Taking Steps of Courage: Teaching Adolescents about Sexuality and Gender in Nigeria and Cameroun

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— Andrea Irvin

Sexuality and power are at the root of most sexual and reproductive health problems. Good health therefore depends in part on having the personal power to negotiate effectively with others regarding one's sexuality and reproductive behavior, not only within intimate relationships but within the institutions of society as a whole (Petchesky & Judd 1998; Zeidenstein & Moore 1996).

To manage their sexual and reproductive lives, people must be able to decide consciously whether, when, and with whom to become sexually active; to avoid nonconsensual sex, sexual violence, and abuse; to plan pregnancies and have access to safe abortion; to avoid acquiring or transmitting sexually transmitted infections (STIs) and HIV/AIDS; to know when they need preventive and curative services; to go through pregnancy and childbirth safely; and to bear and rear healthy children. All of these actions require knowledge of one's own and one's partner's body; the ability to talk about sex and reproduction with one's partners and with others; an understanding of infections and diseases, how to prevent them and how to recognize them; and the ability to access health care. Action also requires the capacity to assert one's right to control one's body and the skills to ensure that one's needs are met and wishes and concerns are respected.

It is unrealistic to expect such knowledge, skills, and attitudes to come naturally. In most societies, issues of sexuality and gender-based interpersonal power are not dealt with openly despite increasingly sexualized mass media. Shrouded in silence and secrecy on the one hand, and distorted and sensationalized in films, newspapers, and magazines on the other, the topic of sexuality often elicits feelings of shame and embarrassment rather than joy. The realistic treatment of sexuality and power can be threatening because it brings to the surface fundamental aspects of people's innermost selves, exposing their vulnerabilities. The staff of reproductive health programs generally experience the same discomfort and taboos as the clients they serve.

Since information is scarce, few reproductive health or family planning programs systematically provide people with the information and skills they need to understand, manage, and enjoy their sexuality (Dixon-Mueller 1993). Most offer limited information, typically in clinic waiting rooms, on topics that are deemed useful for the program, such as contraception or breast feeding. In most countries, schools neglect or give short shrift to sexuality education among adolescents even in the context of "health" or "family life" education. Because the media and most parents, elders, relatives, and friends are also unprepared or unwilling to provide accurate information on sexuality to young people, ignorance, powerlessness, and health problems are passed on from one generation to the next.

Comprehensive sexuality education can improve sexual and reproductive health and enable people of all ages to understand and manage their sexual and reproductive lives. When provided before and during adolescence, it can have a triple impact. It can (1) help adolescents understand and manage their sexuality and reproduction during this crucial period of social and physical development; (2) prepare young people to manage their sexuality in adulthood, including controlling their fertility and maintaining their own and their partners' sexual health; and (3) prepare them for parenthood when they will be called upon to guide, support, and educate their own children.

Sexuality education is most effective when it continues across the life cycle, and when other services are available to help adolescents make lasting social, educational, economic, and lifestyle choices. The

Doing What Comes Naturally?

"Sexuality is learned as the result of a process that should not be left to chance or ignorance.... It is important that the informal process of sex education within the family be supported by planned, enlightened learning opportunities offering information at appropriate times in the growing period."

Quoted from a SIECUS annual report in Carol Cassell and Pamela Wilson, *Sexuality Education: A Resource Book*. New York: Garland Publishing, 1989, pp. xix – xx.

need for sexuality education among adolescents throughout the world is enormous. In most southern countries, nearly one-quarter of the population is between 10 and 19 years old; in the north, 11 to 14 percent of the population is in this age group (*Into a New World* 1998:48). Estimated in 1995 at well over 1 billion people, the world's adolescents simply cannot be ignored.

The importance of addressing adolescents' sexual health needs was highlighted at the United Nations International Conference on Population and Development (ICPD) held in Cairo in 1994. Governments approved a *Programme of Action* that recognizes that adolescents should have access to confidential information, counseling, and services while respecting parents' rights and responsibilities (*Report of the International Conference on Population and Development* 1994). Although many nongovernmental organizations and donors in the fields of health and population have responded to this call to action, few governments have as yet made the political, financial, and institutional commitments required to ensure that information and services are available and accessible. Moreover, much remains to be done to educate the public and change social attitudes and practices.

Since 1990, the International Women's Health Coalition (IWHC) has supported colleagues in Nigeria and Cameroun who are working with young people on sexual and reproductive health and gender roles. In 1990, the recently established Action Health Incorporated (AHI) of Nigeria asked IWHC to support its efforts to reduce the incidence of teenage pregnancy. Since that time many other individuals and organizations have become interested in their work. In Nigeria, IWHC collaborates with the Girls' Power Initiative (GPI), the Conscientizing Nigerian Male Adolescents (CMA) program, the Empowerment and Action Research Center (EMPARC), the Adolescent Health and Information Project (AHIP), and, in Cameroun, Femmes, Santé et Développement, among others. (See Appendixes I, II, and III for profiles.)

This paper outlines some of the lessons about sexuality education that have emerged from our shared experience. The first section describes very briefly the changing context of adolescence in Cameroun and Nigeria. The second discusses what is meant by sexuality and sexuality education as well as some basic guidelines for teaching this topic. The final section outlines issues to consider when developing programs in specific contexts. Although the ideas presented may not be shared by everyone who has been involved in these particular initiatives, they are the products of ongoing, collaborative experimentation, program assessment, direct observation, and discussion.

EVOLVING TRANSITIONS: ADOLESCENCE IN NIGERIA AND CAMEROUN

Signaled by the onset of puberty, adolescence is a time of rapid and profound physical, mental, and social growth and change. The World Health Organization defines adolescence as the period from 10 to 19 years of age (*The Reproductive Health of Adolescents* 1989). Although this definition is convenient for data analysis and discussion purposes, both the physical and social boundaries of adolescence vary across individuals, subgroups, and societies and between females and males.

Throughout the world, adolescence has been undergoing significant changes during the last several decades. Age at onset of puberty has been declining in most regions as a consequence of improved nutrition, while age at first marriage has been rising, especially for females in early-marrying societies. In many countries, formal schooling has increasingly extended into the late teenage years for both sexes. In Nigeria as a whole, for example, 21 percent of females and 34 percent of males aged 16 to 20 years were attending school in 1990; the figures for Cameroun in 1991 were 34 and 48 percent respectively (*Women's Lives and Experiences* 1994:7). Although the proportion of women marrying as teenagers has been declining, as recently as the early 1990s well over half of all women aged 20 to 24 years in both countries had married or started cohabiting before age 18 (*Into a New World* 1998:51) and many enter polygynous unions. Approximately 46 percent of Camerounian women and 35 percent of Nigerian women had at least one child before their eighteenth

birthday (Ibid.: 52). As would be expected, early marriages are far more common in rural areas and among those with a primary school education or less.

With years of schooling lengthening, and age at marriage rising, adolescence is emerging as an identifiable social stage of life, especially in urban areas. In rapidly changing and urbanizing societies, deeply influenced by globalized media, traditional norms and behavioral controls are eroding. For adults, as well as for adolescents, this transition has resulted in an often confusing mix of traditional and contemporary values and mores. Parents continue to have the same expectations of their unmarried adolescent children as their parents had of them, creating a situation that is clearly untenable in a changing world.

For example, according to recent surveys, 94 percent of all Camerounian women and 83 percent of Nigerian women have had sexual intercourse by the age of 20 (Ibid.:51), and the average age at first intercourse (16.0 years in Cameroun, 16.4 years in Nigeria) for women aged 25 to 29 in both countries was almost one year younger than their average age at marriage (Macro International 1994:17). A substantial minority of young people, especially young men, have multiple partners. For example, one Nigerian study found that of the 80 percent of male secondary school students who were sexually active, more than half reported more than one partner (Jinadu & Odesanmi 1993:114 – 115). Moreover, according to anecdotal evidence, increasing economic pressures and greater sexual permissiveness have resulted in a growing number of girls having sex in exchange for money, school fees, gifts, or basic support. Underlying these patterns is the low status of women and their lack of personal power (Kisekka 1992; Osakue & Martin-Hilber 1998). In Cameroun and Nigeria, girls are socialized to be quiet and submissive, and to be, first and foremost, "good" wives and mothers. They are expected to obey their parents and elders before marriage and their husbands afterward. The concept of universal rights, especially individual rights, is not widely recognized or accepted.

In these circumstances, girls and women are particularly vulnerable to exploitation and gender-based violence: sexual harassment, rape, sexual abuse and coercion, domestic violence, and, in Nigeria, genital cutting. Although reliable data are scarce, perhaps half of all Nigerian women have experienced genital cutting (Toubia 1995). (In Cameroun, the procedure is relatively rare.)

In the past, some cultural groups provided "traditional sexuality education" to young people just before marriage or, for girls, at the time of their first menstruation. This education usually reinforced gender-based customary rights and obligations, including the husband's absolute right to his wife's body and the wife's obligation to serve and please her husband. Traditional sexuality education lacked information on the biological process of maturation and reproduction, disease prevention, and so on. As this traditional sex education has disappeared, it has been replaced by little, if anything, for most young people. Furthermore, health educators in Nigeria and Cameroun, as elsewhere, report that many girls find out about menstruation only after discovering with horror that they are bleeding. Parents' discomfort is communicated very early in life and discourages children from asking questions. The implicit messages children are given about sexuality are often negative, distorted by myths, and harmful. When adolescent sexuality becomes undeniable, parents typically resort to vague threats or warnings, such as "stay away from boys." Those who recognize their children's need for accurate information often lack such knowledge themselves. Thus the cycle of ignorance and embarrassment continues.

The school systems of Nigeria and Cameroun, based on rote learning and memorization, tend to reinforce girls' and boys' acceptance of the status quo. The combination of traditional socialization and these educational methods perpetuates girls' passivity and low self-esteem and boys' sense of "natural" superiority. Not surprisingly, girls come to believe that their status and treatment are justified—that is, they internalize their oppression—thus making it doubly difficult for them to break through patriarchal norms and sexist values.

In 1999, the government of Nigeria and various NGOs developed a strategic framework for a national

Pop Ed, Family Life Ed, Sex Ed, Sexuality Ed—What's the Difference?

These labels are used differently in different cultures. The content of the program rather than the name is more important in revealing the type of program. In general, the terms refer to the following:

Population education emphasizes population growth and economic and environmental issues. It aims to relate these issues to the individual in order to encourage people to have fewer children. Such programs often do not include information on sexuality or even contraception.

