

WHAT MAKES

S E X  
U A L  
I T Y  
E D U  
C A T  
I O N

**COMPREHENSIVE?**

Exploring the Indian Context

A WORKING PAPER | TARSHI | 2019

# C O N T E N T S

<b>3</b>	<b>List of Acronyms</b>
<b>5</b>	<b>Overview</b>
<b>7</b>	<b>Section 1: Understanding Sexuality Education</b>
8	Defining terms
11	What is Comprehensive Sexuality Education?
13	What makes Sexuality Education ‘comprehensive’?
<b>16</b>	<b>Section 2: Why Comprehensive Sexuality Education?</b>
17	An overview of adolescents and young people in the context of SRHR in India
26	How can Comprehensive Sexuality Education help?
27	Myths and Facts
31	In summary: Key facts regarding CSE
<b>32</b>	<b>Section 3: Sexuality Education: A Global Perspective</b>
34	Global Agreements and Instruments related to SE
37	SE in the Sustainable Development Goals (SDGs) and the Post 2015 Agenda
39	The Revised International Technical Guidance on Sexuality Education (ITGSE)
<b>41</b>	<b>Section 4: Sexuality Education in India</b>
42	The journey of SE in India
46	Adolescence Education Programme
48	Structure and design of the AEP
<b>53</b>	<b>Section 5: Analysing the Adolescence Education Programme</b>
54	Addressing content: Sex and Sexuality
60	Reviewing implementation of the AEP
<b>65</b>	<b>Section 6: SE Programmes Led by Non-Government Actors</b>
66	NGO-led programmes
70	School-led SE programmes
<b>73</b>	<b>Section 7: Looking Ahead</b>
74	Some pointers to the way forward
80	Conclusion

# ACRONYMS

<b>AEP</b>	Adolescence Education Programme
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARROW</b>	Asian-Pacific Resource and Research Centre for Women
<b>ARSH</b>	Adolescent Reproductive and Sexual Health
<b>AYSRHR</b>	Adolescent and Youth Sexual and Reproductive Health and Rights
<b>CBSE</b>	Central Board of Secondary Education
<b>CEDAW</b>	Convention on the Elimination of All Forms of Discrimination Against Women
<b>CEDPA</b>	India, now called Centre for Catalyzing Change (C3)
<b>CPD</b>	Commission on Population and Development
<b>CSE</b>	Comprehensive Sexuality Education
<b>CSW</b>	Commission on the Status of Women
<b>DoE</b>	Department of Education
<b>FPAI</b>	Family Planning Association of India
<b>GoJ</b>	Government of Jharkhand
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRC</b>	Human Rights Council
<b>ICPD</b>	International Conference on Population and Development
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights
<b>IPC</b>	Indian Penal Code
<b>IPPF</b>	International Planned Parenthood Federation
<b>ITGSE</b>	International Technical Guidance on Sexuality Education
<b>JNVs</b>	Jawahar Navodaya Vidyalayas
<b>JSACS</b>	Jharkhand State AIDS Control Society
<b>KVS</b>	Kendriya Vidyalaya Sangathan
<b>LGBTIQA+</b>	Lesbian Gay Bisexual Transgender Intersex Queer Asexual and all other sexualities, sexes and genders
<b>MHRD</b>	Ministry of Human Resources Development
<b>MDG</b>	Millennium Development Goals
<b>NACO</b>	National AIDS Control Organisation
<b>NHP</b>	National Health Policy
<b>NCERT</b>	National Council of Education Research and Training
<b>NGO</b>	Non-governmental Organisation
<b>NIOS</b>	National Institute of Open Learning
<b>NPEP</b>	National Population Education Programme
<b>NPP</b>	National Population Policy
<b>NVS</b>	Navodaya Vidyalaya Samiti
<b>PoA</b>	Programme of Action
<b>POCSO</b>	Protection Of Children from Sexual Offences (Act)
<b>PWD</b>	People with Disabilities
<b>RGSEAG</b>	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
<b>RKSK</b>	Rashtriya Kishor Swasthya Karyakram
<b>RTIs</b>	Reproductive Tract Infections
<b>SCERTs</b>	State Councils of Educational Research and Training
<b>SEAP</b>	School AIDS Education Programme

<b>SEHER</b>	Strengthening the Evidence base on effective scHool based intErventions for pRomoting adolescent health
<b>SHAPE</b>	School HeAlth Promotion and Empowerment
<b>SOGIE</b>	Sexual Orientation and Gender Identity and Expression
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>SRR</b>	Sexual and Reproductive Rights
<b>SRI</b>	Sexual Rights Initiative
<b>STDs</b>	Sexually Transmitted Diseases
<b>STIs</b>	Sexually Transmitted Infections
<b>TARSHI</b>	Talking About Reproductive and Sexual Health Issues
<b>TYPF</b>	The YP Foundation
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UN</b>	United Nations
<b>UNCRC</b>	United Nations Convention on the Rights of the Child
<b>UNCRPD</b>	United Nations Convention on the Rights of Persons with Disabilities
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Fund
<b>UNESCO</b>	United Nations Organisation for Education, Science and Culture
<b>WHO</b>	World Health Organisation

# OVERVIEW

Comprehensive Sexuality Education (CSE) in India is highly contested territory, with political controversies and social conservatism negatively impacting attempts to institutionalise and sustain it within public education and health systems. As with sexuality in general, there are many layers of inhibitions, fears, and misconceptions that get transferred to Sexuality Education (SE), especially when it comes to talking about Sexual Health, Sexual Rights, an understanding of the diversity and fluidity of sexuality, and the need to empower adolescents and young people<sup>1</sup> to exercise agency over their bodies. Limited political will, inadequate training, insufficient support systems, and the lack of disaggregated data on the Sexual and Reproductive Health and Rights (SRHR) of adolescents and young people<sup>2</sup> pose challenges to ensuring effective CSE programmes.

Does ‘Sexuality Education’ mean the same as ‘Comprehensive Sexuality Education’? Advocacy to push for a more ‘comprehensive’ approach to SE has come from wanting to make sure selective topics within CSE curricula do not get pushed aside based on political convenience and the perceived readiness of the environment to take on sensitive topics. The trajectory of CSE in the country is fraught with tension. The issue of the ‘comprehensiveness’ of SE is also reflected in discomfort around naming Sexuality Education programmes as such. It is locked in the debate that on the one hand, what does not get named, often does not get counted and indeed, funded in the public context. On the other, that an incremental approach to implementing CSE curricula should also be flexible about what the programme is called, to create more public acceptance for it. Does it matter if SE programmes are not called CSE but are referred to in the context of life skills or family planning as long as the curriculum addresses the core topics within CSE?

In this paper, we document the evolving nature and status of SE in India, its historical context and current status. There is a lack of disaggregated, consolidated and cohesive documentation on the status of SE in India. We review the main governmental SE programme at the time of researching and writing this paper, known as the Adolescence Education Programme (AEP), as well as discuss some programmes offered by some non-governmental organisations, for their perspectives, content and impact. The paper examines how SE is currently understood, whether the current programmes are comprehensive, and to what degree they are so. Gaps and challenges have been identified on this basis, with recommendations on possible ways forward.

As an organisation working on issues of gender, sexuality and rights, we are deeply concerned by the limited CSE available for young people in India. The motivation for this paper lies in TARSHI’s belief that CSE is vital to ensuring adolescents’ and young people’s health and rights today. There is a need to understand what it is that makes SE comprehensive and why such an approach is essential, in order to clarify strategies that

---

1 Census of the Government of India describes young people/youth as within the age bracket of 15-24 years of age. Adolescents are further categorised in the 10-19 years age bracket. Collectively, adolescents and young people refer to 10-24 years of age.

2 For the purposes of this paper, adolescents and young people are defined as between the ages of 10-19 (WHO, United Nations) and 15-29 years of age (India’s National Youth Policy, 2014), respectively.

will work in scaling the access and quality of this information. In our work we have come across a range of curricula around Sexual and Reproductive Health (SRH) and SE, and we have come to realise that there is no common, coherent understanding of CSE. This paper builds an understanding of SE and CSE that is rooted in a rights-based perspective, proposing what should be non-negotiable content for CSE programmes in India, even as we recognise the diversity of socio-cultural contexts within the country.

It is beyond the scope of this paper to collate and analyse all the SE programmes in the country, since there are many variations of these, implemented piecemeal by both State and non-State actors. Due to practical constraints, this paper explores only in-school programmes. While out-of-school SE programmes are extremely important, and reference has been made to the Ministry Of Health and Family Welfare's (MOHFW) National Adolescent Health Programme or *Rashtriya Kishor Swasthya Karyakram* (RKSK), it is beyond the scope of this paper to review these vast initiatives. The paper also does not assess the role and contributions of current youth-and-adolescent-led endeavours in the school-based landscape. This is due to both time and resource constraints even while we acknowledge the importance of youth and adolescents themselves in ensuring SE programmes are successful. Therefore, this is not a comprehensive review of SE in India, but is part of a growing, dynamic and open body of knowledge. TARSHI welcomes contributions and feedback to strengthen this effort.

## **SECTION 1**

# **Understanding Sexuality Education**

There are two distinct directions in approaches to SE today: abstinence-only, and comprehensive. In this section we explain how SE is usually defined and what it entails after defining relevant terms like sexuality and Sexual Rights. We take a closer look at CSE, determining what it means and why it matters, including an understanding of the status of SRHR of adolescents and young people in India. This is to establish the context within which CSE must be implemented. Through this section we seek to arrive at an understanding of SE and CSE rooted in a rights-based approach within a framework of feminist principles.

## Defining terms

Despite several national and international advances in recognising young people's need for and rights to SE – most often located within young people's Right to Education and Health – there remains no globally agreed-upon definition of SE between governments, or binding agreement to implement it. The contention in defining SE lies in different cultural interpretations of the agency of adolescents and young people, in the context of their sexuality and their ability to make informed decisions. There are also disagreements on the extent of agency that should be attributed, prescribed or permitted to this demographic. As a result, the majority of global health agreements that reference the need for SRH information, respond to conservative approaches to SRHR by grounding SE in disease and violence prevention and family planning, rather than health promotion strategies.

The World Health Organisation's (WHO) Draft Working Definition (2006) states that **sexuality** is:

*a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.*<sup>3</sup>

In this definition, sexuality is recognised as far more than reproduction or a physical need. Rather, it is characterised as an important and multi-faceted dimension of people's lives. Definitions of sexuality as well as an understanding of the role it plays across the spectrum of human experience is a complex subject, often considered taboo and surrounded by layers of shame and misinformation. It is therefore vital that children, adolescents and young people receive adequate and accurate information on sexuality to lead informed, empowered and healthy lives. This was also highlighted by the UN

---

<sup>3</sup> WORLD HEALTH ORGANISATION. 2006. *Defining Sexual Health: Report of A Technical Consultation On Sexual Health*. Retrieved from [http://www.who.int/reproductivehealth/publications/sexual\\_health/defining\\_sexual\\_health.pdf](http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf)



Special Rapporteur on the Right to Education in 2010, locating CSE as integral to the Right to Education<sup>4</sup>.

**Reproductive Health** is defined by the WHO as

*a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.*

In 1994, the International Conference on Population and Development (ICPD) arrived at a landmark agreement in defining and advancing the commitments that these rights ensured for men, women and young people. The ICPD Programme of Action (PoA) speaks of **Reproductive Rights** as

*embrac[ing] certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.<sup>5</sup>*

The ICPD PoA recognised that people have individual rights to control their reproductive choices as part of ensuring their health and wellbeing, and made commitments to providing SE and counselling for young people. This included universal access to SRH information, education and services. This was also reinforced in the Global Youth Forum of the ICPD in 2012 in Bali, Indonesia, where young people called on governments to “create enabling environments and policies to ensure that they have access to comprehensive sexuality education in formal and non-formal settings, through reducing barriers and allocating adequate budgets.”

Whilst this understanding of Reproductive Rights emerged out of the conference in the 1990s and was considered path-breaking for its time, it has since needed to evolve

---

4 UNITED NATIONS GENERAL ASSEMBLY. 2010. *Report of the United Nations Special Rapporteur on the right to education*. UN Doc. A/65/162. Retrieved from <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N10/462/13/PDF/N1046213.pdf?OpenElement>

5 UNITED NATIONS POPULATION INFORMATION NETWORK (POPIN). 1994. *Report of the International Conference on Population and Development (ICPD). Programme of Action*, UN Doc. A/CONF.171/13 1994, chap. 7.A. Retrieved from <http://www.un.org/popin/icpd/conference/offeng/poa.html>

given the changing realities of adolescence and young adulthood. The articulation and definition of Reproductive Rights has primarily addressed married couples, especially women in their childbearing years and failed to adequately address the issues of fertility regulation in law, for example, abortion still being criminalised in several countries. Whilst discourse around Reproductive Rights since the conference has evolved, steps to advance women's and young people's SRHR in many countries continue to be constrained by legal systems and political opposition.

The WHO defines **Sexual Health** as

*a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.<sup>6</sup>*

**Sexual Rights** are concerned with a person's sexuality, such as the right to one's sexuality, the right to **not** be discriminated against based on one's gender or sexual identity, and the right to be free from violence or coercion in one's sexual life<sup>7</sup>. Sexual Rights often intersect with other human rights, such as the right to privacy and the right to equality and non-discrimination<sup>8</sup>, and include the right to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive, and impart information related to sexuality;
- Sexuality Education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children;
- pursue a satisfying, safe, and pleasurable sexual life.<sup>9</sup>

The term 'Sexual Rights' involves thinking about sexuality as a human right. The 20-year review of the ICPD led to a landmark review of the PoA, with regional declarations that both recognised and highlighted the need to advance investments in SRHR. The review in Latin America, called the Montevideo Consensus of August 2013 was the first United Nations agreement by governments to include a definition of sexual rights as those

6 WORLD HEALTH ORGANISATION. 2006. *Defining Sexual Health*.

7 What are Sexual Rights? Retrieved from <http://sexualrightsinitiative.com/sexual-rights/intro-to-sexual-rights/>

8 For an extensive list on the agreed-upon Human Rights that are crucial for sexual health, see WORLD HEALTH ORGANISATION. 2006. *Defining Sexual Health*.

9 WORLD POPULATION FOUNDATION. 2009. *Evidence and Rights-Based Planning & Support Tool for SRHR/HIV Prevention Interventions for Young People*. Retrieved from [https://www.rutgers.international/sites/rutgersorg/files/pdf/Planning\\_support\\_tool\\_EN.pdf](https://www.rutgers.international/sites/rutgersorg/files/pdf/Planning_support_tool_EN.pdf)

rights “which embrace the right to a safe and full sex life, as well as the right to take free, informed, voluntary and responsible decisions on their sexuality, sexual orientation and gender identity, without coercion, discrimination or violence.” It upheld the rights of adolescents and young people to youth-friendly and confidential SRH services and to “enable young people to have a responsible, pleasurable and healthy sex life<sup>10</sup>”.

SE is understood within the broad umbrella package of, and is delivered within the context of SRHR. SRHR is framed as a critical component of ensuring the universal right to the highest attainable standard of physical and mental health, as defined in the Universal Declaration of Human Rights (UDHR). Human rights are universal agreements on every human’s entitlements and freedoms to live a life with dignity<sup>11</sup>. SRHR are meant for all people and are part of the human rights standards that states are obligated to promote, protect and fulfil. They embrace an affirmative approach with respect to SE. This implies looking at sexuality as a positive and important part of life, framed in the context of pleasure, intimacy, and enjoyment, rather than exclusively focusing on disease and the prevention of violence<sup>12</sup>.

## What is Comprehensive Sexuality Education?

UNESCO defines SE as “an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information”<sup>13</sup>. The revised version of the International Technical Guidance on Sexuality Education (ITGSE) developed by UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO advances this definition of CSE:

*a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.<sup>14</sup>*

The United Nations Special Rapporteur on the Right to Education asserted that SE is part of the Right to Education, which is a human right that needs to be secured for all

10 UNFPA. (2013, August 15). *Population Conference Adopts Montevideo Consensus of Wide-Ranging Priority Actions on Reproductive Health, Gender Equality, Young People*. Retrieved from <https://www.unfpa.org/press/population-conference-adopts-montevideo-consensus-wide-ranging-priority-actions-reproductive>

11 Universal Declaration of Human Rights. Retrieved from <http://www.un.org/en/universal-declaration-human-rights/>

12 CHANDIRAMANI, R. 2007. Why Affirm Sexuality? *ARROW For Change*, 13, (2). Retrieved from [http://arrow.org.my/wp-content/uploads/2015/04/AFC-No.13-No.2-2007\\_Affirmative-Sexuality.pdf](http://arrow.org.my/wp-content/uploads/2015/04/AFC-No.13-No.2-2007_Affirmative-Sexuality.pdf)

13 UNESCO. 2009. *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators*. (Vol. 1).

14 UNESCO. 2018. *International technical guidance on sexuality education. An evidence-informed approach. Revised edition*. Retrieved from [http://www.unaids.org/sites/default/files/media\\_asset/ITGSE\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf)

young people<sup>15</sup>. Given that all children, adolescents and young people are not likely to be able to access adequate and good quality SE at home, it has been argued that SE needs to be instituted within the school system and integrated within the range of health services made available for adolescents and young people. For those who do not go to school, education on sexuality should be integrated into non-formal education and vocational courses.

In the West, support for SE began in the late 1800s in the United States, in response to disease-prevention public campaigns that promoted an approach to ‘regulate sexuality’ in response to cholera and syphilis epidemics<sup>16</sup>. This response was further globally heightened during the HIV and AIDS crises of the 1980s and 1990s. SE was developed in the 19th century as part of the progressive education movement. The starting point of SE was a discussion and education about ‘social hygiene’ that was developed and expanded to sex education in schools<sup>17</sup>. The conventional and traditional understanding of SE is often around issues of human sexuality, human sexual anatomy, sexual reproduction and sexual activity. More recently, globally, the gender and sexuality rights discourse has expanded the scope and understanding of SE.

As mentioned previously, one can identify two types of approaches to SE today: the abstinence-only approach, and the comprehensive approach. The abstinence-only approach focuses on reproductive health, and advocates for sexual abstinence until marriage as the primary way of practicing safer sex, and advocates the benefits of this. The emergence of this approach is linked to concerns about addressing teenage pregnancy and later HIV and AIDS. The Adolescence Family Life Act (AFLA), authorised in 1981 in the United States, is an example of one of the first grants for what was eventually called ‘abstinence-only’ programming, mandated as a ‘family centred’ alternative to contraceptive counselling and services to teenagers, with the stated goal of promoting ‘chastity’ and self discipline<sup>18</sup>.

However, several reviews of global evidence, such as *Emerging Answers 2007*<sup>19</sup>, a comprehensive review of sex and HIV education programmes by Douglas Kirby for the National Campaign to Prevent Teen and Unplanned Pregnancy, have identified that there is no “strong evidence that any abstinence programme delays the initiation of sex, hastens the return to abstinence or reduces the number of sexual partners”<sup>20</sup>.

---

15 UNITED NATIONS GENERAL ASSEMBLY. 2010. *Report of the United Nations Special Rapporteur on the right to education*. UN Doc. A/65/162. Retrieved from <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N10/462/13/PDF/N1046213.pdf?OpenElement>

16 BASS, B. 2016. *The Effect of State Mandated Sex Education on Teenage Sexual Behaviors and Health*. © 2016 by Economic Self-Sufficiency Policy Research Institute. Retrieved from <https://www.esspri.uci.edu/files/docs/2016/ESSPRI%20Working%20Paper%2020161%20Brittany%20Bass.pdf>

17 ZILVERSMIT, A. (n.d.). *Progressive Education*. Retrieved from <http://www.encyclopedia.chicagohistory.org/pages/1012.html>

18 BOONSTRA H.D. 2009. *Advocates Call for a New Approach After the Era of ‘Abstinence-Only Sex Education’*. *Guttmacher Policy Review*, 12, (1). Retrieved from <https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/12/1/gpr120106.pdf>

19 KIRBY, D. 2007. *Emerging Answers 2007: New Research Findings on Programmes to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. ISBN: 1-58671-070-2. © 2007 by The National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from <https://powertodecide.org/sites/default/files/resources/primary-download/emerging-answers.pdf>

20 Ibid.

While some abstinence-only programmes do not mention contraceptives at all, there are others that discuss them openly without encouraging their use, while still others denounce their use; some programmes may be religious whereas others are not<sup>21</sup>. The premise for most abstinence-only programmes is largely a fear-based perspective, arguing that young people need to be protected from ‘bad’ influences and disease. As Boonstra said in the Guttmacher Policy Review, “this kind of education has become increasingly marginalized, as several well-designed studies conducted over the last 15 years have shown just how futile the focus on stopping young people from having sex is”<sup>22</sup>.

The other approach, which is termed ‘comprehensive’, is more recent and is rooted in a rights-based perspective and language. It recognises the agency and rights of young people to make their own informed decisions. It acknowledges that young people may or may not engage in sexual behaviour and sexual activity, and thus strives to provide adequate information regarding safer sex practices<sup>23</sup>. Based on the premise of providing medically accurate information, it goes beyond providing information and education on reproductive health, and addresses issues relating to right to sexuality, builds life skills and aims to increase responsible human behaviour. A study published by the U.S. Center for Disease Control and Prevention in the *Journal of Adolescent Health* highlighted that ‘sex education’ did not decrease the age of first sex but had, in some cases, increased it<sup>24</sup>. Research additionally has shown that abstinence-only education can actually put young people at increased risk of pregnancy and Sexually Transmitted Infections (STIs)<sup>25</sup>. The diversity of opinions on the intent of SE has influenced the development of a wide variety of SE programmes and policies, often making it challenging to neatly place programmes within either approach.

## What makes Sexuality Education ‘comprehensive’?

The lack of understanding and consensus upon a definition of CSE and what it comprises leads to a variety of programmes that differ greatly in their approach, perspective and conceptualisation of SE. This also impacts what is prioritised, monitored and evaluated across SE programmes.

In the first edition of the ITGSE<sup>26</sup>, CSE is described as including age-appropriate information for children and young adults throughout school-going age, and featuring at least four components:

---

21 KIRBY, D. (2008). The impact of abstinence and comprehensive sex and STD/HIV education programmes on adolescent sexual behavior. *Sexuality Research and Social Policy*, 5, (3), 18-27.

22 BOONSTRA H.D. 2011. Advancing Sexuality Education in Developing Countries: Evidence and Implications. *Guttmacher Policy Review*, 14, (3). Retrieved from <https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/14/3/gpr140317.pdf>

23 Ibid.

24 Sex education found to help teenagers delay sex. (2007. December 20). *Reuters*. Retrieved from <https://www.reuters.com/article/us-sex-teens/sex-education-found-to-help-teenagers-delay-sex-idUSN1960794920071219>

25 ROSENBAUM, J. 2009. Patient teenagers? A comparison of the sexual behaviour of virginity pledgers and matched no pledgers, *Paediatrics*, 123,(1), 110–120.

26 UNESCO. 2009. *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators*. Vol 2. Retrieved from <https://unesdoc.unesco.org/ark:/48223/pf0000183281>

1. Information about human sexuality
2. Values, attitudes, and social norms
3. Interpersonal and relationship skills
4. Responsibility

The revised edition of the ITGSE expands these topics into eight key concepts, that are ‘mutually reinforcing’ and evolve through a curriculum with increasing complexity. These are:

1. Relationships
2. Values, Rights, Culture and Sexuality
3. Understanding Gender
4. Violence and Staying Safe
5. Skills for Health and Well-being
6. The Human Body and Development
7. Sexuality and Sexual Behaviour
8. Sexual and Reproductive Health

It provides additional analysis around how to understand what makes SE programmes comprehensive. In particular, that it should meet the conditions of being scientifically accurate, incremental in building upon information through a ‘spiral-curriculum’ approach, age and developmentally appropriate, curriculum-based, comprehensive in the range of SRHR information it provides, based on gender equality, culturally relevant and context appropriate, a transformative approach to developing compassion, critical thinking skills and citizenship and developing life skills to support healthy choices<sup>27</sup>.

According to the International Planned Parenthood Federation (IPPF)<sup>28</sup>:

*a rights-based approach to Comprehensive Sexuality Education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views ‘sexuality’ holistically and within the context of emotional and social development. It recognises that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values.*

IPPF further describes seven basic elements that comprise CSE:

1. Gender (with a focus on difference between gender and sex, gender roles, gender identities and the changing value of gender in people’s lives)
2. SRH and HIV (focusing on sexual anatomy, relationships, conception, reproduction, contraception, abortion, sexually transmitted infections including HIV etc.)
3. Sexual citizenship rights (knowledge of international human rights related to sexuality as well as national laws and policies that affect people’s sexuality)

<sup>27</sup> UNESCO. 2018. *International Technical Guidance on Sexuality Education: An Evidence Informed Approach*.

