LEARNING FROM EACH OTHER

Pushing Forward the Field of Adolescent Sexual and Reproductive Health and Rights in India and Nigeria through a Cross Learning Program

A CREA PUBLICATION

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CONTEXT

Adolescent Sexual and Reproductive Health and Rights

The world's population includes 1.2 billion adolescents between the ages of 10-19, nearly 90 per cent of who live in developing countries.[1] Adolescence is a time of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood. Experiences of adolescence vary by age, sex, caste and class, region, cultural context, religion, marital status and sexual orientation.

Young people in developing countries face issues related to their sexual and reproductive health and rights that differ from those faced by adults in these countries. These issues include inadequate power to make decisions around sexuality and reproduction, forced early marriage, lack of opportunities, unwanted pregnancy, early childbearing, the spread of HIV/AIDS and other sexually transmitted infections, and female genital mutilation.

The International Planned Parenthood Foundation has estimated that:

- Each year one in 20 young people worldwide contracts a sexually transmitted infection before the age of 21 years
- Girls aged 15-19 years are twice as likely to die from childbirth as women in their 20s
- The main causes of death worldwide for girls aged 15-19 years are complications arising due to pregnancy
- Every year adolescents give birth to 15 million infants.

Socially accepted gender roles and the position of women in many societies have a strong impact on the sexual and reproductive health issues that adolescent girls face. Girls often do not know anything about their bodies and how they function. For some, sexual relationships come about as the result of force or abuse, including incest. In many countries, teenage girls have no control over whether, whom or when they marry. While both adolescent boys and girls have inadequate power to make their own decisions, this is more pronounced in the case of adolescent girls.

All young people - both boys and girls - need accurate information, non-judgmental counseling, affordable, accessible youth-friendly services, and youth-centered policies to develop to their full potential. Life, survival, maximum development, access to health and health services, including sexual and reproductive health services, are not just basic needs of young people but are also fundamental human rights.

However, the protection and fulfilment of these fundamental rights depends on the realization of other rights. These include the rights to: non-discrimination; education and access to appropriate information; privacy and confidentiality; freedom from exploitation, abuse and violence; rest, leisure and play; an adequate standard of living; and participation, including the right to be heard. All around the globe, the most successful sexual and reproductive health programs and policies involve young people and take what they have to say into consideration.

SNAPSHOTS: Young People

- One in every 10 births worldwide is to teenage mothers
- Girls aged 10-14 years are five times more likely to die in pregnancy or childbirth than women aged 20-24 years
- At least one in 10 abortions worldwide occurs to women aged 15-19 years
- More than 4.4 million young women in this age group have an abortion every year, 40 per cent of which are performed under unsafe conditions
- People aged 15-24 years account for half of the five million new cases of HIV each year; 62 per cent of these new cases are female[2]

1. Youth are defined as those between the ages of 15-24 years. Most of the 1 billion youth across the world are from developing countries
2. UNFPA, State of World Population 2003: Making 1 Billion Count, UNFPA, New York 2003, p.23

Adolescent Sexual and Reproductive Health - the International Agenda

In 1994, the International Conference on Population and Development (ICPD) at Cairo acknowledged that particular attention needs to be given to the reproductive health needs of young people as a group; their needs had largely been ignored until then. The Cairo program called on governments to make accessible to young people information and services on sexuality and on how to protect themselves from unwanted pregnancies and sexually transmitted diseases (UN, 1994).

Building on this, the five-year review of the Cairo program of action (ICPD+5) explicitly stated that:

> "In order to protect and promote the right of adolescents to the enjoyment of the highest attainable standards of health, provide appropriate, specific, user-friendly and accessible services to address effectively their **sexual and reproductive** health needs, including reproductive health education, information, counseling and health promotion strategies. These services should safeguard the rights of adolescents to privacy, confidentiality and informed consent, respecting their cultural values and religious beliefs and be in conformity with relevant existing international agreements and conventions."
>
> (www.unfpa.org: paragraph 73a)

During the decade since ICPD, there have been some changes in addressing the sexual and reproductive health needs of young people. At the 10-year review of ICPD in 2004, about 139 countries[3] reported having adopted one or more measures to promote responsible, safe reproductive health behavior among vulnerable groups, especially youth. More countries are now willing to provide information, if not actual services, to young people.

Despite this, promoting the health and rights of young people remains a continuing struggle. Adolescents are rarely considered a distinct group with special needs apart from those of children and adults. Many governments still lack policies or services to meet the specific needs of adolescents. Even when governments do invest in adolescent programs, these programs take a narrow approach tailored to specific health concerns (early pregnancy, for example), without considering young people's educational, economic, social and gender needs. Conservative religious and political groups continue to oppose the provision of sexual and reproductive health information and services to young people. And like children, young people continue to be seen, but not heard.

- More than half of young people in a survey of 40 countries had misconceptions about how HIV/AIDS is transmitted[4]
- In Latin America and the Caribbean, 35 per cent of sexually active teenagers aged 15-19 years use contraceptives; in sub-Saharan Africa fewer than 20 per cent do[5]
- A quarter of the world's young people survive on less than a dollar a day[6]
- Each day, 5,000 children become refugees from countries suffering armed violence[7]
- Of the 153 million young people in developing countries who are illiterate, 96 million are young women[8].

3. Out of 151 countries responding to UNFPA's Global Survey of Progress made over the past decade in implementing the goals of the ICPD
4. UNFPA, State of World Population 2003, p.24 5. Ibid. p.24 6. International Youth Foundation, Annual Report 2001: I Want to Belong, Baltimore MD, 2001 7. UN High Commission on Refugees, www.unchr.ch/fdrs/ga99/children.htm 8. UN Secretary General Kofi Annan, Concise Report on World Population Monitoring: Population, Education and Development, (E/CN 9/2003/2), United Nations, New York, 2003

INTRODUCTION

The Creative Learning Initiative

CREA is a not-for-profit organization based in New Delhi, India that empowers women to articulate, demand and access their human rights by enhancing women's leadership and focusing on issues of sexuality, reproductive health, violence against women, women's rights and social justice.

This organizational mandate is carried out through four initiatives:

- New Voices, New Leaders
- Expanding Discourses
- Creative Learning
- Public Education and Advocacy

The Creative Learning Initiative's mission is to enhance leadership among women by implementing innovative learning programs that link theory with practice. This initiative specifically aims to:

- Enable women leaders to strengthen their work and network through innovative learning mechanisms
- Foster effective learning by linking theory and practice
- Ensure the participation of young women.

Pushing Forward the Field of Adolescent Sexual and Reproductive Health and Rights in India and Nigeria through a Cross Learning Program is part of this initiative.

The key methodology used to achieve these is the planning, development and conduct of a series of in-country, regional and international exchange programs and study tours focused on particular themes. Through these, NGO professionals working at diverse levels visit other groups and institutions in different countries, working on similar issues. CREA's exchanges are based on mutual respect and dynamic interaction - and on the understanding that learning need not be the preserve of textbooks and classrooms, but can come about through experiential interactions and exposure to new ideas.

All CREA's exchanges and study tours further the leadership capacities of participants to use a human rights approach in their work, be it in the field of community development, violence against women or HIV/AIDS. Over the last four years, CREA has developed working relationships with NGOs in India, Egypt, Nigeria, Tajikistan, Vietnam, and Bangladesh. CREA's aim in building these partnerships across international borders and across cultures is to raise public awareness, build a culture of human rights and end violence against women globally.

SNAPSHOTS[9]		India	Nigeria
Gross National Income (GNI) per Capita (PPP $) (2002)		$2,570	$780
Human Development Index (2001)		0.590	0.463
Health Expenditure per Capita (US$) (2000)		$23	$8
Average Births per Woman (TFR) (2003)		3.3	5.7
Seats in Parliament Held by Women (2003)		9%	3%
Maternal Deaths per 100,000 Live Births (MMR) (2000)		540	800
Infant Deaths per 1,000 Live Births (IMR) (2001)		67	110
Currently Married Women using any Method of Contraception (2003)		48%	12%
HIV in Young People from 15-24 years	Men	0.59%	4.69%
	Women	0.71%	5.825%
Abortion Policies		Socio-eco grounds	To save woman's life

9. Countdown 2015: Sexual and Reproductive Health & Rights For All, www.countdown2015.org

The Cross Learning Program

India and Nigeria share many commonalities. Both these former British colonies have similar legal systems where laws differ according to culture and religion. Ethnicity and religion form the basis of social organization in both countries, with the interests of the ethnic group being greater than that of the individual. Both countries are also bound by a traditional socio-cultural context that manifests itself in gender, class and other inequities. Since independence, a vibrant non-government sector in both India and Nigeria has participated in the challenge of creating more equitable societies, where all citizens can access, assert and enjoy their rights.

Young people constitute more than one-fifth of the population in India and Nigeria. Teenage girls and boys are sexually active in both settings; a Nigerian study shows that 80 per cent of rural girls aged 17-19 years had had sex[10], while in India, almost half of all young women are sexually active by the time they are 18, largely due to early marriage. Lack of information, knowledge and decision-making power remains a critical issue for young people in both settings.

Despite this, young people's reproductive health needs are poorly understood and ill served in both countries. While programs focus on 'children' and 'women' in both countries, neither services nor research has focused on adolescents and their unique health and information needs (Jejeebhoy 2000). Ignorance and fear surround adolescent sexual and reproductive health and rights in India and Nigeria; understanding and confronting this is important for practitioners and policy makers.

Within this context, the 2003-2004 India-Nigeria Cross Learning Program aimed to:

- Promote a conceptual understanding of the fields of adolescent sexual and reproductive health and rights among activists and policy makers
- Enhance the analytical skills of participants to critically examine how research, program interventions and policies can integrate concerns of young people
- Create a new generation of leaders who will incorporate concerns of adolescent youth into policies and programs undertaken at regional, national and international levels.

In line with these objectives, the Cross Learning Program was carried out in two phases. In the first phase, 10 Nigerian activists and policy makers working on young people's health came to India on a 10-day exchange program from 20-30 October 2003. In the second phase, 10 participants from community-based and advocacy groups visited Nigeria on a 10-day exchange program from 24 May-2 June 2004.

Each phase was designed to create and foster links between organizations, individuals and policy makers; enhance capacities of individuals and organizations to address issues of young people's sexual and reproductive health; and identify culturally appropriate strategies in India and Nigeria to overcome barriers to advocating for young people's sexual and reproductive health and rights.

The cross visits were built around participatory, experiential learning processes and consisted of:

- **Site visits** to community-based organizations and advocacy groups working innovatively on adolescent sexual and reproductive health and rights
- **Presentations** locating young people's health and rights within larger socio-economic contexts and linking adolescent health to broader struggles for social justice
- **Roundtables** on key issues during which participants interacted with program managers and policy makers working in the same field
- **Idea and information exchanges** among participants from the same or different countries through strategy sharing and discussions.

We believe that the exposure gained through this cross learning program has enabled participants to broaden their expertise and knowledge base, and to develop innovative approaches that will strengthen the movement for young people's sexual and reproductive health and rights in both countries.

10. Okonokua F.E., et al. Assessment of health services for treatment of sexually transmitted infections among Nigerian adolescents, Sex Transm Dis, 1999

INDIA CROSS VISIT

20-30 October 2003

Orientation and Introduction

In her opening remarks, Pramada Menon, Director-Programs, CREA, located India within the overlapping contexts of poverty, globalization, religion, caste, patriarchy, and civil society struggles against these.

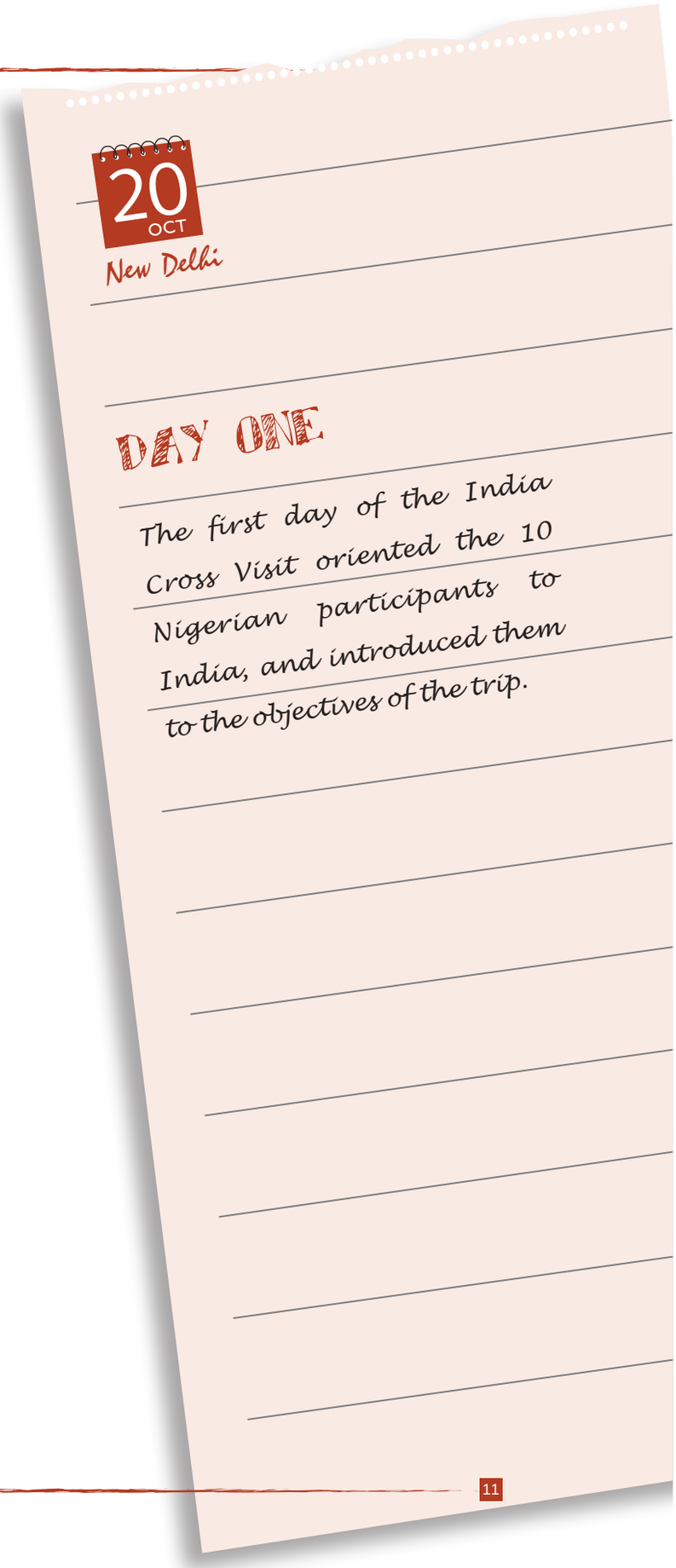
Although one thinks of India as a unified secular country, in reality it is more like a continent with separate countries joined together. Hinduism is the dominant religion, and fundamentalist parties are trying to make all of India a Hindu state. Many Indians supported the genocide of Muslims in Gujarat in 2002; only a small number saw this as a crime against humanity.

Patriarchy is entrenched in this setting; women have to fight patriarchy on a day-to-day basis. This is a difficult terrain to negotiate, with women brought up to be dependent on men, and to exchange fathers for husbands. There is a societal silence around crimes against women, especially sexual violence, with sexual harassment being considered 'normal', not criminal. The legal climate is unfriendly to women; the police often refuse to seriously entertain complaints of domestic violence, and the courtrooms add to the stigma that a raped woman faces.

As India has shifted from having just one state-run television channel to having almost 100 satellite channels, television is increasingly perpetuating gender stereotypes, including the myth of women as domestic beings. At the same time, a new generation of films is bringing issues of homosexuality, HIV, sexuality, etc. into the public domain.

While a growing number of organizations are working on sexuality, including young people's sexuality, this is not seen as valid work in a setting of poverty. People will often say, "Why are you working on issues of sexuality? Isn't there poverty in your country?"

Working with young people poses its own challenges. At what age group should information be aimed at young people? How can one find the appropriate language to talk about young people's issues? Young people do talk about sex, drugs, money - issues that are labeled sexual health, asset building, etc. "That's not their language or their concepts," said Menon. "Young people's needs should be addressed based on what they are articulating - not on what we are articulating."



21 OCT

New Delhi

DAY TWO

In the first substantive session, a series of presentations and discussions introduced participants to issues that influence young people in India: norms of masculinity and femininity, early marriage, media representations of sexuality, etc.

Speakers included:

- Jaya Iyer, PRAVAH
- Manisha Gupte, MASUM
- Radhika Chandiramani, TARSHI
- Sapna Desai, CREA.

Presentations

Youth in India: Issues and Concerns

Jaya Iyer, PRAVAH

In her presentation, Jaya Iyer described how young people are located in the Vedic tradition, which is a significant influence in the lives of Hindu Indians. According to the Vedic tradition, four stages are mapped out in the life of an individual:

Brahmacharya	Student	(phase of learning)
Grihastha	Householder	(phase of provider)
Vanaprastha	Forest	(phase of retreat)
Sanyas	Enlightenment	(phase of detachment)

The movement from being a student to being a householder coincides with being a young person and is delineated more for men than for women in this tradition.

Unlike in ancient times, there is a sudden movement from childhood to adulthood in India today; there is no real concept of adolescence. Young people in contemporary India face three critical issues:

- Acceptance of discrimination along caste, religion and communal lines
- Faith in violence as a solution
- Loss of identity.

A large number of young people today believe in violence, which is seen as legitimate, necessary, glamorous, and result-oriented. Dialog and negotiation are not seen as strong processes, but violence is. Young people who experience a loss of identity feel they can find themselves through violence, including an acceptance of religious and militant violence. Re-orienting young people from seeing violence as a solution is one of the biggest challenges facing organizations like PRAVAH.

PRAVAH

PRAVAH means 'flow'...the, free flow of knowledge, ideas, experiences, and expressions among people to bring about change...the flow of life journeys of every individual from self to society. The organization believes that equipping young people with the skills essential to be sensitive and responsible towards society and helping them to become positive change makers can build a qualitatively different future for India.

PRAVAH came into being in Delhi in 1994, in the context of religious and communal violence following the demolition of the Babri Masjid. The organization started working in schools out of a feeling that schools do not equip students to address such issues. The school curriculum touches on issues of self, skills and society and emphasizes volunteering. Today, this program reaches 4,000 students across 35 schools and is one of the core components of PRAVAH.

Working with college students is another important aspect of PRAVAH's work. "Young people live isolated lives," said PRAVAH's Jaya Iyer. "It is possible to live in Delhi and meet people only from the same socio-economic strata." The organization brings together college students from diverse backgrounds to expose them to different realities, and break barriers of caste, class, and religion through exposure. "Exposure leads to questioning," said Iyer. "It challenges their own assumptions and paradigms."

Discussion

The discussion following Iyer's presentation explored three questions:

- How can young people be brought together to build harmony?
- How does gender affect the perceptions of young people?
- Is health, including sexual health, a central concern for young people?

Iyer explained that young people exist in 'islands' of caste, class, etc., with little interaction between these islands. PRAVAH's youth program, SMILE, enrolls college students from different backgrounds and puts them together in a common environment. As they interact, the students relate to each other as human beings, rather than as rich and poor, Hindus and Muslims. Although differences do not totally disappear in this process, what does get built is trust; this acts as a glue to reduce differences.

Such facilitated interactions are critical in a social climate where hate propaganda prevails, and where young people casually say that "the other should be killed". Interaction is not enough; what is needed is facilitation and process work to unravel hidden fears and assumptions. Otherwise, an intervention can remain superficial with young people taking stereotyped ideas back home.

The enrollment of young people in the SMILE program reveals interesting gender differentials across class. In elite colleges, more girls enroll for this voluntary program than boys; boys in high-income communities feel they have many options and don't feel a need to work on themselves. 'Working on the self' is also considered a touchy-feely issue, not a masculine option. Peer pressure prevents many boys from enrolling. In low-income communities however, more boys participate than girls, largely because girls may not have the same freedom to choose a program that is outside the curriculum. Girls are expected to go to college and no more.

