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Comprehensive Sexuality Education in Indian Schools: Parent and Teacher Perspectives, Implementation Evidence, and Priorities for Bihar—A Critical Integrative Review

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ABSTRACT

Comprehensive sexuality education (CSE) is an age-appropriate, evidence-informed approach that equips adolescents with knowledge and skills related to puberty, sexual and reproductive health, relationships, consent, gender equality, personal safety, and well-being. This critical integrative review examines the inclusion of CSE in Indian school curricula, focusing on parent and teacher perspectives, implementation evidence, and priorities for Bihar. Peer-reviewed studies, policy documents, legislation, and authoritative reports on CSE, adolescent health education, school-based interventions, and Bihar-specific sexual and reproductive health indicators were synthesised. India has established policy platforms, including the Adolescence Education Programme, Rashtriya Kishor Swasthya Karyakram, and the Ayushman Bharat School Health and Wellness Programme, but political contestation and uneven implementation continue to limit classroom delivery. Bihar remains a priority because of persistent child marriage, adolescent childbearing, and educational and socioeconomic inequalities. Evidence from the Bihar-based SEHER intervention supports the feasibility of school-based adolescent health promotion, while highlighting the importance of trained facilitators and sustainability. Direct evidence on parent and teacher perceptions in Bihar remains limited. Effective CSE implementation requires teacher preparation, structured parental engagement, culturally responsive and gender-sensitive content, trusted educators, service linkages, and further research on stakeholder attitudes, delivery fidelity, and long-term sustainability within resource-constrained public school systems in Bihar.

1 Introduction

Adolescence is a formative life stage during which young people experience physical maturation, emotional change, expanding peer relationships and increasing exposure to questions concerning identity, attraction, safety, gender norms, sexual and reproductive health, and future family life. Access to accurate information during this period is consequential. Without structured educational support, adolescents may rely on partial, misleading or stigmatising information from peers, digital media or informal sources.

The internationally established term comprehensive sexuality education (CSE) refers to curriculum-based, incremental, scientifically accurate and age-appropriate education addressing the cognitive, emotional, physical and social dimensions of sexuality. CSE includes sexual and reproductive health, puberty, relationships, consent, gender equality, personal safety, violence prevention, health services and responsible decision-making. The term comprehensive sexual health education (CSHE), used in the original thesis topic, overlaps substantially with CSE; however, this paper uses CSE because it is the terminology adopted in international guidance and contemporary research literature (United Nations Educational, Scientific and Cultural Organization [UNESCO] et al., 2018; World Health Organization [WHO], 2026).

The inclusion of sexuality education in Indian schools has historically encountered political and cultural contestation. The 2006–2007 introduction of the Adolescence Education Programme (AEP), developed through national education and HIV-prevention institutions, faced opposition in several states, including Gujarat, Maharashtra and Kerala, where critics argued that school-based sex education was culturally inappropriate, morally objectionable or likely to

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encourage promiscuity (Joseph, 2023). In some states, this opposition resulted in suspension, rejection or modification of programme content. The controversy was subsequently institutionalised in national political debate: the Rajya Sabha Committee on Petitions' 135th Report recommended that sex education should not be introduced in schools in its proposed form and favoured an approach framed through values and culturally acceptable adolescent education (Rajya Sabha Secretariat, Committee on Petitions, 2009). This history reflects a wider and continuing tension in Indian educational policy between "sex education" as health- and rights-based information and "value education" as moral, cultural and behavioural formation. Contemporary CSE implementation must therefore negotiate public-health objectives, parental expectations, cultural sensitivities and political anxieties about classroom discussion of sexuality rather than treating opposition as a purely technical curriculum problem.

At the same time, India's legal and educational frameworks provide important grounds for school-based adolescent health, safety and child-protection education. The Right of Children to Free and Compulsory Education Act, 2009 does not explicitly mandate CSE, but it establishes the state's responsibility to provide quality, child-centred education that supports all-round development and protects children from fear, trauma and anxiety (Government of India, 2009). The Protection of Children from Sexual Offences Act, 2012 provides the legal framework for protecting children from sexual assault, harassment and exploitation, while the POCSO Rules, 2020 more directly require age-appropriate educational material and curriculum for children on personal safety and protection from sexual offences (Government of India, 2012, 2020).

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These provisions do not amount to a statutory mandate for CSE in its international sense, but they create a child-protection rationale that partially overlaps with CSE objectives, particularly in relation to consent, bodily autonomy, personal safety, abuse prevention and help-seeking.

The educational rationale for CSE is supported by international evidence. WHO reports that high-quality, well-implemented CSE increases knowledge and supportive attitudes, promotes protective behaviours and does not increase sexual activity or encourage earlier sexual behaviour. A meta-analysis by Kim et al. (2023) similarly identified significant educational effects of CSE among children and adolescents. Importantly, Haberland's (2015) review found that sexuality and HIV education programmes addressing gender and power were substantially more likely to improve outcomes relating to sexually transmitted infections or unintended pregnancy than programmes that did not address these dimensions.

For India, CSE is relevant not only as a public-health intervention but also as an educational, gender-equity and child-protection issue. Indian adolescents experience unequal access to sexual and reproductive health information, services and supportive adult communication. National education and health systems have responded through initiatives including the Adolescence Education Programme, Rashtriya Kishor Swasthya Karyakram and the Ayushman Bharat School Health and Wellness Programme. Yet the availability of policy frameworks does not establish that students receive comprehensive, confident or locally acceptable classroom delivery.

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Bihar is a priority context for examining CSE inclusion. NFHS-5 data for Bihar show that 40.8% of women aged 20–24 were married before age 18, compared with 42.5% in NFHS-4, and 11.0% of women aged 15–19 were already mothers or pregnant at the time of the survey. The adolescent fertility rate was 77 births per 1,000 women aged 15–19. In addition, UNFPA's analysis of Bihar data reports substantial educational and wealth inequalities in child marriage: among women aged 20–24, marriage before 18 was markedly more common among those with no education and among those in the poorest wealth quintile than among women with higher education or from the wealthiest households (International Institute for Population Sciences [IIPS] & ICF, 2021; United Nations Population Fund [UNFPA] India, 2022).

