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REPORT

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Contents

ARTICLES

ALSO IN THIS ISSUE...

THE ROAD TO WORLDWIDE SEXUALITY EDUCATION

Mac Edwards

When I first arrived at SIECUS, I was taken on a tour of the offices and introduced to the staff and their work.

One office was conspicuously dark. It belonged to Jim Shortridge, SIECUS director of international programs. I was told that he was on the road helping to facilitate implementation of the *Nigerian Guidelines for Comprehensive Sexuality Education* and that he wouldn't return for a few weeks.

My memory of that day returns to me today as Jim announces in this issue of the *SIECUS Report* the publication of those *Guidelines* signaling the end of four years of work with Nigerian officials. His article on page 4 is an informative look at how the project evolved and succeeded.

A companion piece to Jim's story is an excerpt on page 5 from Nike O. Esiet's speech at the official ceremony in Lagos where over 400 people—from dozens of government and service-related organizations throughout Nigeria—applauded and praised the publication of the *Guidelines.* Nike is the executive director of Action Health Incorporated/Lagos, and she pulled together the Task Force that made the *Nigerian Guidelines* possible. Her speech tells us from her perspective why the *Guidelines* were developed. They also tell us why SIECUS has worked so hard in Nigeria and why it is involved in similar projects worldwide.

SIECUS INVOLVEMENT

As I was editing this issue of the *SIECUS Report,* I frequently talked with Jim about my hope that, taken as a whole, the articles would help people better understand SIECUS's involvement in the development of sexuality education programs around the world.

After one of our talks, he decided to give me a list of the activities that are key to implementing successful programs in different countries:

- researching the population
- acknowledging that many young people are sexually active and that everyone deserves information to help them make responsible decisions
- simplifying goals and expectations
- establishing a Task Force
- involving parents, peers, and the media
- targeting program sites
- training the trainers
- investing time in ongoing advocacy once the program is established.

IN THIS ISSUE

This list reflects many of the subjects discussed by the authors in this issue of the *SIECUS Report.*

Thomas W. Valente and Walter Saba of the School of Public Health at The Johns Hopkins University in Baltimore, MD, tell us of the steps that the Bolivian government took to increase understanding and acceptance of family planning methods in that country. It is an excellent "how to" on reaching people.

Carol Flaherty-Zonis, a consultant and trainer, writes about her work with the Soros Foundation to teach teachers to teach health education. The twist is that she does this in countries where individual thought was previously discouraged and where government control was a way of life.

Valeriy Chervyakov, a leading researcher in Russia, writes that even though 81 percent of Russians support sexuality education and nearly half of all Russian 16-year-olds are sexually experienced, the country is just now starting a sexuality education pilot project. The statistics in his article support the critical need for such education.

Lola Wagner, a consultant with the Health Associate Foundation and the Indonesian AIDS Society in Jakarta, Indonesia, explains how research on the citizens of the Batam Island of Indonesia was used to help develop a culturally appropriate sexuality education program there.

Likewise, Jayanthi Nayak and Rachana Bose of Parivar Seva Senstha Family Planning Programs in New Delhi, India, show how research on South Delhi young people ranging in age from 12 to 20 helped in the development of a life education program for young people in India.

All of these authors show us not only that a lot is happening around the world in the area of sexuality education

but also that much of the work is part of a surprisingly systematic worldwide plan.

WHAT NEXT?

So what can you expect from SIECUS during this fiscal year in the area of global sexuality education?

Jim, of course, will continue advocacy efforts on behalf of the *Nigerian Guidelines.* He has just reached an agreement with Population Services International (PSI) to conduct a series of professional sexuality education and train-the-trainer workshops for the Society for Family Health, a Nigerian partner agency of PSI.

These workshops will help the society's executive staff and regional field workers incorporate sexuality education (based on the *Nigerian Guidelines)* into their work. The workshops will also serve as a model for other PSI partner agencies as well as other international organizations seeking to address sexual health issues.

This year, Jim will also facilitate country-specific *Guidelines* efforts in Swaziland, Russia and India. These initiatives will establish groundbreaking frameworks for reproductive health, family planning, HIV/AIDS-prevention, and population education programs in these three countries.

On the subject of international communications, Jim will work to update SIECUS' Web site (http://www.siecus.org) to provide more information on sexuality education, to increase dialogue via forums for sexuality education professionals and organizations, and to provide indepth information (including contact sites) on colleague organizations around the world.

TALKING POLITICS

SIECUS received a lot of interesting mail about the August-September 1996 *SIECUS Report* on "The Politics of Sexuality Education." Most of it was about the analyses provided by Kelly Nelson of Temple University and Evonne Hedgepeth of Evergreen State College in separate articles about people on both sides of the sexuality education debate.

One such letter was from Linda Hendrixson of Branchville, NJ, who said that she takes exception to Hedgepeth's using Lawrence Kohlberg (and his study of 84 males) as the basis for her analysis.

"Hedgepeth's adaptation of Kohlberg's 'levels' to the sexuality education controversy is one way of understanding the mindsets of both sides," she says. "But we need to be careful not to imply that women (and girls), as a group, somehow miss the mark because, according to Kohlberg, they are unable to transcend the interpersonal domain in life to move to a 'higher level' of moral abstraction." She goes on to say that "for the most part, women make their judgments within the *care* framework, and men do the same within the *justice* framework. But crossover from one to the other viewpoint can also occur."

She refers interested *SIECUS Report* readers to the work of Carol Gilligan (1982), Nona Lyons (1989), and to an article, "Care Versus Justice: Two Moral Perspectives in the Baby 'M' Surrogacy Case" which she herself wrote in the *Journal of Sex Education and Therapy* (volume 15, number 4) in 1989.

Hedgepeth responds that while she agrees with Hendrixson that "Kohlberg's research was admittedly flawed in its interpretation of female moral reasoning, it nonetheless provides a sound model for analyzing the moral perspectives of progressives and the orthodox *using a justice-based moral scale.* She goes on to say that Gilligan's work on female moral reasoning—revealing an orientation based on "caring" rather than "justice"—was also addressed in her article.

In noting that most women, like most men, do not progress beyond the conventional level of moral reasoning, she said that she, unlike Kohlberg, did not suggest that women are incapable of such progression. "I agree with Gilligan that being 'different from' does not mean being 'lesser than' men. Ultimately, whether one uses Kohlberg's or Gilligan's scale, my observations hold true," she concluded.

CALL FOR SUBMISSIONS

The *SIECUS Report* welcomes articles, reviews, or critical analyses from interested individuals. Detailed instructions for authors appear on the inside back cover of this issue. Upcoming issues of the *SIECUS Report* will have the following themes:

Love and Intimacy.
April/May 1997 issue.
Deadline for final copy: February 1, 1997.

The Medicalization of Women's Reproductive Health.
June/July 1997 issue.
Deadline for final copy: April 1, 1997.

New Classroom Approaches to Sexuality Education.
August/September 1997 issue.
Deadline for final copy: June 1, 1997.

NIGERIAN GUIDELINES FOR SEXUALITY EDUCATION INTRODUCED AT CEREMONY IN LAGOS

James L. Shortridge, M.A.
SIECUS Director of International Programs

The Guidelines for Comprehensive Sexuality Education in Nigeria were officially published and introduced to the Nigerian public on Oct. 8, 1996, in a ceremony attended by over 400 people at the Nigerian Institute of International Affairs on Victoria Island in Lagos, Nigeria.

The ceremony capped over four years of collaborative efforts between SIECUS and Nigerian organizations to develop this groundbreaking sexuality education resource.

The publication of the *Nigerian Guidelines* is an important step in incorporating sexuality education into current reproductive health and population initiatives at educational institutions, youth-serving organizations, and community-based groups throughout Nigeria.

PROJECT STARTED IN 1992

SIECUS was first approached by Action Health, Inc. (AHI) to develop the *Nigerian Guidelines* (based on SIECUS' U.S. *Guidelines for Comprehensive Sexuality Education)* during an international sexuality education forum in Cuernavaca, Mexico in 1992.

The first major part of the project took place in January 1995 when SIECUS, in cooperation with AHI, conducted a two-week workshop aimed at building AHI's capability to develop, plan, implement, and evaluate a high-quality sexuality education program for adolescents in Nigeria. Nineteen professionals participated—including representatives from six adolescent-serving nongovernmental organizations (NGOs) from different regions of Nigeria.

Upon completion of this workshop, SIECUS and AHI brought together various key organizations as an advisory group to discuss the need for, and interest in, developing the *Nigerian Guidelines.*

It included representatives from the Association for Reproductive and Family Health (ARFH); the Nigerian Medical Association (NMA); the National Association of Nigerian Nurses and Midwives (NANNM); the Planned Parenthood Federation of Nigeria (PPFN); the World Health Organization—Nigeria; and the Society for Women and AIDS of Africa—Nigeria (SWANN).

Editor's Note: *For more information on the* Nigerian Guidelines *and current activities in Nigeria, contact: Action Health, Inc. (AGI), P.O. Box 803, Yaba Post Office, Lagos, Nigeria. Fax: 234-1-861166.*

GUIDELINES DEVELOPMENT STARTED IN 1995

By June of 1995, this advisory group had secured funding to begin the development of the *Nigerian Guidelines* and had written an initial draft. During the process, SIECUS provided consultation on their structure, content, and publication.

In October of 1995, a National Task Force of 20 key agencies and institutions working in the areas of adolescent health, education, and development convened in Lagos to provide input in making the material country-specific to Nigeria's children and youth. (See "Task Force" on page 6.)

SIECUS was on hand during these meetings to provide technical assistance. Discussions included such controversial subjects as abortion, marriage, gender roles, and sexual orientation.

Over the next six months, the Task Force made revisions to assure the accuracy and appropriateness of the messages. When they reached a consensus, they began developing a plan of action for printing, distribution, and endorsements.

Throughout the process, the Task Force demonstrated a remarkable level of unified interest and commitment. This is uncommon for Nigerian NGOs where competition and rivalry are the operating standard.

MEDIA, WORLD AGENCIES PARTICIPATE

Because the media is such an influential force in Nigerian educational issues, AHI and selected Task Force representatives scheduled a workshop specifically for members of the media just prior to the public release ceremony in October.

The purpose of the workshop was to provide access to data on the current status of adolescent reproductive and sexual health in Nigeria, to increase media professionals' understanding of sexuality education, to introduce the *Nigerian Guidelines* document as a tool for program development, and to discuss avenues through which the media could help promote adolescent health and sexuality education.

The huge turnout at the public release ceremony reflect the timeliness of the *Nigerian Guidelines.* Participants included the Nigerian Minister of State Education, the director of the National AIDS/STD Control Program for the Nigerian Federal Ministry of Health, the Nigerian directors of the World Health Organization, the United

PROVIDING NIGERIAN YOUTH WITH A BETTER LIFE, FUTURE

It is common practice to shield young people from receiving education about their sexuality because of the belief that such access will encourage them to become sexually active. But already, in Nigeria, *without* sexuality education:

- 7 out of every 10 Nigerian boys and 5 out of every 10 Nigerian girls attending secondary school are sexually experienced before the age of 20.
- By the time they leave secondary school, 1 out of every 5 Nigerian girls has terminated an unwanted pregnancy.
- Even though abortion is illegal, hundreds of Nigerian girls are terminating unwanted pregnancies with the help of back-street abortionists.
- 80 percent of patients in Nigerian hospitals with abortion-related complications are young girls.[1] In fact, illegally induced abortions are called "school girl" problems.
- Young people account for more than 50 percent of those contracting STDs and HIV/AIDS annually in Nigeria.[2]
- Apart from the problems associated with limited financial resources, teenage pregnancy is the leading single factor adversely affecting female education in Nigeria.

Unfortunately, whenever people try to provide youth with sexuality education, heated debates result. This is understandable to the extent that nobody wants his or her child to become involved in frivolous discussions about sexuality or early sexual relations.

Fortunately, we know better.

Sexuality education is not about teaching young people the various positions or styles of sexual intercourse. Rather, it addresses the biological, psychological, and spiritual dimensions of a person's being, including the skills to communicate effectively and to make responsible decisions.

Sexuality education involves acquiring information and forming attitudes, beliefs, and values about one's identity, relationships, and intimacy. It includes sexual development, reproductive health, interpersonal relations, affection, intimacy, body image, and gender roles.

In fact, the 1993 World Health Organization study on "The Effects of Sexuality Education on People's Sexual Behavior" shows overwhelmingly that "there is no evidence to support the contention that sex[uality] education in schools leads to earlier or increased sexual activity among young people."[3]

Sexuality education focuses on providing young people with the information to form attitudes, clarify values, and gain insights into the development of relationships with an emphasis on responsibility.[4]

Sexuality education is not about destroying children's moral fiber as some people want you to believe. It is about building and nurturing young people's lives.

Sexuality education reinforces a core set of human values—the same ones that are taught and propagated by most religions—the concepts of honesty, trust, responsibility, and respect for oneself and others.

