
Shareer Apna, Adhikaar Apne

A Policy Brief on Comprehensive Sexuality Education

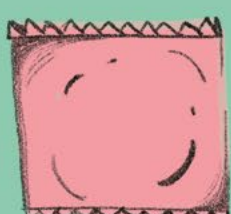
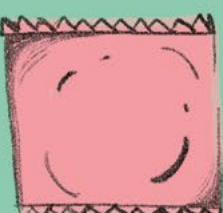
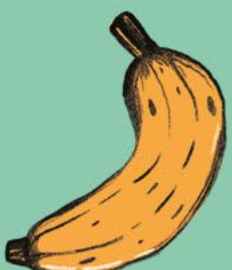
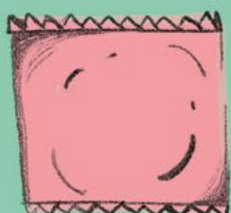
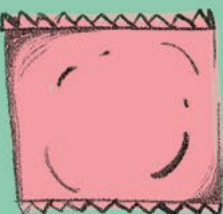
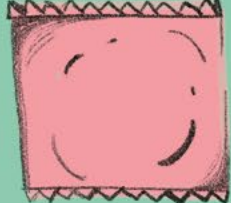
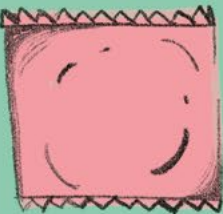


KNOW YOUR BODY



KYBK YR

KNOW YOUR RIGHTS



Shareer Apna, Adhikaar Apne

A Policy Brief on Comprehensive Sexuality Education

Glossary

AEP: Adolescence Education Programme

AFHC: Adolescent Friendly Health Clinic

ARSH: Adolescent Reproductive and Sexual Health

ASRHR: Adolescent Sexual and Reproductive Health and Rights

CBSE: Central Board of Secondary Education

CSE: Comprehensive Sexuality Education

CSO: Civil Society Organisation

C3: Center for Catalyzing Change

DOE: Department of Education

ICDS: Integrated Child Development Services

KVS: Kendriya Vidyalaya Sangathan

LGBTQIA+: Lesbian, Gay, Trans*, Intersex, Asexual, Queer +

MHRD: Ministry of Human Resource Development

MoHFW: Ministry of Health and Family Welfare

MSM: Men who have sex with men

MTP: Medical Termination of Pregnancy Act (1971)

MWCD: Ministry of Women and Child Development

MOYAS: Ministry of Youth Affairs and Sports

NACO: National AIDS Control Organisation

NALSA: National Legal Services Authority v. Union of India

NCD: Non-Communicable Diseases

NCERT: National Council of Education, Research and Training

NFHS-4: Nation Family Health Survey 2014-15

NIOS: National Institute of Open Schooling

NVS: Navodaya Vidyalaya Samiti

NYP: National Youth Policy 2014

RMNCH+A: Reproductive, Maternal, Newborn, Child and Adolescent Health

RKSK: Rashtriya Kishore Swasthya Karyakram (National Adolescent Health Programme)

SCERT: State Councils of Education, Research and Training

SE: Sexuality Education

SOGIESC: Sexual Orientation, Gender Identity and Expression and Sex Characteristics

SRHR: Sexual and Reproductive Health and Rights

SRH: Sexual and Reproductive Health

STI: Sexually Transmitted Infections

STDs: Sexually Transmitted Diseases

TYPF: The YP Foundation

UNESCO: United Nations Educational, Scientific and Cultural Organisation

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

Contents

01	—————	Preface
03	—————	1 / Introduction
09	—————	2 / Why invest in CSE?
20	—————	3 / CSE in India—Where do we stand?
24	—————	Adolescence Education Programme (AEP)
32	—————	Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) and the Rashtriya Kishor Swasthya Karyakram (RKSK)

36	—————	School Health Programme in Ayushman Bharat
40	—————	The Role of Civil Society and Youth
42	—————	Legal Barriers
45	—————	4 / Benchmarking CSE in India to global best practice
49	—————	5 / Recommendations for government
55	—————	Index

Preface

What is CSE?

United Nations Population Fund (UNFPA) defines Comprehensive Sexuality Education (CSE) as “a rights-based and gender-focused approach to sexuality education, whether in school or out of school. CSE is curriculum-based education that aims to equip children and young people with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality, in the context of their emotional and social development.”

and

What are Sexual Rights?

From the International Women’s Health Coalition: “Sexual rights...rest on the recognition that all individuals have the right—free of coercion, violence, and discrimination of any kind—to the highest attainable standard of sexual health; to pursue a satisfying, safe, and pleasurable sexual life; to have control over and decide freely, and with due regard for the rights of others, on matters related to their sexuality, reproduction, sexual orientation, bodily integrity, choice of partner, and gender identity; and to the services, education, and information, including CSE, necessary to do so.”¹

With the impending judgement and current review of Section 377 of the Indian Penal Code underway in the Supreme Court, stories of the stigma and discrimination faced for decades by many people in India are becoming more public. This moment also gives us pause to reflect. **Why is public education, particularly government programmes that provide information on Sexual and Reproductive Health (SRH) still reinforcing similar systemic discrimination or indirectly contributing to advancing the same?** The purpose of this brief is put a spotlight on current opportunities we have regarding public programming on CSE. **How can we work together to address the current discomfort and lack of preparedness within health and education administrative systems to provide information on sex and sexuality in a safe and respectful manner?**



Adolescents and young people deserve the right to grow up living healthier lives, without the fear of discrimination and violence on the basis of their sex, gender, orientation and/or expression.

It is well understood that these changes will not take place in the length and breadth of the public system overnight. However, this cannot become an excuse for the lack of an incremental and consistent strategy to improving the same. We must ensure that not just in law, but also in learning, we set a positive precedent in classrooms and communities that give young people the confidence and information they need to promote, protect, advance and celebrate their rights.

1 / Introduction

At over 368 million in number, 28% of India's population is made up of adolescents and young people between the ages of 10 and 24.²

Alongside these numbers is the mounting evidence of the burden of unmet needs of young people in several sectors, particularly education and health. In most cases, comprehensive national policies that address these development challenges do exist. There is a clear gap between the drafting of national policies and requisite political will and administrative clarity required to see them through state implementation. There are also gaps in effective financing for programmes delivering information and health services that reaffirm agency, consent and in particular, sexual health and rights.

This is further impacted by a political landscape that is more comfortable promoting skill development amongst adolescents and youth with some focus on health, limited to Non-Communicable Diseases, maternal health and reproductive and sexual health.

Whilst these interventions are important towards fulfilling the government's electoral promise of ensuring jobs for 2 crore youth in a year, developing skills and generating entrepreneurship; they are counter productive if we do not address the barriers that prevent many adolescents and youth from equitably accessing them in the first place.

SRHR is currently absent in the National Youth Policy (NYP) 2014.³ Whilst the policy does not have any financial or programme implications, ministries and departments are asked to integrate these into their programmes and schemes. CSE is well established as providing life saving, critical information on SRHR that empowers young people's health, promotes their access to justice, encourages community engagement and inclusion and develops youth leadership.

**CSE IS WELL ESTABLISHED AS
PROVIDING LIFE SAVING, CRITICAL
INFORMATION ON SRHR THAT
EMPOWERS YOUNG PEOPLE'S
HEALTH, PROMOTES THEIR ACCESS TO
JUSTICE, ENCOURAGES COMMUNITY
ENGAGEMENT AND INCLUSION AND
DEVELOPS YOUTH LEADERSHIP.**



It is essential to achieving NYP's vision of empowering young people *'to achieve their full potential'*, of which the realising the right to education and health is an essential component to develop *"a strong and healthy generation"*. The policy also identifies LGBTQIA+ young people as a group that *"require special attention in order to ensure that they can access and benefit from the programme"*.

Yet to say that nothing is being done is unfair. Whilst the country's current economic and financial policy narratives **miss the multiple benefits of investing in SRHR**, the health and education landscape in has steadily improved since the early 2000s towards addressing the same. There has been a clear shift from a population control and maternal health focused approach to addressing adolescence as an important phase for promoting a positive approach to healthy development.

India does not have a direct policy that mandates any form of Sexuality Education (either in school or outside of it), nor is its implementation the explicit responsibility of any one central ministry. It is mainly addressed within education through the Ministry of Human Resource Development (MHRD) in the Adolescence Education Programme (AEP). In health, it is under the Ministry of Health and Family Welfare (MoHFW), through the Rashtriya Kishor Swasthya Karyakram (RKSK) and the upcoming School Health Programme in Ayushman Bharat.

