Interviews

Periodically, youth-policy.com talks with someone, somewhere in the world working to craft or implement youth reproductive health policy.

Our questions and the insightful answers from these practitioners shed light on the always challenging, often interesting, and sometimes frustrating policy process.

Do you know someone working on youth reproductive health policy you think we should talk to? Contact Us with your suggestions. Youth-policy.com will contact that person, find out about his or her work, and figure out how to share their experiences.

September 2009 Youth Policy Practitioner
Theophilus Ekpon, Team Leader, Center for Sustainable Development and Education in Africa, Nigeria.

We spoke with Mr. Ekpon about his role in forging a partnership between the United Nations Population Fund (UNFPA) and the Nigerian Ministry of Youth to review the National Youth Policy and ensure that the revised policy adequately addresses youth reproductive health concerns. View full discussion

Interview Archives

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Note

The views expressed by the interviewees do not necessarily reflect those of the U.S. Agency for International Development or the U.S. Government.

Last Updated: Sep 24, 2009

Mr. Theophilus Ekpon

Team Leader, Center for Sustainable Development and Education in Africa, Nigeria, September 2009

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Mr. Theophilus Ekpon is Team Leader for the Center for Sustainable Development and Education in Africa, based in Nigeria. He is currently a consultant with the United Nations Population Fund (UNFPA) in Nigeria, where he assists with facilitating the ongoing review of the National Youth Policy and development of a national youth profile. He has been the President of Youth Initiators Nigeria and a Special Youth Fellow with UNFPA in New York, where he carried out research on UNFPA-supported integrated livelihoods interventions among young people and developed a report from a global E-consultation on youth involvement in poverty reduction strategies in collaboration with the World Bank.

We asked Mr. Ekpon to discuss his role in forging a partnership between UNFPA and the Nigerian Ministry of Youth to review the National Youth Policy and ensure that the revised policy adequately addresses youth reproductive health concerns.

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Youth-policy.com: Tell us about why there is a need to review the National Youth Policy. Who initiated the review? What was the impetus?

Mr. Ekpon: The need to review the National Youth Policy became obvious due to the fact that the policy was last reviewed in 2001. Again, challenges faced by young people in Nigeria vary with time and need appropriate policies to address them. The idea of the review came as a result of a discussion between the director of the Ministry of Youth and me. The drive to review the policy came as a result of so many development challenges (especially adolescent reproductive health and livelihoods) that were not

adequately addressed in the existing policy.

Youth-policy.com: Tell us about the partnership between UNFPA and the Ministry of Youth to review the National Youth Policy. How did it come about? What does it involve?

Mr. Ekpon: UNFPA is giving both technical and financial support to the Ministry of Youth for the review of the National Youth Policy. This partnership started when I reported back to UNFPA on the outcome of my meeting with the director of the Ministry of Youth to review the policy. It was then followed by a proposal from the ministry to UNFPA. This partnership entails the provision of technical guidance and financial support to the Ministry of Youth.

Youth-policy.com: In what ways do you hope to strengthen the current National Youth Policy with respect to reproductive health?

Mr. Ekpon: I hope to strengthen the reproductive health section of the National Youth Policy by involving young people who work in adolescent reproductive health to provide inputs during the proposed consultations in all geopolitical zones of Nigeria. I am also working with the vast network of adolescent reproductive health experts in Nigeria to get their inputs.

Youth-policy.com: What will the review process involve? Who will take part? How long will it take? Who is financing it? What is the expected outcome?

Mr. Ekpon: The review process involves the development of an initial draft document that will be given to a wide range of stakeholders and the general youth population for inputs. The review is taking into consideration stakeholders in youth development and empowerment, ministries and agencies that work with young people, youth networks, and the underserved youth population. The review process will take close to 12 months and we are expecting it to be completed by February 2008. UNFPA and the Ministry of Youth are the major source of finance. We expect that at the end of the review process, a national policy document with an implementation mechanism that addresses the heterogeneous issues of youth in Nigeria will be developed, launched, and disseminated. The United Nations will assist with the dissemination and implementation of the revised policy.

Youth-policy.com: Tell us a little about how you personally became involved in the review process.

Mr. Ekpon: I became involved in the review process due to my current position with UNFPA as a consultant on youth development issues and my passion to influence policies that affect young people. I was a Special Youth Fellow with UNFPA, President of Youth Initiators Nigeria, and am now on the Advisory Team of the Center for Sustainable Development and Education in Africa. I was also involved in the development of Nigeria's National Economic Empowerment Development Strategy II (NEEDS II), which is Nigeria's Poverty Reduction Strategy Paper.

Youth-policy.com: What challenges do you expect to confront in the policy review process?

Mr. Ekpon: The most noticeable challenge is the issue of getting inputs from rural youth into the review process. Over 70 percent of young people live in the rural areas and getting them to attend such consultative processes has been a major challenge in the past. The issue of bureaucracy in government is another challenge that we will have to cope with.

Youth-policy.com: How are you planning to meet those challenges?

Mr. Ekpon: We are planning to make the consultative process a grassroots-oriented activity rather than one that occurs only at the state or zonal level. The issue of bureaucracy in government will be a difficult one to overcome, but I do hope that, as the government is taking ownership of the review process, things will be able to move faster.

Youth-policy.com: Can we get back to you for an update when it is all over?

Mr. Ekpon: Yes.

Do you have a question for Mr. Ekpon? If so, please email to info@youth-policy.com, and we will synthesize your questions for Mr. Ekpon to respond to. Thank you!

Contact Information for Mr. Ekpon:
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Last Updated: Sep 15, 2009

Ms. Sandra Aliaga

Participation Resident Advisor at the Center for Development and Population Activities, La Paz, Bolivia

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Sandra Aliaga is a social communicator with 25 years of experience in reproductive health and HIV/AIDS policy analysis, advocacy, formulation, implementation, and evaluation throughout Latin America. She is a gender expert who has researched, taught, and published extensively on mainstreaming gender into HIV/AIDS and reproductive health advocacy strategies and polices. She has more than 20 years of experience working as a reproductive health and gender trainer and women's rights advocate. She has extensive experience in HIV/AIDS, reproductive health, and gender policy analysis and advocacy. She has worked in Bolivia and throughout the LAC region on strengthening advocacy networks and the political participation of civil society groups. She is a working journalist with experience in all mass media and in governmental communications. She has taught university courses on communication; reproductive health information, education, and communication; and gender mainstreaming.

Interview Questions

Youth Policy.com: What interested you in youth RH? Could you please highlight some of the YRH-related projects that you have worked on? What particularly interested you about this/these project(s)?

Ms. Aliaga: The possibility of working with youth is very, very big. They [youth] seem to be more willing to assume changes. And working on health issues with youth gives you the possibility of thinking that you are working with people who are not totally consumed with their prejudices or with an old way of thinking about life. And for the Bolivian context, I prefer to talk about sexual and reproductive health (SRH) because I think that adding sexual health to our work is absolutely meaningful because we assume that SRH refers to the question of having or not having kids, [rather] it should be a question of having or not having a good life, and the possibility of exercising your rights—to be happy, to have pleasure, to develop as a human being. When you work in the field of SRH, you work with issues such as gender, human relations, and human development. So, youth are at a beautiful age, where they can build on other values that do not come from a patriarchal society.

As the co-founder of the Center of Investigation, Education, and Services in Sexual and Reproductive Health (CIES), which is a nongovernmental organization (NGO), one of the YSRH projects we developed was the "Youth Corner Program," which is an SRH educational program geared toward adolescents that enabled youth to participate, explore, and discuss information related to adolescent sexual and reproductive health (ASRH) at clinic sites. At the sites, the youth could engage in reading educational materials, discussions, informative games, and other activities. Other components of the program involve ARSH personnel providing information and education to youth, teachers, and student teachers using the *Para vivir nuestra sexualidad* or the "To Live Our Sexuality" module. Volunteer youth replicated the educational activities with peers in and outside of school, while

teachers did the same with their students. The teachers also held meetings with parents to sensitize them to the ASRH issues through face-to-face discussions. The project also implemented the module along with sensitization sessions with government institutes such as the Ministry of Health and the Ministry of Education and health workers. The results of the "Youth Corner Program" along with other activities conducted by CIES showed that youth require special attention when it comes to sexual and reproductive health services—and thereby influenced the Ministry of Health to develop the National SRH Plan with a special component for youth.

