Sexual & Reproductive Health & Rights:

A training manual for NGOs

Australian Government

Aid Program

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This manual is produced with funding from the Australian Government under the Human Rights Small Grants Scheme.

About Center for the Righ to Health (CRH)

Center for the Right to Health is a non governmental organisation dedicated to research, service delivery, advocacy and education the full realisation of the right to heallth in Nigeria.She promotes respect for ethics and human rights in healthcare policies and practices especially for vulnerable populations such as women, youth, children, people living with HIV/AIDS and sexual minorities.

The information and opinions expressed in this manual are those of the authors. They do not imply the expression of any opinion whatsoever on the part of the Australian Government or the High Commission in Nigeria.

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Center for the Right to Health (Nigeria). 2010. Sexual & Reproductive Health and Rights: A training manual for NGOs. 2010

ISBN: 978-978-908-967-3

Foreward

Center for the Right to Health, Nigeria (2010) **Sexual and Reproductive Health and Rights: A training manual for NGOs** (Lagos: CRH).

It is with much delight that I welcome the publication of this five-module training manual as a useful addition to the growing collection of Nigerian training materials that deal with sexual and reproductive health and rights (SRHR) in a holistic and multi-faceted way. It is a manual designed to foster intensive peer learning in a way that serves as a guide to program development and management professionals implementing sexual and reproductive health and rights projects especially at the community level. Though NGO-oriented, its contents are so strongly evidence-based and reflective of the state-of-the-field that a wide range of potential users including donor agencies, for-profit organizations and corporate bodies can make use of it for building the capacity of their staff members that are involved in designing, implementing, monitoring or evaluating SRHR programs and interventions targeting vulnerable populations and communities.

The manual is well-structured through modules that each cover specific thematic areas and by providing succinct overviews and critically introducing the key elements and issues in programming for vulnerable groups around adolescent SRH, gender equity and women's rights dimensions of SRH, SRH of special groups, and SRH advancement advocacy, this manual serves as a good illustration of the multi-disciplinary and cross-sectoral nature of SRHR. In defining and showing linkages between such basic concepts as human rights, sexual health, sexual rights and reproductive rights, the first and subsequent modules of the manual help to clarify and simplify the central point that without enjoying certain fundamental economic, social, political and legal rights, women, young people and vulnerable groups like persons living with HIV, female sex workers and sexual minorities stand very little chance of enjoying sexual and reproductive health and rights.

I strongly believe that users of this manual will find its contents useful as tools for engendering a more informed engagement in advocacy and programming interventions to advance the reduction and eventual eradication of sexual and reproductive ill-health and sexual and reproductive rights abuse in contemporary Africa.

It is therefore my hope that this training manual will catalyze among both trainees and trainers-cum-facilitators a better grasp of basic concepts of SRHR and equip them with the conceptual and advocacy tools for improved programming to advance the SRHR status of vulnerable groups and communities in Africa as a whole and Nigeria in particular. It is a hope founded on the high quality and relevance of its contents.

- Babatunde A. Ahonsi, Ph.D
Population Council
Abuja, December 2010

Acknowledgements

This manual was produced with funding from the Australian Government under the Human Rights Small Grants Scheme. We are greatly indebted to the Australian Government and People for their generous support. We are also grateful to the Australian High Commissioner to Nigeria, Mr Ian McConville and the High Commission Staff in Nigeria for their generous assistance.

This manual was developed by a team of Consultants: Ebenezer Durojaiye Esq, Mrs. Abimbola Onigbanjo-Williams and CRH Staff: Dr Stella Iwuagwu, Dr Godwin Emmanuel, Mr. Bede Eziefule and Ms. Bridget Okeke Final editing by Mr. Bede Eziefule and Dr. Stella Iwuagwu. Dr Pat Matemilola, Dr Kofoworola Odeyemi, Dr Eric Ajayi and Dr Otihbo Obianwu contributed to the review of the Manual. We are very grateful for all their contributions. We thank Dr Babatunde Ahonsi for writing the foreword.

We remain grateful to all the community members and Professionals who further reviewed the manual to ensure they align with their community needs. They include: Oluwatosin Akomlafe, Obi Peter, Osuagwu Glory, Simon Elizabeth, Thaddeus Ugoh, Necus Agba, Faith Edeme, Nwanguma Vanessa, Isigbo Sylvia and Akpa Chinyere. We are equally grateful to all the participants at the Abuja and Owerri Sexual and Reproductive Health and Rights (SRHR) workshops held in 2010 where the contents of the manual were pretested and reviewed.

We are also grateful to the following for their logistic and administrative support. They are Patience Okekearu, Ganiyu Dirisu, Christy Ekerete Udofia and Sunday Ewie.

Abbreviations

AIDS	Acquired Immuno deficiency Syndrome
ACHPR	African Commission on Human and Peoples' Rights
ASRH	Adolescent Sexual Reproductive Health
CBOs	Community Based Organisations
CRH	Center for the Right to Health
CSOs	Civil Society Organisations
CDC	Center for Disease Control
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GIPA	Greater Involvement of People living with HIV/AIDS
HIV	Human Immunodeficiency Virus
HCT	HIV Counseling and Testing
ICPD	International Conference on Population and Development
ICT	Information, Communication and Technology
IDU	Injection Drug Users
ILO	International Labour Organisation
ICRW	International Center for Research on Women
BCC	Behaviour Change Communication
IPPF	International Planned Parenthood Federation
LGBT	Lesbian, Gay, Bisexual and Transgender
MARPs	Most At Risk Persons
MLWHA	MSM Living with HIV/AIDS
MGM	Male Genital Mutilation
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NGO	Non Governmental Organisation
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
STIs/D	Sexual Transmitted Infections/Diseases
SRHR	Sexual Reproductive Health and Rights
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund

UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Childrens Fund
WHO	World Health Organisation
WSW	Women who have Sex with Women
YPLHIV	Young People Living with HIV/AIDS

Table of Contents

User Guide
This manual serves as a guide for training programmers implementing sexual reproductive health and rights (SRHR) projects in Africa, though specifically in Nigeria. This guide provides useful information on prevailing critical issues and interventions to inform useful programming that targets beneficiaries at the grassroots level.

Who is this manual for?
This manual is targeted at non profit organisations, profit organisations, foundations, corporate, and donor agencies to serve as a guide in implementing SRHR programs in Nigeria and Africa. This manual serves as an evidence based tool to implement sustainable programmes that yields results to inform policy changes and programmes for vulnerable groups. This manual can also be used byall levels of programmers , technical advisers on HIV, SRHR programmes as well as trainers in all settings. Thus, this manual is beneficial to all involved in HIV/SRHR Programming.

How should this manual be used?
This manual should be used alongside handouts prepared for each Module. Objectives for each module has been developed as a guide to aid power point presentations for facilitation. Power point presentations for trainings can be developed from the handouts. In preparation for training modules, review definitions of concepts in sexual and reproductive health and rights, be prepared to discuss different concepts in sexual and reproductive health and rights and place instructions for Group Activity on Power Point.

Structure of the manual
The manual is structured into modules covering thematic areas on prevailing sexual and reproductive health issues affecting vulnerable groups. Each module has an overview, critical issues and interventions for program development.

MODULE 1.0

Definition of Concepts

OBJECTIVES

- To explore and deepen understanding of concepts used in sexual and reproductive health and rights.

MATERIALS

- Session objectives written on flipchart, PowerPoint or overhead slides if available
- Flipchart stand, masking tape, flipchart and markers

RESOURCES

? UNAIDS, 2007 AIDS Epidemic Update
? UNAIDS, 2006 Report on the Global AIDS Epidemic or a more current report
? Universal Declaration of Human Rights
? International Covenant on Economic, Social and Cultural Rights
? Constitution of the Federal Republic of Nigeria, 1999
? African Charter on Human and People's Rights (Ratification and Enforcement Act, Cap 10, LFN, 1990
? Programme of Action of the International Conference on Population and Development (ICPD), 1994
? Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, 2007-2010
? WHO working definition, 2002
? General Comment No. 14. The right to the highest attainable standard of health CESCR, 2000
? The Right to Health: Fact Sheet No. 31 WHO and UNHCR
? Joint Fact Sheet WHO/OHCHR/323

(http://www.who.int/mediacentre/factsheets/fs323_en.pdf)

? The Right to Health cartoon (http://www.who.int/hhr/news/en/cartoon_health.pdf)

PREPARATION

- Draft and review Power Point presentation.
- Review definitions of concepts in Sexual and reproductive health and rights.
- Be prepared to discuss different concepts in sexual and reproductive health and rights
- Place instructions for Group Activity on Power Point, fip chart or overhead projector.

STEP ONE

Exploring different concepts

- Review the objectives of Session 1 with the participants on a flip chart.
- Have the group brainstorm, participants record on a flip chart the definitions of each concept.
- Ask the participants to discuss their issues and comments

STEP TWO

Group Activity

- Further review the objectives of Session #1 with the participants on a flipchart.
- Divide participants into three groups. Ask participants to proffer definitions on flip charts.
- Ask participants to have a 10 minutes presentation.
- Present Power Point slide show.

STEP THREE

? Present power point clarifications of all concepts

Human Rights

Human rights are inherent in man; they arise from the very nature of man as a social animal. Human rights constitute a body of unique virtues, which are highly cherished and valued from inception of time. In a paper presented by Hon. Justice Izuako (2002) at a seminar on “HIV/AIDS and Human Rights: The Role of the Judiciary,” human rights were described in the words of former Indian Chief Judge, Justice B.N.Bhagwati, as not ephemeral, not alterable with time and space and circumstances. They are not the product of philosophical whim or political fashion. They have their origin in the fact of the human condition, and because of this origin, they are fundamental and inalienable. More specifically, constitutions, conventions, or governments do not confer them. These are the instruments, the testaments of their recognition; they are important, sometimes essential elements of the machinery for the protection and enforcement of human rights, but they do not give rise to human rights. Human rights were born not of humans but with humans.

The concept of human rights is grounded in concepts of human dignity and equality, which can be found in most cultures, religions, and traditions that are today reflected in many legal systems. Every human being have the same fundamental social, cultural, civil, and political rights as any other person by virtue of their humanity. These rights are universal, indivisible, interdependent, and interrelated. The need to protect and promote human rights is predicated on the standards contained in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights (ratified by Nigeria in 1993), and domesticated by means of the African Charter on Human and People's Rights (Ratification and Enforcement Act, Cap 10, LFN, 1990) and other international human rights instruments, such as International Labour Organisation (ILO) instruments concerning discrimination in employment and occupation, termination of employment, protection of workers' privacy, and safety and health at work. Many of these fundamental rights are enshrined in Chapter IV of the Federal Constitution of Nigeria 1999.

Right to Health

.....

Right to Health is stated in the Universal Declaration of Human Rights, Article 25 in 1948. The article says that "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family..." The Preamble to the WHO constitution also declares that it is one of the fundamental rights of every human being to enjoy "the highest attainable standard of health". Inherent in the right to health is the right to the underlying conditions of health as well as medical care.

The United Nations expanded upon the "Right to Health" in Article 12 of the International Covenant on Economic, Social and Cultural Rights in 1966. Not only did this document guarantee the "right of everyone to the enjoyment of the highest attainable standard of health", but it also specifically called for the "provision for the reduction of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational, and other diseases; and the creation of conditions which could assure to all medical service and medical attention in the event of sickness." In 2000, the United Nations further expanded upon the "Right

to Health" with General Comment No. 14. This lengthier document expanded upon the original ideas from 1966 by exploring the historical context of this right, further defining the meaning of an adequate health care system, detailing obligations of states and NGO's, defining violations, and discussing the basics of implementation.

Even though the right to health care is not expressly provided for under Chapter IV of the 1999 Nigerian Constitution (i.e., under Fundamental Rights), it is provided for under Chapter II of the Constitution (i.e.,Fundamental Objectives and Directive Principles of State Policy). S.17(3)(d) provides that there shall be “adequate medical and health facilities for all persons.” This is further buttressed by Art. 16 of the ACHPR, which provides that state parties to the charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexual and reproductive health and well-being are essential if people are to have responsible, safe, and satisfying sexual lives. Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour. These factors affect whether the expression of sexuality leads to sexual health and well-being or to sexual and reproductive ill-health. Health programme managers, policy-makers and care providers need to understand and promote the positive role sexuality can play in people's lives and to build health services that can promote sexually healthy societies.

[1]WHO working definition, 2002(World Health Organization. WHO global burden of disease (GBD) 2002 estimates (revised). Available from: www.who.int/healthinfo/bodestimates/en/

The past three decades have seen dramatic changes in understanding of human sexuality and sexual behaviour. The pandemic of human immunodeficiency virus (HIV) has played a major role in this, but it is not the only factor. The toll taken on people's health by other sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortion, infertility, gender-based violence, sexual dysfunction, and discrimination on the basis of sexual orientation has been amply documented and highlighted in national and international studies. In line with the recognition of the extent of these problems, there have been huge advances in knowledge about sexual function and sexual behaviour, and their relationship to other aspects of health, such as mental health and general health, well-being and maturation. These advances, together with the development of new contraceptive technologies, medications for sexual dysfunction, and more holistic approaches to the provision of family planning and other reproductive health care services, have required health providers, managers and researchers to redefine their approaches to human sexuality.

Sexual health was defined as part of reproductive health in the Programme of Action of the International Conference on Population and Development (ICPD) in 1994. Statements about sexual health were drawn from a WHO Technical Report of 1975 (1), which included the concept of sexual health as something “enriching” and that “enhance[s] personality, communication and love”. It went further by stating that “fundamental to this concept are the right to sexual information and the right to pleasure”.

Reproductive Health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies

that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Sexual and Reproductive Rights

[2]United Nations International Conference on Population and Development. Reproductive rights and reproductive health. Programme of action of the United Nations ICPD. 1994. (accessed April 29, 2008), Available from: www.iisd.ca/Cairo/program/p07002.html)

Sexual rights are human rights related to sexuality. International Planned Parenthood Federation affirms that sexual rights are human rights. Sexual rights are constituted by a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people.

Reproductive rights

Reproductive rights are a series of legal rights and freedoms relating to reproduction and reproductive health. According to WHO, reproductive rights stem from the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

Reproductive rights began to develop as a sub set of human rights at the United Nation's 1968 International Conference on Human Rights. The resulting non binding Proclamation of Teheran was the first international document to recognize one of these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children." States, though, have been slow in incorporating these rights in internationally legally binding instruments. Thus, while some of these rights have already been recognized in hard law, that is, in legally binding international human rights instruments, others have been mentioned only in non binding recommendations and, therefore, have at best the status of soft law in international law, while a further group is yet to be accepted by the international community and therefore remains at the level of advocacy.

Issues related to reproductive rights are some of the most vigorously contested rights' issues

worldwide, regardless of the population's socio-economic level, religion or culture. Reproductive rights may include some or all of the following: the right to legal or safe abortion, the right to birth control, the right to access quality reproductive healthcare, and the right to education and access in order to make reproductive choices free from coercion, discrimination, and violence. Reproductive rights may also include the right to receive education about contraception and sexually transmitted infections, and freedom from coerced sterilization, abortion, and contraception, and protection from gender-based practices such as Female Genital Cutting (FGC) and Male Genital Mutilation (MGM).

The 1995 Fourth World Conference on Women in Beijing, in its non binding Declaration and Platform for Action, supported the Cairo Programme's definition of reproductive health, but established a broader context of reproductive rights:

> *The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences*
>
> *[Para.96].*

Box 1.1 Gender, Sex and Sexuality

Gender refers to the socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men and women. The distinct roles and behaviour may give rise to gender inequalities, i.e. differences between men and women that systematically favour one group. In turn, such inequalities can lead to inequities between men and women in both health status and access to health care.

Sex refers to one's biological characterstics- anatomical (breasts, vagina, penis etc) that define one as a male or female . Sex is also a synonym for sexual intercourse , which includes penile vaginal sex , oral sex and anal sex.

Sexuality is an expression of who we are as human beings. Sexuality includes all the feelings, thoughts, and behaviurs of being male or female, being attractive, and being loved, as well as being in relationships that include initimacy and physical activity.

MODULE 2.0

Adolescent Sexual and Reproductive Health (ASRH)

OBJECTIVES

- Understand the concept of Adolescent Sexual Reproductive Health (ASRH)
- Define and identify effective youth/adult partnerships and youth involvement.
- Describe the link between ASRH and gender and develop strategies to aid gender-sensitive ASRH programs and services.
- Understand adolescent behaviour change as a multi-layered dynamic.
- Design strategies and programmes providing adolescent-friendly ASRH services.
- Identify the steps in building life skills for youth programmes
- Identify sustainability components intrinsic to ASRH programmes and develop strategies to improve the sustainability of ASRH programmes and services.

MATERIALS

- Session objectives written on flipchart
- Flipchart stand, masking tape, flipchart and markers
- Multi Media

RESOURCES

- UNAIDS, 2010 AIDS Epidemic Update
- UNAIDS, 2009 Report on the Global AIDS Epidemic
- www.youthcoalition.org. Youth & HIV fact sheet
- http://www.avert.org/prisons-hiv-aids.htm
- UNAIDS 1997. Prison and AIDS. http://data.unaids.org/Publications/IRC-pub05/prisons-pov_en.pdf
- WHO, 2004. Evidence for action on HIV/AIDS and injection drug use: Policy brief-Reduction of HIV transmission in prisons. http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.05.pdf
- Cook R. and B.M. Dickens. 2000. Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Health
- James-Traore, T. A. 2001. Developmentally Based Interventions and Strategies: Promoting Reproductive
- Health and Reducing Risk among Adolescents.
- Okonofua F. E. 1992. Factors Associated with Adolescent Pregnancy in Rural Nigeria. [Ob/Gyn Obafemi Awolowo University, Ile-Ife, Nigeria],

PREPARATION

- Draft and review Power Point presentation.
- Review critical issues and interventions from the handouts.
- Be prepared to discuss critical issues and interventions among special vulnerable groups.
- Place instructions for Group Activity on Power Point.

Facilitation session

STEP ONE

- Understand the concept of ASRH programs and services
- Review the objectives of Session with the participants on a flipchart.
- Have the group brainstorm; participant record on a flip chart these definitions: Gender role, Gender expectation, sex, sexuality, sexual health and sexual pleasure.
- Ask participants to discuss their issues and comments

- Present Power Point slide show on the concept of ASRH,
- Ask the participants to give feedback on the definition.

STEP TWO

- Describe the link between ASRH and gender, and develop strategies to develop gender-sensitive ASRH programs and services
- Review the objectives of session with the participants on a flipchart.
- Divide participants into groups based on special groups. Ask participants to discuss the relationship between ASRH, gender and its development strategies. Each group should make a brief presentation on flip charts.
- Present Power Point slide show.
- Discuss issues associated with Adolescent behavior change, (Risky behaviour, sexual education and promotion.

STEP THREE

- Identify the sustainability components intrinsic to ASRH programmes and develop strategies to improve the sustainability of ASRH programmes and services
- Review the objectives of this session with the participants on a flipchart.
- On a flip chart, ask participants to highlight different methodologies that could be adopted in developing a sustainability component in ASRH programme design.
- Present Power Point slide show.
- Discuss other ways of sustaining ASRH programmes and services.
- Ask participants to mention characteristics of adolescent behaviour change as a multi-layered dynamic.

Group Activity

Divide participants into four groups and ask them to develop strategies on providing the following.

- Adolescent-friendly ASRH services.
- Identify the steps in incorporating life skills in a youth programme

Adolescence is a stage in life when boys and girls go through physical and mental developmental growth starting with puberty. This is a period of transition from child hood to adult hood. Their bodies change and they experience new emotions as they begin to become adults. Like any developmental period in the life cycle, adolescence brings with it opportunities for growth as well as risks and challenges. Ideally, adolescents experience their natural sexual development with healthy enjoyment and wonder.

The World Health Organization (WHO) defines "adolescence" as persons ages 0-19 and "young people" as ages of 10-24. However, different countries have different definitions for adolescence and young persons. Youth is a period between childhood and adulthood; it involves distinct physiological, psychological, cognitive, social and economic changes. Terms used to classify individuals between the age of 10 and 24 are referred to as youth, young people, young adults, adolescent and teenagers. Technically, adolescents are defined as individuals ranging in age from 10 to 19, while youths are defined as individuals between ages 15 and 24.

Nature of adolescence

- ? Progression from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity;
- ? Development of adult mental processes and adult identity;
- ? Transition from total socio-economic dependence to relative independence

Stages of Adolescence

- ? Pre-Puberty (Under age 10)
- ? Early Adolescence (10 14)
- ? Middle Adolescence (15 19)
- ? Young Adulthood (20 24)

Factors that influence Adolescent Developmental and Reproductive Health

Several factors that influence adolescent developmental and reproductive health are identified below. Although their degree of influence may vary at different points, they all shape how young people experience the transition from childhood to adulthood.

BIOLOGICAL Biological and physiological changes, such as physical growth, the development of secondary sex characteristics and menarche occur during puberty and early adolescence. They, in turn can influence an adolescent's psychological development, self-image and peer and other relationships, plus the social expectations placed on adolescents.

EMOTIONS The emotional aspects of a young person's development include the role feelings play in motivating behaviour, how adolescents feel about themselves in relation to their peers and others, how they view their bodies and what their interpersonal relationships are. These emotions can manifest as excitement, optimism, change and growth from the perspective of adolescents; however, circumstances can sometimes defeat those very positive emotional characteristics.

COGNITION As development progresses, enhanced thinking skills enable an adolescent to move from concrete to abstract thought. This process has an impact on the way information is perceived and understood. Consequently, it has implications for how behaviour, change communication (BCC) materials, counseling and reproductive health services should be designed and delivered.

IDENTITY Adolescence is a time for discovering "Who am I?" The development of identity largely determined by culture and tradition is also linked to family and peer relationships, values and the meaning of being male or female in a given society. Girls are particularly vulnerable to negative reproductive health outcomes because they are often assigned roles that limit and constrain their independence and decision making, placing them at greater reproductive health risk. Although attitudes vary, most cultures expect young women to abstain from premarital sex while tolerating, or sometimes even encouraging it for males.

FAMILY In most cases, adolescent development takes place within the context of the nuclear or extended family. The degree to which this developmental period results in family tension and conflict rather than support and celebration will vary. Societal and familial expectations and the nature of family relationships, as well as significant events such as births, deaths and separation, all affect how young people develop. Family stability can be especially critical and disruptions, including death, divorce, or separation, can have a lasting effect on adolescent behaviour and development. In addition, some adolescents are institutionalized, fighting wars, living on the streets, orphaned, or have married or formed other partnerships.

SOCIETY Adolescent development also takes place within the context of the adolescent's social environment. The healthy development of social skills is reflected in interpersonal and group relationships and in the balance between healthy group interaction, individuality and independence.

ETHICS AND MORALITY A sense of ethical standards and morality, or values, helps an individual distinguish between right and wrong and shapes decisions about individual behaviour. That sense is evident in an awareness of broader issues affecting not only the individual, but also the family, the community and the society.

Because of these factors, adolescence, especially in its early stage, is an optimal time to influence the development of healthy gender roles as well as positive and productive goal setting. Data confirm that adolescents do listen to adults and that positive relationships with adults can reduce some of the potential hazards associated with adolescence and can increase positive behaviours. Outlined in this tool are intervention strategies that focus on prevention. These strategies hold special promise for younger adolescents.

Key developmental characteristics during the stages of adolescence

A. Pre-Puberty (under age 10)

Biological

- ? Has an immature reproductive organ.

? May begin to develop signs of puberty such as budding breasts and pubic hair.

Emotional
? Can be impulsive.
? Have difficulty expressing feelings.

Cognitive
? Is learning to master skills.
? Finds that play is an essential way of learning.
? Has limited language skills (difficulty putting feelings into words).
? Is curious.
? Has difficulty distinguishing fantasy from reality.
? Is creative.
? Has unrestrained imagination.
? Is oriented to the moment.
? Is receptive to new ideas.
? Has very concrete thinking.
? Sees behaviour in terms of right and wrong.

Identity
? Is sensitive to gender differences.
? Distinguishes gender roles based on observations and societal norms.
? Copies adult behaviour.

Family
? Has values determined by family and society.
? Spends the majority of time with family.
? Is dependent on parents and extended family caretakers.
? Has a parent or relatives who make all decisions.

Sexuality
? Is exploratory, particularly in relation to body parts.
? Is curious about opposite sex.

Social
? Is competitive (especially among boys).
? Shows tendency toward aggressive behaviour (also more often among boys).
? Has strong desire to please (especially among girls).
? Are rules oriented.
? Is physically active.

Ethics/Morality
? Values and beliefs determined by family.
? Adheres to values with little questioning.

B. Early Adolescence (ages 10 14)

Biological
? Puberty begins and body changes; growth spurts occur.
? Ovaries mature in girls in preparation for menstruation.
? Menstruation begins in most girls.
? Breasts enlarge in girls.
? Hips widen in girls.
? Girls are able to get pregnant.
? Boys can produce sperm.
? Genitals enlarge.
? Acne develops.
? Boys experience nocturnal emissions (“wet dreams”).
? Muscles enlarge in boys.

Emotional
? Exhibits behaviour driven by feelings.
? Has a frequent mood swing.
? Is confused about emotional and physical changes.

