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R E P O R T

SEXUALITY AND HUMAN RIGHTS ISSUES WORLDWIDE

DECEMBER 1998 / JANUARY 1999

SIECUS

R E P O R T

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Mac Edwards

As a gay person, I am haunted by the image of young Matthew Shepard, the University of Wyoming student who was tied to a fence post, brutally beaten, and left to die by two men late one Monday evening last October—presumably because of his sexual orientation.

I am haunted because this savage act is in such contrast to the loving acceptance my partner Reggie and I have felt from my family during the past few weeks. We have just returned from a beautiful wedding in the Caribbean. I gave the bride (my cousin) away in marriage. I traveled to North Carolina last Friday to attend the wedding reception. Reggie couldn't attend because he had to be with his 86-year-old father. My family attending the reception asked about Reggie many times. "Where is Reggie? I'm sorry he couldn't be here."

I think that this kind of acceptance is what Matthew wanted but was denied. Unfortunately, there are people in the United States who are determined to deny gays and lesbians like Matthew the right to have the loving and open life they want—and that Reggie and I have. It is our job here at SIECUS to see that people are not denied that right.

HUMAN AND SEXUAL RIGHTS

This *SIECUS Report* includes articles about human and sexual rights worldwide. It is appropriate that they are published on the 50th anniversary of the *United Nations' Declaration of Human Rights*. Since that important date in 1948, the world has witnessed dramatic social and political change. SIECUS itself didn't even exist. And comprehensive sexuality education was virtually unheard of.

We have made great strides since then to ensure that all people have access to knowledge, information, and education about sexuality. But the lack of access to sexual and reproductive health care and information for much of the world's population, violence against sexual minorities, and the staggering HIV rates in many parts of the world remind us that the job of creating a world where all people can live in dignity and enjoy their health and sexuality is still unfinished.

IN THIS ISSUE

When Matthew Shepherd died, I sent an E-mail to Dr. Sally Conklin, a professor at the University of Wyoming, to express SIECUS' and my sympathy and concern. Sally has a background in sexuality education and theology and had previ-

ously written for the *SIECUS Report*. When Sally replied, I asked her to write an article for *SIECUS Report* readers. She subsequently sent us "Wyoming Horror Breaks Silence on Violence Based on Sexual Orientation," that appears on page 9. As always, she has found something positive to report.

Other articles in this issue indicate that significant progress continues to be made in the areas of sexuality education and sexual rights worldwide.

First, SIECUS is proud to excerpt from its new brochure *Making the Connection: Sexuality and Reproductive Health* designed to help practitioners worldwide understand the importance of dealing with sexuality issues in their reproductive health work.

Next, Maureen Kelly of Planned Parenthood of Tompkins County in Ithaca, NY, and Michael McGee of the Planned Parenthood Federation of America, tell us about their participation in a European study tour this past summer on "Teen Sexuality Education in The Netherlands, France, and Germany." It is an informative and promising report.

Then, Rachel Jones of the Women's Commission for Refugee Women and Children reports on services that sexuality educators and clinicians need to consider in the article "Reproductive Health for Adolescent Refugees."

We are also proud to provide you with a new *Fact Sheet* on "Worldwide Antidiscrimination Laws and Policies Based on Sexual Orientation." It shows that a great deal has been accomplished around the world in recognizing and supporting the rights of gays, lesbians, and bisexuals.

MARY CALDERONE

Most of you probably know by now that Dr. Mary Steichen Calderone, one of SIECUS' founders and our president for our first two decades, died in a nursing home in Kennett Square, PA, in October.

I was never prouder to be a part of the SIECUS staff than when I read about her work and accomplishments in the banner-headlined article in *The New York Times* the morning after her death. She was a strong woman and a true visionary. SIECUS President Debra Haffner writes a beautiful tribute to her on page 3.

I know Dr. Calderone was proud of SIECUS and the work we are doing. That alone is enough to keep us going well into the twenty-first century.

IN MEMORIAM

MARY STEICHEN CALDERONE, M.D., M.P.H. 1904-1998

Debra W. Haffner, M.P.H.

SIECUS President and CEO

Mary Steichen Calderone died peacefully in her sleep on October 24, 1998. She was one of the co-founders of SIECUS and our president from 1964 until her retirement in 1982.

Mary Calderone led a remarkable life. She spent her first ten years in France with her father Edward Steichen, the world renowned photographer. Her uncle was Carl Sandberg, the poet. She attended Brearly, Vassar College, married, had two children, and became an actress on the New York stage for three years. At the age of 35, she graduated from the University of Rochester Medical School.

At the age of 49, she took her first paying job as medical director of the Planned Parenthood Federation of America! In 1964, at the age of 60, she helped found SIECUS and served as its executive director until she retired at the age of 78.

People Magazine wrote: "What Margaret Sanger did for birth control and Rachel Carson for the environment, Dr. Calderone has done for sex education."

Mary changed the way America viewed sexuality and sexuality education. She was fond of asking the more than 100 audiences she spoke to each year: "What is a four letter word ending in *k* for intercourse?" After the appropriate shocked pause, she would answer the question herself: "Talk." She'd then proceed to tell them that how people treat each other is the most important thing in the world.

CELEBRATED AND VILIFIED

She complained that America was both a "sex saturated culture" and a "sex starved culture." She asked audiences to consider: "One must decide, will sex use me, or will I use sex? Will it be my master or will it be my servant?" She derided her generation's hypocrisy about sexuality: "Like atomic energy, my generation let sexual energy out.... We did it and then we abdicated responsibility for teaching our children to use it wisely." The same criticism could be made of the baby boom generation as well.

Dr. Calderone was celebrated, and she was vilified. She received more than ten honorary doctorates and countless awards. She was the target of a \$40 million campaign by the John Birch Society to discredit her. They called her the leader of a "conspiracy to demoralize youth" and an "aging sexual libertine." In July 1998, I had the pleasure to speak on behalf of Mary at her induction into the National Women's Hall of Fame.

Sexual rights have changed dramatically in the past 35 years since SIECUS was founded. In 1964, contraception was not protected, even for married women... abortion was illegal...sex education was nonexistent, or else it was a single puberty lecture...and homosexuality was considered a mental illness.

Today, more than 90 percent of couples use contraception...the right to abortion is protected...sexuality education is widespread...and millions of gay, lesbian, and bisexual men and women proudly affirm their sexual orientation in their homes, work places, and religious institutions.

WE CONTINUE OUR WORK

Unfortunately, we continue to have to fight those who would deny people their sexual rights. And the recent murders of Matthew Shepard and Dr. Barnett Slepian underscore just how ugly those struggles remain.

As I have continued Dr. Calderone's work during the past decade, I have been struck by her brilliance, her vision, and her dream of an America where sexuality is affirmed as a natural and healthy part of life.

We will forever be inspired by her courage and commitment.

Dr. Calderone's family requests that in lieu of flowers, donations be made to SIECUS, 130 W. 42nd Street, Suite 350, New York, NY 10036-7802.



Dr. Mary Steichen Calderone

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MAKING THE CONNECTION: SEXUALITY AND REPRODUCTIVE HEALTH

Smita Pamar, M.P.H.
SIECUS Director of International Programs

Debra W. Haffner, M.P.H.
SIECUS President and CEO

(Editor's Note: This article includes information excerpted from SIECUS' new booklet *Making the Connection: Sexuality and Reproductive Health* designed to provide reproductive health clinics and organizations worldwide with information on the relationship between sexuality and reproductive health issues. Single copies are available free upon request. The full text is also on the SIECUS Web site at <www.siecus.org>.)



For the past 35 years, SIECUS has worked with educators, reproductive health care providers, medical professionals, and policy makers to promote sexuality education and sexual health for all people.

SIECUS has compiled information in a booklet *Making the Connection: Sexuality and Reproductive Health* to help program planners, providers, and policy makers understand the connection between sexuality and reproductive health. It defines sexually related health terminology, and also addresses issues relevant to reproductive health care clinics.

MAKING THE CONNECTION

The *Programme of Action* of the International Conference on Population and Development (ICPD) calls on the world to address sexual health as an integral component of reproductive health and family planning programs:

...reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

—*Programme of Action*, 7.2

Two important objectives of the *Programme of Action* address sexuality and the sexual health of clients:

To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals.

—*Programme of Action*, 7.36a

[and]

To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities.

—*Programme of Action*, 7.36b

The *Programme of Action* highlights the necessity for reproductive health care providers, program planners, advocates, and policy makers to address adolescents' needs for education to become sexually healthy adults:

Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values.

—*Programme of Action*, 7.47

Sexuality and reproductive health are connected. Reproductive health care providers help people manage their sexual lives. Although contraceptive services have traditionally helped women plan the number and spacing of children, most clients seek contraception primarily to separate procreation from the recreational aspects of sexual intercourse.

Men's and women's sexual attitudes and behaviors

influence their choice of contraception and their ability to use their methods effectively. Individuals' reproductive health care decisions depend on their ability to make informed and healthy choices about their sexuality.

Providers and program planners need to address sexuality issues as an integral part of reproductive health. In such a setting, practitioners have a special opportunity to provide information, education, and counseling.

