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country advocacy brief

INDIA

COMPREHENSIVE SEXUALITY EDUCATION: THE WAY FORWARD

SECTION 1: Introduction

With over 368 million, 28% of India's population is made up by young people between the ages of 10 and 24[1]. In recognition of the development needs of this demographic and in alignment with the 2015 Sustainable Development Goals (SDGs), India's Central and State governments have renewed their focus on youth issues. This is evident in the present government policies and programme initiatives, such as the National and State level Youth policies. These policies address youth development from an education and skills perspective, with some focus on health, including adolescent reproductive and sexual health (ARSH). While the renewed prioritization of youth development is welcome, policies need to further embed youth participation and ownership in the development, implementation and monitoring of policies and programmes that aim to address their needs. Given the rich diversity of India's population in terms of religion, caste, class, language, and culture, the effectiveness of youth policies and programmes will depend upon how well they understand and address the contextual needs of the specific youth population it targets.

In alignment with the Millennium Development Goals (MDGs), India has made strides in improving reproductive health outcomes over the last 15 years. For example, Maternal Mortality Ratio (MMR) dropped from 374 per 100,000 live births in 2000 to 174 in 2015[2]. Similarly, Total Fertility Rate (TFR) has dropped from 3.2 in 2000 to 2.3 children per woman between the ages of 15 to 24 in 2014[3]. Infant Mortality Rate (IMR) has also improved from 68 per 1,000 live births to 39 during the same time period[4]. Improvements in maternal and child health outcomes coincide with the launch of the National Rural Health Mission (NRHM), in 2005. The central government initiative aimed to make architectural corrections in India's health systems across all levels to improve access and availability to affordable health care to all citizens. Housed under the Ministry of Health and Family Welfare, the initiative further focused on improving the social determinants of health by facilitating the spread of information, basic services and commodities by frontline health workers and by setting up local health centers in each village. This system has since served as the backbone of health service delivery for all national and state initiatives, including recent initiatives that focus on adolescent health, including adolescent reproductive and sexual health.

Despite the introduction of such ambitious and game changing health initiatives, young people in India continue to have inadequate access to information, services and commodities pertaining to their sexual and reproductive health, leading to adverse consequences to their health and well-being. For example, the HIV prevalence rate among young people between the ages of 15 and 24 is 0.11% or 40% of the prevalence rate for all adults between the ages of 15 and 49[5]. Only 34.7% of women

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and 68.1% of married men between the ages of 15 and 49 are aware that consistent condom use can reduce the chances of contracting HIV[6]. Lack of access to sexual and reproductive health information reduces young people's and especially young women's ability to influence critical decisions pertaining to education, health, relationships and marriage, leading to gender discriminatory practices and gender based violence. For instance, only 36.7% of married women have reported to participate in household decisions[7] while 37.2% of all married women have experienced spousal violence[8]. This in turn leads to a violation of young people and especially young women's rights including early and forced marriage. For example, 47% of girls are married below the legal age of 18 in India[9]. Prevailing patriarchal attitudes create a further barrier to comprehensive programming and public conversation on issues of sexual health and gender based violence. These attitudes are furthered by frequent misogynist statements by leading politicians and public figures. For instance, a leader of a national political party proposed to change an anti rape law that entails death for the convicted based on the argument that "The rape accused should not be hanged. Men make mistakes."[10] Similarly, another Member of Parliament dismissed protesters against the gang-rape of a young woman in New Delhi by stating, "Women who are participating in candle-light vigils and those who are protesting have no connection with ground reality. These pretty ladies coming out to protest are 'highly dented and painted'".[11] The misogynistic sentiment demonstrated by the highest elected representatives reflects a deeply rooted gender biased and patriarchal society that restricts women's rights and young people's SRHR and consequently helps perpetuate a cultural acceptance of violence. To bring forth a cultural change that affirms young people's sexual and reproductive rights requires a long term intervention that raises SRHR awareness with a sex positive approach through the Indian central and state education system.