It is not only boys who perpetrate violence; many girls also support and endorse violence,

including communal violence. This has been seen in incidents like the 2002 Gujarat genocide, where women participated in violence against 'the other'. "We always assume that women who have agency will use that agency positively, but this is not so," said one participant. While boys are often the perpetrators of violence, PRAVAH's program shows that boys are not violent towards girls in their project group, which becomes like a surrogate family. Boys feel they must protect the girls in this group. "What they will do with other girls is a different matter," said Iyer.

In PRAVAH's programs, young people identify the following issues as top priorities: Violence, job security, gender-related issues, environment, and corruption. Based on this, Iyer felt that health, including sexual health, is not a key concern for young people, a statement that many challenged. An Indian participant said that young people talk sex all the time. "Maybe when the conversation begins with volunteering, the space to discuss sex does not come up," she said. "It depends on the route you go in with."

Participants identified numerous barriers to young people's sexual well being. The general disapproval of sex before marriage and the premium around virginity prevents young people from seeking medical attention for sexual health. Doctors are often embarrassed by young sexually active women. Young people may suffer from itching and vaginal discharge for years without talking about these. Gynecologists will not recommend a vaginal probe for unmarried girls for fear of breaking the hymen. Young women who are raped do not have the power to access medical help. Families, teachers and health professionals are often protectionist, rather than health-seeking, where the sexual health of young people is concerned.

Norms of masculinity, femininity and gender also feed into young people's understandings of their own bodies and sexualities. Many young men calling a sexuality helpline raise concerns about penis size, while young women ask questions about love and romance. Body image and the fear of being fat results in shame, guilt and discomfort with one's body shape and size, and influences the sexual health of young women.

Participants agreed that changing mindsets, attitudes and practices is the key to strengthening young people's self image and enhancing access to health care, including sexual health care. Provision of information is a critical step towards achieving this goal. Involving, influencing and informing doctors and teachers is also important. Participants felt that the law is of limited use in accessing sexual health. While the law may enshrine sexual rights, accessing these rights is difficult in practice. Young people need to be empowered to freely talk about their bodies and selves.

Participants also noted that religious leaders tend to use 'culture' as the basis for education; instead they should use 'information'. In India, religious leaders are wary of taking on issues related to sexuality in the context of fundamentalism. However, the Shiromani Gurdwara Prabandhak Committee[11] in Punjab passed an edict saying that female feticide is against the tenets of Sikhism. Thus, there is scope, albeit limited, to involve religious leaders in such issues.

11. The religious governing body in charge of the Gurdwara, the Sikh place of worship

Women's Health Movement in India
Manisha Gupte, MASUM

In her presentation, Manisha Gupte explored how contexts of gender, caste, class, religion, poverty, and globalization determine the lives of young people. "Whether you're a girl or a woman doesn't depend on your age. It depends on your address," said Gupte. "A city girl is equal to a village woman." In the city, a girl may get married when she is 25 years old, but in a village setting, a girl is married by the time she is 16. By 18, she has had one child; by the time she turns 20, she has had two children, and by 21, she has had a tubectomy, ending her reproductive career.

The dictates of masculinity mean that a young rural man will never get a vasectomy. He will keep his reproductive options open, a reflection of gender inequalities. If his wife dies, he will get a new wife. The only time large-scale vasectomies have taken place in the Indian context was during the Emergency, when forced vasectomies were carried out selectively on low-income men.[12] "No one would dare enter middle-class homes, but they easily entered the homes of pavement and slum dwellers," said Gupte. "These are people who can't shut the state out if it gets too overbearing."

Building on this, Gupte explained how the poor have no human rights in a national context defined by majoritarianism, and in an international setting defined by globalization. India does not have a voice in the paradigm of globalization, and the country's poor are its biggest losers as everything from health care to education gets privatized. With jobs declining across the country, young people are increasingly frustrated; a frustration that is used by politicians to stoke communal tensions. Young people don't understand that they are not getting jobs because the State is not creating new jobs; they feel people from other religious communities are snatching their jobs.

In terms of health status, tuberculosis and malaria are resurging, as are communicable diseases. Young men and women get reproductive tract infections (RTIs), sexually-transmitted diseases (STDs) and HIV/AIDS. In the 45 villages in which MASUM works, one person dies of AIDS every two months. A young woman of 21 might discover she is HIV-positive during an antenatal check up, or may become an AIDS widow at 21 and be thrown out of the marital home. Many families face situations in which the husband, wife and younger child are positive, while the elder child is negative. How does one allocate meager family resources in such situations?

Young rural women who marry early are also vulnerable to maternal mortality - either due to anemia caused by inadequate nutrition, or due to post-partum hemorrhage. Although hemorrhage after delivery can be cured through a simple medical intervention, this is often not available due to a lack of health services. "A woman is just seen as one big uterus walking around," said Gupte.

Violence is emerging as a major killer of women in the reproductive age group, which includes many young women. Women are often beaten by intimates and raped by known persons. Violence and depression often combine in a woman's life to make her vulnerable to suicide. Society typically won't intervene if a husband slaps his wife, even in public. In rural areas, young women go to different villages after marriage, where they are seen as outsiders. "A village is willing to take up issues of its own daughter, but not of its daughter-in-law," said Gupte.

In a restrictive sexual climate, young women are often unable to distinguish between rights and morality. A woman cannot distinguish between her reluctance to have oral sex (a morality issue), and her husband forcing her to have oral sex (a rights issue). The rights issue pertains to how the decision to have sex is made, rather than what kind of sex is being had, but young women cannot distinguish between these.

While young women do talk of sexuality among themselves, rural society frowns upon this. A young woman's sexuality - and the power she derives from this - is feared. "It takes 24 years for the mother to make an intelligent boy and only 24 hours for the wife to make him a fool," is a rural aphorism. In a situation where the father-in-law is growing economically weaker and the son economically stronger, the daughter-in-law's burgeoning sexuality causes great family anxiety.

12. Indian Prime Minister Indira Gandhi imposed a state of Emergency from 1975-77 during which time thousands of men were forced by the State to undergo vasectomy and sterilization operations to contain the country's growing population

Sexuality, Sexual Rights and Sexual Health

Radhika Chandiramani, TARSHI

"Sexuality is a central aspect of being human throughout life and 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, behaviors, 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, ethical, legal, historical and religious and spiritual factors." (WHO, 2002)

Using this definition as a springboard, Radhika Chandiramani explored the challenges of defining sexuality, which is both intangible and multi-faceted. She felt the World Health Organization's working definition of sexuality is a hopeful one that recognizes aspects of intimacy, eroticism, pleasure, etc., unlike earlier definitions that were based on sexual health. The sexual health paradigm's coupling of sexuality with health brings disease and illness into the frame, and pathologizes sexuality. Pleasure and fun are dismissed as elitist concepts - but even the poorest of people feel sexual desire and have sex. "Poverty and unemployment do not do away with sex," said Chandiramani.

If defining sexuality is a challenge, so is defining 'youth' and 'adolescence'. According to the WHO, adolescence comprises the life period spanning 10-19 years of age, while those aged 15-24 years are youth. Adolescents come from diverse backgrounds and have differing experiences, needs and concerns. Some of them remain financially and emotionally dependent on their parents till many years after their teens. Others are married and are parents before they are out of their teens. Adolescence is an exciting time with its own tugs and pulls. "You feel like the sky may fall on your head," said Chandiramani. "You feel like you are too good for the world. You feel like you have enormous potential."

Adolescence is also a time of sexual awakening. But in discussing young people's sexuality, it is critical to use terms that do not rob people of their status as human beings. "Using the term 'youth sexuality' is like saying 'geriatric sexuality'," said Chandiramani. "The categorization takes away humanity, personhood." It is more meaningful to use terms such as 'young people's sexuality' and 'older people's sexuality'.

Although young people form a sizable proportion of the Indian population, adults are in constant denial where young people's sexuality is concerned. "Young people are seen as sexual only after marriage," said Chandiramani. "An unmarried 19-year-old girl is not seen to have any sexuality, or any right to information on sexuality." Despite this private silence, sexuality surfaces uneasily in the public domain through the media's constant bodily allusions, through jokes, etc. Young people begin to think of sexuality as a mysterious terrain that they cannot enter, and which they learn about from films, music, the Internet and other media.

However, young people enter this mysterious terrain in many different ways. Through penetrative sex with a sex worker without protection, drunk, with friends. Through sex with an older woman or aunty who blackmails them into continuing the relationship. Via a consensual relationship, or an abusive non-consensual relationship. Through a relationship with another person of the same sex. As they enter the realm of sexuality, some young people struggle with their own sexual orientation, and others with their emerging gender identities: Am I a man? Am I a woman?

Unfortunately, the overall lack of acceptance of young people's sexuality translates into a lack of information and services in this realm. Not only does this make young people vulnerable to infection, it also restricts their capacities to make decisions around sexuality. "There is denial of information, even though information leads to better, more responsible choices," said Chandiramani. In this information vacuum, middle-class educated men in their 40s believe that erectile dysfunction is caused by masturbation, and that one drop of semen is equal to 40 drops of blood. "They are terrified and scared of ruining their lives. I feel angry, because simple information could make a big difference."

In a situation where sex and sexuality are never *directly* talked about, young people grow up with a host of misconceptions. Many teenage boys who call the TARSHI helpline have concerns about penis size, penile erection, masturbation, the amount, color, and consistency of semen ejaculated, etc. These fears build up into performance anxiety: Will he be able get and sustain an erection during a sexual encounter? Will he be able to satisfy his partner? Does he know too little? Will he seem foolish?

Girls who call the helpline have questions about menstruation, breasts, white discharge, arousal, pregnancy, contraception, and masturbation. A girl is anxious that her partner may not find her breasts *big* (read 'good') enough, she may not bleed while having sex for the first time with a new partner (implying she is not a virgin), she may seem to know too much and may be seen as being 'experienced', 'over demanding' or a 'slut'. Both girls and boys fear negative reactions from partners or prospective partners.

Another concern for both is the gender-based expectation that boys are supposed to know more about sex than girls. "Boys are worried about knowing too little," said Chandiramani. "Girls are worried about knowing too much." Both boys and girls are expected to conform to the norms of heterosexuality, but male sexual behavior is often naturalized - 'boys *will be* boys' - while female sexual behavior is socially constructed - 'girls *have to* be girls'.

Even when information around sexuality is provided, it is often garbed as 'family life education' or 'life skills education', rather than as sexuality education, which is considered Western and taboo. At schools, sexuality education is all too often taught by embarrassed teachers who won't explain how sperm gets into the uterus. Teachers rarely mention homosexuality or condoms.

It is assumed that information is equal to practice, and that sex education is tantamount to promiscuity. "Young people are taught assertiveness and how to make decisions in all domains except sexuality," said Chandiramani. "Assertiveness is equated with saying no - it should be understood as the ability to say yes or no." When TARSHI does sexuality education in schools, it negotiates to ensure that no teacher is present.

TARSHI's core principles in working on young people's sexuality:

- **Talk with, not down to:** Talking down does not work. Young people are not unthinking. They have a wealth of ideas and feelings.
- **The average adolescent does not exist:** There is no one type of adolescent. Young people have a range of sexual concerns, needs and experiences.
- **Address the competing demands made by the socio-cultural context:** Adolescence is an exciting time. There are different identities to be tried on. There is a pull towards being cool, fashionable and with it, and there is a simultaneous pull towards being dutiful and conforming to social norms.
- **Incorporate the pleasure principle:** Most sexuality education messages focus on safety and restraint. Sexuality is as much about desire, attraction, pleasure and fun as it is about the risk of negative consequences.
- **Invest in the now, not in the future:** Many programs invest in young people as the generation of the future. But young people have concerns in the present that need to be addressed. They are not as worried about some far-off future as they are about what to do now.

Representation and Reality: Sexuality in the Media

Sapna Desai, CREA

85 per cent had sex first time after marriage!

21 per cent have experienced same-sex desire!

1/5 are sexually active by 15!

Indian magazines are replete with this kind of information around sexuality, giving rise to a strange paradox. On the one hand, nobody talks about sexuality. On the other, it's everywhere in the media. In this context, Sapna Desai analyzed what young people see and hear about sexuality in the media.

The presence of 300 million young people in India makes this group a profitable media target. The media is the second biggest source of information on sexuality, after schools. *Femina Girl*, a magazine aimed at girls aged 14-20 years and designed to be 'kept out of the reach of adults', conceptualizes young women as sexualized beings, although it never overtly discusses sexuality. It discusses issues of body image, stereotypes, the 'sensual you', and assumptions of romance, in a young, zippy style. Girls are positioned as grrrls, clearly different from women. Although sexuality messages abound in the media, they are often accompanied by class, language and other biases.

Music television channels also acknowledge young people as sexual beings, and promote an upbeat view of young people's sexuality. An example of this trend is MTV, which is aimed at an audience of 15-24 years and is one of the earliest, biggest movers in youth marketing. Newspapers - which are read by adults and young people, but which reflect adult thinking - typically focus on violations, abuse and HIV when covering sexuality.

On the one hand, a rapidly globalizing media world has opened up new avenues to explore young people's sexuality, with radio stations, agony aunt chat shows ('Ask Dr No all your questions on love'), the Internet and other emerging formats. On the other, government-owned media still retains a discomfort with sexuality, which is presented in moral terms. A state-made show on sexuality might put out the message: 'It is wrong to go to a sex worker', instead of putting out the message: 'Use a condom when you have sex with anyone, including a sex worker'.

By and large, the media offers mixed messages around sexuality, which conflict with other societal messages. While it presents young people as sexual beings and promotes a pleasure-based view of sexuality, it also perpetuates gender stereotypes. What is most often lacking is accurate information; information that is sorely needed in a country where the average age of marriage for girls is 16.4 years, and where sexual activity is very real for all young people in India: married and unmarried, urban and rural.

Discussion

Desai's presentation was followed by a lively discussion on a range of overlapping issues. Participants saw the media focus on pleasure as a positive development in a context where pleasure is rarely talked about in the public domain. A participant shared how homosexuality is often conflated with pedophilia in the Nigerian media through headlines such as 'Man rapes nine-year-old boy', even though homosexuality is consensual and pedophilia is coercive.

One should not assume that young people are passive recipients of all media messages. "There is some information that you take, some you don't," said a participant. What about web-based messages such as, 'enlarge your breast size, enlarge your penis'? An Indian participant felt it was fine for young people to see adult sites, "but they need to know that all adult women don't have 46DD breast sizes."

Participants agreed that media is one of the most important vehicles for providing information to young people on all issues, including sexuality. 'Enter-educate', or education based around entertainment, is a successful strategy to reach young people. "We need to learn how to deal with media," said a Nigerian participant. "What is in those programs that makes them sell? What have we lost out on?"

Site Visit

MAMTA

MAMTA is a community-based organization in Delhi that works on issues of child health, women's health and young people's health with an emphasis on gender, sexuality and rights.

The site visit focused on three aspects of working with young people:

- Addressing maternal mortality at the community level
- Peer education, the formation of youth groups and adolescent health
- Advocating for adolescent health.

Addressing maternal mortality in the community

Both India and Nigeria face a heavy burden of maternal mortality. While the maternal mortality rate (MMR) in India is 540/100,000, there are parts of India where the MMR is as high as that of Nigeria - 800/100,000. In the context of early marriage, safe motherhood is a critical health intervention for young people.

At MAMTA, trained community workers identify pregnant young women as early as possible, typically in the first trimester. They then persuade women to go for regular antenatal check ups to the public health center, a key step in ensuring safe motherhood. A woman who is pregnant for the first time must visit the health center once in two months, until the last trimester when the frequency increases to twice a month.

Pregnant women are thoroughly examined for risk factors, including:

- Age (very old or very young)
- Height (less than 145 cm)
- Weight (less than 42 kg)

On average, 10-15 out of every 100 women are identified as having high-risk pregnancies. They are advised to go in for institutional deliveries, another vital step in ensuring safe motherhood. Community workers follow up with their mothers to ensure that they take this step. Other women may deliver at home if they wish; MAMTA trains and equips traditional birth attendants (TBAs) to ensure safe home deliveries. Community workers follow up on all home deliveries, since many women die after delivery due to post-partum hemorrhage, infection or retained placenta.

22 OCT

New Delhi

DAY THREE

On the third day of the cross visit, participants visited two Indian non-profit organizations in Delhi: MAMTA and TARSHI. Participants saw how young people's issues can be addressed through two avenues - at the community level, and via a telephone helpline.

The site visit to MAMTA consisted of:

- Meetings with Sunil Mehra, executive director, and PK Goswami, medical director
- Discussions with community workers and peer educators at MAMTA's clinic in Tigri, a slum community in Delhi
- Interactions with teenage boys and girls at MAMTA's community-based adolescent development centers in Tigri.

Community workers ensure that women deliver in clean environments and advise them on the four steps that comprise essential care of the newborn:

- Prevention of infection
- Maintenance of optimal body temperature
- Nutrition
- Vaccination.

In India, where the Infant Mortality Rate is 67 per 1,000, 80 per cent of deaths can be prevented through these four steps, according to MAMTA.

Peer education, the formation of youth groups and adolescent health

A lively meeting was held with 12 community workers, who work on different components of MAMTA's program: nutrition, solid waste management, health, entrepreneurship development, safe deliveries, male participation, counseling, peer education training, adult literacy, etc.

At the community level, 2,700 young women have been organized into *samuh sanghs* or groups. Each community block has a group consisting of 20-40 members. The community workers face numerous challenges in mobilizing women in the community.

- Lack of mobility: Many families do not allow women to step out of their houses, let alone attend meetings. This is overcome through discussions with the family, couple meetings, and mother-in-law meetings.
- Outsider mentality: Most people living in the slum have migrated here from other places, and have little attachment to the community. They are not motivated to engage in long-term self-help processes.
- Local interests: Local leaders and other vested interests often try to break budding collectives, which they see as threats to their own power bases.

In this context, it is imperative for community workers to meet felt local needs - around water, immunization, credit schemes, adult literacy, income generation, etc. - while raising issues of adolescent health.

MAMTA's health intervention among young people contains many components:

- Provision of clinical services to adolescents
- Peer education among young people
- Advocacy for improved policies, programs and services for young people
- Research to understand adolescent issues (e.g. why don't teenagers use condoms?)
- Informatics for young people (website, information center, IEC materials).

The organization works with young people in the age group of 10-24 years at the community level, including adolescents in the 10-19 year age group. MAMTA categorizes adolescence into three phases :

- Early adolescence 10-13 years
- Middle adolescence 14-16 years
- Late adolescence 17-19 years

Peer education is one of the most effective strategies to reach adolescents. At MAMTA, volunteers and school dropouts are recruited during community fairs and festivals and trained as peers. A total of 40 peer educators are given rigorous weekly training of over 40 hours. Peers meet weekly to exchange information, share insights, and identify their own information needs. These sessions are also an opportunity to provide training inputs.

Peers discuss opposite-sex attraction, reproductive organs, and reproductive health with boys and girls in group and individual settings, some held separately for boys and girls, some together. "We explain that these are physiological matters - there is no shame in discussing these together," said a community worker. Approval from gate-keeping parents is critical to enable young people to attend the sessions.

Young people do raise confidential issues such as same-sex relationships and unmarried pregnancies, typically in one-on-one interactions, not in group situations. In the case of same-sex relationships, counselors tell young people that this is normal, rather than 'wrong' sexual behavior.

Dealing with unmarried pregnancies is a little more complicated. If a woman has faced sexual abuse, this is brought to the parents' attention. While parents may let her have an abortion, they may not take up the underlying issue of sexual violence. Parents did not take up the case of one 17-year-old girl who was abused by her brother-in-law, since their other daughter was married to the same man.

When a young girl got pregnant after going out with a sex worker, the parents were informed, but the community worker counseled them on this. "Is there an opportunity to meet young people without their parents?" asked a Nigerian participant on hearing this. "What if a pregnant girl wants an abortion without her parents knowing about it?" Community workers clarified that she is referred to an abortion center, after ensuring she has money for an abortion. Her case will be kept confidential. "We have a good rapport with the whole family," said one worker. "So we can go to her house and hang out with her without her parents getting hassled, or without violating confidentiality."