THE DEFINITIONS

Because sexuality is culturally specific, definitions and language may differ from culture to culture and community to community. Program planners and providers must explore and understand what these terms mean in their own communities, languages, and cultures.

Sexuality. Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its parameters include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns.

Sexual health. The World Health Organization defines sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching, and that enhance personality, communication, and love.... Every person has a right to receive sexual information and to consider sexual relationships for pleasure as well as for procreation."

Sexually healthy adults. Sexually healthy adults appreciate their bodies, take responsibility for their behaviors, communicate with both sexes in respectful ways, and express love and intimacy consistent with their own values. SIECUS has worked with non-governmental organizations worldwide to develop a consensus about the life behaviors and characteristics of a sexually healthy adult. In such diverse countries as Brazil, Nigeria, Russia, and the United States, groups have affirmed a similar vision of what constitutes a sexually healthy adult.

Sexually healthy relationships. Sexually healthy relationships are based on shared values and have five characteristics: they are consensual, non-exploitative, honest, mutually pleasurable and protected against unintended pregnancy and sexually transmitted diseases (STDs), including HIV/AIDS.

Sexual rights. Individuals have the right to the information, education, support, and services they need to develop the skills to make responsible decisions about their sexuality consistent with their own values. These include the right to bodily integrity, voluntary sexual relationships, a full range of voluntary accessible sexual and reproductive health services, and the ability to express one's sexual orientation without violence or discrimination.

Sexuality education. Sexuality education is the lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. Sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality.

Comprehensive sexuality education. Whether offered in the home, school, or at a community-based organization, comprehensive sexuality education is designed to prepare young people to become sexually healthy adults. The primary goals of comprehensive sexuality education are to provide individuals with information about human sexuality; to help them explore their attitudes in the process of developing their own values, self-esteem, and insights; to help them acquire interpersonal skills and to build satisfying relationships; and to help them exercise responsibility regarding sexuality. Comprehensive sexuality education should be a central component of programs designed to reduce the prevalence of sexually related medical problems, including teenage pregnancies, sexually transmitted diseases including HIV infection, and sexual abuse.

Sex. An individual's biological status as male or female.

Sexology. The science of sexuality.

Sexosophy. The cultural understanding of sexuality.

Sexual dysfunction. The inability to react emotionally or physically to sexual stimulation in a way expected of average healthy people or according to their own standards. Sexual dysfunctions may affect various stages in the sexual response cycle—desire, excitement, and orgasm. They have a wide range of psychological, physiological, or combined origins and may be either primary or secondary. At one time or another, most men and women experience some sort of sexual dysfunction.

Sexual identity. The inner sense of people as sexual beings, including how they identify in terms of gender identity and sexual orientation.

Sexual intercourse. Penetrative sexual behaviors, including oral sex, anal sex, and penile-vaginal sex.

Sexual orientation. Erotic, romantic, and affectional attraction to people of the same sex, to the opposite sex, or to both sexes.

Bisexuality. Erotic, romantic, and affectional attraction to people of both sexes.

Heterosexuality. Erotic, romantic, and affectional attraction to people of the opposite sex.

Homosexuality. Erotic, romantic, and affectional attraction to people of the same sex.

Gender. An individual's personal, social, and legal status as a male or a female. Words that describe gender are *feminine* or *masculine*.

SEXUALITY ISSUES AND CONTRACEPTIVE METHODS³

	Used at Time of Coitus	Partner Support Required	Affects Sexual Functioning	Can Be Used in Lovemaking	Okay for Multiple Partners
Pill	No	No	May	No	Yes? With condoms
Diaphragm	Yes	No	No	Yes	Yes? With condoms
Condom	Yes	Yes	Yes	Yes	Yes
IUD	No	No	No	No	No
Abstinence	NA	Yes	Yes	Yes	Yes
Coitus Interruptus	Yes	Yes	Yes	Yes	Yes? With condoms
Fertility Awareness	Yes	Yes	May	Yes	No
Sterilization	No	No	No	No	Yes? With condoms

Gender identity. The internal sense of being male or female.

Gender role. The public expression of an individual's gender identity. Gender role may also refer to cultural expectations of male and female behaviors.

THE CLINICS

Many reproductive health care clinics have treated individuals' sexuality needs as separate and distinct from their contraceptive and reproductive health needs. When trained to address sexuality issues, clinicians can provide their clients with information, education, and counseling to manage their sexual lives in ways that are consistent with personal values and goals.

Impact of contraceptives on sexuality.¹ Attitudes about sexuality and the characteristics of sexual relationships will influence individuals' choices of a contraceptive method, their use of that method, and their satisfaction with that method. Ambivalence about sexuality contributes to unintended pregnancies and STDs. Studies have shown that women are less likely to find satisfaction with their birth control method if they believe it will make sex less pleasurable.²

There is no perfectly effective, easy-to-use, pleasurable contraceptive. Providers can advise clients to consider bodily comfort, independence from intercourse, partner cooperation, and protection from STDs when selecting a contraceptive.

The chart below, "Sexuality Issues and Contraceptive Methods," can help clients understand the sexuality issues for different contraceptive methods.

Taking a sexual history of a client.³ In order to help clients make contraceptive choices, practitioners should

understand their sexual history. These questions will help them counsel their clients about such a choice:

- Will you tell me about your earliest sexual experience?
- Will you give me a brief history of your sexual experiences to date?
- Did you agree to these experiences?
- How has contraception fit into your sexual behaviors?
- Are you willing to use a contraceptive method at the time of intercourse?
- Does your partner actively support your use of contraception?
- Are you looking for a method you can integrate into lovemaking?
- How likely is it that you will have more than one sexual partner?
- Do you have any questions or concerns that you would like to discuss about your present response or your relationship?

Skills and Training for Providers. Providers need special skills and knowledge to provide sexuality education and counseling to their clients. They need specialized training in sexuality that address these components:

- **Cognitive.** Practitioners need a sound and comprehensive information base about human sexuality, including human development, relationships, personal skills, sexual behavior, sexual health, and society and culture.
- **Attitudinal.** Practitioners need the opportunity to develop an awareness and understanding of their own sexuality

in order to increase their comfort level in addressing sexuality concerns. Providers will need to demonstrate acceptance of the diversity of values, beliefs, and lifestyles in the community they serve.

- **Skills.** Practitioners should have opportunities to develop counseling and education skills. Any training program must also include opportunities for practice, and must be followed by close supervision in the clinic setting or field.

In addition to this specialized training, those who work with sexuality issues should demonstrate:

- an understanding and comfort level with their own sexuality
- a comprehensive information base about sexuality, including anatomy, physiology, developmental sexuality, and marital and family dynamics
- communication and counseling skills to address sensitive and controversial subjects
- personal qualities such as emotional stability, patience, flexibility and a sense of humor
- the understanding and control not to impose their viewpoints and values on clients, but to act as a catalyst to help others understand their own values
- knowledge of when and where to refer clients with special problems and needs

- an awareness of the community and sensitivity to its concerns
- the motivation and commitment to address the sexual health needs of clients

Understanding sexuality and the sexual health needs of clients requires reproductive health care providers to have adequate training, resources, and materials. *Making the Connection: Sexuality and Reproductive Health* provides a starting point on language, concepts, and needs.

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For more information on the booklet and SIECUS' International Program, write to: SIECUS, International Program, 130 W. 42nd Street, Suite 350, New York, NY 10036-7802. Phone: 212/819-9770. Fax: 212/819-9776. E-mail: <siecus@siecus.org>. Web site: <www.siecus.org>.

TELL US WHAT YOU THINK! THE 35 MOST INFLUENTIAL BOOKS ADVANCING SEXUALITY EDUCATION, SEXUAL HEALTH, AND SEXUAL RIGHTS

Tell us what you think!

The April–May 1999 issue of the *SIECUS Report*—celebrating "SIECUS' 35th Anniversary"—will include a special section highlighting "The 35 Most Influential Books Advancing Sexuality Education and Sexual Rights in the Past Century."

As readers of the *SIECUS Report* and as leaders in the field of sexuality education, sexual health, and sexual rights you are in the best position to provide us with information on these books.

Tell us about the books that you feel have contributed the most to increasing our understanding of sexuality and

that have advanced the cause of sexuality education, sexual health, and sexual rights. What books make up your core library?

Please include (1) book title, (2) author(s), (3) publisher, (4) publication date, (5) brief description, and (6) contact information.

Send your suggestions to Mac Edwards, *SIECUS Report* editor, 130 West 42nd Street, Suite 350, New York, NY 10036-7802. Phone: 212/819-9770, extension 314. Fax: 212/819-9776. E-mail: <medwards@siecus.org>. Please submit all suggestions by February 1, 1999.

WYOMING HORROR BREAKS DAM OF SILENCE ON VIOLENCE BASED ON SEXUAL ORIENTATION

Sarah C. (Sally) Conklin, Ph.D.

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I arrived at my University of Wyoming office on Monday morning, October 19, with a heavy heart. It was the day of the campus memorial service for Matthew Shepard, the young gay student who had been brutally murdered because of his sexual orientation.