In this context, despite the evident need for young people to access information pertaining to their sexual and reproductive health and rights (SRHR), it has been difficult for the central Ministry of Human Resource Development (MHRD) to introduce Comprehensive Sexuality Education (CSE). When the Adolescent Education Programme (AEP) was first introduced by the MHRD in partnership with the National AIDS Control Organization (NACO) in 2007, the curriculum, which covers CSE, was banned across Indian states due to protests by parents and teachers, citing inappropriateness of content. In 2009, the MHRD in partnership with UNFPA re-launched the Adolescent Education Programme. Focused on building life skills, the programme began implementation in over 5000 government and private schools in 2009. This remains the only institutionalized government intervention addressing adolescent health in the education system. While the curriculum includes important SRHR topics such as body changes, RTI/STI and HIV/AIDs, it does not cover topics such as sex or pleasure or gender identities and sexual identities as social constructs, though gender stereotypes are addressed. The launch of the National Adolescent Health Programme or Rashtriya Kishor Swasthya Karyakram (RKSK) presents an opportunity to integrate a comprehensive SRHR curriculum in the out-of-school context. As the programme is in the beginning stages of its roll-out phase where inputs on programme design and rollout are being taken, there is significant scope for civil society organizations to advocate for the integration of CSE using a sex affirmative, rights based approach.

The given brief provides an overview of the existing government programmes that imparts certain elements of CSE to adolescents i.e. the Adolescent Education Programme and the 2014 National Adolescent Health Mission, an out-of-school, adolescent centered, government health initiative. The last section of this brief makes recommendations directed towards the Indian Ministries for Education and Health to advance young people's access to Comprehensive Sexuality Education.

SECTION 2: Comprehensive Sexuality Education in the National Context

Since 2007, both the central ministries of health and of education have recognized, to an extent, the need to provide young people with information and life skills that address their reproductive and sexual health.

From an out-of-school and health perspective, the Ministry of Health and Family Welfare launched the RMCH+A initiative as a part of its National Health Mission. The programme, which stands for "Reproductive, Maternal, Newborn, Child and Adolescent Health" aims to provide 'continuum of care', with equal focus on every life stage including adolescence. In recognition of adolescents' health needs, the initiative set up adolescent friendly health clinics (AFHCs) across urban and rural centers. The clinics provide counseling and curative services as well as commodities and enable adolescents and young people to avail contraceptives, RTI/STI testing and treatment and counseling on puberty, sex, delaying marriage and first pregnancy. The National Adolescent Health Mission (RKSK), launched in 2014, further introduces peer educators linked to the AFHCs who are responsible for collectivizing adolescents and young people to impart information on 5 priority areas, namely improving Nutrition, Mental Health, Sexual and Reproductive health and preventing Injuries and violence and Substance Misuse. As the programme is presently in its design for implementation phase, there is great potential to integrate CSE as a part of the curriculum to be imparted by peer educators with adolescents and young people in the community.

Together, the two programmes introduce a powerful health system that enables young people to access SRH information and services. However, AFHCs have been unable to increase young people' access to services. For instance, a 2014 Population Council report titled "Accessing Adolescent Friendly Health Clinics in India: The Perspectives of Adolescents and Youth" found that only 8% of women and 5% of men surveyed in 3 states were aware of the existence of AFHCs situated within 5-10 kilometers of their villages. Social and cultural norms further prevent young people from accessing services in fear of being

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need for Comprehensive Sexuality Education as the same plays a critical role in affirming young people's right to sexual and reproductive health information and services. A major barrier to youth access to SRH services is the 2013 amendment to India's Protection of Children Against Sexual Offences which mandates all health service providers to report any cases involving sexual activity with or between minors. This leaves young people in consenting sexual relations vulnerable to criminal action, thereby limiting their access to SRH services and compromising their health and well-being.