A Nigerian participant shared how her organization has started a parent-child communication training module. Parents are told of the implications of not discussing these issues with their children, given three days of training and follow-up stints on how to communicate with their children on sexuality. When parents finally start discussing sexuality, they realize they may have less knowledge and understanding than their kids! The module has given young people the confidence that they can change both their parents, and the world around them.

Advocating for adolescent health

MAMTA advocates for adolescent health at two levels:

- At the community level to create a youth-friendly environment
- At the government level to ensure policy formulation and service provision for young people.

Ten years ago, when MAMTA started its work in this field, adolescent health was a new concept, with donors unwilling to provide even minimal support. MAMTA advocated for adolescent health by using data on child and maternal mortality and foregrounding the intergenerational consequences of poor adolescent health. Advocacy was also needed at the community level: parents and young people couldn't understand why they needed to form their own groups around this issue. Why adolescent health? This barrier had to be crossed before focusing on the *sexual and reproductive health* of adolescents.

The next step was policy advocacy, which remains a major challenge to this day. Adolescent health is spread across four government departments in India - family welfare, rural development, youth affairs, and education. Any policy change has to be preceded by policy reviews across all four departments. Adolescent health is often subsumed under child health. "We need to define childhood more clearly," said Mehra. "How do I highlight the specific needs of a 15 year old who is pregnant and needs health care?"

In advocating with the government, MAMTA has learnt certain vital lessons:

- It is easier to change existing policies than to pass new policies.
- Policies are not just stated, written policies; they are both explicit and implicit. When a minister publicly says that condoms are important in HIV prevention, it is noted and acted upon within the bureaucracy. Such public signals have the power to change financial allocations.
- UN documents to which India is a signatory can be used to advocate for change.
- The media plays an important role in influencing policy agendas, through editorials, etc. NGOs need to provide substantiated, evidence-based information to media in this context.
- Lobbying with parliamentarians is useful in bringing down barriers to policy implementation. Parliamentarians often have no knowledge or information about an issue, a gap that advocacy can fill.

Over the years, MAMTA has set up a National Youth Forum as an advocacy platform. This consists of 35-45 people from 10 states in India. Each state sends three to four representatives to the forum, which meets twice a year and produces its own newsletter. Both men and women are equally represented on the forum, which MAMTA funds and facilitates.

MAMTA also advocates adolescent health among young people in many ways. The idea is to form a critical mass of lower-middle and middle-class people who can influence opinion. An essay competition is one strategy. Winning entrants are brought to Delhi, and given a mix of sightseeing and sexuality training. "We look for any opportunity that creates a ripple," said Mehra.

TARSHI

TARSHI - or Talking About Reproductive and Sexual Health Issues - works to expand sexual and reproductive choices in people's lives to enable them to enjoy lives of dignity, freedom from fear, infection, and sexual and reproductive health problems. The organization's work began with a telephone helpline, and has since grown to include training and networking, documentation and research, public education and advocacy, an annual institute, and a regional resource center.

Helpline

The TARSHI helpline has received over 55,000 calls since it began in February 1996. Even though the helpline is aimed at women, most callers are men - partly because men enjoy greater mobility and access to telephones. Trained counselors staff the helpline, which provides information, counseling and referrals on sexuality while maintaining caller anonymity and confidentiality. Some callers require only information; others need information and counseling, or all three.

Each and every call to the helpline is documented in two registers. A short register records gender, language, age, marital status, first question asked, and how the caller got the helpline number. It also records what was provided:

- Information
- Information + Counseling
- Information + Counseling + Referral

Once the call is over, its chronological narrative is recorded in a longer register.

The purpose of documenting each call is twofold: to maintain call records, and to ensure service continuity. About 25 per cent of those who call are repeat clients. TARSHI links them back with the same counselor through a simple color coding system in which each caller is given a unique identification number. This enables the counselor to quickly retrieve and review the caller's records on a repeat call. "The counselor is able to create a safe enough space on the helpline for the caller to share intimate details," explained Chandiramani. "He will feel shattered if the counselor can't remember this. The caller feels validated when you mention the background."

The number of calls varies each day. On an average, there are 15-16 calls in an eight-hour workday. But when the helpline places newspaper advertisements, numbers swell to 50-60 calls per day. Radio advertisements tend to attract more crank and abusive calls, as well as information-based calls. Currently, the helpline gets fewer calls, but these are longer, deeper calls that need more counseling than information.

Issues

People from 7-73 years call the helpline, but most calls are from those between 18-24 years. While callers want information on anatomy, HIV or contraception, there are certain age and gender patterns. Young people are more likely to talk about abuse, while some older callers talk about infertility. Men talk about sexuality more easily, while women tend to start off with a medical problem and raise sexual issues only when they feel comfortable. Men typically bring up sexual issues, women tend to talk about emotional and relational issues. "This is not a stereotype," said Chandiramani. "This is what we are actually seeing on the helpline."

Young people often call about performance anxieties around the wedding night. Many men and women who get married are strangers to each other and feel nervous about suddenly entering an intimate, sexual space. At the same time, they face peer pressure from friends who say they've had sex six times on the wedding night. The helpline advises that they delay sex till they have developed a relationship with their spouse - and concoct a story to stave off peer pressure if needed. Clients often report back, saying they have followed this advice and developed a great sexual relationship.

Approach

Training is a critical component of the TARSHI helpline. Counselors are trained on how to handle each call, how to offer information in a palatable, accessible

manner, and how to end a call well. Instead of telling a young person, "You must be responsible for protecting your partner from STDs," the same information is rephrased to be more digestible.

Counselors follow certain key principles in dealing with calls:

- Don't give out moralistic messages
- Don't assume a caller is talking about his or her spouse. Counselors refer to partners, giving callers the freedom to talk of relationships outside of marriage
- Don't assume the sex of the partner
- Don't cast judgments on the relationship.

Calls are never followed up, as part of maintaining anonymity and confidentiality. "We don't have their names and numbers, as this would violate their privacy," said Chandiramani. "Someone else may pick up the phone in their house if we call." This can be frustrating, since counselors often do not know what happened to callers. "The mystery contributes to burnout. There is no closure, and you are left in the dark."

Like caregivers everywhere, TARSHI's counselors grapple with the threat of burnout everyday. A call can be about anything: abuse, breast size, suicide. A counselor is never left alone in the helpline room. "It's not fair to leave the counselor alone to deal with it," said Chandiramani. "We need to attend not just to our callers, but to our counselors' emotional health. Burnout is a huge issue."

Challenges

Dealing with issues such as abusive calls and suicide is a challenge for the helpline, even though TARSHI's counselors are equipped to deal with such situations. About 10-15 per cent of calls are abusive; a caller may masturbate while on the line. Counselors firmly but gently tell the caller to call back when he has finished what he is doing. Counselors can also assess the seriousness of a suicide attempt and calm the caller down. But they cannot step beyond this. "We cannot live their lives for them," said Chandiramani. "We cannot take decisions for them. We can enable them to make their own decisions."

Unlike face-to-face counseling, helpline counseling poses a new set of challenges. While anonymity makes it easier to discuss taboo subjects like sexuality, the counselor has no visual cues to gauge caller reactions. She has to rely on auditory cues, and has no control - a caller may just hang up. This adds urgency: enough information has to be given before the call ends.

Issues such as transsexualism are coming up on the helpline nowadays. While counselors have been trained to emotionally understand the feeling of being trapped in the wrong body, callers also want information on sex reassignment, and the legal implications of this. This has created new training needs and challenges for the TARSHI helpline.

Population Foundation of India

Established in 1970, PFI aims to stabilize the country's population and establish a balance between resources, environment and population. PFI works on population issues through a dual strategy of advocacy, and capacity building of NGOs and Panchayati Raj institutions. PFI advocates for quality of care in reproductive health among health providers, policy makers and program managers.

PFI's executive director, AR Nanda said that the Cairo legacy could be seen in India's population policies. According to him, the 2000 National Population Policy reflects key aspects of the ICPD+5 recommendations: the use of the life cycle approach, an emphasis on adolescent sexual and reproductive health issues, and the need for policy focus on post-reproductive issues, such as ageing. The policy also emphasizes convergence in programming (as against vertical programs), inter-sectoral coordination, decentralization and autonomy of local governments, all of which are key ICPD+5 recommendations.

23 OCT

New Delhi

DAY FOUR

The fourth day of the India cross visit centered around two events:

- A trip to the Naz Foundation Care Center for People Living with HIV/AIDS
- A roundtable on expanding the discourse around young people, sexuality and rights.

Site Visit

Naz Foundation (India) Trust: Care Center for People Living with HIV/AIDS

The Naz Foundation is a leading community-based organization in the battle against HIV in India. Based in New Delhi, Naz began in 1994 and has since grown to include a service delivery network that promotes HIV/AIDS awareness, and provides care and support for those infected and affected by the virus. Addressing general sexual health and sexuality is a key principle underlying Naz's work around HIV/AIDS.

Irfan Khan, program manager for home-based care programs, described how Naz's work in HIV/AIDS started off with an initiative for men having sex with men (MSM), a vulnerable population that could not talk about its sexual practices or openly seek services, and had no information about HIV.

Naz decided to address this gap through a multi-pronged approach: outreach, peer education, capacity building and advocacy. "We realized we couldn't directly work in remote areas," said Khan. "So we decided to train interested organizations." Naz's training focuses around core issues related to HIV: sex and sexuality, counseling and testing, care and support, ethics. Learning how to negotiate and make decisions around sexuality is central to the training.

During a decade of work in this field, Naz has identified care and support as another critical gap. In the 1990s, Naz started its own clinic for positive persons who found it difficult to access government health services. Counseling is provided within the Naz clinic, unlike in many clinics. At public health centers, all pregnant women are mandatorily tested for HIV, often without being told for what they are being tested. Although it is mandatory to have pre-and post-test counseling and to get the patient's informed consent, this is often done cursorily. "It is important to have meaningful consent," said Khan.

The Care Center

Naz's experiences of working on HIV/AIDS culminated in the establishment of a care home for positive persons. The Naz care home, which is located in a residential area, focuses on positive women and children. "If a woman is HIV-positive, will the marital

family keep her after her husband has died?" asked Khan. "Where does the child go?"

Many of the children at the care home are orphans, who will remain there till they grow up. The children are sent to a neighborhood school where their HIV status is not disclosed for fear of stigma and discrimination. The neighborhood does not know that the Naz home is a care facility for HIV-positive people; all it knows is that this is some kind of medical facility. Non-disclosure in the community is critical to ensure the home's smooth functioning.

Naz also trains families to provide home-based care, partly because this is another critical need, and also to prevent the care home from becoming a dumping ground for women and children. A monthly meeting is held with family members to bridge the gap between infected and uninfected members of the same family. Naz also provides practical tips for managing HIV in a home environment.

The establishment of a support group for positive people is another vital aspect of Naz's HIV/AIDS intervention. The aim is to encourage people to share their experiences of living with the virus and draw strength from each other. Many doctors advise positive persons not to have sex, a position that Naz does not buy into. "Getting HIV does not mean that one is not sexual," said Khan. "In fact, touch plays a very important role in a positive person's life." The organization advises clients to continue having protected sex, and advocates for all people to have protected sex, whether or not they are positive.

HIV tends to lower economic status, because of the cost of medical treatment, and because illness may mean an inability to work. Naz generates livelihood opportunities by marketing products made by positive persons. The products are not advertised as made by positive persons, since this might detract from their sales potential. The organization is networking with other NGOs who are skilled in income-generation, since this is not Naz's core expertise. "There is only so much we can do as an organization," said Khan.

Legal action

In 2001, Naz and the Lawyers' Collective filed a petition in the Delhi High Court, asking for a repeal of Section 377 of the Indian Penal Code. This section, which was drafted in the 1860s, criminalizes 'carnal intercourse against the order of nature' and is often used to intimidate and harass men having sex with men.

Underlying this section is the assumption that only heterosexual peno-vaginal sex is normal, and that all other sexual practices are abnormal, even criminal. Anal or oral sex between consenting adults is considered a crime under Section 377. This section is also used to address child sexual abuse, as there is no specific law against this.

Although there have been few prosecutions, Section 377 is widely used by the police to threaten, blackmail and extort money from homosexual and bisexual men, and *hijras*. HIV/AIDS outreach workers are harassed and not allowed to work freely. Police force many outreach workers to have sex with them, using Section 377 as a threat.

In 2004, the Delhi High Court ruled against repealing Section 377 on the grounds that doing so would encourage child sexual abuse. "The government response equates homosexuality with pedophilia," argued Khan. He highlighted the need for a public debate around this issue.

In a discussion, a Nigerian participant said that since pedophilia is often in the news, people tend to equate it with homosexuality. Similarly, sexual practices such as anal sex - or sodomy - are often seen as homosexual practices, when they are actually practiced across sexual orientations. An Indian participant noted that Section 377 assumes that only men have sex; that two women won't have sex with one another.

In India, all the images of HIV are those of heterosexuals or sex workers. Thus, many men having sex with men feel only heterosexuals or sex workers

can get HIV. HIV messages often come mixed with fear and morality: for instance, a health minister may promote the condom for family planning, but promote abstinence for HIV. Sex workers and drug users are labeled as 'high-risk groups'. It is important to talk of risk behaviors rather than of high-risk groups in the context of HIV.

"Sexuality inevitably comes laden with moral connotations," said a participant. At Naz's trainings, participants often insist that the purpose of sex is reproduction or procreation. "People are unwilling to articulate pleasure as the purpose of sex," said Kalyani Subramaniam, coordinator for programs at the Naz Foundation. She felt that safety, rather than morality, needs to be brought into the picture when discussing sexuality. "Regardless of the sexual practice itself, the question is really this: how can each sexual practice be made safer?" said Subramaniam. "We have to keep the positive person at the center of our focus."

Roundtable

Participants at the roundtable were asked to focus on two key questions:

- What do you see as the two important concerns related to young people's sexuality and rights? What are the challenges in addressing these issues?
- What strategies have you used - organizationally and/or individually, that have helped address these concerns effectively?

In her opening remarks, Radhika Chandiramani of TARSHI, who facilitated the roundtable, provided an overview of important concerns related to young people's sexuality and rights. These include:

- Inaccessibility to information on sexuality
- Lack of accurate information
- Lack of youth-friendly tools to assist open discussion
- Lack of safe spaces for discussion and/or expression of sexuality.

Organizations face numerous challenges in addressing these issues, including:

- Restricted access to young people, often regulated by elders and society
- The shame around sexuality
- Approach of 'damage repair' rather than self-exploration
- Internalization of negative attitudes and stereotypes
- Socio-political hesitation to address sexuality, especially of young people.

Despite this, there are a number of effective strategies for working with young people at individual, institutional and societal levels:

Individual level	***Schools and institutions***	***Societal level***
Counseling	Workshops with parents/teachers	Newspaper columns
Support Groups	Sessions with young people	Films for adults and young people

The presentations and discussions at the roundtable are summarized below.

23 OCT
New Delhi

DAY FOUR continues

The roundtable, 'Expanding the Discourse: Young People, Sexuality and Rights' was collaboratively hosted by CREA and TARSHI - and included individuals and organizations working with young people.

Speakers included:

- Namita Bhandare, The Hindustan Times
- Abha Ranjan
- Maya Shankar, Sangini
- ~~Dorothy Aken'ova, INCRESE.~~

Spaces in the Media

Namita Bhandare, The Hindustan Times

About 47 per cent of India's one billion population is under the age of 20 - and, according to *Businessweek* magazine, wields $2.8 billion of discretionary income. Thus, young people represent a powerful economic, social and political constituency.

Given this, mainstream media cannot ignore young people, either in ideological or in commercial terms. Ideologically, the media simply cannot ignore the concerns of almost half its readers. And commercially, young people represent a growing market, both in terms of readership as well as advertising and marketing.

How has mainstream media tried to address the needs of young people? In the early 1990s following a global trend, most daily papers launched city supplements that were consciously geared to a young audience. These addressed youth concerns and interests - fashion, film, television, campus concerns - that wouldn't find space in the main paper.

In the mid to late 1990s, with the advent of private TV channels and more recently, Internet news services, media once again found itself faced with momentous changes. Coinciding with this technological change, social demographics began getting younger, and youth power became a very real phenomenon.

The media responded to this in many ways: with a greater emphasis on pictures and visuals and snappier, easier to read writing styles; by launching newer, contemporary supplements and magazines like *Seventeen;* by placing lifestyle stories related to young people in the main paper, rather than in the supplement; and by talking about young people's sexuality. Nothing was too sacrosanct; everything was open to discussion.

Despite these developments, the media failed to a large extent to reflect young people's real concerns. It focused on stories that were superficial - 10 ways to please your boyfriend, what to wear this Diwali. It reinforced stereotypes about Indian youth as flippant, self-absorbed people who had no stake in the country's future.

In January 2004, *The Hindustan Times* commissioned a five-city survey on young people from 16-24 years, with questions ranging from career choices to sexuality, from arranged marriages to role models. Much of its findings came as a surprise: one-third of the respondents listed their parents as role models; family ties were important for 84 per cent; religion was important for young people; most respondents said they had no sexual experience and rooted for arranged marriages.

The findings went so against the grain of popular perceptions and stereotypes that the newspaper decided to introduce a regular weekly page that would try and reflect the aspirations of young people. This page runs every Saturday and includes issues of interest to young people. The page includes an 'agony' column in which TARSHI provides expert counseling. One of the page's aims is to promote the idea that sexual choice is okay, that sexuality is okay, and that there's nothing 'abnormal' or dirty about sex.

Working within the School System

Abha Ranjan

In her brief, informal presentation, Abha Ranjan said that schools are concerned about sexual health as part of their overall concern for the health of students. Some teachers have come together in a forum to develop Healthlive, a 12-year curriculum around health; this includes mental health, and sexual and reproductive health, among other aspects.

The Healthlive curriculum has modules on body parts and attitudes to sexuality. It is largely aimed at a pre-adolescent age group. "Issues such as masturbation are very important," said Ranjan. "Kids don't know where to find this information unless gatekeepers allow them to find it."

At the school level, there is not enough exploration of adolescents with special needs. Ranjan shared an attempt to run a workshop for this group, in which adolescents with special needs were trained to say no. "We tried to go as far as possible to stop sexual aggression and violence," she said.

Exploring Sexuality

Maya Shankar, Sangini

Maya Shankar's presentation focused on lesbian women, transgender women and women attracted to women, a community that Sangini, a helpline and support group for women attracted to women, works with. Women who call Sangini are often isolated, lonely and distressed about being attracted to the same sex in a context where they have no information about same-sex relationships. "There is not enough space in India for everyone to explore their sexuality," said Shankar.

The first important realization that many women make at the support group is that there are other women who fall in love with women - and that all of them seem quite normal. This is a moment of tremendous validation. Many women come from a low-income or middle-class background and are not used to thinking critically of society. "Their agenda is to feel comfortable," said Shankar. "We try to get them to consciously explore sexuality and go beyond their personal struggle. This requires both honesty and courage."

Sexual Rights and Diverse Groups - The Nigeria Experience

Dorothy Aken'ova, INCRESE

In her presentation, Dorothy Aken'ova provided an overview of adolescent sexual and reproductive health and rights in Nigeria. Before Cairo, although there were many NGOs working with young people in Nigeria, there was little consciousness that adolescents are different from other groups in society. The 1994 ICPD at Cairo changed all that in a dramatic way. Since then, there has been a change of consciousness, along with scaling-up and expansion in the field of adolescent health in Nigeria.

The 1995 National Policy on Adolescent Health guides interventions and provides an institutional framework for this field. This policy is useful in pacifying those who oppose the provision of adolescent health services. "The fact that it's a government policy makes a big difference," said Aken'ova. In line with this framework, the health division has developed protocols for young people and peer education guidelines, all in consultation with stakeholders.

