

Talking Sexuality Within Community Where Sex is Taboo: A Rural Experience in North India

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Abstract

Talking sexuality in rural areas of Varanasi, where tradition is deep into their ethos, is challenging in itself. In the area where the working population is largely affected by the ill impact of return migration precipitating HIV/AIDS and young people are denied their basic 'right to information', the situation becomes graver. Gender discrimination is evident in every walk of life and sexual abuses are not uncommon. Despite these facts, strategically planned and consistent efforts made ensured that sexuality is being discussed within the community by engaging them in the process from the beginning.

Mamta, a NGO, took initiative to work with young people in the rural areas of Varanasi. Need assessment was done to get first hand information and develop specific need based intervention plans. It emerged that sexuality is the connecting thread to a number of concerns that young people have. Young people should have correct basic information regarding sexuality. Peer Educators among young people were identified and Youth Information Centers where young people can go and get information were initiated within the community. It was taken up at the level of individual, family, system and community as whole. With the support from the community and elected grass root leaders, it is not only feasible to talk on sexuality but also to integrate sexuality education with the formal education / school system. With the active participation of parents, teachers and young people, a local centric and culture specific curriculum on Sexuality Education is being designed on a pilot basis in partnership with RFSU of Sweden, which will be further up-scaled through local network of organisations and institutions. Challenges also came on the way. Apprehension in the mind of parents of young people and gatekeepers initially made the task more difficult. Culturally amphibious people from the community were the key for entry into the community on the issues. Now sexuality is being talked but there is a lot more to be done beyond talking and at a wider scale.

Keywords

Young people, sexuality, India, sexual & reproductive health, community

Introduction

Human sexuality is defined as a function of whole personality that begins at birth and ends at death. Sexuality is a 'multi-faceted concept'. It starts with how we feel about ourselves as men and as women and it continues on through how we express that with other people. 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, behaviour, practice, roles and relationship. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economical, political, cultural, ethical, legal, historical and religious and spiritual factors <http://www.who.int/reproductive-health/>.¹

Understanding sexuality is required in cultural context and a local centric approach is needed to address this issue in appropriate manner. In this endeavour, a need assessment was carried out in the identified areas and field realities mapped. These helped in making strategic plans for addressing the identified needs. Of various needs identified, addressing sexuality of young people emerged out as the links among majority of the concerns that young people have. This paper narrates steps that were taken to make it feasible to talk on sexuality where it is tabooed. It may be useful for those working on the issue — program people associated with intervention activities, researchers and policy makers in understanding the adopted strategies in less favourable circumstances.

The paper first presents an overview of sex and sexuality in Indian context from secondary sources and then about young people in India. Young people's sexual behaviour and socio-cultural influences are also narrated subsequently. It gives an account of methodologies adopted for the need assessment that revealed the ground realities. Then follows the realities from the field that tells about the literacy level, perception of young people on sex and sexuality and also related facts like how do they express their sexuality and their health seeking behaviour. It then explains the strategic plan that was made to reach out to young people on culturally sensitive issue of sexuality. How discussion was initiated and what efforts were made at the level of individual, family and community is also explained along with integration of sexuality with the education system. It also gives the extent of reach in terms of number of young people and geographical coverage. It also narrates in brief about the challenges that came on the way and then summing up.

The paper emphasises the importance of engaging community in efforts that were difficult. Community engagement is the process of working collaboratively with and through groups of

people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well being of those people. It is a powerful vehicle for bringing about environmental and behavioural changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilise resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices. From the social ecology perspective, the potential to change individual risk behaviour is considered within the social and cultural context in which it occurs. Interventions that are informed by this perspective are directed largely at social factors, such as community norms and the structure of community services including their comprehensiveness, coordination, and linkages, in addition to individual motivations and attitudes.

Social ecology theory as it informs health promotion suggests that community engagement efforts need to be focused at multiple levels — individuals; social network and support systems; the range of organisations that serve and influence individuals and the rules and regulations that these organisations apply; the community, including relationships among organisations, institutions, and informal networks; and public policy, regulations, ordinances and laws at the state and national levels.

Sexuality in India

India is land of contrasts. The basics of sex favourability are implicit in the Vedas and later Upanishads; eventually fairly explicit holy books were written about pleasure and particularly about sex, such as the KamaSutra of Vatsayana (Holmberg 1998).² On one hand religion appears to be overt in its expression regarding sex and sexuality. The symbolism of Siva and Shakti cult along with various temple arts and existing Sanskrit literature are evidence of certain degree of transparency maintained regarding sex and sexuality. On the other hand in the mundane affair of the society, sex and sexuality in covert and strict codes governs the people.

In present India, however, sex and sexuality are still considered topics that are tabooed. Topics such as male libido and female orgasm do not trickle the bedroom of an average Indian. Precisely, a vernacular equivalent of orgasm is hard to find. In this context the question often surfaces that how can the women be expected to be knowledgeable about it. The subject of sexuality is neither approached clinically nor as a natural phenomenon. It is always been veiled behind stigma, taboo and mystique (Roy & Rizvi 1998).³

Sexuality remains a taboo in Indian society. Amongst most Indian families thus deny opportunities for open discussion. Such taboos and restrictions are accepted with no question asked. Some examples are “The girl must be virgin”, “Homosexuality is sin against nature,” “Women are

unclean during menstruation”, “Men must be controlling partner in sex”, “Sex with more than one partner is wrong”. All these are just variations on familiar theme. Myths and misconceptions on menstruation, sexual intercourse, homosexuality, sexual identity information and psychological development are not often addressed at all. Existing gender bias puts young women at risk due to the high-risk behaviour of their partner.

