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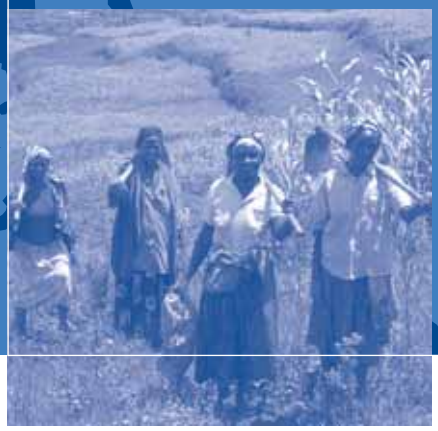
Exchange

on HIV/AIDS, sexuality and gender



Harmful traditional practices

Very little research has been done to establish a firm link between harmful traditional practices and HIV transmission. However, it is likely that any practice that involves transferring blood carries a significant infection risk. It is also likely that practices that involve involuntary or premature sex or concurrent sexual partnerships put men and women at risk of infection. Traditional practices that may directly impact on the spread of HIV include female genital mutilation, sexual cleansing, dry sex, blood oaths, scarification, etc. Practices that have a less direct, but probable, effect on the spread of HIV are widow inheritance, early marriage and polygamy.

These customs and rituals are considered harmful as they often have a huge impact on the health and well-being of people engaged in them and they usually violate their human rights. In most cases, it is women and girls who are forced to undergo traditional practices that undermine their health. In this issue of *Exchange*, three examples of harmful traditional practices that impact on women and girls are highlighted: female genital mutilation, early marriage and widow inheritance. In the first article, the author argues that even though supportive laws that prohibit genital mutilation and other harmful practices are important, in order to be effective, legal approaches to fighting these practices need to be coupled by community approaches.

The thematic part of this issue was produced in collaboration with IAC, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, of which the guest editor, Ms Berhane Ras-Work, is the President.

Nel van Beelen
Managing editor

Berhane Ras-Work
Guest editor

Access to land and widow inheritance in Uganda p.7

Defending sexual and reproductive rights in Argentina p.10

Female Genital Mutilation – a life-threatening health and human rights issue

The World Health Organization defines female genital mutilation (FGM) as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons. This practice is also known as female circumcision or female genital cutting. It is estimated that over 100 million girls and women have undergone some form of genital mutilation, and at least two million girls are at risk of undergoing the practice every year. It is an age-old tradition which is perpetrated in many communities around the world simply because it is customary. FGM is most prevalent in Africa, some Middle Eastern countries, and in immigrant communities in Europe, North America and Australia. The practice ranges from pricking, piercing or incising of the clitoris and/or labia, to excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening, which is the most extreme form of FGM. The age at which FGM is performed varies. In some areas, it is carried out during infancy, in others, during childhood, at the time of marriage, during a woman's first pregnancy or after the birth of her first child. The most common age is 7-10 years or just before puberty.

Female genital mutilation is usually performed by unskilled traditional birth attendants, professional circumcisers or traditional healers using crude instruments such as unsterilized, sharp razor blades or knives and without anaesthesia. The same unsterilized knife is used on other girls with the attendant risks of the spread of infections including HIV. Short-term complications include severe pain and a risk of haemorrhage that can lead to shock and death. In addition, there is a high risk for local and systemic infections, with documented reports of abscesses, ulcers, delayed healing, septicaemia, tetanus and gangrene. Long-term complications include sexual frigidity; genital malformation; urine retention resulting in repeated urinary infections; obstruction of menstrual flow leading to frequent reproductive tract infections and infertility; chronic pelvic and obstetric complications; and prolonged and obstructed labour. FGM has long-term physiological, sexual and psychological effects such as anxiety and depression. It also impairs women's sexual enjoyment.

Because the procedure is coupled with the loss of blood and use of one instrument on a number of candidates, the risk of HIV transmission is high. Also, due to damaged sexual organs, sexual intercourse can result in tissue lacerations, which greatly increases risk of HIV transmission. The same is true during childbirth and subsequent loss of blood.

Female genital mutilation can be approached from different angles: it can be regarded as a health issue, a cultural issue, a women's empowerment or gender issue, and a human rights issue. These different perspectives lead to different ways to address FGM, which are not mutually exclusive.[1]

- The *health approach* stresses the health advantages of not undergoing the procedure. This approach, if not supplemented by other approaches, has tended to medicalize FGM because many people believe they can avoid side-effects by having their daughters circumcised at health clinics or hospitals.
- The *cultural approach* examines how alternative local practices that are not detrimental to women could be enforced. This includes supporting and celebrating the social meaning of rites of passage that are positive to women while condemning and eliminating FGM.
- The *women's empowerment approach* seeks to find positive roles for adolescent girls through education, training and for example, sports. It can also include finding alternative sources of income and status for traditional excisors, who generally, are women. This is a wider approach and needs to involve community and even religious leaders.
- The *human rights approach* provides normative language for saying that the procedure is wrong. The authoritative nature of the ethical, legal and human rights languages legitimizes efforts to advocate for the eradication of FGM. The challenge is to train people in the use of this approach which is based on international treaties, national constitutions, local laws and ethical norms.

FGM as a human rights violation

Female genital mutilation sometimes threatens the lives of girls and women and always violates their human rights. It is a tragic human rights' violation whose cultural and traditional roots run deep, making it difficult to combat. Since FGM involves the removal of healthy sexual organs without medical necessity and is usually performed on adolescents and girls, often with harmful physical and psychological consequences, it violates the rights to freedom from discrimination; torture, inhuman and degrading treatment; the right to life; to security; to physical integrity; and to health. It also violates children's rights to special protections. The most glaring infringements include the rights to freedom from torture or to cruel, inhuman or degrading treatment or punishment, and to the health and security of the person in light of the grave health problems associated with the crude and unhygienic procedure. Female genital mutilation also violates the right to privacy as it is performed on adolescents and girls who are incapable of giving informed consent.

Governments have clear obligations under international laws to take measures to eradicate and prevent FGM by addressing the human rights implications of the practice in a holistic manner. Several international treaties and resolutions explicitly recognize FGM as a harmful traditional practice that violates human rights. Some examples are the United Nations Convention on the Elimination of

> Female genital mutilation sometimes threatens the lives of girls and women and always violates their human rights

All Forms of Discrimination Against Women (CEDAW, 1979); the UN Declaration on the Elimination of Violence against Women; and the UN Convention on the Rights of the Child. At the regional level, the African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity in 1990, contains many similar provisions to those in the United Nations Conventions. The Protocol on the Rights of Women in Africa (2003), states in Article 5 that *"States Parties shall prohibit*

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This issue

and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices."

A multi-disciplinary approach

Female genital mutilation has been outlawed in several African countries. Laws against FGM are necessary, but not sufficient to stop the practice or to enhance women's rights. Making FGM illegal does not eradicate it, but could drive it underground. The use of law should thus be one component of a multi-disciplinary approach; and outreach efforts by civil society and governments aimed at changing perceptions and attitudes regarding FGM should precede or accompany legislation. These activities should reach a wider public with government actors, religious and traditional leaders, health providers, teachers, youth, social workers and media involved. In particular, men must be targeted as well as family members, including grandmothers, mothers-in-law, etc.[2]

In order to empower women against FGM and other harmful traditional practices (HTPs) and reduce their vulnerability to HIV infection, programmes and campaigns should employ the following key strategies from a rights approach:

- Promote a culture of opposition to all forms of harmful traditional practices against women and girls, using the media and involving men in addressing gender stereotypes and discriminatory values and norms which increase the risks faced by both women and girls.
- Organize public education campaigns on the rights of women and girls and encourage the public to report cases of HTPs and gender violence to the law enforcement agencies.
- Enact laws and policies that prohibit HTPs and promote the rights of women to property, inheritance and a minimum age of marriage.