Young people in Nigeria face many challenges related to sexual and reproductive health and rights:

- HIV is ravaging the young population and it is estimated that one young person gets HIV every minute in Nigeria. HIV is often used as an entry point to raise sexuality issues. Condom use is very low in Nigeria, and even though the provision of information related to HIV has gone up, behaviors and attitudes are not changing fast enough. IEC efforts, which did not result in behavior change, are now being replaced by Behavior Change Communication (BCC) initiatives. Capacity building remains a huge challenge as people continue IEC initiatives under the name of BCC.

- Trafficking is a concern, with girls being forcibly recruited to work in dehumanizing conditions through false promises. While there is a law to address trafficking in persons, this is based on an older law against drug trafficking and is not effective. "Drugs and persons are different," said Aken'ova.

- Gatekeepers, ranging from parents to faith-based organizations, restrict the flow of information around sexual health and rights to young people. "Parents are not fully involved even though they are the primary sex educators," said Aken'ova.

- Sexual identities are still kept under wraps, for fear of stigma and discrimination. Although the federal government has acknowledged that there are diverse sexual identities, and accepted this is as part of the right to choice, there is no discussion of this issue. "In talking about behavior change, how do we change behavior towards diverse sexual orientation and different expressions of sexuality?" asked Aken'ova.

Discussion

Following the four presentations, participants engaged in a discussion focusing on:

- Barriers to working on adolescent sexuality in India
- Challenges of addressing traditional harmful practices in Africa
- Priorities in working on young people's sexuality.

Barriers to working on adolescent sexuality in India

Participants listed several barriers they face in their work in this field:

- Young people are not considered a heterogeneous group
- Inadequate resource allocation
- Diffused definition of youth as upto 40 years
- Clubbing of youth and sports into the Ministry of Youth Affairs and Sports
- No implementation, even where policies exist
- No paradigm shift among gatekeepers, even though young people are experiencing rapid mental shifts
- Policy and program focus on 'married young people', not on 'young people'
- Sexuality is not seen as a central aspect of a young person's life
- Inadequate allies and advocates of youth issues within government.

Challenges of addressing traditional harmful practices in Africa

Many Indian participants wanted to know how practices such as female genital mutilation (FGM) that affect young people's health are being addressed. "Female genital mutilation is at the crossroads of culture, tradition, gender and violence," said a participant from Nigeria. FGM exists in some, not all, communities with practices differing from one region to another. In some communities, FGM is carried out within two weeks of birth, in others at six years of age, and in others on puberty - as a rite of passage.

Many communities are resistant to the term FGM - and use the term 'cutting' instead. FGM can be done through different methods - all of which result in painful intercourse for girls. This, in turn, leads to sexual dysfunction. Many strategies have been used to end this traditional harmful practice:

- Developing alternative livelihoods for those dependent on carrying out FGM
- Getting volunteers to talk on radio about how FGM affects their sexual pleasure
- Training community members as watchdogs on FGM
- Creating awareness around FGM through diverse means, including mass media
- Using the law as an instrument, not necessarily to prosecute, but to signal that FGM has no place in society.

Criminalizing FGM is a mixed strategy: in countries like Burkina Faso, where FGM is a crime, the practice has merely been driven underground, not wiped out. In Nigeria, there is now a law against FGM; this has helped change public opinion. "Before the law, by and large, people felt FGM should go on," said a Nigerian participant. "Now they feel differently." She emphasized that laws around FGM should be used to mobilize public opinion, rather than to punish offenders. "When talking about issues such as FGM, it is useful if your voice is the government's voice," she said. "The aim is to not pass on this cultural practice to the next generation."

Women who can't get sexual pleasure because of FGM sometimes take on women partners for gentler, pleasurable sex. Care must be exercised when using terms like traditional harmful practices - not all traditional practices are harmful, but people tend to conflate the two terms. "The Indian tradition of arranged marriage could be seen as a harmful traditional practice," said a Nigerian participant.

Priorities in working on young people's sexuality

Participants listed critical aspects of working with young people. These include:

- Learning progressive values and unlearning regressive values at a young age
- Overturning the system of patriarchy, which is so dominant that adults often don't notice it and young people easily internalize it
- Getting young men to respect young women
- Equipping young people with the right information and the courage of their convictions
- Enabling young people to fight for what they think is right
- Enabling young people to become agents of change within their families, and within society at large
- Enabling young women to find their own perspectives and selves
- Challenging stereotypes such as the 'good girl' which prevent self-development
- Getting adults to talk to, rather than down to, young people
- Ensuring that young people are represented at different forums
- Increasing young people's self-esteem.

Videos

Growing Up

Director: Venu Arora

Growing Up is an innovative video-based initiative on reproductive health for young people in India and south Asia. Designed as a long-term initiative that addresses the entire age band from 9-21 years, the initiative aims to create open discussions on sexuality, safe sex, reproductive health, gender, STIs, HIV and family planning.

Using a variety of components ranging from puppetry to music, animation and role play, the films create a humorous and positive image of the process of growing up. This is expected to result in a more open generation, comfortable with discussing sexuality, and equipped with a context within which to understand messages on STIs, HIV, etc.

Participants saw two half-hour episodes of *Growing Up*. Following the screening, director Venu Arora said that rough versions of each episode had been shown to students and their feedback incorporated into the final version. Many parents said they had no idea what their children were thinking - till they saw the video.

A number of schools have used *Growing Up*, which is ideal for a sixth grade audience. Older students cannot relate to the puppets who anchor each episode. But it is difficult to insist that schools use it only for the sixth grade; what is needed is acceptance within the school system. An original Hindi version is now being prepared, rather than translated from English. "It is essential for Hindi-speaking children to see themselves represented on screen, rather than through the voices of English-speaking children," said a participant.

24 OCT

New Delhi

DAY FIVE

Halfway through the cross visit, participants were shown two videos that are being extensively used to raise issues of young people's sexual and reproductive health and rights in India:

- **Growing Up** by Venu Arora
- **When Four Friends Meet** by Rahul Roy.

Each screening was followed by a brief discussion.

When Four Friends Meet
Director: Rahul Roy

When Four Friends Meet is part of a south Asia-based project exploring masculinities. The documentary focuses on four young men in a working-class colony on the outskirts of Delhi who are trying to make their lives in a rapidly changing environment. Stable jobs are not easy to come by. Sex is a strange mix of guilt and pleasure. Families are claustrophobic. Girls seem to be very bold. And the blur of television is the only sounding board. The four men candidly share with the camera their lives and secrets, dreams and failures, frustrations and triumphs.

After the screening, participants discussed media representation, arranged marriages and the challenge of building lasting relationships. Director Rahul Roy explained that the television is the fifth friend in *When Four Friends Meet* - because it is the only sounding board for young people. "There aren't many discourses for young people to choose from," he said. "Where do they bounce their feelings of love, romance, sex?"

For many teenage girls in India, films and television are like classrooms from which they consciously learn how to negotiate and handle relationships. The problem is that television images do not always promote progressive values of gender equality, making one's own choices, etc. One avid soap opera viewer had this question: Is it always necessary to have an affair with one's brother-in-law?

The challenge is to influence mainstream films and television to develop alternative images, to stop trying to give back to society its exact reflection. This is harder than it sounds, given the commercial motivation behind most mainstream media. However, a new crop of films in India are pushing representational boundaries, depicting female desire, sexual relationships between people of different ages, etc. However, they tend to cling to traditional thinking on other issues.

Talking about the process used to make *When Four Friends Meet*, Roy said he conducted four months of intense workshops with the four subjects before starting filming. The workshops ranged around issues of family, relationships, marriage, aspirations and so on, and threw up telling insights. For instance, these young people had a downbeat view of marriage. "They feel the first three months are fun, and then it's misery," said Roy. "There's conflict. No fun. This is based on what they see all around."

Young people need to be exposed to different ways of resolving conflicts within relationships. They see dysfunctional relationships around them and have absolutely no skill or capacity in resolving conflict situations. They do not know how to express caring; neither do they know how to express anger. "They can't handle it at all," said Roy. "After a while the solution becomes: slap the wife and go on."

Participants felt that young people are inadequately prepared for maintaining relationships because they do not have strong role models. They see very little love and affection expressed in the relationships around them - between their parents or among siblings. This information gets absorbed early on and affects the learning process of forming relationships. "How can one prepare you to start a life where you can live together in the long run?" asked Roy.

Site Visit

MASUM

MASUM - Mahila Sarvangeen Utkarsh Mandal - was formed in 1987 when the women of Malshiras, a drought-prone rural area in western India, decided to create a space for themselves and address the issues that affected their lives. Since then, it has gradually evolved as a development group with a feminist perspective and a democratic approach. MASUM's women's rights programs include components on health, family violence, self-employment and resource development. With 40 full-time workers and 22 part-time workers, MASUM also has programs for children, tribal empowerment, and social awareness.

The site visit focused on three key aspects of working with young people:

- Addressing domestic violence at the community level
- Sensitizing young people to gender equity
- Facilitating women to access credit and increase income.

Addressing domestic violence at the community level

Domestic violence is among the most difficult issues to handle in a rural setting, partly because of kinship structures - men in a village are often related to one another. "The daughter-in-law comes from another village," said Ramesh Awasthi, co-convener and trustee. "When she is harassed and we take it up, there is a lot of resistance."

Cultural norms of suffering in silence and accepting violence as part of marriage pose another challenge. Children internalize the belief that the husband has a right to beat his wife. "There is a need to eliminate violence from the culture," said Awasthi. Through games, stories and skits, MASUM works with children to break gender stereotypes, and to re-orient their understanding of violence. In all its programs with school-going children, MASUM emphasizes three values: equality, secularism, and non-violence.

MASUM's intervention in health and violence is based at its centers, all located in the same or neighboring buildings in a village: Sadaphuli, the Feminist Health Center; Samvad, the Family Counseling Center; and Saathi, the Center Against Violence. The centers are clustered together since health and violence are often strongly related - this makes it easier to address both meaningfully.

27 OCT

Pune

DAY SIX*

From Delhi in northern India, the trip shifted to Pune in western India. The sixth day consisted of a trip to MASUM, a non-profit organization working in the rural areas around Pune with oppressed, marginalized and minority groups.

The site visit consisted of:

- A trip to a village-based micro-credit program led by Ramesh Awasthi, co-convener and trustee
- A trip to Sadaphuli, MASUM's feminist health center.

* Saturday 25 Oct and Sunday 26 Oct were non-working days for participants

Women are often not allowed to go out of the home, but a medical complaint provides a good pretext to break this rule. "A woman's health is also related to how she is treated at home," said Archana More, a counselor at Samvad. A woman may turn up at the center with a health problem due to violence. If she is willing to share her experience of violence, then Samvad, the counseling center, enters the process. Otherwise, she is treated for a health problem.

While Samvad counsels women, cases of violence are handled by Saathi, the center against violence. Saathi's approach is not prescriptive - it enables women to hear their inner voices and make their own decisions in situations of great turmoil. "A girl doesn't come here having decided to take action against her husband or her in-laws," said More. "She often comes to feel around, to see what's possible."

Saathi walks with a woman at her own pace, discouraging her from making hasty decisions that may have unanticipated repercussions. The first step is to give her courage to decide what she wants. Processes of reconciliation are initiated only if a woman feels that outside intervention will help, not hinder. The only time Saathi steps in more forcefully is when a woman faces a life-threatening situation. "Then we have to take spot decisions," said More. "We have to shelter her, call the in-laws and take action."

During reconciliation, Saathi enables a woman to place her problems before her in-laws, rather than speaking for her. Information that might be used against a woman - e.g., that she has tried to commit suicide - is never divulged to the family. Instead, Saathi plays up the dangerous life-threatening aspects of domestic violence.

The main focus of reconciliation is on husband and wife, since the dispute is between them; in-laws come later. "The minute both sets of parents enter the picture, reconciliation becomes difficult," said More. During reconciliation, the husband is asked to state how he will take care of his wife's interests; if she is at fault, this too is brought into the picture.

Husbands are initially defensive during reconciliation processes, which have to be masked as family welfare processes. "He often does not accept all the conditions," said a Saathi worker. "He tries to portray her as a liar, and himself as an ideal husband." He doesn't accept his own violent behavior, but insists it is a reaction to her behavior.

As part of its work, Saathi also helps a woman develop a safety plan to protect her own life, her children, and the little property she may have. This includes identifying safe homes, keeping ration cards, land and property papers in safe, accessible places, and putting a woman's name on the ration card as proof of residence. The plan is built around practicalities. Where should a woman keep her money so she can access it in a crisis? What is the one word a woman should shout when she wants help from a neighbor? "Safety is of two kinds," said a Saathi worker. "Safety from the dangers outside, and safety within herself, in her mind."

But no matter how strong the violence, many women are reluctant to walk out of violent marriages; in fact, norms supporting violence are so pervasive that women do not even complain of undergoing violence. "Violence is related to culture, habit, mentality," said a Saathi worker. "It is not a small disease for which she can be given a tablet and get cured. She has to fight again and again, come again and again to seek help."

Given the culture of silence surrounding violence against women, seeking help is a positive sign, a sign of hope and courage. Saathi workers make home visits to women undergoing violence so they feel empowered and adequately supported. They encourage women to develop their own identities, instead of deriving their identities from their husbands. Parents are also counseled on the importance of supporting their daughters. After a MASUM campaign, parents approached the organization, saying they are willing to support their daughters.

If a case of violence cannot be resolved at the family level, it is brought before the village. Villagers typically hear the husband's point of view; Saathi

enables women to place their perspectives before the village. Pressure from villagers and local leaders is effective in preventing violence, since families are sensitive to having dirty linen washed in public. But such attempts also rub up against village norms. "It is acceptable for a mother-in-law to say something bad about her daughter-in-law," said a Saathi worker. "But the reverse is considered insulting."

Informal community pressure typically works better than formal legal mechanisms in village settings, but here too there are barriers. "Women's organizations are often seen as taking a woman's side, even when she is not in the right," said a Saathi worker. "This belief has to be fought." Saathi continually emphasizes that quarrels between husband and wife are all right, but physical or mental violence are not acceptable.

Of the three to five women in violent situations who come to the center each month, more than half are able to find a way out of their situations. Earlier on, women facing violence would come to MASUM only when thrown out of their marital homes. Now they come much earlier. These are all indicators of the changes that MASUM is creating by empowering women. "But we cannot prevent structural violence," said Awasthi. "To do that, we have to change society."

Sensitizing young people to gender equity

MASUM works with two groups of young people: those between 12-14 years, and those between 14-18 years. In a setting where a girl of 14 years is considered old enough to be married, MASUM provides teenagers information on sexuality, sexual and reproductive rights, body politics and HIV. Women are given a crash course on all these issues from a feminist perspective. One of the key principles: the body should not be considered a source of shame.

Girls are married off early in the Malshiras area for many reasons. Parents tend to accept the first decent marriage proposal that comes along. Girls who look older than their age are married off young. Two sisters are sometimes married together to save money. Socially, a girl is not in a position to reject a proposal, while boys have complete freedom to do as they wish. To equip girls to take on this unfamiliar role, MASUM provides information on the menstrual cycle, physical and mental role changes after marriage, laws related to women, and structures at district, block and village levels that help girls and women. Girls are also taught self-defense skills.

Girls who have dropped out of school are the most vulnerable to early marriage. "There is no excuse they can give for not getting married," said a Sadaphuli health worker. "A school girl can say that she will get married only after the 10th grade." Young girls are presented with a flowery rosy picture of marriage and are themselves attracted to it. Once married, they are expected to bear children within a year. "Motherhood is very much a part of marriage," said another Sadaphuli worker. "It is an immediate next step."

MASUM holds get-togethers for teenage boys and girls on these issues. It is critical for boys to enroll in these dialogic encounters, where they are exposed to alternate notions of masculinity and femininity. One teenage boy said the get-togethers helped ease some of the pressures of marriage, and he and his wife were happier in their relationship. Such sessions help boys change their gender roles and expectations. They also help teenage girls resist the pressures of early marriage; they learn how to assert themselves and say no.

Sewing and other classes that MASUM runs also provide a platform to discuss such issues. A girl who is being forced into early marriage may tell her teacher; if she is willing to seek help, MASUM approaches her parents. Timing is crucial in this venture; one cannot try to stop a marriage the day before it is to take place. Although MASUM is opposed to child marriage, it does not confront such marriages as they take place - it will lose the trust of the community in doing so. Instead, it takes the more long-term path of creating awareness and changing mindsets.

Facilitating women to access credit and increase income

As part of its goal of empowering women, MASUM runs micro-credit and income-generation programs in some villages. The program trains rural women in weaving; rugs and mats thus produced are sold through local outlets. MASUM supplies the raw materials and markets the products; women are paid per meter of cloth they weave.

Initially, some women wanted to own their own looms at home; other women were against this. They felt this would discourage their husbands from working, and that husbands would expect women to interrupt their work at the looms to feed and serve them. They felt their work would not be respected.

MASUM also runs a micro-credit scheme based on the successful Grameen Bank model of Bangladesh, where small credit groups are directly managed by a non-profit organization. Underlying MASUM's micro-credit scheme is the belief that women have a right to their own savings and can withdraw them when needed. At the operational level, each group consists of six to 12 women. A woman has to save at least Rs.10 per month; she earns six per cent on savings, and pays 12 per cent interest on a loan she takes.

The women take all loan decisions, including enrollment of new members. Typically, the groups are led not by the most powerful women in each village, but by the least powerful - Dalit, Muslim, deserted women. The system of group decision-making, rather than individual decision-making, blunts caste, class and other advantages of some group members, and reduces pressure on individuals.

The credit groups have not faced much opposition from village men, with husbands initially being allowed to observe meetings. Some husbands demanded loans on their names, saying they were decision-makers in the family; they were told that the woman's word is final. Men are typically interested in large loans; the group decided to reject applications in cases where men came to negotiate loans on behalf of their wives. MASUM disburses between Rs.3-5 lakhs each year in loans - Rs.3 lakhs in a drought year, Rs.5 lakhs during a good monsoon.

Site Visit

IHMP

The Institute of Health Management at Pachod began its work in health and development 25 years ago in rural Aurangabad district. Today, it is the only non-profit organization with a head office in a rural area, and a branch office in a city. IHMP works on health and development through:

- Programs on women's health, child health, young people's health, water and sanitation
- Training other NGOs and government personnel on its core issues
- Research to understand what the community needs and to demonstrate the impact of its programs.

IHMP's larger objective is to create replicable models and push the government to formulate policies and implement effective programs on health and development.

Although IHMP's work has a rural focus, the organization has started an urban slum program on the outskirts of Pune city. Urban slums are resource-poor islands of deprivation and poverty. IHMP works in 27 slum areas on health and development.

The site visit focused on adolescent health, with a special emphasis on:

- IHMP's life skills development program for teenage girls
- IHMP's work with young men
- IHMP's research on adolescent health
- IHMP's health services for young people.

One year life skills development program for teenage girls

IHMP carries out a community-based program for unmarried girls from 10-19 years to develop their life skills. Girls are taken through a 225-hour curriculum over one year, containing elements of nutrition, health, gender, self-esteem, sexuality and legal rights. The curriculum is designed for use by any community-level worker who has studied upto the seventh grade. "Decentralization is important," said Nandita Kapadia Kundu, coordinator of the Pune center. "We want to develop resources at the community itself."

28 OCT

Pune

DAY SEVEN

On day seven of the India cross visit, participants visited the Institute of Health Management, popularly known as IHMP, another non-profit organization working largely in rural communities. While one of the participants visited the head office in Pachod, the rest visited the Pune center of the IHMP.

The site visit consisted of:

- A trip to an urban low-income community where IHMP works
- A meeting at IHMP's city branch
- A visit to IHMP's head office at Pachod by one participant.

Girls attend three sessions each week. One session focuses on the curriculum, another on arts, crafts and sports, and the third on instilling self-esteem and confidence. During this session, they carry out small group projects in their community - bringing down anemia, advising pregnant women on nutrition, etc. Teenage girls are typically involved in household work and have low mobility. Thus, the sessions are also an opportunity to get together with others and share new experiences.

The curriculum is based on the understanding that health status cannot be enhanced without an increase in social status; hence the emphasis on decision-making, confidence, self-esteem. The sexuality component consists of 22 modules and includes sessions on menstruation, reproductive health and HIV, which is fast emerging as a problem.