When I opened my E-mail, a message brought more tears. It was from Mac Edwards, the *SIECUS Report* editor. He expressed *SIECUS'* horror and concern: "We are sick at heart about this awful tragedy and only hope that something good can come of something so awful," he said. "We hope that the service today will be peaceful and dignified. Let us know how you are."

I was very touched by this E-mail from Mac. So, when he asked me to write an article for this issue of the *SIECUS Report* focusing on "Sexuality and Human Rights Issues Worldwide," I welcomed the opportunity to tell you "how I am" and to talk about some of the good things that have come from this tragedy.

THE WEEKEND OF THE TRAGEDY

On Sunday night of the previous week, I stood shoulder to shoulder with nearly a thousand University students, faculty, and friends on the damp lawn of the Roman Catholic Newman Center for students as candles flickered, people quietly sobbed, and we all sang songs in a vigil for Matthew.

My "Safe Zone Program" (See related sidebar on page 9.) friends Walt Boulden and Jim Osborn spoke fondly of their friend Matt and passionately about the meaning of the tragedy as he lay in a Fort Collins hospital on life support.

University President Philip Dubois spoke brokenly with emotion and sensitivity. "This tragedy has tested our endurance and our sense of community," he said. "But, instead of being torn apart by fear, we have been brought together in unity and purpose.... We must use Matt's example in life to work against hatred, bigotry, and violence."¹

PATTERNS OF RESPONSE

Even as President Dubois spoke, there were patterns emerging in the way the community responded to the atrocity in its

midst. These patterns involved parallels, symbols, music, explanations, and solutions.

The citing of parallel incidents was common.

Other local murders were described: the unsolved beating death of a gay faculty member whose body was discovered along a Denver highway more than six years ago; the rape and death of a young girl visiting her grandparents whose battered body was left in a landfill by the sex offender who murdered her; the death of a pregnant Laramie high school student whose body was found in the nearby wilderness recreation area.

The priest who spoke at the candlelight vigil added another parallel incident that took place nearly 2,000 years ago: the crucifixion of Jesus, a feared and hated young man who was also left to die on a post. The image of young Matthew beaten and tied to a fence post because he was different and part of an unpopular group was vivid.

Letters and headlines described varying viewpoints.

"The hypocrisy of this community has become glaringly evident.... Ask yourselves why you are so outraged now." "Outrage doesn't cut it now. It is time that you did something more than be outraged." "Teach that all life is valuable." "Unfortunately, hate is everywhere." "Don't use this death as an agenda." "Hate crime laws don't stop murders."

An eighth grader, now in the same school that Matthew attended, drew another parallel. She said that he "probably sat in one of the chairs I sit in at school, watched the same movies, listened to the same stories, did the same plays.... So, if he was here, then there, and now dead, where does that put me when I am his age? Should I have to worry about my lifestyle, always looking over my shoulder? The questions can't be answered because of all the hate."²

Other symbols also helped people identify with the tragedy.

The colors yellow (for nonviolence) and green (for peace and "no hate") were first displayed in banners and signs carried by silent marchers at the end of the University of Wyoming homecoming parade. Green symbols on yellow

"I feel an obligation to demonstrate respect and acceptance for differences."

paper were passed out at vigils and printed in the newspapers for individuals to display in their windows and cars. Yellow armbands with rows of green circles were made and distributed by campus student groups. Many friends attending the memorial service wore them. They later showed up all over the campus: on violins and backpacks, on door handles and file cabinets. Mine is hanging over a lamp. A giant armband is still draped over the church sign at the Newman Center, site of the previous Sunday night vigil.

The holding of lighted candles created a warmth and a sense of belonging for many people. The wax-dripped nubbins that I carried still sit on top of my computer as I write this article. They remind me that I showed up. They remind me that I demonstrated that I care.

Flowers were symbolic, too. A basket of bright, colorful flowers was left on the fence where Matthew was found. Bouquets were both elegant and prolific at the memorial service. The same flowers later graced offices, dormitory lobbies, classrooms, and cafeterias as a natural and beautiful reminder of this young gay student.

Music—both with and without words—drew us together, too. The poignant Bach Air that opened a concert was followed by respectful silence—no applause—as people honored Matthew’s memory and reflected on their loss.

Choked with emotion, we also sang the words of songs that we knew: *We Shall Overcome*, *Amazing Grace*, *Let There Be Peace on Earth*. There were also songs of unity and a shared purpose. From the Unitarian Universalist’s hymnal we sang *We Are a Gentle, Angry People*, *We Are Gay and*

Straight Together, Singing, Singing for Our Lives.

WORDS OF EXPLANATION, HOPE

In trying to make sense, to find some good, to ensure that hope overcame despair, people offered explanations—ignorance, fear, intolerance, hate, anger, social and economic inequality—and suggested solutions—legislation, education, teach-ins, more Safe Zone trainings, fishbowl discussions, focus groups, counseling.

My students voiced their feelings in their journals. At times, their thoughts were difficult for me to read: “To tell you the truth, I don’t want to hear about it.” “They can be gay if they want to be, but don’t tell me about them.” “Any murder is the same as any other.” Yet, I know that if my students can say what they feel, they will examine the words they’ve written and learn from them. They are all on journeys toward understanding and acceptance. Where they are and how far they will go on that journey depends on them. I feel an obligation to demonstrate respect and acceptance for their differences, just as I expect them to respect others.

When I joined the faculty at the University of Wyoming, my personal goal was to make a difference in this sparsely populated state. I started by creating a new class called “Teaching Sensitive Issues in Human Sexuality: Methods and Concepts.” I included sexual orientation as an aspect of sexual identity and as one of the most sensitive issues that teachers face.

Some of my colleagues openly questioned my motives. Some whispered behind my back. When asked, I explained

UNIVERSITY OF WYOMING’S “SAFE ZONE PROGRAM”

The Safe Zone Program at the University of Wyoming is an initiative of the Campus Activities Center designed to promote a more positive campus climate for lesbian, gay, bisexual, transgendered (LGBT) and questioning students and employees. It provides individuals with an opportunity to educate themselves and explore their beliefs about sexual orientation.

Safe Zone Program participants must attend a two-hour training session facilitated by a core group of Safe Zone trainers who are University of Wyoming students, staff, and faculty volunteers.

Topics and issues that the Safe Zone participants discuss include (1) myths and stereotypes associated with the LGBT population, (2) definitions and terminology, (3) resources to help people better understand sexual orientation, and (4) ways to individually support the LGBT population and promote a positive campus environment for

everyone.

Goals supported by the Safe Zone Program include actions to challenge heterosexism and homophobia on campuses. They include: (1) educating program participants, (2) modeling non-heterosexist and non-homophobic behavior and attitudes, (3) educating others, (4) confronting overt incidents, and (5) taking public stands.

The Safe Zone Program and similar initiatives are available on many college campuses. To date, over 200 faculty, staff, students, and administrators have completed the training on the Laramie campus.

The Safe Zone Program symbol is a magnet showing a pink triangle inside a green circle. It indicates a space in which all people—regardless of sexual orientation, ethnic background, age, religion, disability, or gender—are respected.

—Sally Conklin

that, as a health educator, my primary concern was to make an impact on preventable causes of death. I cited the disproportionately high rate of suicide among gay and lesbian adolescents and young adults. After Matt's tragic murder, I no longer needed to explain why this topic must be included in my class.

Two weeks before the tragedy, I invited a panel of people with diverse sexual orientations to visit my "Sensitive Issues" class after I showed a video called *Straight From the Heart*. My students wrote questions before the panel arrived. I put them into categories, and the panelists answered the ones they wanted. My students' journals show that this class was very meaningful.

"Two months ago, I would have spent very little time contemplating what took place here. With a new understanding of the gay community revealed to me by this class, I have a totally different perspective on this situation."

I asked my students for ideas. I used the trigger question: "What should colleges do in response to violence against the lesbian, gay, bisexual, and transgendered population?"

Some responses were:

"I personally feel the University has done a stand-out job attempting to remember the victim and say good-bye to a member of the community. As future educators, we have learned to take advantage of 'teachable moments' and that is just what the University has done by holding teach-ins, fishbowl discussions, services, training opportunities, and supporting legislation."

"I do not know how to keep violence from us. It is already here. Education can help overcome ignorance, but Matthew Shepard's death was caused by something more severe than ignorance. I simply don't know how to stop that from happening. I wish that we did."

"The media was great in getting the message across that this was wrong and things need to change."

"The teachers of Wyoming, especially health educators, should speak to their students about sexual orientation, about violence against people because of their differences. Matthew Shepard's death and life should be utilized to teach about the ignorance in our society. He should not be forgotten. Stop the hate in Wyoming! Love thy neighbor."

"How can we send 'no tolerance for hate' messages to our students and community members in a way that can create awareness and true concern for the rights of all people? Somehow, just rehashing the horrible facts makes me feel like we are participating in nothing more than useless gossip. I participated in a walk for Matthew. But that is not enough. I logged onto the National Town Meeting page to sign a petition that deals with hate crimes. But that is not enough. This is truly a life altering point in time for me, and I want to be part of the positive changes that must take place in my lifetime."