<sup>28</sup> INTERNATIONAL PLANNED PARENTHOOD FEDERATION. 2008. *Sexual Rights: An IPPF Declaration*.

and rights)

4. Pleasure (focusing on issues of consent, choice and the understanding that sexuality should be enjoyable and not forced)
5. Freedom from violence (focusing on gender-based violence and non-consensual sex, national laws and policies against violence)
6. Diversity (developing respect for difference)
7. Relationships (looking at power dynamics, communication, honesty and trust in relationships including sexual relationships)

While there are multiple approaches to defining CSE, some common agreements across them can be observed:

- For SE to be considered comprehensive, it needs to move beyond providing knowledge and information, towards addressing values, attitudes, and skills.
- CSE does not use a fear-based approach but instead an affirmative/ sex-positive approach that recognises the centrality of human sexuality in young people's entitlement and enjoyment of their bodily rights.
- CSE employs a rights-based approach that believes that all individuals (including young people) should be able to take informed decisions free of coercion, stigma and discrimination.
- For CSE to be effective, information must be adapted to the needs of different cultures and age groups, paying attention to additional factors that inform them, such as the diversity of sexual choices, sexual orientation and identity, disability, the exposure to and impact of gender-based violence, especially in situations of poverty and/or conflict and humanitarian settings amongst others.

There are varied perspectives on what information is considered age-appropriate and culturally sensitive and it has been challenging to standardise this. In such a scenario a rights-based approach advocates the need for an individual's agency to make informed decisions and choices for themselves. In order to do so effectively, information is delivered such that it is responsive to the development needs of children, adolescents and young people, taking into account their lived realities and cognitive learning abilities.

## **SECTION 2**

# **Why Comprehensive Sexuality Education?**



In this section we present the case for investing in CSE in India, by examining data on a range of sexuality related indicators for adolescents. We then explore how CSE could help address issues highlighted by the data, as well as bust some myths around what Sexuality Education entails.

## **An overview of adolescents and young people in the context of SRHR in India**

India has a large youth population. According to the 2011 Census, India has 253 million adolescents in the age group of 10-19, and 232 million young people aged 15-24<sup>29</sup>. These groups account for 40% of the population, making the country a young nation. Here, we highlight significant trends and facts that are important when addressing the question, 'Why invest in CSE?' using data from various sources, including the 2011 Census, the 2015-16 National Family Health Survey (NFHS-4)<sup>30</sup> and other research.

### **Puberty begins earlier in people's lifetime**

Menarche, the beginning of menstrual function, is a significant milestone in the adolescent girl's life cycle. While the age of menarche varies from 9-18 years, there is documented evidence of earlier onset among girls in urban India<sup>31</sup> as well as in rural India, with field health workers reporting instances of girls as young as 10 years reaching menarche<sup>32</sup>. Globally, it is also reported that boys are hitting puberty a year earlier<sup>33</sup>. While there is currently no clear data available for India, it is suggested that this is the case in our country, too<sup>34</sup>. With the early onset of menarche and the lack of education about the physiological changes occurring in their bodies, adolescents are put in a vulnerable situation<sup>35</sup>.

### **Early and forced marriage is still prevalent**

Despite laws in India that restrict early marriage, almost half of all women<sup>36</sup> aged 20–24 were married by 18, as recently as 2006. Though this trend is on the decline, with

---

29 CENSUS OF INDIA. 2011. Adolescents and Youth in India: Highlights from Census 2011. Retrieved from [http://www.censusindia.gov.in/2011-Documents/PPT\\_World\\_Population/Adolescents\\_and\\_Youth\\_in\\_India\\_Highlights\\_from\\_Census\\_2011.pptx](http://www.censusindia.gov.in/2011-Documents/PPT_World_Population/Adolescents_and_Youth_in_India_Highlights_from_Census_2011.pptx)

30 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) AND ICF. 2017. *National Family Health Survey (NFHS-4) 2015-16*. © 2017 by International Institute for Population Sciences. Retrieved from <http://rchiips.org/NFHS/NFHS-4Reports/India.pdf>

31 ANI. (2018, July 09). Early puberty in girls, a growing trend in cities. *ANI News*. <https://www.aninews.in/videos/Health/early-puberty-girls-growing-trend-cities/>

32 UNESCO. 2014. *Good policy and practice in HIV & AIDS & education Booklet 9 Puberty education & menstrual hygiene management*. Retrieved from <https://asanteafrica.org/wp-content/uploads/2018/03/UNESCO-Puberty-rpt.pdf>

33 ANI. (2010, December 08). Boys hitting puberty a year earlier: Study. *Indian Express*. Retrieved from <http://archive.indianexpress.com/news/boys-hitting-puberty-a-year-earlier-study/721912/>

34 KHADILKAR, V. V., STANHOPE, R. G., & KHADILKAR, V. (2006). 'Secular Trends in Puberty?' *Indian Pediatrics*, 43, (1), 475.

35 GHOSH, A. (2012, July 2). Early puberty on rise in rural areas, govt plans counselling. *The Indian Express*. Retrieved from <http://archive.indianexpress.com/news/early-puberty-on-rise-in-rural-areas-govt-plans-counselling/969164/>

36 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES & MACRO INTERNATIONAL. 2007. *National Family Health Survey (NFHS-3), 2005–06: India. (Vol. 1)*. ©2007 by International Institute for Population Sciences. Retrieved from <https://dhsprogram.com/pubs/pdf/frind3/frind3-vol1andvol2.pdf>

27% women reported as being married before the age of 18 by the NFHS-4 data, the absolute numbers remain staggeringly high at approximately 2 million girls<sup>37</sup>. There are more instances of child marriage in rural areas (where around 48% of currently married women in the age group of 20-24 got married before they turned 18) than in urban areas (29%)<sup>38</sup>. Given low contraceptive awareness, early marriage increases the risk of adolescent pregnancy, with a higher-rate of pregnancy-related complications, including mortality<sup>39</sup>. According to a 2012 UN study, almost 20% of women aged 20-24 had their first child before they were 18<sup>40</sup>.

### **Sex happens early; even outside marriage**

Data focusing on if and when young people are having sex is largely defined around the point of marriage (pre-marital sex, or sex within marriage or outside of it). This is problematic as it limits understanding the diverse contexts and realities within which young people are sexually active, in addition to presenting data as largely heterosexist. Reflecting on the limitations of data collection in this context is important to be able to accurately understand and address educational needs young people have. Despite strict socio-cultural norms in Indian society, research shows that sexual relationships outside marriages do occur. In one study, 11% of young men and 5% of young women aged 15-24 were reported to have had premarital sex during adolescence<sup>41</sup>.

Data from NFHS-4 supports these findings, although the reality that these figures represent may need to be questioned because socio-cultural norms and the stigma attached to sex and sexuality may lead to under-reporting, particularly in the case of women:

- The median age of women (25-49 years) at first sexual intercourse is 19 years; 11% of women in this age group had sexual intercourse when they were not yet 15 years old and 39% when they were not yet 18 years old.
- 59% of women have had sexual intercourse by the time they were 20 years old, and interestingly, average age of men at first sexual intercourse is about five years older than women, at 24.3 years of age. Only 1% of men in the 25-49 age group had sexual intercourse before they were 15 years old and only 7% before the age of 18.
- NFHS-4 data also reveals that in the age range of 15-24 years, 3% of 'never-married women' and 11% of 'never-married men' have ever had sexual intercourse.

---

37 CENSUS OF INDIA. 2011. Adolescents and Youth in India: Highlights from Census 2011 [Dataset 'C-6 Ever Married And Currently Married Population By Age At Marriage, Duration Of Marriage And Educational Level - 2011']. Retrieved from <http://www.censusindia.gov.in/2011census/C-series/c-6.html>

38 MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA 2010. *District Level Household and Facility Survey 2007-08*. ©2010 by Ministry of Health and Family Welfare, Government of India. Retrieved from <https://mohfw.gov.in/sites/default/files/DLHS%20III.pdf>

39 ROY, M.P. 2017. Nutrition in adolescent girls in South Asia. *BMJ*, 357, (j1309).

40 UNICEF. 2012. *Child Marriage in India: An Analysis of Available Data*. Retrieved from [https://www.ecoi.net/en/file/local/1016041/1930\\_1386771388\\_childmarriage.pdf](https://www.ecoi.net/en/file/local/1016041/1930_1386771388_childmarriage.pdf)

41 SANTHYA, K.G., ACHARYA, R., JEJEEBHOY, S.J. and RAM, U. 2011. Timing of first sex before marriage and its correlates: evidence from India, *Culture, Health & Sexuality*, 13, (3).

## Sex is often linked with abuse

Indian Institute of Population Sciences (IIPS) and Population Council's comprehensive study *Youth in India: Situation and Needs*<sup>42</sup> was carried out in six states of India – Andhra Pradesh, Bihar, Jharkhand, Maharashtra, Rajasthan and Tamil Nadu – and represented about two-fifths of the country's youth from across geographic and socio-cultural regions. For 15% of young women who reported being sexually active before marriage, their first encounter was forced, with 14% sharing it was 'persuaded'. Alternatively, 21% of young men who were unmarried reported having ever 'deliberately touched or brushed past a woman' in a sexual way, with 4% reporting having experienced a similar unwanted touch. It also reports that 25% and 21% of sexually experienced men and women who are 15-24 years old, respectively, had engaged in sex with multiple partners. Moreover, consistent condom use was limited – only 13% of young men and 3% of young women reported condom use in all 'premarital encounters'.

Research also reveals that for a majority of young people, the first time they have sex, it is likely unprotected and for a sizeable proportion of young women, forced<sup>43</sup>. Nearly one in five young men who were married admitted forcing their wives to have sex with them, and one-third of married young women reported experiencing forced sex within marriage<sup>44</sup>. There is limited understanding of consent as well as negotiation skills for young people to both give consent to and refuse sexual experiences.

NFHS-4 data adds more context to violence experienced by women. About 30% women have experienced physical violence since age 15, and 6% have ever experienced sexual violence in their lifetime. In the case of spousal violence, physical violence is the most common at 30%, followed by emotional violence at 14%, while findings show that only 7% of 'ever married women' have experienced spousal sexual violence. According to the report: "The percentage of women who ever experienced one or more of the three types of spousal violence by their current or most recent husband declined in the 10 years since NFHS-3. Overall, violence declined from 37% in NFHS-3 to 31% in NFHS-4. However, there has been no decline in the percentage of women who experienced spousal physical or sexual violence in the 12 months preceding each survey (24% in both NFHS-3 and NFHS-4)."

## Child Sexual Abuse

The fear of social stigma discourages individuals and families from reporting instances of sexual abuse, despite well-documented evidence showing that child sexual abuse can have a negative impact on the overall physical, mental, and emotional wellbeing of children, adolescents, and young people. A study conducted among 211 school-going children in Chennai by Tulir – Center for the Prevention and Healing of Child Sexual Abuse in 2006 identified a CSA prevalence rate of 42%, where the vulnerability of

---

42 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES and POPULATION COUNCIL 2010. *Youth in India: Situation and Needs 2006–2007*. © 2010 by Ministry of Health and Family Welfare, Government of India.

Retrieved from [https://www.popcouncil.org/uploads/pdfs/2010PGY\\_YouthInIndiaReport.pdf](https://www.popcouncil.org/uploads/pdfs/2010PGY_YouthInIndiaReport.pdf)

43 SANTHYA, K.G., ACHARYA, R., JEJEBHOY, S.J. and RAM, U. 2011. Timing of first sex before marriage and its correlates: evidence from India. *Culture, Health & Sexuality*, 13, (3).

44 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES and POPULATION COUNCIL 2010. *Youth in India: Situation and Needs 2006–2007*.

children was at par irrespective of their socio-economic status<sup>45</sup>. The 2007 National Study on Child Abuse initiated by the Ministry of Women and Child Development (MWCD) assessed the magnitude of the problem among children, adolescents, and young people in 13 states in India<sup>46</sup>. The study revealed that from the data collected from over 12,000 children, 53% children had faced one or more forms of sexual abuse; out of the total child respondents, 6% reported being sexually assaulted<sup>47</sup>; of those who said they were sexually abused, 57% were boys, highlighting children's vulnerability to sexual abuse irrespective of their gender. The study further revealed that 50% of the abusers were known to the child or were in a position of trust and responsibility. Whilst these statistics have not been updated since, the National Crime Records Bureau conducted a survey in 2016 that concluded that 'Crimes Against Children', including kidnapping, abduction and child rape cases recorded under the POCSO Act were on the rise (rising from 21% in 2015 to 24% in 2016)<sup>48</sup>. Given the magnitude of sexual abuse taking place in India, providing children and adolescents accurate information about their rights and their bodies can help reduce discrimination, increase their confidence and communication skills to report violations and articulate consent, and help position them in an empowered rather than vulnerable context.

### Challenges around HIV and AIDS persist

The NFHS-4 data reveals the following facts on HIV and AIDS:

- In the age group of 15 to 49, 58% women and 74% men “know that limiting sexual intercourse to one uninfected partner who has no other partners” can reduce the risk of HIV infection.
- Overall, 47% of women and 69% of men know that consistent condom use and only having sex with one uninfected partner can prevent HIV infection. There is a significant gender gap in such knowledge.

The National AIDS Control Organisation (NACO) estimates that unprotected (heterosexual) sex remains the major route for HIV transmission, accounting for 87% of transmission amongst individuals in 2015-16<sup>49</sup>. India has the third highest number of people living with HIV in the world. Despite a 32% decline in new HIV infections (to 80,000 new infections in 2016), 35% of AIDS cases are reported among people below 25 years of age and 50% of new infections are reported in young people between 15 and 24 years of age<sup>50</sup>. The substantial decrease in funding for HIV prevention, treatment

---

45 Tulir (Center for the prevention & healing of the child sexual abuse). (n.d.) Retrieved from <http://www.tulir.org/service&programs.htm>

46 KACKER, D., VARADAN, S., & KUMAR, P. 2007. *Study on Child Abuse INDIA 2007*. ©2007 Ministry of Women and Child Development, Government of India. Retrieved from <https://www.childlineindia.org.in/pdf/MWCD-Child-Abuse-Report.pdf>

47 Ibid. Defined as “making the child fondle private parts, making the child exhibit private body parts, and being photographed in the nude.”

48 NATIONAL CRIME RECORDS BUREAU 2017. *Crime in India*. ©2017 by National Crime Records Bureau. Retrieved from <http://ncrb.gov.in/StatPublications/CII/CII2016/pdfs/NEWPDFs/Crime%20in%20India%20-%202016%20Complete%20PDF%20291117.pdf>

49 NACO. 2015. *India HIV Estimations 2015*. Retrieved from <http://www.naco.gov.in/sites/default/files/India%20HIV%20Estimations%202015.pdf>

50 HIV/AIDS in India. Retrieved from <http://unicef.in/Story/601/HIVAIDS-in-India>

and care programmes, with domestic funding for HIV falling overall by 22% from 2014-15 to 2015-16<sup>51</sup>, also highlights the urgency to invest in CSE.

### **Little knowledge about SRH**

Although young people in India are assailed with information on sex and sexuality from popular media and other sources, these sources are often not accurate or reliable. Documented evidence and research shows poor levels of awareness about SRHR among young people in India. The IIPS and Population Council Youth in India study<sup>52</sup>, which surveyed 50,848 married and unmarried people, reiterated that while young people face significant risks related to SRH, they lack the knowledge and power to make informed SRH choices. Almost half of the young women and one-sixth of the young men interviewed noted that they had never received any information on sexual matters. The study showed limited awareness on most SRH matters, including safer sex practices, STIs and HIV, and contraception.

Both the Youth in India study and NFHS-4 data show that accurate knowledge and comprehensive awareness of modern contraception including emergency contraception is limited. NFHS-4 data on contraception shows that 36% of 'currently married women' in the age range of 15-49 use female sterilisation, 6% of male partners use condoms and 4% use pills. Knowledge of emergency contraception is limited to less than 50% of currently married persons (42% women and 48% men). The NFHS-4 report also states: "Three in eight men believe that contraception is women's business and that man should not have to worry about it" and "Twenty percent of men believe that a woman who uses contraception may become promiscuous."

The Youth in India study also highlighted that young women are particularly vulnerable. 3 out of 10 young men and 4 out of 10 young women did not know that 18 years is the legal age of marriage for women and 21 for men. Leading sources of information on sexual matters have been found to be peers and the media. The study found that young people were overwhelmingly in favour of provision of Family Life Education (FLE) or SE (83% of young men and 78% of young women). The findings also suggested that young people who had undergone Family Life Education or SE were indeed more knowledgeable about sexual and reproductive matters than those not exposed to it.

### **Lack of awareness around safe abortion**

Safe abortion services remain elusive for adolescent girls and young women, particularly those from underprivileged and marginalised communities in India. Despite abortion being legal in India, a woman dies every two hours because an abortion goes wrong<sup>53</sup>. India is home to the highest number of maternal deaths in the world, and 50% of

---

51 HIV and AIDS in India. Retrieved from <https://www.avert.org/professionals/hiv-around-world/asia-pacific/india>

52 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES and POPULATION COUNCIL 2010. Youth in India: Situation and Needs 2006–2007.

53 WION (2017. February 21). Trump's decision to deny US funding to foreign NGOs will affect women in India. WION. Retrieved from <http://www.wionews.com/south-asia/trumps-decision-to-deny-us-funding-to-foreign-ngos-will-affect-women-in-india-12640>

these fatalities are in the 19-24 age group<sup>54</sup>. A review of the experiences of unmarried young women between the ages of 15 and 24 in Bihar and Jharkhand seeking an abortion concluded that SE programmes for young women in both in- and out-of-school settings should provide information on the link between a missed period and an unintended pregnancy, the importance of obtaining an early abortion if the pregnancy is unwanted and knowledge of laws that entitle women to terminating a pregnancy in India<sup>55</sup>. SE curriculum that does not incorporate such information falls short of being comprehensive.

### **Additional challenges of transgender youth**

According to the 2011 Census, there are nearly half a million transgender people in India, with actual numbers likely to be higher. There is both external and internalised stigma attached to people with gender identities that do not conform to the norm. The education system seems to have little knowledge about transgender people, as is shown in *Bioscope: Non-Binary Conversations on Education and Gender*, a documentary made by Nirantar<sup>56</sup>. The documentary traces the lives of four transgender people in Kolkata, Bangalore, and Mumbai. All of them narrated the abuse (physical and psychological) they faced from teachers and fellow students, because they were seen as being not 'normal'. Such violence in school settings often leads to transgender children being pushed out of school<sup>57</sup>.

It is also important to let young people know about the range of diverse gender expressions that exist, to build values of acceptance and the freedom to decide and define their gender expressions free from bias and societal constructions. In April 2014, the Supreme Court in *National Legal Services Authority v. Union of India & Others* (the NALSA judgment) affirmed the constitutional rights of transgender persons, including those who identify as third gender and those who identify as a gender different from the gender they were given at birth – such as a person who is assigned the gender female at birth, but who identifies as a man. By recognising diverse gender identities, the Court has disrupted the gender binary, which previously was present in every part of Indian law. Discrimination in the areas of public employment, health care, education, and access to services will be open to challenge and redress.

Whilst the NALSA judgment provided directions on affirmative action to ensure that public health and social welfare services are made available to transgender people, the spirit of the judgment is yet to be recognised, with transgender people still struggling to access self-identification. This is despite a Supreme Court judgment that mandated an expert committee constituted by the Central government, to implement

---

54 BARNAGARWALA, T. (2014. May 7). India has highest number of maternal deaths. *Indian Express*. Retrieved from <https://indianexpress.com/article/india/india-others/india-has-highest-number-of-maternal-deaths/>

55 KALYANWALA, S., ZAVIER, A.J.F., JEJEEBHOY, S., KUMAR, R. (2010). Experiences of Unmarried Young Women In India: Evidence from a Facility-Based Study In Bihar and Jharkhand. *International Perspectives on Sexual and Reproductive Health*, 36, (2).

56 NIRANTAR RESOURCE CENTRE. (2017, June 16). *Bioscope: Non-Binary Conversations Of Gender And Education [Video file]*. Retrieved from <https://www.youtube.com/watch?v=OfxjrMYxs7E>

57 BHATTACHARYA, B. (2014. January 24). 'Thinking outside the box.' *The Hindu*. Retrieved from: <https://www.thehindu.com/features/cinema/thinking-outside-the-box/article5614727.ece>

recommendations within six months. The Transgender Persons (Protection of Rights) Bill 2016<sup>58</sup> was introduced in 2016 in the Lok Sabha and was referred to a Standing Committee soon after. In July 2017, the Parliamentary Standing Committee on Social Justice collated feedback and presented its report to the Ministry of Social Justice and Empowerment (MSJE), who in turn submitted it to the government. In November 2017, MSJE appeared to reject<sup>59</sup> all recommendations made by the committee, with plans to reintroduce the bill in its original form, without changes. Civil society protests resulted in the ministry altering the definition of ‘transgender’ in the bill from the original “someone who was neither wholly female nor wholly male or a combination of female or male; or neither female nor male” to mean “a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), person with intersex variations, genderqueer and person having such socio-cultural identities as kinner, hijra, aravani and jogta”<sup>60</sup>. However, it retained problematic provisions such as the requirement of a screening committee to decide whether a person is transgender, criminalising begging, insufficient provisions for opportunities in education, employment or healthcare and lack of recognition of ‘found family’<sup>61</sup>. The bill which was passed by the Lok Sabha in 2018, and was pending in the Rajya Sabha, has since lapsed due to dissolution of the Rajya Sabha<sup>62</sup>.

### **Youth with disabilities are further discriminated against**

Young people with disabilities face several additional challenges. They are often stereotyped as being either non-sexual or hypersexual<sup>63</sup>. It is often wrongly also assumed that people with disabilities can never have ‘real’ sex, which is viewed as penetrative intercourse culminating in an orgasm. Another common misconception is that sex must involve vigorous physical activity. Sex includes a wide range of behaviours and interactions, and in any case, different people have different preferences, based on several factors. Such assumptions lead people to conclude that people with disabilities do not need SE, including information on how to stay sexually healthy, safe and happy. Often they are excluded from awareness programmes on HIV and AIDS. Sadly, many people with disabilities also believe that sex is not meant for them. The TARSHI working paper, *Sexuality and Disability in the Indian Context*, 2018, presents concepts and

---

58 The Transgender Persons (Protection of Rights) Bill, 2016. Retrieved from [https://www.prsindia.org/sites/default/files/bill\\_files/Transgender\\_Persons\\_Bill%2C\\_2016\\_1.pdf](https://www.prsindia.org/sites/default/files/bill_files/Transgender_Persons_Bill%2C_2016_1.pdf)

59 NAIR, S. (2017. November 19). Transgender rights: House panel proposed, govt rejects. *The Indian Express*. Retrieved from <https://indianexpress.com/article/india/transgender-rights-house-panel-proposed-govt-rejects-4944199/>

60 The Transgender Persons (Protection Of Rights) Bill, 2018. Retrieved from [https://www.prsindia.org/sites/default/files/bill\\_files/Transgender%20persons%20bill%20as%20passed%20by%20LS.pdf](https://www.prsindia.org/sites/default/files/bill_files/Transgender%20persons%20bill%20as%20passed%20by%20LS.pdf)

61 ANASUYA, S.I. and D’MELLO, B. (2018. December 27). How 3 bills violate the rights of the very people they seek to empower. *The Print*. Retrieved from [https://theprint.in/opinion/how-3-bills-violate-the-rights-of-the-very-people-they-seek-to-empower/169515/?fbclid=IwAR2yS-MqDqEFmy9L2lXp37uggrgNPNluarJ5mJHQFw7F\\_uwbT5Ya0HiT\\_w](https://theprint.in/opinion/how-3-bills-violate-the-rights-of-the-very-people-they-seek-to-empower/169515/?fbclid=IwAR2yS-MqDqEFmy9L2lXp37uggrgNPNluarJ5mJHQFw7F_uwbT5Ya0HiT_w)

62 SEBASTIAN, M. (2019. February 14). Triple Talaq, Citizenship, Aadhaar Bills Lapse As Rajya Sabha Adjourns Sine Die. *Live Law.in*. Retrieved from <https://www.livelow.in/news-updates/triple-talaq-citizenship-aadhaar-bills-lapse-as-rajya-sabha-adjourns-sine-die-142883>

63 TARSHI. 2018. *Sexuality and Disability in the Indian Context*. Retrieved from [http://www.tarshi.net/downloads/Sexuality\\_and\\_Disability\\_in\\_the\\_Indian\\_Context.pdf](http://www.tarshi.net/downloads/Sexuality_and_Disability_in_the_Indian_Context.pdf)

perspectives on disability that actively challenge those that by and large prevail. As stated in this paper:

*Attitudes to sexuality education in schools are a huge barrier. Under these circumstances it becomes very difficult to speak of sexuality in the context of children with disabilities. It has also been noticed that where information on sexuality is provided to children or young people with disabilities, it is restricted to information on menstrual management and hygiene for girls and about prevention of abuse. Information about safer sex, contraception and other sexual and reproductive health concerns is not given as it is often thought of as irrelevant for people with disabilities. The 2017 report of the UN Special Rapporteur on the Rights of Persons with Disabilities, affirms the importance of sexuality education and specifically identifies this as one of the key factors for implementing sexual and reproductive health and rights of girls and young women with disabilities<sup>64</sup>.*

## **Mental Health**

A lack of coping mechanisms and life skills in adolescents and young people to address peer pressure, social isolation, substance abuse and addiction, challenges with managing relationships, unemployment, cyber bullying and grief, are often accompanied by an inability to ask for help and support when needed. This is further exacerbated by a lack of adequately trained mental health professionals as well as a lack of awareness in society and communities of the importance of creating strong mental health support networks. CSE is critical in this context to develop self-esteem and confidence<sup>65</sup>, as well as develop coping mechanisms that do not cause further harm. India currently accounts for almost a fifth of global suicides, with 34% of suicides taking place in the age group of 15-29, one of the highest in the world<sup>66</sup>. The Mental Health Care Act, 2017 is considered a landmark legislation and decriminalises attempt to suicide. It also provides a number of legal safeguards for people living with mental illness. However, there remain challenges both in operationalising this legislation and limited investments in advancing good mental health practises and incorporating them within broader health and wellbeing programmes, including SE efforts. CSE can help individuals devise healthy (rather than harmful) ways to cope with and address pressure and anxiety in their daily lives. Additionally, there is a need to sensitise community health workers and teachers, and build their capacities to address these inter-linkages in their existing work.