What, indeed, are morals or morality if not the providing of education and services that seek to sustain, prolong, and protect human life and health? What is morality if it is not the act of supporting young people to engage in personal reflection in order to make caring and responsible choices about matters that can alter their lives.[5]

"Sexuality education is not about destroying children's moral fiber.... It is about building and nurturing young people's lives."

For this reason, the Nigerian National Task Force, has developed *Nigerian Guidelines* to help young people acquire knowledge and develop responsible behavior to help reduce the high rates of unwanted teenage pregnancies, complications from unsafe abortions, STDs and HIV/AIDS in Nigeria today.

As the *Nigerian Guidelines* are released, let us join in this effort to make sexuality education more accessible to our young people. Knowledge is light, and we have a role to play in guiding our young people to the right path.

— From a speech at the Nigerian Guidelines *Ceremony by Nike O. Esiet, project director Action Health Incorporated, Lagos, Nigeria*

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5. D. Roffman, "Defining and Reclaiming the Moral High Ground," *SIECUS Report,* vol. 22, no. 6 (1994): 19.

Nations Children's Fund (UNICEF), and the United Nations Family Planning Association (UNFPA), as well as numerous representatives of individual Nigerian donor agencies.

By its October publication date, the *Nigerian Guidelines* had received formal endorsements from over 75 national Nigerian organizations. As Pauline Makinwa-Adebusoye, consultant to the Nigerian Federal Ministry of Health, said during the ceremony, "The *Nigerian Guidelines* are an important first step to include sexuality education as a vital component of reproductive health programs in Nigeria."

PARTNERSHIP WILL CONTINUE

Improved advocacy, information, and policy dialogue in all of these program areas are important for the ongoing process of enhancing policies, reducing regulatory barriers, and increasing resources for community support for youth services in Nigeria.

SIECUS looks forward to its continued collaborative partnership with organizations in Nigeria to provide technical assistance as sexuality education initiatives based on the *Nigerian Guidelines* are developed.

THE TASK FORCE RESPONSIBLE FOR THE NIGERIAN GUIDELINES

Twenty organization members of the National Task Force were responsible for developing the *Guidelines for Comprehensive Sexuality Education in Nigeria*. They are:

Action Health Incorporated
Adolescent Health and Information Project
Association for Reproductive and Family Health
Christian Health Association of Nigeria
Constitutional Rights Project
Girls' Power Initiative
National Association of Nigerian Nurses and Midwives
National Institute for Policy and Strategic Studies
National Parent Teacher Association of Nigeria
Nigerian Educational Research and Development Council
Nigerian Federal Ministry of Education
Nigerian Federal Ministry of Youth and Sports/ Department of Youth Development
Nigerian Medical Association
Nigerian Union of Journalists
Planned Parenthood Federation of Nigeria
Society for Women and AIDS in Africa, Nigeria
United Nations Children's Fund
Women's Health and Action Research Centre
Women in Nigeria
World Health Organization

FACTS ABOUT ADOLESCENT REPRODUCTIVE HEALTH IN NIGERIA

SEXUAL RELATIONS

Seven out of every 10 males and 5 out of every 10 females attending secondary school in Nigeria are sexually active or have had sexual relations at least once. A study in Benin City showed that 55 percent of the secondary school girls had sexual intercourse before age 16.[1] A more recent study showed that the mean age of initiation of sexual intercourse is 13 years.[2]

PREGNANCY

Two out of every 5 secondary school girls interviewed admitted to at least one previous pregnancy.[3] Over 900,000 births to adolescents occur annually[4] and 150 out of every 1,000 women who give birth in Nigeria are 19 years old and under.

ABORTION

Eighty percent of patients at Nigerian hospitals with abortion-related complications are adolescent girls.[5] These complications include hemorrhage, septicemia, perforated uterus, secondary sterility, and, in many cases, death. Illegally induced abortion is described as a school girl's problem in Nigeria.

MORTALITY

Pregnant girls who are 15 years old and under have a maternal mortality rate 7 times higher than that of women 20 to 24 years old. Girls under 20 years of age suffer more pregnancy and delivery complications such as toxemia, anemia, premature delivery, and prolonged labor than women who are 20 or more years old.[6]

STDS AND AIDS

The World Health Organization estimates that worldwide one out of 20 adolescents contract a sexually transmitted disease (STD) each year. Also, one-fifth of all people worldwide with AIDS are in their twenties, indicating that they probably contracted the AIDS virus during their adolescence (due to the long latency period of the disease).[7] In Nigeria, 15- to 29-year-olds account for 62 percent of all the AIDS cases among females between 1986 and 1995.[8]

SCHOOL DROP-OUT RATES

Teenage pregnancy is a major cause of school drop-out among girls. In a Nigerian study of 127 pregnant school girls, 52 percent were expelled from school, 20 percent were too ashamed to return, 15 percent could not return because their parents refused to pay tuition, and 8 percent were forced to marry.[9]

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9. B. Gyepi-Garbrah, *Adolescent Fertility in Nigeria* (Boston, MA: Pathfinder Fund, 1985).

Editor's Note: *These statistics are from* The Facts About Adolescent Reproductive Adolescent Health in Nigeria, *a fact sheet published by Action Health, Inc. (AHI), Plot 54, Somorin Street, Ifako-Gbagada, Lagos, Nigeria.*

SURVEY SUPPORTS ARGUMENTS TO START SEXUALITY EDUCATION IN RUSSIA

Valeriy Chervyakov, Ph.D.
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Perestroika and the liberation of the mass media in Russia brought with it an open approach to sexuality on television and in magazines and newspapers. Many Russians expected that such a change would result in more young people becoming sexually active. And they were right.

Comparisons between 1993 and 1995 surveys conducted by the Transnational Family Research Institute in Moscow show that the number of sexually active 14- and 15-year-olds increased by more than 30 percent.

The 1993 survey itself showed that half of the surveyed young men and a third of the young women were having sexual relationships before they were 16 years old and that one in eight school-age males and one in 16 school-age females had sexual intercourse by their fourteenth birthday. Young 14-year-old women in vocational schools were as sexually active as boys of the same age in high schools. Twenty percent of all 14-year-old boys in vocational schools had experienced at least one sexual relationship.

Just-released statistical data from the Russian government indicate even more alarming news. The incidence of syphilis among adolescents between the ages of 14 and 18 has increased 25 percent in the past five years. Over 5 percent of young women under the age of 18 have had unwanted pregnancies (with the majority opting for abortions). The first sexual experience for 30 percent of these young women involves sexual abuse. Approximately 8 percent of those experiences fit the definition of rape. One out of every four young men agree with the statement that "You cannot blame a fellow if he has sexual relations with a girl he has dated for a long time—even if it is against her will."[1]

CURRENT EDUCATION IS POOR

These figures provide solid arguments for starting comprehensive sexuality education programs in Russia. Yet, such education is currently very poor. Only 12 percent of high school students and 8 percent of vocational school students in the survey said that they had attended sessions devoted to sexuality issues. And over 65 percent of those who attended said the entire course consisted of only one- or two-hour lectures or seminars.

As a result, only 2 percent of recent survey respondents listed their teachers, professors, or lecturers as the primary source of their knowledge about sexuality. The most significant sources were the print media: books, newsletters, and magazines. Next were friends (with conversations dealing with rumors and myths about sexuality). In reality, most adolescents will gather knowledge about sexuality through their own personal experiences with their partners. Unfortunately, each new generation makes its own way in learning about sexuality.

Luckily, that may change. In October, Russia launched a sexuality education pilot project with the support of the United Nations Family Planning Association (UNFPA) and the United Nations Education, Scientific and Cultural Organization (UNESCO). It will take three years to develop the curriculum, prepare the materials, and test them in schools.

NEW SURVEY RESULTS

Launching this pilot project comes none too soon considering the data about Russian youth and their sexual experiences compiled by the Transnational Family Research Institute from its 1995 survey.

The survey indicates significant differences between the sexual experiences of city and small-town youth as well as between those of high school and vocational school students. Among males, nearly half of Moscow (city) students have had sexual intercourse, while a third of Borisoglebsk (small town) students have had sexual intercourse. Among females, 30 percent of the Moscow students have had sexual intercourse, while just over 10 percent of the Borisoglebsk students have had sexual intercourse. On the whole, vocational school students are 1.5 times more active than their high school peers. (See Table 1, "High School and Vocational Students Who Have Had Sexual Intercourse.")

TABLE 1: HIGH SCHOOL AND VOCATIONAL SCHOOL STUDENTS WHO HAVE HAD SEXUAL INTERCOURSE

Age	16	17
High Schools/Males	43.9%	43.7%
High Schools/Females	24.0%	40.3%
Vocational Schools/Males	62.7%	71.9%
Vocational Schools/Females	46.0%	60.8%

The survey also indicates that individuals who have had sexual intercourse at an early age are usually involved in unhealthy behaviors (smoking, drinking, and using drugs) and usually have had disorganized leisure time (often involving "hanging out" at clubs).

On the subject of unhealthy behaviors:

- boys and girls who do not smoke are more than two times less likely to have had sexual intercourse. On the other hand, 80 percent of regular smokers—boys and girls equally—were more likely to have had sexual intercourse.

- more than 30 percent of the females and more than 50 percent of the males had had their first sexual relationship after drinking alcohol. The same correlation was made with drugs: 25 percent of the females and 30 percent of the males had had their first sexual relationship after using other drugs.

- 48 percent of virgin boys in vocational schools received high grades compared to 28 percent of sexually active boys. Among girls, 61 percent of the virgin girls made high grades while 38 percent of the sexually active girls made high grades.

The survey also indicated that the sexually experienced teenagers felt their learning abilities were lower than those of the inexperienced teenagers. Yet, they felt they were better at making friends, leading groups, and pleasing the other gender. There was an apparent relationship between sexual activity and self-confidence.

Even though many young people were virgins, the survey indicated that they were not against premarital sexual relations. On average, female students felt that they should become sexually active when they were 17 years of age while male students felt they should become sexually active at 16 years of age.

Specifically:

- nearly 60 percent of these young females said they preferred to abstain from sexual intercourse. Their reasons were varied: they had not met the right person (1 out of 3), they were not ready and were not willing to change their mind for someone else's pleasure (1 out of 8), and they feared becoming pregnant (1 out of 10). About one third said they believed they *should not* have sexual relations before marriage and approximately the same percentage said they felt they *would not* have sexual relations before that time.

- the majority of these young males said they had not had sexual intercourse because they did not have a partner, they were indifferent, or they had not had the opportunity.

Some other general statistics from the survey:

- nearly 60 percent believed that sexual relationships were as important as education or a career.

- over 50 percent disagreed with the statement that a young woman must not have sexual relations before marriage.

- 75 pecent of the females and 80 percent of the males considered it necessary for a male to have sexual experience before marriage.

- 75 percent of the females said a person should have sexual relations only with the person they truly loved. Just over 50 percent of the males agreed.

The teenagers were not inclined to overestimate their knowledge of sexual relationships. Only 17 pecent of sexually inexperienced and 30 percent of sexually experienced students said they knew enough about sexuality.

The sexually experienced teenagers were more actively in favor of sexuality education in the schools. (See Table 2, "Agree/Disagree: "It would be good to inroduce special training on sexuality in the school curriculum.")

TABLE 2: AGREE/DISAGREE WITH THE STATEMENT "IT WOULD BE GOOD TO INTRODUCE SPECIAL TRAINING ON SEXUALITY IN THE SCHOOL CURRICULUM."

	Strongly disagree	Rather disagree	Rather agree	Strongly agree	Not sure
Inexperienced/ Male	5.6%	4.9%	25.2%	49.7%	14.7%
Inexperienced/ Female	3.5%	4.2%	27.9%	57.4%	7.0%
Experienced/ Male	2.4%	3.5%	18.3%	60.6%	15.1%
Experienced/ Female	2.7%	1.7%	20.9%	69.8%	5.0%

CONCLUSION

Recent data gathered by the All-Russian Research Center of Public Opinion indicates that 81 percent of a randomly sampled population favor sexuality education in Russia while only 10 percent object to it. Another 9 percent have no opinion.[3]

Even though these figures indicate that Russia has no real opposition to sexuality education for its teenagers, it still has no programs in its schools, no teachers, and no text books.

But the hardest step is often the first. And Russia made the first step last October when it launched its own sexuality education pilot project.

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REPRODUCTIVE HEALTH IS IN YOUR HANDS: THE NATIONAL MEDIA CAMPAIGN IN BOLIVIA

Thomas W. Valente, Ph.D.
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The Johns Hopkins University
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Bolivia has a great need for improved reproductive health services and a high level of "unmet need" for family planning. Consider the statistics:

- 47 percent of Bolivian women who give birth never receive prenatal care.
- 57 percent of births take place in homes, usually without the assistance of a health worker.
- 25 percent of Bolivian women who are married or living with their partner do not practice any form of family planning even though they wish to limit or space births.
- 100 out of 1,000 newlyborn babies in rural Bolivia die.[1]

In response to the needs of its citizens, Bolivian government officials launched the National Reproductive Health Program (NRHP) early in this decade to promote quality reproductive health practices, to improve services, and to increase acceptance of family planning methods.[2]

THE MEDIA CAMPAIGN

Four years later, the government launched a media campaign—with the theme "Reproductive Health Is in Your Hands"/"Salud Reproductiva Esta en Tus Manos"—to make lower- and middle-income women and men between the ages 18 and 35 aware of the NRHP program.

