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Sexual and Reproductive Health, Sexual Education and Development

– A Study of MAMTA's work on sexual education in India

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Abstract

Title: Sexual and Reproductive Health, Sexual Education, and Development– *A Study of MAMTA's work on sexual education in India*
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Purpose and aim: The purpose is to examine the work of the NGO MAMTA. We want to study how they work with aspects regarding sexual health and sexual education. We want to know if they are involved in the education in schools or if they work with the young people who are not in school, and what benefits or consequences the alternatives have. We want to examine if gender is a focus in how they work or in their choice of work field.

- What is the purpose of MAMTA's work?
- How do they operate?
- Does MAMTA have any cooperation with schools?
- Is MAMTA working differently with boys and girls respectively?

Material and Method:
Material used for this thesis include MAMTA's homepage, interviews with two MAMTA employees, Sweden's Policy on Sexual and Reproductive Health and Rights, and various United Nations reports and policies.
The method used was interviews of conversational type to gain information about the work of MAMTA.

Results:
MAMTA's work on a curriculum for sexual education for schools combined with Youth Information Centres for non-school going children make them reach as many children and adolescents as possible. With the Youth Information Centres they reach girls to a further extent, and educate girls on their rights, gender equality and sexual health.
The work MAMTA performs on sexual education is an important step for India to reach the United Nations' Millennium Development Goals. MAMTA's focus on health information to marginalised individuals and communities is vital for the realisation of these goals, as is their focus on adolescents. We feel however that education on sexual health is needed at all stages in life and that even though the health perspective is important, a perspective of intimacy and lust is equally important.

Preface

We went to India to examine sexual and reproductive education, as it is being done by the non-governmental organisation MAMTA Health Institute for Mother and Child. We read in an article by RFSU (Riksförbundet för sexalupplysning, the Swedish Association for Sexuality Education) that sexual education in India was prohibited in many states, and since this is an issue that we feel passionately about, we wanted to see what is being done to implement this education. Through the Swedish Embassy in India, we came in contact with MAMTA. By e-mail correspondence we explained that we wanted to interview MAMTA staff for our thesis on sexual education in India, and they agreed to meet with us.

During the spring of 2008, we were involved in a training program to become peer educators in Gothenburg, and we visited high schools to talk about friendship, love and sexuality. The project was organised by RFSU and was very appreciated among students and teachers. This experience awoke our interest in sexual education and we understood the complexity of talking about sexuality with adolescents, especially in a multicultural classroom, where the students' individual knowledge and attitudes varied enormously. We feel that sexual education is vital for adolescents to form identities and build self esteem, and for the battle against traditional gender roles.

To have the possibility to go to India, we applied for Sida's (the Swedish International Development Cooperation Agency) MFS (Minor Field Studies) scholarship. In the application we had to give a detailed plan of our project, with background, purpose and method. We therefore began working on the project in May 2008, and before we went to India we elaborated these parts concerning background, purpose and method further. We left on November 2nd 2008 and after a week of research about MAMTA, we held our interviews at the MAMTA office in Delhi. Then followed the transcription of the interviews, the organising of the results and the analysis. Since we went away together we have worked closely together, side by side, each step of the way. With the interviews being in English, and most of the other sources as well, we decided to write in English, so that no information would be lost in translation.

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1. Introduction

Sexuality can in many cases be a very sensitive subject. To gain knowledge about sexuality, sexual education is vital. In Sweden, Lpo 94 (Curriculum for the Compulsory School System 1994) gives the ultimate responsibility of sexual education to the headmaster as a topic to be integrated into different subjects, along with information about tobacco, alcohol and other drugs, environmental issues and traffic information (Lpo 94). Presently, the Biology teachers are responsible for the main part of sexual education in Swedish schools. While the curriculum for Biology includes sexuality, it only briefly mentioned: questions of love, sexuality and inter-personal relationships are considered from a perspective of taking responsibility both for themselves and others (Skolverket). The goal for students to attain by the end of the ninth year in school is to have knowledge of the biology of sexual life, sexually transmitted diseases and contraception, and they should be able to discuss sexuality and inter-personal relationships while showing respect for different forms of relationships and for the views of others. It is mentioned in the curricula for Social Science and Religion as well, but even more briefly. The curriculum for Social Science states that questions of personal relations, sexuality and gender shall be discussed, and the curriculum for Religion mentions that the subject should give light to personal relations and gender equality from a philosophy of life perspective (Skolverket). We think that sexuality is such an important matter that it should not primarily be covered in the curriculum of Biology, but given more time and focus in the curricula for Social Science, Religion and also Swedish for a broader perspective, and be present in the everyday discussion and dealings with adolescents in general.

The multicultural school in Sweden today with students from various ethnic belongings place higher demands on the teachers. Since sexuality can be a sensitive subject and attitudes vary from culture to culture, we have to be prepared to deal with the subject at all levels in order to meet each student's individual needs. By examining the sexual education performed by the Indian NGO (Non Governmental Organisation) MAMTA, we hope to reach a deeper understanding of what those different needs may be.

The Swedish government has made a strong commitment to addressing the issues of sexuality in Swedish development cooperation, and the Sexual and Reproductive Health and Rights Policy from 2006 is by some considered to be the most progressive policy of any government on some of the issues of sexuality. The goal "Better health and quality of life for women and men, boys and girls in developing countries" in the policy for global development from 2007 includes strong emphasis on improving knowledge and services related to sexuality, strengthening women's and girls' bodily rights and on supporting the role and responsibility of men and boys in promoting gender equality (Runeberg 2008:12). The Swedish government is committed to addressing the same issues that MAMTA addresses, and both Sida and RFSU are working closely with MAMTA. The Swedish government decides the budget, countries and focus for the Swedish development cooperation, and it is the role of Sida to implement the strategies the Government has adopted, as well as functioning as an advisor to the Government with respect to various national and international forums such as the United Nations (Sida 2008).

2. Background

People around the world lack the right to make decisions about their own bodies and sexuality. The consequences, in poor countries especially, are severe – thousands die every day from not receiving proper medical care, contraceptives and information and from lacking the power to change their situation. This has a negative effect on the countries' development. Sexuality, pregnancy and child birth are strongly connected with issues of poverty, health care, education, power and gender equality. In order to discuss sexuality one has to discuss gender. Girls and women are at a higher risk of infections, socially, culturally and biologically. Women should have control over their own bodies and the power to decide when, if, how and with whom to have sex, and the right to demand the use of condoms. They need to obtain the right information of how to protect and care for themselves. It is necessary that they receive an education concerning sexual health, without which sexually transmitted diseases and unwanted pregnancies will never be prevented. It is also necessary to include men in sexual education, as they in many cases control women's sexuality and thereby their ability to protect themselves. Boys and young men need to be educated about masculinity and gender roles to better understand the women's situation (RFSU 2006:1-2).

In 2000, the United Nations agreed on eight common development goals, called the United Nations Millennium Development Goals. The eight goals to be attained by the year 2015 are to end hunger and poverty, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, environmental sustainability, and global partnership through increased bilateral funding, fair trade and easing the debt burdens for the developing countries (United Nations/milleniumgoals).

The Millennium Development Goals aim to improve global development, and include decreasing child- and mother mortality, and to stop the spreading of HIV and AIDS. Working with young people's sexual health and awareness is a very cost efficient and strategic method to reach these goals (United Nations/milleniumgoals). Sexual and reproductive health is not a goal in itself, but at a follow-up meeting on the Millennium Goals in 2005, it was decided that the issue would be integrated in the strategies for attaining the goals (unfpa.org).

Sexual education and information about contraceptives and safe abortions lead to smaller families with longer birth intervals, which allow families to invest more in each child's nutrition, health and education, aiding the eradication of extreme poverty and hunger as well as achieving universal primary education. To promote gender equality and to empower women, women need to be able to control whether and when to have children and girls need to be educated about contraceptives and abortion. The ability to control pregnancies gives women greater opportunities for education, work and social participation outside the home. It is also an efficient way to reduce child mortality and to improve maternal health. In order to combat HIV/AIDS it is necessary to have sexual and reproductive education on how to prevent infections and how to treat other sexually transmitted infections. Providing sexual and reproductive health services and avoiding unwanted births may help stabilise rural areas, slow urban migration and balance natural resource use with the needs of the population, creating an environmental sustainability. With a secure supply of contraceptives and affordable prices for drugs to treat HIV/AIDS, the reproductive health programs would be advanced greatly, allowing the development of a global partnership (Family Care International).