## **Young people have questions and incorrect information around sexuality**

A cross-sectional survey conducted in 2017 amongst 1,022 adolescent students aged 14-19 in government and private schools of Chandigarh by the Indian Council of Medical

---

64 Ibid.

65 KEENAN, L. (2008. January 26). Case for sex education in schools. *The Hindu*. Retrieved from <https://www.thehindu.com/todays-paper/tp-opinion/Case-for-sex-education-in-schools/article15151577.ece>

66 SAHA, D. (2017. May 8). 'Every hour, one student commits suicide in India'. *Hindustan Times*. Retrieved from: <https://www.hindustantimes.com/health-and-fitness/every-hour-one-student-commits-suicide-in-india/story-7UFFhSs6h1HNgrNO60FZ2O.html>.



Research (ICMR), highlighted that the sexual behaviour of adolescents is changing, with an increasing awareness of sex, as well as a higher likelihood of undertaking 'risk behaviours'<sup>67</sup>. Whilst 33% wanted discussions about sex to be frank, 70% felt the need for 'sex education' and wanted it to be delivered by qualified medical staff. 89% reported exposure to material on sex, 75% were aware of sexual intercourse, with 96% of participants able to identify one form of contraception (95% identified condoms and 67% knew of emergency contraception). Avoidance/abstinence from sex (85%), faithfulness to one partner (82%), and use of barrier methods (90%) were the main reported preventive measures for STIs. Only 3% of all respondents had consulted doctors for medical advice when needed and not more than 6% had reported problems or questions they had related to sex. However, beyond sex and sexuality, this age cohort navigates several inter-linked challenges in their daily lives that make them particularly vulnerable.

### Findings from TARSHI's experience

The TARSHI Helpline ran successfully from 1996 to 2009, providing information, counselling and referrals on sexuality and SRH related concerns to people from all walks of life and was recognised by UNAIDS as one of four international helplines in their Best Practice Collection<sup>68</sup>. Findings from over 60,000 calls on the TARSHI helpline revealed that information related to contraception was one of the highest concerns in the age range of 20-24 (35%)<sup>69</sup>. In addition, a number of callers, including young unmarried callers, inquired about safer sex issues and abortion services<sup>70</sup>. This shows that a number of young, unmarried people are sexually active, whether or not it is sanctioned by various sections of society.

The following are questions asked by students in TARSHI workshops in schools. These sessions were held in the early 2000s, in mixed groups with students aged 10-18:

- What is night fall?
- Why do we have periods?
- What are the side effects of masturbation? Does one get any disease by masturbating?
- What is the difference between homosexual and gay?
- What type of urinary system do eunuchs have?
- How do two boys have sex?
- I have white fluid coming out of my vagina. Is it normal?
- What does loss of virginity mean? And how does it happen?
- How many orgasms can a woman have in one session of intercourse?
- Does body weight have an effect on regularity of periods?

---

67 BAKSHI, R., KUMAR, D., GOEL, N., SHARMA, M., and GHOSH, A. 2017. Sexual behavior of adolescent students in Chandigarh and their perceptions regarding family life education. *Journal Of Family Medicine And Primary Care*, 6, (2).

68 UNAIDS. 2002. *HIV/AIDS counselling, just a phone call away: Four case studies of telephone hotline/helpline projects*. ISBN 92-9173-202-8. Retrieved from [http://www.tarshi.net/downloads/helpline\\_casestudies.pdf](http://www.tarshi.net/downloads/helpline_casestudies.pdf)

69 TARSHI. 2007. *Talking about sexuality: A Report of Preliminary Findings From the TARSHI Helpline*. Retrieved from [http://www.tarshi.net/downloads/tarshi\\_helpline\\_report.pdf](http://www.tarshi.net/downloads/tarshi_helpline_report.pdf)

70 CHANDIRAMANI, R. 1998. Talking about sex. *Reproductive Health Matters*, 6, (12), 76-86. Retrieved from <https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2898%2990010-6?needAccess=true>

- Does masturbation make you weak?
- Is it safe to have sex right after having abortion? If not, then when is the right time?

It is important to see this in the context of often mistaken assumptions around children and young people and their engagement with matters of sexuality.

*The figures highlighted in this sub-section call for an urgent need for CSE to prepare young people to be able to take informed and responsible decisions with respect to their sexual and reproductive lives.*

## **How can Comprehensive Sexuality Education help?**

CSE provides adolescents and young people with the information to understand bodily integrity, consent, ways of identifying and protecting themselves from violence, as well as a comprehensive approach to contraception. For adolescent girls and young women, it contributes to ensuring their reproductive rights, and can strengthen education, health, economic and livelihood assets that challenge gender norms and cultural barriers. Beyond the objective of empowering young people's agency is the argument that CSE is a transformational, positive and proactive investment in advancing and ensuring adolescents and young people's health, which equips them to live just and healthy lives. CSE creates a safe, positive, non-judgemental space for children, adolescents and young people to access information in an age appropriate manner, based on evidence rather than morality.

Additionally, CSE enables young people to develop leadership and life skills to understand their rights, challenge patriarchal systems and advocate for social justice. This approach to investing in SE also strengthens different kinds of economic, social and cultural assets that benefit young people, especially women and girls across their life cycle.

CSE is effective because it takes into account that sexuality and human development relate to all aspects of our lives, and must be understood in the context of the environment a person lives in. Multiple factors such as poverty, religion, caste, climate change, migrant status, disability, HIV status, gender, all impact the kind of SRH information and services that people need, including how they can access these. SE also needs to be cognizant of, and address barriers to access in cases where adolescents are minors and parental consent is required, and where social and cultural barriers restrict accessibility to SRH information and services.

SE programmes have been found to increase self-confidence, access to information and in some cases, mobility. The YP Foundation's *Shareer Apna, Adhikaar Apne* or Know Your Body, Know Your Rights programme on CSE reviewed improvements in SRH and life skills of young people in 14 villages across Lucknow and Jhansi districts in Uttar Pradesh over a period of two years (2013-15). Data collected as part of the project showed that advancing the leadership of young women and girls increased their mobility in the community and ability to address challenges such as early and forced marriage, gender based violence and in some cases, opportunities for employment and vocational training. Parents of peer educators played a key role in shifting from being gatekeepers to enabling their children's participation in the programme, recognising

that the programme increased their access to information. This also significantly increased the number of young people who enrolled in formal education throughout the programme. By working with frontline health workers such as ASHA, Anganwadi and ANM workers, the mobility of girls increased during this time, with frontline health workers advocating for CSE with parents and *panchayat* representatives.

## Myths and Facts

Despite evidence on the pressing need for CSE in the country, social discomfort in addressing questions of sexuality at large, a lack of understanding and acceptance of diverse sexual and gender identities and expression, and public denial that adolescents and young people may be sexually active, has amplified the association of SE programmes with notions of shame and anxiety. This also leads to myths and misconceptions about sexuality and SE that are dangerous and can promote misinformation and further limit public support to SE programmes and result in a lack of political will. In this section, we discuss the most common myths and misconceptions, and present evidence to dispel them.

### **Myth: Children are too young to understand this kind of information.**

One major opposition to SE comes from people who think that children are too young to hear, learn, and talk about sexuality as it might overwhelm or frighten them. Such an anxiety stems from the misconception that matters relating to sexuality are exclusively a part of adult life. Children are usually curious about their own bodies and sexuality<sup>71</sup>. This myth is often based on the belief that SE is exclusively about teaching children to have sex/intercourse. Such a perception stems from a limited understanding of sexuality. As discussed earlier, sexuality includes a whole range of experiences – from body image to anatomy to pleasure to gender expression. SE programmes need to be comprehensive, and provide a safe space for children and adolescents to talk about and develop confidence about their bodies, share their feelings and understand consent. This is important to establish a culture where children are able to recognise violence and abuse and are comfortable speaking up about and reporting these<sup>72</sup> without fear and judgment. The concern that the topic might overwhelm children is understandable, which is why a key idea of CSE is to provide information through an incremental process that matches their development needs and capacities. The aim of CSE is to provide children and adolescents a non-judgmental space to discuss their questions, learn information, values, and skills that are relevant to their lived experiences, and that satisfy their curiosity.

### **Myth: Children mature and process information differently, so CSE can never be appropriate for all.**

This myth is related to the above-mentioned belief that children are too young to

---

71 ALVES, G. (2014. July 27). Three Letter Word: How do we tell the children? *Indian Express*. Retrieved from <https://indianexpress.com/article/lifestyle/three-letter-word-how-do-we-tell-the-children/>

72 JEJEEBHOY, S. (2017. September 22). Why we must talk to children about sex. *Live Mint*. Retrieved from <https://www.livemint.com/Opinion/wl9KCHidKU0AxHG4s97LCI/Why-we-must-talk-to-children-about-sex.html>

know about sexuality. While it is true that people mature differently, both biologically and emotionally, this does not mean that CSE would be inappropriate or irrelevant for those children who mature later on. A well-conceptualised and carefully designed and implemented CSE programme can be adapted to meet the different needs of different children. A crucial aspect of CSE is that it works through operationalising the notion of acceptance. Young people are often afraid of being seen as ‘not normal’ if they do not develop at the same pace as their peers, or because of their body type and image, and so on<sup>73</sup>. Thus, CSE is designed keeping in mind that it is appropriate to provide different groups of children (based on age and other factors like disability), a safe space to understand their bodies and needs, and voice their fears and worries. It is also important to let them know that the way they experience their own development is both personal and normal, as are their feelings. CSE also needs to address the diversity of sexual and gender identity and expression.

### **Myth: CSE corrupts children, adolescents and young people and encourages irresponsible behaviour.**

The reasoning behind this myth is that if CSE gives young people information about sexuality, young people will ‘experiment’ with what they learned in class; therefore, young people should be kept away from ‘bad ideas’. This articulation of young people being ‘irresponsible’ and exposed to ‘bad ideas’ stems from a deep-rooted patriarchal anxiety around sexuality, especially young people’s sexuality.

This myth reflects a misconception of what CSE actually is. CSE is not about teaching children to have sex. It is about providing children, adolescents and young people accurate, age-appropriate and positive information, skills, and values around sex and sexuality, bodies, gender, sexual and reproductive health, HIV and AIDS, pleasure, diversity, and relationships. Contrary to this myth, evidence shows that CSE that is age-appropriate, gender-sensitive and life-skills-based, can provide young people with the knowledge, skills and values to make informed decisions about their own sexuality and lifestyle<sup>74</sup>. It is possible that for many people this is itself a threatening possibility as it redistributes control in unequal power equations. Myths such as this one may be perpetuated by some people who desire to maintain the unequal and unjust status quo because it suits them to do so.

### **Myth: CSE encourages teens to have sex and be ‘promiscuous’.**

As mentioned above, CSE is meant to create a positive, non-judgmental space to talk about sexuality – something that young people are perhaps already thinking about<sup>75</sup>. Several studies in different settings have demonstrated that CSE in fact leads to young people *delaying* their first sexual intercourse<sup>76</sup>. CSE, by its very definition, is

---

73 DOHNT, H.K. and TIGGEMANN, M. 2004. Development of Perceived Body Size and Dieting Awareness in Young Girls. *Perceptual and Motor Skills*, 99, (3), 790-792.

74 Comprehensive Sexuality Education. (n.d.). Retrieved from <https://www.unfpa.org/comprehensive-sexuality-education>

75 RAO, S.T., ISMAIL, S., SHAJAHAN, A. and WYLIE, K. 2015. Adolescent sex education in India: Current perspectives. *Indian Journal of Psychiatry*, 57, (4), 333.

76 GRUNSEIT, A., KLIPPAX, S., AGGLETON, P., BALDO, M. and SLUTKIN, G. (1997). Sexuality Education and Young People’s Sexual Behavior: A Review of Studies. *Journal of Adolescent Research*, 12, (4), 421-453.

concerned about people's physical and emotional wellbeing. This means it encourages young people to use appropriate protection, if and when they have sex with others, and that they only engage in consensual sexual relationships. It does not promote any type of relationship, sexual or otherwise<sup>77</sup>. On the contrary, it equips young people to make choices that contribute to their overall wellbeing. Besides, evidence points in the opposite direction to the myth. It has been observed that students who took part in a CSE programme were reported to have fewer sexual partners than those who were not in the CSE programme<sup>78</sup>.

### **Myth: Sexuality education leads to an increase in teenage pregnancies.**

Interestingly, research that aims to study the effect of SE programmes usually shows that they have a tendency to lead to a decrease in teenage pregnancies – and in risky sexual behaviour and HIV infections<sup>79</sup>. For instance, a study commissioned by UNESCO in Estonia (we could unfortunately not find any similar studies closer to home) showed a steep decrease in unintended pregnancies, STIs, and HIV infections over the course of eight years during which an SE programme was implemented for students in Grades 5-7. This decline was attributed to the programme<sup>80</sup>. SE is aimed at increasing young people's understanding and use of contraception, as well as informed consent, so that if and when they choose to be sexually active, they are informed and prepared.

### **Myth: Abstinence-only programmes are more effective than CSE.**

In a review study of 56 different SE programmes including eight abstinence-based programmes in the USA, it was found that abstinence-only programmes are not successful in delaying adolescents' sexual debut<sup>81</sup>. On the contrary, they tend to expose young people to greater risks because young people who pledge virginity until marriage are as likely to have sex as those who do not, and are less likely to practice safer sex when they do become sexually active<sup>82</sup>. On the other hand, out of the 48 CSE programmes that were part of the study, nearly half of the programmes showed a higher instance of delayed initiation of sex, a quarter reduced the frequency of sex, and nearly half reduced the number of sexual partners<sup>83</sup>. No study on CSE programmes has found evidence that providing young people with sexual and reproductive health information and education results in increased sexual risk-taking. Instead these studies demonstrate that CSE programmes delay sexual initiation and increase contraception usage<sup>84</sup>. In countries of South Asia, the prevalence of early marriage implies that many young people are sexually active. In addition, as highlighted earlier, young people often

---

77 VENKATRAMAN, S. (2017, October 23). Why India Needs Sex Education. *NDTV*. Retrieved from <https://everylifecounts.ndtv.com/india-needs-sex-education-17422>

78 KIRBY, D. 2007. *Emerging Answers 2007*

79 BOONSTRA H.D. 2011. *Advancing Sexuality Education in Developing Countries: Evidence and Implications*.

80 UNESCO. 2011. *School-Based Sexuality Education Programmes: A Cost and Cost-Effectiveness Analysis in Six Countries*. Retrieved from <http://unesdoc.unesco.org/images/0021/002116/211604e.pdf>

81 KIRBY, D. 2008. The impact of abstinence and comprehensive sex and STD/HIV education programmes on adolescent sexual behavior.

82 BOONSTRA H.D. 2011. *Advancing Sexuality Education in Developing Countries: Evidence and Implications*.

83 KIRBY, D. 2008. The impact of abstinence and comprehensive sex and STD/HIV education programmes on adolescent sexual behavior.

84 BOONSTRA H.D. 2011. *Advancing Sexuality Education in Developing Countries: Evidence and Implications*.

have sex before marriage. Contrary to popular belief, providing young people with holistic information is not confusing but “can be realistic and effective”, especially since it is closer to young people’s lived realities<sup>85</sup>. Information both empowers and educates them to make independent and informed decisions<sup>86</sup>.

**Myth: CSE is just about population control.**

As we will discuss ahead, programmes driven by the aim to control human population do indeed exist<sup>87</sup>. However, CSE is not developed with this idea in mind but from a rights-based, affirmative perspective where human rights and the wellbeing of young people is the main focus of the programme. It is grounded in the belief that providing comprehensive education and access to information empowers young people to exercise control over their own bodies and their own lives.

**Myth: Sexuality education should be in the hands of the parents, not the schools.**

The problem with leaving SE to parents is that they usually do not take it up with their children and often, children, adolescents and young people are not comfortable asking questions about sex and sexuality in their homes<sup>88</sup>. Often, the parents TARSHI has interacted with, have spoken of feeling that they lack the information and skills to approach topics related to sexuality with their children. However, CSE can lead to better intergenerational dialogue about sexuality at home, as research has shown<sup>89</sup>. In order to make sure that all young people get the information and skills they need to live empowered, healthy lives and challenge unjust social norms and attitudes, it is necessary to make CSE widely available in public spaces and not just limit the delivery of this information within private spaces.

**Myth: Young people will pick up what they need to know.**

While it is true that children and adolescents constantly pick up messages about sexuality coming from the media, their friends and peers, and by observing the behaviour of those around them, this does not mean that they pick up accurate information<sup>90</sup>. On the contrary, many of these messages are flawed, exploitative, based on misinformation and biases. They are dangerous to young people’s development. The pervasive presence of inaccurate and misleading sexuality messages is precisely the reason why CSE is needed.

---

85 Ibid.

86 Ibid.

87 COUSINS, S. (2017. April 13). Beyond sterilisation: the need for sex education and contraceptives in India. *Guardian*. Retrieved from <https://www.theguardian.com/global-development-professionals-network/2017/apr/13/sterilisation-family-planning-contraception-india>

88 NEWS18.com. (2016, June 30). Presenting A New Web Series About Indian Parents’ Worst Nightmare: Sex Education. *News 18*. Retrieved from <http://www.news18.com/news/buzz/presenting-a-new-web-series-about-indian-parents-worst-nightmare-sex-education-1264159.html>

89 WILSON, E.K., DALBERTH, B.T., KOO, H.P., and GARD, J.C. 2010. Parents’ Perspectives on Talking To Preteen Age Children about Sex. *Perspectives on Sexual and Reproductive Health*, 42,(1), 56-63.

90 WICKI, O. (2015. August 20). From Parents to Principals, Sex Education should be must have discussion. *Nagpur Today*. Retrieved from <https://www.nagpurtoday.in/from-parents-to-principals-sex-education-should-be-must-have-discussion/08200924>

## **Myth: CSE is a Western idea and doesn't conform to Indian values.**

Some argue that CSE is a 'westernised concept'<sup>91</sup> that does not conform to traditional cultural and societal norms of Indian society<sup>92</sup>. However, communication about sex and sexuality has been very present in Indian culture with literary texts both ancient and modern that speak of sexuality, sculpture and art explicitly depicting sexual diversity and our contemporary, highly sexualised mass media<sup>93</sup>. CSE today is essential for children, adolescents and young people to develop critical thinking skills that help them process the deluge of information they receive. Social and popular media can often lead to distorted perceptions and misapprehensions in the minds of young people. Ideally, this information should be freely available across one's life cycle for all people<sup>94</sup>.

## **In summary: Key facts regarding CSE**

1. CSE is rooted in a rights-based approach, which recognises children, adolescents and young people as having personhood and therefore, the right to make their own choices. They may or may not be sexually active but have a right to access both information and services that ensure they understand their SRHR.
2. Children are never too young to learn about sex and sexuality. From ages 5 and upwards, they have a right to learn about issues related to sexuality that are relevant to their lives, in an age-appropriate manner.
3. CSE educates and informs young people on their sexuality and sexual rights, encouraging them to make empowered decisions regarding their sexuality, sexual expression, sexual health and reproductive health.
4. Information provided as part of CSE can help protect from unwanted pregnancies and infection, leading to a decrease in teenage pregnancies and HIV infection. It empowers young people against negative experiences of violence and abuse.
5. Young people need CSE to learn important life skills to be able to make their own healthy choices. CSE believes in an 'empower' rather than a 'protect and save' approach. It engages young people as central stakeholders in defining and creating a learning environment that promotes their leadership.
6. CSE acknowledges specific group identities and their vulnerabilities and needs, such as gender, ethnic, and caste groups, LGBTIQ+, and people with disabilities.
7. Omitting selective topics from CSE often perpetuates misinformation and negative taboos, making SE less effective in the long run.

---

91 EXPRESS NEWS SERVICE (2014. June 27). Sex education and condoms land Harsh Vardhan into 'unhealthy' controversy. *The Indian Express*. Retrieved from <https://indianexpress.com/article/india/india-others/how-sex-education-and-condoms-land-harsh-varadhan-into-unhealthy-controversy/>

92 JOSHI, V. (2015. February 14). Sex education will pollute young minds: RSS ideologue Dinanath Batra. *Hindustan Times*. Retrieved from <https://www.hindustantimes.com/india/sex-education-will-pollute-young-minds-rss-ideologue-dinanath-batra/story-Axqokcmh0MQbmq8W9K7zM.html>

93 IANS. (2015. June 10). Rising porn addiction in Indian youth worrying: Experts. *India Today*. Retrieved from <https://www.indiatoday.in/india/story/porn-addiction-in-indian-youth-worrying-256643-2015-06-10>

94 GHOSHAL, S. (2016. October 24). You Are A Bigger Problem Than Sex Education If You're Offended By It. *Huffington Post*. Retrieved from [http://www.huffingtonpost.in/2016/10/24/you-are-a-bigger-problem-than-sex-education-if-youre-offended-b\\_a\\_21590256/](http://www.huffingtonpost.in/2016/10/24/you-are-a-bigger-problem-than-sex-education-if-youre-offended-b_a_21590256/)

## **SECTION 3**

# **Sexuality Education: A Global Perspective**



We take a brief look at CSE within the UN framework to place the context for CSE in India, focusing on key, related global agreements. Political legitimacy to implement CSE is both created and strengthened in global agreements, as these create important cues for what indicators are measured, and thus what development issues member states are willing to be held accountable for. This chapter presents a historical perspective to enable an understanding of what is now a global movement towards adopting a comprehensive approach to SE over the recent decades.

Globally, there is an increasing emphasis on the need for rights-based SE programmes that are grounded in the realities of young people, and engage various stakeholders, including governments, families, and young people themselves<sup>95</sup>. The adoption of a rights-based approach to CSE, which views it as integral to Sexual and Reproductive Rights (SRR) and Human Rights, represents an important shift in development practice. Historically, SE has been framed by the need to control and influence population dynamics, an idea first noted in the 1974 World Population Conference in Bucharest, where member states recognised the role that social development had in population growth by reducing fertility and discussed the need for programmes that addressed development and population control.

It led to a number of countries developing population policies, including India – some of which was coercive. The United States’ Mexico City Policy, often referred to as the Global Gag Rule, which brought a strong anti-abortion stance to development politics and funding, impacted the global family planning movement as it meant that NGOs could not access US funding for family planning if they used funds from other countries to “perform or actively promote abortion as a method of family planning”<sup>96</sup>. The Policy has been rescinded and reinstated many times in the 35 years since, and is in effect as of 2019.

By the mid 1990s the ICPD PoA heralded a global approach to population policies that broadened from a focus on population control to SRHR. This shift also made linkages with the need to advance women’s rights, reduce inequalities and address poverty and environmental concerns<sup>97</sup>.

Subsequently, the Millennium Development Goals (MDGs) influenced the lack of investments in CSE between 2002 and 2015, because SRHR was left out of the framework. MDG 2 related to universal primary education primarily focussed on access to education, but left out the need for SE. MDG 5.B recognised the need to “achieve universal access to reproductive health” only in 2007<sup>98</sup>. The framework did not acknowledge that equipping young people with CSE could help develop life skills that contributed to achieving a wide range of MDGs, in particular MDG 3 (achieving gender

---

95 BOONSTRA H.D. 2011. *Advancing Sexuality Education in Developing Countries: Evidence and Implications*.

96 The Mexico City Policy: An Explainer. (2019. January 28). Retrieved from <https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/> and SIFFERLIN, A. (2017. January 23). Here’s What the Mexico City Policy Means for Women. *TIME*. Retrieved from <http://time.com/4644042/mexico-city-policy-abortion-womens-health/>

97 WESTENENG, J. and ROLINK, H. (2016). *Population Dynamics and Sexual and Reproductive Health and Rights - What, why and how to be addressed*. © 2016 by Rutgers. Retrieved from [https://www.rutgers.international/sites/rutgersorg/files/PDF/2016\\_Population\\_paper\\_Rutgers\\_auteurs.pdf](https://www.rutgers.international/sites/rutgersorg/files/PDF/2016_Population_paper_Rutgers_auteurs.pdf)

98 Ibid.

equality and empowering women), MDG 5 (reducing maternal mortality and morbidity) and MDG 6 (combating ‘HIV/AIDS’)<sup>99</sup>. The Sustainable Development Goals (SDGs) also do not explicitly spell the need for CSE, although SRHR has stronger focus in this framework.

