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R E P O R T

GLOBAL PERSPECTIVES ON  
GENDER, SEXUAL HEALTH, AND HIV/AIDS

JUNE/JULY 2001

# SIECUS

## R E P O R T

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## GENDER INEQUALITY AND THE AIDS EPIDEMIC

Mac Edwards

This issue of the *SIECUS Report* on “Global Perspectives on Gender, Sexual Health, and HIV/AIDS” coincides with a just-concluded special session of the United Nations to find ways to solve or stem the worldwide AIDS epidemic.

As I was reviewing the many articles we received for this *SIECUS Report*, I was also daily reading reports of the United Nations meeting. None was more poignant than an editorial written by Prime Minister Pascoal Mocumbi of Mozambique.<sup>1</sup>

Mr. Mocumbi, who is the country’s former minister of health and who is also a physician and a Board member of the International Women’s Health Coalition, made the same point that many of our articles make. AIDS is spreading rapidly among heterosexuals because of gender inequality. “In Mozambique,” he said, “the overall rate of HIV infection among girls and young women—15 percent—is twice that of boys their age, not because the girls are promiscuous, but because nearly three out of five are married by age 18, 40 percent of them to much older, sexually experienced men who may expose their wives to HIV and sexually transmitted diseases.... Abstinence is not an option for these child brides. Those who try to negotiate condom use commonly face violence or rejection....”

“As a father, I fear for the lives of my own children and their teenage friends,” he continued. “Though they have secure families, education, and information and support the need to avoid risky sex, too few of their peers do. As prime minister, I am horrified that we stand to lose most of a generation, maybe two. The United Nations estimates that 37 percent the 16-year-olds in my country will die of AIDS before they are 30.”

He goes on to say that the only hope for stopping the AIDS pandemic is through changing men’s behavior by providing them with the sexuality information and education they need to protect themselves and their wives.

## THEME IS REPEATED

As I said, Prime Minister Mocumbi’s theme is often repeated in this *SIECUS Report*.

Articles include: “Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How” by Geeta Rao Gupta, president of the International Center for Research on Women; “Educating Men in South Africa on Gender Issues:

The ‘Men As Partners’ Program” by Andrew Levack, regional programs advisor for EngenderHealth; and “Make Women Central in World Strategy to Fight HIV/AIDS,” a Call to Action by Noeleen Heyzer, executive director of the United Nations Development Fund for Women.

Also “Global Partners Program Connects American and Ecuadorian Youth” by Rachel Russell, program officer of Planned Parenthood’s Global Partners; “Sexual Rights Are Human Rights,” an editorial by Elizabeth Khaxas, director of Sister Namibia in Windhoek, Namibia; and “In America: It Hasn’t Gone Away” by Bob Herbert of *The New York Times*.

And “Strategies for Improving Media Reporting of HIV/AIDS and Reproductive Health in Nigeria” by Akin Jimoh, program director at Development Communications in Lagos, Nigeria; “Risk of HIV Infection and Unwanted Pregnancy among Portuguese Young Adults” by Nuno Nodin, project coordinator of this program at the Associação para o Planeamento de Família in Lisbon, Portugal; and “Integrating Issues of Sexuality into Family Planning Counseling in Egypt” by Nahla Abdel-Tawab, a project coordinator at the Population Council in Cairo, Egypt.

We have also updated the SIECUS Fact Sheet on *Sexuality and Underserved Youth in Communities of Color* in this issue. It is particularly relevant considering that by the year 2050 over 56 percent of American adolescents will consist of Hispanic, African-American, American Indian, and Asian youth.

## CONCLUSION

I would like to close with a plea from Prime Minister Mocumbi about solving the HIV/AIDS epidemic. He said, “We must summon the courage to talk frankly and constructively about sexuality. We must recognize the pressures on our children to have sex that is neither safe nor loving. We must provide them with information, communications skills, and, yes, condoms. To change fundamentally how girls and boys learn to relate to each other and how men treat girls and women is slow, painstaking work. But surely our children’s lives are worth the effort.”

I think this issue of the *Siecus Report* provides some very useful information to help us accomplish this goal.

1. P. Mocumbi, “A Time for Frankness on AIDS and Africa,” *The New York Times*, June 20, 2001.

HELP FOR THE 36 MILLION PEOPLE WITH AIDS?

Tamara Kreinin, M.H.S.A.

**A**s this issue of the *SIECUS Report* goes to press, I am disturbed over the fact that 36 million people worldwide are living with HIV/AIDS today and that 21 million have died. Equally distressing is the fact that 95 percent of those currently infected have no access to treatment, largely because of customs and economic roadblocks.<sup>1</sup>

**CUSTOMS AND ECONOMICS**

It is heartening to know that the subject of HIV/AIDS is not being ignored. The United Nations has just concluded a special session on AIDS—the first ever devoted to a healthcare subject. The entire focus was to help stem the spread of AIDS.

The special session brought to light the prejudicial customs that are helping spread AIDS as well as the ever-present economic barriers.

The challenges faced by numerous countries were discussed.

Mauritania, where condoms are all but illegal.<sup>2</sup>

Kenya, where it is common practice to pass wives down from one infected brother to another.<sup>3</sup>

Nepal, where there is a lack of basic health clinics and where thousands have died from diarrhea.<sup>4</sup>

Islamic cultures that object to the mention of gays and prostitutes.<sup>5</sup>

The sexual trafficking of women and children in India.<sup>6</sup>

The risks of the elderly in Thailand where people over 50 are often not considered sexual.<sup>7</sup>

The rural poor in Africa and other continents who are impervious to traditional prevention methods.<sup>8</sup>

**“SEX TALK” CONSIDERATIONS**

In highlighting such barriers, we cannot leave out the United States. “One of the main problems with this disease and the U.S. government’s policies toward it, is that no one is willing to talk about sex,” said Ruth Messinger, the former Manhattan Borough president, who now heads the American Jewish World Service.<sup>9</sup>

And, of course, the United States is not alone. The challenges we face cross many borders. As Prime Minister Pascoal Mocumbi of Mozambique said in his editorial in *The New York Times* during the United Nations session, “We must summon the courage to talk frankly and constructively about sexuality.... We must recognize the pressures on our

children to have sex that is neither safe nor loving and provide them with information, communication skills and, yes, condoms.”<sup>10</sup>

**FOUNDATION FOR ACTION**

The United Nations Declaration of Commitment on HIV/AIDS is itself groundbreaking because it looks at AIDS as a medical issue as well as a political, economic, and human rights threat.

There is hope and evidence that the Declaration will provide a foundation for future action and that the special session will serve as a catalyst for combating the AIDS crisis.

Writer Tamara Straus recently noted in her article titled “The Pandemic and the Blue Lady” on the AlterNet web site. She said: “On June 26, the U.S. government announced it would drop its litigation against Brazil for planning to make generic anti-AIDS medicine.”

“Earlier in June, she said, “the Coca-Cola Company offered to use its enormous distribution network in Africa to carry information and medicine throughout the continent. Ford Motors, which is one of the largest private employers in South Africa, where one in five adults are infected, is providing anti-retrovirals to its employees and their immediate family for free, as is Daimler Chrysler.”<sup>11</sup>

Let us hope that this is just the beginning of much needed help for the 36 million people now suffering with AIDS.

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## IN AMERICA: IT HASN'T GONE AWAY

Bob Herbert

Syndicated Columnist, *The New York Times*  
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The scourge came upon us rather quietly. In the late spring of 1981, a new president, Ronald Reagan, was rounding up votes for his tax-cut package. Americans were fascinated by Prince Charles's fairy-tale courtship of Lady Diana Spencer, who was routinely referred to as the next queen of England. Al Pacino was starring in David Mamet's *American Buffalo* at the Circle in the Square. And an enormous ad campaign was touting a new movie from the creators of *Jaws* and *Star Wars*, an old-fashioned cliffhanger called *Raiders of the Ark*.

It was then, almost exactly 20 years ago, that the first hint of a serious problem was detected. On June 5, 1981, the Centers for Control and Prevention published an article in its *Morbidity and Mortality Weekly Report* that began as follows:

"In the period October 1980-May 1981, five young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at three different hospitals in Los Angeles, California. Two of the patients died."

A month later, on July 3, *The New York Times* ran an article by Lawrence K. Altman that said: "Doctors in New York and California have diagnosed among homosexual men 41 cases of a rare and often rapidly fatal form of cancer. Eight of the victims died less than 24 months after the diagnosis was made."

"The cause of the outbreak is unknown, and there is as yet no evidence of contagion. But the doctors who have made the diagnoses, mostly in the New York City and the San Francisco Bay Area, are alerting other physicians who treat large numbers of homosexual men to the problem in an effort to help identify more cases and to reduce the delay in offering chemotherapy treatment."

The cancer was Kaposi's sarcoma. AIDS was upon us, and the progression of the disease from that early mystifying period would be swift and horrible. But the reaction to the disease, both in the United States and elsewhere, was tragically slow.

Ronald Reagan's biographer, Lou Cannon, wrote: "Reagan's response to this epidemic was halting and ineffective. In the critical years of 1984 and 1985, according to his White House physician, Brigadier General John Hutton, Reagan thought of AIDS as though 'it was measles and it would go away.'"

By the end of 1988, nearly 90,000 Americans had been diagnosed with AIDS and nearly 50,000 had died. By the mid-90s, the peak of the epidemic in the United States, more than half a million Americans had been diagnosed with AIDS, and more than half of them had died.

Elsewhere the news has been worse. What is happening in Africa is beyond hideous, maybe even beyond comprehension. According to the World Health Organization, more than 25 million people in sub-Saharan Africa are infected with the human immunodeficiency, HIV, and AIDS. More than 12 million African children have been orphaned by AIDS. Nearly four million Africans were infected with HIV last year.

Worldwide, more than 36 million people are infected with the AIDS virus, and in some places much, much worse is yet to come.

Twenty years after the first scientific paper on the disease we now call AIDS, the world is still not ready to properly fight the epidemic that has already killed more than 23 million people and will soon surpass the lethal toll of the bubonic plague of the Middle Ages.