These indicators establish the importance of adolescent health and gender-responsive education in Bihar; they do not, by themselves, demonstrate that CSE is being delivered, that it would independently eliminate child marriage or adolescent pregnancy, or that parents and teachers hold particular views about curriculum inclusion. Parent and teacher perceptions require direct investigation because these stakeholders influence curriculum legitimacy, delivery quality and community trust. In a context where sexuality education has historically been contested, stakeholder perceptions are not peripheral but central to implementation.

This review therefore addresses four questions:

What is the conceptual and evidence-based rationale for including CSE in school curricula?

How is CSE-related content situated within Indian school-health, adolescent-health and child-protection policy?

What evidence exists concerning parent and teacher perspectives and school-based implementation in India?

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What does the available evidence establish, and what remains unknown, for Bihar?

2 Methods

2.1 Review Design

This manuscript adopts a critical integrative review design. This approach is appropriate because the relevant evidence is heterogeneous and includes international guidance, Indian policy documents, survey reports, qualitative stakeholder studies, school-based intervention trials, programme reviews and Bihar-specific adolescent-health evidence. The purpose of the review is not only to summarise available evidence but also to interpret the strength, relevance and limits of different source types for understanding comprehensive sexuality education (CSE) inclusion in Indian schools, with particular attention to Bihar.

The review is intentionally not described as a systematic review or a PRISMA-ScR scoping review. A formal scoping review would require an exhaustive database strategy, duplicate removal, independent screening, a documented record-selection flow diagram and comprehensive data-charting procedures. The present paper instead provides a transparent and evidence-controlled synthesis suitable for identifying policy relevance, implementation lessons and research gaps, particularly where direct Bihar-specific parent and teacher perception evidence remains limited.

2.2 Evidence Identification

Targeted searches and source verification were conducted in May 2026, with legal, policy and reference-list verification updated in July 2026. Evidence was sought through the following sources: PubMed-indexed records and open-access full-text repositories; publisher platforms for

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peer-reviewed studies; official websites and repositories of WHO, UNESCO and UNFPA; Government of India, National Health Mission and CBSE policy documents; NFHS/IIPS survey documentation; Population Council UDAYA reports; Population Foundation of India policy and curriculum analyses. Search concepts included combinations of the following terms: "comprehensive sexuality education," "sexuality education," "sexual health education," "India," "Bihar," "school curriculum," "parents," "teachers," "adolescents," "Adolescence Education Programme," "School Health and Wellness Programme," "SEHER," "UDAYA," "sexual and reproductive health," "child marriage," and "adolescent pregnancy."

Because the review aimed to integrate peer-reviewed evidence with official policy and programme documentation, both academic and grey-literature sources were considered. Grey literature was included only when it originated from official government bodies, international agencies or recognised research and policy institutions.

2.3 Eligibility Logic

Sources were included when they directly contributed to one or more of the following analytical domains: definition, scope or effectiveness of CSE; Indian policy or curriculum frameworks relevant to adolescent sexuality education; parent or teacher perceptions of sexuality education in India; school-based adolescent sexual and reproductive health or whole-school health interventions in India; Bihar-specific adolescent health, child marriage, reproductive-health knowledge or school-intervention evidence.

International evidence was included selectively to establish recognised CSE principles and general effectiveness considerations. Indian evidence outside Bihar was included to identify potentially transferable implementation issues, particularly concerning parent acceptability,

teacher preparedness and school-based delivery. Bihar-specific sources were prioritised for contextual, demographic and implementation claims. Sources unrelated to school-based sexuality education or adolescent sexual and reproductive health were not used as evidence for implementation claims.

2.4 Quality Appraisal Criteria

Formal systematic-review quality-assessment tools were not employed because the review integrated heterogeneous evidence types, including empirical studies, legislation, official policy documents, programme reports and international guidance. Source credibility and relevance were nevertheless appraised using five explicit criteria:

Peer-review status: Preference was given to studies published in indexed, peer-reviewed journals, particularly where research design, sampling, analysis and limitations were transparently reported.

Methodological rigour: Quantitative studies were considered in relation to sample size, study design, measurement clarity, analytical strategy and the fit between findings and conclusions. Qualitative studies were considered in relation to sampling logic, depth of data collection, transparency of analysis and support for interpretations.

Source authority: Policy and grey-literature claims were prioritised when they originated from official government bodies, international agencies or recognised research institutions, including WHO, UNESCO, UNFPA, IIPS/NFHS, the Population Council and the Population Foundation of India.

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Temporal relevance: Preference was given to sources published during 2016–2026. Older sources were retained when historically necessary, conceptually influential or directly relevant to the development and contestation of sexuality education in India.

Geographical specificity: Bihar-specific evidence received the greatest weight for Bihar claims; India-specific evidence informed national or potentially transferable implementation considerations; international evidence established conceptual principles and general effectiveness findings but was not used to infer Bihar implementation outcomes.

These criteria guided evidentiary weighting rather than producing a numerical quality score. Limitations in source quality, geographical transferability and evidentiary completeness are explicitly acknowledged in Section 15.

2.5 Analytical Strategy

Sources were interpreted according to geographical and evidentiary relevance. The review distinguished between evidence that could support Bihar-specific claims, evidence that could inform transferable Indian implementation considerations, evidence that could establish international CSE principles and evidence that could document policy intent without proving classroom implementation.

Evidence level Description Permissible use in this review

Direct Bihar evidence Studies, trials, reports or official data collected in Bihar Supports Bihar-specific contextual or implementation claims

Indian evidence outside Bihar Studies conducted elsewhere in India or across India Supports national or transferable implementation considerations, with caution

International evidence International guidance, reviews or synthesis studies Supports

conceptual principles and general effectiveness rationale

Policy evidence Official curriculum, programme or legal documents Establishes intended policy content, legal relevance or programme design, but not actual Bihar delivery fidelity

Evidence was synthesised thematically around seven domains: curriculum rationale, Indian policy context, Bihar-specific adolescent-health need, parent perspectives, teacher preparedness, school-based implementation evidence and research gaps. Throughout the synthesis, claims were calibrated according to the type and location of evidence. For example, NFHS and UNFPA data were used to establish Bihar's adolescent-health context, SEHER evidence was used to discuss Bihar school-based implementation conditions, and studies from other Indian states were used only to identify plausible stakeholder and delivery considerations requiring Bihar-specific verification.