From an in-school, education perspective, the Ministry of Human Resource Development in partnership with UNFPA has succeeded in introducing the Adolescent Education Programme in select government and private schools.

Framed as a Life Skills Education programme, the AEP curriculum covers the following themes:

- Changes during adolescents
- Body image
- Positive relationships
- Gender and sexuality based stereotypes and discrimination
- Violence and abuse
- RTI/STI
- HIV/AIDS
- Substance abuse

The curriculum itself is delivered by trained teachers through a 16-23 hour model to students in class 8, 9 and 11 i.e. between the ages of 13 and 18. As of 2010, the programme consolidated its focus to 5 UNFPA priority states in 5002 schools that are apart of 3 school systems supported by the MHRD i.e. the Navodaya Vidyalaya Samiti (NVS) and Kendriya Vidyalaya Sangathan (KVS) and select schools affiliated with the Central Board of Secondary Education. The intervention also includes the integration of the curriculum topics in the learning materials of National Institute of Open Schooling (NIOS) at the secondary level. In 2013, the programme focused began to focus implementation solely in all KVS and NVS schools in a phased wise manner. It is difficult to ascertain information on the programme's successes after 2010, when an independent evaluation of the programme was published by the UNFPA. The independent evaluation conducted by UNFPA in 2010-11 surveyed 200 schools across the 5 states where AEP had been implemented. The evaluation assessed the efficacy of the AEP programme in select schools where the curriculum was implemented by comparing student and teacher responses to relevant questions and case students in schools where the curriculum was not implemented. The evaluation reports, for instance, that 70%-80% of students and teachers in schools where the AEP curriculum is implemented are in favour of changing gender based stereotypes with respect to girls playing sports and boys doing household chores[12].

Post 2011 there is no consolidated independent publication available where the entire Adolescent Education Programme's outreach, curriculum or performance indicators are highlighted, though process evaluations and data sets for specific elements of the programme are available.

In addition to government led initiatives, across Indian states, non-governmental organizations also play a critical role in providing information regarding menstruation, early age of marriage and HIV under the ambit of Life Skills Education (LSE) to the 10-14 age group in schools. Due to the risk of community backlash, programmes do not cover the range of topics that come under CSE including masturbation, conception, contraception, pleasure and consent although implementers across these programmes have been asked questions by students on the same. There is no aggregated information available on the number of non-profits that implement various curriculums across schools in different states. Out of school programs and women self help groups at the village level have also been successful in enabling girls to collectivize and to begin conversation on menstruation, marriage and consent. Therefore, even though there is increased government action and support to provide young people with access to SRH information and services, India has a considerable journey ahead to ensure that every young person has access to the evidence based SRH information, services and commodities, free of stigma in a culturally supportive environment.

SECTION 3: Comprehensive Sexuality Education in India in Contrast to International Best Practices

The realization of youth sexual and reproductive health and

rights necessitates the delivery of comprehensive sexuality education and youth friendly SR health services. Since the initial introduction of the Adolescent Education Programme in 2005, the Government of India has taken significant policy decisions and programmatic action to provide the same to adolescents and young people across the country. However, the challenge in the Indian context lies in recognizing and changing patriarchal social and cultural norms that view sexuality outside of marriage as shameful. A common belief is that increased awareness will make young people promiscuous and invite social stigma. Social and cultural norms therefore actively control young people's sexuality and attempt to 'safeguard' young women's 'purity'. As a result, young women across socio-cultural and economic contests are forced to limit their choices, restrict their movement, dress conservatively and silence any questions regarding their bodies. Challenging existing forms of gender discrimination is insufficient to create a cultural shift where young people and especially young women are empowered to take ownership of their bodies and sexuality.

