Adolescent Sexual and Reproductive Health and Rights

In collaboration with Indian Association for Adolescent Health, SLJK Health & Research Foundation and Department of Community Medicine, Vardhman Mahavir Medical College and Safdarjung Hospital

Program period: July 2019 to August 2019

Location: New Delhi

Beyond Eye

About Beyond Eye

Beyond Eye is a youth-led, Indian non-profit trust founded in the year 2018. It seeks to go delve deeper into issues, attempting to reveal their complex realities. Beyond Eye creates an experience for adolescents, youth, and women by facilitating them in realizing their potential through holistic development and increased awareness. The trust is founded by professionals with experience in the development sector to promote leadership and active citizenship in adolescents, youth and women. Beyond Eye is currently operational in Uttarakhand, Delhi, Haryana, and Rajasthan.

The main focus areas of this organization are:

1. Education;
2. Environment;
3. Health; and
4. Livelihood generation training

It works extensively with and for adolescents and youth on the issues of sexual and reproductive health and rights.

Our partners in this program

Indian Association for Adolescent Health ("IAAH")

IAAH was founded in 1987 contemporary to the Australian and Canadian adolescent organizations. It is a non-governmental organization with the aim of developing programs and activities to meet the healthcare requirements of adolescents across India. The founding members, while drawing the charter at a meeting in 1991, decided to include youth health care as one of their goals as it was being continuously challenged at the time by emerging diseases like HIV/AIDS, hypertension, diabetes, obesity and mental disorders. The long term goal of the organization is to fasten the development of effective national network chapters for the promotion of adolescent and youth health.

SLJK Health & Research Foundation ("SLJK")

Dr. SL and Dr. JK Health & Research Foundation is a registered public trust with the aim of promoting health, education, socio-economic development, social welfare, and research focusing on the vulnerable groups of society. It also focusses on improvement and protection of the environment. In short, the aim is a rational and scientific development of the human being. Keeping in mind the dismal state of health in the nation, SLJK aims to develop new approaches and strategies to make health one of the top priorities of development.

Overview & Context

Between July and August 2019, Beyond Eye conducted a series of workshops on issues relating to adolescent reproductive and sexual health with young doctors at the Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi ("VMMC"). The participants were either medical interns or post-graduate students, ranging between the ages of 21 and 29. There were a total of 8 workshops with 41 participants conducted in this period. The sessions were conducted by members of Beyond Eye, faculty from VMMC and external facilitators from organizations such as *Nazariya*.

The conception of this program finds its roots in the challenges faced by the youth in India. Often, the issues faced by this section of the population is overlooked, especially when it comes to their inability to access essential services, both in an urban and rural settings, across the country. As per the National Youth Policy, 2014, "**youth**" is defined as those in the age group of **15-29 years**. **27.5%** of the Indian population falls under this category. The youth face a lot of challenges which is compounded by their heterogeneity as a group and the diverse cultural backgrounds they come from. These challenges include lack of knowledge or access to important sexual and reproductive health ("SRH") information, a lack of agency and decision making power, restrictive gender norms, a prevalence of child marriage, teen pregnancy, restricted access to services and affordable contraception and a prevalence of gender-based violence, among many others.

Given these cultural barriers, an astounding **75% of youth remain poorly informed and in some cases completely unaware of their sexual and reproductive health and rights.** Unfortunately, social stigma limits the youths' knowledge of SRH issues. Parents, teachers, health service providers and other gatekeepers are largely unwilling to have an open and non-judgmental conversation with the youth under their care about sex, because of the taboo surrounding such issues.

In India, **less than 1% of youth reported that a parent had discussed reproductive processes with them**. At the same time, the introduction of health education in schools is controversial. For example, **the Adolescence Education Programme (AEP) that championed Comprehensive Sexuality Education (CSE) within schools was banned in six states as soon as it was introduced in 2007.** This vacuum of safe and trusted sources of information often results in youth acquiring information about sex from unreliable and often inaccurate sources such as pornography, the internet, mainstream media, television serials and movies. As a result, the youth subscribe to misleading notions of sex, sexuality, consent, relationships, gender norms, body image and pubescent changes. Pressing issues such as contraception, child sexual abuse, intimate partner violence and risks of early pregnancy are not discussed leaving the youth with several misconceptions about sex that severely impact their sexual and reproductive health.