3 Conceptual and Evidence-Based Rationale for CSE

3.1 Beyond Reproductive Biology

A narrow approach to sexuality education may focus only on reproductive anatomy, menstruation, pregnancy or HIV prevention. CSE is broader. International technical guidance defines it as education addressing knowledge, values, relationships, communication, decision-making, consent, gender, violence prevention, bodily development and access to appropriate services. It is intended to help young people protect their health and dignity, develop respectful relationships and understand their responsibilities and rights (UNESCO et al., 2018; WHO, 2026).

This comprehensive orientation is relevant to Indian schools because adolescent

experiences are not confined to biomedical risks. Young people also encounter menstrual stigma, digital misinformation, peer pressure, sexual harassment, unsafe relationships, family expectations concerning marriage and unequal gender norms. A curriculum that communicates biological facts without building communication skills, safety awareness and respect for consent may leave major adolescent vulnerabilities unaddressed.

3.2 Health, Knowledge and Behavioural Outcomes

Global reviews have generally found that comprehensive, curriculum-based sexuality education can improve knowledge, attitudes and selected protective behaviours. WHO's current evidence summary states that high-quality CSE may contribute to delayed sexual initiation in some settings, increased contraceptive or condom use, reduced risk-taking and reduced unintended pregnancy or STI risk through improved knowledge and behaviour. It also explicitly states that CSE does not increase sexual activity or sexual risk-taking.

These conclusions require careful interpretation for Bihar. Evidence that CSE can improve adolescent outcomes does not establish that any single curriculum will automatically be effective in Bihar. Outcomes are shaped by implementation quality, teacher or facilitator preparation, parental trust, gender relations, access to health services, school attendance and wider social and economic conditions.

3.3 Gender and Power as Core Curriculum Components

The inclusion of gender and power is particularly important in environments characterised by early marriage, restrictions on girls' autonomy or unequal relationship decision-making. Haberland (2015) examined 22 rigorous sexuality and HIV education interventions and found that programmes addressing gender or power were much more likely to be associated with

reduced STIs or unintended pregnancy than programmes omitting these dimensions. Although the reviewed programmes were international rather than Bihar-specific, the finding provides a strong conceptual rationale for including gender equality, respect, consent, coercion and non-violence in CSE design.

For Bihar, gender-transformative CSE should not be interpreted as education directed only at girls. Girls need information concerning health, safety, agency and continuation of education; boys need education concerning respectful behaviour, consent, non-violence, shared responsibility and rejection of harmful gender norms.

4 CSE-Related Policy and Curriculum Frameworks in India

4.1 Adolescence Education Programme

The Adolescence Education Programme represents an important Indian school-based precursor to contemporary CSE-related education. Official CBSE teaching materials instruct teachers to deliver age-appropriate co-curricular activities with sensitivity to adolescents' needs and attention to local cultural context. The AEP workbook includes a 16-hour educational capsule, with substantial time allocated to life skills. Its guidance permits participatory approaches including role play and group discussion and recognises that certain activities may require gender-sensitive delivery arrangements (Central Board of Secondary Education [CBSE], n.d.).

AEP is important for the present review because it demonstrates that adolescent education concerning growing up, life skills, health and HIV-related issues has already been institutionally recognised within Indian schooling.

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At the same time, AEP documentation does not establish how comprehensively the programme has been implemented in Bihar, how teachers experience its delivery, or how parents perceive its content.

4.2 Rashtriya Kishor Swasthya Karyakram

RKSK, introduced in 2014, positioned adolescent health within a broader framework that includes sexual and reproductive health, mental health, nutrition, substance misuse, injuries and violence, including gender-based violence. The programme is relevant to CSE because effective school education must be connected to youth-responsive health information, counselling and referral pathways, rather than operating as a stand-alone classroom intervention. The Ayushman Bharat School Health guidelines explicitly identify RKSK as a programme that the school-health platform is intended to strengthen.

4.3 Ayushman Bharat School Health and Wellness Programme

The AB-SHWP provides the most current national institutional platform for health education in government and government-aided schools. Its operational guidelines describe schools as a central setting for age-appropriate health education and identify teachers trained as Health and Wellness Ambassadors as delivery agents. The programme includes health-promotion activities, menstrual hygiene promotion and integrated referral functions (Government of India, Ministry of Health and Family Welfare & Ministry of Human Resource Development, 2018).

In a December 2024 parliamentary response, the Ministry of Education stated that AB-SHWP covers most concepts included in international CSE guidance. The identified modules include growing up healthy, emotional well-being and mental health, interpersonal relationships, values and citizenship, gender equality, reproductive health and HIV prevention, violence and

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injury prevention, and safe internet and social-media use. This confirms that a national policy platform exists through which many CSE domains can be addressed. It does not confirm consistent implementation, teacher competence or student reach within Bihar classrooms.

4.4 Policy Intent and Implementation Reality

The Population Foundation of India's review of CSE curricula concludes that India does not have a single mandatory national CSE policy, but that AEP and AB-SHWP provide active national curriculum-based interventions addressing adolescent health. The same review notes that CSE comprehensiveness and programme implementation require continued strengthening, including attention to content, trained educators and youth needs (Population Foundation of India, 2022).

This distinction is central to a Bihar-focused review. Policy documents establish the legitimacy and intended content of school-based adolescent health education. They cannot establish whether sessions are delivered regularly, whether sensitive domains such as consent or gender equality are addressed confidently, whether teachers have adequate preparation, or whether parents trust the process.