For instance, SRHR and Women' issues organizations such as the IPPF, ARROW and the Women's Health and Rights Advocacy Partnership – South East Asia identify 7 elements critical for a CSE curriculum to comprehensively enable young people to realize their SRHR. This includes the adoption of a rights based approach in addressing the 7 issues of gender, SRH and HIV, sexual rights and sexual citizenship, pleasure, freedom from violence, diversity and relationships[13]. In the Indian context, integrating issues of consent, pleasure, sexual diversity, and sexual citizenship in existing school curriculum from a rights based approach is necessary to enable young people to realize their sexual and reproductive rights. Limitations with respect to access to quality schooling and livelihood option increase the focus on marriage. This in turn reinforces social norms that seek to control young people's bodily automony.

The Adolescent Education Program curriculum, for example, does tackle important issues within the Indian context in terms of gender norms, stereotypes and discrimination and have indicated positive attitudes amongst students regarding changing stereotypes of roles and responsibilities of boys and girls at home and at school. However, the curriculum does not discuss various gender and sexual identities, sexual diversity, or pleasure; thereby inadvertedly reinforcing the norms like sexual relationships between a man and a woman have sole legitimacy.

While the 2010 AEP evaluation by UNFPA provides insight into the curriculum's implementation successes and limitations, it is difficult to access the exact curriculum implemented with the students to determine the extension and depth of the topics covered. With respect to topics that are covered by the curriculum, the report indicates gaps in the topics themselves. For instance, within the topic of 'positive relationships', the curriculum discusses positive relationships with friends, family and decision making regarding marriage. It does not, however, discuss relationships, negotiation and consent in the context of an intimate or sexual relationship, neither outside nor inside the institution of marriage. By limiting the discussion to non sexual relationships, students are unable to challenge and change cultural beliefs regarding the power hierarchy and gender roles in relationships. For instance, the evaluation report indicates that 43% of students who underwent the curriculum believed that wife beating is justified under some circumstances[14].

The AEP curriculum does impart information on RTIs, STIs and HIV with low success rates as reported by the 2010 Evaluation. For example, the evaluation report indicates only 21% of AEP students demonstrating comprehensive knowledge on HIV. One can expect knowledge indicators to be mixed or low with any curriculum implemented for a short term period since knowledge retention requires reinforcement. Critically, the extent of success of CSE programmes lies in its ability to create a safe, non-judgmental space where students can raise questions, challenge stereotypes and build perspectives in an enabling and supportive environment. For adolescents, having an empathetic, non-judgmental educator is critical to ensure students' comfort in asking questions. Peer educators are therefore in the best position to impart CSE as students often share teachers' discomfort with teaching classes on body anatomy as a part of biology or uttering the word "condom" during workshops on HIV/AIDS[15].

Sexual and reproductive health, diversity, and pleasure are critical components of any CSE framework. To exercise one's sexual rights - for example, to say yes or no to sex or to access contraceptives and services - requires a clear and comprehensive knowledge of one's body. It is especially important for a CSE curriculum in the Indian context to adopt a sex positive approach that discusses masturbation and different forms of sexual intimacy beyond the lens of marriage and child-bearing. Given a patriarchal culture that restricts women's mobility and choices from adolescence in fear of sexual assault, a CSE programme is a powerful tool that enables young people to develop ownership of their bodies and their rights.

SECTION 4: Recommendations to the Indian Government

The Indian Ministry of Health and Education have introduced and implemented ambitious programmes aimed to address adolescents' reproductive and sexual health. Just as the National Rural Health Mission has served as the bedrock for the delivery of ARSH services, the Adolescent Education Programme has the promise of a foundation to deliver Comprehensive Sexuality Education to adolescents in the Indian context. India has a long way to go before it enables the universal delivery of CSE through a rights based and sex positive approach to adolescents in a supportive environment. Given below are recommendations for how the Ministries for Education and for Health can strengthen the delivery of CSE in the country.