## Global Agreements and Instruments related to SE

In the absence of international agreements on CSE until fairly recently, several global instruments have been interpreted to make a case for SE in schools, including the UDHR, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC)<sup>100</sup>.

Articles within these global instruments have informed other global agreements such as the ICPD, which took a paradigmatic shift away from family planning towards sexual rights. As a first, it put forth comprehensive definitions of Reproductive Health, Sexual Health and Family Planning, placing the autonomy of women and girls, and their control over their bodies, as central to advancing SRHR. The ICPD also made a strong case for CSE for young people in the context of gender equity in society and to realise Sexual Rights, especially those of young people. The PoA that emerged as an outcome, acknowledged for the first time, the links between women’s reproductive lives and gender equality and equity. It also stressed access to reproductive health services. Under its objective of universal access to quality education, the PoA called for the inclusion of gender-sensitive education on population issues, including reproductive choices. It recommended that SE begin in schools from the primary years and continue through all levels of formal and non-formal education, to enable adolescents to deal with their sexuality in a positive and responsible way.

A review of the ICPD PoA took place every five years – in 1999 (ICPD+5), 2004 (ICPD +10), 2009 (ICPD +15) and 2014 (ICPD +20) – to assess the progress that governments had made in addressing its agenda. In 2010, a UN General Assembly resolution called for an open-ended extension of the PoA and a review of progress by the General Assembly in 2014<sup>101</sup>.

ICPD+20 marked an important moment for the global health and education community, to both consolidate ground gained through existing inter-governmental commitments to SRHR and to identify opportunities to advance them. The ICPD Beyond 2014 Global Review Report<sup>102</sup> released by the UN stated “Comprehensive Sexuality Education (CSE), as part of in and out of school education, is recognised as an important strategy that

---

99 YOUTH COALITION. 2010. *The linkages between the MDGs and Comprehensive Sexuality Education for Young People*. Retrieved from [http://www.youthcoalition.org/wp-content/uploads/CSE\\_MDG\\_factsheet\\_webversion.pdf](http://www.youthcoalition.org/wp-content/uploads/CSE_MDG_factsheet_webversion.pdf)

100 UNITED NATIONS OHCHR. 1989. *Convention on the Rights of the Child*. Retrieved from <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

101 UNITED NATIONS. 2011. *Resolution adopted by the General Assembly on 22 December 2010*. Retrieved from [https://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/RES/65/234](https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/65/234)

102 UNFPA. 2011. *Framework of actions for the follow-up to the Programme of Action of the International Conference on Population and Development beyond 2014*. UN Doc. A/69/62. Retrieved from <https://www.unfpa.org/resources/a6962-framework-actions-follow-programme-action-international-conference-population-and>

empowers young people to make responsible and autonomous decisions about their sexuality and sexual and reproductive health". The report also suggested that rights-based and gender-sensitive CSE programmes could lead to greater gender equality, strengthen young people's individual resilience, and create conditions under which they are able to achieve their full potential. It stressed that this rights-based and gender sensitive approach to CSE would also lead to greater gender equality. The report, drawing from the needs and demands of the signatory states, strongly recommended universal access to comprehensive, quality, and integrated SRH, high-quality information, and services. The regional reviews of ICPD+20 that took place in Africa (The Addis Ababa Declaration on Population and Development in Africa Beyond 2014) and Latin America (The Montevideo Consensus on Population and Development 2013) secured important commitments recognising the need for SE.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), 2006, posits that:

*States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall: (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.<sup>103</sup>*

The Committee on Economic, Social and Cultural Rights General Comment No. 22 (2016) refers to the right to SRH as part of Article 12 of the ICESCR. This right to SRH, combined with the right to education (Articles 13 and 14) and the right to non-discrimination and equality between men and women (Articles 2 and 3), entails a right to education on sexuality and reproduction that is comprehensive, non-discriminatory, evidence-based, scientifically accurate and age appropriate.

Closer home, at the UN Sixth Asian and Pacific Population Conference held in September 2013<sup>104</sup>, the Asian and Pacific Ministerial Declaration on Population and Development, although not a negotiated document, was adopted in a landmark process in the region by 47 countries, recognising Sexual and Reproductive Rights as Human Rights that member states must respect, protect and fulfil. This included giving priority to implementing CSE programmes, respecting the SRHR of adolescents and young people, and removing legal and social barriers to youth-friendly SRH services. Governments in the region noted the importance and need of evidence-based CSE, age-appropriate and consistent with evolving capacities, for adolescents and young people to be able to make responsible and informed decisions, exercise their right to control all aspects of

103 UNITED NATIONS. 2006. *Convention on the rights of persons with disabilities and optional protocol*. Retrieved from <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

104 UNESCAP. 2014. *Report of the sixth Asian and Pacific Population Conference*. Retrieved from <https://www.unescap.org/sites/default/files/Report%20of%20APPC%202013.pdf>

their sexuality, and protect themselves from unintended pregnancy, unsafe abortion, HIV and STIs. CSE was also noted as being needed to promote tolerance, mutual respect and non-violence in relationships, and planning for their life. The conference called on Governments to design programmes and to ensure that sufficient resources were allocated to implement CSE programmes.

Global trends observed in recent years from resolutions at the Commission on Population and Development (CPD), The Commission on the Status of Women (CSW) and The Human Rights Council (HRC) at the United Nations reflect the struggle to advance intergovernmental commitment to SE. In 2012, a hard fought negotiation at the 45<sup>th</sup> session of the CPD on Adolescents and Youth<sup>105</sup> called on governments of several countries to “protect and promote human rights and fundamental freedoms regardless of age and marital status, including by eliminating all forms of discrimination against girls and women, and to protect the human rights of adolescents and youth to have control over and decide freely and responsibly on matters related to their sexuality”. The resolution taken here emphasised the need for evidence-based CSE with full respect for the privacy and confidentiality of young people, ensuring that CSE is free from discrimination, especially with respect to SRH, to enable young people to deal positively and responsibly with their sexuality. This was subsequently reaffirmed at the Rio+20 UN Conference on Sustainable Development<sup>106</sup>.

At the HRC, between 2015 and 2017, member states outlined the importance of CSE in some key resolutions, even if most did not explicitly mention CSE. The 2015 Resolution on strengthening efforts to prevent and eliminate child, early and forced marriage recognised the rights of all girls to have autonomous control over decision-making regarding their sexuality<sup>107</sup>, but did not provide an explicit reference to CSE. This changed in the 2016 resolution on Accelerating Efforts to Eliminate Violence Against Women: Preventing and Responding to Violence Against Women and Girls, Including Indigenous Women and Girls<sup>108</sup>. A mention of CSE in the 2017 resolution on Accelerating Efforts to Eliminate Violence against Women: Engaging Men and Boys in Preventing and Responding to Violence Against All Women and Girls<sup>109</sup> was removed after two countries moved against its inclusion<sup>110</sup>.

Commitments to advance CSE at the HRC are in contrast to the hostility and backlash

---

105 UNITED NATIONS COMMISSION ON POPULATION AND DEVELOPMENT. 2012. *Draft Resolution: Adolescents and Youth*. Retrieved from [https://indonesia.unfpa.org/sites/default/files/pub-pdf/CPD\\_45th\\_Session\\_Resolution\\_Adolescents\\_and\\_Youth.pdf](https://indonesia.unfpa.org/sites/default/files/pub-pdf/CPD_45th_Session_Resolution_Adolescents_and_Youth.pdf)

106 UNITED NATIONS. 2012. *The future we want*. UN Doc. 66/288. Retrieved from <https://sustainabledevelopment.un.org/futurewewant.html>

107 UNITED NATIONS HUMAN RIGHTS COUNCIL. 2015. *Strengthening efforts to prevent and eliminate child, early and forced marriage*. UN Doc. A/HRC/29/L.15. Retrieved from <https://digitallibrary.un.org/record/803360>

108 UNITED NATIONS HUMAN RIGHTS COUNCIL. 2016. *Accelerating efforts to eliminate violence against women: preventing and responding to violence against women and girls, including indigenous women and girls*. UN Doc. A/HRC/32/L.28/Rev.1. Retrieved from <https://digitallibrary.un.org/record/845742>

109 UNITED NATIONS HUMAN RIGHTS COUNCIL. 2017. *Accelerating efforts to eliminate violence against women: engaging men and boys in preventing and responding to violence against all women and girls*. UN Doc. A/HRC/RES/35/10. Retrieved from <https://www.right-docs.org/doc/a-hrc-res-35-10/>

110 UNITED NATIONS HUMAN RIGHTS COUNCIL. 2017. *Egypt, Russian Federation: \* amendment to draft resolution A/HRC/35/L.15*. UN Doc. A/HRC/35/L.40. Retrieved from [https://digitallibrary.un.org/record/1305323/files/A\\_HRC\\_35\\_L-40-EN.pdf](https://digitallibrary.un.org/record/1305323/files/A_HRC_35_L-40-EN.pdf)

that SRHR often receive in negotiation processes at the United Nations, brought by member states who advocate for rollbacks in commitments made. The 48<sup>th</sup> and 50<sup>th</sup> sessions of the CPD in 2015 and 2017, respectively, for example, closed without adopting a draft resolution through its negotiations, over member states' conflicting views and inability to commit to ensuring the SRHR of all people, including their access to information<sup>111</sup>. Negotiations fell apart over the notion that SRHR should be seen as “indivisible from Human Rights”, with CSE being seen as “critical to sustainable development” in “protecting the rights of women and girls and ensuring they can make informed decisions about their own bodies”, considered contentious by many member states who do not recognise or support sexual rights<sup>112</sup>.

The 2016 UN CSW<sup>113</sup> and The Political Declaration on HIV and AIDS<sup>114</sup> use very similar language in emphasising the importance of CSE in efforts to eliminate gender inequalities and gender-based violence. The CSW Resolution recognises that the successful implementation of CSE requires partnership between social as well as system stakeholders and political leadership from governments to be sustainable. The Political Declaration expects States to commit to efforts to scale up comprehensive education for providing adolescents and young people information on a range of SRH and sexuality-related issues “to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships... in order to enable them to protect themselves from HIV infection”.

## **SE in the Sustainable Development Goals (SDGs) and the Post 2015 Agenda**

The MDGs did not make substantive progress in advancing SRHR, but they set the stage for the SDGs to advance the implementation of CSE. The poor progress of the MDGs on CSE can be attributed to a number of factors, including political opposition and a lack of global acknowledgement of how SRHR was linked to achieving all eight MDGs. This recognition was first substantively made in 2007, when the role of SRHR was highlighted in achieving universal access to Reproductive Health by 2015 as a key indicator to achieve Goal 5 (on improving maternal health).

Interviews with experts for this paper highlighted the challenges of advocating to include CSE in the design and development of the SDGs. Civil society groups advocated to integrate SE as part of Goal 4 (Quality Education) to address Human Rights information; as part of Goal 3 (Good Health and Well-being) to address disease prevention and strengthen reproductive health; Goal 5 (Achieve Gender Equality and

---

111 Commission on Population and Development Unable to agree Upon Proposed Resolution, Reproductive Rights among Points of Contention. (2015. April 17). Retrieved from <https://www.un.org/press/en/2015/pop1041.doc.htm>

112 Commission on Population and Development Fails to Adopt Outcome Document as Fiftieth Session Concludes. (2017. April 7). Retrieved from <https://www.un.org/press/en/2017/pop1060.doc.htm>

113 UNITED NATIONS. Commission on the Status of Women. 2016. Report on the sixtieth session (20 March 2015 and 14-24 March 2016). UN Doc. E/2016/27-E/CN.6/2016/22. Retrieved from <http://undocs.org/E/2016/27-E/CN.6/2016/22>

114 UNITED NATIONS. 2016. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. UN Doc. A/RES/70/266. Retrieved from [http://www.unaids.org/sites/default/files/media\\_asset/2016-political-declaration-HIV-AIDS\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/2016-political-declaration-HIV-AIDS_en.pdf)

Empower All Women and Girls) and additionally, as part of Goal 10 (Reduced Inequality) to address the vulnerabilities and needs of specific populations. Given the political and cultural tensions that address SRH currently, none of the 17 Goals make explicit references to the need for SE.

The 2030 Agenda for Sustainable Development (commonly referred to as Agenda 2030)<sup>115</sup> includes the following content in its declaration, which point to the need for CSE at the country level:

- It recognises that “realizing gender equality and the empowerment of women and girls will make a crucial contribution to progress across all the Goals and targets”, committing to “work for a significant increase in investments to close the gender gap and strengthen support for institutions in relation to gender equality and the empowerment of women at the global, regional and national levels. All forms of discrimination and violence against women and girls will be eliminated, including through the engagement of men and boys. The systematic mainstreaming of a gender perspective in the implementation of the Agenda is crucial”.
- States also “commit to providing inclusive and equitable quality education at all levels – early childhood, primary, secondary, tertiary, technical and vocational training. All people, irrespective of sex, age, race or ethnicity, and persons with disabilities, migrants, indigenous peoples, children and youth, especially those in vulnerable situations, should have access to lifelong learning opportunities that help them to acquire the knowledge and skills needed to exploit opportunities and to participate fully in society.”
- Lastly, Agenda 2030 states “We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education”.

The extent to which the SDGs are successful in mobilising governments to implement CSE will depend, at the outset, on whether they translate into national level actions, and in particular, how States implement activities towards meeting any relevant indicators they have identified for themselves. Although many countries do not involve civil society in developing these, the indicators, when finalised and publicly available, can be used to hold States accountable to what progress gets measured and reported back at the global levels towards achieving Agenda 2030. The indicators can also help highlight the need for resourcing and funding this agenda.

*In India, the responsibility for implementing the SDGs does not lie clear-cut with any one ministry or run in a linear fashion. The approach to implementing the SDGs has been to integrate targets and indicators within existing national goals and programmes, which requires a convergence in programme implementation and in leadership between the Ministry of Statistics and Programme Implementation (MOSPI), Ministry of External Affairs (MEA), MOHFW and the Ministry of Human Resources Development (MHRD). To this end, a National Indicator Framework (NIF)<sup>116</sup> consisting of 306 statistical indicators was prepared by MOSPI and the Union Cabinet*

---

115 UNITED NATIONS. 2015. *Transforming our world: the 2030 Agenda for Sustainable Development*. UN Doc. A/RES/70/1. Retrieved from <https://sustainabledevelopment.un.org/post2015/transformingourworld>

116 National Indicator Framework . Retrieved from <http://www.mospi.gov.in/national-indicator-framework>

*approved the National Monitoring Framework on Sustainable Development Goals in late 2018 along with the constitution of a High Level Steering Committee meant to review and refine the NIF<sup>117</sup>.*

*Unfortunately, SE or Adolescent Education is not mentioned in the 306 indicators that are part of the NIF developed to monitor the SDGs in India. Agenda 2030 provides, amongst other avenues, the opportunity to mainstream CSE through gender equality and human rights education in schools. At the time of writing this paper, with the exception of the RKSK that in principle is meant to address SE through its programmes primarily in out-of-school settings, and the AEP that addresses life skills development within schools, no national programme currently mandates that CSE be clearly implemented in the public health and education system.*

## **The Revised International Technical Guidance on Sexuality Education (ITGSE)**

In 2009, UNESCO led an inter-agency collaboration with UNAIDS, UNICEF, UNFPA and WHO to review global evidence on Sexuality Education programmes and developing a rationale for investing in and implementing it, with a view to guide education and health-sector decision makers and stakeholders. The first version of the ITGSE provides a voluntary technical framework and a companion guide on supplementary topics and learning objectives that member states should commit to implementing, as a 'basic minimum package' for children and young people from 5-18 years of age. The document was considered a landmark technical advancement for CSE at the time, given the absence of any alternative global technical framework on SE. The absence of an agreed-upon definition of Sexuality Education within the document was also noted. This was reflective of disagreement in the international community on the subject.

In early 2018, UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO launched a revised version of the guidance. Revisions include:

- A comprehensive definition of SE that includes recognition of, and a conceptual framework for, understanding sexuality in CSE.
- Affirmation of the rights of LGBTQI people, the importance of recognising and celebrating sexual diversity and also recognising that the severe restrictions and penalties imposed on LGBTQI rights impact children, adolescents and young people and their mental and social development.
- A broader recognition of evidence that locates CSE within a gender equality and human rights context.
- An expanded understanding of the need to ensure access to safe abortion, including evidence that CSE reduces unintended pregnancies and unsafe abortion<sup>118</sup>.
- Recognition of the role of young people's participation for the successful implementation of CSE programmes, and the building of their agency as an

---

117 Cabinet approves National Monitoring Framework on Sustainable Development Goals. (2018, October 24). Retrieved from <http://pib.nic.in/newsite/PrintRelease.aspx?relid=184326>

118 Updated UN sexuality education guidance expands abortion content. (2018, January 18). Retrieved from <https://ipas.org/news/2018/January/updated-un-sexuality-education-guidance-expands-abortion-content>

important outcome. The guidance notes that programmes should “encourage young people to understand how they can and should play an active role in the decision-making around their care, for example by reflecting on the importance of informed consent, privacy and confidentiality; and learning about how existing legal frameworks support or hinder their ability to make decisions about their health”.

- A revised overview of the global evidence on CSE, including limitations and further areas of research needed to advance our understanding of what kinds of CSE programmes work best and can be scaled. This includes more rigorous evaluation of the ways in which CSE contributes to long-term health improvements, reducing “gender-based and intimate partner violence, discrimination” and increasing “gender-equitable norms”. Additionally, it has more information on “the impact of CSE curricula on already marginalized groups, including young people with physical and/or cognitive disabilities, YPLHIV (Young People Living With HIV) and LGBTI young people”.

The much-awaited revised guidelines do not address mobilising for CSE in contexts where states reject a comprehensive approach to sexuality and/or a recognition of Sexual Rights. It, however, provides an updated understanding of the evidence, outlining key concepts, topics and learning objectives to guide the development of locally adapted curricula for learners 5-18 years of age. It also provides recommendations for all stages of CSE programme development, including planning, delivery, monitoring, evaluation and scale up.

The ITGSE has been accompanied by the development of several notable technical frameworks, all of which advance recommendations to implement SE and/or SRH information with adolescents and young people. Some of these are:

- United Nations Special Rapporteur Report on the Right to Education (2010)
- UNFPA’s Operational Guidance for CSE (2014)
- Evaluation of Comprehensive Sexuality Education Programmes: a Focus on the Gender and Empowerment Outcomes, UNFPA (2015)
- World Health Organization’s Reproductive Health Strategy
- UNFPA’s Technical Guidance for Prioritizing Adolescent Health, Every Woman Every Child (2017)
- Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation, World Health Organisation (2017)



## **SECTION 4**

# **Sexuality Education In India**

Many SE programmes are located within a broader historical Adolescent Reproductive and Sexual Health (ARSH) framework that links the need for SRH with family planning. This perspective rarely teaches SE with an affirmative approach that celebrates both sexuality and diversity, and often conflates empowering adolescents and young people to make informed decisions about their bodies with regulating their fertility in the social context of marriage and families. This excludes the lived realities of adolescents and young people who are sexually active and may not be married.

Whilst the primary mandate for addressing ARSH lies with the Ministry of Health and Family Welfare, no single government agency in India is responsible for ensuring the implementation of SE. SE is implemented across line ministries of education and health, with possibilities for integration in other state and centrally run programmes. The lack of this mandate both expands the possibilities for how CSE can scale in India, and limits the scope of accountability and resources for this work. Education and health are listed as Concurrent and State List subjects, respectively, in India. Whilst CSO-led programmes may have clarity on the range of what CSE programmes can look like, there is no consolidated approach to streamlining CSE across state and central level policy and programmes. In the following sections, we attempt to trace the trajectory of SE in India, then review one of the country's largest SE programmes for its comprehensiveness, and outline some non-governmental programmes on CSE that may have the leeway to be broader in their approach to SE.

## **The journey of SE in India**

Parallel to the international developments regarding CSE, many efforts have been made to implement SE in India over the years. However, the history of SE in the country has many twists and turns, with different actors taking the stage at different points of time – to the extent that when one tries to trace back its trajectory at the national level, we have found it difficult to find a narrative that everyone agrees on.

Until recently, SE in India has largely failed to acknowledge and integrate historic shifts that took place post ICPD internationally, or at the regional level, like the Sixth Asian and Pacific Population Conference in 2013. A large gap between the international commitments that India makes to ensuring standards in SE and the ground reality remains, along with a lack of domestic understanding of these commitments and the political will to fulfil them. SE materials continue to have a morally restrictive undertone, which make open discussions on sexuality, and on CSE, difficult.

In the period following India's independence from British rule in 1947, India's attempt at introducing some form of SE was rooted in the population control discourse. For example, India adopted a population control policy as early as 1951 as part of its First Five Year Plan period (1951-56), being one of the first countries in the world to do so. The policy was geared towards "stabilising and controlling" India's rapidly rising population, which was considered a deterrent to the nation's growth and prosperity. The Second Five Year Plan (1956-61) took forward the same agenda and advocated for the role of education in making contraceptives acceptable. The virtues of small families

were propagated in the Third (1961-66), Fourth (1969-74) and Fifth (1974-79) Plans<sup>119</sup>, reflecting a general anxiety around growing population by the newly independent State.

In August 1969, the National Council of Educational Research and Training (NCERT) held a National Seminar on Population Education, and subsequently prepared a Population Education syllabus by 1971. The syllabus drew upon concepts from diverse fields such as Family Planning, SE, Family Life Education and Population Studies. In 1975, a National Emergency was declared in the country. This period saw huge human rights violations, including a drastic alteration in the nature of family planning initiatives. Sterilisation programmes<sup>120</sup> that were target-driven and often coercive were vigorously implemented across the country. The brunt of these measures was borne by poor, illiterate, and vulnerable people, and resulted in the ruling party's defeat in the subsequent elections.

The nature of family planning programmes in Five Year Plans changed following the Emergency. The State consciously started searching for non-coercive and non-propagandist ways of changing people's reproductive behaviour<sup>121</sup>.

The National Population Education Project/Programme<sup>122</sup> (NPEP) was launched by the MHRD in 1980. In its first two phases (1980-85; 1986-92), NPEP was taken to most states across the country, reaching students in secondary and higher secondary school; resource persons were trained and 'population education elements' were incorporated into teacher training. NPEP was eventually expanded to include students in the non-formal education sector (third phase during 1993-97). Today, we understand that the NPEP is active in 33 states and union territories across India.

In April 1993, the NCERT hosted a national seminar on Adolescence Education (AE) to discuss effective strategies for promoting SE, which came in the context of the ICPD in Istanbul in 1993, a precursor to the ICPD in Cairo in 1994<sup>123</sup>. This seminar brought out the need to re-conceptualise the NPEP, as it was felt that it did not include important elements of the process of growing up, substance abuse and HIV and AIDS education. These had by now become crucial issues in society.

The ICPD in 1994 ushered a paradigm shift for women's health and rights both in the Global South and in India. The Indian government, in contrast to its stance on population control on the domestic front, adopted a benign, Human Rights stance at the conference. This gave civil society in India, in particular the women's movement, the opportunity to advocate for and advance change in population control policies.

From what we have gleaned, working alongside these shifts and its recommendations from the 1993 seminar on AE, the NCERT evolved the NPEP to address SRH, gender, Family Planning and SE. Concepts of small family norms, responsible parenthood, age of

---

119 Five Year Plans. Retrieved from <http://planningcommission.nic.in/plans/planrel/>

120 TARLO, E. 2003. FORGETTING AND REMEMBERING THE EMERGENCY. In *Unsettling Memories*. (pp. 21-61). C Hurst & Co.

121 VENKATASUBRAMANIAN, K. (n.d.) Population Control – Where Has the Strategy Faltered? Retrieved from <http://planningcommission.nic.in/reports/articles/venka/index.php?repts=m-popu.htm>

122 NPEP has been referred to as National Population Education Project and National Population Education Programme in different sources

123 NPEP and NCERT. 1994. *Adolescence Education: Report of the National Seminar*.

marriage, gender bias and cultural and social norms, women's empowerment, etc., were added, as was information on STDs, HIV and AIDS.

In 2005, the MHRD brought together all government initiatives on AE under the umbrella term Adolescence Education Programme (AEP)<sup>124</sup>, in all government schools in India for students of Grades 9 and 11<sup>125</sup>. The AEP was positioned as an umbrella initiative bringing together three already ongoing programmes: the NPEP, the School AIDS Education Programme (SAEP) implemented through State AIDS Control Societies by NACO since 1993-94, and the Project on Adolescent Reproductive and Sexual Health (ARSH) in Schools being implemented by five national agencies with UNFPA's support<sup>126</sup>. Another version of the AEP was developed and implemented by the NCERT with UNFPA support, as we will discuss later.