Table 1: Indian policy platforms relevant to CSE inclusion

Programme or Evidence Source	Principal CSE-Relevant Content	What It Establishes	What It Does Not Establish
Adolescence Education Programme	Growing up, life skills, HIV/AIDS, adolescent health, culturally sensitive teaching	India has an established school-based adolescent education framework	Uniform implementation or parent/teacher acceptance in Bihar

RKSK	Adolescent sexual and reproductive health, mental health, violence, service linkage	A broader adolescent-health and referral framework exists	Classroom delivery of comprehensive sexuality content
AB-SHWP	Growing up, relationships, gender equality, reproductive health, HIV prevention, violence prevention, digital safety	Current school-health policy contains multiple CSE-related domains	Delivery fidelity or effects in Bihar
Population Foundation of India review	Review of government and civil-society CSE curricula and strategies	Identifies policy and curriculum opportunities and gaps	State-specific implementation effectiveness

5 Bihar as a Priority Context

5.1 Child Marriage and Adolescent Childbearing

Bihar's adolescent health context makes school-based CSE relevant, but also demands careful avoidance of simplistic causal claims. NFHS-5 reports that 40.8% of women aged 20–24 were married before age 18 and that 11.0% of women aged 15–19 were already mothers or pregnant. These indicators are higher in rural than urban Bihar: marriage before 18 was reported for 43.4% of rural women aged 20–24 compared with 27.9% in urban areas; adolescent motherhood or pregnancy was reported for 11.6% of rural women aged 15–19 compared with 7.4% in urban areas (IIPS & ICF, 2021).

UNFPA's analysis further indicates that child marriage in Bihar is socioeconomically patterned. Its NFHS-5-based analysis reports that approximately 63% of women aged 20–24 with no education were married before 18, compared with 12% among those attaining higher education; similarly, 54% of women from the lowest wealth quintile were married before 18,

compared with 9% from the highest quintile (UNFPA India, 2022).

CSE cannot independently address the structural determinants of child marriage, including poverty, interrupted schooling, gender inequality and restricted economic opportunities. Nevertheless, a well-designed curriculum can form part of a broader intervention strategy by improving health knowledge, identifying risks associated with early marriage and early pregnancy, strengthening gender-equitable attitudes, promoting personal safety and directing adolescents towards appropriate services and support.

5.2 UDAYA Evidence on Reproductive-Health Information Needs

The Population Council's UDAYA longitudinal study provides Bihar-specific evidence concerning adolescents' and young adults' reproductive-health needs. A policy brief based on Bihar UDAYA data reports substantial unmet need for contraception among adolescents and young women married during adolescence, limited in-depth knowledge of modern contraceptive methods, and continuing constraints in agency, decision-making and spousal communication during transition into young adulthood (Saggurti & Francis Zavier, 2020).

A further UDAYA-based study using data from Bihar and Uttar Pradesh examined 10,425 adolescent girls and reported an association between exposure to social media and sexual and reproductive health knowledge.

This study highlights both the information needs of adolescent girls and the growing relevance of digital sources of sexuality-related information (Saha et al., 2022). It supports the relevance of school-based, scientifically accurate information, but it does not directly assess CSE delivery or stakeholder perceptions in Bihar.

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5.3 The Correct Evidence Gap for Bihar

The evidence does not show an absence of adolescent-health or school-based intervention research in Bihar. NFHS-5, UNFPA, UDAYA and SEHER provide substantial contextual and implementation evidence. The genuine gap is narrower and more consequential for implementation:

Published direct evidence concerning how Bihar parents and teachers perceive the inclusion, content, delivery conditions and cultural acceptability of CSE in school curricula remains limited in the verified literature base.

This is not merely an academic omission. AB-SHWP relies on school personnel, student participation and community legitimacy; without stakeholder-perception evidence, programme planners cannot reliably:

anticipate forms of community concern that may reduce student participation or lead schools to omit sensitive topics; design parent-orientation and communication strategies suited to local expectations; distinguish culturally responsive adaptation from dilution of scientifically accurate and protective content; identify teacher knowledge, confidence, workload and institutional-support needs that may differ from those reported in Odisha or national studies; assess variation in acceptability across Bihar's socially, economically and geographically diverse districts; or select delivery agents and safeguarding arrangements that command sufficient trust among families, teachers and students.

The policy and curriculum review by the Population Foundation of India (2022) identifies national implementation and capacity-building gaps, but it does not provide Bihar-specific estimates of parent or teacher attitudes. No Bihar-specific peer-reviewed study, official

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evaluation or NGO report directly measuring both stakeholder groups' perceptions was identified in the updated search. Grey literature may exist outside the repositories examined, but anecdotal programme accounts cannot substitute for systematically collected stakeholder data.

This framing avoids treating Bihar as unstudied while establishing why a focused parent-and-teacher perception study is necessary for curriculum legitimacy, AB-SHWP delivery planning and implementation fidelity.

6 Parent Perspectives on CSE Inclusion

6.1 Why Parent Perspectives Matter

Parents influence whether school-based CSE is understood as protective education, as legitimate health education, or as an intrusion into family values and decision-making. They may also influence student participation, school leadership decisions and the willingness of teachers to discuss sensitive issues. A curriculum that excludes parents from communication may therefore encounter distrust even when its health objectives are justified.

Parent perception should not be reduced to support versus opposition. Parents may support teaching puberty, menstruation, safety from abuse and HIV prevention while feeling uncertain about contraceptive information, sexual orientation, relationships, consent or mixed-gender classroom discussion. They may support CSE only when delivered by trained teachers, counsellors or health professionals, or when content is transparently explained before delivery.

6.2 Indian and International Evidence

Joshi, Gupta and Mukherjee (2024) investigated parental perceptions of sex-education delivery in India using Total Interpretive Structural Modelling and MICMAC analysis. Their model was

developed from responses from 117 parents across India. The study identified cultural and societal change, open communication between parents and adolescents, and age-appropriate education as important influences on parental perception. It recommended teacher training and parent–teacher conferences concerning curriculum delivery.

This study is relevant because it provides contemporary Indian evidence that parental acceptability is connected to communication, trust, age appropriateness and delivery structure. However, it has clear limitations for the present argument: its sample is small for a national study, it was not designed as a Bihar-specific survey, and it cannot establish the distribution of parental attitudes within Bihar.

International implementation evidence provides useful analytical propositions, but not estimates that can be transferred directly to Bihar. UNESCO's global status report identifies parent and community engagement, trust in educators, age-appropriate sequencing and clear communication about programme goals as recurring implementation conditions (UNESCO et al., 2021). The evidence review informing UNESCO's technical guidance also reports settings, including Bangladesh, in which parents showed substantial support when sexuality education was linked to educational and service-related needs (Montgomery & Knerr, 2018). These findings suggest that parental positions are often conditional rather than reducible to blanket support or opposition. They also caution against assuming that health, safety or abuse-prevention framing will automatically secure acceptance in Bihar; the effects of terminology and communication strategies require direct local evaluation.