Networking and collaborating with NGOs will help to achieve the desired results because of their unique experience and expertise, which enables them to play a crucial role in advocating for the implementation of laws and policies to eliminate FGM. In Africa, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) is an important networking organization. IAC campaigns over the years have led to the demystification of traditional practices and helped put the issue of FGM on the global agenda. It has pioneered world mobilization against harmful traditional practices including FGM. Advocacy has contributed to legislation against HTPs and FGM in some African countries and mobilization of communities has resulted in public rejection of FGM. IAC organized an International Conference on 'Zero Tolerance to FGM'

> Laws against FGM are necessary, but not sufficient to stop the practice or to enhance women's rights

in 2003, during which February 6 of every year was declared 'International Day of Zero Tolerance to FGM'. As a result of the activities of IAC and the collaborative efforts of other networks and organizations, both government and NGOs, there is evidence of a decrease in FGM prevalence in many communities.

The example of Nigeria

In Nigeria, much is being done to combat FGM. IAC/Nigeria holds meetings and programmes in both urban and rural communities to inform the public about this practice. It uses videos, booklets and the mass media to reach school-age children. The government is officially opposed to the practice, to which approximately 19% of women have been subjected (varying from 1% in the north to 60% in the south of the country). Associations of nurses, midwives and doctors have actively campaigned against FGM and several NGOs are active in the field of IEC, advocacy and services. Examples are GPI (Girls' Power Initiative); WACOL (Women's Aid Collective); and WHARC (Women's Health and Action Research Centre).[3] GPI has carried out activities on the promotion of the rights of girls and mobilizes them for development and participation through education, research and relevant studies; WACOL has a shelter/safe home for victims of domestic violence including adult women who would like to avoid circumcision. It also offers legal advice/assistance, counselling, and documentation of cases of abuse. WHARC conducts community sensitization seminars to educate community members on contemporary issues in reproductive health, including the harmful effects of traditional beliefs and practices on the reproductive health of women.

Educating the community is probably the most important way to change the practice of longstanding traditional practices like FGM. Knowledge about its harmful effects is the first step. However, eradicating FGM would entail a comprehensive approach to promoting behavioural change against this harmful traditional practice, combining both legal and community approaches.

Olaide Gbadamosi

Barrister and Solicitor of the Supreme Court of Nigeria; Lecturer and Acting Head, Department of Private and Property Law, Faculty of Law, Benson Idahosa University (Benin City, Nigeria); and Executive Director of Network for Justice and Democracy, Nigeria

Correspondence:
PO Box 286, Benin City, Nigeria
Tel: +234 80 3717 1817 / 5641 5512
E-mail: olaidelaw@yahoo.com
Web: http://www.justicenanddemocracy.org

1. See also United Nations Plan of Action for the Elimination of harmful traditional practices affecting the health of women and children, 1994 (E/CN.4/Sub.2/1994/10), http://www.ohchr.org/english/about/publications/docs/fs23.htm#annex
2. The Cairo Declaration for the Elimination of Female Genital Mutilation (Afro-Arab Expert Consultation on 'Legal Tools for the Prevention of Female Genital Mutilation', Cairo, 23 June 2003), http://www.reproductiverights.org/pdf/pdf_fgm_cairo2003_eng.pdf
3. More information: http://www.gpinigeria.org (website GPI), http://www.wacolnigeria.org (WACOL), and http://wharc.freehosting.net (WHARC)

Early marriage in Ethiopia: Causes and health consequences

Bogalech Alemu

Photo: World Bank Protection of Basic Services Project / Michael Tsegaye

An 11-year-old Ethiopian girl who refused an arranged marriage and chose to stay in school receives an excellence in learning award from former World Bank President Paul Wolfowitz, July 2006

Advocates for gender equality and the abandonment of harmful traditional practices (HTPs) argue that early marriage is one of the most harmful practices as it usually denies girls educational opportunities, leads to poverty and economic insecurity and has a serious negative impact on their health and decision-making capacities. It also reinforces other forms of gender-based violence and problems.[1] Early marriage is mostly common in sub-Saharan Africa and Southeast Asia. It is rampant in Ethiopia, although prevalence varies from one region to another. At the national level, 62% of Ethiopian women aged 20-49 get married before the age of 18.[2]

Comparative studies conducted in 2004 identified the Amhara region as having the highest prevalence, with 48% of rural married women and 28% of urban married women having married before the age of 15.[3] Types of early marriage in Ethiopia include *promissory marriage*, whereby a verbal promise is made at infancy or even childbirth by the parents to have their children get married; *child marriage*, in which children under the age of 10 are wedded; and *adolescent marriage*, which involves girls aged between 10 and 15. In most cases, the child bride is taken to her in-laws immediately after the wedding; in other cases the parents agree that the girl stays with her parents until she is mature enough to live with her husband. In general, husbands are much older than their young wives.

Early marriage is a violation of the fundamental rights of the child. Article 21 of the 1990 African Charter on the Right and Welfare of the Child states that *"Child marriage and betrothal of girls and boys shall be prohibited and effective action including legislation shall be taken to specify the minimum age of marriage to be 18 years."* Also, the Maputo Protocol on the Rights of Women in Africa (October 2005) and the newly adopted criminal law of Ethiopia (2005) acknowledge the minimum age of marriage for women to be 18 years and state that marriage shall only take place with full consent of both parties. Unfortunately, knowledge of and respect for the law is limited among many rural communities.

Understanding the forces at work at the community and family levels that drive parents to marry their girl-children off is essential in the development of effective programmes to tackle this traditional practice. In 2006, Pathfinder International/Ethiopia conducted a study on the incidence, reasons for, and the personal and social consequences of early marriage in both urban and rural areas of the Amhara region. The study aimed to develop solid evidence upon which to build future programming. It combined both qualitative and quantitative research methods. A total of 2,072 women and girls aged 12-49 participated in the quantitative research. Focus groups involved parents (married men and women) and unmarried adolescents (boys and girls separately). Key informants – knowledgeable persons in the study areas including health and social workers, teachers and religious and other community leaders – were interviewed to find out their perceptions of the status of early marriage in their communities and of the problems associated with it. Also, information was collected on existing programme interventions, policies, laws and plans of action on the issue.

> The strongest reason for early marriage is the desire or need to maintain the family's good name and social standing

The decision to marry

More than 55% of the ever-married women interviewed reported having been pressured into marriage. The sources of that pressure were predominantly fathers (91%) and mothers (88%), followed by community elders (22%) and others in the community. Parents were found to have chosen the husband in 85% of the cases, and to have arranged the marriage in 88% of the cases. More than 60% of the women reported that they were not informed about the wedding before the decision was made, and 72% were not asked for their consent, while 75% did not know the groom before the wedding.

One of our findings was that the mean age of marriage, though still very low (14), seems to be rising. According to the 2005 Ethiopia Demographic and Health Survey, 13% of girls between 15 and 19 had been married by the age of 15, against 32% of women in the 25 to 34 age range. This would lend credibility to the argument that more and more young women, as well as community groups, are learning about the legal restraints and are turning to the law and community leaders to resist early marriage.

In general, there was a large age difference between couples: nearly 75% of ever-married female respondents were married to older men, and among these, the age difference was ten years or more in half of the cases. This age differential affects the level of communication, mutual understanding and the balance of influence within the family. It gives the man considerably more power and control than his young wife. One fifth of the women interviewed reported that their husbands had been previously married and 29% of these had been married twice or more times.