The countries that have been hit hardest by the disease do not, in many cases, have the money, the medical resources, or the sociopolitical infrastructure necessary to fight the disease. (In much of Africa it is still taboo to even talk about AIDS.) And there is no real plan among the wealthier nations to fight AIDS globally.

In the United States, where AIDS deaths have been reduced dramatically by the use of protease inhibitors and other drugs, a dangerous sense of complacency seems to have settled in. But there are 40,000 new cases of HIV infection each year, and no one knows, really, how long individuals taking the drugs can survive, or whether the virus will mutate or become resistant to the drugs.

Twenty years later the epidemic is still with us. There is no cure. There is no vaccine. And in a world as interconnected as ours has become, there is no cause for complacency.

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—Editor

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# GENDER, SEXUALITY, AND HIV/AIDS: THE WHAT, THE WHY, AND THE HOW

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The focus of this article, as the title suggests, is on the what, why, and how of gender, sexuality, and HIV/AIDS. It is limited to issues relating to the heterosexual transmission of HIV because that has been the focus of my work over the last decade. I recognize that heterosexual transmission is only one aspect of the epidemic, but it is by no means irrelevant, since the most recent statistics show that heterosexual transmission of HIV remains by far the most common mode of transmission globally.

We have known for at least a decade that gender and sexuality are significant factors in the sexual transmission of HIV, and we now know that they also influence treatment, care, and support. Both terms, nevertheless, continue to be misunderstood and inappropriately used.

Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other.

Gender is a culture-specific construct—there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women's and men's roles, access to productive resources, and decision-making authority.

Typically, men are seen as being responsible for the productive activities outside the home while women are expected to be responsible for reproductive and productive activities within the home. And we know from over 20 years of research on women's roles in development that women have less access to and control over productive resources than men—resources such as income, land, credit, and education.

While the extent of this difference varies considerably from one culture to the next, it almost always persists.<sup>1</sup>

Sexuality is distinct from gender yet intimately linked to it. It is the social construction of a biological drive. One's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behavior; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age,

economic status, ethnicity, and other factors, influence an individual's sexuality.<sup>2</sup>

At the Center at which I work, we talk about the components of sexuality as the *Ps* of sexuality—*practices, partners, pleasure/pressure/pain*, and *procreation*. The first two *Ps* refer to aspects of behavior—how one has sex and with whom—while the others refer to the underlying motives.

But we have learned through data gathered over many years that there is an additional *P* of sexuality that is the most important—*power*. The power underlying any sexual interaction, heterosexual or homosexual, determines how all the other *Ps* of sexuality are expressed and experienced. Power determines whose pleasure is given priority and when, how, and with whom sex takes place. Each component of sexuality

is closely related to the other but the balance of power in a sexual interaction determines its outcome.<sup>3</sup>

Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favors men translates into an unequal power balance in heterosexual

interactions, in which male pleasure supercedes female pleasure and men have greater control than women over when, where, and how sex takes place. An understanding of individual sexual behavior, male or female, thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power.

Research supported by the Center and conducted by researchers worldwide has identified the different ways in which the imbalance in power between women and men in gender relations curtails women's sexual autonomy and expands male sexual freedom, thereby increasing women's and men's risk and vulnerability to HIV.<sup>4</sup> Let me first briefly go through the factors associated with women's vulnerability to HIV.

## WOMEN'S HIV VULNERABILITY

First, in many societies there is a culture of silence surrounding sex that dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction and, even if informed, makes it difficult for them to be proactive in negotiating safer sex.<sup>5</sup>

**Power imbalance  
increases  
HIV risk.**



Second, the traditional norm of virginity for unmarried girls that exists in many societies paradoxically increases young women's risk of infection, because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Virginity also puts young girls at risk for rape and sexual coercion in high-prevalence countries because of the erroneous belief that sex with a virgin can cleanse a man of infection and because of the erotic imagery that surrounds the innocence and passivity associated with virginity.

In addition, in cultures where virginity is highly valued, research has shown that some young women practice alternative sexual behaviors, such as anal sex, in order to preserve their virginity, although these behaviors may place them at increased risk of HIV.<sup>6</sup>

Third, because of the strong norms of virginity and the culture of silence that surrounds sex, accessing treatment services for sexually transmitted diseases (STDs) can be highly stigmatizing for adolescent and adult women.<sup>7</sup>

Fourth, in many cultures, because motherhood, like virginity, is considered to be a feminine ideal, using barrier methods or nonpenetrative sex as safer sex options presents a significant dilemma for women.<sup>8</sup>

Fifth, women's economic dependency increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favors, less likely that they will succeed in negotiating protection, and less likely that they will leave a relationship that they perceive to be risky.<sup>9</sup>

And finally, the most disturbing form of male power, violence against women, contributes both directly and indirectly to women's vulnerability to HIV. In population-based studies conducted worldwide, anywhere from 10 to over 50 percent of women report physical assault by an intimate partner. And one-third to one-half of physically abused women also report sexual coercion.<sup>10</sup>

A review of literature on the relationship between violence, risky behavior, and reproductive health conducted by Heise and colleagues<sup>11</sup> shows that individuals who have been sexually abused are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs. This relationship is also apparent in the findings from a study conducted in India. In this study, men who had experienced extramarital sex were 6.2 times more likely to report wife abuse than those who had not. And men who reported STD symptoms were 2.4 times more likely to abuse their wives than those who did not.<sup>12</sup>

And from other research we also know that physical violence, the threat of violence, and the fear of abandonment act as significant barriers for women who have to negotiate the use of a condom, discuss fidelity with their partners, or leave relationships that they perceive to be risky.<sup>13</sup> Additionally, data from a study conducted in Tanzania by Maman, Mbwambo, and colleagues<sup>14</sup> suggest

that for some women the experience of violence could be a strong predictor of HIV. In that study, of the women who sought services at a voluntary HIV counseling and testing center in Dar-es-Salaam, those who were HIV positive were 2.6 times more likely to have experienced violence in an intimate relationship than those who were HIV negative.

## **MEN'S HIV VULNERABILITY**

Let us move on now to the way in which the unequal power balance in gender relations increases men's vulnerability to HIV infection, despite—or rather because of—their greater power.

First, prevailing norms of masculinity that expect men to be more knowledgeable and experienced about sex put men, particularly young men, at risk of infection because such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and coerce them into experimenting with sex in unsafe ways, and at a young age, to prove their manhood.<sup>15</sup>

Second, in many societies worldwide it is believed that variety in sexual partners is essential to men's nature as men, and that men will seek multiple partners for sexual release—a hydraulic model of male sexuality that seriously challenges the effectiveness of prevention messages that call for fidelity in partnerships or a reduction in the number of sexual partners.<sup>16</sup>

Third, notions of masculinity that emphasize sexual domination over women as a defining characteristic of malehood contribute to homophobia and the stigmatization of men who have sex with men. The stigma and fear that result force men who have sex with men to keep their sexual behavior secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female or male.<sup>17</sup>

Fourth, men in many societies are socialized to be self-reliant, not to show their emotions, and not to seek assistance in times of need or stress.<sup>18</sup> This expectation of invulnerability associated with being a man runs counter to the expectation that men should protect themselves from potential infection and encourages the denial of risk.

Overall, these manifestations of traditional notions of masculinity are strongly associated with a wide range of risk-taking behavior. For example, a national survey of adolescent males aged 15 to 19 in the United States found that young men who adhered to traditional views of manhood were more likely to report substance use, violence, delinquency, and unsafe sexual practices.<sup>19</sup>

## **POWER IMBALANCE AND HIV/AIDS**

In addition to increasing the vulnerability of women and men to HIV, the power imbalance that defines gender relations and sexual interactions also affects women's access to and use of services and treatments. For example, the Tanzanian study conducted by Maman, Mbwambo, and colleagues found that there were gender differences in the

decision-making that led to the use of HIV voluntary counseling and testing services.<sup>20</sup> While men made the decision to seek voluntary counseling and testing independent of others, women felt compelled to discuss testing with their partners before accessing the service, thereby creating a potential barrier to accessing services.

Women's social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma and discrimination associated with HIV infection. HIV-positive women bear a double burden: they are infected and they are women. In many societies,

being socially ostracized, marginalized, and even killed are very real potential consequences of exposing one's HIV status. Yet, HIV testing is a critical ingredient for receiving treatment or for accessing drugs to prevent the transmission of HIV from a woman to her child.

In a recent study conducted by researchers in Botswana and Zambia in collaboration with researchers from the Center, men and women expressed concern for women who test positive because they felt that men would be likely to abandon a HIV-positive partner. On the other hand, it was expected that women would initially get angry with a

## A GLOBAL LOOK AT HIV/AIDS

Since the first AIDS cases were reported in 1981, HIV/AIDS has resulted in approximately 22 million deaths worldwide.

### United States

Approximately 400,000 persons have died of AIDS, and approximately one million are infected with HIV in the United States. Deaths attributed to HIV/AIDS have declined substantially since the introduction of highly active antiretroviral therapies. However, recent reported increases in STDs among men who have sex with men and other indicators of increased risk-taking behavior may lead to an increase in HIV transmission.

### Asia

In *China*, HIV prevalence was as high as 82 percent among injection drug users and six percent in commercial sex workers during 1998-99. A sustained increase also occurred in all reported STDs among males and females between 1989 and 1999.

In *India*, the estimated HIV-infection rate among persons aged 15 to 49 years of age is 0.7 percent. As of mid-1998, an estimated 3.5 million persons were infected with HIV.

### Eastern Europe and Central Asia

In January 1999, approximately 10,000 HIV cases were reported in the *Russian Federation*. By December 2000, the cumulative total increased to 70,000. HIV infection among injection drug users were reported from 82 of the 89 regions in the Russian Federation.

The *Ukraine* was the country most affected in Eastern Europe and Central Asia, where newly reported infections increased from 47 cases per year during 1992-94 to approximately 15,000 cases in 1997. The Ukraine accounted for 90% of all AIDS cases reported in the region in 1998 and 1999.

### Latin America and The Caribbean

As of December 2000, an estimated 1.4 million adults and children in the region were infected with HIV/AIDS compared with 1.3 million in 1999. *Barbados, Belize, the Dominican Republic, Guyana, Haiti, and Suriname* have an HIV prevalence of approximately one percent. Overall, the Caribbean has an adult prevalence of 2.1 percent. It is the second most affected region in the world.

