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# Boys' Sex Education in Rural Maharashtra: Context, Community, and Trust

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*SIT Study Abroad*

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BOYS' SEX EDUCATION IN RURAL MAHARASHTRA:  
CONTEXT, COMMUNITY, AND TRUST

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SIT Study Abroad

India: Public Health, Gender, and Community Action

Fall 2018

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## **Abstract**

The primary research question of this study is: do alumni of CRHP's Adolescent Boy's Program (ABP) and parents of alumni of the ABP report that the boys have changed after completing the program, and if yes, in what ways? Beyond that, the study is also concerned with examining potential reasons behind the results of the primary research question. The researcher conducted interviews with 3 ABP alumni and 3 parents of ABP alumni, in addition to attending information sessions and observing the workings of CRHP. The primary findings were that yes, the respondents reported a change. The change was described as positive, and primarily related to helpfulness and respect for others, especially women. The study concludes that possible causes for these positive results are the comprehensive curriculum and the nature of CRHP as an organization. These results could aid in future attempts to enact sex education programs for boys in rural areas.

## Introduction

This project will explore the opinions and experiences of adolescent boys who are participating or have participated in the Adolescent Boys Program (ABP) at Comprehensive Rural Health Project (CRHP) in Jamkhed, Maharashtra. In addition, it will investigate potential influences on the outcome of the ABP. The ABP is an education program “designed to contend with gender inequality, male underachievement, and lack of health awareness.” (jamkhed.org 2018) It provides education and discussion about reproductive issues, alcoholism, gender-based violence, and more.

The primary focus of this study is two-pronged. Firstly, to find out to whether and in what ways ABP alumni and parents of ABP alumni report that the program changed the boys. Secondly, building on that information, the study seeks to identify potential aspects of the program that may be influencing such change or lack thereof. This will be explored with a focus on comprehensive sex education.

The researcher collected primary data for this study through interviews, information sessions, curriculum materials, and observation. This included 3 interviews with ABP alumni, and 3 interviews with parents, in addition to several information sessions conducted by CRHP staff, and observation on CRHP campus and village visits. In addition, to gather background data, the researcher conducted several interviews at the NGO Sangath in Goa. All interviews were conducted with consent, and with interviewees aged 18 or above. Names were changed to protect participants' privacy.

Findings indicate that interviewees did believe that the boys changed after participating in the ABP. They believed that the boys changed in positive ways. Potential roots for this change

may lie in the comprehensive nature of both the ABP program, and the comprehensive nature of CRHP as a whole.

### **Comprehensive Sex Education**

Despite the benefits of comprehensive sex education, attempts to institute such programs are often met with distrust and opposition from parents, teachers, lawmakers, adolescents themselves, and other stakeholders across the globe. While controversy over sex education extends worldwide, this project focuses on an Indian specific context. This section will begin by investigating the definition of comprehensive sex education, explore the importance of comprehensive sex education, address the current situation surrounding sex education in India, and emphasize the importance of context.

#### *Definition*

The WHO defines sexual health as, “a state of physical, emotional, mental, and social well-being in relation to sexuality and not merely the absence of disease or infirmity.” (who.int 2018) This means that sex education that seeks to promote sexual health must include not only technical information about anatomy, but also guidance in the emotional, mental, and social aspects of adolescent life. No factor in a human life exists in a vacuum. A young person’s self-esteem, ability to cope with challenges, understanding of interpersonal relationships, and much more all factor into their experience of sexuality. Comprehensive sex education must take a holistic approach when structuring curriculums, so that the aspects of adolescents’ lives which influence their relationship with their bodies and sexualities are addressed. Therefore, for the



purposes of this project, I will refer to the comprehensive life skills curriculum that ABP covers as sex education.

This is where the term *comprehensive sex education* comes into play. Comprehensive sex education includes many topics in addition to basic biological facts. Authors Ismail, Shajahan, et al. explain that, “Comprehensive sexuality education must be age appropriate, scientifically accurate, culturally competent, and grounded in human rights, gender equality, and a positive approach to sexuality and pleasure.” (Ismail et al. 2015) This definition of comprehensive sex education allows for the fact that communities across the globe have widely varying cultural norms and expectations. The education must be culturally competent, meaning that the curriculum that may be appropriate in London would not be appropriate to teach in Varanasi. The curriculum must be tailored to the community that it serves. At the same time, no matter where it is being taught, the foundation must prioritize human rights, gender equity, and a positive approach to sexuality and pleasure. Consent in particular is a topic that is crucial in all contexts, although the methods of teaching may vary.

This comprehensive approach to sex education is broadly applicable and provides transferrable skills. The lessons learned in this type of education apply not only to sexuality but can also be used across all areas of a young person’s life. As Ismail et al. put it, “the skills, adolescents develop from sexuality education are linked to more general life-skills, such as communication, listening, decision-making, negotiation and learning to ask for, and identify sources of help and advice such as parents, care givers, and professionals through the family, community, and health and welfare services.” (Ismail et al. 2015)

### *Importance*

Adolescence can be a vulnerable and tumultuous time. It is a time when young people learn how to conceptualize themselves within their families, communities, and the world. During adolescence, young people's bodies and minds go through vast changes, many of which can be confusing or frightening, especially without adequate guidance and education. Comprehensive sex education for adolescents can help develop adults who are confident in their own bodies and minds. Comprehensive sex education can also function as a preventative tool for issues such as sexual violence, addiction, and HIV and STIs.