Several policies supported the gradual shift from the population control perspective of the previous decades towards a rights-based approach as central to SE. These include the National Population Policy (NPP), 2000 and the National Youth Policy (NYP), 2003<sup>127</sup>, which recognised adolescents as a vulnerable group, requiring special attention and affordable and accessible SRH information and services. The National Health Policy (NHP), 2002 encouraged health-promoting behaviours among young people in schools and colleges, while the National AIDS Prevention and Control Policy (NACP), 2002 underscored the need for a better understanding of HIV and safer sex practices for young people. The National Curriculum Framework (NCF), 2005 emphasised linking education with skill development among adolescents to prepare young people to face the challenges of life including violence, drug addiction, teenage pregnancy, HIV and AIDS. NYP 2014<sup>128</sup> does not refer to SE or SRHR, but mentions that certain high-risk or marginalised groups, including LGBTIQ+ young people, "require special attention in order to ensure that they can access and benefit from the programme."

Recent updates to the status of CSE in the country include the RKSK<sup>129</sup>, launched in 2014, and the very new *Ayushman Bharat*, which includes SE as part of its school-based engagement.

RKSK seeks to address adolescent health comprehensively by highlighting issues of most concern to adolescents, such as nutrition, SRH, non-communicable diseases, substance misuse, injuries and violence, including gender-based violence, and mental health, which was not a part of programmes in the past. The objectives of RKSK are to

---

124 JAYA, MEHROTRA, D. P., PATRA, S., SRIVASTAVA, N., SINGH, A., & YADAV, S. 2017. India's Adolescence Education Programme: Status and opportunities for scaling up. *Indian Journal of Adult Education*, 78, (3).

125 NATIONAL AIDS CONTROL ORGANISATION. 2011. *Report of the NACP- IV Working Sub-Group on Stigma*. Retrieved from <http://naco.gov.in/sites/default/files/REPORT%20OF%20THE%20WORKING%20SUB-GROUP%20ON%20ADOLESCENTS%20%26%20YOUTH%20FOR%20NACP-IV.pdf>

126 NATIONAL AIDS CONTROL ORGANISATION. *Adolescence Education Programme & Life Skills Development: Facilitators' Guide*. Retrieved from <http://164.100.130.11:8091/webarsh/Resources%20on%20ARSH/Adolescent%20Education%20Programme%20Facilitators%20Guide.pdf>

127 JEJEEBHOY, S. J. & SANTHYA, K. (2011). *Sexual and Reproductive Health of Young People in India: A Review of Policies, Laws and Programmes*. © 2011 by Population Council.

128 GOVERNMENT OF INDIA, MINISTRY OF YOUTH AFFAIRS & SPORTS 2014. National Youth Policy 2014. Retrieved from <https://yas.nic.in/sites/default/files/National-Youth-Policy-Documents.pdf>

129 Rashtriya Kishor Swasthya Karyakram - Government of India. Retrieved from <http://nhm.gov.in/rashtriya-kishor-swasthya-karyakram.html>

increase the availability and access to information about adolescent health; increase accessibility and utilisation of quality adolescent counselling and health services; and to create a safe and supportive environment for adolescents. The programme marked a major shift in health programming by moving from a clinic-based approach to a more holistic model that includes community-based health promotion and strengthening the health system response. A key component of the RKSK are the Adolescent Friendly Health Clinics (AFHCs), which are meant to serve as dedicated spaces for adolescents in the existing health system, to be supported by sensitised and trained staff.

While schools provide captive audiences to work with, they can also be restricted environments bound by time and teaching capacity constraints, and leave out the millions of young people who are not in school for various reasons. Therefore, out-of-school approaches such as RKSK could offer more flexibility in how information on CSE can be integrated and understood in the community itself.

In February 2017, the MOHFW, in collaboration with development partners launched the *Saathiya* Resource Kit including the *Saathiya Salah* app for adolescents<sup>130</sup>. The programme envisioned training 1.6 lakh peer educators to work in collaboration with community health workers<sup>131</sup> as catalysts to generate demand for adolescent health services and to provide information on various CSE topics as part of adolescent health sessions led in peer groups. *Saathiya's* content includes the expected information on access to safe abortion, substance abuse, STIs, gender stereotyping, gender based violence and contraception. It additionally makes significant strides in acknowledging desire as 'normal' across and between different genders<sup>132</sup>, with a key focus on the need for and to understand consent, a welcome step in public health programming.

In a recent initiative by the MHRD to improve the quality of school education, a life skills programme that responds to development concerns across all stages of schooling was proposed. This was aligned with MOHFW's commitment for a comprehensive school health programme as a key approach under RKSK, which will come under the aegis of the new *Ayushman Bharat* initiative. As of the time of writing this paper, details of this new initiative were not public yet, but we understand that the programme has objectives similar to the AEP, with the aim of increasing knowledge, inculcating positive attitudes and enhancing life skills among adolescents<sup>133</sup>. A 'Health and Wellness' framework is being developed, which seeks to harmonise content from existing school-based programmes<sup>134</sup>.

Ongoing revisions to the AEP are also to be included under this school-health component of *Ayushman Bharat*, and it is likely that the AEP will be folded into this.

---

130 Health Secretary launches 'SAATHIYA' Resource Kit and 'SAATHIYA SALAH' Mobile App for Adolescents (2017. February 20). Retrieved from <http://pib.nic.in/newsite/PrintRelease.aspx?relid=158578>

131 Ibid.

132 SINGH, A. (2017. February 22). Homosexual Attraction Natural In Adolescents, Says Health Ministry Sex Education Kit. *NDTV*. Retrieved from [www.ndtv.com/education/sex-education-kit-prepared-by-health-ministry-says-homosexual-attraction-natural-in-adolescents-1662233](http://www.ndtv.com/education/sex-education-kit-prepared-by-health-ministry-says-homosexual-attraction-natural-in-adolescents-1662233)

133 CHAUDHRY, I. 2018. *Shareer Apna, Adhikaar Apne A Policy Brief on Comprehensive Sexuality Education*. © 2018 by The YP Foundation. Retrieved from <https://static1.squarespace.com/static/5837d4b3725e25680b8b758e/t/5b6056700e2e72e41d094f14/1533040281142/CSE+Policy+Brief-Final+web.pdf>

134 Ibid.

In the remainder of this section, we go into the development and structure of the AEP in greater detail as it is still the mainstream government-led programme as of early 2019.

## Adolescence Education Programme (AEP)

As mentioned earlier, the AEP was the result of the harmonising by MHRD of several existing programmes on adolescence education in 2005. Soon after its launch, however, the AEP faced many hurdles in its implementation.

### Backlash

The rollout of the first draft of the AEP curriculum, developed by NACO-UNICEF for MHRD, faced severe backlash from several state governments in 2006-07<sup>135</sup>. With education being on the Concurrent List of the Indian Constitution, state governments could decide how they chose to utilise the AEP toolkit. Protests originated from local teachers unions and schools to State Council of Educational Research and Training (SCERT) agencies, expressing reservations and discomfort with, in particular, the teaching aid material and the illustrations in the manual, identified as culturally inappropriate. Protests by conservative groups and opposition parties at state level followed. By March 2007, twelve states including Maharashtra, Goa, Gujarat, Karnataka, Kerala, Chhattisgarh, Madhya Pradesh, and Uttar Pradesh, banned the implementation of the curriculum. The central government now called for a review of the AEP.

Public comments from government officials reinforced SE to be a “foreign conspiracy by international NGOs to get money under the guise of AIDS control and education<sup>136</sup>”, as well as sparked a public letter from the Madhya Pradesh Chief Minister, recommending to the state assembly that classes teaching SE through the AEP should be replaced with yoga<sup>137</sup>. Similar expressions of discontent were made by Rajasthan Education Minister Ghanshyam Tiwari and Karnataka Chief Minister H.D. Kumaraswamy. A member of parliament said “Sexuality Education (is) against Indian Culture. This manual will corrupt our children and encourage sexual experimentation.” A Rajya Sabha committee chaired by M. Venkaiah Naidu was asked to look into the matter<sup>138</sup>.

In 2008, NACO released a revised curriculum that did not include any ‘explicit’ pictures or ‘offensive words’ such as ‘penetrative sex’ and ‘sexual intercourse’, and replaced detailed diagrams of the anatomy for teachers with animations. The revised version was critiqued by civil society groups for providing inaccurate or inadequate information (for example, in the context of Child Sexual Abuse, the text seemed to advise that

---

135 GENTLEMEN, A. (2007. May 24). Sex education curriculum angers Indian conservatives. *The New York Times*. Retrieved from [http://www.nytimes.com/2007/05/24/world/asia/24iht-letter.1.5851113.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2007/05/24/world/asia/24iht-letter.1.5851113.html?pagewanted=all&_r=0)

136 RAI, U. (2007. October 22). Sex education can save lives: Sexuality is too all pervasive to ignore. *The Tribune*. Retrieved from <https://www.tribuneindia.com/2007/20071022/edit.htm>

137 NEWS 18. (2007. March 22). No sex education, only yoga in MP. *News 18*. Retrieved from <https://www.news18.com/news/india/no-sex-education-only-yoga-in-mp-261398.html>

138 RAJYA SABHA. (2009). *Hundred and Thirty-fifth report on Petition praying for National debate and evolving consensus on the implementation of the policy for introduction of sex education in the schools and holding back its introduction until then*. Retrieved from <http://164.100.47.5/newcommittee/reports/EnglishCommittees/Committee%20on%20Petitions/135-A5-English-petitions.pdf>

adolescents trust family members and not strangers). The revision also advocated an abstinence-based approach, including “faithfulness to one’s partner” and “no sex before marriage”, and provided no explanation on how STIs occur, or how to use a condom. It went as far as to say “adolescents confront(ed) problems because of their inability to properly manage the sudden development of their interest in the opposite sex<sup>139</sup>.”

While the revisions to the curriculum were yet to be finalised, the report submitted by the M. Venkaiah Naidu committee in 2009 recommended that the existing material of the AEP curriculum be withdrawn<sup>140</sup>. The text of the recommendations stated: “The Committee discovered that in the name of ‘Adolescence Education’, multiple agencies of the Government of India had tried to introduce a syllabus in the school curriculum which had the potential to pollute the young and impressionable minds of students by exposing them to indecent material”... and ... “It is to be remembered that in the past, elders themselves taught values to their wards. Parents led by example. Grandparents enlightened young receptive minds with stories, fables and parables. Today, many Indian parents have hardly any ‘Quality Time’ for their children because of their preoccupations. Often grandparents are in homes for the aged. Young people pursue glamour and materialistic attainment.”

The controversy did cause concerns that decades of gains on SE would be lost, but it also provided an opportunity to “collaborate, strategize and reconfigure the programme” with key stakeholders at MHRD, NCERT and SCERTs<sup>141</sup>. It was gradually positioned in the context of strengthening life skills development for young people, to equip them to meet the challenges of daily life and achieve their potential, ultimately reducing somewhat, the stigma its politicisation received<sup>142</sup>. Updates were made to the guiding principles (2010) and training and resource materials (2013), aligning with UNESCO’s International Technical Guidance of 2009. The content had moved forward slightly from the abstinence only approach<sup>143</sup> and the guiding principles called for an education programme that is non-judgmental and does not stigmatise or induce fear.

All the same, off-the-record conversations among organisations and individuals indicated that the controversy also created fear across central and state government departments. It was perceived that continuing to champion the AEP as well as SE in the absence of public support and/or political will would lead to individual officers risking penalisation, which could impact their employment and official deployments. As the controversy began fading from public memory, public records tracking the progress of the AEP and its decentralised implementation have been harder to find. Advocacy for SE programmes and the implementation of the AEP however continued, adopting

---

139 NATIONAL AIDS CONTROL ORGANISATION. *Adolescence Education Programme & Life Skills Development: Facilitators’ Guide*. Retrieved from <http://164.100.130.11:8091/webarsh/Resources%20on%20ARSH/Adolescent%20Education%20Programme%20Facilitators%20Guide.pdf>

140 RAJYA SABHA. (2009). *Hundred and Thirty-fifth report on Petition praying for National debate and evolving consensus on the implementation of the policy for introduction of sex education in the schools and holding back its introduction until then*.

141 JAYA, MEHROTRA, D. P., PATRA, S., SRIVASTAVA, N., SINGH, A., & YADAV, S. 2017. India’s Adolescence Education Programme: Status and opportunities for scaling up.

142 Ibid.

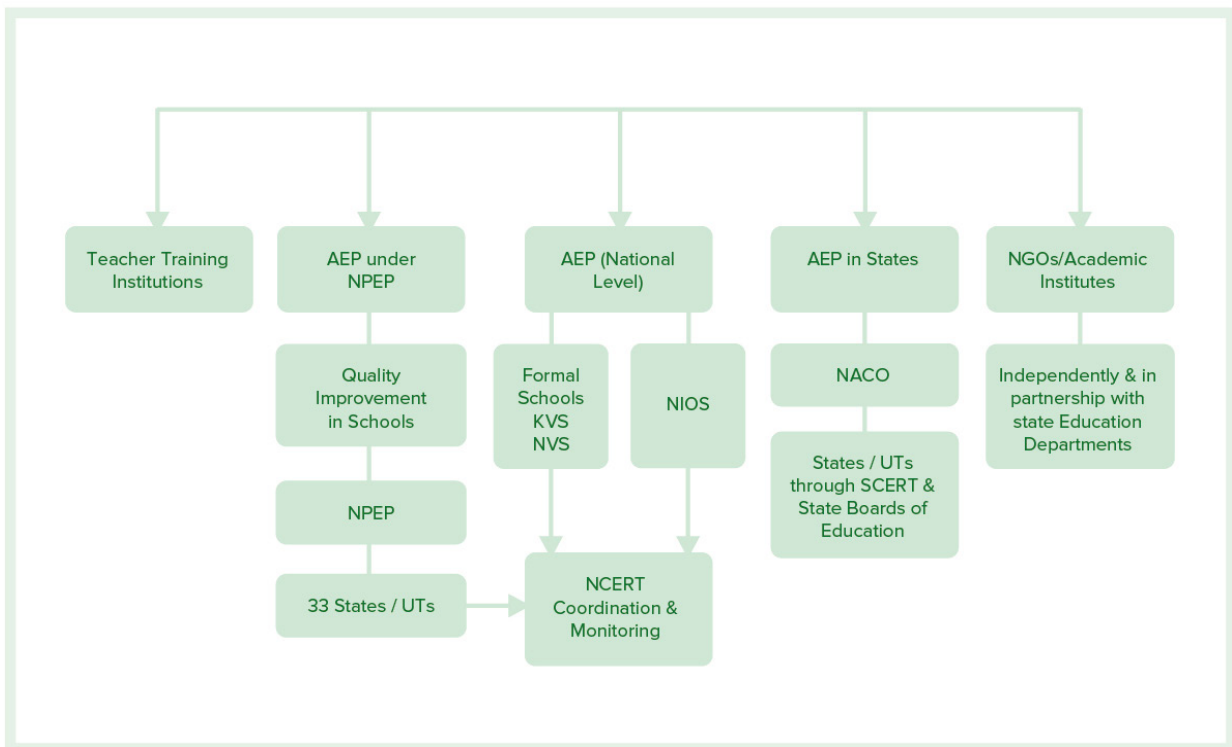
143 NCERT. 2010. *Conceptual Framework: Adolescence Education Programme*. Retrieved from <https://mittalsouthasiainstitute.harvard.edu/wp-content/uploads/2014/05/NCERT-AEP-Conceptual-Framework-and-Implementation-Challenges.pdf>

a softer, less public approach of working with state departments and through central programmes. Several states, such as the Kerala government, eventually reported adapting versions of the AEP after restructuring it, laying greater emphasis on life skills, rather than CSE.

## Structure and design of the AEP

### Background

The AEP has been implemented through several agencies, with the NCERT coordinating initiatives at the national level (including the NPEP) and NACO implementing it in states through state boards of education. These AEP programmes should not be seen as competing or contradictory, given the challenges of ensuring scale and coverage in the government schooling system, as well as the urgency of implementing SE. The following graphic illustrates the different AEP initiatives ongoing in the country.



#### Key:

NPEP: National Population Education Project / Programme

NIOS: National Institute Of Open Schooling

KVS: Kendriya Vidyalaya Sangathan

NVS: Navodaya Vidyalaya Samiti

SCERT: State Council of Educational Research and Training

#### Image credit:

JAYA, MEHROTRA, D. P., PATRA, S., SRIVASTAVA, N., SINGH, A., & YADAV, S. 2017. India's Adolescence Education Programme: Status and opportunities for scaling up.



## **AEP coordinated by NACO**

NACO's implementation of the AEP focussed on the following learning outcomes<sup>144</sup>:

- Making learners aware of major concerns during adolescence, in particular issues related to growing up, 'HIV/AIDS' and drug/substance abuse
- Inculcating in young people positive attitudes regarding these concerns
- Helping young people acquire life skills to avoid risky situations such as HIV infection and drug abuse and promoting healthy and responsible behaviours

Content on HIV prevention was also integrated into curricula and textbooks in the in-service and pre-service teachers' training curricula.

This version of the AEP faced backlash in 2006-07 and we understand that the programme has since been substantively scaled down or even discontinued in several states over the years.

## **AEP coordinated by NCERT**

NCERT had designed and implemented the initial versions of the AEP along with NACO and UNICEF. In response to the backlash in 2006-07, NCERT worked to develop a (separate) revised version, with support from the UNFPA and including inputs of teachers, psychologists, NGOs, women's groups active on sexuality, gender, and youth issues (e.g. Nirantar, Pravah, Sangath, TARSHI), and representatives from NVS and KVS schools. It is noteworthy that experts invited to review government curricula, such as in this case, have included several non-governmental organisations, educationists and independent specialists working on sexuality issues with a rights-based perspective. Whilst these interactions have naturally seen conflicts in how and what content should be prioritised and delivered, these conversations have resulted in greater mutual understanding and respect, and the AEP has benefited from this<sup>145</sup>.

The NCERT's version of the AEP is implemented with technical support from UNFPA, through the NIOS, NVS and KVS. *Mentions of 'AEP' in this paper moving forward refer to the version developed by NCERT with support from UNFPA.*

## **Design of AEP training and implementation**

The AEP reaches out annually approximately to 340,000 adolescents directly through the KVS and NVS systems, and 221,000 young people at secondary level in the NIOS<sup>146</sup>. No comprehensive public record providing a state wise analysis of the current implementation of the AEP was found during the research for this paper.

---

144 Sex Education in Schools. (2007, May 4). Retrieved from <http://naco.gov.in/pressrelease/sex-education-schools>

145 MEHROTRA, D.P. (2014). *Critical Analysis: Sexuality Education/AEP – Trends and Opportunities* [Power-Point slides]. Presented at TARSHI and The YP Foundation's Landscaping and Strategy Meeting on 'Exploring the Dynamics of Sexuality Education for Adolescents and Young People in India', New Delhi.

146 JAYA, MEHROTRA, D. P., PATRA, S., SRIVASTAVA, N., SINGH, A., & YADAV, S. 2017. India's Adolescence Education Programme: Status and opportunities for scaling up.

The programme uses a cascade training approach in the formal school systems (KVS and NVS). It has created a pool of master trainers who orient nodal teachers who are responsible for providing life skills based education to secondary school students (Grades 9 and 11, ages 14 through 18) through interactive methodologies. It also includes an online resource centre and a moderated online discussion forum for teachers<sup>147</sup>, which provides teachers with a platform to share experiences and learning, and includes an online question box for teachers to post and receive confidential responses. Finally, advocacy sessions are organised with principals of participating schools and sensitisation sessions are held with parents to promote an enabling environment<sup>148</sup>. Additionally, AEP is supposed to be integrated into teacher training both at pre-service and in-service levels.

In addition, the implementation of the AEP within the KVS and NVS systems includes<sup>149</sup>:

- Allocating 23 hours of the school timetable for AEP with Grades 9, 10 and 11
- Conducting the 'Question Box' activity, where students write in concerns anonymously and trained facilitators respond
- Conducting thematic events such as school assemblies, role plays, writing and poster making

Within the NIOS, which is an open schooling system focused on youth who drop out of formal schooling, AEP related content is integrated into the curriculum and taught across subjects at the secondary level, using a life skills approach rather than as a standalone topic.

Different agencies and school systems have adopted or adapted the AEP in somewhat different ways. Whereas some have chosen to integrate AEP in the school curriculum, adding relevant content in syllabi, teaching and pre-service teacher education, others have preferred to introduce it as a co-curricular activity, focusing on learner-centric participatory activities within the classroom and outside. Several arguments have been made about the strengths and weaknesses of having an integrated approach to the AEP. On the one hand, assimilating the AEP into existing curricula does not require additional resourcing<sup>150</sup>; however, this is also likely to burden and compete with existing priorities under a system with limited resources, including infrastructure and teachers.

Since 2010, the programme has also made progress through civil society led partnerships to roll out the AEP. More information on this can be found in Section 6 of this paper.

---

147 Adolescence Education Programme. Retrieved from <http://www.aeparc.org/>

148 NCERT, UNFPA and UNESCO. 2017. *Assessment of Select Adolescence Education and Life Skills Education Programs in India*.

149 JAYA, MEHROTRA, D. P., PATRA, S., SRIVASTAVA, N., SINGH, A., & YADAV, S. 2017. India's Adolescence Education Programme: Status and opportunities for scaling up.

150 Ibid.

## Guiding framework for content

The guiding principles<sup>151</sup> of the revised conceptual framework mention the importance of respecting the heterogeneity of young people, including diversity in terms of caste, class, gender, sexual orientation and disability. The framework is also positioned as respectful of adolescents as independent and intelligent people, who are able to actively participate in decision-making, and exercise their rights. Even as the materials are positioned as going beyond the abstinence only approach and as aligning with ITGSE which are anchored in a human rights perspective<sup>152</sup>, abstinence related messages do find a place in the curriculum; it is however clearly stated that this does not reflect the beliefs and customs of all young people in India. The framework encourages coordinated action by parents and schools to initiate youth-friendly services, and emphasises the need for monitoring at various levels, continuous research, and updated content.

The training and resource materials address the following themes:

- Understanding the changes during adolescence and being comfortable with them (including differences in the process of maturation and the effects on body image)
- Establishing and maintaining positive and responsible relationships
- Understanding and challenging stereotypes and discrimination related to gender and sexuality
- Understanding and reporting abuse and violations
- HIV and AIDS: Prevalence, Prevention, Vulnerability, Dealing with Stigma, Access to Services, Linkages with Reproductive Tract Infections (RTIs)/ STIs
- Substance Abuse: Causes, Access to safety net (protection from abuse), Consequences, De-addiction, Care and Support.

## AEP curriculum

The AEP curriculum was initially mandated to be implemented over 16 hours, which was critiqued by civil society organisations as being too short. This was subsequently addressed with support from UNFPA, by increasing the mandated duration to 23 hours, alongside revised training and resource materials.

The AEP curriculum of 2013<sup>153</sup> consists of five sections, each representing a broad thematic area. Each section is organised into modules, which deal with certain core sub-themes. Each module consists of activities, discussion sessions and fact sheets to help guide the facilitators to conduct the sessions with adolescents.

Section I of the curriculum presents the introduction and context of AE in India as well as the conceptual framework that guides the curriculum.

---

151 NCERT. 2010. *Conceptual Framework: Adolescence Education Programme*.

152 JAYA, MEHROTRA, D. P., PATRA, S., SRIVASTAVA, N., SINGH, A., & YADAV, S. 2017. *India's Adolescence Education Programme: Status and opportunities for scaling up*.

153 NCERT. 2013. *Training and Resource Materials: Adolescence Education Programme*.

Section II (Process of Growing Up) talks about a number of important aspects of adolescent life – changes at puberty, developing a relationship with the self, boosting self-esteem and confidence, peer relationships, friendships and attraction.

Section III (Prevention of Substance Misuse) deals with substance misuse and identifies peer pressure in its diverse forms (including as violence in the home), as well as challenges and opportunities for adolescents to cope with these issues. It makes an important point about substance misuse being an issue, but about not stigmatising the substance user. The section provides comprehensive information to clarify myths and misconceptions that adolescents may have. It ends with highlighting the importance of active safety needs and good communication, providing relevant legal information.

Section IV (Prevention of HIV and AIDS) discusses the prevalence of HIV and AIDS in India, information regarding transmission and prevention, and links it to the particular vulnerabilities of young people and women.

Section V discusses the skills required for facilitators, and the significance of training and advocacy for better efficacy of the programme. While certain modules are meant specifically for facilitators, the other parts lay out activities and discussion sessions to be facilitated with school students.

The AEP does not teach themes in isolation, but connects chapters with each other, building on themes and highlighting the connections between information, skills and behaviours. The situations and case studies provided at each stage become increasingly complex.

The present version of the AEP contains a few illustrations which were developed through poster and art competitions held in a number of schools across the country. The illustrations depict real life situations that adolescents and young people feel they often need guidance with or would like to discuss in classroom settings. Anatomical depictions of human beings have not been used in this material, in order to avoid potential controversy of the kind that took place in 2007. Even though such illustrations are in the biology curriculum of secondary and senior secondary Grades, we have heard from many sources that the section on reproductive anatomy is often skipped or taught without placing it in real-life contexts.