Cognitive
· Is learning to master skills.
· Sees behaviour in terms of right and wrong.
· Responds best to rewards and punishment.
· Has thinking that becomes more abstract and less concrete.
· Tends to suppress feelings.
· Is receptive to new ideas.
· Questions conflicting messages.
· Feels invincible or fatalistic.
· Is fearful of the future.
· Lacks control over life or feels that he or she lacks control.
· Seeks to make more decisions.

Identity
· Models same-sex behaviour.
· Learns gender roles and differences.
· Tends to associate with members of the same sex.
· Girls tend to focus on relationships and nurturing, while boys focus on achievement and competition.
· Has self-esteem that is primarily influenced by others.
· Is preoccupied with physical appearance.

Family
· Spends majority of time with family but is beginning to move away from family toward peers.

- Generally has close relationship with parents or extended family, caretakers and advisors.

Sexuality
- Begins to develop interest in opposite sex.
- Is interested in own physical development, particularly in relation to peers.
- May begin to masturbate.
- May begin to experiment with sex play.
- May have sexual intercourse.

Social
- Increasingly transfers interest from family to friends and others as central focus.
- Recognizes wider social spectrum outside the family.
- Is concerned with social and sexual behaviour and acceptance by peers and adults.
- Begins to interact with opposite sex.
- May be socially recognized as an adult. May go through pre-marriage or marriage rules or rituals.
- Experiences rites of passage in various forms.
- Seeks acceptance by peers.

Ethics/Morality
- Has values, beliefs and religion primarily determined by family.
- Is aware of different values.

C. Middle Adolescence (ages 15 – 19)

Biological
- Continues physical growth, development and sexual maturation.
- Pace of physical and emotional development in relation to peers' development is important.

Emotional
- Starts to challenge rules and test limits.
- Feelings contribute to behaviour but do not control it.
- Is less impulsive. Begins to respond based on thoughtful analysis of potential consequences.
- Develops more advanced problem-solving skills.
- Concerned with self-image compared with peers.
- May be encouraged to participate in rites of passage.
- Males more likely to engage in sexual activity before marriage, with multiple partners, than females.

Cognitive
- Desires more control over own life.
- Begins to develop own value system.
- Thinks in more abstract terms.

Identity
- Has sense of self that is largely shaped by peers, although becoming less so.

- May be struggling with gender identification.
- May be married and under strong influence of spouse, relatives.

Family
- May become more distanced from family and may seek more privacy.
- Moves away from parents toward peers.
- May marry and move away from family of origin.
- May have children.

Sexuality
- Has increased sexual interest.
- May initiate sex within or outside of marriage.
- May struggle with sexual identity.
- May be introduced into various sexual acts.

Social
- Peers influence leisure activities, appearance, substance use and initial sexual behaviors.
- Family influences education, career, religious values and beliefs.
- Relationships are developed and are based on mutual expectations and on conformity to group norms
- Regarding time apart from spouse and children, family obligations, hairstyles, dress, music, etc.

Ethics/Morality
- Increases exposure to the values and beliefs of others.
- Starts to question own beliefs, which may lead to conflicts with parents or family.
- Begins to develop own set of values.

D. Young Adulthood (ages 20 – 24)

Biological
- Has reached sexual and physical maturity.

Emotional
- Is better able to resolve conflicts.
- Develops more stable relationships.
- Is able to recognize and seek help when needed.
- Has developed a stronger sense of self.

Cognitive
- Demonstrates improved problem solving skills.
- Shows greater understanding of behavioural consequences of actions.
- Has clearer definition of self.

Identity
- Struggles with adult roles and responsibilities.
- Struggles between dependence and independence.

- Struggles with competing demands of spouse, family, community and self.

Family
- Begins to reintegrate into family as a new, emerging adult.
- Begins to create a "fit" between newly defined self and family.
- Is clearer about roles and expectations.
- Is more aware of self in relation to others, including spouse.
- Relates to spouse and family as a fully autonomous adult.
- Is comfortable with role as adult.

Sexuality
- Develops serious intimate relationships that replace group relationships as primary.
- Develops adult social relationships.
- Is ready to enter into a committed relationship.

Social
- Shows that importance of peer interaction for decision making has diminished.
- Has a diminished role of peer relationships as a decisive factor in personal beliefs and actions.
- Makes choices about career or vocation and about roles inside and outside the home.
- Completes education; prepares for employment.
- Prepares for parenthood.
- Can balance the needs of self and others on the basis of healthy interaction.
- Achieves socially recognized status with clear adult rights and responsibilities while showing advanced stages of "social conscience."

Ethics/Morality
- Is often caught between traditional and modern roles and values.
- Balances between own beliefs and those of the family

However, many adolescents and youth face sexual and reproductive health risks —sexually transmitted infections (STIs); HIV/AIDS; too early or unwanted pregnancy; unsafe abortion; and violence - which may be exacerbated by factors related to their age and physical maturity, and by gender-based biases. From a public health perspective, it is therefore important that adolescents have the right to obtain factual information and to comprehend all phases of their development, including their sexual development.

Critical Issues Facing Adolescents in Our Society

- Coping with the physical, emotional and social changes that accompany this period of transition from childhood to adulthood.
- Inadequate access to appropriate information, education and services to meet their peculiar needs during this transitional period.
- Weakening of traditional norms and support systems for adolescence
- Reduction in the influence of the extended family due to urbanization
- The globalization of communication and the mixed and confusing messages about male versus female sexuality portrayed in the mass media.

- Decline in annual earnings of families resulting in pressure on young people to contribute to family income in the face of decreasing job and economic opportunities.
- Gender inequities including the double standard on sex before marriage, where premarital sex is restricted for girls and tolerated for boys.
- Sexual exploitation and abuse of children and teenagers, sometimes by family members and people with authority over them such as teachers, clergy, mentors e.t.c.
- Rape of young college girls especially in university campuses, villages and cities.

Although many young people are unprepared to face these challenges, the way they respond to them now can affect the rest of their lives.

Unwanted Pregnancy
It is defined as a pregnancy that is not wanted either by one or both of the biological parents.

Factors responsible for unwanted/unintended pregnancy in Nigeria include:
- Limited access to accurate and comprehensive information and services on sexual and reproductive health
- Unprotected sex or ineffective use of contraception by sexually active persons
- Societal, parental or partners' pressure on young women to bear children
- Unwanted sexual relations, sexual exploitation and abuse

The health and social consequences of unwanted pregnancy include:
- Girls aged 10 -14 years are five times more likely to die in pregnancy or childbirth than women aged 20 – 24 years.
- Pregnancy-related complications are the main cause of death in 15-19 year old girls worldwide.
- Other health complications for mother and child include bleeding in pregnancy, severe anemia, prolonged difficult and obstructed labour, still birth, low birth weight and infantile death.
- Socio-economic consequences for the young person may include termination of education, poor job prospects, loss of self-esteem and broken relationships.

Unsafe Induced Abortion
Abortion can be defined as the termination or loss of a pregnancy at an early stage. Pregnancy can terminate on its own (miscarriage or spontaneous abortion) but when pregnancy is intentionally terminated, it is referred to as induced abortion. Induced abortion is unsafe when untrained personnel using inappropriate and contaminated instruments, under unhygienic conditions to perform it. The extent of unsafe abortion in the country is difficult to ascertain. This is largely because induced abortion is illegal and as such it is done secretly and thus under-reported.

Complications of unsafe induced abortion include:
- Excessive bleeding or hemorrhage, perforation of the uterus or bowel
- Infection that can result in infertility and death

Reasons why young girls continue to procure abortions include:
- Lack of accurate and comprehensive information about their sexual and reproductive health
- Lack of appropriate reproductive health counselling and clinical services
- Non-use or ineffective use of contraceptives by sexually active young people

- Fear of rejection by partners, parents, peer group, religious and community leaders, once they find out about their pregnancy.
- Financial and emotional inability to care for a baby

Induced unsafe abortion has a lot of health and socio-economic consequences for the young woman, her parents and the society at large.

STIs/HIV
Sexually Transmitted Diseases (STIs) are infections that spread from one person to another through sexual intercourse. Examples of common STIs are Gonorrhea, Syphilis, Chlamydia, Trichomoniasis, Herpes and HIV. STIs are often untreated, with young women especially being vulnerable to infertility and premature deaths.

Why are Young People at Risk of STIs/HIV?
Most young people know very little about STIs/HIV even when they are sexually active. Many young people engage in sexual relationships with more than one partner. Even when sexually active young people know about STIs/HIV, most of them don't protect themselves from being infected, while many young people are often reluctant to seek treatment for STIs because hospitals are not youth friendly. Some young people especially females, exchange sex for money for varying socio-economic reasons. Many young people are coerced into exploitative sexual relationships which they have little control over in their homes, school or work places.

Health Consequences of contracting STIS/HIV can lead to serious health problems if they are not treated early and properly. These health complications include:
- Chronic lower abdominal pain and infertility
- Menstrual problems and ectopic pregnancy
- Problems with passing urine
- Death

Factors influencing sexual and reproductive health of adolescents in sexual activity

- Early outset of sexual maturation and the accompanying natural increase in body secretions (sex hormones) which stimulate sexual urges in adolescent boys and girls.
- Pressure by the peer group and adults on young people to engage in sexual relations.
- Increasing socio-economic problems which result in pressures on young people to exchange sex for money.
- Glamorization of sex in the mass media without equally highlighting the associated risks.
- Permissive attitude of society towards premarital sexual relations for boys as part of their predatory sexual socialization.
- Culture which places higher value on child-bearing as a greater achievement for girls.
- Parents who give out their daughters in marriage at an early age for economic gains or under the guise of protecting her from herself or temptation from others.
- Delayed marriage for reasons of increasing focus on educational/career pursuits. While marriage is being delayed, the other factors listed above combine together to influence sexual activity among young people.

Barriers to adolescent sexual and reproductive health

- In most countries, adolescents face significant barriers to using contraception. Service-related barriers include incorrect or inadequate information, difficulty in traveling to and obtaining services, cost and fear that their confidentiality will be violated.
- Personal barriers that especially deter young women from accessing and using contraception include fear that their parents will find out, difficulty negotiating condom use with male partners, fear of violence from their partner and concerns about side effects.
- Social, cultural and economic factors also greatly influence young people's ability to protect themselves from unwanted pregnancy and STIs, including HIV. Mass media, materialism, migration and/or urbanization may increase both the desire and opportunity for sexual activity and many youths feel strong peer group pressure to engage in sexual intercourse. Some cultures may promote early sexual intercourse by expecting women to marry and begin childbearing at an early age.

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Gender and Adolscent Sexual & Reproductive Health (Exploring Sex, Gender, roles and expectations)

Gender is defined as the social relationships between men and women and the way that relationship is made by society. In other words, gender is how we are shaped after we are born into society. While biological attributes can sometimes be altered, biological sex is essentially fixed. In contrast, gender definitions are in a constant state of flux in response to changing social and economic conditions. For example, in situations of war with migration of men, women may take on traditional male roles e.g. heads of families, soldiers. Because gender is constructed by society and not fixed, stereotypical constructed notions of male and female roles can be challenged. When we say that men and women are not the same, we refer not only to their biological sex differences, but also to the different gender roles that have been created by society. Women and men have different needs, because of their sex and gender differences. Human rights and development concepts that recognize gender differences seek to address these needs in a way that promotes women and men's full participation in community and political life.

Gender can also refer to the economic, social, political and cultural attributes and opportunities associated with being male or female. The nature of gender definitions (what it means to be male or female) and patterns of inequality vary among cultures and change over time. Also, gender refers to the socially constructed roles and responsibilities of women and men. The concept of gender also includes the expectation held about the characteristics, attitudes and likely behaviours of women and men (femininity and masculinity). These roles and expectations are learned, changeable over time and variable within and between cultures.

Gender Perspective: A gender perspective is a theoretical and methodological approach that permits us to recognize and analyze the identities, viewpoints and relations, especially power relations influenced by gender systems. A gender perspective allows providers to go beyond focusing on women to view reproductive health as family health and as a social issue. It addresses the dynamics of knowledge, power and decision making in sexual relationships, between providers and clients and between community or political leaders and citizens.
Gender Equity: Gender equity is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that

prevent women and men from otherwise operating on a level playing field. Equity leads to equality.

Gender Equality: Gender equality requires equal access by women and men for socially-valued goods, opportunities, resources and rewards. This also means equality under the law, equality of opportunity (including equality of rewards for work and equality in access to human capital and other productive resources that enable opportunity), and equality of voice (the ability to influence and contribute to the development process). A gender approach looks not only at the roles and activities that women and men do, but also at the relationship between women and men. In defining Gender, equality outcomes should also be included which entails:

- Different cultures and societies can follow different paths in their pursuit of gender equality.

[3] OECD, 1998
[4] CIDA, 1999
[5] Paulson, et al., 1999 & Paulson, 1998
[6] Engendering Development, A World Bank Policy Research Report, 2001

- Equality implies that women and men are free to choose different (or similar) roles and different (or similar) outcomes in accordance with their preferences and goals.

Gender relations: This involves the way women and men relate to each other in their individual relationship and in groups. The issue here is: does either one have more power or authority than the other? If the answer is yes, then this creates inequality in the relationships between men and women. The use of gender relations as a tool of analysis shifts the focus from viewing women in isolation from men.

Gender Justice: Gender Justice refers to ideas and beliefs about gender relations, through increased levels of women's active engagement and critical leadership in institutions, decision-making and change processes.

Gender Mainstreaming: This is the process of assessing the implications for women and men of any planned action, including legislation, policies and programmes, in any area and at all levels.
It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and social spheres so that women and men benefit equally, and inequality is not perpetuated. It is vital to integrate a gender perspective and gender analysis into all stages of designing, implementing and evaluating projects, policies and programmes in social, economic and political spheres.

Feminism: Feminism advocates the social, economic and political equality of women and men. It is concerned with eliminating all forms of discrimination and gender-based violation against women.

Gender Roles: Who is a male? Who is a female? Your answers to these questions may depend on the types of gender roles you were exposed to as a child. Gender roles can be defined as the behaviours and attitudes expected of male and female members of a society by that society.

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Gender roles vary. Different cultures impose different expectations upon the men and women who live in that culture. Nigeria has experienced tremendous upheaval and revising of its

traditional gender roles in the last generation. These changes in gender roles affect the home, the workplace, and the school, and they affect all Nigerians to some degree.

Where Do Gender Roles Come From?

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A person's sexuality comes from within him or her, making a person heterosexual, homosexual, bisexual, or asexual, depending on the partners he or she is(or not) attracted to. Unlike sexuality, however, gender roles are imposed from without, through a variety of social influences. Formed during the socialization phases of childhood and adolescence, gender role issues influence people

throughout their lives. Conflict can arise when someone does not feel at ease with his or her gender role.
The first and one of the strongest influences on a person's perceived gender role is his or her parents. Parents are our first teachers-not only of such basic skills as talking and walking, but also of attitudes and behaviours. Some parents still hold traditional definitions of maleness and femaleness and what kinds of activities are appropriate for each.

Parents start early in treating their baby boys and baby girls differently. Although baby boys are more likely to die in infancy than girls, and are actually more fragile as infants than girls are, studies have shown that parents tend to respond more quickly to an infant daughter's cries than they are to those of an infant son. Parents also tend to cuddle girls more than they do boys. They are also more likely to allow boys to try new things and activities-such as learning to walk and explore-than they are girls; parents tend to fear more for the safety of girls.

According to Dr. Benjamin Spock, people are likely to appreciate girls' cuteness and boys' achievements. For example, a girl may receive the comment, "You look so pretty!" for the outfit she is wearing. While this compliment isn't harmful in itself, repeated over and over the message the girl gets is that she is most appreciated for her looks, not for what she can do. Boys, on the other hand, are praised for what they can do, "Aren't you a big boy, stand up by yourself!" Many parents encourage and expect boys to be more active, to be more rough-and-tumble in their play than girls. A boy who does not like rough play (and so goes against the gender role he has been assigned) may be labelled a "sissy." A girl who prefers active play to more passive pursuits may be called a "tomboy."

Children look to their parents for example as role models. If a girl sees her mother taking part in physical activities, for example, she will grow up with the idea that it's okay for girls to play sports. If a boy sees his father helping to take care of the new baby, he will integrate this image of "daddy as care giver" into his developing definition of masculinity. But just as parents can provide positive role models, so too can they serve as negative role models. For example, children who grow up with parents who are in an abusive relationship have been found to repeat the same pattern as adults: male children of abusive husbands often grow up to abuse their own wives, and daughters of abused wives can grow up to be victims of domestic violence, because their parents have shown them that this is "normal." Children develop their gender identity (knowing whether they are male or female) by the age of three. As preschoolers, they use some sexual stereotypes to help them differentiate between men and women-for example, to a preschooler, long hair may mean "female" and short hair, "male."
Another influence and reinforcement of gender roles comes from the toys children play with. During their infancy and toddlerhood, children get most of their toys from parents and other

family members; their choice of toys supports their own view of gender roles. For example, parents may give their little girl a doll to sleep with, while the boy gets a teddy bear. A grandparent may give a grandson a toy truck but never consider giving the same to a granddaughter. Such gifts set children up early on for the roles they are expected to play. As they get older, children are influenced in their choice of toys by television remote-controlled vehicles. Although they can be equally enjoyed by males or females, are generally targeted at boys by advertisers. Girls are the advertising targets of the manufacturers of dolls, craft kits, and so on; advertisers are careful not to call boys' toys "dolls"- they're "action figures"! Again and again, we see toys and toy advertisement reinforcing the traditional gender roles: boys are active and adventurous, while girls are passive and mothering. Parents need to be aware of the messages TV advertisements and toys present to their children. They need to help them understand and reconcile the person they are with the sexual stereotypes they may see on TV and in other media.

Nevertheless, parents can and do reinforce sexual stereotypes, whether deliberately or unwittingly. Not wanting to see a daughter fall and get hurt, a mother may forbid her from climbing trees; although her brother is allowed to do so with gleeful abandon, and his bumps and bruises are taken in stride. Clothing manufacturers produce (and parents buy) clothing in gender-neutral shades such as yellow and green, but the traditional blue for boys and pink for girls are still favourites. Even the cultural habit of assigning pink to girls and blue to boys raises a question, what's becomes of the boy who genuinely likes the colour pink? This question leads us to another group that has strong influence over gender roles: peers.

Peer pressure is a means of reinforcing a culture's traditional gender roles. It can come in the form of taunting or teasing a child who does not fit the traditional gender roles that other children in the peer group have been exposed to, even to the point of excluding that child from group activities. Peers react more positively to children who fit traditional gender roles. Gender roles are also reinforced by school. Teachers and school administrators have great influence as they pass along cultural information and expectations.

In school, children are expected to sit still, read, and be quiet. Such expectations may have been part of the gender role that a child has been learning from the parents, especially if the child is a girl. But for a boy who has been encouraged to be loud and boisterous prior to starting school, these expectations can lead to trouble. In fact, some researchers maintain that all boys face difficulty with expectations such as these because the structure of their brains makes them less able to meet these expectations than girls are. In my culture

- Men are expected to be tough
- Men are discouraged from crying
- Men are expected to show no emotions
- Men are expected not to back down
- Women are expected to be passive
- Women are expected to be caretakers
- Women are expected to act sexy, but not too smart
- Women are expected to be quiet
- Women are expected to listen to others
- Women are expected to be homemakers

Box 2.0 The More Things Change

The shifting of gender roles in the past 30 years has been huge. It has happened so quickly that men and women are still trying to sort out what the new roles and rules mean to them. Although women are no longer expected to be the keepers of the house, in reality, they are in most families. Although men are generally open to the successes enjoyed by the women they share their lives with, some still find it hard to celebrate a woman's triumphs because they feel it diminishes their own.

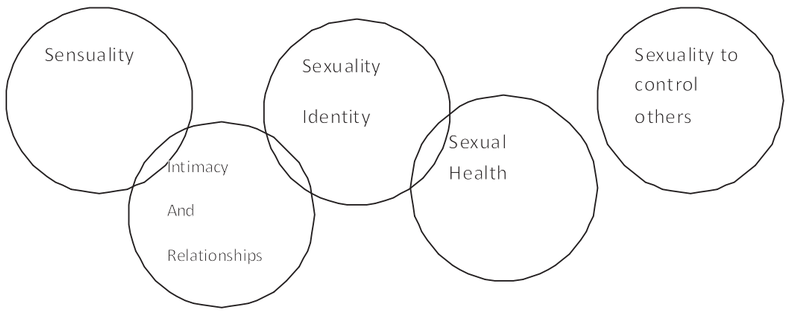
Sex, sexuality and sexual health

Understanding Sexuality

Sex, sexuality and sexual health (sexual desire and sexual pleasure)

Sex refers to one's biological characterstics- anatomical (breasts, vagina, penis , testis) as a male or female. Sex is also a synonym for sexual intercourse, which includes penile –vaginal sex, oral sex and anal sex. Sexuality is an expression of who we are as human beings. Sexuality includes all the feelings, thoughts, and behaviours of being male or female, being attractive, and being loved, being in love, as well as being in relationships that include initimacy and physical activity. Sexuality begins before birth and lasts through out the course of the life span. A person's sexuality is shaped by his or her values, attitude, behaviours, physical appearance, beliefs, emotions, personalities, likes and dislikes, spiritual life and all the way in which he or she has been socialized. Consequently, the way in which individuals express their sexuality are influenced by either ethical, spiritual, cultural and moral factors.

Box 2.1 The five circle of Sexuality



When all these five cricles are placed together, they suggest the total definition of sexuality. Value, Spirituality and Culture all play a role on how an individual express the components of sexuality.

Other factors influencing sexuality inlcude: *'Biological factors, Psychological barriers, Social barriers, Economic barriers, Political barriers, Cultural barriers, Ethical barriers, Legal barriers, Historical barriers, Religious barriers, and Spiritual barriers'.*

Sexual desire and sexual pleasure

Sensuality: This is how our bodies derive pleasure. It is the part of our body that deals with the five senses: touch, sight, hearing, smell, and taste. Any of these senses when enjoyed can be sensual. The sexual-response cycle is also part of our sensitivity because it is the mechanism that enables us to enjoy and respond to sexual pleasure.

Our body image: is part of our sensuality. Our feeling attractive and proud of our bodies influences many aspects of our lives.

Our sensuality: also involves our need to be touched and held by others in loving and caring ways. This is called "skin hunger". Adolescents typically receive less touch from family members than young children do. Therefore, many teenagers satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from an adolescent's need to be held , rather than from sexual desire.

Fantasy: This is another part of our sensuality. Our brain gives us the capacity to fantasize about sexual behaviours and experiences without having to act on them.

Intimacy and Relationships: Our ability to love, trust and care for others is based on our levels of initimacy. We learn about initimacy from the relationships around us, particularly those within our families.

Emotional risk: Talking is part of initimacy. In order to have true initimacy with others, an individual must open up and share feelings and personal information . We take risk when we do this , but initimacy is not possible otherwise.

Sexual identity: Every individual has his or her own personal sexual identity. Four main elements make up an individuals sexual identity. These are:

Biological Sex is based on our physical status of being either male or female

Gender identity is how we feel about being male or female . Gender identity starts to form around age 2 , when a little boy or girl realizes that he or she is different from the opposite sex. If a person feels like he or she identifies with the opposite biological sex, he or she often considers him or her self transgender. In most exreme cases a transgender person may have an operation to change his or her biological sex so that it can correspond to his or her gender identities.

Sexual orientation: This is the fourth part of our sexual identity. Sexual orientation refers to the biological sex we are attracted to romantically. Our orientation can be heterosexual(attracted to the opposite sex), bisexual (attracted to both sexes) or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. Actually, however, the man and woman are expressing different gender roles. Their feminine and masculine behaviour respectively has nothing to do with their sexual orientation.

Sexual Health: This involves our behaviour related to producing children,enjoying sexual behaviours and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and sexually transmitted infections (STIs) are part of our sexual health.

Risk and Protective Factors for Sexual Health

Human beings are sexual beings throughout their lives and human sexual development involves many other aspects of development- physical, behavioural, intellectual, emotional, and interpersonal. Human sexual development follows a progression that, within certain ranges, applies to most persons. The challenge of achieving sexual health begins early in life and continues throughout the lifespan. The actions communities and health care professionals must take to support healthy sexual development vary from one stage of development to the next. Children need stable environment - parenting that promotes healthy social and emotional development, and protection from abuse. Adolescents need education, skills training, self-esteem promoting experiences, and appropriate services related to sexuality, along with positive expectations and sound preparation for their future roles as partners in committed relationships and as parents. Adults need continuing education as they achieve sexual maturity to learn to communicate effectively with their children and partners and to accept continued responsibility for their sexuality, as well as necessary sexual and reproductive health care services.

There are also a number of more variable risk and protective factors that shape human sexual behaviour and can have an impact on sexual health and the practice of responsible sexual behaviour. These include biological factors, parents and other family members, schools, friends, the community, the media, religion, health care professionals, the law, and the availability of reproductive and sexual health services.

Biological Factors

Although human sexuality has come to serve many functions in addition to reproduction, its biological basis remains fundamental to sexual experience. Sexual response involves psychological processing of information, which is influenced by learning, physiological responses and brain mechanisms which link the information processing to the physiological response. Although there is much that is not well understood about this complex sequence, it is understood that individuals vary considerably in their capacity for physical sexual response. This variability can be explained only in part by cultural factors. The role of early learning or genetic factors, or an interaction between the two, remains to be determined by further research.