3. Purpose and Aim

The purpose of our project is to examine the work of the NGO MAMTA. In particular, we examine how they work with regard to sexual health and sexual education. We want to know

if they are involved in the education in schools or if they work with the young people who are not in school, and what benefits or consequences the alternative forums have. Furthermore, we investigate the extent to which gender is a focus in how they work or in their choice of work field. More concretely, we will focus on the following questions:

- What is the purpose of MAMTA's work?
- How do they operate?
- Does MAMTA have any cooperation with schools?
- Is MAMTA working differently with boys and girls respectively?

4. Method and Selection

4.1 Method

The method employed was interviews with people working for MAMTA. The interviews were of the conversational type focusing on how the work is performed within MAMTA regarding sexual education and gender. The advantage of the conversational type of interview is the ability to register unexpected responses as well as the possibility to follow up on the answers with additional questions (Esaiasson, Gilljam, Oscarsson & Wägnerud 2004:279). We wanted to determine what the conceptions of the present situation were regarding sexual education and health held by the organisation. We assess the validity of the information gained through the interviews as high, as it could be verified by Sida and RFSU, and also the Indian government since MAMTA is designing the curriculum on their request.

An alternative method that we could have used is participatory observations of MAMTA's work. The advantage of this method would be the opportunity to observe how they actually operate as opposed to how they say they operate. Observations are an appropriate method for investigating phenomenon that are difficult to describe with words, when there are discrepancies between the attitudes of insiders and outsiders, when investigating social interaction or when the phenomenon is hidden from the public in one way or other (Esaiasson, Giljam, Oscarsson & Wägnerud 2004:334). Since this is not the case for our investigation, we did not choose observations as our method for this project. Another disadvantage of participatory observations for our project is that MAMTA does not work with English speaking adolescents, and we would have had to rely on an interpreter to provide us with the correct information, why the information would be second-hand and perhaps not be as reliable. While working with professional interpreters usually does not affect the reliability, it would demand time and resources that were not available for this thesis.

A second alternative method could have been questionnaires distributed among teachers, students, peer educators and visitors to the Youth Information Centres, drop-in centres organised by MAMTA that provide information and education on sexuality and health. In doing so more information about MAMTA could have been gathered, but again, the problems of translation would arise. Furthermore, since the subject of sexual education is a sensitive subject in India, it would have been very difficult to make sure that people answered the questionnaires. Due to our time limitation it would be problematic to use this method.

A third possible method is textual analysis of MAMTA's documents and reports of their work. This method has the benefit of ascertaining a fuller picture of how they work, and not just the picture that they choose to offer us during the interview. By textual analysis it is possible to

understand the context of things in a broader perspective (Esaiasson, Giljam, Oscarsson & Wägnerud 2004:235). This method however would not be as spontaneous as using interviews, and would not give us the possibility to ask follow-up questions. In an interview, unexpected answers, and the fact that informants do not have time to censor or deliberate their answers can lead to information unattainable by other methods.

Before going to India to perform our interviews, we searched for background material. We used Birgitta Sandström (1995) for information about sexual education in Sweden, and Landguiden and RFSU publications for the situation in India. Our other references, literary sources as well as electronic sources, were chosen along the way as the need for more information arose.

4.2 Selection of Informants

We wanted to study the sexual education with focus on gender in a developing country and chose India. In May 2000 India reached the number of one billion inhabitants and is expected to become the most populated country by the year 2030 (Landguiden/Indien). Our choice of institution was on MAMTA, because they are one of the leading organisations in India working with sexual and reproductive health, and because it is supported by the Swedish bilateral funding agency Sida. We chose to interview two informants working at MAMTA, which in our opinion provides an accurate survey of the work of the organisation. Since we are not trying to detect variations within the organisation, two informants are enough to gain significant insight into the work of the organisation. One informant is in charge of the training of peer educators, and the other informant works with the curriculum for schools. Together, they provided us with both sides of the organisation's work regarding sexual education. We estimate the reliability of the interviews as high, since they did not have any known reason to mislead us, they knew that we were there on a scholarship from Sida and we could easily check their information.

4.3 Research Ethics

According to the Swedish Research Council, a government agency which has designed guidelines for research ethics, research is important and necessary for the development of both society and individuals. Society and its citizens therefore have a rightful demand that research is done and that it is of good quality. This demand on research means that available knowledge has to be enhanced and developed, and methods improved. The citizens in a society have the right to be protected against physical or mental harm, humiliation and violation. The protection of individuals is the foundation for all ethical research deliberations. Before every scientific study, the researcher must weigh the value of the expected acquisition of knowledge against possible risks of negative consequences for participants and informants involved in the research, short term as well as long term. The demand of research is often strong, and it would be unethical to refrain from doing research on factors that could improve health or living conditions for human beings, increase people's awareness of how to better use their own resources, or reduce prejudice (Vetenskapsrådet 1990:5).

The protection of individuals consists of four general demands on the research. The first one is the demand upon information, which states that the researcher must inform the participants and informants about their part in the study, what conditions are applied for their participation, and they should be informed about the voluntary nature of the participation and the right to discontinue their participation. The second demand is the requirement of consent; the researcher has to collect the participants' and informants' consent, and they must not be

coerced into participation. The third demand is that of confidentiality. Ethically sensitive information about identifiable individuals should be protected and remain confidential, and the individuals should not be identifiable by people outside the project. The forth demand is the demand of usage, no information acquired through the research may be used for commercial purposes or other non-scientific purposes (Vetenskapsrådet 1990:6-14).

In our interviews, we followed the four demands of protection of individuals as described by Vetenskapsrådet. Our informants were given information about their part of the study, they gave their consent and were aware that the participation was voluntary, we have kept their identities confidential and we will not use the information given for commercial purposes or any other non-scientific purposes.

4.4 Literary Source Criticism

The sources used are primarily non-scientific sources, but policies and normative goals. Our purpose with this thesis is to examine how the Indian NGO MAMTA works with issues of sexuality and sexual and reproductive health, and such issues are strongly connected to attitudes, and development work to policies and norms. We find that this combined with the low availability of scientific research on the subject make the normative character of our sources appropriate for the intended purpose.

4.4.1 Printed Sources

Sexuality: A Missing Dimension in Development by Runeberg commissioned by Sida 2008, we used because Runeberg has written about sexuality and the importance of sexual education in developing countries. Being a Sida publication, we found it a reliable source being a scientific report.

Entertainment – Education: A Communication Strategy for Social Change (1999) by Singhal and Rogers is used only to explain the term *entertainment education*, and there is no reason to doubt the reliability as it is simply stating facts to a non-controversial subject.

Ungdomssexualitet som undervisningsämne och forskningsområde (1995) by Sandström was used as a source for the background of sexual education in Sweden. We trust its reliability as it is published by Högskolan I Stockholm.

We used RFSU's *Information sheets on Global Sexual Politics* (2006) as a source for the issues of sexual and reproductive health and rights. Where they used references in the form of web pages of different United Nations bodies, we checked these references in order to obtain first hand information. Where they did not state their source, we used their information but are aware that it may not be first hand information. Since RFSU has been working with sexuality related issues for over 75 years and is an established organisation, we see however no reason to doubt the reliability of their information.

4.4.2 Electronic Sources

We have used internet sources for many of our facts about India, its constitution and education, and about the issues of sexual and reproductive health. One reason for this is that we have been in India writing our thesis and thus have not had access to research libraries. Another reason is the lack of previous research on sexual education in India. To the extent where it has been possible, we have tried to find other sources such as books or reports. When

we could not find such sources, we tried to use two different internet sources to increase the reliability.

The internet source countrystudies.us/india is an electronic version of the book *India: A Country Study* by Heitzman and Worden (1995). This is why this book is listed under our literary sources, and why the source seems reliable even though it is electronic.

For the background facts to the introduction to the work of MAMTA, we used MAMTA's homepage, mamta-himc.org. There was a direct correlation between the homepage and the information we were given during the interviews, which we found verified the information from both sources.

4.5 Limitations

We are aware of the fact that this thesis is limited in that we only talk about MAMTA from their own point of view, but that was the actual purpose of the thesis, examining the work of this particular organisation. We have, however, in order to verify their information, been in contact with Sida to get their perspective on the cooperation and the work of MAMTA as well.

5. Key Concepts

5.1 Internationalisation

By internationalisation we mean the process in which formerly national affairs become international (NE search internationalisering). When discussing the relevance of this thesis for our future work as teachers, we point to the fact that we live in a world where globalisation and internationalisation are a part of our every day life, and is highly present in the classroom. When we use the term globalisation we mean the process where states and societies around the world are joined in mutually dependent relations (NE search globalisering). Development of communication strategies and information satellites have lessened distances and to a certain extent standardised our horizon of understanding (Brante, Andersen & Korsnes 1998:106). Cooperation between countries is therefore easier than before, and more important.

