

# Seen, Not Heard

Youth Led Audit of Sexual and  
Reproductive Health Services in Lucknow





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## Youth Led Audit of Sexual and Reproductive Health Services in Lucknow



The research study was done in collaboration with the Yeh Ek Soch Foundation, Lucknow.



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# About The YP Foundation

The YP Foundation (TYPF) is a youth -run and led organisation based in New Delhi, India, that supports and enables young people to create programmes and influence policies in the areas of gender, sexuality, health, education and governance. In the last 13 years, TYPF has worked directly with 6,500 young people to develop their perspectives and critical thinking on issues of social justice and human rights, and set up over 300 projects in India, reaching out to 450,000 adolescents and young people between 3-28 years of age across 18 states.

The organisation was formed to address the gap between young people's desire to engage more deeply with themselves and with the world around them and the lack of opportunities or encouragement for the same in institutions or community environments. To do this, TYPF builds young people's feminist and human rights based perspective on social change, connects them with opportunities to lead and create on ground impact on relevant issues and enables them to address systemic gaps by policy and public advocacy based on their on

ground experience. Over the course of time, young people entering TYPF have shaped the focus areas of the organisation and evolved each programme division.

TYPF currently implements programmes in The National Capital Region (NCR), Uttar Pradesh and Rajasthan. Programmes work with young people and adolescents with 60% outreach to including young women and adolescent girls from poor and socially marginalized communities. These include Dalit and Muslim communities in rural areas as well as in resource poor neighborhoods such as slums in urban areas. Urban programmes also work with young people and adolescents from difficult family backgrounds and tenuous life situations, living in institutional care homes.

Sexual and Reproductive Health and Rights (SRHR) is one of the core issues that TYPF addresses. TYPF recognises the paucity of information on sexuality available to young people, especially young women, as a severe deterrent to their health and well-being and leads to poor physical and mental



MY DREAM IS THAT  
I BECOME AN I.A.S  
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FAMILY



health outcomes and exposure to sexual and other forms of violence. TYPF's flagship program – Know Your Body Know Your Rights - is a youth-led peer education programme that empowers young people to access information on their gender, sexuality, health, rights, HIV and youth friendly health services. The program implements a Comprehensive Sexuality Education curriculum with young people between the ages of 10 and 25 in Delhi and Uttar Pradesh. The programme advocates for the inclusion of Comprehensive Sexuality Education in policies and government programs.

While KYBKRY has increased the levels of information, knowledge and skills on SRHR amongst the young people it reached out to, several attempts have been made to improve young people's access to SRHR services. However, several barriers come to light. Firstly, legal aspects make it challenging for young people to access SRHR services. For example, the requirement of a guardian's consent to access certain services such as abortion (if the girl is under 18 years of age), push girls towards accessing illegal and unsafe abortion services. The recently enacted law against child sexual abuse – POCSO – contains certain clauses that prevent medical practitioners from providing services. Section 20 of the Act makes it mandatory for service providers to report any sexual acts between people under 18 years of age. In practice, this translates to doctors refusing to provide a SRH

service to young people under 18 years of age, since they will then be liable to mandatorily report. In the light of such barriers, linking young people to SRH services has been an uphill task. Given this reality, TYPF undertook this mapping study on youth friendly health services to generate evidence on the current situation of health services for young people in Lucknow. In this case, young people set their own knowledge agenda (by recognising the absence of information on quality of existing services). The study also served as an opportunity for young people to articulate their own analysis stemming from their own experiences of accessing these services. The study therefore offers useful insights emanating from young people to government and non-government actors who create and offer SRH services for diverse communities of young people.

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# Young People and Sexuality

## What's the Problem?

30% of India's total population constitutes young people aged between 10 and 24. Adolescent girls account for nearly 11% of the Indian population and 20% of the world's adolescent girl population. Despite these numbers, young people are systematically kept away from access to information, services, and any form of decision-making. Young girls are marginalised within the larger constituency of youth and remain an invisible group. Society usually fails to respect their human rights, leaving them powerless to act in a way that improves their lives at home, school or work. This is manifested in five key aspects of their lives - sexual health, early marriage and early pregnancy, domestic violence, education, productivity and income. Inequalities arising out of gender

are prevalent across all ages, castes, classes and geographies across India. According to a report, *Landscaping Women's Empowerment through Learning and Education*, compiled in 2010 by Copal Partners, gender inequality is particularly skewed in Bihar, Rajasthan and Uttar Pradesh. This is confirmed by the Census of India 2011, which measures gender-critical districts in India on the basis of child sex ratio (ratio of girls to boys), girls' education and female workforce participation (1). Identifying priority districts for gender equality interventions, the census report showed that Uttar Pradesh has the highest number of gender critical districts, followed by Bihar (60 and 28 respectively).(2)

The silence around sexuality

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The Adult Education Program, a school-based program, conceived by the Union Ministry of Human Resource Development and the National AIDS Control Organization (NACO), was introduced in 2007 with the aim of providing sexuality education to in-school students. The State governments that objected to specific illustrations and exercises in the AEP are Chhattisgarh, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra and Rajasthan. In Orissa, the State Council of Educational Research and Training (SCERT) threw up its hands following protests over the "explicit" content and decided that only teachers and not the students would be given exercises designed to teach reproductive changes. There were random protests in Jharkhand by the Islamic Students Organization of India and in Srinagar, Jammu and Kashmir's capital, by a women's separatist outfit, Dukhtaran-i-Milat. The Jammu and Kashmir government, however, told a news agency that it did not have any proposal to introduce the program. (<http://communalism.blogspot.sg/2007/09/culture-policing-in-schools-state-govts.html>)

## ***widespread outrage against the AEP was prompted, primarily, by a flip chart of illustrations that was to be used by teachers, as they summarised the physical changes experienced by teenagers during puberty.***

issues is particularly acute for young people. Increasingly, by the age of 8, young people have entered into puberty, and by the age of 16, most young people have engaged in sexual relationships. (3) Yet, research studies from across the country, confirm a critical gap between young people's need for comprehensive rights-affirming information on sexual and reproductive wellbeing, and the access to this information. Societal and cultural norms that label any conversation on sex as immoral or bad, make it impossible for most people to access any information on their bodies, sexuality, desire and preventing sexual violence.

Young people are also not seen as capable decision makers owing to their explorative and experimental nature (4). Therefore, it is largely interpreted that pre-emptively mandating sexuality education for young people can promote risky sexual behaviour. This mind-set has deeply hindered any attempts (by the government and NGOs) to make Comprehensive Sexuality Education accessible. The Adult Education Program (AEP) launched by the Government of India in 2007 is a case in point. The AEP was suspended in several states due

to objections raised by teachers, parents and policy makers on grounds that its explicit content was contrary to Indian culture and morality (5). Such widespread outrage against the AEP was prompted, primarily, by a flip chart of illustrations that was to be used by teachers, as they summarised the physical changes experienced by teenagers during puberty (6). The curriculum's content on contraception and sexually transmitted diseases also provoked anger. A parliamentary committee was set up to review the need for CSE as well as the content and implementation of AEP across the nation. The committee in 2009, recommended that the curriculum should be withdrawn pending on the revision of content. Uttar Pradesh is one of the states where AEP continues to be banned for the sake of morality and preserving "Indian culture".

The consequence of such indiscretion runs far and deep. Most conversations pertaining to the body, sexuality and sexual and reproductive health remain actively suppressed – in the hope that denying young people information, will discourage them from exploring their bodies and their sexuality. As a result, when young people do



become involved in sexual activity, they do so without the information necessary to make decisions in their own best interests or protect themselves (7). This has impacted young people severely in the form of sexually transmitted infections (STIs), violence, early marriage, unplanned pregnancy and mental health issues etc. Increased rate of deaths due to HIV have escalated it to second position in the top 10 causes of death among adolescents (8). Patriarchal and unjust gender norms make matters worse for young girls as they bear the brunt of severe regulation of mobility, expression and freedom. In TYPF's own experience, even when girls have been collectivised and given comprehensive sexuality education, girls' ability to negotiate with their families to step out of their homes without guardians or in groups, has been very hard to achieve. In view of such a harsh reality, it is no

surprise therefore, that services (for example- abortion services) lie beyond their reach and access.