Sex education in India is important in part because adolescents in general do not get information from their parents about sex. Researchers Mahajan Payal, and Neeru Sharma's study surveyed 200 parents (100 urban and 100 rural areas of Jammu) of adolescent girls. The study found that "mothers were reluctant to talk about sex education to their daughter as they found it embarrassing to discuss these issues. Generally, they avoid any mention to sex in their day-to-day relationships with their children." (Mahajan and Sharma 2017) Discussing sex is generally a taboo practice in Indian society. (Mahajan and Sharma 2017) This means that parents tend not to feel comfortable educating their children, and children tend not to feel comfortable seeking knowledge from their parents. In addition, even when parents do speak about sex with adolescents, they often do not have accurate scientific knowledge about it themselves due to their own lack of sex education. (Mahajan and Sharma 2017) This emphasizes the need for wide-reaching comprehensive sexual education, not only for the current generation of adolescents, but also for generations to come. If adolescents today grow into well-informed adults, they will have the information necessary to potentially begin teaching their children about sex.

This is not entirely different from common practices in the global North. For example, Snikka Elliott summarizes general findings of past studies examining parental behavior in relation to sex education in the US thus: “these studies find, for example, that parents tend to avoid topics such as the mechanics of sex (Angera, Brookins-Fisher, and Inungu 2008; Regnerus 2007). Parents instead center their lessons on sexual morality (Fisher 1986; Martin 1996; Regnerus 2007; Sanders and Mullis 1988) and, to a lesser extent, contraception, sexually transmitted infections, and pregnancy prevention (Epstein and Ward 2008; Dittus and Jaccard 1998; Hutchinson 2002).” (Elliott 2010) It may be slightly more common in the US for parents to mention contraception and STIs than in India. However, the overall landscape of how much parents share with their children about sex is not wildly different.

Comprehensive sex education could provide a remedy for many difficulties facing India today. Ismail, Shajahan, et al. list, “early and closely spaced pregnancy, unsafe abortions, sexually transmitted infection (STI), HIV/AIDS, and sexual violence,” (Ismail et al. 2015) as some issues that sex education can help address. In addition, comprehensive sex education can help address patriarchal power imbalances by empowering girls and teaching boys how to respect women.

AIDS is a pressing problem in India. There is an estimated 2.1 million Indians living with HIV as of 2017. (aidsdatahub.org 2018) Adolescents between 15 and 24 years of age make up 31% of HIV cases in India despite the fact that they make up less than 25% of the Indian population. (Benzaken et al. 2011) Effective sex education could aid in remedying this disproportionate burden of HIV in adolescents. According to Benzaken et al. the, “Indian National Family Health Survey 2005-06 reported that only 36% of male youths and 20% of females had a comprehensive knowledge of HIV/AIDS.” (Benzaken et al. 2011) More education

about risks and prevention methods of HIV/AIDS would help to reduce HIV cases in adolescents. Ross, et al. surveyed 22 sex education programs across developing countries, and found that “a large majority of school-based sex education and HIV education interventions reduced reported risky sexual behaviors in developing countries.” (Ross, et al. 2006) Sex education works as a preventative tool for HIV/AIDS.

Sexual violence is a key concern in India. The Ministry of Women and Child Development has shown that 53% of boys and 47% of girls surveyed faced some form of sexual abuse. (Ismail et al. 2015) Comprehensive sex education can address sexual violence from several angles. It can help young people learn recognize sexual abuse, in addition to recognizing signs of abusive relationships and identifying what is and is not consensual touch. It is not a survivor’s responsibility to prevent or stop abuse, but more education could help them recognize and seek help for abuse. Educating adolescents about abuse does not address the power structures in place that allow abuse to continue, but it can be a step in the right direction. In addition, teaching young people, especially boys, respect for other people’s bodily autonomy could potentially prevent them from growing up to abuse others.

An interview with Tanvi, an adult woman who works with the SIT study abroad program SIT India: Public Health, Gender, and Community Action, provided insight into one woman’s perspective on sexual education in India. She reported that her mother and sister taught her about menstruation and sexual topics when she was a child, unlike many of her friends. She said she was supported and informed when she first began menstruating, but “most of my friends had a really horrible time” when they first began menstruating. (Tanvi 2018) Because of her friends’ bad experiences, she said, “I feel that [education] is really important.” (Tanvi 2018) feels it is important to educate girls about menstruation. In addition, she explained that she and her friends

did not receive formal education about relationships and sex, saying “It was kind of unanswered for most of the girls at that time.” (Tanvi 2018) Sisters and female friends who were already married would “talk a little bit about it, but this was not taught in a class with a teacher.” (Tanvi 2018) At the beginning of the interview, Tanvi stated that “I’m talking about 18 or 19 years back, so people were not that much open and talking about sex education, especially relationships and sex and all that.” (Tanvi 2018) She explained about sex education that, “It’s not always easy. Mostly it’s difficult.” (Tanvi 2018) However, she expressed that she is “happy that now boys and girls are more getting those life skills education.” (Tanvi 2018). From her explanation, we can gather that when she was young many people did not receive adequate sex education. However, she is hopeful that now more adolescents have begun to have access to such important information.