Family life education emphasizes family life and relationships, for example, preparation for marriage, household finances, parenting skills, and life planning. It may also cover population growth, personal health and nutrition, self-esteem, and gender roles. Some programs include reproductive physiology, sexual behavior, and contraception. It sometimes aims to discourage premarital sexual intercourse. Regardless of program content, the term "family life education" is frequently used because the term sounds more culturally acceptable than other terms.

Sex education emphasizes basic information about sexual anatomy and physiology, puberty, reproduction, STIs, HIV/AIDS, and pregnancy prevention. Its goals are to prepare young people for puberty and prevent unwanted pregnancies and STIs.

Sexuality education emphasizes a broad approach to sexuality, focusing on the whole person and presenting sexuality as a natural and positive part of life. It covers all aspects of becoming and being a sexual, gendered person and includes biological, psychological, social, economic, and cultural perspectives. It explores values and develops social skills with the goal of promoting sexual health.

adolescent health policy. The Ministry of Education convened a working group on curriculum development that includes NGOs. It remains to be seen how progressive and effective it will be. In Cameroun, the government has adopted (in the absence of its own program) a curriculum for training primary school teachers in sexuality education that was designed by the organization Femmes, Santé et Développement. However, it is not clear that teachers are yet required or even authorized to teach the curriculum in schools.

In any case, without specialized training, teachers are no better equipped to provide sexuality education than are parents. Like parents, teachers who are uncomfortable with the topic convey their own uneasiness and often give incorrect information. For example, a Nigerian girl who had been part of a sexuality education program, reported that her teacher told the students that the name for the female external genitals is "private parts." When the student said that the correct name was "vulva," the teacher told her she was a "nasty girl."

Sexual exploitation, violence, unwanted pregnancies, unsafe abortion, STIs, and HIV/AIDS: all these risks and more confront today's young people. Unwanted pregnancy among unmarried teens is a serious problem. For example, in Cameroun, 25 percent of all births to women under age 20 are to unmarried adolescents; in Nigeria, 6 percent (*Into a New World* 1998:52). Schoolgirls who become pregnant are faced with the "choice" of having an illegal, usually unsafe, abortion or dropping out of school to have the child, thereby seriously limiting their options for the future. Reluctant to turn to their parents for help, with little or no money of their own to pay for an abortion and no knowledge of where to seek safe services, girls seeking to terminate an unwanted pregnancy most often turn to inexpensive, untrained providers. Although the number of adolescents having abortions is unknown, in Nigeria, adolescent girls account for 80 percent of the complications from unsafe abortion that are treated in hospitals (Ministry of Heath and Social Services 1994:20).

Sexually active young people are also at high risk of contracting STDs, STIs, or HIV/AIDS from unpro-

tected sex. The Nigerian National AIDS and STD Control Programme reported that fully 63 percent of all new AIDS cases documented between 1986 and 1995 were among women between 15 and 29 years of age (National AIDS and STD Control Programme 1996). A study in Lagos state in 1990 – 91 found that 20 percent of all pregnant women aged 15 to 19 were HIV-positive (*Into a New World* 1998:37).

SEXUALITY: IT'S MORE THAN "HAVING SEX"!

Sexuality is a natural, integral part of every human being, but its definition is a subject of continuing intellectual debate. Sexuality is based in the physical body, and its expression is influenced by personal and social forces. It encompasses all parts of life that are related to or associated with sexual behavior or with one's sex. For educational purposes, it can be described as having five overlapping aspects: human development, emotions and relationships, sexual health, sexual behavior, and sexual violence.

Learning about sexuality is a lifelong process and an essential part of every person's socialization. Messages about sexuality are communicated directly or indirectly through everyday interactions and experiences and exposure to a wide variety of influences. Sources and places of sexual learning include parents and other relatives, close friends and peer groups, schools, the mass media, religious institutions, workplaces and other gathering places, health care service providers, social institutions, and the arts. Sexuality education, thus, is something that happens whether or not we undertake it consciously and formally.

Comprehensive sexuality education is a consciously planned, usually formal process for teaching about the biological, psychological, sociocultural, and spiritual aspects of human sexuality, and for developing the skills and attitudes necessary for a positive and healthy sexual life. Sexuality education approaches sexuality as a natural, positive, and healthy part of human life and addresses the pleasures and joys of human sexuality as well as its undesirable aspects, such as sexual violence or sexually transmitted infections (STIs).

Six Key Concepts in a Comprehensive Sexuality Education Program

Key Concept 1: Human Development
Reproductive Anatomy and Physiology
Reproduction
Puberty
Body Image
Sexual Orientation and Identity

Key Concept 2: Relationships
Families
Friendship
Love
Dating
Marriage and Lifetime Commitments
Raising Children

Key Concept 3: Personal Skills
Values
Decision Making
Communication
Assertiveness
Negotiation
Looking for Help

Key Concept 4: Sexual Behavior
Sexuality Throughout Life
Masturbation
Shared Sexual Behavior
Abstinence
Human Sexual Response
Fantasy
Sexual Dysfunction

Key Concept 5: Sexual Health
Contraception
Abortion
Sexually Transmitted Infections, including HIV Infection
Sexual Abuse and Violence
Reproductive Health

Key Concept 6: Society and Culture
Sexuality and Society
Gender Roles
Sexuality and the Law
Sexuality and Religion
Diversity
Sexuality and the Arts
Sexuality and the Media

Guidelines for Comprehensive Sexuality Education, Kindergarten – 12th Grade. Lagos, Nigeria: National Guidelines Task Force, Action Health Incorporated, 1996, p. 13. Adapted from *Guidelines for Comprehensive Sexuality Education*, published by SIECUS, New York.

SEXUALITY EDUCATION: WHAT DOES IT TEACH?

The main goal of sexuality education is the promotion of sexual health. An expert group convened by the World Health Organization has defined sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching, and that enhance personality, communication, and love. . . . Every person has the right to receive sexual information. . . . and to consider accepting sexual relationships for pleasure as well as for procreation." (WHO 1975)

Sexuality education aims to:

- Provide accurate information on all aspects of human sexuality, including gender
- Assist people to consciously explore, consider, question, affirm, and develop their own feelings, attitudes, and values on the various dimensions of sexuality
- Enhance self-esteem and social skills for developing mutually satisfying, supportive, equitable, and loving intimate relationships, and for self-determination in the experience of one's sexuality, including the expression of one's gender, and control of one's reproduction
- Enable women and men to act responsibly in the expression of their sexuality, in their reproductive behavior, and in their intimate and social relationships.

For programs to be effective, three distinct learning domains must be addressed:

- The *affective domain*, which addresses the emotional and attitudinal component of sexuality
- The *behavioral domain*, which addresses specific behaviors and teaches the skills needed to negotiate sexual health and pleasure safely and responsibly
- The *cognitive domain*, which addresses the factual or knowledge aspects of sexuality.

Ten Elements of Effective Sexuality Education

1. The program presents a positive, accurate, and comprehensive view of human sexuality.
2. The program respects and empowers students.
3. The program respects cultural and sexual pluralism and promotes universal values.
4. The program addresses a diversity of learning styles and abilities.
5. The program addresses all three learning domains: cognitive, affective, and behavioral.
6. The program is interdisciplinary and integrated across the curriculum.
7. The curriculum is comprehensive in scope, age- and experience-appropriate, and logically sequential.
8. The program is supported and reinforced by the family, peers, religious groups, reproductive health clinics, and local media.
9. The teachers are willing, comfortable, and well-trained.
10. The program promotes lifelong learning.

Adapted from Evonne Hedgepeth and Joan Helmich, *Teaching about Sexuality and HIV: Principles and Methods for Effective Education*, New York: New York University Press, 1996, pp. 14 – 38.

Although the majority of programs have focused on the cognitive aspects, many are adding behavioral components that enable students to learn and practice the skills they need to deal with social pressures, such as how to say no to unwanted sex and how to negotiate the use of condoms, among other behaviors. Many fewer, however, work actively with young people on the affective domain of sexuality. Given that our sexual behavior and ways of dealing with other aspects of our sexuality are driven by our feelings of embarrassment, vulnerability, and fear, and by our need for love and acceptance, sexuality education must address the affective domain to be successful.

Both the affective and behavioral domains require the use of active, participatory learning methods that are quite different from the didactic educational techniques employed in most countries.

Taking a positive approach with young people is indispensible if they are to understand that sexuality is a natural, pleasurable part of their lives and something with which they can and ought to feel comfortable. This understanding is a necessary precursor to the ability to talk with a partner about issues such as contraception. An honest and open approach that encompasses the positive aspects of sexuality as well as the risks is also essential. Too many programs cover only the risks of sexual activity, such as disease, dishonor (getting a "bad reputation"), and shame, and try to persuade youth not to have sex before they are married. Because adolescents know that sexual activity is also pleasurable, biased information only creates an atmosphere of distrust and disbelief.

The idea of sexuality education often initially provokes negative reactions among parents and in the community at large. Among other concerns, people fear that such programs will encourage teenagers to experiment with sex and even become "promiscuous." For this reason, programs need to do considerable preliminary work in building understanding and support regarding what sexuality education encompasses and why it will not lead to increased sexual activity among adolescents. In our experience, once people understand what sexuality education actually is, their negative views greatly diminish and often disappear.

Sexuality Education Does *Not* Lead to Increased Sexual Activity

A survey carried out by the World Health Organization Global Programme on AIDS revealed no evidence that sex education in schools leads to earlier or increased sexual activity in young people. The 35 studies reviewed showed that:

- Sex education resulted in either delayed sexual activity or decreased overall sexual activity (six studies).
- Access to counseling and contraceptive services did not encourage earlier or increased sexual activity (two studies).
- The remaining studies showed neither an increase nor a decrease in the levels of sexual activity.
- Sex education increased the adoption of safer sexual practices among sexually active youth (ten studies).

"Sexuality Education Does *Not* Lead to Increased Sexual Activity." Press Release, 26 November 1993. Geneva: WHO, 1993.

Sexuality Education *Does* Lead to Other Important Changes

The full potential of comprehensive sexuality education is still unknown. Most sexuality education programs have not been truly comprehensive in either scope or sequence due to many limiting factors, including organized opposition. Nonetheless, research reveals that sexuality education is correlated with the following significant changes:

- Increases in sexual knowledge and personal comfort with sexuality
- Increased tolerance toward the behaviors and personal values of others
- Delay in the onset of sexual intercourse and increased likelihood of using contraception when individuals do begin having intercourse
- Increased communication with parents about sexual matters, which correlates with more responsible behavior
- Increased self-esteem and decision-making skills.