Technical assistance was provided by The Johns Hopkins University/Population Communication Services (JHU/PCS) and support was received from the United States Agency for International Development (USAID).

The overall goals of the campaign were to explain the nature of reproductive health, disseminate information on the benefits of acting on reproductive health issues, and motivate people to seek information and services at the health centers.

The specific objectives were to increase:

- recall of the campaign and its logo
- positive attitudes toward reproductive health and encourage the use of such services
- knowledge of at least one benefit of reproductive health and where to obtain reproductive health services
- knowledge of where to obtain family planning services
- partner communication about reproductive health
- use of reproductive health services at health centers.

The media messages emphasized ways to develop preventive-care approaches, reproductive health care, including prenatal visits, postpartum care, and family planning as a way to enable couples to choose when to have children and how many, and, when possible, to avoid abortion.

The concept of reproductive health was framed in terms of the health of the entire family. Messages instructed people where to go for reproductive health services and emphasized personal responsibility in obtaining services for the benefit of the family.

The media campaign was carried out in three phases:

- *Phase 1* (May-June) introduced the concept of reproductive health, introduced the logo, and provided general information.
- *Phase 2* (July-August) featured health professionals in a clinic setting talking about prenatal care, family planning, postnatal care, breast feeding, and abortion.
- *Phase 3* (Sepember-November) featured testimonials by satisfied users of reproductive health services.

The *Little Hands/Las Manitos* logo was featured on all materials to provide consistency and easy identification of all messages. The communication vehicles included 11 television spots and 44 radio spots scheduled for broadcast over an eight-month period. In addition, 100,000 copies of two posters were disseminated, two videos were produced for viewing in clinic waiting rooms, a comprehensive set of provider-client print materials was developed, and four audio cassettes on reproductive health topics were created and distributed for use on city buses. (See page 12 for more detailed information on the television and radio spots.)

PRECAMPAIGN SURVEYS

For two months prior to the campaign, The Johns Hopkins University Population Communication Services surveyed 2,256 men and women between the ages 15 and 49 in seven

urban areas: La Paz, Santa Cruz, Cochabamba, Sucre, Oruro, Tarija, and El Alto. Most of the evaluation focused, however, on the cities of La Paz, Santa Cruz, Cochabamba, and El Alto. The surveyors used open- and close-ended questions to collect information about current reproductive health and family planning knowledge, attitudes, and practices.

(For background, the population of Bolivia is approximately 7.2 million. Nearly half are concentrated in the seven urban areas mentioned above. The percentage of people in rural areas remains high at 43 percent. Catholicism is practiced by 92 percent of the population. Spanish is the dominant language, with Quechua and Aymara spoken by the two main indigenous groups.)

The survey covered current use rates of both modern and traditional contraceptive methods. The intrauterine device (IUD) was the most prevalent modern method, used by 10.3 percent of women in the survey, followed by condoms, the pill, and female sterilization. The rhythm method was the most prevalent traditional method, used by 16.5 percent of women in the sample. A total of 30.9 percent of women in the sample used modern methods and 22.1 percent used traditional methods (also including withdrawal and periodic abstinence). Of the 16.5 percent of women who said they currently used the rhythm method, 39 percent could not identify the "dangerous time" in the menstrual cycle for risking pregnancy.

"The campaign... produced substantial change in awareness, knowledge, and behavior...."

Johns Hopkins also scheduled 16 focus group discussions to better understand the context of family planning decision-making in Bolivia. They learned that Bolivians associated reproductive health with a broader range of services, that family planning had negative connotations, and that many people misunderstand—or were misinformed about—family planning methods.[3] Based on these findings, the government decided that it would promote family planning as part of reproductive health rather than by itself.

As soon as the campaign materials were developed, Johns Hopkins pretested them by gathering 147 men and women (about 50 people per city from La Paz, El Alto, Cochabamba, and Santa Cruz) in an auditorium to complete a questionnaire on their perceptions of the four television spots, the five radio spots, and a poster. Their suggestions were used in the revision process.

POSTCAMPAIGN RESULTS

Immediately after the campaign, Johns Hopkins conducted a second survey to assess its impact. It included 2,354 men and women in the seven urban areas and measured their exposure to the campaign as well as their message recall. (Respondents were divided into two categories—corresponding to low and high exposure to and recall of the communication messages.)[4]

Results showed that 85 percent of the respondents had been exposed to the campaign, and that this high rate produced substantial change in awareness, knowledge, and behavior. Family planning was the most frequently remembered message, followed by the messages "to obtain information at health centers," "to obtain prenatal care," and to remember that "reproductive health is in your hands."

In the four main cities, the level of exposure was found to be significantly associated with education, gender, and age, where those with high exposure tended to be better educated, female, and slightly younger.

More awareness. Among the most important results of the media campaign was an increase in awareness of family planning methods and information sources as well as an immediate recognition of the campaign logo.

The percentage of respondents spontaneously identifying at least one family planning method increased substantially between the first and follow-up surveys. In the four main cities, awareness increased from 84 to 91 percent among high-exposure respondents in the ten months between surveys. Overall, 97 percent of the postcampaign respondents in the four main cities said they recognized the logo; only 57 percent had recognized it in the baseline survey. There was an increase from 24 to 66 percent in the four main cities of respondents citing television as their source of reproductive health information. There was also a 4 percent increase in the number of respondents citing radio as their source for such information.

Increased knowledge. In the area of detailed knowledge of and positive attitudes toward family planning, there was no significant increase. (Perhaps this is because "detailed knowledge" was not an emphasis of the "Reproductive Health Is in Your Hands" campaign.) Of the questions asked about specific knowledge, respondents scored lowest on modern family planning methods such as a condom, an IUD, the pill, female sterilization, and spermicide. Although a positive attitude toward reproductive health was generally high among women 18 to 35 years old in the targeted cities, this percentage increased from 86 to 91 percent for those with high exposure to the campaign.

Respondents showed a bigger increase in knowledge about preventive reproductive health measures (such as prenatal care and duration/consistency of breast feeding). In the four main cities, the average score on preventive health knowledge increased from 19 to 24 percent among low-exposure respondents and from 19 to 32 percent among high-exposure respondents.

RADIO AND TELEVISION SPOTS: OVERVIEWS, EXPLANATIONS, AND TESTIMONIALS

The radio and television spots for the "Reproductive Health Is in Your Hands" campaign were introduced in three phases: the first, a general overview of reproductive health; the second, specific explanations of reproductive health; the third, testimonials by satisfied users of reproductive health services.

PHASE 1—GENERAL OVERVIEW

The first spots explained reproductive health and why it is important:

Introduction: In introducing the campaign logo of an adult's hand holding a small child's hand, the spots say, "For your health, for your partner, for your children, for your family, reproductive health is in your hands. The announcements that will follow will provide more information. Ask for information where you see the little hands."

Message from a government official: Bolivian Health Secretary Joaquin Monasterio explains the problem and the main causes of maternal mortality (induced abortion, failure to obtain maternal health care, and closely spaced births) in Bolivia. He then talks about the government's commitment to support the reproductive health centers and closes by saying that he places responsibility with the Bolivian people: "The government cannot do it alone.... Reproductive health is in your hands."

The concept of reproductive health: A couple is at home listening to the radio. The woman asks her partner about the meaning of reproductive health. The radio announcer explains that reproductive health means that couples can have the number of children they want, when they want them, and that they are able to care for their children from pregnancy to maturity, protecting the lives of both mother and child, for the good of the family. The man tells his partner that she should get more information about reproductive health. She replies, "Didn't you hear what he told us on the radio? Reproductive health is for both of us."

PHASE 2—SPECIFIC EXPLANATIONS

All spots began and ended with the same music. The television spots included the "little hands" logo and voice-overs with the phrases "reproductive health is in your hands" and "look for services where you see the little hands." Various spots discussed specific aspects of reproductive health:

Family planning: Without family planning, problems can arise. Part of reproductive health is being able to decide how many children to have and when to have them. There are methods that are easy to use.

Prenatal care: Women should avoid the risks of pregnancy by seeking prenatal care. This is part of reproductive health.

Prepartum and postpartum care: People should avoid health risks to mother and child by getting prepartum and postpartum care. Going without care can result in maternal and infant death. Prepartum and postpartum care are part of reproductive health.

Breast feeding: Mothers should breast feed their newborn child during the first six months to protect him/her against illness.

Abortion: Family planning is crucial to preventing an unwanted pregnancy and a subsequent abortion. Partners should use contraceptive methods to prevent unwanted pregnancies.

PHASE 3: TESTIMONIALS

"Reproductive Health Is in Your Hands" was repeated in these spots. The logo was always prominent. Music was used. In many of the spots, the people giving the testimonials said at the end of the spot: "Do as we did. Ask for services at the reproductive health centers where you see the little hands."

The testimonials covered these issues:

Prenatal care: A couple explains they have received prenatal care since they discovered the woman was pregnant. They are now ready to have their baby and the doctor has told them that all is well.

Family planning: A young couple says that they are planning for their family and that they are going to wait at least two years before they have their second child.

Prepartum and postpartum care: A doctor visiting a woman who has just given birth explains that it is important that she take care of herself and recuperate so that they she and the doctor can both take care of the little girl.

Behavior change. Significant changes were also found in interpersonal communication and family planning use. The percentage of women 18 to 35 years old who reported speaking to someone (other than their partners) about reproductive health in the past six months increased from 71 to 82 percent among "high exposure" respondents.

The male respondents who answered "definitely yes" to the question, "Do you intend to use or continue to use a [family planning] method in the future?" increased from 25 to 60 percent.

In the four main cities, family planning use among respondents in the "high exposure" category increased from 5.4 to 8.7 percent. This 3.3 percentage-point increase translates into a 61 percent increase in the rate of reported use of family planning. Among women between ages 18 and 35 in the same category in the four main cities, the percentage of new users increased from 9.1 to 13.0 percent.

The evaluation revealed, however, that a misunderstanding persisted about the *details* of specific family planning methods and that more research was needed on communication between partners.

RECOMMENDATIONS

The positive results of this evaluation make a strong case for expanding the campaign to other urban areas that received little or no exposure to the campaign:

- Exposure and recall were high in dense urban areas and low in rural areas. Future communication should strive to close these gaps.
- There was a perceived lack of communication between partners in deciding to use family planning services. Future survey questions might improve measurement of the partner communication variable.
- There was a more significant increase in the intention of men to use family planning methods. Future work and efforts should continue to focus on men.
- Mass media proved an effective vehicle for addressing the sensitive issue of abortion. Future efforts should expand on this success.

The NRHP campaign has generated a demand for reproductive health services. The evaluation shows that a large segment of the intended audience has formed a positive attitude toward reproductive health and intends to use such services.

The private and public system of service delivery in Bolivia now faces the challenge of responding to this demand by facilitating access to quality services and meeting increased demand by providing information to clients to increase their possibilities for informed choice.

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CAMPAIGN MESSAGES

The key campaign messages of "Reproductive Health Is in Your Hands" were:

- The government is interested in reducing maternal mortality attributable to childbirth and abortion.
- Reproductive health means the health of the mother, the child, and the couple.
- Women should have their children while under the care of a doctor.
- Expectant mothers should receive prenatal care to avoid perinatal problems.
- Mothers need to breast feed only (without supplementation) until their child is six months old.
- Family planning allows couples to decide how many children they want and when they will have them.
- Family planning has many benefits.
- Information about reproductive health is available in family planning clinics and health centers.
- Family planning is a way to avoid abortion.
- Couples should decide together the kind of family planning method they will use.
- There are a variety of family planning methods including the rhythm or calendar methods and the IUD.
- Reproductive health depends on the couple; it is in your hands.

HELPING TEACHERS TO CREATE A CLIMATE FOR LEARNING ABOUT SEXUALITY

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At the conclusion of one of my workshops designed to teach teachers to teach health education, a young woman from Latvia stood in front of her colleagues. All of them immediately stooped to the same height. She then ran her hand across the tops of their heads and spoke haltingly, yet eloquently, in her newly learned English about their training.

"Before this program, we believed we all had to be the same—just as you are all now standing at the same height. But our work during these five days has made us realize our own individual spirits," she said. "Now, we know we all belong at our own different heights."

Teachers who experience their own individuality—and, with it, a sense of freedom—can bring the same experience to their colleagues and students. This is particularly important when teaching health and sexuality issues that involve learning what it means to be a whole (including sexual) person.

The Soros Foundations/Open Society Institute, for which I conducted this session, was created to help people from countries where individual thought was previously discouraged and government control was a way of life. Work supported by the foundation throughout its network (including Central and Eastern Europe, Centeral Asia, and the former Soviet Union) include, but are not limited to, health care, arts support, science education, women's programs, and debate/speaking skills.

"We all belong at our own different heights."