In *Brazil*, reported HIV-related deaths have declined from approximately 25 per 100,000 in 1995 to approximately 15 per 100,000 in 1999, mostly because of free access to antiretroviral therapies.

### Sub-Saharan Africa

*Uganda, Kenya, and Tanzania* were among the countries where the HIV epidemic was first recognized during the early 1980s. In 2000, an estimated 25.3 million persons in this region were infected with HIV, and the average national prevalence of HIV infection among persons 15 to 49 years of age was 8.8 percent.

To continue the fight against HIV/AIDS, the U.S. Centers for Disease Control has outlined a new strategy to reduce HIV infection. This plan includes intensifying efforts to help all infected persons learn their HIV status, and establishing new prevention programs to help HIV-infected persons develop and maintain safer behaviors, combined with improved linkages to treatment care, and expanding highly targeted prevention programs to reach all HIV-negative persons at great risk.

*For more information: "First Report of AIDS" and "The Global HIV and AIDS Epidemic 2001," Morbidity and Mortality Weekly Report, June 1, 2001, vol. 50, no. 21.*

HIV-positive partner but ultimately accept him.<sup>21</sup>

## OVERCOMING INEQUALITY

How is one to overcome these seemingly insurmountable barriers of gender and sexual inequality? How can we change the cultural norms that create these damaging, even fatal, gender disparities and roles? An important first step is to recognize, understand, and publicly discuss the ways in which the power imbalance in gender and sexuality fuels the epidemic.

There has been a definite shift in the international public and political rhetoric on HIV/AIDS over the last two years. The dominant discourse now reflects an increased acknowledgment of the role that gender plays in fueling the epidemic. Unfortunately, aside from a few exceptions, such public discourse on sex and sexuality is still invisible. There is an urgent need to break that silence because we know that talking openly about sex is the first step to reducing denial and bringing about acceptance of our collective vulnerability.

In contrast, public health discourse, as seen in scientific journals and forums, reflects definite progress in understanding the importance of both gender and sexuality. But because this increased understanding is fueled in large part by the need to interpret the dynamics of the AIDS epidemic, the analysis of gender and sexuality is situated firmly within a framework of disease. Sexuality as seen through the public health prism, therefore, is still a potential determinant of ill health and little else. As a result, safer sex is the mainstream theme within this discourse, while sexual health, pleasure, and rights remain on the margins.

It is also important to note that the progress in the public health discourse on gender and sexuality is not matched by progress in action. There is a substantial gap between the walk and the talk. This is partly because it is easier now to explain the why and the what with regard to gender, sexuality, and HIV/AIDS, but there is less known about the how—how to address these issues in a way that has an impact on the epidemic. It must be said, however, that the relatively scant information on the how is not due to a lack of innovation and trying. Although there are still no clear-cut answers and there is very little data to establish the impact of the efforts that have been tried, it is possible to look back and identify clear-cut categories of approaches—approaches that fall at different points on a continuum from damaging to empowering.

To effectively address the intersection between HIV/AIDS and gender and sexuality requires that interventions should at the very least not reinforce damaging gender and sexual stereotypes. Many of our past and, unfortunately, some of our current efforts, have fostered a predatory, violent, irresponsible image of male sexuality and portrayed women

as powerless victims or as repositories of infection. The poster in which a sex worker is portrayed as a skeleton, bringing the risk of death to potential clients, is an example of the latter. From experience we can suppose that it probably succeeded in doing little other than stigmatizing sex workers, thereby increasing their vulnerability to infection and violence.

There are many other examples of such damaging educational materials. A particularly common type is one that exploits a macho image of men to sell condoms. No amount of data on the increase in condom sales is going to convince me that such images are not damaging in the long run. Any gains achieved by such efforts in the short-term are unlikely to be sustainable because they erode the very foundation on which AIDS prevention is based—responsible, respectful, consensual, and mutually satisfying sex.

## APPROACHES THAT DO NO HARM

In comparison, gender-neutral programming is a step ahead on the continuum because such approaches at least do no harm. Examples include prevention education messages that are not targeted to any one sex, such as “be faithful” or “stick to one partner.” However, some treatment and care services make no distinction between the needs of women and men, not recognizing, for example, that female clients may need greater social support than men or that women might prefer female counselors and health care providers over male providers. While such gender-neutral programs are better than nothing, they often are less than effective because they fail to respond to the gender-specific needs of individuals.

## GENDER-SENSITIVE APPROACHES

In contrast, gender-sensitive programming that recognizes and responds to the differential needs and constraints of individuals based on their gender and sexuality is another step forward on the continuum of progress. The defining characteristic of such interventions is that they meet the different needs of women and men. Providing women with a female condom or a microbicide is an example of such programming. It recognizes that the male condom is a male-controlled technology, and it takes into account the imbalance in power in sexual interactions that makes it difficult for women to negotiate condom use, providing women with an alternate, woman-initiated technology.

Efforts to integrate STD treatment services with family planning services, to help women access such services without fear of social censure, are another example of such an approach. We know that pragmatic approaches to programming are useful and necessary because they respond to a felt need and often significantly improve women’s access to

*Gender plays  
role in fueling  
epidemic.*

protection, treatment, or care. But by themselves they do little to change the larger contextual issues that lie at the root of women's vulnerability to HIV. In other words, they are necessary, even essential, but not sufficient to fundamentally alter the balance of power in gender relations.

### TRANSFORMATIVE APPROACHES

Next on the continuum are approaches that seek to transform gender roles and create more gender-equitable relationships. The last few years have seen a burgeoning of such efforts. Two excellent examples of this type of intervention are the Men as Partners (MAP) project being conducted by the Planned Parenthood Association of South Africa in collaboration with AVSC International and the Stepping Stones program.

Both programs seek to foster constructive roles for men in sexual and reproductive health. The curricula for these programs use a wide range of activities—games, role plays, and group discussions—to facilitate an examination of gender and sexuality and its impact on male and female sexual health and relationships, as well as to reduce violence against women. What is novel about these programs is that they target men, particularly young men, and work with them and women to redefine gender norms and encourage healthy sexuality.

These are just two of an increasing number of innovative efforts working with men, women, and communities. There is an urgent need now to rigorously evaluate the impact of these and other creative curricula in the settings for which they were developed and to find ways to replicate their use on a larger scale.

There is also a need to find ways to intervene early to influence the socialization of young boys in order to foster gender equitable attitudes and behaviors. Recent research conducted by Barker in Brazil suggests that one way to do this is to study the many adolescent boys who do not conform to traditional expectations of masculinity. By studying these “positive deviants,” Barker was able to identify a number of factors associated with gender equitable attitudes among young adolescent males. These factors include: acknowledgement of the costs of traditional masculinities, access to adults who do not conform to traditional gender roles, family intervention or rejection of domestic violence, and a gender equitable male peer group.

These factors underscore the importance of male role models, within the peer group and the family, who behave in gender-equitable ways. More such creative research on masculinity and its determinants is necessary in order to identify the best approaches to promote gender-equitable male attitudes and behaviors.<sup>22</sup>

Other programs that seek to transform gender relations include efforts to work with couples as the unit of intervention, rather than with individual women or men. Couple counseling in HIV-testing clinics to help couples deal with

the results of their tests and in family planning programs that promote dual protection against both unwanted pregnancy and infection are recent examples of efforts that seek to reduce the negative impacts of the gender power imbalance by including both partners in the intervention.

Some programs, however, have reported difficulty finding and recruiting couples who are willing to participate, although many couples who do participate describe couple counseling as a positive experience. Research is needed to identify ways to overcome the barriers to couple counseling and to test the effectiveness of this method in creating more gender-equitable relationships and in reducing vulnerability and stigma.

### APPROACHES THAT EMPOWER

And finally, at the other end of the continuum—far away from programs that foster damaging gender stereotypes—are programs that seek to empower women or free women and men from the impact of destructive gender and sexual norms.

These are programs that empower women by improving their access to information, skills, services, and technologies but that also go further to encourage participation in decision-making and create a group identity that becomes a source of power—a group identity separate from that of the family, because for many women the family is often the social institution that enforces strict adherence to existing gender norms.

The Sonagachi sex worker project of West Bengal, India, is an excellent example of a project that sought to empower a community through participation and mobilization. What began as an HIV/AIDS peer education program was transformed into an empowering community organizing effort that put decision-making in the hands of the most disempowered—the sex workers.<sup>23</sup> How can we replicate Sonagachi in multiple sites worldwide? What are the ingredients that contributed to its success in mobilizing and organizing a disempowered community? Without the answers to these questions, Sonagachi will remain the exclusive exception rather than the rule.

In the ultimate analysis, reducing the imbalance in power between women and men requires policies that are designed to empower women. Policies that aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation, and protect women from violence are key to empowering women.

We now have two international blueprints—the Cairo Agenda and the Beijing Platform for Action—that delineate the specific policy actions that are essential for assuring women's empowerment. Since governments worldwide have committed to these blueprints, it would be useful for the HIV/AIDS community to join hands with the international women's community to hold governments accountable for their promises and ensure that the actions recommended in these documents are implemented.

Creating a supportive policy and legislative context for women is crucial for containing the spread of the HIV/AIDS epidemic and mitigating its impact.

### MOVING AHEAD

It is clear that the sensitive, transformative, and empowering approaches to gender and sexuality that I have just outlined are not mutually exclusive. They must occur simultaneously and efforts should be made to expand the portfolio of options within each category. In this, as in other AIDS programming, we need a multipronged approach. We must continue to address the differing needs and concerns of women and men, while we work on altering the status quo in gender relations, in minor and major ways.

As we look to the future, let us be alert to the potential impediments to our success. Let us ensure that new, promising HIV/AIDS biomedical technologies, such as vaccines, which have the potential for making a substantial dent in the epidemic, are not impeded by entrenched gender barriers. Let us acknowledge that no biomedical technology is ever gender-neutral. To ensure equal access for all, women and men, girls and boys, we must work hard now, well before these technologies are ready for use, to identify the potential gender-specific constraints to their use and find ways to overcome them.