### *Sex Education in India*

Currently, India has taken measures to provide sex education to adolescents, but much improvement and expansion is needed. The existing sexual education program in the Indian curriculum is called Family Life Education (FLE). It is associated with a program called the Adolescence Education Programme, which was began by the Ministry of Human Resource Development and the National AIDS Control Organization in 2002-03. (Benzaken et al. 2011) It is an educational program that complements but is not part of the regular school curriculum and provides education on a range of topics to grades 9 through 12 (ages 14 to 18). (Benzaken et al. 2011) The topics covered include “Human sexual anatomy, sexual reproduction, reproductive health, reproductive rights and responsibilities, emotional relations, contraception, and other aspects of human sexual and nonsexual behavior.” (Ismail et al. 2015) Between 2003 and 2007

FLE was taught in nearly 150,000 schools in India but was banned in 2007 in six states. FLE was banned where it is needed the most—in both Maharashtra and Karnataka, two states in which HIV prevalence is highest. (Benzaken et al. 2011) FLE is a promising start to providing comprehensive sexual education across India, but the banning of the program in six states has been a significant setback.

NGOs are a significant portion of the provision of healthcare across India, and sex education is no exception. While the Indian government's FLE program attempts to fill the need for comprehensive sex education, many NGOs are also striving to meet that need. Sangath is a mental health-focused research organization based in Goa. Sangath has invested a great deal of time and resources developing adolescent health education programs and pilot testing them in Goa schools. These programs address topics of sex, menstruation, how to say no, study skills, time management, and more. This represents one model of comprehensive sex inclusive adolescent health education that has proven to be effective in teaching students how to cope with both life in general and sexuality specifically. NGOs can be a tool to help bridge the gap between the number of adolescents in need of comprehensive sex education, and the number of adolescents which actually receive government sponsored sex education.

In India many members of the population oppose teaching sex education to adolescents. A key argument from those who oppose it is that sex education corrupts youth and leads to more nonmarital sex. However, evidence contradicts that argument. In Ross, et al.'s study. out of 22 sex education programs surveyed “only one of the interventions...increased any measure of reported sexual intercourse; 7 interventions delayed the reported onset of sex; 3 reduced the reported number of sexual partners; and 1 reduced the reported frequency of sexual activity.” (Ross, et al. 2006) Sex education does not increase premarital sex, and in some cases even

decreases it. In addition, in India “about 30 percent of males and up to 10 percent of females are sexually active during adolescence before marriage,” (Tripathi and Sekher 2013) despite the fact that, culturally, premarital sex is intensely discouraged. In addition, “less than 10% of sexually active adolescents in India using contraception.” (Benzaken et al. 2011) This shows a disparity between what Indian society generally considers proper and what adolescents are actually doing. Many adolescents are sexually active but are not using protection from pregnancy or STIs.

Despite much popular opposition to sex education, youth in India tend to report a desire for it. In Benzaken et al.’s 2010 Study of adolescents in Mumbai, a questionnaire was completed by 427 students. The results showed that “Almost 90% of students believed it important to have sex education as part of school curriculum; over 60% reported prior exposure to sex education in school. However, only 45% were satisfied they had good access to advice about contraception and sexual health.” (Benzaken et al. 2011) This shows a gap between desire for comprehensive sex education and receipt of such education. In addition, Tripathi and Sekher found that Indian youth tend to want sex education but did not feel they were receiving it. It found a, “substantial gap between the proportion of youth who perceived sex education to be important and those who actually received it, revealing considerable unmet need for FLE. Youth who received FLE were relatively more aware about reproductive health issues than their counterparts.” (Tripathi and Sekher 2013) The data from these two studies suggests several things. It suggests that FLE is not implemented widely enough to meet the demand and desires of India’s youth. The data also suggests that in cases where adolescents did receive FLE, it was relatively effective in informing adolescents about some reproductive health issues. However, it seems to be lacking in practical information about contraception.

The status of sex education in India is a precarious yet hopeful one. Despite much opposition from some sectors of the population, movement has been made in the direction of comprehensive sex education for all. The FLE program is a start which, while dealing with setbacks, may prove to be a useful and effective strategy. As with any movement for human rights and improving quality of life for all, it is generally a matter of two steps forward, and one step back. Obstacles and issues do not mean that progress is impossible.