Systemic silencing and shaming, also translates to deep levels of stigma and discrimination for young people while accessing sexual and reproductive health services. Judgemental/moralising attitudes at the medical service provider end impedes a young person's access to quality healthcare. Several studies mapping the quality of SRHR

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services on various parameters (described in detail in the next section) have repeatedly pointed out that young people, especially young women face tremendous levels of stigma because of the larger mindset that adolescent sexual behavior is not “allowed”. In a recent study – Youth in India: Situation and Needs – 52 percent of young women from the sample group report that they would be uncomfortable to obtain contraceptive supplies from any health care provider (10). This is especially true in the case of single/unmarried young women. Those young women who have accessed these services despite the discouraging environment, have also witnessed a ‘hierarchy of services’, whereby, some are perceived acceptable and others as downright unacceptable. During TYPF’s own experience of mapping SRH services in New Delhi, a young researcher noted, “...On other occasions, doctors were found to be selectively empathetic – privileging one SRH service over the other. There was a stark difference in the attitudes of some health care practitioners who were warm and

helpful when it came to services such as contraception, HIV and STIs, but haranguing when it came to abortion.” (11) This in turn pushes young people to put their physical and mental health at great risk and/or access illegal health practitioners for the sake of receiving confidential care. A study assessing young women’s access to SRH services in Jharkhand found that around 3% of married young women reported experiencing induced abortion; 92% of these women used private or illegal providers(9).

The critical information and counselling that eludes youth, does not/cannot transpire in adult consciousness. More myths than facts are found in the public domain sourced primarily from

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misconceptions, rumours and culturally acceptable narratives from older members in the family and community. This dearth of information evidence-based information on sexual and reproductive well-being, causes adult subjects too to rely chiefly on public health systems for the same. However, a combination of ill-monitored systems, inept staff, inadequate services and peer transmitted misinformation accompanied by doubt/fear, adversely impacts women's autonomous decision-making on matters of sexual and reproductive health.(12)

Thus, there is an urgent need to clarify concepts regarding young people's bodies, sexuality and SRH. A young person with access to comprehensive information on sexuality (including concepts such as bodily integrity and consent) and quality SRH services, is empowered to make the right choices that uphold her/his/their health and well-being. Recognising this, in 2006, the National Adolescent Reproductive and Sexual Health (ARSH) Strategy established clinics dedicated to young people's health

(10-24 year olds) - Adolescent Friendly Health Clinics (AFHCs) – to guarantee stigma-free preventive, promotive, curative and referral services. However, the failure of these AFHCs to markedly promote young people's access to SRHR is attributed to: non-availability of the clinics, lack of privacy and confidentiality, Poorly-trained staff, clinic timings and young people's personal fear of being recognised and/or stigmatised. (13) Therefore, in 2014, the Rashtriya Kishor Swasthya Karyakram (RKSK) was instituted to strengthen existing AFHCs, and to make available and accessible, a continuum of care to comprehensively address adolescent health and development needs. It is in this progressive policy climate that TYPF-KYBK YR's audit of the availability, accessibility and quality of YFHS was studied.

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# Mapping Health Services for Young People

## What is the evidence telling us?

In the past decade, there have been multiple reviews of health systems, both public and private. Research studies have reviewed health systems from various entry points and towards varied objectives. Some of the aspects that have been researched include – availability of contraceptives; socio-economic and legal barriers to accessing SRH services for various constituencies such as HIV positive people, sex workers, and trans people; and, availability and quality of ANC and PNC services. There has been significant investigation of maternal and child health services as well as the implementation of various schemes such as Janani Surakhsha Yojana. Noteworthy amongst these is Sahaj - Shishu Milap's study of the status of maternal and child health services in the urban slums of Vadodara (14); Human Rights Law Network's investigation on women's access to contraceptive information and services and state implementation of reproductive

health schemes, undertaken in Mewat, Haryana (15); and Sohini Chattopadhyay's 'mystery client' audit of the labour ward in a Kolkata Public Hospital. (16)

Findings from these studies resonate with some other efforts, as well as with TYPF's study, that map the current scenario of SRH services vis-à-vis young people. For example, there is a complete lack of awareness especially amongst women and young people on the availability of services. HRLN's study in Haryana found that women were completely unaware of their contraceptive choices and relied on the public health system for information on the same. Lack of counselling services is another common finding. This holds true across the levels of health services – the HRLN study found that women were not receiving any counselling on contraceptives from front line workers (ASHAs and ANMs); while, the Shishu Milaap study found

that no counselling services were available for pregnant women at a tertiary hospital. Across all studies, the public health practitioners' attitudes were negative and discouraging. Their own biases towards specific communities often reflected in the services they offered. Offering a limited number of contraceptive options to poor and/or rural women is one of the many manifestations arising from practitioners' biases.

Given the abysmal situation of women's access to services, it is not surprising that young people find it much harder to access SRH services. Age is seen to be a significant marker that determines women's experiences while accessing services. While not much is known about abortion among the young, it is estimated that between one and 10 percent of abortion-seekers in India are adolescents (17). As mentioned earlier, evidence suggests that young women—irrespective of marital status—are more disadvantaged than adult women, and that unmarried young women are particularly disadvantaged. Several attempts have been made to map access to health services for young people, especially young women. With the introduction of the ARSH Strategy (2006), there has been considerable focus on the evaluation of Adolescent Friendly Health Services (AFHS), predominantly led by various civil society organisations. According to a 2009 study commissioned by the World Health Organisation (WHO) through the Ministry of Health and

Family Welfare (MoHFW) aimed at evaluating the role, feasibility and sustainability of adolescent-friendly health clinics (AFHCs), enhanced accessibility was visible across all 3 sites of intervention – Delhi, Kolkata and Chandigarh. Another study undertaken in 2012 by MAMTA, analyses clients' perspectives on the quality and accessibility of Youth Friendly Health Services (YFHS) across Varanasi and Bangalore. The study utilises qualitative research methodologies such as f2f interviews and focus group discussions (FGDs) and concludes with a largely positive feedback on service delivery, aside of making certain recommendations such as improving the availability and outreach of services.

Perhaps the most recent, is a 2014 evaluation of YFHS conducted by Population Council jointly with the MoHFW. The study is comprehensive and makes use of a combination of qualitative methodologies such as interviews, focus group discussions and mystery client audits (13). It evaluates the successes and challenges in implementation of AFHS upon analysis of a comprehensive group of stakeholders. The study refers to previous evaluations of AFHCs (18, 19), conducted in the early days of their establishment - that note their **uneven distribution, the limited utilisation of services by young people and the poor quality of services provided at these clinics.** Even in Gujarat, one of the states in which AFHCs are concentrated, evidence from an evaluation of 21 Adolescent Reproductive and Sexual

Health (ARSH) clinics observes that not all were functional. Very few had separate OPD (Out-Patient Department) hours and days designated for adolescents and youth or provided auditory and visual privacy. Additionally, few young people were aware of these clinics and it was further predicated that even fewer would use them because of the lack of privacy, fear of attending clinics located in health centres and hospitals, and fear of service provider attitudes (18).

While findings from Population Council's 2014 study are mixed in terms of quality and accessibility, **the report cites the critical lack of awareness amongst young people about AFHCs as responsible for low utilisation of AFHS - less than one percent of young men and women have ever sought services from an AFHC!**

Broadly, findings from the above studies lay the onus of responsibility – for low levels of awareness and information outreach among target population and immediate stakeholders - on the state government functionaries, and recommend that community mobilisation around the importance and need for AFHCs begin at once. **At the same time, the studies acknowledge youth accessibility of services has improved in AFHCs, largely due to stigma free delivery.**

TYPF has drawn heavily from the existing body of research while framing its own study. TYPF has also used several other inputs emanating from other countries

and geographies. For example, several tools to measure service providers' stigma were referred to. The methodology of this study is also perceived as an advantage. All researchers came with at least a year of experience of working on SRHR issues and came with clear and rights affirming values towards young people's sexuality and sexual rights. This was a significant advantage as the researchers were aware of and confident to demand their entitlements related to SRH services. They were forthright about how their experiences were telling of rights violations and brought a strong analysis to this research.



# About the Study

## Study Objectives

a) *Generate evidence through youth centered processes.*

The study aimed to create evidence from the experiences of young people while accessing SRH services.

b) *Increase visibility of existing youth friendly health services, particularly stigma free abortion services.*

The study aimed to create visibility of health services pertinent to young people's Sexual Reproductive Health and Rights. Within the spectrum of SRH services, abortion related services, for young unmarried women, is most stigmatised and hidden. Since no information on the existence of such services is made available by State and non-State actors, this is a first step for young people to begin accessing SRH services.

c) *Create a cadre of young leaders equipped to advocate for and assess stigma free health services including abortion counseling and provision.* This project aimed to create a cadre of young leaders who have technical knowledge on issues of SRHR and research

techniques, which in turn enables them to be mystery clients to assess stigma free health services in the district and advocate for effective implementation of Youth friendly and stigma free health services.

d) *Contribute to existing information on the availability and quality of existing health services, especially abortion services.*

The study aimed to create knowledge on the current state of health services and rate their youth friendliness. By employing youth centered methodologies – young people framing the research agenda, collecting data and analysing findings – the study ensures that it is grounded in the lived experiences of young people, thereby making the findings relevant for all young people.