Youth Policy: Next, I wanted to ask you about your work on the USAID?Health Policy Initiative's *Avances de Paz* model. That was used in a gender-based violence (GBV) project, correct?

Ms Aliaga: Yes, that is correct. The *Avances de Paz* or the "Advances in Peace" project was conducted from June 2006 to 2008. The project worked in four municipality communities (Quillacas, Machareti, Oruro, and El Alto) to integrate family planning and reproductive health policy with efforts to prevent and reduce incidences of gender-based violence. There were essentially four phases to this project:

(1) Training local people who were considered to be leaders within the four municipalities. We trained the participants continuously for one year on topics such as what is GBV, gender role dynamics, how to participate in the community response to GBV, and how to raise awareness and create a dialogue about GBV with community members. The participants committed to attending 30 or more training sessions in that year.

(2) Community processes analysis and planning, defining the root causes of GBV and opportunities for change, and developing and advocating for GBV action plans at the municipal level. In the community process, the leaders went through auto-diagnostic exercises with community members in order to facilitate a process by which the community members would (a) identify that GBV exists in their communities and (b) identify the root causes related to GBV in their own family and community structures. Along with the community process, we implemented a parallel process, which was going and visiting leaders from the different sectors (education, justice, police, local powers, health sector, youth organizations) that had the power to intervene in any kind of gender-based violence policy. During these visits, the communities were able to advocate for the implementation of their action plans with the authorities. They said that they "empowered themselves" and feel that they "are able to provide their own solutions to their own problems from their own perspective."

(3) Obtaining political and funding support in order to implement the activities they proposed. All four action plans were funded either by municipal governments or other sources. For example in Machareti, the municipality created a two-year plan for a local network against violence that included the different sectors. In El Altiplano, which is a Quechua and Ayamara indigenous zone, they saw a need for hiring a lawyer to develop a plan to eliminate violence. The lawyer gave continuity to the plan that the community proposed, which was to follow-up on GBV cases that were presented at the health center. They also implemented awareness-raising programs and workshops and created a committee with indigenous authorities from different sectors. In Oruro, they were able to work with a pre-existing network to conduct education and prevention activities with the prefecture, the local government, and the *departmento*, the state government. In El Alto, They advocated for a five-year plan called "Violence and Art," where they had a GBV-themed theater contest. Sixteen theater groups participated from El Alto. The entire community of El Alto participated, and there are over a million inhabitants of El Alto, where parents, teachers, and adolescents participated in these plays. The project provided them technical assistance on how to convey theses issues through stories and acting. The play that won the contest was hired around five or six times in other places.

(4) Monitoring and evaluation; and you just heard the results from our discussion. Another result that municipality members continuously reported was that the amount of people that attended sexual and reproductive healthcare centers increased. *The project had over 1,000 participants across all four municipalities—of which 40 percent were youth.*

This project was a success because *"we really stressed the fact that it had to start from the facilitators and end in the community. It had to be something that you learned with your stomach and your heart and not with your brain."*

Youth Policy.com: What are the greatest gaps or challenges in youth SRH programming and policy implementation?

Ms. Aliaga: The challenge is always that you get these beautiful policies sometimes, and do they get implemented? Not always. For example, when we are talking about YSRH policy, you need an office or an institution to articulate with the other national offices, sectors, and stakeholders to guarantee implementation. You need money. You need commitment. You need trained people. You need possibilities of hiring and paying well. Many times, the NGOs [nongovernmental organizations] have more possibilities of implementing policies than the state. For example, CIES, Save the Children, and PCI [Project Concern International] in Bolivia have a lot of success stories in implementing policies. They have advocated for the implementation of particular policies. From our very small perspective as institutions or NGOs that work in this field, we do implement the policy because we have the money, the commitment, the trained people, possibly the hiring and paying well, and the infrastructure.

Lastly, YSRH planning and policy issues should integrate into the area where youth tend to have issues: work issues, labor

issues, educational issues, etc. Health is not an isolated issue, especially when we're talking about SRH. The main goal is that youth should be able to live better, have better human relationships, and contribute in a better way to their own local development.

Last Updated: Sep 24, 2009

Mr. Jeff Yussuf Ayami

Executive Secretary, Zambia Interfaith Networking Group on HIV/AIDS (ZINGO), June 2007

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Mr. Jeff Yussuf Ayami has worked at the Zambia Interfaith Networking Group on HIV/AIDS (ZINGO) since 2001 and is currently Executive Secretary. His background is in business management and he is also a trained Islamic theologian. His work with ZINGO focuses on mobilizing financial and human resources for communities to respond to the social and economic impact of HIV/AIDS. He is a qualified facilitator and works with many communities to improve the skills of project managers. He advocates a holistic approach to HIV/AIDS, including the need to address human rights and governance issues.

We asked Mr. Ayami to discuss the efforts to produce guidelines to increase young people's access to reproductive health information and services in Zambia.

Youth-policy.com: What prompted you to work with faith leaders and young people?

Mr. Ayami: That is a very good question, but before I answer your question allow me to thank you for according ZINGO an opportunity to interact with you and your audience around the subject of youth reproductive health.

Coming to your question, as you well know, a lot of negative things have been said about the contribution of religion to the AIDS problem in Zambia. Many people have concentrated very much on the negative things, such as their views on condoms or their judgmental attitude towards people living with HIV, etc., and overlooked the many positive contributions the church has made in the fight against HIV and AIDS. The positives include the influence religion and faith leaders have on our communities. Nobody has so much access and influence to people in the communities as the faith leaders. It is this that prompted us to work with faith leaders.

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Regarding the reasons for working with youth, we all know that our population in Zambia is heavily populated with the youth. They are the majority and account for about 60 percent of the entire population. If you consider that this number represents our future leaders, then it makes so much sense that our energies should be directed towards protecting this important resource for our country's development.

Youth-policy.com: Tell us a little bit about the Zambia Interfaith Networking Group on HIV/AIDS.

Mr. Ayami: Well, the Zambia Interfaith Networking Group on HIV/AIDS, ZINGO in short, is a network of the major faith bodies in Zambia. These include the different brands of Christianity—Catholic, Protestant, Evangelicals and more recently the independents who are basically a break away from the Evangelicals, the Muslims, Bahá'í, and the Hindu community. The network was established in 1997 but actually was formalized in 2003. The network has its own secretariat that is mandated to coordinate and monitor the faith-based response to HIV and AIDS within its members for and on behalf of the National AIDS Council of Zambia, which is a government creation.

ZINGO works through the faith mother bodies and, therefore, its work is virtually everywhere across the country. Our thrust is mainly HIV and AIDS.

Youth-policy.com: Why did you feel there was a need for policy guidelines specific to young people?

Mr. Ayami: As I have stated earlier on, one of our mandates is to coordinate the FBO response to HIV and AIDS interventions. What we have realized is that whilst many of the FBOs are engaged in very encouraging interventions on HIV and AIDS targeting the youth, many of these interventions are driven by emotion and not by guided and proven strategies. This has resulted in this action being uninformed with realities on the ground. Just to give you an example, while the church talks about abstinence among the youth, the reality is that many youths within and outside the church are freely engaging in sex. Some of these youths might even be holding influential positions within the church structures. The church has not done much with regard to ensuring that the call for abstinence is matched with a suitable environment that promotes abstinence or addresses the sexual developments and needs taking place within the youth as they grow and interact with youths from the wider community.

Another example could be the issue of confidentiality. Our culture dictates that sexual issues are too sensitive to be discussed by one's own parents. Previously, young people would turn to grandparents for counsel. Lately, and with the break up of such arrangements due to 'westernization' of our societies, faith leaders are among the few points of counsel available for our youth. However, faith leaders have not lived up to their responsibility because they have failed to instill confidence in the youth that approach them. As a result, youth are now getting counsel and misinformation from some of their peers who they trust in so much.