Sexual experimentations are common amongst young people. Because of tremendous societal pressure, trying to define their own sexual identity is a problem for both the sexes. On one hand girls grow up with the idea of “having to fulfill male sexual desire in specific way”. Women are seen primarily as being responsible for producing children and are not expected to express sexual enjoyment. Women are not expected to express sex within the ‘desire’ and ‘pleasure’ perspective. (Verma et al. 2004).⁴ On the other hand, the “macho” image of masculinity as “the person always in control” puts a lot of pressure on boys to conform to it and “prove their masculinity”. Social pressure severely limits men’s ability to speak about their need for more information or about their doubts and fear. Besides, both sexes believe the myths of men’s uncontrolled sexual drive, which cannot be interrupted or diverted. This idea implies that women must take the responsibility for moral standards and contraception. Sexual abuse and risk behaviour are not uncommon. Unmarried men describe instances when their friends not only justified but supported coercive sex with a unwilling women partner. (Verma et al. 2004).⁵ Indian youth are torn between cross currents of reality, fantasy and dream. A strict moral code at home and the selection of a life partner are in contrast to the visuals a youth is exposed to in day-to-day activities. (Roy & Rizvi 1998).⁶ Moral standards set by societal norms through socialisation process and prevailing situation in which they live in is putting young people at the crossroad.

Young people in India

India was never so young as is now. “There are 300 million young people age 10–24 years in India, comprising thirty per cent of India’s total population. Health-related experiences, attitude and behaviour of these youth are intimately linked to their social, educational and economic aspirations and options, which will have a strong impact on the future India. Unfortunately, the unique developmental, sexual and reproductive health needs of this segment of the Indian population are poorly understood and under-served” (ICRW Information Bulletin, Feb 2001).⁷

Sexual behaviour and reproductive health among young people in India

While international attention tends to focus on premarital sexual activity among young people, for young women in India, sexual relations occur overwhelmingly within the context of marriage (Pelto, Joshi and Verma 2000⁸). Despite the rising age at marriage and laws prohibiting early marriage (Child Marriage Restraint Act of 1929 and its amendment in 1978), half of all women

aged 20 to 24 were married by 18 years and a quarter by 15 years (IIPS and ORC Macro 2000⁹; Santhya and Jejeebhoy 2003¹⁰). Among females aged 15 to 19, one-third were already married. In contrast, boys rarely marry in adolescence — only six per cent of those aged 15 to 19 were married at the time of the survey (IIPS and ORC Macro 2000¹¹; Kulkarni 2003¹²).

The prevailing family system in India is based on premarital chastity and monogamous marital sex, particularly for women. However, a number of small-scale studies, despite limitations in their designs and methodologies, have found a more permissive attitude towards sexual pleasure and higher-than-expected levels of premarital and extramarital sexual activity among men and women in India (Sarah Hawkes K. G. Santhya, 2001¹³). Younger age at sexual debut is associated with a higher number of lifetime sexual partners, greater risk for unintended pregnancy, and higher risk for STDs. Other studies find that for the majority of people, first sexual experience occurs within marriage. A population-based survey of urban and rural men found that only 25 per cent had sex before marriage, and the overall mean age at first sex was 23 years (Collumbien, M., Das, B., Bohidar, N. and Pelto, P., 2000¹⁴). Even studies among college boys (where social constraints may be relaxed) have found that less than one third report sex before marriage (Jejeebhoy 1998¹⁵). Reports (often from qualitative studies) of premarital sexual contacts of men have found a wide variety of partners: sex workers; friends; relatives; and future spouses (Sarah Hawkes K. G. Santhya 2001¹⁶). Among girls, reported premarital sexual contact is mainly with future spouses, friends and relatives (Sarah Hawkes K. G. Santhya 2001¹⁷). Large-scale country surveys highlight initiation in sexual activity among males at as early as 11 years (NACO 2001¹⁸), with a median age of 20 for males in rural areas and 21 for urban areas, whereas, for females it is 18 years in both areas. For one-third of males, the first sexual partners are commercial sex workers.

Premarital sexual activity is clearly more common among men than women, although some difference may reflect over-reporting among males and under-reporting among females. Typically, fewer than 10 per cent of young women reported premarital sexual experience, while a higher range (15–30 per cent) was observed among young males (Abraham and Kumar 1999¹⁹; Awasthi et al. 2000²⁰; Bang et al. 1989²¹; Bansal 1992²²; Bhende 1995²³; Goparaju 1993²⁴; IMRB 1993²⁵; Jejeebhoy 2000²⁶; Kaur et al. 1996²⁷; Mehra et al. 2002²⁸; Savara and Sridhar 1993²⁹; 1994³⁰; Sehgal et al. 1992³¹; Sharma and Sharma 1995³²; Watsa 1993³³).

According to a report on knowledge, attitudes and practice of youth drawn from the National AIDS Control Organisation (NACO), National Behavioural Surveillance Survey, some ten per cent and eight per cent of rural and urban young men aged 15 to 19, respectively, reported a casual sex encounter in the 12 months preceding the survey compared to two per cent of sexually active

young rural and urban females (NACO and UNICEF 2002³⁴). Furthermore, age appears to be associated with increased casual sex experiences, particularly among young males; for females, there is no corresponding variation.