Reproductive hormones are clearly important. However, their role is best understood and most predictable for men and much more complex for women. For example, apart from the fact that women may experience a variety of reproduction-related experiences-the menstrual cycle, pregnancy, lactation, the menopause, and hormonal contraception-all of which can influence their sexual lives, there does appear to be greater variability among women in the impact of reproductive hormones on their sexuality. In addition, variations in the onset of puberty and menstruation can represent special challenges for girls in some populations.

Parents and Other Family Members

A number of family factors are known to be associated with adolescent sexual behaviour and the risk of pregnancy. Adolescents living with a single parent are more likely to have had sexual intercourse than those living with both biological parents. Having older siblings may also influence the risk of adolescent pregnancy, particularly if the older siblings have had sexual intercourse, and if an older sister has experienced an adolescent pregnancy or birth. For girls, the

[7] Bancroft, 1987
[8](Miller, 1998)
[9](East, 1996; Widmer, 1997)

experience of sexual abuse in the family as a child or adolescent is linked to increased risk of adolescent pregnancy. In addition, adolescents whose parents have higher education and income are more likely both to postpone sexual intercourse and to use contraceptives if they do engage in sexual intercourse.

The quality of the parent-child relationship is also significant. Close, warm parent-child relationships are associated with both postponement of sexual intercourse and more consistent contraceptive use by sexually active adolescents. Parental supervision and monitoring of children are also associated with adolescents postponing sexual activity or having fewer sexual partners if they are sexually active. However, parental control can be associated with negative effects if it is excessive or coercive.[8]

Schools

Evidence suggests that school attendance reduces adolescent sexual risk-taking behaviour. Around the world, as the percentage of girls completing elementary school has increased, adolescent birth rates have decreased. In the United States, youth who have dropped out of school are more likely to initiate sexual activity earlier, fail to use contraception, become pregnant, and give birth. Among youth who are in school, greater involvement with school-including athletics for girls-is related to less sexual risk-taking, including later age of initiation of sex, and lower frequency of sex, pregnancy, and childbearing.

Schools may have these effects on sexual risk-taking behaviour for any of several reasons. Schools structure students' time; they create an environment which discourages unhealthy risk-taking particularly by increasing interactions between youth and adults; and they affect selection of friends and larger peer groups. Schools can increase belief in the future and help youth plan for higher education and careers, and they can increase students' sense of competence, as well as their communication and refusal skills.

Schools often have access to training and communications technology that is frequently not available to families. This is important because parents vary widely in their own knowledge about sexuality, as well as their emotional capacity to explain essential sexual health issues to their children. Schools also provide an opportunity for the kind of positive peer learning that can influence social norms.

The Community

[10] (Browning, 1997; Roosa, 1997; Miller, 1998)
[11](Miller, 1998)
[12](Jaccard, 1996; Resnick, 1997)
[13]Hogan and Kitagawa, 1985; Miller, 1998; Upchurch et al, 1999
[14]Mauldon and Luker, 1996; Brewster et al, 1998, Manlove, 1998; Darroch et al, 1999
[15]Holden et al, 1993; Billy et al, 1994; Resnick et al, 1997
[16]Manlove, 1998; Moore et al, 1998

Community can be defined in several ways: through its geographic boundaries; through the predominant racial or ethnic makeup of its members; or through the shared values and practices of its members. Most persons are part of several communities, including neighborhood, school or work, religious affiliation or social groups. Whatever the definition, community influence on the sexual health of those who comprise it is considerable, as is its role in determining what responsible sexual behaviour is, how it is practiced and how it is enforced.

The measurable physical characteristics of neighborhoods and communities, such as economic conditions, racial and ethnic composition, residential stability, level of social disorganization, and service availability have demonstrated associations with the sexual behaviour of their residents-initiation of sexual activity, contraceptive use, out-of-wedlock childbearing and risk of STD infection. An understanding of these characteristics and their impact on individuals is important in planning and developing services and other interventions to improve the sexual health and promote responsible sexual behaviour of community residents.

A shared culture based either on heritage or on beliefs and practices, is another form of community. Each of these communities possesses norms and values about sexuality and these norms and values can influence the sexual health and sexual behaviour of community members. For example, strong prohibitions against sex outside of marriage can have protective effects with respect to STI/HIV infection and adolescent pregnancy. On the other hand, undue emphasis on sexual restraint and modesty can inhibit family discussion about sexuality and perhaps contribute to reluctance to seek sexual and reproductive health care. Gender roles that accord higher status and more permissiveness for males and passivity for females can have a negative impact on the sexual health of women if they are unable to protect themselves against unintended pregnancy or STI/HIV infection.

When a community-defined by it's culture-also has minority status, its members are potential objects of economic or social bias which can have a negative impact on sexual health. Economic inequities, in the form of reduced educational and employment opportunities, and the poverty that often results there from , has obvious implications for accessing and receiving necessary health education and care. In addition, a history of exploitation has, in some cases, led to distrust and suspicion of public health efforts in some minority communities.

The Media

[17]Billy and Moore; 1992; Brewster et al, 1993; Grady, 1993; Billy et al, 1994; Grady et al, 1998; Tanfer et al, 1999
[18]Comas-Diaz, 1987; Kulig, 1994; Savage and Tchombe, 1994; Sudarkasa, 1997; Tiongson, 1997; Abraham, 1999; Amaro, 2001
[19]Hiatt et al, 1996; Schuster et al, 1996; He et al, 1998; Tang et al, 1999
[20]Amaro and Raj, 2000; Bowleg et al, 2000; Castaneda, 2000
[21]Tafoya, 1989; Thomas and Quinn, 1991; Wyatt, 1997

The media-whether television, movies, music videos, video games, print, or the internet-are pervasive in today's world and sexual talk and behaviour are frequent and increasingly explicit. More than one-half of the programming on television has sexual content. Significant proportions of music videos and movies also portray sexuality or eroticism. Among young people, 10-17 years of age, who regularly use the internet, one-quarter had encountered unwanted pornography in the past year, and one-fifth had been exposed to unwanted sexual solicitations or approaches through the internet.

Media programming rarely depicts sexual behaviour in the context of a long-term relationship, use of contraceptives, or the potentially negative consequences of sexual behaviour. The media do, however, have the potential for providing sexuality information and education to the public. For example, more than one-half of the high school boys and girls in a national survey said they had learned about birth control, contraception, or preventing pregnancy from television; almost two-thirds of the girls and 40 percent of the boys said they had learned about these topics from magazines.

While the available research evidence shows a connection between media and information regarding sexuality, it is still inadequate to make a strong link between media and sexual behaviour.

Religion

Simply being affiliated with a religion does not appear to have great effect on sexual behaviour; however, the extent of an individual's commitment to a religion or affiliation with certain religious denominations does. For example, an adolescent's frequent attendance at religious services is associated with less permissive attitudes about premarital sexual activity and a greater likelihood of abstinence. On the other hand, for adolescents who are sexually active, frequency of attendance is also associated with decreased use of contraceptive methods among girls and increased use by boys.

Health Care Professionals

Physicians, nurses, pharmacists and other health care professionals, often the first point of contact for individuals with sexual health concerns or problems, can have great influence on the sexual health and behaviour of their patients. Yet, both adolescents and adults frequently perceive that

[22]Cope and Kunkel, in press
[23]Greenberg et al, 1993; DuRant et al, 1997
[24]Finkelhor et al, 2000
[25]Sutton et al, in press
[26]Brewster et al, 1998
[27]Ku et al, 1993; Billy et al, 1994; Werner-Wilson, 1998
[28]DuRant and Sanders, 1989; Ku et al, 1993

health care providers are uncomfortable when discussing sexuality and often lack adequate communication skills on this topic.

Health care providers typically do not receive adequate training in sexual aspects of health and disease and in taking sexual histories. Ideally, curriculum content should seek to decrease anxiety

and personal difficulty with the sexual aspects of health care, increase knowledge, increase awareness of personal biases, and increase tolerance and understanding of the diversity of sexual expression.

The Law

The law regulates sexual behaviour in complicated ways through criminal, civil, and child welfare law and operates at local, state, and federal levels. Criminal law in Nigeria imposes penalties for certain kinds of sexual activities, considering factors such as age, consent of parties, the actual act performed, and the location in which it takes place. Civil law complements criminal law and can extend the law's reach. Civil law, for example, provides individuals with protection from sexual harassment and allows legal redress for some victims of sexual violence. It can also have an impact through regulation of relationships such as marriage, divorce, and child custody and support.

The law may also regulate some aspects of the community's influence on sexuality, including the family, schools, and media. While it generally protects parental rights (Levesque, 2000), the law also imposes limits. For example, it protects children from sexual victimization by a family member. The law also regulates access to sexual health services through mechanisms such as parental notification and waiting period requirements.

Sexuality control to others: This element is not a healthy one, unfortunately many people use sexuality to violate some one else or get something from another person. Rape is a clear example of using sex to control some one else. Sexual abuse and commercial sex work are others. Even advertising often sends message of sex in order to get people buy products.

Note: An individual can be sexually active and still considered sexually healthy, if he or she engages in certain sexually healthy behaviour and demostrate sexual knowledge. Also a person can be sexually unhealthy still does not enage in sexual intercourse. Opportunites to support a young person's sexual health can occur during counselling session or in group during sexuality education.

High Risk Behaviour

[29]Croft and Asmussen, 1993
[30]Levesque, 1998

High risk behaviour is a term used to describe certain activities that increase the risk of transmitting/ contacting infection and other health implications for instance tobacco use, driving too fast, use of alcohol or drugs, excessive stress, not getting a physical rest. Protective factors influence the community to help one to make healthy decisions. Protective factors may include:

- Support from the community
- access to services
- self-esteem
- self-efficacy skills
- Goals for the future
- Negotiation and communication skills
- Positive role modeling
- Family support
- Understanding susceptibility/severity awareness and exploration of costs/benefit

Factors that can affect behavioural change

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Adolescent – lack of motivation
Family – pulling girls out of school to care for younger siblings
Community – providing poor role-modeling of healthy behaviour
Nation – few programmes offering adolescent friendly reproductive health services
Society – little value given to youths as contributing members of society

It is important to note that risk factors at various levels can influence whether or not a person seek services again; can encourage behavioural change; and can influence whether or not the changed behaviour is sustained.

Access to Youth friendly services

Youth-friendly sexual and reproductive health services are those that attract young people, respond to their needs, and retain young clients for continuing care. Youth-friendly services are based on a comprehensive understanding of what young people in a given society or community want, and respect for the realities of their diverse sexual and reproductive lives. The aim is to provide all young people with services they trust and which they feel are intended for them. All clients of sexual and reproductive health services have the right to information about the benefits and availability of services and to access these services, regardless of their race, gender, sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability. They have a right to protect themselves from unwanted pregnancy, disease and violence and to decide freely whether and how to control their fertility and other aspects of their sexual health. Service providers should treat all young people with dignity and respect, assure confidentiality, offer a comfortable and relaxed environment and provide services for as long as needed. Optimum youth-friendly services offer an integrated range of different services, or a good referral system to high-quality specialist services which should include:

- Sexuality information
- counselling
- Family planning
- Pregnancy testing
- Safe abortion
- Testing and treatment for sexually transmitted infections (STIs) and HIV including services for those who experience emotional or physical violence, rape, gender-based violence, trafficking or female genital mutilation.

In addition, youth friendly services should be created such that if a young person requests emergency contraception she/he will automatically receive counselling and information on other risks related to unprotected sex as well as encouraged to undertake STI screening. Youth-friendly services can be provided in a variety of settings, ranging from a clinic reserved exclusively for young people, to adding 'adolescents-only' hours at existing facilities, providing emergency hotlines, or offering services in places where young people congregate, such as schools, youth centers, sporting events or work sites. For community and/or outreach workers, this might mean including sexual and reproductive health discussion or counselling during their outreach activities and home visits to young people. When sexual and reproductive health services are provided

within a larger healthcare facility, young people should be able to reach them without drawing attention to themselves, for example through a separate and discreet entrance/exit from the main clinic entrance.

However, providing youth friendly services does not necessarily mean building a new clinic. It can mean adding adolescent-only hours or offering services in places where adolescents congregate. For community-based workers, it can mean including young people in home visits while for all health workers, it means establishing or working within a referral network. Family planning/reproductive health programmes may not be able to offer all methods and services to young people, they can link with other organizations that offer services to young people, including educational and social service programmes

Strategies to make services more youth friendly

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- Actively involve adolescents in programme design and service delivery.
- Consider how adolescents' needs differ from those of adults and provide services that specifically meet the needs of young people.
- Involve young people in planning and implementing health services.
- Make all staff – receptionists, nurses, physicians – aware that they should treat adolescents with respect and dignity.
- Revise clinic policies and procedures that prevent youths from getting services and information. For example, revise age requirements for contraceptive use or requirements that clients must be married.
- Ensure that young clients have privacy and that clinic policies emphasize confidentiality.
- Train staff in counselling techniques and make sure they have the most current information on contraceptives.
- Allow enough time for counselling.
- Develop referral systems. Find out about other services in your community for adolescents. Keep a list of these services readily available.
- Offer separate services for adolescents and adults.
- Offer services at hours that are convenient for adolescents, such as after school or on weekends.
- Make the clinic attractive to adolescents (bright colors, posters, popular music).
- Offer information and education to young clients, both at the clinic and as part of community outreach.
- Reduce prices for young clients. Provide services free or based on a sliding scale.
- Involve young people by creating a youth advisory board.
- Advocate improving national policies and service delivery guidelines for adolescents.
- Develop community outreach programmes and off-site clinics held at schools, in factories or on the streets. Reach adolescents through educational talks before they need reproductive health services.
- Train peer educators to provide information, education and certain methods to youths.
- Use mass media to communicate reproductive health messages- billboards, soap operas, videos, radio dramas, comic books, popular songs or plays.
- Create or work with “youth development programmes” – programmes that improve socio-economic status, such as literacy programmes or job training.
- Evaluate your programme. Examine quality, gender equity and respect for adolescent rights.

Evaluations may include:

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Simple Observations
Review of clinic statistics to determine if more young people are attending clinics and returning for follow-up visits, collection of data to compare services before and after youth friendly services are implemented and outcome evaluations to assess whether the project met its goals.

Steps to ensure that programmes are effective:

- Identify specific target groups to be served. The group can be defined by age, school status, marital status or place of residence (urban versus rural).
- Establish specific objectives and indicators to measure whether these objectives were achieved. For example, an objective might be to increase awareness about STIs. An indicator might be that 10 peer educators were trained and then they reached 100 young people with safer sex messages.
- Involve young people in programme planning, implementation and evaluation.
- Consider the potential effects of gender, culture and tradition on service delivery.
- Offer short waiting times and welcome drop-in clients.
- Welcome boys and develop programmes targeting them.
- To be successful, you also may need to consider approaches to service delivery that involves the community, such as: Peer motivators and educators.
- Contraceptive information at schools, sports events, youth clubs, concerts or other places where young people congregate.
- A parents' day at the clinic to provide information to adults about adolescents' reproductive health needs.
- A young people's day at the clinic to provide information about good health. Children of all ages, not just adolescents, could be invited.
- Community feedback sessions to solicit ideas from young people about the types of health services they want, their satisfaction with current services and their ideas for changes and improvements.

The key to providing quality services for adolescents is to treat clients with courtesy and dignity. Above all, young people who seek reproductive health information and services deserve respect.

Characteristics of Youth – Friendly Service

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Programmatic Characteristics

1. Youths are involved in programme design
2. Both boys and girls are welcomed and served
3. Married adolscent clients are welcomed and served
4. Group discussions are avaialble
5. Parental involvement is encouraged
6. Fees are made available
7. A wide range of services is offered and necessary referals are available
8. An adequate supply of commodities is available
9. Drop in clients are welcomed, and appointments are arranged rapidly
10. Waiting times are short

11. Educational materials are available on site
12. Services are well promoted in areas where youths gather
14. Linkages are made with schools, youth clubs and other youth friendly institutions
15. Alternative ways to access information, counselling and services are provided

Service Provider Characteristics
1. Staff are trained on adolescent issues
2. Respect is shown to young people
3. Privacy and confidentiality are maintained
4. Adequate time is given for clients-provider interaction
5. Peer counsellors are available

Health Facility Characteristics
1. Convenient hours
2. Convenient location
3. Adequate space
4. Sufficient privacy
5. Comfortable surroundings

Youth Perception of programme
1. Privacy is maintained at the facility
2. Confidentiality is honoured
3.Youth are welcome regardless of marital status
4. Boys and young men are welcome
5. Service providers are attentive to youths needs

Impact of culture and religion on the realization of access to sexual and reprductive health services for adolescents

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Culture may be described as “the attitudes and behaviour that are characteristic of a particular social group or organization”, and includes “traditions that reflect norms of care and behaviour based on age, life style, gender, and social class.” Religion plays a significant role in culture, as do social and political institutions such as media and communications, systems of education, and modes of governance. The case for involving religions in sexual and reproductive health and rights is almost self-evident. Through their influence on individuals, cultures, and policies, religion play a critical role in shaping people's and governments' attitude toward reproduction and sexuality. Whatever one may think about religion personally, its importance is undeniable. Thus, the world's religions can be an important ally in the effort to advance sexual and reproductive health and rights. Religious teachings deeply influence personal conduct, especially in the areas of sexuality, marriage, gender, childbearing, and parent-child relationships. Moreover, secular notions of justice and rights draw upon interpretations of religious morality. Not only do religions shape the values of individuals and the cultures of societies, they have the power to influence government policy. They affect public policies through the involvement of religions in political processes and also through the religious beliefs of political leaders, policy makers, and civil servants.

- Religion is a prominent force in all societies, as it is estimated that more than five billion people follow one of the world's religions.[4] In many societies, religious people and institutions promote human rights. However, some use religion to justify violations of human rights or to oppose certain rights, including SRHR.

- While the fundamental values of all religions promote the integrity and well-being of all human beings, different interpretations and the ways that values are translated into practice can create barriers to SRHR. This is especially so for young people seeking to make choices about their sexual and reproductive lives that in any way deviate from common practice.
- Young people often face contradictions between their religious beliefs, as passed on by religious leaders and institutions, and their life circumstances.

Culture is also an important element that plays a key role in the realization of sexual and reproductive health. Culture provides the framework for people's social behaviours, contributes to their feeling of community, and helps individuals form their identity. However, constraints arising from cultural traditions often limit young people's access to the information and services they need to make informed and responsible decisions about their sexual and reproductive lives. Because it is often used to justify social inequality and can be a road block to achieving the full spectrum of human rights "Culture" must be addressed in the discussion around the rights of young people starting from the premise that "rights are universal but cultures are different". It is important to understand the various cultural issues that are of great significance to young people worldwide, including such factors as information and communication technologies (ICTs) and media's influence on young people's choices.

The effect of culture on sexual and reproductive health policy and programmes for youth

In some countries, cultural taboos on sexuality have made it very difficult to create adequate policies and programmes to deal with adolescent sexual and reproductive health and rights (SRHR). Sexuality itself is a difficult topic to broach in the public arena, and the idea of young people and sexuality introduces another level of difficulty. Even when laws and policies exist to protect young person's SRHR, cultural and religious climates may hinder their implementation.

For example in Nigeria, where there is widespread discomfort with sexuality, accurate information on sexuality is scarce, and health care and reproductive health service is hard to come by for young people. Those who seek reproductive health services often are met by judgemental health providers, and are afforded little or no privacy in which to discuss their problems . In most countries, taboos on sexuality impede open communication and access to information about SRH. In some areas, low levels of literacy increase these problems.

In some countries, attention to the sexual and reproductive lives of young people arises from concern over national population momentum. In such cases, the focus is mostly on delaying childbearing and not on the overall well-being of young people. Growing rates of HIV infection among young people may also compel governments to look at SRHR education, less from concern for individuals than from concern about national goals and priorities.

Cultural and religious restrictions often mean that SRH is a part of a public health agenda, which is quite different from a rights-based approach to SRH. Public health policy usually look at effects on entire populations and focuses less frequently on effects on individuals and their rights.

Some cultural traditions and expectations can place disproportionate constraints on girls and challenge the "physical and psychological health and integrity of individuals." This is most evident in the practices of marrying female children and very young women and female genital cutting (FGC).

Marrying girls at a young age is common in many cultures where girls are undervalued. They are an additional expense if dowry is to be paid; dowries are one incentive for marrying girls earlier, as is the common belief that an early marriage ensures a long period of fertility.

The role of information and communication technologies (ICTs) and media culture in the lives of young people: The global media culture can be an independent force in the lives of young people, influencing behavioural and value patterns that differ from those of their elders. Some argue that ICTs carry a "cultural package" of values associated with Western popular culture. Facilitated by ICTs, media culture can sometimes conflict with more traditional concepts of how youth should behave. In urban centres, media culture and its predominant messages permeate almost all aspects of young people's lives. Increasingly, access to ICTs influences youth's education, personal relationships, employment opportunities, and more. The culture "industry", referring to the entirety of the media and ICTs, is a powerful tool through which young people can access information about SRH. With such information, they can exercise their sexual and reproductive rights and make better-informed decisions about their lives. Thus, ICTs should be available to all and should offer accurate information.

Building skills, values, ethics and attitude

Life skills refer to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively and develop coping and self-management skills that may help them lead a healthy and productive life. Life skills may be directed toward personal actions and actions toward others, as well as actions to change the surrounding environment to make it conducive to health. Examples of life skills include empathy building, active listening, negotiation and conflict management, values clarification, creative and critical thinking, goal setting, self-esteem, coping with peer pressure, identifying personal strengths and weaknesses, interpersonal communication, giving and receiving feedback and analytical skills.

Capacity Building is the process of enhancing knowledge, skills and attitudes. Knowledge is the mastery of content. Skills are abilities to carry out behavioural tasks at a defined level of competence. Attitudes are values and beliefs that affect the probability of behaviour. Capacity building is facilitated through formal and non formal learning opportunities and the support of technical resources. Capacity building recognizes that all individuals require different levels of skills building and enhancement throughout their lives

Services/programmes that build capacity in the area of life skills

- life skill (decision making)
- self-esteem
- Assertiveness
- Negotiation /Refusal skills
- Problem solving
- Empathy
- Advocacy skills

Self esteem is simply valuing ones self and not looking down on self. Liking yourself as well as having confidence in your self. It also means accepting both your strengths and weakness and making the best use of your attributes.

Factors that influence self esteem

- Upbringing/Environment
- Accomplished goals
- Bad company

Two Types of self Esteem

High Self Esteem: When a person recongizes and accepts both his / her strengths and weakness and believes in his/her ability and self importance and self worth.

Low Self Esteem: When a person only sees his/her short comings and weakness and sees nothing good in himself/herself. The person does not believe in himself /herself, has low self importance and low self worth.

High self esteem leads to confidence , ability to relate well with others, ability to make descisions for ones self and resist peer infulence while low self esteem on the other hand causes people to be indecisve, lack confidence and unsociable.

Box 2.2 Characterstics of Self Esteem

High	Low
Confident, Humble	Arrogant, Gossip
Assertive, Discuss ideas openly	Critical to others
Interactive	Rebellious Withdrawal and isolation
Caring Attitude	Inferiortity Complex
Respect for others	Allows self to be pushed around and ineffective

Goal Setting

This is the process of determining a goal/goals, planning and working towards it. Goal setting is important because it gives directions, helps planning to be organised. Difficulties in setting goals for future are:

- Pessimistic attitude
- Lack of ambition
- Procrastination
- Low self esteem
- Ignorance of the importance of goal setting

Barriers to achieving goals:

- Teenage pregnancy
- STIs, including HIV and AIDS

- Bad company
- Lack of information
- Alcohol and substance abuse

Effects of achieving goals:

- Increased self esteem
- Motivation
- Feeling of Achievement

Decision Making

This is simply the process of making up our mind on an issue or situation and taking a position on it.

The Steps involved are:

- Recognize the decision to be made
- List all the possible choices
- Weigh the" pros" and cons" of each choice
- Examine your values
- Make the decision
- Review the decision (Choice) - was it good or not for you?

Factors that affect young people in decision on sexuality:

- Peer pressure
- Inadequate decision making skills
- Alcohol and drug abuse
- Lack of access to adequate information and facts
- Lack of access to trusted and experienced persons
- Economy
- Religion
- Social influences
- Media

Possible barriers to implementing decisions:

- Peer pressure
- Poor planning
- Decisions not consistent with set goals or values

How to overcome these barriers:

- Take decisions that are in line with your set goals or values in life
- Be goal oriented
- Set a time frame
- Develop refusal and negotiation skills
- Make proper planning
- Take Action

Strategies for avoiding repeated mistakes:

- Evaluate past decisions and outcomes and learn from them
- Patience
- Think positively

Characteristics of a good decision

- Goal oriented
- Consistent with values (personal values)
- Based on correct information and facts from experts in the that area of life

Assertiveness

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This is standing up for your rights or what you believe in without violating someone else's right(s). In some cultures however, asking directly for what one wants is still considered impolite. So also is speaking in public.

Barriers to females being assertive include:

- Religion
- Culture
- Ignorance
- Male dominance

Rights that support Assertiveness are:

- Right to hold views and express them
- Right to choice
- Right to fair treatment and not be intimidated

Behaviours that improve Assertiveness:

- Honesty
- Uprightness
- Quickly expressing or communicating feelings /needs as they come up rather than waiting

Benefits of assertiveness in sexual situations:

- Prevention of sexual exploitation
- Prevention of unwanted pregnancy
- Prevention of STIs, HIV and AIDs
- Taking responsibilities for one's feeling, needs etc

Consequences of non-assertiveness in sexual situations:

- Pregnancy
- Diseases
- Sexual exploitation
- Hurt
- Unhappiness/ dissatisfaction

Refusal skill

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This is the ability to clearly say NO or show that one is not willing to do, give or accept what the other person is requesting of him /her. In refusal, the response is NO and it should be clear, simple and straight forward while in negotiation, there is no compromise.