## Study Setting

The study is set in Lucknow where TYPF has been implementing its KYBK YR programme since 2009. Through the programme, TYPF has implemented its CSE curriculum and advocated for policy change in Lucknow. In doing so, we have found that studies documenting young people's access to SRH



services have not been conducted in Lucknow thereby leading to non-availability of evidence related to the same. TYPF also leveraged on the presence of its Peer Educators from the KYBKYP programme, who were inducted as the researchers for this study.

Lucknow as a 'site of intervention' posed multiple challenges. Lucknow expands over a much smaller geographic area than Delhi - about 2,528 square kilometres. Despite its high literacy rate (84.72%), stigma on issues of sexual and reproductive relevance remains entrenched, thereby imposing severe limitations on the mobility of adolescent girls and young women as well as conversations around the same.

The city also has an overall population of 2817105, with a staggering population density of 1,815 inhabitants per square kilometre, thereby emerging as the most populous city in Uttar Pradesh; a plummeting sex ratio of 915 females per 1000 males, which is significantly lower than the national average (940 females per 1000 males) (20). Health service needs are high and are largely unmet by scant healthcare infrastructure, especially for adolescent and young people - only 2 AFHCs exist, one each for young men and women, respectively.

## **Scope and Limitations of the Study**

The issue of access to SRH services is vast and comes with several axes of analysis. This study does not cover all of the complex issues involved. For example, legal barriers for young people in accessing SRH services has not been covered, even though they are a critical marker. Age of consent related to SRH services is most relevant to young people. Certain services such as abortion are guided by provisions under the Medical Termination of Pregnancy Act (1971). Individuals seeking an abortion who are under 18 years of age need approval from their guardian. While this study is limited in its scope in mapping how the law per se impedes women from



accessing abortion related services, it does document interactions with health providers on their reading of the law. Therefore, this study strongly recommends that direct and indirect legal barriers to accessing all SRH services, including abortion, need to be researched in detail.

TYPF has learnt from other similar initiatives such as a study conducted by Population Council (13) that also collected quantitative evidence on the awareness about AFHCs amongst youth. A similar component could have added new insights into this study as well, since it was found that the two existing AFHCs have a modest footfall (please see textbox “AFHCs” in the Findings section), thereby suggesting that young people in Lucknow have limited awareness about their existence. However,

this was out of the scope of this study and can be included in future attempts at collecting evidence on the accessibility of AFHCs.

The study has been a huge learning experience for TYPF. It has primarily served the purpose of capturing first-hand experiences of young people (who have worked with us as peer educators) while accessing SRH services. More importantly, it has opened up new mediums for TYPF to develop youth leadership and generate youth-led evidence that leads to advocating for policies affirming young people’s SRHR.

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# Study Design

As initial steps of the intervention, the research team at TYPF necessitated the need to finalise a team of young researchers based in Lucknow, and institute a rigorous training programme that would focus on strengthening/fine-tuning their knowledge on issues of SRH and related rights, policies and schemes. More importantly, it was decided that the week-long training programme would also be designed to capture the team's collective views on what would make health service delivery "youth-friendly". Based on this input and that obtained from select external resources, standards of youth-friendly health services would be delineated against which, the quality of each service/health centre would be assessed. Accordingly, a 'mapping implementation tool' would be developed to facilitate collection of the corresponding data.

## Selection of Fact Finding Team

TYPF has been implementing the KYBKRYR programme in partnership with Yeh Ek Soch Foundation - a Lucknow-based organisation, which works on strengthening young people's perspectives on issues of

health, population, habitat, gender stereotypes, sexual exploitation and sexual abuse of women, child & youth, national integration and peace. Through the KYBKRYR program, many young volunteers Lucknow University have undergone a systematic year-long engagement with rights based perspectives on issues of gender, sexuality, SRHR and relevant government policies and schemes. Alongside this, they have led community interventions with over 1500 young people across low resource localities in urban and peri-urban Lucknow, and other relevant stakeholders both at community and policy levels, to ratify and advance the demand for young people's SRHR. As a result, the KYBKRYR volunteers come with an express realisation and articulation that sexual health rights are in fact human rights, which is befitting of SRHR advocates. 12 young volunteers from this cohort then came forward to conduct this study. Volunteer ages ranged between 18 and 27 with an average age of 23. They are all unmarried except for 1.

## **Training of Young Researchers**

TYPF conducted 2 week-long trainings with them to:

- a) Build their capacities to lead a research study and conduct a social audit,
- b) enhance their knowledge on current government schemes and guidelines that endorse YFHS, and
- c) Refresh their technical knowledge on SRHR.

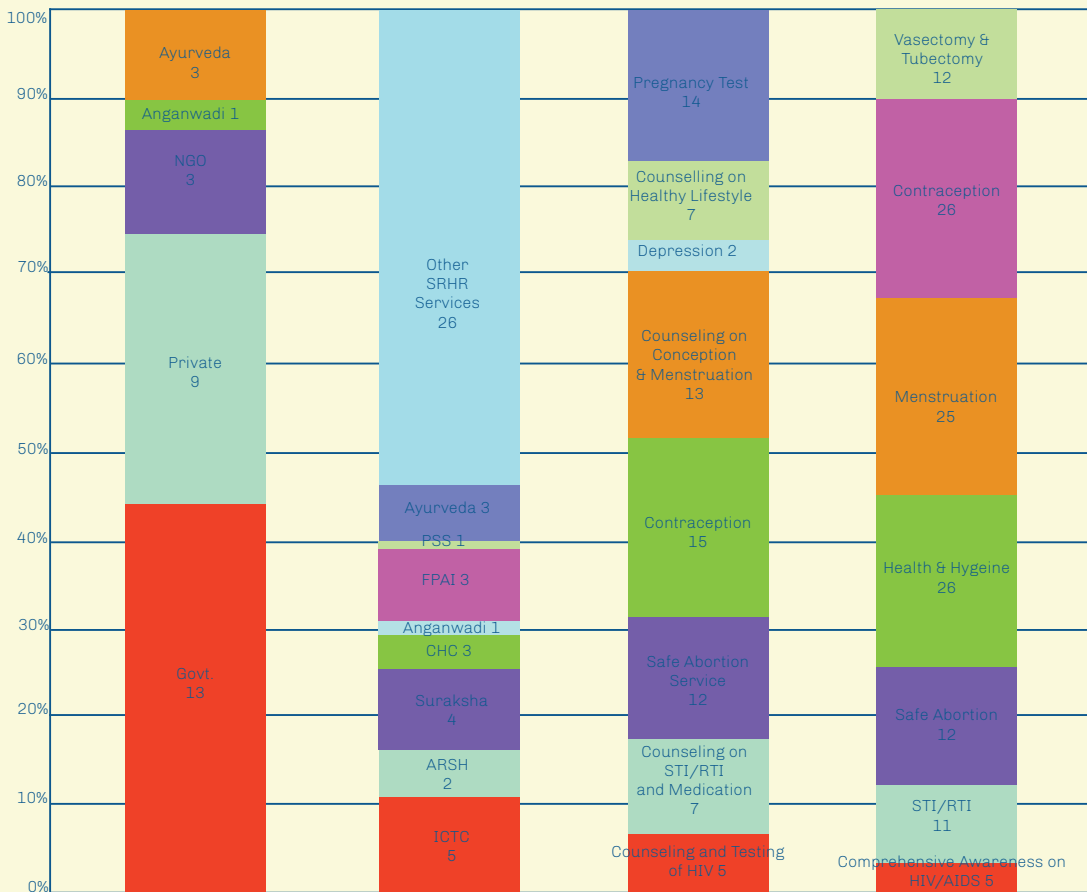
During this phase, TYPF and the researchers together, also devised a system for debriefing/recording findings. TYPF also organised a number of exposure visits to health facilities towards building their confidence on accessing SRH services.