The incidence of homosexuality at initiation is reportedly low (1.5 per cent) (NACO 2001³⁵). Over all ages homosexuality is reported to be between three and seven per cent (Naz Foundation International³⁶). Open discussion of men having sex with men (MSM) is not well tolerated in Indian society, which continues to place extremely high values on the family and lineage. Recent research has concentrated on describing the practices, lifestyles and cultures of MSM in India, but not on hypothesising the extent of the practice among men. In part this may be a result of the often hidden nature of MSM in India. Data show that Indian populations are not as chaste and monogamous as has been claimed (Ravi Verma et al. 2004³⁷).

The environment

Young people are poorly informed about their own bodies and matters related to sexuality and health. The information they have is often incomplete and they remain confused. Low rates and levels of schooling, attitudes that prohibit discussion of sex and sexuality thus limiting access to sex education. It furthers their ignorance. As gatekeepers who should play a pivotal role in enabling adolescents to protect their sexual and reproductive health, parents often obstruct rather than facilitate informed choice. Young people commonly report that discussions with parents about sex or reproduction are taboo. Parents and family members say that boys and girls prefer to talk to peers rather than parents. They describe feeling acutely embarrassed at the thought of discussing sexual matters with their children. They also lack the vocabulary and the basic information about sexuality that would help them talk about these matters with their adolescent children. Furthermore, they express concern that discussing such matters might appear to give tacit “permission” to engage in sex. They associate knowledge of sexual matters with promiscuity and a loss of parental control. They are generally concerned for sexual security of their daughters, but indifferent about their sons’ behaviour. (Masilamani 2003)³⁸ In both rural areas and urban slums, parents often want and expect their young children, particularly daughters, to remain uninformed about sex. The situation is such that neither parents nor young people feel comfortable talking about sexuality and are just trying to provide excuse for not talking. Education systems also tend to be ambivalent about sex or sexuality education, though this has begun to change in the wake of the HIV/AIDS pandemic. In many cases, sex education continues to put emphasis on biological and scientific information over broader issues of sexuality. Teachers often find the topic embarrassing, shameful, and avoid such issues, even in schools that supposedly teach a family life/sex education curriculum. As a result of adults’ reluctance to address these

issues, young people tend to rely on peers and mass media for information about sex, reproduction and STIs including HIV/AIDS (Bott and Jejeeboy 2003³⁹).

At the cross roads of sexual maturation and reproductive capability on the one hand and lack of information on the other, adolescents are vulnerable to sexual experimentation and risk of early and unintended pregnancy, RTI and STI. Awareness about sexual and physiological changes in adolescence eludes large number of adolescents. Articles on adolescent sexuality and fertility emphasise the lack of information that both girls and boys have on their anatomy and reproductive physiology; but do not make the link between this fact and the unfortunate circumstances of some girls' early sexual encounters. There is little appeal for young couples to delay the birth of the first child or space out their children. The first child must arrive soon after marriage to establish a girl in her in-laws' home, and if that child is not a boy, then there is additional pressure to produce the second (Greene 1997⁴⁰). Awareness about contraception is very vague among married as well as unmarried adolescents.

Socio-cultural influences

The transition from childhood to adulthood is sudden in India, especially for young girls, and more so in rural areas, where the majority of these girls live. Sometimes withdrawal from school and marriage follow the onset of puberty directly, especially among girls in rural India (Greene 1997)⁴¹ In Indian societies on the other hand, particularly in rural areas, decisions like when to marry, whom to marry, how many children to have, etc. go by cultural dictates and are usually decided by elders in the family. Any activity, even talking in public, in a mixed gender setting (other than with family members) has partial sanction for a boy/man but not for a girl/ woman. She is invariably labeled as of 'loose character'. This gender discrimination has the sanction of the society. There is great need to look at sexuality and sexual behaviour in affirmative, accepting manners, to recognise sexuality as integral part of health and well being (Verma et al. 2004).⁴²

MAMTA's role

Very little information is available about young people (10 to 24 years) as a distinct group in India. MAMTA, a Non-Governmental Organisation (NGO), is working with young people since 1990. It recognises the urgent need to identify effective approach to address concerns of young people. It took the initiative to work with the young people of Pindra block of Varanasi district. It has the proven capacity to work with the young people on Sexual and Reproductive Health and Rights. MAMTA in twin partnership with RFSU, an organisation from Sweden, planned to work with young people in that area. RFSU has over seventy years of experience of working on sexuality issues in diverse conditions. Technical inputs from RFSU with MAMTA's strength of working with young people paved the way forward. Need assessment was planned. The assessment was

done in 33 villages of Pindra block in Varanasi district, in the month of March 2003 and subsequently intervention was planned that initiated in July 2003 to create an enabling environment.

Methods

Participatory Rural Appraisal (PRA) method was used to assess needs of the community, especially target population. Young people (10 to 24 years of age), their parents, key community workers and service providers are mainly targeted. Both quantitative and qualitative data were collected. Questionnaire was used for quantitative data collection. For qualitative data collection, resource mapping, body mapping, focused group discussion (FGD) and in-depth interviews were conducted. Data on 511 young people (10 to 24 years) were drawn as sample from 33 villages of Pindra Block, District Varanasi, Uttar Pradesh. Total 85 FGDs were conducted. 50 FGDs with young people, 25 with their parents and 10 with key community people. In depth interviews were conducted with 54 service providers. The need assessment was done in March 2003 before the intervention started in July 2003. An assessment was done after 18 months of intervention to review the project in December 2004.