### *Context*

When discussing sex education in developing countries, it is important to keep historical and global context in mind. The global North has a history of imposing family planning measures on the global South as a form of eugenics. Indira Gandhi instituted forced sterilization of mainly poor, lower-caste men under the guise of family planning. Colonialist, racist, and classist perspectives have led to the argument that a high birth rate is the cause of poverty. However, in reality, that causal link between high birth rates and poverty has not been proven. People are not struggling financially because they have too many children. High fertility levels are likely associated with poverty for reasons associated with the structures of societal power and wealth imbalances that cause poverty to begin with. High infant and child mortality rates will drive parents to have more children, because they are not sure their existing children will survive. Lack of access to family planning methods and education also contribute to high birth rates among lower income populations. (Kurian 2018) In addition, access to education usually depends on socioeconomic status, meaning that wealthier populations receive more education, and therefore are better informed on the subject of family planning.



The goal of sex education, especially in developing countries, ought not be to control overpopulation or reduce birth rate. It must be to provide information so that people can make informed choices about their own bodies. The goal of comprehensive adolescent sex education is not to reduce fertility rates in India, it is to empower Indian youth to make informed decisions about how they want to live their lives.

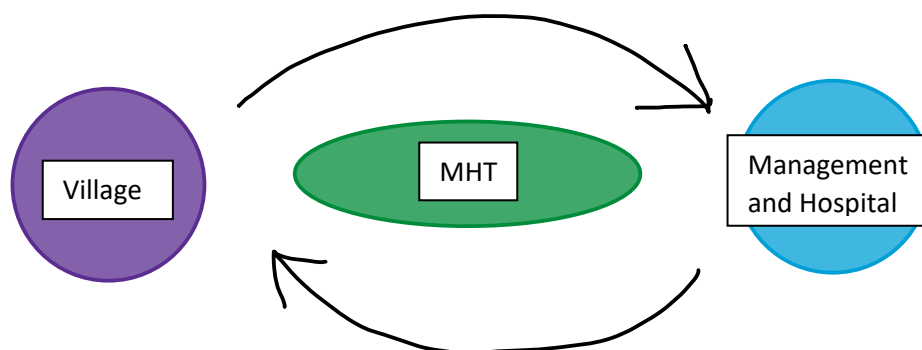
In addition to being mindful about global context, it is important to be mindful of socioeconomic status when implementing sex education. School based sex ed doesn't reach those who may be most in need of it. So, even if FLE were implemented in every school across India, a large portion of adolescents would remain without sex education. This means that in addition to working towards FLE implementation in schools, a basic push to improve literacy and poverty rates, especially in rural areas, is an essential factor in any long-term sex education strategy.

It is also key to remember that imposing western standards and ideas on Indian sex education is both harmful and useless. Indian culture does not view sex in the same way that the US and other Western countries do, and that is entirely valid. The goal of comprehensive sex education in India is not to change the fabric of Indian culture or shift views to a more Western perspective. Effective sex education in India must be driven and designed by locals. The goal is to improve the lives of Indian citizens, not to judge or change Indian culture.

### **CRHP Model**

The ABP is best understood in context with the work of CRHP. CRHP separates its work into three interconnected categories. (Aakhya 2018) One category, which this paper will call

“Village” includes Village Health Workers, Men’s and Women’s Groups, the Adolescent Girl’s Program (AGP) and the ABP. Another category is the Mobile Health Team or “MPH”. The third category, which this paper will call “Management and Hospital” includes secondary care given at a hospital run by CRHP called Julia Hospital, administration and management, and trainings completed on CRHP’s campus. The interconnection between these 3 categories are best shown through a visual aid:



The Mobile Health Team functions as a bridge between the Village category and the Management and Hospital category. (Aakhya 2018)

Village Health Workers are not paid. However, they gain much from their volunteer work with CRHP. They learn valuable and marketable skills (for example, pickle-making) through CRHP, and gain access to the CRHP bank which offers loans at very low interest rates. This allows them to pursue business ventures outside of their work as VHWs, and become financially self-sustaining. (Aakhya 2018) They also gain respect from their village community for the work that they do as VHWs.

## **ABP**

India, like most of the world, functions within a patriarchal framework. Women are not treated as equal to men, and that is apparent in many aspects of society. When the patriarchy is discussed, people often focus exclusively on women and girls. This is understandable, given the fact that women and girls are the most directly and immediately affected by patriarchy related problems such as gender-based violence, sexual assault, and restriction of personal liberty. However, boys and men also merit attention when seeking to address the patriarchy. In fact, focusing some attention on shaping boys into well-rounded, self-assured, compassionate men may help remedy many aspects of gender discrimination in the long run.

In English, some people use the phrase, “Boys will be boys,” to excuse sexist behavior from young men. However, we do not have to accept boys’ young stirrings of oppressive attitudes. Comprehensive sex education as one tool that can stunt the growth of negative, patriarchal attitudes in boys, and instead empower them to feel secure in themselves and respect women. This is why this study is interested in comprehensive sex education for adolescent boys. If adolescent boys can learn to respect women, and to feel confident enough in their own self-image that they don’t need to tear others down to build themselves up, then we will have taken a massive step towards destroying the patriarchy. CRHP’s ABP is a program in pursuit of those goals.