And let us work together to fight against two commonly held beliefs that continue to stand in the way of our efforts. The first mistaken belief is that empowering women will disempower men. This is not true. Empowering women is not a zero-sum game. Power is not a finite concept. More power to one invariably, in the long-term,

means more power to all. Empowering women empowers households, communities, and entire nations.

The second is the fear that changing gender roles to equalize the gender power balance conflicts with the value of multiculturalism and diversity. In point of fact, what is being altered by changing gender roles is not a society's culture but its customs and practices, which are typically based on an interpretation of culture.

I believe that customs and practices that seek to subordinate women and trap men in damaging patterns of sexual behavior are based on a biased interpretation of culture that serves narrow interests. We know that the customs and practices associated with male and female roles and sexuality in many societies today are compromising the rights and freedoms of individuals and promoting a cycle of illness and death. This must stop.

There can be no more powerful reason for change; gender roles that disempower women and give men a false sense of power are killing our young and our women and men in their most productive years. This must change. That is the message that must be communicated—without any caveats, ifs, or buts.

*This article is based on the plenary address that Dr. Gupta made at the XIIIth International AIDS Conference in Durban, South Africa on July 12, 2000. It is reprinted with the author's permission.*

—Editor

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## SIECUS/INDIA PARTNERSHIP RESULTS IN PUBLICATION OF *COMMON GROUND SEXUALITY*

SIECUS' ongoing international partnership with TARSHI (Talking about Reproductive and Sexual Health Issues) in India has resulted in the publication of the booklet *Common Ground Sexuality* for sexuality educators and service providers in India.

The publication includes sections on sexuality education, health, and rights, as well as guiding principles for programs, educators, and service providers on addressing sexuality and sexual health in India.

The publication was developed to articulate common ground on sexuality and sexual health by integrating multiple perspectives from different fields. It is intended as an action tool to inform program formulation, implementation, and evaluation.

SIECUS will continue to work with TARSHI on related projects. For more information, contact Smita Pamar, SIECUS director of international programs, at 212/819-9770, extension 308 or e-mail her at [spamar@siecus.org](mailto:spamar@siecus.org)

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# EDUCATING MEN IN SOUTH AFRICA ON GENDER ISSUES

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In recent years, many reproductive health programs have focused on the importance of male involvement.

Such efforts are welcome because studies have shown that men who have information about reproductive health issues are more likely to support their partner's family planning decisions and use contraception themselves.<sup>1</sup>

While the benefits of sexuality education for men are well documented, many questions remain about how to provide men with such education. For example, what are the specific issues that need addressing? What educational methodologies are most effective? What male populations should the programs target?

EngenderHealth and the Planned Parenthood Association of South Africa (PPASA) are tackling these issues by implementing a national Men As Partners (MAP) Program in South Africa.

## GENDER INEQUITY

The health situation in South Africa demonstrates that there is a critical need for effective sexuality education for men. South Africa has one of the world's fastest-growing AIDS epidemics. It is estimated that as of the end of 1999, 4.2 million people in South Africa were infected with HIV.<sup>2</sup>

Gender-based violence also plagues South Africa. Research on domestic violence has found that up to a third of women have been beaten by an intimate partner.<sup>3</sup> According to South African Police Service statistics, there were 51,249 cases of rape reported to police nationally in 1999, giving South Africa the highest per capita rate of reported rape in the world. Rape Crisis Cape Town believes that the real figure is at least 20 times higher—the equivalent of one rape every 23 seconds.

A fundamental factor behind both AIDS and violence against women is gender inequity. For women, their subordinate status in society may contribute to the inability to negotiate condom use. Economic dependency may increase a woman's vulnerability to HIV by making it more likely she will exchange sex for money. Such dependency may also make it less likely that she will leave a violent relationship.

Men do not escape the negative impact of gender dynamics. Constructs of masculinity send a message that men

should be knowledgeable about sex, even if they have never had contact with any reliable sources of factual information.

Existing gender norms also emphasize that men must sexually dominate women and pursue multiple partners, which puts men at higher risk for HIV infection.

## MEN AS PARTNERS

Recognizing the importance of these issues, a Men As Partners Program was established in South Africa by PPASA with technical assistance from EngenderHealth. The program conducts educational workshops with male and mixed-sex audiences.

Central to any MAP workshop is the discussion of gender issues. This includes reflecting on participant values about gender, examining traditional gender roles, understanding the power dynamics that exist based on gender, assessing gender stereotypes, and sharing male and female perspectives on gender. All of the activities strive to increase men's awareness of the inequities that exist between men and women. They also allow an opportunity to share progressive views of gender relations in an environment that is safe and supportive.

Following the initial activities, the workshop participants receive information on HIV/AIDS prevention, healthy relationships, sexual rights, sexual violence, and domestic violence. These exercises constantly refer back to the subject of gender. For example, an activity about HIV transmission concludes by asking participants how certain messages that men receive about sex can put them at higher risk for HIV. Activities that discuss rape help participants understand that sexual assault is a result of men seeking power and control rather than sexual pleasure.

A common question that MAP facilitators ask during the discussion of any activity is "how does this issue affect men and women differently?"

## GROUP DYNAMICS

Ideally, such discussions on gender include both men and women. A healthy exchange on views about gender can allow men to hear women's viewpoints and perspectives,

*The oppression of women has been incorrectly identified as an aspect of culture.*

possibly for the first time. This approach, however, is sometimes quite challenging. PPASA educators have found that women are often uncomfortable in mixed settings and are reluctant to participate in discussions. Male participants also report that they are sometimes unable to express themselves openly due to the presence of women in the group.

The topic of gender-based violence may be particularly difficult to broach within a mixed-sex group. Observations of MAP workshops found that men were much less likely to acknowledge rape as a serious issue in workshops where both men and women were present.

Such observations point to a need for organizing MAP workshops for groups of men only. Yet broad generalizations do not apply. The PPASA Adolescent Reproductive Health Project has found that youth respond very enthusiastically to gender activities conducted with a mixed group of male and female participants. This may be explained, in part, by research showing that younger men are more likely than older men to challenge traditional roles of masculinity and sexual behavior.<sup>4</sup>

In the Western Cape Province, the MAP Program has teamed up with the PPASA Women's Wellness program. After both programs have completed their own workshops, the male and female participants come together to discuss gender relations with each other. Educators find that this approach brings about a more fruitful dialogue due to the benefits of the participants' opportunity to reflect on the issues first among their own gender.

### REACHING OLDER MEN

Reaching adolescent males has been a fairly easy task for the MAP Program. Finding ways to reach older men, many of whom are engaged in a variety of high-risk sexual behaviors, is much more difficult. PPASA has implemented various strategies to engage hard-to-reach men. Informal health talks are facilitated by MAP educators in a variety of settings, including taxi stands, bars, and truck stops. More formal workshops take place in workplace settings. In both cases, PPASA has found that its hardest challenge is securing the appropriate amount of time needed to explore gender issues in depth. MAP educators have found that they can easily provide basic information about condoms and AIDS to men. Longer discussions over a number of days and weeks are challenging. Because of that, PPASA has educated managers in workplace settings on the importance of the longer sessions. By bringing about a better understanding of the gender-based approach of the MAP program, PPASA has secured more time for sessions with employees.

### PANDORA'S BOX

Simply discussing issues of gender and violence with men may not prove helpful. In fact, it could have an unintended negative influence on participants. During a focus group discussion

for the MAP program, a group of men were asked to share their views on reproductive health and violence. After the hour-long session, a male participant thanked the facilitator for his work and said, "It is very helpful to talk about rape. Some men here have raped women. By talking about it, men won't feel bad about what they have done."

This painful comment stresses the need for MAP educators to take a strong stand against gender-based violence in workshops. The MAP educator's guide sets out a clear methodology for responding to remarks that condone the violation of women's rights. Standing up against a negative social norm within a group setting can be quite difficult and demands the skills of a well-trained educator.

In many parts of the world, large education programs are taken to scale by recruiting peer educators to provide information to others. While this strategy is worthwhile, it may not be appropriate to discuss such sensitive topics. In some provinces the MAP Program uses peer educators for basic information on condoms and AIDS. More complex issues of violence are left for highly skilled professional educators.

### SIGNS OF CHANGE

Some individuals believe that promoting concepts of gender equity is in direct conflict with African culture. The MAP Program believes that the oppression of women has been incorrectly identified as an aspect of culture, especially since other forms of discrimination such as racism, religious intolerance, and ageism are not regarded as cultural constructs.

Even if one regards such oppression as cultural, it should be noted that culture is dynamic: it can and does change over time. In South Africa, we are beginning to see signs of such change taking place. The following data is from an evaluation of attitudes among 58 men in a MAP workshop following their participation (as compared to men in a control group who did not participate in a workshop) in the Western Cape.<sup>5</sup>

71 percent of past MAP workshop participants believed that women should have the same rights as men, whereas only 25 percent of men in the control group felt this way.

82 percent of the participants thought that it was not normal for men to sometimes beat their wives, whereas only 38 percent of the control group felt that way.

96 percent of participants believed that children from abusive homes could become abusive parents, but only 19 percent of the control felt that this was true.

82 percent of the participants thought that sex workers could be raped, whereas only 33 percent of the control group thought so.



These findings point to the fact that, while much work remains to be done, changes in attitudes are visible. We must continue to help men plan a key role to help achieve more equitable gender relations. Both men and women will see the benefit of the work currently underway through the Men As Partners Program in South Africa.

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## BRAZILIAN GOVERNMENT'S MODEL CAMPAIGN FIGHTS HIV/AIDS WITH FREE DRUGS, CONDOMS

Brazil has developed a model and aggressive campaign against AIDS that involves government officials, religious organizations, and activists helping HIV-negative citizens protect themselves from the virus and providing HIV-positive citizens with drug combination therapies at no charge.

"The 'broad coalition of activists' reflects an openness about the realities of life that most countries lack," said Fernando Zacarias, AIDS coordinator for the Pan American Health Organization and a member of the National AIDS Commission.