These issues are also compounded by the inaccessibility and often, paucity of professional willingness and help. Lack of privacy in government hospitals is often a barrier for the youth to

be open about their problems in front of doctors. The doctors' assistants and other non-medical staff often decide and discuss the young patient's issues conversationally and nonchalantly during the consultation. The judgmental attitude and lack of privacy make the young patient feel extremely uncomfortable resulting in their reluctance to ever come back for a consultation. **It is the health service provider's judgmental attitude and imposition/display of moral values that affect the quality of services they provide to young patients.** The government has decided to make Adolescent Friendly Health Clinics ("AFHC") for easy accessibility of young patients. However, due to huge rush and non-compliance, the AFHCs are not being set up and operated as per the norms.

Therefore, it was realized that it is imperative to spark a conversation in this gap that exists between adolescents and medical practitioners. For this to come to fruition, the intervention was sought to be made at a stage when the doctors are still under training at their respective medical colleges, at whatever stage. Through exposing these young doctors to discussions on gender, sexuality, contraceptive choices and abortion rights, among many other topics, an understanding of human rights was sought to be imparted as these issues form the base of SRHR itself. Experientially, it has been realized that whenever such interventions have been made in the past, such issues have hardly been touched upon. Moreover, to borrow a quote from one of the participants from the program, *"the questions/lack of knowledge/prejudices amongst the doctors/medical community is not only because of innate misunderstandings/ biases but also because of their medical education "*. Hence, there exists an actual gap between what adolescents expect from doctors and what their training has been and this is what this program eventually seeks to do: bridge this gap. By training young doctors on the issue of adolescent SRHR, the capacities of these young doctors are sought to be built so that they can deal with adolescent related SRH issues enabling them to tailor their interventions accordingly.

Objective(s)

Beyond Eye's workshops under this program are intended to realize the following aims:

1. Generate conversation and discussion amongst the participants on issues of human rights, gender, sexuality, choices and safe spaces for adolescents;
2. Stress on the importance of the provision of a non-judgmental space to adolescents for them to be uninhibited when seeking services;
3. Expose the participants to the consequences adolescents face due to the lack of such spaces;
4. Through partnering with other organizations, educate the participants on issues which typically don't form a part of their medical curriculum (such as sexuality, SRHR, gender, choices and abortion rights); and
5. Eventually, leave an impact on their thought process concerning these issues so that it has a manifestation in the manner of them providing adolescent-friendly SRH services in their medical practice in the future.

Methodology

Partnership

Beyond Eye partnered with the following institutions/organizations for carrying out the program:

1. Indian Association for Adolescent Health;
2. SLJK Research and Health Foundation;
3. Community Medicine Department, Vardhman Mahavir Medical College & Safdarjung Hospital, New Delhi; and
4. Nazariya - A Queer Feminist Resource Group

Workshop model

The program was conducted over 8 weeks, with one session (2 hours) per week commencing from July 4, 2019. The topics covered in each session are stated in brief below:

1. *Understanding Adolescent Sexual and Reproductive Health Issues*
   This session involved coming to terms with the participants' understanding of SRHR, phases in and changes during adolescence and the possible strategies for adolescents who approach doctors with peculiar sexual health issues. The participants were involved in a team-based exercise where they were required to identify root causes, consequences and possibly solutions to a problem presented in a case study involving adolescents.

2. *Significance of Core Values in Life and Practice; Sexuality*
   This session involved the participants discussing the value they consider the most important in their practice as well their personal lives; the importance of certain core values (choice, respect, equality, dignity and diversity) was stressed using case studies. There was also a discussion by Prof. (Dr.) Prema Bali on sexuality, stressing on the importance of having a comprehensive understanding of adolescents' sexuality when they come seeking help.

3. *Sexuality; What is Normal; LGBT*QIA+ Issues*
   This session was conducted by *Nazariya* (a queer feminist resource group), led by Ritambhara and Rituparna. It touched upon and discussed issues relating to normality, gender and perception of gender, sexual identities (specifically transgender and intersex) and sexual norms.