Evonne Hedgepeth and Joan Helmich, *Teaching about Sexuality and HIV: Principles and Methods for Effective Education*, New York: New York University Press, 1996, p. 3.

SEXUALITY EDUCATION: GUIDELINES FROM EXPERIENCES IN NIGERIA AND CAMEROUN

Organizations planning sexuality education programs need to ask a series of questions. Who are the programs for, and why? Where should they be offered? When, and for how long? What should be included in the curriculum? How can the messages be best conveyed? And how will we know if we are doing a good job?

Based on their own analysis of the particular interests and needs in the populations they serve, IWHC's Nigerian and Camerounian colleagues, working primarily in nongovernmental organizations, have determined what can and should be done and how to do it. IWHC has supported their work, encouraging (and sometimes dissuading) them, sharing and debating new ideas and perspectives, bringing a critical eye and outside view, learning together about what is needed, how much can be done, and what works, while always striving for excellence. It has been a rich collaborative effort through which everyone involved has learned and changed. Over time and with experience, certain elements have emerged as key factors to consider in developing programs for adolescent girls and boys. Here we recount some of the recurrent themes and avoidable mistakes.

- ❖ Determine what adolescents need to know and what they already know in an unbiased and nonjudgmental manner. They probably know more than you think but they also have a lot of misinformation.

Most adults view adolescents as less knowledgeable and experienced than they actually are. They forget how much they themselves knew and when, and what their preoccupations were when they were adolescents. Whether through formal research or simply by "getting to know" the adolescents that the program will serve, it is essential that program implementers and educators listen to young people. What do they know and believe? What do they *want* to know? What are the differences of experiences and needs among young people and how should that affect program design? What are their concerns?

Often the answers to such questions will not be those that adults expect. Program implementers in Cameroun and Nigeria, for example, discovered to their surprise that young people of both sexes were often more interested in learning about romantic relationships than about sex. "How do I talk to a girl?" "How can I get the boy I like to notice me?" "How do I know if I am in love?" Interestingly, many programs that emphasize abstinence, contraception, or STIs do not talk about feelings such as love.

A clear analysis of the information that is needed by the learner and of how the learner will use the information should precede the development of lessons on the topic. The teaching of the menstrual cycle offers a good example of the dangers of oversimplification. Girls and women often calculate "safe days" for sex on the basis of what they understand about the menstrual cycle. Although educators may assert that "safe days" cannot be accurately predicted, this message gets lost when educators say, as they often do, that an average menstrual cycle is 28 days, a persistent myth, and that ovulation occurs approximately in the middle of the cycle. Instead, students need to learn that the length of the cycle is notoriously unpredictable, varying from person to person, from month to month, and with age. Students also need to know that ovulation occurs between 12 and 16 days *before* the beginning of the next period, something that cannot be predicted (Walker 1997; Carlson et al. 1996).*

Teaching about sexually transmitted infections provides an example of how important it is to think about what information is needed for students to maintain their sexual health. Educators usually talk about how STIs are transmitted, their signs and

* "Many textbook descriptions imply that once the first period has occurred, menstruation occurs regularly every 28 days (the menstrual cycle), unless interrupted by pregnancy, until the menopause at around age 50. A number of extensive longitudinal studies in which women record the dates of menstruation as it happens have shown this to be relatively rare, however. The time between periods can vary between 10 and 60 days. Menstrual cycles vary in length both among women and from one cycle to the next, with only around one in eight cycles being exactly 28 days in length. Vollman found that cycle length also changes with age, with an average length of 35 days in early teenage years, reducing to a minimum of 27 days in the early forties and increasing to 52 days in the mid-fifties. . . . So, menstruation is not as predictable as folklore medical texts would have us believe."

symptoms, and how to prevent and treat them. They emphasize the specific symptoms of each STI and mention, only in passing, that the *majority* of women show no signs or symptoms of infection. Too many girls and women thus think they are healthy when they are not (Germain et al. 1992:2).

Demystifying Sexuality Education: One Woman's Experience

Ayo, a woman in her mid-thirties, is a member of an organization working on AIDS prevention in Nigeria. When the organization decided to provide training in sexuality to members working with young people, Ayo, in charge of the youth program in her state, was selected to go to the training. Her first reaction was negative. She understood the word "sexuality" to mean "sexual intercourse" and thought that sexuality education would be about how to have sex. Ayo found this bizarre and was put off. Why should they teach that? Didn't people learn about making love by doing it? Despite her reservations, Ayo decided to go to the training. When she returned, she was bursting with enthusiasm. Ayo had not realized that something like menstruation, a regular part of her life, was part of sexuality. In addition, she was deeply struck by how little she actually knew about sexuality, including menstruation, wet dreams, and other aspects of puberty that she was expected to understand and to teach. She stated emphatically that schools should provide sexuality education to young people. "We all need sexuality education. Sexuality education is different from sexual education," says Ayo. This kind of turnaround in attitude is common if training on sexuality is done well.

- ❖ Be aware that inadequately trained program implementers (teachers, planners, activists, etc.) will be uncomfortable dealing with some topics, may distort or exclude topics, and may give incorrect information.

It is essential that implementers be trained in a way that reveals their own prejudices, enables them to examine their biases, and raises their level of tolerance and comfort in discussing issues such as masturbation, same-sex attractions, child sexual abuse and incest, sexual violence and coercion, body parts, and other areas of concern to adolescents. In a session about AIDS in Cameroun, for example, when asked why the vagina itched during menstruation, an educator said, "The vagina is not a clean place. It is dirty." In fact, the vagina is not only quite clean, it cleans itself. Fostering the notion that the vagina is dirty is detrimental to the young person's body image and to her feelings about herself and her sexuality. Moreover, the educator loses an opportunity to provide assistance. It is not normal for the vagina (or, more likely, the vulva) to itch during menstruation; it is possible that the young woman who posed the question had an infection that could cause harm if left untreated or that she was using something to collect her menstrual flow which was irritating her genitals, a solvable problem.

- ❖ Do not assume that controversial topics will meet with negative community reactions or allow the possibility of such reactions to determine program content.

Community concerns should of course be considered in developing any program, but the primary criterion for topics should be the young person's well-being. Very often the community does not react as expected, even to topics considered "controversial" or sensitive, and typically there is a range of opinions in the community, some of which can be drawn upon for support. In our experience, if program implementers feel comfortable with the topic, they can find ways to develop community support.

In 1990, when Action Health Incorporated of Nigeria first became concerned with teenage pregnancy, they focused on encouraging abstinence in their programs through messages such as "just say no." Although staff members did not personally believe that this was the message that adolescents needed most, they thought that dealing with adolescent sexuality in a more comprehensive way would be culturally and politically explosive. Through a simple survey, they discovered that 50 percent of the adolescents in the area they were serving were already sexually active. They realized they would need to provide a comprehensive program to reach these youth. The program did not, in the end, generate as many problems as they originally feared and the adolescents are far more engaged in the program than they would have been otherwise.

❖ Treat controversial issues in an open, factual manner, and encourage the sharing and analysis of emotional responses.

Generally speaking, programs that want to address issues that could be controversial in their cultural context do well if they focus on facts and encourage discussion and critical thinking about feelings and attitudes. Masturbation, for example, is usually a taboo subject and commonly the subject of intense moralizing. Yet experience has shown that when educators broach the topic in an unemotional, nonjudgmental way and lead participants in a discussion and critical assessment of their own and societal beliefs, to separate facts from myths and to determine their own values about masturbation, many participants become comfortable in discussing the topic. This helps lift the taboo and decrease the shame surrounding the practice, which is natural, common, and healthy rather than harmful.

Taboo issues are surrounded by feelings of shame and hidden from view, to such an extent that people often incorrectly believe that they do not exist in their culture. They frequently are the subject of tenacious and vicious prejudice, discrimination, and oppression. Sexual orientation is one such issue. Some young people have sexual experiences with partners of the same sex. They need information to understand their own experiences and alleviate anxiety. Many others do not know anyone who is openly gay or bisexual and cannot imagine their realities. Educators can share real-life stories (anonymous or not) about gay and bisexual people and their families to decrease fear and hatred by creating familiarity with the characters, personalities, experiences, feelings, and humanity of gay and bisexual people. Even briefly addressing such issues in a nonjudgmental manner begins to break down the barrier of silence, a vital step in the educational process. Educators who feel comfortable doing more should be supported and encouraged.

❖ Provide children and adolescents with needed information *before* they experience various aspects of sexuality.

It is essential to inform girls about menstruation before it begins, for example, and young people need to know about pregnancy, STIs, and condoms before they have sex. Most adults don't know when it is appropriate to provide this information, and they are often reluctant to provide information before it is actually needed.

In a program designed to encourage communication about sexuality between mothers and daughters, some of the mothers did not want their daughters (most between the ages of 13 and 20) to be informed about sexual intercourse because they were "too young." The mothers met separately to decide what to do. When they emerged, one of the daughters said to them, "That thing you don't want us to know about, we already know. We have seen it in videos and on TV. Why are you trying to keep things from us?" Instead of opening the lines of communication, the mothers showed that they were not prepared to talk honestly.

When developing educational programs for teens, adults should think about what teens will need to know when they do get married and use that as a guide for what they should teach. How will they manage their sexual relationships? What will be the sexual expectations of their partners? What are their own expectations? How can they plan their families? What about infidelity and the possibility of STIs? How can they talk about contraception and infection prevention, not to mention pleasure, with their partner?

❖ When feasible, divide learners into age groups.

Given the enormous changes that take place during adolescence, levels of maturity and experience differ significantly among younger and older adolescents, and also within age groups. Young people of different ages have different concerns and levels of experience; they need different types of information and approaches to learning. Many young people also find it helpful to have sessions that are segregated by gender.

❖ Where possible, provide written materials as a backup.

Educators often encourage young people to share the information they have learned in a class or program with their friends. In principle this sounds good, but it assumes that adolescents remember the lessons

accurately and in detail, which is not the case. Although written materials cannot substitute for direct communication with knowledgeable adults, they can help ensure that shared information is accurate and complete.

- ❖ Implement programs that are as in-depth and comprehensive as possible, and regularly revise them in response to feedback and program evaluation.

Short programs for a youth group or a school class on selected topics are likely to have only a very small effect. Longer, in-depth programs can change lives—if they are done well. If programs are to build self-esteem or change sexist attitudes, and if they are to have a significant impact on knowledge of sexuality and the level of comfort surrounding sensitive issues, they need to work with participants over months, or even years. There are no shortcuts.