Causes of early marriage

Despite the legal sanctions against marriage before age 18 and the growing awareness among leaders and educators that it is harmful to girls and their families, parents continue to insist upon marrying their daughters in their mid-teens and go to some lengths to resist all opposition. Why? More than 80% of respondents could cite no reason other than it being a tradition they had to adhere to. According to interviewees, the strongest reason for early marriage is the desire or need to maintain the family's good name and social standing. For men in particular, the success of their children is a measure of manhood and community status, and a daughter's success rests in her making a good marriage and linking her family to another family. Concern about a girl becoming pregnant out of marriage is also prevalent, though not nearly as significant as the issue of status. Only about one-fifth of the respondents reported this as a reason for early marriage. For some families, the desire to get *'macha'* (money paid to the girl's family by the boy's family upon agreement to marriage) is an incentive.

There is little doubt that parents are well aware of the negative consequences of early marriage, which are commonly discussed in communities. Though many condemn it in public, they seem compelled to continue its practice. This pursuit of tradition in the face of compelling negative evidence is common to most cultures and must be well understood when developing social change programmes.

Consequences for health and well-being

Early marriage has severe consequences for the health and well-being of girls and women. In the Ethiopian context, some of these include:

- *Marital instability* – Among the respondents, about 27% of marriages in urban areas and 19% in rural areas had ended in divorce or separation. Of those that had married more than once, 56% reported that their first marriage ended either because they were too young or 'not interested' in the marriage. Many girls run away from unhappy marriages only to be sent back by their parents.
- *Termination of education* – In almost every setting, better-educated women are more likely to use contraception, bear fewer children, raise healthier children, make better decisions for themselves and their children and to make greater economic contributions to the household. More than 80% of girls aged 12 to 14 in our sample were in school. However, among out-of-school respondents, 28% cited marriage and 19% cited childrearing obligations as their reasons for quitting school. Four percent cited their husbands' disapproval of their school attendance as a reason.

Reasons for getting married (in order of importance):

1. It is a tradition in the area
2. To strengthen relationships
3. For prestige
4. Difficult to get married if older
5. The family will be victim of gossip
6. To earn dowry
7. To protect virginity and avoid premarital affairs

> Married adolescent girls' inability to negotiate safer sex and other social pressures represent a critical channel of vulnerability to HIV infection

- *Inability to plan or manage families* – Statistically, women who marry early are likely to bear more children. Among our respondents, those married under 15 averaged 4.96 children; those married between 15 and 17 had 4.15, and those over the age of 18 averaged 3.12 children. Young mothers exercise less influence and control over their children and have less ability to make decisions about their nutrition, health care and household management.
- *Impact on sexual health of women and girls* – Young girls can face considerable physical pain associated with sexual intercourse as a result of the physiological immaturity of their sexual organs. Complications due to pregnancy at a young age frequently include obstetric fistula (perforation of the bladder or bowel, due to prolonged labour).
- *Vulnerability to HIV infection* – A girl is physiologically more prone to contracting HIV than a male, as her vagina is not well lined with protective cells and her cervix may be penetrated easily. Young women are several times more likely than young men to contract the disease through heterosexual contact. Also, deeply entrenched socio-economic inequalities further compound their risk. Marriage can increase married girls' exposure to the virus, especially as older husbands may engage in unprotected sexual relations with other partners. The risk of HIV infection is higher among the poorest and most powerless in society, and, as such, married adolescent girls will be more at risk of infection than unmarried girls who are not having sexual intercourse. Married adolescent girls' inability to negotiate safer sex and other social pressures represent a critical channel of vulnerability.

What needs to be done?

The results of this study clearly confirm that early marriage practices in Ethiopia are driven by deeply-held beliefs and traditions that do not necessarily lend themselves to discouragement through rational arguments. Further examination and understanding of the forces

weighing on parents will prove invaluable to the development of effective ways to address their concerns. A big challenge is the long-term goal to enhance the status of women in Ethiopia, to strengthen their personal and reproductive rights, to strengthen their access and control over resources and thus fight women's poverty and economic insecurity, to heighten their influence and decision-making power within the family and the community and to firmly establish their value as equal partners in development and members of society.

Elimination of early marriage is a clear starting point. The outcomes from this study suggest the following strategies to address this problem:

- Challenge the traditions that surround early marriage. Inform parents, community members, and youth about the negative consequences of early marriage.
- Create a supportive network of (religious) leaders and teachers who can empower girls to negotiate with their parents.
- Expand training for health and community workers on the dangers of early marriage, engaging them as advocates and change agents in their communities and institutions.
- Strengthen and establish community networks and partnerships involving girls clubs, teachers, elders, local government officials, women and youth groups, community and religious leaders, etc., that jointly work towards ending early marriage.
- Strengthen the role of the judicial system particularly the police, judges and persecutors through training on enforcement of the law against early marriage.
- Develop strong support systems to keep girls in school. Provide scholarships where necessary and encourage teachers to support girls.
- Finally, bring leading professional women to communities to talk to girls as role models and a source of inspiration.

Pathfinder International/Ethiopia has adopted all these strategies and has developed concrete activities to fulfil its objectives. We provide information to the public (including women, youth, religious and community leaders) through electronic, audiovisual and print media. We mobilize communities to take action through for instance community networks, arts competitions and mass rallies. We also provide training and capacity building to government officials, NGOs and community-based organizations and we work together with a number of implementing partner organizations (IPOs) to eradicate the practice in our project areas. To gain the support of influential people – including political, religious and community leaders – we carry out policy and community level advocacy continuously. In collaboration with the Ethiopian Women Lawyers Association and the Ministry of Justice we have been conducting legal literacy training on the issue of early marriage. As a result of our work and that of our partners, more than 9,000 early marriages in Amhara and some 3,000 in Tigray were prevented in 2005. Communities in these project areas have widely accepted reasons to end early marriage through the educational efforts of health workers, women's associations, teachers and religious leaders. Finally, Pathfinder International has played an important role in influencing legislative bodies and other influential groups to enact and implement laws that protect women and girls from early marriage and other harmful traditional practices.[4]

It is the girls themselves who will ultimately change the custom and end the prevalence of early marriage in Ethiopia. It is our vision that girls ultimately refuse to get married at an early age, challenge their traditional role as mothers and family care givers, and aspire to be educated and improve their status in society as female professionals and women leaders in their communities.

More information about this study can be found in the* Report on Causes and Consequences of Early Marriage in Amhara Region. *Pathfinder International/Ethiopia, 2006: http://www.pathfind.org/publications

Bogalech Alemu
Gender Technical Advisor, Pathfinder International/Ethiopia

Correspondence:
Tel: +251 11 6613330
E-mail: balemu@pathfind.org, Web: http://www.pathfind.org/Ethiopia

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3. Birham Research and Development & Pathfinder International/Ethiopia, 2005. *Report on Knowledge, Attitudes, and Practices in Family Planning: Results of a September 2004 Survey in Amhara, Oromia, SNNPR and Tigray Regions of Ethiopia*, http://www.pathfind.org/publications
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Resources
on harmful traditional practices

How to end child marriage
Action strategies for prevention and protection
International Center for Research on Women, 2007 (6 p.)