Ground Realities

About the area

Intervention area in Pindra Block, District Varanasi, represents a typical rural setting of eastern Uttar Pradesh, with few channels of information. Agriculture is the main source of livelihood. There are large numbers of landless labourers. Women work in agricultural fields and work also as maids. Some sections of the population practice traditional occupations of pottery making, carpet, saree weaving, carpentry, sheep and goat rearing, dairy and tailoring. Very few people are employed in government or private jobs. With small land holdings and large family size, the area is experiencing bulk out migration of males for better job opportunities. Income level of general household is low. More than 33 per cent of the households have monthly income below Rs. 2000.

Literacy

The literate population among the young people (10 to 24 years) of the area is 52 per cent, among which 57 per cent are males and 43 per cent are females. Girls are discouraged to attend schools. There are high percentages of school dropouts, especially among girls, after age of 13 as they attain puberty by this age. Nearly 16 per cent of young people have never been to school. As people live in poverty conditions, they are not ready to invest years in schooling.

Perception of young people on sex and sexuality

Getting “attraction to opposite sex” along with the urge to indulge in sexual activity is widely accepted by boys. There is prevalence of sexual activities through various manifestations, including masturbation, visits to prostitutes, and sex with girls in school and neighbourhood and homosexuality. Fantasising and day dreaming are common feature among young people. Girls do experience attraction to boys but were not really forthcoming about it. The socialisation process plays an important role here, where girls are made to think of, and interact with, only the husbands, apart from other male members of her family. Also there are too many restrictions imposed on their movement and socialising. Girls said these restrictions leave them depressed. Some of them did talk about fantasising on film heroes. Only in co-educational schools girls found an opportunity to talk to boys, as in most other environment it was prohibited. The girls found it hard to share their experience of sexual urges. For some of these girls who belonged to the lower caste and lower socio economic strata, marriage and motherhood coincides with menstruation. Parents are too concerned about their girls respect when the latter attain sexual maturity.

Bodily changes and awareness

Growing of beard and moustaches, changes in voice and rebellious nature marks the sign of maturity for boys. And for girls, maturity come with menarche, growth of pubic hair and when breast start developing. Boys consider themselves grown up when the length of the penis increases, height increases, and hair growth is seen in private parts. Turning shy and seriousness characterises girls' maturity. Also there is increase in breast-size and mensuration starts. With maturity, unmarried girls are restricted from certain activities like mixing with boys. But, so much restriction is not applied to boys. Not many unmarried youths have accepted having friendship with members of the opposite sex. They make indirect references to others having such relationships. The common notion among elders is when a boy and girl is matured enough to reproduce then they should be married off as soon as possible. Not much awareness exists among the young people regarding sexual health. Lack of information, incorrect and incomplete information regarding menarche along with myths and misconceptions were found among girls. The common age of onset of menstruation is 13 to 14 years: 44.7 per cent of the girls have undergone menarche in that age group and another 11 per cent had their menses at below 13 years. It is noteworthy that about 85 per cent girls had no knowledge about menarche before it occurred. More than 80 per cent girls commonly use old used cloth for menstrual management and only about 2.2 per cent use fresh cloths or napkins. During Focussed Group Discussions, most of the girls said that they suffered pain and discomfort during periods. Girls are not aware of the processes underlying menstruation.

Discussing sexuality in public is objectionable to young people (15 to 19 years) as it is considered as 'something dirty'. Parental interaction regarding growth and development, especially concerning menarche, is negligible and sources of information are brother's wife, friends and siblings/relatives. Some sort of parental communication was found in the case of girls who were studying and had educated mothers.

Among boys also, there are various misconceptions on sexual health issues. Like, nightfall is perceived as a problem/illness. Boys are taking medicine for nightfall to get cured. The myth associated with masturbation among boys is that it brings weakness and adversely affects the sexual prowess and performance. Young people are aware of homosexuality and oral sex.

Sexual interests have varied outlet apart from the intercourse method in the form of masturbation, sex with animals, and anal sex. There are cases of sexual relations developing between father and daughter, between father-in-law and daughter-in-law, brother-in-law and sister-in-law and between male teacher and female students. Forced sex under the influence of alcohol is common. Though there are some incidents of sexual violence and coercion within the conjugal relationships. It was observed that sexual harassment in the public sphere is not easily tolerated. The FGDs also revealed that sex during menstrual periods is common within the marital relationship. The women in the area admitted that they could never question or refuse men in the matter of sex.

Sexual health

Sexual health is not attended and addressed within the community due to unawareness, embarrassment and unavailability of proper services of information. During menses, vomiting, dizziness, itching, RTI infection affects the women's sexual relations with their husbands. Back pain is common and old cloth is used during menarche. White discharge is considered as 'normal' post marriage phenomenon. Social and religious taboos are attached with menarche like not visiting temple, not entering the kitchen, not to eat hot and sour things, etc. Women believe that eyesight is affected when period stops. It has been learnt that many understand 'unprotected sex' as those having sex with multiple partners. Community members revealed their ignorance about RT's and ST's, though young people, as well as their mothers, have talked about white discharge, rashes, and pain during menses, irregular menses and pain after intercourse. Out migration of male working population from the area brings in additional risk of STD and HIV infection to both the male and in turn to the females. Young people, especially girls and women do not seek treatment for STI due to embarrassment. Some of the health professionals cite cases of STI for which their advice has been sought. They estimated that the prevalence rates of STI must be much more than the reported cases.

Cultural influences

Early marriage and early pregnancy are common. More than 85 per cent of females and more than 60 per cent males get married before eighteen years of age. Among these, 36.55 per cent of females get married between 13 and 15 years of age. In case of males, more than 50 per cent get married in the age group of 16 to 18 years. Forty-seven per cent had their first child by the age of 18 years; 12 per cent have the first child at the age of 19 years and the rest at the age of 20 to 23 years. The low age of first pregnancy is primarily the result of early age at marriage. There continues to be familial and social pressure on couples to have the child soon after marriage.