When the Girls' Power Initiative (GPI) in southeastern Nigeria began in 1994, no one thought the weekly three-hour meetings with girls would develop into a three-year program. However, on the basis of experience and self-assessment, GPI found that three years were needed both to cover the issues and to develop in girls the self-esteem and strength required for enduring change. Between meetings, the girls absorb and use the information, attitudes, and skills that they learn. The impact of the GPI approach is reflected in part in the girls' own life decisions and decisions by several members of the initial group to continue to work on sexuality and women's issues on their own.

As teachers and program managers are exposed to young people's realities and gain direct experience with sexuality education, their understanding and views inevitably evolve. Implementers need to regularly assess and modify the content of their programs based on their experiences. Assessments of program effectiveness need not be highly formalized, but should look regularly and critically at program content; at the quality of implementation (accuracy and completeness, teaching skills, attitude, and rapport); and at the changes in participants' knowledge, attitudes, and skills over time. Program planners need to foster an attitude and commitment to continual self-assessment and improvement that goes beyond questions of "quantity" (numbers of participants, numbers of meetings, etc.) to explore effectiveness.

SEXUALITY, GENDER, AND SOCIAL JUSTICE: ADDRESSING ISSUES OF POWER, RIGHTS, AND RESPONSIBILITIES

The relative power of individuals and the unequal distribution of rights and responsibilities is a defining factor in how individuals experience sexuality and reproduction. Because girls and women have less power than boys and men do, they need to learn about their rights, about discrimination, and about the ways in which power is used and manipulated. Adolescent girls can make important changes in their self-perception, in their intimate relationships, in the ways in which they handle discrimination, and in the course their lives take. With support, the majority of

Girls Get Power!

One young Nigerian woman who participated in the Girls' Power Initiative had this to say:

"GPI weekly meetings . . . opened my eyes really wide. I began to take note and notice that girls were in the past and even presently being denied enjoyment of fundamental human rights all because of sex. I realized that women are being raped, cheated upon, pushed to the background, sexually harassed and battered by their so-called husbands and yet nobody says anything, nobody seems to notice because it has to do with females/women. Seeing all [this] and with the knowledge gained with the help of GPI's weekly meetings, I took a step of courage, made up my mind and decided to be part of the struggle to let the world know that [women's] rights are human rights. If women are human why can't they enjoy . . . fundamental rights?"

Felicia Asuquo, "Report on My Experiences in GPI Weekly Meetings . . ." in *Girls' Power Initiative Nigeria End of Grant Year Report*. Vol. 2: Programme Execution Team Members' Evaluation, Benin City: Girls' Power Initiative, 1996.

girls can clearly recognize and articulate the gender-based discrimination they face in daily life and its effects on their lives. Sexuality education should include developing skills for dealing with situations in which the power of others is illegitimately used against them. If sexuality education programs are to make a real difference in sexual health, they must address these issues.

The Girls' Power Initiative has developed many innovative techniques for increasing girls' awareness and problem-solving skills. They address sexual violence and harassment directly and striking changes have occurred in participants' knowledge, self-esteem, ambition, and capacity to act on their own behalf. GPI's weekly meetings always begin with a process called "checking in" during which each girl introduces herself and shares something that happened to her during the week and any experience in which she used information or skills she acquired in the program. Attempted sexual exploitation by a teacher is a typical example. One girl described how she used a strategy suggested by GPI, namely, to take a friend with her when she met with a male teacher. The teacher tried to get her alone, but rather than confronting him directly, the student used a variety of excuses to avoid being alone with him. Following this report, the rest of the group discussed how she had handled the situation. Some believed she had done well, while others believed she should have confronted the teacher, although that might have resulted in negative consequences for her. This analytical process, in which strategies are evaluated in a practical and realistic way, reinforces and supports participants to take action, and creates and reviews strategies for doing so. The participants' own attitudes and behaviors change, shifting from passive to active; and with this shift, they begin to transform social attitudes about gender.

Work on power, rights, and gender needs to be undertaken with both boys and girls. Boys and men need to be taught about rights and responsibilities and the abuse of power. It helps to begin by examining situations in which the boys believe they have been oppressed or discriminated against because of their race, ethnicity, age, class, personal appearance, or some other characteristic over which they have no control. Once they have explored their own experiences of injustice, they can begin to understand the experiences of other oppressed groups and how they themselves contribute to injustice. Such transformation is a long-term process that requires ongoing support. Boys need to know that the struggle for equality and justice will be long and difficult, and they need to understand that even those whose rights they are working to support will not always support their efforts.

Helping boys to understand the concept of consent is especially important. They need to think about a number of questions. What does "consent" mean in particular contexts? How does a boy know if he has consent? What should he do if he is not sure? Why is consent important? When can consent be withdrawn? What are the necessary conditions for a girl to give consent to an arranged marriage? Does a woman "consent" to have sex with a man when her economic support depends on staying in his favor?

As a complement to the Girls' Power Initiative in southeastern Nigeria, the Centre for Research, Information and Documentation (CENTRID) began a program for young men called "Conscientizing Nigerian Male Adolescents." Through interactive discussions and activities, on a broad range of topics, the program aims to develop independent, critical thinking among boys about their own lives and about the condition of their society. Among other issues, it leads them to question and change their sexist attitudes and behaviors. For example, students were asked to examine the contributions that adolescents and women have made to Nigerian history and to analyze why such contributions were not addressed in their regular classes. In another exercise, they were first asked to list professions that "only men can do." Then they were asked how they justified their sexist views. Prejudices and stereotypes are challenged. If, for example, a boy says, "Men can be politicians but women cannot, because men are smarter," the facilitator might say, "Does that mean that because you are a boy, you are smarter than all of the girls in your class on every topic?" and a debate ensues. At the end of the first year of the program one boy wrote: "I believe that given the singular fact that the contributions of . . .

husbands, wives and children help any family forge ahead and succeed. . . men should stop dominating their wives on the grounds that they, husbands, are the breadwinner of the homes. This belief is really wrong."

Effectively addressing such issues as women's and children's rights, sexual harassment, and sexual and domestic violence requires a deep understanding of the reasons for injustice, how it is perpetuated, a sense of one's own responsibility, and skills for social-change work. Young people need to learn to see when an individual's experience, for example a particular rape case, is part of a social problem that needs to be analyzed and addressed as a social concern. It is vital for young people to understand that, as citizens, they have a responsibility and role to play in making their communities better.

TRAINING SEXUALITY EDUCATORS: WHAT WORKS?

Investment in the high-quality training of educators is one of the most important requirements for an effective program, yet it is among the factors most overlooked because continuing education is expensive, experienced trainers are not easy to find, and many people erroneously believe that sexuality education does not require special training. Training, practice teaching, follow-up supervision, and continuing education are all essential. Through a process of trial, error, and success with our Camerounian and Nigerian colleagues, we have learned the following points about training.

- ❖ Untrained sexuality educators often believe that they know more than they do, and do not realize the importance of specialized expertise.

Numerous programs have been staffed with enthusiastic volunteers and staff members with only minimal special training or none at all. Those who provide sexuality education with little or no training typically use their own beliefs, values, logic, or misinformation in their teaching, and the consequences can be severe. While it can take time to identify skilled trainers, and it certainly requires funds, the investment is essential because sexuality is extremely complex, involving not only facts but also an array of feelings, attitudes, and beliefs for both the educators and the students. Educators need to know considerably more about sexuality than they will actually teach, including knowledge about topics that they may not address directly but which come up in private questions or discussions. In a session on AIDS, for example, a young woman asked, "If a man is HIV-positive and HIV is in one of his sperm and that sperm enters the woman's egg and fertilizes it, can the woman stay HIV-negative and the baby be HIV-positive?" It takes knowledge, skill, and experience to answer adolescents' questions and a lot of self-confidence to say, when necessary, "I don't know. I will find out." It also takes considerable training to answer questions about personal values, attitudes, emotions, and personal experiences thoughtfully, neutrally, and in a way that enhances learning.

- ❖ Not just adolescents, but educators, need to identify and work through their own attitudes and values, biases and prejudices.

Just as sexuality education addresses three areas of learning, so too the training of educators needs to include knowledge about sexuality (the cognitive domain), teaching skills (the behavioral domain), and the examination of feelings, values, and beliefs (the affective domain). Training helps educators become comfortable talking about sex and sexuality. Educators also need help assessing their biases and prejudices, and if they cannot become nonjudgmental, they must at least learn how to keep their personal views out of their educational work. Not everyone will be able to do this.

On some topics, it is essential that educators change their views in order to be effective. For example, many trainees initially believe that it is the woman's fault if she is raped and that she must have done something to make it happen. Intensive training is required to work through such deeply ingrained prevailing attitudes, not only about rape but also about gender relations, sexual orientation, and harmful behaviors such as wife beating, physical or sexual harassment, and sexual violence.

- ❖ Developing expertise in sexuality education takes training, practice, feedback, supervision, refresher training, and time.

Two weeks of basic training is not sufficient to develop expertise. Good initial training needs to be followed by regular practice with feedback from experienced observers. The Girls' Power Initiative, for example, reinforces and builds on its training by holding weekly meetings in which each educator talks about how her lesson went during the previous week and the problems she encountered. Together they discuss suggestions for changes in the future, and each educator presents her plans for the next week's session. The group makes suggestions on content, method, and preparatory reading.

Refresher training solidifies and reinforces the gains made during initial training. Such training may expand upon the key elements of the initial instruction or, as skills increase, can be used to develop skills to train others. When a staff member at GPI took what was essentially the same training course again after an interval of two years of teaching, she remarked that she learned more from the second course than from the first because now she knew exactly what she needed to know.

- ❖ Providing reference materials to educators on sexuality and sexuality education is a simple, essential step.

Reference materials must be available so that educators can find the information they need when they need it most. This is especially important where there is no access to experts. A young woman who was running discussion groups on body awareness for Action Health Incorporated described a session in which the group talked about menstruation, wet dreams, masturbation, and sexual fantasies. She gave examples of the questions students asked and how she had handled them. When asked how she had developed her impressive knowledge of the issues, the educator responded that both before *and* after each session, she spent a lot of time in AHI's resource center. (See Resources section, page 30.)

- ❖ Sexuality educators must be carefully selected. Not everyone is suitable!