4. *Gender: Problem and Solution. Role of Medical Science, Planetary Humanity and Religion*
   This session concentrated on notions and/or perceptions of gender, especially the female gender. The role of religion in reinforcing gender stereotypes, setting standards of feminine behaviour and beauty and normalizing inherently misogynistic practices was discussed. Statistics for gender-based violence, possible reasons for the vulnerability of women and measures to address these problems in the future were also discussed. The role of doctors in not perpetuating such stereotypes/biases in their practice was stressed upon.

5. *Adolescent Contraceptive Counselling*
   This session concentrated on the barriers to and facilitators of contraceptive usage and the role of medical practitioners as contraceptive consultants. The participants were made to enlist the working, advantages and disadvantages of different contraceptive methods by using case studies, in a team-based exercise.

6. *Contraception & Choices; Adoption Rights*
   This session concentrated on the attitude of doctors towards patients who come to avail contraceptives. The participants were involved in a role-playing exercise where they were required to provide choices to adolescent men and women on contraceptives. Another exercise the participants were involved in was to drive home the point that women/girls seek abortion services for a variety of reasons. The importance of safe abortion services was stressed upon. Towards the end, the legal barriers (under the Medical Termination of Pregnancy Act, 1971) to safe abortion services were also discussed.

7. *The Construct of Gender - Imagined and Real-Life Perceptions of the same*
   This session revolved around perceptions of different gender identities, what the participants think they look like, the difference between gender identity and gender expression and the participants' reactions to statements on varied sexual behaviour. The session ended on the note of stressing non-judgmental attitude as an important aspect of a medical practitioner's service on a daily basis.

A team-based exercise in progress

8. *Privilege Identification; Adolescent Friendly Health Services*
   This session involved the participants listening to a certain set of statements and identifying if they applied to them - the statements were questions of privilege and the purpose was to make the participants realize that these privileges are so normalized in day-to-day life, that we fail to realize them - this eventually becomes a communication barrier as one assumes that everyone is in the possession of such privileges. The second part of the session involved a discussion on adolescent-friendly health services (AFHS) and what should they be like. The participants were asked to imagine an ideal adolescent-friendly health clinic (AFHC), and set out what would its environment, service/staff and policies/procedure be like. The responses were then judged against the WHO standards of an ideal AFHC. Important developments in the field of AFHS in India and around the world were also discussed.

Discussions on crucial issues

I. Gender and Sexuality

The discussion on this topic spanned several sessions, ranging from basic questions of *"what is gender"* to nuanced understandings of gender identities, expressions and norms. The theme of sexuality was explored through understanding different identities (LGBT*QIA+) and perceptions surrounding such identities.

The basics

One of the earliest discussions was on the topic of "normal"/ "normality". The participants were asked to list one food item they liked and one they didn't. The idea behind such an exercise was to depict the fact that despite our commonality as human beings who consume, our choices vary to a great extent. The source of comfort for some may be a cause of deep discomfort to someone else. In such a situation, what is "normal"? The question was extended to "who is a normal man?" The responses were in the lines of behavioural performance ("appropriate reaction"/ "mentally stable"/ "participates in daily events"). When the question was modified to what does a normal man "look like", the responses concentrated on bodily appearances ("short hair"/ "body structure similar to other men - only a little variation"). However, when there was a discussion on the term 'normal' itself, it was said that "normal is a range" and that people who fall out of this range, or are in the peripheries of what is acceptable within this range, are subject to much ridicule and shame.

The discussion above formed the foundation for the eventual discussion on "gender". When the participants were asked what is gender, their responses were:

- It is "what we feel";
- It is multi-dimensional: there are many facets to it;
- An understanding of gender is quite fixated on physicality; and

• There are some microbiological determinants: chromosomes - XX, XY etc.

At a later point, the participants were informed of a basic differentiation between gender and sex: gender is a **social construct**, whereas sex is **biologically determined/assigned**.

Decoding gender

Gender norms

Taking the dialogue on gender further than just meanings, few sessions concentrated on what it means to be a woman, rather what are the notions surrounding woman-hood. How is a woman supposed to look like, behave and conduct herself? The following were realized to be certain parameters around which a woman's identity is usually framed: *beauty, servility, pliability, delicate* and *innocence*. These factors have contributed to narrowing down the identity of a woman, depriving her of any other attributes. Moreover, social practices and customs (mostly, in religion) serve to perpetuate these notions often relegating a woman to a lower status, to be taken care of by a man, devoid of agency. Natural processes like pregnancy and menstruation are often used as reasons to portray women as vulnerable beings and as a result, deny them equal opportunity. In addition to discussing the notions around a woman, the sessions also concentrated on perceptions of different gender identities.