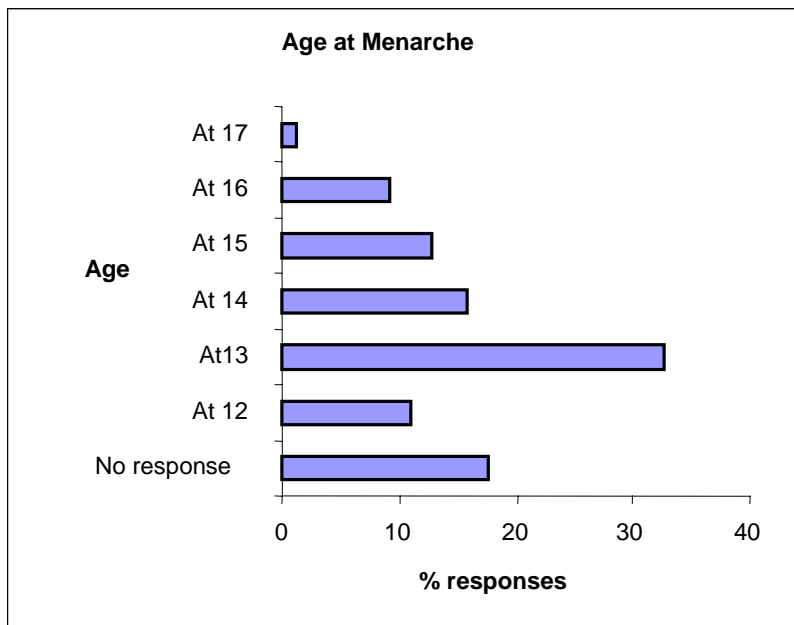


Figure 1. Age at Menarche

Most of the deliveries are done at home. Unsafe abortion is widely prevalent in the community. The women told about some home preparations that are widely used in the area. Abortion is done mostly when the pregnancy takes place out of wedlock. Girls (15 to 16 years) revealed the incidences of abortions primarily in case of relationship not having societal sanction. Women who cannot conceive take the help of Ojha (spiritual healer) as infertility treatment in hospitals is expensive. Couples who are unable to have children have little scope for appropriate medical care. Infertility is not often disclosed.

Concerns

A common expression of young people has been 'control and restrictions' on them by parents and the elders in the family. It is leading to anger, depression and irritability among them, more so in

case of girls. Mothers accepted that there is a communication gap between them and their daughters. There are many common needs such as 'poor knowledge on contraceptives', 'incomplete information and misconceptions related to menarche management', 'gender bias' etc. The concerns expressed by women are the 'management of menarche', 'premarital sex', 'lack of appreciation for the many chores that women perform', 'lack of awareness for earning livelihood' and 'income generation programs'. Parents were worried about poor knowledge of adolescents and their parents on sex and sexuality and misconceptions related to it. Elders have expressed grave concern about their young ones being rebellious and communication gap between them and their children.

There have been 14 reported cases of HIV/AIDS. The HIV infection seemed to be coming through the people who have migrated to large cities and who regularly visit the native villages. Only 7.4 per cent of young people surveyed have heard about HIV. While awareness regarding HIV/AIDS is very low among the young people, but among those who have heard about it most of them have cited unprotected sex as the major reason for the spread of HIV/AIDS. Television and radio are also the most common source of information for the community and the young people about HIV/AIDS. For girls, mother and peer are source of information.

Health-seeking behaviour

Young people cope up with illness in a wide variety of ways. In the event of falling sick, the options available to them are no treatment but rest. Block Hospital, Quacks (unqualified private practitioners), Ojha (spiritual healer), qualified doctor, household remedies and District Hospital are the source of services. Experience is reportedly not favourable in the case of government-run hospitals, which is used only in emergency and as a last resort. Quacks (unqualified private practitioners) are easily accessible and people have faith in them. Ojha (Spiritual healers) also thrive on people's trust and they are easily accessible, although people go to them in desperation.

People tend to use home remedies for most illnesses not perceived as severe. Only when an illness persists or aggravates over several days then they seek help. The quacks (unqualified private practitioners) are most preferred because they are locally available, less expensive, have trust on them and people perceive that they provide good treatment. Only in case of any acute illness do they go to government health centers because they are not easily accessible. Table 1 depicts the health care seeking behaviour of the young people. It shows that the private unqualified doctor is the most preferred practitioner among young people. If the problem aggravates further, they go to a hospital in Pindra or Varanasi. The first choice here too, is a private hospital. The government hospital comes only as a last resort. Only 2.5 per cent (both married and unmarried) of young people visit government hospitals.

Table 1. Health-seeking behaviour of young people (10-24 years)

Health services	Unmarried (%)	Married (%)
None /no response/don't know	1.9	1.3
Sub-centre	2.5	2.5
PHC/CHC	2.5	2.5
Private Unqualified Doctor	80.9	58.0
MBBS	4.9	4.2
Private hospital	7.4	2.5
Ojha/ other traditional practitioner	-	29
Total	100	100

Around one-third of the total pregnant women are below 19 years of age. Nearly 58 per cent married and 80.9 per cent unmarried young people go to private unqualified practitioners for treatment. Though the unqualified medical practitioners are the most preferred for giving treatments but they have stated that they do not handle cases related to sexual and reproductive health, as they are not qualified for it. The ANM provides the necessary service and in some cases, which are complicated like high-risk pregnancies, they refer the patient to either PHC at Varanasi or to private hospitals.