As part of this self-development exercise, girls are taken through a 20-session four-day residential workshop. The sessions explore sexuality more deeply, touching on body mapping, sexual and reproductive systems, romantic love, abortion, infertility, HIV/AIDS, contraception, RTIs and STDs. This session is held at the end of the year, when girls and their parents are more receptive to them getting this information.

Program evaluations have shown an increase in knowledge levels. A survey before the four-day residential workshop showed that 60 per cent of girls had low knowledge, while only one per cent had high knowledge of love, sex and romance. At the end of the workshop, this situation had reversed, with 60 per cent of girls having high knowledge.

There are other anecdotal indicators of success. Sixteen girls' groups organized cricket matches or other International Women's Day programs in their slum communities. "Women who had never held a bat or a ball played cricket," said Kapadia Kundu. Many girls then asked to be taught cricket, breaking the traditional male-female divide.

Girls started asking questions, a surefire indicator of confidence. Other girls lost their fear of public speaking, and were transformed into confident young women. Many girls started echoing the program's demand for HIV testing before marriage. Others persuaded their parents to delay their marriages by a year or two. "It's all an issue of providing opportunity," said Kapadia Kundu. "The sky's the limit for them." About 250 NGOs are currently using the IHMP curriculum in their own programs, and the Maharashtra state government has taken 100 copies on a trial basis.

Working with young men

IHMP began working with men in the 15-29 year age group in 1997, and now works with 13 youth groups. A survey showed that young men were interested in vocational guidance and sports; health was not expressed as a need. "Young men are not interested in only talking about HIV, etc." said a male health worker. "Jobs are a prime need."

At group sessions, half the time is spent on issues that the group raises; the other half is spent on HIV, sexual and reproductive health. HIV is emphasized, given the high prevalence rates in Pune city. Young men are counseled, advised to test themselves, and trained to look after positive persons in their families. "These young men are caregivers to people with HIV, even though we never think of young men as caregivers," said a male health worker.

Violence is another area of emphasis, since domestic violence among young married couples is extremely high. A male youth group performed a play on prenatal sex determination on International Women's Day. Discussions on violence are held with unmarried girls and boys as a preventive step. All such discussions inevitably focus on gender and sexuality. "Gender and sexuality are intimately related in the lives of young people," said a health worker. "You can't talk about one without the other."

The work with young men consists of individual interactions, group meetings and case follow-ups. Health services are provided to young men through the public health system, and there are plans to start counseling centers for young people. IHMP's workers also help young men to meet other developmental needs - getting ration cards and driving licenses, or helping place a post box where none exists. This strategy of holistic development has been effective in raising the health status of young men.

Researching adolescent health

IHMP carries out qualitative and quantitative research at the community level. Before starting its intervention with young men and women, the organization carried out a slum-level survey of 1,500 married women from 15-49 years, and 803 unmarried teenage girls. The survey showed that 60 per cent of girls aged 10-19 years were severely anemic, that contraception was rarely used in the 15-19 age group, and that RTI prevalence was higher among young women than among older women.

"There is a large area of morbidity here which is unrecognized and untreated," said Tara Kanitkar, consultant, reproductive health. "It is important to provide health services to young people, and to integrate these with other services." Based on its findings, IHMP has started an intervention to prevent anemia at a low cost. Girls are advised to eat four meals a day; married teenagers are advised to delay the first pregnancy as much as possible.

Providing health services for young people

IHMP provides services for young people at three levels:

- Through home visits by community-based workers. The worker carries five basic drugs with her, and refers young people for abortions and other health issues.
- Through slum visits made by nurses every 21 days. The nurse does antenatal check-ups and keeps visit records.
- Through a clinic at the municipal hospital, with a gynecologist present.

The organization unsuccessfully experimented with providing counseling services to young men at the hospital, who were not comfortable in institutional settings. Learning from this, IHMP is aiming to set up decentralized, informal systems through which young men can meet counselors in community spaces - at temples, near trees, among others.

The community is at the core of all IHMP programs. The organization has developed a community-based program for monitoring and evaluation, and has started committees and federations in each slum. When IHMP tried to stop a nine year old from getting married two days before the event, the community begged them not to do so. The slum committee eventually signed a contract with IHMP agreeing to stop child marriages in that slum. "This was more deep-rooted than bringing in the police," said Kapadia Kundu. "A program is not successful unless the community stands with us shoulder to shoulder."

Discussion

In a discussion following the visit, participants from Nigeria shared examples of similar programs in their own country. Grace Osakue described how the organization she works with, Girls' Power Initiative, has a three-year life skills program for girls of 10-18 years, with content similar to that of IHMP. Modules include health, society and culture, violence, relationships, and so on. Before finishing the course, girls carry out community-based interventions in groups.

Re-orienting parental attitudes is a key aspect of this work. "When you deliver a boy or a girl, the celebration is not the same," said Osakue. "The father jumps up if it is a boy, and walks out if it is a girl. The girl feels she is a nobody." As they grow up and are groomed to be ideal wives, girls end up losing even more of the self-esteem they never had. At 20, a girl in Nigeria can be married and divorced three times already. She is told that she was groomed to be a wife and she can't even be that - so she is useless.

It is critical to teach girls that gender roles are dynamic, not static. "Girls are good change agents," said Osakue. "Women are not willing to take risks and have accepted their roles. Girls have not."

Reducing maternal mortality

Dr Dyalchand, an ophthalmologist and public health physician began work in the semi-arid drought prone region of Aurangabad after the severe drought of 1972-75, when a post-drought survey showed high levels of infant and maternal mortality, and malnutrition in the area.

A 1976-77 baseline survey revealed the need for provision of maternal care at the time of delivery - since 94 per cent of deliveries were conducted at home. IHMP started addressing this by training Traditional Birth Attendants (TBAs), who conduct most of the deliveries in this area.

At the start of the program, the focus was on improving maternal care to reduce maternal mortality. The program later expanded to include child health care - marking a shift from vertical programming to multipurpose programming to meet community needs.

The first formal evaluation of IHMP in 1982 showed that the Infant Mortality Rate had dropped to 68 from 129 per 1,000 births. Neonatal mortality showed the largest change, from 98 to 38 due to training of TBAs. The Maternal Mortality Rate reduced from 12 to 4 per 1,000 live births.

Today, IHMP has maternal health centers in all the villages where it works. Community health workers, TBAs and nurses jointly monitor the health status of pregnant women and young couples, provide timely and safe delivery services, and monitor neonatal and postnatal health of infants and mothers. A detailed record is maintained of pre and post-delivery maternal health status, child nutrition and vaccination.

Roundtable

FPAI's Experience with the NCERT Curriculum on Adolescence Education

Anant and Shanta Sathe

Anant and Shanta Sathe are pioneers in the field of sexuality education in India. While Anant Sathe is a surgeon, gynecologist and sexologist, Shanta Sathe is a sex and marriage counselor. Both have worked with youth and sexuality since the mid 1970s, and are consultants on sexuality education and youth for the Family Planning Association of India (FPAI), Pune.

In a joint presentation, the Sathes shared how FPAI had started work on sexuality education in 1976, long before HIV/AIDS prompted others to work on this issue. FPAI felt it was important to address adolescent sexuality, since teenagers undergoing rapid changes are eager for information to clear their worries, anxieties, doubts, fears and apprehensions. By 1989, FPAI was providing sexuality education to more than 10,000 students in 69 schools.

In the 1990s, policy makers and educators in India also felt the need to provide sex education in schools, despite reservations from parents, social and political leaders. The National Council of Education Research and Training (NCERT), which controls the school curriculum, recommended the introduction of 'adolescence education' in 1993. 'Adolescence education' was a euphemism to make sex education more acceptable to alarmed constituencies. However, this recommendation has not been put into practice.

The Sathes emphasized the need to provide sexuality education, rather than sex education to young people. Sexuality education inculcates in young people positive values and attitudes towards human sexuality, and helps them develop self-esteem and the skills for making rational and responsible decisions related to sexual and reproductive behavior in the context of their particular society. This is a more holistic approach than sex education.

29 OCT

Pune

DAY EIGHT

The India cross visit ended with a roundtable collaboratively hosted by CREA and Tathapi, a non-profit organization based in Pune. The roundtable exposed the Nigerian participants to individuals and organizations in western India working with young people using different approaches and strategies.

Speakers included:

- Anant and Shanta Sathe, FPAI
- Minaxi Shukla, CHETNA
- Medha Kale, Tathapi
- Ashwini Mahadeokar and Ajita Ganoo, Abhivyakti
- Swatija Manorama, VACHA
- Sanjeevani Kulkarni, Prayas.

These two terms were defined as follows:
Sex education covers only human reproduction, the physical aspects and related issues such as contraception, STDs and HIV/AIDS. The original objective of sex education was to reduce the increasing incidence of unintended pregnancies, abortions, and STDs. Thus, it sprang from a negative, bio-medical approach. It did not teach students to differentiate between right and wrong, proper and improper, beautiful and ugly, healthy and unhealthy, the beauty of relationships, and responsible sexual and reproductive behavior.

Sexuality education includes not only the anatomy and physiology of the sex organs but also the secondary sex characteristics and their growth and development. It provides knowledge about the changes that take place in the emotional make-up of the person, thus determining individual responses to different life situations. It includes human dignity and interpersonal relationships, changing family roles, the status of women in the family and society, healthy and responsible man-woman relationships, respect for the sex partner, and mutual concern in sexual relationships.

Adolescent Girls' Concerns in Gujarat's Rural and Urban Areas

Minaxi Shukla, CHETNA

CHETNA - or the Center for Health Education, Training and Nutrition Awareness - is based in Ahmedabad, Gujarat. It works on young people's issues in a number of ways: capacity building, developing innovative health education programs, action research, networking, and advocacy.

The organization started an adolescent health and development program in 1986, which works with urban, rural and tribal girls and boys between 10-19 years who are married and unmarried, and in formal and non-formal settings. This program is centered around five principles:

- Life cycle approach: It is assumed that the needs of young people are dynamic, not static, and change with age
- Comprehensive health: Sexuality education is integrated into a larger health education program for greater effectiveness
- Gender sensitive: The program instills the value that boys and girls need to respect each other
- Rights-based: Having information, including sexuality-related information, is seen as a right of young people
- Life useful education: The program aims to prepare teenagers for life.

Building self-esteem and ensuring teenage participation is a key program strategy.

In 2002, CHETNA started Learning For Life - an AIDS education program - in 120 urban and rural schools in Gujarat. The program sensitizes school-going adolescents and raises their awareness so they can resist peer pressure and adopt safe and responsible lifestyles. This is done by building the capacities of school principals, teachers, peer educators, and community members on ways to educate students on sexual and reproductive health and HIV/AIDS. A question box is provided in each school for students to clarify their doubts while retaining anonymity.

A total of 96 principals, 158 teachers and 193 peer educators have been trained in this program, resulting in increased confidence and comfort levels around

discussing sexual and reproductive health issues. These issues, along with HIV/AIDS, have been integrated into several school curricula. Based on its experience, CHETNA recommends the integration of sexual and reproductive health in school and college curricula, and in the teachers' training curricula.

The following lessons have emerged from this experience:

- Appropriate communication approaches are needed to discuss sensitive issues such as sexuality. Games and exercises are often more effective than talk.
- Young people must be involved, not just as receivers, but also in planning and executing educational programs.
- Families and communities need to be involved in responding to the sexual and reproductive health needs of young people.
- Gender is a critical component of any adolescent education program.

Discussion

The discussion following these presentations was triggered off with a Nigerian participant asking: "Why don't we sense the presence of lesbian, gay, bisexual, transgender, and queer rights in these presentations which talk of comprehensive sexual education and rights?"

An Indian participant said that in rural areas, where talking of sexuality is a radical step, talking of homosexuality would be seen as too radical. Parents are opposed to the inclusion of such issues in school curricula. "But we don't ask parents what should be the content of the history curricula in schools," said an Indian participant. "So why do we keep referring back to parents on this?"

Another participant clarified that homosexuality is included in some sexuality education curricula; while it is not seen as abnormal, neither is it framed from a rights perspective. Several participants said that sexuality education should not intentionally or unintentionally uphold the norm of compulsory heterosexuality. There are no images or information around homosexuality anywhere; sexuality education needs to fill this gap.

Sexuality education should not promote sexual majoritarianism (i.e. most people are heterosexual, thus heterosexual is the norm). Nor should it build hierarchies - information on menstruation is more important than information on sexual orientation.

Sexual orientation needs to be placed at the center of sexuality education curricula as an issue concerning everyone, rather than in special ghettos. Homosexuality needs to be accepted as part and parcel of all cultures. "There is a discomfort on our side as agents of change," said a Nigerian participant. "How much are we going to soften the ground for those who make choices that are not heterosexual?"

Some participants also expressed discomfort at the term 'responsible sexual behavior' and the conflation of healthy and responsible behavior. A presenter clarified that responsible behavior meant: no coercion; no deception; no taking advantage. Many participants said that there is a moral undertone to the concept of 'responsible sexual behavior'. For instance, teenage girls who get pregnant are labeled irresponsible. In this context, it is necessary to examine the underlying implications of such terms.

Body Literacy with Pre-Teen Children in Schools

Medha Kale, Tathapi

The Pune-based Tathapi Trust was founded in 1999, and is dedicated to resource development in the area of women and health, including access to information and building skills at the grassroots level. The organization has developed a Body Literacy program for use in schools and colleges. The program grew out of a survey of adolescence education programs in Pune, and a review of curricula around the country which showed that boys, power and gender were excluded from most curricula; puberty changes and menstruation were the only components of sexuality in these curricula.

Body literacy empowers young people to understand the scientific processes and working of the body as it changes with age. It is about making friends with one's body, learning to read its language, understanding how it works, respecting oneself and accepting others. It equips students to acquire basic skills in understanding:

- Body and mind
- Gender differences and unequal power relations
- Puberty and growing up.

The program teaches young people about the connections between body and mind, how to read the pulse, take temperatures, and detect anemia. Interesting info-nuggets are provided: the heart beats one lakh times a day; when full, the stomach can contain up to four liters of food. Another component focuses on making friends, dealing with emotions such as anger, infatuation and attraction, talking to each other in equal terms, recognizing power in relationships, and so on. Young people are also taught to recognize abusive relationships, and find ways to remove themselves from these.

The Body Literacy program has been successful in developing a positive non-threatening approach to sexuality. Another strength is that the program addresses men - young men, fathers and male teachers. The program is being popularized among college students, who both arrange and pay for the workshops. It has also been included in the syllabus of a management institute.

Sangaati: An Innovative Parents' Group

Ashwini Mahadeokar and Ajita Ganoo, Abhivyakti

Based in Nasik in western Maharashtra, Abhivyakti has been working in the fields of education and media for over two decades. The organization has developed a group of aware parents in a middle-class Marathi-speaking urban setting. The parents' group is trained on the same set of issues that teenagers receive training on: developing a health perspective, HIV/AIDS, child sexual abuse, psychosocial aspects of advertising, and similar issues. The portrayal of women in mass media is an area that is included in this capacity building exercise. The program has succeeded in breaking down taboos related to sexuality among parents.

VACHA's Work with Pre-Adolescent Girls

Swatija Manorama, VACHA

VACHA is a Mumbai-based organization that has just completed a large pilot project called *Kishori Prakalp* with pre-adolescent girls in the Mumbai Municipal Corporation school system. The organization works with 9-13 year old low-income girls in Mumbai, Valsad and Sangli. Because of their malnourished status, many girls in this age group start pre-menstruating. They experience physical, psychological and physiological changes, which need to be visibilized. However, they often fall between the two stools of childhood and adolescence.

One of VACHA's goals is to enable these girls to develop self-esteem. This is done in small steps, and through innovative mechanisms. For instance, each girl has her own diary with her photo - her own private space to express her thoughts and feelings. Sexuality is not discussed directly with this group; instead of talking about child sexual abuse, for instance, the girls are taught about the right to say 'no'.

The Impact of HIV/AIDS on the Lives of Teenagers

Sanjeevani Kulkarni, Prayas

Prayas, Pune, was one of the first NGOs to tackle the medical, social and educational issues arising from the spread of HIV/AIDS. The organization, which sees 700 persons with HIV each year, has been working on this issue since 1994.

Kulkarni explained how HIV has provided a new dimension to sexuality education. Half of all new cases of HIV are seen among young people between 15-24 years. HIV is an adolescent health issue because of:

- Teens who get directly infected with HIV during adolescence
- HIV-infected children who become HIV-positive teenagers
- Women who get infected during adolescence due to early marriage
- Teenage children of HIV-positive parents.

HIV-positive teenagers often don't know anything about HIV or sexuality. Even when they have information, they do not know how it relates to them. Their understanding of sexuality is constantly influenced by notions of morality - right and wrong.

Teenagers who are affected or infected by HIV face a slew of issues related to symptoms, disclosure, medical treatment, relational or marital prospects, acceptance in the family and community, uncertain futures, possibility of impending death, among others. Teens with HIV-positive parents get a major jolt on disclosure; they must now cope with unanticipated role changes within the family.

Kulkarni recommended six steps to strengthen young people's capacities to understand and cope with HIV:

- Provision of quality sexuality education before introducing HIV
- Establishment of non-moralistic awareness programs
- Efforts to reduce stigma and discrimination
- Quality support systems to address teenage issues
- Early detection, care and support systems
- Access to treatment.

Summing Up

The Pune roundtable ended with participants agreeing that sexuality needs to be seen as an integral part of an individual's life, not as an add-on. Some participants felt programs must incorporate sexual pleasure as an important component of sexual rights. The body is a source of pleasure, not just of pain. How can work on young people's health and rights integrate this affirmative aspect of the body, not just the violative aspect? How can programs, services and information be made more subversive and political - to include concepts of gender, power and oppression?

Key Learnings

The 10-day India cross visit provided many insights and learnings on addressing adolescent sexual and reproductive health and rights. Participants agreed that:

- The average adolescent does not exist. Adolescents come from diverse backgrounds and have differing experiences, needs and concerns.

- Young people are sexual beings, regardless of their marital status. They need information and services in the realm of sexuality.

- Work on young people's sexual and reproductive health needs to be grounded in a positive, affirming view of sexuality. Sexuality is about pleasure and pain, but the pleasure aspect is often neglected in programs around sexual health.

- Young men and women face gendered expectations in relation to their sexuality. Male sexual behavior is often naturalized - 'boys *will be* boys' - while female sexual behavior is socially constructed - 'girls *have to* be girls.'

- The media is one of the most important sources of information on sexuality for young people, with films shaping young people's scripts of love and romance. The media needs to be influenced to move away from gender stereotypes, and provide accurate information around sexuality.

- Sexuality education must teach young men to respect young women.

- There should be no hierarchies of information in sexuality education curricula - e.g. information around menstruation is more important than information around violence. All information around sexuality is important and must be provided.

- Young women, in particular, need to be taught to say no and to say yes. Related to this is the need to distinguish between 'rights' and 'morality' issues in relation to sexuality and reproduction.

- Young people struggle not just with issues of body image and sexual health, but also with sexual orientation and gender identities. Sexuality education should not intentionally or unintentionally uphold the norm of compulsory heterosexuality. Issues of sexual orientation need to be placed at the center of all sexuality education curricula, rather than in separate ghettos.

- Young people need to be exposed to different role models to build and manage relationships, and to resolve conflicts within relationships.

- In the context of early marriage, safe motherhood is a critical health intervention for young people.

- Programs, services and information on adolescent sexual and reproductive health must include concepts of gender, power, oppression and rights if they are to truly transform young people's lives.