THE HEALTH EDUCATION PROGRAM

The health education program is currently underway in 21 countries such as Albania, Kazakhstan, the Czech Republic, and Bosnia. Its curricula include sexuality, AIDS, nutrition, alcohol/other drugs, smoking, the environment/global community, and conflict/communication.

As a consultant to the foundation, I have traveled to 17 of these countries with my colleague and co-trainer, Susan Shapiro, to bring innovative teaching strategies and an interactive learning environment to teachers and professionals. Most were unfamiliar with such an approach. They definitely had not taught in groups where individuals laughed, shared, *and* learned together.

Originally hired to write health education curricula, I was soon totally involved in teaching teachers how to teach in their own unique and different ways. In the process, I tried to help them to:

- discover and use their own spirit and voice to realize their potential as teachers.
- transfer their love of learning to their students.
- learn more about health to facilitate the improvement of student health.
- overcome reluctance to and anxiety about giving up old ways and established roles
- find value and respect in the uniqueness of each person.
- learn and appreciate both the substance and the process of learning.

ADAPTING THE WORKSHOPS

When I started conducting the workshops, I needed to determine immediately if I would have to adapt the sessions to the individual countries. Luckily—and surprisingly—I discovered that almost all the participants took to the sessions with minimal change. So I continued to use the multiple-intelligence approaches to learning (based on Howard Gardner's work) that suggest that people learn in a variety of ways including music, movement, and drawing.

A good example is my experience in Albania. Prior to leaving home, I was told that cultural differences might affect the way I taught the sessions. I was told that the session on sexuality, in particular, might prove difficult because the subject is rarely discussed in public.

I proceeded undaunted and asked the participants in our session on sexuality to form groups and discuss situations that would have put them in difficult situations and required them to make important decisions. I asked them to role play the problems and their resolutions.

I was amazed at the ease with which they accomplished the assignment. Members of the group (mostly male, which is unique in my work) borrowed my jacket and purse to role play women. They were sensitive and humorous in explaining their dilemmas. And this was in Albania, one of the countries longest closed to outsiders, especially Westerners!

So why did this happen here and in all the other countries when experience tells us that we must adapt sessions to fit cultural differences? I am convinced it is because these individuals had learned to trust me, to trust themselves, and to trust each other. At this point in the sessions, they were able to feel and express vulnerabilities that were previously off limits.

I cannot discount their sincere desire to understand and to learn. This, too, must have played a part in their taking so readily to the sessions. They definitely did have a curiosity, enthusiasm, and intensity as they searched for meaning in what they were doing. I personally felt I was witnessing true creativity and a joy in both the process and substance of learning.

SAYING "AHA"

In teaching the value of a caring and interactive classroom, I challenged much of what participants had previously learned about the role of the teacher solely as the giver of knowledge.

Many were initially uncomfortable even though they sincerely wanted to learn. They had never opened themselves to new experiences and teaching techniques. Most, however, eventually relaxed, laughed, and shared with each other. I watched as they said "aha" over and over again when they realized that:

- education is more than an intellectual experience; it is also an emotional and spiritual one
- a teacher who shows his/her human side will enhance the learning process
- learning is easier when it is fun
- both teachers and students have experiences they can bring to bear in the classroom
- students (children and adults) are more likely to change their behavior (especially relating to sexuality education issues) if they understand the significance of the change and the positive effect it will have on their lives
- change can start at the bottom of an organizational chart and it can take place one person at a time
- sexuality is an integral part of life, and education about sexuality belongs in the schools.

LEARNING ABOUT SEXUALITY

On the day we discussed sexuality, I began with a question adapted from Gregory Stock's *Book of Questions* that was designed to focus on issues of self image, personal values, and meaningful relationships.

The question goes like this: "If someone offered you an all-expense-paid, year-long, round-the-world trip for two in exchange for pulling a wing from a living butterfly, would you do it?" For those who said "no," there was a follow up question: "If someone would give you all of these things for killing a cockroach, would you do it?" Many people reluctant to say "yes" to the first question quickly responded in the affirmative to the latter.

As participants discussed the difference between removing the butterfly's wing and killing the cockroach, they decided that one of the main reasons they would kill the cockroach and not harm the butterfly was because they felt that the cockroach was ugly and that the butterfly was beautiful.

This led us to an examination of self-esteem and such questions as "Have you ever felt like a butterfly or cockroach?" "Do you have students who have felt like a butterfly or cockroach?" "How do/did these feelings affect your behavior and your attitude about yourself, your sexuality, and your ability to make thoughtful decisions?"

This, in turn, led to a discussion that most had previously felt was impossible to have: looking at sexuality in terms of *self, relationships,* and *values* as opposed to *body parts* and *functions.* This discussion was filled with celebration. The participants eventually saw beyond the physical aspects of sexuality. They realized the importance of the spirit—encompassing their values and their beliefs—in their lives and in their sexuality. They realized, too, that sexuality was expressed in many ways and that sexuality education was a vehicle leading to that expression.

Finally, the participants understood the importance of creating such an environment in their own classrooms. If they wanted their students to say "yes" to a healthy lifestyle, if they wanted their students to experience the joy of their uniqueness (rather than the pain of not being as pretty or as handsome as someone else), then they had to understand, experience, and share the same risks, fears and joys.

THE MISSING PIECE

In some ways, the experiences of these workshop participants are similar to the search of the PacMan-like creature in Shel Silverstein's *The Missing Piece* who tries to find her/his missing piece. The search involves numerous adventures, and finally ends with the creature realizing that her/his journey and the experiences along the way are what really mattered.

I read the book to the group, much as elementary teachers read to children. We sat in a circle, many on the floor, almost always with an interpreter (who had to get the words *and* the meaning behind the words).

Many teachers arrived at the workshop wanting to find the unidentified, missing piece in their lives to help them enhance their roles as teachers. During our five days and nights together, they searched for it. Some found the piece

too sharp, different, and risky. Some were challenged by the adventure of the search. Most realized the search was more significant than finding the single piece. Some realized they already had the piece and liked the way it fit. I myself learned a great deal from the participants as I saw firsthand their openness and their willingness to question long-established traditions in their search.

I must admit that I, too, have been changed by the work that I have accomplished. I have been forced to reexamine my spiritual core and to examine my own values and beliefs about sexuality education and how it fits into people's lives. This has helped me not only with these workshops but with my more specific sexuality education workshops themselves.

OPEN LEARNING ENVIRONMENTS

The foundation's workshop evaluations show that many of these teachers have subsequently changed their classroom practices, and have created open learning environments in a variety of subject areas. Many have instituted the first health and sexuality education classes in their own countries.

They have accomplished their work in spite of the fact that they do not have the literature and other resources available in the United States. They have had to rely primarily on the curricula and activities supplied in our workshops and, of course, on their own creativity.

The foundation is not the only organization doing important work. I recently worked with SIECUS's Jim Shortridge on its *Guidelines* project in Russia. I conducted workshops on sexuality education and strategic planning to help organizations in that country understand how to implement a program using the *Guidelines for Comprehensive Sexuality Education*. SIECUS is playing an important part in helping Russia and other countries to develop the literature and other materials they need to implement their own health and sexuality education programs.

There is much change taking place as a result of the work of many groups:

- In Moldova and Albania, where many decisions are made centrally, the health education curricula is now included as part of the national school program.
- In Romania, the health education program is widely accepted. They even have a student newspaper dealing exclusively with health education issues, and radio and television broadcasts about health issues.
- In Bosnia, the foundation's health education coordinator has implemented plans for International AIDS Day programs and activities.
- In the city of Sarajevo, people received training through the health education program broadcast on the radio in the midst of fighting a war.

The people in these countries face many obstacles that could have stood in their way. But they have a passion for and a commitment to their work and the difference it can make in young people's lives. They have made things happen.

They serve as a model to me as I continue my work in the United States and around the world to help people understand and effectively implement the goals and objectives of comprehensive health and sexuality education programs.

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RESEARCHING CULTURAL BACKGROUNDS TO ESTABLISH EFFECTIVE SEXUALITY EDUCATION PROGRAMS

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Situated in the Indonesia-Malaysia-Singapore Development Growth Zone, Batam Island is a fast-growing part of Indonesia targeted for tourism, investment, and trade.

Since the 1980s, it has seen dramatic growth in factories, recreation facilities, and infrastructure. Many people from throughout Indonesia and the world have migrated to the island to take part in this growth.

Still, many local people who have had ties to the island for more than a century live there as fishermen and as part of the peasant society. They do not possess the skills and educational background to take part in the new industrialization and globalization. In fact, many of the older generation never attended school and some of the younger generation, particularly the women, quit before completing elementary school.

The young people from this island are beginning to adapt to the new, modern culture as they see it through the media—especially television and movies—from neighboring countries. The older generation of islanders, however, is still living the traditional island lifestyle. Unfortunately, both young and old face eviction from their homes and land because of the rapid economic growth.

"The researchers studied the islanders...as individuals and as a collective group..."

For all of them, the Moslem religion is central to their lives. The older, more traditional members of the community go to the mosque and pray five times a day. The women use veils to cover their hair and most parts of their bodies. They all follow Moslem tradition in terms of the way they perceive sexuality and sexual relationships. Men are allowed to divorce and remarry (some have four or more wives). Women are taught to stay at home and take care of the children. Young people understand that they will be severely punished if they have premarital sexual relations *(zina)*.

When foreign men come to the Batam Island to conduct business, they usually enter into temporary marriages with the Indonesian women who have migrated to the islands (not the native women themselves). The Moslem faith does not have a position against these temporary marriages.[1] Many also frequent the new prostitution services that have cropped up with industralization and tourism.

RESEARCH ON THE BATAM CULTURE

The Perspective Foundation of Indonesia recently conducted research to study the culture of the islanders and to use that information to develop an effective sexuality education and reproductive health program.

Five researchers worked with 125 respondents in 11 villages on the island to determine general sociocultural beliefs, practices, and values relating to sexuality, and feelings about a variety of subjects such as STDs and prostitution.

The researchers studied the islanders—through interviews, direct observations, and informal conversations—both as individuals and as a collective group. They looked at ideals vs. actual practice, public vs. private conduct, and prescribed vs. voluntary behavior. They also studied documents, reports, newspapers, and other data related to the islanders' approach to sexuality-related issues.

The research and interviews conducted by the Perspective Foundation resulted in the following findings:

Sexually Transmitted Diseases (STDs). Most islanders do not know anything about STDs. They know that people suffer from STDs and that they usually do not seek medical help until they are very ill. But they know practically nothing about symptoms, treatment, and diagnosis. Until recently, the islanders did not, for cultural reasons, favor the use of condoms. The younger generation uses them for protection when they have sexual relations with prostitutes but not when they have sexual relations with their primary partners. The women consider contraceptives as a method of preventing unplanned pregnancies, not as protection from STDs.[2] They have learned about HIV/AIDS through radio or television broadcasts from Malaysia and Singapore. They believe that HIV is a result of syphilis and is primarily a homosexual disease. They believe it is spread through touching.

Polygamy/Prostitution. The islanders feel that having many wives is favorable to having sexual relationships with prostitutes. The women, however, do not always feel comfortable with polygamy—especially when their husbands do not ask permission or keep it a secret. The reasons for

polygamy are a woman's infertility and a man's lack of interest in a sexual relationship with a current wife. The older islanders have more of a problem with prostitution and sexual relationships outside of marriage than do the younger islanders, who tend to imitate modern lifestyles.

Contraception/Reproduction. The women islanders feel uncomfortable with contraceptives. They are uncomfortable about their side effects (menstrual bleeding) and how they will affect their daily lives and their relationships with their partners. They tend to think of contraceptives solely as a means to preventing pregnancy and have very limited knowledge about any of their other health-related uses. The islanders have little understanding of the reproductive anatomy. The older men refuse to discuss the topic because they consider it too private. The younger women have more knowledge as a result of education. The older women have gained knowledge through women's health organizations and traditional healers. Even so, this knowledge is confined to a general understanding of the egg and sperm in heterosexual intercourse.

Femininity/Masculinity. The islanders understand *femininity* and *masculinity* primarily in terms of stereotypes. They feel that women should be modest and responsible to their husband, children, and household chores. They feel that men should represent the family in public, make the family decisions, and serve as head of the household. They consider women *unfeminine* if they are intelligent, preoccupied with appearance and physical beauty, or involved in public life and organizations outside the family. They consider men *not masculine* if they are caring and supportive of their partner's needs. Because of these beliefs, women are usually economically dependent on men and have little chance or time to improve their income, knowledge, or skills outside the home.

Sexual Drive. The islanders feel that the male sexual drive is designed for procreation and pleasure while the female sexual drive is strictly for procreation. Many of the women feel that sexual intercourse is their fate and an obligation. They feel guilty if they refuse their husbands. They never ask to have sexual intercourse and never talk about sexual relations.

CONCLUSION

Based on the group discussions and additional study, the researchers/facilitators found that the best way to address sexuality education on the Batam Island was to incorporate it within the broader context of health promotion and disease prevention.