Sweden's current international policy on sexual and reproductive health and rights from 2006 is considered by many the most progressive of any government in regard to some sexuality related issues. Sweden has long fought for sexual and reproductive health and rights in international discussions and in development cooperation (Runeberg 2008:10-12). Sweden's policy on sexual and reproductive health and rights is the basis for Sweden's bilateral, multilateral, operational and normative work carried out in international context. It is based on the results of the United Nations International Conference on Population and Development and on the policy *Shared Responsibility – Sweden's Policy for Global development.* Sweden focuses on a number of central issues that make the work difficult, such as poverty and lack of information and knowledge. Sexual education, attention to vulnerable groups, gender, equality, and combating HIV/AIDS, prostitution and human trafficking are all interlinked and included in the Swedish policy on sexual and reproductive health and rights (Sweden's policy on sexual and reproductive health and rights 2006:3-9).

As the world becomes smaller and boundaries erased, we find ourselves in need of a great internationalisation in Swedish schools. The students in Sweden need to acquire a broader perspective and a greater understanding of other cultures. Sweden is no longer an isolated country in the north, but part of the world as a whole and it is important for Sweden to set up relations world wide. Moreover, the Swedish student has changed over the years. With immigration to Sweden, a multicultural school with students from all over the world has emerged. Thus it is important for the teachers to have an understanding of other cultures and what sexual education means for different individuals from various cultures. We as teachers have to be able to adapt both ourselves and our education to meet the individual need of all students, Swedish and foreign alike (Fredriksson & Wahlström 1997:52).

5.2 Sexuality

WHO (World Health Organisation) gives a definition of *sexuality* and Runeberg uses their definition in *Sexuality: A Missing Dimension in Development*. WHO is a United Nations body and since the Swedish school values are based on a western humanism and human rights (Lpo 94), this definition seems appropriate:

"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, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced and expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors" (WHO 2006, Runeberg 2008:13).

5.3 Gender

By gender we mean the concept used in social science research in order to understand and explain conceptions, ideas and actions that together form our social sex (NE search genus). It used to be widely believed that "social" gender was simply mapped onto biological sex. It is also about power (Runeberg 2008:14). Female and male are not merely social constructions, but also psychological constructions. Becoming a boy or a girl is not only a matter of adapting into the gender roles of society, but the socialisation and the forming of identities are a process where the individual actively creates meaning, consciously or unconsciously (Börjesson 1998:32). In every society, girls and boys are brought up learning that the differences of their bodies mean that they should be treated differently, and that they are expected to behave differently, that there are differences in what they are being criticised and appraised for, and in what they are allowed or not to do (Runeberg 2008:14).

5.4 Sexual Education

Sexual education is education or information about sexuality and its different aspects. Sexual education can be offered as a subject on its own, or integrated into other activities depending on the context (Runeberg 2008:30). The contents of the sexual education provided are very important, as is the methodology, in order that the sexual education does not become counter-productive. In many cases, the sexual education is very hetero-normative. The education has to include everyone, without values or judgement, to ensure that the adolescents do not have to rely on seeking information through unofficial channels such as pornography (Nyanzi in Runeberg 2008:30).

Sexuality is a sensitive subject, and for adolescents to understand all the perspectives of sexuality and reproduction, they have to be educated on the subject. If sexual education is

provided, with information and values clarification, the adolescents can be enabled to make choices about their sexuality, be in charge of their sexual lives, form identities and build self-esteem. Lack of sexual education impoverishes people and decreases the quality of life (Runeberg 2008:30).

The information that young people receive about sexuality often focuses on negative aspects such as unwanted pregnancies, sexually transmitted infections, and abuse, creating feelings of uncertainty, shame, guilt or fear. Although the physical safety aspect is important, pleasure and intimacy are equally important aspects of sexuality. One can address both aspects of sexuality by using a positive rights based approach to sexuality instead of one based on fear and guilt (Runeberg 2008:31). Development agencies often focus on physical health and disease prevention when it comes to sexual education, and portray women only as victims of sexual and gender based violence and trafficking, rather than social agents with their own sexuality. Sexuality is not only a problem to be solved by technical solutions, but also a forum for empowering women from a rights based perspective (Runeberg 2008:13).

To promote improved sexual and reproductive health and a safer sexual behaviour of vulnerable groups such as women, gay people, young people, drug users and sex workers, much work is needed in order to build self-esteem, challenge stigma, and improve legal rights and justice (Runeberg 2008:31).

Sexual education in Sweden in the 20th century was highly influenced by scientific and biological perspectives, focusing on health and diseases. At the turn of the last century the prior Christian concepts of sin and shame were replaced by sick and healthy when describing sexual acts. Until 1938 contraceptives were prohibited and it was not until 1956 that sexual education became compulsory in the class room (Sandström 1995:10).

5.5 Sexual and Reproductive Health

Sexual health refers not only to counselling and health care related to reproduction and sexually transmitted infections, but also to the related quality of life and personal relations. People shall have a safe and satisfying sex life (Sweden's policy on sexual and reproductive health and rights 2006:7). The WHO definition of health states that it is a state of complete mental, physical and social well-being, and not only the absence of disease. Reproductive health addresses the reproductive processes and functions at all stages in life. Therefore reproductive health implies that people shall be able to have the capability to reproduce safely, and the freedom to decide if, when and how often to do so. WHO further states that men and women have the right to be informed of, and have access to safe, effective, affordable and acceptable methods of fertility regulations, and the right to appropriate health care services (WHO/reproductive health).

According to Statens Folkhälsoinstitut (Sweden’s National Institute of Public Health), a safe and secure sexuality is fundamental for the individual's experience of health and well-being, and society has to focus on areas such as sexual education, family planning and maternal health care. Safe sexuality, free from prejudice, discrimination, violence and force is a healthy sexuality. For example, in society where gay people are subject to prejudice and discrimination, ill health often results (Folkhälsoinstitutet).

Sexuality and reproduction should be seen from a wider perspective. RFSU argues that sexuality and reproduction are strongly connected to issues of poverty, health care, power,

education and equality. They state that poverty reduction is not tenable without recognizing these connections. After having read the United Nations' Millennium Development Goals, we agree. At the United Nations Population Conference in 1994, 179 countries determined that questions of population have to be connected to sexual and reproductive rights. Poverty is not only the lack of money, but also the lack of possibilities to affect society and one's life situation. The overall health of a nation has large effects on the economy and the production. Poor sexual and reproductive health constitutes a fifth of the world's total ill health, and a third of women's ill health. People who live in poverty rarely have access to health care and information about sexual and reproductive health. The most common cause of death among women of reproductive age is complications during pregnancy and child delivery (RFSU 2006:1). The fastest growing disease in India is HIV/Aids, and the difficulties to discuss sex and sexuality in India do not help in preventing spreading of the disease. India has a highly qualified medical knowledge, but only a fraction of the population has access to it (Landguiden/Indien).

6. Previous Research

To date, little research has been done on the subject of sexual education in India. There is some research on the subject in other developing countries such as the study *Impact of HIV/AIDS and Sexual Health Education on Sexual Behaviour of Young People: A Review Update* made by UNAIDS in 1997, which found that young people who have received adequate information on sexual health are better at protecting themselves, talk more to their parents and are more tolerant towards each other, and thereby they can make more intelligent decisions about their sexuality.

The Alan Guttmacher Institute has published the study *Adding it up – The Benefits of Investing in Sexual and Reproductive Health Care,* which has calculated the costs and benefits of sexual and reproductive health care in developing countries. It finds that investing in sexual and reproductive health services contribute to improved health, sexual and reproductive health, as well as economic growth, societal and gender equality, and democratic governance. The benefits can be divided into two categories, medical and non-medical. The medical benefits are the easiest to measure, but one has to acknowledge the non-medical as well to fully understand the benefits of investing in sexual and reproductive health care (Adding it up 2003 Summary).

Runeberg's report *Sexuality: A Missing Dimension in Development* published by Sida examines how, in development studies and projects, sexuality is not a focus and why it should be. The report concludes that without a focus on issues regarding sexuality, the United Nations Millennium Development Goals cannot be achieved (Runeberg 2008 Executive Summary).

We hope and think that more research will be done on the subject in the future, since education on sexual and reproductive health is urgent and necessary in order to attain the United Nations Millennium Goals.