Recommendations for the Ministry of Human Resource Development

To Policy Makers:

1st: Present government and non-government CSE/LSE programmes focus on limited themes under CSE such as puberty,

menstruation, gender norms and discrimination, HIV and early marriage. The programmes recognize the effectiveness of knowledge dissemination on these issues in reducing stigma, improving health and wellbeing and preventing violence. However, to enable young people to make informed decisions regarding their bodies and to increase their health outcomes, the Ministry of Education i.e. the MHRD should **integrate the 7 elements of gender, SRH and HIV, sexual rights and sexual citizenship, pleasure, freedom from violence, diversity and relationships in the sexual and reproductive health components of Adolescent Education Programme's curriculum to make it comprehensive.** This is in accordance to best practices articulated by the IPPF and SRHR and women's organizations in South East Asia with respect to CSE programme interventions[13, 16]. The Adolescent Education Programme should especially incorporate issues of sexual and gender identities, diversity of identities, consent, negotiation and pleasure for young people to develop sex positive attitudes, not ruled by stereotypes, stigma, shame or fear that will play a critical role in young people's ability to challenge gender/sexuality based discriminatory practices.

2nd: In India the CSE/LSE curriculum begins at secondary level. However, CSE/LSE curricula across the world including some countries in Africa, US, and Europe have been adopted from the primary level. The UNESCO technical guidance document on Sexuality Education, which is based on a review of CSE/LSE curricula across 12 countries and a consultation with 13 international experts sets out a framework of an effective CSE curriculum which provides age-appropriate, culturally relevant and scientifically accurate information across the 6 broad categories for implementation across 4 age groups (level 1 to level 4) from 5 years to 18+ years[17]. **The MHRD should introduce age-appropriate CSE right from the primary education level to develop body and sex positive attitudes, to address gender discriminatory practices that begin before puberty, and to build the confidence necessary to ask questions and seek help, for example, in case of sexual molestation.**

3rd: The Adolescent Education Programme recognizes the need to sensitize key people in the system such as the school principal and teachers on the relevance and need for CSE to facilitate the delivery of the existing curriculum. **To strengthen the comprehensiveness of the curriculum to cover all themes under CSE mentioned above, the programme should further require teachers to engage and to sensitize parents on the need for CSE and the need to encourage students to ask questions without shame or fear of rebuke**.

4th: With the introduction of the Adolescent Education Programme, the MHRD has recognized the clear need to provide information and develop life skills amongst adolescents regarding puberty, gender, relationships, and certain aspects of sexual and reproductive health. The aim of the programme is to enable adolescents to make informed decisions regarding their health and well-being. To establish the benefits adolscents achieve by being engaged in such programmes, there is a clear need to generate evidence of impact on the efficacy of such programmes. **The MHRD should look towards publishing the impact of the AEP curriculum on an annual basis with the aim of building a case to strengthen the programme's present expansion.** Publicly available information on the programme's delivery including curriculum, methodology, successes and challenges is further necessary to help inform and strengthen other similar interventions.

To Curriculum Developers:

1st: Given the diversity in culture and language across Indian states, **it is critical for all CSE or LSE curriculum to be translated meaningfully and appropriately at the state level.** Translations should be undertaken by SRHR experts in each language to ensure user friendliness in the context of each state's social and cultural norms.

2nd: Additionally, to enable young people to **recognize and exercise rights associated with LSE and CSE**, the Adolescent Education Programme should encourage adolescents undergoing the curriculum to **visit their local Adolescent Friendly Health Clinic**, set up by the Ministry for Health to provide information, services and commodities that address adolescents' health needs.

Recommendations to the Ministry of Health and Family Welfare

To Policy Makers and Programme Developers:

1st: The launch of the National Adolescent Health Programme or RKSK is an excellent opportunity to deliver CSE to out of school adolescents and young people. The "Saathiya toolkit"[18] is a step in the right direction. However, **the MoHFW must invest in the training and mentorship of the programme's peer educators to effectively collectivize young people to impart CSE and to address community concerns.** In this regard, the programme must ensure that peer educators have a support system consisting of other educators, AFHC counselors and the like to answer their questions and to facilitate their role in the programme. Frontline health workers such as the Accredited Social Health Activist should also be trained on CSE in order to engage young girls on SRH issues and to help support peer educators at the community level.