People who are empathetic by nature, who like and respect young people, who are open to new ideas and have an accepting, nonjudgmental style are most likely to be skilled sexuality teachers. Those who have very strong moral beliefs about sexuality and little tolerance for people who do not share their views are unlikely to be good teachers.

In many school programs, however, the decision about who will teach sexuality is made by subject. Typically, the teacher of biology or physical education is designated, reflecting the misunderstanding that sexuality is primarily about the body. The person selected may or may not show interest and talent. If possible, it is better to allow sexuality educators to identify or select themselves, and even in this case, caution is advised.

It is often assumed that medical personnel such as doctors and nurses are qualified to talk about sexuality, though they have had no special training and may, like others, convey misinformation based on their personal beliefs. For example, an organization invited a doctor to participate in developing lesson content. When the planning group came to masturbation, the doctor insisted that the topic should not be addressed because the practice is harmful and bad. Even though some of the others present knew this to be inaccurate, they agreed to leave the topic out of the curriculum in deference to his authority.

Counterbalancing or challenging advice from so-called experts can be difficult. It is important to remember that although some medical personnel may have good factual knowledge about such topics as anatomy and physiology, the biology of reproduction, or STIs and AIDS, they are not necessarily trained in the behavioral, social, or psychological aspects of sexuality and are subject to the same biases, judgments, feelings, and misinformation as everyone else.

WHAT ABOUT PEER EDUCATION? ISN'T THAT BETTER?

Peer education—that is, supporting young people of approximately the same age and social category to

educate their peers—has gained popularity in southern countries. The assumption is that adolescents communicate better with their peers than adults. IWHC and our colleagues have found that peer education is a potentially useful supplement to a comprehensive program provided by trained, skilled adults—but it should not be a substitute. Adolescents rarely become experts, and they typically lack adults' maturity for handling difficult situations.

Doing a peer education program well is expensive and time-consuming. It requires careful selection of young people who are outgoing, interested in sexuality, open-minded, empathetic, and conscientious; extensive training covering the same areas as any other sexuality education training; a process for qualifying as a peer educator at the end of the training; and extensive supervision and backup by a qualified adult educator at all educational sessions. This last aspect is often neglected.

It is also important to set clear limits with adolescent peer educators about the types of situations they can handle and those they need to refer to adults. Many programs use the term "peer counseling." Peer counseling and peer education are not the same thing and require quite different types of training. A counselor is someone who helps another person work through a problem, often emotional in nature, by listening empathetically and assisting the person to find solutions. An educator is someone who develops the knowledge, skill, or character of another person through teaching. Few, if any, adolescents will be able to counsel others on problems such as unwanted pregnancy, sexual violence, rape, sexual orientation, or depression.

NOW THAT WE'VE GOT YOUR ATTENTION: MEETING RELATED NEEDS

A good sexuality education program generates the demand for other services and referrals, especially personal counseling and health services. Program implementers need to be prepared for these requests. All sexuality educators should have basic skills in counseling to deal with questions and feelings that may result from group discussions. Ideally, in addition, programs should have well-trained and knowledgeable counselors, to whom educators can refer participants. Similarly, programs must be able to respond to adolescents' needs for health services. At a minimum, programs should be able to refer adolescents to existing services in the community. IWHC's colleagues have found, however, that adolescents hesitate to go to services designed for adults, especially family planning clinics, and many have general health concerns or specific needs for STI testing, pregnancy testing, prenatal care or abortion, not met in existing services. IWHC's colleagues therefore work to identify adolescent-friendly providers (often in the private sector) and develop systems for referral. Some provide limited services themselves, but this requires an investment in training beyond the resources of most programs. Action Health Incorporated, for example, provides basic health care at its youth center and refers participants for other services.

When programs refer adolescents for services, they need to carefully screen potential providers to ascertain their experience, skills, and attitudes toward services for adolescents, as well as their willingness to maintain confidentiality. Ideally, they should also be trained in sexuality and counseling to fully understand young people's needs and encourage clients to be open and specific with regard to their needs and activities. Clear mechanisms for referral should be agreed upon with the providers, and in many cases, programs may also need to help young people find the resources for services and medicines. GPI has found, for example, that even if girls receive free or low-cost consultations, they often cannot afford the recommended treatment or medicine.

When an adolescent comes to a clinic, the visit is an opportunity to anticipate and prevent future problems. If the client indicates that he or she is sexually active, the provider needs to discuss pregnancy prevention, condoms and STI/HIV prevention, even if the client comes in for other reasons and does not ask for this information. Given that the majority of HIV infections occur in adolescence and young adulthood and the number is rising (WHO 1989), it is unconscionable for a sexually active adolescent not to be counseled in depth on HIV and encouraged

strongly to use condoms. Clients who are not yet or not currently sexually active should also be educated about pregnancy and STI/HIV prevention and encouraged to visit a service provider before becoming sexually active.

Health services for adolescents need to be specifically tailored to their age and maturity in a variety of ways. If a genital examination is necessary, for example, the reasons and method for doing it should be clearly explained before and during the procedure and the client made to feel comfortable. The means for prevention of STIs and pregnancy need to be made very clear, and clients should be encouraged to think through the specific practical issues involved. In prescribing the contraceptive pill, for example, the provider needs to ask certain specific questions. "Where will you store your pills?" "Who might find them there?" "Will that matter to you?" "Exactly how will you remember to take them?" "What about protection from STIs and HIV?" If clients—male or female—are using condoms for the first time, they should be encouraged to familiarize themselves with their use beforehand and plan how they will introduce and negotiate condom use with their partner. Role-playing is a helpful, concrete technique that can be done in a clinic.

To the extent possible, sexuality education programs should seek information and feedback from the health care providers to whom they refer. For example, young people may raise issues with the service provider that should be added to the curriculum, dealt with in more depth, or approached with a different emphasis. Action Health Incorporated learned that they need to stress personal hygiene more in their educational programs. In addition, by recording the number of clinic clients who had undergone genital cutting, they learned that the prevalence was much higher than they had thought, and they modified their educational program to treat the topic more fully.

Providers of sexual and reproductive health care to adolescents face particular dilemmas of conscience for which there are no simple solutions. For instance, in assisting adolescents with contraception, abortion, or STI treatment and prevention, providers may be required by law, or may feel a need, to balance a commitment to confidentiality (the right of the adolescent) with their sense of obligation to inform parents or obtain parental consent.

In countries where abortion is highly restricted legally, helping a young woman with an unwanted pregnancy is perhaps the most difficult dilemma facing those who work with adolescents. The situation is further complicated by the issue of parental consent. If the girl is willing to tell her parents, then the responsibility for helping her can be shifted to them. But if the girl refuses to inform her parents, what can or should providers do? Good counseling technique dictates that it is not the counselor's role to try to influence her decision or make her change her mind, but rather to help her clarify her options and objectives and think through the consequences of her actions, whatever she decides to do. If a young woman has made up her mind to have an abortion and the clinic refuses to help, she may well turn to an untrained provider or attempt to induce a miscarriage herself. Her health and even her life will be in danger. Program managers and service providers need to grapple with both the risks in their country and their own convictions and consciences to find answers they are comfortable with. Some will provide counseling and perhaps advice or referrals; some will let the girl cope on her own; others will do what they can to ensure her safety; some will also engage with other advocates of reproductive health and rights to develop supportive abortion laws and policies.

WHAT CAN INTERNATIONAL DONORS DO?

Comprehensive sexuality education can be a highly effective strategy for transforming the quality of people's reproductive and sexual health and lives. Adolescents participating in such programs can learn invaluable lessons and skills that apply not only to their current life situations but also to their futures as fully involved members of society.

Sexuality education goes far beyond what we might ordinarily think of as "sex and reproduction" to encompass a broad range of interconnected topics and approaches. It aims not only to inform but to change and empower. It is aimed at individuals, cou-

ples, families, communities, and societies. It is not only for adolescents but for people of all ages. It analyzes the complexities of gender—of socially imposed notions of what is appropriate "male" and "female" behavior—and how gender ideologies may be questioned and transformed. It looks at power relationships and analyzes the effects of unequal resources on people's capacity to negotiate their sexual and reproductive health and rights.

The experiences of groups in Cameroun and Nigeria, with whom the International Women's Health Coalition collaborates, point to the necessity of working carefully to build local capacity and create linkages among sexuality education programs, activists, and health service providers. International donor agencies can help to develop the skills of those involved in local projects, offer reference materials and curricula that can be adapted to local conditions, and provide support for services once programs are in place. They can support and encourage the intensive effort it takes to develop high-quality comprehensive programs. They can provide much-needed moral support and encouragement to those pioneers who have the foresight and courage to provide sexuality education and who may face opposition and attack. They can support and encourage the inclusion of gender and social responsibility in sexuality education programs. They can support public education programs and share the vision of national coverage and expertise. Their efforts will be met with the tremendous enthusiasm and energy that young people bring to the issues that most concern them.

APPENDIX I

ACTION HEALTH INCORPORATED, LAGOS, NIGERIA

Mia MacDonald and Christine Camacho

Action Health Incorporated (AHI) is one of Nigeria's largest and most effective non-governmental organizations (NGOs) working for reproductive and sexual health and rights. Since its founding in 1989 by project director 'Nike Esiet and her husband, Uwem, a medical doctor, Action Health's mandate and programs have evolved to be on the cutting edge of work with young people. Based in Lagos, AHI offers adolescents reproductive and sexual health education and services at its Youth Center and clinic; provides sexuality education to high school students through teenaged peer educators and Health and Life Planning clubs in 33 Lagos schools; and has spearheaded the development of national guidelines for teaching and communicating about adolescent reproductive health and sexuality. AHI's first grant came from the International Women's Health Coalition (IWHC) in 1990.

Listening to Youth

In 1992, AHI opened the Youth Center to meet a gaping need among Lagos youth for a safe place to learn about and discuss issues of sexuality and reproductive health. The center has the freedom to provide innovative educational activities independent of the confines of a school setting.

Each weekday, anywhere from 40 to 100 young people between the ages of 10 and 25 participate in programs at AHI's Youth Center, including video presentations, discussions, and interactive group work on sexuality issues. At least 38 young people visit the clinic each week to get care for a reproductive health problem or discuss and obtain contraception. Some use the well-stocked library, while others, mostly young women who are out of school, attend a vocational class in computer operation. Many of the programs have been designed by the young people themselves; they serve as facilitators and assistants and even produce videos for their peers. All programs run by adult staff have a youth assistant so that skills and confidence are passed on. Many young people come to the center several times a week to meet with other youth and soak up information.

