course of action and its implications will enable one to understand the effectiveness of using a rights approach to impart sex education or CSE. The State's AEP needs the political will of the government in power. But neither the then (United Progressive Alliance) UPA government nor the present NDA (National Democratic Alliance) government has shown such willingness yet.

CONCLUSION

Unlike the countries in Europe sex education in India has not received enough attention. Sex education has been overshadowed by concerns over population control and lately by HIV/AIDS control and prevention agendas. My contribution to the existing literature on sex education is that I have laid out the trajectory of the limited discourse and practice of sex education in India since independence from 1950 to contemporary developments. I have also brought out the changes that have gone into addressing the issue of sex education over the span of 68 years and the factors that have brought these changes. I have done this by exploring the ideas and claims of the dominant stakeholder in the discourse and practice of sex education ranging from doctors, social workers, feminists, academicians, NGOs and parents.

WHAT IS NEW

The debate on sex education in the 21st century India has a tone of urgency unlike what it was in the initial years of the discourse. This is apparent not only in the views of experts like sex therapists, counsellors and NGOs but also in the views of the state prepared AEP and some of the parents.

NGOs like Family Planning Association of India and TARSHI have prioritized the issue of sex education in India and are trying to build awareness through advocating CSE and breaking the silence on sex talk.

RESEARCH FINDINGS

The State has been showing interest in imparting some sort of sex education in the form of its Adolescence Education Programme because firstly the number of adolescents getting affected by sexually transmitted diseases is on a rise, secondly India is one among the few countries in the world which has the highest number of youth population, thirdly cognizant of the fact that this demographic opportunity will prove fruitful only if the youth particularly the adolescent population (which is 22% of the entire population) contribute qualitatively to the country and fourthly this depends on them (adolescents) developing into sexually responsible citizens.

But this hasn't removed population control from being the priority. Population Education still receives more attention and funds than proposals and programmes on sex education. Also, there are states in India such as Maharashtra, Madhya Pradesh, Rajasthan and some others that had imposed a ban on any kind of sex education. Education and health are subjects under concurrent list and this allows both Centre and State governments to decide on education and health issues. However, it is unclear as to what is the Centre is doing to advocate AEP in states that have put a ban on it.

The lesson has not been learnt from the European history of sex education that mere sexual information does not automatically translate in change in the sexual behavior of individuals. Also, the abstinence until marriage approach to imparting sex education has proved limited and often unsuccessful in deterring or bringing down the number of teen pregnancies or deaths due to sexually transmitted diseases. In the Indian case teen pregnancies exist within marriage. Hence any sex education programme in India needs to start before children reach their adolescence rather than just for adolescents.

The National AIDS Control and Prevention organization too have acknowledged that HIV/AIDS is more than a public health issue. Reiterating the argument that mere sexual information is inadequate measure to control or prevent spread of HIV/AIDS. Sexual behavior that is aggressive and promiscuous is appreciated as masculine. Such dominant cultural and social notions of sex discourage safe sex practices. Adolescent boys and girls are at a larger risk to fall prey to these cultural and social notions of sex because of their lack of knowledge and experience. Adolescents girls are at the lowest rank of powerlessness because of the existing gender inequalities.

The reproductive and sexual health research in the country has also pointed out that no homogenous sex education programme will work or be acceptable to every state of India. Also, research in this field has to be encouraged to fill existing gaps of information such as what is the difference between the reproductive and sexual health needs and sexual knowledge of adolescents living in rural areas to that of those in urban areas. There have been cases from the rural parts of the country where non-governmental organizations had distributed condoms to men. But through feedback it was realized that many men didn't knew how to use a condom.

From the general history of sex education, I have understood that the discourse and practice of sex education has been pushed by sexologists, psychologists and physicians (experts on health) and this has been the case even in India. The tussle lies in the unresolved question as to where sex education belongs- health, education or sexuality. The field of sexuality in itself is new. Within sexuality as a field sex education has received least attention. It is in the discipline of health that has paid most attention to sex education. Unlike India the content of sex education was hotly debated in Sweden between the progressives and traditionalists in the public domain. The progressives who were mostly health experts from different disciplines who formed associations with political groups to mobilize people on the issue of sex education emphasized on prioritizing biological information over normative aspects in the content of sex education. they argued that 'knowledge was not only a precondition for correct conduct, but also enabled such conduct' (Lennerhed, 2009). On the other hand, traditionalists particularly Church leaders and educationalists emphasized on prioritizing ethics over biological details of the body in the content of sex education. Church leader Reverend Allan Svantesson argued against the claim that 'knowledge in itself would produce norms of conduct or ethical approach to life' (Lennerhed, 2009). On the other hand, Svantesson claimed that knowledge could sometimes be 'deplorably double-edge' (Lennerhed, 2009) especially sexual knowledge that has the potential to not only protect but also corrupt. Hence, it has been observed that in general in Europe the experts on health emphasized or pushed forth the biological model of sexuality over the content on sex education in schools whereas the educationalist and religious leaders stressed on the moral/religious model of sexuality. Accordingly, the content of sex education in schools in the countries in Europe were decided by those in power (progressive or traditionalists).

In India unlike countries in Europe where experts on health who mobilized people on the issue of sex education and formed political associations, pioneering initiatives during the 1950s and 60s taken up by individuals like Dhun Panthaki, Dr. Mahindra Watsa and Anthony D'Souza remained largely unknown to the State and aloof from the public domain as sex was considered a taboo and a public discussion on sex education a risky task to undertake. As Watsa mentions even doctors were hesitant to discuss matters on sex and unwilling to push the proposal for sex education in schools in India.

