Sexual Health Education Camps in Rural Maharashtra

Project Country: **India**
University of California, San Diego | International House
Niraj Malliwal '14, United States of America, UCSD
Website: projectrishi.ucsd.edu | ***Blog:*** projectrishi.wordpress.com

At the end of 2012, the gang rape in New Delhi, India received widespread international media attention. People around the world held their breath to hear about the fate of the poor girl in India who had been brutally beaten, raped, and left to die naked on the side of the road. Her tragic death mobilized protesters and cries for legislative change all over India. Over the past three decades, the number of rape victims officially recorded in India has increased from 2,487 (1971) to 24,206 (2011).[1] While India does not have the highest incidence of rape in the world, the sexual health education provided to children there is uneven and incomprehensive. Sexual health topics are taboo in India, and in some extreme cases such as Punjab and Uttar Pradesh, police officers turn on the victims who come to report assaults. This leaves women in India scared to speak out and mistrustful of their local law enforcement authorities. However, the current momentum surrounding the Delhi gang rape and its trial makes the political and social climate in India uniquely charged to galvanize larger social change across the country.

Background: At 1.24 billion people, India's population is the second largest in the world, however according to World Bank statistics in 2010, 29.8% of India's total population is under the international poverty line.[2] While metropolitan cities such as New Delhi, Bangalore, and Mumbai boast high literacy rates and function as technology centers where the rich elite of the country live, most of the country is made up of small villages based on subsistence farming. Due to the extent of poverty in India, the government is stretched too thin and cannot afford to set up rural social and health programs across the country. They rely on non-profit organizations such as Project RISHI to come in and set up their own programs. Project RISHI at UCSD is a chapter of a 501(c)(3) non-profit organization originally established at UCLA in 2005 whose mission is to promote the sustainable development and growth of rural Indian communities. Our target village is Anandwan, a community rehabilitation village for leprosy patients and disabled people shunned from society spread over 200 hectares. It has two hospitals, a university, an orphanage, and a school for the blind. In partnership with local community members and social enterprises, we identify issues central to our target communities and provide the resources necessary to implement solutions through extensive field research and on-campus initiatives.

Anandwan is located near Warora, in the Chandrapur district of rural Maharashtra, India. Baba Amte, the renowned Indian social activist who established Anandwan, emphasized "green" practices such as sustainable energy utilization, waste recycling, and minimizing usage of natural resources. In the spirit of sustainability, the only two commodities imported into Anandwan are oil and salt. To account for their other needs, the ashram boasts vocational rehabilitation training centers so its residents can learn a trade that takes into account their disability. These skills are applied at the various small-scale industry units at the village that generate income and provide other basic commodities such as refrigerators and bicycles.

Project Proposal: During Project RISHI's last trip to Anandwan, the frequency of sexual harassment and rape cases was brought to our attention, therefore sexual health education became the focus of our agenda. Our Project for Peace is to create age-specific sexual health education camps, set up bystander prevention training seminars for adolescents and adults, and establish a support system for victims and their families at the village. The camps would be organized into hour-long seminars that would use tactile diagrams and visual aids in order to educate them appropriately and effectively.[3]

Anandwan, Hindi for "forest of joy," is a sanctuary for people rejected by society. The grounds are unusually safe for its inhabitants, and although this is a boon for those who live there, the children who grow up with aspirations of starting a new life in other parts of India do not receive a realistic picture of outside societies. These children, many of which are disabled, often fall victim to sexual abuse. Many of the children do not realize they are being abused until it is too late to escape the situation. This

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[1] Udas, Sumnima. "Fast-track Court Hearings Begin in India Gang Rape Case." *CNN*. N.p., 21 Jan. 2013. Web. 22 Jan. 2013.
[2] "India." *The World Bank*. N.p., n.d. Web. 23 Jan. 2013.
[3] Sharma, B. R. "Acquaintance Rape among Adolescents and the Youth: A Fast Emerging Public Health Problem." *Trends in Medical Research* 2.1 (2007): 21-26. Print.