All of the things mentioned above prompted us to enlist faith leaders as our entry point to provide accurate reproductive health information and services to youth so as to

in developing the policy guidelines?

Mr. Ayami: One of the most successful strategies was using the youth themselves to develop the guidelines. This not only meant that the guidelines were owned by the youth but also that the contents were informed by their own experiences with regard to issues of sex.

Youth-policy.com: What indications do you have that the policy guidelines have been a success?

Mr. Ayami: The overwhelming response their endorsement received by the religious community and the faith leaders. You need to note that initially the Catholics did not want to involve themselves with the project, but because the manner in which the guidelines were developed did not intimate any coercion of any particular group to do what they were not comfortable with, they signed the document, which for us was a major success.

Youth-policy.com: What have been some of the challenges in advocating for endorsement of the guidelines by the various faith groups?

Mr. Ayami: One of the major challenges we faced as mentioned earlier was the suspicion by the Catholic faith that promoting youth reproductive health was more like promoting usage of condoms, abortion, etc. This nearly resulted in them not wanting to be part of the whole project in the first instance. However, their participation in the actual development of the guidelines as well as the strategy to focus the guidelines to deal more with issues of processes and actual guidelines as opposed to services meant that their fears were allayed.

Youth-policy.com: What advice would you give to other practitioners undertaking a similar policy process?

Mr. Ayami: First, consultation is critical. It cannot be overemphasized. Because the subject of reproductive health is sensitive and usually misunderstood, faith organizations involved in the process should be consulted and be part of decision making all the way.

Secondly, it is better that when such an undertaking is considered, the focus should be much on issues such as mobilization and referrals as opposed to actual service delivery. Determining what kind of youth reproductive health services would be provided should be left entirely up to each particular faith group. Now I don't know if I am clear on that point and perhaps let me use an illustration
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Last Updated: Oct 9, 2007

Dr. Richard Curtain

Public Policy Consultant, Curtain Consulting, Melbourne, Australia, April 2007

Periodically, youth-policy.com talks with someone, somewhere in the world working to craft or implement youth reproductive health policy.

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Dr. Richard Curtain is a public policy consultant with Curtain Consulting, based in Melbourne, Australia. A sociologist and demographer by training, his current work includes assignments for UNICEF's East Asia and Pacific Region on youth livelihoods. For UNFPA, he recently completed a diagnostic tool titled *Putting Young People into National Poverty Reduction Strategies: a Guide to Statistics on Young People in Poverty*. He is the author of many publications on youth, including a recent article in the December 2006 edition of *Current History,* "For Poor Countries' Youth, Dashed Hopes Signal Danger Ahead."

We discussed with Dr. Curtain his experience assisting in the development of a national youth policy in Timor-Leste. At the time of the interview, the national policy was still in the process of getting approval by the Council of Ministers.

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Read this interview, and then Contact Us with your own comments, questions, and other input.

Youth-policy.com: What has been your role in formulating the policy and how did you get involved?

Dr. Curtain: I was employed by UNICEF to design and supervise a national survey of young people and to pull together all other relevant data. I was also asked to work with the Secretariat of State for Youth and Sport of the Government of Timor-Leste to prepare a draft of a national youth policy.

I got involved because I wanted to get into the thick of doing some good policy work on the ground. I had written a number of papers for UN agencies on young people in extreme poverty and the case for investing in young people as part of a national poverty reduction strategy. These made me keen to do some "hands-on" work, away from desktop analysis.

My opportunity to work in Timor-Leste arose through a long-term interest in that country, as a supporter of its independence from my time as a graduate student at The Australian National University in the 1970s! I found out that UNICEF was looking for a consultant to work on youth policy and I approached them while I was visiting Dili to help set up a system for disbursing funds for a philanthropic foundation.

Youth-policy.com: Why is it important that Timor-Leste have a national youth policy?

Dr. Curtain: A national youth policy is crucial to Timor-Leste's future because one in three people in the adult population are aged 15 to 24 years. This high share of the adult population points to a classic "youth bulge." In a post-conflict country where the economy is weak and government capacity limited, the youth bulge suggests that the potential for social conflict is high.

This scenario has been borne out in the period after I completed my assignment for UNICEF. From April 2006 and continuing into 2007, life in Timor-Leste, and specifically in the capital, Dili, has been disrupted by gangs of young males, as young as 10 years of age. Despite the presence of foreign peacekeepers and international police since mid-2006, peace still has not returned. News reports of warring gangs and gang violence are commonplace. In particular, clashes between martial arts groups of mostly young men are blamed for the violence, sometimes resulting in deaths and always increasing fears and insecurity of the general population.

Youth-policy.com: In your recent article for *Current History*, "For Poor Countries' Youth, Dashed Hopes Signal Danger Ahead," you write, "the view of young people as critical assets for lifting economies and societies out of poverty offers the most potential for change, yet it has gained the least attention." Why is this so and how did you address this problem in Timor-Leste?

Dr. Curtain: My analysis of the focus on young people in Poverty Reduction Strategy Papers showed that most policymakers viewed young people as vulnerable, for example adolescent girls, or as a threat, for example unemployed youth. However, few Poverty Reduction Strategy Papers proposed policies to build up young people as positive assets. Many UN agencies also have a narrow view of young people, highlighting their vulnerability. The challenge in writing an evidence-based national youth policy was to go beyond narrow and negative stereotypes of young people and to understand the world from their own perspective.

So in Timor-Leste, we started from a much more positive perspective. In the national youth survey, we asked young people about their own capabilities and their access to power resources. The survey was designed to enable young people to rate their access to economic, social, political, and information-based assets, their perceptions of personal security, the quality of their education, and assessments of their current and future prospects.

This emphasis on the positive carried over into the draft policy, which highlights the value of government supporting young people's collective endeavors. One specific proposal is to encourage young people's sporting and cultural organizations to link into the government's national poverty reduction strategy. This is to be done by funding them to undertake simple but important tasks such as distributing bednets and getting rid of stagnant water as part of a campaign to reduce malaria.

Youth-policy.com: Timor-Leste is a "post-conflict" country. How did this influence the policy development process?

Dr. Curtain: In general, I think that the government and international agencies such as the World Bank failed badly to incorporate an appreciation of the vulnerabilities the population has been experiencing. Little attention was paid to social protection policies, for example, to ensure that people had enough to live on in the poorest country in Asia.

In relation to the national youth policy, we focused on ways to integrate young people into the new structures being set up. On the face of it, young people were the 'lost generation' – they were educated under the Indonesians, with many gaining tertiary education. However, the new government specifically excluded them from government service by mandating that all official business being conducted in Portuguese. Finding ways to incorporate young people into the mainstream institutions was the big challenge.

Youth-policy.com: Your Current History article also discusses how governments tend to see young people in need of protection against problems such as early pregnancy and HIV infection. To what extent does the policy in Timor-Leste address these reproductive health issues?

Dr. Curtain: Timor-Leste has one of the highest adolescent fertility rates in the world— 177 per 1,000 women aged 15-19 years in 2004 and it is rising, it was 130 per 1,000 in 2000. However, the draft national youth policy did not address reproductive health issues directly as there was already a new reproductive health policy in place. The draft policy highlighted the need to coordinate policies to reduce poverty among young people. The policy proposes using as key performance measures the youth-oriented indicators of the Millennium Development Goals (youth employment, literacy), and key poverty reduction indicators (improvements in food security, rural incomes). The additional indicator of the adolescent fertility rate is also proposed.

Youth-policy.com: What were some of the successful approaches you used in drafting the policy?

Dr. Curtain: It was important to give young people opportunities to express their views about their situation and about how they wanted to make a positive contribution. The national youth survey, based on a random sample of 1,100 youths, was a powerful way to provide evidence of young people's attitudes to rural livelihoods, and the specific attitudes of young women in relation to their choices.