For most of the second half of the twentieth century population education remained a priority over sex education for the Indian State. It was only after 1980s AIDS pandemic and the international pressure on India to deal with not only its population growth but also the increasing number of HIV cases, that the State initiated a discussion on having an exclusive educational programme in the 1990s to impart sexual knowledge to the young.

The quick response that many non-governmental organizations showed after national and international funding were made available to impart sexual knowledge to young demonstrates the welcoming nod to sex education. However, one can argue that the sex education programmes of the 1990s taken up by various organizations were fund driven rather than a sign of acceptance of sex education. Contestations among parents, teachers, principals, conservative political groups like RSS and for that matter even some liberal groups rose over imparting sexual knowledge to young minds. The 1990s also saw the rise of the Right-wing Hindu political party like BJP over concerns of diminishing Indian cultural values because of the new challenges posed by the liberalization and globalization of the Indian economy. The right-wing political parties and other conservative groups portrayed any kind of sex education as against Indian culture and value system. Further arguing that the spread of sexually transmitted diseases is a consequence of fading Indian cultural norms and family values.

FPAI too from the 1950s till 70s focused on population education. It was only in 1980s that FPAI came up with its sex education programme but found it difficult to convince parents of the need to impart sex education to children or even adolescents. It was only in the 1990s that FPAI's sex education programme got a boost.

As opposed to the State or the government the significance of strength of NGOs like FPAI and TARSHI lies in the fact that their approach to studying the situation of sex education in India is community and association based unlike the top-down approach of the State. For instance, Amita Dahanu mentions that further research in adolescent reproductive and sexual health and rights field has led to findings that divide the adolescent age group of 10-19 into three parts. The early adolescence 10-13 age group need is information on puberty (biological process) and the physical, emotional and intellectual changes resulting from puberty. Adolescent in the age group of 14-16 have shown the need for guidance in terms of handling peer pressure, parental pressure, self-

confidence and self-esteem issues and learning socialization or communication. The last age group of 17-19 looks forward for guidance in the area of higher education and career.

Even though sexuality education as a concept was conceptualized to go beyond the narrow concerns of sex education it primarily got reduced to HIV prevention measure. The efforts to promote sexuality education receive a significant setback during the 1980s when the religious model of sexuality advocated for abstinence approach to sex education. The 1990s brought new insights and demands in the form of prioritizing sexual and reproductive health, followed by the development of sexual rights as human rights to formulate claim to sexual health and CSE that linked reproductive and sexual health with the right to education on sex and sexuality (sexual right).

The significance of CSE as a concept lies in its breath of topics it has encompassed as sexual knowledge. It has not only acknowledged the lack of sexual knowledge that young people particularly adolescents face but also the social, economic and political conditions that obstruct dissemination of sexual information. As opposed to sexuality education that aimed to move beyond the biological aspects of sexuality but failed to do so, CSE has explicitly stated its positive approach to sexuality. It focuses on enabling sexual agency, rights and equality between sexes rather than solely adopting a disease prevention approach. In doing so CSE had proposed that young people can be taught to not only enjoy and determine their sexual identity (as heterosexual or homosexual or queer) but also make them 'sexually responsible individuals'[1].

FPAI refers to CSE as "a strategic vehicle of promoting gender equality and human rights including the right to health and non-discrimination" (FPAI, accessed 2018). TARSHI on the other hand has been using the contemporary discourse on CSE as an opportunity to explore the field of sexuality and reproductive health in India. Through its online magazine '*In Plainspeak*' TARSHI routinely publishes articles on range of sexual issues such as challenging heteronormativity, exclusion of sexual concerns of intersex people and people with disabilities, rape, sexual harassment and many others. Though this dissertation has focused on FPAI and TARSHI there are many other NGOs

[1] Sexually responsible individual is the one who is aware of the fact that every sexual practice has consequence on the sexual health of the individual and the other (if involved) and accordingly adopts safe sex practices.

like CARE, CINI that routinely collaborated with these organizations. The efforts to bring diverse sexual issues into public discourse are also meant to expand the horizon of sexual liberties and tackle the social and cultural negative imageries that sexuality is loaded with.

The Swedish physician Gunnar Inghe was of the opinion that sex education has a liberating effect. One of the findings of Annabelle Duncan's feedback response on her sex education talk has been enhancement of self-confidence and self-esteem in girls. Even the sex education initiatives conducted by NGOs like the CINI during 1990s in India found that girls internalize sex education differently. Understanding of the sexual body equips girls with the agency to make decisions with regard to the body whether that is reproductive health decisions or the decision to engage in sex. Having of a sense of agency does not directly translate into the ability to make decisions. But many girls find the sense of having an agency over the body itself empowering as for generations a woman's body has been at the center of surveillance and regulation by the society and the State.

ETHICAL ISSUES

As sex is a sensitive issue research on sex education needs to adhere to the confidentiality of resource person or participants if so demanded. Also, addition attentions need to be paid to ethical issues when doing a qualitative research that aims to study through recording some of the private experiences of the participants.

DIRECTIONS AHEAD

As research on sex education is hardly present there is an ocean of issues to research on. TARSHI has YouTube clips where adolescent girls and boys are asked what they understand or mean by sexuality. The organization is also trying to understand the number of young people who have received sex/sexuality education of any kind and from where. Future research can explore the relationship between sex education and change in sexual behavior, sex education and girls/women empowerment, sex education and the insights and limitations of a biological model of sexuality, sex education and the indigenous or Indian literature on sexuality to name few. As the State led AEP is for school children future research can explore the reach of sex education that is restricted to schools.

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