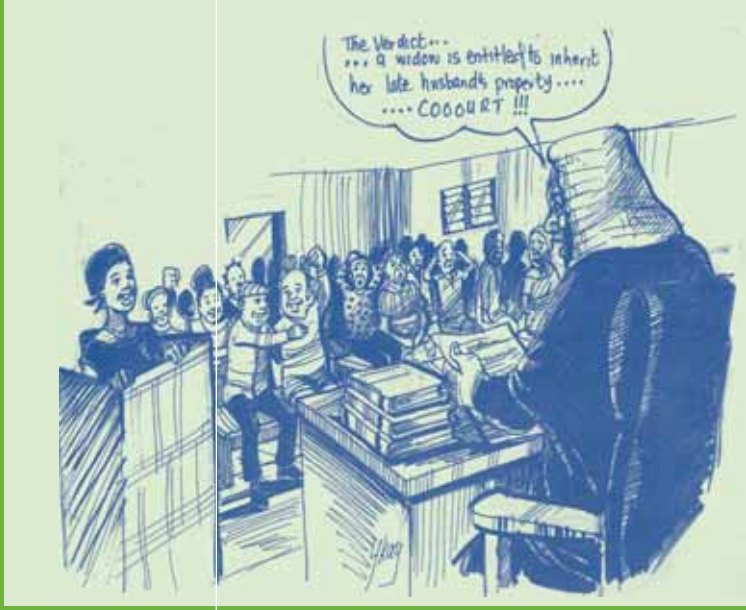
This policy brief outlines what we can and should be doing to end child marriage: changing harmful cultural norms, supporting community programmes, maximizing foreign assistance, increasing access to girls' education, providing young women with economic opportunities, addressing the unique needs of child brides and evaluating programmes to determine what works.

http://www.icrw.org/docs/2007-childmarriagepolicy.pdf

Passive victims or active agents?

Experiences of widow inheritance in Uganda

Stella Nyanzi & Margaret Walakira-Emodu



In patriarchal cultures where women and girls are perceived as commodities belonging to the male family line, widow inheritance is widely practiced. Evidence shows that widow inheritance is common in several countries in Africa and Asia – including Ghana, Kenya, Nigeria, South Africa, Tanzania, Uganda, Zambia, Zimbabwe, India and China.[1-2] Due to the diversity of cultures, there are several differences in the actual enactment of widow inheritance: the heir remarries the widow; an older brother to the deceased takes over the widow's sexual and reproductive rights; or the widow is handed over by the clan-elders to an unmarried member of the clan.

Widow inheritance is an ancient custom among the Baganda, who are the largest ethnic group in Uganda. In the absence of state provision of a welfare system of any sort, this cultural institution protected both the widowed and the orphaned. It facilitated a cultural system through which the male relatives of the deceased man took care of the grieving widow and supported orphans through payment of school-fees, medical bills, clothes, shelter, etc. Unlike other societies where widows were inherited because their deceased husband's lineage had contributed to the bride price, among the Baganda the practice was a ritual to appease the departed man and ensure that his descendants were assigned an over-seer. Furthermore, strong patrilineal kin ties were realized through symbolic group ownership over the reproductive rights of the wife: her children belonged to the husband's clan.

In 2006/7, we conducted a study among 35 widows and nine widowers from the Baganda tribe living in the environs of Kampala. The study aimed at exploring local experiences of widowhood in the era of HIV and AIDS, with a focus on how different widowed people negotiate their sexuality based on various social prescriptions. Data collection combined participant observation, in-depth interviews and focus group discussions.

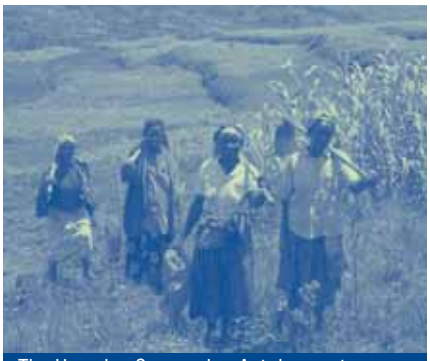
A few elderly widows in our study vehemently supported the practice, as one of them relates: *"I never suffered after my husband was killed in 1963. Two years after his burial, I was given to his younger brother. I accepted because I had no job, yet he is the one who had taken over the responsibility of our providence as we waited for the last funeral rites. I had three children with him and we were happy together."* Generally, it is believed that traditional families mostly insist on maintaining their ownership over young widows who are still in the reproductive age. A woman who was affected in this manner narrated her experience: *"My in-laws know that my husband's first wife died before him. They must have suspected that I also had HIV. But because I am fat, look good and have my business, they wanted me to stay married within their family. So Ibrahim, who is a paternal first-cousin to my husband, kept pestering me for sex. 'Our family still wants to get children from those eggs remaining in your body. We paid for you!', he said. He bothered me for a long time. It was only after I remarried that he left me in peace."*

Problems associated with widow inheritance

Due to its association with increased HIV infection rates, widow inheritance has been criticized by public health specialists locally and internationally. In cases where either the widow or the inheritor is infected with HIV, widow inheritance involving unprotected sexual intercourse could expose the virus to the uninfected person. As the sexual rituals connected to the widow inheritance ceremonies are often forced upon widows, this use of force not only increases their risk of HIV infection but also violates their sexual and reproductive rights, including their rights to self-determination about their sexuality, whether to remarry or not, to resume sexual activity or remain chaste, to choose their own sexual partner, etc. For some widows, retention of their marital property is conditional upon accepting the required terms of widow inheritance: *"I was*

As the sexual rituals connected to the widow inheritance ceremonies are often forced upon widows, this use of force not only increases their risk of HIV infection but also violates their sexual and reproductive rights

Photo: Bertus Wennink



The Ugandan Succession Act does not ensure equal inheritance rights for women; a woman's access to land and property rights is dependent on her marital status

shocked when my brothers-in-law who previously visited my home, turned against me. They said that if I did not accept to be remarried to Eddie – the one chosen to be my levirate-husband,[3] they would not allow me to return to our home. I was to go back to my family. The only way I could keep the home was to comply."

While some narrated how they had turned to the law to contest such unfair loss of property, several others revealed their deep sense of powerlessness in the face of extreme patriarchy. *"I was just a woman, what could I say or do?"* was a common theme running through many narratives of widows who did succumb to the pressure for sexual relations with their in-laws after the death of their husbands. These widows came across as passive victims of a male-dominated cultural system.

Many widows reported their ignorance of the sexual nature of the rituals: *"I was born here. I grew up here. I have attended many burials and last funeral rites ceremonies. However, I had never heard about what actually happens to the widow concerning the deceased's brothers. When my husband died, many people were telling me to have sex with the levirate-husband."* This particular woman could escape the sexual ritual that was part of her husband's last funeral rites because the levirate-husband proposed an alternative: *"It was him who told me that it would be better for me to sit on the floor, stretch my legs and let him jump over me three times. That is a modern way of doing sex. It is because of the fear of AIDS."*

Negotiating widow inheritance

As seen above, women inheritance rituals are not observed to the letter. There were many reports of both widows and levirate-husbands negotiating ways of compromising with some rites that posed the risk of HIV infection. The widows in our study resorted to a wide range of techniques to challenge or refuse the uninvited sexual advances from their in-laws. Some of these strategies included:

- Referring to taboos: *"I told him I was in my menstrual period! There was no way he was going to have sex with me when he believed that blood was still coming. So he left me alone during the last funeral rites ceremony."*
- Referring to religion: *"Everybody in that clan knows that I am a Born-Again Christian. I have previously refused to join them in their cultural rituals because I tell them they are satanic and sinful. Even for the funeral rituals, I told them to exclude me from them. They did so out of respect for my faith."*

There were many reports of both widows and levirate-husbands negotiating ways of compromising with some rites that posed the risk of HIV infection

- Proposing alternatives: *"…So when the clan elders asked me about the choice of a levirate-guardian, I proposed my sister-in-law instead of a man. They accepted. I never faced that problem of male in-laws demanding sex."*
- Threatening to apply the law: *"I told him that I would report him to the courts if he ever touched me again. I have a friend whose sister is a lawyer. I asked her to telephone and threaten him with imprisonment."*
- Using fear: *"It was too much for me. He was pestering me for sex, sex, sex. But I kept telling him that I have HIV."*

As illustrated in the last quote, many widows used the metaphor of HIV to negotiate against the sexual advances of their in-laws. This was with the hope that the widespread fear of AIDS would discourage interested individuals. For some participants this strategy worked. For others, their pursuers countered their argument either with the availability of protection in the form of condoms, or the increasingly accessible antiretroviral therapies.