7. Information about India

In order to put the results of the study into a context, we first provide some background information about India, the constitution, education system and the situation regarding sexual and reproductive health.

India is an incredibly diverse country. There are regional differences, as well as differences between urban and rural areas. The Indian society is unequal; very wealthy elite and a quickly growing middle class, and a vast poverty. Around 260 000 000 (of 1 135 600 000) live within the boundaries of poverty in India, and the poverty is in many ways regional. The south is more developed than the north, and the most acute poverty is found in the slums of the big cities and in the rural country side. The government of India has been working with five year-plans to fight poverty, diminish social injustices and lessen the regional disparities, but India has long been a corrupt country where the work is slow due to problematic bureaucracy (Landguiden/Indien).

7.1 The Constitution of India

India is a union of 28 states, divided into 604 districts administered by their respective state. On the homepage of India's government, India is described as a Sovereign Socialist Secular Democratic Republic with a parliamentarian system of government. India is governed in terms of the Constitution of India which was adopted in 1949 by the Constituent Assembly. India has a parliamentary form of government with federal structure but certain unitary traits. The President of India is the head of the Executive of the Union. The President together with two houses, known as the Council of States and the House of the People, form the Council of the Parliament of the Union. There is a Council of Minsters which includes the Prime Minister as its head to aid and advise the President. The President has to operate in accordance to this advice. The real power thus lies with the Council of Ministers (india.gov.in).

Every state has a Legislative Assembly, and each state has a governor appointed by the President. The Governor is the head of the state, and the executive power of the state is vested in her or him. The Council of Ministers advises the governors and the Council of Ministers of a state is responsible to the Legislative Assembly of the state (india.gov.in).

7.2 Education in India

The education in India is divided into different levels; pre-primary, primary, middle, secondary (high school), and higher levels. Children between the ages six and eleven attend primary school, organised into classes 1-5. Between the ages of eleven and fourteen the children attend Middle school organised into the classes 6-8, and the classes 9-12 at high school is for those between the ages of fourteen and seventeen. The higher levels after that are colleges or universities (Country Studies/India). Primary and Middle school is free of charge and officially mandatory for children between the ages of six and fourteen (India Education Guide).

Educational differences are immense, between sexes, between states and between social groups. School is mandatory for all children between six and fourteen, but the reality is different. Sexuality related discrimination can affect the access to education (Runeberg 2008:31). Most boys go to school for at least a few of years, but in rural parts of the country, the children often have to help support the family. Many girls are kept at home, and many are very young when they enter into arranged marriages (Landguiden/Indien). Teenage mothers often lack the ability to continue schooling, and girls may stay away from school during

menstruation due to social stigma, lack of adequate school toilets or sanitary towels (Runeberg 2008:31). Only slightly more than fifty per cent of the children between the ages of six and fourteen actually attend school, although a far higher percentage is enrolled. The schools are state governed and there are big differences regarding standards, policies and curriculum. Though the schools are state governed, the central government provides financial assistance and planning (Country Studies/India).

In India there are public as well as private schools, and they all are regulated by the Education Board (Interview with MAMTA 2008-11-11 Informant A). Public schools are free of charge but the educational standards are often poor. Private schools are better but they can be very expensive (Landguiden/Indien). Ten per cent of all the children who enter the first grade are enrolled in private schools. Almost no children in private schools drop out (Country Studies/India). The national government wants to create an equal education for everyone and special attention is being given to the education of girls (Landguiden/Indien). In 1986, the implementation of the National Policy on Education initiated a series of programs to improve the education system in India by ensuring that all children at the primary level have access to education of comparable quality regardless of sex, caste, or location (Country Studies/India). The goal of the policy was that by 1990, all children by the age eleven should have five years of schooling, and that by 1995 all children by the age of fourteen should have been provided free and mandatory education for eight years. The targets were not achieved, but the government expressed its commitment to the ideal of universal education by setting these goals. There are several factors that work against universal education in India. Although Indian law prohibits the employment of children in factories, the law allows employment of children in cottage industries, restaurants, family households or agriculture (Country Studies/India).

The Department of Education implements the responsibilities of the central government in educational matters. The Department of Education is part of the Ministry of Human Resource Development which coordinates planning with the states, provides funding and acts through the University Grants Commission and the National Council of Education Research and Training. These organisations aim to improve the standard of education. State-level ministries of education coordinate education programs at local levels. The State Education Ministry and the district government both supervise the city school boards. In rural areas, the school boards are supervised by either the district government or the village council. The important role of the village councils in education often means a politicisation of elementary education since the appointment and transfer of teachers often is an emotional and political issue (Country Studies/India).

7.3 Sexual and Reproductive Health in India

About 50 per cent of all the people in the world who have recently been infected with the AIDS virus are between the age of 15 and 24. Around 6000 young people are infected every day, one every 14th second (UNFPA 2003). South and South-east Asia are an epicentre of the HIV epidemic. India is estimated to have the largest burden of all countries in this region, with about 3.7 million infections (Bharat 2001:7). According to WHO, 21 per cent of Indian girls between the age of 15 and 24 have knowledge of HIV prevention methods, and 17 per cent of the boys (WHO/Countries/India). Young women are the most affected group; 7 million young women in the world live with HIV today, compared to 4.5 million young men (UNFPA 2003). Due to biological, social, economical and cultural reasons, young women are

more easily infected through sexual relations. Early marriages for girls in poverty can be seen as a way of ensuring economical stability for the family, but early marriages are closely linked to poverty. Instead of going to school, these young women stay at home to have children. Complications during pregnancy and child delivery are more common and more serious for women under the age of twenty than for women in their twenties (RFSU 2006:7).

Every year, 80 million women in the world have unplanned pregnancies against their wishes. About 50 per cent of these pregnancies end in abortions, and among those 50 per cent, 19 million are unsafe. Unsafe abortions cause 13 per cent of all cases of maternal mortality in the world globally, but in the least developed countries this figure can be as high as 20-50 per cent. The figures for maternal mortality reflect the biggest difference between rich and poor countries. The risk of dying as a result of complications during pregnancy and childbirth in rich countries is one in 4000, while in the least developed countries the figure is one in 17 (Sweden's Policy on Sexual and Reproductive Health and Rights 2006:7-11).

Abortion has been legal in India since 1972 only if it can save the woman's life, in order to preserve physical and mental health, if the pregnancy is result of rape or incest, if the foetus is impaired, and for economic reasons. It is not legal to perform abortions on request, there has to be a legitimate reason approved by a doctor (United Nations Abortion Policies). The abortion has to be performed before the 20th week, and between week 12 and 20, a second opinion from another doctor has to approve of the procedure. The Medical Termination of Pregnancy Act from 1971 was an attempt from the Government to reduce the number of illegal abortions and the consequent maternal mortality rate. The implementation has been slow and geographically uneven. Abortion services are inaccessible in many places, and the lack of confidentiality and anonymity make many women turn to illegal abortion alternatives. The legal abortion rate is around one million each year, while the illegal abortion rate is between two and six million each year. Women who use the legal hospital facilities for the medical termination of pregnancy are mostly married, educated women from urban middle-class between 20 and 30 years of age. Women who are admitted to hospitals because of complications from illegal abortions are often illiterates from the poorer parts of the population. The awareness of the legality of the procedure is low and many high-risk women seek illegal abortions (United Nations Abortion Policies).

The strong preference for sons in India, and the availability of inexpensive prenatal diagnostic techniques have made more people use prenatal gender tests, even people in poor rural areas. Some private clinics provide these tests and offer induced abortions if the parents are not happy with the sex of the child. There are no reliable figures on the occurrence of this practice, but highly distorted sex ratios in regions where these practices are believed to be common suggest that a significant number of female foetuses are aborted every year. In 1994, the government introduced a legislation regulating prenatal testing, allowing it only in cases involving serious diseases and abnormalities. The prohibition of prenatal testing to determine sex was an effort to end the discrimination against the female sex and the affect such testing could have on the status of women (United Nations Abortion Policies).

7.4 Introduction to the Work of MAMTA

The Hindi word *mamta* means a mother's affection for her child. MAMTA Health Institute for Mother and Child is a non-governmental and non-profit organisation that started in 1990 in the urban slums of Delhi. The experience of working in the poor communities made MAMTA realize the benefits for the overall health and development of working with young people along with women and children. With the intergenerational perspective, young people (10-24

years of age) became their main focus. While working with the young, MAMTA was made aware of the significant concerns young people have regarding sexual and reproductive health issues, which mainly remained unexpressed due to lack of information. MAMTA therefore initiated a broad based integrated approach to address these issues with a gender and rights perspective (mamta-himc.org/about).