As mentioned earlier, TYPF through its KYBK YR programme, had previously piloted an audit of YFHS across 19 government and non-government health centres across Delhi NCR. Initially, it was envisioned that a similar design and structure could be adopted for the present audit. However, Lucknow as a 'site of intervention' posed multiple challenges. Lucknow expands over a much smaller geographic area than Delhi. This coupled with the prevalence of high levels of stigma on issues of sexual and reproductive relevance, results in greater surveillance of young girls

and women, which in turn restricts their mobility around, and access to, SRH clinics or gynaecologists. Thus, during the course of the initial training, the young researchers expressed their inhibitions around being recognised and ostracised by family, friends and peers if caught in the act of accessing SRH services. The researchers, despite recognising SRH services as a right, and being fully cognisant of the importance and need for advancing young people's access to the same, feared the backlash they would face if recognised during the audit. To address this, the TYPF team invested significant efforts in helping peer educators overcome their initial inhibitions by building their capacities to mitigate backlash through one on one and group counselling sessions and trust building exercises, towards building personal confidence-levels as well as strengthening peer support networks.

## **Selection of sites of intervention**

The initial list of health facilities focused on public health services. However, in-depth conversations with YES Foundation and other stakeholders well versed with the landscape of Lucknow, deepened our insight into the wide range of actors (government, private, NGOs, street-side) active in the space of sexual and reproductive health service delivery and the



Health Facility Profile

varying degrees of privacy and confidentiality, affordability, accessibility etc. accorded by them. TYPF recognised the need to broaden the scope of the audit and to bring within its ambit, as many diverse actors as possible, in order to arrive at a comprehensive analysis of the landscape of YFHS. Thus a list of 29 health centres was finalised. (see data above).

A noteworthy inclusion was the 'neem Hakeem'/road-side services (indigenous health providers) whose audit has generated some interesting insights. Housed in road-side tents, these unauthorised health centres provide confidential counselling (no records maintained)

and broad-range Ayurvedic medication/solutions for a variety of problems, particularly those pertaining to sexual and reproductive health. Because of the 'publicness' of the designated space for service delivery, the tents are predominantly frequented by men. However, numbers are widely circulated for the benefit of patients who seek privacy and would like to avail of these services at a less conspicuous location of their choice. We also audited toll free health service helplines numbers provided for the Suraksha clinic by the National AIDS Control Organisation and RKSK, by the Ministry of Health and Family Welfare.



## **Development of a mapping tool for data collection**

The mapping tool was modelled on that which was utilised during TYPF's pilot audit (2015) of YFHS in Delhi NCR. TYPF also followed the Checklist published by The National Adolescent Health Program and culled out parameters of assessment of health services that determine its youth friendliness. These included whether clients experience privacy at the facility; attitudes and responses of health providers; and, accessibility of the health service. Additionally, it was further vetted by a SRHR expert from Asia Safe Abortion Partnership (ASAP). Her comments were critical in ensuring that the tool covers a wide gamut of not only SRHR issues but also its intersections with gender, Gender Based Violence and marginalised identities. The tool was finalised during one of the trainings with youth researchers and translated to Hindi. The tool can be found in the Annexure and can be used by other organizations and collectives to conduct a similar audit of SRH services.

The trained team of 12 young researchers implemented the 'mystery client' audit across 27 health centres - private, government, non-government and indigenous health providers - in urban and peri-urban Lucknow. The team of researchers visited the health facilities, individually, or in groups of 2 or 3, and accessed

sexual and reproductive health services such as abortion counselling, HIV counselling and testing, RTI/STI counselling and testing, contraception services etc. as per data depicted below. Rich qualitative and quantitative data was captured through the mapping tool as well as through face-face interviews with individual researchers, FGDs with the cohort and in-depth interviews with a small number of service providers, health counsellors and state-level nodal officers of the RKSK.

# TEMPORARY METHODS OF FAMILY PLANNING

## परिवार नियोजन की अस्थायी विधियाँ

### NATURAL SYSTEM

प्राकृतिक साधन



1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

### SAFETY PERIOD सुरक्षित काल

FOR WOMEN WITH 28 DAYS PERIODS  
28 दिन के चक्रीयकाली महिलाओं के लिये

1 TO 3	MEASUREMENT PERIOD मापक अवधि
4 TO 9	UNCERTAIN SAFE PERIOD अनिश्चित सुरक्षित काल
10 TO 17	CONCEPTION PERIOD गर्भधारण काल
18 TO 28	SAFE PERIOD सुरक्षित काल

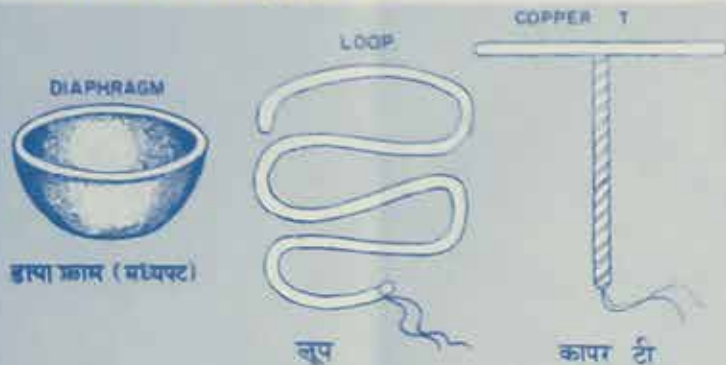
### SELF CONTROL

आत्म संयम



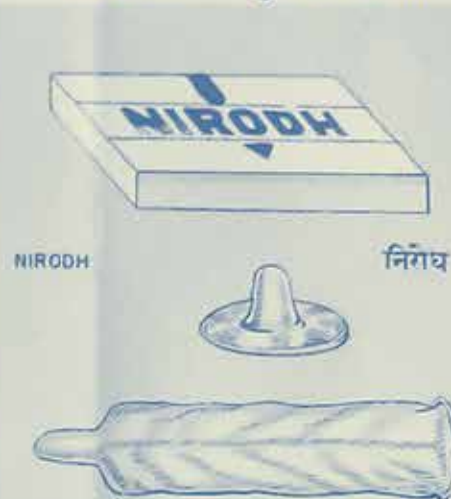
## MECHANICAL METHODS

FOR WOMEN महिलाओं के लिये



## यान्त्रिक विधियाँ

FOR MEN पुरुषों के लिये



## CHEMICAL METHODS रासायनिक विधियाँ



## MEDICAL TERMINATION OF PREGNANCY चिकित्सीय गर्भ समापन

MEDICAL TERMINATION OF PREGNANCY CAN BE AVAILD DURING THE FIRST THREE MONTHS OF PREGNANCY THIS SERVICE IS AVAILABLE IN ALL FAMILY WELFARE CENTRES AND HOSPITALS. IT IS RISK TO LIFE AFTER THREE MONTHS.

अनबाह्य गर्भ को गर्भ रहने के तीन महिने के अन्दर परिवार कल्याण केन्द्र और सरकारी अस्पतालों में उपलब्ध चिकित्सा सेवा से समाप्त किया जा सकता है। इस काल के बाद गर्भ समापन क्रिया से जीवन को खतरा है।



# Findings

While many findings resonate with the worrying state of public health in general, they also may be relevant to host of other constituencies including women in general, especially those from marginalised communities, trans people, disabled people, and, young men. The study intends to capture first-hand experience of the young researchers in order to identify key barriers for young people in general, especially young women to access SRH services. However, it is also important to note, that these findings may vary. Stigma, especially, may be intensified for marginalised young people, such as young sex workers, or disabled young people.

Key findings from mapping 48 health services accessed across 29 health centers in Lucknow, Uttar Pradesh, are listed below:

## **Inadequate distribution of clinics, their infrastructure, and staff capacities disrupts quality of youth friendly health services at government health centres.**

Right from the registration counter, hospital staff were unaware of the functions of policy mandated facilities such as the Suraksha Clinic, Integrated Counselling and Testing Centers (ICTCs), and Adolescent Reproductive and Sexual Health (ARSH) clinics that are housed within all public health

centres - they were only capable of responding very broadly to very basic queries. As a result, young researchers were many a time misdirected and in the process, discouraged, as it is an overwhelming experience to try and find one's way through the maze that is a large public health centre. The situation is further compounded by the critical lack of sign boards and a roadmap that indicates the precise coordinates of these specialised clinics.

The inattentive infrastructure of government health centres has failed to take into account the sheer density of footfall that a government health centre experiences on any average day. Such near-sighted planning has invariably compromised young patients' privacy and confidentiality. For example, in most clinics, 3 or 4 doctors were seen sitting side by side, consulting simultaneously. Yet, it was observed that cursory care in the form of low tones and examination behind curtains, was granted exclusively to female patients while male patients were denied even this perfunctory privilege. During the audit, a young male researcher visited a Medical College and requested the doctor to examine him for sexually transmitted infections (STIs). Much to his discomfort, the attending doctor promptly examined the



patient right in front of the 3 other doctors and patients within the consultation room.