Factors that help refusals:

- High self esteem
- Having a goal
- Good communication skills

Other skills

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Empathy

- Ability to listen and understand another's needs and circumstances and express that understanding

Cooperation and team work

- Expressing respect for other's contributions and different styles
- Assessing one's own abilities and contributing to the groups

Advocacy skills

- Influencing skills and persuasion
- Networking and motivation skills
- Decision making and critical thinking skills

Critical thinking skills

- Analyzing peer and media influences
- Analyzing attitudes, values, social norms, beliefs and other contributing factors affecting these
- Identifying relevant information and information sources
- Coping and self management skills

Skills for increasing self control

- Self esteem / confidence building skills
- Self awareness skills including awareness of rights, influences, values, attitudes, strengths and weakness
- Goal setting skills
- Self evaluating, self assessment, monitoring skills

Skills for managing feelings

- Anger management
- Dealing with grief and anxiety
- Coping skills for dealing with loss, abuse and trauma

Skills for managing stress

- Time management
- Positive thinking
- Relaxation techniques

Conclusion

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Effective communication skills contribute to effective prevention interventions against HIV/AIDS and other sexual and reproductive health and rights issues.

MODULE 3.0

Harmful Cultural Practices

OBJECTIVES

- To understand the link between harmful cultural practices (HCPs) and its effect on the attainment of the highest standard of sexual and reproductive health by Women.
- To enlighten and build the capacity of participants on intervention strategies to aid programming on the elimination of all forms of harmful cultural practices against Women.

MATERIALS

- Session objectives written on flipchart
- Flipchart stand, masking tape, flipchart and markers
- Multimedia

RESOURCES

- Convention on the elimination of all forms of discrimination against women(CEDAW)www.un.org/womenwatch/daw/cedaw
- How to end child marriage: Action Strategies for Prevention and Protection www.icrw.org/docs/2007-childmarriagepolicy.pdf WHO /female Genital Mutilation.
- WHO /female Genital Mutilation. www.who.int › WHO › Health topics -
- Harmful Traditional Practices Affecting the Health of Women and Children. www.ohchr.org/Documents/Publications/FactSheet23en.pdf
- Advocates for Human Rights.
- Early Marriage Problems-causes of Early Marriage-Harmful Effects of Early Marriage. www.ygoy.com

1. Religious Oriented Approach to Addressing Female Genital Mutilation/Cutting among the Somali Community of Wajir, Kenya. www.popcouncil.org/pdfs/frontiers/reports/Kenya_Somali_FGC.pdf
2. Lead Nigeria Creating awareness among Nigerian Women-16 days global campaign to highlight gender violence practices in Nigeria. www.leadsnigeria.org/index.php?option=com
3. NIGERIA: Female Circumcision: The Good, the Bad and the Ugly? www.fgmnetwork.org/gonews.php?subaction

PREPARATION

- Draft and review Power Point presentation.
- Review critical issues and interventions from the handouts.
- Be prepared to discuss critical issues and interventions to eliminate all forms of harmful cultural practices (HCPs).
- Place instructions for Group Activity on PowerPoint.

Facilitation session

STEP ONE

Exploring the different special vulnerable groups

- Review the objectives of session 3 with the participants on a flipchart.
- Ask the participants to discuss their issues and comments
- Present power point slide show. Start with the definition of harmful cultural practices (HCPs) and its types. Ask participants to give feedback on the definition and types of HCPs mentioned

STEP TWO
Characteristics, critical issues and interventions

- Review the objectives of Session 3 with the participants on a flipchart.
- Divide participants into groups based on types of HCPs presented in session. Ask participants to identify reasons why these harmful cultural practices are still being perpetrated in most societies. Each group should make a brief presentation on flip charts.
- Present power point slide show.
- Discuss critical issues and generate feedback from participants

STEP THREE
Intervention strategies to aid programming

- Review the objectives of session 3 with participants on a flipchart.
- Divide participants into groups based on types of HCPs presented in session. Ask participants to design evidenced based intervention strategies to aid programming on flip charts.
- Ask participants to have a 10 minutes presentation.
- Present power point slide show.
- Discuss intervention strategies

Group Activity

Divide participants into four groups and assign each group one of the following to discuss ways of rehabilitating and mainstreaming victims of the below into the normal spheres of society :

- Female Genital Mutilation
- Early Marriage
- Widowhood Rights
- Gender-Based Violence

Harmful Cultural Practices

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include female genital mutilation (FGM); forced feeding of women; early marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices; male child preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Despite their harmful nature and their violation of international human rights laws, such practices persist because they are not questioned and take on an aura of morality in the eyes of those practising them.

A number of reasons are given for the persistence of traditional practices detrimental to the health and status of women, including the fact that, in the past, neither the Governments concerned nor the international community challenged the sinister implications of such practices, which violate the rights to health, life, dignity and personal integrity of the Woman. The international community remained wary about treating these issues as a deserving subject for international and national scrutiny and action. Harmful practices such as female genital mutilation were considered sensitive cultural issues falling within the spheres of women and the family. For a long time, Governments and the international community had not expressed sympathy and understanding for women who,

due to ignorance or unaware of their rights, endured pain, suffering and even death inflicted on them and their female children. These practices expose women to sickness and death from hemorrhage, infection, keloid formation, and consequent obstructed labour. Ironically, while many traditional practices are intended to control women's sexuality and reproductive capacity, these practices expose women to reproductive health risks that threaten women's fertility and lives.

Human Rights Implications

Harmful traditional practices violate a number of recognized human rights protected in international and regional instruments and reaffirmed by international conference documents. These rights include:

- *Right to life*
- *Right to health*
- *Right to non-discrimination on the basis of sex*
- *Right to liberty and security of the person, which includes the right not to be subjected to violence and recognizes the need for children to receive special protections*
- *Right to freedom from inhuman or degrading treatment, which recognizes the inherent dignity of the person.*

Relevant Human Rights Documents

The following human rights treaties bind almost all countries and prohibit countries from tolerating harmful traditional practices:

- Article 5, State Parties must undertake "all appropriate measures [to] modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women".
- Convention on the Rights of the Child (CRC), Articles 2, 6, 12, 19, 24, 27 and 28
- International Covenant on Civil and Political Rights (ICCPR), Article 7

Agreements reached at the 1994 International Conference on Population and Development (Cairo) and the 1995 Fourth World Conference on Women (Beijing), reinforce CEDAW, CRC, and ICCPR by including commitments to remove discriminatory, harmful, and coercive traditional practices.

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice is mostly carried out by traditional circumcisers, who often

play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers. FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruelty, inhuman or degrading treatment, and the right to life when the procedure results in death.

Female genital mutilation is classified into four major types.

1. Clitoridectomy: Partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
2. Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
3. Infibulation: Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
4. Others: All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

No health benefits, only harm

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue.

Long-term consequences can include:

- recurrent bladder and urinary tract infections
- cysts
- infertility
- an increased risk of childbirth complications and newborn deaths
- the need for later surgeries. For example, the FGM procedure that seals or narrows a vaginal opening needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing and repeated both immediate and long-term risks.

Reasons for the practice

The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities.

- Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice.
- FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage.
- FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido, and thereby is further believed to help her resist "illicit" sexual acts. When a vaginal opening is covered or narrowed (infibulation), the fear of pain of opening it, and the fear that this will be found out, is expected to further discourage "illicit" sexual intercourse among women with this type of FGM.
- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are “clean” and "beautiful" after removal of body parts that are considered "male" or "unclean".
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.
- In some societies, FGM is being practised by new groups when they move into areas where the local populations practice FGM.

Who is at risk?

- Procedures are mostly carried out on young girls sometime between infancy and age 15, and occasionally on adult women. In Africa, about three million girls are at risk for FGM annually.
- About 100 to 140 million girls and women worldwide are living with the consequences of FGM. In Africa, about 92 million girls' age 10 years and above are estimated to have undergone FGM.
- The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among certain immigrant communities in North America and Europe.

FGM Practice in Nigeria

In Nigeria as a whole, female genital mutilation was and is still practiced in different forms, in different places. The pervasiveness of the different forms of the ritual generally varies across geographic, religious and ethnic groups and vast variation exists within each subgroup. For example, clitoridectomy and excision are practiced on women in the three dominant ethnic groups in Nigeria: Ibo, Hausa and Yoruba {Mclean, 1983, Odey 1986, Babatunde 1998}. Among the

Yoruba of South-western Nigeria, only the Ijebu and some Egba are known as the uncircumcising ethnic groups {Adeneye, 1995, Orubuloye and Caldwell, 2000]. It is also widespread along the South-southern region, among the ethnic groups such as the Benin, Urhobo, Ijaw, Ika, Ibibio, Efik and Kwale with the exception of the Itsekiri in Delta State. But infibulation is mostly practiced in the Northern part of Nigeria, especially among the Tiv [Hosken, 1982] while the Gishiri cuts and hymenectomy are common among the Hausa {Mandara, 2000}.

Addressing FGM

The following goals needs to be met for us to adequately tackle FGM

1. To prevent the practice of FGM
2. To provide high quality, appropriate health care and support for women and girls who have undergone FGM
3. To contribute to the worldwide campaign to end FGM

In setting the objectives necessary to achieve the above goals, the Plan of Action has been developed in line with the following principles:

- Utilize international human rights frameworks at all stages;
- Acknowledge that FGM is an expression of structural gender inequality related to the broader social, political and economic context in which women have access to less power, resources, education and autonomy than men;
- Respect the dignity, identity and culture of all people and communities affected by FGM;
- Consider that communities affected by FGM are well placed to advocate for the prevention of FGM;
- Reject any move towards medicalisation of FGM;
- Recognise that abandonment of FGM requires a holistic approach.

Four Strategies for Action

Four strategies have been identified as being essential to addressing FGM. These strategies build upon best practice experiences which combine top-down policy and legislative measures with bottom-up community development approaches to maximise impact.
Actions flow from the following strategy headings which act to progress the goals of the plan:

- Legal
- Health
- Community
- Development Aid

Way Forward

Continue with religious clarifications
Working with the religious scholars and leaders as change agents is vital in the community; they can be used for programmes that are related to FGM. For instance, clarifications around the gender and human rights implications of FGM from a Christian or Islamic perspective will be useful for expanding the horizon to include reproductive health (RH), family planning (FP) and HIV/AIDs in community education campaigns.

Mainstreaming FGM in other development programmes
Africa is a region that is lagging behind in development and due to the many calamities afflicting it, there are lots of challenges. It sometimes becomes difficult to engage in discussions on FGM with people who are moving around in search of basic necessities like water and food. The programme should expand to include some practical as well as strategic needs of the community, especially those of women and youth like provision of portable drinking water etc.

Strengthen partnerships
Given the challenges associated with FGM, it is important to seek partnerships with development partners working in this field so as to share expertise and resources to enhance the campaigns against FGM.

Target the whole community
Adult women (as mothers and as practitioners), as well as men (especially the youth), uncles, aunties and grandmothers, are all part of the immediate and the extended family who have a say in decisions concerning FGM on girls. It is critical, therefore, to reach out to all groups within the community with campaigns targeted at stopping FGM. In addition, others in leadership positions in the community should be engaged during community education, e.g. political and civic leaders, community elites/professionals, teachers, community-based organizations (CBOs)/nongovernmental organizations (NGOs), medical personnel, and government officials.

Target the youth
The youth are the future parents and need special emphasis in order to save future daughters from FGM. Many are educated and it is much easier to convince them with facts. Since girls are cut at a tender age in the community, it is vital to have the parents saying no to the practice, hence the importance of targeting the youth early enough.

Use of mass media
Many people in the community listen to the radio. Opportunities to raise this debate through these stations as well as through television should be explored, in addition to other mass media channels such as newspapers, posters, public address systems for the religious scholars, films/documentaries, and T-shirts with anti-FGM information.

Early marriage

There are numerous problems a couple can face when marriage happens at an early age for them. Early marriage which is also referred to as child marriage is common all over the globe and has inflicted dangerous and devastating effects on young children who are coerced into these arrangements. Child marriage is also indicative of the levels of development of a region or country and is generally conducted between very young girls and older men. In many parts of the world child marriage is a means for overcoming the family's financial and social needs.

Causes

Early marriage can arise due to a number of reasons such as these:

- To raise the economic and social status
- Religious beliefs
- Gender bias promotes early marriage of girls

- Lack of education
- Myths and misconceptions about early marriage
- Pressures from older members of the family and community
- The notion that early pregnancy leads to larger families and hence will provide for sufficient heirs
- In patriarchial societies, some communities regard their girl children as a burden and think of getting rid of them by marrying them off early

Harmful effects

Early marriage can cause severe problems like the following:

- Psychological and emotional stress like forced sexual relations, denial of freedom and personal development as household chores now become a priority.
- Denial of personal development and education.
- Maturity levels become an issue as the little girl is now expected to play the role of a mother and wife.
- Girl children are at risk of developing severe health problems during pregnancy and childbirth.
- Increased risk of contracting sexually transmitted diseases due to immature sexual and reproductive tracts
- As girl children are still vulnerable and submissive, they can be subject to domestic violence and abandonment.
- Mental and emotional stress in girl brides is high because they are not old enough to cope with maternal, marital or in-law issues.

Though the respective governments and societies are doing much to abolish early or child marriage through campaigns, laws, policies and individual support of people, it is still a far reaching dream for young girls who are still repeatedly forced into such liaisons.
Most early marriages are considered to be forced which is true but children entering into an early marriage out of choice should also be warned of various personal and health issues that can complicate their lives forever.

Strategies to halt Early Child Marriage

Transform Harmful Cultural Norms

Child marriage is deeply embedded in cultural traditions, which can be difficult to change. However, as the campaign against female genital mutilation demonstrates, community mobilization can be effective in initiating behaviour change and discouraging harmful practices. Many indigenous communities already are taking action to end child marriage. A programme scan conducted by the International Center for Research on Women (ICRW) found these community-based interventions are working to reduce early marriage with multifaceted programmes that educate families and community members on the dangers of child marriage, provide girls with education and life skills, and offer legal services, among other activities.

Support and Scale Up Community Programmes

Grassroot efforts, coupled with national policies that prohibit child marriage, signal a desire among governments and local communities to end the practice. Yet many of these countries lack

the resources to implement, coordinate and expand efforts to reduce early marriage. ICRW's web-based programme scan found only 69 programmes addressing child marriage. These programmes, of various sizes and resources, are missing from areas where the needs are greatest. In six of the 20 countries with the highest prevalence of child marriage, no programmes were found. Aside from ICRW's programme scan, there is no known effort to compile information on approaches to reduce early marriage. More information on existing programmes can help fill gaps in understanding the complexities of child marriage prevention and identify best practices for replication and scaling up. Policy-makers and programme planners could also benefit from improved coordination across countries to share programme and advocacy designs, experiences and lessons from their work to delay marriage.

Maximize aid support

The negative consequences of child marriage impede international development efforts. The top 20 “hot spot” countries for child marriage also have some of the highest rates of maternal and child mortality as well as extreme and persistent poverty. International donors could improve the effectiveness of financial support by integrating child marriage prevention initiatives into existing development initiatives. The United States, European Union, United Nations and Other donors already fund many programmes worldwide to reduce poverty; ensure the survival and health of infants, children and mothers; provide access to voluntary family planning; fight AIDS; and invest in girls' education. All of these are undermined by the practice of child marriage.

Increase access to Girls' education

Research suggests programmes that provide or increase access to education for girls are crucial to delaying marriage. Girls with eight or more years of schooling are less likely to marry early than girls with zero to three years of education. But primary education is not enough. Women are more likely to control their own destinies and effect change in their communities when they have higher levels of education. All levels of education must be made more accessible to girls so that more girls will be enrolled and retained. Parents and community leaders also need to be sensitized to support girls in school. And married girls, too, need to be encouraged to continue their education.

Provide Economic Opportunities for Young Women

Child marriage is inextricably linked to poverty, and families' economic status strongly indicates whether their daughters will be married early. Child brides have less access to schooling and paid work. Cut off from educational and economic opportunities, girls who marry young are more likely to be poor and remain poor. Eliminating child marriage could contribute to broad efforts to reduce long-term poverty. In the short term, targeted incentives for postponing marriage into adulthood and providing economic opportunities for unmarried girls after they finish school can help delay marriage. These livelihood opportunities include skills training, microcredit or savings clubs, and jobs and job placement services. Policy-makers and programme planners should also consider ways to make it easier for families to afford education fees and send girls to school. Expanding opportunities for girls and young women can help change social norms that view marriage as their only option, particularly in cultures where bride price and dowry are common.

Support the needs of Child brides

Prevention is the primary focus of child marriage interventions, but policy-makers and programme planners must not overlook the millions of girls who have already married early and who bear children while still children themselves. To guard against the increased health risks, programmes focused on child marriage should support child brides and their families by promoting earlier and more frequent use of family planning, HIV/AIDS and maternal health services. Adolescent girls face

a greater risk of sexual and reproductive health problems than adult women, but they are less likely to seek health services, often because of their low status in the marital home and community. ICRW research on adolescent reproductive health found that it is possible to change social taboos and gender norms that restrict young people's access to and use of health services in a relatively short period of time by involving family elders, peers and health care staff. Married girls also need educational and economic opportunities to help break the cycle of inequality, illiteracy, illness and poverty that perpetuates child marriage. Educated women have more opportunities to improve their own well-being and that of their family than women without an education. Research shows that the education of girls and mothers leads to sustained increase in educational attainment from one generation to the next. Also, improving women's access to paid work is critical to the survival and security of poor households and an important way to lift these households out of poverty.

Widowhood rights

It can be said that there is no group more affected by the sin of omission than widows. They are painfully absent from the statistics of many developing countries, and they are rarely mentioned in the multitude of reports on women's poverty, development, health or human rights published in the last twenty-five years. Growing evidence of their vulnerability, both socio-economic and psychological challenges many conventional views and assumptions about this “invisible” group of women. Whereas for developed countries substantial statistical information exists on the ages and numbers of widows, the data available on the subject of widowhood for developing countries are extremely limited. In many developing countries the exact numbers of widows, their ages and other social and economic aspects of their lives are unknown. According to available information, it is in developing countries that there has been the most neglect and where the need for action to eliminate discrimination is most urgent.

Almost worldwide, widows comprise a significant proportion of all women, ranging from 7 per cent to 16 per cent of all adult women. However, in some countries and regions the proportion is far higher. In developed countries, widowhood is experienced primarily by elderly women, while in developing countries it also affects younger women, many of whom are of child bearing age. In some regions, girls become widows before reaching adulthood. Although social rules differ greatly, all cultures have rules which govern women's lives. Across a wide range of cultures, widows are subject to patriarchal customary and religious laws and confront discrimination in inheritance rights. Many of these widows suffer abuse and exploitation at the hands of family members, often in the context of property disputes. Few cases proceed successfully through the justice system. However, many perpetrators go unpunished, while others either remain undeterred or undetected.

Even in countries where legal protection is more inclusive, widows suffer from the loss of social status and marginalization. Neglected by social policy researchers, international human rights activists and the women's movement, and consequently by Governments and the international community, the legal, social, cultural and economic status of the world's widows now requires urgent attention at all levels of society, given the extent and severity of the discrimination they experience. This urgency is increased by the fact that, in all countries, developed and developing, widows far outnumber widowers, due to longer life expectancy for women and the frequent age disparity between partners. Therefore, the ageing trend of the population globally implies that the majority of the elderly in all countries will be made up of females, many of them widows requiring

support. Widowers, even when elderly, are far more likely to remarry, but this is not the case for widows who, if they do remarry, rarely do so of their own free will. In some communities, widows may be forced into new conjugal relations with a male relative or be forbidden to remarry, even if they wish to do so. As a result, many women tend to spend a longer period of their lives in widowhood, with all its associated disadvantages and stigma.

Widows are usually, but erroneously, assumed to be elderly. However, many widows in developing countries, in areas of conflict or in communities ravaged by HIV/AIDS are young or middle-aged. Widows, of all ages, are often evicted from their homes, stigmatized and physically abused—some even killed. Widowed mothers, as sole supporters of their offspring, are forced to withdraw these children from school and to rely on their labour. The daughters of widows may suffer multiple deprivations, increasing their vulnerability to abuse. The extreme plight of child widows in Asia and Africa are yet to be researched and addressed by agencies and non-governmental organizations (NGOs) committed to safeguarding the rights of the child. While the problems are worse in the developing world, recent conflicts elsewhere have created a new class of widows—the product of armed conflict and ethnic cleansing.

Profile of widowhood

Widows across the globe share two common experiences: a loss of social status and reduced economic circumstances. The relative poverty of older widows and young widowed mothers and their children, due to the dismantling of welfare systems in the North and in Eastern Europe, while not comparable to the pauperization of widows in Asia and Africa, marginalizes them from mainstream society and increases vulnerability to depression, ill health and violence. However, it must not be forgotten that many widows are enormously resourceful and resilient and live successful creative lifes, both personally and professionally.

African widows, irrespective of ethnic groups, are among the most vulnerable and destitute women in the region. Common to many countries in the region is the concept that death does not end a marriage. While the widow may have no rights to ownership of her husband's property, she is usually expected to fulfil obligations towards her deceased husband through her participation in traditional practices. In return she would be allowed to remain in her home and to have rights to cultivate the land.

In the past, this pattern of reciprocal duties and obligations in an extended family protected the widow and her children. Today, the custom is more likely to be used to oppress and exploit them. The low status, poverty and violence experienced by widows in Africa stem from discrimination in inheritance custom, the patriarchal nature of society, and the domination of oppressive traditional practices and customary codes, which take precedence over constitutional guarantees of equality, modern laws and international women's human rights standards. Debt in the developing world, structural adjustment policies, land shortage, natural disasters, the HIV/AIDS pandemic and armed conflict have had a multiplier effect on all poor people in the region, but especially on widows and children.

A widow's late husband's brothers can be covetous and unscrupulous. “Chasing off” and “property grabbing” are common features of widowhood everywhere in Africa, and even newly reformed

laws have been ineffective in protecting the victims. Widow abuse is visible across ethnic groups, income, class and education. Legislative reform in compliance with international treaties, such as the Convention on the Elimination of All Forms of Discrimination against Women, has largely failed to take precedence over local interpretations of customary law. In many countries, widows' coping strategies involve exploitative informal sector work, putting children into child labour, begging and, ultimately, sex work. On the other hand, many widows have shown remarkable determination and courage in the face of tragedy and, either individually or in cooperation with other widows, have become self-supporting and entrepreneurial, running small businesses, farming, and supporting their children and other dependants.

In Nigeria depending on the ethnic group a woman is married to she is subjected to one form of dehumanizing condition or the other. Below are some of the identified types of widowhood rites practiced in the Country:

* Shaving of hair
* Sitting/sleeping on the floor
* Drinking of water used to bathe corpse of late husband
* Jumping over corpse/grave
* Sitting/sleeping with corpse
* Eating from a broken plate and not washing hand used to eat
* Crying/wailing early in the morning
* Seclusion/restricted movement
* Taking of oath to prove innocence
* Disinherited of property acquired with spouse

With these practices the death of a husband for most Nigerian women signals the beginning of physical and mental torture, in a guise of culture and demonstration of love for the dead. In, contrast, widowers are showered with sympathy and compassion on the death of their wife. As has been observed a woman could be procured for the widower even on the night of the wife's death to keep him "company". The practical implication of the above scenario is to say the least horrendous.

We strongly condemn

- The continuing formulation, use and enforcement of laws and customs that perpetuate the violation of women's human rights, through legal, cultural and religious institutions;
- The mental, physical, emotional and sexual violation of widows;
- The absence of the right of widows to inheritance, property and land ownership;
- The systematic victimization, exploitation or neglect of older widows;
- The neglect and abuse of children of widows and child widows.

We recommend strongly that

- Action be taken to end cruel, dehumanizing, repugnant and discriminatory practices, and that laws be strengthened to ensure the punishment of perpetrators;
- Customary, religious and modern laws reinforcing discriminatory practices be abolished;
- Legal reforms in inheritance and land ownership rights be enacted and enforced;
- Independent research be undertaken into the extent of violations against widows, young and old;
- All aspects of government policy-making agendas mainstream widows' concerns;
- National, regional and international meetings be convened regularly to ensure that the collective voices of widows are heard;
- The right of widows to be included in all appropriate international instruments.

We ask Governments, the United Nations and its agencies, the media and civil society organizations to recognize the contribution that widows have made and will continue to make to the development of their societies, and demand urgent and immediate action be taken to end these violations.

Gender Based Violence

Violence against women is a persistent and universal problem occurring in every culture and social group. Around the world, at least one in every three women has been beaten, coerced into sex, or otherwise abused in her lifetime – most often by someone she knows, including a member of her own family, an employer or a co-worker. Violence against women has been called "the most pervasive yet least recognized human rights abuse in the world." Accordingly, the Second World Conference on Human Rights in Vienna in 1993 and the Fourth World Conference on Women in 1994 gave priority to this issue, which jeopardizes women's lives, bodies, psychological integrity and freedom. Violence against women is often known as 'gender-based' violence because it partly stems from women's subordinate status in society.