PROGRESS AND PEACE

Ideas such as these give me hope. They indicate progress. And, yet, they are realistic in their recognition that change is not easy or quick. We have experienced a tragedy at many levels, and although we must face the fact that all is not right with the world, these students, their institution, and this community have made progress that allows me to say sincerely, "It is well, it is well with my soul." Thanks for asking, Mac.

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CALL FOR NOMINEES WORLD ASSOCIATION OF SEXOLOGY EDUCATION AWARD

The Sexuality Education Committee of the World Association of Sexology (WAS) invites organizations, activists, and educators from Latin America, Africa, and Asia to submit nominees for the 1999 WAS Sexuality Education Award scheduled for presentation at the 14th World Congress of Sexology in Hong Kong, China, in August 1999.

This award, which recognizes significant and outstanding achievements in sexuality education, highlights the efforts of educators to promote the understanding of

comprehensive sexuality education, to develop unique advocacy strategies to increase greater acceptance of sexuality education, and to develop innovative sexuality education programs for people of all ages.

Individuals should submit nominations to Smita Pamar, director of international programs, by February 18, 1999, at SIECUS, 130 W. 42nd Street, Suite 350, New York, NY 10036-7802 U.S.A. Phone: 212/819-9770, extension 308. Fax: 212/819-9776. E-mail: <spamar@siecus.org>. Web site: <www.siecus.org>.

REPORT FROM A STUDY TOUR TEEN SEXUALITY EDUCATION IN THE NETHERLANDS, FRANCE, AND GERMANY

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You would think a two-week trip to Europe would yield stories of picturesque walks through ancient towns and beautiful churches and conversations over a glass of wine or a great cup of coffee. Our stories do involve such things, but the real story behind our trip is not simply tourism.

In 1985, the Alan Guttmacher Institute published the findings from their "Euroteen" study highlighting the different rates of teen pregnancy, births, and abortion in 37 developed countries.

To learn how some European countries yield their low rates of negative outcomes and high rates of positive outcomes from adolescent sexual behavior, Advocates for Youth and the University of North Carolina at Charlotte organized a six-city study tour of three countries in July and August of 1998.

On July 25, 40 professionals and graduate students from the United States set out to learn about adolescent sexual behavior and responsibility from some of the people and places that report the greatest success—the residents of The Netherlands, France, and Germany.

From site visits and lectures, to panel discussions with health educators, youth workers, policy makers, AIDS activists and general practitioners, we have returned to the United States with a new view of the positive impact of access to sexuality education, public information, and medical services targeted to young people.

WHAT DID WE FIND?

In The Netherlands, France, and Germany, adolescent sexuality is regarded as a health issue, rather than a political or religious one. An overwhelming majority of the people and institutions in these countries support sexual health. In all three countries, but most notably in The Netherlands, teens are educated about safer sex and have access to both birth control pills and condoms if they have sexual intercourse.

In a lecture given by Jany Rademakers, one of the pre-

miere researchers on adolescent sexuality at The Netherlands Institute of Social Sexological Research (NISSO), we learned that the efforts toward education and access are working: 85 percent of Dutch teens use contraceptives at first intercourse; 46 percent report using condoms only, and 24 percent report using both a condom and birth control pills, known in The Netherlands as "Double Dutch." Birth control pills and condoms used together not only work to prevent pregnancy and sexually transmitted infections, but they also encourage both partners to take an active role in preventing infection and pregnancy.

In the countries studied, adolescents are valued, respected, and expected to act responsibly. Equally important, most adults trust adolescents to make responsible choices because they see young people as assets, rather than problems. That message is conveyed in the media, in school texts, and in health care settings.

Consider these simple comparative facts. According to 1990–95 data from the United Nations Population Division, the teen birth rate per 1,000 girls 15 to 19 years old is 64 in the United States, 13 in Germany, 9 in France, and 7 in The Netherlands.¹

Teen abortion rates are also profoundly lower in Europe than in the United States. Comparative data compiled by Advocates for Youth shows that the abortion rate per 1,000 women 15 to 19 years old is 17 in the United States, 7.9 in France, and 5.2 in The Netherlands. (For Germany, the abortion rate is 8.7 for women ages 15 to 49.)² Additionally, in the countries studied, teens begin having sexual relations more than one year later than American teens and have fewer sexual partners during their teen years than their American peers.³

The reality is that teens in The Netherlands, France, and Germany have intercourse without as many negative consequences as teens in the United States. But European teens get something that American teens don't. They get inundated with positive messages aimed at helping them avoid

unplanned pregnancy and sexually transmitted infections.

Most important, the messages sent to Dutch, German, and French teens are not designed to ask them to abstain from intercourse until marriage. In our visit to the Mouvement Français pour le Planning Familial (MFPF), we asked the speaker, Monique Bellanger, director of the MFPF Documentation Center, if her organization promoted abstinence until marriage. Her response was to laugh and say, "We don't give such a message. It's bad for your health!"

The impetus to provide access to contraception, condoms, and comprehensive sexuality education is based on the desire to further reduce abortions and sexually transmitted diseases. Sexuality education is not necessarily one "course," but is integrated throughout many subjects and grade levels. The focus of sexuality education is on normalizing sexuality in the context of adolescent development, assuring medical accuracy, promoting values of respect and responsibility, and encouraging communication in relationships.

In reviewing curricula at a site visit to the Catholic Pedagogical Center (a teacher training center in The Netherlands), we were struck by how much sexuality was taken for granted. At first glance, the curricula stumped us. We wondered where the sexuality education was. On closer inspection, and with the help of a translator, we found that nearly all the curricula included sexuality information within the context of life skills.

One chapter would explain how to do laundry. The next would explain contraception. School teachers also reported taking this comprehensive approach to heart by leading discussions and lessons on relationships and sexuality in literature classes while reading classics such as *Romeo and Juliet*.

In Germany, there is a national sexuality education policy, but individual states can determine which curricula to use. In France, sexual health is promoted through national campaigns that encourage students to participate in safer sex and AIDS prevention poster contests. The winning posters then become an integral part of national media campaigns. In The Netherlands, schools distribute safer sex pamphlets just before the school holidays because officials know that many students will have sexual relationships while on vacation. Students in The Netherlands are also tested on national school exams for proficiency in sexuality education.

One of the key findings from our review of educational materials in all three countries about the various teaching approaches to sexuality was that professionals and educational materials honored the fact that sexuality exists for more than one week during one year in high school.

All three countries also have massive public education campaigns targeting safer sex behaviors and condom use. Media are engaged in helping young people make healthy sexual choices, not simply titillating audiences with sexual content for the sake of advertisers' money. Television, radio, billboards, tour buses, discos, pharmacies, post offices, and medical clinics are all enlisted in the public education efforts. In The Netherlands, parents can pick up informational booklets on tips for talking to their children about sexuality from their local post office. One of France's safer sex media campaigns targeting young people during school breaks exclaims, "On Holiday I forget everything...except condoms!"

These countries also appear to have little concern that sexually explicit media messages will encourage young people to have intercourse. In fact, most of the school curricula for adolescents include some nudity, as do most television and print media campaigns. Humor also plays a big role in conveying messages of safer sex and responsibility.

The bottom line for the European media approaches to sexuality is that accurate and factual information is used in accessible, realistic, and humorous ways to reach their audiences.

The mass media sexuality education campaigns are supported and encouraged by a broad array of people with an equally broad array of beliefs and values, ranging from AIDS educators and parents to religious leaders and policy makers. We in the United

States can learn from this non-adversarial relationship between religious communities and advocates for sexuality education, and, as a result, should encourage all groups to make strides toward a place where young people and families are supported to be sexually healthy.

Religion and politics have little influence on policies related to adolescent sexuality in the European countries we visited. For example, the church in France doesn't involve itself in school sexuality education, contraceptive services, or safer sex messages in the media. And with multiple political parties in The Netherlands, no single candidate or party can polarize the electorate around adolescent sexual issues.

National health insurance in all three countries gives youth convenient access to sexual health care, including contraception and emergency contraception. In The Netherlands, a teen girl who wants to use a birth control pill does not need to have a medical exam, to complete any forms, or to give her real name at the clinic. A health professional interviews the young woman, conducts a health history screening, and barring any contraindications, the young woman will leave with free birth control pills.

All three countries provide youth-friendly access to

*"The focus...
is on normalizing
sexuality in the
context of adolescent
development."*

sexual health care by having free or low-cost services, numerous locations with generous hours of operations, and social support for making responsible sexual choices. Most young people get contraceptives through their family physicians, and clinics run by MFPP in France, the Rutgers Stichting in The Netherlands, and Pro-Familia in Germany provide services as well.

The tour yielded little new information about working with parents on family communication about sexuality. European studies about family sexuality education revealed dynamics similar to American families. In a study presented by Janita Ravesloot, a professor from Leiden University in The Netherlands, Dutch parents and teens expressed different impressions of the communication and education that happens at home regarding sexuality. This finding is similar to studies of parent-child communication in the United States.