The incessant workload also impacts provider attitudes. Hospital staff become apathetic, irritable and quick to dismiss patients. For example, Ravindra (name changed) who has a walking disability was denied the wheelchair service or any other form of assistance, at both the government health centres that he audited. Similarly, during 4 independent visits to distinct departments of government health centres, the researchers were granted a brief conversation after which they were handed brochures or asked to browse the internet for further information. During other instances, the counsellor's answers were pointed and cryptic, discouraging the researchers from asking further questions

and thereby not providing comprehensive information or preventive counselling on the issues at hand. This is especially concerning as many a time medical practitioners posted in sexual and reproductive health clinics are the first point of contact for patients seeking treatment on a range of sensitive not to mention heavily stigmatised issues, including first-hand experiences of STIs, violence and rape. Gross negligence on the part of a service provider could result in a missed opportunity to duly reach out to a patient, which could bear negative impact on the physical as well as the mental health of the survivor. Thus, it is very important for the service provider to be forbearing and attentive over a prolonged engagement, in order to gain the trust of the latter, so that they may be able to disclose the issue at hand.



## Adolescent Friendly Health Clinics (AFHCs)

In a city like Lucknow with a staggering population of over 28 lakh, where nearly 30 percent of the population belongs to the 15-30 age bracket, there are a sum total **of 2 AFHCs – one for adolescent girls and one for adolescent boys - with 1 counsellor**, in each. Thus **there exists a critical gap between young people's need for information regarding their sexual and reproductive health and rights and the availability of the same**. Despite remote distribution of clinics, and acute shortage of AFHS, existing AFHCs only experience a modest footfall of 20-25 patients a day, on an average. This points to the need to investigate the levels of awareness amongst young people about these clinics, as this finding seems to suggest a lack of the same. This in turn leads to perceived low demand for SRH services by young people.

During the audit, it was observed that the AFHCs are functional, but active promotion of the same within health centers (advertisements, signboards, information education and communication (IEC) material) or, in spaces frequented by young people (schools, colleges) takes place sporadically. The RKSK has in fact provisioned for a strong community sensitisation component around raising awareness on the importance and need for YFHS at the community-level and school-level through peer-education processes. However, the recruitment and training of the Peer Educators is yet to be initiated. A roadblock to accelerating a more structured in-school intervention is the possibility of a backlash similar to that evoked by attempts to mainstream CSE across classes IX, X and XI, through the Adolescent Education Programme (AEP) 2005. Until this date, the AEP continues to be banned in Uttar Pradesh. As a result, at present, there is no ongoing programme that systematically equips young people with information on their bodies, sexual health and rights except for weekly school activation programmes by AFHC counsellors (1 school per week). This is a singularly unfeasible model for promoting adolescent demand for CSE, simply because it cannot achieve the desired scale. At the same time, to increase demand without increasing the capacity of existing AFHCs - in terms of staffing, adequate trainings, accurate IEC material etc. - or distribution, for that matter, would adversely impact quality of treatment and care. Given the dearth of authentic information available to young people, about their bodies, and in particular their sexual health, they rely heavily on the opinions and reviews of their extended peer communities/networks. Therefore, **compromised quality of healthcare meted out to one adolescent or young person, could result in significant loss of potential patients from his/her/ their extended friends circle**.

During the audit, it was also observed that the **AFHCs were located at a safe distance from the OPD, thereby lending adolescents anonymous access to the clinic**. This worked in its favour, as it was evident from the patient records that the clinic enjoyed a small (20-25 patients – as mentioned earlier) but steady footfall despite the fact that its operational hours coincided with that of most schools in Lucknow (10 AM to 2 PM). It was conjectured that students either slip away for a few hours in between school, or skip school altogether in order to enquire about specific SRH issues that concerned them. One counsellor reasoned that students probably find it easier to bypass school authorities than to negotiate parental inquisitiveness. However, it was simultaneously observed that the AFHCs were frequented more by female patients than male patients. Despite the prevalence of risky behavior and a higher mortality rate among men, they seem less willing to talk about their health problems, especially sexual health problems. The reason behind the silence could be the society's misguided tendency to valorise a man's masculinity (known as 'mardaangi' or 'manhood' in colloquial parlance) on the basis of his sexual health. Thus, there emerged a need to rigorously target young men to normalise conversations around sexual health and well-being.

## Unregulated pricing of private healthcare providers makes them unaffordable for young people

On the other hand, at private health centres, whilst motility was enhanced owing to the availability of free bus services, wheel chair services etc., these novelties were countered in equal amounts by the high fees charged for procuring SRH services (250 – 300 INR). In the case of adolescents, spending power is most often extremely limited, as they are either dependents and/or do not make decisions related to expenditure. Therefore the accessibility of healthcare for young people is directly proportionate to its affordability.

Moreover, some of the private health clinics lacked counselling services altogether and in some others it was available, but for a very high price, so much so that they were deemed exclusive and unaffordable by the researchers alike.

## Information either absent or inaccurate resulting in the propagation of misinformation and stigma

The RKSK also enacts the importance of **Information Education Communication (IEC)** on issues ranging from Nutrition, SRH, Mental Health, GBV, NCD and Substance misuse. However, out of the 29 health centres visited, IEC was typically available on issues of nutrition, 'save the girl child' and family planning. On matters of sexual health (menstruation, contraception, STIs/RTIs), mental health and abortion, there was a critical dearth of IEC material. Further, there is an absolute lack of articulation on why these issues are relevant concerns for young people. Thus, as if by design, conversations on sexual health are stifled even inside health centres, leaving adolescents and young people alone with the arduous task of negotiating their right to access the same.

It was also observed that the content of available IEC material is inaccurate. For instance, at one of the AFHCs it was noticed that IEC messaging incorrectly touted that abortion can be availed within the first 3 months of pregnancy, but strongly discouraged one from accessing abortion beyond the first trimester to avoid 'risk to life'. This was an incorrect representation

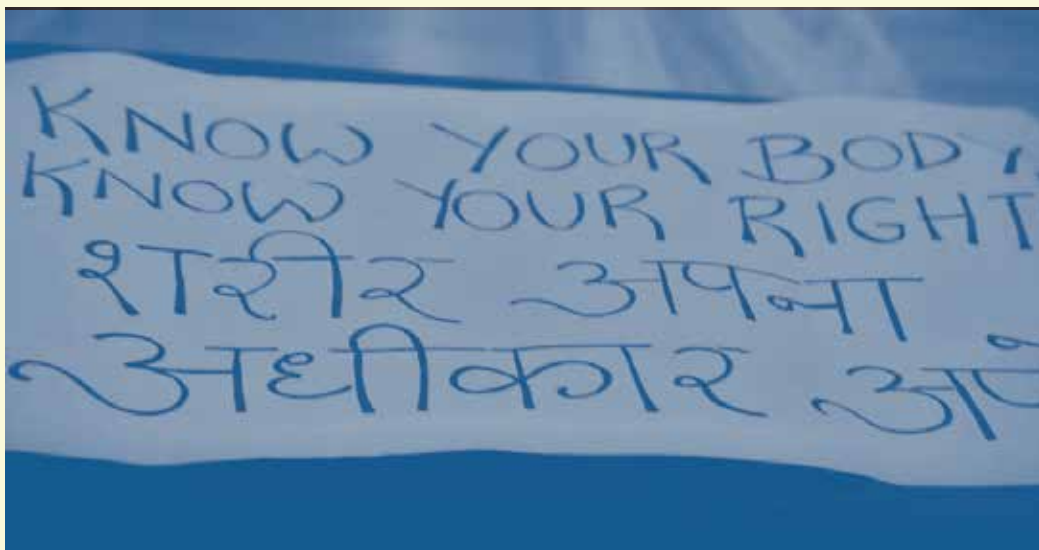
of the Medical termination of Pregnancy Act (MTP) 1971 that clearly states that abortion is permissible up to 20 weeks or five months of pregnancy under specific circumstances.

This served as preliminary evidence of the heightened levels of stigma surrounding abortion services that are embedded in the state – and were further demonstrated across government and non-government health centers alike. The RKSK Operational framework has formally identified abortion counselling as an essential clinical service to guarantee to all adolescents, and by extension of the same, to all young people too. Yet, abortion counselling was available only in 1 out of the 5 health centres that were audited for abortion services. Moreover, all 5 hospitals denied the availability of medical abortion or Medical Methods of Abortion (MMA) drugs which upon a doctor's prescription, can be utilised until the first 7 weeks (49 days) of pregnancy as per the 2002 amendment of the MTP Act.