Gender-based violence is violence against women based on women's subordinate status in society. It includes any act or threat by men or male dominated institutions that inflict physical, sexual, or psychological harm on a woman or girl because of her gender. In most cultures, traditional beliefs, norms and social institutions legitimize and therefore perpetuate violence against women. These include physical, sexual and psychological violence such as domestic violence, sexual abuse, including rape and sexual abuse of children by family members, forced pregnancy, sexual slavery; traditional practices harmful to women, such as honour killings, burning or acid throwing, female genital mutilation, dowry-related violence, violence in armed conflict, such as murder and rape, and emotional abuse, such as coercion and abusive language. Trafficking of women and girls for prostitution, forced marriage, sexual harassment and intimidation at work are additional examples of violence against women. Gender violence occurs in both the 'public' and 'private' spheres. Such violence not only occurs in the family and in the general community, but is sometimes also perpetuated by the state through policies or the actions of agents of the state such as the police, military or immigration authorities. Gender-based violence happens in all societies, across all social classes, with women particularly at risk from men they know.

Types of gender-based violence

1. Overt physical abuse (includes battering, sexual assault, at home or in the workplace)
2. Psychological abuse (includes deprivation of liberty, forced marriage, sexual harassment, at home or in the workplace)
3. Deprivation of resources needed for physical and psychological well-being (including healthcare, nutrition, education, means of livelihood)
4. Treatment of women as commodities (includes trafficking in women and girls for sexual exploitation)

Sites of gender-based violence

Family

- Is one of the primary sites of gender violence.
- Prepares its members for social life, forms gender stereotypes and perceptions of division of labor between the sexes.
- Is the arena where physical abuses (spousal battering, sexual assault, sexual abuse) and/or psychological abuses occur. Domestic violence can also take such forms as confinement, forced marriage of woman arranged by her family without her consent, threats, insults and neglect; overt control of a woman's sexuality through either forced pregnancy or forced abortion.
- Because violence within the family and household takes place in the home, it is often seen as a 'private' issue and information about it is lacking.

Community/Society

- As a group sharing common social, cultural, religious or ethnic belonging, it perpetuates existing family structure and power inequalities in family and society.
- Justifies the behavior of male abusers aimed at establishing control over women in the family, and supports harmful traditional practices such as battering and corporal punishment
- Workplace can also be a site of violence. Either in government service or in a business company, women are vulnerable to sexual aggression (harassment, intimidation) and commercialized violence (trafficking for sexual exploitation).

State

- Legitimizes power inequalities in family and society and perpetuates gender-based violence through enactment of discriminatory laws and policies or through the discriminatory application of the law.
- Is responsible for tolerance of gender violence on an unofficial level (i.e. in the family and in the community).
- To the extent that it is the State's recognized role to sanction certain norms that protect individual life and dignity and maintain collective peace, it is the State's obligation to develop and implement measures that redress gender violence.

The primary inequality that gives rise to gender-based violence is the power inequality between women and men. The majority of perpetrators of gender-based violence are men. However, despite the fact that no society is free from it, male violence against women varies in degree and intensity according to specific circumstances. Many men choose to reject dominant stereotypes of violence and controlling masculinity.

Some types of violence against women are perpetrated by women. Some authors (e.g. Francine Pickup, in Ending Violence Against Women: A Challenge for Development and Humanitarian Work, Oxfam GB 2001) pointed out that often times, women commit violence as a way to ensure their own survival and security within a social, economic, and political context that is shaped and dominated by men. For example in some societies, older women may display violent behaviour towards their daughters-in-law. Race and class may also interact to increase violence against women, where these are the factors increasing women's vulnerability. Upper-class women who are socially and materially dependent on their husbands may use violence against their domestic workers to protect and assert their position as wives.

Gender-based violence is not exclusively a woman's concern. It is both a cause and consequence of gender perceptions. The use of the term 'gender-based violence' provides a new context in which to examine and understand the phenomenon of violence against women. It shifts the focus from women as victims to gender and the unequal power relationships between women and men created and maintained by gender stereotypes as the basic underlying cause of violence against women.

Gender-Based Violence: A Human Rights Violation

The conceptualization of violence against women and girls as a violation of human rights was one of the achievements of the women's movement during the Second World Conference on Human Rights in Vienna in 1993. In March of the following year, the United Nations Commission on Human Rights set forth a resolution that integrated women's rights within the mechanisms assuring protection of human rights. In answer to the request of women's organizations at the Vienna conference, this Commission also named a Special Rapporteur on Violence Against Women. The Special Rapporteur's mission is to receive and investigate information on situations of gender-based violence throughout the world. Also in 1993, the UN General Assembly adopted the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), which is currently the main international document addressing the problem of gender-based violence. In CEDAW, the UN offered the first official definition of gender-based violence. In the remaining time we will explore the definition of gender-based violence found in the CEDAW. The Declaration was the first international document which defined violence against women within a broader gender-based framework and identified the family, the community and the state as major sites of gender-based violence. The Declaration's basic assertion is that violence against women arises from historic inequality between men and women that results in the domination of men over women and causes gender discrimination. It emphasizes that violence is one of the crucial social mechanisms "…by which women are forced into a subordinate position compared with men." Since the adoption of the Declaration, international law can be interpreted to define gender-based violence as a human rights violation. The historic significance of the Declaration lies in the identification of practical measures needed to combat gender-based violence. The Declaration reflects growing international concern about the problem and calls on States to develop national action plans to promote the protection of women against any form of violence, create effective legislative remedies to eliminate such violence, review and reform legislation and law enforcement policies to ensure proper protection of women's rights.

[31] Source: UNIFEM Gender Fact Sheet No., available at http://www.unifemeseasia.org/Gendiss/downloads/UNIFEMSheet5.pdf

Furthermore, the Declaration recommends that States adopt measures in the field of education to modify "…the social and cultural patterns of conduct of men and women and to eliminate prejudices, customary practices and all other practices based on the idea of the inferiority or superiority of either of the sexes and on stereotyped roles for men and women." Finally, it is of great importance for both law enforcement agencies and NGOs that the Declaration states clearly that violence against women constitutes a violation of women's fundamental rights and freedoms. Thus gender-based violence is incompatible with the values of a democratic state and the rule of law.

Ending Violence against women and girl children

- Violence against women and girl children is a global phenomenon which cuts across geographical, cultural and political boundaries and varies only in its manifestations and severity. Gender violence has existed from time immemorial and continues up to the present day. It takes covert and overt forms, including physical and mental abuse. Violence against women, including female genital mutilation, wife burning, dowry-related violence, rape, incest, wife battering, female foeticide and female infanticide, trafficking and prostitution, is a human rights violation and not only a moral issue. It has serious negative implications for the economic and social development of women and society and is an expression of the societal gender subordination of women.
- Governments should openly condemn all forms of violence against women and children, in particular girls, and commit themselves to confronting and eliminating such violence.
- To stop all forms of violence against women, all available media should be mobilized to cultivate a social attitude and climate against such totally unacceptable human behaviour.
- Governments should set up monitoring mechanisms to control depiction of any form of violence against women in the media.
- Violence being a form of social aberration, Governments should advocate the cultivation of a social attitude so that victims of violence do not suffer any continuing disability, feelings of guilt, or low self esteem.
- Governments should enact and regularly review legislation for effectively combating all forms of violence, including rape, against women and children. In this connection, more severe penalties for acts of rape and trafficking should be introduced and specialized courts should be established to process such cases speedily and to create a climate of deterrence.
- Female infanticide and female foeticide should be openly condemned by all Governments as a flagrant violation of the basic right to life of the girl child.
- The hearing of cases of rape should be in camera and the details not publicized and legal assistance should be provided to the victims.
- Traditional practices of dowry and bride-price should be condemned by Governments and made illegal.
- Families, medical personnel and the public should be encouraged to report and have registered all forms of violence.
- More and more women should be inducted in law enforcement machinery as police officers, judiciary, medical personnel and counsellors.

Gender-sensitization training should be organized for all law enforcement personnel and such training should be incorporated in all induction and refresher courses in police training institutions.

- Mechanisms for networking and exchanges of information on violence should be established and strengthened.
- Governments should provide shelters, counselling and rehabilitation centres for victims of all forms of violence. They should also provide free legal assistance to victims.
- Governments must develop and implement a legal literacy campaign to improve the legal awareness of women, including dissemination of information through all available means, particularly NGO programmes, adult literacy courses and school curricula.
- Governments must promote research on violence against women and create and update databases on this subject.
- Community-based vigilance should be promoted regarding gender violence, including domestic violence.
- At the national level, Governments should promote and set up independent, autonomous and vigilant institutions to monitor and inquire into violations of women's rights, such as national commissions for women consisting of individuals and experts from outside the Government.
- Governments which have not done so are urged to ratify the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, to ensure full gender equality in all spheres of life. The States parties to these Conventions must comply with their provisions in order to achieve their ultimate objectives, including the eradication of all harmful traditional practices.
- NGOs should be active in bringing all available information on systematic and massive violence against women and children, in particular girls, to the attention of all relevant bodies in country, United Nation's Centre for Human Rights, the Commission on the Status of Women and other specialized agencies, for the necessary intervention. Such information should also be shared with the Governments concerned, women's commissions and human rights organizations.
- Women's organizations should mobilize all efforts, including action research, to eradicate prejudicial and internalized values which project a diminished image of women. They should take action towards raising awareness among women about their potential and self-esteem, the lack of which is one of the factors perpetuating discrimination.

Conclusions

Most women in developing countries are unaware of their basic human rights. It is this state of ignorance which ensures their acceptance and consequently the perpetuation of harmful traditional practices affecting their well-being and that of their children. Even when women acquire a degree of economic and political awareness, they often feel powerless to bring about the change necessary to eliminate gender inequality. Empowering women is vital to any process of change and to the elimination of these harmful traditional practices.

Since the World Conference on Human Rights, held in Vienna in 1993, it is hoped that all States will recognize and accept the universality and indivisibility of the human rights of women. It is also expected that there will be more ratifications of the Convention on the Elimination of All Forms of Discrimination against Women. However, much remains to be done in the field of equality, taking into account the absence, in many countries, of real constitutional guarantees of fundamental human rights for all. The persistence of negative customary norms that conflict with and undermine implementation of both national legislation and international human rights standards must be addressed.

Although such national legislation and international standards are vital in tackling the issue of harmful traditional practices, there is an urgent need for a parallel programme that addresses the cultural environment from which these practices emerged, in order to eliminate the various justifications used to perpetuate them. It is the duty of States to modify the social and cultural attitudes of both men and women, with a view to eradicating customary practices based on the idea of the inferiority or superiority of either sex or on stereotyped roles of gender.

Comprehensive and intensive programmes of formal and informal education, awareness raising and training are the approaches followed by some Governments, non-governmental organizations and women's groups. Efforts should be made by women's organizations to empower women and service providers in an effort to change attitudes regarding harmful traditional

practices. This approach needs to be supported by implementation of national and international human rights norms relating to the elimination of discrimination against women. The environment of discrimination, which denies women and the girl child equal access to health care, education, employment and wealth, must also be addressed and reformed.

In the international debate, the father's responsibility towards the girl child has never been challenged. However, the duties and responsibilities of men within the family have begun to receive special attention as instruments of change. The Programme of Action adopted by the International Conference on Population and Development in September 1994 states: Changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving the harmonious partnership of men and women. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life. Male responsibilities in family life must be included in the education of children from the earliest ages.

One of the most noticeable achievements at the international level has been the lifting of the taboo against addressing the issue of female genital mutilation, which is now acknowledged as a violation of the human rights of women and the girl child. This has created new sociocultural forces in the countries concerned, particularly among women participating in the crusade against FGM. None the less, unprecedented efforts are needed at the national and international levels to eradicate all forms of harmful traditional practices.

Governments, the United Nations and its specialized agencies, and NGOs should now play a more important role in monitoring and implementing the Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children. Technical and financial support should be given to national and regional organizations which advocate gender equality and promote human rights for all.

MODULE 4.0

Special Vulnerable Groups

Special Vulnerable Groups

OBJECTIVES

- To explore the different special groups (Young people living with HIV/AIDS, prisoners living with HIV/AIDS, the sexual and reproductive rights of persons with disability, female sex workers, and sexual minorities such as lesbians, men who have sex with men, bisexuals, and transgender).
- To identify characteristics and critical issues facing special vulnerable groups.
- To build the capacity of participants with intervention strategies to aid programming.

MATERIALS

- Session objectives written on flipchart
- Flipchart stand, masking tape, flipchart and markers
- Handout on "Special Vulnerable Groups")
- Handout on Young people living with HIV/AIDS
- Handout on Prisoners living with HIV/AIDS
- Handout on the sexual and reproductive rights of people with disability
- Handout on Female sex workers
- Handout on Sexual minorities

RESOURCES

- UNAIDS 2010 AIDS Epidemic Update
- UNAIDS, 2009 Report on the Global AIDS Epidemic
- www.youthcoalition.org. Youth & HIV fact sheet
- UNAIDS1997, Prison and AIDS.
- http://www.avert.org/prisons-hiv-aids.htm
- UNAIDS 1997. Prison and AIDS. http://data.unaids.org/Publications/IRC-pub05/prisons-pov_en.pdf
- WHO, 2004. Evidence for action on HIV/AIDS and injection drug use: Policy brief-Reduction of HIV transmission in prisons. http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.05.pdf

PREPARATION

- Draft and review power point presentation.
- Review critical issues and interventions from the handouts.
- Be prepared to discuss critical issues and interventions among special vulnerable groups.
- Place instructions for group activity on power point.

Facilitation session

STEP ONE (
Exploring the different special vulnerable groups

- Review the objectives of session 4 with participants on a flipchart.
- Have the group brainstorm while a participant records on a flip chart the definitions of each group.
- Ask participants to discuss their issues and comments
- Present PowerPoint slide show; Start by offering the definition of special groups.
- Ask participants to give feedback on the definition.

STEP TWO
Characteristics, critical issues and interventions

- On a flip chart, review the objectives of session 4.
- Divide participants into groups based on special groups. Ask participants to identify critical issues facing special vulnerable groups. Each group should make a brief presentation on flip charts.
- Present power point slide show.
- Discuss critical issues by special groups and generate feedback from participants

STEP THREE
Intervention strategies to aid programming

- Review the objectives of session 4 with participants.
- Divide participants into groups based on special vulnerable groups. Ask participants to design intervention strategies to aid programming on flip charts.
- Ask participants to have a 10 minutes presentation.
- Present power point slide show.
- Discuss intervention strategies
- Ask participants to develop an action to target special groups in programming.

Group Activity

Divide participants into five groups and assign each group one of the following topics:

- Young People Living with HIV/AIDs
- Prisoners Living with HIV
- Sexual reproductive rights of People with Disability
- Female Sex Workers
- Sexual Minorities

Special Vulnerable Groups

This manual looks at the various special vulnerable groups with reference to young people living with HIV/AIDS, prisoners living with HIV/AIDS, the sexual and reproductive rights of people with disability, female sex workers, and sexual minorities. For the purpose of intervening for these groups, they are regarded as special vulnerable groups because they have been marginalised and excluded from SRH including HIV intervention programmes. These groups are special because of their peculiarities and high vulnerability. Despite having a high prevalence of HIV/AIDS and practicing behaviours that increase their vulnerability, these groups are often marginalized. Their existence is often denied, criminalized and the "illegal" nature of their activities means that governments fail to take appropiate actions to meet their needs. As a result, these vulnerable groups are excluded or marginalized from the design, implementation, and evaluation of national SRH and HIV/AIDS policies and programmes. HIV further increases loss of livelihoods, cost of healthcare, stigma and discrimination and denial of human rights for marginalized groups. Stigma and discrimination against marginalized groups can take varying degrees and different forms including preventing people from being tested for HIV or receiving adequate care including SRH services. Significant financial barriers such as high cost of transportation, fees associated with HIV diagnosis and treatment, lack of health care infrastructure and inadequate human resource capacity can impede their access to care and treatment even where treatment is provided for "free".

We need to be pragmatic on two fronts: first to integrate special groups into HIV/AIDS programming and,

secondly, to ensure sustainability of ongoing programmes and to expand them. In Nigeria, documents such as the National Strategic Framework and National Prevention Plan have integrated programming for vulnerable groups i.e. Men who have Sex with Men (MSM), Youths etc. CSOs, advocates will need to take the words of these policies on HIV prevention and make them operational realities where it matters most at the community level – where vulnerable groups in general can have access to comprehensive HIV/STI services. It is critical for healthcare providers, NGOs, policy makers to understand which groups are particularly at risk of HIV/AIDS or are unable to access information and services appropriate to their specific needs. Healthcare systems and stakeholders need to adapt and modify structures on ground to suit the needs of these groups. Without urgent attention to these key issues, the internationally declared goal of universal access to HIV/AIDS prevention, treatment, and care is not achievable. Moral questions about these groups should not influence their access to prevention and care programmes to reduce and eventually stop the spread of HIV/AIDS. National governments and international agencies must collaborate more effectively with civil society groups in order to hear their concerns and address their needs. It will only be through the active and meaningful participation of these marginalized, most affected groups that countries will be able to achieve universal access to HIV/AIDS prevention, treatment, care, and support and halt the progress of the HIV epidemic.

Young people living with HIV/AIDS

Globally, 1.7 billion young people aged 10-24 make up one quarter of the world's population, 1.5 billion of them in developing countries – the largest-ever generation of adolescents. Young people make up a large percentage of the "marginalized groups:" injecting drug users (IDUs), sex workers (SWs), men who have sex with men (MSM), homeless or living on the streets, disabled, imprisoned or care-giving youth, youth in conflict zones. These groups are often at risk of stigma, unprotected sex, transactional sex (money or food for sex), and substance abuse.

Despite young people's vulnerability to HIV infection, their needs are often overlooked when national AIDS strategies are designed and implemented. As of 2007, an estimated 33.2 million people were living with HIV, 5.4 million of whom were young people 15-24 years of age. 40% of all new HIV infections occur among young people 15-24 years old, most of them female. In sub-Saharan Africa, 3.2 million young people are living with HIV (YPLHIV) and three young women are infected for every young man. Gender inequality reduces the ability of young women (especially those who are married) to negotiate condom use and access services. The vast majority of YPLHIV do not know that they are infected. With increasing access to testing, including through provider-initiated testing and counselling, more and more of these young people will know their HIV status. Pregnant women are often young women who need to receive antiretrovirals for the prevention of mother-to-child transmission of HIV.

Young people living with HIV/AIDS are often blamed for their risky behaviours often resulting in stigma and discrimination from clinical and non clinical care settings therefore damaging their self esteem and compromising their sexual health.

Out of School Youths

Across the globe, out-of-school youths are a diverse group. They may have completed school, dropped out, or never started school. They may have jobs or be married, or may be girls who have been forced to quit school because they need to work in the home, are pregnant, or have babies. They work in factories, live on the streets, hawk vegetables in the market, stay at home for house work or child care, or are unemployed.

> ***The term "out-of-school youth" is used to define several groups of young people: those who have dropped out of school, those who never attended school, or those who participate in non-formal school programmes. When considering out-of-school services or programmes, this paper is not referring to "after-school" programmes for youth who attend school, but rather programmes and services specifically geared toward youth who do not or cannot attend school.***

responsibility for their own lives and information on sexual health issues, including contraception and HIV prevention. Some out-of-school youths are especially vulnerable and socially marginalized.

Many young persons who are out-of-school and unemployed spend much time on the streets, where they are vulnerable to experimentation with risky behaviours such as alcohol and drug abuse. Street kids, adolescents involved in sex work, and gay and bisexual males are particularly vulnerable and are often out of school. The abuse of drugs and alcohol is associated with an increase in unsafe sexual behaviour and its consequences of sexually transmitted infections (STIs)/HIV and unintended pregnancies, as well as an increased risk of violence.

Critical issues

- Regular health centers are 'not friendly' and youths do not feel comfortable accessing services – HCT, STI screening and management, ART uptake, condoms and lubricants, resource materials etc.
- Many young people still don't know enough about the HIV/AIDS epidemic, or how to protect themselves.
- Fear of disclosure to family members impedes young people from getting tested or accessing services.
- Accessibility and availability of condoms/lubricants, family planning and sexual reproductive health services as essential components to care and support programmes.
- Lack of accurate information on sexual reprdocutive rights including the right to live free of persecution based on a person's sexuality.
- Laws that prohibit young people under 18 from accessing HIV testing or health services without parental consent are a major barrier to reaching young people at risk for infection. Few young people want their parents to know they are having sex and need an HIV test and SRH intervensions.
- Service providers often forget that YPLHIV are sexually active, and that young women living with HIV may not want to become pregnant.
- Lack of reliable data on young people and YPLHIV. Few countries follow the UNGASS core indicators under which they are required to disaggregate [collect separate] data by gender and age. Current data only reflect trends and behaviours among children (0-14) and adults (15-49)- not young people. Without evidence, it is not possible to identify drivers of the epidemic, where to target our efforts, what the human and financial resource needs are,

what the barriers to access are, what the entry points to reach young people are, and what progress has been achieved. Social, cultural and economic factors also greatly influence young people's ability to protect themselves from unwanted pregnancy and STIs, including HIV. Mass media, materialism, migration and/or urbanization may increase both the desire and opportunity for sexual activity and many young persons feel strong peer group pressure to engage in sexual intercourse. Some cultures may promote early sexual intercourse by expecting women to marry and begin childbearing at an early age.

- Sexual exploitation and abuse of young children and teenagers, sometimes by family members and people with authority over them such as teachers, clergy, mentors e.t.c.
- Rape of young college girls especially in university campuses, villages and cities.

Way forward

The urgency of the AIDS epidemic demands dynamic, new approaches that are inclusive, and involve young people. YPLHIV need psychosocial support and youth-friendly services to deal with their diagnosis, disclosure, treatment adherence, issues of motherhood and relationships, financial stability, and positive living.

Design programmes with inbound package and delivery of services – distribution of condoms/lubricants, referrals and resource materials. Health care providers must be trained and retrained to provide accurate, relevant, appropriate and non-judgemental information targeting young people.

Youth friendly, confidential contraceptive services should be available and services must include HCT with pre and post-test counselling in a confidential setting, and referrals to other services (ideally affordable, proximate in location, and accessible to youths). Also, culturally appropriate information and services should be integrated. Accurate information and age-appropriate services that focus on behaviours and gender-specific information and services that address young women's needs should be paid attention to.

Involvement of young people in HIV programming especially adopting the bottom top approach through the programme cycle- design, implementation and evaluation. Youths should be encouraged to participate in programmes that affect them, identify gaps and profer recommendations for future programming. The idea of involving people living with HIV was formally adopted as a principle at the Paris AIDS Summit in 1994, where 42 countries declared the Greater Involvement of People Living with HIV and AIDS (GIPA) to be critical to ethical and effective national responses to the epidemic.

Advocacy visits to donors, faith based organisations, media, corporations, educational institutions, foundations, NGOs, CBOs, policy makers and other key stakeholders to sensitise stakeholders on issues that affects the lives of YPLHIV - agriculture, food security, employment, work place etc. Parents and other community members should be involved too.

Outreach activities and peer education should be adopted. Training peer educators from within

the community with accurate information on HIV/AIDS and provision of HIV services. Peer educators are familiar with their groups and terrain and can deliver effective messages to their peers in the community. Many effective programmes also provide integrated services to create an empowering environment for young people and to address their multiple needs. Capacity building and other activities should aim at building young persons skills in communication and negotiation.

Complete sexual abstinence is the most effective means of protection against both pregnancy and HIV infection. Messages of abstinence appear to work best when aimed at younger youth who are not yet sexually active, especially girls. Adolescents who successfully practice abstinence require strong social support from community members and the development of specific skills, including a high degree of motivation, self-control, and communication. Programmes that include comprehensive messages can teach skills for practicing abstinence as well as provide information for sexually active youths about condoms and reducing the number of partners.

[36]Centers for Disease Control & Prevention. HIV/AIDS among US Women: Minority and Young Women at Continuing Risk. Atlanta, GA: The Centers, 2002.
[37]Youthnet. Abstinence and delayed Sexual initiation. www.fhi.org/youthnet

Prisoners living with HIV

Prison conditions are often ideal breeding grounds for onward transmission of HIV infection. They are frequently overcrowded. They commonly operate in an atmosphere of violence and fear. Tensions abound, including sexual tensions. Release from these tensions, and from the boredom of prison life, is often found in the consumption of drugs or in sex." UNAIDS 1997, Prison and AIDS.

In many prisons around the world there are high rates of infection with the human immunodeficiency virus (HIV), the virus that causes AIDS. At the same time, prisoners often also have tuberculosis (TB), syphilis and various strains of viral hepatitis. The prison population is not eternally sealed off, but is constantly changing, with people going in and out. In some places, the average stay in prison is quite short. Various target groups exist in prisons – Injection drug users, Men who have Sex with Men, In and Out of School youths etc. within prisons is often far higher than in the general community, and prisons are a high-risk environment for HIV transmission. However, when it comes to tackling the epidemic, prisons and prisoners are often neglected and overlooked. The HIV prevalence of prisoners varies from country to country, America has the highest prison population in the world, around 1.7% of whom are HIV positive.[1] Although this figure has declined, the HIV prevalence is still higher for incarcerated populations than for the general population. Studies from prisons in Brazil and Argentina reveal a particularly high HIV prevalence – ranging from 3.2 to 20% in Brazil and 4 to 10% in Argentina. The prevalence rates for sub-Saharan African countries are also high; an estimated 41.4% of incarcerated people in South Africa are infected with HIV. Generally, the HIV prevalence in the country reflects the prevalence in prisons. So while South Africa has a high percentage of HIV positive inmates, the HIV prevalence in the general population is also high, at an estimated 18.1%.