Although European young people report receiving very little sexuality education at home, when asked specific questions about sexuality and sexual health, it becomes clear that young people are still successful in getting information about responsibility in relationships, where and how to get safer sex protection, and their family's values about sexuality.

Parents in The Netherlands may not directly teach their children everything they want to know about sex—a third of parents in the study view their adolescents' sexual lives as private.⁴ Dutch parents consider themselves “supportive from a distance” around their teens' sexual behaviors. They don't forbid sexual intercourse because they don't want their teens' experience to be like the parents'. They fear it may push their children to rebellion and risk. One parent we interviewed said, “I don't want my kids to be sneaky.” Most parents don't set rigid rules—but they do want children to have serious, responsible, healthy relations. As in the United States, mothers do most of the communication with their children about sexual and relationship issues. Mothers negotiate with teens about their sex lives. Also, as in the States, parents say they've talked with their children about sex, while their children say they have not. Parents say they are “liberal” while their adolescents say they (their children) are restricted. Parents consider themselves liberal in comparison to their own upbringing. Only 1 percent of Dutch parents in the study insisted on abstinence for their adolescents.

In a German study, the findings were similar to the Dutch. Some of the specifics include the fact that 80 percent of the family communication about sexuality is introduced by the mothers, and that 40 percent of German young men report that they get no sexuality education from their parents.⁵ Findings from the same German study indicate that almost 60 percent of parents regard human sexual

behavior as a natural part of their life and, as a result, German families are taking sexuality education far more seriously than earlier generations. The role of the family in sexuality education is profound, not simply as a prevention method, but as a model for building healthy relationship and communication skills.

All three countries that we visited during the European Study Tour have one major thing in common. The positive and inclusive nationally funded sexuality education initiatives have all come about in the past 40 years. The Dutch, French, and Germans have made significant strides within the last two decades toward implementing national harm-reduction programs at their best. They saw the negative outcomes of HIV infection and too-early pregnancy, and worked collaboratively to create educational materials and provide access to services to address the negative outcomes, not by attempting to prevent sexual behaviors.

A portion of an interview journalist Bill Beckley had with artist Louise Bourgeois appeared in the September 1998 *Harper's Magazine*. The exchange that follows best sums up the contrasting social norms between European countries and the United States. The interview read:

Bill Beckley: You were born in France, but you lived a long time in the United States. What is the difference between the aesthetics of the two countries?

Louise Bourgeois: I'll tell you a story about my mother. When I was a little girl growing up in France, my mother worked sewing tapestries. Some of the tapestries were exported to America. The only problem was that many of the images of the tapestries were of naked people. My mother's job was to cut out the—what do you call it?

Beckley: The genitals?

Bourgeois: Yes, the genitals of the men and women, and replace these parts with pictures of flowers so they could be sold to Americans. My mother saved all the pictures of the genitals over the years, and one day she sewed them together as a quilt, and then she gave me the quilt. That's the difference between French and American aesthetics.⁶

CLOSING THOUGHTS

Reframing our society and culture while affecting beliefs and practices about adolescent sexual behavior in the United States will not be easy, but we have seen that it can be done.

We cannot ignore the fact that poverty, lack of hope for the future, and an inadequate public education are strong predictors for sexual risk taking. But we can help adolescents make responsible choices about sexuality.

Adolescents can make healthy decisions. We need to help build a context in which they are supported to feel good about themselves and their bodies, remain healthy, and build positive, equitable, loving relationships. Our European neighbors reminded us that sexuality can be a normal, healthy, and pleasurable aspect of being human—even for adolescents.

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UNAIDS PROGRAM URGES ADOLESCENT SEXUALITY EDUCATION

Dr. Peter Piot, the executive director of UNAIDS said at a Joint United Nations Program on HIV/AIDS in Geneva this fall that restricting adolescent sexuality education violates children's rights and excludes them from valuable prevention information.

He said that "the world's children are under increasing threat from the AIDS epidemic" and that more than 500,000 infants last year became infected with HIV through their mothers. "Girls and boys need to understand how to protect themselves and others from the [HIV/AIDS] virus in situations of risk," he said.

Statistics were presented at the meeting to show that adolescents are among those at the highest risk of HIV infection from having unprotected sex or sharing contaminated needles. Over 16,000 new HIV infections occur each day among young people ages 10 to 24.

The meeting was organized by the Committee on the Rights of the Child, a United Nations human rights body that monitors states' compliance with the United Nations Convention on the Rights of the Child. The Convention commits 191 nations to provide health care, education, and psychological and social support to all children.

REPRODUCTIVE HEALTH FOR ADOLESCENT REFUGEES

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Young people between the ages of 10 and 24 represent over a third of the world's population. These adolescents¹ are at high risk for unintended pregnancy, sexually transmitted diseases, and HIV transmission.

These risks increase for adolescent refugees because of the instability of their living situations.² Unfortunately, these young people are often unwilling or unable to pursue reproductive health services due to insecurities, cultural barriers, lack of awareness, and insensitive service providers. Consequently, almost 15 million young women under 20 give birth each year, and 20 to 60 percent of these pregnancies are untimely or unwanted.³

For example, a recent Knowledge Attitude Practice study of such adolescent internally displaced persons (IDPs)⁴ in the Soviet nation of Georgia has revealed that only 10 percent could name two ways to prevent HIV/AIDS; that only 10 percent could name three modern forms of family planning; and that only 30 percent could name one symptom of a sexually transmitted disease.⁴

Conducted by the International Rescue Committee,⁵ this study is particularly disturbing because of the statistics mentioned above—statistics that point to the need for local and international organizations to target adolescents—and particularly refugee adolescents—when providing reproductive health services.

THE KAKUMA CAMP IN KENYA

One example of the need for reproductive health services for refugee adolescents is seen in the Kakuma camp in Kenya. Of the 47,500 registered refugees in this camp, approximately 8,000 are unaccompanied youth who are mostly boys. The United Nations High Commissioner for Refugees (UNHCR) recently conducted a reproductive health services assessment and made a number of important observations.⁶

First, it is difficult to accurately track the adolescent users of clinic reproductive health services in Kakuma

because the clinic staff register as adults all those over the age of five who do not know their ages. In addition, the weekly report form of the community health workers does not ask for the exact age of patients. Instead, it asks if they are either over or under five years of age.

Second, the Kakuma health clinics are overcrowded and do not allow for either privacy or confidentiality. Most young people said it is common to return home after waiting all day without having seen a medical practitioner. Even those who see a practitioner complain that the care is rushed and that prescriptions are given without thorough knowledge of the patient's condition. In addition, most of the clinic staff is male. This keeps many young women from openly discussing sensitive issues or from going to the clinic at all.

Third, most of the Kakuma youth go to the clinic because they think they have an STD. Yet, the clinics are not prepared to handle such cases. Health workers and young people alike express a lack of confidence in the results of camp laboratory tests. In fact, some young men said they travel to the Sudanese border for STD tests and treatment.

Anemia, due to malnutrition, is a common health problem, particularly among young Kakuma men. Many adolescent males, especially those unaccompanied, often sell their food ration and use the money to buy clothing, shoes, soap, and sex. They spend the money on brothels and pornographic videos allegedly provided by other refugees. Many also visit sex workers who live in the town near the camp.

Child spacing is another problem. According to UNHCR staff, people in the camp believe that children must be born as quickly as possible to replace those lives lost during the conflicts in their home countries. Surprisingly, adolescent childbearing is not seen as a problem. This is possibly because contraceptive injectables and pills are available through the clinics. Contraceptive user rates are, however, unknown. Sexual issues are not usually discussed, and girls are expected to remain virgins

"Young people are often unwilling or unable to pursue reproductive health services."

before marriage. If an unmarried girl becomes pregnant, her family quickly arranges a marriage either with the baby's father or with another man in order to save the family's honor.

Most of the young women from Ethiopia and Somalia are circumcised. Although they are aware of the dangers of female genital mutilation, they want to maintain their culture through this tradition. Leaders against this procedure are educating communities on the dangers of infibulation. But, rather than advocate for the total abolition of female genital mutilation, they promote the less dangerous Sunna method that involves the pricking or removal of parts of the clitoris.

Drug abuse—especially opium and alcohol—is another problem among the refugee youth. Camp elders believe that lack of discipline and idleness are to blame. This is the result of not having space for all the youth in secondary schools and not having jobs for the majority of school graduates.

PROVIDING REPRODUCTIVE HEALTH SERVICES

There are ways to provide reproductive health services specifically for adolescent refugees. They include peer education, school-based programs, social marketing campaigns, and health facility programs.

Peer Educators

Because young people typically receive most information about sexuality issues from their peers, it is logical that peer educators become involved in promoting reproductive health. Such educators are not health service providers but, rather, young people trained in counseling and in referring peers to reproductive health services.

Almost all existing refugee reproductive health programs can easily add a youth component to their activities by using peer educators. They will usually work one-on-one or in small groups. They can, however, make presentations to large groups. The Focus on Young Adults program of Pathfinder International outlines the benefits of peer reproductive health programs⁷:

- Peer groups naturally exchange information.
- Young people relate easily to those of similar age and background.
- Cultural similarities among peers ensure that the languages and messages conveyed are appropriate and effective.
- Peer groups have the ability to change social mores in support of long-term risk-reducing behaviors.
- Peer programs require the direct involvement of young people in their own programs.