2nd: The MoHFW must ensure non-judgmental and non-discriminatory service delivery that is youth friendly by sensitizing health care professionals and holding professionals accountable for quality care delivery. For example, all staff at Adolescent Friendly Health Clinics should be sensitized on how to handle young people coming to these clinics in a non-judgemental and non-threatening manner. They should also be informed on reproductive and health issues including laws such as the Medical Termination of Pregnancy Act in order to provide non biased services to young people. Toolkits like the "Saathiya"[18] should be readily available at such centers for the staff to share with young people and enable them to use it.

3rd: The Ministry should also invest in the dissemination of government provided service options pertaining to sexual and reproductive health to inform young people of their SRH options. For example, by increasing the visibility of IEC materials that provide evidence based stigma free information on SRH issues such as contraception options, RTI and STI prevention, testing and treatment and abortion laws. The information should be available at the centers themselves and should also form a

part of the RKSK peer educators' tool kit. Thus the toolkit needs to have more comprehensive evidence based information about Sexual and reproductive health as well as about laws and provisions pertaining to SRH and bodily rights. In addition, clear mechanisms that allow young people to easily access such information, without fear of any stigmatization.

4th: As the National Adolescent Health Programme (RKSK) begins its roll out across districts, **the MoHFW should organize platforms that engage youth SRH advocates, implementers and front line health workers to input into the programme's design and implementation and to help support the implementation and monitoring and evaluation process.** By doing so, the programme will take into account young people's contextual realities and further create a community awareness and support system for the programme.

In conclusion, the Government of India has introduced promising policies and programmes in recognition of the development needs of its youth population. This includes the national and state youth policies and the National Adolescent Health Programme which recognize the need to address adolescent reproductive and sexual health. In alignment, India is a signatory to the post 2015 MDG Sustainable Development Goals, which includes commitments towards enabling good health and well being, providing quality education, and bringing about gender equality (SDGs 3, 4 & 5)[19]. It is our hope that these commitments will enable both government bodies and civil society organizations to challenge and change deep rooted cultural norms that stigmatize young people's sexual and reproductive health and rights.

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ABOUT The YP Foundation and Pravah

About The YP Foundation

The YP Foundation (TYPF) is a youth -run and -led organization that supports and enables young people to create programmes and influence policies in the areas of gender, sexuality, health, education, the arts and governance. The organization promotes, protects and advances young people's human rights by building feminist leadership, and strengthening youth led initiatives and movements.

Founded in 2002, and legally incorporated as a Public Charitable Trust in 2007, TYPF has worked directly with 6,500 young people to set up over 300 projects in India over the last 14 years, reaching out to 450,000 adolescents and young people between 3-28 years of age across 18 states and union territories in India.

About Pravah

Pravah was formed in 1993 with the mission to work on 'prevention' of social conflicts by developing social responsibility and personal leadership among young people. The organization believes that social change is effected through deep mind-set change of individuals and along with the empowerment of the socially excluded it is imperative to hugely shift the attitudes of individuals in powerful decision making positions in order to change the social structures that marginalize communities. Their approach is to build Inside-Out Youth Leadership by creating 5th Spaces (5thspace.in). Pravah recognized the need to work with young people so as to be able to facilitate the creation of leaders who are self-aware, deeply empathetic, systems thinking and socially responsible.

Since its inception, Pravah has impacted over 150,000 youth extensively and worked intensively with over 50,000 young leaders. Through its work the organization has impacted issues like education (child literacy), sexual and reproductive health, environmental sustainability, social inclusion (changing community perspectives, social conflicts), gender based violence, employability.

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