NIGERIA CROSS VISIT

24 May-2 June 2004

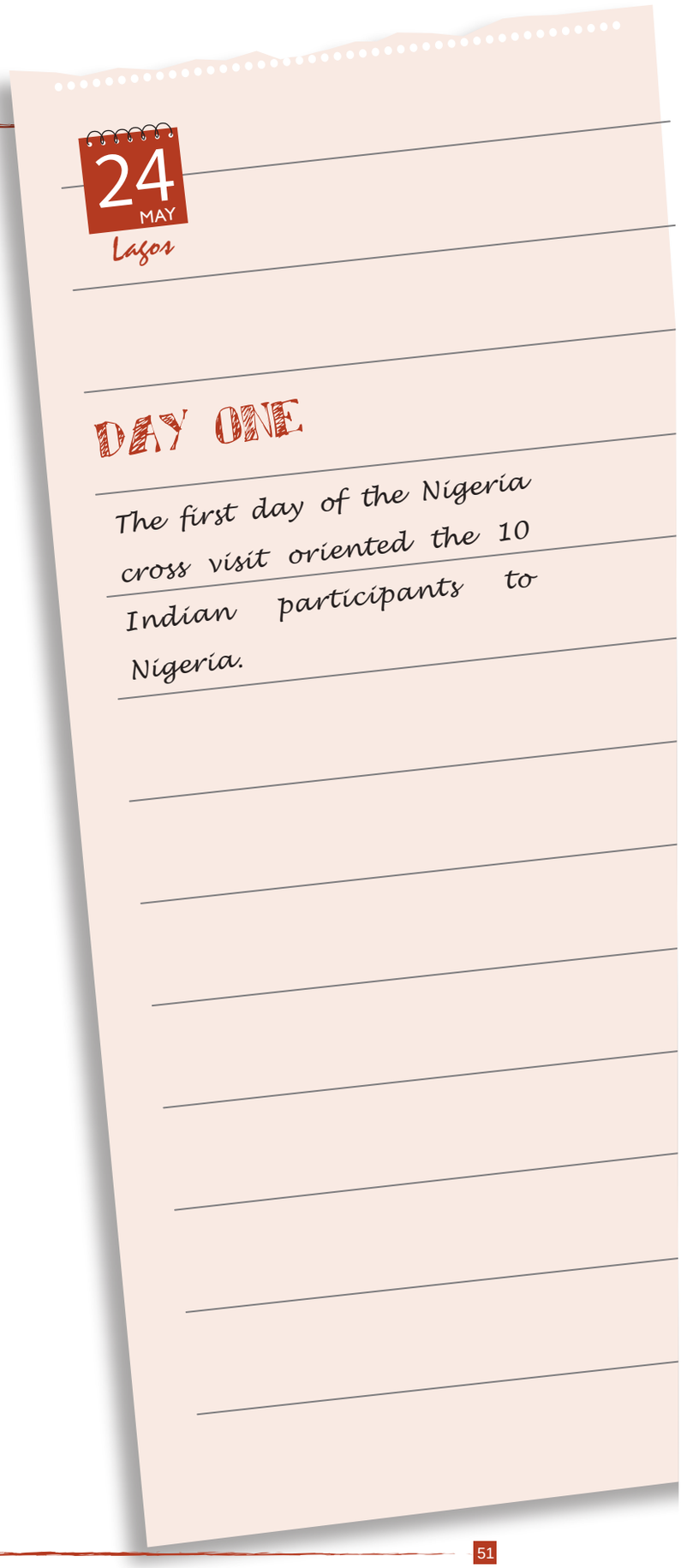
Presentation

In a brief presentation, Mojisola Odeku from the Federal Ministry of Health and Safe Motherhood located adolescent health within Nigeria's socio-political context.[1]

Nigeria consists of 120 million people from varying ethnic groups. While English is the official language, there are five major languages and 280 other languages and dialects. A three-tier federal system of governance spans the center, 37 states, and 774 districts. "Given the magnitude of diversity and needs, we operate a decentralized system across sectors, including health," said Odeku. Given that 77 per cent of the population lives in rural areas, and that rural-urban migration is common, ensuring access to health, education, water and other resources is a critical challenge.

Young people from 10-24 years comprise one-third of Nigeria's population. Three government sectors work on young people's issues: the youth ministry, the women's ministry and the health ministry. The 1994 Cairo conference catalyzed the Nigerian government to start framing policies on adolescent health, with the health ministry playing a lead role. NGOs played an advocacy role and urged that Nigeria's policies reflect commitments made at ICPD.

In 1999, a landmark national stakeholders' meeting was convened with the participation of NGOs, health advocates, donors, government and young people. "Young people were given a voice for the first time," said Odeku. "What are their health and well being issues?" The document that emerged from the 1999 meeting provides a strategic framework for working on sexual and reproductive health. It includes components such as youth-friendly services, sexuality education, Behavior Change Communication (BCC), research, monitoring and evaluation. Six zonal dissemination meetings were held in 2001 to share meeting outcomes across the country and to discuss how sexuality education could be integrated into existing programs.



1 Mojisola Odeku's presentation was actually made at a roundtable held on 29 October 2003 in Pune during the India cross visit. It is included here as an introduction to the Nigeria cross visit.

Based on this, the Federal Ministry of Health formulated a national reproductive health policy and strategy in 2001 that explicitly aims to achieve quality sexual and reproductive health for all Nigerians. This comprehensive policy addresses the following:

- Maternal morbidity and mortality
- Family planning
- Abortion
- Infertility
- HIV/AIDS and other sexually-transmitted infections
- Adolescent reproductive health
- Gender violence
- Harmful practices
- Reproductive rights.

It outlines the role of federal, state and local governments, NGOs, mass media and professional bodies working on reproductive health, provides guidelines for sexuality education and provision of youth-friendly services. It also recommends reviewing obsolete laws related to reproductive health.

The formulation of this policy has been followed up with other steps. The education sector, which is responsible for curriculum development, reviewed the sexuality education curriculum and built national consensus around its content. It recommended that the sexuality education curriculum be integrated into existing curricula, instead of running it as a vertical program. It also recommended that existing teachers be used to teach sexuality education, instead of building a separate cadre for this purpose.

Five years after the landmark stakeholders' meeting, implementing a sexual and reproductive health program across the country remains a serious challenge. Having a national curriculum has yet to translate into increased access to information on sexuality. Some states do not want to use the term 'sexuality'; this is acceptable as long as content is not watered down. "The content has to be the same," said Odeku. "The approach and strategy may differ." Teachers need to be trained, and their comfort levels built to discuss such intimate issues in classroom settings.

There are plans to review implementation progress and lessons learnt using a triangulated approach built around adolescents, systems and environment. NGOs are shifting their advocacy efforts from national-level policy formulation to program implementation at state levels to ensure that all Nigerians, including young people, are able to address their sexual and reproductive health needs.

National Reproductive Health Policy and Strategy
Federal Ministry of Health, Abuja, Nigeria July 2001

Section 3.2.8
Goal:
To increase knowledge of reproductive biology and promote responsible behaviors of adolescents regarding prevention of unwanted pregnancy and sexually-transmitted infections

Targets:

- Increase access to appropriate reproductive health information to all in-school and out-of-school adolescents
- Introduce into school curricula, sexuality and family life education
- Increase access to comprehensive, youth-friendly health services, including counseling, for all young people, including youths with disabilities, to 20 per cent
- Initiate and support the enactment and review of laws relevant to adolescent health

Site Visit

Action Health Incorporated

Action Health Incorporated (AHI) has been working in the field of adolescent health since 1989. The organization advocates for and catalyzes adolescent well being by increasing public awareness and implementing innovative education, health care and youth development programs.

AHI's work with adolescents has been guided by the vision of a Nigeria where:

> "...appropriate guidance is provided to enable adolescents to assume control of their lives, where adolescents are guaranteed basic information, education, skills, and services to enhance their sexual and reproductive health and rights."

The organization works to fulfill this vision via six strategies:

- Increasing access to sexuality education
- Community advocacy for sexuality education
- Provision of adolescent health services
- Promoting access to resource materials and publications
- Networking, training and technical assistance
- Promoting a better understanding of human sexuality.

The key learnings from the site visit are summarized below.

Increasing access to sexuality education

AHI increases access to sexuality education in a number of ways:

- By providing information, education and counseling to about 1,200 young people every month.
- Through a peer education program run via youth clubs in Lagos schools.
- By developing the Guidelines for Comprehensive Sexuality Education in Nigeria.
- Through national advocacy to promote comprehensive sexuality education. For example, AHI was instrumental in organizing a national conference in 1999 to operationalize the National Adolescent Health Policy.
- By working with the Lagos state education ministry to implement a curriculum-based sexuality education program in 100 public schools.

25 MAY
Lagos

DAY TWO

The Nigeria cross visit was launched with a site visit to Action Health Incorporated, a non-profit, non-governmental organization dedicated to the promotion of adolescent health and development.

The site visit to AHI consisted of:

- A comprehensive tour of AHI's facilities to promote adolescent well being
- Meetings with Nike Esiet, executive director and Chieme Ndukwe, program officer
- Discussions with key personnel at the units that implement these strategies
- Interactions with some of AHI's teenage peer educators.

AHI hosted a half-day roundtable that introduced the Indian participants to other organizations working with young people in Nigeria.

Much of this work is centered around the Information, Education and Communication (IEC) Unit. The IEC Unit conducts weekly sexuality education sessions through movies, group discussions, body awareness sessions, and an anonymous question box into which sensitive questions can be dropped. One-on-one counseling is also provided. It reaches out to teenagers in innovative ways, e.g. while jogging. Young people open up about their issues here because they know the service is confidential, approachable and friendly.

Occasions such as International Women's Day and World AIDS Day provide good opportunities for sexuality education. Every year, the unit organizes the Teenage Festival of Life, at which young people are educated on sexual and reproductive health issues, and get a chance to show off their skills in acting, song, poetry and art competitions.

The IEC Unit increases access to sexuality education in many ways, including training youth-friendly teachers who are nominated by teenagers. A total of 50-60 school-going boys and girls also go through an in-depth 10-day reproductive health course. More girls than boys come to the unit; boys say girls get pregnant and need to learn about these issues. "Who impregnates them?" boys are asked.

Community advocacy for sexuality education

When a newspaper reported that AHI was distributing condoms in schools, the organization was banned from providing sexuality education in schools. The Advocacy Unit has a tough job on its hands: it must change negative attitudes to the provision of sexuality education among parents, community and opinion leaders. "It is not enough to work with young people," said a member of this unit. "Other people must understand this work if we are to continue doing it."

In working to create an enabling environment for sexuality education, the advocacy unit has to combat the myth that AHI is encouraging sexualization. "We have to make people understand what we stand for and why we are doing what we are doing," said a staff person. This involves identifying potential allies, even among religious and other groups traditionally opposed to sexuality education. "Winning them over is the strategy."

The Advocacy Unit tries to win over people via a host of outreach activities: through associations of hairdressers, mechanics, community development associations, landlords and parents. The media is another important constituency that is targeted. AHI's work is pioneering in this field: it organized the first civil society dialog on sexuality for young people in Nigeria.

Advocacy strategies include:

- Hosting a regular television program
- Networking with other civil society organizations
- Convening meetings and seminars for policy makers.

Where policy is concerned, advocacy is needed to ensure implementation of policies - and to push for access to services, not just information, for young people. The work with policymakers is carried out at local and national levels.

AHI's advocacy efforts have been effective in contributing to the development of the adolescent reproductive health policy, which is now a law. The National Council on Education has integrated a comprehensive sexuality education module into the national school curriculum.

Provision of adolescent health services

In 1993, AHI established a youth-friendly clinic, which provides non-judgmental counseling to individuals and couples on contraception, STDs and RTIs, HIV/AIDS, as well as routine gynecological check ups, pregnancy tests and referrals. Data collected at the clinic is used to develop AHI's advocacy programs.

Promoting access to resource materials and publications

At its Resource and Documentation Unit, AHI provides information on sexuality in many formats: videos, newsletters, training manuals, Internet databases, etc. Some of these are produced by AHI, such as the quarterly Growing Up newsletter, which has a print run of 5,000 copies.

Each month, more than 1,000 young people access this unit, with the youngest being eight years old! Information is classified by topic for easy access by young people. No information is hidden from users, who are free to read what they want. An Indian participant asked how the unit handles 'age-inappropriate' requests for information. A unit member explained that they were guided to other information if they were too young, but were not stopped from accessing this information.

Parents are free to walk in and see what young people are doing. This was a suggestion that emerged from young people, who do not feel this interferes with their lifestyle.

Networking, training and technical assistance

Through its Training Unit, AHI builds the capacities of organizations in the government, non-profit and private sectors to work on adolescent health issues. It has developed several training manuals and guides on comprehensive sexuality education and youth-friendly health services, which are in much demand.

Promoting a better understanding of human sexuality

A recent initiative, the Africa Regional Sexuality Resource Center (ARSRC), has been based at AHI since 2002. This center aims to build a more informed, positive and affirming discourse around human sexuality at the regional level, and to thus inform policies and programs.

In a pioneering effort in the region, the center will provide information and resources on sexuality from different perspectives - sexual rights, sexuality as identity, sexual cultures, etc. Many programs are already in place:

- An annual Sexuality Leadership Development Program for participants from Nigeria, Kenya, Egypt and South Africa
- A summer institute for professionals in sexuality
- Regular publications on Sexuality in Africa, and Sexuality in the Media
- A seminar series on Sexuality and Well Being
- Occasional papers, publications, seminars, meetings, public debates, etc.

Much of the Regional Resource Center's work is web-based to enable other countries to access it. As part of its mission of expanding scholarship and knowledge around sexuality, the center plans to publish theses and research papers at universities of high quality. Many of these have been written, but never used.

An Indian participant asked if the center has scope for using entertainment-education approaches in its work on sexuality. Richmond Tiemoko, director of the center, said films would be used to introduce issues related to sexuality. An Indian participant emphasized the efficacy of using infotainment to attract young people. "The more Bollywood films[2] we showed and analyzed, the more everyone remembered the issues," she said.

Some Indian participants asked how the issue of 'sexuality as identity' had emerged in the region. Tiemoko said this issue was emerging in urban areas, specially in gay and lesbian communities. For the first time in Nigeria, a homosexual man attended the National AIDS Conference in 2004. Homosexuality is illegal in Nigeria, but talking about homosexuality is not. The center plans to document legal changes around sexuality-related issues in Nigeria.

In a free-flowing discussion, some Indian participants wondered why AHI's reception area has strong do's and don'ts for young people, including dress codes. Tiemoko clarified that AHI was the first organization to take sexuality education to schools in Nigeria, and that its messages spring from a need to fit into the socio-cultural framework of Nigeria. The do's and don'ts need to be understood in this context.

Building on this, a participant described how the discourse on sexuality was traditionally framed in the context of violence or health in India; organizations such as TARSHI and CREA want people to talk about sexuality from the perspective of pleasure and rights as well. In India, where social movements have matured, NGOs can no longer work in isolation without critical feedback on their work. "You can't be an emperor in your island anymore," one participant said. "Many more NGOs are working on that issue." This has created accountability, a sense of being part of a larger cause or movement.

2. Films made by the Indian film industry, popularly referred to as Bollywood, the Indian equivalent of Hollywood

Interactive session

An interactive session was held with some of AHI's peer educators, school counselors, community leaders, youth assistants, religious leaders and health counselors. The two-hour interaction brought many differing perspectives on AHI's work to the table.

A health counselor at a public secondary school in Lagos described how the Health Alive planning clubs that AHI has started, give young people the information they need to take charge of their lives - on personal health, decision-making, goal-setting, reproductive health and anatomy. Information is provided through role plays, quizzes, dramas, poems and songs. Health Alive provides counseling for both members and non-members, as every student is not a member of the club. The club also talks to parents during parent-teacher association meetings, and trains parents on parent-child communication.

The chairman of a Community Development Association who has been taking part in AHI's activities since 1989, explained that each member of the community is a member of this association. AHI does not start any program without consulting community leaders, out of a belief that cooperation is essential for development. He felt that AHI's programs help children become leaders in their own communities; such programs even create employment for young people.

Building on this, a Muslim leader who has worked with AHI since 2000 said that involving the community is essential. "The community is the grass root of the government," he said. "It is the cloth our children have to wear their behaviors on." AHI creates awareness among Muslim leaders on several issues; *imams* pass on this knowledge to the community during sermons.

Three peer educators described the impact of AHI's work on their own lives. A girl who is president of her Health Alive club said she was now considered a role model; many of her friends find her more mature than her peers, and seek her advice. A young man said peer education had helped him focus and understand what he wanted. All three felt their peer education work had made them more creative and friendly, and strengthened their facilitation skills. "Earlier, I would get frightened to discuss issues with adults at the same table," said a peer educator. "I felt we didn't count. It helped me get over that."

A health counselor outlined the major challenge she faces: making young people understand that sexuality is not just sex, but part of the totality of being human. She underscored the importance of confidentiality. Girls and boys often send their friends first to test the water. "You need to keep young people's secrets secret," she said. "If your reactions are sharp and negative, that's the end of counseling. They will never return."

A school principal who volunteers at AHI explained how she encouraged them to start a health club in her school. "There was bad news everyday at school," she said. "Abortions. A father beating up his daughter." She advocates around sexuality education with parents, making them understand that this education prepares their children for life. "Parents are not able to give the right direction to their children," she said. "It's a case of the blind leading the blind." She strongly believes that sexuality education will reduce violence and help create a better society.

During a lively discussion on AHI's program, Ndukwe clarified that peer educators are still school students, while youth assistants have finished school. Peer educators organize activities of the Health Alive clubs in their schools, while youth assistants are attached to different units at AHI. "Youth assistants create a friendly atmosphere for young people who come in," she said.

Several adolescent health programs in Nigeria, including AHI, prescribe dress codes for young people, and emphasize abstinence. In this context, one participant asked: "Given the importance of respecting young people's opinions, how can one not impose, how can one let young people wear what they wear? How do values such as abstinence square with respecting young people's opinions?"

In response, Ndukwe clarified that while there was a

need to be sensitive to one's culture, privileging one behavior over another - e.g. abstinence over condoms - should be discouraged. This would set up social norms in the community by which people would judge one another.

"Is there a difference between AHI's teachings and those of religion?" another participant asked. Responding to this, Ndukwe said that religious leaders who had attended a meeting on the National Sexuality Education Curriculum had stated that both Islam and Christianity support sexuality education.

The peer educators explained that being a role model is a mixed blessing. "It is not easy to carry the tag of being a role model," said one. "A simple mistake could send wrong messages." "Role models have to practice what they preach," said another. "You can't get pregnant while preaching abstinence and use of condoms!"

Roundtable

During the half-day roundtable at Action Health Incorporated, participants from both Nigerian and Indian organizations outlined diverse strategies for working with young people. These informal presentations are summarized below.

Youth Empowerment Foundation

Youth Empowerment Foundation (YEF) is a non-profit organization that undertakes in-depth research to identify the reproductive health needs of adolescents in three states of Nigeria. YEF works with three major stakeholders: adolescents, school principals and school counselors. From 1995-98, the organization trained counselors and principals on managing and implementing programs for young people; this intervention has since been institutionalized.

In 2000, on Valentine's Day, YEF started a 24-hour HIV/AIDS helpline to provide information, counseling and emotional support to young people, who often went to quacks when faced with HIV. Callers are referred to the 50 organizations that form part of YEF's referral network on issues such as anti-retrovirals, voluntary counseling and testing, family planning, violence, STDs, etc.

Development Communication Network

In 1992, the Development Communication Network started building the capacities of journalists to report on public health and science. The organization initially worked on enhancing coverage of guinea worm disease[3]; it also did baseline research on reproductive health reporting in the media. The research showed that the media does not cover public health issues adequately or competently, and that such issues need to be reported in a manner that is easily understood by the public. This is critical since the media is the first point of contact for getting information, often before people have first-hand contact with an issue.

A media resource center was started in 1998 to meet the information needs of journalists. "It is one thing to have a resource center," said Akim Jimoh of the network. "It is another to have one which has material that people want." The media resource center trains

3. A parasitic disease caused by infection with the guinea worm (Dracunculus medinensis), the largest parasite known to plague people. Guineaworm disease is also called 'end-of-the-road disease' because it is not seen in the big cities

journalism students, and has set up a computer clubhouse where journalists and young people can access the Internet. Can newspapers reach young people? This question has prompted the network to explore the possibility of enabling young people to produce a low-cost newspaper meant specifically for young people.