- Peer educators can also serve to reach their own families and neighbors and those of their direct audience—young people of the community.
- Peer educators gain long-term benefits from their experiences, including an ongoing commitment to responsible reproductive health behaviors, leadership and communication skills, employment experience, and personal growth.

An added benefit of peer educators in refugee settings is that many of these young people have lost their parents and are relying almost exclusively upon their peers for support and information sharing. Those peer educators who have lost parents will also benefit from the adult role models who train and supervise them.

The Women's Commission for Refugee Women and Children⁸ recently funded the Tanzania Red Cross Society to institute a peer-based reproductive health project for adolescent refugees in the Kigoma region of Tanzania.⁹ This project uses peer educators who will provide one-on-one counseling in camp youth centers. The centers will also host a variety of non-reproductive health related activities so that the young people will not be scared away from a personal association with sexual health services. They will also provide outreach to young people in the refugee and local communities on reproductive health issues.

In Kenya's Kakuma refugee camp, 86 young people—including 20 girls—were trained as reproductive health peer educators to help sensitize young people in their communities about reproductive health issues through dramatic improvisations, visual aids, and other education and communication activities.

The U.N. Commission's staff observed that the male peer educators were assertive and outspoken in these settings while the girls were usually too shy to prove effective. The young men explained this as male superiority (with most young women agreeing). The young women were also hindered because they were expected to spend much of their time on household work (while most young men were not).

This is a possible obstacle to using peer educators in refugee camps because girls should be equal beneficiaries and participants in reproductive health interventions.

In Guinea, Options Sante Familiale (OSFAM) has recruited six youths—three Guineans and three refugees—to serve as peer educators for special events. These young people are paid to conduct condom demonstrations and to distribute condoms during organized special events.¹⁰ Eleven volunteer youth refugees known as ACT (AIDS Control Team) were also trained to provide outreach to peers on HIV/AIDS prevention.

School-Based Programs

Schools can reach large numbers of young people and their families with reproductive health messages. In fact, students are often an eager and captive audience for reproductive health education. Beneficial reproductive health practices are known to rise exponentially with one's level of education.

Non-formal educational settings are often quite effective in providing reproductive health information to young people. In Guinea's Gueckedou refugee camp, for example, a regional working group has integrated reproductive health education into the home economics program for 15- to 25-year-olds.¹¹ The Centers for Disease Control and Prevention (CDC) has instituted a similar school-based STD/HIV prevention campaign¹² in the United States that combines classroom and community activities.

There are, however, some drawbacks to using school-based reproductive health programs in refugee settings. The instability of some refugee settings can, for example, result in a very transient student body. This may prohibit students from receiving consistent and cohesive lessons in reproductive health that will have a lasting effect upon their attitudes and behavior. In addition, not all young refugees can attend school past the primary level. Of those that do, boys typically outnumber girls.

Schools may, however, provide the only place for some young refugees to receive information on reproductive health.

The International Rescue Committee's (IRC) Guinea program is, for example, running a formal school system for refugee children that includes a reproductive health education program. There are 12,500 students in grades five through 12, and most of them are assumed to be adolescents.¹³ Pre-kindergarten through sixth-grade students attend two hours of health classes per week. The fourth- through sixth-grade health curriculum includes sections on puberty, contraception, human reproduction, menstruation, STDs and HIV.¹⁴

Such integration of reproductive health information within the school curriculum increases the likelihood that students will take the subject seriously and retain the information long-term. The IRC has produced a manual series based on this project.¹⁵

Social Marketing Campaigns

Social marketing of reproductive health issues for adolescents means using commercial advertising techniques such as flyers, posters, radio broadcasts, and television commercials. Successful social marketing interventions have addressed such topics as breast-feeding, safe motherhood practices, STD/HIV transmission, and malaria.

Some obstacles in using social marketing as a reproductive health intervention for young refugees are lack of access

to technological media such as radio and television; illiteracy; the mobility of the refugee population making initial analysis of attitudes and follow-up difficult; and limited financial and material resources. Also, the reproductive health messages must be reinforced through interactive activities if they are to prove effective.

The Focus on Young Adults project has outlined the following key elements of effective social marketing to reach young people:

- Involve young people at all levels of the intervention.
- Address the behavioral issues of young adults themselves along with the environmental factors and social norms influencing their behavior.
- Involve key leaders and stakeholders at the outset.
- Pretest all messages.
- Ensure supportive networking and training activities throughout the life of the project.
- Include an evaluation component in the design of the project.¹⁶

In Kenya's Kakuma camp, a reproductive health social marketing campaign was conducted throughout the camp through the distribution of posters and other educational materials. In Thailand, service providers to Burmese refugees collaborated on a reproductive health poster campaign using cartoon illustrations to reach illiterate and non-Burmese speaking refugees. These posters are popular with the refugee communities and are found throughout the refugee camps on the Thai-Burma border.

Health Facility Programs

The needs of adolescents have traditionally been overlooked in the design of health clinics providing refugee reproductive health services. This is because many facilities presuppose their target audience to be adult married women. This leads to neglect of the reproductive health needs of girls, young unmarried women, and men and boys who are unlikely to have anywhere else to turn for these services.

Outreach can prove effective in helping established health clinics to begin to include these typically marginalized populations in their reproductive health services. For example, in Kenya's Kakuma refugee camp, 15 male reproductive health counselors were trained to educate and refer adolescents regarding available reproductive health services. And, in most of the refugee camps in Tanzania's Kigoma region, Health Information Team (HIT) workers doing outreach in the camps strengthen the services of the health clinics by informing youth of what is available to them.

The following story that was told to the author by

health workers illustrates how health facilities can make themselves available to the reproductive needs of adolescents. A 10-year-old Congolese refugee girl was raped by a 15-year-old boy when she was fetching water one evening. A week later she went to the camp clinic, run by the Tanzania Red Cross Society, complaining of abdominal pain. Through counseling and a physical examination, the clinic staff realized that she had been raped.

She was treated with antibiotics for a sexually transmitted infection and the clinic staff informed the police and her family of what had happened. The family wanted the girl to marry her rapist to avoid disgrace within the community, but she and the clinic staff were able to convince her family otherwise. The police said they were not able to intervene because there was no physical evidence remaining after the week that she remained silent about the rape. In the end, the boy was punished by a camp leader and ordered to materially compensate the young woman's family.

CONCLUSION

Although relief service providers to refugees are beginning to recognize the importance of reproductive health care, these services are not reaching the majority of refugee adolescents. This situation can and will improve by using adolescent reproductive health intervention techniques and by learning from the lessons of providers already working in this area.

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15. *How-To Guide—Reproductive Health Education for Adolescents*, International Rescue Committee, N'zeredore, Guinea, February 1998; T. A. James-Traore, *Counselor Training: A Manual for Counseling Adolescents with a Special Emphasis on Reproductive Health*, International Rescue Committee, March 1998; T. A. James-Traore, *Training of Trainers Manual—Counselor Training: A Manual of Counseling Adolescents with a Special Emphasis on Reproductive Health*, International Rescue Committee, March 1998; T. A. James-Traore, *Training of Trainers Manual—Counselor Training: A Manual for Counseling Adolescents with a Special Emphasis on Reproductive Health—APPENDIX: Reference Materials*, International Rescue Committee, March 1998.
16. *In Focus*, "Reproductive Health Programs for Young Adults: Social Marketing and Mass Media Approaches," Washington, DC, August 1998.

ABOUT THE WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN

The Women's Commission for Refugee Women and Children is an advocacy and public education organization that speaks out on behalf of refugee and displaced women and children around the world. It was founded in 1989 under the auspices of the International Rescue Committee.

The Women's Commission makes recommendations on how to improve assistance to refugee women and chil-

dren. It is currently working on three major projects: promoting participation and protection of refugee women; promoting protection and care of refugee children; and promoting access to reproductive health care. It is also involved in national and grassroots advocacy efforts.

For more information, call 212/551-3111 or E-mail <marta@intrescom.org>.

FACT SHEET

WORLDWIDE ANTIDISCRIMINATION LAWS AND POLICIES BASED ON SEXUAL ORIENTATION

This *Fact Sheet* reviews the antidiscrimination laws and policies based on sexual orientation of various countries and international organizations.

It was adapted with permission from a *Fact Sheet* of the International Gay and Lesbian Human Rights Commission (IGLHRC), 1360 Mission Street, San Francisco, CA 94103; Phone: 415/255-8680; Fax: 415/255-8662; E-mail: <iglhrc@iglhrc.org>; Web site: <www.iglhrc.org>.

That *Fact Sheet* was based on data from these sources: D. Sanders, "Getting Lesbian and Gay Issues on the International Human Rights Agenda," *Human Rights Quarterly* 18 (1996), pp. 67-106; "Promoting Lesbian and Gay Rights through International Human Rights Law" (New York: Center for Constitutional Rights); J. D. Willets, "International Human Rights Law and Sexual Orientation," *Hastings International and Comparative Law Review*, vol. 18, no. 1, pp. 1-120.