Despite occasional attacks from some parents and government officials who consider it "immoral" to provide sexuality education to young people, AHI continues to focus squarely on facts about young Nigerians' sexuality, including high rates of teenage pregnancy, clandestine abortion, and sexually transmitted diseases (STDs). Its work demonstrates the need for education, services, compassion, honesty, and partnerships with young people to improve their reproductive and sexual health. "I knew from my experience as an adolescent that rather than unilaterally decide what was their best interest, it made sense to first listen to them," says 'Nike Esiet. Since the early days of AHI, Esiet and her staff have been committed to listening. "We would ask, 'How do you want us to work with you? What do you think would work?'," Esiet recalls. "One of the main things young people said was that they would like to get information from other youth: 'Parents talk down to us. We'd like information to come from people as young as ourselves because they tell us the truth.' "

Founding Vision

Formerly a journalist with the respected Nigerian daily *The Guardian*, and public relations officer for SWAAN (Society for Women and AIDS in Africa, Nigeria Chapter), 'NikoneEsiet has become a leader in her country's movement for adolescent reproductive health. Her contacts in the media and abilities as a public speaker help ensure continuing press coverage of AHI's ld, as well as access to policy makers and leaders in the Lagos business and medical communities.

Early in her career at *The Guardian*, Esiet found herself attracted to stories about youth dealing with their reproductive health, usually with little or no support from parents or communities. "I remember the editor of the newspaper asking, 'Isn't there anything more to write about than young girls getting pregnant?'," Esiet recalls. Deciding she wanted to do more to promote adolescent reproductive health, Esiet considered her options. "I had gone through many of the kinds of problems young people face," she says, "and I thought what was really needed was information." The seed was sown for Action Health's founding. The name was chosen to represent its mission: Don't just talk about health; take action. Esiet left her career as a writer in 1991 to work full-time on building AHI into a multifaceted youth-serving organization.

Taking the Lead

Adolescent sexuality remains a contentious topic in Nigeria. A recent survey of urban youth revealed that by the end of their adolescence, 41 percent had had sexual intercourse. Of those, 82 percent of girls and 72 percent of boys had had sexual intercourse by age 19. Fully 62 percent of AIDS cases documented between 1986 and 1995 were among young women aged 15 to 29. Teen pregnancy is common, as is unsafe abortion; over 80 percent of women admitted to Nigerian hospitals for treatment of abortion-related complications are under 20 years. Unfortunately, many parents, policy makers, and school administrators prefer to ignore these facts, while some even attack NGOs like AHI who are trying to help adolescents make informed choices and get the information and services they need.

On one occasion, AHI was "banned" from working in schools, accused by conservative school officials of promoting promiscuity and "corrupting" adolescents. They were reinstated; and in the process, they were able to develop their advocacy skills. Esiet's strategy has been to undertake public education and outreach to the media to make better known the facts about young Nigerians' sexuality and put AHI's work in perspective. Sexuality education, Esiet argues, reduces misinformation and confusion among adolescents, delays premature sexual intercourse, and enhances safer-sex practices among teenagers who are already sexually active.

In 1996, AHI began to train others: with a grant from IWHC, it coordinated a two-week session in sexuality education for 20 women and men from six Nigerian NGOs. AHI continues to conduct sexuality programs for selected NGOs; to date it has trained over 60 participants. In collaboration with SIECUS (Sexuality Information and Education Council of the United States), AHI also initiated the development of written guidelines for comprehensive sexuality education in Nigeria. The guidelines, produced by 20 organizations, helped solidify AHI's alliances and develop common ground with other NGOs and key actors in Nigeria. They offer a detailed framework for sexuality education programs for school-age youth, as well as for parents and communities. More than 70 national organizations have endorsed the guidelines, which have been well received by local and federal ministries of education. AHI launched an effort to get the guidelines integrated into school curricula in Lagos state, the expectation being that if Lagos state takes the lead, other states will join in. In this effort, AHI sought the support of multiple stakeholders, including the press, community organizations (market women, transport workers, Girl Guides), school principals, and key policy makers in national and local government. Today these guidelines are a point of reference for discussions at the national level.

With generous funding from the Ford Foundation and the John D. and Catherine T. MacArthur Foundation, AHI, in collaboration with others, has played a pivotal role in cultivating and coordinating a new adolescent reproductive health constituency in Nigeria. In January 1999, AHI served as the secretariat for the first Nigerian National Conference on Adolescent Reproductive Health. The conference convened over 350 participants—youth as well as adults—from various government ministries and NGOs to produce a strategic framework for implementing a national policy on adolescent health. Building on this success, AHI was asked to participate in a working group convened by the ministry of education to develop a national curriculum on sexuality education. Presently, AHI, with input from a

nationally representative review committee made up of governmental representatives and private individuals from six geopolitical zones, is working on developing a curriculum.

"Body Awareness" and Other Activities

Action Health's offices, Youth Center, and clinic occupy a large building behind a high fence brightly painted with scenes of young people taking action in their lives: discussing a teen pregnancy, working on computers, educating friends about sexuality. Across the dusty street, a vendor sells fruits and drinks from a small stall, chickens walk free, and cars and trucks rumble along a major highway. Behind the AHI gates and beyond a courtyard, nearly 100 young people are engaged in discussion. Downstairs, a group of 40 adolescent boys and girls are taking part in a "playback" session. They watch a video and then discuss the issues it raises, including teen pregnancy, HIV/AIDS infection, and STDs. Although formal in their attire—the boys in dark trousers and light shirts, the girls in dark skirts and white shirts—they are unrestrained in their participation. A youth facilitator is in charge and an adult assists.

Upstairs, in an airy but crowded hall, a "body awareness" session is underway. About 80 teenage boys and girls crowd the rows. In seven minutes, the adult facilitator has covered "curiosity," unsafe abortion, STDs, AIDS, and the childbirth complications that often afflict and sometimes kill teenagers. The format is interactive: the facilitator does not give answers, but asks the young people to reply. Both the boys and girls are articulate in their responses and surprisingly well-informed. They talk about the need for good communication skills, the ability to say no—"capital NO" when necessary—appropriate dress, behavior on dates, and the dangers of drugs and alcohol.

Model Services

In 1993, in another attempt to meet young people's self-defined needs, AHI launched a reproductive health clinic. "If that's what young people need, then we had better just start doing it," Esiet recalls saying. The larger goal is to create a model of how to provide reproductive health services to adolescents—a model that could be replicated by the government or donors. The clinic got off to a slow start; it was plagued by the lack of medical personnel with the right orientation to provide reproductive health services to adolescents. The result: low client patronage. Now, after much reorganization, the clinic is thriving and even oversubscribed many afternoons. A young female doctor, a nurse-midwife, a laboratory technician, and a youth assistant provide a range of services: counseling and individualized education, testing, and treatment or referral for general health concerns, sexual health, birth control, pregnancy, pregnancy options, reproductive tract infections (RTIs) and AIDS, and sexual violence. Consultation and counseling are free; diagnostic tests, prescription drugs, and contraceptives are slightly above AHI cost, but below commercial rates.

The clinic space is bright and airy, and the staff welcoming. Young people are asked for their feedback on how to improve services and the service delivery environment. Clients range from 10 to 22 years of age. Twenty-six percent of young men and women say they are sexually active. Clinic records show high rates of unprotected sex, significant incidence of reproductive tract infections (RTIs), and poor personal and sexual hygiene. The clinic focuses on increasing its young clients' knowledge of reproductive health.

The clinic is innovative in Nigeria, and elsewhere, for the comprehensive nature of its services. It provides counseling for sexual health concerns, services for rape and sexual abuse, and counseling around unwanted pregnancy, services that most family planning clinics in Nigeria and other developing countries would not think of offering. The clinic is, in essence, operationalizing the *Programme of Action* agreed to at the 1994 International Conference on Population and Development (ICPD) in Cairo. "We are helping make Cairo a reality," Esiet says, "by providing services, providing information, and empowering young people to be able to take charge of their lives in ways they otherwise wouldn't."

"A Long Way"

Since 1989, AHI has grown from an idea into a very tangible reality. In the coming years, its work and reach will continue to grow and evolve in line with the needs of adolescents and in close partnership with the youth it serves. When Esiet first began full-time work on AHI, one of her first projects was a series of seminars for parents, teachers, and young people, supported by a grant from IWHC. The main focus of the seminars was preventing teen pregnancy, and the message "Just say no" was central. Summing up, Esiet declares: "We've come a long way."

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APPENDIX II

GIRLS' POWER INITIATIVE, CALABAR, NIGERIA

Mia MacDonald and Christine Camacho

It is 4 p.m. on a quiet Sunday afternoon in the green, tranquil city of Calabar, Nigeria. Just down the road across the street from a local bakery, 200 teenage girls are "checking in" with their peers in the Girls' Power Initiative (GPI). In what has become a Sunday afternoon ritual, these young women are sharing experiences from the past week.

"I'm feeling fine because I was healthy during the week," reports one young woman named Josephine. She goes on to say that her sister recently said that girls who wear short skirts are "calling for rape." How did Josephine react to this statement? "I set my sister straight. Rape is violence and boys will rape no matter what is worn. What about boys who wear short shorts?" When she finishes speaking, the others cheer and clap, and another girl stands to tell her story.

So begins another remarkable meeting of GPI, a program launched in 1993 to build the self-esteem of young Nigerian women by giving them information about reproductive health and rights—and by teaching them to speak up about what they want or don't want when it comes to sex. To this end, GPI runs the Sunday program, holds public workshops, and organizes activities based on the GPI curriculum in several schools in Calabar, a city of 500,000 located about 50 kilometers from the Cameroun border in southeast Nigeria. GPI also operates a program in Benin City in the southwestern part of the country. As many as 1,450 young women, ages 10 to 18, are GPI members; 300 more attend intensive GPI programs during school holidays; and thousands have access to GPI's unique blend of information and empowerment through a quarterly newsletter that is entitled *Girls' Power*.

The Nigerian Context

What makes GPI extraordinary is the fact that it exists at all in Nigeria, where the vast majority of young women are trained to be subservient to their parents, their brothers, and their husbands. Although the number of Nigerian women professionals is increasing, and women have greater access to higher education and senior positions in academia, law, and some private companies, the traditional Nigerian girl's upbringing of submission and acceptance persists throughout the country. It is especially strong in the country's vast rural areas. GPI's commitment to frank discussions about reproduction, women's health and rights, domestic violence, and male-female relationships is highly unusual, and even controversial. The group has, on occasion, been accused of corrupting young women, encouraging them to be sexually active, or making them "too bold" to find good husbands.