Among the work currently underway in Brazil:

- Free government distribution of triple-drug HIV-combination therapies that cost over \$1,000 a month in the developed world. The program currently serves over 90,000 Brazilians through a government-run pharmaceutical laboratory on the outskirts of Rio de Janeiro. Public health officials indicate that the anti-AIDS cocktail has relieved the strain on the public health system by cutting AIDS hospitalization rates by up to 80 percent. Dr. Beatriz Grinschtein, a public health expert, says she hopes "we Brazilians are able to help people around the world see that there's a way out of this that doesn't require being rich."<sup>1</sup>
- Pending legislation will require that all pornographic films in Brazil carry a five-second opening message advising the practice of safer sex by using condoms during sexual intercourse. Celio de Mello, chief adviser to bill sponsor Deputy Fernando Goncalves, explained that "our objective is to alert people to the importance of using the condom. We want people to be well-informed."<sup>2</sup>
- The National Business Council to Prevent HIV/AIDS—which includes companies such as the Brazilian division of Volkswagen and the national airline Varig—recently funded

an effort by the Brazilian government to distribute 800,000 free condoms on Brazil's Lovers' Day (the equivalent of American's Valentine's Day) to heterosexuals, who account for 43.5 percent of the country's new HIV infections. Paulo Teixeira, head of the government's anti-AIDS efforts, said the Brazilian Health Ministry currently gives away 200 million condoms a year and plans to triple condom usage from its current level of 600 million condoms per year.<sup>3</sup>

The AIDS mortality rate in Brazil has fallen from 73.7 percent of HIV-positive people in 1990 to 24.8 percent in 1999. Only 0.6 percent of the adult population is currently infected with HIV.<sup>4</sup>

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# MAKE WOMEN CENTRAL IN WORLD STRATEGY TO FIGHT HIV/AIDS

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**T**he United Nations Development Fund for Women (UNIFEM) has just released a five-point Call for Action to make women central to every strategy in the fight against HIV/AIDS.

“There is a direct correlation between women’s low status, the violation of their human rights, and HIV transmission,” said Noeleen Heyzer, executive director of the Fund, in announcing the Call for Action. “This is not simply a matter of social justice. Gender inequality is fatal.”

“The reason that AIDS has escalated into a pandemic is because inequality between women and men continues to be pervasive and persistent,” she continued. “Too often, women and girls cannot say no to unwanted and unprotected sex without fear of reprisal.”

She pointed out that last year 1.3 million women died of AIDS, that nearly half of all new HIV infections occur in women, that teenage girls in Sub-Saharan Africa are five times more likely to be infected than boys, and that surveys in 17 countries found that over half of girls could not name a method of protection against HIV transmission.

“It is time for the AIDS community to join hands with the international women’s community to hold governments accountable,” she said as she laid out strategies in the Call for Action to challenge the pandemic.

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## CALL FOR ACTION

### 1. Guarantee Access to HIV/AIDS Prevention and Treatment

Make female and male condoms affordable and accessible to all. Ensure that National AIDS Councils and National AIDS Strategies incorporate gender balance and gender equality in all policies and strategies. Set up women-friendly centers for voluntary and confidential counseling and testing and referrals. Include detection and treatment of the disease in primary health care.

### 2. Make Research Gender Sensitive

Disaggregate all HIV/AIDS-related data by gender. Accelerate research to develop women-controlled prevention methods like microbicides and affordable female condoms.

### 3. Educate and Inform

Disseminate HIV/AIDS and STD information to reach girls and women. Educate adolescents and young people about sexual and reproductive health. Involve women and girls in the design of policies and education campaigns. This should include training materials that enable women to negotiate safer sex and avoid unwanted and unprotected sexual intercourse.

### 4. Address Gender Inequality in Policy

Recognize and account for women’s role in caring for the infected and supporting families left destitute by the epidemic. Enact and enforce laws to criminalize violence against women. Enforce the Cairo agenda, the Beijing Platform for Action, and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). Work to change the social norms and traditional practices that place women at risk, such as early marriage and female genital mutilation. Allocate funds for gender-specific programming to address the pandemic.

### 5. Address HIV Transmission in Conflict Situations

Ensure gender-sensitive HIV/AIDS awareness and prevention, care, and treatment programs in humanitarian assistance. Strictly enforce the Code of Conduct for peacekeeping personnel to uphold women’s rights and report on sexual violence in peace-keeping and peace-building.

UNIFEM has worked to mainstream gender within the United Nations system and to promote gender equality, women’s development, and human rights in developing countries. UNAIDS has signed a cooperation agreement with UNIFEM to help strengthen the gender perspective in the United Nations’ response to the pandemic.

*For more information, visit the UNIFEM Web page on HIV/AIDS at [www.unifem.undp.org/hiv\\_aids.html](http://www.unifem.undp.org/hiv_aids.html)*

# AMERICAN AND ECUADORIAN YOUTH CONNECT

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*“Everything connects, the worlds revolve, and finally it becomes clear to us that international family planning is crucial to harmony. It’s crucial to Bombo’s [our Amazon guide’s] family survival, it’s crucial to the survival of every bird that flew by, it’s crucial to me. Coming here I had no concept of the importance of this campaign. Today it is everything I believe in. I’ll never be the same, nor will anything I touch. This is my life’s work.”*

—Emily Calhoun, age 18, Teen Council Member

## YOUTH ARE THE KEY

Over the last decade, there has been an increased recognition of the reproductive and sexual lives of young people. At the most recent United Nations conferences on population and development (International Conference on Population and Development and the subsequent five-year review), an unprecedented focus was placed on an international commitment to acknowledging and respecting young people’s sexual and reproductive rights. Demographically, this generation of young people is the largest single generation in history (over three billion under the age of 25) and they are entering their reproductive years.

The result is an increased focus on young people and their pivotal role in shaping sexual and reproductive health care access, programs, and policy. Young people are major stakeholders in the future of reproductive health policy as they enter their reproductive years and seek out the services that they need. The field of sexual and reproductive health will need to take into consideration the specialized needs that young people may have, such as evening hours, peer counselors, teen-only clinics, and youth-friendly reproductive health care delivery. These changes are critical in order to adequately meet the needs of young people and to ensure they have access to the health care and information they need to make informed choices about their sexuality and reproductive lives.

Undeniably, the most effective way to develop programs and design policies to meet the needs of any target group is to directly involve the members of that group in the process. This has been proven true with women, ethnic populations, international communities, lesbian, gay, bisexual and transgender individuals, and many others—and it remains true for young people. Unfortunately, the previously identified trend toward focusing on young people has been primarily ‘about’ and ‘for’ young people, and less ‘by’ young people.

In our efforts to serve young people and ensure that

sexual and reproductive rights are not disqualified, diminished, or otherwise limited based on an individual’s age, Planned Parenthood Federation of America (PPFA) is committed to directly involving young people in the design, development, and implementation of programs and policies that directly affect their lives. Equally important are the young people’s activism, commitment, and involvement, which will safeguard the right of all individuals to safe, accessible, and affordable services, now and in the future.

## GLOBAL MOVEMENT

In 1998, PPFA launched Global Partners to raise awareness and leverage U.S. support for international family planning and a global movement for sexual and reproductive health and rights. The strategy of the program is to link Planned Parenthood affiliates in the United States with family planning organizations in other countries so that service providers and local advocates can experience a world of reproductive health and rights beyond their doorstep. The partnership enhances community programs on both ends and leads to a greater understanding of the impact that U.S. policy has on similar family planning programs overseas.

In response to the need for a youth-focused development strategy, the Global Partners program designed and implemented a unique type of partnership called a youth partnership. Youth partnerships are formed to engage young people as full partners in the development of programs that serve their peers and train future leaders. Global Partners’ youth partnerships enable young leaders to make the connection between their community and the world, family planning, the environment and population, education and advocacy, and the impact of every individual’s voice in creating positive change.

This generation of young people is part of a globalized generation that is even more likely than their parents to understand that sexual and reproductive rights have no borders, and that the United States must play a positive role in ensuring that those rights are respected both here and abroad. We believe that the future of the sexual and reproductive rights movement relies on these young people making that connection...and more importantly, making the commitment.

## PIONEER PARTNERSHIP

One year ago, Global Partners awarded the first three youth partnerships, in addition to 18 core<sup>1</sup> partnerships already in

progress. This article follows one of them as a case study: the youth partnership between Planned Parenthood of Western Washington (PPWW) and Centro Obstetrico Familiar (COF), a family planning organization based in Quito, Ecuador.

This partnership was based on peer education models incorporating satellite “Teen Councils” or “Promotora” programs. Delegations from each organization travel to their partner country for 10 days to two weeks, during which time they experience hands-on learning related to their respective programs and cultures. Youth partnership delegations must include at least two youth program participants under 25 and at least one senior staff person.

### LEARNING EXPERIENCE

*“This work, sexuality education, is exactly the sort of thing that makes people comfortable with each other, because it implies certain things about a person. They are open and willing to talk about...ssshh...sex, of all things, just like my friends, and so I wasn’t really afraid of saying the wrong things.*

*Their program [the Ecuadorian family planning association, COF] is a little bit different than ours in that they are older, of course, but also they distribute contraceptives to students and kids in neighborhoods. They do a lot more in the community than Teen Council does, for we only do presentations in classes. But fundamentally the programs are so similar.”*

—Annika Shore, age 17, Teen Council Member

In February 2001, five teens, three sexuality educators, a Board member, and the CEO of PPWW headed to Ecuador for the first partnership exchange. After months of international communication and planning, the delegation arrived in Quito and began their 15-day journey into the world of cross-cultural learning and global activism.

During the exchange trip, the PPWW delegation joined Ecuadorian peer educators in their respective communities, which ranged from urban to rural, mountainous to coastal, as they educated their peers, answered questions and encouraged them to visit the local COF family planning clinic. The unique peer education program in Ecuador diverges from PPWW Teen Council because they can distribute condoms and birth control pills directly to their peers.

In contrast, the peer educators from Washington are invited to give presentations, or “do gigs” in local schools. School-based peer outreach and education is an extremely effective venue to reach teens with a safer sex message, but peer educators are strictly confined to the rules of the local School Board—most notably, no handing out condoms, no mention of sexual orientation unless in response to a question, and absolutely no mention of abortion.