Also J. D. Willets, "Using International Law to Vindicate the Civil Rights of Gays and Lesbians in United States Courts," *Columbia Human Rights Law Review*, Fall 1995, vol. 27, no. 1, pp. 33-56; L. R. Helfer and A. M. Miller, "Sexual Orientation and Human Rights: Toward a United States and Transnational Jurisprudence," *Harvard Human Rights Journal*, Spring 1996, vol. 9, pp. 61-103; Communications with the Magnus Hirschfeld Center for Human Rights and other human rights organizations, and IGLHRC files.

This *Fact Sheet* was adapted by Amy Levine, M.A., SIECUS librarian, and Stephanie Campos Watson, SIECUS intern.

COUNTRIES

Fourteen countries have national laws that protect gays, lesbians, and bisexuals from discrimination:

- **Canada.** The Canadian Human Rights Act forbids discrimination based on sexual orientation by federally regulated employers, landlords, and services. The law applies to the federal government, banks, broadcasters, the phone and telecommunications industry, railways, airlines, and shipping and inter-provincial transportation. Federal constitutional protections are provided by the Canadian Charter of Rights and Freedoms. Provincial human rights laws provide protection based on sexual orientation in all Canadian provinces except Alberta, Newfoundland, and Prince Edward Island.
- **Denmark.** The Danish Penal Code has an antidiscrimination clause dealing with sexual orientation. It includes public employment and the private labor market.
- **Finland.** The Finnish Penal Code protects individuals from discrimination based on their sexual orientation in terms of public or commercial services or access to public meetings. The law also prohibits discrimination in hiring and working conditions.
- **France.** The French Penal Code prohibits discrimination based on "moeurs" (morals, habits, or lifestyles). This includes sexual orientation. The Code of Labor law prohibits discrimination based on sexual orientation in the workplace, including civil service and armed forces positions.
- **Iceland.** The Icelandic Penal Code criminalizes actions that defame, slander, humiliate, or degrade a person or a group because of their sexual orientation and makes it illegal to deny goods or services based on a person's sexual orientation.
- **Ireland.** The Irish Employment Discrimination Law protects against dismissal from employment based on sexual orientation. The Prohibition of Incitement to Hatred Act protects against hate in speeches.
- **Israel.** Israel's Knesset has passed a law prohibiting employers from discriminating against employees and job applicants because of sexual orientation.
- **The Netherlands.** The Dutch Penal Code bans discrimination on the basis of "hetero- or homosexual orientation." Article One of the Constitution also prohibits discrimination based on sexual orientation. The Equal Treatment Commission provides redress from discrimination in work-, education- and service-related situations.
- **New Zealand.** The New Zealand Human Rights Act includes protection based on sexual orientation in employment, education, access to public places, provision of goods and services, and housing and accommodation.

- **Norway.** The Norwegian Penal Code prohibits discrimination based on sexual orientation in the provision of goods and services and in access to public gatherings. It also prohibits hate speech directed at sexual minorities.
- **Slovenia.** The Slovenic Penal Code includes protection based on sexual orientation and denounces anyone who “denies someone his human rights or fundamental freedoms recognized by the international community or set by the Constitution or a law.”
- **South Africa.** The South African Constitution includes sexual orientation as a protected category.
- **Spain.** The Spanish Penal Code declares the right to express one’s sexual orientation as a fundamental freedom and bans discrimination based on sexual orientation in housing, employment, public services, and professional activities. It also criminalizes hatred and violent acts against individuals based on their sexual orientation.
- **Sweden.** The Swedish government has passed laws forbidding commercial organizations from discriminating on the grounds of homosexuality.

Many municipalities and states within nations extend legal protection to sexual minorities.

- **Australia.** The Australian Parliament is considering federal legislation to prohibit discrimination based sexual orientation. Such protections against employment discrimination are already part of the Australian Human Rights and Equality Commission Act. Several states—including New South Wales, South Australia, Northern Territory, and Capital Territory—have passed antidiscrimination legislation based on sexual orientation.
- **United States.** California, Connecticut, Hawaii, Massachusetts, Minnesota, New Jersey, Rhode Island, Vermont and Wisconsin have passed civil rights laws that include sexual orientation. The U. S. Supreme Court has ruled that an amendment to the Colorado State Constitution that would have banned antidiscrimination laws based on sexual orientation violated the equal protection clause of the U. S. Constitution and was, therefore, unlawful. This ruling is a landmark victory for equal rights and may provide an important precedent for future U.S. anti-discrimination cases.

INTERNATIONAL JURISPRUDENCE AND POLICY PRECEDENTS

These governmental organizations, international conferences, and non-governmental organizations working in the context of international and regional human rights protections have recognized the duty of governments to protect persons against discrimination based on sexual orientation.

United Nations

- **The United Nations Human Rights Commission** monitors steps taken by state parties to carry out their obligations to protect human rights as guaranteed by the International Covenant on Civil and Political Rights (ICCPR). It can hear and issue opinions on cases filed by individuals alleging violations of their rights.

United Nations Programmes

- **The International Labour Office** has conducted a survey examining issues of discrimination in employment based on sexual orientation and is recommending the inclusion of sexual orientation in a new protocol to extend application of its 1958 Convention.
- **The Development Program** has introduced a “Human Freedom Index” in its *Human Development Report*. This index ranks 88 countries by 40 indicators of democracy, including the personal right of consenting adults to have same-sex relationships.

United Nations

High Commissioner For Refugees

- **The High Commission for Refugees** states in its publication, *Protecting Refugees* that “homosexuals may be eligible for refugee status on the basis of persecution because of their membership of a particular social group. It is the policy of [the High Commission] that persons facing attack, inhumane treatment, or serious discrimination because of their [sexual orientation], and whose governments are unable or unwilling to protect them, should be recognized as refugees.”

United Nations Conference Resolutions

- **The Fourth World Conference on Women** has recognized in its *Platform for Action* that women and men must be able to decide freely on all matters relating to their sexuality, free from coercion, discrimination, or violence.
- **The Economic Council of Europe’s Regional Platform for Action** includes as one of its principles that the promotion, protection, and realization of the human rights of women must reflect diversity...including sexual orientation. It also directs governments to include lesbian organizations in developing and implementing strategies for the advancement of women.
- **The International Conference on Population and Development’s Plan of Action** acknowledges the necessity of recognizing the diversity of family structures.
- **The Habitat II Summit’s Global Plan of Action** reinforces

the anti-discrimination language of the Beijing Platform and other United Nations documents by including "other status" (encompassing sexual orientation) in clauses which guarantee protection from discrimination in housing and human settlements.

REGIONAL HUMAN RIGHTS BODIES

Council of Europe

- *The Council of Europe* encourages respect for human rights among member states through a treaty—the *European Convention for the Protection of Human Rights and Fundamental Freedoms*—and through resolutions of its Parliamentary Assembly.

Complaints of human rights violations under the European Convention are adjudicated by the European Court of Human Rights in Strasbourg. The European Convention establishes a right to privacy, and the European Court of Human Rights has ruled that state signatories to the European Convention cannot criminalize same-sex sexual relations because such laws violate the personal right to privacy.

European Union

Human rights issues are addressed in the European Union by its legislative body, the European Parliament, and by its judicial body, the European Court of Justice. These bodies act to secure human rights primarily in relation to economic issues such as protection from discrimination in the workplace.

The European Parliament has adopted a resolution that calls on member states to abolish all laws that criminalize

same-sex activity; equalize age of consent laws for all sexual activity; end unequal treatment of gays, lesbians, and bisexuals in social security systems, adoption laws, inheritance laws, and housing and criminal law; take measures to reduce violence against gays, lesbians, and bisexuals; prosecute those who commit such violence; initiate campaigns to combat social discrimination against gays, lesbians, and bisexuals; and provide funding to gay, lesbian, and bisexual social and cultural organizations.

NON-GOVERNMENTAL ORGANIZATIONS

The decisions and actions taken by these organizations exemplify the human rights advocacy efforts undertaken by many non-governmental organizations worldwide:

- *Amnesty International* has included in its definition of prisoners of conscience those individuals who have been incarcerated for their sexual orientation.
- *The International Human Rights Law Group* has worked to promote the applications of international human rights standards to persons facing violence or discrimination because of their sexual orientation.
- *The Human Rights Watch* has declared that it opposes "state-sponsored and state-tolerated violence, detention and prosecution of individuals because of their sexual identity, sexual orientation, or private sexual practices."
- *The International Planned Parenthood Federation* has approved a *Charter on Sexual and Reproductive Rights* which recognizes, among other rights, the rights of women to privacy, to equality, and to freedom from all forms of discrimination. This *Charter* includes protection based on sexual orientation in providing information, health care, and reproductive health services.

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:

"SIECUS: 35 Years of Leadership

April/May 1999 issue.

Deadline for final copy: January 2, 1999.

"Sexuality Education Across Cultures"

June/July 1999 issue.

Deadline for final copy: March 1, 1999.