"If you ask girls, 'What is your name?' their head is down," says GPI founder and co-coordinator Dr. Bene E. Madunagu, a highly respected international advocate for women's reproductive and sexual health and rights. "When you ask the girls, 'What rights do you have as a human being?' the girls almost always are blank, or they say, 'A right to live, to eat well, to education.' No one thinks about the right to their health, especially girls."

According to Dr. Madunagu, who heads the program in Calabar, GPI works to provide girls with critical information they otherwise wouldn't have, and then, as the name indicates, helps them develop skills to make their own informed decisions about their health and lives. The larger goal is to help these young women gain the self-confidence and self-knowledge to attain their potential in education, careers, motherhood, and relationships. "We don't teach, we share," Madunagu says. "They have the power to take their life into their own hands through information. The information is powerful."

GPI's Beginnings

Madunagu founded GPI in 1993 in partnership with Grace Osakue, a school administrator in Benin City who is, like Dr. Madunagu, a national and international advocate for women's health and rights. They started with an idea and a strong vision. "We wanted to catch the girls when they are young, teach them differently, socialize them differently, give them different information—factual information—in a nonjudgmental way," says Madunagu.

GPI's goal is to start from where these girls are and "make them look beyond: 'Must it always be like this? Could it be different? What could be different? What can we do to make it different?' "

Working with a handful of colleagues, Madunagu gathered a group of nine adolescent girls together, including her own daughter, now 17, for the first Girls' Power Initiative meeting in July 1994 in Calabar. "The nine girls went back to tell their friends, and we continued increasing," Madunagu recalls. In the southwest, Grace Osakue, who started with seven girls, has also seen substantial and sustained growth in the program.

IWHC's Catalytic Role

The International Women's Health Coalition (IWHC) has played a key role in GPI's development ever since the idea for it was first conceived. IWHC gave GPI its first seed grant and immediately furnished technical assistance. Andrea Irvin, IWHC's former Africa Program Officer, provided Dr. Madunagu with strategic advice on program design; just as important, she provided the founders with a sounding board. "There was so much encouragement from Andrea for GPI," says Madunagu. "In fact, Andrea's critique of my reports, the questions that she raises on my proposals—these are the things that help to sharpen my thoughts and give me a clearer vision of GPI's mission."

Another critical component of IWHC support is furnishing factual, scientific, and advocacy materials on women's health and rights—information that is not available in Nigeria and most other parts of Africa. This literature has been vital to both GPI facilitators and the girls who attend the gatherings and take part in the classroom curricula. With IWHC materials, says Madunagu, "We feel that we are just on top of the world."

Seizing Public Attention

Over the past years, young women from GPI have held public education events on violence against women, AIDS, and women's rights; they even staged a dramatic production called "Sex Is Not Love." Although opposition to these events has been minimal, Madunagu says that all public activities are introduced with the following statement: "GPI is just making a little contribution to what our government agreed to at recent world conferences in Cairo and Beijing." This reassures parents that the government knows about these things, she explains. In fact, federal and state libraries get *Girls' Power* and even ask for extra copies. In addition, GPI has also tested its sexuality education curriculum for use in school settings and is implementing an intensive program on an experimental basis during vacation periods in a number of outreach schools. GPI has also developed popular education materials for the general public on violence, empowerment, and self-esteem. It has been instrumental in fostering critical debates on adolescents' sexual and reproductive rights and health among parents, educators, and state-level government officials.

As the program expands and moves into new areas, GPI is testing approaches for sharing its vision and expertise with other organizations. The goal is to foster leadership and capacity-building among African colleagues and NGOs interested in the GPI philosophy and methodology. Currently, GPI serves as a training resource on gender and adolescent reproductive and sexual health for other interested organizations. It conducted a workshop for leaders in other organizations and published the *GPI Training Manual*, which provides guidelines for those interested in implementing similar programs. Because the program has expanded significantly, GPI has recently moved to larger facilities.

Young women around Nigeria read *Girls' Power* and write to Madunagu for advice and answers to their

questions. Responding to the mounting volume of correspondence keeps her up late many nights, but Madunagu says it is worth it if she can help girls see and live their lives differently. One letter came from a girl who lives in Lagos, Nigeria's largest city, but who had gone to GPI Sunday meetings while on vacation with her family in Calabar. The girl was subsequently the victim of a gang rape by teenage boys in a school library. Her family is mostly men, she wrote, so she didn't feel she could talk to anyone about the rape. On a trip to Lagos, Madunagu went to see the girl, counseled her not to feel shame over the rape, and urged her to report it to the legal authorities—something most women are reluctant to do since rape cases are heard in open courts and often bring blame and scorn to victims. GPI is now working with the Nigerian Women Lawyers' Association to get rape hearings and trials moved to the privacy of judges' chambers.

The Bigger Picture

GPI's greater goal is to encourage a new generation of strong, aware young Nigerian women to take their destinies into their own hands and, in the long term, change the lives and perceived roles of women—and men—in their country. "We are raising girls who will begin to think differently on gender issues," Madunagu says. "This is the nucleus of a collection of feminists who can address the issues in more concrete ways. GPI will be the training ground for this."

Regarding GPI's remarkable growth, Madunagu says: "I think I was quite voracious in my idea, and it paid off." Each Sunday, more and more girls arrive at GPI's suite of green offices, located in a quiet lane off a busy street. Some are as young as 8, often sisters of older girls in the program, who learn age-appropriate lessons about self-esteem and reproductive health.

Madunagu would eventually like to make Girls' Power Initiative a national program, but funding constraints and the difficulty of finding and training staff, including those who are not judgmental about adolescents, make this a long-term goal. Still, she has found ways to spread the word about women's health and rights to broader audiences. GPI's school program is expanding, and it could be in as many as 15 schools by year's end. At a meeting between GPI staff and school principals, the program's expansion was strongly urged by both school officials and parents.

Empowerment in Action

At the Sunday GPI meeting, Josephine's tale of the disagreement she and her sister had about what causes rape has led to a group discussion among the young women, moderated by Eka Bassey, one of GPI's adult facilitators. Bassey asks for definitions of rape and why men rape. One young woman says that it is not about what girls wear. Bassey asks the others whether they support or oppose this idea. Ruth opposes. "A girl should be cautious and dress modestly," she says. Eka discusses the need to be aware of appropriate dress. "Consider where you are going," she suggests, "but ways of dressing should not lead to rape." Bassey adds that young women do need to protect themselves from being harassed and avoid potentially dangerous situations. As Madunagu warns, "In Nigeria, we have a saying: 'No bottle of Coke is free.' "

The GPI curriculum defines rape as a nonconsenting sexual act, no matter whether it is with a boyfriend or involves "sweet talk." GPI training on rape prevention includes practical tips on how to prepare for dates: don't take short cuts that lead into alleys or dark, desolate places; share expenses on dates; and perhaps most important, don't feel that you have to have sex with your boyfriend to prove you love him. GPI feels that the exhortation to "just say no" is insufficient; the girls are given factual information on sex and sexuality, including contraception, so they can make choices for themselves, Madunagu says. Some delay sexual activity, while some start it. "They don't abstain from sex because we told them to abstain," she says, "but because they have the information."

Madunagu tells the story of a GPI girl who went to the chemist's shop to buy condoms. The man behind the counter said he wouldn't sell them to anyone "underage," and when the girl asked what underage was, he said, "Thirty." "You don't know that I'm not over 30," she asserted, "and I will have the condoms." He sold her the condoms. A young woman expressing such confidence and determination about

so intimate a topic is, Madunagu submits, "like something out of the blue—something you would never think of in our society."

The Truth about True Love

This particular Sunday falls just before Valentine's Day, which is increasingly celebrated in Nigeria. Roadside vendors sell elaborate cards that cost half a day's pay. After checking in, the young women, and another group of 50 Girls' Power Initiative girls ages 10 to 14, explore what true love is. From group work and interactive games, they come up with this definition: devotion, sacrifice, not expecting too much, caring, understanding mistakes, accepting faults, sex that is nonabusive, affection, talking matters over, and settling misunderstandings.

Eka Bassey begins another discussion. "What is the test of true love?" she asks the young women. "Do you talk about things? Does he listen to you? Do you talk about how you feel? Does he say, 'That's your GPI talk' when you discuss protection from pregnancy and disease?" In what is surely as rare an occurrence in the United States as it is in this quiet corner of Nigeria, the young women then share their ideas about intimacy, trust, abuse, and respect for their own and their partner's freedom. The group concludes that "real love takes time."

The true measure of a program like GPI is, of course, the changes that have taken place in the girls themselves. Many of the teenage girls now speak with either a quiet or a more robust confidence; those who are shy at first gain strength from the encouragement of their peers. Some of the younger girls are quite withdrawn, but GPI facilitators employ inventive ways—interactive dialogues, games, and group work—to draw them out, making them feel that their ideas and opinions matter. Madunagu plans to undertake a full-scale evaluation of the GPI program in the coming year, but the evidence so far is that the program is launching a peaceful, but potentially powerful, revolution.

After the meeting, facilitators ask their groups what they have learned. This Sunday, one girl, about 12 years old, answers, "The difference between love and infatuation." An older GPI girl says she was asked by a teenage boy to be friends, and she asked, "What kind of friendship?" Surprised, he answered, "You know, girlfriend, boyfriend, sex." She replied, "If that's the kind of friendship, I am not ready for it." Boys, including this one, often ask: "Why do GPI girls ask all those questions?"

Building Girls' Self-Esteem

Madunagu's overarching goal remains unshaken: the political and social empowerment of Nigerian women, who "will not wait to be nominated to be a commissioner, but who will on their own recognition achieve what it is they have envisioned to achieve." With Nigeria's youngest generation, on a quiet street in a quiet city, such empowerment is becoming raucously real. "Girls now go beyond just saying, 'Oh, I want to be a nurse; oh, I want to be a teacher,' " Madunagu reports, "to saying, 'oh, I'm very good in physics, chemistry, math, so I think I want to do medicine, or be an engineer.' "

On the terrace outside of GPI's offices, the Sunday meeting is wrapping up. Facilitators tell the teenage group and the younger girls that they have learned a lot from them, and ask for feedback about what they as facilitators could do better. Before lining up to receive their transport allowance—an important part of the program that allows poorer girls to participate—each group joins in the three verses of the "Women's Decade" anthem, "Equality, Development and Peace," by Carole Etzler. Rising from the green rooms above the verdant city, the girls' voices are strong and hopeful.