Umbrella term(s)

The discussion on LGBT*QIA+ began with narratives around transgender and intersex. At a later session, the participants were asked what they understood by each term in the acronym. Their responses are as follows:

L: Lesbian

Response "Female having a female partner"

Who is female? "One who considers herself female"
Is having a partner always necessary? "No, but attraction is"
What kind of attraction? "It can be sexual/emotional/romantic"
What do lesbian women look like? "As they are portrayed in popular culture, short hair, tom boyish, have a lot of pet animals"

After discussion, a definition that was arrived at was this: a person who identifies as a woman attracted to another person who identifies as a woman is a lesbian. Therefore, it is what the person identifies as is what is important rather than what they look/seem like.

G: Gay

Response: "Person with a male gender identity attracted to another person with a male gender identity".

The participants recalled the example of Chanchal. Chanchal was a trans-man. Let's say if he was, hypothetically, in a relationship with one of the persons in the session who identified as a cis-man, what would that relationship be called? A gay or a straight relationship? It was discussed that for all practical purposes Chanchal is a man because that's what he identifies as and if he is in a relationship with another man, then that would be 'gay' relationship. A trans-man is a man, because that's what his gender identity is.

B: Bisexual

Response: "A person who is attracted to both men and women".

However, since it had been discussed that gender is not necessarily restricted to the binary, this definition was re-worked and it was concluded that a bisexual person is one who "is attracted to people of their gender and people other than their gender".

T: Trans*

Before the discussion on definitions, one of the participants asked that if we are to consider transmen/transwomen as men and women respectively for all practical purposes then why do we even need to use the prefix 'trans'. Why can't we simply call them men or women?

It was discussed that they are men and women for all practical purposes. However, the use of 'trans' is to highlight the politics behind such terminology. Although they would have loved to be considered as men and women, trans people, by no measure, have the same privileges as cis-men and women do. They come from extremely different contexts, face different levels of discrimination and have differing levels of benefits. Moreover, for placing their claims before the

State and asking for benefits from the State, it becomes important to highlight one's identity and place oneself in some context. Therefore, that's when the use of identities becomes important.

What is normal?

Q: Queer

Response: "Its an umbrella term"

In addition to the definition above, it was also explained the "queer perspective", saying that it is a way of looking at the world with a perspective which is different from the "normal".

The word 'queer' is also an act of reclaiming or owning a term. At some point of time in the past, being referred to as 'queer' was to call someone weird or different. Today, that term has been reclaimed to say that "yes, we are different/weird, so what!?".

I: Intersex

The participants were asked if they had ever come across the term "intersex", and they answered that they had encountered it before in gynaecology, forensic medicine, genetics and in their 12th standard study. They were shown a video which had an interview with individuals who identified as intersex, outlining their interaction with the medical community. The discussion on this video mainly revolved around the debate between the choice of the individual to retain an "intersex" identity versus the medical community's insistence on (and sometimes forceful imposition and carrying out of) surgeries to restore "normalcy". The discussion tended to centre around one particular aspect of the video: an intersex person (who normatively seemed like a woman) told the viewers that they have testes and that they prefer to keep it that way, despite doctors forcing her to undergo surgery to remove them. The participants tended to agree with

the doctors' advice as narrated in the video on the premise that if the testes are inside the body, then they need to be surgically removed as they tend to increase body temperature increasing the chances of cancer. And that this should be an approach with any intersex individual as any such "deformity" tends to increase the risks of other complicated diseases. However, it was told by the facilitators that having testes in the seeming body of a "woman" is *one* aspect of intersex identity. An intersex individual might not have a case of unwanted testes but might have a permutation/combination of chromosomes or some other form of intersex identity. Therefore, it is not as if all intersex individuals have a case of an extra pair of testes that needs to be surgically removed. This was just one variation in intersex. And even if it is not, it is upto the individual concerned to make that decision.

What's it like to be intersex?

A: Asexual

Response: "No sexual attraction to anyone"

It was discussed that asexual people might indulge in sex but they are not attracted to that activity or do not enjoy it. They might also be involved in romantic relationships.