Journalists Against AIDS

Information has always been an important tool to prevent the spread of HIV/AIDS - but in Nigeria, as in many other societies, there are large information gaps. In 1997, Journalists Against AIDS (JAA) started making information on HIV/AIDS more accessible to diverse publics, as part of its overall aim of building a more informed society.

JAA houses several programs. One program builds the capacities of journalists to inform others on HIV/AIDS; this is carried out through three of the most important journalists' associations in Nigeria. A media resource center provides information on reproductive health and HIV/AIDS. Other initiatives include a program to combat stigma and discrimination, an online discussion forum, policy mapping, media monitoring, and the establishment of a Red Ribbon Award for Excellence in covering HIV/AIDS.

In its work to mobilize the media around HIV/AIDS, Journalists Against AIDS faces numerous challenges: mistrust between media and people living with HIV/AIDS; lack of consultants with skills in policy research; inadequate policy attention to its events; poor staffing and documentation. Geography is another challenge: it is critical to involve journalists in areas other than Lagos for the program to fulfill its ends.

Youth-to-Youth

This organization, set up by some of Action Health's peer educators, is unique in that it is conceived, led, managed and implemented by young people. The work started when an Action Health peer educator joined college. "Peer education stops once school ends," she said. "Nothing exists for students in universities."

Responding to this gap, four graduate students and three undergraduates got together and set up Youth-to-Youth. The organization, which looks at peer education from a holistic perspective, aims to develop a core group of Nigerian youth as agents of social change. It provides university students with leadership skills, information on responsible parenthood and sexuality, and access to relevant services. As such, Youth-to-Youth's work includes elements of advocacy, training, capacity building and behavior change.

One of Youth-to-Youth's main activities is the production and dissemination of a newsletter on HIV, targeted at undergraduates. The first newsletter, which was created from personal savings, was released in February 2004, and distributed free. While funding still remains a challenge for this young organization, it has also taught its founders the value of sacrifice. "You have passion," said one of the founders, who anchored a popular television program for Action Health. "You can't keep waiting for funders."

Youth-to-Youth believes that peer education is an extremely effective strategy for working with young people. In this context, it believes that:

- Policies, programs and donors need to recognize young people as program implementers, not just as beneficiaries
- Bigger organizations need to encourage and mentor youth-led organizations.

Nigeria Youth AIDS Program

The Nigeria Youth AIDS Program works on three related issues: HIV, reproductive health and sexuality. From its start in 1993, the program has aimed to create a national environment where young people can take on leadership roles in reproductive health programs. The program does reproductive health training in 36 schools, conducts research, and builds the capacities of religious leaders, principals and other gatekeepers.

Young people are on the governing board of the Nigeria Youth AIDS Program, and are involved in the design, implementation, monitoring and evaluation of projects. Projects are carried out both with funding support and by drawing upon organizational savings.

The program uses the 'Enter-Educate' approach to provide information to young people via entertainment formats - dramas, films etc. This is more effective than lectures and presentations.

The program also has internships for young people, and nominates youth ambassadors who form youth clubs in their communities. In more than a decade of work, the program has faced challenges of funding, changing government policies and outreach - it is still not as national as it wants to be. It has also learnt that participatory approaches, combined with the provision of leadership skills, are very effective in working with young people.

Swasthya

Swasthya, meaning health, is an Indian non-government organization whose vision is to bridge the gap between micro-level needs and macro-level policies and programs. The organization uses intervention research and advocacy to demonstrate that macro-level policies and programs do not often meet the real needs of people. This advocacy is based on evidence generated at the ground level, and as such, cannot be challenged.

One of Swasthya's research interventions focuses on the sexual behaviors of unmarried adolescent girls and boys in a resettlement colony in Delhi. Young people in the community were involved at all stages of the study as well as in the program implementation arising from this study. Swasthya's work with teenage girls includes components of perspective and skills building, and information provision. The organization also works to provide information and influence the perspectives of gatekeepers in the community, including parents. As part of its aim of facilitating an inter-generational dialogue, video footage filmed by young people was beamed back to the community via cable television.

In working with young people, Swasthya believes that it is critical to work on three programmatic strands simultaneously:

- Expanding the knowledge base
- Building skills
- Enabling social support.

"A program needs to be as comprehensive as this to be effective," said Swasthya's Geeta Sodhi. It is also important to correlate program indicators and outcomes. For instance, what does increased self-determination of an adolescent girl actually translate into? Does it translate into an increase in the age of marriage? What is the outcome of this indicator?

Replicability and sustainability are the two key challenges that Swasthya faces in its work. The program, which has been handed over to the community, is already sustaining itself at a scaled-down level. A partnership with a quasi-government organization is one mechanism to replicate not the organization per se, but its strategic framework. "It is important that both program and outcome be sustainable," said Sodhi. "We want to show that micro-level NGO programs can be both sustainable and replicable." Swasthya is looking at how its model can be implemented in the government health system.

Indian Institute of Young Inspirers

The Indian Institute of Young Inspirers grew out a workshop held by the International Planned Parenthood Federation in India. It works with school and college students who are more than 11 years old through the Enter-Educate approach. Entertainment-based forms - ranging from puppet shows and magic tricks to board games - are used to stimulate young people into thinking about issues that are critical to their development.

The organization works on the principle of self-finance. Funds are raised at and through puppet shows and other Enter-Educate platforms, and fees charged for conducting summer camps. In-kind support is generated via local-level sponsorships and discounts from local suppliers. Costs are kept to a minimum, with executive members locating offices at their own residential premises. A more recent development is the establishment of an Entertainment-Education Resource Center with donor support.

Site Visit

Girls' Power Initiative

GPI, as it is popularly known, is committed to transforming girls into healthy, self-reliant, productive and confident women as part of its feminist vision of overturning patriarchy. Towards this end, GPI empowers girls between 10-18 years in the south-east and south-west parts of Nigeria through education, counseling and social action. In a context where gender discrimination, poverty and lack of information on sexuality abound, GPI helps teenage girls acquire skills and information on gender, human rights and sexuality. The end goal is to enable teenage girls to overcome the challenges of adolescence and grow up as women who can make positive contributions to society.

Apart from this, GPI runs interactive sessions with parents, teachers and school principals to create an enabling environment for adolescent girls. It produces newsletters, radio and television programs around young people's issues, and has run a Gender Development Institute since 1999. GPI also advocates and networks to end trafficking, female genital mutilation and other practices that are harmful to girls, and promote progressive practices like widow remarriage.

At the heart of GPI's work is its intensive three-year program for teenage girls. About 300 girls sign up for the program each year, which is built around a three-hour weekly session. These sessions provide inputs on public speaking, personal development, skills development, conflict resolution, sexuality education, and constitute a safe space for girls to share their lives, dreams and hopes. At the end of three years, each girl receives a certificate that entitles her to be a peer educator.

The three-year curriculum is divided into three levels:

- Level 1 - 10-12 years
- Level 2 - 13-15 years
- Level 3 - 15-18 years.

26 MAY

Calabar

DAY THREE

From Lagos, Nigeria's largest city, to Calabar in the south-east, the Nigeria cross visit continued with a trip to Girls' Power Initiative (GPI), a not-for-profit organization which empowers girls between the ages of 10-18 years.

The site visit consisted of informal meetings and interactions with staff and girls who are part of the GPI program.

All girls start off at Level 1; typically two-thirds of the 300 girls who enroll for the curriculum each year finish the program. Girls who cannot read or do not attend school are given remedial literacy classes as part of the program. An abridged version of the curriculum is offered to girls who cannot enroll for the three-year program. Overage girls are allowed to join, but do not receive certification like the others. "There are cases of 23-24 year olds wanting to join," said a GPI staff member.

No fees are charged to participants, who receive transport and food subsidies to enable them to finish the program. At each level, girls are further divided into groups based on age, and given upbeat names such as Seeders, Precious, Shining Stars, etc. Each weekly meeting begins with girls sharing what they did with the information provided in the previous session. This is an important step that shows empowerment in action. One girl described how she challenged an older man who tried to buy her a Coke. She has understood that a bottle of Coke may come with strings attached - and that she has the right to say no.

Gender equality is at the core of the GPI curriculum. Marriage is not seen as a priority in a girl's life; a girl is taught to live by her own identity, not as part of others' identities. As part of this emphasis on developing her own identity, she is enabled to become mature in all ways - economically, educationally, mentally and sexually. She is encouraged to identify and realize her own career choices, including non-traditional choices. "In the outside world, boys can become engineers, girls can't," said one GPI graduate. "At GPI, we are taught that boys and girls are the same except for reproductive functions."

One of GPI's aims is to promote the sexual and reproductive health and rights of teenage girls. The girls who enroll for the program have never talked about sexuality before; one girl described how only girls with breasts were given sexuality education at school, while others were asked to leave. At GPI, they are taught that sexuality is part and parcel of a human being from birth to death. They are taught about sexual pleasure and sexual violence. They are taught that sexual orientation is an individual choice.

"We know that people derive sexual pleasure in many ways," said one girl. "We know that lesbianism exists, and that this is not harmful."

Such information is essential in a setting where parents stop their daughters from leaving home for fear that they might become pregnant. "Parents will tell their daughters not to go near a boy when menstruating because she may get pregnant, but they won't tell her how she can get pregnant," said a staff person. The organization holds parent-daughter forums to educate parents on the importance of giving their daughters information that they can live by. "Parents can't control their daughters' movements." Parents are informed in advance of the amount GPI spends per girl to ensure they do not withdraw their daughters; home visits are also made as a supportive step where needed.

In the early days, parents often accused GPI of teaching girls to have sex and increasing the proportion of teenage pregnancies. Today, this perception has changed and parents enroll their daughters in the GPI program as a privilege. A GPI graduate described how her mother, when in school, was beaten up by her parents for talking to boys. But now her mother is able to accept that she has male friends. "When I go home with a guy, mum sits me down and gives me information. She discusses the boys I meet with me, and asks me about my relationship with them," she said.

There are many other indicators of the program's acceptance and its success at empowering teenage girls:

- Girls themselves have developed the ability to change risky sexual behavior. They often defer their first sexual encounter, or practice safer sex.
- Girls have become more assertive, focused and confident as evidenced by their actions. They take informed decisions. They challenge violence. They defend their peers from exploitation. They bring in other girls for counseling. They have become leaders at home and in school. They pursue male-dominated positions. They challenge gender discrimination and harmful practices. They speak more in public. They have become change agents.

Many girls who graduate from the program give their

time and resources to take the program forward, another indicator of the program's impact. The GPI Alumni Association is a crucial link in this process. GPI's work has had a wider societal impact by strengthening parent-child communication, building parenting skills, and increasing general consciousness of gender and women's rights. School administrators and parent-teacher associations invite GPI to run programs in their schools. "We do not advertise for girls any longer," said a staff member. "Parents advertise for us."

A group of teenagers talked about how the program has influenced their lives. "Before GPI, I never talked to boys," said one girl. Another girl described how she got over her shyness. Another explained how the program helped her set long and short-term career goals; her long-term goal is to be a pharmacist, for which her short-term goal is to excel at subjects like biology in school. Many girls said that their brothers and male cousins have started doing more household work - influenced by GPI's philosophy that girls and boys have no differences apart from reproductive functions, "We call ourselves Royal Ambassadors," said one girl proudly.

GPI believes that the information it provides is information that every adolescent should have. Since the organization cannot directly reach every adolescent, it tries to influence the government to do so. "We hold our relationship with the government very dear," said a staff person, "Only they can make this happen." GPI tried running a mixed program with boys and girls, but found that boys' needs quickly took over the program. It now networks with other organizations that do similar work with boys. Like every organization, GPI faces its own challenges: one of them is that parents enroll girls as a privilege, rather than an entitlement - and threaten to withdraw them at will.

GPI also works with 12 secondary schools in Calabar. It trains schoolteachers to administer an abridged version of the curriculum, and provides them with materials. Teachers are given a week's intensive training on sexuality as part of this. However, getting schools to impart sexuality education remains a continuing challenge in a setting where talking about sexuality is still taboo. The state government's policy of introducing sexuality education at the school level helps GPI's efforts in this direction. GPI's radio and TV programs, and newsletters also help advocate for this issue.

In a discussion during the site visit, one Indian participant asked what it is that brings about a change among the girls. Is it the placement of girls in a supportive environment or the elements of the program? A GPI staffer explained that it is the specific training program that helps a girl to grow. "We don't believe that the girls come totally blank," she said. "If a child is taken at an early stage and passed through processes of critical thinking, analysis, etc., then she gets to understand who she is, and sets goals for the future. This is what is done here."

Another Indian participant asked if there is a dress code at GPI. A staff person clarified that girls are allowed to wear what they feel comfortable in, but are advised to dress appropriately during office visits, etc. "Each region has its own culture and values," she said.

Girls typically hear of the GPI program from their peers. As part of its overall goal, GPI encourages participating girls to bring up uncomfortable issues - such as child sexual abuse and sexual harassment - with their parents and teachers. GPI staffers identify teachers who harass girls and make complaints to the principal. "If you keep quiet about these things, they may continue forever," said a staff person. Girls who undergo harassment, abuse or violence are counseled at GPI. This is a slow, long-term process, "but girls expect you to be a magician," said one counselor.

Female genital mutilation is one form of gender-based violence that prevails in the areas where GPI works. The organization identifies villages practicing FGM and undertakes a series of actions: intervention research, focus group discussions, seminars, awareness on the laws around FGM, etc. "We get in touch with community leaders and present our plan to them," said a staff member. "Sometimes the circumscriber brings the instruments and lays them down." The curriculum has also enabled girls to re-orient their understanding of cultural practices such as FGM, which have existed since time immemorial. "We now see this is a violation of a girl's right," said a GPI graduate.

27 MAY

Calabar

DAY FOUR

On the fourth day of the cross visit, GPI staff arranged a trip to a program that works with young men - the Conscientizing Male Adolescents program of CIINSTRID. This program is the male counterpart of GPI's program for girls.

The site visit consisted of meetings and interactions with staff and teenage boys who have enrolled for this program.

Site Visit

Conscientizing Male Adolescents

The Conscientizing Male Adolescents (CMA) program is the male equivalent of Girls' Power Initiative. It is institutionally housed in CIINSTRID - the Calabar International Institute for Research, Information and Development - which runs a library and documentation center on progressive issues. CMA started in 1994 in Calabar, the same town where GPI works. The program enables adolescent boys to reframe their understandings of gender and masculinity. "It is necessary to let boys know that men cannot be truly happy and liberated as long as they hold down a section of society in bondage," founder Edwin Madunagu once told a researcher. "They have to understand that their superiority and advantages are ultimately illusory."[4]

CMA's mission of reframing masculinity is built on two assumptions:

- All the issues which are of concern to adolescent girls - reproductive health and rights, sexual health and rights, fundamental human rights, ignorance, poverty, violence and oppression - are, and should be, of concern to adolescent boys and their families.
- Educating men on issues of specific concern and interest to women is a critical contribution to the struggle against patriarchy[5].

Part of CMA's agenda in educating teenage boys is to ensure that they will not inflict violence on women. In this, and in its overall aim and strategies, it is both influenced by and complementary to GPI's program. "If men are not vested in the mission to end violence against women, you may not be able to achieve your aims," said a staff member.

The program is rooted in the belief that change is easier during adolescence than later on. "We don't indoctrinate men," said a staff person. "We facilitate them to express their own oppression." Young men who enroll in the program go through a two-level curriculum consisting of weekly discussions, seminars, exposure visits, forums, leadership trainings, etc. "They recognize that they are the tools of oppressing women."

Young men who are part of the program constantly grapple with received notions of masculinity - how does being a man affect one's location in the community and in society? Several young men who

5. This quote is taken from 'My Father Didn't Think This Way': Nigerian Boys Contemplate Gender Equality (Quality/Calidad/Qualite 2003 published by Population Council, USA, 2003 pg.6)
6. This paragraph is based on information provided in the above publication, pg.7

were present during the site visit attested that their understanding of masculinity has changed over time. "All that makes me male is having a penis," said one man. "The fact that you are a man does not make you superior or inferior," said another.

Masculinity can also be a double bind, like femininity. Men must observe certain codes, symbols and behavior rituals in order to be accepted as men by other men. "We have to behave like male stereotypes or we are accused of being women," said one man. Being a man means not expressing love, not crying or being demonstrative. "There is nothing special about being a man," said another. "Masculinity is an illusion."

Many young men said they faced peer pressure as they went through the CMA program. "Any idea that's unusual is treated with contempt," said one participant. "Our peers say to us: 'Those girls are things. We can treat them how we want.'" Against this backdrop, the CMA program has taught young men to have value for life, helped them change their relationships with male friends, and taught them to change violent behaviors. As part of its overall emphasis on gender equality, practical examples are used to inculcate the understanding that girls are equal to boys.

As part of the interaction, some Indian participants shared their programmatic experiences of working with men. Manish Kumar of the Indian Institute of Young Inspirers explained how he had given skills training to men in slums in northern India. However, the community was loath to accept these shifting roles and referred to the men as 'henpecked husbands'. He currently uses entertainment-education approaches to raise issues of adolescent health with young men.

Lolichen P. Joseph of The Concerned For Working Children described how his organization forms groups of working children upto the age of 18 years, and working young people upto the age of 26 years. All these working children and young people are from low-income backgrounds and work in the unorganized sector; many of them are male. The organization trains them to take charge of and make decisions around their own lives. Some of these groups have emerged as powerful advocates and can negotiate with state governments, represent their own interests at international conferences, etc. The organization feels it is easier to work with a mixed-gender group than a group of only boys or girls.

In the context of discussing programs for men, Shaleen Rakesh described the men having sex with men (MSM) program that he works with at the Naz Foundation. The MSM program does outreach, provides information, runs support groups, clinics, conducts research and advocacy on issues related to being gay, bisexual or transgender. All these groups transgress societal norms of masculinity through their gender or sexual orientations. "Homosexuality is seen as emasculating," said Rakesh. "But masculinity is not watertight; there is freedom to move within this. Challenging the paradigm of masculinity is difficult but critical."

A Nigerian man said that Nigerians are not open or comfortable discussing issues of homosexuality. How can work be started on this issue? "It is critical to understand the human issues lurking behind sexuality issues," said Rakesh. "We need a fundamental change of consciousness. Homosexuality is not abnormal. It is possible for any human being to get pleasure from both sexes."

Following these brief presentations, an intense discussion sprang up on gender equality. A Nigerian participant said that Nigeria should have a woman candidate in the 2007 presidential elections. "But is having a female prime minister a sign of gender equality," an Indian participant asked? "Having a woman prime minister does not mean that all is fine where the power and voice of women is concerned," she said. "Less privileged women need to have their own voices, and take control of more political spaces." She felt that both men and women who come to power can be patriarchal in their thinking.

Another Indian participant said that gender expectations dictate our understandings of leadership. It is assumed that a man who is in power has the capacity to lead, but the leadership capacities of women coming to power are often questioned. Will men allow their wives to participate in late-night political meetings? Apart from voting for female candidates, how can young men help break barriers so that women can participate more fully in politics?

Site Visit

INCRESE

INCRESE - the International Center for Reproductive Health and Sexual Rights - is currently the only organization in Nigeria working on sexual rights. It was founded to reduce resistance to issues of sexual and reproductive health and rights in Nigeria, and to empower disadvantaged groups with the information, skills and services needed to enjoy their sexual and reproductive health and rights.

The idea of forming an NGO in northern Nigeria to work on these issues was seeded during the ICPD process, when issues ranging from abortion to sexuality created huge tensions, discomforts and controversies. "I remember being stunned," said Dorothy Aken'ova, who started INCRESE in a one-room office without any funding. "I had an issue, I had a location, and I had a dream."

INCRESE was set up in 2000, the same year that Sharia law[7] came into Niger state. In this context, accepting international funding was as risky as was the decision to work on issues of sexuality. "The impact of sexual health and rights is separate from that of reproductive health and rights," said Aken'ova. "What about those who have sex but are not ready to reproduce? Don't they have rights?"