### *ABP Inception and Rationale*

According to a social worker, Aakhya, from CRHP who gave a presentation covering the ABP’s inception and workings, CRHP founders Dr. Mabel and Raj Arole began thinking about

adolescent programs while working with a Navajo community in the US. “There they learned how adolescent boys and girls can influence public health.” (Aakhya 2018)

Later, while working on CRHP in Maharashtra, the issue of female feticide and gender equity became highly relevant due to a doctor in a nearby district who was practicing female feticide, and was caught and convicted with much media coverage. The doctors decided to investigate into further ways that CRHP could remedy these issues. They completed focus group discussions with members from local villages. Based on the paraphrased quotation in the presentation conducted by social worker Aakhya at CRHP, a person from a local village said, “I appreciate that you are working with the women’s group and the adolescent girls. But you need to understand there is oppressor and there is oppressed. Then why don’t you work with the oppressor’s future generation. Because boys are going to become head of the family after a few years.” (Aakhya 2018) This idea prompted the creation of the ABP. (Aakhya 2018)

Dr. Shobha Arole, current co-director of CRHP and daughter of Dr. Mabel and Raj Arole, explained her thoughts about violence perpetrated by men. She said, “Violence was the way [men] showed power over their lives...and women.” (Arole 2018) A key component of the ABP is to empower boys to become confident, productive men. If men feel empowered and secure in themselves, they may not feel the need to perpetrate violence against women.

As told by Aakhya, the CRHP social worker, “We were very clear that with this program we are going to build gender equity and empowerment. Empowerment of girls, empowerment of women, and empowerment of boys. These are major goals of the vision we thought we are going to achieve with this program.” (Aakhya 2018) The challenge they faced was how to create a curriculum. He explained that, “We said in our criteria [for building the program], there will be full community participation at each and every stage. So this program is emerged from the

community.” (Aakhya 2018) Therefore, CRHP included extensive community input in the formation of the ABP curriculum.

### *ABP Goals and Curriculum*

The problems that the ABP explicitly set out to address included the low status of women, male underachievement, and lack of health knowledge. (CRHP ABP Design Plan 2012) A strong focus of the plan was gender equity. A male dominated society harms not only women, but also men. As the ABP Design Plan explains, “by reducing the opportunities for women to progress and reach their fullest potential, men are decelerating their own development along with that of the women around them. Holistic health and development for both genders can be compromised when the two genders do not support each other.” (CRHP ABP Design Plan 2012) The quest for gender equity benefits all people because, at its core, patriarchy harms all people.

The program has three primary objectives. First, “to promote the present and future well-being of females in the project villages.” (CRHP ABP Design Plan 2012) Second, “develop skills and instill knowledge in the participants that will improve their ability to transition successfully into adulthood.” (CRHP ABP Design Plan 2012) And third, to promote health awareness in the participants, in areas such as sexual health, nutrition, hygiene, and the health of their future children.” (CRHP ABP Design Plan 2012)

The ABP enacts these goals through a thoughtfully constructed curriculum. The curriculum topics included the following: Health, Leadership, Gender Roles, Environment and Sanitation, Violence, Sexual Health, and Alcohol. A sample curriculum plan is included in Appendix A. The enactment of the curriculum is flexible and allows for teachers to respond to

the boys' attitudes and needs in the moment. The 6 official ABP curriculum categories include: Leadership, Gender Equity, Violence, Alcohol Abuse, Health, and Microfinance. (Aakhya 2018)

### **ABP interview results**

#### *Adhrgu*

In the village Khurdaithan the researcher interviewed 21-year-old Adhrgu, an alumnus of the ABP. He held himself confidently and maintained much eye contact with the translator and researcher. He reported that in the program the boys learned about health information, and social topics such as gender equity. When asked what his favorite part of the program was, he said, "Gender equity. That I liked most in the program." (Adhrgu 2018) When asked if he felt changed by participating in the program, he said yes. He explained how he felt changed and how he shared what he had learned with others who had not participated in the program:

"In the program, I learned about gender equity. And that was the information that before it was not known to me. Also before that I was not known about how to take care of my own health, then I learned in the program. I shared whatever I learned in the program to the others and then they follow the same thing." (Adhrgu 2018)

#### *Prathu*

The researcher interviewed 18-year-old ABP alumnus Prathu in the village Khurdaithan. He presented a slightly nervous demeanor, fidgeting and making very minimal eye contact. When asked what was shared in the ABP, he responded that he learned, "about diabetes. Like, not sugar. Avoid addiction. Drink clean water." (Prathu 2018) When asked if he thought he was changed by the program, he said that, "I learned about personal hygiene when I attended the

program. Also I learned to clean environment. Also in the house also.” (Prathu 2018) He went on to explain that he now participated in household chores such as fetching water and washing clothes, whereas before the program he did not do those tasks. His favorite part of the program was learning about diabetes.