The opportunity to see the community-based education strategy being implemented by the COF peer educators broadened and challenged the PPWW teens’

understanding of peer education. The PPWW delegates took advantage of the presence of their affiliate decision-maker and immediately began brainstorming and lobbying for the ability to distribute condoms, possibly in an out-of-school setting. Working with their Ecuadorian peers not only gave the PPWW teens experience that informed their project development but also empowered them to become agents of change within their program and their communities.

### TRANSFORMING EXPERIENCE

*“Talking with the official [an American representative of the U.S. Agency for International Development] revealed an Ecuadorian belief that pregnancy prevention by education and contraception use is the sole goal of family planning advocacy. This implies that abortions should never be offered because they should never be needed. Our view on this subject is that while their belief is ideally true, it disregards the thousands of women who annually die from unsafe abortions, and is ultimately a detriment to women in this country.*

*This meeting made us realize how fragile the funding for our very important program is, and reinforced the need for strong advocacy. I think all of us were made aware that our partnership is creating new opportunities to improve international family planning, if only in small ways.”*

—Lindy Blodgett, age 18, Teen Council Member

As part of their exchange, all partnership delegations are encouraged to meet with U.S. representatives in the international partner country. The U.S. Embassy, U.S. Agency for International Development (USAID), and country representatives from the cooperating agencies serve as “ground-zero” for the implementation of U.S. international family planning assistance.

The PPWW delegation met with the USAID representative in Ecuador. Though received with genuine congeniality and appreciation for the work that the teens were doing, the USAID representative unveiled an approach to family planning that did not satisfy what the teens felt defined comprehensive reproductive health care and education. Though the teens from Washington were able to initiate a discussion with the USAID representative, they were still shocked that the United States seemed to ignore what they felt were the real needs of young people in Ecuador, and around the world.

In the week before this meeting, the teens participated in the first Ecuadorian National Youth Assembly for Sexual and Reproductive Rights. The Youth Assembly called for “respect for sexual orientation,” more programs to prevent teen pregnancy and policies allowing teen parents to stay in school, and greater attention to the fatal risk being taken by women and girls who seek unsafe abortions. With this in mind, the PPWW delegation realized that their greatest contribution to their own goals, as well as those of their

Ecuadorian peers, would be to educate and lobby their own government on behalf of global reproductive rights. The delegation took advantage of the opportunity to pose questions to the U.S. representative on issues including safe abortion, access to contraception, sexuality education, and the effects of a global gag rule: a U.S. policy that restricts foreign NGOs from using their own, non-U.S. funds to lobby, counsel, educate and refer patients on abortions. The meeting served as their first real encounter with government and national policy and they left with a feeling of empowerment and a commitment to their role as agents of change.

## CONCLUSION

With information about the global gag rule, the experience of working with their Ecuadorian colleagues, and the knowledge

of how young advocates in Ecuador are speaking out in support of their reproductive health rights and needs, the PPWW peer educators made an important transformation from peer educators to global activists and informed advocates.

Ultimately, the direct involvement of young people in Planned Parenthood Global Partners has had a beneficial impact on peer education programs in Washington State, has armed the reproductive health movement with an informed network of young activists, and has imparted a global vision to local teens.

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1. Core Partnership: A global partnership without the distinct focus on youth involvement. The delegation members are staff and the topics of the exchanges range from fundraising to sexuality education curricula.

## CURRENT GLOBAL PARTNERS PROGRAMS

### Africa

- Planned Parenthood Golden Gate (San Francisco) and the Ethiopian Evangelical Church McKane Yesus (Ethiopia)
- Planned Parenthood of Northern New England (Williston, Vermont) and the Association of Uganda Women Medical Doctors (Uganda)
- Planned Parenthood of Omaha-Council Bluffs and Foundation for Youth Development (Cameroon)
- Planned Parenthood of New York City/Margaret Sanger Center International and the Family Life Movement of Zambia

### Asia

- Planned Parenthood of Stark County (Canton, Ohio) and SAHAS Project (India)
- Planned Parenthood of Los Angeles and the Provincial Committees on Population and Family Planning of Haiphong and Danang (Vietnam)
- Planned Parenthood of San Diego and Riverside Counties and the Women's Health Care Foundation and ReachOut Foundation International (Philippines)

### Europe and Eurasia

- Planned Parenthood Association of Utah (Salt Lake City) and KIDOG (Turkey)
- Planned Parenthood/Chicago Area and the Irish Family Planning Association
- Planned Parenthood of Greater Iowa (Des Moines) and Samara Oblast Health Division (Russia)
- Planned Parenthood of Idaho (Boise) and the Family Planning Association of Latvia\*
- Planned Parenthood of Northeast Florida (Jacksonville) and the Murmansk Regional and City Health Administrations (Russia)

### Latin America and the Caribbean

- Planned Parenthood of Delaware and Otsego Counties (Oneonta, NY) and K'inál Antzetik (Women's Land) and Jolom Mayaetik (Women Who Weave) (Mexico) Planned Parenthood of Arkansas and Eastern Oklahoma (Tulsa) and the Barbados Family Planning Association\*
- Planned Parenthood of Columbia/Willamette (Portland) and the Asociación Demografica Costarricense (Costa Rica)
- Planned Parenthood of Delaware (Wilmington) and PLANFAMI (Peru)

- Planned Parenthood of Delaware and Otsego Counties (Oneonta, NY) and K'inál Antzetik (Women's Land) and Jolom Mayaetik (Women Who Weave) (Mexico)
- Planned Parenthood of Houston and Southeast Texas and Mexfam Tampico, (Mexico)
- Planned Parenthood of Minnesota/South Dakota (St. Paul) and PRO-FAMILIA (Colombia)
- Planned Parenthood of Nassau County, (Hempstead, NY) and FAM-PLAN (Jamaica)
- Planned Parenthood of the Palm Beach and Treasure Coast Area (West Palm Beach) and Asociación Pro-Bienestar de la Familia (Guatemala)
- Planned Parenthood of Southern Arizona (Tucson) and Asociación Demografica Salvadoreña (El Salvador)
- Planned Parenthood Southeastern Pennsylvania (Philadelphia) and SI Mujer (Nicaragua)
- Planned Parenthood of Southwest and Central Florida (Sarasota) and Centro para los Adolescentes de San Miguel de Allende (Mexico)\*
- Planned Parenthood of Western Washington (Olympia) and Centro Obstetrico Familiar (Ecuador)\*
- Planned Parenthood of Houston and Southeast Texas and Mexfam Tampico, (Mexico)
- Planned Parenthood of Minnesota/South Dakota (St. Paul) and PRO-FAMILIA (Colombia)
- Planned Parenthood of Nassau County, (Hempstead, NY) and FAM-PLAN (Jamaica)
- Planned Parenthood of the Palm Beach and Treasure Coast Area (West Palm Beach) and Asociación Pro-Bienestar de la Familia (Guatemala)
- Planned Parenthood of Southern Arizona (Tucson) and Asociación Demografica Salvadoreña (El Salvador)
- Planned Parenthood Southeastern Pennsylvania (Philadelphia) and SI Mujer (Nicaragua)
- Planned Parenthood of Southwest and Central Florida (Sarasota) and Centro para los Adolescentes de San Miguel de Allende (Mexico)\*
- Planned Parenthood of Western Washington (Olympia) and Centro Obstetrico Familiar (Ecuador)\*

*Denotes Youth Partnerships, which are developed and implemented by youth of the partner organizations.*

SEXUAL RIGHTS ARE HUMAN RIGHTS

Elizabeth Khaxas

Director, Sister Namibia

Windhoek, Namibia

Today I am speaking as an African, feminist, lesbian activist. I want to start by saying that sexuality and sexual orientation are used in Namibia to divide the women's movement and civil society.

Using sexuality or sexual orientation as a means of attacking and silencing women is not new. It has been used the world over and is called *sexuality baiting* or *lesbian baiting*. This is the practice of strategically using prejudices about women's sexuality to intimidate, humiliate, embarrass, or stifle women's public political expression.

Lesbian baiting is used to discourage women from organizing around issues of sexuality—both issues that are accepted and those that are marginalized. The baiting is also used in Namibia to discourage women's autonomy and independence in other areas, such as preventing us from uniting around Namibia's Women's Manifesto, which urges Namibian voters to consider issues important to women and children when selecting a candidate or party for election.

We have to articulate why this should matter to everyone in the women's movement and in civil society and why this is not just an issue for gay and lesbian people.

The foundation for advocates of women's human rights is that such rights for women and for all people are universal, indivisible, and interdependent. Essential to all freedoms that human beings enjoy is the right to bodily integrity: a freedom to inhabit and to control one's body, to claim and experience it immune to the instructions of the state, religion, or other institutions.

Each human being, thus, has a right to experience her sexuality freely, fully, and consensually—within herself and with other adults. Sexuality is not seen as a static identity but as a realm of experience, potentially encompassing sexual orientation, gender identity, and sexual identity, desire, pleasure, and sexual practices. There is strong agreement among women's human rights activists that gender equality cannot be achieved without sexual rights and vice versa.

WHAT SEXUAL RIGHTS?

When we talk about sexual rights, what are we talking about? We mean:

- the right to happiness, dreams, and fantasies

- the right to explore one's sexuality free from fear, shame, guilt, false beliefs, and other impediments to the free expression of one's desires
- the right to live one's sexuality free from violence, discrimination, and coercion—within a framework of relationships based on equality, respect, and justice
- the right to choose one's sexual partners without discrimination
- the right to full respect for the integrity of the body
- the right to have sexual relations that are consensual and the right to enter into marriage with the full and free consent of both partners
- the right to be free and autonomous in expressing one's sexual orientation
- the right to express sexuality independent of reproduction
- the right to sexual health, which requires access to the full range of information and education on sexuality and sexual health, and the right to confidential health services of the highest possible quality
- the right to insist on and practice safer sex for the prevention of unwanted pregnancy and STDs, including HIV/AIDS

These are rights that we want for all people, including lesbian, gay, bisexual, and transgender people in Namibia. They may seem novel but their conceptual foundations are not. They grow out of the understood and shared framework of the *Universal Declaration of Human Rights* and are, thus, universal and indivisible. Sexual rights are grounded in the physical lives that are the condition of our being human.