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6.3 Implications for Bihar Parent Research and Engagement

In Bihar, future research should examine parent perspectives empirically rather than assuming resistance. Parents should be asked about: the perceived need for education on puberty, menstruation, personal safety, consent, child marriage, reproductive health, contraception, STIs/HIV, gender equality and digital safety; the age or school class at which particular topics should begin; preferred delivery agents, including teachers, counsellors or health professionals; preferences concerning mixed-gender or separate sessions; concerns about morality, cultural appropriateness, privacy and behavioural effects; trust in schools and teachers; willingness to attend orientation meetings or review curriculum content. Such evidence is crucial because CSE may become more acceptable when it is framed around health, safety, dignity, prevention of abuse, continuation of education and respectful relationships rather than through politically charged or culturally unfamiliar terminology. This subsection concerns parent communication and research design; the substantive requirements for gender-responsive curriculum content are addressed separately in Section 9.3.

7 Teacher Perspectives, Training and Delivery Capacity

7.1 Teachers as Curriculum Gatekeepers

Teachers are central to the operational success of school-based CSE. Curriculum documents alone cannot create safe educational environments. Teachers require accurate content knowledge, facilitation skills, confidence with sensitive questions, safeguarding procedures, clarity on confidentiality and referral information. Teachers may support adolescent health education while simultaneously feeling inadequately prepared to deliver it.

Discomfort can lead to omission of difficult topics, reliance on biological instruction alone or avoidance of student questions. Accordingly, teacher perception research must distinguish willingness from preparedness and institutional support.

7.2 Teacher-Perception Evidence from Odisha

Alekhya et al. (2025) conducted twelve in-depth interviews with principals and teachers from eight secondary girls' high schools in Odisha. Participants expressed unanimous agreement on the need for comprehensive sexual and reproductive health education for adolescent girls. Reported concerns included poor student knowledge, curriculum inadequacies, limited parent and community involvement, myths surrounding menstruation, limited awareness of adolescent health services and digital-media misuse. The authors recommended curriculum integration, improved teacher training, community and parent involvement, technology use and monitoring systems.

This study is directly relevant to teacher-related implementation questions in an eastern Indian setting. However, it must not be represented as evidence about teachers in Bihar. Its appropriate use is to identify plausible domains for Bihar research and to demonstrate that teachers in at least one Indian context perceive both a need for sexual and reproductive health education and significant delivery constraints.

7.3 Evidence of Educational Effects from Odisha

Alekhya et al. (2023) evaluated a school-based sexual and reproductive health education programme among adolescent girls in eight government girls' high schools in urban Odisha. The cluster-randomised trial reported significant improvements in knowledge and attitudes concerning puberty, menstruation, contraception, pregnancy, sexually transmitted and

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reproductive tract infections, and HIV/AIDS in the intervention group.

The Odisha intervention supports the feasibility of delivering school-based sexual and reproductive health education within an Indian government-school context. Nevertheless, it cannot directly establish effectiveness in Bihar because it was conducted among girls in urban Odisha, and contextual, institutional and social conditions may differ.

8 Bihar School-Based Implementation Evidence: The SEHER Programme

8.1 Importance of SEHER for This Review

The most important direct Bihar implementation evidence identified in this review is the SEHER programme: Strengthening Evidence base on scHool-based intErventions for pRomoting adolescent health. SEHER was a multicomponent whole-school health-promotion intervention implemented in government-run secondary schools in Nalanda district, Bihar. It addressed school climate and adolescent health-related outcomes, including gender-equity attitudes, violence, bullying, depression and reproductive and sexual health knowledge.

SEHER was not a stand-alone CSE trial. All three study arms received Bihar's teacher-delivered Tarang Adolescence Education Programme, consisting of approximately 16 hours per academic year on growing up, positive and responsible relationships, gender and sexuality, HIV and other sexually transmitted infections, and substance use. The two active SEHER arms added whole-school, group-level and individual-level strategies, including school health committees, student participation mechanisms, peer groups and counselling (Shinde et al., 2020; Shinde et al., 2023).

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The trial therefore tested the incremental effects of a broader school-health and school-climate intervention delivered by different personnel over an existing adolescence-education platform; it did not compare comprehensive CSE with no sexuality education.

This distinction makes SEHER relevant but limits direct generalisation. It provides Bihar-specific evidence about delivery conditions, school systems and adolescent-health programming, while leaving unresolved whether the same delivery-agent effects would occur for a more extensive CSE curriculum.

8.2 Delivery-Agent Findings

The initial SEHER cluster-randomised controlled trial evaluated delivery by a lay counsellor, termed a SEHER Mitra, and delivery by an existing teacher, compared with a control condition. The trial concluded that the lay-counsellor-delivered intervention generated substantial improvements in school climate and health-related outcomes, whereas teacher delivery did not produce comparable effects (Shinde et al., 2018).

The subsequent extended evaluation reported similar conclusions after two years. It involved 74 government-run secondary schools and found improvements in school climate, depression, bullying, attitudes towards gender equity, violence victimisation and violence perpetration among students exposed to the lay-counsellor-delivered intervention. The study found no evidence of an intervention effect for the teacher-delivered model at either follow-up (Shinde et al., 2020).

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8.3 Interpretation for CSE Inclusion

SEHER should not be interpreted as demonstrating that teachers are intrinsically unsuitable for CSE. Rather, it indicates that expecting existing teachers to implement sensitive, multicomponent adolescent-health interventions without sufficient time, role clarity, training, supervision and institutional support may be ineffective. Three critical caveats qualify its application to CSE policy.

First, SEHER evaluated a broad health-promotion and school-climate intervention that included reproductive and sexual health knowledge but was not designed as a comprehensive sexuality curriculum. Its reproductive-health exposure partly derived from the Tarang AEP received by all trial arms. The trial therefore cannot establish whether a curriculum covering the full range of consent, contraception, relationships, gender, violence, digital safety and service access would produce the same delivery-agent pattern.