### *Navjat*

Najvat is a young man in his mid to late 20s in Nimbodi Village who had completed the ABP several years before the time of the interview and had gone on to achieve a BA in Chemistry. He held himself confidently, with an upright posture and relaxed movements. During the interview, he held strong eye contact with both the researcher and the translator.

The interview took place sitting on a cot outside of Navjat’s house, which he shared with his sister, Shuki, and mother, Vedika. Shuki, who was about the same age as Navjat, had completed the AG, and worked as a tailor, making sarees and other clothes. Before the interview she brought out a box of blouses and sarees she had made and showed them to the translator and researcher. She was clearly proud of her work and asked the researcher to take photos of her holding the clothes. During the interview she stood nearby and listened.

When asked about what was shared in the program, Navjat responded that the boys learned, “about higher education, how to behave, how to help each other. So, how to overcome the obstacles in the life.” (Navjat 2018) He paused, and added, “Respecting to the womans and helping them.” (Navjat 2018) At that point, he motioned to his sister. He, his sister, the translator, and the researcher all laughed together for a moment. He then continued to explain that the program shared, “about clean village and sanitation. About health also.” (Navjat 2018)

It's impossible to say for certain, but when he motioned to his sister in reference to respecting women, he seemed to be identifying his sister as someone whom he had learned to respect more through the program. Perhaps the laughter was nervous laughter at speaking about a personal, potentially sensitive subject, or perhaps it was about finding humor in his previous attitudes as compared to his present attitudes. Perhaps it was both.

When asked if he thought he was different from other young men his age who did not do the ABP, he said yes. He said that the difference was that he was, "working in the household, helping to the mom," (Navjat 2018) while young men who had not participated in the ABP may not be doing that kind of work. When asked if he felt changed by the ABP, he also said yes. He said that after the ABP, he was "helping to others and always working instead of wasting time. And that helped me to improve myself." (Navjat 2018) He reported that his favorite part of the program was playing cricket.

### *Vedica*

Navjat's mother, Vedica, was interviewed after Navjat. She explained that in the ABP the boys learned, "about health, about family planning, and about games. In the hospital big machineries they saw in the program. About information about different diseases and why it happens." (Vedica 2018) When asked if her son Navjat had change after the program, she said, "Yes. So we were proud when he was sharing the information learned here with us." (Vedica 2018) She emphasized the importance of his sharing what was taught in the ABP with other members of his family and community. She also told the researcher with pride that because of CRHP, the family had made a kitchen garden. She said that for three years they grew and ate eggplant.



*Pravika*

Another mother of an ABP alumnus named Pravika was interviewed. She explained that in the program the boys learned to, “take care of your parents, respect your parents. Then do work. So, concentrate on your studies. Working with your parents in the farm.” (Pravika 2018) When asked if her son had changed after participating in the program, she said yes. She said that there was, “good information in the program. Then after that he completed his master’s in art faculty. Then he learned about computers. So previously he was very angry, aggressive. Then he becomes patient. Very good education was there. So because of the program he change a lot. Like he was helping in the household work... he is very respecting to the girls and women in the village. He is working now hard.” (Pravika 2018)

*Sirak*

The mayor of the village Nimbodi, whose son was an ABP alumnus, was also interviewed. He explained that in the program, “They learned there about agriculture, how to behave in the family, how to respecting the family. About nutrition, about healthy diet, water purification methods.” (Sirak 2018) He also emphasized that the boys shared what they had learned with other members of the community, explaining that, “When they were attending the program and they were sharing this thing to us.” (Sirak 2018) He said that, “after every session was finished they were sharing what they learned there.” (Sirak 2018) He elaborated that, “behavioral change was there. Avoiding like fast foods outside. Like speak nicely, respecting, listening to the elders. And helping to us also, helping in the family.” (Sirak 2018)

When asked if his son had changed because of the program, he responded that, “Tremendous change was there.” (Sirak 2018) He elaborated that, “behavioral change was there.

Avoiding like fast foods outside. Like speak nicely, respecting, listening to the elders. And helping to us also, helping in the family.” (Sirak 2018)

### **Possible Reasons Behind Results**

#### *Curriculum's Broad Range of Topics*

This paper will argue that a likely reason that interviewees reported positive change in the boys after participation in the ABP is the broad and comprehensive nature of the curriculum. It has been observed in the past that sex education programs in rural India tend to be more successful and popular when other topics, such as marketable skills, are also covered in the training sessions. An example of such results can be found in *The Unheard Scream*, which explains that, “Many organizations...started out with a module focusing on reproductive health alone, but had to add a vocational training component to sustain the programmes.” (Rao 2004) Participants, in this case girls, were more interested in the program when the curriculum contained, “practical information, coupled with vocational training.” (Rao 2004)

Sex education would not work without the context of broader health and life skills education. Culturally, it would be unacceptable to attend or enact a program focused solely on sexual health. In addition, families and adolescents will be far more likely to participate in a program providing a broad range of topics and skills to be gained. This is not a problem, because comprehensive sex education by definition must include a broader education on health, relationship, violence, and other topics in order to truly cover all facets of an adolescent's life that have to do with their sexual life. Thus, the broad range of topics covered in the ABP curriculum is likely a key component that leads to the positive results observed in this study.