Not all widows can negotiate their way out of sexual advances by those wishing to inherit them. This is particularly due to poverty, unemployment and other factors as the following woman reveals:

"I was widowed when I was only 18. My husband left me with a three-month-old son and two-year-old daughter. The house he was building was incomplete. And he left no will. So after the burial, his family and clan members had a meeting. They chose Kato as the *Omukuza* [inheritor]. He is very rich with much land, businesses and children. When I was told, I was happy because he had three wives and many children. He began well by visiting and giving me some money to look after the children and myself. Afterwards he started asking for sex. He would even touch me when the children were watching. I refused for a while. He then stopped his financial support. He started threatening me. He even mentioned throwing me out of the house my husband built. I needed money to take my son to hospital. I looked for ways of earning, but all failed. I tried to borrow money, but I failed. So when he came, I gave in to his demands for sex. My third child belongs to Kato. He helps us a lot because he has a child here. He bought me this sewing machine, which I use for business. He pays school-fees for all the children. He even completed the house for us."

Empowerment through association

All the groups of widows and widowers we met confirmed they were not aware of any projects, interventions or policies specifically targeting the widowed in Uganda. *"The orphans have many people interested in them, but the widowed are largely neglected,"* they said. Therefore they warmly welcomed and enthusiastically appreciated our efforts to collect them into groups, as well as provide them with a

space where they ably discussed their issues at length. Although our discussions with them were solely for research purposes, each of the groups we interviewed decided to start an association. These associations created visibility for the widowed. They provide a platform through which widows can appeal for assistance, advice and interventions from interested parties; fight the stigma attached to widowhood particularly in association with HIV and AIDS; share experiences and encourage each other; seek and receive advice regarding specific personal challenges; and exchange relevant knowledge about the law, health, micro-credit schemes and projects targeting orphans. Since the formation of these associations, the widows can strategize and discuss potential solutions to their individual and group problems.

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Stella Nyanzi
Health Policy Unit, London School of Hygiene and Tropical Medicine

Margaret Walakira-Emodu
Community Based Health Care Programme, Mengo Hospital

Correspondence:
Stella Nyanzi
Health Policy Unit, London School of Hygiene and Tropical Medicine
Keppel St., London WC1E 7HT
United Kingdom
E-mail: snyanzi@yahoo.com

Margaret Walakira-Emodu
Mengo Hospital
PO Box 7161, Kampala, Uganda

1. M. Owen, *A world of widows*. Zed Books, 1996
2. B. Potash, *Widows in African societies*. Stanford Press, 1986
3. A marriage between a widow and one of her deceased husband's brothers is called a levirate marriage.

Resources

on harmful traditional practices

No more excuses!
Ending all Harmful Traditional Practices against Girls and Young Women
L. Stormorken, K. Vincent, A.-K. Vervik & R. Santisteban, Plan Norway and Plan Finland, 2007 (40 p.)

http://www.plan.fi/uploads/media/No_more_excuses.pdf

Questioning the role of culture and traditional practices in HIV transmission
B. Bruun, Aidsnet – The Danish NGO Network on AIDS and Development, 2006 (33 p.)

The present working paper was developed as a follow-up to a workshop in December 2004. The workshop was based on the experiences of ADRA Malawi, the Adventist Development and Relief Agency in Malawi. Following the meeting, Aidsnet's Working Group on Children and Young People decided to explore further how NGOs can work with practices that are considered to be important elements of local culture, but which are also likely to carry the risk of transmitting HIV.

http://www.comminit.com/en/node/222256/347

FGM. Reaching the tipping point against female genital mutilation
L. Shaaban & S. Harbison (Bureau for Global Health, USAID)
The Lancet, 2005 (366): p. 347-349

This article in *The Lancet* identifies successful and unsuccessful approaches to address female genital mutilation. It concludes that the way to overcome female genital mutilation is through multiple strategic approaches with various different messages, which collectively tip the weight of public opinion.

http://www.popcouncil.org/pdfs/frontiers/journals/lancet_fgc2005.pdf

Abandoning Female Genital Mutilation/Cutting
An in-depth look at promising Practices
C. Feldman-Jacobs & S. Ryniak, Population Reference Bureau (PRB), 2006 (74 p.)

In this publication, the authors present an in-depth look at three promising interventions identified through collaboration by five organizations: the Population Reference Bureau, Family Health International, PATH, Population Council, and The Manoff Group. The objective is to meet the primary information needs identified by hundreds of organizations and individuals working toward the abandonment of FGM: information on case studies that illustrate what is working and why.

https://www.popcouncil.org/pdfs/frontiers/reports/PRBFGMReport.pdf

Defending the sexual and reproductive health rights of women affected by HIV in Argentina

Mabel Bianco & Maria Ines Ré

Awareness activity developed in a poor neighbourhood of Buenos Aires as part of the "16 days campaign" (of activism against gender violence) developed by positive women and others about the right to live free of violence

Feminization and pauperization together with an increased concentration of AIDS cases in urban environments are the main characteristics of the HIV and AIDS epidemics in Argentina. Increased infection of HIV among poor young child-bearing women generates an increase in the demand for public health care and services. Although the country has had a legal framework guaranteeing reproductive health care for all women since 2002, a lack of collaboration between reproductive health services and HIV/AIDS programmes has denied women living with HIV (WLWH) access to adequate health care, particularly for their sexual and reproductive health (SRH) needs. Additionally, WLWH's access to information on reproductive health, family planning services, control of cervical cancer, STIs and other gynecological problems is limited.

A qualitative research by FEIM (Foundation for Studies and Research on Women) conducted in 2005 and 2006 examined the availability of reproductive health and HIV/AIDS services in Argentina and highlighted in what way women living with HIV have been affected by the lack of coordination between both types of services.[1] Our team reviewed national legislation and international documents such as the Millennium Development Goals (UN 1999), 'Women and HIV: Barcelona Bill of Rights' (Barcelona 2002), and the 'International Guidelines on HIV/AIDS and Human Rights' drafted by UNAIDS and OHCHR (Office of the United Nations High Commissioner for Human Rights). Further, 46 interviews were undertaken with key informants including representatives of NGOs and networks working on HIV/AIDS, youth, women, or people living with HIV (PLWH); governmental programmes and public health services. Respondents came from different cities with high HIV and AIDS prevalence.

A difference was observed between the discourse of government officials and the reality of the care being provided. In practice, reproductive health services were not incorporating specific HIV/AIDS care. Women living with HIV were discriminated against at service points and were forced to conceal their condition in order to be served. Within HIV/AIDS services, there are sometimes professionals who attend to WLWH when they get pregnant, joining aspects of HIV/AIDS care with reproductive health, but this is on a limited scale. Some NGOs and PLWH organizations identify those 'friendly doctors' and refer women only to them because they incorporate HIV/AIDS care in their services. In the majority of cases, the demand for gynecological services is not adequately met, and for this reason many WLWH avoid consultations regarding their sexual and reproductive health.