When the work with young people and adolescents started, the concept of adolescence was foreign in the Indian context, and not seen as an actual stage in life (mamta-himc.org/strengh). Now a recognized organisation with the support of the Indian government, United Nations agencies and bilateral funding agencies, MAMTA is implementing programs for adolescents in other parts of India as well as Delhi (mamta-himc.org/field_int). MAMTA has since expanded into areas such as adolescent health, education and empowerment of young people. In the process, MAMTA has deepened its knowledge and understanding of working with young people from different socio-cultural backgrounds and has developed strategies to address health and development issues at different levels in the country as well as globally (mamta-himc.org/about).

MAMTA has started collaborating with Lund University in order to organise a training program, “National Training Program on Youth Friendly Health Services”. The National Training Program is customised for the public health functionaries, both clinicians and program managers, working at different levels of the state, such as teaching institutions, state health departments, state AIDS control organisations and district level hospitals. The National Training Program provides exposure to the best practices in Sweden and India. Sweden has had Youth Clinics for more than 30 years now and is one of the countries with the lowest rate of unwanted and teenage pregnancies and HIV in the world (E-mail from Senior Health Programme Adviser at Sida).

8. Results

The results that follow are based on the interviews with two informants working at the NGO MAMTA in India. Instead of calling them by their real names, we refer to them as Informant A and Informant B.

8.1 What is the Purpose of MAMTA's Work?

MAMTA's mission is to empower marginalised individuals and communities by providing preventive, health education to women and children. The purpose of MAMTA's work is to increase the sexual and reproductive health of the people in India. Working with sexual and reproductive health is essential if one wants to improve health and lessen poverty. Without

focusing on these matters, the United Nations' Millennium Goals cannot be reached, nor can they be reached if one does not focus on girls and women. By educating girls and women on how to prevent sexually transmitted infections and pregnancies, how to get safe abortions, and on their rights, their position in society can be strengthened. MAMTA stresses that it is equally important that boys and men are educated on these matters, as well as on gender roles and responsibilities, as men in many ways still control women and their sexuality (Informant A).

Sida describes the key objective of the cooperation with MAMTA as creating an enabling environment for young people's sexual and reproductive health through gender and rights–based approaches. Sida is running a Young People Health and Development project in India with RFSU and MAMTA as collaborating partners. They are working together with 137 NGOs through the program "Young People's Health and Development – A Sexual and Reproductive Health Centred Action Approach" since 2003. The 137 partner NGOs are organised in a network, SRIJAN, that covers seven states and about 90 districts (E-mail from Senior Health Programme Adviser at Sida).

Issues MAMTA is focusing on include early marriages and adolescent pregnancies, retention of adolescents in school, youth and HIV, sexuality education, youth friendly health services and gender issues. Over five years, community support has been built in order to increase access to appropriate information on these issues. The program from 2003 has increased the awareness of the need for youth friendly health services (E-mail from Senior Health Programme Adviser at Sida).

8.2 How Does MAMTA Operate?

Sexuality is a forbidden issue in India today, and the work to implement sexual education is difficult. MAMTA has developed strategies to reach adolescents, which include gathering communities to involve people and find out what the needs of the adolescents and the students are, and also what the needs of the education, of the teachers and the parents are. MAMTA has established Youth Information Centres to reach children and adolescents in their local area. The information centres constitute a platform supported by the community. The centres focus on children not attending school, but also serve children who attend school. Youth Information Centres keep material for recreation as well as education. They supply material with information about health, sexuality, rights and gender (Informant A).

The centres provide a "learning package" with recreation, education and extra-curricula activities. MAMTA strives to encourage as many children and adolescents as possible to come to the information centres, and offers workshops where the youth can perform odd jobs such as mending and embroidering to earn a little money. The workshops are very small scale, but it is an efficient way to get poor children and adolescents to come (Informant B).

Each information centre has a parent committee. Parents in the village unite, support and monitor the centres. However, first the parents need to be convinced that the centres are helpful and a good platform for the children. It is very difficult to convince parents to let their children go to the Youth Information Centres if the centres only deal with sexual and reproductive health. For example, if the centres offer competitive games such as cricket as well as sexual and reproductive health education, it is easier to convince the parents to let their sons and daughters attend (Informant B).

The Youth Information Centres are a platform with the objective to encourage young people to express their needs and reach a solution to their own problems with the guidance of the peer educators. The peer educators at the centres offer guidance and refer them to appropriate places for consultation at the gynaecologist or health centres. MAMTA has trained nearly 900 peer educators. The peer educators are trained and provided with new methodologies for making the sexual and reproductive health information more accessible. They are trained in entertainment education[1] to reach more children, using methods such as puppet theatre and illustrated stories that are especially effective for children and adolescents who cannot read. The peer educators share their knowledge in their villages at the information centres (Informant A).

The training of peer educators is conducted via network partners. The network, called SRIJAN, which means "creating something new" in Hindi and is an abbreviation of Sexual and Reproductive Initiative Joint Action Network, involves 137 NGOs. The key areas of SRIJAN are early marriage and pregnancy, HIV/AIDS and young people, education retention in school, youth friendly health and information services, and sexual education. SRIJAN addresses young people between the ages of 10 and 24, both those in formal institutions like schools, colleges and work places and those in more vulnerable settings as out of school, on the streets, and migrant populations. They address married young people as well as unmarried, in rural areas and urban slums, with greater emphasis on the marginalised and disadvantaged young people.

SRIJAN has started a magazine of young people, by young people and for young people, called *Arushi*. SRIJAN wants young people to get involved in advocating for their needs and concerns, and the magazine is a platform for young people to present their views and opinions on different issues. The publication of a youth magazine is an effective medium to fill in information gaps and initiate a dialogue not only among young people, but also with decision makers at different levels of the society and the governance. SRIJAN has selected and formed an editorial board for *Arushi*, consisting of young editors from the huge cadre of peer educators in the 93 districts and seven states served by SRIJAN. The editors collect, compile and develop material on a theme chosen by the editorial board for each issue of *Arushi.* Every issue has a certain theme, such as Early Marriages and Early Pregnancies, HIV/AIDS, and Gender Discrimination. During the editorial meetings, orientation workshops for the editors are organised to further enhance their knowledge on the chosen theme. Based on these sessions and discussions, the members prepare a final copy for the publication. The partner NGOs help with the translation of the magazine to other languages like English, Hindi, Bangla and Telugu (Informant B and *Arushi* (2006).

The organisations of SRIJAN felt that their own knowledge of sexuality, rights and gender was poor, and that by enhancing their knowledge a larger population could be reached. MAMTA thus organised workshops on these issues on a state level, and has been doing so since 2002. MAMTA now has a core group of master trainers from all the organisations, one for each state. The master trainers educate teachers, service providers, hospitals and gynaecologists for the government (Informant B).

[1] Entertainment education is the deliberate usage or designing of a media message in order to both entertain and educate, so that the audience's knowledge about an educational issue is enhanced, favourable attitudes created and behavior changed. The method uses the attraction of entertainment to show individuals how they can live safer, healthier and happier lives. The method is often used to promote family planning, HIV/AIDS prevention and gender equality. (Singhall and Rogers 1999, Preface xii)

Some of the trainers are involved in advocacy, advocating for sexual health issues to schools, to teachers, and to health providers. Every state has a state level youth forum and they are advocating for these issues to politicians, schools and teachers at all levels, village level as well as national level. SRIJAN has partners at different levels. For example, if one of the partner organisations works at the district level they perform advocacy at the district level, and if they operate at the village level, they perform advocacy at the village level. In India, the health service is a state matter and therefore advocacy at the national level is not enough, but has to be taken to the state level. There are policies in favour of the young at the national level since 20 years ago that discuss information about sexuality, early marriages and preventive methods, but the policies are very difficult to implement at state or district level. The significant resistance among the people causes government concern and fear of the resistance causing them to lose power, making this a politically sensitive matter. The network partners are now performing advocacy at state level and are in conversation with the state government. It is a long process, but something has started Informant B said.

MAMTA is attempting to sensitise service providers by organising training programs on youth friendly services for doctors and nurses from different states. The training programs consist of three weeks' training, two weeks in India and one week in Sweden, where they are being exposed to youth friendly services, sexual education and information as it is done in Sweden, as Sweden has a relatively long experience with this kind of work and has been practising sexual education for more than fifty years. The cooperation with the Swedish organisation SIDA was of course a key factor in the choice of country as well, Informant A added. The training participants meet Swedish politicians, visit centres and schools to get ideas on how to implement policies in India. In 2008 the network partners of SRIJAN went to Sweden to observe policies and procedures in order to develop better tools to work with sexual issues in India. Today, most people within the health and education sectors in India know that there is such a thing as youth friendly services and sexual education. While the importance of such services and education is understood, there remains confusion about how to effectively provide such services and education (Informant B).