They determined that they should work with community leaders involved in health and family planning, higher education/research, cultural affairs, social services, and human resources/employment. They also decided that they should intensify mutual cooperative efforts with nongovernmental organizations (NGOs) in Raiu-Sumatra.

As a result of the work, the researchers, islanders, and health professionals joined together to form the Health Associate Foundation (HAF) to develop sexuality education programs on the island.

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CD-ROM DATABASE AVAILABLE ON "CONTEMPORARY WOMEN'S ISSUES" WORLDWIDE

Responsive Database Services, Inc. (RDS) has introduced "Contemporary Women's Issues," a full-text CD-ROM database to access global information on women's issues.

It provides information on such topics as: human rights; violence and exploitation; women in politics, the workplace and education; legal status; lifestyles; and health and reproductive rights.

The information is available for a wide range of uses including college and university programs/courses, student/faculty research, public libraries, and for developing nations where organizations can keep abreast of activities around the world.

The annual subscription for the CD-ROMS is $600.00. Developing nations receive a 40 percent discount. An abridged version is available to schools for $300.00.

Contact information: RDS, 23611 Chagrin Boulevard, Suite 320, Beachwood, OH 44122. Phone: 216/292-9620. Fax: 216/292-9621. e-mail: customer_service@rdsinc.com

MAKING SENSE, TALKING SEXUALITY: INDIA REACHES OUT TO ITS YOUTH

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- *Masturbation wastes semen and causes weakness.*
- *The longer the penis the more the sexual satisfaction.*
- *A woman is impure when she menstruates and should be restricted from certain activities.*

Parivar Seva Senstha (PSS) Family Planning Programs has heard these and many other myths while working with young people. Unfortunately, this is expected in a land where sexuality is rarely discussed.

A pioneering family welfare organization in India, PSS operates a network of clinics throughout the country. Over a period of time, it began to realize that a steadily increasing portion of its clientele were young women seeking abortions. It also found that, for the most part, they were totally ignorant about the anatomy and the physiology of reproduction.

Concerned about this lack of important health-related knowledge, PSS decided to launch a program to provide family life education to young people in India through workshops in schools and community groups. Its ultimate goal was to help prevent teenage marriage/parenthood, sexually transmitted diseases, (STDs) and maternal mortality.

"[These young women] were totally ignorant about the anatomy and the physiology of reproduction...."

SURVEY OF INDIAN YOUTH

PSS's first step was to determine the level of knowledge of Indian youth about the sensitive issues of sexuality and reprodution. To accomplish this, it distributed a survey to 236 South Delhi youth ranging in age from 12 to 20. The majority (50 percent) were 15 to 17 years old. Over 40 percent were 12 to 14 years old, and 9 percent were 18 to 20 years old.

The results confirmed that most young people were unaware of the anatomy and physiology of the reproductive organs, were not knowledgeable about STDs, and were uncomfortable talking about sexuality-related issues. Some specific findings included:

Anatomy and physiology of reproduction. Young people of both genders were generally unaware of the anatomy and physiology of the reproductive organs (especially those of the oppositve gender) and were not knowledgeable about STDs. Most of the students at all-girls schools denied that they had sexual desires and expressed resentment about many of the survey questions. They also did not want to discuss masturbation in either general or personal terms. Many of the older youths were uneasy when the subject related to physical development.

Interpersonal relationships. Most of the young people expressed irritation at parental controls and wanted to have opportunities to enjoy the company of members of the opposite gender without adult supervision. Most expressed a sincere belief in the equality of males and females.

Marriage. Indian marriages are traditionally decided by the parents and families of the bride and groom. Such decisions are based on class and social status. Very few marriages are decided by the personal choice of the involved individuals. The surveyed youths indicated, however, that they wanted to break from this tradition. The young men wanted wives who were faithful, flexible, and caring. The young women wanted husbands who were affectionate, understanding, faithful, and not domineering. Most of those surveyed were idealistic about marriage.

SURVEY FINDINGS

Based on the survey results, PSS decided to develop a three-year family life education program designed to raise young people's awareness and knowledge of the physical, emotional, and social changes that take place during adolescence.

The workshop curriculum, which was designed with the help of educators, psychologists, counselors, and doctors, was divided into three age and awareness Levels: Level 1 for 12- to 14-year-olds; Level 2 for 15- to 17-year-olds and Level 3 for 18- to 20-ycar-olds.

Topics included:

Family: concept, structure, function, importance.

Adolescence: process of growing up; myths and misconceptions about sexuality.

Biology: anatomy and physiology of reproduction; motherhood.

Health and hygiene: necessity of good health; nutritive value of various foods; prevention of diseases; immunizations; STDs, including HIV/AIDS.

Interpersonal relationships: peer group relations; heterosexual attraction; love and friendship; personal values and standards; attitudes toward members of the other gender.

Planned parenthood: responsibility; planning; the population and environment; contraception.

The workshops —supported by films, slides, flash cards, flip books, and print materials—included such activities as debates, group discussions, role plays, and quiz competitions.

TARGET INSTITUTIONS

PSS decided that it would target the program to the above students through the following institutions:

- ***Schools and colleges:*** The central and state government schools as well as the private schools in Delhi and Lucknow.
- ***The National Service Scheme (NSS):*** A volunteer group of high school and college students organized by the Ministry of Human Resource Development.
- ***The Bharat Scouts and Guides (BSG):*** A structured national organization involved in social and welfare activities.
- ***Nongovernmental Organizations:*** Groups that can provide access to young people who have dropped out of school. (This included economically disadvantaged youth as well as those who had married.)
- ***The Teacher Training Institutes (TTI):*** Schools that trained nursery and primary school teachers as well as doctors and nurses.

In addition, PSS developed a Distance Learning Program (DLP) in Family Life Education to reach wider audiences throughout India. This project reached not only young students but also NGO staff, teachers, doctors, and young married couples.

This program is especially relevant in India, where distances are long and there are major cultural inhibitions. Over 150 students enrolled in the first DLP program.

ADDED INNOVATIONS

As the project evolved, several innovations were introduced to help reach specific groups who were not in schools or community groups.

The "Sparsh" reproductive health line. This phone service was launched as an extension of workshop activities. It sought to answer delicate reproductive health questions relating to family planning, contraception, sexuality, STDs, HIV/AIDS, drugs/alcohol, legal aid, and family/adolescent issues. It also provided counseling and, upon request, referred individuals to appropriate qualified professionals.

"Face-to-face" counseling services. This extension of the "Sparsh" service asked individuals requiring more intensive counseling to visit the PSS office to meet face-to-face with someone who could help with referrals.

"Aadhaar." Another extension of the "Sparsh" service, this course was designed to provide young people who are planning to get married with information on relationships, sexuality, contraception, and home management. Limited to 15 participants, the course was advertised through newspapers and posters. Participants requested that PSS extend the popular course to include additional sessions.

"Kaam Ki Baat." This was a reproductive health education help line on TIMES FM, the youth channel on All India Radio. Listeners called or wrote seeking help on sexuality-related issues. PSS provided answers to the questions each week.

PSS'S EXPERIENCES

When the project was launched, PSS faced some opposition due to the strong taboos associated with sexuality and family life education. On several occasions, schools refused permission to organize the workshops and asked the team to leave the premises because they felt the information would corrupt the students. Such reactions are now rare. In fact, PSS is often invited to schools to organize workshops.

PSS also faced problems relating to the terminology used for family life education. It was often referred to as adolescent education, life-useful education, and sex education, depending on needs and local taboos. PSS eventually used the term *family life education* in all its work.

PSS noticed interesting differences in the reactions and responses of workshop participants.

- ***11- to 13-year-olds:*** The young people in this age group were not usually aware of the changes taking place (or about to take place) in their bodies. This indicated that parents, elders, and teachers were probably inhibited in talking about these issues. The young women very often felt that the menstrual blood was impure and that they should, therefore, follow certain social restrictions during that time of the month. The young men were either not aware of nocturnal emissions or inhibited in talking about them. Questions centered around the duration and pain of menstruation, the relationship between loss of semen and physical growth, details about reproduction, and AIDS.
- ***14- to 16-year-olds:*** Most of the young people in this age group were aware of changes taking place in their bodies. They said they frequently shared information and compared body changes with their peers. The questions they asked were more explicit than those of the young people in the previous group. They wanted to know more about sexual intercourse, childbirth, homosexuality, and other subjects.

- ***17- to 18-year-olds:*** Before attending the workshop, these young people felt that they knew all they needed to know. They soon, however, said that they had many questions about the changes taking place in their bodies and about what they read or saw. They wanted to know more about using condoms, having sexual intercourse during pregnancy, giving birth through caesarean section, and having sexual intercourse with people of the same gender.
- ***19- to 20-year-olds:*** The young men in this age group were planning for their careers. The young women were planning for marriage. Both wanted more information on contraception, HIV/AIDS, virginity, and how gender is determined in a fetus.

Teachers: Although the teachers were positive about the workshops, they were still inhibited about talking to their young students. They preferred that PSS conduct classes.

CONCLUSION

As a result of the success of this family life education project, PSS has decided to expand in a new direction. It now has become actively involved in training trainers to teach the curriculum in various organizations throughout India. PSS feels strongly that this new approach is well worth the effort because it will help to reach more of India's young people with this important information.

WORLD ASSOCIATION OF SEXOLOGY SEEKS NOMINATIONS FOR MODEL SEXUALITY EDUCATION PROGRAMS

The Sexuality Education Committee of the World Association of Sexuality (WAS) is seeking nominations for model sexuality education programs to highlight at the 13th World Congress Meeting, June 25-29, 1997, in Valencia, Spain.

Applicable programs include:

- Country initiatives to improve policies addressing adolescents, reproductive health, family planning services, HIV/AIDS, or population education policy.
- Curricula developed and/or implemented in a school- or community-based setting that show promise.
- Videos about human development, culture, and sexuality among adolescents.
- Books, brochures, or pamphlets developed for public dissemination and positively received by the target community.
- Internet Web sites that contain comprehensive information and education about sexuality for adolescents, parents, teachers, or the media.

Applicants should include as much information as possible to answer such questions as:

- How was the program developed?
- Who was involved in its creation?
- Who is the target audience?
- What are the expected outcomes of the program?
- How does the program affect existing programs?
- Why is the program unique to other initiatives in your country?
- Have colleague organizations reviewed the program?

The deadline for submission is March 31, 1997. Send applications to: WAS Award Nominations, c/o SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036 USA.

THE BRIDGE TO THE 21ST CENTURY: WHERE IS IT LEADING AND WHAT IS THE TOLL?

Daniel Daley
SIECUS Director of Public Policy

The first two national elections of the 1990s marked political sea changes: in 1992, American voters put a Democrat in the White House; in 1994, they gave control of Congress to the Republicans for the first time in 40 years.

The big news in 1996 is that the American electorate did something it has never done before—it elected a Democratic President and a Republican Congress.

It is ironic that the 1996 elections, which were supposedly about charting a course for the next century, brought no sweeping change or mandate for charting that course.

And, sadly, fewer than half of all Americans turned out to vote—another first in American history.

THE ELECTION RESULTS

President Clinton soundly defeated former Senator Robert Dole in both the electoral and popular vote. President Clinton won 379 electoral votes from 31 states and 49 percent of the popular vote while Senator Dole gained 159 electoral votes from 19 states and won 41 percent of the popular vote.

In the Senate. The balance between Republicans and Democrats in the Senate of the 105th Congress will remain virtually the same as the 104th Congress: 54 Republican senators and 45 Democratic senators (at press time one race in Oregon is undecided). The split was 53 to 47 in the 104th Congress.

Despite these similar statistics, the new Senate will become noticeably more conservative. This is the result of moderate Republican senators retiring and more conservative Republicans winning their seats. Alabama, Arkansas, Colorado, Kansas, Louisiana, Nebraska, and Wyoming elected conservative Republicans to the Senate. Only one conservative, antichoice Republican senator (from South Dakota) was defeated.

Because most incumbents were successful in their reelection bids, most committee chairs will not surprise anyone. Although committee assignments are not finalized until January, one can expect these peaceable changes: Senator Ted Stevens (R-AK) will chair the Appropriations Committee; Senator Arlen Specter (R-PA) will become the chair of the Veterans Affairs Committee; and Senators Richard Lugar (R-IN) and Jesse Helms (R-NC) will exchange chairmanships of the Foreign Relations and Agriculture Committees. It appears that conservative Senator Dan Coats (R-IN) will challenge moderate Senator Jim Jeffords's ascendancy to chair the Labor and Human Resources Committee, a post vacated by retiring Senator Nancy Kassebaum (R-KS).

In the House. Although Democrats made incremental gains in the House by picking up seven seats, Republicans retained control. Of the 435 House seats, the GOP will hold at least 225 and the Democrats will hold 205. (Four races will involve December run-offs. One independent was elected.) Three House incumbent Democrats lost their reelection bids, whereas 18 House Republicans were defeated—eight of whom ranked 100 percent on the Christian Coalition's score card.

"The perceived 'moderate' climate is a call to action for sexuality advocates...."