### *CRHP's Foundational Approach*

This paper will also argue that it is likely that CRHP's functioning as an organization is a key component that influences the outcome of the ABP. The ABP functions in context of all the other projects and work that CRHP does. Just as the strength of the sex education in the ABP potentially comes from the comprehensive nature of the curriculum, it may be that the strength of the ABP itself comes from the comprehensive nature of CRHP.

### Community

When CRHP first began its work over 40 years ago, first it set out to build rapport with the Jamkhed and surrounding village communities. It began by providing curative care, to prove to the communities that CRHP could be trusted to help them. They also worked on basic needs in the villages, such as food and water shortages. Then, they began formation of women's and men's groups, which grew organically from villagers' needs. (Arole and Arole 1994)

This building of trust was essential to CRHP's approach. A core value of CRHP is to work alongside the communities they serve, as equal partners, not outsiders who claim to know better. When CRHP begins work with a new village, the MHT keep an eye out for socially minded people. As CRHP social worker Aakhya explained, "Success always lies within the community." (Aakhya 2018) He explained that it is CRHP's responsibility to find what's working well already in the community, and work with community members to expand on that positivity. In addition, CRHP is always consciously working to involve lower caste and lower SES women, who are a highly vulnerable group. CRHP focuses on empowerment of both individuals and communities as a whole. (Aakhya 2018) Programs are developed in response to community needs, with input from the community, and not imposed. As CRHP co-director Dr.

Shobha Arole explained, “The real key to is to get to where the people are. Go with them, sit with them, understand their problems.” (Arole 2018)

Adolescent boys’ health ed is what this study focuses on, but that program is in a larger picture of comprehensive health care. The community centered nature of this comprehensive approach is likely essential to the apparent success of the ABP. The community takes part in the formation of the program, and trusts CRHP enough to be open to the program.

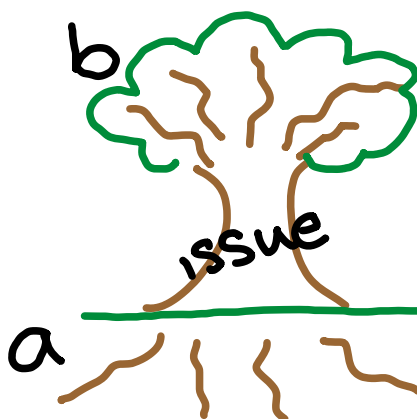
### Comprehensive Nature of CRHP

Academic theorists Link and Phelan note a tendency of some people to focus on individual rather than systematic factors, in the context of determining causes of disease. They emphasize that when determining causal factors of illness, it is important to consider societal processes, and not only “individually-based risk factors that lie relatively close to a disease in a causal chain.” (Link and Phelan 1995) Examining social factors as fundamental causes of disease can be beneficial when searching for a place to start fighting disease. The term social causation refers to the idea that social processes can be fundamental causes of disease. As Link and Phelan explain, “a fundamental social cause of disease involves resources that determine the extent to which people are able to avoid risks for morbidity and mortality.” (Link and Phelan 1995) Fundamental causes look at the root of the problem, not simply the mechanisms, such as individual behavior and choices.

This method of seeing social processes as fundamental causes of disease is useful when framing the work that CRHP does in project villages. CRHP addresses such fundamental causes of disease exceedingly well. It does not simply focus on curative care, which addresses immediate causes of ill health, such as malnutrition or anemia. In addition to providing curative

care, CRHP also examines social conditions in the project villages which may lead to health issues, such as access to resources like food and water. It seeks to address problems like lack of access to nutrition, lack of water, and gender inequity while also caring for people's immediate medical needs.

An essential component to CRHP's approach is addressing root causes of health issues, and not only focusing on symptoms of the problem. (Arole 2018) CRHP uses a tool called the problem tree to illustrate this approach. (Pranal 2018) It is a visual tool using an image of a tree. The trunk is the issue at hand, for example malnourishment.



The roots ("a") represent fundamental causes of the issue, for example poverty, lack of nutritional knowledge, and drought. The branches ("b") represent consequences of the issue, for example child illnesses, paying high fees to hospitals, and death. It's important to CRHP to address all components of the problem tree. (Pranal 2018) That is a way to give truly comprehensive health care.

CRHP looks at the context of health issues. They know that they can't expect people to wash their hands regularly with soap and water if they don't have money to buy soap or access to water. They start at the basic level, originally with watershed development, nutrition programs for young children, and curative care, and then build on that. Decades ago, when CRHP first

began, they built a relationship with the Jamkhed and surrounding village communities. They build trust. Then they aided in the formation of women's and men's groups and taught about health and wellness and pre/post-natal care, and taught skills to manage money and start businesses. All these projects influence health. As a CRHP social worker Aakhya explained, "You can't separate health from other sectors of life." (Aakhya 2018) This rings true for the ABP. You can't separate health from other sectors of life, and you can't separate sex education from other sectors of life. The complete nature of CRHP's work allows the ABP to function as a part of a whole.