8.3 Does MAMTA Have Any Cooperation With Schools?

MAMTA staff has created a curriculum for sexual education for the eighth, ninth and tenth grade. First staff proposes a curriculum to the district level education officials, who are the local level politicians. Secondly staff request feedback from students, teachers and parents in an open feedback forum. Thirdly, based on the received feedback, they design the sexual education curriculum. One example of how feedback can affect the design of the curriculum is in one instance when parents did not want their children to know about masturbation in the eighth grade, so its inclusion in the curriculum was postponed until the ninth grade. So was the information about condoms and safe abortion. Finally, once the curriculum has been approved by students, teachers, parents and the local level politicians, the curriculum is implemented in the schools. Some time after the implementation, MAMTA staff requests additional teach feedback about the curriculum (Informant A).

In 2006 the curriculum was launched and introduced by the national government called Adolescent Education Program, which was poorly received and many states banned it. The government was criticised and there were rallies against the government. Media supported the program, and organisations working with development issues were in favour of it, but the people of India were against it and the teachers refused to use it. The curriculum was banned, and the parliament formed a committee to investigate the matter. While the parliament was not against the curriculum, it they found some of the content objectionable. MAMTA was

contacted to revise the curriculum. MAMTA formed a committee of experts from the national department of education, teachers, doctors from various faculties and parents, and coordinated the revision of the curriculum (Informant B).

The curriculum is now ready but is yet to be implemented in the states. The teachers need to be trained at the state level in order to educate the students, but it is hard to convince them to attend the training. It is hard for the teachers because they find some issues objectionable. MAMTA sees the curriculum as a model and the teachers are at liberty to adapt it to their own cultural context. The teachers can adapt it and translate it so that they feel comfortable, but there is a list of non-negotiable things that have to be dealt with. Condoms are very controversial in India, but methods of preventing HIV and AIDS is one of the non-negotiable things in the curriculum, and one cannot discuss prevention methods without talking about condoms. If the teachers do not want to talk about masturbation, they have to at least give the information that it is not harmful. They have to inform students about menstruation and ejaculation. The aim is that the students should learn about safer sex practises. Many teachers want to stress abstinence, but they are required to talk about other ways of protection as well (Informant B).

All curricula for different subjects have to be revised and updated periodically; it is not specific for the Adolescent Education Program, so Informant B feels positive and confident that the curriculum will be accepted.

There are differences between how MAMTA works with the curriculum for the schools and with the youth information centres, as the school is a formal setting and the information centres are an informal setting. In school the education is age specific whereas the information centres serve children and adolescents of all ages. Although biological age is important, it does not guarantee that all the individuals have the same needs. At the youth information centres it is easier to focus on mental age and individual needs (Informant A).

8.4 Is MAMTA Working Differently With Boys and Girls Respectively?

In India, more boys than girls go to school, especially in the rural areas. The location of the schools is very important, as girls have a more restricted mobility. If the school is far away from the village, many girls tend to be kept at home and to drop out more often than boys. Therefore it is very important to have youth information centres nearby in order for the girls to learn about sexual and reproductive health. Depending on the village, some youth information centres have more boys attending, and some have a majority of girls attending (Informant A).

MAMTA thinks that there are huge differences between boys and girls, and thus how they work with them differs accordingly. Sometimes they separate the boys and girls when they talk to them, with a female peer educator for the girls, and a male peer educator for the boys.

One method of educating the adolescents about gender and women's position in society is role playing. By acting out different scenarios and situations, adolescents reach a deeper understanding of each other and the current social circumstances (Informant B). Role play about women's rights, domestic violence and sexual harassment assists girls and young women in learning how to safely handle similar situations in real life. Informant A explained that role play opens up the eyes of girls, as well as boys, to reality, and the inequities of Indian society.

Another way of raising the awareness of the adolescents about the inequality of society is to let the boys and girls write a list of the chores they have at home during one week, and then let the boys and girls compare their lists. It usually becomes very clear how much more the girls have to do in the household. This opens up a discussion of what is fair and what they want the future to look like (Informant B).

In a society where masculinity is the norm, qualities considered masculine are more highly valued than those considered feminine. The norms of what is feminine and what is masculine are stereotyped and stigmatised. Feminine qualities include weakness, nurturing demeanour, and passivity, while masculine qualities include strength, power and responsibility. A stereotypical view on masculinity can make the male role very macho, repressing all the feminine qualities. When you are taught to repress everything that can be seen as feminine inside you, it is very easy for boys and men to repress feminine qualities and traits outside themselves as well and thus end up oppressing girls and women. It is therefore very important to discuss the male role and masculinity. The traditional male role is in need of a great revision, it needs to allow all different kinds of qualities and traits, even those traditionally considered feminine, if you want an equal society, Informant A stated.

9. Analysis

The mission of MAMTA and the purpose of their work is to empower marginalised individuals and communities. Providing sexual and reproductive education is an efficient way to achieve that mission. MAMTA is concerned with issues such as early marriages, adolescent pregnancies, youth and HIV, gender issues and youth friendly health services. MAMTA's work is focused on rural areas and urban slums, which are the areas the most affected by acute poverty in India. Their work is extensive, and controversial in a society that is unwilling to accept the necessity of sexual education. MAMTA is determined and willing to work hard for its acceptance. An acceptance that will require much time, hard work and persuasion.

MAMTA works with two focus areas, designing a curriculum for sexual education for school and providing Youth Information Centres for those children who do not attend school. Only about 50 per cent of all the children in India attend school until they are fourteen. For the children who are kept at home, have dropped out or are working, the Youth Information Centres are an important substitute for the sexual education that they would have received in school. If parents are reluctant to let their children attend school, they might be more inclined to let them attend the information centres where recreation activities are provided, as well as small-scale workshops where they can earn a little money by mending or embroidering. Recreation activities are also a way of attracting children to the centres, and making the education enjoyable. If children enjoy learning something, they are more likely to remember the information, and to think that the information is important. At the Youth Information Centres, peer educators are available to guide and aid the adolescents. There are benefits in having peer educators for the adolescents to turn to with their questions and worries, as they might not feel comfortable in asking their teachers or parents sensitive questions.

The network SRIJAN is an important channel to reach out to young people. It has partners in 93 districts through seven states, which enables the network to reach young people close to their homes. SRIJAN focuses on marginalised and disadvantaged young people, which makes this accessibility to information close to home even more important, as they lack the means to travel. Girls especially have mobility restrictions, and by providing information at village

level, they can be reached to a further extent. MAMTA provides training programs for the SRIJAN network partners on sexual and reproductive health, in cooperation with Sida.

With globalisation and internationalisation, matters of health and rights are no longer isolated to the concerned nation, but are a global concern. The United Nation's Development Goals include 179 nations, and it makes sense for the nations to work together to reach them. Sweden's policy on sexual and reproductive health states that Sweden should work actively with issues of sexuality in their development work, and hosting the training programs for SRIJAN is one step on the way.

MAMTA cooperates with schools in that they design the curriculum for sexual education. If the United Nations Millennium Development Goal that by the year 2015, all children will attend elementary school is attained, school is an appropriate forum in which to address sexual education. If all the children in India attend school until the age of fourteen, and the schools have a curriculum for the subject that has been approved by students, teachers and parents, a good foundation can be laid for the knowledge of sexual and reproductive health. The curriculum that MAMTA has created is to be seen as model for the teachers to interpret and adapt into their own cultural context, but it has a list of non-negotiable, obligatory topics.

MAMTA has a gender focus in their work and work differently with boys and girls. At the information centres, the peer educators sometimes separate boys and girls when discussing gender. They use role playing as a way of illustrating gender related issues and thus preparing the adolescents on how to act in real life to battle gender inequities. Letting the adolescents write lists of qualities they consider feminine or masculine is one method used to make them reflect over the stereotyped gender roles, and the lists of chores they perform at home make the gender inequities evident. The work MAMTA performs on gender is vital in a country like India, with such big differences between the sexes. Girls and women are more vulnerable, and their empowerment is important to gain a more equal society. The vulnerability of girls is double, they are more vulnerable in biological and social aspects, and become even more so as they are often kept from school. Since girls cannot be reached through formal education in school to same extent as boys, the Youth Information Centres are an important channel. The Youth Information Centres are situated in villages, making them more accessible for girls who are otherwise more restricted in their mobility than boys.