In Nigeria, not many studies have been carried out to assess the prevalence of HIV/AIDS among prison inmates. In sub saharan Africa, HIV prevention programmes are rarely available in prisons and many prisoners with HIV/AIDS are unable to access antiretrovirals. In many parts of the world

prison conditions are far from satisfactory and HIV positive inmates barely receive the most basic healthcare and food. Some prison authorities enforce mandatory HIV counselling and testing, which is a violation of their fundamental human rights. Issues of mandatory testing for HIV is not confined to male prisoners but also to female prisoners. Several factors make prisons an ideal breeding ground for onward transmission of HIV infection. HIV is transmitted through injection drug use, unprotected sexual intercourse and multiple sexual partners. Non-consensual sex can cause tear and bleeding which further increases their risk to HIV transmission. Fights and

UNAIDS 1997. Prison and AIDS. http://data.unaids.org/Publications/IRC-pub05/prisons-pov_en.pdf
http://www.avert.org/prisons-hiv-aids.htm

assaults are common in prison and carry a risk of HIV infection if people are exposed to blood and bodily fluids.

Critical issues

Condoms and lubricants which can prevent HIV infection if used consistently and correctly are unavailable in the prisons. Condoms are often considered contraband within prisons and prison inmates are forced to engage in unprotected sexual intercourse with their partners.

HIV prevention programmes are not provided for inmates for fear of undesirable behaviour which often increases their risk and vulnerabilty to HIV/AIDS. Prison officicals feel that providing HIV prevention programmes would promote promiscuity.

Prevention of HIV transmission in prisons is mostly hampered by the denial of governments on the existence of injecting drug use and sexual intercourse in prisons, rather than by a lack of evidence that key interventions work. There is ample evidence that drug use in general, injecting drug use in particular and sexual intercourse between inmates are widespread in such institutions. Furthermore, there are data indicating that the risk of HIV infection in prisons is usually higher than in the general community: prisons are a high-risk environment for HIV infection.

Interventions

"All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality. The general principles adopted by national AIDS programmes should apply equally to prisoners and to the community".

- Advocacy with key stakeholders to educate them on integrating HIV programming for prisoners to prevent the spread of new infections, reduce stigma and discrimination and reduce the burden of HIV/AIDS.
- Collaboration with NGOs and CBOs to provide on going HIV education in prisons to prisoners and prison staff on the need to provide HIV care and treatment services in prisons and provide accurate information on HIV prevention, care and support, positive living/prevention with positives.

[40] WHO, 2004. Evidence for action on HIV/AIDS and injection drug use: Policy brief-Reduction of HIV transmission in prisons. http://whqlibdoc.who.int/hq/2004/WHO_HIV_2004.05.pdf

- Harm reduction programmes should be designed to reach injection drug users to reduce exchange of unsterilised and infected needles. Drug substitution therapy is another harm reduction approach that should be implemented both within the community and within prisons.
- Provision of HIV care and treatment in prisons and accurate information on positive living, prevention with positives, palliative care and psyschosocial counselling. It will be necessary to create support groups where HIV positive persons can have access to discuss issues affecting them and a safe place to receive psychosocial counselling and support. Palliative care kits can be provided as a means of support to living positively.
- Condom and lubricant distribution in prisons is necessary. Correct use of condoms could be demonstrated on models and consistency stressed. The use of automated distribution machines could be explored.
- Increase uptake of HIV counselling and testing to diagnose new infections, identify risky behaviours and provide an opportunity to provde accurate information on HIV/AIDS.
- Distribution of clean needles and syringes in prisons by prison health personnel or through automatic distribution machines should be encouraged. The aim of this strategy is to reduce sharing of needles and syringes and to maintain stability or decrease in consumption of injection drugs. However, officials may fear that needles or syringes could be used as weapons if not monitored properly.

In summary, HIV transmission in prison settings can be reduced by:

- Needle exchange programmes, whereby a used needle is exchanged free for a sterile (clean) one;
- Discreet and easy access to condoms and lubricants for all prisoners.
- An end to overcrowding in prisons, and control of prison health by the public health authorities, acting freely and independently of the prison service.

Sexual reproductive rights of persons with disability

Many people believe that physically challenged persons or persons with disability do not have sexual reproductive health and rights. About 10 per cent of the world's population, 650 million people live with a disability, and their sexual and reproductive health has been neglected. This figure is increasing through population growth, medical advances and the ageing process, says the World Health Organization. In countries where life expectancy is more than 70 years, individuals spend on average eight years of their lives with one or more disabilities. However, 80 per cent of persons with disabilities live in developing countries, most without social systems to support them. Their burdens are tremendous. In addition to the impact of physical, mental, intellectual or sensory impairments, persons with disabilities often face stigma, discrimination, violence and poverty. They must cope with inadequate health services and have limited access to education. They experience the deprivation of opportunities in all aspects of life, including access to essential services. In particular, their sexuality has been ignored and their reproductive rights denied. People who are blind, deaf, or have intellectual or cognitive impairments find that information on sexual and reproductive health is often inaccessible to them. Moreover, because of the lack of physical access, the lack of disability-related technical and

human supports, stigma and discrimination, sexual and reproductive health services are often inaccessible as well.

"Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Persons with disabilities are as likely as persons without disabilities to be sexually active and thus at risk of HIV/AIDS. They are three times more likely to be victims of physical and sexual abuse and rape and have less access to physical, psychological and judicial interventions. Persons with disabilities often experience forced sterilization, forced abortion and forced marriage.

International instruments on the Sexual Reproductive Health of Persons with Disabilities

Box 4.0 The United Nations Convention on the Rights of Persons with Disabilities

Article 23: Respect for home and the family

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

a. The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;

b. The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;

c. Persons with disabilities, including children, retain their fertility on an equal basis with others.

Article 25: Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

c. Provide these health services as close as possible to people's own communities, including in rural areas;

d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through

Critical issues

- Persons with disability especially women are marginalized and excluded from services. The failure to recognise the sexual and reproductive needs of disabled persons is a violation of

their basic human rights as embedded in both international and national declarations.

Persons with disabilities are seldom included in HIV-prevention and outreach efforts due to the assumption that they are not sexually active and at little or no risk for HIV infection.

- IEC materials are not appropriately specific to display messages to persons with disability – for example, blind persons are not able to read current IEC materials.

- Persons living with HIV and AIDS experience AIDS-related physical disabilities. AIDS itself can biologically and psychologically cause mental health problems such as depression, acute psychotic disorders and dementia. Psychological causes, especially, stem from stigma, discrimination and the fear of death.

- Parents and community members do not support people with disability in realizing their reproductive rights. Men mainly abuse women with handicap when they force them into sex, make them pregnant and deny responsibility. What makes matters worse is that there are certain myths held by men, for example they think that disabled women are free from HIV, so men go to them and do not use condoms most of the time. In addition the disabled women give in easily because they think it is a chance for them.

Women with disabilities are prone to sexual exploitation. Society does not expect women with disabilities to be informed about sex. There is also a general belief that young girls

[44]Nangendo, F. Awareness of reproductive rights, HIV prevention and sexual exploitation among women with disabilities. Child Health and Development Centre.

and women with disabilities are not infected with HIV/AIDS. Hence a tendency to exploit them sexually. They lack safer sex negotiation skills; feel powerless and sometimes can be raped and sexually abused.

Interventions

- Advocacy visits with key stakeholders to advocate for the inclusion of persons with disability in HIV programming.

- Persons with disability should be included in sexual and reproductive health policies and programmes to consider their needs in policies, strategies, trainings, projects, publication and decision making process. Data on persons with disability living with HIV/AIDS should be established so programmers can influence policies and design interventions programmes to reach out to HIV positive persons.

- Healthcare providers should be trained on providing specific sexual and reproductive health services and needs for persons with disability. HIV positive persons with disability should be trained too.

- Culturally acceptable information, education and communication (IEC) materials should be designed in several languages. Resource materials should be designed for HIV positive persons with

disability and provision of accurate information on SRHR should be accessible to persons with disabilities and their families.

- Health services and youth friendly facilities should be physically, psychologically, economically and socially accessible to everyone.

- HIV positive persons with disabilities could be trained as peer educators on sexual and reproductive health for Persons with Disabilities to disseminate messages to their peers and distribute resource materials and make referrals to SRHR services.

Commercial Sex Workers

Commercial sex workers have been known since olden times. In most countries, commercial sex work is not a legally recognized 'profession'. However, most of the establishments where the sex workers are based (hotels, bars/restaurants, night clubs etc.) operate 'legally'. Commercial sex workers are exposed to numerous adverse conditions such as poor living conditions, social stigma and sexually transmitted infections, including HIV. Sex workers can be grouped as establishment based sex workers- those associated with, or located at working establishments (e.g. hotels, bars, restaurants, brothels, red-light houses) and street-based sex workers — those who could be located along main streets in the cities.

This manual will look at both Female and Male Sex Workers (FSW and MSW). In nearly all settings, female sex workers are a stigmatized group of people. Their very existence challenges the standard family and reproduction-oriented sexual morality found in most societies. Yet they exist nearly everywhere, clearly indicating that they fulfill a function for society. Hypocritically, most mainstream societies have relegated them to the margins, abused them, exploited them and restricted their rights as citizens. [45]

Male Sex Work (MSW) is the sale of sexual services by a male (a gigolo, manwhore, hooker, rentboy, boy2rent, rentman, callboy, hustler, or male prostitute).

The gender of the customer and the (s) or sexual behaviour that the sex worker engages in with that person may not correspond to the sex worker's own sexual orientation. Compared to female sex workers, male sex workers have been far less studied by researchers, and while studies suggest that there are differences between the ways these two groups look at their work, more research is needed. [46]

[45] Female sex worker HIV prevention projects: Lessons learnt from Papua New Guinea, India and Bangladesh. UNAIDS Case study November 2000 http://data.unaids.org/publications/IRC-pub05/JC438-FemSexWork_en.pdf

[46] Wikepedia. http://en.wikipedia.org/wiki/Male_prostitution

Critical issues

As women (in contrast to male sex workers), they are doubly powerless. With the advent of the HIV pandemic, they have been the first group in many nations to be targeted as vectors and seen as dangerous to the general population. They are seen as the agents of infection and their clients as unwitting victims.

Sex workers either male or female generally have multiple sexual partners, however, this number increase among FSW. They have relatively high numbers of sexual partners and have unprotected sexual intercourse or inconsistent use of condom which increases their vulnerability to HIV/AIDS. In some cases, this is because sex workers have no access to condoms, or are not aware of their importance. In other cases, sex workers are simply powerless to negotiate safer sex, even if they try to do so. Clients may refuse to pay for sex if they have to use a condom, and use intimidation or violence to enforce unprotected sex. They may also offer more money for unprotected sex – a proposal that can be hard to refuse if the sex worker in question is in desperate need of an income.

Often times sex workers are stigmatized, and criminalised by the societies in which they live in which increases their vulnerability to HIV/AIDS. This makes it difficult for them to access health, legal and social services – a violation of their fundamental human rights.

For one thing, even though sex work is at least partially legal in many countries, sex workers are rarely protected by the law. Around the world, there is a severe lack of legislation and policies protecting sex workers from the unscrupulous actions of clients that can put them at risk. For example, a sex worker who is raped will generally have little hope of bringing charges against their attacker. The lack of protection in such cases leaves sex workers open to abuse, violence and rape, and in such an environment it is easier for HIV transmission to occur.

In some countries, large numbers of sex workers are also injecting drug users. Some become involved in sex work as a means of financing their drug use, while others are involved in sex work first, and then turn to drug use – perhaps to escape from the intense emotional and physical burden of their work, or because other sex workers have introduced them to it. Since needle sharing is one of the most efficient ways of passing HIV between people, sex workers who inject drugs and share needles face a particularly high risk of becoming infected with HIV.

Migration and sex work are often linked, as poor migrants who have newly arrived in an area sometimes turn to sex work because they cannot find any other way to make money. As well as selling sex themselves, migrants may also become the clients of sex workers, sometimes as a means of escaping the loneliness that often accompanies migration.

Boyfriends, husbands, wives and other non-commercial sexual partners frequently place sex workers at more risk than do their clients, particularly after they have learned to persuade clients to use condoms. This aspect of the lives of sex workers needs specialized attention.

Interventions

Building the capacity of sex workers to take the lead in programmes that respect human and citizen rights has proven to be one of the most successful strategies in preventing the spread of HIV. It promotes solidarity, enables them to reach more of their peers and share their knowledge on health matters. They no longer need to rely on outsiders, thus giving them increased control over their own health."

A. **Prevention campaigns** aimed at sex workers not only reduce the number of HIV infections that result from paid sex; they can also play a vital role in restricting the overall spread of HIV in a country. Proof of this can be seen in countries such as Bangladesh, Benin, Cambodia, the Dominican Republic and Thailand, where general reductions in the national HIV prevalence have been largely attributed to HIV prevention initiatives aimed at sex workers and their clients.

B. **Increase level of condom use** and safer sex amongst sex workers and their clients through peer education which can be used to convey information and persuade people to change their behavior. Its great advantage is that peers can utilize their normal venues and modes of communication.

There is need for programmers to respect commercial sex workers, see them as partners and encourage collaborative efforts to reduce the prevalence of HIV/AIDS. Involving sex workers directly in HIV prevention campaigns can raise their self-esteem and empower them, thereby encouraging them to look after their health and to access services that could help them. Sex worker involvement could enhance increased control over their working and social conditions.

[47] United Nations (2003, 22nd January), 'Sex workers mobilize to fight HIV/AIDS, UNAIDS says', press release

[48] Sex workers and HIV prevention. http://www.avert.org/sex-workers.htm

A. **Reducing the number of STIs** amongst sex workers by providing:
   - free condoms, lubricants, educating sex workers and their clients about HIV
   - encouraging non penetrative sex;
   - encouraging peer education (where sex workers inform one another about HIV);
   - helping sex workers to group together;
   - reducing the stigma that communities attach to sex work;
   - ensuring that laws and policies respect sex workers' human and citizen rights.

Addressing clients with specific programmes tailored to their needs strengthens sex workers' abilities to negotiate condom use. Personnel well trained in current STI diagnostics and treatment must oversee the establishment and management of clinics for sex worker projects.

- STI and other studies undertaken with sex workers must be carried out with their full understanding and assure their right to refuse.

- Programmers sometimes need training in human sexuality in order to be able to speak about sex with ease and convey explicit messages. Trainings will diminish moralistic and judgmental attitudes among staff.

- Documentation is more than periodic surveys and counting monitoring indicators. Writing and/or using tapes and film to document the history of a project is a worthwhile endeavor of its own and has potential value to many others.

- Workplace policy workshops with key stakeholders should be held with security firms, shipping firms, police etc and men at large to discuss condom use.

- Resource materials should be specifically designed for commercial sex workers so they can relate to the situation and personalize messages.

- Supported healthcare facilities should be identified and designated as friendly places where sex workers can have access to STI/HIV services.

- It is necessary to add a component of empowerment in intervention package so sex workers could have their skills built in may be vocational trainings or skill acquisition. They will be able to fend for themselves and gradually diminishing sex trade.

- For HIV positive sex workers, it is necessary to encourage the formation of support groups to help members spiritually, physically and emotionally. The groups will be managed and coordinated by the leader chosen by the group and several sessions could be held to further strenghthen their skills in living positively.

In summary, a comprehensive approach should be adopted in programming for commercial sex workers to integrate HIV/STI prevention services that includes syndromic management of STIs, HIV counselling and testing, referrals for ART uptake, provision of accurate information on HIV/AIDS, distribution of free condoms and lubricants, and provision of palliative care for HIV positive persons.

Defining the LGBT Community

Loosely defined grouping of Lesbian Gay Bisexual and Transgender (LGBT) and LGBT-supportive people, organizations and subcultures, united by a common culture and civil rights movements. The term "gay and lesbian" refers to men and women with sexual preferences for men and women respectively. Bisexual refers to sexuality with both sexes and transgender is state of one's "gender identity (self-identification as woman, man, neither or both) not matching ones "assigned sex" (identification by others as male, female or intersex based on physical/genetic sex).

Criminalization and economic disenfranchisement of sexual minorities cause social dislocation, influence transnational migration, and fuel human rights abuses, which in turn heighten the risk for HIV transmission. Without appropriate health messages, support, and services, sexual minorities are at continued and elevated risk of HIV infection. As a result, HIV infection rates remain disproportionately high among sexual minorities in both developed and developing countries and access to services unacceptably low. The HIV/AIDS prevention, care and treatment needs of the LGBT community or sexual minorities are not always addressed in national prevention efforts. Men

who have Sex with Men (MSM) are more likely to have access to HIV services than transgender individuals. The needs of Women who have Sex with Women (WSW) and lesbians are rarely addressed in HIV intervention programs.

Most countries in Africa do not acknowledge the LGBT community and so do not have prevention and treatment programmes targeting them. In Nigeria, homosexual behaviour is a criminal offence and presents a significant barrier to reaching out to MSM. Homosexual practice can carry a 14-year jail sentence under Federal laws. In 12 northern states that have adopted Islamic Shari'a law, adults who are found to engage in homosexual intercourse can be stoned to death. Because of this many gay men live in denial and silence.

Lesbians

Lesbian is a term most widely used to describe sexual and romantic desire between females or refers to women who identify themselves or who are characterized by others as having the primary attribute of female homosexuality. Women who identify as lesbian or bisexual and have sex with men may be at higher risk for HIV than heterosexual women. Lesbians and bisexual women may have sex with gay or bisexual men and not use condoms. Lesbians exist in every culture and race. Generally lesbians are at low risk of HIV infection and unplanned pregnancy. However sex between women is not always safe and lesbians are just as vulnerable to certain sexually transmitted diseases as women who have sex with men.

Lesbians have different sexual practices, which have different levels of risk for HIV. Oral sex is thought to pose a relatively low risk. Acts such as sharing sex toys, hand play with long fingernails or cuts pose higher risk. Societal pressure and negative attitudes about homosexuality may increase young lesbians risk for contracting HIV. A study in San Francisco found that young lesbians engaged in high rates of alcohol and drug use, unprotected sex with men and sexual experimentation with young gay men as a way of coping with homophobia and societal pressures.

Some lesbian sexual practices do carry a risk of HIV transmission and precautions need to be taken to protect against infection. [49]

- Oral sex - the risk of HIV being passed on through oral sex is low, but it is increased if a woman has cuts or sores in her mouth, or if the partner receiving oral sex has sores on her genitals or is having her period.
- Sharing sex toys - sharing sex toys (for example vibrators) can be risky if they have vaginal fluids (juice), blood or faeces on them. Always clean them well and have one each. This is one area of sex where sharing is a bad idea.
- Rough sex - any sexual activity that can lead to bleeding or cuts/breaks in the lining of vagina or anus is risky, including 'fisting' or certain S&M (sadomasochism) activities.
- Donor insemination - if a woman is thinking about using a sperm donor to get pregnant, she needs to be aware of the potential donor's detailed medical history and any possible risk factors - including drug use and sexual history. It is important that the donor has taken an HIV test.

Women who have Sex with Women (WSW)

Women who have sex with women (WSW) is a term used to identify women who have sex with other women, but may or may not self-identify as lesbian or bisexual. The term is often used in medical literature to describe such women as a group for clinical study, without needing to consider the issues of sexual self-identity. WSW face unique physical and mental health issues and

[49] Gay Men's Health Crisis (2009, June), 'HIV risk for lesbians, bisexuals & other women who have sex with women

challenges. In terms of medical issues, lesbians are referred to as WSW due to the misconceptions and assumptions about women's sexuality and some women's hesitancy to disclose their accurate sexual histories even to a physician. Many self-identified lesbians neglect to see a physician because they do not participate in heterosexual activity and require no birth control. Lesbians also have a lower perceived risk of acquiring a sexually transmitted disease or types of cancer.

The risk for exposure is higher through a mucous membrane. Potentially, HIV can be transmitted through the exposure of a mucous membrane (in the mouth, for example), especially if the tissue is cut or torn. The potential for transmission is greater during early and late-stage HIV infection, when the amount of virus in the blood is expected to be highest. Case reports of female-to-female transmission of HIV and the well-documented risk of female-to-male transmission indicate that vaginal secretions and menstrual blood are potentially infectious.

Men who have Sex with Men (MSM)

Men who have sex with men (MSM) are "one of the high-risk groups vulnerable" to HIV transmission. MSM are members of all communities, all races and ethnicities, and all strata of society. Gay men interact sexually among themselves and with men not identified as gay (married men or with female sexual partners).This epidemiological vulnerability is strongly linked to socio-cultural, religious beliefs and political vulnerability. These factors prohibits same sex practice in Nigeria, and those engaged in them are seen as evil and as such are highly stigmatized and discriminated. They face social discrimination at work, school, and university, in clinics, hospitals and in their own families.

The stigma associated with homosexuality may inhibit some men from identifying themselves as gay or bisexual, even though they have sex with other men. Some men who have sex with men and with women don't identify themselves as gay or bisexual. The result of this is the increase in STIs and HIV/AIDS and hindered access to health care services and treatment options. Lack of sexual reproductive health and HIV integrated services targeting MSM and also with women fuels the epidemic among women and play a key role in the dynamics of the epidemic (bridging population).

In many parts of the world, MSM remain the group most affected by HIV. In 2000, HIV sero prevalence among MSM in Latin America was estimated at 25%. In Nigeria, a study conducted by the Center for the Right to Health (CRH) showed the prevalence of HIV/AIDS among MSM in

[50] Wikepedia. Women who have Sex with Women.
http://en.wikipedia.org/wiki/Women_who_have_sex_with_women

Abuja, Nigeria at 36.4% while the IBBSS survey showed an HIV prevalence of 13.5% among MSM in Nigeria. Sero prevalence studies in Asia, Australia, Africa, the Caribbean, Eastern Europe, and North America around the world yield higher than average estimates that range between 7% and 46%.

In 2008, sexual minorities faced arrest in 85 countries around the world if they openly state their sexual orientation. In some, the penalties for expressions of same-sex affection can include imprisonment.

Critical issues

People may believe that the LGBT and specifically WSW and MSM are at little or no risk for HIV, other sexually transmitted infections (STIs), and unintended pregnancy when, in fact, risk behaviours and barriers to health care put them at risk.

Safer sex information seldom covers protective methods for oral or manual sex, encouraging the myth that WSW and MSM are not at risk for STI. Underreporting of HIV among lesbians seems likely given that many women are reluctant to acknowledge their sexual orientation to their doctor.

- Studies show that adult lesbians, fearing discriminatory and negative responses from health care providers, seek out health care services less often than heterosexual women. When they seek out health care, they may volunteer incomplete or inaccurate information about themselves. Some face bias because their gender and gender presentation are incongruent. For YWSW, these problems are compounded by discrimination based on their being youth. Many WSW especially Young WSW receive little support at home or in their communities due to cultural and familial attitudes that being LGBT is unhealthy or unacceptable. They are continuolsy discriminated because of their sexual orientation and become more vulnerable to HIV/AIDS.

- Substance use is a risk behaviour that research has frequently found to cluster with other risk behaviours, including unprotected sexual intercourse. Research also suggests that

[51]Center for the Right to Health (CRH). Assessing the burden of HIV/AIDS among Men who have Sex with Men (MSM) in Abuja, Nigeria. 2008

[52]FMOH. HIV/STI Integrated Biological and Behavioral Surveillance Survey (IBBSS). 2007

[53]Richardson D. The social construction of immunity: HIV risk perception and prevention among lesbians and bisexual women. Culture, Health & Sexuality 2000; 2(1):33-49.

[54]Scherzer T. Negotiating health care: the experiences of young lesbian and bisexual women. Culture, Health & Sexuality 2000; 2(1):87-102.

[55]Alford S. Substance Use among Youth. [The Facts] Washington, DC: Advocates for Youth, 1996.

young LGBT are twice as likely to use alcohol, three times more likely to use marijuana, and eight times more likely to use cocaine/crack compared to heterosexual youths. In one survey, one-third of lesbians reported smoking daily and thirty percent, drinking alcohol more than once a week. [57]

Interventions

Because the criminalization of homosexuality is thought to be a contributing factor in HIV transmission and inequities in access to prevention, care and treatment services for sexual minorities, all international actors engaged in HIV or human rights advocacy should adopt decriminalization as part of their advocacy agenda. Multilaterals, foundations and donor agencies must expand their leadership on and identify their responsibilities towards LGBT communities.

- Funds dedicated to these services must be monitored in an accountable manner and must be proportional to the impact of HIV to that population in the country. Funds should be monitored to ensure persons are adequately reached with HIV/STI services. Programmers should think of ways to expand access to prevention and treatment technologies for all sexual minorities.

- The LGBT community need accurate information and programmes that specifically address their complex needs and that will encourage them to protect themselves. Thus, they need access to accurate and reliable resources and materials that highlight information on HIV/AIDS and STI prevention and transmission. IEC materials should be appropriate and specific to address the sexual health needs of the LGBT community.

- Intervention programmes should include culturally competent staff and volunteers to familiarize staff and volunteers with the needs of LGBT and train them to be nonjudgmental and use inclusive language i.e sexual partner. Programmes that involve the LGBT community in the project development proves to empower them to train and develop support groups for other LGBT and allow the programs to focus on the needs identified by them.