Understanding and addressing the human rights of women, therefore, has involved saying that women have a legitimate interest in their own bodies—prior to and superior to the interest that the state, religion, or family may take in those bodies. Such claims evoke outrage and anger because to inhabit one's body securely is also to claim the right to enjoy it and to derive pleasure and desire from it, free of male control.

Women's rights and sexual rights are human rights.

## THE ETHIC OF DIVERSITY

Finally, I want to introduce a new concept to you. I call it the *ethic of diversity*. Because people come from so many diverse backgrounds, it is important that we develop an *ethic of diversity*. We need to meet. We need to ask each other questions. We need to discover what we have in common while respecting our differences. We need to put effort into meeting each other halfway and into learning from each other. The *ethic of diversity* is different from religious or political values because it does not claim one truth. Rather, it aims to deal with differences, to respect, and to accept.

The daily practice of this ethic means that we must build networks and organizations that are inclusive: that have space for all the different people that we are. This will enable us to build a culture of respect. Such a culture will allow us to find new solutions to old problems—new solutions based on agreement and peace and not in excluding and eliminating people whose way of life we do not approve.

Returning to the issue of sexual orientation, here are some strategies individuals can apply in their work. If they

are teachers, they should talk about sexual diversity and different lifestyles. If they are health workers, they should not assume that everyone is heterosexual or that everyone's needs are the same as heterosexuals. If they are working on human rights, they should work on issues relating to women, lesbian, and gay rights. If they work for the media, they should include realistic reports about the lives of gay, lesbian, bisexual, and transgender people. If they are lesbians, they should come out and speak out.

We need many voices to strengthen our claim for the recognition and protection of our human rights. They must all ensure that the sexual rights of all people are respected as an essential human rights issue.

*This speech, which the author delivered at the Rally for Democracy and Human Rights on April 28 in Windhoek, Namibia, provides SIECUS Report readers with a global perspective on the discussions in the April/May SIECUS Report on lesbian, gay, bisexual, and transgender issues. We thank her for submitting this speech for inclusion in this international issue.* — Editor

## PLANNED PARENTHOOD OF NEW YORK CITY PARTNERS WITH FAMILY LIFE MOVEMENT OF ZAMBIA

Planned Parenthood of New York City (PPNYC) has formed a partnership with the Family Life Movement of Zambia (FLMZ) to explore similar reproductive health issues faced by both organizations.

As part of the partnership, a PPNYC delegation visited Zambia in March, and a FLMZ delegation visited New York in June.

While in Zambia, the PPNYC delegation saw how their colleagues in Africa work together with the religious community to promote sexual and reproductive health, including the prevention of HIV/AIDS. The delegation learned that these groups have succeeded in working together by focusing on this common commitment rather than on ideological differences.

While in the United States, the FLMZ delegation met with secular and religious organizations to learn how they provide services for people in the United States living with HIV. They also visited the PPNYC-sponsored Adult Role Model Program (ARM) program, among others, to learn how they involve parents in sexuality education.

FLMZ is a nongovernmental, reproductive health, faith-based organization headquartered in Lusaka with offices throughout Zambia. It was established with funds from the International Federation for Family Life Promotion and is affiliated with the Christian Council of Zambia, the Zambian Episcopal Conference, and the Zambian Council for Social Development.

FLMZ's mission is to enable individuals and couples to enjoy happy, healthy, and fulfilling sexual lives and to ensure equal opportunity and access for all individuals to sexual and reproductive health services.

FLMZ firmly believes that to achieve this vision and to have a positive impact on the populations it serves, especially the youth of Zambia, it must work with other agencies, even when ideologies may differ.

# STRATEGIES FOR IMPROVING MEDIA REPORTING OF HIV/AIDS AND REPRODUCTIVE HEALTH IN NIGERIA

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Program Director  
Development Communications  
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The mass media in Nigeria—including newspapers, magazines, radio, and television—can play an important role in communicating the need for health-intervention programs.

To develop strategies for more effective dissemination of population and reproductive health issues in the media, we formed a target group to understand the Nigerian mass media and to improve methods of collaboration to create a more focused popular debate.

## TARGET GROUP

The target group consisted of both print and electronic mass media practitioners. We collected data by analyzing reports/articles, conducting in-depth interviews, holding focus group discussions, and submitting questionnaires. The resulting data will now help us to:

- Determine information sources on reproductive health issues in the mass media
- Determine problems relating to effective publication or broadcast of reproductive health issues
- Determine available means of disseminating reproductive health information through the mass media in Nigeria
- Identify journalists' backgrounds and their influence on reproductive health reporting
- Determine the training needs of journalists to disseminate reproductive health information
- Design intervention strategies to address obstacles to dissemination and communication of reproductive health issues

## KNOWLEDGE-PRACTICE GAP

The study revealed a knowledge-attitude-practice gap among journalists relating to issues such as HIV/AIDS and reproductive health. They themselves recognized the importance of reproductive health and their communication role. Yet, most were not equipped to play this role. Specifically, they lacked knowledge about reproductive health issues to make appropriate news judgments that would allow them to develop feature stories and provide sustained coverage.

Even though the journalists said they had favorable attitudes about and interest in reporting on reproductive health issues, their outlook was not reflected in their actual day-to-day activities. This was due to (1) their lack of up-to-date

information on reproductive health, (2) their lack of background information on reproductive health, (3) a low employer priority on reporting on health issues, (4) pressure by the community to avoid discussing such issues, (5) lack of journalists with a specialized knowledge of the subject, and (6) difficulty obtaining information and data from government agencies and nongovernmental organizations (NGOs).

## FUTURE STRATEGIES

Based on the study, we developed a number of strategies to improve media coverage and advocacy of reproductive health issues. They included:

- Developing media materials that combine accurate and comprehensive information about both HIV/AIDS and other reproductive health issues
- Providing training opportunities on reproductive health and other emerging issues, including trends in HIV/AIDS
- Developing and establishing a media material resource center that contains a reproductive health data bank, provides access to experts, helps interpret demographic and vital health statistics, and offers other services that improve the information flow to journalists
- Creating of forum for communication between journalists, health professionals, and the general public
- Giving awards for media coverage of HIV/AIDS, reproductive health issues, and other health-related subjects
- Holding events for journalists and social communicators that will attract their attention and clear up their doubts and prejudices about these subjects
- Providing media skills training for community groups and NGOs, particularly to help them work more effectively with journalists

## CONCLUSION

We feel that the strategies we developed will help us to disseminate more information on population and reproductive health issues to the people of Nigeria. We also feel that they will help us to develop an ongoing collaboration with the Nigerian media that will help our people conduct a more substantive debate on population and reproductive health issues in the future.



# RISK OF HIV INFECTION AND UNWANTED PREGNANCY AMONG PORTUGUESE YOUNG ADULTS

**Nuno Nodin**

Project Coordinator

Associação para o Planeamento da Família  
Lisbon, Portugal

**H**IV and unwanted pregnancy are two major health issues affecting Portuguese young people. Both have serious emotional and psychological consequences not only to those affected but also to others around them. Both can also cause serious economic and social consequences.

Considering these facts, the Portuguese Family Planning Association (APF), a nongovernmental organization (NGO) working in Portugal since 1967 on sexuality education and sexual and reproductive health issues, developed an investigative and intervention project. Our goal was to learn more about the sexuality of Portuguese young people 18 to 25 years of age and to analyze their sexual risk behavior.

APF developed the project with the collaboration of regional branches from the areas of Oporto, Coimbra, Lisbon, Alentejo, and Algarve. Staff and volunteers in those areas contacted institutions and organizations and held sessions with groups of young people from several regions of the country.

Because many of the young people in the study needed sexual and reproductive health information, APF decided to include a training session after participants completed the questionnaire.

## THE STUDY

APF distributed 1,402 questionnaires to young adults throughout Portugal. The sample consisted of 47.1 percent males and 52.9 percent females. Of that group, 95.3 percent were single. In terms of their geographic location, 70.9 percent were from urban areas, 18 percent from somewhat urbanized areas, and 11 percent from rural areas. In terms of careers, 34 percent were professionals.

The majority of the sample had already started having sexual relations. That was the case for 80.5 percent of the males and of 75.6 percent of the females. Only a small portion of the sample indicated that they had homosexual behaviors (1.5 percent). Of the sample, 54 percent of the males said they had a permanent partner as compared to 85.7 percent of the females. The questionnaire verified that 42.7 percent of the males and 6.2 percent of the females had had casual sexual contact.

**Contraceptive use.** The questionnaire showed no significant difference between genders in terms of the use of contraceptives. Nearly 70 percent of the young people said they use a contraceptive during intercourse. On the other hand, 24.4 percent said they do not consistently use a contraceptive.

The most popular contraceptive among these young people was the condom, used by 73.8 percent. It was followed at a considerable distance by the pill, used by 44.2 percent. Males used condoms more frequently than females (82.9 and 65.2 percent, respectively). Females used the pill more frequently than males (24.9 and 62.6 percent, respectively). It is worth noting that 15.7 percent used a combination of different contraceptives simultaneously (for example, the pill and the condom or the condom and a spermicide). Some used inefficient methods such as withdrawal (9.5 percent) or the calendar method (3.2 percent).

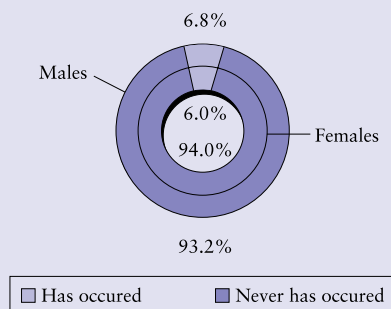
## CONTRACEPTIVE USE

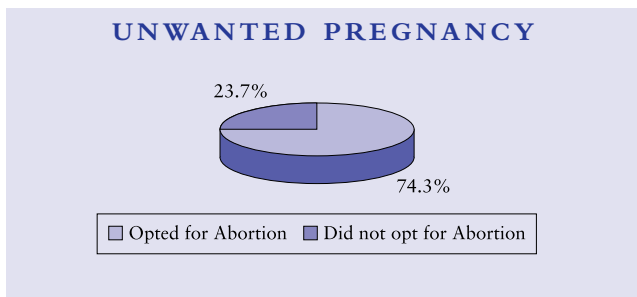
	Males		Females		Total	
	No.	%	No.	%	No.	%
Always use	335	63.1	427	76.1	762	69.8
Use sometimes	84	15.8	55	9.8	139	12.7
Rarely use	50	9.4	29	5.2	79	7.2
Never use	28	5.3	21	3.7	49	4.5
No data	34	6.4	29	5.2	63	5.8

**Unwanted pregnancies.** The PFA questionnaire verified that 6.8 percent of the young people had had an unwanted pregnancy. This figure was modest considering the high percentage of individuals who did not always use contraceptives.