MAMTA is involved in schools as they are assigned by the Government to design a curriculum for sexual education, and they provide information centres for non-school going adolescents as well. The double effort makes them reach as many young people as possible with the important information on sexual and reproductive health. With their gender- focus they perform important work on gender equality, working differently with boys and girls as the differences between sexes are significant in Indian society.

10. Concluding discussion

MAMTA's mission to empower marginalised individuals and communities places their efforts with the disadvantaged youth. The marginalised and disadvantaged young people are an urgent target group. They are more likely never to attend school or drop out early, and the Youth Information Centre is their only arena to gain information on sexual and reproductive health and rights. The disadvantaged young people are also a more vulnerable group. Early marriages can be seen as a way to secure financial stability, and with early marriages, early pregnancies often follow. For women less than 20 years of age, carrying and giving birth is more dangerous, and is the most common cause of death for women of fertile age.

Information about HIV/AIDS and other sexually transmitted infections is vital for the disadvantaged young people who live in a world where sex can be seen as merchandise, and are probably more exposed to abuse and sexual violence.

The purpose of MAMTA's work is very important as they address the important issues of sexual and reproductive health and rights. These issues became an international focus through the United Nation's Millennium Development Goals, which brought to attention the necessity of including a sexuality perspective. The goals increased the awareness around the world and made it clear that something had to be done. Though people were aware of the problems before the population conference, it became more evident that steps had to be taken. Many developing countries such as India need help in order to create a better sexual and reproductive health, and it is important that these issues become integrated and focused on in development projects.

MAMTA, as many development agencies, focuses on the health perspective of sexuality. As WHO states, sexual and reproductive health is not merely the absence of diseases but a state of well-being with personal relations and a safe and satisfying sex life. In our opinion, sexual education should cover both aspects of sexuality, the problematic issues such as unwanted pregnancies, sexually transmitted infections and gender-based violence, as well as the positive, empowering aspects as intimacy, pleasure and love. Through inventive methodologies and entertainment education, MAMTA bases their educational approach at the information centres on positive feelings as opposed to shame and fear. We think that MAMTA's work with the curriculum and school needs to adopt a similar approach of intimacy and pleasure of sexuality as well. We understand that it is difficult in a society where sexuality is not an open subject, but that makes the work even more urgent.

Even though we would like this added perspective to MAMTA's work, we still think that what they do is very important, and that their work is vital for the development of India. India, and many other developing countries, lacks the means to make education, contraception and abortion more accessible, and need help from other countries. With the internationalisation of today, we cannot close our eyes to the needs of others. The Sida cooperation with MAMTA for the national training programs is one example of help provided. In our opinion it is important however that the training does not stop there but continues on in India. How it is done it in Sweden is based on the Swedish culture and traditions and may be hard to translate into an Indian context. With further training they can be given the proper tools to design a system of sexual education and youth friendly services based on the Indian culture and traditions, with the knowledge of the importance of such education and services. Informant B says that today most people within education and health sectors understand the need for sexual and reproductive education and youth friendly services, but that they are confused about how to actually do it. Further training could ease the confusion and make it clearer on how to proceed.

The United Nations Millennium Goals only concern school attendance in elementary school. It is important that the information about sexual and reproductive health continues after the turn of fourteen years of age as well. The Youth Information Centres that MAMTA has established are open to children and adolescents of all ages, and are thus a good forum for further information and education. The information centres are a good complement to the sexual education in school. As India has such big differences between regions, class and gender, it is important to provide alternative forums for education and information so that all young people are reached.

MAMTA's curriculum for sexual education for school is a good way of ensuring that children are informed about sexual and reproductive health. The curriculum is for the grades 8-10 and thus the sexual education starts when the children are 14 years. School is only free and mandatory up to the age of 14, and many adolescents therefore miss the rest of the sexual education. We think it is necessary to introduce sexual education earlier in order for as many children as possible to learn about them. We posit that the eighth grade is too late to begin the sexual information. Many issues, such as menstruation, have to be dealt with at much lower ages, since many girls begin to menstruate long before their teens. Many topics, such as condoms and abortions, are not introduced until the ninth grade. These topics are very important, but all the children who do not continue their education after the eighth year will not be informed about them.

Teachers have reacted and protested against the curriculum, but the list of non-negotiable topics ensures an equal education and guarantees that all children receive the necessary information. The educational standards vary from state to state in India. If the curriculum is implemented in all states, and the teachers in the different states are free to adapt it into something that they can accept and stand for, the list of compulsory topics will diminish the variation of the standards of the sexual education.

The strategies MAMTA has developed for their work on gender issues can be rewarding in order to empower girls. Separating boys and girls from time to time, with a same sex peer educator, can have the benefits of more relaxed and comfortable discussions. In a society with stigmatised views on gender, girls may not feel comfortable of discussing for example menstruation in front of boys. Boys may feel that they have a macho-image to live up to, and may feel more secure discussing sexuality in the absence of girls to impress. Role playing as a methodology in gender education is a good way of opening up young people's eyes to hidden power structures, and through acting out they become more prepared to deal with situations like sexual harassment, domestic violence or violations in real life. The list of chores that boys and girls write makes it evident how much more the girls have to do at home, and is a good starting point for discussions on equality and justice. The other list, where the adolescents make two lists, one with qualities they consider feminine, and one with masculine ones, is an efficient exercise to illustrate how stereotyped traditional gender roles are and a good base for discussion about the possibilities for an individual to contain qualities from both lists. The traditional male role is indeed in need of a revision, and so is the female. By opening up a discussion, you also open up for change. As gender is a social construction with rules of what boys or girls can or cannot do, the social construction can be reconstructed into a gender equal set of rules.

10.1 Relevance to the Teaching Profession

The internationalisation of Swedish society puts great demands on people's ability to live together and on their ability to appreciate the values of a culturally diverse society (Lpo 94). The school is a social and cultural meeting place, and therefore holds both the opportunity and the responsibility to equip all people who work in school, students and teachers alike, with these abilities. Due to the internationalisation Swedish teachers and students need to get a wider perspective and a fuller understanding of other cultures. An international perspective helps the students develop an understanding of cultural diversity, within as well as outside their own country (Lpo 94). One of the goals in Lpo94 to strive towards is that students should develop their understanding of other countries, as well as the interdependence of countries and different parts of the world, and a goal for the school is to create international solidarity and to prepare the students for a multicultural society. By going to India to examine

MAMTA's work on sexual education, our perspective has become more international and we feel better equipped to prepare our students for a multicultural society. We have reached a deeper understanding of cultural differences, and especially differences when it comes to attitudes towards sexuality. In integrating knowledge about Indian school system and the Indian sexual education in our minds and thereby our teaching, we can give a little part of the world to our students. MAMTA's cooperation with Sweden and Sida makes the interdependence of countries and different parts of the world evident.

In the multicultural classroom, we as teachers have to be able to focus on the individual needs of each student, culture and ethnic belonging regardless. Sexuality and sexual education can be sensitive matters, and the attitudes towards the issues can vary between cultures, gender and religion. Lpo94 states that no-one should be discriminated at school based on gender, ethnic belonging, religion, sexual orientation or subjected to other degrading treatment. “Xenophobia and intolerance must be met with knowledge, open discussion and active measures” (Lpo 94 1994:3). Lpo 94 also states that the education has to be adapted to each student's circumstances and needs. Education should promote the student's learning and acquisition of knowledge, based on his or her background, language, earlier experiences and knowledge. In the Swedish school today, we have students from different countries, cultures and religions, and their attitudes towards sexuality and sexual education may vary enormously. This became poignant to us when we in the spring of 2008 visited a very multicultural high school in Gothenburg to talk about sexuality as peer educators. The FHI (Folkhälsoinstitutet) report on sexual education in elementary school in Sweden finds that the education is very traditional in Biology, and that the more students from foreign background the school has, the more traditional are the teaching methodologies. Study visits, discussions and role play are rare teaching methodologies in immigrant-dense schools (Jarlbro 1997:21). It is therefore important that teachers gain knowledge on new methodologies that can be applied in the multicultural classroom.