Also, an important evidence source was the results of focus groups of young people held in all the major regional centers as well as in the capital city. These discussions highlighted a number of concerns that the survey did not tap. This applied especially to how girls and young unmarried women were viewed and treated by the community and the constraints these views imposed on the options available to them.

Youth-policy.com: What were some of the big challenges you faced in developing the policy?

Dr. Curtain: The biggest challenges came from a lack of strong interest from the government in tackling young people as a cross-cutting issue. The new ministries operated as silos and they saw the Secretariat of State for Youth and Sport as a junior ministry with few resources.

The World Bank, despite an interest in training youth leaders through the Leadership for Economic Development program, had a narrow view of only supporting young people as individual job seekers. The World Bank office in Timor-Leste objected to one of the main proposals of the draft national youth policy—to set up a national fund for youth to provide a guarantee of future funding for youth organizations to engage directly with the government's national poverty strategy.

Youth-policy.com: If you were doing it all over again, what might you do differently?

Dr. Curtain: The big problem was lack of a youth focus in the government. This has changed now with the ongoing civil unrest, and the key role played by youth gangs in this. But, the response by the government in late 2006/early 2007 has been ad hoc and short-term—providing funding to build youth centers and sporting facilities. These facilities cater mostly to young males. A focus on cementing ties among mainly young males will backfire if it only reinforces an "us against them" attitude. Policies to link young people into the wider community are still missing—the national youth policy is still in draft form and has not yet been adopted by the government!

The pressures are strong to write up a policy that confirms existing arrangements and makes at best only small changes. Forging a new policy direction requires, in hindsight, much more ground work with the key stakeholders. Providing good evidence is part of this, but this may not be enough. Lobbying key politicians, using another form of evidence in the form of stories and anecdotes, can play a valuable role. Responding to opportunities as they come up to bring home the need for a new policy direction is also part of it. But, this can mean big time lags.

In the end, it is waiting until the time is right—when policymakers can see that the old approach is not working, and one or more of them are willing to take on the role of champions of the proposed new approach and push their colleagues into accepting a new direction.

Do you have a question for Dr. Curtain? If so, please Contact Us and we will synthesize your questions for response from Dr. Curtain. Thank you!

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At the time of the interview, the National Youth Policy was still in the process of approval and not yet available as a public document. However, you can find the national reproductive health strategy that Dr. Curtain refers to, as well as other policy documents from Timor-Leste, through youth-policy.com's policy database.

View all interviews

Last Updated: Sep 15, 2009

Dr. Margaret E. Greene

Senior Technical Expert, Reproductive Health, Washington, D.C., August 2009

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Dr. Margaret E. Greene has more than 20 years experience working in the fields of family planning, gender, and youth sexual and reproductive health policy. Dr. Greene has worked with many instrumental public health and international development organizations, such as the Population Council, Population Action International, Center for Health and Gender Equity, and the International Center for Research on Women. She is also the director of the Center for Global Health at George Washington University (GWU) and teaches several classes at GWU. Dr. Greene is a member of the Technical Advisory Group to USAID's Interagency Gender Working Group.

We spoke with Dr. Greene about her experiences in the field of youth reproductive health and policy.

Youth-policy.com: What interested you in youth reproductive health?

Dr. Greene: I first became interested in reproductive health when I was in college. There are so many obstacles toward attaining good reproductive healthcare for young people and adults as well. Those obstacles are expressed more intensely for young people, and so if you can really figure out what's going on with young people and solve the problems of accessing information, then you could actually improve things for everybody. There's something really unjust about the conditions young people face and ignorance around the fact that sexual relationships tend to begin at an earlier age, there is a lot of coercion involved, and early marriage is happening, etc.

The women's movement raised awareness of the difficulties women faced in accessing things that were commonly available—jobs and so on in society. That same perspective could shed light on reproductive rights and young people, who I believe are not treated as full human beings on some level—that they have not been treated as full citizens. They are the bearers of rights, but they are not given their rights. Parental rights take precedence. In a way, that [precedence] is damaging; in a way, that [precedence] does not even work for parents. So I think there are some insights from the women's movement, where the dichotomy is male/female, that could be applicable for young people, where the dichotomy is young people and adults. Where you see a whole category of people as lesser somehow, then you are going to have the consequences that we see.

Youth-policy.com*:* And following up on that, there seems to be a third dichotomy of people in between a child or an adolescent without completely assuming the rights and responsibilities of an adult.

Dr. Greene: This really gets to me—that you can be drafted to the military but you can't have access to full sex education. I find [it] very inconsistent. It's not rational. So, big changes have to happen to benefit young people.

Youth-policy.com: What do you think are the most important changes that we need to work toward? Or what are the key policy areas that need to be targeted?

Dr. Greene: I think it's great that parents and families remain the locus of conversations about values and how the proper conduct of behavior and conduct of relationships is formed, but the society, the education sector, and the health sector in particular have to provide the information so that the young person is able to make a decision about his or her own rights—guided by the ideas that they get from their families. For me, access to information is so profound. It's the most important thing. And I think it's so transformative—when people understand how their bodies work and when they understand some of the challenges they will face in entering relationships or fending off relationships. They have to have people to talk to, and then if they need additional information, they know they can go somewhere. It's really mostly adult information. That, to me, is just fundamental.

And I know that one of the big obstacles is this argument that if you provide this information, young people will run wild. But they are hurting their own health significantly without that information. And it seems very punitive and controlling for their parents.

Youth-policy.com: Yeah, it kind of handicaps them in becoming full adults, in becoming health adults.

Dr. Greene: Yes, I think that's fundamental. Somebody shared something interesting with me about what they saw as [an] obstacle in the provision of services—particularly [with] information to young people—that had to do with adults' ambivalence with their own sexuality or their sense of loss or misconduct in their own sexual lives, so they resent the beauty and strength of young people. And I see this as a very interesting, psychological explanation. There may be an insight there. I have to think about it in terms of programs and policies.

Youth-policy.com: That's an interesting perspective because I think most people attribute the lack of attention to youth reproductive sexual health being a result of the stigma placed on sex education. You seem to say it's a more convoluted issue than that and we need a deeper look at the adult psyche.

Dr. Greene: Well, there's the joke that sex is so disgusting that you should avoid it at all costs and save it for the one you love the most. I think, in many societies, there is that sort of ambivalence about it.

Youth-policy.com: What kind of polices promote access to information? Have you done any policy-related work to promote access to information?

Dr. Greene: It's very difficult to point your finger at something in particular. I think I can come up with a couple examples. By simply sharing the example of Iran, which has special schools for married girls. So, just to share the example, instead of having pregnant or married girls out of the school system (they're done with education), here's this conservative Muslim society that has found a way of formally structuring girls' ongoing education and access to information. I think it's really important that sex education is a fundamental requirement for obtaining a marriage license. It's so funny, in the U.S., I got married 10 years ago, and all I needed was a syphilis test. It is such a missed opportunity to hand out pamphlets and talk to people and pass out information. The connection that I am making is that in having highlighted this really great example in this review of youth policies I did for Population Action International, so many people have commented on it—expressed interest—because if that conservative society can do it, can we replicate it in other places?

Youth-policy.com: A similar disconnect seems to exist between education-focused programs or public health programs. There seems to be a gap between public health programs that focus on schools and sex education programs that are out of schools. Do you find there to be a gap?

Dr. Greene: Between the services provided and the information provided through schools?

Youth-policy.com: Many IEC [information, education, and communication] campaigns are not channeled through schools.

Dr. Greene: Sex education varies so much from place to place. And it's always charged. In general, I agree with you. I also think there is a gap. In school sex education, it is a lot about the biology. It's not about the nitty-gritty. It's not about relationship negotiation—not about how you handle yourself. Maybe increasingly that's there—more about the decisionmaking—but the curriculum in schools is very biologically oriented; also there is not the interconnection with services because you might think it is incentivizing sex. But if there is [interconnection], you know when it hits. You're so much more likely to use it. And you're not intimidated. There is a friendly person sitting behind the desk and it makes a difference.

Youth-policy.com: How do you feel the field of adolescent health has changed over the years? How have the priorities changed while you've worked in it?