## Provider biases interrupt access to services for single/unmarried young people, especially young girls and women

Ideally, anyone who seeks sexual and reproductive healthcare is a **rights-holder**, and service providers are duty-bound to provide quality and stigma-free/non-judgmental treatment regardless of the patient's identity. However, in practice, access to available SRH services is facilitated or deterred, depending upon the discriminatory attitude of the service provider based on the acceptability of a service for any patient or the legal/moral legitimacy of a patient and/or her/his/their concern (21). As a consequence, sexually active adolescents, especially single/unmarried young women, marginalised gender identities etc. are heavily disadvantaged.

As per the RKSK Operational Framework the availability of commodities such as weekly Iron & Folic Acid supplementation, Albendazole, Sanitary napkins, Contraceptives and other relevant medication is mandated for all adolescents (10-19 yrs), and by extension all young people too (10 – 30 yrs). Yet, during 43 percent of the audit visits, a high level of reluctance to meet the needs of the



researchers was displayed by the service providers. Researchers were arbitrarily denied access to information, condoms, ECPs and birth control pills.

*For instance, one of the researchers Sana (name changed), visited the OB/GYN department of the PHC and placed a request to avail herself of counselling services for her menstrual problems. The doctor provided sufficient information in response to all her queries and she gained the confidence to ask for emergency contraception too. However, at this juncture, she reports that the attitude of the service provider underwent an immediate transformation, and his sharp retort, "Thumko Chahiye?" ("Do you want it?"), caused Sana to instinctively deny and claim that the contraceptive was in-fact for her sister-in-law. Not trusting Sana, the service provider banged the registration slip on the table and rebuked, "Kya thumko yeh dukaan lagta hai?" ("Do you think this a*

*shop?')*

*At the OB/GYN department of PHC II, Sana decided that she would attempt to access Mala D (birth control pills), in the guise of a married woman – having applied the ultimate marker, the 'sindoor' on her forehead. Sana reports that she faced no problems in accessing the commodity. The service provider granted her birth control and responded to all her queries adequately.*

*In another instance, Vinod (name changed) was effectively escorted outside the hospital premises on the orders of an indignant counsellor, for seeking counselling on birth control on behalf of his 'girlfriend'.*

Further, 2 government health claimed that condoms had been out of stock for over 1 year. Instead, researchers were redirected to pharmacies outside the health centre to procure the same at a much higher rate.



sexual and reproductive **health** insofar as she/he/they are bound by the institution of marriage.

These experiences make it important for us to analyse the social and cultural norms that lead to stigma and discrimination. Young and single/unmarried people, more so adolescent girls and women, are infantilised by society. They are neither conceded bodily integrity nor opportunities for autonomous decision-making, especially on issues concerning their bodies, sexuality and SRH. This is accompanied by the heavy regulation of their access to comprehensive information that is critical in facilitating healthy and informed decision-making. Thus, the perceived gender and marital status of these researchers, and the confidence exhibited while placing queries regarding heavily stigmatised services, may have been viewed as transgressions of unsaid social norms that affirm a patient's right to choice on matters of their

***Ravindra explained that he engaged in regular sexual intercourse with his girlfriend. The receptionist seemed shocked and demanded for a photo of the girlfriend. A confused Ravindra told him that he did not have a photo on his person, and asked the receptionist what purpose that would serve.***

Ravindra (name changed), one of our researchers is a 27 year old man with a significant limp in his stride. During his audit, he was stopped at the reception and interrogated by the man and woman attending to the reception, "mujhe batao kya kaam hai?" ("Tell me, what work do you have here?") Ravindra was hesitant to answer their questions at first, as there were three other people sitting on a bench adjacent to the reception, and it was unclear if they were hospital staff or patients. But the man and woman at the reception counter persisted saying that the consulting doctor would charge a hefty sum of Rs.500, and therefore recommended that Ravindra tell them what health problems he was facing. Ravindra explained that he was sexually active and has been experiencing symptoms of STIs. The man at the reception promptly enquired, "What is your age and height? How many times have you had sex? And with whom have you had sex?" Ravindra explained that he engaged in regular sexual intercourse with his girlfriend. The receptionist seemed shocked and demanded for a photo of the girlfriend. A confused Ravindra told him that he did not have a photo on his person, and asked the receptionist what purpose that would serve. Then, the man at the reception insisted that Ravindra bring his girlfriend along for the next check-up but assured Ravindra that privacy and confidentiality would be maintained.

This experience left Ravindra with a very confused and unpleasant feeling. During the debriefing session, Ravindra voiced that had been "harassed" by the hospital staff. It is true that such persecution could have been administered upon anyone notwithstanding their identity or its markers, and would be condemnable all the same. However, there exists a corpus of work in the area of disabilities and sexual health and rights that details the misconceptions and stigma surrounding persons with disabilities' sexual rights and capabilities. Thus, a more nuanced reading of this episode points us to the possibility that the targeted disputation of claims of sexual activity and the repeated dismissal of claims of a regular sexual partner could in fact, be directly linked to Ravindra's disability.

Accessing sexual and reproductive health services is in of itself stress-inducing given the high levels of stigma and 'othering' meted out to anybody, by his/her/their immediate environment. Thus, placing the burden of proof of sexual behaviour, sexual partners or even 'love', on a patient who has come to access these services, due to preconceived notions stemming from societal stigma, is to deliberately cause the patient trauma and mental anguish. It is a deplorable practice that demands immediate remedy.

## Medical diagnosis is seen to override patient's informed 'choice' and 'consent'

In 2010, the medical procedure of 'intimate examinations' came under the spotlight when it was found that women in Canada were being subject to examination of their genitalia during the time that they were under the influence of general anesthetic. The primary outrage was that the procedure was being performed without the knowledge and consequently the 'informed consent' of the patient. This was seen as a breach of the patient's right to privacy as well as an assault on the dignity of the patient.

In India, the most recent public debate on 'bimanual examinations' occurred in 2013 when the infamous 'two finger test' or the per-vaginal examination was conducted on a 'rape' survivor to assess her habituation to sexual intercourse among other things. Public outrage was registered after which the Delhi Government instituted a 3-member committee who maintained that the examination was critical to evince forced penetration and evaluate the 'extent of injuries', but additionally drafted strict guidelines mandating **express and informed consent** of the patient as a prerequisite to carrying out the procedure.

However, such profound articulation of 'consent' seems tethered to the subject of 'sexual violence'. Intimate

examinations undertaken during the course of routine consultations that are outside the ambit violence/coercion, do not elicit the same extent of debate or disapproval. Over time, medical institutions have acquired the license to appropriate bodies of patients insofar as it is towards the sacrosanct task of healing or restoration. This is a silent contract that has evolved between the medical community and those who lie outside of it, which invests significant power in the former whilst simultaneously negating the latter's agency by presuming his/her/their consent as 'implicit' for all actions and decisions taken upon the former's 'enlightened' discretion.

**During 20 year old Rani's (name changed) mystery audit at a CHC, she was directed to a general physician due to the unavailability of a specialised counsellor for abortion. The elderly practitioner inquired about Rani's health. Rani told her that her period had been delayed by three months and that she had been experiencing bouts of vomiting and nausea. Rani admitted to being sexually active. Rani was then asked to step behind the curtain for a check-up, whereupon the practitioner proceeded to conduct an intimate pelvic examination i.e. she inserted a finger inside Rani's vagina to assess the cervix. This procedure took Rani by complete surprise and made her feel violated.**

The patient's complaint was one of a potential pregnancy. There were no signs of abnormalities and no



complaints of abrasions or unusual bleeding that could have prompted the procedure. Yet, the attending doctor had **not thought it necessary** to inform the patient of the range of options available for detection of pregnancy such as urine test or the pregnancy kit. Instead, the patient's informed choice had been superseded by the practitioner's technical expertise and medical diagnosis skill, and a bimanual (internal) pelvic examination was undertaken to assess the womb. Even if the act was committed in good faith - in the interest of the patient's well-being and time at hand – the practitioner had not thought it necessary to clarify with the patient whether or not she would be comfortable with such an invasive procedure being carried out on her body. This pattern of casually compromising the dignity of a young researcher's personhood,

was observed throughout the audit.