At the end of the discussion on terms and assigned meanings, it was also stressed that although terms and definitions are good instruments to gain an understanding, in real-life situations, they fall flat on people's faces. By assigning *a* definition to a term, one often restricts what can fall within that definition's scope, hence although the definitions the terms in LGBT*QIA+ serve to be inclusive in intention, but by defining these terms, one often makes them exclusive. Therefore, definitions need to be reworked with time. They need to be re-visited, reclaimed and re-interpreted. However, for political recognition and making one's claims before the State and its authorities, one does need to don some identity as often, identity forms the marker for claiming benefits from the State.

One of the core takeaways from the discussion on gender was the importance of **self-identification** and everyone's duty to **respect** such a choice. It was repeatedly stressed that what gender identity one chooses to adopt is a choice of that person alone. One can have a penis, and identify as a woman, or one can have a vagina and/or breasts and identify as a man. What is important is what identity does that particular person *choose*; the choice is completely upon the person, and not for others to judge or assume. This discussion also highlighted the importance of asking what pronoun does a person prefer.

II. The interplay of law and medical practice

The discussion on **abortion rights** is what led to the above issue. The Medical Termination of Pregnancy Act, 1971 ("**MTP Act**") is a piece of legislation in India that seeks to regulate the practice of abortion in the country. By making registered medical practitioners as the sole professionals to carry out the abortion procedure, it aims to ensure safe abortions in the country. However, when it comes to adolescents who seek abortion services, the law acts as a barrier. The following points emerged from a discussion with the participants:

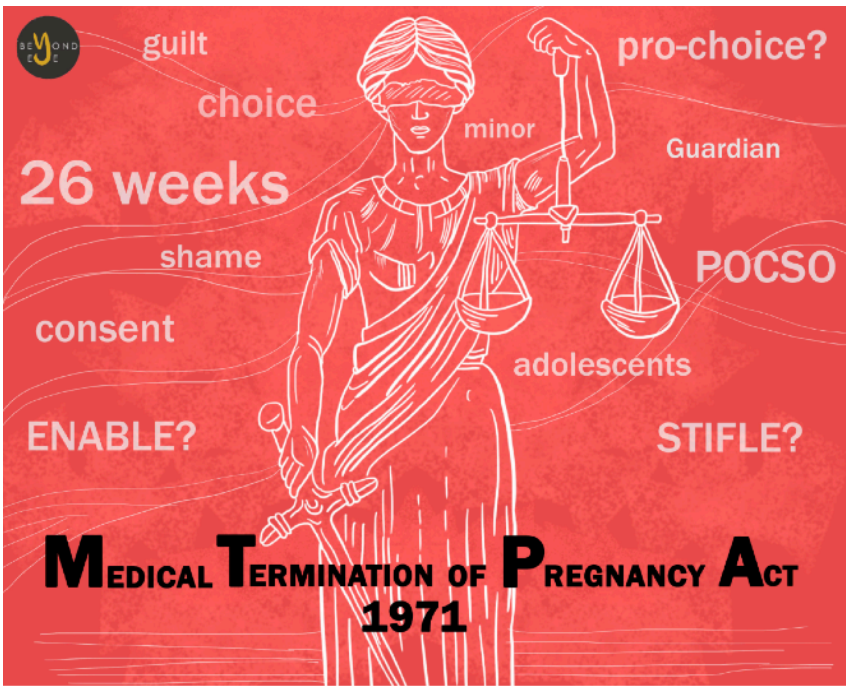
- As per the MTP Act, any girl below the age of 18 years or 18 years of age but mentally ill, who needs to access abortion services needs the consent of her 'guardian' in writing. This is a problematic provision because *first*, sex itself being a taboo topic of discussion in Indian homes and families, the adolescent might never feel comfortable to approach guardian. This is a possibility because there might be a consideration of shame and guilt in the family concerning pregnancy and abortion, especially when the girl is unmarried or in her adolescence.

- *Secondly,* the case of the girl below the age of 18 years who wants to access abortion will fall under the aegis of the Protection of Children from Sexual Offences Act, 2012 ("**POCSO**") as the girl is a 'minor' under the eyes of the law and law doesn't assume consent below 18, hence it would be considered child sexual abuse. This also means that the medical professional to who the girl has come seeking abortion services would also need to report this instance, as that is a requirement under POCSO. this will induce fear in the minds of adolescent girls who want to seek safe abortion services.