Dr. Greene: I'm not sure. It's not something that I've thought about. I'll have to think about it as I speak. Well one thing that occurs to me is that [there is a] greater sense and a stronger international mandate for addressing the reproductive and sexual health of young people. So, it's not just about contraception; it's not just about stopping childbearing. Now there is talk about

delaying, spacing, managing healthy relationships, STIs. It's partly a function of the Cairo conference—that there is a greater attention to a broader span of RH issues—that makes it much more appropriate to youth.

I think that many global changes have been empty. There is a lot of talk about their [youth] rights, but you don't necessarily see it all that much in practical terms. I just think about the tone people are spoken to—in African clinics, young people are spoken to in very judgmental terms. And it doesn't have to be just there. Ten years ago, I spoke to this doctor in Chennai who basically talked about inserting an IUD [intrauterine device] after doing an abortion without asking the patient and then informing her afterward and telling her that she will have to undergo another procedure to remove the IUD—but without asking her if that was okay. There is a very strong sense of adults knowing what's right for young people. I don't think that broader commitment at the international level has transmitted practically to real change for young people.

Youth-policy.com: And why do you think that is? Do you think it's because there are no representatives for youth or of youth? The people making the decisions for youth are either in international organizations or MOHs [ministries of health]. Do you think that's the reason for the gap?

Dr. Greene: I think it's partly that they are not represented. They have the original problem that the older they get, they lose that experience, and then they're out and then you have new youth. I think that there is more representation over the years. Organizations like IPPF [International Planned Parenthood Federation] have young people on their boards, but I think that young people are not taken as seriously as adults, and that seems to persist. I always feel embarrassed when I go to meetings about youth and people make jokes about how we're all young at heart. I feel like there needs to be more equal conversations between younger people and older adults, and it just doesn't happen all that much. And here we are—exposed to the international agreements and the high-faluting language—and we still struggle with it in Washington, D.C.; but if you go to Mozambique, it'll just be really hard to have serious conversations.

Youth-policy.com: It seems more revolutionary than the women's movement because…it's similar in the sense that you are revamping these traditional familial and society structures. How do you begin to engage a child who doesn't speak, doesn't have role?

Dr. Greene: I agree. It just seems really hard to accomplish. It may take a long time and require such a different mindset. And it's ironic that it wasn't that long ago when the creation of childhood [as a sociological concept] happened in Western society in the last 200 years. And it was like it was overdone. Children are different from adults, but now we have those two categories. And this gets back to what you were saying earlier—can we have more of a transition period where you are adapting to the category and status of being an adult?

Youth-policy.com: I think the culture of the U.S. is unique in that children have the ability to explore; they have a safety net to explore being an adult. Whereas in developing countries, children get married and instantly transform into adults and assume all the responsibilities of an adult.

Dr. Greene: Or [children do not gain any responsibilities or rights once they are married]. Or you are completely disempowered when you go to another household. Or you are an adult in that you are supposed to have a child, or you have this new role, or the mother-in-law snaps her fingers and you have to rush around.

Youth-policy.com: It's interesting then—I'm wondering if the best way to advocate for youth needs is in a forum separate from adults or whether we have to integrate it into health programs overall, where we have to bring in youth representatives, or whether the adults who speak louder and are bigger would accommodate for the needs of youth within such settings.

Dr. Greene: Honestly, I think that both are necessary. Before I became more educated, a friend of mine was working with a Norwegian children's organization and the rights of children and children as citizens. And I didn't really take it all that seriously, and I'm someone who should have been especially attentive to that kind of thing. But look at me; it was my resistance. I am a product of my culture. So, I guess that there are some groups and organizations that are doing that. But then young people have to come forward and make statements about the things they need and the things they want and why they need them; and they need to mobilize resources on their own behalf. And organizations like the IPPF and others need to continue to do their thing and integrate young people into their boards and so on. So, I think it needs to happen. And it's ironic, but these are the types of conversations women had—should we do things separately or do we want to integrate ourselves into male systems of power? All of the above.

Youth-policy.com: Looking back as an adult, it's interesting to consider my experience growing up partially in India and partially in the U.S. and how different my upbringing has been from that of children in developing countries.

Dr. Greene: I am writing this report for UNFPA [United Nations Population Fund] that is called "Girls Speak," which is trying to use qualitative data about what girls say about their own life to give some finer messages about health and schooling, etc., and rights and violence. When someone from the West makes a recommendation about what you should do about your girls, it's being

colonialist and there's no connection with their lives. But when it's girls themselves who are saying these things, they have more authority to bring about the change. So, maybe that is just going back to how you do that practically; how do you tell young people—look you are not telling us about sex, but 15 of the 85 girls in our class dropped out because they got pregnant last year. What's wrong with this picture? I look at the TOSTAN model. The model has taken this concept of rights and helping people come to some of these conclusions on their own and helping them find solutions to their own problems through their own routes. It's very owned by the people of the culture.

Youth-policy.com: What kind of policy do you think would enable such types of interventions? Such types of projects?

Dr. Greene: I think that there has to be some national conversation about rights—just as a general conference; it doesn't have to be lecture but rather a general awareness raising about rights and capacity building. So, you have some kind of basic reference. Devolution of power to the local level. This may be positive, but devolution could also mean power in the hands of the local religious leader who may be running the show. If it were accompanied by some types of conversations… I just always come back to these abstract conversations when I talk about young people. It's not about service provision. It's just not. It's so much bigger than that. Service provision is literally a bandaid for the giant problem. It's so limited and it's so driven by the health sector. And I think one of the big challenges is…everyone says [youth programming] needs to be multisectoral, but what does that mean? When you have government sectors and money is spent sector by sector, multisectoral means that no one is ever going to do anything. And so [youth programming] has to belong to somebody. It can't be this nice idea—we're going to create this ministry of youth that has no budget—that is so often the case. We need some fresh ideas about how to drive people toward youth causes. I was really impressed by Zambia. And this is not youth-specific—the ministry has these coordinating bodies at every level (national and district). They visibly replicate these multisectoral advisory groups that reach right down to the local town. And they have conversations like "this is what our epidemic looks like; what do we need to do to address it." And I think that people at the most local level don't know what challenges young people are facing as a whole. They don't have the statistics. It's no wonder young people are struggling. They don't have enough information to know how to act in the best way possible.

Dr. Greene: How do you increase communication between youth and adults in an environment where youth feel comfortable? It seems to me that one of the biggest obstacles (based on my field work in Nepal with Save the Children) is that speaking with girls about RH is like pulling teeth. Even young girls in the U.S. don't want to talk about it. I wonder, what is the best strategy to make them talk?

Youth-policy.com: As you know, a policy is only as good as its implementation strategy. What do you think are the key components to implementing the policy?

Dr. Greene: I think another obstacle is that because budgets don't track beneficiaries by age as a general rule, an MOH can say that, yes, we have youth family services—but if they spend $3 on that [the youth services], you would want to know. You want to see how many young people are coming. Just being able to focus on that [the details] is so fundamental. It requires a lot of record keeping, but in general, you need to know more, much more. Budgets are behind a real implementation strategy.

Youth-policy.com: What future directions do you see for yourself in youth health? Where would you like to go?

Dr. Greene: Recently, I have done some work on youth but more on the social science side on early marriage, and I'd like to get back to work on youth RSH more centrally. One of the things that came out of working with men and boys is doing awareness raising about gender inequality at a very early age. That's really fundamental. I had this utopian view about men and women, boys and girls…what world would we live in if we had mutual respect and support and cooperation for each other? It would be better for everybody. I can't tell you how many people say, "Well, what do you tell men and boys? What can you say to persuade them? What have they got to gain from it?" They've got everything to gain. It's ridiculous, the thought. And doing the awareness raising early.