The questionnaire results showed that 74.3 percent chose to end an unwanted pregnancy. This number is a concern. Considering that abortion in Portugal is illegal except for specific health-compromising situations, these individuals likely had their abortions under very poor medical and emotional conditions.

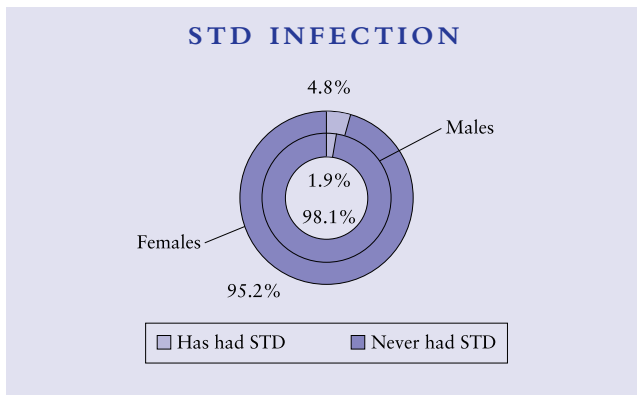
## UNWANTED PREGNANCIES





**Sexually transmitted diseases.** As for sexually transmitted diseases (STDs), 3.4 percent of the sample had already contracted such a disease. From national statistics, APF knows that STDs are increasing among young people as well as among adults. Females have shown a higher proportion of STD infection (4.8 percent) than males (1.9 percent).

Beyond this analysis of sexual behavior, APF also analysed the potential risk factors for HIV infection and unwanted pregnancy using the criteria of gender, residence, profession, and sexual activity.



### COMPARISION OF RESULTS

In terms of both HIV and unwanted pregnancy, males showed a higher behavioral risk than females. The results of the APF questionnaire showed that males are more likely to behave in a way that can affect both their health and the health of their sexual partners. It is still expected that males will have a

greater initiative for sexual activity than females and that they will not necessarily have an attitude toward prevention.

In terms of the geographic area, the APF study showed that individuals from non-urban backgrounds had a higher behavioral risk in terms of HIV and unwanted pregnancy. It is possible that individuals living in small towns or villages—as opposed to rural areas—have access to information and resources relating to sexual health that may affect their behavior in positive ways.

As for professional careers, the APF study verified that people who had already started their professional lives had more potential risk than those who did not work. This is likely due to increased social contacts that might lead to the increased possibility of sexual encounters.

Finally, the APF study verified that risk factors were similar between individuals who had already initiated sexual activity and those who had not. We must keep in mind that sexual activity at this stage of life usually begins in the context of a steady emotional relationship. Perhaps the risk factor is not the start of a sexual relationship with a partner but rather the quality of the relationship which might influence the use of protection against disease and pregnancy.

### CONCLUSION

The APF study indicates that there is need for concern regarding sexual risk factors and behaviors among Portuguese young people. This is verified by the high percentage of individuals who do not use effective contraception in every sexual encounter, by the elevated number of unwanted pregnancies, by the use of abortion to terminate unwanted pregnancies, and by the rates of STD infections.

The results of the study help us to conclude that HIV and unwanted pregnancy are two closely related areas. Both are dependent on an individual's behavior. Consequently, we need to think about the integration of prevention and intervention. If sexuality is the complex and integrated subject that we sexuality educators say it is, then this is one of the logical approaches to sexual and reproductive health intervention.

VARIABLE	HIV		UNWANTED PREGNANCY	
	Lower Risk	Higher Risk	Lower Risk	Higher Risk
Gender	Females	Males	Females	Males
Residence	Urban	Non-Urban	Urban	Non-Urban
Professional Activity	No	Yes	No	Yes
Sexual Activity	No	Yes	No	Yes

# INTEGRATING ISSUES OF SEXUALITY INTO FAMILY PLANNING COUNSELING IN EGYPT

**Nahla Abdel-Tawab**

Population Council

Cairo, Egypt

**T**he Population Council recently studied the acceptability of including sexuality issues in family planning in Egypt, a conservative society with social restrictions concerning the discussion of such issues. The study focused on these research questions:

Would family planning clients in Egypt accept discussing issues of sexuality during family planning counseling?

Would family planning providers in Egypt accept training on gender and sexuality?

Would training in sexuality and gender have an impact on providers' attitudes and counseling practices, and on clients' acceptance of barrier methods?

## THE STUDY METHODS

The study was conducted in six family planning clinics selected from Egyptian Ministry of Health and Population and Clinical Services Improvement Project clinics. Clinics were randomly assigned to either an intervention or a control group. Physicians and nurses/counselors in all six clinics received contraceptive update training. In addition, providers in intervention clinics received three days of training on issues of gender and sexuality as they relate to family planning.

Clinic acceptance of discussing sexuality issues was assessed qualitatively using focus group discussions. Client exit interviews were also conducted with family planning clients from both intervention and control clinics to gauge their satisfaction with various aspects of providers' counseling behavior. In the exit interview, clients who received sexuality counseling were asked if they were embarrassed by the discussion they had with service providers.

Provider acceptance of sexuality training was assessed through observation of providers' reactions during the course, course evaluation forms, and a provider questionnaire that was completed six weeks after the training course. The impact of sexuality training on providers' attitudes toward barrier methods and sexuality counseling was measured using multi-item indices relating to the principal features of barrier methods and dimensions of the sexuality counseling. Changes in counseling practices were measured both qualitatively and quantitatively, using "mystery clients" and client exit interviews.

Client acceptance of barrier methods in the two groups of clinics was also measured in the two groups of clinics using client exit interviews. The study sample included 25

service providers and 503 female clients. The provider sample included all physicians and nurses/counselors working in the study clinics. The client sample included all new and continuing family planning clients who visited the study clinics during the data collection period with the purpose of receiving a family planning method or switching to a different method. Seven mystery clients were recruited to report on providers' counseling practices. Also, five focus group discussions were held in order to measure clients' acceptance of sexuality counseling.

## STUDY FINDINGS

The study results showed that sexuality counseling is acceptable to family planning clients in Egypt.

Sexuality-related problems and concerns were found to be very common in the study group. In focus group discussions, participants indicated a desire to discuss their sexuality-related problems or concerns with family planning service providers but said they felt embarrassed to initiate the discussion.

According to participants, it would help if the provider asked them some routine questions about their sexual relations with their husbands. In discussing their sexual problems/concerns, female clients tended to prefer a female provider, especially a doctor. Exit interviews showed that three out of four clients who reported having a sexuality-related discussion with service providers (n=174) did not feel embarrassed by the discussion. Moreover, clients in intervention clinics were more likely than those in control clinics to indicate that the provider encouraged them to ask questions (95 percent versus 84 percent) and to indicate that they received all the information they expected from the service provider (89 percent versus 81 percent).

Training family planning service providers on issues of sexuality is both feasible and acceptable to providers. Observation of providers' initial reactions to the training course showed that they were very much interested in the subject. At first, some providers, especially young women, seemed uncomfortable and were reluctant to take part in any discussions. In the course evaluation as well as in the provider questionnaire that was administered six weeks after the training course, providers expressed an appreciation of the training course and requested additional training on management of sexual problems.

The study results suggest a positive impact of the sexuality training course on providers' attitudes toward barrier methods. For all three barrier methods investigated in this study (male condom, female condom, and foaming tablets), providers' attitude scores were consistently more positive in intervention than in control clinics. Providers' attitudes about sexuality counseling, however, did not change substantially as a result of the training. Many providers in the intervention clinics still feel embarrassed discussing sexual issues with their clients. Also, many providers still believe that most sexual problems require a specialist to manage, and that asking clients about their sexual history would cause embarrassment.

The sexuality training course seemed to have an unexpected negative impact on providers' practices in relation to counseling about barrier methods. Although providers in intervention clinics were more likely than those in control clinics to mention foaming tablets to their clients (77 percent versus 61 percent), they were less likely to give complete information about the female condom and foaming tablets compared with providers in control clinics. This finding suggests that providers may have focused on the new sexuality counseling component at the expense of counseling on barrier methods.

The intervention had a positive impact on providers' counseling practices. Clients in intervention clinics were significantly more likely to receive counseling about the impact of the chosen family planning method on their sexual relations (42 percent versus 22 percent). Clients in intervention clinics were also more likely than those in control clinics to report having a sexuality-related discussion, not related to family planning, with the service provider (44 percent versus 18 percent). Mystery clients reported that providers in intervention centers were less inhibited in discussing sexuality-related issues with their clients and that they encouraged clients to present their sexuality-related question/concerns. However, mystery clients reported several deficiencies in the content of sexuality counseling. Providers were not able to adequately handle clients' complaints about a loss of sexual desire, and some providers seemed unaware of potential changes in sexual desire associated with use of hormonal methods. In managing clients' complaints about loss of sexual desire, providers were likely to blame the woman rather than to examine the dynamics of the sexual relationship with her husband or the social context in which those relations took place.

The study results also suggest a positive association between training providers on sexuality-related counseling and client acceptance of barrier methods. Clients in intervention clinics were more likely than those in control clinics to receive a barrier method (nine percent versus two percent in control clinics). It should be noted that at the time of the study the male condom was the only barrier method available to most clients. There was no difference in the potential use of barrier methods between intervention and control clinics (31 percent). However, client approval of barrier methods (as measured by the multi-item attitudinal index) was higher among clients in intervention clinics compared with those in control clinics.

## STUDY RECOMMENDATIONS

Recommendations for refining existing family planning training programs and services include:

- Integrate issues of sexuality into family planning counseling. