SHAREER APNA ADHIKAAR APNE

A Youth-Led Report on Policy Recommendations for
Enabling Comprehensive Sexuality Education (CSE)
 in Uttar Pradesh

जागरूकता

परिवर्तन

भागीदारी

समाधान

समुदाय स्तर पर जागरूकता

- अपने हेल्थ के बारे में पापा से बात करना व बतना जरूरी है। - सलाह, पैसा व उनकी सहमति के लिए।

युवाओं का स्वास्थ्य सेवा

UP में युवाओं

AEP implementation

लड़के व लड़कियों की आपस में बात करना हमारी नजरिया से सही है व आधिकार है लेकिन समाज सही नही मानता है।

युवा भागीदा
सहभाग मा

- स्वास्थ्य की जानकारी स्कूल से मिलती है इसलिए शिक्षा जरूरी है।
- पाठ्य क्र में हो।
- गुणनित्ता शिक्षा स्कूलों में दी जोमेव तो पूरी जानकारी मिलेगी व माहौल मिलेगा।

Commun

- HIV व AIDS एक ही नाम/चीज है।
- HIV व AIDS अलग-2 हैं परन्तु जुड़े हैं।
- युवाओं के स्वास्थ्य की जानकारी दास्तां
- लड़कियों/लड़को का लम्बा या होता होना वंशानुगत होता है।

Sources of information

स्वास्थ्य व शरीर के बारे में हमारा अधिकार है।

अनिवार्य स्वास्थ्य का अधिकार है।

मौलिकता शिक्षा स्कूलों में दी जाए।

- स्वास्थ्य के विषय में जानकारी का स्तर?
- युवाओं को अपने शरीर व स्वास्थ्य के बारे में जानना जरूरी है व हक है
- जानकारी ही बचाव है, नही होगी तो हमारे बिमारी बढ़ेगी

नए तरीके

- दोस्तों से किसी भी विषय पर बात करना आसान होता है।
- सारी बातें अगर दोस्तों को बता दीजा तो वो धोखा भी दे सकते है
- युवा साथियों के बीच जानकारी का स्त्र
- हमें अपने शरीर व स्वास्थ्य के विषय में जानकर अन्य मुझसे द देना होगा

री व युवा
डल

स्वार्थ

स्वामी ब्र

रे में

बा

CONTENTS

Reporting Back: Regional Assessments on the Status of CSE in UP
Photo: Rachit Sai Barak

1. PREFACE

'Shareer Apna, Adhikaar Apne': A Youth-Led Report on Policy Recommendations for Enabling Comprehensive Sexuality Education (CSE) in Uttar Pradesh, is an amalgamation of experience sharing from young people who are leading peer-based interventions on Sexual and Reproductive Health and other youth-related issues working in rural and urban contexts with in- and out-of-school groups. These youth leaders are actively addressing the need for Sexual and Reproductive Health (SRH) through a package of programmes that use a wide diversity of entry points to discussing this issue.

The consultation and key interviews conducted across 2010 – 2012, as well as this report, are located within a rights based framework, where CSE needs to be seen as a constitutional right that would bolster an evidence-based and informed understanding of young people's sexual and reproductive health. The use of the rights-based approach is critical, as it recognises the value of youth interventions and youth leadership at the community-level as something that is integral to policy-making. The report highlights that any policy pertaining to young people that does not accord them with the position of being equal stakeholders, would remain incomplete and in the longer run, unsustainable.

The argument that young people in Uttar Pradesh do not need or want information on sexuality and related issues is primarily what this report seeks to clarify. The lack of documented voices from young people themselves is where the need for this policy report is situated. Designed as a tool for young people to enable stronger political will for sexuality education, the usefulness of this report is not just for agencies who are committed to engaging young people in securing their right to CSE in Uttar Pradesh but also for young people themselves to legitimately

document their needs and concerns and use this report as a tool to actively advocate, in youth-led campaigns at village, district, state and eventually national levels.

Information in this report can largely be seen as of two kinds: (a) the perspectives and recommendations of youth leaders in Uttar Pradesh who have undertaken campaigns and grassroots work on issues of gender and SRH with communities that surround them, and (b) a documentation of the feedback of young people on the broad ground reality in Uttar Pradesh with reference to both available infrastructure, as well as the nature of the social and cultural milieu. This policy report is based on feedback and recommendations from young people and an attempt has been made to retain the authenticity of their feedback. In order to contextualise any information in this report, it is also important to apply a gendered lens, something that we have sought to highlight. Gendered realities, that are as much communal, class and caste realities, inform all community-oriented work that has been shared from these consultations.

We believe that it is critical for young people to step into this debate, frame their needs and concerns for themselves as well as reclaim the language of how sexuality education can and should be addressed at both local and policy levels. This should complement and strengthen the work that civil society organisations have undertaken since 2007 at national and state levels. At the same time, we support a broader diversity of young people[1] with latent leadership skills from both rural and urban contexts to use the 'Shareer Apna, Adhikaar Apne / Know Your Body, Know Your Rights' programme to assert their participation in policy and programming that ultimately impacts their own health and rights and those of their peers.

Ishita Chaudhry
THE YP FOUNDATION

Palasri Roy Das
SAHAYOG

February 1, 2013

---

[1] The programme works with a cross-section of young people who are both in- and out-of-school at national and state levels. Young people who have participated in this process, as well as those who lead its implementation as peer educators and youth leaders are diverse in their representation. They include both girls and boys, those living with

disabilities, married and unmarried young people, young people living with HIV and those with different sexual orientation and gender identities from low-income communities. Advancing the participation of young women and girls, particularly those from Dalit and Muslim communities has been a key focus within the programme.

Consultation In Progress
Photo: Rachit Sai Barak

2. ACKNOWLEDGEMENTS

Fifty-two fantastic, energetic, passionate, bright and incredible young people, who are actively working across 19 districts with adolescents and youth to give them critical, life-saving information regarding their sexuality and health gave their time, energy and expertise to putting this report together. We are incredibly grateful and excited for having met each other. These young people create a vibrant landscape in their solidarity, advocacy and activism to ensure their sexual and reproductive health and rights across Uttar Pradesh.

The 'Shareer Apna, Adhikaar Apne / Know Your Body Know Your Rights' programme is our platform and commitment to consolidate our learning, share success stories and work through challenges to collaborate and advocate together towards ensuring that Comprehensive Sexuality Education is understood by policy-makers and is available and accessible to young people and their communities alike. As with many community-led and supported processes that enable and empower young people, these would not have been possible without the joint partnership between UNESCO, SAHAYOG and The YP Foundation and the support of the John D. and Catherine T. MacArthur Foundation throughout this period. We are also very grateful for the support of the International Planned Parenthood Federation (IPPF) across 2011 to the programme. We are grateful to Dr. Shankar Chowdhury and Dipa Nag Chowdhury for their mentoring and inputs, as well as Nadine Schuepp and Shishir Chandra for their valuable support with editing the final stages of this report.

The programme in Uttar Pradesh is the combined partnership of The YP Foundation and SAHAYOG. We are grateful to Jashodhara Dasgupta, Coordinator SAHAYOG, Palasri Roy Das, Sunil Kumar Maurya, Annu Singh, Shishir Chandra, Esha Saraswat, Ratna Sharma, Ravi Shekhar, Ekta Singh, Shraddha Pandey and Manish Teckchandani from SAHAYOG and to Gopika Bashi, Radhika Mathur, Disha Sethi, Maneesha Singh, Rachit Sai Barak, Gaurav Madan, Basant Ram Neeraj Kumar, Mohona Chatterjee and Pooja Verma from The YP Foundation and Divya Gujral, for their collaborative work in supporting and facilitating the consultations that have led to this report.

Sharing Aspirations: Can CSE be a reality for young people in UP?
Photo: Rachit Sai Barak

3. INTRODUCTION

A vast range of policies and programmes that exist nation-wide and specifically in Uttar Pradesh, have the potential to address issues of Sexual Reproductive Health and Rights (SRHR) for young people.

There is an important need to consistently review and understand ways of supporting the transitions from policy-making to successful policy-implementation. Successful implementation from policy to reality also asks for a more complex understanding of the larger structural concerns relating to how policy is made operational at state and local levels. To enable SRHR for adolescents and young people in this situation, policy-makers need to take into account bureaucratic and infrastructural hurdles, gaps in capacity building of healthcare personnel, as well as the need for fiscal and political commitment.

Additionally, it is commonly understood that in a decentralised system of governance, there is no single standardised way in which to analyse, how Comprehensive Sexuality Education (CSE) is made available and accessible for adolescents and young people that are both in-school and out-of-school. The increasingly powerful role of Civil Society Organisations (CSOs), multilateral and bilateral donors as well as International Non-Governmental Organisations (INGOs) in addressing and investing in both family-planning and maternal health approaches have also increased investments as well as focus in reaching adolescents and young people. At the same time, the lack of a clear rights-based approach in addressing adolescent sexuality as well as the lack of accessibility to basic

reproductive health services, as findings from the consultation showed, have resulted in instances of multiple and mixed messaging, as well as a vertical approach in treating sexuality education through the lens of disease prevention and / or population control instead of health promotion.

But CSE is not designed to treat a disease or illness and does not consider a young person as ill, to begin with. It consists of much more than a simple understanding of anatomy and reproductive health. A rights-based approach to sexuality education seeks to equip young people with scientific, evidence-based information designed to be delivered in an age-appropriate manner giving young people the knowledge, skills, attitudes and values they need to acquire essential life skills and develop positive attitudes and values. It views 'sexuality' holistically and within the context of emotional and social development and assures young people's right to access accurate information[2]. Additionally, sexuality education creates a space for a young person to critically assess information about these issues, clarify their own values and make an informed choice reflecting these values. Young people need these skills in order to navigate the constantly shifting boundaries between cultural acceptability and stigma, discrimination and social taboos.

In this context, Uttar Pradesh is one of the 11 states in India that witnessed the withdrawal of the Adolescence Education Program (AEP)[3] in 2007[4]. Media coverage at the time provided insight into the challenges that had led to the curriculum being banned consequently.

---

[2] Inputs: IPPF Framework for CSE, January 2010

[3] The Adolescence Education Programme (AEP) is a key policy initiative of NACP II. The Ministry of HRD and NACO collaborated to develop this school-based programme that is implemented with the objective of reaching out to about 33 million students within two years in India. The Department of Education and the National AIDS Control Organisation in partnership with UNICEF, UNESCO & UNFPA, launched the Adolescent Education Programme. Implemented in all states across the country, the objective of the AEP is to ensure that all students in classes IX – XI have

adequate and accurate knowledge about HIV in the context of life skills. The programme aims to support young people's right to know about themselves their adolescence and their sexuality, get basic facts on HIV and other sexually transmitted infections, protect themselves by developing and reinforcing life-skills and access knowledge to dispel myths and clarify misconceptions. Source: UNICEF, Online Media Centre.

[4] The number of states that withdrew the AEP or banned the same is unclear. Varied media reports estimate the same to be between 11 – 13. By 2009, five states continued to maintain the ban, of which Uttar Pradesh is one.

An excerpt from an article in October 2007 reads as follows:

Storm Over Sexuality Education in Uttar Pradesh[5]

'Recent data from NFHS-III reveals that an overwhelming majority of Indians feel their children should be taught about sexual behaviour and HIV/AIDS in school. Nevertheless Uttar Pradesh, with the country's highest infant mortality rate and high maternal mortality and fertility rates has chosen to ban its very successful Adolescent Education Programme in schools across the state …
The education department runs the AEP with support from the Uttar Pradesh State AIDS Control Society (UPSACS), and Uttar Pradesh's State Council for Education Research and Training (SCERT), which prepared the curriculum. Agencies like UNICEF and the National AIDS Control Organisation (NACO)

provided their expertise in shaping the course material for schools. The material evolved over a decade and was adapted, changed and tested in a number of states. It was also reviewed by teachers, SCERT District Institutes of Education and Training (DIET) and National Council for Education Research and Training (NCERT) at the national-level, before being translated into Hindi. In Uttar Pradesh, the material was field-tested by training a number of district resource persons. Teachers were taught to use tools to enable them to provide information on life skills; one section details information on HIV … Initial rumblings against the AEP began on July 4, 2007 when schools in the state reopened after the summer vacation. By July 6, the issue of life skills education for adolescents was being discussed by the Opposition in the state Vidhan Sabha.

(A) Principal in Lucknow points out that the programme was introduced in his school only after he had called a parent-teacher meeting and held several meetings on the issue. This was part of state-level advocacy where students and teachers presented their response to the AEP programme. During these interactions, there was no opposition to the programme … Adolescent education was introduced in UP during 2005 – 2006 when two lessons were incorporated into the social-sciences and physical education curriculum for Classes IX to XII.

This year, when the Uttar Pradesh Secondary Education Board made the Kishor Awastha Shiksha Yojana (Adolescent Education Programme) aimed primarily at AIDS awareness among adolescents, compulsory from the 2007 – 08 session, teachers threatened a mass boycott. The new lessons, a set of four, were based on material provided by NACO and the Ministry of Human Resource and Development … Among the many interviews carried in the local media when the controversy broke, there were some with adolescents and their parents who said they wanted systematic and formal information dissemination. Most said this was necessary especially in a world that is witnessing an information explosion with adolescents being exposed to adult-life much earlier than previous generations …'

Link:
<http://infochangeindia.org/public-health/features/storm-over-sexuality-education-in-up.html>

---

[5] Excerpts from the article above have been provided to give an illustrative example of context of the ban in the AEP and the reporting in Uttar Pradesh at the time and should not to be seen as a factual account of the same.

The withdrawal of the AEP in 2007 has since been revisited by several different health and education bodies of the government, including the National AIDS Control Organisation[6] that are exploring curriculums with revisions that can be put into place, to make the content as well as context of teaching the same, more feasible for the local communities, which this education will ultimately reach out to. Since the withdrawal of the AEP, an alternate policy in the state of Uttar Pradesh legitimises an opportunity for CSE to be available and accessible through the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA, which aims to empower girls (with a specific focus on out-of-school girls) between the ages 11 – 18 years by improving their nutritional, reproductive and sexual health status, and seeks to upgrade their home-, life-, and vocational skills. Additionally, there are Adolescent Reproductive and

Sexual Health (ARSH) programmes being implemented under the National Rural Health Mission (NRHM) by the Ministry of Family Health and Welfare that are focusing on designing Youth Friendly Health Services (YFHS) in Community Health Centres (CHCs) at the district-level. Whilst the focus on sexual and reproductive health, family welfare and hygiene allows for a space where CSE could be brought in, there is still no policy that directly focuses on providing CSE.

By 2009, the national media response to the state-imposed ban of the AEP, as well as advocacy and awareness-raising by multiple CSOs, had made the need for sexuality education for young people a more public topic of interest. Simultaneously, observations from youth-led and -run movements including youth organisations were that young people were largely absent in their response

to and knowledge of the series of political events that had taken place in the preceding two years.

The 'Shareer Apna, Adhikaar Apne / Know Your Body Know Your Rights' programme was launched in 2009 as a national and state level youth-led and -run campaign in response to the growing absence of young people's voices. This report, resulting from the activities of this programme takes the work a step forward in Uttar Pradesh by putting young people's voices in the centre of attention. Until today, the campaign has captured the voices of more than 6,500 young people and 300 youth leaders across 18 states in India, who are speaking up on the need for sexuality education and are exploring positive approaches to implementing information on Sexual and Reproductive Health in both in- and out-of-school settings.
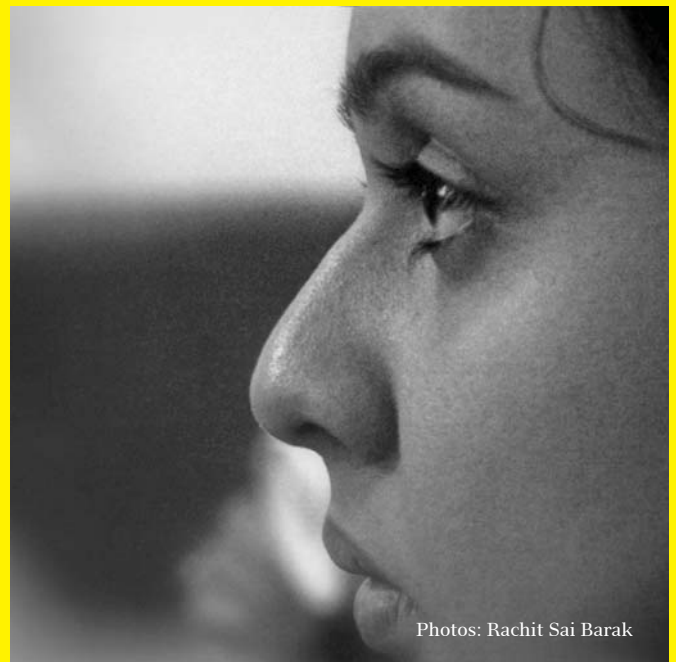
Photos: Rachit Sai Barak

[6] <http://articles.timesofindia.indiatimes.com/2008-03-30/india/27750966_1_education-naco-k-sujatha-rao>

4. UNDERSTANDING THE CONTEXT IN UTTAR PRADESH

4.1. Yahaan Ka Mahaul: The situation at hand

The need for CSE in Uttar Pradesh is backed by a strong evidence base that highlights a multitude of issues, from the socio-cultural barriers of accessing CSE, to the kinds of media being used to communicate to young people[7]. Despite the efforts of the government, civil society and NGOs to provide access to information and services to adolescents and young people, there still remain alarmingly low levels of awareness about SRHR especially amongst young women and adolescent girls who are the most vulnerable in terms of lacking access to information and services[8].

जानकारी

The Uttar Pradesh Population Policy (2000)[9], a key document that informs approaches towards the health strategies for young people, places a strong focus on increasing the age of marriage and reducing family size. The policy points out measures to engage with young people and adolescents as through the provision of adolescent education and Family Life Education (FLE), both in and out-of-school. Whilst young people are at times consulted during policy planning regarding CSE issues[10] their level of participation in designing, implementing and evaluating interventions that directly address their health and rights is still deeply limited.

Frequent concerns of young people regarding their roles in policy making are summarised as follows:

~ What are successful ways of integrating young people's expertise in existing programmes?

~ How can Sexual and Reproductive Health information and services effectively reach in and out-of-school young people?

~ What kind of information do policy-makers require from young people and how should this information be delivered?

~ How can young people interact with policy-makers more sustainably and systematically? Also to help address issues of 'culturally sensitive' and 'age appropriate' information?

Sharing Challenges faced at Community Levels
Photo: Rachit Sai Barak

---

[7] Report: 'Broadening girls' horizons: Effects of a life skills education program in rural Uttar Pradesh', Population Council, 2009.
Link: <http://www.popcouncil.org/pdfs/2009PGY_IndiaLifeSkills.pdf>

[8] Shivani Vig (2009), 'Sex education must for adolescent girls: Study'
Link: <http://articles.timesofindia.indiatimes.com/2009-06-04/kanpur/28163078_1_rural-girls-adolescent-girls-knowledge>

[9] Department of Health and Family Welfare, Government of Uttar Pradesh (2000), 'Population Policy of Uttar Pradesh'

[10] Link: <http://www.hsph.harvard.edu/population/policies/indiauttar.pop.pdf>

4.2. Shareer Apna, Adhikaar Apne / Know Your Body, Know Your Rights

A National Programme on Comprehensive Sexuality Education (CSE)

'Know Your Body, Know Your Rights' (KYBKYR) is a youth-led and -run national policy and peer education program, founded in 2002, that empowers young people to address their sexual and reproductive health issues and rights. The programme's focus is to enable young people to advocate for and access information regarding gender, sexuality, health, rights, HIV, and youth-friendly health services. It also empowers young people to advocate on behalf of their peers for the implementation of CSE, by establishing and enabling dialogue between young people policy-makers and key stakeholders at district, state and national levels, who ensure young people's health and rights. With these efforts the programme aims at ensuring that young people can effectively participate in policy processes and programme implementation relating to the same, and provide critical inputs that correspond with their lived, daily realities.

A rights-based approach to CSE seeks to equip young people with the knowledge, skills, attitudes and values they need to make informed decisions regarding their Sexual and Reproductive Health. This is considered in both physical and emotional terms and includes young people's understanding of themselves as individuals and their relationships. CSE views the information young people need on issues of sex and sexuality within the context of their emotional and social development as well as their right to both health and education. The programme believes that young people need to be given the opportunity to acquire essential life-skills and develop positive attitudes and values that this education takes into consideration. The content within CSE has no universally agreed definition, but has broad agreement on encompassing issues of gender, sex and sexuality; sexual and reproductive health and HIV; violence; negotiation and consent in relationships. Its approach is in encouraging young people to be comfortable with the information they receive and to be able to exercise informed decision-making that is consensual[11].

CSE is critical for ensuring women, young girls and vulnerable groups can access information that helps them understand their Reproductive and Sexual Health choices and are then able to negotiate relationships and access education and health services relating to the same. KYBKYR is rooted in the experience that CSE is critical in empowering young people to negotiate vulnerabilities and challenges of violence, HIV, abuse, gender inequality and poverty. The programme aims at working with young people to challenge silences that exist in society around these issues.

---

[11] With inputs from IPPF's Framework on CSE, Jan 2010.

4.2.1. Programme Overview: Objectives and Methodology

As part of this programme, a state-level consultation was carried-out in 2011 in Uttar Pradesh. The key aim of the consultations was to integrate the voices, experiences and expertise of young people implementing SRHR community-based programmes, in the framing of policies and programmes on CSE.

The objective of the report was to share the context, challenges and key recommendations with respect to the implementation of CSE in Uttar Pradesh, how young people from both in and out-of-school contexts access information and services, and the role of young people in these processes.

Additionally, to share successful strategies that young people are applying to implement CSE in their state, as well as the ways in which young people can actively participate and contribute to the same.

Methodology

The two-day consultation was conducted through a rights-based participatory process that follows the belief that young people, as key stakeholders, should have an active voice in providing feedback and recommendations on how best to implement CSE in their communities.

Through the two-day consultation, The YP Foundation and SAHAYOG engaged with 52 youth activists and leaders, from 19 districts across Uttar Pradesh, whose programmes are reaching out to 1,96,905 beneficiaries. Participants included peer educators, community leaders and activists from Hardoi, Farukhabad, Jaunpur, Ambedkar Nagar, Balrampur, Jhansi, Mirzapur, Chandoli, Lucknow, Saharanpur, Barabanki, Muzaffarnagar, Bareilly, Banda, Azamgarh, Orai, Mau, Gorakhpur and Varanasi.

Mediums used to conduct the consultation were peer-to-peer and interactive so as to create a dialogue that is youth-friendly. The primary language for the consultation was Hindi. The process of carrying out Focus Group Discussions (FGDs) aimed to ensure that over two days, the participants felt comfortable expressing their attitudes and opinions about issues related to CSE as well as openness in sharing key successes and failures. FGDs were conducted in small groups, divided across mixed gender and age cohorts with facilitators as well as documenters assigned for each session. Separate interviews were also conducted with some of the participants, which were video documented. Written consent was collected from all the participants at the consultation, with regards to both photo and video documentation. Interactive mediums spanning case studies, relationship mapping and role-plays proved helpful in creating an atmosphere of comfort, trust and engagement amongst participants from diverse backgrounds. Thematic areas upon which the consultation formats were designed have been attached in the Annexure to this report.

Total Number of Consultations

1

Length

2 days
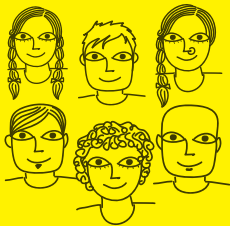
Participants

52

(28 M, 24 F)

Facilitators & Documenters for the Consultation

7 Facilitators   **1** Photo Documenter

7 Documenters   **1** Video Documenter
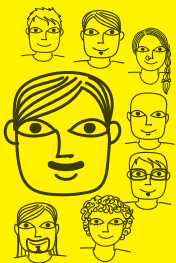
Ratio of Facilitators & Documenter to Participants Per Consultation

2 : 6 to 8

Districts Represented[a3]

19

Total Number of Participating Organisations

14 Organisations   **2** State-Level Networks

[a5] Details have been provided in Annexure 3.

[12] Youth For Change (Pariwartan mein Yuva, Y4C) is a platform of youth leaders across 10 districts of Uttar Pradesh who lead youth groups between 13 to 24 years of age. Created through a four-year process of capacity building, Youth for Change eventually prepared

4.2.2. Selection Criteria

Nominations were sought from a network of local organisations and partners working in Uttar Pradesh for young people who are:

~ Actively addressing young people's SRHR across different districts in Uttar Pradesh, including participants from Uttar Pradesh's Youth For Change[12] programme.

~ Have experience in working with young people in their local areas as well as understanding community attitudes.

~ Are comfortable communicating in Hindi.

~ Are comfortable with discussing and speaking on issues of sexuality, reproductive health and discussing / sharing these in their local, political and cultural contexts.

~ Are between 13 and 25 years of age.

~ Representatives of diverse backgrounds, across caste socio-economic backgrounds, are married, unmarried, Living with HIV, Living with Disabilities, Sexual Orientation and Gender Identity, in and out-of-school.

~ Are passionate and committed to engaging in follow-up activities to advocate for CSE at village, district and state levels.

To ensure sustained support in this process, a limited number of selected older youth from local partner organisations that were supporting the participation of youth leaders were also invited to join the consultation.

youth leaders to form a Youth Policy Advocacy Network (YPAN) in Uttar Pradesh. Since 2010, YPAN has been campaigning for a comprehensive Youth Policy to address the health and development needs of the 60 million young people of the state. The Y4C network is anchored by SAHAYOG.
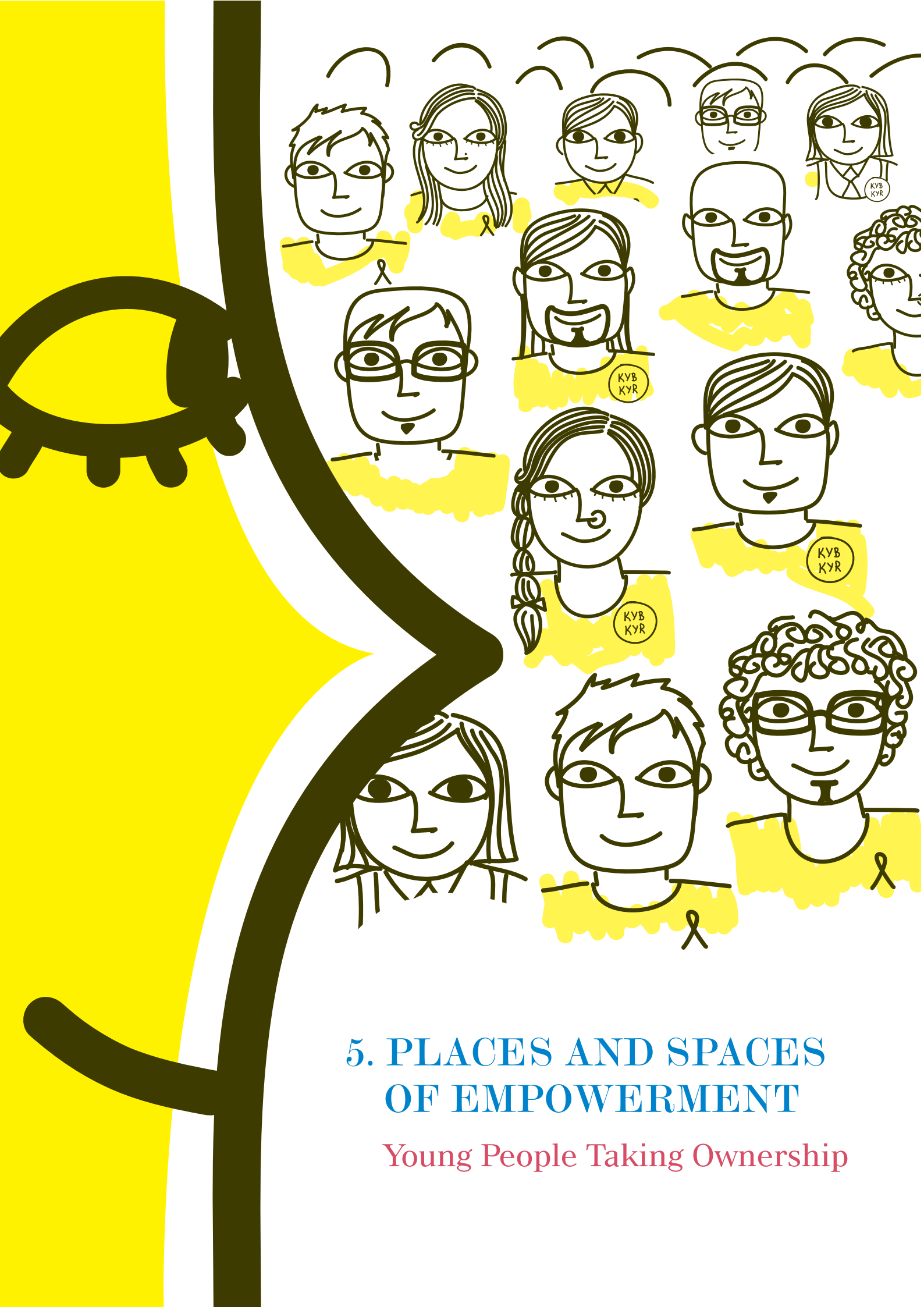
5. PLACES AND SPACES
OF EMPOWERMENT

Young People Taking Ownership
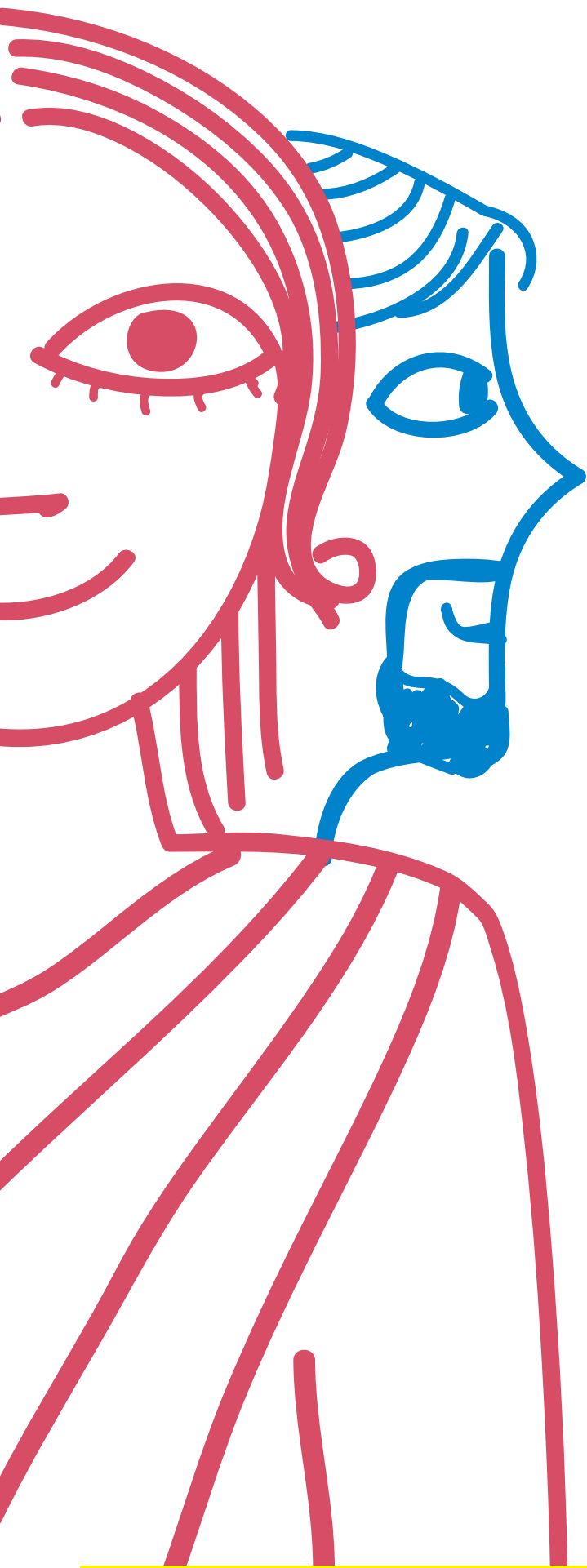
The consultation process led to some key strategies being planned and recommendations being made by young people, which would allow them better access to information and services. These have also come from participants based on their experience of working with their peers in their communities.

> "Without youth participation, the implementation of comprehensive sexuality education will not be successful. Young people need to be trained well so that they can participate in the implementation and evaluation of CSE programmes." – M/19 years (Jhansi)

The participants stated that young people's participation in local governance and politics is very informal at this juncture. Active participation could be witnessed during elections and campaigning, both at college and district level. Due to a lack of family support and because young girls already have very little social mobility, they are far less active than boys in their involvement in election campaigns. Many young people are currently working on mobilising their peers at a community, village, college, district and state level to raise awareness on SRHR issues. They have done so through rallies, small group discussions, college meetings and hosting festivals, where they raise awareness through interactive mediums, such as theatre, puppet shows, role-plays and community meetings.

Young people felt that there is an urgent need to mobilise large numbers of youth to advocate for the successful implementation of sexuality education and youth-friendly health services. Participants also engage with politicians and government officials by inviting them for their programmes, writing petitions and involving the media in this process. The following recommendations and strategies have been formed by youth leaders in the consultation.

5.1. Leadership Training

Shareer Apna, Adhikaar Apne Training in Progress
Photo: Disha Sethi
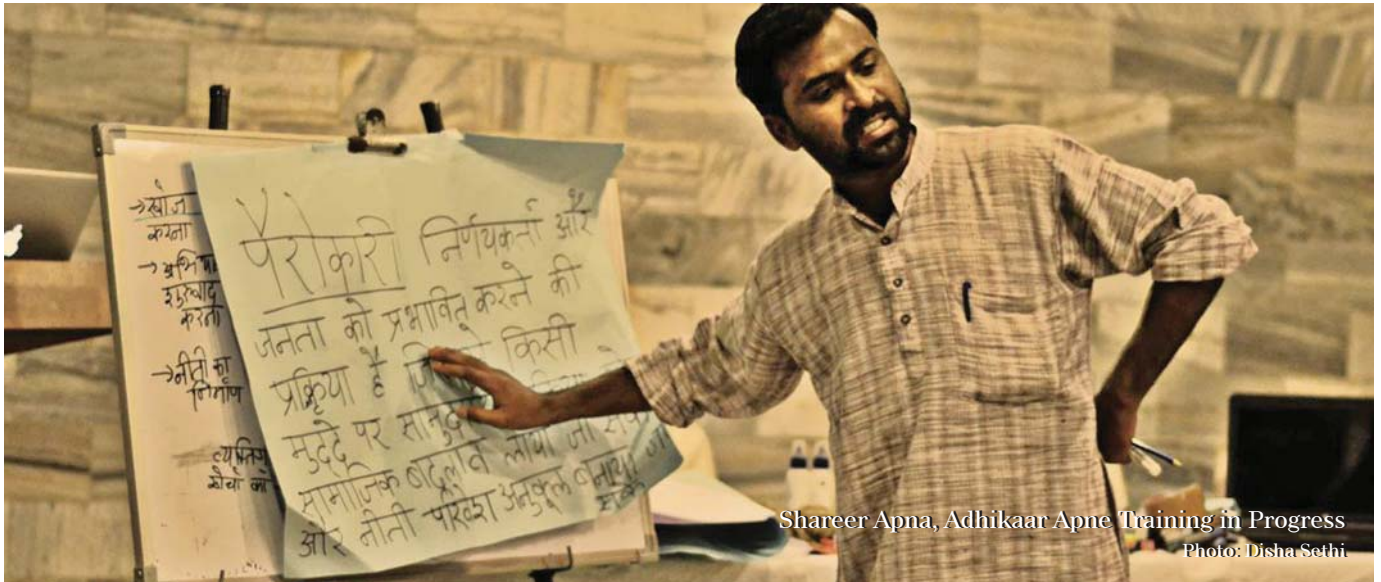
A key challenge in increasing ownership of young people is the lack of training and leadership opportunities for young people living in Uttar Pradesh, especially young girls who are out-of-school. Young people are eager to build their skills and knowledge on planning, implementing and monitoring programs aimed at advancing young people's sexual health and reproductive rights. The need for leadership training arose from the following reasons:

~ Young people feel most comfortable discussing issues of sexuality and health with their peers; however, participants cited that lack of knowledge among their friends was common.

~ There is a strong need expressed for spaces such as discussion forums, youth collectives and workshops where young people can interact freely and exchange knowledge and skills.

> "Without youth participation CSE implementation will not be successful. The young people need to be trained for them to have the ability to participate."
> – F/19 years (Bareilly)

~ Capacity-building for young people to be able to run their own programmes through training on various issues including leadership-building skills.

~ Developing strategies and building skills to negotiate with community members, that include identifying key gatekeepers and engaging them in the programmes and negotiating with the opposition. Additionally, increasing access for other young people especially, girls.

~ Creating a space for young people to interact with each other, such as Nehru Yuva Kendra[15] and space at public health centers.

---

[15] Nehru Yuva Kendra Sangathan NYKS was set up during 1987 – 88. It is an autonomous organisation under the Government of India, Ministry of Youth Affairs and Sports. Nehru Yuva Kendra Sangathan has established a network of youth clubs in villages, composed of youth members ranging between the age group of 13 – 35 years, the objective of which is to render community support through developmental initiatives involving activities with particular focus on youth empowerment.

5.2. Ensuring Accountability and Increasing Sensitisation

~ Increasing the level of accountability of health services offered through government schemes, which includes knowledge levels of the service-provider, such as doctors, ASHA / ANM workers, teachers, etc. comfort, confidentiality and easy access for young people. Service providers, especially doctors in hospitals and PHCs should be of the same gender as the patients.

~ Building awareness in the community: community awareness could be built through various mechanisms that have been tried and tested by participants themselves such as a larger Jan Sunvai or Baithak, which calls forth to all community members to understand the work that they do. This also enables parents and families to be aware of the need for such spaces for their children to access.

~ The need for building awareness on sexuality education in the community was very clearly reflected through the course of the consultations. The participants were sure of achieving outcomes, such as change in perceptions, permission for comfortable sharing of information and greater access to information and services on sexuality and health within the community.

~ There are many different agencies that are meant to provide health services at the village-level, such as ANM, PHC, Aanganvadis, etc. Out of these there has to be one particular agency that specifically targets and provides information to adolescents and young people. The selection criteria need not have to be based on gender but men might feel uncomfortable talking to women and vice versa.

a. It should be imperative for community-based health workers to be trained on being youth-friendly and respecting confidentiality, even if their primary role is addressing issues of maternal health with married women and girls at community-level. Frontline health-workers, if often embarrassed or uncomfortable with issues of SRH stigmatise these issues further by scolding young people for asking them questions on the same.

b. There should be a concerted effort made by NGO workers to involve parents in programs relating to aspects of health along with young people.

Agree and Disagree: Strategies for Young People to Challenge Gatekeepers to CSE
Photo: Rachit Sai Barak

5.3. CSE as a Constitutional Right

Emerging as one of the strongest recommendations from the consultation, many young people asked why CSE was not seen as a Constitutional Right, within the mandate of young people's Right to Education. For participants, the need for such information is not contentious, and is evident even at community-level. Key points that emerged from this are:

~ CSE should be seen as a critical and non-negotiable component of Youth Sexual and Reproductive Health. It is important to link both education and health systems with how this information is operationalised in programme implementation, to ensure that it can be followed up with effective, accessible and available SRH services.

~ The primary barrier, as young people see it, seems to be political commitment to want to push through the implementation of such information. If the need to access life-saving information on young people's health (that CSE provides) is widely understood as within their Right to Health and Right to Education, participants felt that it would be easier to negotiate both systematic and community challenges and render arguments that such information is 'western' / 'against Indian culture' / 'morally corrupt' and invalid. Participants also mentioned that it is not unusual to have groups who think so and gave the examples of groups like *Khap Panchayats*, but however, the fear of what such groups might say should not be a deterrent in implementing programmes on CSE as it is primarily young people who suffer the consequences of both a lack of access to information and services.

~ Participants that had exposure to understanding international agreements that India had made regarding people's health and welfare strongly mentioned that the ban that occurred in 2007 on the AEP curriculum was unconstitutional in many ways. They felt it violated their Right to Information, Right to Education and Right to Health under the Indian Constitution and also breached

India's international commitments under UN treaties and declarations such as the International Conference on Population and Development (ICPD) PoA.

5.4. Developing Partnerships

There are many forums for young people to come together and form partnerships – workshops and meetings organised by NGOs, college meetings, small needs based groups where young people with common concerns meet, sports activities, talent forums, various festivals and internet and technology. Youth partnerships should focus on sharing responsibilities and encouragement.

Participants also mentioned the responsibility of the government to take initiatives and make critical efforts to build youth partnerships and provide youth support groups. Young people from southern Uttar Pradesh spoke about building partnerships between educational institutions, youth groups and non-government organisations.

5.5. Implementation of Programmes

~ Creating spaces for peer-to-peer interaction and learning that provides young people with a safe space to access information on these issues.

~ Implementation of CSE in school curriculum and additionally, the creation of community-based discussion groups for young people and adolescents who are out-of-school on these issues.

~ Sustained mechanisms for peer-to-peer based education programmes that address creation of resources.

> "Since I work on these issues, I have now become a source of information for both, my male and female friends."
> – F/23 years (Lucknow)

5.6. Tools of Information Dissemination

Female participants felt the use of tools, including various forms of media would largely help in bridging barriers between various members of the community, and could be an effective mechanism for encouraging discussion on these issues, something that they don't have easy access to currently. These include:

~ Designing and disseminating creative IEC strategies and materials.

~ IEC on different aspects of adolescent and youth sexual and reproductive health that should be made available in local primary health centers.

There is a need to create spaces where the media could be actively involved in disseminating information on aspects of sexual health. Community members often watch television; it has proven to be a powerful medium through which to impart key messages.

~ Participants agreed that institutionalising teaching of sexuality and health in school by teachers, through a curriculum would enable young people's access to information and services at a community-level.
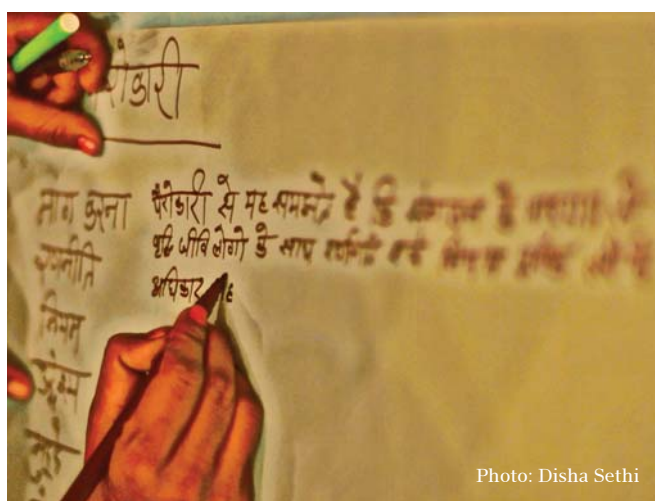

Photo: Disha Sethi

5.7. Tackling Challenges and Changing Attitudes

For programmes and policies to be effective, the focus should include changing the attitudes of different stake-holders in the community. Communities very often set norms that are deeply tied to their moral and social fabric. Deep-rooted community as well as religious beliefs that attempt to control women's sexuality through social taboos and norms that dictate daily behavior, as well as other beliefs like son-preference have given rise to phenomena like sex-selective abortion, which women do not have a say in or sometimes are complicit, but very unwillingly and usually due to family pressure. All these curtail the woman's right to making decisions that concern her body.

~ A suggestion was made to consciously encourage peer group discussions.

"We can talk freely with individuals between the age group of 13 – 25. We usually hesitate whilst talking to older people."– M/20 years

Group discussions on topics such as sex, sexual health, etc. that may create discomfort could be discussed separately with boys and girls. In most instances, girls are uncomfortable relating personal experiences and challenges in the presence of men. Programmes that structure their workshops separately for boys and girls have shown higher rates of participation from young girls.

~ Participants stated that members of the Muslim community don't often participate in programs run by NGO's and / or the government on aspects of sexuality and health. This challenge can be overcome if CSE is implemented in schools, because students from different religious backgrounds study together. Also, parental approval and permission will be easier to garner if CSE is implemented in schools. If the curriculum is implemented in the classroom, it acquires the legitimacy of being attached to an institution, and parents would perceive it to be 'formal education' that would benefit their child.

~ One of the core strategies proposed was to have a female Accredited Social Health Activist (ASHA)[14] for every village covering a population of 1,000 community members.

"ASHA would be chosen by and would be accountable to the *Panchayat*, to act as an interface between the community and the public health system. As an honorary volunteer, ASHA would receive performance-based compensation for promoting variety of primary health care services in general and reproductive and child health services in particular such as universal immunisation, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions."

---
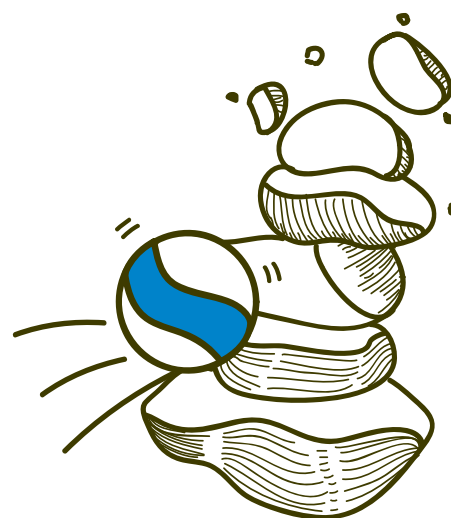
[14] ASHA/ANM: Accredited Social Health Activists (ASHAs) are community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM). In the governmental rural health set-up, the Auxiliary Nurse Midwife (ANM) is the health functionary closest to the community. She deals with aspects of health and family welfare and is responsible for the implementation of Reproductive Child Health programme.
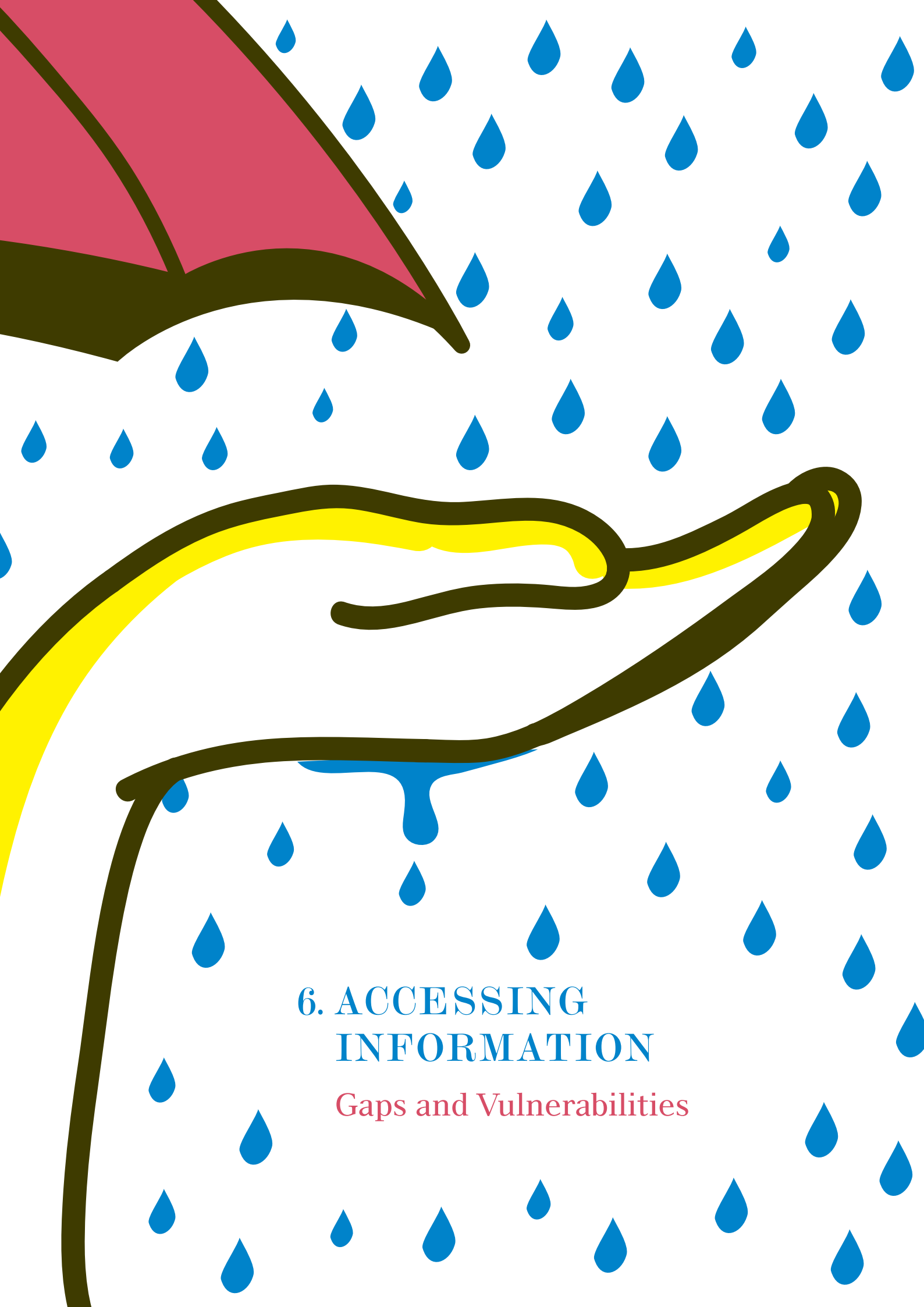
6. ACCESSING INFORMATION

Gaps and Vulnerabilities

6.1. Parde Ke Peeche: Adolescent Girls Speak Out

In Uttar Pradesh, a significant number of adolescent girls withdraw from formal education systems early on (62.16% from primary education, GOI, 2001c[15]); put in 2011 census information. Since this happens at an age which is crucial for absorbing relevant information regarding their health and rights, formal schooling systems can no longer be the only targeted space where this information is disseminated. Girls and young women become extremely vulnerable without access to relevant information on sexual-health sexuality and understanding the body as well as their right to make choices about reproductive health care.

> "What about non school going adolescents... don't school-dropouts require sex education as well? This is why awareness is a must."
> – M/23 – 28 years

"Abhi mein kuch zyada jagrook ho gayi hoon!"

Zarine* works as a Youth Leader with the Youth For Change programme in Muzzafarnagar. She joined the programme three years ago and reaches out to 120 adolescent girls, who dropped out of school in her community. As someone who dropped out of school herself; Zarine understands the challenges that young girls in her community face and works on providing them with access to education including re-admitting them into formal schooling and negotiating with their family members for the same.

The Youth For Change – Parivartan programme that Zarine works with, has five groups, of which she works with the Zeenat group in a Muslim community that has extremely limited access to formal education and health services. Like many other Muslim girls, Zarine is aware of the gender-differential that exists in society between girls and boys. "There is low awareness amongst (the) girls. Boys move around more, as they are allowed (more freedom) and thus they can seek information from different sources. But girls aren't allowed to move around."

When Zarine was first approached to create a youth-group within the community, she had been volunteering with a programme in her community. After getting herself re-admitted to formal schooling, she continued to attend trainings with the programme she was with; a strategy she feels is key to ensure the skills and knowledge she subsequently gained. Zarine began her work with mobilising young girls within the community an advocating for the need to educate young girls, especially those who had already dropped out of school. As she built a relationship with the families of the girls and gained their trust, she began working with them on health which included taking them to the Astitvya (main office) to attend workshops. She also took young girls from the community to visit doctors, as they aren't allowed to go on their own and they didn't find medical professionals accessible and comfortable to talk to. Her responsibilities as a youth leader also include holding meetings with the youth-group once a month, where everyone comes together to discuss their concerns and gives feedback.

[15] Link: <http://mohfw.nic.in/WriteReadData/l892s/1318292396Home%20Delivery%20of%20Condems.pdf>
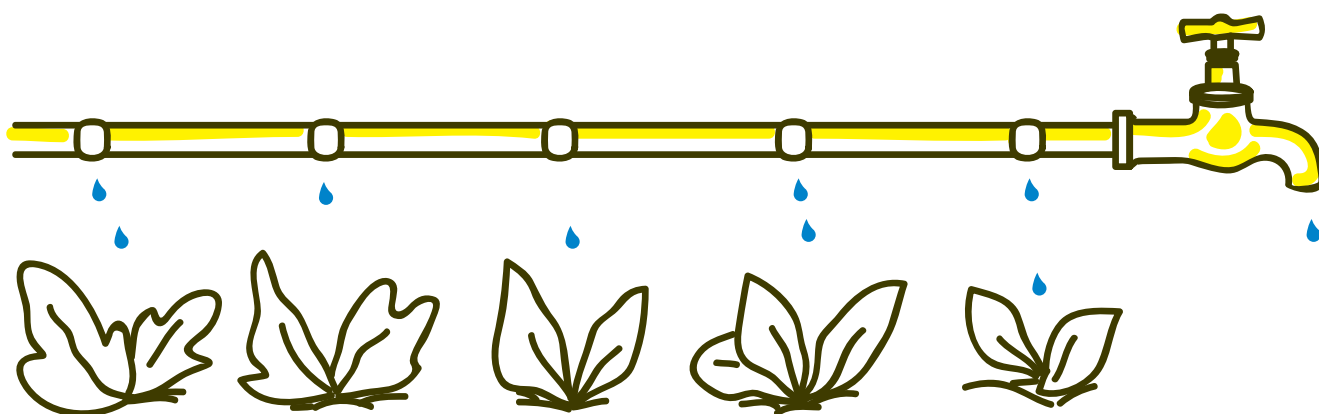
"Now I've become a little too aware!"

"Initially when I started, it was not easy to work. We could only talk to the girls in the neighbourhood but when we had to take the girls to the office then there was opposition from their family (especially their brothers). If you are talking about education, then you can do it within the community, however, we could not talk to them about their health within the community. Additionally, the girls liked and wanted to go out. So, I organised a discussion (bethak) with the girls and asked them "aap hi battao" (you tell us what you want). They asked us to do a collective meeting with their family members (including their brother and mothers) so they could see what we discuss in our programme and so they would, too, understand why the girls wanted to be a part of it." Zarine organised a workshop and invited families to attend. "In the workshop we told them that if a girl is educated then she can negotiate any challenge in her life. We also spoke about child-marriage. We used interactive mediums to bring our message across. Through musical performance and puppetry programme we managed to spread our work and gain more support. Additionally, we asked the girls who we trained, to showcase their learning within the community."

She feels that a critical point of change happened once she gained the trust of community members. "That is when they started supporting us and we were even able to bring the mothers of the girls to our sessions." When asked how she negotiates issues such as the lack of mobility in the community, Zarine mentions how important it is sometimes to be able to provide personalised support in the early stages of the process. "I have the responsibility to take the girls myself. They can't go alone so I take them and then I drop them personally to and from the meeting in office."

"When we started working, community members insisted that the only thing that the girls were meant to study was the Quran Sharif. There were a lot of girls who were dropouts. Additionally, girls are looked upon as the pride of the family and families are scared that if a boy makes a

pass at an unmarried girl, the family's reputation will suffer. Through consistent communications, the girls started to open up and asked to study, in response to which we have appointed a Masters of Science Education teacher there who can teach the girls in the neighbourhood itself." She has also partnered with MG Fire, an NGO from Delhi, which works on education in government schools that focuses on dropouts to re-start their education.

Not all issues are easy for Zarine to speak about within the group; she faces high opposition within the community on giving young girls information on Sexuality Education. So, how does she do it? "We take the girls to our main office. If we say that we will do the program in the *zilla* (village), then the challenges start. It is easier to take the girls out, which they also enjoy and talk on issues relating to their health and bodies." What's the content she talks about and what kinds of questions does she get? "We talk about hygiene, menstruation, periods mein kya problem ho sakti hai (what are the problems girls can have during their periods), bodily changes, safed panni (vaginal discharge), masturbation, child marriage, gender discrimination and anatomy as well as what services exist and how they should be availed."

"I personally love role-plays. We use it when we were talking about child marriage through role-plays. Nobody wants to listen to you if you're giving a bhashan (lecture)."

When asked about whether the local administration is supportive of her work, Zarine mentions that there is nothing available for young people in her community, in terms of Primary Health Centers (PHCs) or Yuva Kendras. She and her colleagues have organised seminars and rallies to advocate for the need for youth-friendly health services in her community especially for young girls. She has received little response from the government so far, but the stakeholder Zarine is the most disappointed with, are doctors and service providers. "Doctors said that if you have any problem then you can come and talk to us. However, when people go, they don't give information and are not comfortable to talk too. I personally take people to doctors as I am not hesitant, (but I) have developed a relationship with them. There are ASHA and ANM workers too, but they don't have information themselves."

How does Zarine find the energy to keep doing this work? How does she negotiate any opposition she receives herself? "When I began working I did face opposition, but it was much stronger from the neighbours than my own family." While girls in her family are largely educated, her family members began to oppose her involvement in the programme due to pressure from the community.

"I spoke to my family. I said, if you trust me, then I'll do it (my work) and the day it (trust) breaks, I'd stop myself. I had to negotiate with them daily, as there were always meetings in the office I had to go for. Then I finally put my foot down."

"Finally they said, if you want to go then go, but remember that if you break the promise you made to us, your group will also break. Today there is a sense of achievement and they are proud of my achievements. I just came back from Moradabad and I go to Lucknow for community mobilisation programme. Today, my community comes to me to share and seek advice on any issues regarding problems with girls."

*Name changed

6.2. Existing Policies: With Specific Reference to Gender-Based Discrimination

A review of existing policies throws light on the SABLA Scheme, launched early in 2011, that addresses empowerment of young women aged 11 – 18 years through spreading awareness on issues of health hygiene, sexual and reproductive health as well as upgrading home-, life- and vocational skills. This has been one of the first initiatives that recognise the state of the lives of young women and adolescent girls, which prevent them from accessing information and services regarding sexual health and rights.

According to UNFPA's Country Report on Adolescent Health and Development (2003): The "four most populous states namely (BIMARU Raj) UP, Bihar, Rajasthan and MP constitute 22 percent of India's population and have below national-level sex ratios and therefore contribute significantly to overall decline in sex ratios. The strong preference for a malechild, which manifests itself in the form of sex-selective abortions, infanticide, malnutrition, neglect and exploitation of girls and women, is a major cause behind the adverse sex ratio".

These findings are corroborated by participant feedback during small group discussions during the consultation. Whilst international conventions such as Convention to Eliminate All Forms of Discrimination Against Women and the Convention on the Rights of the Child have made commitments globally to promote gender equality, the challenge lies in changing attitudes at the level of the community. Adolescent girls are offered limited opportunities for growth, some of which have been detailed in the sections below.

Women participants at the consultation spoke about the differential opportunities offered to boys and men with regard to education and employment; spaces that are completely closed to adolescent girls and young women, and considered outside the confines of the domestic sphere.

"The police should be informed when girls' rights are denied. Being uneducated is one amongst many reasons why girls are denied equality, parents and family and all stakeholders should come forward and discuss about it. Case studies are necessary in schools. Initial sex education should be separate; unless we have primary information we would hesitate to come together. If the counselor are adequate available there would be a change."
– FGD/ 19 – 20 young girls

Additionally, adolescent boys are able to access physical spaces outside the home and given the opportunity to interact with other members of society, whereas adolescent girls are usually expected to remain at home. An example that was cited was youth participation in local governance and politics. Most young people are encouraged to engage with political activities during elections, through public campaigning, as they comprise a large part of the vote-bank. However, due to lack of family support, women in the community are less active and are discouraged from participating in any form of public work.

> "Young girls in our village are raised only to become mothers."

"Key challenges that need to be addressed to improve the availability of educational opportunities for adolescents are poor attendance in schools, lack of accessible middle schools in rural areas, unimaginative curricula, dysfunctional schools in remote areas, low motivation of teachers and early entry to the work force. For girls, the situation is worse due to burden of sibling care, early assumptions of domestic responsibilities, early marriage, absence of female teachers and reluctance on the part of parents for continuing their education[16]."

"This is not where women belong."

Young women who had taken the initiative to be involved in community-based programs, expressed the lack of 'emotional and financial support' required to sustain their work. Further, community members consider them to be a 'bad influence', and ostracise them. Moreover, it is fairly common in the Indian context to see adolescent boys being given social sanction, by the communities they inhabit, to be more 'outspoken', and encouraged to express their point of view, whilst adolescent girls are expected to be obedient and submissive.

6.3. Gaps and Opportunities for In-School Young People

Through discussions and group interaction, participants cite illiteracy and the lack of access to formal schooling as the main reasons as to why young girls are denied their rights. To begin with, adolescent girls are largely unaware of what their basic rights are, hence, are unable to claim them. Here again, the family proves to be an obstacle rather than an enabler: instead of encouraging girls to avail educational schemes made available by the government, they keep their daughters busy with household chores and responsibilities, ensuring they are unable to attend school regularly.

The lack of trained female teachers also restricts the access that young girls have to information regarding sexuality and health. "We really need to trust the person who gives us information on issues of sexuality, and we can't generally discuss these issues with our mother" – F / 23 years. Another participant commented "We get information regarding our bodies only from our mothers, and the information is restricted to menstruation only". Often, upon asking teachers for information regarding their bodies and health, girls are told they will "know with time", therefore hitting a wall here too!

Participants highlighted how there exists a discomfort on the part of the teachers in talking about sex, even as a biological 'act' that is taught as part of their curriculum. Add the lack of information, the issue of sensitivity when discussing the same with teachers, that it is not part of the mandate or the thinking behind the syllabus, the information becomes increasingly inaccessible.

---

[16] UNFPA's Country Report on Adolescent Health and Development (2003)

"In our Biology class, we are taught well but the chapter on Anatomy is quickly skipped over. When we conduct workshops on HIV and AIDS, and use the word 'condom' we are opposed again."– F/35 years

Furthermore, female participants spoke about instances of sexual harassment that they have had to face in the hands of male teachers, a question that needs to be addressed within the ambit of CSE.

"The teacher did not have good intentions; he used to touch in the wrong way. How can he teach?"– F/35 years

Photo: Disha Sethi

6.4. Accessing Information on SRH: Spaces and Sources

Coupled with a lack of literacy and corresponding skills access to nutrition and health facilities is restricted in many areas of Uttar Pradesh. In districts where there is a wide distribution of PHCs, they are located at a distance from most rural areas, and are under-staffed, which again curbs access.

The average distance that needs to be traveled to access a PHC was estimated to range between 3 to 35 by participants in the consultation in their own communities.

Due to the sheer distance as well as the monetary resources required to reach the PHC, participants often resort to visiting local community doctors who don't have legitimate knowledge or resources to provide safe and reliable medical services.

"The right to compulsory health services should be available through constitution. Govt. doesn't give any charity, as it has to give us our rights according to constitution."
– M/22 years (Varanasi)

"It's important to get full information on health. Otherwise you will not be able to prevent yourself from getting diseases. This is what worries me."
– M/24 years (Barabanki)

27

The Role of Frontline Workers

Participants stated that a majority of young people who visit doctors in health centers for medical care and treatment are met with hostility and lack of support. Participants cited examples of caste discrimination, wherein community members from a particular caste that is socially considered 'inferior' were denied treatment. Further, there have been instances where male doctors have sexually harassed female patients. Instances like these deter young girls from visiting medical centers without parental supervision, and further silences adolescent girls due to existing notions of shame and honour. There exist no spaces for girls within the community to bring up these issues.

What was reflected very clearly through the consultation was that young people perceive a serious lack in their access to SRH services they have – both in cases where services have been mandated but their operationalisation is poor and in instances where the services are available, but the distance they need to travel to reach the same makes its efficacy limited. Participants also felt that exploring the role that community health workers could play is perhaps the most effective way of disseminating CSE and SRH information.

Existing health services personnel could also capitalise on the availability of interested young people as a leadership resource at village-level to be able to create initiatives for the effective dissemination of such information.

They could use 'their positions' as many participants described it creatively in providing access to further spaces of dialogue.

ASHA and ANM workers usually conduct discussions in large groups and often don't have the time or space to conduct individual sessions with community members. As such participants in these programmes particularly adolescent girls, hesitate in sharing their concerns in front of a large group, due to which many of the issues don't come forth.

Often, in not keeping queries and individual discussions confidential, ASHA and ANM workers break the fragile space of trust that gets built. The lack of professionalism and confidentiality that can often occur in these situations through ASHA and ANM workers, can lead to a lack of trust and absence of young girls approaching community-based health workers for information. However, squaring this responsibility on ASHA

and ANM workers, a few participants pointed out, may not be effective since disseminating information on SRH and CSE to young people is not the primary mandate that these community health workers have. There are challenges with not just increasing their workload but asking them to distribute contraceptives door-to-door in homes, as was mandated in 2011 by the Ministry of Family Health and Welfare[17], without training ASHA and ANM workers on how to be youth-friendly, and provide confidential access to such services for young people who are of the age where it is legal to have sex. Whilst many young people do ask ASHA and ANM workers questions, they also felt that it was risky, and that challenges can arise when young people who are minors, are asking health-workers for access to contraceptives, or in cases where minors have been married and require access to the same.

"We go to access information from ASHA and ANM workers, however most of the time they make fun of the questions we ask and don't keep it confidential which is why I don't want to go and speak to them anymore. But I still need answers, so where to go?"
– F (UP)

---

[17] Link: <http://mohfw.nic.in/WriteReadData/l892s/1318292396Home%20Delivery%20of%20Condems.pdf>

6.5. Koi Na Bole:
Silent Spaces

At several junctures in the consultation the topic of Sexual Orientation, Gender Identity and Same-Sex Desire repeatedly came up. Participants expressed a variety of opinions either in support or against the idea of the same, with a clear request with more information. Whilst some young people considered identities such as 'Homosexuality' 'unnatural', others used pictorial representations to express their positivity and support. Some of the insights the discussions threw up were as follows:

a. Different sexual identities should not be seen as a medical disease because this perception makes it difficult for people to access health services, and even if they manage to access the service, service providers meet them with hostility.

b. In the context of HIV, it becomes all the more imperative for these issues to be de-stigmatised, so that access to SRHR becomes far easier.

c. Due to discrimination and exclusion from society, people who self-identify with different sexual orientations and / or identities find it difficult to access education services and other government schemes.

d. People with different sexual identities also experience high levels of physical and sexual abuse and so health-care services need to be designed and made accessible accordingly.

"If two people of the same gender are staying together they should not be discriminated against. This change in attitude will only come about once people begin talking to one another about these issues."– M/20

Discussions around (a) other gender identities like Transgenders, Hijras, Kothis, Intersex people, and
(b) Live-In relationships did not come up in any of the discussions, were also completely absent from the dialogue that was generated. These are issues that need specific attention, as it was evident that curiosity around the same exists.

Photo: Disha Sethi

7. CREATING AN ENABLING ENVIRONMENT FOR CSE

Strategies to Engage and Involve rather than Resist

7.1. 'Family members' as crucial to any debate around CSE: Women as agents of change

The consultations reflected that most often, community members may prove an impediment in creating spaces where constructive dialogue on SRHR issues could be enabled. In that sense, they prove to be 'gatekeepers' of information access and dissemination. The community actors who could be identified as gatekeepers are families formal educational institutions and religious leaders. Participants identified these stakeholders however, also as sources from whom they could potentially access information about their bodies, sexual and reproductive health, highlighting the need to involve them in advancing the existing debate on CSE.

The most immediate source of information is the family the site where any young person's primary education begins. However, CSE cannot be addressed in isolation and needs to be woven into in-school curriculum or into programmes that address adolescence education and capacity building for the family. Simultaneously, there is also a need to address the silence that exists about these issues. There were important points raised during the consultation around the need to mainstream the identification of out-of-school populations of young people as being distinct from those who go to schools across all policies and programmes.

"What about non-school going adolescents, don't the school dropouts require sex education as well? This is why awareness is a must." – M/23 years

While the family has the potential to be a crucial agent at the community-level and could become a responsible source of information on sex, sexuality, gender and health so far, families have mostly played a role in reinforcing gender norms, for both young men and women. There is restriction placed on young girls in terms of accessing opportunities outside the household space. The role that family members, including parents and immediate relatives play, and the fact that they do not have enough information about these issues, was a fundamental part of the debates that came up at the consultation. This observation was also made in the Population Council's 2009 study on programmes for adolescent girls, which noted that though parents were consulted during the formulation of programs, they were not as involved during the implementation. Therefore, parents not only have to be sensitised, but also actively involved in the planning and implementation of various interventions. Young people within UP have taken concrete steps to involve parents in this process.

However, parents felt that this process, if it all it were to take place, was best done at the school, 'class work', that should not be discussed in the 'home space'. In most cases, as one participant pointed out, "parents feel that delivering information of this nature will cause them to lose control over their children". There exists a discomfort in just having discussions around sex, sexuality and sexual health. If at all such discussions take place, they happen only within peer groups, specifically with those of the same gender. Feedback from participants reflected that there is disapproval towards young men and women communicating or interacting with each other before marriage, while they feel that, "it is our right to choose who we want to interact with, and it is based on these relationships that a community is formed".

"To involve parents, there are different situations for urban and rural contexts. Urban schools regularly have PTA meetings, which can be a good platform to involve parents. What can work at rural-level is availing *Panchayats* as a platform to involve parents. In the beginning it can be introduced in *Panchayats* with lighter terms, then can be taken into further depth later." – F/23 years (Lucknow)

Young female participants expressed a lack of trustworthy sources of information on their sexual and reproductive health. While the family has the potential to be a crucial agent at the community-level, which could become a responsible source of information on sex, sexuality, gender and health, so far, families have mostly played a role in reinforcing gender norms, for both young men and women. Many young women and girls do get information from mothers, sisters-in-law, aunts and other female members of the family and are often unable to tell if the information they are getting is correct or simply superstition. The 'passing down' of stories is seen as a key way of sharing information, that traditionally is shared with a young girl in three phases of her life – the first, when she gets her periods and learns about menstrual hygiene, the second, when she is getting married (as participants said that many of their families feel girls need to understand their 'married responsibilities') and third, on managing a pregnancy. Many

married girls amongst the consultation participants, shared that when girls in their community get married, they are often not given any information on the kind of relationships – both physical and emotional – they will be expected to build or maintain with their partners. Some shared that this meant that they experience violence for a considerable period of time, before identifying and learning (usually from an external source) that consent and violence are not an acceptable part of how their partners must treat them.

The idea of consent was perhaps identified as an extremely critical subject to both learn about and discuss within all programmes, and participants linked it as key to ensuring that women and girls, and even men and boys have agency in terms of their behaviour and relationships. Families are often uncomfortable with the idea of giving girls agency, and therefore, as one participant put it, "never explain the whole picture. We are left to find out

for ourselves". Female participants identified male members in the family, particularly fathers, as agents with whom interaction and discussion on these topics was considered difficult and a father's role was seen only in the light of providing monetary support. However, many participants said that mothers, with some degree of training, could be potential confidantes for young girls.

However, young people who work with these communities are in a constant process of evolving strategies, which would enable an easier creation of such spaces of engagement.

Amina, a youth leader from Muzzafarnagar spoke about the particularities of working with Muslim communities on SRHR issues. In conversations, she said that it has been very important to gain the trust of families of the young women she works with, and

on their request, organised Baithak with the entire community, where most of their families were present. Once family members were aware of the kind of discussions that were happening, and gauged that it was a 'safe' space for their daughters, they were comfortable with letting their daughters go to the office space of the Youth For Change program that she works with. This has been very crucial, as there is now a space that the girls can access for information, and attend workshops and training programmes on a range of topics – ranging from sexual health to challenging gender roles. Mothers of the girls also took the initiative to visit the office, which is important, as mothers could be that potential source of information on SRHR when trained.

"Community members should be called for combined meetings with young people and adolescents."
– Participant, Purvanchal region

7.2. Engagement of Religious Leaders and Politicians

The engagement of religious leaders in the debate was also a key point that arose during the consultation. In some cases, they may work very closely with community members as agents who control and restrict access to services and information. For young people it is important to be able to engage and dialogue directly with these religious leaders, and these could be done through campaigns or activities that help them build support for receiving this kind of education from whichever source is most easily available and accessible to them. Further, formalised programmes and outreach campaigns further legitimise the need for this dialogue through policy-level processes, which religious leaders also respond to with more enthusiasm. Participants highlighted the need to talk about various

social control mechanisms like *Khap Panchayats* and *Jati Panchayats* that exist in society, which prove to be an impediment to creating spaces for discussions around one's body and sexuality. This would enable the dialogue to include, as well as get disseminated through them.

Being a community where honour-killings are a norm, work with young people becomes very difficult unless the approval of a community / religious leader is won. Also, this form of violence and discrimination is intrinsically tied to the level of access and mobility young people have to access information as well as engage in free discussions.

"Last year, the *Khap Panchayat* issued a fatwa, which ordered girls to not wear jeans and have a mobile. In response to that, youth leaders organised a media conference and took the matter to the district court. They lobbied against this fatwa saying, "if you expect girls to not wear jeans and not have mobiles then it should be the same for boys. And if you feel girls misuse mobiles then can't boys also misuse it." They raised the issue of safety and the need for girls to have a mobile and rationalised the use of mobile phones. There was a lot of uproar, yes I was really scared. Muzzafarnagar is famous for that. We personally invited people from the media, doctors, teachers and community members. Eventually, people did support us." – F/19 years

In this context, working through local people's representatives, politicians (at a local, district and state level) to disseminate supportive messaging to the community is important. Bringing in experienced professionals to facilitate conversations between community members and young people has also proved to be effective, as it helps address myths and misconceptions that many people hold on issues of Sexual and Reproductive Health.

> "Some religious leaders will never support it. (But) if they are given awareness they let awareness reach every village, block and every district."
> – M/24 years (Mau, UP)

Additionally, working on issues that community members resonate with, such as education and then broaching topics of health and sexuality within the same. Once the programme has gained the trust of the community members it has been an effective strategy in garnering community support.

Photo: Disha Sethi

34
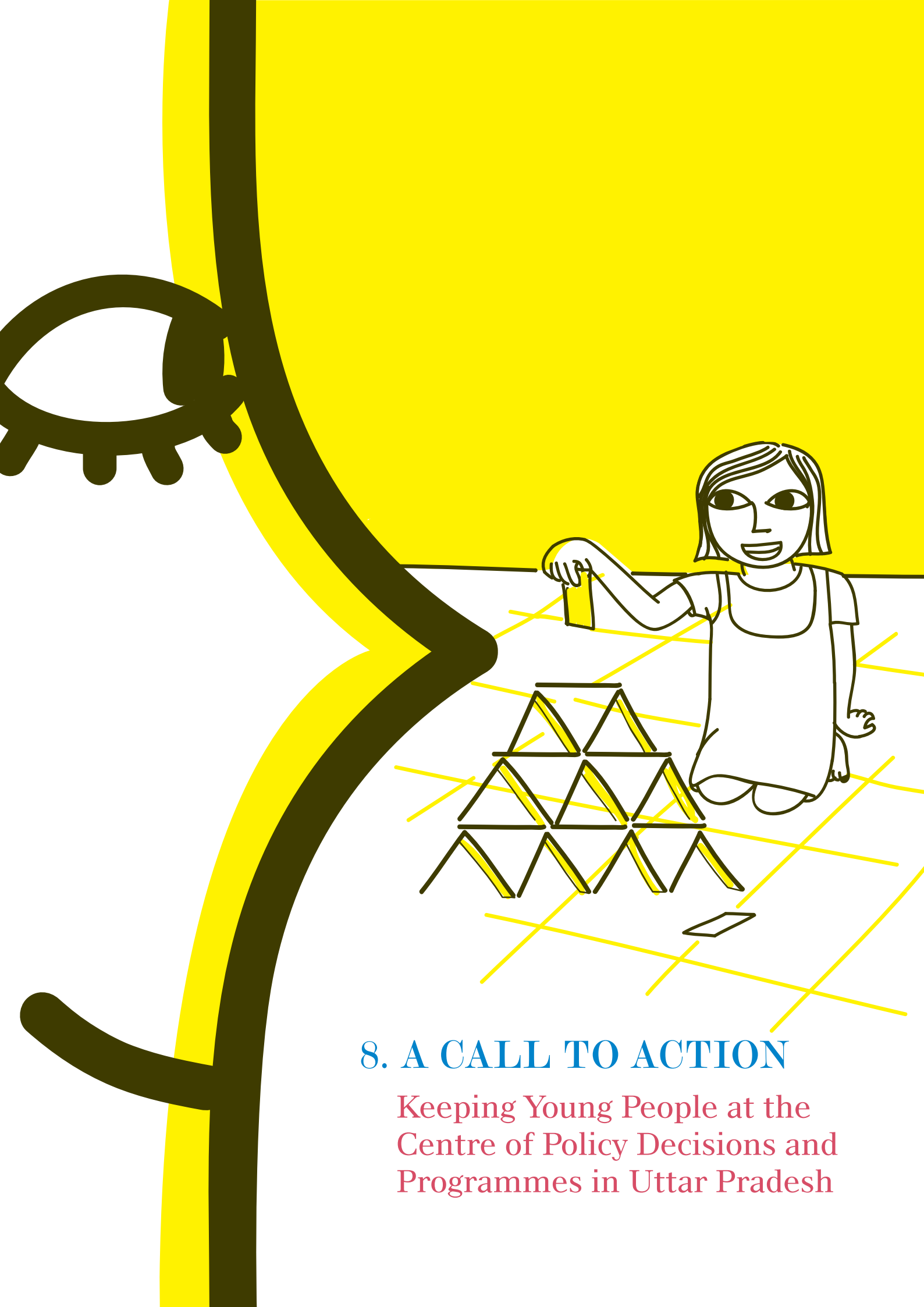
8. A CALL TO ACTION

Keeping Young People at the Centre of Policy Decisions and Programmes in Uttar Pradesh

This chapter highlights recommendations in addition to findings that have already been shared in this report. There were similarities across the regional analysis and responses received from young people on the identification of key stakeholders as well as next steps that need to be prioritised to encourage strengthening and/or enabling the implementation of CSE, within existing efforts that ensured young people's access to Sexual and Reproductive Health and Life Skills.

Participants from across all regions of Western, Northern, Central, Eastern and the Poorvanchal Region of Uttar Pradesh suggest a call-to-action that needs to be a common starting point between young people, Civil Society Organisations, State-Level Networks and technical and funding bodies that address young people's SRHR amongst others.

These recommendations form the basis of key actions that youth leaders from the consultation agreed needed to be integrated within existing programme implementation at community/village, block and district and state level. Participants agreed to share back this learning within their programmes to explore scope for integration with the same. It was broadly agreed that learning from the same would be shared back with the 'Shareer Apna, Adhikaar Apne / Know Your Body, Know Your Rights' Campaign that would continue to work in the state across 2011 – 2013. These were as follows:
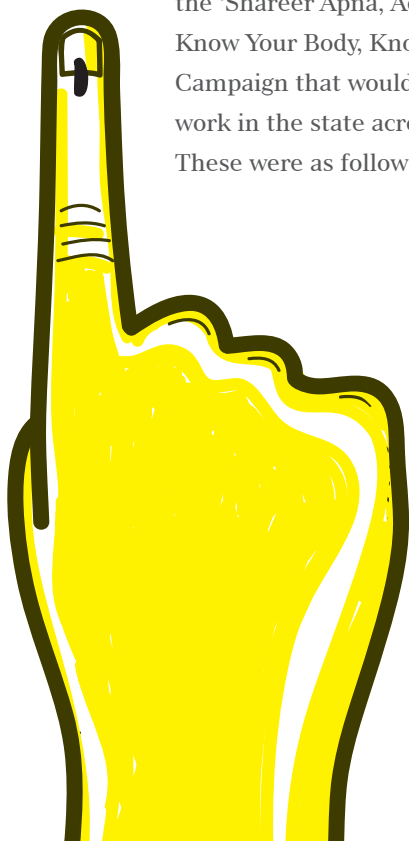
8.1. State and Regional Level Government

a. Work with government officials to develop a cohesive approach based on how central-level policies are addressed and how they are operationalised within districts to ensure that ground realities are accurately reflected in policy-planning and that feedback is reaching all levels of policy systems that address YSRHR.

b. The state does not have a policy that directly addresses young people. There is a need to support the adoption of the proposed Youth Policy. The Youth For Change programme in collaboration with several networks and partners has built considerable momentum for the same and the policy addresses young people's need for CSE and SRH. Dialogue with the State Government on the need to advance the same should be sustained.

c. Young politicians and youth wings of political parties should be sensitised on the need to address young people's SRH, as there is a lack of knowledge on the same. Their mobilisation and participation at policy levels should increase as much as possible and be supported by CSO networks and youth groups that work together.

d. The establishment of a state-level working group of CSOs and young people who can strengthen collaborative efforts to work with policy implementation to advance the availability of CSE and SRH services for young people.

e. In Western Uttar Pradesh, many young people working with different departments across the region felt that they were often opposed in attitudes and thinking on the need for SRH information for young people. Feedback from officials indicated that the potential reaction of teachers that is a cause for concern, since many teachers in the state opposed the AEP text that was introduced in 2007.

f. An increase in the availability of data on young people's SRH that is disaggregated on the basis of age, sex and gender should be disseminated more regularly amongst policy-makers and government officials to ensure they are accurately informed.

g. Increasing partnerships between government departments and young people and / or youth-led initiatives to address sustainable implementation of SRH programmes at community-level. Young people are able to harness key leadership experiences through this process and strengthen inter-generational dialogue on issues that are seen as 'sensitive'.

h. Components within the Adolescent Sexual and Reproductive Health Strategy and National Rural Health Mission that address Sexuality Education need to be examined to ensure they are comprehensive (i.e. addressing all aspects of CSE).

8.2. Education Department

a. Currently provides limited content to young people regarding their Sexual and Reproductive Health as it may lack the freedom to take independent decisions on curriculum content.

b. Consultations on the subject of CSE should be conducted with officials from within the department as it strengthens buy-in as well as stimulates discussions on the need for the same.

c. Myths and misconceptions regarding CSE that can be often directly co-related to the questioning of the 'cultural relevance' of such education need to be cleared. If these are addressed as part of teacher-training, there is likely to be more support from school teachers and administration.

d. Perceived hesitancy across Education Departments especially in Northern Uttar Pradesh, to want to pick-up

the responsibility of implementing CSE programmes due to concerns of community backlash as well as lack of teacher-training to do so.

8.3. Educational Institutions

a. Do not hold public meetings on the issue that involve young people or members of the community, however, in certain regions educational institutions have tried films as an effective medium of raising conversation on the need for SRHR and CSE. This has been an inclusive strategy that many participants felt should be scaled as a medium for discussion.

b. Need to acknowledge that adolescents have questions on issues of menstruation, masturbation, HIV and AIDS, reproductive and sexual health, not just on nutrition and pregnancy.

c. Girls and boys want separate sessions initially, after which they want to be able to talk together on the subject. When the educational institution does not recognise, this young people fail to be able to create spaces where they can learn to interact with one another and develop healthy relationships.

d. NGOs that conduct programmes (that participants had personal experience with) tend to focus more on HIV prevention or family-planning and give less information on CSE[18], the latter component should be strengthened within the same.

---

[18] Examples were shared of the organisation Gramya in Chandoli that runs an informal school where they address aspects of CSE for adolescent girls from classes six – eight within their programmes. SAHAYOG additionally

has run the Youth For Change programme as well as TARANG, that works with rural adolescent girls in five districts of Uttar Pradesh and integrates components of CSE within its programming.

8.4. Teachers Union & Teachers

a. There are many myths and misconceptions regarding sex and sexuality, and belief systems are largely against such education. The key concern shared was that it would be difficult for teachers to address queries from students they may perceive as embarrassing, once the government endorsed AEP is made available to students. In one instance, this was further endorsed in a press-statement from teachers themselves[19]. Participants suggested that within Teacher-Training, there could be exercises where young people and teachers are both able to work together so that the discomfort on discussing SRH issues is lowered from the start.

b. Participants felt that even if individual teachers are motivated to address the same, they do not believe that the government will be supportive of their efforts and they need to be assured of the same. Many also noted that despite the initial resistance to introducing such information, there has also been a perceived change in attitude[20] at local levels more recently.

c. The alternate concern many teachers share is the backlash they can receive from community members and parents, who may not understand the content or context of the information. Principals should hold focus-group discussions with parents prior to implementing curriculums on CSE so that parents are supportive of the same; this has been done before by some Principals and has been a successful approach. The establishment and frequency of Parent-Teacher Meetings need to be increased.

8.5. Community Responses

a. Policy implementation on Sexuality Education is influenced by and dependent largely on vote-banks therefore making it a politicised issue.

It is therefore critical that a bottom-up approach be invested in, where more sensitisation and awareness can reach communities, with higher outreach to ensure sustainable support for the issue at political levels.

b. There are mixed responses from community members on their willingness to address CSE with young people. Whilst many recognise the need for this information and do not dispute the same, people are unsure of how to approach the same. Communities that have a strong presence of Civil Society Organisations are far more likely to be open towards discussing CSE, than those who don't, as they are usually more informed. Scope and openness for discussion exists primarily in urban areas, whilst there is hesitation and discomfort with public-open discussions in rural areas. However, smaller discussion groups at rural-level have experienced success in holding conversations on the same. These platforms should be scaled-up and encouraged.
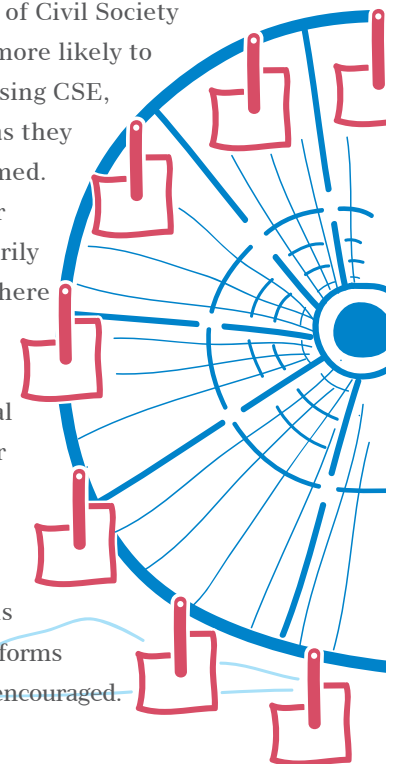
[19] 'No Sex Education, Say Uttar Pradesh Teachers', carried in Hindustan Times, Lucknow, July 9, 2007.

[20] A recent study was conducted by Awadhesh Kishore, M.P. Gupta, Lalit Mohan Sharma and Rakhi Sharma from RBS College Agra, and the Institute for Development of Technology for Rural Advancement, Mathura on the 'Perception of teacher trainees of Uttar Pradesh on effectiveness of sex education to avoid development of inferiority in children'.

Recorded amongst 200 teacher trainees, with 124 males and 76 females and 100 each of two systems of education (traditional and distance), with respondents from 23 districts out of 75 and between the ages of 22 – 35 years. 69% noted that sex education was required to 'avoid development of inferiority in the child'.
Electronic Source: <http://socyberty.com/sexuality/how-sex-education-can-be-percept/>

c. Printed IEC material needs to be disseminated in local languages; these should lead to discussions with parents and community leaders to sensitise them to the need for including CSE in the school syllabus, which would lead to greater acceptability. Additionally, participants felt that this would increase community support for young people to be able to access SRH services as well, where available.

d. The primary fear shared by most community members is that providing Sexuality Education will increase the age of first-sex, and in that light 'negatively' influence young people's behaviour. Whilst this is contradictory to what established evidence on the impact of CSE on young people says, many felt that the lack of access to evidence-based information only fuels this fear[21]. There is a significant amount of confusion on what constitutes 'age-appropriate' CSE education, however it was felt that providing such education in an age-appropriate manner is very important. IEC material distributed should be able to clarify the same.

e. Community members that are called should have the combined participation of adults as well as young people and adolescents. Civil society interventions that work with parent-groups particularly should support these.

Young people need to be empowered to advocate for this information within their homes, so that parents can become strong allies. Participants in the consultation indicated the desire to have the opportunity to address religious conservatism in their own communities. There was positivity, willingness and an excitement amongst participants to be able to take these discussions forward and tackle the challenges that the same would bring.

Youth Leaders from the 'Shareer Apna, Adhikaar Apne' Programme in UP
Photo: Disha Sethi

[21] Studies by WHO as well as UNESCO's International Technical Guidance on Sexuality Education cite data that shows that providing age-appropriate sexuality education actually decreases sexual risk-taking as well as does not decrease the age of first-sex amongst young people.
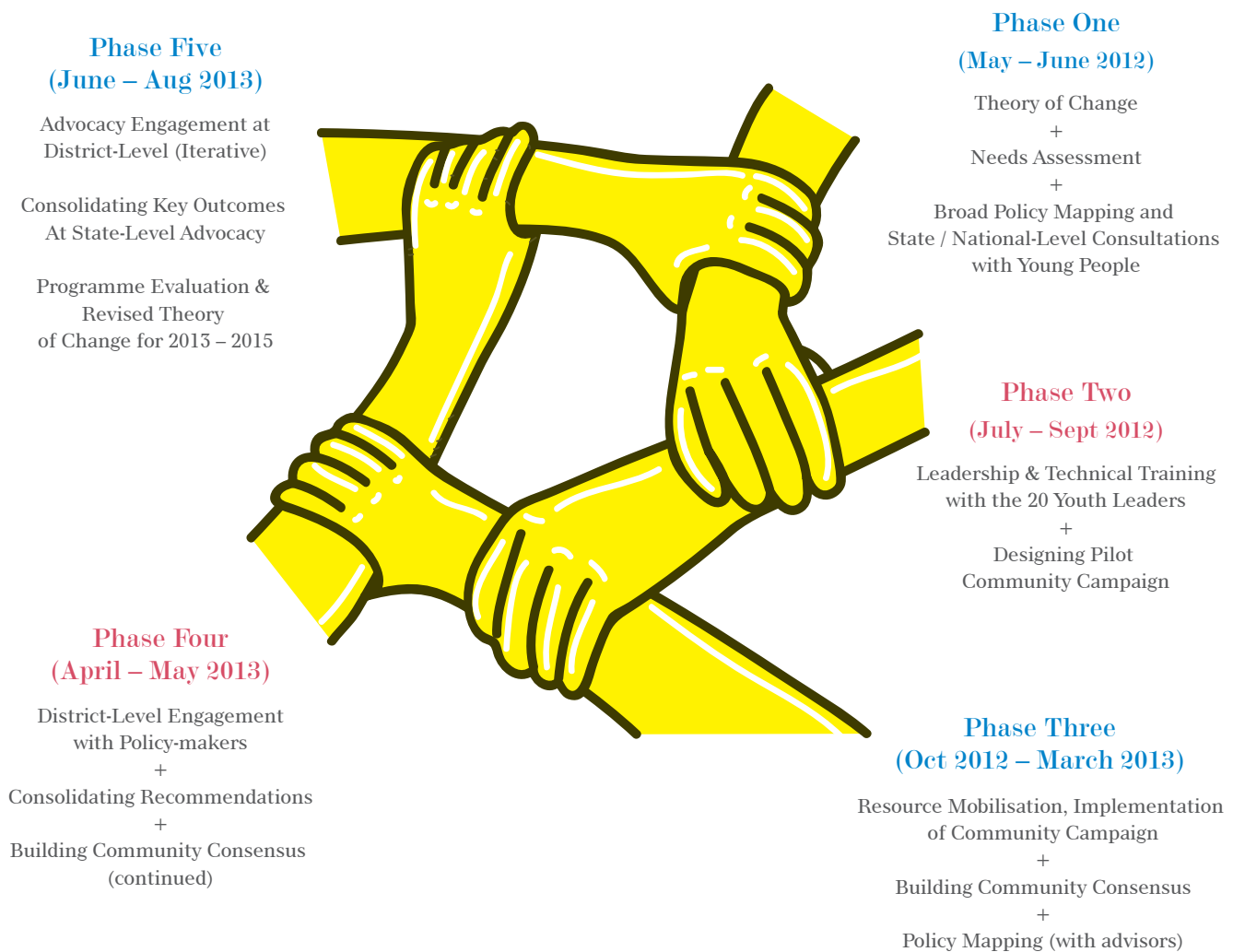
9. THE WAY FORWARD

Today, many young people across Uttar Pradesh are taking steps towards addressing key issues related to their health, education and rights at community-level and with their peers. This report has attempted to capture some of the strategies that these young advocates are recommending and / or implementing within their local contexts to ensure that their peers and community members are more aware and sensitive towards these issues. However, there still exist silent spaces and challenges when raising these issues both at community and policy levels.

The 'Shareer Apna, Adhikaar Apne / Know Your Body, Know Your Rights' programme will continue to work in the state, having taken its first step towards this process in early 2012. The programme is working through a rights-based approach of electing and working with a core group of 20 young leaders who are working in two districts of UP (from Jhansi and Lucknow) in both rural and urban settings to support them to continue to work with their own communities as well as to work with their local government officials and policy makers to ensure that they have the support and advice that they need to continue with their work. The programme, implemented jointly by SAHAYOG and The YP Foundation, along with support from partner organisations, Bundelkhand Development Foundation and Humsafar at district-level is working collaboratively through capacity-building community-level campaigning, state and district-level advocacy across 2011 – 2015 to work towards establishing building blocks, to enable an environment for Sexual and Reproductive Health information and addressing key challenges related to its implementation at community village, block and district level. The programme model that was implemented across 2011 – 2013 is represented below:

Phase Five
(June – Aug 2013)

Advocacy Engagement at District-Level (Iterative)

Consolidating Key Outcomes At State-Level Advocacy

Programme Evaluation & Revised Theory of Change for 2013 – 2015

Phase One
(May – June 2012)

Theory of Change
+
Needs Assessment
+
Broad Policy Mapping and State / National-Level Consultations with Young People

Phase Two
(July – Sept 2012)

Leadership & Technical Training with the 20 Youth Leaders
+
Designing Pilot Community Campaign

Phase Four
(April – May 2013)

District-Level Engagement with Policy-makers
+
Consolidating Recommendations
+
Building Community Consensus (continued)

Phase Three
(Oct 2012 – March 2013)

Resource Mobilisation, Implementation of Community Campaign
+
Building Community Consensus
+
Policy Mapping (with advisors)

Reviewing The Way Forward - Shareer Apna, Adhikaar Apne State Level Consultation, Lucknow
Photo: Rachit Sai Barak

The aim is to ensure that lessons learned and shared by young people both through this report and from their own communities can continue to be articulated at all levels right from the grassroots-level to the state and eventually to the national-level. It is only through this process that the continuously changing landscape of young people's challenges related to their health and rights can be reflected in policies. Across 2013 – 2015, the programme will build on lessons learnt from the first phase of its implementation (2011 – 2013) and look at strengthening collaborative partnerships and collective action with regards to the same.

CSE can be clearly identified within young people's right to education information and health. Many young people see that as a right that empowers them with evidence-based information and negotiation skills that they can help make safe and informed choices. Young people in Uttar Pradesh need support from their communities, their leaders and their peers to ensure that this can be a reality. We hope that this report can be shared and discussed across spaces to build political will and encourage conversations about these issues amongst key stakeholders and most importantly – to ensure that young people's voices in Uttar Pradesh can be heard, and feed into policy processes that effect and impact their everyday realities.
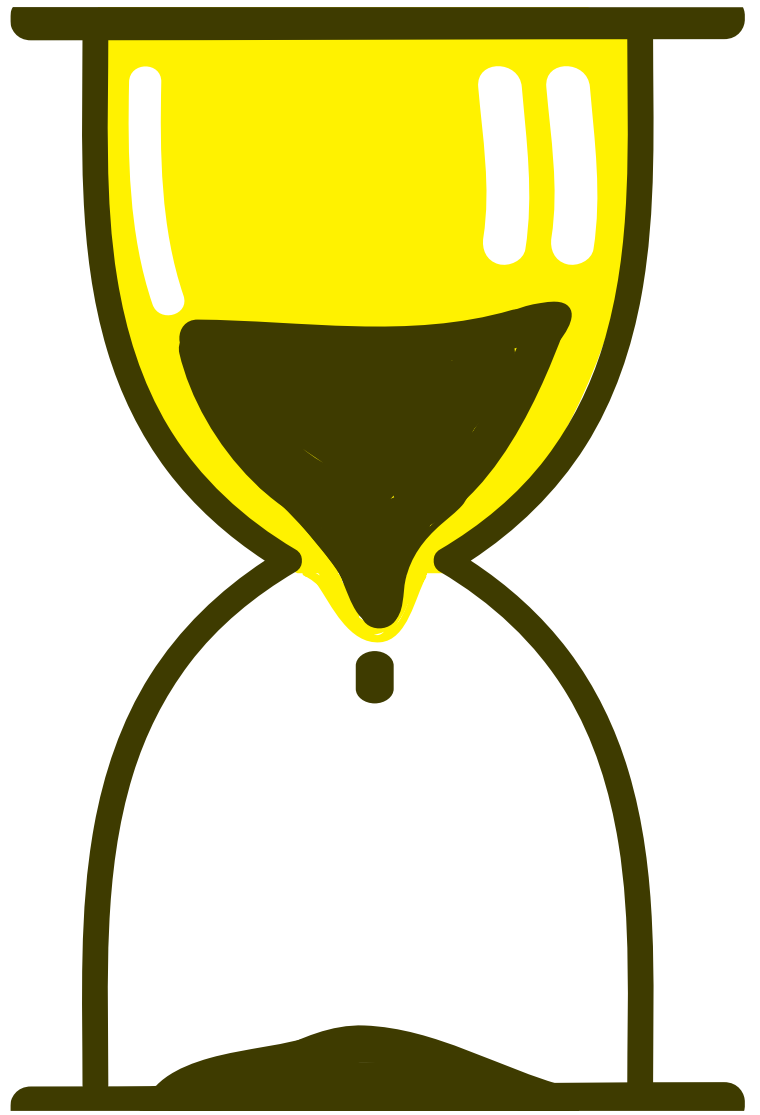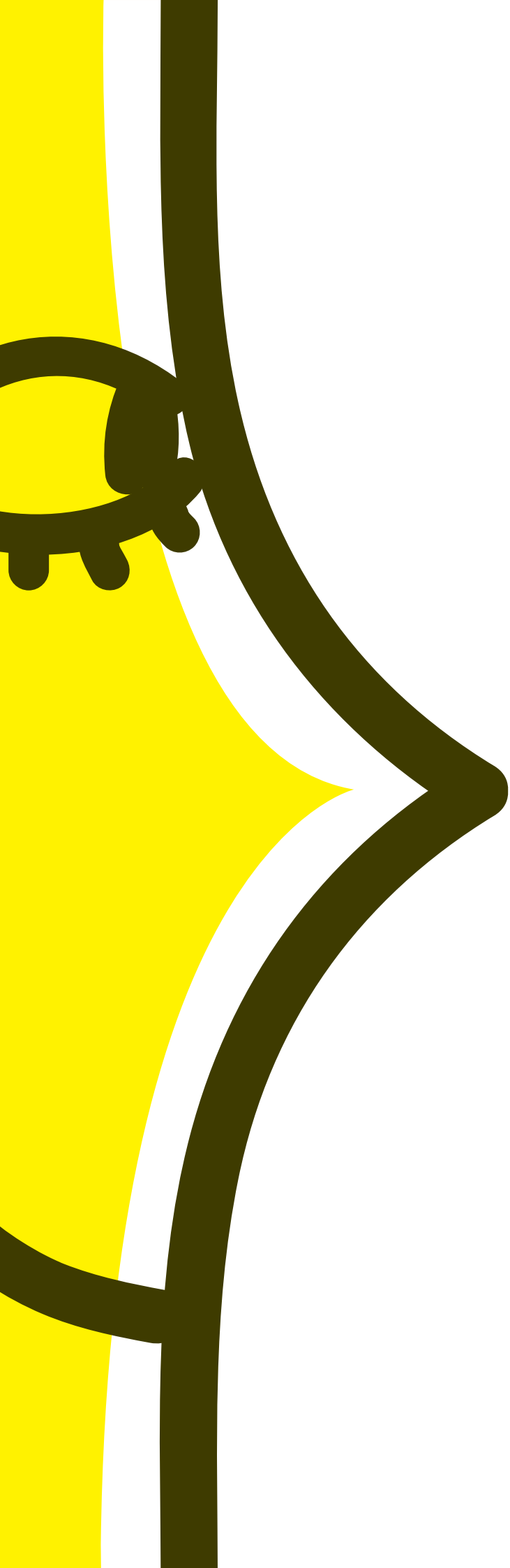
10. ANNEXURES

1. Thematic Areas
2. Profile: The YP Foundation
   and SAHAYOG
3. Participant List

Annexure 1: Thematic Areas[i]

Thematic Areas	Discussion Points

Theme 1: Needs of Young People
 What do young people want information on within sexuality education? (Content)
 	
 Methodology: Case Study
	1. Inclusion of Content:
	   a. What do young people feel is critical to address within CSE?
	 2. Comprehensiveness of Content[22] (how should it address):
	   a. Sexuality
	   b. Interpersonal relationships
	   c. Violence / abuse, power dynamics
	   d. Communication and decision-making skills
	   e. Anatomy / body
	   f. Puberty
	   g. Reproduction
	   h. Sexual and Reproductive Health
	   i. Sexually transmitted infections, including HIV / AIDS
	   j. Decisions about one's own fertility: contraception and safe abortion
	 3. Contextualisation / validity of content

Theme 2: Role of Key Stakeholders – Impact of Family / Community / Government / Peers Methodology: Relationship mapping with participants on supporters, gatekeepers and community members who are supportive / against / neutral to the delivery of CSE with young people	1. Engagement of community members and families in Youth Sexual and Reproductive Health 2. Prevailing attitudes, expectations and practices 3. Degree of influence (including positive influence, such as the presence of peer groups / peer support networks / counselling) 4. Potential / accessibility and availability to Sexual and Reproductive Health information

---

[i] The thematic areas and corresponding guiding questions in this table were used as a starting point to work with young people and develop a region wise / district level matrix during the consultations. This was used to provide inputs on assessing access to Sexual and Reproductive Health Information in Uttar Pradesh and enable sharing on the same, using small group settings with a ratio of 1 Facilitator for 10 Youth Leaders. The matrix and original documentation can be made available upon request to theypfoundation@gmail.com

[22] Thematic areas have been put together referencing the 'It's All One Curriculum' and 'Adolescence Education Programme' by NCERT.

Thematic Areas	**Discussion Points**

Theme 3: Transaction Methods

Methodology: Focus Group Discussion

1. Content of the curriculum
2. Delivery of content / preferred methodology
3. Feedback mechanisms
4. Community

Theme 4: Innovations at Community-Level on SRHR

Methodology: Region-wise discussions and chart work

1. Examples of programmes that have reduced stigma and discrimination
2. Strategies for effective programming on issues of sex and sexuality with young people and key gatekeepers and stakeholders at community and policy levels
3. Example of, or ideas for campaigns with community endorsement and positive messages on sexuality education
4. Strategies of engaging young people and increasing participation and leadership
5. Strategies to strengthen youth-adult partnerships
6. Feedback from and engaging / impacting policy makers and key government officials
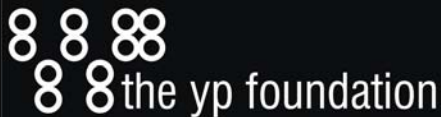
Theme 5: Youth Friendly Health Services

Methodology: Pictorial representations and symbol recognition of community-level facilities available to young people

1. Existing facilities
2. Availability of youth friendly services
3. Involvement / stake of youth in the delivery of youth friendly services
4. Attitudes of service providers

Annexure 2: Profile

The YP Foundation (TYPF) is a non-profit, youth-run and -led organisation that supports and enables young people to create programmes and influence policies in the areas of gender, sexuality, health, education, digital media, the arts and governance. The organisation promotes, protects and advances young people's human rights by building leadership, and strengthening youth-led initiatives and movements. Founded in 2002, TYPF has worked directly with 6,500 young people to set up over 300 projects in India over the last 11 years, reaching out to 350,000 adolescents and young people between 3 – 28 years of age. TYPF empowers young people by supporting their work through four key focus areas:

~ Strengthening access to education, information and knowledge-building

~ Advancing young people's participation in policy formation and implementation

~ Digital-media training and life-skills development

~ Community-based programming with young people who are both in- and out-of-school

TYPF has implemented programmes and worked with youth groups and partner organisations across 18 states in India, namely, Punjab, Haryana, Tamil Nadu, West Bengal, Karnataka, Andhra Pradesh, Madhya Pradesh, Maharashtra, Chhattisgarh, Kashmir, Jammu, Nagaland, Gujarat, Jharkhand, Uttar Pradesh, Rajasthan, Meghalaya, Bihar and NCR. TYPF believes in empowering young people's access to information, services and rights such that they can build collective platforms to challenge and develop their leadership potential. It is only when the change required is actually understood and supported by the community at large that it can be sustained.

Keeping with this theory of change, TYPF engages young people through five programmatic divisions that work with:

a. Life Skills, Education and Health for Children: Blending Spectrum

b. Sexual and Reproductive Health and Rights: 'Know Your Body, Know Your Rights'

c. Right to Education (RTE) and Right to Information (RTI): The RTI Programme

d. Human Rights, Digital Media, and Learning: The Butterfly Project

e. Music Education, Artist Rights and Livelihood Sustainability: Silhouette

For more information please visit, www.theypfoundation.org

About SAHAYOG

SAHAYOG is a non-profit NGO working to promote gender equality and women's health from a human rights framework. Its key activities include advocacy and strengthening partnerships.

SAHAYOG believes that socially marginalised individuals and groups must participate in decision-making that affects their lives, such as poor rural women, youth, non-literates, Dalits, tribal's and minorities.

SAHAYOG works at the community-level in partnership with local NGOs to build capacities and provide information so that the marginalised individuals can exercise their rights and access services. SAHAYOG has been advocating on various issues of women's rights at state, national and international level. With SAHAYOG's regular research, documentation and evidence base, it reaches out to organisations, educational institutions state actors and the media, as well as anchors campaigns and advocacy efforts in partnership with other organisations and individuals.

Within its work on gender equality and women's health SAHAYOG recognises that young people of Uttar Pradesh face high risks for their reproductive and sexual health making it imperative that they should have access to information and services for their Sexual and Reproductive Health and Rights (SRHR). Towards this, SAHAYOG has initiated a programme called 'Youth For Change'. The programme in partnership with 11 NGOs, located in 10 districts, strengthen a network of over 100 youth groups compromised of over 1000 youth members. 'Youth For Change' activities will prepare youth leaders to join with adult stakeholders to form a Youth Policy Network (YPN) for building and sustaining advocacy efforts towards a comprehensive SRHR policy for youth at the state-level.

For more information visit, www.sahayogindia.org

Deep In Thought - Strengthening Youth Participation in Policy Processes at State Level
Photo: Rachit Sai Barak

Annexure 3: Participant List

No. of Participants		District / Block	Organisations Represented
Female	Male		
1	0	Hardoi	Youth Policy Advocacy Network
1	0	Farukhabad	Youth Policy Advocacy Network
9	6	Lucknow	HAMSAFAR, Breakthrough, FPAI, IISD (Partners of Youth Policy Advocacy Network)
1	3	Varanasi	MASVAW
0	5	Azamgarh	MASVAW
3	2	Barabanki	IISD, Vigyan Foundation
0	1	Ambedkar Nagar	Youth Policy Advocacy Network
0	1	Mau	Grameen Vikas Sansthan
0	1	Orai	MASVAW
1	1	Gorakhpur	DMCGVS
1	1	Banda	TVS
1	1	Chandoli	Gramya Sansthan
1	1	Bareilly	Suchetna
1	2	Mirzapur	SPS
0	1	Jaunpur	MASVAW
1	0	Saharanpur	Anchal Gramin Vikash Sansthan
1	0	Muzaffarnagar	Astitve Samajik Sansthan
0	1	Balrampur	Youth Policy Advocacy Network
2	1	Jhansi	Bundelkhand Development Foundation
24	28		
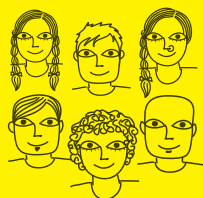
52
Total Number of
Young People

19
Total Number of
Districts Represented

Organisations
14

State-Level Networks
2

16
Total Number of
Participating Organisations

The 'Shareer Apna, Adhikaar Apne' Youth Leaders in Uttar Pradesh
Photo: Rachit Sai Barak