> In Argentina, sexual and reproductive rights are not respected and defended by the majority of women and women's organizations

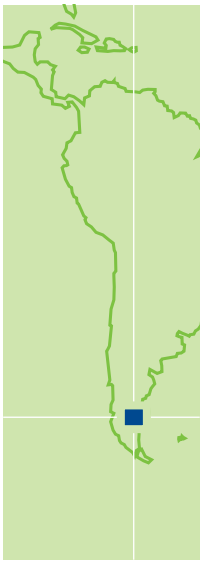
Political correctness

Our research also examined information on the recognition and respect of the sexual and reproductive rights of WLWH. We found that these rights were part of the discourse by HIV/AIDS programme officials with 'politically correct' language, but in general this did not correlate with the reality of services offered daily. These rights, as with human rights in general, are recognized 'in theory' by the health system but in the majority of cases not incorporated into practice.

During the interviews, prejudices among doctors came to the fore. For example, the idea that it is unadvisable for WLWH to have sexual intercourse and if they do, it is unacceptable that they become pregnant. These prejudices lead to advising, even promoting and facilitating women's sterilization, a practice that was illegal in Argentina until mid-2006 when the law was amended.

Additional problems identified are related to other omissions in reproductive health care, such as the absence of clear rules about prevention and early diagnosis of cervical cancer and the lack of protocol for rape and sexual violence victims that include pregnancy prevention with emergency contraception and HIV prophylaxis (PEP). In March 2007, the national government started distributing emergency contraceptive pills ('morning-after pills') to all public health services, but the idea is resisted by a good number of health personnel. A related problem is that abortion is illegal in Argentina, so it is a factor that puts at risk the life and health of all women, more so women living with HIV.

In general, there is a lack of participation of PLWH in the design of programmes. There are a few organized WLWH groups and the few existent do not address sexual and reproductive health. On the other hand, the participation of PLWH in public health services is poor, yet both PLWH and health facilities appreciate its importance.



Building connections

In Argentina, sexual and reproductive rights are not respected and defended by the majority of women and women's organizations. Our study observed that, with a few rare exceptions, PLWH organizations, women and other NGOs addressing HIV/AIDS do not include the defense of these rights and access to SRH in their agendas. Familiarity with international documents on sexual and reproductive rights by the interviewees was very limited. Similarly, women's organizations and groups that defend SRH are not aggressive in ensuring that WLWH enjoy these rights. This is why FEIM advocates for a strategic alliance between women's health rights organizations and associations of WLWH that incorporates this demand into both groups' advocacy agenda and forge a collaborative front.

Since its inception, FEIM has worked on SRH and HIV/AIDS, raising awareness among women's groups addressing reproductive health and rights about the need to incorporate HIV/AIDS into their agendas. Since 2005, we have organized workshops, dialogues and meetings to bring together WLWH and women's groups working on SRH and rights to share their ideas and to monitor how the government implements SRH laws including HIV prevention, treatment and care. In 2006/7 we organized international and regional dialogues among SRH and HIV/AIDS networks in Africa, Asia, Latin America and the Caribbean to jointly advocate for the incorporation of sexual and reproductive health care for WLWH in their programmes. Recently, we met with 12 Argentinean women's NGOs including those representing WLWH, sex workers and transgender/transvestites. Together, we examined the progress made by the government towards fulfillment of its obligations regarding the UNGASS Declaration of Commitment goals related to SRH.[2]

> Sexual and reproductive rights are part of the discourse by HIV/AIDS programme officials with 'politically correct' language, but in general this does not correlate with the reality of services offered daily

We create spaces to bring together these groups because it is essential to improve the quality of care and treatment for WLWH and to ensure the respect of those rights for all women. Currently, both movements – of groups of WLWH and of women's groups working on SRH – are advocating together for sexual and reproductive health and rights in Argentina.

This research by FEIM was part of a multi-national study in several countries in Latin America, Eastern Europe and Africa coordinated by Ipas (USA). More information:* "There's nothing you could do if your rights were being violated." Monitoring Millennium Development Goals in relation to HIV-positive women's rights. *M. de Bruyn, Ipas, 2006: http://www.ipas.org/Publications/asset_upload_file211_2896.pdf.

Mabel Bianco & Maria Ines Ré
President & Associate Researcher, Foundation for Studies and Research on Women (FEIM – Fundación para Estudio e Investigación para la Mujer)

Correspondence:
Paraná 135, fl.3º dpt.13
Buenos Aires, Argentina (1017)
Tel/Fax: +54 11 4372 2763
E-mail: feim@ciudad.com.ar, Web: http://www.feim.org.ar

1. The report of this research, in Spanish only, can be downloaded from the FEIM website: http://www.feim.org.ar/Informe_Ipas_05.pdf
2. More information: http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS

Addressing the sexual and reproductive health needs of young people in the informal sector in Mali

Fatimata Kane & Boubacar Soumano

From December 2005 to November 2007 Family Care International (FCI) and the Association of Child and Young Workers of Mali implemented a project that employed the life skills approach to promote sexual and reproductive health and prevent HIV infection among young people in the informal sector in the capital city of Bamako. The project was financed by the Bristol Myers Squibb Foundation. The project targeted females and males aged 14 to 25 years who were among others apprentices, hand carters, domestic workers, laundry-girls or mobile vendors. Most of them did not complete primary education or never went to school.

Several studies in Mali show that young people in the informal sector live in an unstable environment characterized by transactional sex: they are often forced to exchange sex for money due to poverty. Further, girls are often subjected to sexual harassment and rape. These studies also indicate that young people's sexual debut comes at a young age, and that their sexual relations are frequent, without protection and with multiple partners.[1] Their knowledge levels on the basic aspects of sexual and reproductive health (SRH) including the transmission of and protection against STIs and HIV is very low. They also have low levels of uptake regarding HIV testing and utilising health facilities.

Lessons learned

- The SRH information and services needs of young people in the informal sector can be addressed by involving them both as actors (peer educators, trainers) and beneficiaries.
- The engagement of young workers' bosses and other adults (foremen, employers of the domestic workers, landlords/landladies of the migrant girls, religious leaders, etc.) is of key importance.
- The life skills approach is appreciated by the youths because it does not only allow them to learn from the SRH information but also to discuss and practice it.

In 2002-2003, FCI implemented a regional advocacy project aimed at building the capacities of organizations working for and/or representing young people. In Mali, it worked with the Association of Child and Young Workers of Mali (AEJT), which aims to promote the Rights of the Child among young workers through advocacy and sensitization activities. The AEJT has some 5000 members, mostly young people from the Bamako district. In the framework of this project, the AEJT advocated with community leaders for the adaptation of SRH information and services to young workers' needs and specific situations. The key lesson learned from this experience is that to be effective, this work must involve young people themselves as actors and beneficiaries. An effective strategy is to build their capacities to advocate for their own cause and empower them to offer services to their peers.

Building capacities of young people

At the conclusion of this project, the AEJT intended to continue working with FCI on the promotion of SRH and the prevention of STIs and HIV. To achieve this goal, FCI and the AEJT conceptualized a pilot project in 2005. This project, implemented in three communities in Bamako, had two principal elements, namely: 1) to provide knowledge, skills and materials (notably condoms) for the prevention of STIs and HIV among young people through peer educators (we call them educator-leaders) and 2) to establish a bridge between HIV prevention and HIV and AIDS care by creating a framework for cooperation between the AEJT and health facilities, to build capacities of young people to utilise these services, and to reduce any existing barriers.