The school should actively work on equal rights and opportunities for men and women, and counteract traditional gender roles (Lpo 94). In the multicultural high school in Gothenburg where we worked as peer educators, we met different classroom constellations. One class that we worked with consisted of only students of Swedish origin, while in another class, all the students came from foreign backgrounds. One of the most prominent differences between these two classes was how boys and girls interacted with each other. In the “Swedish” class, the boys and girls could talk openly in front of each other about all the aspects of sexuality, but in the other class with students of foreign background, it was problematic for the boys and girls to discuss these matters in the same room. The boys seemed to have a macho image to maintain while the girls were not supposed to be sexual creatures at all. Boys may find themselves pressured into particular risky sexual behaviours to live up to macho stereotypes (Runeberg 2008:19). It is therefore extremely important to discuss gender in multicultural schools, and to actively work to counteract traditional gender roles.

MAMTA has a gender perspective on their work, and work differently with boys and girls respectively, sometimes separating them for sessions with same-sex peer educators. This may give the positive effect of making both the boys and the girls more comfortable in discussing sexuality. It could have a positive effect to separate the sexes in Sweden as well from time to time, and sometimes the open discussion between boys and girls may be important as well in order to gain an equal society. In India, the consequences of poor sexual education and strong gender roles are severe. Many girls are kept from school, and many of the girls who are enrolled in the school system drop out due to early marriages or early pregnancies. Their lack of education can in many ways exclude young women from economic opportunities, and it

strongly affects their ability to influence the society (RFSU 2006:3). Education on sexuality and gender is important in school to empower girls, but also outside of school to reach those adolescents who are not attending school. In Sweden, the consequences of poor sexual education and strong gender roles are not the same as in India, but they are still severe. Sexual education and gender discussions are important steps towards the empowerment of girls and women, and have to be taken seriously in Swedish school. Through this thesis, we are now more aware of the issues and have access to more proper tools to address the matters of sexuality, gender and empowerment of girls and young women.

11. Suggestions for Further Research

As mentioned previously, the subject of sexual education is relatively unexplored and further research is important. One suggestion for further research is to examine how the work of SRIJAN and MAMTA is received by the target group, and how young people feel about sexual education. Another suggestion would be to examine teachers' attitudes and feelings about their work and sexual education. It would also be interesting to examine the resistance in the states which are not involved in SRIJAN, to see why that is and if there is a possibility to convince them of the importance of addressing the issues. According to Sweden's Policy on Sexual and Reproductive Health and Rights, questions concerning sexual and reproductive health require interdisciplinary research efforts and collaboration, as they are complex. Researchers from different disciplines such as for example sociology, medicine, biomedicine, epidemiology, anthropology and law must be involved and able to see problems and issues from a global perspective (Sweden's Policy on Sexual and Reproductive Health and Rights 2006:27).

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12.3 Other Sources

Email from Senior Health Programme Adviser at SIDA (Appendix 2)

Kristina Cellton
Anna Öberg

Appendix 1

Interview questions

1. What is the purpose with your work?
2. How do you work?
3. Who do you reach?
4. Do you have any cooperation with schools?
   If yes, how?
   If no, why not?
5. Do you work differently with boys and girls?
   What does that work look like?
6. How does the society react to your work?

Kristina Cellton
Anna Öberg

Appendix 2
Email from Senior Health Programme Adviser at Sida

Re: Fw: MAMTA

Från: **gunilla.essner@sida.se**
Du vet kanske inte vem den här avsändaren är. Markera som säker | Markera som osäker
Skickat: den 24 november 2008 14:21:02
Till: stina cellton (scellton@hotmail.com)
Kopia: regevu@sida.se; registrator@sida.se

Dear Stina,
At the Embassy of Sweden you have a national programme Officer/Health, Yasmin Zaveri-Roy, who can assist you directly in the country. Please receive her e-mail address yasmin.**zaveri-roy@foreign.ministry.se** and her **tel no: 241971125, or by mobile 9899575714.**

I write you some lines about the project below, if you need some additional information, please contact Yasmin at the Embassy at Nyaya Marg, Chanakyapuri.

YOUNG PEOPLE'S HEALTH AND DEVELOPMENT PROJECT IN INDIA

National Context:

RCH II (under NRHM) includes Adolescent Reproductive and Sexual Health (ARSH) as a key strategy. State PIPs committed to establishing 'Adolescent Friendly Health Services' at state level, and have allocated budgets for the same. However, very few states have prioritized the 'roll out' of this strategy.
NACP III recognizes young people as a 'vulnerable group' and has special focus on them in its various schemes (eg., the Link worker scheme).
This focus on young people will significantly contribute to the overall (national) goals of reducing Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate, and reducing the incidence of HIV by delaying age at marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications including access to early and safe abortion services and reduction of unsafe sexual behaviour.

Key Objective:

Create an enabling environment for young people's sexual and reproductive health through gender and rights-based approaches.

Collaborating Partners:

RFSU (Swedish Association for Sexuality Education) & MAMTA –Health Institute for Mother and Child, New Delhi have been working together with 136 NGO's through the programme: 'Young People's Health and Development-A Sexual And Reproductive Health Centred Action Approach', since 2003.

The 136 partners are organised as a network, SRIJAN (Sexual and Reproductive Health Initiative for Joint Action Network) that spans across seven states (Rajasthan, UP, Bihar, West Bengal, Maharashtra, Gujarat, Andhra Pradesh) and about 90 districts.

RFSU has a history of working with sexual and reproductive health issues for over 75 years across many parts of the world. In this partnership, RFSU brings technical expertise on issues of sexuality and sexual health, sexual and reproductive rights, working with young men and

participatory approaches for capacity building on these issues. MAMTA along with the SRIJAN network are the key implementing agencies at state and district level.

Key interventions and achievements:

i) Early marriage and adolescent pregnancies, ii) Retention of adolescents in school, iii) Youth and HIV, iv) Sexuality education/Adolescence Education, v) Youth Friendly Health Services, and vi) Gender issues (incl. the sex ratio).

Over five years community support has been built in order to undertake specific interventions for young people that will enhance access to age appropriate and culturally appropriate information on these issues. As awareness increased, the need for relevant services delivered in a youth friendly environment has emerged. Establishment of Youth Friendly Health Services is thus a logical outcome in the overall framework of the Sexual & Reproductive Health and Rights as it delivers on the right of young people to have access to appropriate reproductive health information and services and also meet the demand for services that address youth specific concerns.

Under the mandate of this programme, MAMTA has entered into technical Collaboration with Lund University, (Division of Global Health and Social Medicine), Malmo, to organize National Training programme on Youth Friendly Health Services.

National Training Programme on Youth Friendly Health Services:

The National Training Program (NTP) aims at facilitating the roll out of Adolescent/Youth Friendly Health Services, as stated under the National programme, through technical support for capacity building, especially focusing on NRHM states.

The goals set out in NRHM have been the guiding principles for developing the contents of the training programme with emphasis on reinforcing the Public Health Standards and Management Information System (under RCH II and NRHM).

The NTP is customized for the public health functionaries (both clinicians and programme managers) working at different levels in the state (in Teaching institutions, state health departments, State AIDS Control Organizations, District level hospitals, CHCs and PHCs).

The NTP provides scope for developing skills in adolescent specific areas of health and exposure to best practices in India and Sweden. Sweden has Youth clinics for more than 30 years now and is one of the countries (ranking high on HDI) with lowest rates of unwanted and teenage pregnancies and HIV in the world.

It is planned as a comprehensive four weeks training programme (in two phases) to be organized in India (3 weeks total) and in Sweden (one week). The participants will be mentored to develop a ‘Change Project’ that will be implemented at the health facility or integrated in state supported programmes for young people. This should create examples/models of youth facilities and interventions across the participating states.

An important aspect has been the advocacy at the highest levels and an effort to garner support from key government officials (Secretary Health, Mission Director, NRHM, Project Director-SACS) in the state so as to ensure sharing of responsibility as well as commitment to further support the participants after they return to the state.

Expected Outcomes:

A trained group of health service providers with:

Enhanced knowledge and skills on adolescent and young people's health issues;
Attitudinal change –gender sensitive, rights based approach in clinical services;
Established Demonstration 'models' on Adolescent/Youth Friendly Health Services in states;
Documentation and evidence for public health impact of youth friendly health services that is widely disseminated.

The first training programme started on 3rd November 2008 and the first two weeks have been completed on 14th. The evaluation from these two weeks shows a definite change in the sensitivity of the participants to issues of young people. The public health professionals have shown great interest in discussing approaches that are more gender sensitive, and youth friendly and are more prepared to discuss sexual health issues with young people.

A structured evaluation (based on theories of behaviour change is being administered before and after the training programme as well as at follow up 6 months later. This should demonstrate measurable change in knowledge, attitudes and practices (clinical).

Best regards,
Gunilla

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