problem stems from the lack of sexual education within Anandwan. The blind and deaf schools lack the proper models and know-how to effectively teach the children the difference between a "good" or "bad" touch. This distinction would allow a child to recognize sexual advances and either get help or stop the situation before it escalates. According to studies, female victims of these attacks have historically been at greater risk for mental disorders such as depression or post-traumatic stress syndrome leading to suicide, unwanted pregnancy, miscarriages and other complications during pregnancy.[4]

These health education camps will give the children a safe, stigma-free space where they can learn about issues that they will face outside of Anandwan. By also using methods that are tailored to the child's specific disability, our initiative will try to empower the children with the knowledge necessary to lead safe, stable lives in society. According to UN statistics, only 10%–20% of child sexual abuse cases are officially reported.[5] People need to feel comfortable speaking out to decrease the prevalence of these cases and increase their self-esteem. In India, sexual health and abuse are taboo topics and even the teachers do not know how to tackle them appropriately. Acknowledging that this will be a sensitive subject in India, we will work with the school to develop an approachable curriculum. We are also finding local organizations who work with blind and deaf children to help us find tactile models that we can use to demonstrate anatomy. The administrators at Anandwan will provide us with interpreters and sign language experts who will make communicating with the children easier. They will also help the children more effectively call out for help in a given scenario. The informational health kits we hand out at the end of the camps will include items such as a whistle which can be used to draw attention when in distress. Ideally, the exposure provided by the sexual health education camps will make the children more comfortable speaking out about these situations.

Another big part of sexual assault prevention is bystander intervention training. In the gang rape case in India, many civilians as well as police officers saw the victim lying helplessly on the ground after being brutally attacked. Despite this scene in front of them, not one individual bothered to call for medical attention or even attempt to help her.[6] This type of behavior will only convey the notion that such behavior is socially acceptable, and thus will result in further incidents. To avoid this bystander behavior, we will initiate a program that trains people how they can help someone who is being sexually assaulted. We would like to hold a seminar once a month on this topic with the people of Anandwan. By intervening, bystanders can stand up to perpetrators by showing that they do not condone of such behavior, and garner the support of their peers.

There are multiple tools we will use to measure the success of our camps: the number of children attending the camps, the amount of audience participation, the surveys given to children and administrators after the seminars, and the frequency of people seeking help. Attendance will help us gauge the breadth of our outreach, and audience participation will show us how engaged the children are in the content and activities. Finally, anonymous surveys and the frequency of visits will show us how much impact our curriculum had on the community. These tools will help us quantify how much information the children absorbed from the seminars, and using this information we can better tailor our efforts in the future. In the long-term, a decline in the incidence of sexual abuse cases will be the best impact of our initiative. We hope to bring peace of mind and stability in gender relationships. It will be a small step in resolving the conflict brewing in India over women's rights and equality between genders.

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[4] Jewkes R, Sen P, Garcia-Moreno C. Sexual violence. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. World Health
Organization. Geneva, 2002

[5] Violence Against Children: United Nations Secretary-General's Study, 2006; Save the Children, 10 Essential Learning Points: Listen and Speak out against Sexual Abuse of Girls and Boys – Global Submission by the International Save the Children Alliance to the UN Study on Violence Against Children. Oslo, 2005

[6] Chowdhury, Kavita. "45% Delhi Women Believe Police Will Not Do Anything: Study."*Business Standard*. N.p., 14 Jan. 2013. Web. 24 Jan. 2013.

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Davis Project for Peace – Sexual Health Education Camps in Rural Maharashtra

Tentative Budget

Health Kits (1000) at $5 each - $5000

Doctors (3) at $500 salary each - $1500

Therapists (2) at $300 salary each - $600

Teachers (2) at $200 salary each - $400

Supplemental information packets for adults (200) at $5 each - $1000

Sexual Health Education course and supplies - $500

Projectors (2) at $150 each - $300

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