Reaching out to young people

Strategic planning

Multi strategic planning was done to address the concerns of young people. After series of brain storming sessions with experts and professionals in the field, key persons from the community and community workers, a holistic plan was developed.

Key stakeholders were identified and activities were planned to address the concerns of young people including the issue of Sexuality. To begin the activities in the community, issues that concern the community most were identified. These identified issues acted like entry point to the communities. Specific activities were planned to suit the stakeholders and also it was made very explicit in the plan document that how different activities feed into each other to make holistic impact. It was evident from the assessment that environment in the community was not conducive to talk on sensitive issues of sexuality. The community, as a whole, was not comfortable with the issue. Culturally amphibious people were identified from the community and were sensitised first on the issue to facilitate the entry into community. These people often play

the role of advocates for the issue in the community. Particular emphasis was on the gatekeepers of the communities viz. elected members of the local bodies, influential persons in the communities and service providers to the young people like doctors, teachers and barbers. Simultaneously young people were sought out by community workers for direct interventions to make them aware about the issues that concern them. Some of them volunteered as Peer Educators who were educated in programd manner on the issues over a period of six months. These peer educators were to be the carrier of the issue and are responsible to sustain the effort within the community. Peer Educators participated in the different activities at community level as well as state and national level and helped the community workers in carrying out these activities. This was planned with the objective to make peer educators understand the issue in operational ways. Space within the community was identified as Youth Information Center (YIC) where young people will come and discuss their concerns in free atmosphere. It was also planned that the links will be established with the existing health and educational establishments. These establishments in future hoped to act as place for dissemination of information on issues. And as these centers are integral part of the community, taking up of sexuality by them would lead to its sustainability.

Apart from these strategic plans, consistent effort with elected local body members were made to make them participate from program planning to its carrying out in the community. This would lead to further realising the importance of young people by them and also their importance in electoral politics, as they would be the future vote banks. The need for these programs for young people to be the integral part of the planned activities of local bodies would be the ultimate outcome where young people will feel free to discuss their concerns with the concerned.

Talking sexuality within the community

As it was felt from the Need Assessment, Sexuality needs to be talked not only with young people but also with their parents, gatekeepers in the community and also with the service providers that includes doctors and teachers. Talking on the issues, which is taboo in the community and attracts bad name and disrepute for those involved in these talks, need to be dealt very carefully and cautiously. Strategic planning helped to deal with the issue at different levels.

At family level, parents are targeted to make them understand the need of talking sexuality for their children. Specific activities with parents are planned and designed in which they are being contacted in person individually as well as in groups. Trained community workers are there to facilitate these planned activities and communicate with them in cultural sensitive language. These community workers visit their houses at the time of their convenience and discuss the issue and share their concerns. Also at times, these community workers act as communicator between parents and their children on the issues/matters that parents are not able to

communicate but feel that they must tell their children. Community workers visit the houses of parents of young people and talk to them about the concerns of young people and ways to tackle them in friendly manner. Parents do share their concerns about their children and express their helplessness in addressing them.

Parents are specially called at the Mass Meeting for awareness to develop and refine their understanding of the issue of Sexuality. Such occasions also provide an opportunity for the parents to talk and discuss about their concerns pertaining to their children, including sexuality, with other parents, community workers and other project staff. During such activities they get a chance to see IEC materials on the related issues including those made by young people from the area itself in local dialects. These local centric IEC materials developed by young people are very helpful in communicating the young people's feeling to their parents in very subtle ways which otherwise young people need not dare to communicate to their parents. At times parents are surprised to see the IEC materials prepared by their children. Parents confess that they would not have known all these if these types of activities were not there.

At the level of community, the gatekeepers are mainly targeted. Panchayati Raj Members (PRI Members), elected people's representative from a group of villages (Panchayat) and local leaders are sensitised in planned manner and made aware about the young people's needs and concerns. Meetings are organised with these PRI members and local leaders. During these meetings apart from sharing of views and opinion, parents concerns are also communicated to them to make them feel the need and importance of sexuality in their lives. This also helps in building their opinion to support the cause and the initiatives. Special sessions are planned with PRI members for their better understanding of the project as well issues of sexuality. Now they are integral part of the project planning. They acts as 'watch-dog' for all activities and started coming up with valuable suggestions to improvise and improve project activities to suit local needs. Good rapport with the gatekeepers not only eased the operation of the project but also their proactive role reduced the effort load of community workers. With their cooperation and support, project is heading towards sustainability.

To sensitise and orient *service providers* on the issues of sexuality and develop better understanding of young people, workshops are planned in which experts on these issues are called. This has not only helped in developing perspective amongst service providers but also provided a platform for developing better understanding between project staff and service providers. Apart from these, special events are planed at strategic locations such as school premises, Panchayat Building and health centers. To establish good rapport with the health service providers, community workers provide support to doctors working at government

dispensaries during public health campaign. These community workers help them by collecting people from the community to seek and utilise services available with the government setups (like polio drops). This has proved very fruitful. It also helped doctors to understand young people and respond to their problems in friendlier manner. And also at the same time young people get more chance to interact with doctors and paramedical people.