INCRESE does not focus its work on a 'given' population, such as adolescents. Instead it provides information around sexuality-related issues to various groups, including:

- Women's groups, especially those working with widows
- People with disabilities
- Out-of-school young people
- Sex workers
- Sexual minorities
- Religious groups and faith-based organizations.

HIV/AIDS is often used as an entry point in INCRESE's work with its constituencies.

INCRESE works on strengthening sexual rights in various ways.

- It does capacity building on sexual rights and gender.
- It advocates for the rights of women under Sharia law and seeks redress for those whose sexual rights have been violated.

28 MAY

Minna

DAY FIVE

The cross visit continued with a trip to Minna, a city in the northern part of Nigeria. Minna is the capital of Niger state, and is also the home of INCRESE, a non-profit organization working on reproductive health and sexual rights.

The site visit to INCRESE consisted of:

1. A tour of the INCRESE office and discussions with program staff
2. Participation in INCRESE's programs for young people.

7. Traditional Islamic law that covers not only religious rituals, but many aspects of day-to-day life

- It networks at national and international levels to push for the reversal of sentences on women who have had sex outside marriage, including Amina Laval[8].
- It uses international treaties on rights to train people on sexual rights.
- It addresses female genital mutilation from a sexual pleasure perspective.

All of this is challenging work in a context where those who talk of empowerment and sexual rights are seen as western agents. "We first go on advocacy visits to community gatekeepers and cultivate their friendship," said Aken'ova. "People respect their traditional leaders and spiritual leaders more than their parents." Different aspects of INCRESE's work on strengthening sexual rights are described below.

Working with young people

INCRESE's work with young people is built around an outreach program and a youth center, where young people come and play games after school. In this setting, they are given information about their bodies, sexuality, gender, etc. Both boys and girls come at the same time. "Under Sharia, many NGOs have desegregated boys and girls," said Aken'ova. "We have not, because we believe that boys and girls need to interact with one another in order to respect each other."

In its work with young people, INCRESE uses the Behavior Change Communication (BCC) model - unlike most NGOs who use the IEC model of Information, Education, Communication. "Through information, one can become conscientized," said Aken'ova. "But you can be informed and aware, and never budge from there to action. You need something extra to change behavior."

In the BCC model, young people are asked to create real-life scenarios based on information provided to them. These scenarios make them understand their own behavior and actions in various situations. "We guide young people through the jump from awareness to behavior change," said Aken'ova.

INCRESE follows certain other principles in its work with young people. One is to never turn away a young person, no matter what. "It is critical to meet the immediate needs of a young person," said Aken'ova. Another is to ensure that staff working with young people have the right values and perspective. A resource person who sees menstruation as dirty or abortion as criminal may not have the values required to strengthen sexual rights.

Working on sexual minority issues

INCRESE's work in this area is structured around an online advocacy group on lesbian, gay, bisexual, transgender, queer (LGBTQ) issues. The online group consists of 51 members across nations and continents, and puts out regular alerts on rights violations faced by sexual minorities in different parts of the world.

Many LGBTQ individuals suffer from isolation, guilt and low self-esteem because they are seen as 'abnormal'. INCRESE provides them online counseling, builds their self-esteem, gives them non-judgmental advice, and educates them on their rights. In a Sharia-practicing state, where it is difficult to talk openly about sexuality, outreach is carried out during events and through informal networks. The program is also trying to build the capacities of LGBTQ individuals so that they can become advocates at their own level.

INCRESE also works on sexual minority issues in other ways. It has located terminology for same-sex behavior in local languages, showing that this is not 'imported' behavior. INCRESE also sponsored a roundtable on MSM issues during a national HIV/AIDS conference in Abuja. It plans to conduct research on homosexuality and human rights in Nigeria. It consistently raises these issues at all platforms. "We know that if we don't raise issues of sexual orientation, no one else will," said Aken' ova. "We need to push the boundaries beyond the comfort zone."

In its work with sexual minorities, INCRESE faces several challenges including the silence around same-sex relations, religious norms and beliefs, and lack of capacity within the NGO sector. "Many NGOs working on human rights still don't believe that LGBTQ people have rights," said Aken'ova. "But if

8. A young woman who had given birth out of wedlock and had been sentenced to death by stoning under Sharia law as a punishment for having sex outside marriage. Her stoning sentence was overruled in 2003

everybody's right is not respected, then nobody's right is respected."

Working in a Sharia state

Despite several protests, Sharia law was brought into Niger state, where INCRESE works, in 2000. Since then, the Sharia law has never been published, making it difficult to challenge. However, it is implemented by the *ulamas*[9], who report anything they consider suspect in a Sharia state.

INCRESE educates young people about their rights using a human rights framework, and tells them of specific laws under the Sharia related to abortion, rape, incest, etc. This is important to enable young people to make informed decisions.

"Although legally Sharia is supposed to apply only to Muslims, it affects everyone," said Aken'ova. In a Sharia state, sex workers are beaten up and harassed; gay men, lesbian women and transvestites can't come out in public; bars are shut down. One way to challenge Sharia is by declaring oneself a non-Muslim and asking that one be tried in a civil court, since Sharia legally applies only to Muslims.

Using international treaties and conventions

During a workshop, Indian participants observed how INCRESE uses international rights instruments to trigger dialog around rights concepts. The instrument used at this workshop was the Convention on the Rights of the Child. The convention sees a child as a human being with rights, rather than privileges, including the right to choose. But do parents or the government enable a child to make his or her own choices? What can a child do if denied the right to choose? What are the barriers to realizing this and other rights? How can these barriers be overcome?

The convention also mentions that a child has the right to family, but what does family mean? Is 'family' necessarily a man-woman combination, or can two women/two men constitute a family? What is the role of a family? What happens when a family separates - does a child have the right to choose which part of the family he or she wants to belong to? These were some of the issues raised during this stimulating workshop.

9. Islamic religious leaders

29 MAY

Minna

DAY SIX

The trip to Minna concluded with a multi-sectoral dialog held with a diverse group of INCRESE's constituents - ranging from academicians and school principals, to mechanics and agriculturists.

Multi-sectoral Dialog

The principal of a government school with more than 5,000 students and 145 teaching staff explained how he had decided to join hands with INCRESE in a context where students are exposed to several sexually-transmitted infections. The principal of an elite boarding school explained that even though students know about sex, they don't know about it the way they should. INCRESE has started workshops in this school. The first session proved so popular that students asked the teachers present at the session to leave.

An agriculturist outlined how parent-teacher associations could be used to spread sexuality education. A mechanic described how he had started educating others on his street on the importance of safe sex, after he himself understood and reaped its benefits.

Site Visit

Adolescent Health and Information Projects

Welcoming Planet. Friends Galaxy. Viewing Mars. These are some of the names that welcome young people to AHIP. Welcoming Planet is actually an orientation room, while Friends Galaxy is the counseling room and Viewing Mars is the video screening area. But all these have been named to appeal to young people, who are at the heart of all of AHIP's work.

AHIP - or Adolescent Health and Information Projects - is a non-profit organization that is committed to working with young people, and partnering with other stakeholders to empower young people and women. This is done through trainings, sensitization, service delivery, providing factual information and necessary skills development. The program is rooted in the belief that empowerment of young people should start early in life to enable them to make responsible decisions concerning sexual and reproductive health and rights issues for their total well being.

In line with this vision, AHIP's facilities include a Behavior Change Communication unit, a day-care center, an Internet café, a library, and other facilities for young people. Teenage pregnancies, drug abuse and HIV/AIDS are among the issues that AHIP regularly encounters in its work with young people. "A 16-year-old girl was recently impregnated by a 27 year old," said Mairo Bello, director and national coordinator. "She was planning to abort in the seventh month. This is dangerous."

Young people who visit AHIP's center may exhibit visible symptoms of HIV/AIDS, such as Kaposi's sarcoma[10]. If so, they are counseled and referred for testing elsewhere. "When diagnosed positive, we don't provide support, but refer him or her to other counseling facilities," said Bello. For instance, HIV-positive teenage girls are referred to the Society for Women and AIDS in Africa (SWAN) for free anti-retrovirals. "We work on the social aspects."

One of AHIP's most innovative programs is the creation of three basketball teams, which compete in

30/31 MAY

Kano

DAYS SEVEN/EIGHT

The cross visit continued with a trip to Kano, a city in the northern part of Nigeria. Kano is the capital of Kano state, and is also where AHIP, a youth-focused organization established in 1989, is located.

~~The site visit to AHIP consisted of:~~

- A tour of the office and ~~discussions with program staff~~
- A stadium visit to the football and basketball teams set up by AHIP
- An interactive session with young people who are part of AHIP's programs
- ~~A tour of AHIP's outpatient clinic in a village and its vocational training center.~~

10. A malignant tumor of the connective tissue, often associated with AIDS

the national league and double as peer educators. "Their main task is to disseminate information," said Bello. "They go state to state, playing basketball. In the process, they carry IEC material and do youth outreach and dissemination." The basketball teams - AHIP Giants, AHIP Rising Stars and AHIP Queens - are already role models for other young people in their age group of 15-25 years. Thus, they are easily able to establish credibility as peer educators. "When we play ball, we interact with other youth," said one rising basketball star. "We educate them too."

Interactive session with young people who are part of AHIP's programs

A lively interaction was held with 15 of AHIP's youth mobilizers and youth facilitators, in which the young people fielded several questions from the Indian delegation. These are reproduced below in a question-answer format.

Q: There is peer pressure among young men to have lots of sexual activity. But at AHIP, the main messaging is around abstinence. How do you cope with peer pressure in this situation?
A: Peer pressure plays a major role in HIV prevention. If you belong to a group of friends who believe in having sex, you must do so too, to be in tune with your friends. You don't want to be left behind. Peer pressure is nothing but damning the consequences of what you do.

Q: Is condom usage an important issue?
A: A vast majority of young people having sex do not bother with consequences; they don't see HIV as a real thing. So why would they use condoms?

Q: If your best friend were to have sex, what would be the biggest fear in your mind?
A: The biggest fear is what the consequences would be. She may want to use a condom, he may not. She may agree to this out of love for him.

Q: Love? Or fear?
A: Love actually.

Q: When you come across someone having unsafe sex, would you ask him to have an HIV test?
A: Young people do not believe that HIV is real, that it exists. It has a psychological effect if you ask a young person to have an HIV test. They will not have one unless there is major counseling.

Q: Since Kano is still under Sharia, what would you do if a young person is attracted to someone of the same sex?
A: We would give them guidelines, not make choices for them; let them choose. We would make them understand the consequences and apprise them of the legal situation.

Q: Is gender a major component of AHIP's work? How?
A: We put gender first. We don't send young men to talk to young women. We try to make them understand the social construction of gender roles - that it is not natural, but man-made. A woman's place is not in the kitchen.

Roundtable

The half-day roundtable provided an opportunity to interact with donors, policy makers and health advocates. It consisted of several presentations on programming in sexuality and reproductive health.

IPAS

IPAS' work with young people in Nigeria is carried out in the overlapping contexts of low sexuality education, low contraceptive prevalence and high incidence of abortion-related complications. In this context, IPAS' work is focused around the triple A of Adolescents, Abortion and AIDS.

IPAS' work to improve the sexual and reproductive health status of young people involves training young people in reproductive health issues, linking them up to service delivery sites within their environment, making available to service providers, training and equipment to carry out high-quality, safe abortions, and funding training workshops and educational materials for NGOs working on these issues.

In recent years, IPAS has:

- Trained peer health educators within the army in three zones, and run workshops in three cities
- Supported training workshops for adolescents in six local governments
- Trained 20 adolescents in reproductive health issues and drama
- Had interactive sessions with providers to get adolescents' perceptions and requirements of youth-friendly centers
- Developed youth-friendly centers in Abuja
- Trained providers that work with INCRESE
- Trained providers that work with the army.

In the future, IPAS will be working with AHIP to get services across to young people. It also plans to work with Girls' Power Initiative. IPAS' work will aim to bring out the correlation between abortion and HIV/AIDS, and to incorporate program elements that will highlight dual protection in a broad sense.

CAUP

The Campaign Against Unwanted Pregnancy (CAUP) is a registered non-governmental, not-for-profit, multi-disciplinary initiative comprising doctors, women's rights activists, lawyers, nurses, media practitioners,

1 JUNE
Abuja

DAY NINE

The cross visit concluded with a roundtable held at Abuja, the capital of Nigeria.

Speakers came from the following organizations:

- IPAS
- CAUP
- UNFPA
- FMOH ARH Program.

Geeta Sodhi of Swasthya made a joint presentation on behalf of the Indian delegation.

social scientists and other interested Nigerians committed to the promotion of women's sexual and reproductive health and rights.

The vision of CAUP is that of a Nigeria free of unsafe abortion. While there is no abortion law in Nigeria, abortion is part of the penal code. Attempts to legalize abortion have typically met with resistance; a highly-placed religious leader said Nigeria would burn if abortion is legalized, thereby scuttling any such attempt. Currently, 650,000 women die of unsafe abortions in Nigeria each year, of whom two-thirds are young women.

In line with its vision of a Nigeria free of unsafe abortion, the campaign aims to:

- Sensitize policy makers and the public at large to the problem of unwanted pregnancy and its consequences
- Promote the enactment of responsible reproductive health legislation
- Advocate for the training of medical personnel in safe abortion care services to the full extent of the law
- Advocate the teaching of comprehensive sexuality education to in-school and out-of-school adolescents.

The campaign's overall strategy is to create a conducive political and socio-cultural climate in the country that:

- Allows women to decide freely whether or not they want to have babies
- Supports the availability of nationwide family planning services
- Supports the provision of safe and accessible abortion care services.

This strategy has been operationalized through many activities. These include consultative group meetings, law review meetings, media sensitization campaigns, abortion methodology workshops and studies, a national conference on abortion, and a review of the sexual and reproductive health curriculum of medical schools. Nigeria's first lady agreed to be the guest of honor at the national conference on abortion held in 2000, and said that unsafe abortion needs to be seen as a social problem. The campaign works with young people, community-based organizations and policy makers, and produces IEC material and publications on unsafe abortions.

UNFPA

UNFPA's program strategy around promoting adolescent health and rights in Nigeria is built around the following components:

- Promotion of partnerships, networks and coalitions
- Knowledge and evidence-based approaches, including knowledge sharing to promote best practices
- Documentation
- Advocacy and resource mobilization
- Capacity building.

Key programmatic activities in this area include:
Conducting baseline surveys: UNFPA has done a state-specific baseline survey in 15 states, which covers adolescent reproductive health and rights, population and gender. The findings will be used to develop evidence-based approaches for working in this field.

Trainings: In 12 states in Nigeria, UNFPA has in- and out-of-school programs that include training of peer educators, parents, teachers and community sensitization. It also promotes curricular and extra-curricular activities - e.g. establishment of school health clubs, drama, debates and quiz activities.

Youth participation in conferences: UNFPA has a major program focus on prevention of HIV/AIDS among adolescents and young people. UNFPA sponsored many young people to attend the HIV/AIDS Conference 2003 (International) and the HIV/AIDS conference 2004 (National). Young people ran a booth for Voluntary Counseling and Testing at the national conference.

Behavior Change Communication: UNFPA has been involved in the design of messages that are culture-sensitive, gender-sensitive and youth-friendly. A major activity in this area is the airing of the popular series 'I Need To Know' on major radio and television stations across the country. UNFPA is using sports as entry points, with special emphasis on infotainment. This was done at the National Sports Festival of 2002, and at the eighth All Africa Games held in Abuja.

FMOH ARH Program

In his presentation, Tunde Segun of the Federal Ministry of Health outlined the structure of the health care delivery system in Nigeria, the role of the Federal Ministry of Health, and its experience in program implementation. Reproductive health consists of five components in the Federal Ministry of Health:

- Adolescent reproductive health
- Family planning
- Integrated child survival and development
- Safe motherhood
- Women-in-health-development/gender.

The Federal Ministry of Health is responsible for policy formulation, setting standards and guidelines, training, monitoring and evaluation, funding and research on this issue.

The Federal Ministry of Health has framed many policies to address adolescent reproductive health in Nigeria. These include:

- Adolescent Health Policy (1995)
- Reproductive Health Policy (2001)
- HIV/AIDS Emergency Action Plan (2001-2004)
- National Reproductive Health Strategic Framework and Plan (2002-2006)
- National Policy on Youth (2001)
- National Economic Empowerment Development Strategy 2004.

At the programmatic level, the ministry has:

- Developed a national training manual on adolescent health and development, as well as clinical protocol and service guidelines for adolescent health services
- Trained doctors, nurses, providers from NGOs, secondary school teachers and students from selected states using these documents
- Designated youth-friendly health facilities in selected states
- Trained selected secondary school students across the six geo-political zones as peer health educators
- Established a 30-member standing committee on school health to promote health through schools
- Developed training manuals for health providers on the management of children with special needs
- Held a national conference on adolescent reproductive health in 1999, and developed a strategic framework for action.

The ministry faces challenges of funding, coordinating activities among stakeholders, and building partnerships with different sectors in fulfilling its aim of promoting adolescent reproductive health.

Indian delegation

Geeta Sodhi of Swasthya made a joint presentation on behalf of the Indian delegation. Her presentation identified the commonalities among four NGOs working with young people: Swasthya, Mamta, Sangat and Chetna.

All these organizations work in contexts marked by patriarchy, constant changes in government, globalization and increasing consumerism.

Against this backdrop, young people have the following issues and concerns:

- Age at marriage
- Age at first birth, since teenagers in India get pregnant mostly within marriage
- HIV/AIDS, since half of new infections occur among young people
- Sexual exploitation
- Lack of youth-friendly services.

The four NGOs use certain key principles in their work with young people:

- All of them subscribe to the rights-based approach and address vulnerability, rather than taking a bio-medical approach. They address the economic, social and physical vulnerabilities faced by young people and aim to create not just awareness, but empowerment among young people. They enable young people to take charge of their own lives through strategies that are similar and different.
- All of them use contextually appropriate strategies and work with gatekeepers.
- None of them look at health in isolation; health is woven together with other programs, rather than being seen in isolation.
- All of them use participatory, sustainable approaches and invest in building local capacities, rather than setting up parallel NGO-based systems.
- All use evidence-based approaches and emphasize evaluation and replicability.

Key Learnings

The 10-day Nigeria cross visit provided many insights and learnings on addressing adolescent sexual and reproductive health and rights. Participants agreed that:

- Peer education is one of the most effective strategies for working with young people.

- Policies, programs and donors need to recognize young people as program implementers, not just as beneficiaries.

- Young people can design and implement their own programs. It is vital to build the capacities of young people to lead and manage programs. Bigger organizations need to encourage and mentor youth-led organizations.

- Confidentiality is a critical aspect of services and information for young people.

- Sports is an innovative entry point for working with young people.

- Adolescent health and rights programs need to address the economic, social and physical vulnerabilities faced by young people and create not just awareness, but empowerment among young people. Health should not be seen in isolation, but in the context of other issues that affect young people.

- It is important to work with gatekeepers - parents, teachers, community leaders, religious heads - who often control the lives of young people.

- Enhancing parent-child communication is an effective strategy for working with adult gatekeepers. Not only does this facilitate two-way communication, it also gives young people the confidence that they can change their parents, and the world around them.

- Teenage girls who acquire skills and information on gender, human rights and sexuality show signs of assertiveness and self-confidence. They take informed decisions around many issues, including risky sexual behavior, and are more likely to become change agents.

- All the issues which are of concern to adolescent girls are of concern to adolescent boys. It is thus critical to provide information not just to young women, but also to young men.

- Young men constantly grapple with received notions of masculinity, just as young women struggle with given norms of femininity. But norms of masculinity and femininity are not watertight; they can be negotiated and subverted.

- Sexual health and rights is separate from reproductive health and rights, even though there are overlaps between the two. It is important to create policies and programs for that aspect which is 'sexual, but not reproductive'.

- Governments can play a vital role in enhancing young people's health and rights, by formulating policies, setting standards, and framing guidelines for program implementation. Civil society organizations must advocate for progressive policies on paper to translate into effective programs on the ground.

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- Population Foundation of India (PFI)
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Roundtable, Delhi

- Abha Ranjan
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Roundtable, Pune

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