All across the nation,
All around the world
Women are longing to be free.

No longer in the shadows,
Forced to stay behind,
But side-by-side in true equality.

So sing a song for women everywhere.
Let it ring around the world and never, never cease.

So sing a song for women everywhere:
Equality, development and peace.

APPENDIX III

CONSCIENTIZING NIGERIAN MALE ADOLESCENTS, CALABAR, NIGERIA

Mia MacDonald and Christine Camacho

The Conscientizing Nigerian Male Adolescents (CMA) program was launched in 1995 to educate adolescent Nigerian boys ages 14 to 20 to develop a critical consciousness and reject existing sexist prejudices and practices. CMA was launched with a grant from the International Women's Health Coalition. Based in the city of Calabar near the Cameroun border, CMA is unique in West Africa and, most likely, further afield. The program is built around an intensive curriculum that covers Nigerian society, women's roles and family structures, sexuality, reproductive health and rights, and violence against women; boys can also receive confidential counseling. CMA's founder, Dr. Edwin Madunagu, a journalist, scholar, teacher, and social theorist, is a nationally known and respected political activist. Madunagu's long-term goal is to create a movement of progressive men who will work as allies with Nigeria's feminist movement to build a society based on gender equality. "The program is not just another program," he says. "It has to do with an ideological—a political—vision, a commitment to and passion for change, and faith in the possibility of change."

The Ability to Question and Analyze

CMA began with 25 boys drawn from three Calabar secondary schools and a cross section of the community. They attended a rigorous nine-month afterschool program, meeting weekly to discuss and debate and to learn new ways of thinking and behaving. For most, it was their first exposure to ideas of gender equality, human rights, reproductive health and rights, and realities like violence against women. A dialogical method of teaching is used, with adult facilitators guiding the boys in examinations of their own ideas, ideals, and prejudices. This style of imparting information, which involves developing a critical ability to think independently and to analyze, is based on the work of Paolo Freire and Simone de Beauvoir, as well as Madunagu's own work as a teacher and social theorist. The curriculum seeks to highlight the experiences of five marginalized populations in Nigerian society: women, workers, peasants, minorities, and youth.

In CMA's fourth year, 100 adolescent boys are participating in the two-year program. The boys meet weekly in groups of 15 to 25 for 12 months. During the second year, they have monthly meetings to reinforce what they have learned—an adjustment made after evaluating the success and shortcomings of the first year of the program. Most recently, a practicum has been added to the program—that is, a supervised peer education experience designed to develop a core group of strong community activists. Participants serve as educators and mediators in their communities, intervening, for example, in cases of violence and the oppression of women. The newly revised curriculum places emphasis on core CMA concepts, including sexism in the family and society, sexuality and reproductive health and rights issues, and violence against women. Madunagu and staff are determined that active and continuous involvement with CMA will also help strengthen the boys' resolve in the face of the criticism, mockery, and disbelief many experience with families, peers, and teachers. "It's too early to allow them to melt back into society," says Madunagu. "They could get drowned once more."

In addition, CMA has also expanded its program beyond the center. CMA has established an outreach program in five secondary schools in Uyo, a neighboring town in Ibom state. To date, 150 adolescent males have benefited from the one-year outreach program. Staff are also working in tertiary institutions in Calabar, focusing on 20 young men who are currently active leaders on their campuses. The program covers the same material in greater depth, emphasizing issues of violence against women, including sexual harassment and rape. Finally, in

order to facilitate sharing, staff are finalizing CMA's training manual, which will serve as a curriculum guide and reference manual for other youth development specialists interested in adolescent male programs.

Male Responsibility in Sexual Relations and Love

Conscientizing Male Adolescents is housed in the Center for Research, Information and Documentation (CENTRID), an NGO Madunagu set up in 1990. CENTRID and CMA occupy a suite of second-floor offices off a busy street in Calabar, a quiet city of 500,000 residents surrounded by water and thick trees. The focal point of the CENTRID office, and a critical resource for the CMA program, is an extensive library. Ten big bookcases hold the complete works of Lenin and Marx, novels, books on African and Nigerian history, several works by Ken Saro-Wiwa, Wole Soyinka, and Ben Okri, *Roots, Presumed Innocent*, the *Satanic Verses* (shelved next to the *Koran*), and sections on human rights, women, gender studies, and reproductive health.

On a recent afternoon, nearly 50 boys had assembled in a large, crowded room in the CENTRID office to discuss sexual relations and love, and male responsibility in each. The boys are quite formally dressed in the uniform of Nigerian schools: white button-down shirts and dark blue trousers. Eka Bassey is the facilitator. As the discussion proceeds, the boys are in turn playful and earnest and do not seem put off by two female visitors or a female facilitator. Bassey puts forward a series of hypotheses, which the boys then discuss and debate. The first, "spontaneous sex is better" elicits murmurs of "Yes." One boy says, "When I see food, I like to eat it," which is greeted by the laughter of his peers. Another boy, in reply, raises the risk of sexually transmitted diseases, including HIV/AIDS. Bassey spurs further reflection by asking, "What about pregnancy?" and says it is important to plan for sex and to know a person's sexual history.

Next proposition: "If you love your partner, do you show that love through sex?" The boys are engaged: "No, you show it through caring and talking," says one boy. Another: "Sex can lead to the dissolution of the relationship. You need to know your partner's feelings and needs." A third: "Express yourself, but keep the friendship."

Meanwhile, in the library, 10 boys who were members of the pilot program are preparing for CMA's quarterly public workshop, this one entitled "Cultural Impediments to Gender Equality." Each has prepared a paper for discussion; they will write a group paper to present at the workshop. A 19-year-old wearing a Blockbuster Video T-shirt reads from what he has written: "As good males and females move into the transition . . . we must separate maleness from dominance and femaleness from subordination. Arise and end gender equality in our society and in the world."

CMA Origins

For more than 25 years, Madunagu has been a campaigner for political rights and a student and theorist of socialism. While studying at the University of Lagos, he cofounded the Anti-Poverty Movement of Nigeria. For several years, he taught mathematics at the University of Calabar. After determining that he could not combine an academic career with political activism, he joined *The Guardian*, a Lagos-based daily newspaper with a liberal perspective, as a columnist, editor, and member of the editorial board. He left when Nigeria's military regime shut the paper down in 1994.

Madunagu returned to Calabar and began turning his mind to other possibilities and venues for social transformation, among them the concepts that led to the Conscientizing Male Adolescents program. He discussed them with his wife, Bene, coordinator of the Girls' Power Initiative, and later with Andrea Irvin, IWHC's former Program Officer for Africa. "I thought it was a theoretical discussion, and I suffered a lot of inertia. . . . We have done so much in this country . . . we have no less than five manifestos, five political parties, and files and files of programs."

Irvin persevered, and encouraged Madunagu to write a framework for the CMA program and develop a curriculum. In 1995, the program was launched. CMA, Madunagu says, would not have gotten off the ground without Irvin's insight and encouragement and IWHC's funding. Madunagu himself undertakes some of the teaching and facilitating, which he loves, and sees CMA as a small-scale enactment of his larger vision: "This conscientization is very, very funda-

mental: mobilization from the roots. This is like going back to the fundamentals, to the work we started in 1973 with the Anti-Poverty Movement of Nigeria."

Process and Evaluation

While it is difficult to evaluate CMA's impact on the development of antisexist attitudes and critical thinking abilities among the boys, Madunagu and his staff see evidence that CMA is bringing about some significant changes. At the end of their nine-month experience, CMA's initial 25 participants held a public workshop where they presented papers on themes they had covered in the program. Journalists were invited to attend, and afterward, the boys held a press conference at which they effectively—and aggressively—defended their antisexist positions. Many of the boys will now also conduct debates with their parents, highly unusual behavior in a society in which elders are still treated with great reverence.

Other boys have shown new openness to participating in housework, normally the province of their mothers and sisters. One was even scolded by his mother for his help: it seemed that he brought in laundry hanging outside to dry, much of it his mother's underwear. The boys are also less domineering in their interactions with girls, both inside and outside of the family. One place where they have made less progress is in challenging the facts or attitudes of teachers and other school officials. This will take time; Madunagu says that students are still regularly expelled for even appearing to question school authority. There have, of course, been objections from some parents—mostly middle class—to their son's participation in such an unorthodox program. Others, though, encourage participation.

What has surprised Madunagu and his staff most about CMA's two years of operation is the lack of cynicism from the community about such an undertaking, and the rapid development of the first group of participants. "We are not preparing souls for heaven or candidates to go to paradise," Madunagu says. "We want quantifiable development, we want identifiable changes to take place for the transformation of this society, and therefore transformation of the human beings in this society."

Reaching More

In CMA's next phase, several new initiatives will become part of the program, with the goal of "maximizing and extending its benefits," Madunagu says. Staff will undertake outreach to postprimary and secondary schools in Calabar and an adjoining state with the goal of launching in-school CMA discussion groups. CMA's newsletter, *The Male Adolescent*, will be distributed in schools that are amenable. Five schools will be selected for follow-up visits to assess the impact of the newsletter on male students. Initial feedback from teachers has been very positive. Some schools request more copies; in one, though, a librarian screamed "Get out" and called a security guard to expel a CMA staffer. School principals who do not find the program too controversial will be invited to attend CMA's quarterly workshops and then recommend boys for participation.

In future, Madunagu sees operating full-fledged CMA programs in two or three other locations and CMA being part of a larger effort, joined perhaps to a regional or national network; however, he does not want the program to grow so large that the Nigerian state sees it as a threat, and attempts to silence the work. "Ultimately I want CMA to be linked up with a larger attempt to change this society," Madunagu says, "but not in the short run. . . . It is only then that it will bring about any qualitative difference. I want CMA to be viewed as an element in the process of transforming our society. . . . It is now generally accepted by the women's movement in particular and by the progressive democratic movement in general, that the social transformation necessary to free women from domination, exploitation, oppression, abuse, and indignity requires the efforts not only of women but also of men." Madunagu also sees a future alliance between CMA and the Girls' Power Initiative, which is working to develop the self-esteem of young Nigerian women by increasing their knowledge of their reproductive health, reproductive rights, and human rights. "Both organizations will have benefited from the experience, and our own new thinking and new vision and new perspective. . . . At a certain level of organization of those who are oppressed, an alliance must take place; this joint work must take place."

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