- *Third*, the term 'guardian' is defined in the MTP Act as "*a person having the care of the person of a minor or mentally ill person*". This is a vague formulation as the terms 'having the care' have a wide scope of interpretation. It could mean a parent, a friend, a relative or anyone else. Because of its vagueness, there are chances of it being misused too. This adds on to the complication of a medical service provider as she might be at a loss to determine who would qualify as a 'guardian' according to law.

- *Lastly*, because of the existence of such provisions in the law, even medical service providers are at a loss to provide abortion services to a woman below the age of 18 years without the consent of her guardian. Even though they might think in the best interests of the girl, the

law prohibits them from doing anything if there is no consent from the guardian. This increases the chance of unauthorized and unsafe abortion practices



Law: enabler or stifler?

It was realized after this discussion is that although the hands of medical practitioners are tied because of the law, it at least needs to recognize that seeking an abortion is a woman's right alone. Even in terms of the law, there have been several discussions in print and media as to how the MTP Act needs to be amended to enable a woman (of whatever age) to exercise her agency.

III. Choice and contraception

The discussion on this issue began with adolescent contraceptive counselling. It was discussed that as medical practitioners and health service providers, one needs to understand that **adolescents do not form a homogenous group**. The diversity amongst this group is of various kinds - marital status, age, religion, sexual identity etc. They might even have a different choice of contraceptive they prefer. It was also said that in today's age and time, it needs to be realized and acknowledged that adolescents indulge in sexual activity, and even if they don't, the desire to indulge is persistent. Certain barriers and facilitators towards contraceptive use were also discussed, such as sex education, peer encouragement and legal access (as facilitators) and lack of awareness of contraceptive methods, institutional environment and parental/guardian consent to access abortion services (as barriers).

What are the choices you value?

Another important factor highlighted during the discussion on contraceptives was **choice**. It is the choice of the individual which matters when it comes to contraceptive use. If the individual is not able to choose for themselves then as a health service provider, it is one's duty to make them *aware* of the range of choices available so that they can *make a well-informed choice*. This point was stressed using a team-based exercise where the participants were divided into 2 groups: 3 judgmental doctors and 3 non-judgmental doctors. Each doctor was then assigned a participant who was role-playing as an adolescent who came with some problem (with respect to sexual health/contraceptive counselling). Each participant who was role-playing as an adolescent was then required to narrate their experience to everyone and whether they would ever visit the particular doctor again.

Most of the participants chose not to visit the doctor again because of the way they were counselled. At most instances, the doctor either imposed their own moral choices on the adolescent or made them uncomfortable about their problems. By the means of this exercise, the participants were made to realize the importance of a **non-judgmental attitude** in their medical practice. As practitioners, they are supposed to provide a **safe space** to their patients so that they can be uninhibited about their problems. One needs to treat their patients with **dignity** and **respect**.

This led to, in one of the other sessions, a participant asking that being a non-judgmental doctor is, of course, a good thing, however shouldn't a more skilled doctor (say, a surgeon) who is judgmental be preferred over a lesser skilled doctor who is non-judgmental, because it is a question of someone's health and life? It was discussed that one might be a fantastic doctor (skill-wise) but if you're judgmental and do not treat your patients with respect then you will lose your patient-base. And if no one comes to you, what use are those skills. Therefore, it was

concluded that being non-judgmental is an essential skill that doctors need to imbibe not only for the sake of their patients' well being but also for their career to thrive and prosper.

IV. Adolescent-friendly health services

This was a culmination of all the sessions that had been conducted throughout the program. It was realized during the discussions that the existing infrastructure of hospitals does not allow adolescents the access to certain spaces where they can be as free and uninhibited about their issues, especially concerning sexual and reproductive health. It was also discussed that the world over, nations have begun to prioritize a **human rights-based approach to health and health services**.

Several milestones in the evolution of adolescent health services in India were discussed: the *Tenth Five Year Plan (2002-7); National Population Policy 2000; National Youth Policy 2003; National Curriculum Framework 2005 for School Education; NRHM, 2005, the RCH II ARSH strategy;* and the *Rashtriya Kishor Swasthya Karyakram (RKSK).* The six qualities of adolescent friendly health services (AFHS) were also emphasized: equitable, accessible, acceptable, appropriate, effective and comprehensive.