Of the 73 much-talked-about GOP freshmen of the 104th Congress—those who allied themselves with the "Contract with America" and with House Speaker Newt Gingrich—56 were reelected, 13 were defeated, three did not run for reelection, and one faces a December run-off.

While the election favored incumbents, victorious GOP freshman incumbents had lower vote percentage averages in their reelection races than other categories of incumbents. Winning GOP freshman averaged 55 percent of the vote, GOP leaders averaged 60 percent, Democratic incumbents averaged 67 percent, and Democratic freshman averaged 68 percent.

There is no expectation that the elections will have any impact on the current chairmanships of the House committees.

WHERE ARE WE GOING?

Between now and Inauguration Day, many will try to figure out the meaning of the 1996 elections and what they foretell about the immediate political future in the United States. Voters did not indicate whether their support for the

status quo was an endorsement of "divided government" (with the legislative and administrative branches of the government held by different political parties) or simply an indication that they did not like their political options and therefore went with the known candidates.

Many pundits are claiming that the elections were a call for moderate, centrist government. It would not be surprising in view of the fact that the campaigns worked hard to point out and make unattractive the most politically extreme factions of both major parties. After the much-criticized government shut down last year and the failure of such extreme political agendas as the "Contract with America," perhaps voters and politicians alike are considering moderate, divided government as the only means of accomplishing anything.

With "moderate" and "centrist" political labels in vogue, the bridge to the 21st Century will probably not be revolutionary in design or material. Instead, it will more likely to be old-fashioned, modest, and built brick by brick. The public will unlikely see broad, fast-tracked political agendas, like the "Contract with America" or sweeping reforms such as the Clinton Administration's original health care effort. The 105th Congress is likely to pursue incremental change by reviewing existing federal efforts and assessing the appropriate expenditure for the effort.

WHAT IS THE TOLL FOR SEXUALITY ISSUES?

For the most part, the 1996 campaigns avoided sexuality issues. Members of Congress did, however, bring two such issues to the elections when they passed legislation restricting late-term abortion procedures (the so-called partial-birth abortion) and opposing same-sex marriage and employment nondiscrimination based on sexual orientation.

Both Presidential candidates made references to the issues in targeted campaign advertisements, but, in general, they did not debate them. It was not until two citizens asked the candidates about gay and lesbian issues at the "Town Meeting"–style Presidential debate that President Clinton and Senator Dole gingerly—albeit briefly—spoke about sexuality issues before a mass public audience.

It is unclear whether the campaigns dodged sexuality issues because they were not viewed as political "wins" or because the President and the Congress had frequently grappled with these issues frequently in the past two years. Or both.

The election provides few insights into the political course for sexuality issues. Sexuality advocates should, however, approach the future with cautious concern. Those favoring sexual rights and sexual health services may look for solace in the belief that more extreme conservative politics appear to be waning. They may seek relief in the pronouncement that "moderate" is the current political climate.

But this "moderate" government does not necessarily hold promise for a better approach to sexuality issues. First, the "moderate" 105th Congress includes many of the strident, antisexuality Members of the previous Congress. In addition, the Senate is decidedly more antichoice than the previous Congress. It is now split 50-50 between prochoice and antichoice Senators. Those holding key committee chairs are also more likely antichoice and antigay and antilesbian civil rights. While the House is slightly improved when compared with the 104th Congress, it is still far from a prochoice, prosexuality body.

Furthermore, "moderate" may also mean "noncontroversial." This would not bode well for sexuality advocates whose issues are considered controversial and not part of the common ground. This might result in a popularity contest of sorts among sexuality issues. Those issues with demonstrated public support would move forward while others without demonstrated public support would not see the light of day.

What is clear is that the perceived "moderate" climate is a call to action for sexuality advocates. Rather than reacting to attacks from critics or finding fault with others' approaches, they must articulate their vision of what is sexually healthy. And they must articulate this vision in the full strength of their individual and collective voices. Then—and only then—will the "sensible center" recognize that the majority of Americans support sexual rights and sexual health services.

STRATEGIES TO BUILD SUPPORT FOR HIV-PREVENTION AND SEXUALITY EDUCATION PROGRAMS

There are many strategies individuals can use to build broad-based support for HIV-prevention and sexuality education programs.

This list—the result of a SIECUS needs assessment of over 150 education and health leaders—offers sound advice from professionals in the United States involved in such programs.

Each person was asked: "Are there successful strategies that your agency has employed?"

The list shows that, with a little creativity, everyone has a role to play in supporting HIV-prevention and sexuality education programs for young people.

WORK WITH OTHER GROUPS

- Form a coalition and invite representatives from throughout the community, including colleague organizations, parents, faith communities, and business leaders. Work together on common messages and policy recommendations to key decision-makers. This will result in a strong, unified message and will decrease the likelihood of challenges. (One such coalition schedules time at meetings to write letters to the editor on different issues of concern to coalition members.)
- Seek opportunities to facilitate meetings with other local, state, or national organizations. (Cosponsor meetings when possible.) Groups like the American Cancer Society sometimes cosponsor health programs such as a statewide health education summit or a community health fair.
- Form a committee when reevaluating health, HIV-prevention, or sexuality education curricula. Include people that reflect a diversity of viewpoints: school staff, administrators, business people, parents, and religious leaders. Invite teachers and staff to explain what students are learning.
- Avoid duplicating efforts. Whenever possible, coordinate activities such as educational programs.
- Actively involve the state Parent Teacher Association (PTA). Consider offering HIV/AIDS workshops at its convention. Publish newsletters or brochures for its local presidents and school principals. (The National PTA publishes an *HIV/AIDS Education Kit* available from state chapters.)
- Seek the involvement of local and state public health agencies. Ask for representatives to make classroom presentations, to provide support to HIV-positive students, to conduct inservice training for teachers, and to work with peer educators.

DEVELOP MODELS

- Develop model comprehensive school health education sites within your state that include HIV-prevention and sexuality education components. Staff at these sites can provide teacher training to other communities on how to implement a comprehensive program.
- Focus on providing a model of technical assistance and support for schools. Balance public policy efforts with support for those who are trying to provide HIV-prevention and sexuality education within the current environment.
- Clearly define the terms that refer to curricula (i.e. "abstinence-based," "abstinence-only," "fear-based," or "comprehensive"). Be consistent.
- Emphasize the big picture when referring to specific components of a comprehensive program. Talk in terms of comprehensive health programs that include HIV-prevention *and* sexuality education instead of just the HIV-prevention or sexuality education components.
- Seek out culturally competent programs. Use models (and educators) that work within specific cultures.

PROVIDE UP-TO-DATE INFORMATION

- Develop policies and written guidelines for guest speakers. Make certain they understand district/agency policy regarding the discussion of topics and understand the parameters of their presentation and how to handle questions from students that go beyond these parameters. If speakers are not experienced in working with students, make certain a staff person helps them develop age-appropriate material. Arrange for a staff person to attend the presentation.
- Develop a resource library for health educators. Include curricula, audiovisuals, and the latest data and research.

- Send packets of information on comprehensive health education, including HIV-prevention and sexuality education, to all libraries. Include materials for students, teachers, other school staff, and parents.
- Help improve a teacher's knowledge, skill, and comfort level by teaching her/him how to build parental understanding and support for HIV-prevention and sexuality education. Whenever possible, collaborate with other agencies and local colleges/universities to provide training. Consider offering continuing education credits as incentives.
- Invite medical students or doctors to talk to teachers and older students about their experiences working with people living with HIV or AIDS.

ENGAGE THE MEDIA

- Work proactively with the media. Mail press releases, try to place articles in newspapers, and respond to editorials if a constructive debate seems possible.
- Appoint a staff person to handle media requests if your agency does not have a public relations department. Make certain all staff keeps this person informed to better anticipate hot spots and respond quickly to media requests.
- Arrange for the media to contact your public relations department staff for assistance. (This staff can help prepare responses before you go to the media.)
- Make certain that the local media is acquainted with health education programs and issues. If specific materials are contested in the community, acknowledge that challenges are inevitable. Remind the media that good curricula are developmentally appropriate and based on sound research.

BUILD COMMUNITY SUPPORT

- Help community-based organizations understand the intricacies of working with schools so the programs they develop are responsible and realistic.
- Work with school administrators. Make them aware of the support in your community for school-based comprehensive health education programming, including HIV-prevention and sexuality education. Encourage them to support the work their teachers are doing in these areas.
- Conduct community-wide polls and focus groups to see what information community members want in the local school-based health education curriculum.
- Arrange for PTA and community representatives to attend teacher and administrator training sessions if appropriate.

ORGANIZE PUBLIC MEETINGS

- Arrange to have an experienced meeting facilitator—ideally someone perceived as neutral, with no stake in the outcome of the meeting.
- When planning the agenda, consider the audience. Meeting planners should closely assess the program and prepare to address issues of concern.
- Anticipate differences of opinion. Make certain the facilitator respectfully involves people with all viewpoints. Let people with children in the public schools speak first, followed by taxpayers living in the community, and finally, people from outside the district, if there is time.
- Set time limits for speakers. Ask for testimony in advance.

PREPARE FOR CHALLENGES

- Take inventory of the materials distributed by your organization. Know the content and how people interpret it.
- Do not make assumptions about who will support your efforts. Many do not reach out to religious organizations because they do not expect support. In reality, many "institutional" positions do not always play out on the local level.
- Meet with those who are resistant to comprehensive programs to find areas of common ground. Whenever possible, work on these areas and agree to disagree on others.
- Learn as much as you can about those who challenge comprehensive programs in your community—get on mailing lists, attend meetings/trainings, ask questions.
- Learn and practice conflict resolution skills. Role-play situations involving development of a consensus.

INVOLVE PARENTS

- Build parental understanding and support for health, HIV-prevention, and sexuality education programs. Inform parents in advance of classes. Schedule a parent preview night. Encourage parental involvement.
- Serve as a resource for parents. Help them acquire skills to become involved in their children's education.
- Schedule an evening parent education series. Include diverse topics related to health issues, including "Talking to Your Children about Sexuality." Widely publicize the series, including mailing announcements to the homes of parents.
- Schedule a one-day retreat for middle-school students and their parents. Focus on communication skills between students and parents, including the discussion of sexuality issues. Encourage their involvement in the planning process.
- Publish a monthly newsletter for parents on child and adolescent health. Include book reviews and resources. Encourage parental involvement in the newsletter.
- Create "health knapsacks" for young students to take home to their parents. These are especially useful for parents who can't attend all school functions. Include reading materials and suggestions for parent-child activities.

Working with Young People on Sexual Health and HIV/AIDS

Hand-in-Hand Network
Appropriate Health Resources and Technologies Action Group
Farringdon Point, 29-35 Farringdon Road
London EC1M 3JB, United Kingdom
1996, 56 pp
$10 U.S. Free to developing countries

Working with Young People on Sexual Health and HIV/AIDS serves as a resource for those who work with and educate youth around the world.

What makes it unique is the sensitive approach it takes to multicultural, international, and special-needs populations (which, of course, could include all of us) while targeting young women, young people living with HIV, street youth, young people with disabilities, young people attracted to the same gender, and refugees and migrants.

The booklet includes discussions on such topics as how to avoid unwanted sexual relations as well as unwanted pregnancy and sexually transmitted diseases (STDs); how to have healthy sexual relationships that are free from pressure or violence; how to develop confidence to deal with emerging sexual feelings and situations, and how to identify services that enable young people to act on this information.

The materials include suggested activities, games, comics, videos, and books that youth workers and educators may want to consider for their individual programs. Readers are encouraged to adapt the materials and to use them as jumping off points for the creative involvement of both the youth and the youth workers.

Excellent questions are readily at hand to help the educator or youth worker decide if the materials are appropriate for the audiences with whom they will work. For example, what can an educator use to replace handouts at a session when the individuals cannot read? Flannel boards with pictures or comic strips are suggested alternatives.

I was delighted to see listed *Sex: A Guide for the Young*, a video I use here at Columbia University with college students. This cartoon video covers a lot of ground through graphics. As they say, a picture is worth a thousand words. And these pictures help to minimize embarrassment with laughter, too.

Educators and youth workers are encouraged to contact organizations before they purchase materials to make certain the order information is current. Happily, e-mail adresses are included.

Ironically, my only reservation about these materials concerns order fulfillments. Since many of the materials are only available outside the United States, will American community-based organizations and educational bureaucracies find it too challenging to meet order and payment requirements in a timely manner?

No matter; there is still much of benefit here—even if the educator or youth worker order nothing but the booklet itself.

Reviewed by Judith Steinhart, a health educator with Healthwise *University Health Service at Columbia University in New York City.*

Sexual Behavior and AIDS in India

Moni Nag, Ph.D.
Vikas Publising House Pvt., Ltd.
576 Masjid Road,
Jangpura New Delhi, 110 014, India
1996, 157 pp
Rs. 250

Sexual Behavior and AIDS in India opens a window onto sexuality in that country and provides a broad overview of the sexual behaviors and practices of its citizens—with discussions on premarital and extramarital sexual relations, prostitution, homosexuality, safe sex practices, and sexual abstinence.