While it is too soon to expect that the revised AEP material aligns with the 2018 ITGSE, it only partially aligns with the standards outlined in ITGSE 2009. It acknowledges adolescents as a positive human resource, and emphasises adolescence as a time of possibilities, adventure, curiosity and learning. It discusses physical and emotional changes during puberty, gender roles, nutrition, emotions like anger and self-esteem, as well as issues like sexual harassment and abuse, domestic violence, adolescent pregnancies and related risks, and the incidence of STIs including HIV among young people. The aim of the material is to introduce young people to a broad range of life skills that include reasoning and analytical strength, understanding and managing emotions and engaging with others.

The 2018 ITGSE has a more comprehensive articulation of the minimum standards to be met when explaining sexuality, agency and Sexual Orientation and Gender Identity and

Expression (SOGIE). Ongoing revisions of the AEP for Grades 6-8 – which are being pitched as part of the school health component of *Ayushman Bharat* – have advanced to explaining ‘the third gender’/ the term transgender, alongside the plurality of identity and expression and the importance of non-discrimination, particularly in the context of ensuring rights. Some of these revisions will, in the next phase, move to the primary school.

## **SECTION 5**

# **Analysing the Adolescence Education Programme**

In the following pages, we make an effort to analyse the 2013 version of AEP<sup>154</sup> with a rights-based, sexuality-affirming perspective. While we draw from our over two decades of work on sexuality, SRHR and particularly young people's access to CSE and learning, we are acutely aware of gaps in the information we have been able to find and substantiate. Having said this, we present this analysis based on our experience as well as on external evaluation and assessment reports commissioned jointly by NCERT and UNFPA available in the public domain.

## **Addressing content: Sex and Sexuality**

It is promising that the AEP curriculum embraces the notion of SE. The approach acknowledges the diversity of young people and considers them intelligent and capable human beings who can participate actively in reflecting on, choosing, and determining their own actions and lives. However, in its present state, there is much scope for improvement in terms of the content and approach. Additionally, several laws related to sexuality have changed in the years since the last update to the curriculum: Section 377, which criminalised homosexual sexual behaviour, was read down in 2018; the 2014 NALSA judgement accorded fundamental rights to transgender people and declared them to be a third gender; adultery no longer falls under criminal law; there are new laws for persons with disability and on mental health, reflecting (to some extent) global discourses on these topics; the Protection of Children from Sexual Offences (POCSO) Act, 2012, deals exclusively with sexual offences against children. The curriculum needs to catch up with these, and with other changes as they have a bearing on gender norms and SRHR. Some critical points of the content are examined below.

### **A 'strategic' way of (not) talking about 'sex' and 'sexuality'?**

While much of the information provided in the curriculum falls under the wide gamut of sexuality related information, the programme covers it under the title of 'life skills'. The programme itself is called Adolescence Education Programme rather than Sexuality Education. It is a moot point whether this is a strategic ploy (in order to avoid controversy of the kind that was raised in 2007), or whether it would have been better to call a spade a spade. Semantics are central to any CSE programme. The very nature of CSE is rooted in the need for comprehensive information, knowledge, vocabulary, communication and skills. The government is not a monolithic institution with a common position or approach to implementing CSE. It is also a political reality that department officials do not call the programme SE given the real fear of being used as public scapegoats. The lack of a structured institutional response to dispel apprehension surrounding CSE and help overcome public inhibitions only limits the programme from openly addressing SE, both in title and content.

The tightrope of shying away from using terms such as 'sexuality' and 'sexual health and rights' can defeat the purpose of helping students develop positive attitudes and life skills, as it reinforces the concept of shame and attaching it to sex.

In the curriculum, sex is talked about covertly and mostly in abstract terms: for instance, there is no mention of what sexual intercourse entails and this could leave young

---

154 NCERT. 2013. *Training and Resource Materials: Adolescence Education Programme*.

people confused. The chapter on conception and pregnancy is illustrative of this: “New life occurs when male (sperm) and female sex cells (ovum) unite at conception. At the time of conception the genes and chromosomes from the mother and father unite to form a unique individual with particular traits and characteristics”<sup>155</sup>. Abstract language used for talking about conception and what sex entails is likely to encourage facilitators, in turn, to speak in vague terms, leaving students to figure out basic facts on their own. Moreover, sex is touched upon in the curriculum exclusively within the context of conception, leaving out the domain of pleasure, thus limiting sex and sexuality to the domain of reproduction, reinforcing social norms and anxiety around sex. Additionally, the use of terms such as ‘mother’ and ‘father’ also subtly reinforces cultural stigma that sex outside of procreation is inappropriate.

The curriculum also does not have a comprehensive, affirmative approach to sexuality. For instance, there is hardly any discussion about masturbation in the AEP content, except a brief mention in the AEP Scheme of Content<sup>156</sup> noting that there is a need to talk about it. However, the same curriculum mentions a 2010 training programme for teachers to transact the AEP curriculum, where the Question Box activity includes questions pertaining to masturbation. These questions range from whether masturbation can cause any problem in the future, to how one could ‘avoid’ masturbation after viewing pornography, to whether masturbation is good for one’s health. TARSHI’s helpline experience revealed that people lack basic information on sexuality, especially on anatomy, sexual processes, and behaviours, including masturbation<sup>157</sup>. The curriculum, however, does little to address these concerns.

### **Challenging heteronormativity**

Section II discusses issues such as developing a relationship with the self, boosting self-esteem and confidence, peer relationships, friendship, and attraction. The curriculum acknowledges that young people experience sexual attraction and form romantic and sexual relationships – something which is still largely unacceptable in many sections of society in different parts of the country, especially for young women. Therefore, the fact that the curriculum talks about organic friendships, relationships, and socialising between young men and women is a plus.

Although the text makes important progress from its earlier version, it does have a strong heteronormative bias. The only case study provided under the section on attraction and romantic feelings presents a heterosexual relationship. There is no mention of same-sex attraction and relationships even within the summary points in this section. Although there is some mention of same-sex relationships in an activity presented in the latter half of section IV, it is an inadequate representation of LGBTIQ+ people in a country where consensual adult same-sex sexual behaviour continues to be stigmatised and where it was, until very recently, criminalised.

Decriminalisation within the law does not automatically translate to greater social acceptance. The lack of information about diverse sexual orientations and gender

---

155 Ibid.

156 Ibid.

157 CHANDIRAMANI, R. 1998. Talking about sex.



identities is a serious gap in the curriculum as it alienates young people who do not conform to the heteronormative society and grow up feeling confused and marginalised. There is no mention in the curriculum of the LGBTIQ+ community and their concerns. The 2017 assessment by UNFPA also notes that “different types of gender orientation and gender identity” and “harassing or bullying on the basis of sexual orientation or gender identity as a violation of human rights” are not covered sufficiently<sup>158</sup>.

### **A binary view of sex and gender**

Section II of the curriculum presents the pubertal changes that girls and boys can expect. While it correctly points out that these changes do not take place in the same way for all young people, it does unfortunately uphold a binary view of sex by tabulating the changes that take place in girls and boys, making clear distinctions between two sexes. However, in practice, the sexes are not always so clearly delineated. Decision-making about the sex of a new-born baby in cases relating to intersex children have increasingly become more complex, and also take into account the chromosomes as well as the hormonal makeup of the child<sup>159</sup>. In addition, the real-life fluidity of sex, gender, and gender expression shows us that people are diverse and cannot be confined to two neat boxes of sex or gender. This information is lacking in the current curriculum.

The AEP does introduce the third gender and mentions that the decision of the Government of Tamil Nadu to introduce ‘transgender’ as an option for gender into its forms is a sign of “progressive thinking and social change”, which is a very positive mention. It is also telling that one of the questions listed in the curriculum about the training programmes for master trainer and nodal teachers in the 2010 Training Workshop was “Who is a Transgender?”, indicating the need for more information to enable facilitators to explain concepts well. It is important for this content to expand, and for the gender binary perspective to not be upheld in the AEP. A lack of articulation of the challenges experienced by transgender youth growing up in India in the curriculum can reinforce experiences of violence and isolation.

### **Right to (not) marry**

Marriage comes up a few times in the curriculum in the context of early marriage and adolescent pregnancy. It is discussed in relation to HIV infection when one of the partners is infected with HIV. There are, however, no discussions in the curriculum on decisions relating to marriage, the right to (not) marry, the right to choose one’s partner, and the right to decide when to marry. The only place where this is discussed is in a Module 3 fact sheet, which mentions that young people may often find their own values (related to marriage) in conflict with the values of the society and culture they reside in. The curriculum does not build this conflict into discussions or methods of empowering young people to make these decisions independently. Debates and discussions related to marriage and relationships are crucial, especially in a country where there is near

---

158 NCERT, UNFPA and UNESCO. 2017. *Assessment of Select Adolescence Education and Life Skills Education Programs in India*.

159 How can you assign a gender (boy or girl) without surgery? Retrieved from [http://www.isna.org/faq/gender\\_assignment](http://www.isna.org/faq/gender_assignment)

universality of marriage<sup>160</sup> and the marriage of adolescent girls is common<sup>161</sup>. In the Indian context, adolescents and young people grow up with social pressure to conform to relationships within marriage. There are tight parameters of selecting people to match religion, caste and/or socio-economic background and challenging these parameters often means taking on the risk of extreme violence and even death. In this context, awareness and information about rights and sources of legal support, is critical.

### **Consent, Sexual Harassment and Rape**

Consent finds a place in the curriculum, but it is insufficient and placed within very narrow contexts.

In the context of addressing young people's curiosity, the AEP articulates the importance of preparing young people for relationships that are responsible, based on equality, respect, consent and trust. The scheme of content for secondary and senior secondary school students mentions the need to provide information on the social and health consequences of early marriage and on marriage without the consent of partners, towards the larger objective of enabling "adolescents to make informed decisions related to their sexual and reproductive health choices". However, it does not go into the importance of decision-making and consent with regard to relationships or marriage, or how consent is framed within the law (for example, that marital rape is not criminalised in India and that consent is not recognised within marriage, for either gender, is not discussed). The discussion on consent needs to be comprehensive, including the contexts of negotiating contraceptive use and the linkages between violence, power and consent, given that these are complex realities for young people.

The issue of consent is both legally and socially vague in India. On the one hand, data (as mentioned earlier in this paper) shows that adolescents are sexually active, and that not all such instances are known to be forced or non-consensual. On the other hand, the POCSO Act, 2012<sup>162</sup> unanimously criminalises sex between minors (18 years and younger) as non-consensual. Mandatory third-party reporting violates the principle of confidentiality, which is critical for educators and service providers in providing counselling, sexuality education as well as access to safe abortion services in cases of teenage pregnancy. It also creates a fear amongst minors in talking about it if and when they are sexually active. This presents a confusing picture on consent for young people, confounded by lack of CSE and spaces to discuss these confusions.

The curriculum also adopts a mixed approach when it comes to domestic violence. Although it defines domestic violence as physical, sexual, verbal, emotional and/

---

160 PALRIWALA, R. & PILLAI, N. 2008. *The Political and Social Economy of Care: India Research Report 1*. © 2008 by United Nations Research Institute for Social Development. Retrieved from [http://www.unrisd.org/80256B-3C005BCCF9/httpNetITFramePDF?ReadForm&parentunid=52825846F6477276C1257417002E6DCC&parent-doctype=paper&netitpath=80256B3C005BCCF9/\(httpAuxPages\)/52825846F6477276C1257417002E6DCC/\\$file/IndiaRR1.pdf](http://www.unrisd.org/80256B-3C005BCCF9/httpNetITFramePDF?ReadForm&parentunid=52825846F6477276C1257417002E6DCC&parent-doctype=paper&netitpath=80256B3C005BCCF9/(httpAuxPages)/52825846F6477276C1257417002E6DCC/$file/IndiaRR1.pdf)

161 SANTHYA, K., RAM, U., ACHRAYA, R., JEJEEBHOY, S., RAM, F., & SINGH, A. 2010. Associations Between Early Marriage and Young Women's Marital and Reproductive Health Outcomes: Evidence from India. *International Perspectives On Sexual And Reproductive Health*, 36, (3), 132-139.

162 GOVERNMENT OF INDIA. The Protection of Children from Sexual Offences Act, 2012. Retrieved from <http://wcd.nic.in/sites/default/files/childprotection31072012.pdf>

or economic abuse, it does not do adequate justice to the gendered nature of such violence in households. The curriculum mentions that abuse could happen to “both boys and girls”; and to anyone “irrespective of class, caste, educational status, urban-rural locations”<sup>163</sup>. However, it does not mention that some people may be especially vulnerable to abuse and violence because of gender, age, caste, class, religion, sexual orientation or disability.

The curriculum also uses rape and sexual harassment as interchangeable concepts. For example, it mentions that sections 354 and 356 of the Indian Penal Code (IPC) specify “attempt to rape” as “punishable crime”. However, section 354 is about “assault or criminal force to woman with intent to outrage her modesty” and its subsections A, B, C and D (added in the Criminal Law (Amendment) Act, 2013) detail Sexual Harassment. Section 356 is about “assault or criminal force in attempt to commit theft on any property which that person is then wearing or carrying”, and is not about rape or sexual harassment. Rape is criminalised under sections 375 and 376. This is misinformation regarding legal provisions. Further, the curriculum restricts examples of domestic violence and abuse to ‘wife-beating’, and this tends to obscure the reality of the abuse of mothers, daughters, sisters, sisters-in-law, (live-in) partners, transgender persons, sons, etc.

These approaches reflect societal discomfort and confusion around the issues of consent, power and sexual violence. Not addressing these intersections defeats the purpose of such education. It does not empower young people to protect themselves from violence and prevent such forms of violence through condoning peers’/family members’ behaviour.

### **HIV transmission**

One of the factsheets provided in Section IV on preventing HIV mentions that a majority of infections are transmitted during heterosexual sexual encounters, while men who have sex with men account for less than 2% of cases. The framing of the transmission of HIV as a ‘gay disease’ is predominant in society at large, and an enduring myth about AIDS globally, but it is not specifically addressed in the curriculum within the section on myths and stereotypes. While the curriculum does not perpetuate this myth, it does not expressly debunk it either.

### **Conception, Contraception and Abortion**

The curriculum mentions the presence of “effective modern contraceptive (birth control) methods that provide protection against unwanted pregnancy”<sup>164</sup>. However, there is no description of different methods of contraception and safe termination of pregnancy, nor of their availability, accessibility, usage, advantages, and risks. Abortion is only mentioned in the context of gender-biased sex selection and RTIs. There is no mention of the Medical Termination of Pregnancy (MTP) Act and the provisions under which adolescent girls and young women can access safe abortion facilities at medical centres.

---

163 NCERT. 2013. *Training and Resource Materials: Adolescence Education Programme*.

164 Ibid.

## Reproduction

The curriculum tends to reinforce some stereotypes and mislead the learner by using universal language while talking about issues such as reproduction. For example, it states that “menstrual periods are symbolic of a woman’s capacity to reproduce which should be universally respected”<sup>165</sup>. In fact, it is important to help young people recognise that whereas the capacity to reproduce may be respected in some cultures, it may also be used and manipulated in order to denigrate, subjugate and exploit women. The curriculum does not empower young people to make the choice of whether or not to reproduce. Further, the rhetoric of universal respect for reproductive capacity makes it seem as though all young women want to reproduce, and their primary function in society is to bear children. It also marginalises those who may not be able to or do not want to reproduce.

## Sexuality and Disability

Although the curriculum attempts to be inclusive of diversity and mentions disability in the introduction, in the context of diversity of people and of their bodies, there is no mention of young people with disabilities anywhere in the curriculum, not even in case studies and activities. The curriculum also doesn’t include provisions or suggestions on transacting this curriculum with young people with disabilities, contributing to the continued dismissal of sexuality in the lives of people with disabilities. This points to how people with disabilities get excluded from mainstream discourse on sexuality.

It is important to read and understand this discussion about the lack of sexuality and disability in the AEP curriculum in conjunction with other studies and observations on the subject of sexuality, disability and the role of CSE. For example, TARSHI’s 2018 working paper on Sexuality and Disability notes:

*Societal attitudes that define the individual with disability by their disability alone fail to acknowledge the person as a whole. The same view further leads to the belief that people with disabilities are not sexually assaulted or abused as no one will desire them. It is also falsely assumed that all people with disabilities are incapable of engaging in any sexual activity, or of being sexually intimate. The consequence is that there is a severe lack of accessible resources and support for persons with disabilities. Given that rights based comprehensive sexuality education resources are difficult to create and to access even for non-disabled people due to factors such as age, internet access, insufficient or no focus in school and educational curriculum, socio-cultural norms, gender and other such, the situation is even more constricting for persons with disabilities who may often be dependent on others for their access to and understanding of these issues.*<sup>166</sup>

The challenge with incorporating content and transaction methods for young people with disabilities in SE lies in helping them “understand and accept their sexuality in

---

165 Ibid.

166 TARSHI. 2018. *Sexuality and Disability in the Indian Context*.

a social context where their actual opportunities for sexual expression and guiltless pleasure may be extremely limited. Adolescents and young people with disabilities must cope with all physical changes, emotional anxieties and social conflicts of able-bodied adolescents, in addition to those produced by their disabilities”<sup>167</sup>.

It is encouraging to see the movement towards change in small pockets, albeit not in the AEP curriculum being discussed here. In a newspaper article from 2017, Mumbai-based NGO Urmi Foundation reported developing their own SE curricula as part of a larger training and support resource for adolescents with disabilities. This is being implemented in a partnership with the Brihanmumbai Municipal Corporation (BMC) in Maharashtra, reaching more than 1,000 adolescents with disabilities across 13 schools<sup>168</sup>.

## Reviewing implementation of the AEP

This sub-section presents key highlights from the following two documents, in line with the working definition of CSE, which addresses knowledge, skills, attitudes and values:

- The 2010-11 concurrent evaluation<sup>169</sup> of the AEP, which covered 21,967 students, 1,000 teachers, and 200 principals from government and private schools in five states (Punjab, Odisha, Karnataka, Maharashtra, and Madhya Pradesh). The students covered were adolescent girls and boys aged 14-18, of which 19,666 were from schools implementing the AEP and 2,301 from non-AEP schools.
- A 2017 assessment<sup>170</sup> of select programmes by UNFPA gathered data from 5,172 students, 230 teachers and 94 principals from across 95 schools (of KVS, NVS, Bihar State Board and Odisha’s residential tribal schools).

A direct comparison on progress made between the data presented in the 2010-11 evaluation and 2017 assessment is difficult to make. The assessment is based on the self-reported Knowledge, Attitude and Practices (KAPs) of students across three schooling systems where the AEP is implemented, whereas the 2010-11 evaluation is of the differences in KAP between students who have been exposed to the AEP and those who have not.

The Evaluation and the Assessment suggest that the AEP has made a modest contribution in students’ knowledge and attitudes about the topics in the curriculum<sup>171</sup>.

---

167 ADDLAKHA, R. (2009). Gender, Subjectivity and Sexual Identity: How Young People with Disabilities Conceptualize The Body, Sex and Marriage in Urban India. *Sexuality And Disability* 25, (3). Retrieved from <http://www.cwds.ac.in/wp-content/uploads/2016/09/GenderSubjectivity.pdf>

168 GOEL, D. (2017, August 06). Meet Mumbai’s ‘Miss Manual’ who is helping children with disabilities get access to education. *The Indian Express Edex Live*. Retrieved from <https://www.edexlive.com/live-story/2017/aug/06/meet-mumbais-miss-manual-who-is-helping-children-with-disabilities-get-access-to-education-946.html>

169 NCERT and UNFPA. 2011. *Concurrent Evaluation of Adolescence Education Programme*. Retrieved from <https://mittalsouthasiainstitute.harvard.edu/wp-content/uploads/2013/06/UNFPA-Concurrent-Eval.pdf>

170 NCERT, UNFPA and UNESCO. 2017. *Assessment of Select Adolescence Education and Life Skills Education Programs in India*.

171 Ibid.

## Accurate information and knowledge transfer

As a direct impact of knowledge through the AEP, some findings are as follows:

- From the 2017 assessment, on the question relating to the possibility of becoming pregnant at first sexual intercourse (if no birth control is used), less than 40% of Grade 9-10 students gave the correct answer (“yes, it is possible”), with 23% giving the wrong answer (“no, it is not possible”), with girls across school systems being more aware of the possibility of pregnancy due to first time intercourse, than boys<sup>172</sup>. It is worth noting that any negative consequences arising from this belief would be borne by girls and women in terms of unwanted pregnancy, stigma and discrimination. Interestingly, the 2010-11 evaluation showed that knowledge on this issue among girls in schools that had AEP was considerably different from those in non-AEP schools (34% vs. 28%)<sup>173</sup>.
- The 2010-11 evaluation showed that more students correctly distinguished between HIV and AIDS in AEP schools (66%) than in non-AEP schools (52%). Students from AEP schools also knew more about the spread of HIV than students of non-AEP schools. Approximately 31% students from AEP schools and 20% from non-AEP schools had “comprehensive” knowledge on the modes of transmission, that is, they got all the answers correct. However, 31% is still a very low figure and merits a review and improvement of material and training on HIV and AIDS<sup>174</sup>.
- Only 59% AEP students could identify the key characteristic of STIs, which is that they are “spread through sexual contact”, as compared to 55% non-AEP students, as stated in the 2010-11 evaluation. Girls fared marginally better than boys<sup>175</sup>.
- Nearly 46% of AEP students said that they did not know about the symptoms of RTIs in comparison to 55% of non-AEP students. According to the 2010-11 report, this signifies improved knowledge levels among AEP students in relation to non-AEP students, although the level of information regarding RTIs remains low even in AEP schools<sup>176</sup>.
- Responses to a case study on child sexual abuse indicated insufficient understanding of the issues involved. As per the 2010-11 evaluation, only 22% non-AEP and 24% AEP students recognised that in the case study the boy’s uncle was trying to sexually abuse him. On some counts, AEP students had better understanding than non-AEP: 65% AEP and 54% non-AEP students reported that the boy’s parents should try to understand why he has become quiet and withdrawn. Girls displayed better understanding than boys: more girls (74% in AEP, 63% non-AEP) reported that the boy’s parents should try to understand why he has become so quiet and withdrawn, as compared to boys (58% AEP, 47% non-AEP)<sup>177</sup>. The 2017 assessment observes that “at Grade 9-10, less than one-third students (32%) are able to identify the issue as sexual abuse, while for teachers the frequency is nearly double (62%). For Grade 11-12 students the proportion is 47%. Thus there is a considerable gap in the basic awareness of students and teachers, right from the definition itself.”

---

172 NCERT and UNFPA. 2011. *Concurrent Evaluation of Adolescence Education Programme*.

173 Ibid.

174 Ibid.

175 Ibid.

176 Ibid.

177 Ibid.

## Attitudes and values

- With regard to menstruation, the 2010-11 evaluation showed that AEP resulted in some positive impact on attitudes towards existing social taboos. Beliefs that menstruating women and girls should be isolated, should not go to sacred places, should not touch pickles, etc. were shown to have attenuated. Girls' attitudes on these indicators were found to be significantly better than boys' attitudes<sup>178</sup>.
- The majority of students said that in case their parents want to get them married against their wishes, they would try to convince the parents otherwise. Girls opted more often to try to convince their parents than boys. AEP students scored higher than non-AEP students, among girls as well as boys<sup>179</sup>.
- AEP students were more likely (79%) to choose positive responses against gender stereotypes (in case studies of boys doing housework and girls engaging in sports after puberty) than non-AEP students (74%)<sup>180</sup>.
- An interesting pattern can be observed wherein girls recorded more progressive stances or indicated significantly greater benefits from the AEP than boys, across a range of issues including views on decision-making within families, performance in schools and clothing, and violent acts such as 'wife-beating'. The 2017 assessment states that "Interestingly, although girls still have the more progressive attitudes, the gender gap has reduced in both JNV and KV schools, indicating greater positive attitudinal change in boys as compared to girls (between Grade 9-10 and Grade 11-12) – on the option 'Rajan should feel proud he does housework and not try to hide it.'"
- A considerable number of students in the 2017 assessment considered wife-beating to be justified under some circumstances, such as (in descending order in terms of being 'justified'): "she neglects her children", "she goes out without telling him", "she argues with her husband", "she dresses in a manner to attract attention", "she is unfaithful", "she burns the food" and "she refuses to have sex with him". The 2017 assessment goes on to note "This is a very serious issue and needs to be addressed in the programme." The 2010-11 evaluation interestingly states that while most students considered it to be unjustified under any circumstances, "a higher proportion of students in non-AEP schools (61%) mentioned this compared to 57% of AEP school students."
- With regard to the knowledge about and experience of physical attraction as a legitimate part of growing up, high disparities between girls and boys in both AEP schools and non-AEP schools were seen, with boys showing a greater acknowledgement of their desires<sup>181</sup>.