Judith Bruce, from the Population Council pounds away about rights—basic human rights education that is well structured. Everything that we are talking about can be placed in a human rights context with a little bit of RSH education. A properly structured curriculum on human rights gives people the basis for understanding their ability to negotiate healthy relationships, how to have equal relationships with future employers, and their ability to respect the other sex. It [this understanding] can be an umbrella—so many fundamental things that end up being important in societies across the world. It is way upstream in many ways, but I think it affects so many facets of our lives—a boy that learns through a human rights-related education about how one should never force anyone to do something they don't want to—it would be so incredible. You would have a generation of people who are thinking twice before engaging in coercive sex. I know that's very abstract, but I think there is something really important there.

Brad Kerner at Save the Children USA has this idea that he has developed a game in Nepal called the gender equality game. Or Ravi Verma at the ICRW [International Center for Research on Women] Asia Regional Office has been working with the Family Violence Prevention Fund on a project called Coaching Boys into Men. That's using cricket—working with a cricket coach to support boys…the gender socialization is often reinforced by sports to get them to be thinking differently or talking differently about

sports. The worst insult you can possibly give somebody when they don't kick the ball or do whatever they are supposed to do with the ball is to call them a girl or female genitalia. There is just a really huge opportunity there.

I guess that continues to be very exciting to me. I guess it's still very upstream, but it includes RSH and is so directly connected. I think that's maybe where it's going to overlap with the work that I'm doing with men and boys and youth RSH.

Youth-policy.com: Are there any other ideas that came to your mind as we were speaking?

Dr. Greene: Another obstacle that I see that has to be reconciled before a lot of progress can be made—we perceive conflict between the rights of parents and the rights of children. Two places that come to mind where that really plays a role are in the U.S. and Mexico. Parents are deciding that what's being shared with their children is smut. I don't know how to resolve that, but I think it's one of the great challenges of our time and it totally illustrates the point we discussed earlier about the rights of children as lesser [being less important]—my right to information is less than your right to deny access to that information. And the whole kind of private control of children that is taking hold in our legal system.

Youth-policy.com: That makes me think of how families are the unit of relations to society—whether it is an extended or nuclear family that has the authority to make decision about the child.

Dr. Greene: I'm trying to think about how they solved the problem in Iran. I think that parents had the right to prevent their children from going to school, but there is an alternative. If you are not going to put your child in school for this program, then you accept a health worker coming to your house to discuss what you need to talk about with your child. There needs to be a back-up plan. I know that it's costly, and it can be relatively costly. But if this information is provided early, then large groups of kids can have this exposure.

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Ms. Neema Mgana

Founder, African Regional Youth Initiative, Dar es Salaam, Tanzania, May 2007

Periodically, youth-policy.com talks with someone, somewhere in the world working to craft or implement youth reproductive.5 cm /Im2

When ARYI started, we mostly focused on creating a platform for youth and community-based organizations that worked on HIV/AIDS in Tanzania. I remember then getting e-mail messages from different groups in Kenya stating that they were interested to join. These groups not only worked on HIV/AIDS, but also gender, poverty, youth empowerment, and other issues. Soon afterward, a number of e-mails from Ghana and Nigeria requested that ARYI have a presence in West Africa. Since then, ARYI has not stopped growing. We now work with over 400 African organizations addressing development issues as outlined in the United Nations' Millennium Development Goals— namely, poverty and hunger, HIV/AIDS and malaria, primary education, gender equity, child mortality, maternal health, and environmental sustainability. It's not just the issues that set us apart but our structure. ARYI works actively in 20 countries through country teams, country and regional representatives, and program coordinators. The work of ARYI is based on action plans developed by country and regional teams. In addition, ARYI is the only organization that places youth and communities at the forefront of activities that operate cross-regionally through programs such as the African Poverty Monitoring Initiative program planned to take place in 20 countries, an HIV/AIDS project implemented in 16 countries, an African Women of Leadership project active in 17 countries, and a Panel on African Commissions that is operating in several countries in Africa.

Youth-policy.com: What policy issues does the group focus on and why are these important?

Ms. Mgana: ARYI has recognized that youth in Africa have tremendous unmet family planning and reproductive health needs that require urgent national and international attention. The need for urgent attention is supported by findings from Population Action International, which classified several countries in Africa as "very high risk" in its *Reproductive Risk Index*. This index is a measure composed of 10 key indicators of sexual and reproductive health that documents vast disparities between rich and poor countries and the urgent need to accelerate progress in sexual and reproductive health as narrated in the 1994 International Conference on Population and Development.

Of particular concern are policies (or lack of) addressing sexual and reproductive health that are meant to help young people to exercise their rights, for example, to access youth-friendly health services and gain information on sexual and reproductive health. A number of meetings held by YouthNet/Family Health International on these issues made me personally aware of the experiences among young people on very specific cases calling for reproductive health policies to protect the rights of young people. Too many countries in Africa are challenged in devising and implementing reproductive health policies, thus increasing the vulnerability of youth to HIV/AIDS, unplanned pregnancies, high morbidity and mortality due to risky pregnancies (usually due to the young age of the woman), female genital mutilation, and abortion.

To address this issue, ARYI started creating Youth Policy Groups to bridge the gap between policy and its implementation, promote and advocate for reproductive health policies, and build a foundation of youth leadership around reproductive health care services, programs, and policies. We are currently focusing on three tools to assist the Youth Policy Groups. One is the use of videoconferencing as a way to bring these groups together (for example, a videoconference planned among Tanzania, Ghana, and Ethiopia). A second is the use of the policy compendium available at youth-policy.com. Lastly, we created a forum through the Implementing Best Practices Knowledge Network that facilitates the communication and action plans between these groups while sharing best practice experiences and information on reproductive health care services, programs, and policies in Africa.

Youth-policy.com: What have some of the big challenges been in setting up and maintaining the ARYI?

Ms. Mgana: A challenge in setting up and maintaining ARYI stems from its creation in the first place. The organization was formed to fill a gap and, as such, there was no 'template' to follow in setting it up. However, this challenge has allowed for much uniqueness within the operation of ARYI in that we don't necessarily fit within a mold, and thus have flexibility to adapt according to different situations and also cater more so to on-the-ground needs.

In addition, I had no real experience in starting something of this nature and magnitude. What I did was spend time talking to people and reading books on organizational management, financial management, program planning, how to register an organization, website development, and the like. This helped a great deal to orient myself on the day-by-day operation of the organization.

Every day is a learning experience for me and I am grateful to work with a strong leadership team, composed of mostly young people who are either in school or transitioning between school and work. As such, the organization works around time availabilities of each person, including my own time, since from the start of ARYI, I have been either a full-time student or an employee in another organization. This leaves nights and weekends to work on ARYI. Within the last year, we have been focusing on the decentralization of ARYI to country levels, which has helped tremendously not just in terms of overall coordination but also in the support of local talent and leadership among national ARYI teams.

Funding is always an issue, as we have mostly received financial support for specific projects rather than organizational support.

Youth-policy.com: Of the work the organization has carried out, what are you most proud of?

Ms. Mgana: I am proud of all the work ARYI has carried out, but I am most proud of the over 100 programmatic collaborations that have formed as a result of ARYI. It is common now to read a message posted to the ARYI listserv from an organization in Africa with some need (i.e., looking for partners to implement a project, lacking resources for an activity, etc.) and soon afterward reading a reply from another organization interested to form a partnership and share their resources. I remember the first such message of that nature that was sent to the listserv in 2004 by a group in Kenya that was looking for soccer balls and jerseys for a tournament organized as an HIV/AIDS awareness activity. When I read that message, I had no idea what would happen. Within weeks, soccer balls and jerseys were mailed to them by another group that was interested in the project. ARYI then also contacted equipment stores and others for additional support, as well as facilitated a fundraiser to be done to further their project on using sports as a way to raise awareness on HIV/AIDS.

Another example was in 2005 when we developed a concept for a series of children's forums as part of a global awareness raising and advocacy on the needs and rights of orphaned and vulnerable children in Africa. A call for organizations was made through the listserv and, within weeks, 40 organizations signed on to conduct these forums. All 40 organizations held the forums, but I remember one group in Kenya in particular who wrote a report and sent pictures of the thousands of people that took part in the forum, which was followed by a large march across Nairobi on the rights of children. This was a completely inspiring experience.