## Stigmatising HIV related services and absence of counseling services create anxiety and uncertainty among young people

Researchers who sought HIV counselling, were commonly asked, up-front, if they belonged to a 'high-risk' category. Firstly, the use of such ominous technical terminology that is not easily comprehensible to laypersons, only serves to exacerbate the fear that already surrounds STIs, in particular HIV. This could cause the young patient





to retreat immediately.

Secondly, the pattern of questioning exposes the lack of comprehensive knowledge on the transmission of HIV and/or the insensitivity of the service provider, as it reinforces the myth that only MSM (men who have sex with men), GBT (Gay Bisexual and Trans), sex workers or people with multiple sexual partners are likely to contract HIV. Besides, the prevalence of extreme social stigma and indirect legal barriers in the form of Section 377 of the Indian Penal Code further preclude one's avowal of belonging to a 'high-risk' category. Formally admitting to this, could endanger one's sovereignty. Thus, the patient is most likely to evade this question.

All private health centres charged a heavy fee for HIV counselling – anywhere between Rs 350 – Rs 500. Further, counselling services were granted only if the patient had already been tested for HIV and could evince status of the same. Such conditional counselling is first and foremost irresponsible on the part of the counsellor. The status may already be known to the patient who may choose to not disclose the same, whilst reserving the right to counselling and information - that could potentially

change risk behaviours to control the transmission of HIV- alongside the right to privacy. Withholding such important information could endanger the patient's life.

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# Recommendations

The findings from this study point to establishing the identity of young people as rights holders and not just beneficiaries. For most researchers, the stigma and judgmental attitude meted towards them by service providers led to high levels of anxiety and dejection. This held true even when researchers possessed information and knowledge about their sexual and reproductive rights. Therefore, the effect of this stigma on young people who have limited or no awareness about their sexual and reproductive rights can be profound. This points to an urgent need to improve the quality of health services and make them “youth friendly” that ultimately promotes health well-being, rather than the contrary.

Based on the findings listed above, the study urges state and non-state stakeholders to:

## **ENSURE THAT ALL HEALTH CENTER STAFF POSSESS BASIC KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH**

All health centre staff, especially those posted at the registration counters, should be well equipped with basic nomenclature related to sexual and reproductive health, information on the exact location and responsibility/scope/concern of all departments and facilities housed within the health centre.

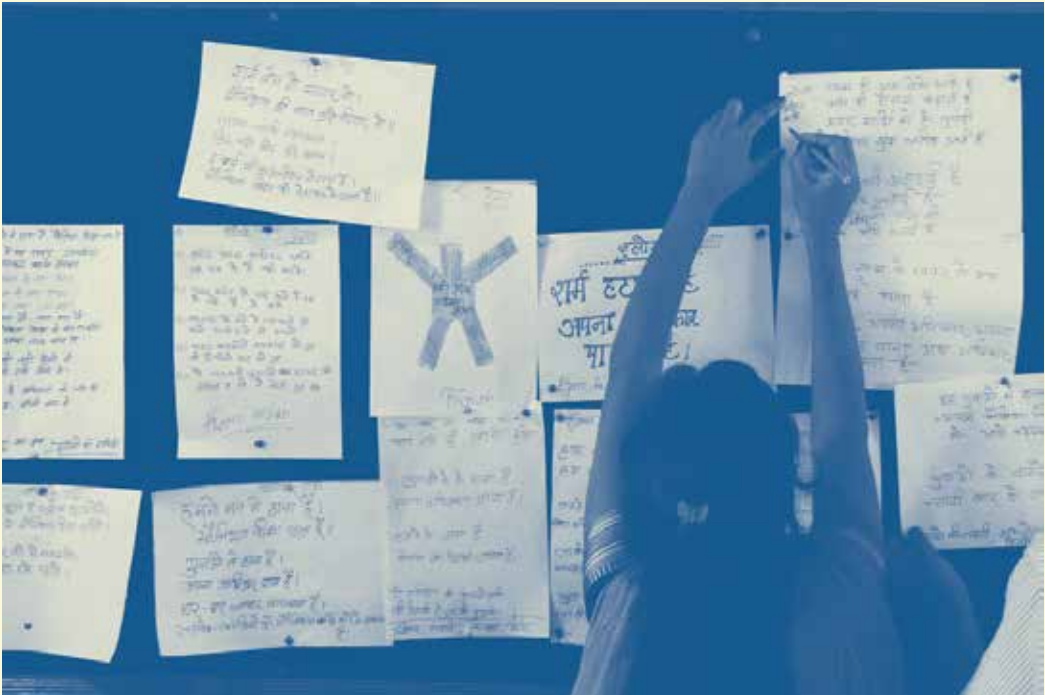
This is especially important in government health centres where all staff should additionally be well-informed about those facilities that are mandated by government schemes and policies.

## **WARRANT NON JUDGMENTAL AND RIGHTS AFFIRMING SERVICE DELIVERY**

All health care providers must guarantee inviolable privacy and confidentiality for all young people; Respect the bodily integrity of all young people; provide services to all, without discrimination on the grounds of age, sex, gender, sexuality, class, caste, economic status, religion, ability, employment etc.; and, adhere to a patient and thorough approach while treating young people, especially adolescents.

## **INTENSIFY THE OUTREACH OF QUALITY INFORMATION ON YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH AND SERVICES**

The State must intensify the publication and visibility of stigma-free, evidence-based and factually accurate information, education and communication (IEC) material through diverse media, to promote awareness on the sexual and reproductive health concerns of young people (including STIs/



RTIs, contraception, abortion etc.). Existing IEC material must be reviewed and revised in order to remove inaccurate information.

### **ENSURE AFFORDABILITY OF COMMODITIES AND SERVICES**

The pricing of all SRH services must be regulated and made available at affordable prices, keeping in mind that most young people may not be in positions to make decisions related to expenditure.

### **MAKE FACILITIES AND INFORMATION ACCESSIBLE**

Even though this study is limited in this scope to map experiences of disabled young people, there is an urgent need to make information accessible (such as IEC material in Braille) and facilities friendly for disabled people (for example, wheelchairs easily available and

given to people with disabilities).

### **EXPAND OUTREACH OF AFHCs**

As mentioned earlier, Lucknow with a population of 2.186 million has only 2 AFHCs. This points to the urgent need to expand the number and reach of AFHCs. Additionally, proactive steps to increase awareness about AFHCs, especially among its target audience – adolescents and young people – must be taken.

### **FAST TRACK THE SELECTION, APPOINTMENT AND TRAINING OF RSKS PEER EDUCATORS**

The peer educators under the RSKS program are critical link between communities and services. They will raise community consciousness on the importance of sexual and reproductive health information

and services for young people and sensitise these environments to young people's need for the same, thereby promoting an enabling environment for young people's demand and access to sexual and reproductive health services. Therefore, ensuring that peer educators are identified and trained is necessary.

### **IMPROVE INFRASTRUCTURE TO ENSURE PRIVACY FOR PATIENTS**

Urgent installation of separate enclosures within SRH departments of all health facilities must be carried out in order to enable individual practitioners to attend to patients simultaneously, whilst upholding the privacy and confidentiality of each patient.

### **MAINSTREAM COMPREHENSIVE SEXUALITY EDUCATION – LIFT UTTAR PRADESH'S BAN ON ADOLESCENT EDUCATION PROGRAM (AEP)**

Without access to information on their bodies and rights, young people will continue to be disempowered and unable to make healthy and informed decisions.



शरीर को प्यार से छुम लो  
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ये जानकारी पहुँचनी हर घर तक सीमित न रहे ये सिर्फ़ तुम तक!

राम ने पढ़े बाकर ने पौनिकता की बात करो भीकर 2

शरीर अपना, अधिकार अपने!  
शर्म हटाओ, यौनिकता शिक्षा लाओ!

**KNOW YOUR BODY  
KNOW YOUR RIGHTS**

शरीर अपना, अधिकार अपने

## Conclusion

Findings from this study underline the deep discomfort that the society at large, feels with regard to young people's ability to make decision, especially with relation to their sexuality. Despite several research studies pointing out the early age of initiation into sex, and challenging our own assumptions on young people's sexuality, social beliefs dismiss young people's decisions around their bodies and sexuality. This denial of the reality is further perpetuated by moral standards that legitimise sex only within marriage. Age at which people have sex is therefore not probed enough, given the high incidence of early and child marriage in India. Therefore, in our quest to make SRH services rights-affirming, we have to fundamentally shift our attitude and move towards beliefs that affirm young people's abilities to make decisions around their bodies. We must also challenge moral codes that equate sex with marriage and come to terms with the reality of all people, including young people engaging in sexual activity outside, or regardless of marriage. We also need to consider the role of health service providers and the larger health system, especially the public health system. Service providers – doctors, nurses, ANMs, ASHAs, paramedics and other facilities staff – are from the same society that disregards young people's sexuality. Their

own attitudes and beliefs play out in service delivery. However, no focused attention is paid to examine these, during their professional training. In order to shift towards non-judgmental and rights affirming service delivery, it is therefore important to work with this cadre of health care providers.