Sexuality education

Integrating sexuality into the existing system was a challenge. Though it was the felt need to initiate Sexuality Education, initiating it was a mammoth task. Sensitisation of community about the issue and gradual increase in their participation in community based activities helped in taking the steps forward. Concerned authorities in school as well as with education department were contacted and convinced about the need of starting sexuality education. After lots of persuasion and consistent effort it became possible to initiate the sexuality education in school. School authorities have given permission to conduct sessions on Sexuality Education. Simultaneously local centric and culture specific curriculum is developed in participatory manner. Community workers who understand the community and young people very well were the key in developing Sexuality Education Session Plan. RFSU, a Swedish organisation, provided the technical support.

The Sexuality Education Curriculum takes a holistic approach to young people's health, covering reproductive health topics as well as broader health and other issues related to transition to adulthood. This approach tries to put sensitive reproductive health information into a positive, non-threatening context, by emphasising the effect on adolescents' overall health. Specifically, the project addresses topics such as human body and physical changes, female and male reproductive parts, sexually transmitted infections (STI), contraception, pregnancy, gender roles, self-esteem, hygiene, disease prevention and healthy relationship. MAMTA uses a participatory, interactive training methodology, both for adult trainers (community workers and teachers) as well as for adolescent peer educators. The approach emphasises on 'experiential learning' or 'learning by doing'. Participants work in small groups and learn by taking part in activities rather than passively receiving information through lecture or reading. Such activities include dance, role-play, skits and games.

Project staff reached out to all 33 villages at least twice during the project period. In various activities 5618 young people participated; 6131 members from the community along with 183 PRI Members and 58 Service providers were sensitised. Initially the turnout rate was as low as 45 to 50 in a Mass Meeting which rose to above 500 over a period of eighteen months of intervention. In the beginning getting a place in the community was not easy whereas now community people

themselves are making places available. Girls participation in the program was almost 'nil' when community workers started the project. But now parents ask community workers about the program schedule. Where boys and girls were not allowed to talk earlier, now both are participating together in even sports activities. There has been occasions when community members took the role of community worker in meetings.

Challenges

Initially opening the channel of communication was really tough. Parents, as expected, were initially not comfortable with the issues of sexuality. Bringing boys and girls together on these issues was a big challenge. There was lot of apprehension in the mind of parents and gatekeepers that discussing Sexuality would deteriorate the family and community environment. Working conditions are tough as there is poor infrastructural support. Community workers need to travel long distances in hot summers and chilling winters. Changes in the project staff also at times hampers the progress of the project. Despite these challenges, with people's support it is now possible to talk on sexuality.

Conclusion

Sexuality is taboo in Indian society despite the fact that it was rooted into their way of life since prehistoric time, as depicted in literature and monuments. The fact cannot be denied that there is need to talk about it in light of the prevailing situation. Young people are poorly informed about their bodies and matters related to sexuality. There is opposition in norms and practices. Societal norms preach to be faithful to sexual partner, but the prevalent behaviour shows extra and premarital relationships. Substantial number of young people experiences first sexual intercourse in mid-teens. Homosexuality though not tolerated in society but are in practice.

There is growing trend of RTI/STI including HIV/AIDS, consequence of conservative approach toward life. There is prevalence of myths and misconception concerning sexual and reproductive health of young people. Young people do not have knowledge to make informed choice and correct decisions. They are guided more by traditional value than scientific knowledge. Teachers in school who has been entrusted with the responsibility of providing information and impart knowledge on sexuality and related matters to young people feel handicapped in dealing with it.

Despite social conditions not very conducive to talk and discuss sexuality in family and with community members, strategic planning, consistent and pragmatic approach resulted into a situation where sexuality is discussed by and among them. Steps taken over four and half years have resulted into a situation where discussing sexuality is a reality. The gatekeepers of the community has sensed the need of hour and allowed the discussion. It has been accepted by

society and only after support from the community it become possible for initiating it with school system.

It may be relevant to mention here that issues related to sexuality are to be looked at beyond the talking point. It has wide connotation, particularly in culture which is less open and more rigid. Being culturally sensitive is key, but the need is to address the issue at larger level. And that is the desire of young people.

References

- ¹ <<http://www.who.int/reproductive-health>>
- ² Holmberg, Carl B. (1998), *Sexualities and popular culture*, Sage Publication. Thousand Oak
- ³ Roy, Shibani and Rizvi, S.H.M (1998) *Sexuality: meaning, myth and practice*, B.R. Publishing Corporation, Delhi
- ⁴ *ibid*
- ⁵ *ibid*
- ⁶ Roy, Shibani and Rizvi, S.H.M (1998) *Sexuality: meaning, myth and practice*, B.R. Publishing Corporation, Delhi
- ⁷ ICRW Information Bulletin, Feb 2001
- ⁸ Pelto, P.J., A. Joshi and R. Verma. 2000. *Development of Sexuality and Sexual Behaviour among Indian Males: Implications for Reproductive Health Programmes*. New Delhi: Population Council.
- ⁹ International Institute for Population Sciences (IIPS) and ORC Macro. 2000. *National Family Health Survey (NFHS-2) 1998-99: India*. Mumbai: IIPS.
- ¹⁰ Santhya, K.G. and S.J. Jejeebhoy. 2003. "Sexual and reproductive health needs of married adolescent girls," *Economic and Political Weekly* 38(41): 4370-4377.
- ¹¹ International Institute for Population Sciences (IIPS) and ORC Macro. 2000. *National Family Health Survey (NFHS-2) 1998-99: India*. Mumbai: IIPS.
- ¹² Kulkarni, S. 2003. "The reproductive health status of married adolescents as assessed by NFHS-2, India," in *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*, ed. S. Bott et al. Geneva: World Health Organisation, pp. 55-58.
- ¹³ Sarah Hawkes K. G. Santhya *Diverse Realities: Understanding Sexually Transmitted Infections and HIV in India*, 2001, Population Council.
- ¹⁴ Collumbien, M., Das, B., Bohidar, N. and Pelto, P. 2000. *Male sexual behaviour in Orissa*. Paper presented at the Workshop on Reproductive Health in India: New Evidence and Issues, Pune, February 28- March 1.
- ¹⁵ Jejeebhoy, S. 1998. *Adolescent sexual and reproductive behaviour: A review of the evidence from India*. *Social Science and Medicine* 46(10):1275-1290
- ¹⁶ Sarah Hawkes K. G. Santhya *Diverse Realities: Understanding Sexually Transmitted Infections and HIV in India*, 2001, Population Council
- ¹⁷ Sarah Hawkes K. G. Santhya *Diverse Realities: Understanding Sexually Transmitted Infections and HIV in India*, 2001, Population Council
- ¹⁸ *National Base Line High Risk and Bridge Population Behavioural Surveillance Survey*, 2001, NACO, GOI
- ¹⁹ Abraham, L. and K.A. Kumar. 1999. "Sexual experiences and their correlates among college students in Mumbai city, India," *International Family Planning Perspectives* 25(3): 139-146.
- ²⁰ Awasthi, S., M. Nichter and V.K. Pande. 2000. "Developing an interactive STD prevention programme for youth: Lessons from a north Indian slum," *Studies in Family Planning* 31(2): 138-150.
- ²¹ Bang, R.A., A.T. Bang, M. Baitule et al. 1989. "High prevalence of gynaecological diseases in rural, Indian women," *Lancet* 8629: 85-88.