Adolescent health services still leave a lot to be desired

The participants were also asked to envision their ideal adolescent-friendly health clinic on the following parameters: environment, service/staff and policies/procedure. Some of the points discussed under the above parameters were:

- **Environment**: warm and welcoming; gender-specific timings; culturally sensitive; link with the community;

- **Staff**: sensitive; competent; trustworthy; interested in their jobs; well versed with topical adolescent issues;
- **Service**: efficient treatment services; availability of RKSK information; counselling services; audio-visual material; and
- **Policies/procedure**: holistic approach; confidentiality; not make parental consent mandatory for accessing these services

Outcome

The sessions conducted in the duration of this program focused on building the perspective of the participants to different aspects of human rights, gender, sexuality, choices and safe spaces for adolescents. As mentioned earlier, the aim was to impart as much information on the above issues as possible, so that an understanding of these issues eventually percolates into their daily practice and the services they provide to adolescents.

To comprehend what understanding the participants brought with them at the beginning of this program, they were given a baseline survey with a host of questions related to SRHR issues. The questions spanned queries of the following kind:

1. Do you agree that:
    a. Sexuality equals sex?
    b. Other than penal-vaginal, all sex is unnatural
    c. There are only two genders: male and female
2. How comfortable are you in talking about sex/discussing topics like sexuality, safe sex, contraception, abortion with your siblings and/or cousins?
3. If a 15-year old boy asks you about information on masturbation, how will you react?
4. If a 15-year old girl asks you about information on sex/masturbation, how will you react?
5. When meeting for the first time, do you ask your client their sex/gender/preferred pronoun/nothing at all?
6. What contraception do you advise to an unmarried person below the age of 18 years?

On the last day of the program, the participants were given the same survey to answer again. The responses on the first and last day are analyzed here, to understand what effect the program has had on the participants' understanding of issues relating to gender, sexuality, choices and safe spaces for adolescents, among other things.

Before and after

Some of the key transitions in the participants' responses can be enumerated as follows:

- At the beginning of the program, **more than half** of the participants agreed that other than penal-vaginal sex, all sex is unnatural. However, by the end of the program, **only 2** participants agreed with the statement;

- By the end of the program, **only 1** person agreed with the notion that sexuality is the same as sex; and
- By the end of the program, **not even one** participant agreed with the statement that there are only two genders.

On issues of discussing and talking about sex/sexuality/safe sex/contraception/abortion with siblings and/or cousins, there were also some transitions. A participant (male, 28 years, MD student) had earlier responded that he was "*slightly comfortable*" with discussing the above issues. However, by the end of the program, he responded saying that he is "*very comfortable*" talking about such issues with his cousins and/or siblings.

Similarly, when the participants were asked how they would respond when a 15-year old boy asks them information about masturbation, a participant (male, 23 years, MBBS student) at the beginning responded saying that he would "*tell him not to do it because its not the right age*". However, by the end of the program, he responded saying that he would "*make him comfortable, listen to his concern and provide him information*".

Another such transition was seen on the question of a 15-year old girl asking information about sex. At the beginning, a participant (male, 28 years, MD student) responded saying that he would "*tell her not to do it because its not normal*". However, by the end of the program, he said that he would "*make her comfortable, listen to her concern and provide her information*".

Personal reflections

At the end of the program, some participants also reflected on the effect(s) the sessions have had on them. One participant (female, 26 years, MBBS intern) said "*I knew some of the difficulty and judgy eyes but I learned how many difficulties [adolescents] have to face to get any services not [only] in health services, but in all kinds of services. [H]ow they have to face in everyday life different issues regarding health and service provision.*"

Finding one's safe space

Another participant (male, 24 years, MBBS intern) said that "*I a) learned about broader concept regarding adolescents, their needs, making them comfortable; b) promoting adolescent-friendly health [services] and providing [a] better environment for adolescents.*"

Reflecting on the discussion around sexuality, one participant (male, 22 years, MBBS intern) commented that "*I learnt about adolescent health issues LGBTQIA+ issues in detail*". The participant also said that in the future, he would "*apply them to my practice*". On the same aspect, another participant (male, 25 years, MBBS intern) said that "*I learned a lot about sexual orientation, sexuality, gender equality, non-judgmental attitude [and] adolescent-friendly environment in the workplace.*"