The most important learning from this study has been in relation to the vulnerability of young women. The judgmental attitude and shaming of sexuality is mostly meted out to young women. Any young woman coming to the service with any experience of sex, is shamed, harassed and in some cases, hurriedly put in the "high risk" category. Abortion related services are the most stigmatised and difficult to access. During the course of this audit, the plight of women who have had to depend on unsafe and illegal services, because of fear of ridicule and harassment, was truly felt by the researchers. That women, especially young and unmarried women risk their own life to escape judgmental attitudes of service providers, was unimaginable, deplorable, and caused anger amongst the research team.

This mapping study has been a critical opportunity for TYPF to build youth-led research agendas and take youth-centered methodologies in the field of evidence generation. Even though this study has



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attempted to map first-hand experience of our researchers, it contains important qualitative evidence on what young people actually face when accessing SRH services. As mentioned earlier, these barriers may resonate with experiences faced by other communities – women, trans people, same- sex desiring people, sex workers, disabled people and other disadvantaged communities. We recognise that all those factors create further stigma and marginalisation, making the decision and the experience to access health services even more difficult. Location has also been an important factor – we assume that such services may be easily accessible in urban areas. However, despite Lucknow being a city, we faced several challenges in increasing young researchers' confidence in accessing SRH services. Generating such evidence, emanating from similar methodologies in rural and semi-rural locations must also be undertaken and will throw light on other forms and experiences of stigma and vulnerability faced by young people that require specific and specialised attention. In conclusion, TYPF has conducted its study as one of the several means of foregrounding young people's voices in articulating their sexual and reproductive rights as well as of ensuring young people's participation in holding States accountable. We are committed to facilitating processes wherein young people determine their own knowledge agendas, generate evidence, and use this evidence to advocate for their rights with

government and non-government stakeholders. This study is a step in that direction.

### **A note on the title of this study:**

The original form of this proverb, "Seen, Not Heard" was specifically meant for young women who were expected to keep quiet. This opinion is recorded in the 15th century collections of homilies written by an Augustinian clergyman called [John] *Mirk's Festial*, circa 1450. The proverb is also used often for children who are expected to show "good behavior" by being quiet. We found this proverb befitting for the state of young people, especially young women. Despite a staggering number of young people in India and the world, their voices and opinions are seldom heard. This study is an attempt to make young people's voices heard.

Source: <http://www.phrases.org.uk/meanings/children-should-be-seen-and-not-heard.html>

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The Audit team includes:

**TYPF:**

Reena Khatoon  
Manasa Priya Vasudevan  
Anuj Gopal Dubey

**Yeh Ek Soch Foundation:**

Shariq Ahmad Khan  
Madhulika Mishra  
Md Zeeshan Siddiqui

**Study Researchers:**

Amit Verma  
Imtiyaz Ahmad  
Mahendra Dixit  
Mohit Siwach  
Neelam Nishad  
Pawan Yadav  
Rajini Kashyap  
Ranjesh Singh  
Sahiba Khan  
Shaheen  
Vidushi Sinha  
Zainab Siddiqui

**Illustrations:**

Vanika Sharma

**Design and Layout:**

Sandip Kuriakose

# Glossary

**TYPF** - The YP Foundation  
**SRHR** - Sexual and Reproductive Health & Rights  
**KYBKYP** - Know Your Body Know Your Rights  
**HIV** - Human Immunodeficiency Virus  
**POCSO** - Protection of Children from Sexual Offences Act  
**SRH** - Sexual and Reproductive Health  
**AEP** - Adolescent Education Program  
**NACO** - National AIDS Control Organisation  
**SCERT** - State Council of Educational Research & Training  
**CSE** - Comprehensive Sexuality Education  
**STI** - Sexually Transmitted Infections  
**ARSH** - Adolescent Reproductive and Sexual Health  
**AFHC** - Adolescent Friendly Health Clinics  
**RKSK** - Rashtriya Kishor Swasthya Karyakram  
**ANC** - Ante Natal Care  
**PNC** - Prenatal Care  
**HRLN** - Human Rights Law Network  
**ASHA** - Accredited social health activists  
**ANM** - Auxiliary Nurse Midwife  
**WHO** - World Health Organisation  
**MoHFW** - Ministry of Health and Family Welfare  
**YFHS** - Youth Friendly Health Services  
**FGD** - Focus Group Discussions  
**OPD** - Out- Patient Department  
**AIDS** - Acquired Immuno Deficiency Syndrome  
**ASAP** - Asia Safe Abortion Partnership  
**RTI** - Right To Information  
**ICTC** - Integrated Counselling and Testing Centres  
**IEC** - Information Education and Communication  
**OPD** - Outpatient Department  
**GBV** - Gender Based Violence  
**NCD** - Non-Communicable Diseases  
**MTP** - Medical termination of Pregnancy Act  
**MMA** - Medical Methods of Abortion  
**ECP** - Emergency Contraceptive Pills  
**OB** - Obstetrics  
**GYN** - Gynecology  
**PHC** - Public Health Centre  
**CHC** - Community Health Centre  
**MSM** - Men who have sex with men  
**GBT** - Gay Bisexual and Trans

# Seen, Not Heard

## Youth Led Audit of Sexual and Reproductive Health Services in Lucknow (2016) Assessment Tool

1. Name:

2. Gender:

3. What is the name of the PHC/CHC/DHC you visited?

4. List the services and/or commodities you attempted to access, the cost of each and whether or not you receive them?

Service/Commodity	'√' to indicate that you received, and 'X' to indicate that you did not	Cost
1.		
2.		
3.		
4.		
5.		

5. Comment on the availability of the following commodities based on your observations:

- Sanitary napkins
- Contraceptives (condoms, OCP, ECP)
- Pregnancy testing kits
- Abortion pills

## Assessing the quality of the health centre

6. Was the health centre easy to find? Were there signboards en route to direct you to the location? Describe.

7. Comment on the cleanliness and hygiene levels of the health centre.

8. No. of days the clinic is functional in a week? Pls. Specify.

9. What are the clinic timings? Pls. Specify.

10. Was there any indication/mention of adolescent friendly health clinic (AFHC) at the facility? Where and how were they mentioned? (for example, was there a signage for a AFHC? A poster?)

11. Was IEC material available on the following issues:

- A. Nutrition
- B. SRH
- C. Mental health
- D. Gender based violence
- E. Substance misuse
- F. Sex-determination
- G. Female foeticide
- H. Abortion

## **Assessing the quality of the department**

12. Which department were you directed to? Was it the appropriate department?

13. Did the health centre have a department-specific room? Describe the layout of the room you were directed to.

14. Comment on the location of the department. Was it away from the OPD/ Labour Room or any other crowded place?

15. Did the consultation room ensure privacy and confidentiality? Illustrate with examples.

## **Assessing attitudes of the medical practitioner**

16. Please specify who attended to you - was it a senior practitioner or an assisting nurse (VHN, ANM etc.), or other? Why?

17. If you did not receive the service(s)/commodities you sought, what were the reasons stated by the service provider?

17.a. Were you asked by the service provider to come back with a guardian?

18. Did the service provider ask questions to verify if you had experienced any form of sexual assault or violence? Comment on this.



19. Did you find the service provider to be sensitive and non-judgmental in his/her interaction with you? Why did you think so?

20. Did the medical practitioner proactively provide information on the service you sought? (for example, if you went for HIV counseling, did the service provider give information on modes of transmission, prevention etc?) Support your answer with examples from the interaction

21. Are you satisfied with the services that you received here today? Why or why not?

22. Would you like to refer your peers to this clinic for Adolescent Health issues? Why or why not?

23. Please utilise this space to elaborate on any additional comments or anecdotes that you would like to share.

**For queries and feedback contact:**



**The YP Foundation**

N 204, Greater Kailash, Part 1, New Delhi - 110048. India  
Phone : +91.11.46792244 | Email: [info@theypfoundation.org](mailto:info@theypfoundation.org)

Facebook : [theypfoundation](https://www.facebook.com/theypfoundation) | Twitter: [theypfoundation](https://twitter.com/theypfoundation)

[www.theypfoundation.org](http://www.theypfoundation.org)