In the 2017 assessment, students and teachers across both national and state schooling systems were of the opinion that the AEP has been effective in providing certain information. Students reported a positive impact on the dispelling of their fears and attitudinal improvement, which was tested on the basis of the statement, "I try to look at things from the other person's point of view".

---

178 Ibid.

179 Ibid.

180 Ibid.

181 Ibid.

## Facilitation of the curriculum

A considerable part of the 2010-11 evaluation focuses on the knowledge and perspectives of the teachers and facilitators, given the bulk of the success of the programme is dependent on how they transfer knowledge to students. Overall, some key findings were:

- The AEP has been impactful with teachers, with nodal teachers displaying a significantly more positive attitude towards, as well as an increase in their knowledge about, sexuality. A number of teachers who had AEP training shared that it changed their perspective and skills as teachers<sup>182</sup>.
- Students ranked teachers (in AEP and non-AEP schools) as the top source of knowledge of reproduction, and second (after books/magazines) for knowledge of contraception. The proportion of students identifying teachers as their source of information is higher in AEP as compared to non-AEP schools.
- The AEP helped teachers appreciate adolescents and peer groups as positive resources. The nodal teacher training helped improve teachers' knowledge, attitudes and ability to transact adolescence issues, including sexuality-related themes<sup>183</sup>.
- On the theme of domestic violence, the proportion of male teachers who believe that wife-beating is not justified under any circumstances is 60-64%, while 70-73% female teachers hold this belief. It is remarkable that a considerable proportion of teachers – “in fact a far higher proportion of teachers than students” – justify wife-beating if the wife is unfaithful in both AEP and non-AEP schools<sup>184</sup>.
- Teachers identified ‘RTIs/STIs’, ‘Sexual Abuse’ and ‘Gender Sensitivity’ as themes/sessions they felt least comfortable with. These are also sessions that students found less interesting. So it appears that teachers' discomfort with a theme brings down the quality of a lesson. Themes not liked much by students, according to teachers' perceptions, included ‘Substance Abuse’, ‘RTIs/STIs’ and ‘Anger Management’<sup>185</sup>.
- Teachers reported feeling most comfortable with teaching ‘Good Nutrition’, ‘Life Skills Development’, ‘Decision Making Skills’ and ‘Positive Relationships’ – all four of which are among students' self-reported top preferences. Analysis of the evaluation shows a strong correlation between teachers' comfort levels in teaching particular themes/sessions, and students' liking these themes. According to teachers, themes most liked by students included ‘Growing Up and Adolescent Health’, followed by ‘Life Skills Development’ and ‘Self Esteem’<sup>186</sup>.

In the 2017 assessment, teachers' responses noted that the programme has been “immensely effective” in some “extremely important areas”, including avoiding sexually transmitted infections and pregnancy, building equal relationships and reducing sexual preference-based discrimination and bullying.

Findings from the 2017 assessment also indicate that the integration of AEP themes with other school subjects has taken place less in the State Schooling systems (Odisha

---

182 Ibid.

183 Ibid.

184 Ibid.

185 Ibid.

186 Ibid.



and Bihar) as compared with National Schooling systems, in which the KV Schools have been reported to have furthest integration<sup>187</sup>. As an important step towards institutionalisation, AEP has been included in the school timetable and at least 23 hours of AEP teaching time has been allocated to the programme in one academic year (increased from the 16-hour requirement that prevailed up to 2013). In addition, based on popular demand, it was decided that AEP would also be provided in Grade 8.

### **Students' and teachers' feedback on AEP**

Overall, in the evaluation and the assessment, although with differing percentages, teachers and students are in favour of continuing the AEP and even lowering the initiation age for it. The 2017 assessment indicated that school principals have expressed their preference of an even earlier initiation of the AEP, for Grades 1-5<sup>188</sup>. The 2010-11 Concurrent Evaluation<sup>189</sup> reports:

- A high proportion of students (52% AEP, 38% non-AEP) responded in favour of introducing AEP to students below the age of 14 years, i.e. 9 -13 years. More girls than boys favoured lowering the age of initiation of AEP.
- Students exposed to AEP reported benefits they have experienced: it has dispelled some of their fears (40%); they now try to look at things from the other person's point of view (34%); have found ways to relax (30%); and have more questions (28%). However, for 13% there is no change, and 10% were more confused than before.
- Several students felt AEP helped them open up, learn how to deal with friends, and learn about issues they hadn't even thought about earlier.
- Teachers found that AEP sessions helped students develop life skills, including problem-solving in real situations, communicating, managing stress, relationship building, understanding emotions, accepting criticism, being patient, anticipating problems, decision-making, and resisting adverse peer influence. They felt that these sessions give students skills for negotiating in different spheres of life. As many as 86% of the teachers agreed that AEP helped students to acquire life skills to a great extent, while only 11% teachers believe that AEP has helped students to some extent<sup>190</sup>.

---

187 NCERT, UNFPA and UNESCO. 2017. *Assessment of Select Adolescence Education and Life Skills Education Programs in India*.

188 Ibid.

189 NCERT and UNFPA. 2011. *Concurrent Evaluation of Adolescence Education Programme*.

190 Ibid.

## **SECTION 6**

# **SE Programmes Led By Non-Government Actors**

In this chapter, we look at some prominent programmes designed and offered by NGOs and private organisations in different parts of the country. These are not meant to paint a representative image of the diverse SE programmes in the country, nor is it within the scope of this paper to analyse the comprehensiveness of the sexuality education provided in these programmes. We only seek to highlight the various ways of designing and implementing SE in diverse socio-cultural contexts across the country.

## NGO-led SE programmes

### Centre for Catalyzing Change (C3)

The UDAAN programme is a unique partnership between C3 (formerly known as CEDPA, India), the Government of Jharkhand (GoJ) and the Jharkhand State AIDS Control Society (JSACS), in response to a national policy directive for states to provide school-based ASRH education in all secondary and senior secondary schools in 2003. Responding to the School AIDS Education Programme (SEAP), the GoJ expanded the curriculum's focus in 2006 by implementing a version of the AEP that has reached over 500,000 adolescents in secondary/senior secondary schools and 20,000 students in upper classes of primary schools<sup>191</sup> with life skills education. Additionally, by including its curriculum in select B.Ed. colleges, a total of 600 trainee teachers were trained in 2015-17 on adolescence education content<sup>192</sup>. A similar pattern was replicated in Bihar, where the programme is called TARANG.

The UDAAN curriculum was created for providing life skills and adolescent SRH knowledge to young people in Grades 9 and 11 during the regular academic year. The curriculum and the facilitation methods were conceptualised keeping the AEP model in mind. At the request of the GoJ, C3 was able to expand the curriculum and adapt it for upper primary classes<sup>193</sup>. The programme transitioned leadership from JSACS to the Department of Education (DoE) in 2007, with technical assistance from C3 to design, monitor and evaluate and assist with programme implementation throughout.

The success of the programme should not necessarily be measured only in terms of absolute percentages, such as whether a knowledge indicator shows improvement over time. Adapting to the working modalities of any government-led programme will always limit/define the thoroughness with which SRHR information can be delivered to young people. Having said this, it is important to note that UDAAN's evaluation indicates that students learned certain types of information more easily than others, such as on puberty, positive self-efficacy, peer pressure and HIV and AIDS. Awareness of female oral contraceptives and male condoms was high, and attitudes towards gender equality improved, with 70% of students saying they believed that household work should be shared, and 60% of students reported believing that reproductive decisions should be made jointly. Students tended to prefer delaying marriage and childbirth, and

---

191 CHANDRA-MOULI, V., PLESONS, M., BARUA, A., PATNAIK, A., GOGOI, A., KATOCH, M., ZIAUDDIN, M., MISHRA, R., SINHA, A. 2017. *What Did It Take to Scale Up and Sustain Udaan, a School-Based Adolescent Education Program in Jharkhand, India?* © 2017 by David and Lucile Packard Foundation and Department of Reproductive Health and Research, World Health Organization. Retrieved from <https://www.packard.org/wp-content/uploads/2017/05/Udaan-case-study.pdf>

192 Ibid.

193 Ibid.

expressed the desire to limit the number of children they would have in the future. They also reported improved communication with their parents. 79% of students reported involvement in decisions about their life partner.

C3 noted that Grade 11 was too late to make effective interventions in young people's views of sexuality and gender, with attendance being very low and many students at this stage completing their education at junior college rather than school. Furthermore, baseline study findings from this programme showed that such programmes have a more lasting impact when introduced early. Therefore, in 2013, the GoJ agreed to introduce the programme in Grades 6, 7 and 8. C3 reported that it was challenging to introduce the curriculum to junior classes<sup>194</sup>.

There are a number of factors that worked in how UDAAN's model supported the state in sustaining the programme as well as in taking it to scale across 24 districts. Chief amongst these was supporting the integration of the programme into a budget line, and creating ownership from JSACS to the DoE. This involved advocacy as well as investment of time and resources, such as C3's continued staffing and office presence in the state, which enabled them to work closely and provide key technical inputs. The convergence of willing Education and Health government departments, as well as a favourable national mandate with policies like RKSK and Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA (RGSEAG SABLA)<sup>195</sup> have also worked in UDAAN's favour.

Despite these supportive factors, the programme was unable to resolve certain challenges, such as high turnover and shortage of staff, and a lack of female nodal teachers and clearer selection criteria for these teachers. Another key barrier was in creating linkages with service provision for adolescents and young people<sup>196</sup>. C3 has pointed out the need to invest in teacher training and sensitise facilitators to ensure they are comfortable and seasoned with navigating the topics in the curriculum, as they could identify a direct link between facilitators' discomfort with a topic and students' knowledge on these topics. C3 also faced hostility and resistance from many sections of society in the initial years of running the programme; therefore, they emphasised the importance of engaging with parents early on to dispel misunderstandings and misconceptions.

### **Naz Foundation (India) Trust**

Naz Foundation (India) Trust<sup>197</sup> started a programme called Goal<sup>198</sup> in 2006 for adolescent girls in Delhi. Using the medium of sports (netball), they taught young girls about HIV prevention. Working in collaboration with five Sarvodaya schools, they held hour-long

---

194 GOGOI, A. & NATHANI, V 2014. *Policy Landscaping and Strategies in In-School Adolescent Programmes* [PowerPoint slides]. Presented at TARSHI and The YP Foundation's Landscaping and Strategy Meeting on 'Exploring the Dynamics of Sexuality Education for Adolescents and Young People in India', New Delhi. © 2014 by Centre for Development and Population Activities (now C3 India).

195 GOVERNMENT OF INDIA. MINISTRY OF WOMEN AND CHILD DEVELOPMENT. Approval of Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) - SABLA (2010. September 27). Retrieved from [http://wcd.nic.in/sites/default/files/1-SABLAScheme\\_0.pdf](http://wcd.nic.in/sites/default/files/1-SABLAScheme_0.pdf)

196 CHANDRA-MOULI, V., PLESONS, M., BARUA, A., PATNAIK, A., GOGOI, A., KATOCH, M., ZIAUDDIN, M., MISHRA, R., SINHA, A. 2017. *What Did It Take to Scale Up and Sustain Udaan, a School-Based Adolescent Education Program in Jharkhand, India?*

197 The Naz Foundation (India) Trust. Retrieved from <http://nazindia.org/>

198 Goal Programme. Retrieved from <http://nazindia.org/goal/>

sessions twice a week, for girls aged 12 to 18. Small groups of young women were taught netball and life skills. Talented girls were identified and selected to become Goal Champions, who were trained as Community Sports Coaches, and would deliver 'Goal sessions' to new groups of girls. The programme was designed to enhance personal empowerment as well as social empowerment, and has reached 15,708 girls in Delhi.

A small baseline survey of parents in Delhi conducted by Naz in 2013 showed that 44% of parents thought that girls should not play sports after menarche/during menstruation. Even girls had a problem with playing: they were inhibited about their bodies, saying that if they jumped, their legs would show, and that they were uncomfortable with standing tall. In such a scenario, a programme that expected them to play during their period was a big challenge. However, after a few sessions, all the girls started playing, irrespective of whether they had their period. During discussions with the girls, Naz asked many questions on issues like early marriage, girls' agency in the decision to marry, love, infatuation, sexuality, HIV, menstruation etc. Naz found that the principals and teachers were happy to talk about HIV, but not about how it spreads and how it can be prevented – they were loath to talk about sexuality, sexual intercourse, and condoms.

In 2013, Naz also began teaching self-defence and found that there was a lot of demand for this. Many schools approached them to conduct these self-defence classes. These classes provided a chance to start a dialogue with the school, and soon Naz started educating young women on sexuality as well. On the whole, Naz programmes create a safe space where girls can have fun, do what they want to do, enjoy the sessions, and end up learning. Naz facilitators aim to get clear information across to the girls. Their focus is on sexuality, health, hygiene, menstruation, HIV, rights, how to access critical resources in their communities, and the importance of individual safety<sup>199</sup>.

## Sangath

SE was a part of the School Health Promotion and Empowerment (SHAPE) programme that Sangath implemented in schools across Goa in 2009-11<sup>200</sup>. Using WHO's Health Promoting Schools model, SHAPE used school health counsellors as an entry point for schools, making the case that school health counsellors can be a low-cost human resource investment. The programme worked at three levels, the school as a whole, the classroom, and individual counselling. The school level included addressing school health policies, health camps, establishing an advisory board, integrating school assemblies amongst other activities. The classroom focused on delivering workshops on life-skills through tools that address academics, goal-setting, examination stress, personal space, gender and violence, anger management, self-esteem, nutrition, SRH<sup>201</sup>.

---

199 TIWARI, J. 2014. The Goal Programme [PowerPoint slides]. Presented at TARSHI and The YP Foundation's Landscaping and Strategy Meeting on 'Exploring the Dynamics of Sexuality Education for Adolescents and Young People in India', New Delhi. © 2014 by Naz Foundation (India) Trust.

200 RAJARAMAN, D., TRAVASSO, S., CHATTERJEE, A., BHAT, B., ANDREW, G., PARAB, S. AND PATEL, V. 2012. The acceptability, feasibility and impact of a lay health counsellor delivered health promoting schools programme in India: a case study evaluation. *BMC Health Services Research*. Retrieved from <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-127>

201 SHAPE – Sangath. Retrieved from <http://www.sangath.in/shape/>

SE was conducted in classroom sessions. Life-skills modules were designed for and taught to students of Grades 5 to 12. This curriculum was age-appropriate and covered three different domains – physiological, psychosocial and effective learning. Sangath had learnt that this kind of intervention was feasible and acceptable only if teachers provide support<sup>202</sup>. Parents did not pose much resistance to the programme; they wanted children to get the information through a school programme. Based on their experience, Sangath felt that programmes that explicitly focused on sexuality could begin from Grade 6 onwards, but general education on the body, hygiene, and related topics should begin earlier. During Grades 1-4, some basic knowledge should be provided, with sessions on body parts, ‘good touch and bad touch’, personal safety, growing up, menstruation, gender, rights, responsible sexual behaviour, and seeking help for problems or to get correct information. The most common questions asked by young people in Sangath’s experience were on SRH, homosexuality, masturbation, HIV, and child abuse. More boys asked about homosexuality, masturbation, and HIV, and more girls asked about SRH and child abuse. The sexuality of persons with disabilities was quite often unrecognised<sup>203</sup>.

Lessons learned from SHAPE formed the foundation for another of Sangath’s programmes, called SEHER (Strengthening the Evidence base on effective school based interventions for promoting adolescent health), run in collaboration with the London School of Hygiene and Tropical Medicine, Public Health Foundation of India and SCERT, Bihar. A four-year project funded by UNFPA and MacArthur Foundation focused on select schools in the Nalanda district in Bihar, SEHER works with students, parents and teachers, and includes a component of SRHR. The programme uses SHAPE’s framework to enhance SRH, creating a positive school climate and equitable gender norms as intermediate outputs. Reduction in substance use, sexual risk behaviours, depressive symptoms, and bullying and violence, are long-term outcomes<sup>204</sup>.

SEHER added the SHAPE framework, adapted it to the local setting to the then current (usual care) practice implemented by the state’s DoE, comprising 16 hours of classroom sessions on the thematic areas described above, through the government’s TARANG life-skills programme. Trainings were conducted separately for teachers and school counsellors who would deliver streamlined curriculum developed for the respective groups.

A pilot test evaluated intervention delivery and found that principals and teachers identified the programme with (i) delivering information on SRH issues (ii) through participatory methods (iii) by engaging the school in identifying and communicating key messages. Students made many submissions to the ‘speak-out box’ and many students accessed counselling services through the programme<sup>205</sup>. The programme also experienced common barriers, such as the school management committee perceiving

---

202 ANDREW, G. 2014. (2014). CSE within In-School Context [PowerPoint Slides]. Presented at TARSHI and The YP Foundation’s Landscaping and Strategy Meeting on ‘Exploring the Dynamics of Sexuality Education for Adolescents and Young People in India’, New Delhi. © 2014 by Sangath and CorStone.

203 Prachi Khandeparkar. 2012. Personal communication.

204 SHINDE, S., PEREIRA, B., KHANDEPARKAR, P., SHARMA, A., PATTON, G., ROSS, D. A., WEISS, A. H., and PATEL, V. 2017. The development and pilot testing of a multicomponent health promotion intervention (SEHER) for secondary schools in Bihar, India. *Global Health Action*, 10, (1).

205 Ibid.

SE content as inappropriate for secondary year students, as well as, in some schools the counsellors were not accepted (they were perceived as external, too young, or not qualified enough)<sup>206</sup>.

The evaluation refers to some challenges such as hesitancy in participating in mixed gender groups, irregular attendance, and girls not feeling comfortable approaching male counsellors or teachers for counselling services<sup>207</sup>, despite the assurance of confidentiality and (where possible) the availability of a confidential physical space for counselling. The programme showed that whole-school interventions with the engagement of a health promoting coordinator have greater potential for health promotion compared to classroom-based curricula, by increasing “social connectedness, reducing health risks and increasing physical activity”<sup>208</sup>. The “whole-school approach” has been adapted to implement SE by other non-profit organisations, such as the We All Benefit manual by Rutgers. The approach gives the school complete control over the programme and brings together parents, teachers, health care providers and officials<sup>209</sup>. A trial conducted to assess the effectiveness of the programme in Grade 9 students in Nalanda, Bihar, showed that it “had substantial beneficial effects on school climate and health-related outcomes when delivered by lay counsellors, but no effects when delivered by teachers<sup>210</sup>.”

## School-led SE programmes

Schools are becoming more cognizant of the need for SE programmes, although to varying degrees: some feel this is necessary information and others bring resistance to the implementation of CSE in the classroom. The absence of mandated technical guidelines means there is limited accountability to the quality of information being given to students. Whilst the full range of CSE is absent in most schools, the introduction of SE

from the perspective of preventing HIV, Child Sexual Abuse and sexual violence, is more common.

---

206 Ibid.

207 Ibid.

208 Ibid. The paper provides the following references:

Stewart-Brown S *What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach?* Copenhagen, WHO Regional Office for Europe. [cited 2017 Aug 18]; Available from: <http://www.euro.who.int/document/e88185.pdf>;

Senior E. *Becoming a health promoting school: key components of planning*. Glob Health Promot. 2012;19:23–31; 429871.;

Turunen H, Tossavainen K, Jakonen S, et al. *Did something change in health promotion practices? A three-year study of Finnish European network of health promoting schools, teachers and teaching*. Theory Pract. 2006;12:675–692.;

Shackleton N, Jamal F, Viner RM, et al. *School-based interventions going beyond health education to promote adolescent health: systematic review of reviews*. J Adolesc Health. 2016;58:382–396.

209 Whole School Approach for sexuality education: step-by-step. Retrieved from <https://www.rutgers.international/what-we-do/comprehensive-sexuality-education/whole-school-approach-sexuality-education-step-step>

210 SHINDE, S., WEISS, H.A., VARGHESE, B., KHANDEPARKAR, P., PEREIRA, B., SHARMA, A., GUPTA, R., ROSS, D.A., PATTON, G., and PATEL, V. 2018. Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: a cluster-randomised controlled trial. *The Lancet*. Retrieved from [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31615-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31615-5/fulltext)

Examples of this can be observed in the National Capital Region (NCR). In 2017, schools in NCR reported implementing such versions of SE programmes in Delhi at the primary, pre-primary, secondary and senior secondary levels<sup>211</sup>. Variations included:

- not having a curriculum in place but conducting classes (Ryan International School, Faridabad);
- providing information on sex and contraception but a lack of open discussion about these (Ryan International School, Faridabad);
- teachers using images circulated between students on platforms such as WhatsApp to generate discussion in classrooms (Nigam Pratibha Vidhyalaya, MCD school);
- bringing in a doctor to explain hygiene as well as how students should define acceptable and unacceptable behaviour within relationships (Mamata Modern School, West Delhi);
- limiting content on preventing and identifying CSA, with provisions for a counsellor but the position unfilled (Shaheed Hemu Kalani Sarvodaya Bal Vidyalaya, Lajpat Nagar and Govt. Sarvodaya Kanya Vidyalaya, both Delhi Government Schools);
- advocating that young people should “keep distance from the opposite sex” (many schools such as Govt. Sarvodaya Kanya Vidyalaya reported this).

Similarly, schools affiliated with the Catholic Church in Maharashtra reviewed the need to address SE in 2017, through the Western Region Catholic Association for Education (WRCAE) that covers 1,500 educational institutions across Goa, Gujarat and Maharashtra. These discussions revolve around the need to advance content from beyond reproduction and ‘safe sex’ to address family life and moral values, and are prominent as a way of working around the perception that SE is against Indian culture. However, this approach prioritises the emotional, intellectual and social development of a young person over physical and physiological changes taking place. It also runs the risk of advocating abstinence in place of providing information on the body and anatomy, and creating an environment of avoiding discussions on sex and sexuality. Constructive aspects of this approach include bringing in trained speakers to conduct sessions with parents and to provide better resource material<sup>212</sup>.

### **Step by Step School**

Step by Step School<sup>213</sup> is a school in NOIDA, in the National Capital Region. The student body includes persons with disabilities. The AEP is incorporated into the school curriculum for all children, especially for those with disabilities. Step by Step has modified the current AEP curriculum to suit the school’s needs.

Younger students are introduced to the topics of safety and privacy, such as personal space, and ‘stranger danger’. For students with disabilities, from the age of 8, information about menstruation and other bodily changes is communicated, and ways

---

211 KHANDELWAL, H. (2017. May 5). Sex education in schools limited to good-bad touch. *Daily News and Analysis*. Retrieved from <http://www.dnaindia.com/india/report-sex-education-in-schools-limited-to-good-bad-touch-2428007>

212 SHUKLA, A. (2017. Jan 21). Catholic church discusses teaching of sex education. *Daily News And Analysis*. Retrieved from <https://www.dnaindia.com/academy/report-catholic-church-discusses-teaching-of-sex-education-2294583>

213 Step by Step School. Retrieved from <http://sbs-school.org/sbsweb/index.cfm>



of using and disposing of sanitary napkins are explained through flashcards and other visual aids. Girls are usually told about menstruation before their periods start, so that they are better prepared. When preparing students for menstruation, particular attention is paid to girls on the Autism Spectrum, as they may react strongly to new situations. Despite initial resistance from some staff members and parents, Step by Step believes that AEP is crucial for all children, including children with disabilities, and invests in trainings for teachers and conversations with parents.

According to a former counsellor of the school, students in Grades 4 and 5 attend sessions on 'growing up' given by professionals such as gynaecologists. Those in Grades 6 and 7 attend workshops and sessions, and talk to the school counsellor about emotional issues. The senior school counsellor, teachers, and resource persons address students on life skills and sexual health issues from Grade 9 onwards. Special educators conduct sessions for students with special needs as well. The counsellors may meet students once or twice a week, depending on the need. Parents are regularly updated about these sessions. The frequency and content of these sessions vary according to the age of students, as well as their specific education needs, based on the varied characteristics and the diversity of students with disabilities.

Students not exposed to AEP are often shy, embarrassed, and ashamed about sexuality. However, after attending these sessions, the students of Step by Step report that the sessions have increased their self-confidence and comfort with their bodies and bodily changes during puberty. They show positive behavioural changes as well – for example, girls started carrying sanitary napkins regularly<sup>214</sup>. Students with disabilities have also reported feeling comfortable with these sessions. Regular feedback from students is encouraged and they are welcome to ask questions anonymously. The topics discussed include physical changes, emotional needs, body image issues, and questions around sexuality and sexual health from a rights-based perspective. Parents who may be neglecting sexuality-related issues, or calling sexual behaviour 'problematic', are involved in these programmes from the very beginning and the merits of AEP are explained to them. Parents have often reported being satisfied with the programme. Through these experiences, Step by Step has gained important insights to add to a growing knowledge around CSE.

---

214 Prachi Shrivastava. 2012. Personal communication.

## SECTION 7

# Looking Ahead

We have examined the trajectory of SE in India and analysed the implementation of what has been, at the time of writing the paper, the mainstream CSE programme in the country. Keeping in mind the conditions under which SE programmes in the country are situated and implemented, this section outlines some broad strategies that could be considered by various stakeholders whom we see as critical for CSE in the country. Some of these stakeholders include programme implementers, the government, donors, educators, and young people themselves.