### **Limitations**

One limitation in this study is the fact that all interviews were conducted with help from a translator. The ABP alumni and parents all spoke Marathi and some Hindi, but not English. The researcher spoke a very limited amount of Hindi, only enough for introductions and some limited small talk. The translator was needed for the bulk of the interview. Some things may have gotten lost in translation.

Another limitation to this study is sample size. The small sample size of 3 ABP alumni and 3 parents of ABP alumni, while informative, is not enough to conclusively generalize to the larger population of ABP participants. The data from these interviews are useful in achieving a preliminary indication of findings, but more research would be needed to definitively prove the generalizability of these initial findings. CRHP has conducted KAP (Knowledge, Attitude, Practice) studies to explore results of the ABP.

Also, the researcher was an outsider in many ways—she was a foreigner, white, and a native English speaker, to name a few. In addition, the time she spent in the villages with the interviewees was very limited, and so they did not have time to get to know and trust her. Also, the researcher was associated with CRHP, as was the translator, which may have discouraged interviewees from expressing any possible less-than-perfect opinions about CRHP. For these reasons the interviewees may not have felt entirely comfortable sharing freely. Plus, the researcher was a Westerner, and thus all her thoughts were processed through a cultural lens different from rural India's cultural landscape. She has done her best to avoid and challenge assumptions, but there will always be a Western bias to some degree.

Due to these cultural differences and the lack of bond or trust between the researcher and the interviewees, some components of the study did not pan out. Initially, the study was meant to include an investigation into what ABP alumni and parents of ABP alumni thought could be added to or changed in the program for future participants. The interviews included asking a question, phrased delicately, attempting to find the answer to that question. However, the responses were not conclusive. Interviewees restated positive aspects they had already mentioned or said that the program was good and needed no changes.

### **Contribution to Larger Body of Research and Knowledge**

This research will contribute to the field of knowledge around sex education by providing data that could give direction to future evaluation of sex education effectiveness and methods behind sex education. This study reveals preliminary results that suggest boys in the ABP were changed in a positive way by participating in the program. More research would be needed to

corroborate these initial results. This paper also explores what qualities in the program may have contributed to the observed results. This could give direction for both future studies to explore in more depth, and organizations seeking to recreate CRHP's results.

### **Conclusion**

This study accomplished, as much as possible within the limitations elaborated upon above, its goals. It discovered that, according to the ABP alumni and parents of ABP alumni interviewed, the boys did change. In general, interviewees reported that boys helped out their families more, and respected women more. In addition, the study examined possible reasons for these results. It speculates that core reasons for the positive reports about the ABP stem from the comprehensive and community centered approach of CRHP. This information could be useful to organizations and projects in the future who intend to enact sex education programs.



## Appendix A

### *Course Syllabus ABP 18/08/2012-20/10/2012*

Week	Content
<b>1</b> <b>Intro</b> <b>18/08/2012</b>	<b>Session 1:</b> Program Introduction and Pre-Test Questionnaire <b>Session 2:</b> Self-Help Group: Formation, Principles, Rules, and Regulations
<b>2</b> <b>Health</b> <b>25/08/2012</b>	<b>Session 1:</b> Hygiene <b>Session 2:</b> Nutrition
<b>3</b> <b>Leadership</b> <b>01/09/2012</b>	<b>Session 1, 2:</b> Leadership
<b>4</b> <b>Gender Roles</b> <b>08/09/2012</b>	<b>Session 1:</b> Introduction to Gender Roles <b>Session 2:</b> Role and Job Gender Roles
<b>5</b> <b>Gender Roles</b> <b>15/09/2012</b>	<b>Session 1:</b> Power in Male-Female Relationships <b>Session 2:</b> Behavioural Gender Roles
<b>6</b> <b>Environment and Sanitation</b> <b>22/09/2012</b>	<b>Session 1, 2:</b> Environment and Sanitation ( <b>FROM GIRLS</b> )
<b>7</b> <b>Violence</b> <b>29/09/2012</b>	<b>Session 1:</b> Physical, Sexual, and Emotional Abuse <b>Session 2:</b> Female Feticide
<b>8</b> <b>Violence 2.0</b>	<b>Continue violence lesson from last week</b>
<b>9</b> <b>Sexual Health</b> <b>06/10/2012</b>	<b>Sessions 1, 2:</b> Reproduction and Sexually Transmitted Infections
<b>10</b> <b>Alcohol</b>  <b>13/10/2012</b>	<b>Session 1:</b> Effects of Alcohol <b>Session 2:</b> Alcohol and Peer Pressure
<b>11</b> <b>Drama and Conclusion</b> <b>20/10/2012</b>	<b>Session 1:</b> Drama Project Presentations <b>Session 2:</b> Program Conclusion and Post-Test Questionnaire

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