The book indicates that India is ready to talk about sexual issues and sexual expression because AIDS is spreading in the general population and is no longer thought of as a disease that affects only foreigners.

It also lends support to the fact that there is still little research-based information on the behaviors and attitudes of people most likely to contract HIV and get AIDS and that there is a need for comprehensive surveys with experimental designs and methodologies to obtain reliable, valid, and useful information and results.

The author suggests a course of action for conducting research and educational campaigns. He also recommends the importance of the multipronged approaches for quantitative and qualitative data collection on prostitutes, their clients, homeless children, poor children, and children of rape. In addition, he directs attention toward the changing role of women in India and its impact on their sexual behavior.

In no way is *Sexual Behavior and AIDS in India* an exhaustive presentation of what is truly being undertaken to combat AIDS in India. Nevertheless, it is a good start. It is undoubtedly a challenge to prepare a comprehensive document on the expression of sexuality in a country of 900 million people where, for many years, research on sexuality has been limited. It is even more challenging to come up with a national plan to educate different age groups about HIV/AIDS.

I must point out that the book brings some record-keeping and research problems to light. Many research studies on sexual behavior and attitudes are missing. Readers are cautioned not to generalize about the sexual behaviors of the people of India based on such a limited sampling.

Indian policy planners, educators, and other leaders, in turn, should not decide on a national intervention program based on such incomplete information. They need more planned research. For example, information about rural populations is insuffcient. Such an omission is akin to missing a big piece of the jigsaw puzzle because 70 percent of the Indian population lives in rural areas.

Still, this book is a good start. It will help educators and government leaders realize the importance of forming a plan of action to stop the spread of AIDS in India.

Reviewed by Minakshi Tikoo, Ph.D., C.F.L.E., assistant professor in the School of Family Studies and Human Services, College of HHuman Ecology, Kansas State University, Manhattan, KS.

A SIECUS Annotated Bibliography of Organizations and Available Materials

Educators must target sexuality-related materials and programs in order to reach individuals of differing ages, genders, sexual orientations, socioeconomic backgrounds, races, and cultures. Many recent materials provide information about sexuality in such a culturally competent manner.

Cultural competence means more than writing in a language other than English or including photographs of people of color. Besides using appropriate language and visual images, health education materials that are culturally competent must reflect the target audience's:

- styles of communication
- beliefs about the causes and remedies of illness
- structures, roles, and expectations of family relationships
- attitudes toward intimacy, sexual identity, and sexual behavior at different age levels and stages in a relationship
- beliefs about the appropriate gender roles of males and females
- beliefs about spirituality and religion, and the roles they play in the lives of individuals and the community.

(from *A Youth Leader's Guide to Building Cultural Competence*, Advocates For Youth)

This bibliography focuses on materials that provide HIV/AIDS prevention and sexuality education, pregnancy prevention, and other areas of sexual health education for culturally diverse audiences. As with all sexuality education materials, SIECUS recommends that educators screen materials to make certain they are relevant to the target audience.

With the exception of materials printed by SIECUS, none of the publications listed here are either sold or distributed by SIECUS. Most of these resources are available, however, at the Mary S. Calderone Library at SIECUS, which is open by appointment to SIECUS members and accessible to the general public by phone. All of the resources in this bibliography are available from the listed distributors.

Copies of this bibliography are available for purchase from the SIECUS Publications Department at the following costs: 1-4 copies, $2.00 each; 5-49 copies, $1.75 each; 50-99 copies, $1.50 each; 100 or more copies, $1.25 each. SIECUS is located at 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770.

This bibliography was compiled by Pierce Mills, M.A.

BOOKS FOR PROFESSIONALS

A Youth Leader's Guide to Building Cultural Competence

Susan A. Messina

This book is designed to help educators, health care professionals, and other service providers meet the challenges of targeting sexuality education to culturally diverse groups. Using a four-step model, this resource helps build the knowledge, attitudes, and skills necessary to reach young people from a variety of backgrounds, with a specific focus on African-American, Latino, and gay, lesbian, and bisexual teenagers. 78 pp. 1994.

Advocates For Youth, 1025 Vermont Avenue N.W., Suite 200, Washington, DC 20005; 202/347-5700. $12.95.

AIDS Education: Reaching Diverse Populations

Melinda K. Moore and Martin L. Forst, Editors

This book describes how to tailor HIV/AIDS education and prevention efforts to specific cultural and ethnic groups, including gay men, lesbians, Asian American and Pacific Islanders, Latinos, sexual assault survivors, and homeless youth. It includes discussions on how to identify those most at risk within these communities, what types of interventions are most appropriate to these communities, and the role of evaluation in determining the success of community education efforts. It also explores the social, political, and cultural barriers that impact health educators' abilities to function effectively. 248 pp. 1996.

Praeger Publishers, 888 Post Road West, Box 5007, Westport, CT 06881; 800/225-5800. $55.00.

Bodies and Biases: Sexualities in Hispanic Cultures and Literatures

David William Foster and Roberto Reis, Editors

Looking at a broad spectrum of popular culture (including television and music), this book addresses how sexual behavior and collective identity, homosexuality, and gender are represented in historical and contemporary Hispanic literature. 440 pp. 1996.

University of Minnesota, 111 Third Avenue South, Suite 290, Minneapolis, MN 55401-2520; 800/388-3863. $21.95.

Educating Everybody's Children: Diverse Teaching Strategies for Diverse Learners

Robert W. Cole, Editor

This book is as a practical guide to developing school programs that can improve the performance of students from diverse cultural, ethnic, linguistic, and socioeconomic backgrounds. While some of the techniques are specifically designed to increase student achievement in reading, writing, mathematics, and oral communication, others apply to any subject area. 184 pp. 1995.

Association for Supervision and Curriculum Development, 1250 North Pitt Street, Alexandria, VA 22314; 800/933-2723. $21.95.

Hispanic Sexual Behavior: Implications for Research and HIV Prevention

This report is based on the findings of a leadership roundtable convened by the National Coalition of Hispanic Health and Human Services Organizations. It provides information about sexual behavior and summarizes implications for HIV prevention. It also provides recommendations for research to investigate how sexual attitudes, beliefs, and behavior among Hispanics relate to safer sex practices. 53 pp. 1991.

COSSMHO, 1501 16th Street N.W., Washington, DC 20036; 202/797-4324. $15.00.

Multicultural Human Services for AIDS Treatment and Prevention: Policy Perspectives and Planning

Julio Morales, Ph.D. and Maria Bok, Ph.D., Editors

This book discusses specific suggestions for prevention, education, and behavioral change strategies that are culturally relevant to African-Americans, Native Americans, Native Hawaiians, Puerto Ricans, and Mexicans. 122 pp. 1992.

Harrington Park Press, 10 Alice Street, Binghamton, NY 13904-1580; 800/342-9678. $29.95.

Sexual Cultures and the Construction of Adolescent Identities

Janice M. Irvine, Editor

This book explores how a teenager's race, class, gender, sexual orientation, religion, and family relationships affect the development of his or her sexual identity. With a specific focus on Asian, Latino, gay, lesbian, and physically disabled teenagers, this text challenges common generalizations about cultural groups to help educators develop culturally competent sexuality education curricula. 325 pp. 1994.

Temple University Press, 1601 North Broad Street, University Services Building, Room 305, Philadelphia, PA 19122; 800/447-1656. $19.95.

Sexuality Education Across Cultures: Working with Differences

Janice M. Irvine

Using social-constructionist theory, this book describes how culture shapes the ways that individuals may differ in their sexual thoughts, feelings, and behaviors. The book is not a prescription for a curriculum, but, rather, a vehicle to provide insight into research and examples of problems that sexuality educators may face as they develop culturally competent programs. 184 pp. 1995.

Jossey-Bass, Inc., 350 Sansome Street, San Francisco, CA 94104; 415/433-1740. $29.95.

Sexuality, Poverty, and the Inner City

Elijah Anderson, Ph.D.

This report from the seminar series, "Sexuality and American Social Policy," focuses on the effects poverty has had on the sexual behavior and gender roles of urban youth. The text also compares the sexual attitudes and experiences of poor white teenagers with those of minority youth. 81 pp. 1994.

Kaiser Family Foundation, 2400 Sand Hill Road, Menlo, CA 94025; 800/656-4533. Free.

JOURNALS, NEWSLETTERS, AND BOOKLETS

Family Planning and Birth Control

Four separate booklets explain family planning and contraception in Vietnamese, Farsi, Khmer (Cambodian), Russian, and English. The booklets provide information about the female reproductive system (with simple graphics), the reproductive process, and different contraceptive methods. They include charts on each contraceptive with information on effectiveness, side effects, availability, and approximate cost. 16 pp. 1994.

New York Association for New Americans Inc., Health Education Department, 17 Battery Place, New York, NY 10004-1102; 212/425-5051. Free.

Guia Para una Educación Sexual Integral Para la Juventud Hispana/Latina: Kindergarten—Grado 12

This booklet is an adaptation and translation of *Guidelines for Comprehensive Sexuality Education: Kindergarten—12th Grade* for Spanish-speaking communities in the United States. Designed to help school boards, curriculum specialists, and other educators create comprehensive sexuality education programs, these guidelines were developed by a task force of leading health, education, and sexuality experts. The Spanish/English text includes resource materials for Hispanic/Latino youth.

115 pp. 1995. A 1996 revision of the English language edition is also available. SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. 1-4 copies, $5.75 each; 5-49 copies, $5.25 each; 50-99 copies, $4.75 each; 100 or more copies, $4.20 each.

Instantes

Published quarterly by the National Latina Institute for Reproductive Health, this bilingual newsletter provides information, public policy updates, and opportunities for advocacy.

National Latina Institute for Reproductive Health, 1420 16th Street N.W., Suite B, Washington, DC 20036; 202/588-9363. $30.00 per year.

Perceptions of Risk: An Assessment of the Factors Influencing Use of Reproductive and Sexual Health Services by Asian American Women

This booklet details the findings of in-depth interviews with health care advocates, practitioners, and focus groups with Asian American women. It discusses how misinformation, poverty, sexism, and privacy issues severely limit their access to health care services. Many specific recommendations for educators and counselors working with this population are included. 28 pp. 1995.

National Asian Women's Health Organization, 250 Montgomery Street, Suite 410, San Francisco, CA 94104; 415/989-9747. $10.00.

Addressing Sexuality Across Cultures

This resource is designed to help educators, health care professionals, and other service providers improve their ability to talk about sexuality with people from different cultural backgrounds. It explores key elements of sexual health, basic principles of health communication, and cultural appropriateness. 12 pp. 1996.

SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. $3.00.

SIECUS Report: The Challenge of Diversity

This *SIECUS Report* (February–March, 1995) includes the following articles: "American Indians: Reclaiming Cultural and Sexual Identity," "The Problem of Using Race to Understand Sexual Behaviors," and "A Guide to Working with Youth of Various Backgrounds."

SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. $9.20.

SIECUS Report: Sexuality Education

This *SIECUS Report* (August–September, 1994) includes the following articles: "Sexuality Education for Communities of Color," "Sexually Transmitted Diseases and Street Youth," and "Sexuality Education for Youth in High-Risk Situations."

SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. $5.75.

Stopping Sexual Assault in Marriage/Supresion Del Ataque Sexual en el Matrimonio

This booklet (written in both Spanish and English) provides women, counselors, and advocates with factual definitions, causes, attitudes, treatments, and laws regarding sexual assault by husbands. 12 pp. in each language. 1990.

The Center for Constitutional Rights, 666 Broadway, 7th Floor, New York, NY 10012; 212/614-6464. $1.00.

Transitions

Published quarterly by Advocates for Youth, this newsletter provides youth-serving agencies, professionals, policy makers, and the media with information and opportunities for advocacy regarding the abilities of youth to make healthy decisions about sexuality.

Advocates for Youth, 1025 Vermont Avenue, N.W., Suite 200, Washington, DC 20005; 202/347-5700. $15.00 for one year; $20.00 for two years.

What Are African-Americans' HIV Prevention Needs?

Produced by the Center for AIDS Prevention Studies, this fact sheet provides details regarding the statistics, risk behaviors, prevention programs, prevention obstacles, and remaining challenges to fighting HIV transmission in the African-American communities in the United States. Available in English and Spanish. 1995.

Kaiser Family Foundation, 2400 Sand Hill Road, Menlo, CA 94025, 800/656-4533. Free.

What are Latinos' HIV Prevention Needs?

Produced by the Center for AIDS Prevention Studies, this fact sheet provides details regarding the statistics, risk behaviors, prevention programs, prevention obstacles, and remaining challenges to fighting HIV transmission in Latino communities in the United States. Available in English and Spanish. 1995.

Kaiser Family Foundation, 2400 Sand Hill Road, Menlo, CA 94025, 800/656-4533. Free.