## **Shifting the needle: CSE beyond disease-prevention and Reproductive Health**

The lens through which we approach SE will dictate the content, approach and outcomes of these programmes, on the kinds of knowledge that we trust young people with, and whether we can strengthen their agency as individuals to make their own choices.

Positioning SE only through the lens of disease prevention or Reproductive Health ignores the lived realities of young people. Young people have questions and concerns around a range of sexuality-related issues, from understanding their feelings of attraction towards other people, to peer pressure on sexual activity, to critically understanding popular culture or societal perceptions or stereotypes about different gender or sexual identities. The AEP has done well in not restricting its positioning to one based on fear or solely on disease prevention, but instead recognising the role that it can play in building young people's capacities to face the complex experiences they are likely to face in their lives. However, it is also time to move beyond this and adopt a comprehensive, sexuality-affirming approach that recognises young people as individuals with sexual rights, as individuals who have to navigate an increasingly tricky landscape regarding consent, attractions and relationships.

Indeed, CSE should be reinforced as advancing individual and social mobility, confidence in one's self and bodily integrity, developing sex-positive attitudes to respecting diversity, and strengthening interpersonal relationships for adolescents and young people to communicate confidently and safely with adult stakeholders. Given our socio-cultural milieu, this is not easy; a starting point could be, then, to highlight the role of CSE in preventing gender-based violence, early and forced marriage, unwanted pregnancies, new HIV infections and unsafe abortions. However, as confidence in CSE programming increases and there is trust amongst stakeholders, it becomes important to introduce pleasure or expressions of sexuality that are self-affirming, positive and not harmful, within SE curricula. Funding for CSE often comes from budgets or organisations focused on family planning or adolescent health, which makes it challenging to adopt a sexuality-affirming perspective. Corporate Social Responsibility funding for CSE is absent, finding no space in education or health activities because of its taboo nature in Indian society. Here is an opportunity to see how other countries, including those that may have equally conservative cultures, have managed to initiate and sustain CSE programmes. For instance, AAHUNG in Pakistan has been able to scale up a rights-based programme that provides CSE through life skills in conservative Muslim contexts

in the country. Involving religious leaders at rural and peri-urban levels can facilitate access to SRH services and advocate for inclusivity<sup>215</sup>.

Coming to a consensus on what constitutes SE, and what its non-negotiable elements are, will be essential elements to this conversation on making SE comprehensive. Standards for CSE already exist globally, as highlighted in Section 3, and India has committed to several international agreements and covenants that offer a framework for reference, which can then be contextualised. Watering down values that define CSE in an attempt to make this education more palatable to a wider audience is short-sighted. Rather, supportive actions to roll out key messages can be strengthened with stronger collaborative partnerships to support the implementation of CSE programmes. Existing content in this regard could be pooled and reviewed to assess the context in which we work, the CSE we visualise, what in the content is non-negotiable, and see if it is scalable. There are issues of strategy, and then there are issues of depth. The revised UN ITGSE establishes a good ‘minimum’ intervention package that states can follow.

## **Building a landscape that is conducive for CSE**

Despite a number of youth-friendly policies on paper as well as a revised AEP curriculum, the lack of political will towards respecting, protecting, and fulfilling the Sexual and Reproductive Rights of young people makes the journey of achieving CSE difficult. One major point of contention in the previous AEP curriculum was the presence of illustrations of the human body, which some deemed to be against the ‘cultural and moral fabric’ of the country. Arguments pitting sexuality education against the cultural, religious, and moral ethos of India are still a big deterrent in designing and implementing CSE across the country.

Publicly, the progress we make in SE (slowly but steadily in classrooms<sup>216</sup>) is often held back by repeated political tensions that conflate access to this information with distrust, morality, religious beliefs and the idea that this education is against our idea of cultural nationalism. The challenge to implementing SE at scale in India also lies at the level of the community, with a strong need to change social attitudes. It goes beyond the type of content, to the need to shift the lack of acceptance of plurality, empathy and diversity in human lives.

The recommendations of the Verma Committee, which followed the brutal gang rape in New Delhi in 2012, to implement age-appropriate ‘sex education’ and criminalise marital rape, were squarely rejected by the Parliament. The need to defend women’s and girls’ ‘honour’ and safety was cited by those who were seemingly unconcerned with ideas of consent and bodily integrity. The discourse did not go into enabling women’s and girls’ access to information, but reinforced cultural morality and the sanctity of the institution of marriage. In fact, across the religious and political spectrum, CSE is not considered an important issue that needs to be discussed in the school curriculum. Many are reluctant

---

215 SVANEMYR, J., BAIG, Q., & CHANDRA-MOULI, V. 2015. Scaling up of Life Skills Based Education in Pakistan: a case study. *Sex Education*, 15(3). Retrieved from <https://www.tandfonline.com/doi/pdf/10.1080/14681811.2014.1000454>

216 KHANDELWAL, H. (2017, May 5). Sex education in schools limited to good-bad touch. *Daily News and Analysis*.

to risk advocating for it. The high turnover rate of bureaucrats and policy makers also makes it difficult to advocate consistently and effectively in favour of CSE.

At the community level, young women who have worked as community youth leaders and peer educators in The YP Foundation's Know Your Body, Know Your Rights/*Shareer Apna, Adhikaar Apne* programme in Uttar Pradesh, shared that at times it was tricky to navigate and dialogue with their families about the outcomes of the programme. Not all families responded positively to peer educators articulating their beliefs or standing up for their rights. The perception was that the content made girls "too independent" and "difficult to control", leading to outcomes such as a refusal to marry partners selected for them and wanting to pursue their education and build a career instead<sup>217</sup>.

These experiences highlight that building a conducive environment for CSE at the community level takes time, and needs consistent, long-term engagement with multiple stakeholders – from families (parents, concerned adults such as grandparents or caregivers), to community leaders, to figures of influence in the community. Making SE programmes risk-averse to community backlash – to a degree – requires intergenerational dialogue and counselling, though they cannot be inherently free of such a response, given they are designed to challenge power hierarchies and inequalities. Government backed campaigns and initiatives are well placed to sensitise communities at large to young people's rights. Political will is essential for this.

At its most effective, CSE empowers young people to recognise and challenge discourses of patriarchy and power, to redefine and change discriminatory social norms. This may be viewed as a positive outcome by many, but not so by those who subscribe to patriarchal norms. The pathways to sustaining design, implementation and scaling of CSE rest squarely on changing social behaviours and attitudes to make them more inclusive about young people's sexuality and agency at all levels.

However, despite conservatism in the larger education system, the current social and political landscape is more accepting than before of the overall need for SRH, with a somewhat generalised acceptance of the need for SE, albeit with a lack of clarity on what it is and what they are therefore generally accepting. Unfortunately, there is a low bar set for the kind of information government programmes are able to/are committed to providing in SE.

To build stronger acceptance from the community, sensitisation programmes that challenge the stigma and discomfort associated with the framing of sex and sexuality, have been found to be useful. Anecdotal evidence suggests that regional/ local strategies work best, given different audience geographies, language and economic inequalities as well as other forms of diversity that exists. It is important to identify which stakeholders and partners (within the media, for example) are best placed to help disseminate this information at scale, given that CSE requires a nuanced approach to implementation.

---

217 THE YP FOUNDATION. 2013. *Know Your Body, Know Your Rights: Monitoring and Evaluation Report 2012 – 2013*.

Such sensitisation is also important within the government, an important stakeholder that is capable of creating large-scale positive impact on SRHR. CSE is competing for priority in a landscape where state governments do not want to take up Adolescent Health issues, largely because Adolescent Health is seen as the last brick in the wall. There is more concern with implementing programmes that have indicators and targets, such as Family Planning, Maternal Health and Child Health.

With the government, CSE can be advocated for by CSOs and activists – or other government departments that are working on CSE-related programmes – by emphasising its role in addressing current day challenges in gender-based violence and gender inequity. Also, department officials could be provided with resource and advocacy materials, as in the case of AEP advocacy material<sup>218</sup>, or other material that emphasise the international and regional agreements on CSE and national laws that the Government of India has committed to.

Evidence-led sensitisation can be very effective in building political will and cultural acceptance for CSE: for instance, in TARSHI's trainings on CSE in school settings, sharing evidence on how CSE has helped young people delay their first sexual activity helps us address teachers' resistance to the subject and myths such as CSE will encourage young people to 'experiment'. However, longitudinal studies that measure qualitative and quantitative changes in KAPs in CSE programmes are few, and Monitoring and Evaluation (M&E) systems in programmes tend to focus on short-term outcome studies<sup>219</sup>. Some international donors such as IWHC have already recognised the need for this and are supporting NGOs and governments in building better quality M&E systems in CSE programmes.

UNFPA recommends that evaluation designs of CSE programmes triangulate a number of different information sources and use mixed methods to build more rigorous evidence, in particular, costing strategies<sup>220</sup>. Indicators and research parameters need to advance from current practices to represent and better reflect sexual health and rights<sup>221</sup>. National and regional language media can be very useful in disseminating this data widely to shape public opinion and influence positive opinions around CSE.

## **Creating opportunities and safe spaces for young people to articulate their SRHR concerns**

Any CSE programme must involve and integrate young people across its design, implementation and evaluation phases. This is an important way of enabling young people to be empowered to address barriers to their own sexual health and rights. It also supports them in creating meaningful youth-adult partnerships with stakeholders

---

218 *Adolescence Education Programme Advocacy Manual: Role of Schools, Principals & Facilitators*. Retrieved from <http://www.cbse.nic.in/aep/ADVOCACY%20FINAL%201-40.pdf>

219 UNFPA. 2015. *The Evaluation of Comprehensive Sexuality Education Programmes: A Focus on the Gender and Empowerment Outcomes*. Retrieved from <https://www.unfpa.org/sites/default/files/pub-pdf/UNFPAEvaluationWEB4.pdf>

220 Ibid.

221 Ibid.

at programme and community levels, as well as advance their own capacities to understand evaluation, conduct research and improve data<sup>222</sup>.

This is useful and essential for several reasons. First, any CSE programme that does not incorporate the needs of young people – articulated by them – is not going to be in touch with ground realities. Some instances of young people's demands are available from The YP Foundation internal progress report for April 2014-March 2015, *Advancing Leadership and Life Skills to Enable Young People's Access to Sexual and Reproductive Health Information and Services*, submitted to the John D. and Catherine T. MacArthur Foundation. It reports that when consulted for inputs, young people asked for toll-free helplines which would not only be free of stigma and shame, but would also be a safe space for them to access any health information on issues of sex, sexuality, and substance use. They also asked for the establishment of health information centres at the district and village levels.

Second, young people can advance the commitment of organisations implementing CSE programmes, be it the government, CSOs or their schools, to design and implement CSE by bringing sustained, fresh voices to the table. The YP Foundation report mentioned above also states that district level officials are often willing to accept local realities of adolescents and young people and understand their unmet need for SRH more readily when they hear feedback directly from youth in their own communities. This also helps dispel the myth that the evidence only applies to young people from urban cities or that SE is an elitist concern.

Third, such platforms – if made safe, confidential and non-judgmental – can highlight the diversity of needs of different groups of adolescents and youth, and strategise on attempts to respond to these needs. This will be especially useful in involving young people that are both married and unmarried, those that are minors and are sexually active (given current legal constraints), those living with disabilities, those living with HIV and those who face discrimination based on caste, class and gender, in the access to services. As such, platforms that allow them to engage with district and other local officials and community leaders, and invest in youth leadership, are central to helping young people articulate their demand for CSE and their needs within their communities and local contexts. Organisations like Naz Foundation India Trust and The YP Foundation have developed innovative programmes, which take the realities of young people into account and are specially designed to tackle gender and sexuality issues within a rights-based perspective.

Finally, creating safe spaces for affirmative discussions on sexuality can be truly empowering for young people, thereby contributing significantly to the acceptance and outcomes of the CSE programme. Considering how difficult these discussions can be, and the risks attached to them, it is important to create such spaces that are conducive to help students talk about the real issues they are facing.

Where these discussions require further support, a referral system with peer educators, teachers, counsellors, SRHR groups, and youth groups needs to be built to provide support to students who may require it. This requires both the development of such

---

222 Ibid.

services and information on these services to be clearly communicated through a CSE curriculum. While the RKSK has attempted to develop this referral system, opinions on its uptake and quality vary.

## **Preparing teachers to transact CSE**

The importance of preparing teachers who will transact CSE with students cannot be over-emphasised, especially given evaluations of AEP which have shown that teachers are a top source of information on SRHR for young people.

In the case of AEP, the current resource manual is aimed at training nodal teachers, who will then teach the AEP curriculum to school students. There is no material directly available to and for young people. This makes the information young people receive dependent on the will and discretion of the nodal teachers, as well as their ability to provide this information in a comfortable and safe manner. Considering that sexuality is a taboo subject, it is important that teachers undergo rigorous training to correct their own misconceptions, clarify their values, confront their inhibitions and become capable of teaching the information to young people in an atmosphere which is both safe and comfortable. It is uncertain whether a five-day training workshop, such as the AEP's, is sufficient to provide the facilitators with the necessary knowledge and skills to teach it to young people, build a safe space for the students, or strengthen their ability to understand the experiences of young people that are diverse and are a departure from their own.

Integrating CSE into teacher training is essential to addressing this gap. A quick look at the B.Ed. and M.Ed. syllabi of various universities revealed that SE is almost totally absent from the curriculum of people training to be teachers, with the notable exception of the B.Ed. syllabus of the Central Institute of Education, that offers an elective course on Adolescent Education which includes SRH<sup>223</sup>, although we have not had the chance to analyse the content for its comprehensiveness. SCERTs and DoEs at the state level can be tapped to include SE in teacher training curricula.

Alongside, continuous improvement of teaching methods is required, especially in large-scale programmes such as the AEP or CSO-led programmes such as UDAAN, since this is central to the teaching-learning process. The quality of teacher training will have to be progressively enhanced, emphasising the importance of participatory approaches to learning, and keeping in mind the diverse cognitive capacities and lived realities of young people.

Programme implementation must also recognise the importance of support and incentives for teachers, who are already overworked, underpaid and under-trained, to ensure that they give equal priority to this curriculum in addition to their regular teaching responsibilities within school hours.

Finally, the mainstream school system in India is not very well-suited to teaching CSE. The system is based on academic achievement, competition, a standardised

---

223 B.Ed. Two Year Programme E.8: Adolescence Education. Retrieved from [http://cie.du.ac.in/academics/bed/syllabus/E.8\\_Adolescence%20Education.pdf](http://cie.du.ac.in/academics/bed/syllabus/E.8_Adolescence%20Education.pdf)



curriculum, discipline, self-denial, conformity, obedience, reward and punishment. There is a persistent fear of girls and boys socialising in an unsupervised manner, and a fear of sexuality itself. In the hands of teachers and the school administration who are not convinced of CSE's underlying principles, it may be used to reinforce control and surveillance and regressive social and sexual norms. It is necessary to foresee and guard against such a possibility through intensive training and close monitoring.

## Conclusion

Even as we recognise that there is a significant majority of children and young people that remain out of school in India, discussing opportunities for this cohort is beyond the scope of this paper. There is a need for more rigorous analysis and evidence on what works when implementing CSE at scale in out-of-school (and indeed in-school) settings, and how to address issues of quality within them. Schools remain more controlled environments to engage with, and to assess and address risks more clearly, as well as provide opportunities to develop scalable models. For CSE to be implemented at scale across schools, it needs to be firmly anchored within a core, national, school-based curriculum with which states are also aligned. There needs to be a comprehensive set of supporting strategies that facilitate stakeholder engagement, teaching/curriculum transaction capacities and parental support led by the government system itself. This also requires a common vision to be built between parents and government system stakeholders on how we want to educate and raise adolescents and young people in India. Several states (such as Maharashtra<sup>224</sup>, Bihar, Odisha, Chhattisgarh<sup>225</sup>) have varied expressions of interest in wanting to scale up or implement SE. Whilst there is a limited blueprint for how to do so that works for the Indian context, this provides an opportunity for states to develop a common understanding of CSE.

CSO partnerships are critical to advancing this agenda. The government can support with political will and scale, and CSOs can support with perspective, technical assistance and feedback. Whilst technical support can be provided by civil society in the short, medium and long-term for scaling interventions, CSOs cannot be expected to replace state systems and have accountability for implementation itself. CSOs can also bring innovative approaches to the table, such as in using technology; organisations like Love Matters<sup>226</sup> and on a more niche level, Agents of Ishq<sup>227</sup>, engage young people and adults alike with a nuanced analysis of CSE and rights through public platforms, using a clear rights-based lens and a non-stigmatising approach. Content on CSE does exist in the public domain (though much of it is not formally evaluated) that can be drawn upon, without having to reinvent the wheel. In building sustained, long-term partnerships between CSOs and governments, donor support with responsive, flexible

---

224 NAIR, A. (2018, September 22). Next year on, expect holistic sex education in Maharashtra schools. *The Times of India*. Retrieved from <https://timesofindia.indiatimes.com/city/pune/next-year-on-expect-holistic-sex-education-in-state-schools/articleshow/65906162.cms>

225 SEBASTIAN, S. (2018, April 13). Sex education set to become part of school curriculum. *India Today*. Retrieved from <https://www.indiatoday.in/mail-today/story/sex-education-set-to-become-part-of-school-curriculum-1211116-2018-04-13>

226 DUA, M. (2018, October 12). 'Love Matters: Beyond sexual fantasies and myths, turning a new page for honest sex education.' *The Indian Express*. Retrieved from <https://indianexpress.com/article/lifestyle/life-style/love-matters-beyond-sexual-fantasies-and-myths-turning-a-new-page-for-honest-sex-education-5397557/>

227 Sex education Archives. Retrieved from <http://agentsofishq.com/tag/sex-education/>

funding can be key. The UDAAN case study makes the case for having sustained funding mechanisms in programmes that are patient and not just looking at short term wins. UDAAN was able to learn from programme implementation and correct course as needed, enabling C3 to support its journey of scaling up<sup>228</sup>.

An issue to contend with is whether we should call it 'Comprehensive Sexuality Education'. Not naming SE in programme titles, but including or providing it under a broader banner of health or life skills (or other umbrellas) raises less suspicion and backlash at the outset and requires less political manoeuvring. This gives stakeholders a chance to engage with the content of SE, before getting derailed by pre-formed myths and misinformation about sex and sexuality. Normalising sex and sexuality is a long-term process, but one that takes place by increasing comfort with these terms, their meaning and content. Achieving this without using the actual words themselves is likely to be counter-productive. Entry points to integrate SE in the current landscape should be taken up, with a clear short and long term approach to sensitising officials and stakeholders on the need to name CSE and clarity on using the term without shame at the outset.

Another issue that requires deliberation is the stage at which CSE programmes can begin in a school setting. Although the AEP curriculum is aimed at Grades 9 and 11<sup>229</sup>, certain portions such as the parts on early marriage, adolescent pregnancy, and understanding and challenging domestic violence, are meant only for students of Grade 11 and above. Even as NFHS-4 shows declines in the numbers of young women and men married by the age of 18 and 21 years respectively and the number of women in the age group of 15-19 who had children at the time of the survey, these are still significant figures given the country's population<sup>230</sup>. As such, it is vital that young people receive information related to their sexual and reproductive health and rights before they could possibly be married or become pregnant – and therefore, such information should be made available to young people before Grade 11 as well. This has been corroborated by the experiences of several civil society programmes, including those of C3, and The YP Foundation's experience<sup>231</sup> in Uttar Pradesh and the 2017 UNFPA assessment, where some principals expressed their preference for an even earlier initiation of AEP, as early as in Grades 1-5.

Making this information available only to students from Grade 11 and above may be particularly damaging, especially for girls. In comparison to boys, a large percentage of girls drop out of school early for a variety of reasons, such as the increased burden of housework and restricted mobility after puberty. Girls may be removed from schools before they have had a chance to receive important information on early marriage, pregnancy and domestic violence. Within a patriarchal set-up, where girls and women are most drastically affected by early marriage, pregnancies, and domestic violence,

---

228 CHANDRA-MOULI, V., PLESONS, M., BARUA, A., PATNAIK, A., GOGOI, A., KATOCH, M., ZIAUDDIN, M., MISHRA, R., SINHA, A. 2017. *What Did It Take to Scale Up and Sustain Udaan, a School-Based Adolescent Education Program in Jharkhand, India?*

229 Grade 10 is exempt as students take a public exam in this year.

230 INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4) 2015-16*.

231 THE YP FOUNDATION. 2013. *Know Your Body, Know Your Rights: Monitoring and Evaluation Report 2012 – 2013*.

information on these issues can help enhance their ability to resist oppression and discrimination, and seek redress when required.

The context of implementing CSE in India presents a complex narrative of debate, dialogue and programming, involving a number of stakeholders, local, national and global. Programme interventions and curricula are often rooted in evolution from previous programmes within public health, and draw from differing approaches and thinking in health and population policies. Whilst some programmes have been scrapped for political and socio-cultural reasons, others have emerged, but cannot be analysed in isolation without engaging with their history.

This working paper has been a challenging task and is the result of the time, experience and energy of a number of contributors over the past several years. In our approach we have attempted to be inclusive of different perspectives, tried to understand diverse narratives, and at the same time stay grounded in the facts and realities of a country that has strong and conflicted feelings, attitudes and reactions to sex, sexuality, relationships, changing value systems and SE. There are several additional CSO programmes that bring further learning and innovations to implementing SE programmes, and the field would benefit from further contributions to both what works, and also what has not worked, when engaging with young people. Adolescents and young people have huge scope to play this role themselves, and are yet to be fully meaningfully integrated into SE programmes. With an education system so diverse, navigating this territory effectively is a challenge by itself. Even as this paper was finalised, newer initiatives were emerging and shifts taking place in the AEP and *Ayushman Bharat*. This is a work in progress, and we are aware that there are gaps of knowledge and inclusion. We are unable to include all materials, intervention attempts and points of view within the scope of this paper. Despite these limitations, we hope it provides an adequate platform for diverse users who require a reference point for research or programme planning and implementation to engage with CSE in India.

## **Acknowledgements**

We are grateful to many individuals who have generously contributed their expertise, insights and time, to help develop this paper. Their encouragement and patience with our efforts have remained unflagging over what has been a long journey.

We would specially like to acknowledge the following persons for their support, inputs and/or feedback:

Dr. Shankar Chowdhury (formerly at UNESCO), Sheena Hadi (AAHUNG), Dr. Jaya (UNFPA), Prachi Khandeparkar (Sangath), Ruchika Tara Mathur (Independent Consultant), J.L. Pandey (formerly with NCERT), and Prachi Shrivastava (former counsellor, The Step by Step School)

Dr. Sudha Balakrishnan (UNICEF), Dr. Venkatraman Chandra-Mouli (World Health Organization), Dipa Nag Chowdhury (John D and Catherine T. MacArthur Foundation), Dr. Sushma Dureja (Ministry of Health and Family Welfare, Government of India), Harish Meena (NCERT), Anand Sinha (The David and Lucile Packard Foundation), Oriana López Uribe (Balance), Marisa Viana (RESURJ) and Dr. Saroj Yadav (NCERT)

We are thankful to Arpita Das, Deepti Priya Mehrotra, Dyuti Ailawadi, Inga Marie List, and Ishita Chaudhry for writing earlier drafts of the paper, and to Prabha Nagaraja, Radhika Chandiramani, Shikha Aleya, and Vani Viswanathan for their diligent and painstaking review of multiple drafts.

Many thanks also to Chitra Bianca Appasamy for lending her creative skills for the design and layout.

We also thank International Women's Health Coalition (IWHC) for their ongoing support in helping us continue our work on sexuality and SRHR.

## About TARSHI

TARSHI is an NGO based in New Delhi, India, working on sexuality and Sexual and Reproductive Health and Rights (SRHR) since 1996.

TARSHI believes that all people have the right to sexual wellbeing and to a self-affirming and enjoyable sexuality. TARSHI supports and enables people's control and agency over their sexual and reproductive health and wellbeing from an affirmative perspective, focusing not only on violence prevention, reducing unwanted pregnancies or infections, but also on pleasure and individual rights to self-identity, safe and enjoyable sexual and reproductive health. TARSHI strives to be as inclusive as possible and work for the sexual and reproductive rights of all people, irrespective of their gender or sexual identities, disability, class or caste locations.

TARSHI conducts trainings and online courses on sexuality and SRHR, develops publications, runs a bi-monthly eMagazine In *Plainspeak*, and actively disseminates information on SRHR on social media. For more information, visit [www.tarshi.net](http://www.tarshi.net).

**Address:** C-29, Basement, East of Kailash, New Delhi 110065, India

**eMagazine:** [www.tarshi.net/inplainspeak](http://www.tarshi.net/inplainspeak)

**Facebook, Twitter, Instagram:** @tarshingo

**YouTube:** @tarshidelhi

**eMail:** [tarshiweb@tarshi.net](mailto:tarshiweb@tarshi.net)