Second, the lay-counsellor model raises sustainability and scalability questions for Bihar's government school system. SEHER Mitras were locally recruited graduates supported through project financing, a one-week initial training, monthly in-service meetings and regular supervision. A post-trial case study found that none of the four examined schools sustained the intervention in its original form; two retained selected components and two discontinued it. Reported requirements included continuing resources, external support, supervision and formal government authorisation (Shinde et al., 2023). Scaling a counsellor model would therefore require recurrent financing, recruitment standards, supervisory capacity and integration with education and health governance rather than simple replication of a research-project post.

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Third, the teacher condition does not exhaust the range of feasible teacher-led models. Participating teachers continued to operate within existing school roles and workloads, and the trial did not test designated health educators with reduced timetables, co-facilitation with counsellors or health workers, longer competency-based preparation, stronger leadership support, or phased implementation with fidelity feedback. The null teacher-arm findings should consequently be interpreted as evidence against unsupported role addition, not as evidence against all teacher participation.

Possible implementation models for Bihar include: specially trained school counsellors or dedicated adolescent-health facilitators with an explicit sustainability plan; co-delivery by trained teachers, counsellors and health personnel; designated teacher educators with protected timetable allocation, competency assessment, supervision and refresher support; linkage with RKSK counsellors or adolescent-friendly health services; and phased implementation that monitors content coverage, student safety, referral quality, costs and post-project continuation.

The SEHER evidence therefore shifts the Bihar question from “Should schools include CSE?” to the more implementation-sensitive question: “Which supported delivery model can provide CSE effectively, safely, equitably and sustainably within Bihar’s school system?”

9 Cross-Cutting Implementation Issues

9.1 Cultural Responsiveness Without Content Dilution

CSE must be contextually acceptable, but cultural responsiveness should not be used to remove essential information. Indian policy already recognises this balance: AEP guidance instructs teachers to consider local cultural context while maintaining sensitivity to adolescent needs and

delivering age-appropriate activities. UNESCO likewise emphasises that CSE should be culturally relevant while remaining scientifically accurate, rights-informed and comprehensive.

For Bihar, contextual adaptation may involve careful terminology, parent orientation, examples relevant to local adolescent realities, gender-sensitive facilitation and collaboration with trusted school-health actors. It should not require excluding consent, safety, gender equality, reproductive health or help-seeking information.

9.2 Parent–Teacher Trust as an Implementation Condition

The available Indian evidence suggests that parents and teachers should be treated as interdependent implementation actors. Parents may be more receptive when they understand curriculum goals and trust those delivering it. Teachers may be more willing to address sensitive topics when schools provide training, parent communication and institutional protection against misunderstanding or backlash.

Structured engagement can include:parent orientation before student sessions; plain-language curriculum summaries; opportunities for parents to ask questions; school-level safeguarding protocols ;referral pathways for health or protection needs; guidance for responding to student disclosures; periodic monitoring of teacher comfort and student perceptions.

9.3 Gender-Responsive Curriculum Design

Bihar's child-marriage and adolescent-childbearing indicators strengthen the rationale for gender-responsive content. Such content should address not only girls' risks but also the social responsibilities of boys and young men. Themes should include respect, non-violence, consent, shared decision-making, continuation of girls' education, opposition to coercion and recognition of health-service needs.

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The inclusion of gender and power does not require framing families or communities as adversaries. A constructive curriculum can emphasise the health, educational and social benefits of respectful relationships and delayed, informed family formation.

9.4 Digital Information and Misinformation

Adolescents increasingly encounter information about bodies, relationships and sexuality through digital environments. UDAYA-based evidence from Bihar and Uttar Pradesh indicates an association between social-media exposure and sexual and reproductive health knowledge among adolescent girls. This does not establish that all digital exposure is beneficial; it demonstrates that digital media have become relevant information environments for adolescents (Saha et al., 2022).

Accordingly, CSE in Bihar should include digital safety, identification of misinformation, privacy, online harassment, non-consensual sharing of images and guidance on trustworthy sources of health information. The presence of safe internet and social-media use within AB-SHWP modules makes such integration policy-consistent.

10 Evidence Map and Implications for Bihar

Table 2- Principal verified sources and their contribution to the Bihar argument

Source	Evidence Type and Setting	Principal Finding or Contribution	Appropriate Use for Bihar
WHO (2026)	International guidance	Defines CSE and summarises evidence that high-quality CSE improves knowledge and protective behaviours without increasing sexual activity	Establish conceptual and evidence rationale

UNESCO et al. (2018)	International technical guidance	Identifies comprehensive, age-appropriate, gender-responsive curriculum domains	Benchmark curriculum content
Haberland (2015)	International review of interventions	Gender and power content associated with stronger outcomes	Supports gender-responsive curriculum rationale
CBSE AEP materials	Indian official curriculum material	Provides adolescent education and culturally sensitive teacher guidance	Establish policy history and teacher role
Government of India AB-SHWP guidelines	Indian official programme document	Provides school-health delivery model and CSE-related content areas	Establish current policy platform, not fidelity
Population Foundation of India (2022)	Indian curriculum and strategy review	Identifies AEP and School Health Programme as active national curriculum-based initiatives and notes implementation/content gaps	Analyse policy–practice gap
NFHS-5 Bihar	Official population survey	Reports 40.8% marriage before 18 and 11.0% adolescent motherhood/pregnancy	Establish Bihar public-health rationale
UNFPA India (2022)	Bihar-specific analytical brief	Reports education and wealth inequalities in child marriage	Support equity-focused interpretation
Saggurti & Francis Zavier (2020)	UDAYA Bihar policy brief	Identifies contraceptive-knowledge, unmet-need and agency challenges	Establish adolescent information and service needs
Saha et al. (2022)	Bihar and Uttar Pradesh adolescent girls	Links social-media exposure with SRH knowledge	Support digital-information relevance, not CSE efficacy
Joshi et al. (2024)	Indian parent-perception study	Identifies age appropriateness, communication and teacher preparation as influences	Inform parent-research domains; not Bihar prevalence