PUBLICATIONS FOR FAMILIES

¡Ay No! Que Hago Ahora? Mensajes Sobre la Sexualidad: Cómo Dar Sus Mensajes a Sus Hijos

An adaptation and translation of *Oh No! What Do I Do Now?* Messages about sexuality for Spanish-speaking communities, this booklet presents eight hypothetical situations that help teach parents of preschool children how to analyze their feelings, formulate responses, and become more relaxed when discussing sexuality with their children. 24 pp. 1983.

SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. 1-4 copies, $2.00 each; 5-49 copies, $1.75 each; 50-99 copies, $1.50 each; 100 or more copies, $1.25 each.

Cómo Hablar Con Sus Hijos Sobre el SIDA

An adaptation and translation of *How to Talk to Your Children About AIDS* for Spanish-speaking communities, this booklet is designed to help parents talk with their children about HIV/AIDS. It offers basic information about HIV/AIDS and guidelines of appropriateness for specific age levels: preschool, young children, preteens, and teenagers. 20 pp. 1990.

SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. One copy free with a self-addressed, stamped, business-size envelope; 2-49 copies, $1.00 each; 50-99 copies, $.80 each; multiples of 100, $65.00 per hundred; multiples of 1000, $400.00 per thousand.

Hablemos de Sexo

An adaptation and translation of *Talk About Sex* for Spanish-speaking communi-

ties, this booklet was developed to help teenagers communicate more openly and effectively about issues related to sexuality and HIV/AIDS. It offers clear, honest, straightforward information about relationships, communication skills, and safer sexual behaviors in a very engaging, youth-friendly manner. 46 pp. 1995.

SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802; 212/819-9770. 1-4 copies, $2.00 each; 5-49 copies, $1.75 each; 50-99 copies, $1.50 each; 100 or more copies, $1.25 each.

Stand Strong

This 16-page comic book focuses on the lives of several African-American teenagers at an urban youth center. It highlights the difficulties they face in overcoming peer pressure, preventing pregnancy, resisting alcohol and other drugs, and in building a positive self image. Ages 12-18. 16 pp. 1991.

Wisconsin Clearinghouse, P.O. Box 1468, Madison, WI 53701; 608/263-2797. $2.25 each; 10 for $22.00; 100 for $215.00; 500 for $1,000.00.

What Caring Adults Can Do

Intended as a companion to *Stand Strong,* this booklet is for parents, teachers, and counselors who work with African-American youth. It provides valuable tips for talking with youth about their sexual behavior, alcohol and other drugs, and other difficult issues which arise in teenage relationships. 24 pp. 1991.

Wisconsin Clearinghouse, P.O. Box 1468, Madison, WI 53701; 608/263-2797. $1.25 each; 25 for $30.00; 50 for $56.00; 100 for $105.00; 500 for $500.

AUDIOVISUAL MATERIALS

Adolescence — A Woman's First Transition

Tape 1: A Young Woman's Guide

This video is designed to help young women understand changes in adolescents. A small group of diverse teenage girls discuss what occurs during puberty, including emotional, hormonal, and physical changes. Two female counselors also answer questions regarding pelvic exams, eating disorders, reproduction, contraception, sexual orientation, and safer sexual relationships. Ages 10-18. 50 minutes. 1995.

Women's Healthcare Video Library, 55 Pond Avenue, Brookline, MA 02146; 800/300-8273. $29.95 for both tapes.

Tape 2: A Parent's Guide to Adolescence

This companion video is designed to help parents understand their role in supporting their adolescent daughters. Parents and medical experts answer questions relating to pubertal changes, menstruation, preventative health care, contraception, safer sexual relations, body image, sexual orientation, and communication skills so that parents are better able to help their daughters make healthy decisions. 55 minutes. 1995.

Women's Healthcare Video Library, 55 Pond Avenue, Brookline, MA 02146; 800/300-8273. $29.95 for both tapes.

Between Friends

Using a Spanish-language soap opera format, this video tells the stories of three Hispanic teenagers who are confronted with choices regarding their own sexual behavior and drug use. The story line addresses issues of rebelliousness, the desire to experiment with sexual activity and drugs, and the effects of peer pressure. The video underscores the importance of condom use during sexual intercourse. Available in English and Spanish.

Ages 13-18. 26 minutes. 1994. Churchill Media/Society for Visual Education, 6677 North Northwest Highway, Chicago, IL 60631-1304; 800/829-1900. $99.95.

A Family Talks About Sex

Aimed at parents, this video illustrates the need for honest and direct conversations with children about sexuality. Dramatizations by African-American, Hispanic, Asian, and white families stress the importance of having ongoing discussions throughout all stages of development, from infancy to adulthood. Conversations take place with both male and female children. Topics include: reproduction, menstruation, nocturnal emissions, contraception, masturbation, and teenage sexual relationships. 30 minutes. 1988.

Churchill Media/Society for Visual Education, 6677 North Northwest Highway, Chicago, IL 60631-1304; 800/829-1900. $89.95.

Now We're Talkin' — Facts and Feelings About Teenage Sexuality

Planned Parenthood educators are shown conducting workshops on contraceptive information and correct condom use for two single-gender groups of culturally diverse teenagers. The facilitators use role plays in another coed group to address the need for teenagers to take responsibility and accept the consequences of sexual behavior. This video, which was produced by Planned Parenthood of New York City, comes with a discussion guide that includes suggested activities for teachers. Ages 13-18. 15 minutes. 1995.

Intermedia, 1300 Dexter Avenue North, Seattle, WA 98109; 800/553-8336. $198.00. Reduced price for Planned Parenthood affiliates.

Real People: Teen Mothers and Fathers Speak Out

This video is designed to help teenagers understand their own motivations and sexual behavior. It presents interviews with several African-American, Hispanic, and white teenage mothers and fathers who explain why having a child seems so attractive to them and to many young people. They also discuss the realities of teenage parenthood, including limited freedom, financial hardship, and the difficulties in maintaining relationships with partners and families. The video comes with a transcript and a teacher's guide.

Ages 12-18. 27 minutes. 1995. Sunburst Communications Inc., 39 Washington Avenue, P.O. Box 40, Pleasantville, NY 10570-2838; 800/431-1934. $189.95.

Staying Out of the Risky Zone

David Vaughan

This unique musical approach to sexuality education and HIV prevention includes

two compact discs or cassettes of eight songs each that are intended to supplement other curricula. The songs convey information and address personal and cultural attitudes related to sexuality. The songs vary in both musical style and topical content. Issues covered include HIV/AIDS, teen pregnancy, abstinence, safer sex, communication skills, media impact, sexual assault, sexual orientation, and homophobia. A 30-page discussion guide for each volume contains suggestions for effective use of the songs in an educational setting. Ages 12-18. 1996.
Risky Zone Initiatives, 74 Emory Street, Portland, ME 04102; 207/761-6981. $30.00 for both CDs; $26.00 for both cassettes.

Take Charge: Managing Your Sexual Health

Hosted by an African-American mother and using interviews with African-American and white teenagers, this video emphasizes that managing sexual health is as important as taking care of other aspects of health. Although sexual abstinence is strongly suggested as the safest option for teenagers, the importance of condom use is also discussed. In addition, the video encourages sexually involved teenagers to get tested and treated for STDs. An African-American teenage male and a white female are filmed throughout their appointments at an STD clinic in order to demystify physical exams. Ages 13-18. 29 minutes. 1995.
ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830; 800/321-4407. $99.95.

CURRICULA

Becoming a Responsible Teen: An HIV Risk Reduction Intervention for African-American Adolescents

Janet S. St. Lawrence, Ph.D.

This manual was designed as a resource to help educators and health care providers establish an HIV-prevention program for African-American teenagers. Selected by the Centers for Disease Control as a "Program That Works," this skills-training curriculum is credited with helping adolescents learn to lower their risk of unintended pregnancy and STDs, including HIV. It is based upon a research intervention called BART ("Becoming a Responsible Teen") that was funded by the National Institute of Mental Health, and developed and evaluated in cooperation with Jackson-Hinds Comprehensive Health Center, a community-based organization in Jackson, MS. 156 pages. 1995.
Janet S. St. Lawrence, Ph.D., Community Health Program, Jackson State University, 2310 Highway 80 West, Suite 3130, Jackson, MS 39204; 601/973-3693. Free.

A Cultural and Empowerment Approach to HIV Prevention Among Latinas/ Hispanic Women

Written in English, this 12-module curriculum provides an empowerment approach to sexuality education among Latinas/ Hispanic women. The lessons include information on HIV/AIDS prevention and transmission as well as exercises for examining the role of Latinas/Hispanic women in preventing HIV infection. The set includes a 221-page participant's manual, a 213-page trainer's manual, and evaluation materials. 1991.
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO), 1501 16th Street N.W., Washington, DC 20036; 202/797-4324. $67.00.

It's Up to Us: An AIDS Education Curriculum for ESL Students

Henry Lesnick

This curriculum provides lessons for five hours of HIV/AIDS instruction for high school and young adult students who speak English as a second language (ESL). Using exercises which require students to use listening, reading, writing, speaking, and critical thinking skills, the curriculum helps students develop English language skills while learning how HIV is transmitted and prevented. Copy-ready background materials, exercises, and activities are provided for each lesson. A list of international HIV/AIDS education and support service providers is also included. 72 pages. 1995.
Hostos Community College, Department of English, City University of New York, Bronx, NY 10451; 718/518-6597. Free.

Teen Pregnancy: A New Beginning

Linda Barr, M.N. and Catherine Monserrat, Ph.D.

This workbook was designed for individuals working with pregnant teenagers in educational, clinical, and counseling settings. It provides teenage women and men with information and guidance so they can make healthful decisions for themselves and their babies. The contents span the entire childbearing cycle, from contraception through early parenthood.
109 pages. 1996. Bureau for At-Risk Youth, 135 Dupont Street, P.O. Box 760, Plainview, NY 11803-0760; 516/349-5520. $16.95.

Working with Pregnant and Parenting Teens

Linda Barr, M.N. and Catherine Monserrat, Ph.D.

Designed as a teacher's guide to *Teen Pregnancy: A New Beginning,* this workbook provides professionals with practical resource information, complete lesson plans, reproductive charts, and diagrams regarding teenage pregnancy and early child care. 167 pages. 1996.
Bureau for At-Risk Youth, 135 Dupont Street, P.O. Box 760, Plainview, NY 11803-0760; 516/349-5520. $29.95.

ORGANIZATIONS

These members of the SIECUS-coordinated National Coalition to Support Sexuality Education (NCSSE) have improved the sexual health of communities of color, and are helpful sources of information and support:

Advocates for Youth

1025 Vermont Avenue N.W.
Suite 200
Washington, DC 20005
Phone: 202/347-5700
Fax: 202/347-2263

BEBASHI
(Blacks Educating Blacks About Sexual Health Issues)
1233 Locust Street
Suite 401
Philadelphia, PA 19107
Phone: 215/546-4140
Fax: 215/546-6107

Child Welfare League of America
440 First Street N.W.
Suite 310
Washington, DC 20001
Phone: 202/638-2952
Fax: 202/638-4004

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
Phone: 408/438-4060
Fax: 408/438-3618

Girls, Inc.
30 East 33rd Street
New York, NY 10016
Phone: 212/689-3700
Fax: 212/683-1253

Latina Roundtable on Health and Reproductive Rights
116 East 16th Street
7th Floor
New York, NY 10003
Phone: 212/533-9055
Fax: 212/982-3321

National Latina/o Lesbian and Gay Organization
1612 K Street N.W.
Suite 500
Washington, DC 20036
Phone: 202/466-8240
Fax: 202/466-8530

National Asian Women's Health Organization
250 Montgomery Street
Suite 410
San Francisco, CA 94104
Phone: 415/989-9747
Fax: 415/989-9758

National Minority AIDS Council
1931 13th Street N.W.
Washington, DC 20009
Phone: 202/483-6622
Fax: 202/483-1135

National Native American AIDS Prevention Center
2100 Lake Shore Avenue
Suite A
Oakland, CA 94606
Phone: 510/444-2051
Fax: 510/444-1593

National Urban League
500 East 62nd Street
New York, NY 10022
Phone: 212/310-9238
Fax: 212/593-8250

Planned Parenthood Federation of America
810 Seventh Avenue
New York, NY 10019
Phone: 212/541-7800
Fax: 212/247-6269

YWCA of the USA
624 9th Street N.W.
3rd Floor
Washington, DC 20001
Phone: 202/628-3636
Fax: 202/783-7123

OTHER SOURCES OF INFORMATION

Office of Minority Health—Resource Center
P.O. Box 37337
Washington, DC 20013-7337
Phone: 800/444-6472
Fax: 301/589-0884

National Coalition of Hispanic Health and Human Services Organizations
(COSSMHO)
1030 15th Street N.W.
Suite 1053
Washington, DC 20005
Phone: 202/387-5000
Fax: 202/797-4353

National Latina Institute for Reproductive Health
1420 16th Street N.W.
Suite B
Washington, DC 20036
Phone: 202/588-9363
Fax: 202/588-9369

National Youth Advocacy Coalition—Bridges Project
1711 Connecticut Avenue N.W.
Suite 206
Washington, DC 20009
Phone: 202/319-7596
Fax: 202/319-7365