Those connections facilitated by ARYI that form into meaningful collaboration and action are what make me feel proud and honored to be part of the overall experience.

Youth-policy.com: What are the group's current activities?

Ms. Mgana: Although we continue our work in HIV/AIDS, there are six main activities that ARYI is spearheading at the moment. One is called the African Women of Empowerment Project (AWOE), co-founded by Amanda Koster, a photojournalist, which highlights through mentorship, the media, and leadership activities, the role of women within development processes in Africa. A heavy focus of the project is nurturing the leadership of young women in Africa and we do this through inter-generational dialogues that are held across the African continent. To date, there are over 180 young men and women AWOD leaders in 17 countries in Africa who are coordinating the project's activities in their respective countries.

Recently, we increased our work with the Reproductive Health Youth Policy Groups, which were set up to promote and advocate for young women's participation in sexual and reproductive health issues at national and international levels.

Another project we are involved in has been the creation of the African Poverty Monitoring Initiative. The goal of this initiative (which resulted after a detailed research on the poverty reduction strategy paper [PRSP] process) is to increase the participation of civil society groups in Africa to engage within the African Poverty Reduction Strategies. The initiative was launched on March 5, 2007, in Yaoundé, Cameroon, and plans are to conduct civil society consultations similar to the one held in Yaoundé in 20 countries in Africa by 2009.

The setting up of Development Analysts within the last few months has been something I am very proud of. These analysts, who applied for the position and currently number six within the continent, provide regular commentaries on Africa's development. Their commentaries are posted on the ARYI website as well as on a blog site. In addition, starting in April 2007, we will hold local gatherings whereby the Development Analysts will have an opportunity to present their commentaries to audiences in order to promote dialogue on key issues that they write about, which have to date included commentaries on elections in Nigeria and human rights issues in South Africa.

The Millennium Community Foundation, which launched in April 2007, aims to facilitate private-public and community linkages in addressing and supporting solutions to community needs.

The Panel on African Commissions (PAC) was launched by ARYI in late 2006 and we recently organized the PAC with ten youth coordinators residing in different parts of Africa. The goals of the PAC are to facilitate public dialogue concerning development processes in Africa, coordinate the work of at least ten national commissions throughout Africa by October 2007, produce clear recommendations to be delivered to government representatives, nongovernmental organizations, donor agencies, and other development actors, and popularize development initiatives (i.e., the African Youth Charter) at community and national levels through publications, research methodologies, conferences, and media work.

Youth-policy.com: What is the single most important thing that makes the ARYI effective?

Ms. Mgana: The people—including Sesan and Bella in Nigeria, Frehiwot in Ethiopia, Jeannie in South Africa, Zachary in Kenya, Cleophas in Rwanda, and Mohamed in Somalia. These are just a few of the people who have been committed to the organization for a long time, are passionate about Africa, and who are clearly tomorrow's African leaders.

Youth-policy.com: What are the criteria for joining the ARYI? How can people or organizations join?

Ms. Mgana: There are two types of members within ARYI, one is as an individual and the other is as an organization. There are no criteria for joining as an individual other than an expression of interest either emailed to us or via the membership form available on the website. Organizations, however, must send us their profile (which includes a mission statement, objectives, a description of their target group, and where they operate) and a contact name and address. We then use that information to invite them to join their respective country team for in-person meetings and planning sessions. Both types of membership are free to the individual and organization.

Do you have a question for Ms. Mgana? If so, please email to info@youth-policy.com and we will synthesize your questions for Ms. Mgana to respond to. Thank you!

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Dr. John Santelli

Department Chair and Professor of Clinical Population and Family Health at Columbia University's Mailman School of Public Health, New York, NY, September 2009

Periodically, youth-policy.com talks with someone, somewhere in the world working to craft or implement youth reproductive health policy.

Our questions and the insightful answers from these practitioners shed light on the always challenging, often interesting, and sometimes frustrating policy process.

Dr. John S. Santelli is the Department Chair and a Professor at Columbia University's Mailman School of Public Health. Previously, he was Chief of the Applied Sciences Branch in the Division of Reproductive Health at the U.S. Centers for Disease Control and Prevention (CDC). Dr. Santelli is a pediatrician and adolescent medicine specialist whose past research includes HIV/STD risk behaviors, programs to prevent STD/HIV infections among adolescents and women, school-based health centers, clinical preventive services, and research ethics. He has been a national leader in ensuring that adolescents are appropriately included in health research. He has written numerous articles on adolescents, including "Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991–2007."

Youth-policy.com: What interested you in youth RH? Could you please highlight some of the YRH-related projects that you have worked on? What particularly interested you about this/these project(s)?

Dr. Santelli: I became interested in adolescent reproduction in medical school. I did a summer research project in Buffalo on teen pregnancy, and following that, I was doing an adolescent medicine fellowship for pediatrics. My first job out of my training was running school-based health centers in Baltimore. It was a fabulous experience because it was a model for taking clinical care to another level in terms of turning it into a public health intervention. In essence, we took clinical care out of the hospital and into schools where adolescents were. As part of that, I worked for a health department and became involved in all sorts of youth policies, including how schools can be either health promoters or negative influences and compared how those different environments affect sexuality education or health education.

After about five years, I moved to the CDC and worked on HIV/STDs, adolescent school health, and finally reproductive health. At every stage, I received the chance to work with youth issues, including street youth, so called "high-risk youth," youth coming into STD clinics, and youth in foster care or detention. In all those areas, I think the center of what I have been most interested in is adolescence, reproductive development, and how that [reproductive development] fits into the whole development of healthy individuals and successful adults.

Youth-policy.com: How has some of the work that you have mentioned aided in developing policies for youth?

Dr. Santelli: I think that public health is intrinsically tied to health policy. I have been involved in a whole set of issues, and the most visible has been abstinence-only education. I was working at the CDC when the [second] Bush Administration began, and I

saw this slow then more rapid shift in the emphasis on adolescent health programs in ways that I thought were pretty disturbing because the [policy changes] were not science-based. For four years I put up with it. There came a point, however, when I decided I needed to get out of government and moved to Columbia University. At this university, I felt I could be more public in my critiques, and I've been a major and visible opponent to abstinence-only education for the last five years. I think we've actually been enormously successful in ending this program that was poorly conceived, not science-based, and that violates people's reproductive rights. Every day in public health whether you're doing research or you're a practitioner, you're making decisions based on policy and hoping to advance policy.

Second, I've been involved in ensuring that adolescents are adequately involved in research because oftentimes adolescents are systematically excluded from research. This is because it's been very difficult at various times to ask adolescents questions about their sexual health and also drug use, but if you don't include them in research studies, then we don't know how best to design programs and policies to improve their health. I've been a big advocate through the Society of Adolescent Medicine to try to improve adolescent inclusion in research.

Third, I was trying to improve the CDC's efforts to improve teen pregnancy prevention through policies and also with HIV and STDs. In each of those areas, I've tried to take what I know as a scientist and researcher as well as this sort of "street smarts" I developed in Baltimore to see what you can implement and to see that we have programs and policies that make good sense.

Youth-policy.com: In your opinion, why is it important to develop policies targeted specifically toward youth?

Dr. Santelli: Youth are different than children, and they're different than adults. "Youth" is variously defined, but it begins somewhere in the early teen years and extends into the twenties. The evolving health needs, increased developmental capacity, the ability to make good choices, the transitions from dependency on family to making your own decisions both in health and other realms all emerge during that period of time. I think you need policies that are sensitive to that.

Additionally, adolescent legal status intersects with health status so at age 18 you can make a decision in this country whether you want to be hospitalized or have surgery or see a doctor or not. At age 17, you may be developmentally similar but you lack many of the same rights, and so we have to develop a whole series of laws, including minor consent laws, that allow adolescents to make decisions about those things. Understanding what the difference is between a 12 year old, a 15 year old, and a 22 year old is intrinsic to what adolescent medicine and adolescent public health thinks about, but not something everybody sees. A question we continually ask ourselves is, "How do you craft policies that work for most if not all adolescents at a particular stage? "

Youth-policy.com: Can you give us an example of a successful policy that you have helped to develop and some real examples of how this policy has affected the lives of youth?