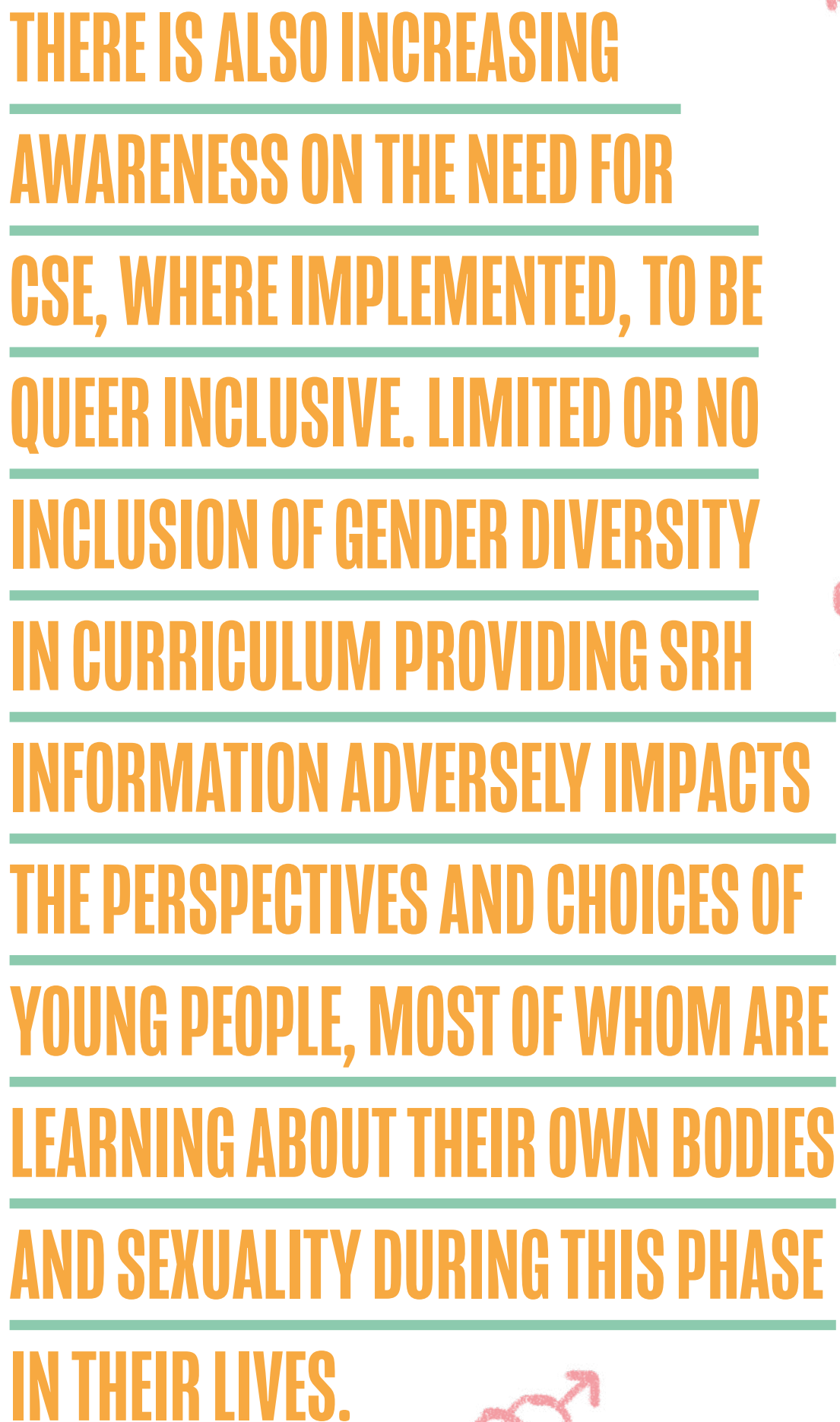
Public programmes often reflect the pulse of social conservatism and prevailing patriarchal attitudes. A review of the current public

content in the AEP and RKSK reveals a selective focus on issues that get covered under CSE.

Information on reproductive health, with limited content on sexual health in some cases reproductive rights is most common. The AEP provides a largely heteronormative view in teaching materials and key messages in campaigns. It has made some movement forward through a current revision of its materials for Classes 6-8 in this context since 2017. This shift is an effort to address the current indirect heteronormative messaging to explicitly incorporate messages of diversity, explaining the importance of non-discrimination and pluralism.

Traditional gender binary norms are reinforced in RKSK and Ayushman Bharat, which is currently developing a first stage framework on health and wellness. This is despite the introduction of ambitious and game changing SRHR health initiatives over the years by CSOs that demonstrate positive reproductive health outcomes and improvement in knowledge, attitudes and behaviours relating to SRHR in India.

While all groups calling for this may not have the same definition of sexuality education, there is a clear public demand for the need for CSE from different movements. Kailash Satyarthi's national campaign '*Surakshit Bachpan, Surakshit Bharat*' for example, placed with state governments a demand for basic sex education to address sexual assault and pornography.⁴ There examples of independent films being independently produced by citizens in Gujarati to demystify the sensitivities associated with sexuality education.⁵ Schools and CSOs working with parents of children and young people living with disabilities in Tamil Nadu are calling for CSE and the need for it to address learning disabilities.⁶ There is also increasing awareness



**THERE IS ALSO INCREASING
AWARENESS ON THE NEED FOR
CSE, WHERE IMPLEMENTED, TO BE
QUEER INCLUSIVE. LIMITED OR NO
INCLUSION OF GENDER DIVERSITY
IN CURRICULUM PROVIDING SRH
INFORMATION ADVERSELY IMPACTS
THE PERSPECTIVES AND CHOICES OF
YOUNG PEOPLE, MOST OF WHOM ARE
LEARNING ABOUT THEIR OWN BODIES
AND SEXUALITY DURING THIS PHASE
IN THEIR LIVES.**

on the need for CSE, where implemented, to be queer inclusive. Limited or no inclusion of gender diversity in curriculum providing SRH information adversely impacts the perspectives and choices of young people, most of whom are learning about their own bodies and sexuality during this phase in their lives. It results in young people in India continuing to have inadequate access to information, services and commodities pertaining to their sexual and reproductive health, including SOGIESC (Sexual Orientation, Gender Identity and Expression, and Sex Characteristics, leading to adverse consequences to their health and well-being.

But these initiatives lack responsive and informed support from a vast majority of political leaders, who give mixed messages in the media. There is a dire need to sensitise parliamentarians and politicians themselves, to counter uninformed opinions in the media that excuse sexual violence in the name of social norms, disregard the need for agency, and use culture as an excuse to deny adolescents and young people CSE. Whilst this is not a legal barrier in and of itself, these are the political voices that champion legal reform and can be a significant barrier to legalising, mandating and implementing CSE. Social and cultural norms they endorse impact how policies are implemented and land up actively controlling and policing young people's sexuality. This is often justified in the name of protecting a conservative, nationalist notion of Indian culture and in the name of keeping women and girls safe.

To socialise CSE and create a sex-positive approach, a comprehensive, longer term and targeted model of campaigning needs to be taken up, at community levels and with policy makers and state and district government officials themselves. It will need to de-stigmatise sexualities, address current legal barriers to accessing services and demystify the evidence on unmet need. Using a **'Whole School Approach'**⁷ to implementing CSE, social fear and traditional closed-door approaches to talking about the same needs to be addressed.

2 / Why invest in CSE?

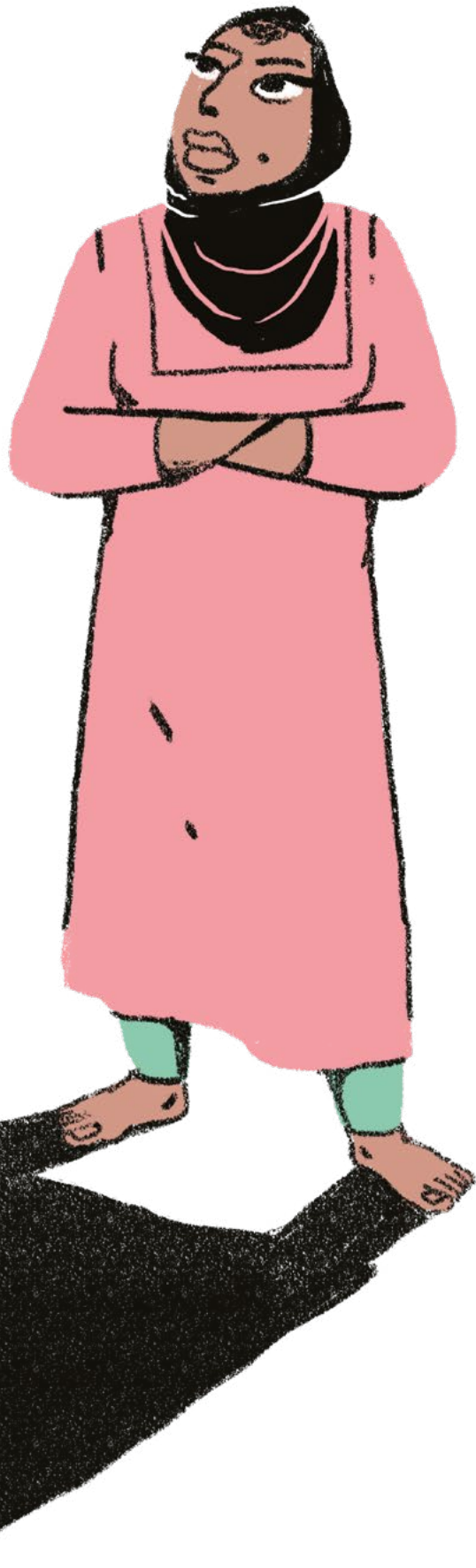
Consider two lenses to thinking through why information on CSE is relevant for adolescents and youth. The first is a **rights-based approach** where CSE helps affirm and empower young people with scientific, non-judgemental information that helps them make informed decisions about their bodies, health and negotiate relationships in their lives.

The second is a preventative lens. It looks at how CSE could help equip young people to prevent negative health outcomes and strengthen their ability to address their vulnerabilities to sexual and gender based violence (SGBV), substance abuse and HIV.