-
- ²² Bansal, R.K. 1992. "Sexual behaviour and substance use patterns amongst adolescent truck cleaners and risk of HIV/AIDS," *Indian Journal of Maternal and Child Health* 3(4): 108–110.
- ²³ Bhende, A. 1995. "Evolving a model for AIDS prevention education among underprivileged adolescent girls in urban India," *Women and AIDS Research Program Report, Series No. 5*. Washington, DC: International Centre for Research on Women.
- ²⁴ Goparaju, L. 1993. "Unplanned, unsafe: Male students' sexual behaviour," Paper presented at the Workshop on Sexual Aspects of AIDS/STD Prevention in India, Mumbai, 23–27 November.
- ²⁵ Indian Market Research Bureau (IMRB). 1993. "For better or for worse," *Femina* 8 July: 6–21.
- ²⁶ Jejeebhoy, S. 2000. "Adolescent sexual and reproductive behaviour: A review of the evidence from India," in *Women's Reproductive Health in India*, ed. R. Ramasubban and S. Jejeebhoy. Jaipur: Rawat Publications, pp. 40–101.
- ²⁷ Kaur, U., S.P. Sahni, P. Bembery et al. 1996. "Sexual behaviour, drug use and Hepatitis B infection in Chandigarh students," *National Medical Journal of India* 9(4): 156–159.
- ²⁸ Mehra, S., R. Savithri and L. Coutinho. 2002. "Gender double standards and power imbalances: Adolescent partnerships in Delhi, India," paper presented at the Asia-Pacific Social Science and Medicine Conference, Kunming, China, October.
- ²⁹ Savara, M. and C.R. Sridhar. 1993. "Sexual behaviour patterns amongst men and women in Maharashtra: Results of survey," Paper presented at the Workshop on Sexual Aspects of AIDS/STD Prevention in India, Mumbai, 23–27 November.
- ³⁰ ———. 1994. "Sexual behaviour amongst different occupational groups in Maharashtra, India, and the implications for AIDS education," *Indian Journal of Social Work* 55(4): 617–632.
- ³¹ Sehgal, V.N., A.K. Sharma and S.N. Bhattacharya. 1992. "K.A.B.P. study on AIDS among school boys," abstract published in the 2nd International Congress on AIDS in Asia and the Pacific Abstracts. Randwick, Australia, AIDS Society of Asia and the Pacific.
- ³² Sharma, V. and A. Sharma. 1995. "Safe sex: A mirage in a desert? The sexual behaviour of adolescent boys in Gujarat, India," Paper presented at the 6th International Congress on Adolescent Health, Vancouver, 20–25 March.
- ³³ Watsa, M.C. 1993. "Premarital sexual behaviour of urban educated youth in India," paper presented at the Workshop on Sexual Aspects of AIDS/STD Prevention in India, Mumbai, 23–27 November.
- ³⁴ National AIDS Control Organisation (NACO) and UNICEF. 2002. *Knowledge, Attitudes and Practices of Young Adults (15–24 years)*. New Delhi: NACO and UNICEF.
- ³⁵ National Base Line High Risk and Bridge Population Behavioural Surveillance Survey, 2001, NACO, GOI.
- ³⁶ Sexual health of males in South Asia who have sex with other males results of situational assessments in four cities in India and Bangladesh, Naz Foundation International
- ³⁷ Verma, Ravi K, et al. ed. (2004), *Sexuality in the time of AIDS*, Sage Publication. New Delhi
- ³⁸ Rekha Masilamani, 2003 cf. Verma, Ravi K, et al. ed. (2004), *Sexuality in the time of AIDS*, Sage Publication. New Delhi
- ³⁹ Bott, Sarah et al (2003), *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*, WHO, Geneva
- ⁴⁰ Greene, M.E., 1997 Regional working paper No. 7, Pop. Council
- ⁴¹ *ibid*
- ⁴² Verma, Ravi K, et al. ed. (2004), *Sexuality in the time of AIDS*, Sage Publication. New Delhi