Dr. Santelli: Almost 20 years ago there were guidelines that we at the Society for Adolescent Medicine developed on adolescent health research. [They were] designed to provide some ethical guides to institutional review boards and adolescent researchers. To do this, we had a conference in 1994 where we brought a whole group of adolescent medicine specialists including researchers, IRB members, and chairmen to say, "These are the ambiguities in federal policy. How can we craft a better solution? " We were seeing teens that weren't being included in all sorts of studies. There would be an STD study and everybody would realize adolescents get STDs or STIs, but that they are excluded from the actual study. This conference fundamentally made the climate for doing adolescent research better.

The other area where I've been successful is spearheading the efforts against adolescent medicine and abstinence-only education. I think most people in this society thought it was a crazy idea, but most people couldn't figure out how to deal with it. Knowing what was driving it from inside government in terms of social forces, we put together a team that drafted some very strong statements that have been widely used by advocates as well as policymakers, and I think we've been successful in ending that program. We've seen many states that have rejected funding because their health departments are saying this is not science; this is not good policy. We've seen the Obama Administration zero out the funding in the 2010 budget.

Youth-policy.com: What are some of the RH challenges facing youth at this moment in time? And how do these challenges affect the development of policies that could help in creating a more enabling environment for them?

Dr. Santelli: What we see globally are kids who are not able to reach their full potential because of sexual orientation, abuse, or lack of education. Every human being in their adolescence matures sexually, and it's a challenge for society to have to deal with it. In this country, for example, there are many people who do not accept individuals who have same-sex orientation or who are not traditional in their orientation. We have many people who are not accepting of adolescent sexual behavior outside of marriage. The vast majority of Americans initiate sex before marriage, but we have a vocal minority in the country that believes that that is wrong and that government policy should try to suppress that. Every society has various issues that they have to deal with.

The U.S. is somewhat unique in the sense that it has some of the worst public health indices on adolescent sexual and

reproductive health in the world at least vis à vis other developed countries. We have much higher rates of teen pregnancy and STDs. It's pretty clear it reflects not only social mores in this country but also an inadequacy in public health programs to help young people. Everyone needs help in making the successful transition to adult sexuality, but I don't think we're doing such a great job of being supportive. In the last few years, we've seen higher rates of STDs and teen pregnancy. Most of that reflects a failure of public programs including sex education and access to healthcare.

Youth-policy.com: In your most recent paper, "Changing Behavioral Risk for Pregnancy among High School Students in the United States, 1991–2007," you asserted that the increasing rate of teen pregnancy in the U.S. is associated with weaker HIV prevention efforts. What kinds of policies would revitalize HIV prevention efforts? How can these policies target youth?

Dr. Santelli: In the 1980s, we also had some great public policy leadership, particularly in the office of the Surgeon General Koop during the time of the HIV epidemic in the U.S. He told us we had a big issue, had to take it seriously, and this is what we can all do to prevent people, including young people, from being infected with HIV. As a result, we had widespread implementation after 1987 of HIV education and prevention programs of all sorts. Not only did he help create programs but also raised public awareness. Both of those are important. You have to have political leadership saying, "This is important," so people pay attention. I think we were very successful. Rates of condom usage rose dramatically between the 80s and 90s and into the current decade. We saw a reduction in sexual partners, and we saw a delay in sex among young people. We saw all the demographic trends that would reflect the message we were sending out. I still credit Surgeon General Koop and the public health service for accomplishing that. Surgeon General Koop's leadership was essential.

What we've seen in the last 10 years is a shift from HIV prevention to this talk about abstinence. Abstinence can be a very healthy behavior, but abstinence is a "one size fits all" solution for everybody. So to talk about condoms in abstinence-only education, you had to tell people that they didn't work. That's not likely to engender a lot of confidence. The biggest change in contraceptive use we've seen recently since 2003 is a downturn in condom use in this country as well as increases in STD rates and pregnancy. At the same time, there has been very little change in sexual activity. I think we need to talk to young people honestly and straight forwardly about the importance of condom and contraceptive use. I think young people are no longer hearing that message.

Youth-policy.com: What are the greatest gaps in youth RH programming and policies?

Dr. Santelli: Again, I don't think we're taking young people seriously enough. I think we still think of them as children and not as something else. Society has to recognize that adolescents are unique and valuable human beings. We need to recognize adolescents' reproductive rights as well as their human rights. They have rights to privacy and a right to participate in the political process even if they are underage. They show an emerging capacity to make their own decisions. They need to be supported and not suppressed. We need policies like that. That's the broadest change I would like to see. I would also like to see a change in the dialogue around human rights and reproductive rights in this country.

In terms of specific policies, we need to improve access to healthcare for young people, including reproductive healthcare. Care gets worse as you enter the young adult years. Health insurance, access to care, and use of healthcare drops dramatically as you enter the mid-twenties, particularly for young men; and it's because they don't have jobs that have health insurance and we don't have systems of care that are friendly to them. Even younger teens oftentimes don't know where to go to get healthcare. We have great pilot programs, great adolescent health centers, and school-based health centers that serve adolescents, but those only reach a minority of youth. We really need to be serious about providing health insurance and health access for all young people.

Secondly, we need to rejuvenate health and sex education in this country. We need to have health education that provides all the facts they need to improve their health and supports them on healthy goals, such as using contraception and avoiding drinking in certain situations when you know it's highly risky. We need a much stronger and better set of health education policies.

Youth-policy.com: How has the field of adolescent health changed over the years? What new priorities have emerged in policymaking related to youth health?

Dr. Santelli: There have been multiple changes. What's emerged in this country is a strong, vocal well-trained scientifically based group of professionals who take care of adolescents. The number of people in public health who are trained to deal with adolescents has also increased. I don't think we have enough people working in the field, but we clearly have some terrific professional standards we can look to. We've done a great job of professionalizing health education and moving it to a more scientific basis. We've learned a lot about what adolescents are and we've got a good body of research on effective programs such as sex education and contraceptive programs, health promotion programs, and counseling programs.

I still think the biggest priorities to address are these social and cultural barriers; the ability for adults to deal with and accept adolescent sexuality [and] for adults to recognize that adolescents are unique. We are clearly in an upswing, however, and that's really exciting.

Youth-policy.com: Based on your experience, what are the key areas for policy action?

Dr. Santelli: We have to move from ideology back to science in terms of development of public policies. Key areas include women's health and the development of drug policies by the FDA. If we can get policymakers, congressmen, and other types of influential people all supporting an agenda based on health and science, I think we'll be at a much stronger stance to face the future. From that will follow human rights. We need to recognize that healthcare and access to healthcare is a right. If we continue to treat it as a commodity, I think we will see the failure of healthcare reform. I think we need to utilize both a human rights and science-based perspective.

Youth-policy.com: As you know, a policy is only as good as its implementation strategy. Could you please give us some examples of an YRH policy that has been implemented successfully? And, what do you think are the key components to implementing the policy?

Dr. Santelli: To successfully implement a policy, one needs to have cultural and professional buy-in on basic policies. We have a set of legal rights that young people have to reproductive healthcare. If practitioners are not knowledgeable about those, if they don't support them because of their own religious or cultural beliefs, then we see a failure of those policies. In theory, young people are supposed to access care independently until they're ready to talk to their parents about reproductive issues, and in many places, they can't get that kind of care.

We now have laws in the 50 states that allow a young person to access healthcare independently—in many cases for emergency and mental health and STD diagnosis and treatment. In general, I think it's well-accepted by the professional community and by the public that when they [youth] are engaged in adult behaviors, they should be able to take care of themselves. That's a big success. There are now 2,000 school-based health centers serving a considerable fraction of youth in urban and rural areas, and that's a tremendous accomplishment. We're seeing the recognition of this idea of taking healthcare to people where they are.

Santelli, J.S., M. Orr, L.D. Lindberg, and D.C. Diaz. 2009. "**Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991–2007**." *Journal of Adolescent Health* 44(7): 25–32.

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