Both lenses make the case for why investing in CSE is necessary. In both, the individual is at the center of programming. They should develop the agency and understanding to be able to take decisions appropriate to their age and life contexts. This is not a process that should isolate a young person from their social environment, but instead strengthen the quality of their communication and relationships at family and community level. It should equip them to be able to ask for information, know their legal rights, seek help and garner support at critical moments, without the fear of shame, discrimination or stigma. An affirmative approach to investing in CSE argues this information equips young people ‘with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality—physically and emotionally, individually and in relationships. It views sexuality holistically and within the context of emotional and social development, recognising that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.’⁸


A fear about disseminating information on sex and sexuality is often based on misconceptions that CSE programmes will decrease the age of first sex—resulting in, CSE programmes often following an abstinence-based approach. However, a review of global evidence⁹ clearly indicates that there is no strong evidence to suggest such programmes work.¹⁰ What they *did* show is that abstinence-only education often increased the risk of pregnancy and STIs for young people.¹¹ CSE programmes, even in diverse settings, have often demonstrated that they can lead to young people delaying their first sexual intercourse.¹²

THIS IS NOT A PROCESS THAT SHOULD ISOLATE A YOUNG PERSON FROM THEIR SOCIAL ENVIRONMENT, BUT INSTEAD SHOULD STRENGTHEN THE QUALITY OF THEIR COMMUNICATION AND RELATIONSHIPS AT FAMILY AND COMMUNITY LEVEL. IT SHOULD EQUIP THEM TO BE ABLE TO ASK FOR INFORMATION, KNOW THEIR LEGAL RIGHTS, SEEK HELP AND GARNER SUPPORT AT CRITICAL MOMENTS, WITHOUT THE FEAR OF SHAME, DISCRIMINATION OR STIGMA.



A lack of investments in ensuring the SRHR of adolescents and youth from marginalised communities and vulnerable contexts, particularly young women and girls from Muslim, Dalit and tribal communities result in increasing isolation and social stigma, that cause poor quality of living and well-being.

There is often further discrimination that takes place, over and above barriers of caste, gender, class and religion. The lack of recognition of SOGIESC within health and education programmes further invisibilizes the contexts and needs of adolescents and young people. It affects their mental health and well-being, increasing their vulnerability to public transphobia and homophobia, internalised stigma, mental health problems (such as depression and anxiety related disorders) and daily mental stressors.¹³



70% YOUNG WOMEN REPORT NOT KNOWING THAT A MALE CONDOM CAN BE USED JUST ONCE

From the perspective of prevention, with puberty beginning earlier in a young person's lifetime (as early as age 10 for girls¹⁴ in some cases, including India¹⁵) social discomfort with young people being sexually active should be confronted rather than accepted.

For a majority of young people in India, the first time they have sex, it is unprotected and for a sizeable proportion of young women, it is forced.¹⁶ Whilst this statistic refers to mostly penetrative penile-vaginal sex, there is limited disaggregated data on other kinds of sex young people are having, and whether it is safe and/or consensual. Communication and negotiation with partners regarding safe sex is rare, with limited consistent condom use and understanding of consent, and almost 70% of young women reporting not knowing that a male condom can be used just once.¹⁷



87% OF HIV TRANSMISSION IN 2015-16 WAS BECAUSE OF UNPROTECTED SEX

India has the third highest number of people living with HIV in the world, with unprotected (heterosexual) sex accounting for 87% of transmission amongst individuals in 2015-16.¹⁸ Despite an overall decline in new infections, 50% of all new infections are reported in young people between 15-24 years of age.¹⁹ Thus, there is a need to increase young people's knowledge of Sexually Transmitted Infections (STIs), Sexually Transmitted Diseases (STDs) and the prevention of HIV.



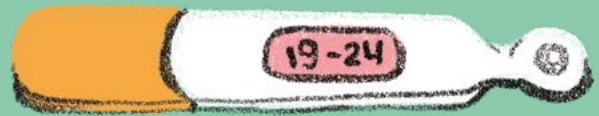
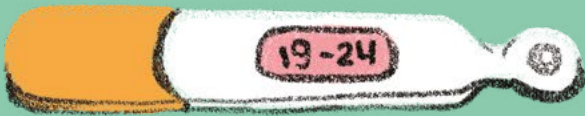
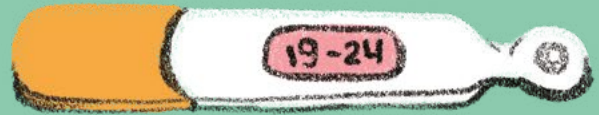
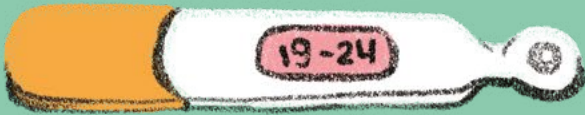
50% OF ALL NEW INFECTIONS ARE REPORTED IN YOUNG PEOPLE BETWEEN 15-24 YEARS OF AGE



26.8% OF WOMEN IN INDIA ARE MARRIED BEFORE THE AGE OF 18 (NFHS-4 DATA)

India also has the second highest number of child marriages in the world and is a global leader in teenage pregnancy. NFHS-4 data reveals that 26.8% of women were married before the age of 18—an approximate 2 million girls.²⁰ 20% of women between ages 20-24 reported that they had their first child before they were 18 years old.²¹

20% OF WOMEN BETWEEN AGES 20-24 HAD THEIR FIRST CHILD BEFORE THEY WERE 18 YEARS OLD



DESPITE ABORTION BEING LEGAL
IN INDIA, ON AVERAGE, A WOMAN
DIES EVERY TWO HOURS BECAUSE
OF ABORTIONS GOING WRONG²²
WITH 50% OF MATERNAL DEATHS
THAT TAKE PLACE BEING AMONGST
THE 19-24 AGE GROUP.²³





**NATIONAL DATA FROM THE
MINISTRY OF WOMEN AND CHILD
DEVELOPMENT ASSESSED THAT
MORE THAN 53% OF CHILDREN
THEY SURVEYED IN 13 STATES IN
INDIA REPORTED ONE OR MORE
FORMS OF SEXUAL ABUSE, OF
WHICH 57% WERE BOYS.**



For LGBTQIA+ adolescents and youth, there is evidence of the physical and psychological abuse that students have experienced at the hands of teachers, school administration staff, fellow students and in accessing health systems from service providers.²⁴ Young people living with disabilities face exclusion in similar and different ways: their sexuality often goes unacknowledged and there is limited to no information on their SRHR that is mandated to be provided in schools across the country. All these statistics indicate that policy makers are well aware of the urgent unmet needs of young people, and the failings in current systems.

A major challenge in the Indian context lies in adequately recognising SOGIESC.

While the NALSA judgement²⁵ provides scope for CSE curricula to recognise and explain the third gender within the law and state curricula,²⁶ current government curricula on CSE make inadequate representation of the LGBTQIA+ community. A lack of recognising the same translates into a non-inclusive understanding of gender, imparted through public education to adolescents and young people. This is further confused by public discourse on Section 377 of the Indian Penal Code, which is inaccurately interpreted as the country's law that criminalises homosexuality.²⁷

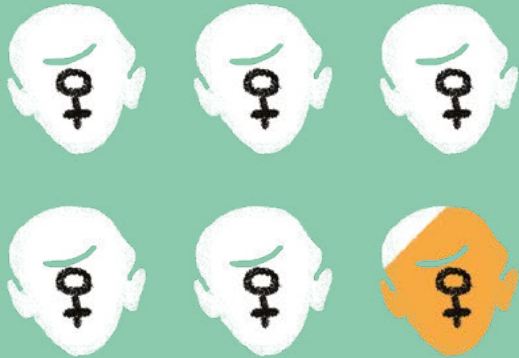
Sexual and reproductive health, diversity, SOGIESC, and pleasure are critical components of any CSE framework. To exercise one's sexual rights—for example, to say yes or no to sex or to access contraceptives and services—requires clear and comprehensive knowledge of one's body. It is especially important for a CSE curriculum to adopt a sex-positive approach that discusses masturbation and different forms of sexual intimacy outside the

framework of marriage and childbearing. Given our patriarchal culture that **restricts women's mobility and choices right from adolescence as a preventative measure against sexual assault**, a CSE programme is a powerful tool that enables young people to develop ownership of their bodies and their rights.

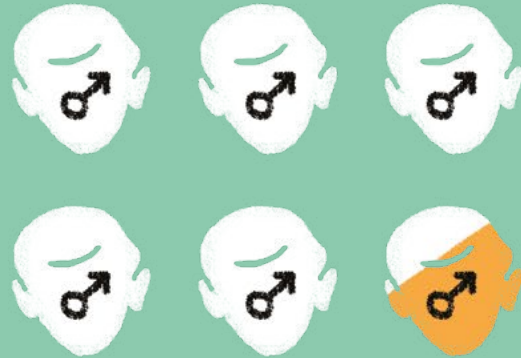
CSE programmes also explore effective linkages with mental health, encouraging young people to seek help and talk, and sensitise healthcare providers and teachers. *India has the highest suicide rate in the world amongst young people.*²⁸ **The Mental Health Care Act 2017** decriminalises suicide, and provides legislation to prevent discrimination against and ensuring the rights of people living with mental illness. There are additional mechanisms needed, to ensure life skills and provide healthy and safe coping mechanisms for young people to cope with social pressures of different kinds, including a lack of access of accessible mental health professionals.