"Sexuality Education in the United States

August/September 1999 issue.

Deadline for final copy: May 1, 1999.

"The Construction of Gender"

October/November 1999 issue

Deadline for final copy: July 1, 1999.

HIV/AIDS: IT CAN HAPPEN TO ME

American Association of Retired Persons
601 E Street, N.W.
Washington, DC 20049
28 minute video; \$20.

Almost two decades into the HIV/AIDS epidemic, there is a emergence of new materials that address HIV/AIDS infection in middle and later life. *It Can Happen to Me* is one of these current resources.

Emphasizing that at some point we will all be effected or affected by the HIV/AIDS epidemic, this video portrays the older faces of HIV/AIDS. Through brief, straightforward personal accounts of adults in middle and later life, the audience learns once again that HIV/AIDS does not discriminate.

The diverse individuals that share their stories have been effected or affected—they, their spouse, their children, or their grandchildren are infected—with the HIV virus. The stories behind the faces demonstrate that “It Can Happen to You.”

Mary, is one woman who shares her story. She states: “The person that sits there and says it’s not going to affect me, is the person that’s more at risk than anyone else.”

The overall goal of this video is to heighten awareness in an age group that is not always thought to be at risk. And many middle and older adults do not think they are at risk. One can only hope these personal narratives will make them aware of factors that would place them at risk—a blood transfusion before 1985, unprotected sexual activity, or intravenous drug use. The risk factors are mentioned in simple language, although never discussed in detail.

This video can be used as a tool to serve the general public as a catalyst for discussion in many settings. It would be more informative if followed by a workshop on HIV/AIDS transmission. In addition, it can be used to increase awareness of older adults with HIV/AIDS among health professionals.

Incorporated into this video are a few HIV/AIDS statistics and statements that

put the epidemic in perspective. One of the more powerful statements is: “The death toll attributable to AIDS among older Americans by 1998 will approach the number of Americans killed during the Vietnam War”—American Medical Association.

This reality demonstrates the need for an increase in HIV awareness, prevention, and early detection among the middle and older adult population.

Reviewed by Amy Levine, M.A., SIECUS librarian.

**WHAT I’VE LEARNED ABOUT SEX:
LEADING SEX EDUCATORS,
THERAPISTS, AND RESEARCHERS
SHARE THEIR SECRETS**

Debra W. Haffner, M.P.H.,
and Pepper Schwartz, Ph.D.
Perigree Books
The Berkeley Publishing Group
New York, NY
1998, 113 pages
\$10.95

The first time that I read this lovely and lively compilation of—as the sub-title suggests—“learnings,” I thought, “What fun this must have been to put together.” The next thought was, “How many copies should I buy and send to my friends?” Then, “I wonder which sexologist said that?” And, every now and again, “That is a particularly interesting observation. I wish that nugget of wisdom or point of view had been expanded upon.”

As you can see, this small gem of a book does indeed provoke thoughts—and how wonderful that is!

What I’ve Learned About Sex is a collection of close to a thousand observations dealing with many aspects of human sexuality. The authors, well known sexology professionals, canvassed over 40 leading sexuality educators, therapists, and researchers, and asked them to write—in just one or two sentences, and without individual attribution—what they had learned about sex and sexuality. These pithy statements are

grouped into 20 chapters, ranging from sections on men, women, love, attraction, bodies and dating, through observations on sexually explicit materials, marital and extramarital sex, sex after 40, pleasure, peak experiences, raising sexually healthy children, and so on.

The book’s wisdom is dispensed in a “user friendly” manner and seems designed to diminish defensiveness and encourage openness to considering new ideas. Since the top of each page repeats the sentence stem “I’ve learned that....,” the unmistakable message is that this is not necessarily dogma but rather just what one person has come to believe. It is offered up to the reader for consideration. Additionally, except for the five pages of resource organizations, hot lines, and Internet addresses, there are no footnotes, there is no glossary, there is no index, and vulgar and slang expressions are avoided.

Some of the “I’ve learned that....” statements are of a personal nature (“Verbal sounds of my partner’s pleasure add immeasurably to my excitement” or “I can enjoy sexual feelings about another person and not act upon them”) though most are more general (“One of the ways to kill a good sex life is to have a TV in the bedroom” and “Unless you want to break up your marriage, only have an affair with someone who has a much to lose as you do”).

By universalizing experiences, books permit readers to say: “If this is included in a book, I must not be the only one to experience it! Perhaps I’m not so weird.” That’s reassuring. That this areas is universally compelling (perhaps only excepting the terminally disaffected) is acknowledged in one “learning” from the very first chapter: “Sex is the most commonly searched topic on the Internet.”

What I’ve Learned About Sex provides not just an opportunity for personal learning and reflection—along with some smiles and chuckles—but also can be a useful resource for encouraging communication and understanding with a spouse/partner/lover.

Indeed, this is a particularly useful and low-threat book for couples. Among the couples whom I see in therapy, I would

certainly encourage one of the partners to highlight for the other a statement with which s/he agrees, differs, or questions, or which s/he wishes to discuss.

Designed for the mass market reader, this book contains a variety of thoughts with which sexologists are quite familiar, but which might be novel and provocative to a more general public.

Just think of the wonderful individual thoughts or partner conversations which the following quotes might spark:

- "Married couples should spend as much time thinking about what they are going to do in bed on the weekend as they do thinking about where they are going with their friends."
- "People in happy sexual relationships still masturbate."
- "It is possible to have really great sex with a partner without having intercourse."

While many of the papers delivered at professional sexological conferences are often quite esoteric, it is worth being reminded—as this book often does—that providing information, reassurance, and permission is an important educative task. And this book does it very well.

Reviewed by Dr. Robert Selverstone, a sexuality therapist and educator from Westport, CT.

**LESBIAN & GAY YOUTH:
CARE & COUNSELING**

Caitlin Ryan and Donna Futterman
Columbia University Press
New York, NY
1998, 175 pages
\$21.00

Lesbian & Gay Youth: Care & Counseling, a resource for adolescent health care providers, arose out of a Federal Conference on Primary Care Needs for Gay and Lesbian Adolescents held in Washington in December 1994. The

authors, Caitlin Ryan and Donna Futterman, a pediatrician and social worker both well known for their professional experience with gay and lesbian adolescents, have written a comprehensive "how to" guide for caregivers, educators, program developers, and families.

This book signals the arrival of a new phase in providers understanding an adolescent minority long ignored and answers the call for them to educate themselves about lesbian and gay youth.

Medical and mental health assessment, treatment, and prevention are presented concisely enough that providers will no doubt come to rely on this small volume as a source for both professional practice and education. Individual chapters on clinical care for HIV disease and on addressing the concerns of the families of lesbian and gay youth are especially timely and informative. Additionally, the text provides numerous quick reference tables of statistics, protocols, and intervention guidelines that are both detailed and accessible.

The first part of *Lesbian & Gay Youth: Care & Counseling* synthesizes what is currently understood about adolescent identity development. Emphasis is placed, as it is throughout the book, on the reality of stigma and its consequences. Internalized homophobia may result in serious deficits in self esteem and in acting out behaviors while, at the same time, gay youth are at considerable risk for being victims of violence or abuse.

The discussion of stigma attempts to resolve a paradox for health care providers: how to effectively assess and treat the needs of a minority without contributing to its marginalization. The authors make a good case that gay and lesbian youth are a special needs group. Early in *Lesbian & Gay Youth: Care and Counseling*, they argue that when isolated from the larger community, lesbian and gay adolescents appear to have more problems than heterosexual adolescents.

Stigma is subsequently identified as the key developmental variable which differ-

entiates these young people from their heterosexual peers. How, then, does the clinician best provide for a stigmatized minority? Sadly, one youth the authors quote refers to his contacts with mental health professionals: "When they find out you're lesbian or gay, they focus on your sexuality as the basis of all your problems." Indeed, clinicians themselves may be homophobic or simply share the common worries of parents aware of the vicissitudes of life as part of a minority.

Lesbian & Gay Youth: Care and Counseling's broader message is that all adolescents need better access to appropriate health care. Resources are still seriously deficient in most states, particularly in services for mental health. Since lesbian and gay youth are a significant part of an underserved minority, they will profit from the expansion of services for all adolescents.

Clinicians must have knowledge about this group's particular needs and some may choose to focus on lesbian, gay, and transgendered youth. Such emphasis may be understood as a phase in our professional understanding of sexual orientation and a fair response to decades of silence from the care giving community. As a result, questions about sexual behavior may be answered and special programs, once assailed as marginalizing, developed. Evidence may be gathered to what degree depression, substance abuse, and other problems associated with gay youth differ, if at all, from the same difficulties experienced by heterosexual teens.

Lesbian & Gay Youth: Care & Counseling is intelligent, well written, and instructive. It is also the work of advocates. *Lesbian & Gay Youth: Care & Counseling* sounds the alarm for health providers to learn more and get to work on behalf of a minority which continues to experience the painful effects of social isolation and stigma.

Reviewed by Grant Stitt, M.S.W., a psychotherapist at the Columbia Center for Gay, Lesbian, and Bisexual Mental Health.