The principal strategy was to use the life skills approach to build the capacities of young workers to be able to sensitize and counsel their peers on SRH and HIV issues. Life skills are a wide choice of aptitudes and capacities that allow someone to use his or her knowledge to address given situations in an appropriate manner. These skills, notably in communication, decision-making or negotiation, direct the development of one's self-respect, self-esteem, self-reliance and self-confidence to face peer pressure;

discuss issues related to sexuality with parents and other adults; negotiate abstinence or safer sex; and seek sexual and reproductive health services in a timely manner.

A committee was set up composed of the AEJT, FCI, the National High Council Against AIDS and some key leaders in the fight against AIDS and the promotion of SRH among young people, to guide and provide technical and political support to the pilot project.

Some achievements

From the beginning of the pilot project in December 2005 to November 2007:

- One hundred young AEJT members (56 girls and 44 boys) were trained by a pool of 12 young AEJT trainers and equipped to start SRH promotion and HIV/STI prevention activities among their peers. Some 20,500 young people were reached by these educator-leaders and 272 received pre-test counselling. A total of 13,352 condoms were sold to 1941 clients.
- Some 50 members were trained to start income-generating activities for the association, such as making soap, dyeing and lending (portable) stereo systems.
- The AEJT received institutional support for training and follow-up with regards to administrative management and accounting.

A major achievement of the advocacy process was the devotion and mobilization of employers, other adults responsible for the young workers and religious leaders for the prevention of HIV/STIs among youth. The employers were sensitized through successive exchange meetings on the factors of vulnerability to HIV and STIs. At one advocacy event, young people used theatre to transmit messages on health problems in general and vulnerability to HIV and STIs in particular. For religious leaders, a one-day advocacy meeting was organized at which a presentation was made using Quranic verses, which greatly facilitated their mobilization for the promotion of the health of young people in the informal sector.

Lessons learned

We have not formally evaluated the project yet, but through focus group discussions with young people and various meetings held with their guardians and employers, we have learned some important lessons, which include:

- It is possible to address the SRH information and services needs of young people in the informal sector. To work with young people as both actors (peer educators, trainers) and beneficiaries is a key factor in the success of the project.
- The fact that the association already undertook awareness activities among their members on issues of workers' rights facilitated the establishment of activities on sexual and reproductive health. At the request of the AEJT, FCI has built the capacities and skills of the educator-leaders on SRH and STI/HIV. In turn, they have sensitized their comrades at the workplace.
- The engagement of young workers' bosses and other adults (foremen, employers of the domestic workers, landlords/landladies of the migrant girls, etc.) is of key importance. Advocacy with these groups is critical in facilitating young workers to attend the information sessions. Providing information about SRH and HIV to the persons in charge also allows them to support the young people.
- The life skills approach is appreciated by the youths because it does not only allow them to learn from the SRH information but also to discuss and practice it. The following are some of the testimonies given by young people during workshops: "*After your facilitation on voluntary and anonymous testing, I promised to change my behaviour but before that I will take my test because I have been at risk of HIV infection,"* (mechanics apprentice). "*In our workplaces, we did not believe HIV exists. From the exchange of ideas during the educational chats with the educator-leaders, we are now convinced that HIV is a reality and we are all concerned now,*" (laundry girl).
- Building the institutional capacity of the AEJT and initiating activities that generate income, are important components of the project.

Photo: Veronique Elam

The pilot project ended in November 2007. Nevertheless, there were a lot of requests for its continuation in the three communities and to expand it to other parts of Bamako and other regions of the country. Fortunately, we have, so far, secured funding for another year to enable the project to continue, starting February 2008. The fact that there is a committee comprising influential actors in the struggle against AIDS and the promotion of sexual and reproductive health has resulted in a strong support for the project that, we hope, will be translated in its further continuation.

Fatimata Kane & Boubacar Soumano
Coordinator Family Care International Mali & President AEJT, Bamako

Correspondence:
BPE 1080, Street 124
Pt 64 Korofina-Nord, Bamako, Mali
E-mail : fkane@fcimail.org, Web: http://www.familycareintl.org

1. Integrated STI Prevalence (ISBS) and Behaviour Survey. Programme National de Lutte contre le SIDA, CDC, USAID, 2003

Erotic sculpture at a temple at Khajuraho archaeological site, Madhya Pradesh State, India

Between tradition and modernity: Controversy in India about the sex education programme in state-run schools

Renuka Motihar

India is a society in transition. On the one hand, we have a thriving economy and modernization and on the other, an uneasy debate raging on sex education for young people – "Should a 15 year old Indian student be permitted to look at anatomical drawings that illustrate how an adolescent's body develops into an adult form?" In 2007, a number of state governments passed orders banning an adolescent education programme designed for 15-17 years in all state-run schools. It was devised by the National Education Ministry and the government body responsible for combating the spread of HIV/AIDS – the National AIDS Control Organisation (NACO). The immediate provocation was a manual for teachers that allegedly featured offensive illustrations and classroom exercises. Information in the curriculum on contraception and sexually transmitted diseases also provoked anger. One by one, the states of Gujarat, Madhya Pradesh, Maharashtra, Karnataka, Rajasthan, Kerala, Chhattisgarh and Goa – some of the largest Indian states – declared that the course content was unacceptable and banned the programme. Unfortunately, the subject became a political flashpoint.

The debate has been between educators who say sex education will reduce HIV rates and help young people protect themselves and critics who fear it will corrupt young minds and ruin Indian culture.[1] The critics feel that *"Sex education may be necessary in western countries, but not in India, which has a rich culture. It will have adverse effects on young minds."* According to them, sex education is only for married people. On the other hand, the proponents of sex education say that conservative ideas have little place in a modernizing country where attitudes towards sex are changing rapidly. They point to surveys showing that for a generation of Indians exposed to television and the internet, casual sex or sex outside marriage is no longer taboo.

What are the facts? – According to the Population Council in India, there are 315 million young people aged 10-24 years in India, representing 30% of the country's population. This cohort is healthier, more urbanized and better educated than earlier

> *"Sex education may be necessary in western countries, but not in India"*

generations. At the same time, these young people face significant risks related to sexual and reproductive health, and many lack the knowledge and power they need to make informed sexual and reproductive health choices. They are growing up in a fast-changing world with rapid changes in attitudes and expectations. A popular magazine (*India Today*) poll revealed that one in four Indian women between 18 and 30 in eleven cities had sex before marriage. A youth survey in Maharashtra conducted by the International Institute of Population Sciences (IIPS) and Population Council in 2006-2007 among unmarried women and men (15-24 years) and married women and men (15-29 years) found that there is a huge lack of awareness about sexuality among women and that information on sex is still considered taboo.[2] The findings show that 18% of men and 3% of women have had pre-marital sex. Men have comparatively more access to information, though not always the right source, while women still do not feel free to discuss issues openly. Only 33% of unmarried women knew that they could get pregnant from their first sexual encounter as compared to 46% of men. According to NACO's research, one-third of reported HIV infections across India are in the 15-29 age group and 50% of all new infections are in this category. As Sujata Rao, Director of NACO has said, *"We are worried about our young people"*.[1]

NGO responses

Except for the banned sex education programme developed for use in state-run schools, there have been several NGO-led interventions in India to address the neglected needs of young people. Highlights of three different kinds of innovative programmes are described below. TARSHI,

Photo: WHO Photolibrary

Sex education class in an Indian school

Talking about Reproductive and Sexual Health Issues is an NGO based in Delhi working on sexuality issues. It has been running a telephone helpline on sexuality since 1996, and has responded to more than 59,000 calls. Most callers say they want to know about basic facts like sexual anatomy and physiology, underlining the need for the introduction of comprehensive sexuality education in the school curriculum. TARSHI also runs a resource centre on sexuality and a training programme entitled 'Sexuality Rights Institute'.