Whilst CSE is not a one-stop solution to ending discrimination, violence and ensuring holistic SRH, it has long been the missing link to providing comprehensive information on SRHR to adolescents and young people in a safe manner in both urban and rural settings.

84% GIRLS (12-14 YEARS)



86% BOYS (12-14 YEARS)



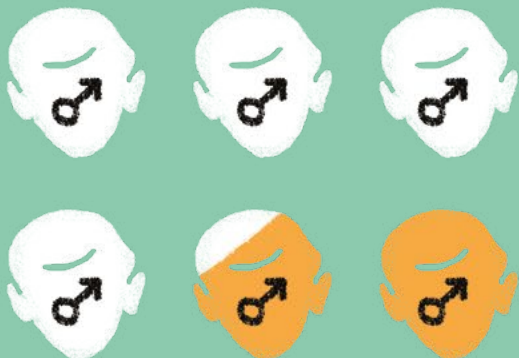
→ CURRENTLY IN SCHOOL ←

70% GIRLS (15-16 YEARS)



The conversation on the need for it should not just be limited to sex and sexual health, but should be understood from a life cycle perspective. CSE builds different kinds of economic, social and cultural assets that benefit young people. It teaches concepts of bodily integrity, agency and autonomy, and brings young people's issues to the surface.

73% BOYS (15-16 YEARS)



Given that 84% of girls and 86% boys in the age group of 12-14 and 70% girls and 73% boys in the age group of 15-16 are currently in school, as well as the state focus on scaling school enrollment and retention at the primary and secondary levels through various policies, schools continue to be the primary catchment area to provide CSE to adolescents and young people. However, it is also necessary to ensure that CSE is freely accessible in out-of-school settings because of the number of adolescents and youth that **are either not in school or have dropped out**, and so that it is also available for adults, particularly parents, teachers and health providers.

3 / CSE in India—Where do we stand?

Two streams of programming initiated at central level currently provide young people with life skills and CSE:

- **The Adolescence Education Programme (AEP),²⁹** whose implementation has been through two agencies.

- **The National AIDS Control Organisation (NACO)** in collaboration with UNICEF and UNESCO, mostly in out-of-school settings.
 - NACO also focussed on CSE as part of its HIV prevention strategy in National AIDS Control Programme III and IV.
- MHRD through the NCERT and SCERTs, in collaboration with UNFPA.

- **The National Health Mission, MoHFW** focuses on:

- Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)³⁰ which RKSK³¹ is under and
- The School Health Programme under Ayushman Bharat.

A historical review of central CSE programming highlight some common trends.

The first, that there has never been a clear policy mandate for CSE to be provided by a specific ministry, nor has there been any programme that such a mandate could be pegged to for accountability or budgetary clarity.

CSE has been partially integrated in public health responses to adolescent and young people's unmet needs (as described in Section 2). Despite India having ratified several international agreements, no ministry or agency is held accountable to the standard of CSE met in programmes. Overall, as CSE programmes are rolled out, backlash is anticipated often but met with minimal investments in behaviour change communication to address public misconceptions. An exception to this in ASRHR was NACO's national campaigning and Long Format Program Mass Media Campaigns on HIV prevention across 2005-2007. Its targeted messages to increase condom usage and safer sex also aimed at decreasing stigma and misinformation about People Living with HIV.

The second, is that a majority of campaigns and subsequent curricula reinforce a heteronormative understanding of families and relationships, which automatically exclude young people who do not identify within the same.

MOHFW's messaging for ARSH is closely aligned with menstrual hygiene, reproductive health and/or maternal health. When addressing sexual health, it is generally targeted at married young people. The references to 'gender' in education policies and programmes are non-inclusive of diversity. Most policies and programmes relating to health refer to 'sex' which again does not go beyond 'male' and 'female'. In the National Health Policy (2017), 'transgender' people are described as a group whose health needs are required to be well researched due to scarcity of data and in the same policy, 'MSM' are referred to as high risk groups for HIV/AIDS. Across all policies described, the approach to discussion on non-normative identities and orientations is solely health- and risk-oriented. There is a marked absence of focus on sexual health and rights outside the context of reproduction. The fear of this within government ministries comes from the roll-out and subsequent backlash to the AEP, expanded below.

The third trend is that programmes are unable to sustain a strong position on comprehensively addressing all curricula topics under CSE.

This includes doing the legwork, with state governments, of contextualising this content in preparation of its regional to local rollout with state departments. In the absence of this, topics under CSE land up being cherry picked, with a shifting scale of what becomes non-negotiable, reducing the efficacy of programmes. This is a large effort that requires significant resources, strong partnerships with civil society and state departments, clear political commitment, regularised line item budgets and long-term investments in regularly training personnel and implementing infrastructure. Given India's positive track record and previous investments in improving the landscape of maternal and child health, we know that despite being a tall order, this can be done. Given the ample data that describes the benefits in investing in SRHR, our government is in a position to make a strong push to leverage political support for CSE implementation. Some efforts are strategically underway to strengthen the content and messaging of ARSH programmes within RKSK (such as the *Saathiya Salah Toolkit*, CSO led partnerships and state pilot case studies for good practice) and the AEP, as described in sections below.

Adolescence Education Programme (AEP)

The two versions of the AEP have been implemented at national level through two agencies, driven by different objectives. The NACO-led version was developed between 2004-2005 with the aim of addressing HIV prevention, developed in collaboration with the MHRD and UNICEF as part of accelerating efforts to scale the AEP and strengthen school AIDS programmes. The content focussed heavily on helping students in grade 9–11 acquire life skills to promote healthy behaviours and reduce their vulnerabilities to substance abuse and HIV, promoting positive attitudes and coping mechanisms for young people to deal with the challenges of growing up. As funding to NACO decreased in recent years, the programme has also been scaled down and in some states, discontinued.

**NCERT'S AEP REMAINS THE
ONLY INSTITUTIONALISED
GOVERNMENT
INTERVENTION ADDRESSING
ADOLESCENT HEALTH
WITHIN THE CURRENT
EDUCATION SYSTEM.**

It is implemented across the country through three schooling systems—the National Institute of Open Schooling (NIOS), Kendriya Vidyalaya Sangathan (KVS) and Navodaya Vidyalaya Samiti (NVS). Using a cascade training approach, the programme orients a pool of master trainers who further train nodal teachers that implement a maximum 26.5 hour module through five modules for adolescents between 14-19 years of age, through classes 6-12. Implemented with technical support from UNFPA, it was launched in 2005 by MOHFW.

The rollout of the first draft of the curriculum faced severe backlash in 2007, with 12 state governments³² banning the same. It was protested by local teachers and parent groups, expressing discomfort with the perceived ‘inappropriateness of content’ and teaching aid material, identified as culturally inappropriate. It was relaunched in 2009 after a parliamentary enquiry and curriculum review, less publicly, with the ban providing an opportunity to reframe the AEP with key stakeholders in central and state education departments.

The AEP annually reaching out to approximately 340,000 adolescents directly through the KVS and NVS systems. It has 221,000 young people enrolled at secondary level in the NIOS. Presently the curriculum is banned in an estimated 6 states³³. Whilst NCERT and UNFPA have released two central evaluations of the programmes, within the information in the public domain, there is a lack of clarity on the status of these curricula i.e. which states are implementing them, and which version of the AEP.

The AEP does not set out a clear objective to provide CSE, but addresses issues within the same with a strong focus on developing life skills. It identifies adolescence as a period of positive transformation, with great potential.

Its curricula aims to provide young people with information to help them understand the changes that take place during this period. Additionally, it aims to develop skills that help establish and maintain positive relationships, challenge stereotypes and discrimination (in particular, those related to gender and sexuality), identify violations and report the same, and understand information about their SRH (including HIV/AIDS) and substance abuse. The curriculum does not explain SOGIESC. It has taken an incremental approach through revisions in the text to explain concepts, divided across learning objectives for primary, upper primary, secondary and senior secondary levels. Its *revised conceptual framework* currently identifies the importance of respecting the heterogeneity of young people, which includes recognising diversity in terms of caste, class, gender, sexual orientation and disability. The text focuses through activities on developing an understanding of self, bodily integrity and developing interpersonal skills.

Given there is flexibility for schools to integrate the AEP in different ways (some do so through co-curricular activities, and other within the school academic curriculum), there are gaps in aligning the conceptual framework with messaging in practice. Integrating this message successfully and comprehensively across the implementation of the AEP is a critical first step to including information about SOGIESC and young people's rights in this context.

Ongoing revisions for classes 6-8 include an explanation of the word 'transgender' or 'third gender', highlighting the importance of non discrimination and plurality, particularly in the context of ensuring rights. But plurality is essential to explain outside of gender as well.



Young people and adolescents living with disabilities feature nowhere in the AEP currently, nor do their sexual desires and rights.

The AEP addresses gender equality and SRHR by developing an analysis of how both issues impact social and cultural norms, and the agency, mobility and rights of adolescents and young people. Currently, its examples are limited to heteronormative frameworks, and can reinforce gender based stereotypes.

For example, the curriculum has limited conversations on the rights of young people to not marry or on young people's right to choose their own partners. While gender inequality is challenged through highlighting nutritional discrimination against girls, marriage or the right to reproduce is not described as optional for young women. Even while talking about reproductive rights, the curriculum identifies the role of condoms in preventing pregnancies and STIs, but there is no mention of the **Medical Termination of Pregnancy (MTP) Act** and the provisions under which women and girls have the legal right to access safe abortion services.

Objectives of the AEP include identifying gender violence and harassment, including mechanisms for protection, respecting rights and understanding how to mutually coexist. The text explains, by secondary and senior secondary level, how to identify different kinds of gender based violence and the impact and influence of social norms. The gendered nature of violence in the AEP needs to be challenged.

THE SYSTEMIC AND STRUCTURAL DISCRIMINATION THAT TAKES PLACE IN SOCIETY MUST BE ADDRESSED

in order to highlight how vulnerability exists on the basis of gender, age, caste, class, sexual orientation or disability.

Current laws such as the NALSA judgement, the move to state issued identification that identifies third gender and cases like the Sabarimala Temple's rule against women entering the temple should be integrated and updated within the text to inform young people of India's currently changing landscape.



While the 2010 AEP evaluation²¹ by UNFPA provides insight into the curriculum's implementation successes and limitations, it is difficult to access the exact curriculum implemented with the students to determine the extension and depth of the topics covered. With respect to topics that are covered by the curriculum, the report indicates gaps in the topics themselves.

For instance, within 'positive relationships', the curriculum discusses relationships with friends, family and decision-making regarding marriage. It does not discuss negotiation and consent in the context of an intimate or sexual relationship, even within marriage. By limiting the discussion to non-sexual relationships, students are unable to challenge and change cultural beliefs regarding the hierarchy of power and gender in relationships. This is shown by one stark statistic from the evaluation report, which states that

**43% OF STUDENTS
WHO UNDERWENT THE
CURRICULUM BELIEVED
THAT WIFE BEATING IS
JUSTIFIED UNDER SOME
CIRCUMSTANCES.**

A larger challenge is developing the leadership of school administration to prioritise these discussions, and ensure they are not skipped; contextualising discussions to local realities; and making students aware of where rights violations are taking place.

Master Trainer and Nodal Teachers capacities will need to be substantively strengthened such that they can speak transparently about issues of sex and sexuality. Facilitators must be trained such that they do not use substitute words and abstract terms that often encourage misinformation.

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) and the Rashtriya Kishor Swasthya Karyakram (RKSK)

The MoHFW launched the RMNCH+A initiative in 2013 as a part of its National Health Mission. The Reproductive, Maternal, Newborn, Child and Adolescent Health programme aims to provide a 'continuum of care' with equal focus on every life stage, including adolescence. The initiative mandates adolescent friendly health clinics (AFHCs) across urban and rural centers that provide counseling, curative services and commodities, and enable adolescents and young people to avail of contraceptives.

The clinics also deliver counseling on puberty, sex, delaying marriage and first pregnancy. In 2014 the National Adolescent Health Mission launched the ambitious RKSK Programme, envisaging a converged approach to comprehensively addressing adolescent health, which linked peer educators to the AFHCs. RKSK does not have a standardised approach to implementing SE across the 231 districts it targets. The programme concentrates on health promotion behaviours amongst adolescents, addressing nutrition, SRHR, injuries and violence, substance misuse, NCDs and mental health.

Collaboratively, AFHCs and RKSK (through its peer education programme) have the potential for a powerful health system that enables adolescents to access SRH information and services that include SE. A convergent approach however, requires alignment from vision to implementation and partnerships with the Department of

**RKSK CONCENTRATES
ON HEALTH PROMOTION
BEHAVIOURS AMONGST
ADOLESCENTS, ADDRESSING
NUTRITION, SRHR,
INJURIES AND VIOLENCE,
SUBSTANCE MISUSE, NCDS
AND MENTAL HEALTH.**



Education (DoE), ICDS, MHRD, Panchayati Raj Institutions, MWCD and MOYAS. These are all departments entrusted with or currently addressing the wellbeing, education and health of adolescents and youth. In reality, AFHCs have been unable to increase young people's access to services.

**A 2014 POPULATION
COUNCIL STUDY³⁴ FOUND
THAT ONLY 8% OF WOMEN
AND 5% OF MEN SURVEYED
IN 3 STATES WERE AWARE
OF THE EXISTENCE OF AFHCS
SITUATED WITHIN 5-10
KILOMETERS OF THEIR
VILLAGES.¹⁴**

The YP Foundation (TYPF) also conducted a youth-led audit of the state of youth SRH services in Lucknow in 2016, which confirmed that social and cultural norms further stigmatise young people from accessing services for fear of being recognised, discriminated and judged.³⁵



Homosexuality is addressed as a health 'risk' for individuals on page 34 of the RKSK Strategy Handbook 2014, with no clarifications or explanations.

These references are at odds with the progressive messaging by the MoHFW towards the RKSK peer educators, seen most clearly in the *Saathiya* Resource Kit and the *Saathiya Salah* app. Launched in February 2017,³⁷ the app was meant to train 1.6 lakh peer educators in a phased manner to work with and support community health workers in generating demand for adolescent health services as well as provide information on CSE in peer groups. The *Saathiya Salah* toolkit makes an important deviation from the government's usual approach to CSE by providing an unbiased platform for young people to access information on gender based violence, access to safe abortion, STIs, substance abuse, gender based violence and contraception amongst other topics. It is significant because it highlights the importance of consent and acknowledges desire as normal across and between genders.³⁷ This is also important when viewing how public health programming has traditionally worked with men and boys, and further aids in challenging patriarchal notions of masculinity and its link with violence.³⁸ There is limited public data on the current status of the implementation of the toolkit. RKSK has faced challenges in generating state interest in scaling up work with peer educators to address SRHR components of the programme. Whilst programming adolescent pregnancy are taken up, SRH information delivery

continues to face barriers.

Given that RKSK is presently in its design for implementation phase, there is great potential to integrate CSE within current efforts to operationalise services.

Socialising the key principles of CSE with health service providers, particularly Asha and ANM workers is no small undertaking, and would make a drastic impact in improving the availability of CSE³⁹ at community level.

School Health Programme in Ayushman Bharat

The School Health Component of Ayushman Bharat is developed in alignment with the RKSK. The objective of the programme is somewhat similar to the AEP, with a focus to increase knowledge, inculcate positive and oppressive attitudes and enhance life skills to promote informed, responsible and healthy behaviors among adolescents.

The programme is in the phase of developing a Health and Wellness framework, that sensibly looks to harmonise existing content from similar school based programmes to avoid duplication. To maximise

lessons learned, initiatives reviewed include the AEP, Value Education, Life Skills Education (LSE), Peace Education, Environment Safety and NPEP. These are combined with the experiences of state governments, NCERT, CBSE, NACO, and CSOs and with the aim to prevent further burdening teachers.

The curriculum thematically addresses growing up healthy, well-being and mental health, gender equality, interpersonal relationships, nutrition, sanitation and health, substance abuse, preventing non-communicable diseases, SRH, safety and security against injuries and violence, value education and the promotion of safe use of social media. It will

integrate teaching relevant laws and policies, within each section.

Whilst public reporting indicates the programme will provide Sex Education in the government's 115 aspirational districts,⁴⁰ a closer examination of the topics drafted reveal a similar pattern of avoiding addressing 'rights' as a part of SRHR, and a less than comprehensive approach to providing CSE. Instead, the programme focuses on reproductive health and the inter-linkages between CSE and other issues.

There are, again, no safeguards against public backlash, as previously experienced with the AEP in 2007. This approach, of cherry picking topics, does not meet existing international standards of CSE (explained in further detail in the next section), and is sexuality education in name only. The content, training for School Health Ambassadors, as well as teachers, needs to align with global, evidence based standards for CSE, and identify good practice in this regard.

In 2017, a NACO assessment of the AEP in six states revealing that whilst knowledge levels had increased slightly, gaps remained in implementing the programme. This was attributed, amongst other factors, to 'political sensitivities to the curriculum and poor linkage to service delivery'.⁴¹ Thus, continuing with this cautious approach is unlikely to address the fear of implementing CSE.

There are some changes to this approach: NCERT is reportedly



considering updating the images in its textbooks to include pictures of the anatomy at an earlier age to explain sex.⁴² Under RKSK, the state of Haryana has collaborated across its HRD and WCD departments to design a sex education programme for classes 8 to 12, with the aim of expanding the same to anganwadi centers.

THE PROGRAMME INTENDS TO TREAT THE SUBJECT OF SEX 'AS A NATURAL DESIRE' AND NOT THE EQUIVALENT OF A DISORDER.⁴³

Ayushman Bharat presents another opportunity to create a new public narrative on CSE, and could be supported with a national campaign led by the central government, to demystify myths and stereotypes related to the same in the public domain.

The Role of Civil Society and Youth

In all of this, what is the role that CSOs and young people themselves play?

In addition to government led initiatives, a large range of SRH, and within that a more select list of youth-led and/or focused programmes on CSE are being implemented. A public compendium does not exist on how to identify best practices from existing CSE programmes, whether state or CSO led, and particularly those that are youth-led and -run.

Broadly, non-governmental organisations implementing in both urban and rural contexts play a critical role in contextualising information on CSE, and address similar challenges of community backlash. Not all cover the range of topics that come under CSE, including masturbation, conception, contraception, pleasure and consent. At the same time, participants across these programmes ask about precisely these issues.

There are few standalone examples of CSOs that have been able to successfully scale sexuality education programmes in collaboration with state governments. C3's Udaan programme in partnership with the Department of Education, Government of Jharkhand is one such successful example. The programme provides information on Reproductive Health and Reproductive Rights, and aspects of Sexual Health, but is yet to integrate Sexual Rights within the same.⁴⁴

Several NGO programmes having developed strategies to address and talk about sex and sexuality through peer-led approaches. They use tools such as sports, campaigns, the arts and media, as well as platforms such as self help groups, panchayat meetings, advocacy dialogues with block and district level officers and confidential workshops that provide safe spaces for adolescents and young people to ask questions and get information.

More entry points for CSE exist within programmes that discuss SRH more broadly. CSOs play a valuable role in providing technical support to state departments in sustaining and scaling the quality of content.

Young people working at community level play a critical role in scaling a bottom up demand for this CSE.⁴⁵ They are important partners in the process of building community trust, bringing expertise in knowing what works at local levels, and can make recommendations for how to successfully integrate CSE within communities.

A state-level consultation conducted by TYPF, SAHAYOG and UNESCO in 2011⁴⁶ brought together 52 youth activists and leaders from 19 districts whose programmes reached out to 1,96,905 beneficiaries in Uttar Pradesh, highlighting policy recommendations to the state government for the roll out and scale up of CSE. Their involvement as critical stakeholders in rolling out content on CSE, contextualising and advocating for it with key stakeholders in their local communities is recognised as best practice in the ITGSE 2018 and the Whole School Approach to implementing CSE.⁴⁷

Legal Barriers

In the absence of a direct policy on CSE, an intersection of laws (in no particular order) impede or facilitate access to the services and information on CSE that should be made available to adolescents and youth. Whilst the law is looked at to protect SRH and Human Rights, in the case of CSE, it is often in the process of catching up with global standards and best practice. Separate to law, is the challenge of how policies are framed versus how they are implemented and the several gaps that exist between the two. National laws, as currently framed, have room for improvement but are still secondary barriers to the implementation of CSE. The primary challenge remains at state level. With education and health on the Concurrent list⁴⁸, it is desired but not considered essential for SE programmes to meet any uniform standards.

The current education system is a long way off from encouraging adolescents and young people to make informed decisions about the range of diverse gender expressions that exist. Or to encourage the freedom for young people to decide and define themselves free from social biases. This section highlights some of the key laws that impact or impede an adolescent and/or young person's access to CSE.

On preventing violence and addressing consent.

CSE curricula should advocate for non-discrimination as a key principle, located in current practices and policies. The NALSA Judgement, ongoing process to finalise the Transgender Persons (Protection of Rights) Bill and the 2017 Justice K.S Puttaswamy (Retd) v. Union of India judgement on the right to privacy are progressive examples that should be included in CSE curricula. Contradictions within the law also send confusing messages, such as the revised guidelines by the National Voluntary Guidelines on Social, Environmental & Economic Responsibilities of Business.⁴⁹

Given the magnitude of data on different forms of sexual and gender based violence in India that is being increasingly reported in the media, a hasty government reaction to appease

public anger often creates more complications than provides solutions. The passing of laws and ordinances in a reactive fashion does not address the root causes of violence or create effective mechanisms to protect young people. In response to the incidence of gang rape reported in Delhi in 2012 that sparked global outrage, the central government supported by parliament, ignored the *Justice Verma Committee* recommendations⁵⁰ and pushed through a hasty amendment in 2013 to the **Protection of Children Against Sexual Offences (POCSO) Act**.

The irony is that the committee was constituted by the central government with the mandate of recommending amendments to existing Criminal Law so as to provide quicker trial and enhanced punishment for criminals accused of committing sexual assault against women. The committee recommended the implementation of age appropriate sex education, as well criminalisation of marital rape. Both recommendations were rejected in Parliament and by the central government on the grounds that they challenged the sanctity of the institution of marriage. The call to protect the honour of young women and girls was reinforced by strengthening a protectionist approach instead. The government introduced an amendment to POCSO where the death penalty could be provided as maximum punishment in child rape cases where the victim is under 12 years of age and the crime is considered particularly heinous. If the aim is to prevent sexual violence in the first place, global evidence has shown that the death penalty is not an effective deterrent to the same.

Empowering adolescents and young people with information about their bodies can help increase their confidence and improving their



communication skills can give them the tools to articulate their consent and report violations, without fear that they will not be believed, or heard.

By assuming that minors have no agency and cannot exercise consent, POCSO further makes sex between minors a crime, irrespective of consent. Given that the legal age of consent for sex in India is 18 years old, and data shows that adolescents are sexually active prior to turning 18, denying minors access to services (without the consent of their guardians), as well as CSE, only increases their vulnerability. Additionally, since rape within marriage not recognised and the age of marriage is 18 for girls and 21 for boys, it becomes increasingly important for consent to be understood and for adolescents and young people to have a voice. To promote reporting of violations, POCSO further mandates all health service providers to report any cases involving sexual activity with or between minors. This leaves young people in consenting sexual relations vulnerable to criminal action, limiting their access to SRH services and compromising their health and well-being. In cases where girls need to access a safe abortion service, and have the consent of their legal guardians, they are unable to do so without running the risk of the provider filing a First Information Report (FIR), on the assumption within POCSO that sex was not consensual. An FIR cannot be filed without declaring the name of the adolescent in question, in turn contradicting the MTP Act where providers should ensure confidentiality. These two acts overlap, creating confusion and delays for minors seeking SRH services that include safe abortion.⁵¹

4 / Benchmarking CSE in India to global best practice

The 2018 International Technical Guidance on Sexuality Education (ITGSE) Revised Guidelines by UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO provides a global benchmark to governments on what inclusive and comprehensive content and approach to implementing CSE looks like. The ITGSE remains the only recognised global technical standard on SE by the UN system, and hence is recognised by its member states as a roadmap to implement SE at national levels.

The 2018 version is significantly more advanced than its earlier version of 2009. The current framework provides a clear definition for what CSE entails and how it is conceptually framed.

The ITGSE 2018 affirms the rights of LGBTQIA+ people and celebrates sexual diversity even while it recognises the discriminatory barriers faced by LGBTQIA+ people and its impact on their health, wellbeing and rights.

It has a more comprehensive understanding of safe abortion and reinforces the importance of young people's leadership and participation as critical in SE programmes to advancing their agency. Finally, it conducts a substantive review of global evidence, in

particular ‘the impact of CSE curricula on already marginalised groups, including young people with physical and/or cognitive disabilities, YPLHIV and LGBTQIA+ young people’. Whilst the AEP meets the criteria set out in the 2009 version of the ITGSE, it is yet to align with the standards proposed in the 2018 revision.

Other noted frameworks that advance a progressive approach to CSE include **IPPF’s Framework for CSE (2006)**⁵¹, **UNFPA’s Operational Guidance for CSE (OGCSE) (2014)**⁵³ and **United Nations Special Rapporteur Report on the Right to Education (2010)**. India is a global signatory to several commitments that require it to ensure the provision of CSE domestically, additionally inferred as guaranteed under the right to information, right to education and right to health under the Indian constitution. This includes the **Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights, Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child**. Each of these treaty monitoring bodies support the case for CSE and/or the need for the same in schools.

India is also a signatory to the **International Conference on Population and Development Programme of Action (ICPD PoA)** since 1994. In 2013, as chair of the negotiations, India led 47 countries to a landmark regional renegotiation of this agreement (ICPD+20) at the 6th Asia and Pacific Population Conference. The Asian and Pacific Declaration on Population and Development⁵³ highlighted India’s commitment to ‘implement CSE programmes and to respect sexual and reproductive health and rights of adolescents and young people, including removing legal and social barriers to youth-friendly sexual and reproductive health services’.



Similarly, India is a signatory to the Sustainable Development Goals (SDGs), which includes commitments towards enabling good health and well being, providing quality education, and bringing about gender equality (SDGs 3, 4 & 5).²⁴ The SDGs also comprise more specific targets for 2030 such as 3.7⁵⁵, 4.7⁵⁶ and 5.6 (ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the **Beijing Platform for Action** and the outcome documents of their review conferences). The **High Level Political Forum** at the United Nations is mandated to review member states progress on specific SDGs. India volunteered its review in 2017, presented by NITI Aayog. Under progress reported in areas of health, CSR and SRHR were absent, with a focus on NCDs instead. Similarly, given the Prime Minister's Beti Padhao, Beti Bachao programme and priority on empowering the girl child, SDG 5 on gender equality should hold greater priority with the government and include ensuring missing gaps in meeting SRHR investments.

Challenging existing forms of gender discrimination is insufficient to create a cultural shift if young people, especially young women are not empowered to take ownership of their bodies and sexuality.

The opportunity to input the national indicators that the **Ministry of Programme and Statistics (MOSPI)** is drafting for Niti Aayog for India to measure and reports its progress in implementing the Agenda 2030 roadmap provides an entrypoint to both advocate for and monitor the implementation of CSE. CSOs working across different thematic sectors—sanitation, health, gender, food security, education, sustainability, water, the rights of marginalised communities and technology for example—will need to align on recognising the need for CSE that is also inclusive of, and does not exclude Sexual Rights. Advocacy between sectors for this, and increased sensitisation amongst CSOs is also required.

The dichotomy often lies in what gets promised at international levels, and the lack of translation, prioritisation and knowledge of the same at national and state levels.

CSO participation in regional and global advocacy platforms is strategic therefore, to ensure that messaging at global level with opportunities to advance CSE are based in young people's lived realities. Given that RKSK (since 2016) and Ayushman Bharat (in 2018) are being developed after the AEP's implementation since 2009, there is a critical opportunity to make sure good practice is transferred and that the content meets standards set out in the ITGSE 2018.

5 / Recommendations for government

There is both need and scope for CSOs to advocate with state governments for greater integration of a sex-positive, affirmative, rights-based approach to providing information on SRH within existing programmes.

An often overlooked, yet essential component to doing this is to strengthen the voices of adolescents and young people themselves, so they can generate demand and articulate their need for CSE with health providers, block and district officials as well as in their communities.

Scaling the demand for CSE complements existing pilots by MOHFW in different states to increase effective outreach to adolescents and young people. The Udaan⁵⁷ project in Rajasthan, for example works with adolescents to identify a user centered design to making youth services comprehensive and accessible, with potential for large scale integration within RKSK.



Given below are recommendations for how MHRD, NCERT and SCERTs and MOHFW could strengthen the delivery of CSE that is inclusive of SOGIESC in the country. These recommendations are not exhaustive and cannot be developed overnight. However, they do need to be prioritised by the government, followed by making changes to existing programmes.

For government officials

- Scale partnerships with state governments expressing positive intent to strengthen CSE by:
 - Strengthening the technical capacities of state officers and departments to implement and understand the same.
 - Develop a joint roadmap that can serve as good practice for other states on how to operationalise CSE programmes. Lessons from programme evaluations such as the UDAAN programme by C3 and the Government of Jharkhand can feed into the same.
 - Work with local media (including conducting training and sensitisation with health and education sector journalists) on CSE and young people's unmet need for SRHR information.
- In their multi-year planning, MOHFW and MHRD should develop Behaviour Change Communication campaigns that sensitise the public on the need for CSE, thus proactively addressing adverse responses that often arise from a lack of information.
 - These campaigns should particularly target parents, encouraging inter-generational communication on SRH issues and the need to encourage adolescents and young people to ask questions without shame or fear of rebuke and/or violence.

Encourage policies to further embed youth participation and ownership in the development, implementation and monitoring of programmes that aim to address SOGIESC in CSE.

- In particular, dialogues between decision makers, programme implementers and young people must be held in a safe environment.
- There is a clear need to generate evidence of the efficacy of such programmes and the benefits they hold for adolescents. The MHRD should look towards publishing the impact of the AEP curriculum on an annual basis with the aim of building a case to strengthen the programme's present expansion. Alternatively, information used to monitor and evaluate the programme must be shared publicly on a regular basis. This should also be applicable to Ayushman Bharat, with the approach that CSOs and youth organisations can support strengthening the same through partnerships and technical assistance.
- Further, information on the programme's delivery including curriculum, methodology, successes and challenges should be made publicly available to help inform and strengthen other similar interventions.

For Policymakers and Curriculum Developers

- Undertake a review of existing SRH programmes that provide information on SE, in particular the AEP, RKSK and Ayushman Bharat and align curricula with the standards set out in the ITGSE 2018.
 - This should be supplemented with national meetings conducted with relevant state education and health departments and nodal officers to train and orient them to the ITGSE 2018, addressing key concerns.
 - A central pool of resources can be developed for all states to access to strengthening existing ToT programmes for master trainers, facilitators and Heads of School to align with the same.

Strengthen all 3 programme curricula to address diversity in identities, consent, negotiation and pleasure such that young people develop sex positive attitudes that are not ruled by stereotypes, stigma, shame or fear.

- Lesson plans can be upgraded using seven elements identified in IPPF's Framework for Sexuality Education and ITGSE guidelines that recognise SOGIESC issues right from the primary education level. Upgraded lesson plans can strengthen addressing body and sex positive attitudes; address gender discriminatory practices that begin before puberty; and build the confidence necessary to ask questions and seek help.
- Translations should be undertaken by SRHR experts in each language to ensure user-friendliness in the context of each state's social and cultural norms, working with young people.
- A focussed approach to sensitising key stakeholders (as identified above) at regional levels is required. NCERT should include within its ToT young people working at community levels implementing CSE or Sexual Health and Rights programmes to engage with programme facilitators to reduce discomfort at the outset.

For the AEP

- Enable young people to recognise and exercise rights associated with LSE and CSE
- The Adolescent Education Programme should encourage adolescents undergoing the curriculum to visit their local Adolescent Friendly Health Clinic, set up by the Ministry for Health to provide information, services and commodities that address adolescents' health needs.
- Young people and adolescents should be informed of current laws in regards to accessing the same, so they are aware of their rights and if minors, the need for parental/guardian consent in certain instances.
- Conduct pilot sessions with parents in schools that report positive success stories with implementing the AEP and have well trained master trainers. These should explain the need for SOGIESC in CSE with support from CSOs, young people and subject experts that are well trained in modeling how to conduct community discussions on the same.

For RKSK

- As the RKSK rolls out its peer education programme across districts, MoHFW partner with states to organise platforms that engage youth SRHR advocates, implementers and frontline health workers to input into the programme's design and implementation on CSE and help support the implementation and monitoring and evaluation process.
- The launch of the National Adolescent Health Programme or RKSK is an excellent opportunity to deliver CSE to out of school adolescents and young people. The "Saathiya toolkit" is a step in the right direction. However, the MoHFW must invest in the training and mentorship of the programme's peer educators to effectively collectivise young people to impart CSE that also effectively addresses SOGIESC and other community concerns.

Frontline health workers such as the Accredited Social Health Activist should also be trained on SOGIESC-friendly CSE in order to engage with often marginalised constituencies like young girls and gender non-conforming youth on

SRH and gender diversity issues and to help support peer educators at the community level.

- Invest in the dissemination of government-provided service options to inform young people of available SRH services. This requires partnerships with major medical networks and groups and needs a long term view.
- The programme should sensitise and advocate with health service providers to ensure non-judgmental and non-discriminatory service delivery that is youth friendly and holds professionals accountable for quality care delivery. For example, all staff at Adolescent Friendly Health Clinics should be sensitised on how to handle young people coming to these clinics in a non-judgmental and non-threatening manner. They should also be informed on the diversity of SOGIESC, reproductive and health issues including laws such as the Medical Termination of Pregnancy Act in order to provide unbiased services to young people. Toolkits like the Saathiya toolkit should be readily available at such centers for the staff to share with young people and enable them to use it. District wide plans should be developed and systematically rolled out to ensure coverage.

CSOs play a critical role in enabling government bodies to implement these recommendations successfully, exploring pilot innovations and testing models to provide real time feedback to programmes. CSOs are also uniquely placed in being able to collectivise communities to provide input to and engage with government campaigns to challenge and change deep rooted cultural norms that stigmatise young people's SRHR and SOGIE.

Even though there is increased government action and support to provide young people with access to SRH information and services, India has a considerable journey ahead to ensure political will, adequate financing and administrative clarity for every young person and adolescent to have access to evidence-based CSE and SRHR services that responds to their lived realities.

Index

1. International Women's Health Coalition, "Sexual Rights are Human Rights". Link: <<https://iwhc.org/articles/sexual-rights-human-rights/>>
2. 2015 UNPD World Population Prospects. Link: <https://esa.un.org/unpd/wpp/publications/files/key_findings_wpp_2015.pdf>
3. The NYP sets out 5 objectives and 11 key priorities. These are education, skill development and employment, entrepreneurship, health and healthy lifestyle, sports, promotion of social values, community engagement, participation in politics and governance, youth engagement, inclusion and social justice
4. Chaudhry I, On Denying Young People the Right to Know: A Policy History of CSE in India, Feminism in India, August 2017. Link: <<https://feminisminindia.com/2017/08/24/policy-history-cse-india/>>
5. Link: <<http://www.dnaindia.com/ahmedabad/report-sex-education-gujarati-movie-aims-to-break-taboo-2626228>>
6. Link: <<https://timesofindia.indiatimes.com/city/trichy/sex-edu-must-for-children-with-learning-disabilities-experts/articleshow/64725228.cms>>
7. Rutgers, 'We All Benefit: An introduction to the Whole School Approach for sexuality education', Utrecht, 2016 and UNFPA and BZGA Federal Centre for Health Education, 'Sexuality Education Policy Brief Number 4', 2017.
8. International Planned Parenthood Federation, 'Sexual Rights: An IPPF Declaration', London, 2008
9. Amongst several global reviews, these findings were confirmed by Mathematica Policy Research mandated by US Congress in 2007. They conducted a comprehensive review of sex and HIV education programmes by Douglas Kirby for the National Campaign to Prevent Teen and Unplanned Pregnancy.
10. Boonstra D. Heather, Guttmacher Institute, 'Advocates Call for a New Approach After the Era of 'Abstinence-Only Sex Education'', Volume 12, Issue 1, March 4, 2009.