The participants were also asked whether they would apply any learnings from this program in their practice in the future, and if in the affirmative, what would be their approach of doing so. One participant (male, 22 years, MBBS intern) said that "*I would be non-judgemental, warm, compose[d] and welcoming in my approach. [I will] allow people to make their own choice, whilst providing them [with] adequate information.*"

Another participant (female, 23 years, MBBS intern) commented that "*I will have more concentration on my words when it comes to gender identity [and] will be non-judgmental in all perspectives.*"

The sessions conducted in the program also concentrated on the heterogeneity of adolescents. On that issue, a participant reflected that "*all these activities changed my way to lookup to adolescents' problems and the way to deal with them. [I] will make my workplace more youth-friendly.*"

What did you learn today?

Learnings

The major learnings from this program have been rooted in its novelty. This was the first time that a program on sexual, reproductive health and rights was being conducted with doctors-in-training. Hence, the learnings happened at both ends: for the participants as well as the facilitators. Some of the participants gave the following feedback:

- In addition to educating students (interns and PG students), also involve faculty members of other departments;
- The incoming batches of fresher students should also be exposed to such sessions; and
- The discussion was very involved: people were receptive of differing ideas - always ready to hear and discuss

The participants also provided their inputs on certain topics that could have been dealt with in more detail. This was a learning point for the facilitators, and the same have been listed below:

- Parental Counselling: "*counselling of parents when they come with the children who are not behaving as how they should be behaving based on gender*"; and
- The legal angle: "*adolescent-health related laws*" and "*laws related to LGBTQ community, adolescents etc.*"

Coming up with solutions

On the other hand, the following is what a few of the facilitators had to comment on their learnings from the program:

a. Learning on a personal and professional level

Dr. Jugal Kishore, HoD, Community Medicine Department, Safdarjung Hospital & VMMC	Ankita Rawat, Beyond Eye
Teaching is always a self-learning experience. I develop the confidence to talk professionally on the topic which is taken most controversial. It was very satisfying when one of the participants sent a message after the session: "Sir, today's class was very moving. Never imagined someone would talk about these issues about our culture and world so clearly and openly. I feel so proud to have my HoD like you. Your research and details were hard hitting. In future I will get to quote what you taught today so much. Thank you so much! "	This was my first time training doctors on SRHR and building their human rights perspective on providing SRH services to adolescent and youth. Being doctors, they see the issue of SRH from a health lens and have strong opinions on how one has to be careful with their choices. Doctors see the SRH from the point of prevention or cure which makes them judgemental towards the patient's choices. Hence, this makes doctors a target audience in terms of changing their behaviour towards the patient and treat them well. As a trainer, when we talked about the issue in the doctor's behaviour, they felt attacked and got defensive. This made me realize that we have to be careful when we are talking about these issues: health service providers need to be safe and non-judgemental. We need to have facts and stories (published in mainstream media) to support our statements. Also, I felt it's important to conduct a session on identities where participants understand how one has a different identity- caste, class, religion, gender and how social norms, or our identity/ upbringing influence our thoughts. As a human being, it is our responsibility to treat everyone equally and with dignity. So let's break and challenge those notions or norms in our life which leads to negative behaviour. Added an angle of active citizenship because participants were absorbing the knowledge but weren't thinking out loud in terms of how they can bring a change and challenge the protocol/law which acts as a barrier to adolescent to access SRH services.

b. What could be the future of such an initiative?

Dr. Jugal Kishore, HoD, Community Medicine Department, Safdarjung Hospital & VMMC	Ankita Rawat, Beyond Eye
The future of such initiative is bright. We should have more such workshop and at the wider scale	It was a long series of workshop and doctors, PG students and interns have a very busy schedule. We could have done two days of residential Bootcamp. Create a Facebook group where we can continuously engage with them by providing readings, videos which keep them thinking on the same line.

c. What would you have done differently?

Dr. Jugal Kishore, HoD, Community Medicine Department, Safdarjung Hospital & VMMC	Ankita Rawat, Beyond Eye
It was an eye-opening session and may be people sceptical to accept. More elaboration of evidence and explanation could have been interesting.	No new participants should be allowed to join from the middle of the program as they proceed with half information.

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