- Intervention strategies such as strengthening the skills and capacity of LGBT should involve improving their low self esteem, developing healthy relationships, negotiating safer sex with partners, using condoms, lubricants and dental dams (for WSW), communicating with steady and casual partners, and saying "no" to unwanted sex.

[56]Telljohann SK et al. Teaching about sexual orientation by secondary health teachers. J Sch Health 1995; 65:18-22.

[57]Bradford J et al. National lesbian health care survey: implications for mental health care. J Consult Clin Psychol 1994; 62:228-242.

- Partners should know their own and their partner's HIV sero status which can help those who are not infected to change their behaviours and thus reduce their risk of becoming infected. For women who are infected, this knowledge can help them get early treatment and avoid infecting others. Condoms should be used consistently and correctly during every sexual contact with their partner or when using sex toys. Sex toys should not be shared. [58]

The risk of HIV infection and its impact feeds on violations of human rights, including discrimination against women and marginalized groups such as sex workers, people who inject drugs and men who have sex with men. HIV also frequently begets human rights violations such as further discrimination and violence. Over the past decade the critical need for strengthening human rights to effectively respond to the epidemic and deal with its effects has become ever more clear. Protecting human rights and promoting public health are mutually reinforcing. Protecting people living with, or affected by, HIV, with an emphasis on those who are especially vulnerable — and preventing its further spread — is a major development and human rights challenge. Stigma, silence, discrimination, privacy issues and denial of psychosocial and medical services, including antiretroviral treatment, undermine prevention and care efforts. The fact that the epidemic is increasingly affecting young people and women, who may have limited power to refuse sex or negotiate safer sex, brings additional human rights dimensions to this tragic disease.

Even in places where epidemiologic and behavioural research indisputably support prioritizing sexual minorities, there is a shameful neglect of their needs in discussions about policy, programmes, and resources, which is often expressed through silence, denial or explicit exclusion. Worsening an already dire public health situation are persistent human rights abuses waged against sexual minorities that severely complicate our prevention, care and treatment efforts. Inadequate representation of sexual minorities in planning processes at the country and regional-

[58]Center for Disease Control (CDC). HIV/AIDS among Women who have Sex with Women. http://www.cdc.gov/hiv. June 2006.
[59] UNAIDS. Human Rights and HIV. http://www.unaids.org/en/PolicyAndPractice/HumanRights/default.asp
[60] UNFPA. Human Rights. Putting Rights into Practice: Preventing HIV. http://www.unfpa.org/rights/hiv.htm

levels and the widening disparity in resources devoted to programmes targeting sexual minorities are unacceptable.

Programming success often relies on empowering individuals to discuss issues that concern them and to claim their rights to life, health, information, freedom from discrimination, and to be part of the social and economic life. Addressing the stigma associated with HIV and bringing the issue into the public sphere are critical to protecting the rights of those affected. Programmes must be designed with participation of the people (rights holders) they are intended to serve, and must have clear-cut strategies to be inclusive at all levels, from national plans to community led-interventions. In addition, legal mechanisms should be established or reinforced to ensure compliance of the different duty bearers (governments, service providers, community leaders) to meet their responsibilities to people infected or affected by AIDS.[29]

Multi-sectoral collaboration is needed in reforming laws and policies that are based in deeply-rooted social attitudes and norms such as gender inequality. Though, this might not be sufficient to change present social and cultural norms and values, legislation are critical in addressing issues of HIV stigma and discrimination. People living with HIV/AIDS, NGOs, donor agencies, human right agencies, media, etc all have peculiar roles to play.

Protecting human rights also advances public health issues specifically directed towards vulnerable groups and PLWHA which in turn produces positive results with a reduction in the national HIV prevalence rates, attitudinal behavioural changes, and reduced HIV stigma and discrimination. Specifically, it is important to note that:

- Active involvement and participation of PLWHA and vulnerable groups in local and national responses
- To avoid HIV infection, re-infection and reduction in stigma and discrimination, the human rights of women, and children, and young people must be protected and promoted.
- The human rights of marginalized, special groups and sexual minorities must be protected and respected.
- Supportive frameworks of policy and law are essential to effective HIV responses.

Key points to ensure protection and full enjoyment of all human rights:

- Promoting access to HIV education and information through resource materials, and capacity building trainings
- Full protection of confidentiality and informed consent for HIV counselling and testing, drug adherence counselling, safe needle injection exchanges etc.
- Effective advocacy will intensify efforts to ensure a wide range of prevention programmes, including information, education and communication, aimed at reducing risk-taking behaviours.
- Encouraging responsible sexual behaviour, including abstinence and fidelity
- Expand access to essential commodities, including male and female condoms and sterile injecting equipment.
- Clinical and non clinical sites should be friendly and provide services irrespective of sexuality, HIV status, age and gender.
- Integrate harm-reduction efforts related to drug use in prevention programmes
- Expand access to HIV counselling and testing (HCT), safe blood supplies
- Insist on early and effective treatment of sexually transmitted infections
- Develop strategies to combat stigma and social exclusion connected with the epidemic.

Box 4.1 Empowering right holders to claim their rights

- **Non-discrimination/equality before the law :** same access as others to services
- **Rights to education and health :** same access to HIV prevention education and information, and health care services, including STI services and condoms
- **Liberty , security of person and freedom from cruel, inhuman and degrading treatment :** freedom from violence, including sexual violence, freedom from mandatory testing
- **Right to participate in public life :** participation in the formulation and implementation of HIV policy

For those living with HIV or otherwise affected by it, the following rights should be protected:

- **Non-discrimination and equality before the law:** right not to be mistreated on the basis of health status, i.e. HIV status
- **Right to health:** right not to be denied health care/treatment on the basis of HIV status
- **Right to liberty and security of person:** right not to be arrested and imprisoned on the basis of HIV status
- **Right to marry and found a family** regardless of HIV status
- **Right to education:** right not to be thrown out of school on the basis of HIV status
- **Right to work:** right not to be fired on the basis of HIV status
- **Right to social security, assistance and welfare:** right not to be denied these benefits on the basis of HIV status
- **Right to freedom of movement** regardless of HIV status
- **Right to seek and enjoy asylum** regardless of HIV status

NOTE

- **Non-discrimination :** protection against discrimination if you seek help or are HIV+
- **Right to privacy :** protection against mandatory testing; HIV status kept confidential
- **Right to liberty and freedom of movement :** protection against imprisonment, segregation, or isolation in a special hospital ward
- **Right to education/information :** access to all HIV prevention education and information and sexual and reproductive health information and education
- **Right to health :** access to all health care prevention services, including for sexually transmitted infections, tuberculosis, voluntary counseling and testing, and to male and female condoms

Access to information and services of public health concerns- HIV, STI

An integrated approach to promoting marginalized and vulnerable group's access to information and services of public health concerns should be of utmost interest. STI and HIV prevention services must be available at all times and if unavailable referral linkages must be done by healthcare providers to ensure clients have access to information at the right time.

Sexual health information should be incorporated into youth development and reproductive health programmes to ensure that all channels of delivering information is not lost. Programmes/ projects should look at innovative ways to offer health and social services and information under one roof or take steps to link youths to needed health and social services.

In a practical sense, integrating HIV/STI and pregnancy prevention may involve organizations in a wide range of activities, including developing integrated messages and programmes, networking with other service providers, approaching sexual health issues holistically, and shifting the organizations overall approach regarding the delivery of programmes and services.

Civil societies and non governmental organisations have a crucial role to play in providing accurate information and services to the LGBT community. NGOs should play active roles in designing specific IEC and resource materials that provides appropiate HIV/STI prevention messages. Civil society organizations are often uniquely positioned to reach, serve, and advocate on behalf of sexual minority communities in almost all parts of the world.

Education, information, support, and advocacy are critical to provide culturally appropriate and accessible resource materials to vulnerable groups.

Youth friendly centers, community centers, libraries should be strenghtened to provide youths, sexual minorities, at risk polutions with HIV prevention, care and support services and information such as referrals for HCT, ART uptake, STI identification/management, peer support groups, palliative care and counsellings, distribution of resource materials, IEC materials in different languages, condoms and lubricants etc. Healthcare providers should be encouraged to provide youth-friendly services.

Continuous advocacy visits are necessary to provide up to date information, sensitize and educate policy makers, healthcare providers, advocates, youths and other stakeholders.

MODULE 5.0

Promoting sexual and reproductive health and rights in Nigeria

Promoting Sexual and Reproductive health and Rights in Nigeria

OBJECTIVES

- To explore definitions of Advocacy as strategies to promote SRH in Nigeria.
- To identify ways to strengthen linkages across the three tiers of health care system for effective service delivery
- To link legal reforms to promote SRH in Nigeria
- To promote access to information and services for all from a public health perspective.

MATERIALS

- Session objectives written on flipchart
- Flipchart stand, masking tape, flipchart and markers

RESOURCES

- Global consultation on the sexual and reproductive health and rightsof people living with HIV: Consultation report. (2007). www.gnpplus.net
- Reproductive Health Matters. (2007). 15(29, Suppl.). www.who.int/reproductive-health/hiv/docs.html
- Meeting the sexual and reproductive health needs of people living with HIV. (2006). New York and Geneva, Guttmacher Institute and UNAIDS. www.guttmacher.org/pubs/IB_HIV.html
- Universal Declaration of Human Rights. (1948). Paris, United Nations General Assembly. www.unhchr.ch/udhr/lang/eng.htm
- Family Planning and Reproductive Health-IntraHealth. www.intrahealth.org/page/family-planning-reproductive-health
- An analysis of family planning content in HIV/AIDS, VCT, and PMTCT policies in 16 countries. www.policyproject.com/pubs/workingpapers/wps-09.pdf
- Strengthening Family Planning Policies and Programs in developing countries: An AdvocacyToolkit.
  www.policyproject.com/.../Family%20Planning%20Toolkit%20final.pdf

PREPARATION

- Draft and review Power Point presentation.
- Review critical issues and interventions from the handouts.
- Be prepared to discuss critical issues and interventions to among special groups.
- Place instructions for Group Activity on Power Point.

Facilitation session

STEP ONE

Promoting Sexual and Reproductive Rights in Nigeria

Review the objectives of Session 5 with participants on a flipchart.

- Have the group brainstorm, participant record on a flip chart the definitions of thematic areas.
- Ask the participants to discuss their issues and comments
- Present power point slide show. Start by offering the definition of Sexual Reproductive Health and Rights.
- Ask participants to give feedback on the definition.

STEP TWO

- Review the objectives of session 5 with the participants on a flipchart.
- Divide participants into groups based on Media, Government, NGOs and Healthcare Providers. Ask participants to identify ways to promote SRH in Nigeria. Each group should make a brief presentation on flip charts.
- Present power point slide show.

STEP THREE

Intervention strategies to aid programming

- Review the objectives of session 5 with participants on a flipchart.
- Divide participants into groups as above. Ask participants to design intervention strategies to strengthen SRH in Nigeria.
- Ask participants to have a 10 minutes presentation.
- Present power point slide show.
- Discuss intervention strategies
- Ask participants to develop an action plan to promote SRH in Nigeria.

Sexual Reproductive Health and Rights

Sexual reproductive health and rights can simply be understood as the rights for all regardless of sexual orientation, age, HIV status, and economic differences to make choices regarding their own sexuality and reproduction, and respecting the rights of others to body integrity. Also, inclusive in this definition is the right to access accurate information, resources and services needed to support the choices and decisions we make towards optimizing health. At the International Conference on Population and Development (ICPD) held in Cairo in 1994, the international community for the first time agreed on a broad definition of reproductive health and rights, recognizing that "reproductive health is a state of complete physical, mental and social well-being…in all matters relating to the reproductive system" (ICPD Programme of Action). This definition was extended to cover sexuality. "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence". Key aspects of sexual rights were included in the definition, although the term itself was rejected at the 1995 Fourth World Conference on Women, held in Beijing. The WHO's working definition of sexual rights includes a right to achieve "the highest attainable standard of sexual health, including access to sexual and reproductive health care services". Other rights listed under sexual rights include rights to sexuality education and bodily integrity, and the right to "pursue a satisfying, safe and pleasurable sexual life". There is no universally recognized definition of SRHR among major international organizations.

Critical issues

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The rise of conservatism: While calls for SRHR have increased since the Beijing Declaration and Platform for Action in 1995, there has also been a rise in political and religious conservatism, accompanied by a growing resistance to sexual and reproductive rights. The US President's Emergency Plan for AIDS Relief (PEPFAR), a $15-billion, five-year plan announced in 2003, spends one third of prevention funds on abstinence-until-marriage programmes which explicitly condemn condom use and discourage sex education. In some countries, such as Uganda, abstinence-only programmes have been coupled with misinformation about condoms. This has

[61] www.unfpa.org/icpd/icpd_poa.htm#ch7

[62] An international agenda for women's human rights, sexual and reproductive health and gender equality Fourth World Conference on Women / UNESCO – Education Sector (1995)

[63] www.who.int/reproductive-health/ gender/sexual_health. html

led to a decrease in condom supplies and use, with potentially grave consequences for the sexual and reproductive health of women, men and transgender people.

Also, "Global Gag Rule" (also known as the Mexico City Policy) prevented USAID money going to family planning agencies that provide or promote abortion or even give abortion information in counselling sessions, which resulted in the closure of some services. The US Trafficking Victims Protection Act and the Bush administration's Global AIDS Act of 2003 both forbid funding to any group which does not explicitly oppose prostitution and sex trafficking. This includes any organization engaged in sexual health outreach or HIV prevention work with sex workers.

These externally imposed constraints to realizing SRHR have coincided with a backlash against sexual rights in a number of developing countries. This backlash has focused on sexuality, particularly the right to express sexual orientation. Some countries oppose sexual rights on the grounds of culture or nationalism, others on religious grounds.

Women often lack the rights or the opportunities to make choices around reproduction. Population control polices, pressure from family members, and social and cultural norms may restrict their options. In many countries, women have difficulty accessing family planning services. In many societies, women have limited opportunities to establish their own households and live alone, or to pursue sexual relationships outside marriage. Men also experience pressure to marry and have families.

Cost, illegality or stigma around abortion can also make it very difficult for women to access abortion services. A cultural preference for sons may encourage women to terminate pregnancies when the fetus is female, or engage in female infanticide.

Other groups such as HIV positive people face pressure not to have children, rather than being able to make an informed choice and receiving the necessary support to safeguard their own and their children's health. Youths, persons with disability have limited access to appropriate services and accurate information on their reproductive health.

Violence in the context of sexual relationships (intimate partner violence) is common across the world, and marital rape continues to be unrecognized by many legal systems. Due to gender inequalities, and lack of negotiating power, women are more likely to be at the receiving end of such violence. This also places them at greater risk of sexually transmitted infections including HIV.

[64] www.eldis.org/hivaids/prevention/abstinence.htm

[65] Health and Development Information Team. Health Key Issues Guide: Sexual Reproductive Health and Rights. July 2006.

[66] No more skirting the issue: tackling power in sexual relationships key to combating HIV/AIDS Population Council / Population Council, USA (2001)

Interventions

- Approaching reproductive health as a human rights issue: Programming and research has shown the need for collaboration on reproductive health programmes especially with experts in the fields of ethics, law and human rights in order to address the multiple factors that affect women's and men's reproductive health. This will enhance provision of an ethical framework for public health practitioners; the positive influence of international treaties, which put pressure on governments to provide adequate health services; and identification of health issues such as maternal mortality as human rights or social justice concerns, which raises their profile and level of urgency for policy makers.

- The principles of human rights should be integrated to guide policy, programme design and service delivery, including clients' access to information, quality of care, and the relationship between clients and providers.

- There is need for intensive advocacy efforts to health providers, policy makers, human rights advocates, public health professionals and the media to empower community members to realize their own reproductive rights.

- Boys and men should be engaged in addressing SRHR of women and girls and the fight against HIV/AIDS in order to have a real impact on the epidemic. Thus, it is necessary to identify what their roles and responsibilities are in different contexts, and developing strategies to work with them.

- Programmes should be linked and strengthened to address HIV, AIDS and sexual and reproductive health to create and influence public health benefits. Activities should be geared towards promoting safer sex, increasing uptake of HCT, optimizing connections between the two programmes, and integrating HIV and AIDS with maternal and infant health. This linkages should lead to a number of public health benefits, including: improved access to and uptake of key HIV, AIDS and SRH services; better access of people living with HIV and AIDS (PLWHA) to SRH services; reduced HIV-related stigma and discrimination; and improved coverage of underserved and marginalized populations.

- Efforts could also be focused on human rights and gender; promoting a coordinated and coherent response; meaningful participation of PLWHA; fostering community participation; and reducing stigma and discrimination. LGBT and intersex issues should be treated as a human rights concern and regarded as an essential part of a gender equality and social equity agenda.

- It is important to address sexual reproductive health services through a rights based approach that responds to the basic fundamental human rights to be healthy, have equal access to services, and control in decision making.

Box 5.1 IPPF Charter on Sexual Reproductive Health and Rights

In 1995, the International Planned Parenthood Federation and its 127 member associations approved a Charter on Sexual and Reproductive Rights, based on international human rights instruments. The twelve basic human rights are relevant to sexual and reproductive rights work as follows:

1: The Right to Life

2: The Right to Liberty and Security of the Person

3: The Right to Equality, and to be free from all forms of discrimination

4: The Right to Privacy

5: The Right to Freedom of Thought

6: The Right to Information and Education

7: The Right to Choose whether or not to Marry and to Found and Plan a Family

8: The Right to Decide whether or when to have Children

9: The Right to Health Care and Health Protection

10: The Right to the Benefits of Scientific Progress

11: The Right to Freedom of Assembly and Political Participation

12: The Right to be Free from Torture and ill Treatment

[67] IPPF Charter on Sexual Reprodictive Health and Rights. http://www.unfpa.org/swp/1997/box8.htm

Advocacy

Advocacy by an individual or by an advocacy group normally aim to influence publicpolicy and resource allocation decisions within political, economic, and social systems and institutions; it may be motivated from moral, ethical or faith principles or simply to protect an asset of interest. Advocacy can include many activities that a person or organization undertakes including media campaigns, public speaking, commissioning and publishing research or poll or the 'filing of friend of the court briefs'.

Advocacy for HIV/AIDS prevention is the combined effort of a group of individuals or organizations to persuade influential individuals and groups and organizations through various activities to adopt an effective approach to HIV/AIDS among groups such as IDUs, MSM, Youths, PLWHA as quickly as possible. Advocacy also aims at starting, maintaining or increasing specific activities to a scale where they will effectively prevent HIV transmission and assist in the prevention, care and support services.

Core principles

Advocacy activities should avoid increasing harm. When change is sought to an existing system, those advocating change may not be able to control all of the results. Advocacy activities should aim to protect the rights of vulnerable groups, i.e. PLWHA, youths, sexual minorities. Vulnerable groups are often denied basic human and legal rights. Advocates should carefully examine and research these issues and collect evidence to make an appropriate case. Human rights issues can often be an important entry point to discussing specific issues such as access to care and treatment, information and resources.

Advocacy activities should balance short-term pragmatic goals with long-term developmental goals. The objectives of advocacy must relate to approaches and activities shown by research to be effective in addressing HIV/AIDS among vulnerable groups. It may seem obvious, but all advocacy activities must work towards implementing programmes that research has shown to be effective. Advocates need to be aware of the research basis of approaches and to keep up to date with new research and new ideas related to preventing HIV/AIDS. Advocacy activities should concentrate on both HIV/AIDS prevention, care and support services.

[68] WHO. UNAIDS. UNODC. Advocacy Guide: HIV/AIDS Prevention among Injection Drug Users. 2004

Specific and targeted advocacy activities should fit the social, cultural, political and legal context of the society. In many ways, the advocacy approach used and the key targets of the approach depend on the overall societal context. Activities that are highly successful in one country may be difficult to implement and even counterproductive in another. Advocates should know the history, society, cultural and political systems in the country in which they are working and adapt their activities to suit that context.

Advocacy activities should target different sectors of society and key individuals, using multiple advocacy techniques at the same time if possible. Successful advocates use multiple complementary strategies to achieve their goals. Many influential individuals and groups need to be targeted at the same time to achieve widespread implementation of and a supportive environment for HIV/AIDS[67]. Advocacy should aim at quickly establishing supportive policies and large enough programmes within the social, political and funding context of the country. Advocacy should both lead to establishing new policies and programmes and react to how institutions, the mass media and others deal with HIV/AIDS. The advocacy process should be considered not only in terms of working towards the goals set by the advocacy group but also in reaction to unfolding events. At each level where advocacy is carried out, events may occur that lead to new opportunities for advocacy. Advocacy activities should involve, to the extent possible, vulnerable groups in planning, implementing and evaluating programmes. This involvement increases the speed with which programmes can assist groups and leads to higher programme quality. Advocacy activities should consider differences between groups according to gender and ethnic background and to vulnerability to HIV/AIDS and promote equity in prevention, care and support.

Critical issues

Programmes and policies have been slow to address the full spectrum of sexual and reproductive health and human rights issues connected with vulnerability to HIV, the impact of AIDS, and the overall well-being of people living with and affected by HIV. To be effective, the needs and rights of people living with HIV must be at the centre of all policy and programmatic efforts. Most global efforts to increase access to ARV treatment, accurate information on HIV prevention targeted at sexual minorities and marginalized groups have not addressed sexual and reproductive health and rights.

Interventions

- Stakeholders' analysis should be conducted during programme planning and development phase to identify key stakeholders that would be necessary in collaborating and mainstreaming SRHR activities into HIV programming.

- Advocacy organizations should work both externally and internally to foster an environment where people living with HIV and other vulnerable populations have the freedom and the capacity to advocate for their sexual and reproductive health and rights. Advocacy visits should be made to key stakeholders with an overall goal, objectives of the visit, and topics to be discussed. To further strengthen our advocacy visit with stakeholders, it is necessary to develop a report on the visit held and shared with them for documentation purposes. Also, stakeholders should be invited at every programme opportunity and activity to further push our cause or efforts.

- Individuals should be trained as advocates and have their capacities built with up to date resources and publications on their thematic area of collaboration. Advocates must fight stigma and discrimination against people living with HIV, patriarchal attitudes toward women and young people, the marginalization of many groups of people most vulnerable to HIV, persistent poverty, and a lack of coordination and collaboration. Vulnerable groups should be trained and engaged in community education programmes to overcome stigma. Advocates should ensure that programmes to bolster participation of groups also help build needed skills. In particular, women and young people should be provided with advocacy training. Partnership among vulnerable groups should be encouraged. Groups should form alliances and partnerships with government institutions, healthcare providers, human right organizations, NGOs, association of lawyers etc.

  Governments, international agencies and NGOs should support income-generating programmes, in particular by directly employing people living with HIV and paying them for their work. People living with HIV should conduct their own sexual and reproductive health-related research and should have substantive input into the research of others. Advocates must do more to ensure that women and young people have the information, training, and support they need to speak out on behalf of their own needs. Stakeholders, advocates and vulnerable groups should be educated and counselled on integrating sexuality and HIV/STI prevention into healthcare, family planning/maternal and child health, PMTCT services. Ongoing advocacy should be made to key stakeholders to continuously sensitize them on critical issues and work with them in advocating for solutions to mitigate the burden of HIV/AIDS and address sexual reproductive health and rights among vulnerable groups. National laws and policies could be reformed in many ways to better support the sexual and reproductive health of vulnerable populations. Some of these directly involve sexual and reproductive health services (for example, ensuring that young people can access these services without parental consent, if necessary), while others improve sexual and reproductive health by fostering a more supportive environment.

Advocacy usually starts when a group of concerned people perceives an issue as being so problematic that they decide that it should be put on the public agenda with the aim of addressing the problem. Advocacy includes developing possible proposals to solve the problem and building support for acting on the solution. This process consis[ts] of a set of steps, carried out for different aspects of an issue at many levels of society simultaneously in varying order. These steps may include starting up, analysis, strategy, action and reaction and evaluation[68].

Box 5.2 Conducting an advocacy

Becoming an advocate urges one to prioritize areas that need to be addressed. Advocates have the power to impact, protect and empower vulnerable groups. Advocates have power in their voice and can speak out against issues and demand leaders and stakeholders invest time, energy and resources to ending the public health issues and concerns i.e. SRHR, HIV/AIDS. No matter how much we know or how much we care, we will only succeed if we all speak out and demand action from our leaders.

Make Your Case

What has inspired you to act? The single most important component to being a successful advocate is passion. Passionate advocates are persuasive advocates. So speak from your own personal experience and from your own personal passion.

Contact stakeholders

Urge stakeholders to take action to protect and empower vulnerable groups.

Set up a Meeting

Request to meet your stakeholders working on HIV/AIDS and SRHR. Start by calling NGOs, donor agencies, government institutions working on HIV/AIDS, etc. Phone calls are more efficient than e-mailing or sending a letter. Make sure you include all of your contact information, a few possible dates, and your reason for wanting to meet.

Don't be discouraged if they are unable to meet with you. Ask if you can meet with his/her Program staff or any other staff with access to relevant information. And remember, you can still be an effective advocate even if you don't meet the stakeholders.

Follow up

If you are able to meet with your elected official, keep the following in mind:
Be prepared and research the issue.

For background on the issues, you can read resource materials from organizations working on HIV/AIDS such as UNAIDS, WHO, USAID etc.