Alekhya et al. (2025)	Odisha teacher qualitative study	Teachers identify curriculum, parent involvement and training gaps	Regionally relevant teacher evidence; not Bihar views
Alekhya et al. (2023)	Odisha school intervention	School-based SRH education improves short-term knowledge and attitudes	Supports Indian feasibility; limited transferability
Shinde et al. (2018, 2020)	Bihar school-intervention trials	Lay-counsellor delivery improved outcomes; teacher delivery did not show comparable effects	Direct Bihar implementation evidence concerning delivery model
Shinde et al. (2023)	Bihar post-trial qualitative case study	No examined school sustained SEHER in its original form; continuation depended on resources, support and governance	Direct Bihar evidence on sustainability limits and system requirements

11 Research Gaps

11.1 Direct Parent and Teacher Perception Evidence in Bihar

The principal evidence gap is not the absence of adolescent-health research in Bihar. Rather, it is the limited availability of direct, peer-reviewed research on how Bihar parents and teachers perceive the inclusion of CSE in school curricula. Future research should avoid assuming either acceptance or opposition and should document the range of views across districts, genders, rural and urban settings, school types, educational backgrounds and socioeconomic groups.

11.2 Curriculum Fidelity and Classroom Delivery

India has policy platforms addressing multiple CSE-related themes, but verified evidence on the fidelity of classroom delivery in Bihar remains limited. Research should assess whether schools deliver relevant modules, which topics are included or omitted, how teachers are trained, whether students perceive sessions as safe, and whether schools maintain referral pathways for adolescent

health or protection needs.

11.3 Delivery-Agent and Capacity Questions

SEHER demonstrates that delivery arrangements can materially influence outcomes in Bihar schools, while its post-trial case study shows that effectiveness during a funded trial does not guarantee institutional continuation (Shinde et al., 2023). Future CSE research should compare delivery through trained teachers, counsellors, health educators or blended models. It should assess not merely training attendance but educator competence, protected time, classroom fidelity, student trust, recurrent cost, supervisory requirements and sustainability within school systems.

11.4 Parent–Teacher Interaction

Existing evidence tends to examine parents or teachers separately. Yet curriculum implementation depends on their relationship. Research should examine how parental concerns affect teacher delivery, how teacher preparation shapes parental trust, and whether structured orientation improves acceptability.

11.5 Outcome Evaluation

Stakeholder acceptance is necessary but insufficient. Bihar research should evaluate whether CSE improves: sexual and reproductive health knowledge; menstrual-health understanding; awareness of contraception and services; consent and personal-safety knowledge; gender-equitable attitudes; communication with trusted adults; recognition and reporting of violence or abuse; confidence in accessing adolescent-friendly health services.

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Longer-term outcomes such as continuation in school, delayed marriage or reduced adolescent pregnancy would require carefully designed longitudinal research and should not be inferred from short-term knowledge outcomes.

12 Implications for a Bihar-Based Parent and Teacher Study

A primary study based on the evidence gap identified in this review would be timely and defensible.

12.1 Proposed Aim

To examine parents' and teachers' perceptions of including comprehensive sexuality education in secondary-school curricula in Bihar and to identify acceptable, feasible and culturally responsive implementation conditions.

12.2 Proposed Objectives

To assess the perceived need for CSE among parents and secondary-school teachers in selected districts of Bihar.

To compare parent and teacher acceptance of specific CSE domains, including puberty, menstruation, consent, personal safety, gender equality, child marriage prevention, contraception, STIs/HIV and digital safety.

To identify perceived barriers, preferred delivery agents and training requirements.

To examine variation in perceptions by rural–urban setting, gender, education, school type and other relevant socioeconomic characteristics.

To develop an evidence-informed implementation framework for CSE delivery within Bihar schools.

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12.3 Recommended Study Design

A sequential explanatory mixed-methods design would be appropriate. A cross-sectional survey of parents and teachers could quantify attitudes toward content, age appropriateness, delivery preferences and perceived barriers. Subsequent interviews or focus groups could explain the cultural and institutional meanings underlying those attitudes. Sampling should include rural and urban districts and, where feasible, government and private schools.

Table 3- Proposed variables for a Bihar stakeholder-perception study

Domain	**Illustrative Measures**
Perceived educational need	Support for puberty, menstruation, consent, reproductive health, safety, gender and digital-literacy education
Content acceptability	Acceptance of individual topics and perceived appropriate school grade
Delivery preferences	Teacher, counsellor, health worker or blended facilitator; mixed or separate sessions
Parent engagement	Orientation attendance, curriculum review, home communication confidence
Teacher preparedness	Knowledge, training received, comfort, perceived institutional support
Cultural concerns	Privacy, embarrassment, family values, behavioural concerns, local acceptability
Implementation feasibility	Time allocation, materials, referral systems, monitoring and safeguarding
Equity dimensions	Gender, residence, education, socioeconomic position and school type

13 Recommendations for Policy and Practice

13.1 Use Existing Policy Platforms but Evaluate Delivery

CSE-related content can be integrated within AB-SHWP and linked with RKSK rather than developed as an isolated parallel curriculum.

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However, programme monitoring in Bihar should assess actual delivery, content completeness, teacher preparation, student participation and referrals rather than relying only on counts of trained ambassadors or distributed materials.

13.2 Avoid Assigning Sensitive Delivery Responsibilities Without Adequate Support

SEHER indicates that teacher-led delivery cannot be assumed to be effective merely because teachers are present in schools. Bihar should consider trained counsellor-supported delivery, co-facilitation, protected teaching time, structured manuals, supervision and refresher support. Teacher training should include adolescent development, consent, gender, confidentiality, safeguarding, referral and handling difficult questions.

13.3 Engage Parents Transparently

Parent engagement should begin before curriculum rollout. Schools should communicate the aims, content sequence and protective purpose of CSE. Orientation materials should explain that CSE concerns health, safety, puberty, respect, prevention of violence, responsible decision-making and service awareness. Engagement should seek community trust without compromising accurate and essential content.

13.4 Ensure Gender-Responsive and Safety-Oriented Content

Given Bihar's documented burden of early marriage and adolescent pregnancy, curricular content should include child-marriage risks, educational continuation, consent, personal boundaries, prevention of sexual harassment and violence, respectful relationships and gender equality. Both girls and boys should participate in gender-responsive learning.