Other organizations have been implementing more comprehensive programmes for young people that go beyond just sexuality. The Centre for Development and Population Activities (CEDPA) has been implementing a programme for adolescent girls and boys for many years. The programme, using the Better Life Options and Opportunities Model (BLOOM), focuses on holistic development of the young person that includes all facets of life – friends, work, relationships, family, gender relations, physiology, marriage, parenthood, nutrition, health, hygiene, etc. Implemented with in-school and out-of-school youth in India, the initiative has helped empower thousands of young people and prepared them to make better life choices.

The Association for Promoting Social Action (APSA), a child and youth-centred organization based in the southern city of Bangalore, Karnataka, ran a mobile phone sex education campaign in mid-2007. The campaign used four statements which were sent out by SMS to 5000 people, creating a cascading effect. The statements were:

- *Sex education is a must!* Silence and taboo help to spread AIDS!
- Do you want (your) children to be free from sexual abuse? *Sex education is a must!*

> More than 60% of men say that both boys and girls should be taught about sex and sexual behaviour in school, but less than half of women agree

- A child giving birth to a child (teenage pregnancy): Better not? – *Sex education is a must!*
- You want (your) children to be Happy, Healthy and Responsible? *Sex education is a must!*

The response was positive and helped raise awareness and engage people in a debate and discussion.[3]

What do adults think?

Several national surveys are shedding light on what adults think about sex education for young people. According to the findings of the 2005-2006 National Family Health Survey, most adults agree that children should be taught moral values in school, and think that children should learn about changes in their bodies during puberty.[4] Men and women differ somewhat on whether children and youth should be taught in school about contraception. About half of women and two-thirds of men think girls should learn about contraception in school. Both women and men are slightly less likely to say that contraception should be part of boys' school education. Most men and women believe that information on HIV and AIDS should also be part of the school curriculum: about 80% of men think boys and girls should learn about HIV and AIDS, compared with 63% of women. More than 60% of men say that both boys and girls should be taught about sex and sexual behaviour in school, but slightly less than half of women felt that this was an appropriate topic to be taught to girls and boys in school.

To combat the mounting criticism, the Government of India set up a review committee that reviewed the programme and assessed the situation. Committee members travelled to states to visit schools and talk to teachers, young people, parents and NGOs. Another committee reviewed the training materials – the manuals – assessing their content and cultural sensitivity. As of now, a new toolkit is being developed. The findings from these committees will determine the future of this programme in India.

Renuka Motihar
Independent consultant based in New Delhi, India

Correspondence:
E-mail: renuka.motihar@gmail.com

1. *"Get real" and save Indian youth from AIDS: official.* Reuters, May 17, 2007, http://www.reuters.com/article/healthNews/idUSDEL6968520070517
2. *Project Youth in India: Situation and Needs Study*, http://www.popcouncil.org/projects/TA_IndiaYouthSituationNeeds.html
3. More information about these organizations: http://www.tarshi.net, http://www.cedpa.org and http://www.apsaindia.org
4. National Family Health Survey, http://www.nfhsindia.org

Online resources

➔ Manuals & Guidelines

Toolkit for mainstreaming HIV and AIDS in the education sector: Guidelines for development cooperation agencies. UNAIDS Inter-Agency Task Team (IATT) on Education, 2008 (75 p.)
PDF: http://unesdoc.unesco.org/images/0015/001566/156673E.pdf

The *Toolkit for mainstreaming HIV and AIDS in the education sector* aims to help education staff from development cooperation agencies, including both development and humanitarian-oriented multilateral and bilateral agencies as well as NGOs and other civil society organizations, to support the process of mainstreaming HIV and AIDS into education sector planning and implementation. It provides resources and support to assess the progress countries have made with respect to HIV and AIDS mainstreaming; to identify entry points and opportunities; and to establish priorities for advocacy and action.

Network capacity analysis: A toolkit for assessing and building capacities for high quality responses to HIV and AIDS – Workshop facilitation guide and Rapid assessment guide. International HIV/AIDS Alliance, 2008 (53 & 26 p.)
PDF: http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=279

The aim of this toolkit is to build the skills required by civil society networks to develop and strengthen their capacity. They can be used by networks to help identify their capacity-building needs, plan technical support interventions, and monitor and evaluate the impact of capacity building. The toolkit consists of a *Workshop Facilitation Guide* and a *Rapid Assessment Guide*. Both resources provide a structured approach to generating both quantitative and qualitative information about the situation of an organization at the time of analysis. The resulting outcomes can also be used to track progress when developing capacity.

Out of the Margin: Harm Reduction and HIV Prevention. Dutch Ministry of Foreign Affairs, 2007 (48 p.)
PDF: http://www.minbuza.nl/binaries/en-pdf/out-of-the-margin---harm-reductioin-and-hiv-preven.pdf

This booklet sets out the components of effective harm-reduction programmes as evidenced by the experience gained in many countries around the world and demonstrated by scientific research. They can be summarized as a comprehensive and coherent package of interventions and services, promoted through outreach and peer education and delivered in the framework of a rights-based approach.

➔ Factsheets & Issues briefs

Young people's sexual and reproductive health in the Middle East and North Africa. J. DeJong; B. Shepard & F. Roudi-Fahimi, Population Reference Bureau, 2007 (8 p.)
PDF: http://www.prb.org/pdf07/MENAYouthReproductiveHealth.pdf

This policy brief highlights research results from the Middle East and North Africa region concerning young people's sexual and reproductive health (SRH). The brief discusses barriers to SRH information and services including cultural taboos and young women's lack of mobility and decision-making power, and draws attention to opportunities to provide young people with correct information about SRH in schools. The brief concludes that while some countries have taken pioneering steps in reaching out to young people to address their needs, the region as a whole lacks the political commitment and institutional capacity to do so.

What's culture got to do with HIV and AIDS? Developing creative cultural approaches to HIV prevention work. Healthlink Worldwide, 2007 (8 p.)
PDF: http://www.healthlink.org.uk/PDFs/findings7_hiv_culture.pdf

What's culture got to do with HIV and AIDS? argues that developing more effective cultural approaches to HIV prevention should be a priority. The paper draws on the preliminary findings of a study co-sponsored by UNESCO to examine the role of culture in HIV work.

➔ Research reports & Reviews

Addressing violence against women and HIV testing and counselling: A meeting report. World Health Organization, 2007 (60 p.)
PDF: http://www.who.int/gender/documents/newpublications/en/index.html

This meeting report is an outcome of a consultation held in 2006 on how HIV testing and counselling programmes can take into account and address intimate partner violence and other concerns related to women. The report describes how fear of violence and/or violence itself affects the uptake of HIV testing and counselling programmes and disclosure of HIV status. It highlights programmes that have addressed violence against women in HIV testing and counselling including through training of counsellors, couple counselling, and addressing HIV/AIDS in services for women experiencing intimate partner violence.

Making the connections: why literacy matters for HIV prevention. UNESCO Institute for Lifelong Learning, 2007 (18 p.)
PDF: http://unesdoc.unesco.org/images/0015/001541/154159e.pdf

Making the connections looks at the relationship between literacy and HIV prevention education. The authors identify the wide range of non-formal education efforts to address not only HIV prevention but also HIV treatment and care. Non-formal education initiatives are often not recognized and therefore remain marginalized despite their valuable contributions. The document aims to demonstrate how literacy (one of the key areas of non-formal education) is making a difference in HIV prevention through innovative approaches, where community participation and involvement of people living with HIV are the main underlying programme principles.

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Royal Tropical Institute
Information & Library Services
PO Box 95001
1090 HA Amsterdam
The Netherlands
e-mail: exchange@kit.nl
web: http://www.exchange-magazine.info

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