11. Rosenbaum ,. 'Patient teenagers? A comparison of the sexual behaviour of virginity pledgers and matched nonpledgers', *Pediatrics*, 123 (1), 110–120, 2009.
12. Grunseit, A., Klippax, S., Aggleton, P., Baldo, M. & Slutkin, G., 'Sexuality Education and Young People's Sexual Behavior. A Review of Studies', *Journal of Adolescent Research*, 12(4), p. 421-453, 1997.
13. Moleiro, C. & Nuno, P., 'Sexual orientation and gender identity: review of concepts, controversies, and their relation to psychopathology classification systems', 2015 and The Royal Australian & New Zealand College of Psychiatrists, March 2016.
14. United Nations Educational, Scientific and Cultural Organization, 'Good Policy And Practice In Health Education Booklet 9: Puberty Education & Menstrual Hygiene Management', Paris, 2014.
15. Khadilkar, V. V., Stanhope, R. G., & Khadilkar, ..' Secular trends in puberty. *Indian pediatrics*', 43(6), 475.
16. K.G. Santhya, Rajib Acharya, Shireen J. Jejeebhoy & Usha Ram, 'Timing of first sex before marriage and its correlates: evidence from India', *Culture, Health & Sexuality*, Vol. 13, Iss. 3, 2011.
17. International Institute for Population Sciences (IIPS) and Population Council. 'Youth in India: Situation and Needs 2006–2007', Mumbai, 2010.
18. NACO, India HIV Estimation 2015 report, SIMS data 2015-16.
19. UNICEF, HIV/AIDS in India, Link: <<http://unicef.in/Story/601/HIVAIDS-in-India>>
20. Census of India. Adolescents and Youth in India: Highlights from Census 2011, 2011.
21. United Nations Children's Emergency Fund, ' Child Marriage in India: An Analysis of Available Data', New Delhi, 2012.
22. IPAS
23. Link: <<http://world.time.com/2013/07/19/world-population-focus->

on-india-part-2-unsafe- abortions> and <<http://indianexpress.com/article/india/india-others/india-has-highest-number-of-maternal-deaths>>

24. Gee Imaan Semmalar, 'Trans Rights in India', The YP Foundation, 2017. Link: <<http://www.theypfoundation.org/s/Longformatillustrations-web.pdf>>
25. The National Legal Services Authority vs Union of India (NALSA) Judgment 2014 was a landmark judgement that recognised transgender individuals comprising a 'third gender' with equal constitutional rights, creating protections against discrimination that takes place across sectors of public employment, healthcare, access to education and public services of the same. However, the spirit of this judgement is yet to translate to state and central agencies (that enforce the need for physical proof of identity/sex change to receive benefits), that continue marginalisation, harassment and policing of individuals of the transgender community.
26. The judgement states that "gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body which may involve a freely chosen, modification of bodily appearance or functions by medical, surgical or other means and other expressions of gender, including dress, speech and mannerisms. Gender identity, therefore, refers to an individual's self-identification as a man, woman, transgender or other identified category."
27. Section 377 of the Indian Penal Code does not criminalise identity, but any form of sexual intercourse that is non penile-vaginal in nature, with imprisonment for life / for a defined term extendable to 10 years and/or a fine. In practice, it has been used to criminalise, harass and intimidate LGBTQIA+ people. Recognising this, as well as the right to privacy (2017 Justice K.S Puttaswamy (Retd) v. Union of India judgement), the state has no right to interfere or regulate consensual relations and/or relationships between consenting adults. In 2001, the Naz Foundation (India)

Trust filed a petition in the Delhi High Court, that was dismissed 2 years later. It was subsequently appealed in the Supreme Court, instructing the High Court to reconsider. The landmark judgement in 2009 by Chief Justice AP Shah and Justice S. Muralidhar read down Section 377. The judgement was overturned in December 2012 by a two panel bench of the Supreme Court, citing the power to amend the law as with the Parliament and not the High Court, and holding that LGB individuals constitute a small section of society. In January 2018, the Supreme Court agreed to revisit the 2013 judgement, with a larger constitutional bench re-examining Section 377's constitutional validity. The case was being heard in court at the time of writing this paper.

28. Link: < <https://www.thebetterindia.com/108700/suicide-prevention-a-growing-public-health-concern-in-india/>>
29. Link: <<http://www.aeparc.org/>>
30. Link: <<http://www.nhm.gov.in/nrhm-components/rmnc-h-a.html>>
31. Link: <<http://www.nhm.gov.in/nrhmcomponents/reproductive-child-health/adolescent-health/arsh.html>>
32. Maharashtra, Goa, Gujarat, Karnataka, Chhattisgarh, Madhya Pradesh, Odisha, Punjab, Uttar Pradesh, Kerala and Rajasthan.
33. Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Chhattisgarh, and Karnataka.
34. Santhya KG; Prakash R; Jejeebhoy SJ; Singh SK, Accessing Adolescent Friendly Health Clinics in India: The Perspectives of Adolescents and Youth, Population Council, New Delhi, July 2014.
35. Link: <<http://www.theypfoundation.org/publications/>>
36. Link: <<http://pib.nic.in/newsite/PrintRelease.aspx?relid=158578>>
37. Link: <www.ndtv.com/education/sex-education-kit-prepared-by-health-ministry-says-homosexual-attraction-natural-in-adolescents-1662233>
38. Link: <www.firstpost.com/india/health-ministrys-new-sex-education-manual-enters-as-yet-untouched-territory-of-sexuality-and-gender-3295642.html>

39. Link <<http://www.theypfoundation.org/kybkyr-2-0campaign/>>
40. Link: <<https://www.indiatoday.in/mail-today/story/sex-education-set-to-become-part-of-school-curriculum-1211116-2018-04-13>>
41. UNICEF Annual Results Report 2017, HIV and AIDS
42. Link: <<https://www.thetimes.co.uk/article/india-overhauls-sex-education-to-halt-rise-in-rape-and-abuse-rbcgwn0ms>>
43. Link: <<https://www.indiatoday.in/education-today/featureophilia/story/sex-education-importance-978571-2017-05-23>>
44. ChandraMouli V., Plesons M., Barua A., Patnaik A., Gogoi A., Katoch M., Ziauddin M., Mishra R., Sinha A., 'What did it take to scale-up and sustain Udaan, a school-based adolescent education programme in Jharkhand, India?', David and Lucile Packard Foundation, Department of Reproductive Health and Research, World Health Organization, 2017.
45. 'Comprehensive Sexuality Education: The challenges and opportunities of scaling up', UNESCO, 2014.
46. Chaudhry I., Chandra S., 'Shareer Apna – Adhikaa Apne – A Youth-Led Report on Policy Recommendations to Enable CSE in Uttar Pradesh', 2013, The YP Foundation & Sahayog.
47. Link: <<https://www.rutgers.international/what-we-do/comprehensive-sexuality-education/whole-school-approach-sexuality-education-step-step>>
48. Population Control and Family Planning and Education are listed as part of 52 subjects on the Concurrent List The guidelines are for businesses to maintain equal opportunities at the time of recruitment and during the course of employment. The revised text drops references to discrimination on the specific grounds of caste, creed, gender, race, religion, disability or sexual orientation that was made in its earlier version, diluting that employers should not discriminate in general.
49. The guidelines are for businesses to maintain equal opportunities at the time of recruitment and during the course of employment.

The revised text drops references to discrimination on the specific grounds of caste, creed, gender, race, religion, disability or sexual orientation that was made in its earlier version, diluting that employers should not discriminate in general.

50. Link: <<http://www.prsindia.org/parliamenttrack/report-summaries/justice-verma-committee-report-summary-2628/>>
51. Link: <<https://www.ipasdevelopmentfoundation.org/publications/policy-brief-the-pocso-act-and-the-mtp-act-key-information-for-medical-providers.html>>
52. Link: <http://www.ippf.org/sites/default/files/ippf_framework_for_comprehensive_sexuality_education.pdf>
53. Link: <<http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Operational%20Guidance%20for%20CSE%20-Final%20WEB%20Version.pdf>>
54. Link: <<http://icpdtaskforce.org/task-force-welcomes-landmark-asian-and-pacific-declaration-on-population-and-development/>>
55. 'Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.'
56. 'Ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development.'
57. Link: <<http://www.theypfoundation.org/udaan>>

Author: Ishita Chaudhry

Research and Additional Writing: Shruthi Basavaraj

Illustration and Design: Kruttika Susarla

Editing and Review: Esther Moraes, Manak Matiyani, Souvik Pyne

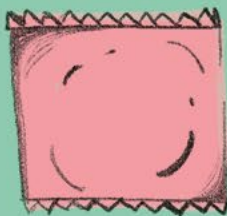
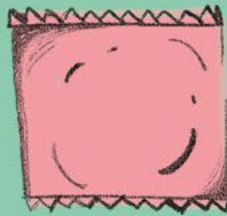
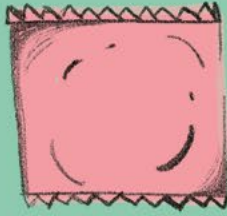
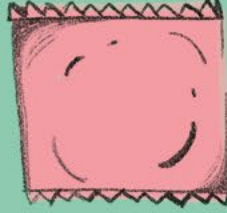
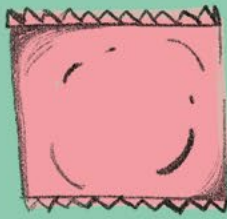
Produced by the YP Foundation with support from

the David &
Lucile Packard
FOUNDATION

CHOICE FOR
YOUTH &
SEXUALITY

arrow 

 **INTERNATIONAL
WOMEN'S HEALTH
COALITION**



8888 the yp foundation

   / theypfoundation

The YP Foundation is a youth-led, feminist, and rights-based non-profit organisation based in New Delhi. Founded in 2002, TYPF works with and for young people across issues such as gender, sexuality, leadership, health, and education. TYPF's Know Your Body, Know Your Rights programme provides CSE to young people from diverse backgrounds across Delhi, Uttar Pradesh and Bihar.

www.theypfoundation.org