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13.5 Link Education With Services

CSE should include information on where adolescents can obtain confidential counselling, menstrual-health support, reproductive-health advice, protection from violence or abuse and mental-health assistance. School-health education is more meaningful when adolescents know how to act on information safely.

13.6 Build Evidence Before Statewide Expansion

Before advocating statewide scale-up of any specific model, Bihar requires empirical stakeholder research and implementation pilots that compare educator models, assess parent acceptability and measure delivery fidelity and student outcomes.

14 Discussion

This review demonstrates that CSE in Bihar is a justified but under-investigated educational priority. The evidence for need is strong: Bihar continues to report high levels of marriage before age 18 and adolescent childbearing, with marked educational and economic inequalities. The policy context is also enabling: India has institutional platforms that address many CSE domains through adolescent education and school-health programmes.

However, the paper identifies a crucial distinction between contextual need, policy availability, implementation evidence and stakeholder-perception evidence. NFHS-5 and UNFPA demonstrate adolescent vulnerability; they do not establish stakeholder attitudes or programme effects. AEP and AB-SHWP establish policy and curricular possibilities; they do not demonstrate comprehensive delivery in Bihar. SEHER establishes that school-based adolescent-health intervention delivery is possible in Bihar and that delivery-agent arrangements matter; it

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does not directly measure parents' or teachers' attitudes toward a CSE curriculum and was not itself a full CSE trial. Joshi et al. provide Indian parent-perception evidence, and Alekhya et al. provide Odisha teacher-perception evidence, but neither permits direct generalisation to Bihar.

This disciplined interpretation strengthens rather than weakens the case for a Bihar-focused study. It shows that an empirical study of parents and teachers would address an implementation determinant that existing Bihar adolescent-health evidence has not resolved. The study would also clarify whether concerns vary by topic, age group, delivery agent, district and school type, rather than treating "acceptance" as a single attitude.

Acknowledging alternative perspectives strengthens the review's credibility. Critics in India have argued that sexuality education belongs primarily within families, may weaken parental authority, could divert scarce school time and resources from core academic subjects, or should be replaced by value education centred on abstinence and character formation (Joseph, 2023; Rajya Sabha Secretariat, Committee on Petitions, 2009). These arguments identify legitimate questions about institutional roles, curriculum time and democratic accountability, even when some associated claims about behavioural harm are not supported by the evidence.

The reviewed evidence provides four responses. First, a family-only model is unlikely to ensure equitable access because adolescents differ in whether knowledgeable and comfortable adults are available to them, while UDAYA and other Bihar evidence document substantial information and agency constraints. Second, AB-SHWP places relationships, reproductive health, gender equality, violence prevention and digital safety within an integrated school-health platform rather than treating CSE-related content as an isolated add-on. Third, WHO's evidence summary and Indian feasibility evidence indicate that well-implemented CSE improves

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knowledge and selected protective outcomes without increasing sexual activity (Alekhya et al., 2023; WHO, 2026). Fourth, structured parent engagement can protect rather than displace parental roles by making curriculum aims, content boundaries, safeguarding procedures and referral pathways transparent. Nevertheless, the allocation of limited instructional time and public resources between CSE, counselling, academic priorities and other school-health needs remains a legitimate policy question that requires cost, feasibility and opportunity-cost evidence beyond the scope of this review.

The literature also suggests that CSE should be understood as a health, safety and gender-equity intervention rather than a narrow discussion of sexual activity. In Bihar, where adolescents may face early marriage pressures, unequal gender expectations, limited communication and digital misinformation, CSE may be particularly relevant when presented through culturally respectful, age-appropriate and scientifically accurate formats. Cultural responsiveness, however, must remain compatible with essential content on consent, bodily autonomy, contraception, violence prevention and help-seeking.

Finally, SEHER offers a more qualified policy lesson than a simple preference for counsellors over teachers. Effective school-based interventions require more than curriculum content: they require capable personnel, protected time, supervision, leadership support, referral systems and sustainable financing. The post-trial SEHER evidence shows that even effective research-supported interventions may not become embedded in routine school operations. For Bihar, teacher training, counsellor support, parent communication, governance authority, monitoring and post-project continuation should therefore be treated as core implementation components rather than optional additions.

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15 Limitations

This review has five limitations. First, it is a critical integrative review rather than a registered systematic or scoping review; it does not claim exhaustive retrieval of all relevant literature. Second, although explicit appraisal criteria were applied, formal design-specific risk-of-bias tools and duplicate independent appraisal were not used. Third, direct published evidence on Bihar parents' and teachers' perceptions of CSE inclusion remains limited, and relevant local NGO or programme documents may exist outside the repositories searched. Fourth, studies conducted outside Bihar, including the Odisha teacher and intervention studies, the national parental-perception study and international parent-engagement evidence, provide analytical insights but should not be treated as representative of Bihar. Fifth, the review does not evaluate the quality or fidelity of AB-SHWP or AEP implementation within Bihar schools because suitable direct evidence was not identified.

These limitations point directly to the need for structured empirical research involving Bihar parents, teachers, school leaders and relevant adolescent-health stakeholders.

16 Conclusion

Comprehensive sexuality education is an evidence-supported educational approach addressing adolescent health, relationships, consent, gender equality, safety and access to services. India already has policy platforms through which many CSE-related domains can be provided in schools. Bihar is an important priority context because of persistent child marriage, adolescent childbearing and social inequalities affecting girls' health and educational opportunities.

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The evidence base requires careful interpretation. Bihar has meaningful adolescent-health and school-intervention research, especially through NFHS-5, UNFPA, UDAYA and SEHER. However, direct evidence concerning how Bihar parents and teachers perceive the inclusion and delivery of CSE in school curricula remains limited. Claims of uniform stakeholder resistance or support are therefore premature.

A Bihar-specific study of parent and teacher perceptions is both justified and necessary. Such research should examine acceptable curriculum content, preferred delivery models, teacher-training requirements, parental engagement strategies and variations across social and geographic groups. The most promising policy direction is not the mechanical addition of sexuality-related lessons to an existing timetable, but the development of a supported, culturally responsive, gender-sensitive and service-linked school-health model capable of protecting adolescent dignity, health and educational futures.

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