You can also register with these organizations to recent alerts and up to date current areas of research, issues and tools
Delegate a program staff if going as group or organization to lead the discussion
Find out if there is legislation involving your issue—Visit the National Human Rights Commission, or non profits organizations working on human rights such as Center for the Right to Health www.crhonline.org.

Tips for the Meeting
Introduce yourself, let them know where you are from, and tell them which issue you'd like to discuss.

If you are having difficulty engaging in discussion, ask open-ended questions.
For example—how much do you know about sexual minorities in Nigeria?
Did you read about the recent news on stigma and discrimination among PLWHAs in Ghana?
Can you tell me about your views and position on criminalization of same sex?

Remember that if you are meeting with a Programs Assistant, they might not know everything there is to know about sexual reproductive health and rights.
Offer to provide resource materials and discuss the issue.

Be clear and concise—make your point, and do not ramble.
Ask them to take action—if there is a piece of legislation in the works, ask them to co-sponsor it.

Be polite and thank them for their time—remember, even if they don't agree with you, be nice!

Follow-Up
If a stakeholder tells you that they will look into issues, schedule a time to follow up.
As you advocate to others about an issue, let other stakeholders know what you are doing to make an impact.

Continue to keep them updated on the issue

Box 5.3 Advocacy and Related key concepts

	Advocacy	Information, education and communication	Community mobilisation	Networking and partnerships	Fundraising and resource mobilisation	Overcoming stigma and discrimination
What can it change?	Policies, implementation of policies, laws and practices	Awareness and behaviour	Capacity of communities to identify and address their problems	Isolation and duplication	Level of resources available for HIV/AIDS work	Level of stigma and discrimination against PLWHA
Target group	Decision-makers, leaders, policy-maker, people in positions of influence	People of a particular gender or age group, residents of a particular area, etc.	Members of a particular community	Individuals or groups with similar agendas	Communities, local councils, government, donors	People who stigmatise or discriminate
Typical indicators of success	Policies, implementation, laws or practices which enable improved HIV/AIDS prevention and care, budget allocation, formation of alliances	Percentage of youth using condoms; changes in attitude to people living with HIV/AIDS, increased awareness, changes in attitudes, skills and behaviour	A community problem is solved; more people attend community meetings	Members of the network or partnership achieve more than they could if they worked alone	Local officials allow a building to be used for meetings; members of mosque give alms; donor gives grant	Fewer workers dismissed due to HIV status; fewer cases of depression among PLWHA

Source: Adapted from: International HIV/AIDS Alliance (2002). 'Advocacy in Action – A toolkit to support NGOs responding to HIV/AIDS'.

This manual proposes a set of key programme actions to strengthen linkages between sexual and reproductive health and HIV/AIDS programmes. These linkages work in both directions, by integrating HIV/AIDS issues into ongoing sexual and reproductive health programmes, and conversely, sexual and reproductive health issues into HIV/AIDS programmes. Our goal is to enhance sexual and reproductive health, contribute to reversal of the AIDS epidemic and mitigate its impact.

Linkages are needed between the local, national, regional, and international responses to HIV and SRHR, and among organizations working on HIV and SRHR, health professionals, governments, and the media. In addition, HIV-focused activists can make important contributions to the broader sexual and reproductive health advocacy agenda through partnership with other groups. These include harm reduction networks, women's rights organizations, youth groups, human rights bodies, and organizations representing sex workers, men who have sex with men, transgender people, migrants, prisoners, refugees, and ethnic minorities. Advocates can also become more proactive in getting involved in local health and education departments, migrant organizations, and labour unions.

Strategic partnerships can help to strengthen the advocacy efforts of organizations and networks. Non profits, governments, donor agencies, International NGOs have the institutional resources and skills to help ensure the continued development of networks and self-help groups of vulnerable populations. Advocates and allies can provide guidance to organizations of vulnerable groups and populations on how to undertake strong organizational development and ensure good governance. They can help to train representatives who can liaise well with government officials, and mentor individuals for roles in the health and community sectors, among others.

Critical issues

Unfriendly policy environment has affected HIV programming for vulnerable groups i.e. MSM. MSM is criminalized in Nigeria and other African countries and until recently there are few donor funded programmes targeting MSM. Even if interventions strategies are provided, there is a need for collaborations and partnerships with other organization to further reduce the burden of HIV/AIDS.

There are strong international commitments but limited scale up. At international level major agreements and commitments emphasize the importance of approaches that link SRH, HIV and AIDS and other key services such as child health and TB. Yet despite the existence and support for these commitments, successful efforts to scale up have been limited. This is partly because promoting synergistic approaches between these major areas is perceived to be programmatically complex. More significantly, existing policy, institutional and financing arrangements for HIV prevention, and AIDS treatment and care, and for SRH programmes are exacerbating the separation of programmes rather than providing incentives to bring them together.

Funding modalities can distort health funding and weaken health systems. While there is a clear need for increased funds for HIV and AIDS, there is a concern that this finance is often narrowly earmarked for specific programmes and that these programmes are also narrowly defined. HIV-related activities receive substantial funds which are 'off budget' and inflexible, creating parallel systems to those set up to support basic health services and other programmes. Separate financing and management of supplies and logistics is common for anti-retroviral drugs and other HIV related commodities, in Kenya and Malawi for example. SRH programmes are also recipients of targeted financing and technical assistance that may not take HIV and AIDS implications into account.

International leadership for the promotion of linkages is weak. The UN agencies have a key role to play in providing technical support and leadership but there is broad consensus that much more progress is needed. UNFPA has not substantially developed its leadership role on integration issues or on scaling up comprehensive approaches for young people. Although UNAIDS' Intensifying HIV Prevention strategy urges for strong linkages with SRH, several PCB members are keen to see greater efforts to promote practical strategies at country level, as part of the UNAIDS co-ordinate process for division of labour, mandated by the Global Task Team. As PMTCT lead, there are also concerns about UNICEF's limited advocacy for PMTCT as part of routine MNCH services. WHO has made progress with 3 by 5, but the recent evaluation found that prevention did not feature sufficiently in the initiative, and linkages with SRH and other health services have been slow to develop institutionally.

Interventions

- Allocation of funds and resources to support cross cutting public health issues will promote synergies.

- Improved government and donor co-ordination is helping to develop HIV and AIDS policies and plans for the health sector as a whole.

Cross programme working groups and task forces will help develop linkages. For example, in Nigeria, the National Technical Working Group (TWG) has created a platform to interact with representatives of donor agencies, vulnerable groups, NGOs etc.

[69]Nel Druce. Claire Dickinson. et. al. Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up. DFID Health Resource Center. 2006

- These range of stakeholders help in developing joint policies and guidelines to support delivery of HIV and SRHR services.

- Demonstration projects with scale up plans, together with targeted finance and expert technical assistance help to develop linkages. For example, several USAID implementing agencies such as Family Health International, Population Council are providing support to integrating family planning, HCT, HIV intervention strategies, and PMTCT.

- The role of dual champions as high level advocates in national and international agencies

has great potential in building support, ownership and strengthening linkages.

- Advocacy should be encouraged through coalitions and partnerships with stakeholders working on HIV, SRHR and other thematic areas to strengthen referral linkages.

- Evidenced based research, reviews and cases studies should be conducted by organizations to discover new areas for collaborations to strengthen partnerships.

- Sexual reproductive health services should collaborate and work with national human rights institutions to monitor implementation and enforcement of policies and legislations. NGOs should also collaborate and work with lawyers to defend the rights of marginalized and vulnerable groups whose rights have been violated. Lawyers may also be able to enforce legal obligations to protect sexual and reproductive health and rights. Governments also need to better understand the size and specific needs of key populations, particularly groups at increased risk of HIV who are often marginalized and hard to find.

- Existing national surveys and HIV epidemiological surveillance systems should collect data on the sexual and reproductive health of groups including young people, sex workers, men who have sex with men, transgender people, and people who use drugs. Governments and donors should also support epidemiological, social, and behavioural research for and by these groups. All efforts to develop laws and policies in this area must be undertaken with the full involvement of people living with HIV, including members of marginalized groups.

- Networks of vulnerable groups should be involved in programme development and implementation to develop tools and methodologies to monitor progress, suggest innovative strategies in reaching their communities.

Promoting access to information and services

Promoting access to accurate information and quality HIV/STI services is crucial in reducing the burden of HIV/AIDS and promoting sexual reproductive health and rights of vulnerable groups.

Much has been accomplished since world leaders met at the 2006 United Nations General Assembly High-Level Meeting on AIDS and committed to scaling up towards the goal of universal access to HIV prevention, treatment, care and support services by 2010. The International Community has set 2010 as a deadline to achieve universal access to HIV Prevention, treatment and care for all those in need. This commitment was first made by the Group of 8 Nations (G8) in 2005, and was subsequently endorsed by all UN Member States at the 2005 UN Millennium Summit and then incorporated in the 2006 Political Declaration on HIV/AIDS. Though this progress remains fragile, an advocacy campaign has been launched to hold world leaders accountable for their promise to fund universal access, if necessary for stakeholders to hold themselves accountable and take action to build a stronger and more vocal movement in support for universal access.

Critical issues

Information on risk behaviours and coverage of interventions are limited. Vulnerable populations

are continuously faced with poor access to appropriate and accurate information on HIV/STI prevention and transmission. Many adapt resource materials focused on heterosexual messages and thus feel they are safe without using condoms during intercourse since materials are not available. Availability of resource materials and bureaucratic process hampers access to obtaining accurate information and even conducting reliable research that influences policy and decision making affecting vulnerable groups.

Persons with disability e.g. physically challenged persons; blind and deaf persons have limited access to accurate information on HIV/AIDS. They are hardly represented at trainings and workshops and even if present, facilities and materials are unsuitable for their active participation. Stigma and discrimination of Most at Risk Persons (MARPs) has resulted in non friendly healthcare services thus pushing away such groups to seeking information elsewhere. For instance, a PLWHA will not be comfortable in a healthcare facility that discriminates against positive persons and might result in seeking interventions that may be drastic.

[70] The IAS "Universal Access Now" campaign will include meetings with civil society, governments and G8 health experts to promote fulfillment of the universal access pledge; mobilizing IAS members to urge their national leaders to support increased AIDS financing; promotion of evidence to support HIV treatment and prevention scale up; media and social media outreach in support of universal access; and prominent programming on universal access.
http://www.iasociety.org/universalaccessnow.aspx

Interventions

Significantly scaling up access to HIV /SRHR information and services prevention interventions requires combining multiple approaches and stakeholders. Healthcare providers are key entry points for providing and delivering HIV prevention information and services and must continue to advocate for expanding them. Education and training of vulnerable groups and stakeholders is necessary to promoting access to information and services. Policies that bolster participation of HIV-positive people must also ensure that the people who are representing the community have the skills to do so. First and foremost, people diagnosed with HIV need education about their human rights, including those related to their sexual and reproductive health. Most people diagnosed as HIV-positive voluntarily and willingly take on the responsibility not to infect others, yet many are not aware that they have any right to be treated with dignity and respect in return. Women and men living with HIV need training so that they can have meaningful involvement and participation on all decision-making bodies relevant to their lives, such as United Nations bodies, Global Fund committees, and National conferences too.

Organizations and stakeholders should be encouraged to make available electronic and printed materials to provide and improve access to HIV/AIDS related information. These resources should be made available to stakeholders, target beneficiaries and vulnerable populations. Access to HIV/AIDS-related documents and referrals to appropriate healthcare services should be provided and made available to all regardless of age, sexuality, HIV status, tribe and religion. Engagement of media personnel in trainings, sensitization, and outreaches is vital to further sensitize the public on health issues while serving as medium to create change in the society. Access to a broad range of quality HIV and SRH information and services should be improved and measures should be

devised to increase access of IEC materials and quality services to rural communities.
Promote participation of youths, PLWHA and other vulnerable groups in programme development and implementation to strengthen their skills in providing accurate information on SRHR and HIV information and services is crucial. Strengthening strategic information capacity and investing in further research is also necessary towards strengthening continued efforts to collect, analyse and use high-quality data to develop evidence-driven policies and interventions and to monitor their effects. Thus, it is necessary for countries and organisations to promote research and documentation of evidence based research on issues and barriers to scale up access to information and services for MARPs and vulnerable groups. Culturally appropriate and specific educational or information materials should be developed to reach a wider variety of vulnerable groups. Also, these IEC materials should be specific to target groups and acceptable to all regardless of disability.

Strengthening Reproductive health choices and family planning for women, Girls and PLWHA

Women and adolescent girls need access to high-quality reproductive health services, including family planning, in order to prevent unwanted pregnancies and better plan the number and spacing of their children. Some 200 million women in developing countries have an unmet need for effective and available family planning services. Meeting this need would prevent 23 million unplanned or unwanted pregnancies per year. Up to a quarter of maternal deaths—and more than a million infant deaths—would also be averted.

The Programme of Action of ICPD Cairo, 1994 offers a comprehensive framework for achieving sexual and reproductive health and rights, including the prevention and treatment of HIV/AIDS, and for advancing other development goals. The United Nations Millennium Development Goals now incorporate a target of universal access to sexual and reproductive health within the goal of improving maternal health.

Considered in the broader context of reproductive health, more than 180 countries have affirmed the right of individuals and couples of access to the means to achieving good reproductive health, including access to family planning and access to STI and HIV/AIDS services.
All investments in research, policies and programmes should build systematically on the natural synergies inherent in the ICPD model to maximize their effectiveness and efficiency and to strengthen the capacity of health systems to deliver universally accessible sexual and reproductive health information and services. As policies are developed, they present an excellent opportunity to ensure that supporting guidelines emphasize the importance of family planning. Such policies should also stress the importance of using condoms in conjunction with another contraceptive method, including pills, injectables, and IUDs (dual method use), to prevent both unintended pregnancies and STIs.

At the operational level, service delivery guidelines, protocols, and tools are needed to address explicitly how family planning can be integrated into new or existing services while ensuring that adequate support, including human and financial resources, are available to make integration work.

- Guidelines should carefully address counselling and emphasize the dual protection afforded by condoms as well as the need for high-quality counselling services, refresher training, and the institution of standard counselling protocols.
- Further, adequate dissemination of protocols is critical to ensure that providers know what is expected of them.
- Legislative guidelines need to be reviewed and adapted as necessary to ensure that providers can legally provide necessary services.
- Technical guidelines for training staff should be adapted to train staff in both reproductive health/family planning and STI/HIV treatment and prevention.
- Supervision and follow-up among service providers are essential to ensure that guidelines are implemented.

Family planning remains one of the most cost-effective public health measures available in developing countries. Use of family planning is associated with lower rates of maternal and infant mortality and can influence economic growth. It is an essential component in the prevention of mother-to-child transmission (PMTCT) of HIV/AIDS and in adolescent reproductive healthcare programmes, and it can play a role in improving gender equity. Expanding access to and improving the quality of family planning programmes around the world is central to improving and maintaining the health of individuals and societies and helping them reach their full potential.

Despite some attempts to integrate family planning with sexually transmitted infection (STI) and HIV/AIDS services, policies and programmes continue to treat them as unrelated areas of intervention. Furthermore, international attention to the HIV/AIDS pandemic has overshadowed attention to family planning, particularly in Africa where the HIV/AIDS epidemic is most acute. Yet family planning is closely related to two components of HIV/AIDS services: prevention of mother-to-child transmission (PMTCT) and HIV counseling and testing (HCT).

It is important that family planning information and services be provided in the context of HIV/AIDS programmes for several reasons. In many countries, HIV is primarily sexually transmitted, and the majority of infections occur during the reproductive ages. Women seeking PMTCT services are both sexually active and fertile. Obtaining these services offers the woman and her partner options to either practice birth spacing which can reduce infant, child, and maternal mortality rates or avoid future pregnancies thereby avoiding transmission of HIV to an infant. In addition, limiting the number of births may result in fewer orphans and vulnerable children. Counselling for HIV/AIDS is an opportune time to discuss family planning and high-risk fertility behaviour. Clients receiving antiretroviral therapy (ARV) may also have a need for family planning since a large percentage of these clients will be of reproductive age. Sexually active men and women receiving information on either family planning or STI/HIV prevention should have access to information and services to help prevent all unintended outcomes of unprotected sex, including unplanned pregnancies and STIs/HIV. Access to family planning information and services linked with HIV/AIDS services may enable sexually active persons to make informed decisions about their reproductive and sexual health and lead to reductions in both unintended pregnancies and STIs/HIV.

Key Points

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Improvements in reproductive health have consequences at the individual, family, and household levels (micro level). Reproductive health increases the human capital of women who directly contribute to socioeconomic development. Indirectly, reproductive health increases the human capital of children by keeping their mothers alive.

Improvements in reproductive health have consequences at the societal level (macro level): Women with access to family planning information and methods and to other social services such as education and healthcare can control their reproductive outcomes and typically give birth to fewer children (Tsui, 1991, referenced in Seligman et al., 1997). Fewer births in turn slow population growth, which relieves some pressure on natural resources and overstretched public services.

Safe, effective, and affordable reproductive healthcare provides women with the opportunity to enjoy both non-reproductive and reproductive roles in society, thereby contributing directly to socioeconomic development through increased per capita income: When women have the opportunity to assume non reproductive roles in society, they increase their productivity both in and out of the household and enhance the quality of time they spend with their children, increasing their children's human capital (Seligman et al., 1997).

Promotion of a mother's reproductive health influences the formation of her children's human capital by encouraging smaller family size and greater attention to child development: Parents with fewer children are more able to invest significant time, typically the mother's time, and other resources in each child than parents with more children.

Investments that promote reproductive health improve a woman's human capital by contributing to her knowledge, reducing family size and promoting child development, promoting the health of the mother and child, promoting the nutritional status of the mother, and empowering women. Knowledge helps women work smarter and be better caretakers of their children. Reduced family size allows a woman to spend more time on activities that directly improve her human capital or help her children develop mentally and emotionally. Better health status improves the level of effort a woman is able to put forth in productive activities or activities associated with the improvement of her children. Good nutritional status provides women with the ability to ward off future or proximate health problems and, on a daily basis, influences women's activities depending on their caloric intake. Empowering women provides them with economic opportunities that enhance their ability to benefit from other social investments such as education and family planning programs.

Social programmes benefit more the individual who consumes program services: To understand the full effects of a program, it is essential to take into consideration others who may benefit from an individual's participation in a particular program. For example, iron supplements directly affect the nutritional status of a woman by preventing iron-deficiency anemia. Prevention of iron-deficiency anemia prevents anemia-related maternal complications, thus reducing maternal mortality and morbidity and improving maternal health status. In addition, anemia prevention decreases the risk of a low birth weight baby, thus increasing the prospects of child survival. If both mother and child have sufficient iron, the child will be better able to learn, leading to a positive effect on knowledge. Finally, reducing infant mortality due to iron deficiency will reduce fertility as the child will not have to be replaced, thus affecting family size and child development.

Strategies to promote family planning

Increasing access to high-quality family planning services is the principal strategy for promoting optimal maternal health. Critical issues related to the strategy include:

Ensuring the availability of a full range of family planning methods to allow couples to find a method that suits their needs. The availability of a complete mix of methods offers couples the option of returning to a provider for an alternative method if they are dissatisfied with a previous method, thereby encouraging uninterrupted use of family planning.

Providing access to a variety of sources of family planning to help individuals obtain needed contraceptive supplies. Contraceptive security helps ensure continuation of use.

Integrating family planning counselling into antenatal, postpartum, and postabortion care to provide women with critical information at a time when they need to know about the benefits of birth spacing.

Working with communities to facilitate the communication of messages about birth spacing to people where they live and work. Informing religious leaders of the many benefits of birth spacing and encouraging the discussion of the topic at places of worship is just one example of working with non-traditional or non-health community partners. Community-level communication can help health workers better understand how to work within cultural environments; to address norms and practices that may be detrimental to optimal birth spacing.

Working and advocating with family health partners not usually involved in family planning to expand the opportunities to promote the health benefits of spacing. Such health partners may include pediatricians and nurses who can discuss birth spacing with parents during child health visits.

Working with political leaders and other policy and public finance leaders to help ensure political capital and funds dedicated to birth-spacing activities.

Reducing stigma and discrimination

This is an extremely important element in providing care and support for vulnerable populations. Stigma often results in low self esteem, removes persons so stigmatized from openness and positive living. Often times, abuse, negative attitudes, maltreatment are directed to vulnerable groups –PLWHA, MSM, IDUs, CSWs etc. Stigma lead to discrimination against PLWHA, who risk being isolated, judged, or blamed for being infected. PLWHA are often rejected by family members, at work, in hospitals, communities etc. which can ultimately affect their uptake in ARVs. Stigma and discrimination exists worldwide, though this varies across countries, communities, religious groups and individuals. They occur alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution or drug use.

Critical issues

- PLWHA are automatically linked to behaviours disapproved by the society- Men who are HIV positive are judged to be Men who have Sex with Men (MSM) or Injection Drug Users (IDUs) and HIV positive are judged to have been involved in having multiple sexual relationships or even Female Sex Workers (FSW).

- Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. PLWHA tend to remain invisible and deny their status for fear of being stigmatized which may result to physical attack, blackmail or violation.

- Stigma and discrimination is higher among some vulnerable groups than others. Homosexuality is criminalized and those who engage in it are seen as 'immoral'. There is high stigma and discrimination targeted at Men who have sex with Men (MSM) and this reduces access to healthcare services, reduces their low self esteem.

- Household affected by AIDS suffer loss in productivity ultimately affecting them financially while affecting their foods, access to healthcare services and social activities.

- Stigma and discrimination can keep people from getting tested, accessing ARVs, deter them from seeking ways of living positively with their status.

- Vulnerable groups in rural settings have limited access to IEC material and thus most PLWHA are often dejected and driven from their community.

Interventions

"Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."
UN Secretary-General Ban Ki Moon.

- Scale up access and referrals to small loans and microcredit facilities. However, it is best to provide a sought of vocational skills training to empower them on business management, skills and sustainability.
- Sensitisation and education for healthcare workers, vulnerable groups on stigma and discrimination. NGOs and healthcare institution need to provide on trainings for healthcare providers at facilities. As a result of the brain drain of healthcare workers, there is need for continuous training. Trainings should focus on palliative care, positive living, stigma and discrimination, healthcare workers too.
- NGOs should focus more attention to the rural settings (villages) to further sensitise vulnerable groups on HIV prevention, care and support.
- Provision of resources materials on HIV/AIDS at friendly clinics and youth centers to further educate people on HIV/AIDS.
- Institutional and other monitoring mechanisms can enforce the rights of people with HIV and provide powerful means of mitigating the worst effects of discrimination and stigma. The fear and prejudice that lie at the core of the HIV/AIDS discrimination need to be tackled at the community and national levels, with AIDS education playing a crucial role. A more enabling environment needs to be created to increase the visibility of people with HIV/AIDS as a 'normal' part of any society. The presence of treatment makes this task easier; where there is hope, people are less afraid of AIDS; they are more willing to be tested for HIV, to disclose their status, and to seek care if necessary. In the future, the task is to confront the fear-based messages and biased social attitudes, in order to reduce the discrimination and stigma of people living with HIV and AIDS.

Promoting and protecting sexual and reproductive health- the role of Government

Under international Law the Government have three fold obligations in respect of sexual and reproductive health:

[71]Ban Ki-moon op-ed (2008, 6th August), 'The stigma factor', The Washington Times
[72]http://www.avert.org/aidsstigma.htm

- **To respect:** The duty to respect requires the State to refrain from interfering with rights. This includes an obligation to abstain from enforcing discriminatory practices as a State policy, including practices relating to women's health status and needs. States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters.

- **To protect:** The obligation to protect is a responsibility to ensure that third parties do not interfere with the enjoyment of sexual and reproductive health rights. For example, States should ensure that the actions and beliefs of private healthcare providers do not limit people's access to health-related information and services.

- **Fulfil:** The obligation to fulfil requires States to give sufficient recognition to sexual and reproductive health rights in national political and legal systems. States must adopt and implement laws and policies that guarantee sexual and reproductive healthcare, including in rural areas. Policies and laws relating to conscientious objection should not compromise the fulfilment of sexual and reproductive health rights.

It is the responsibility of States under international law

- to ensure available, accessible, acceptable and quality health care which is not compromised by individual health care providers exercising their legitimate right to conscientious objection;

- ensure the functioning of administrative procedures that provide immediate alternatives to healthcare users when conscientious objection would otherwise lead to a denial of services, and effective remedies where necessary;

- monitor the exercise of conscientious objection with a view to ensuring that all services are available and accessible in practice

States have to ensure that:

Health service providers who conscientiously object to a procedure have the responsibility to: treat an individual whose life or health is immediately at stake; otherwise refer the patient to another provider.

Group 1 – Young person living with HIV/AIDS

Group 2- Prisoners living with HIV

Group 3 –Sexual and reproductive rights of people with disability

Group 4- Female Sex Workers

Group 5 - Sexual Minorities

Create an imaginary HIV positive person for this activity.

What kind of situation would this person be in?

What can be done to address this situation?

What can you, I, government, media, community, and NGO do to address this situation?

Create a collage of this person and present it to the group.

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Appendix 1Group Presentation Assessment Tool

	Name of person presenting	What did you gain from the presentation? Knowledge, Attitude and Skills	What from this presentation can you adapt or take home?	Comments / Questions for follow up
PRESENTATION #				
PRESENTATION #				
PRESENTATION #				
PRESENTATION #				

**** This guide will assist participants in note taking during presentations***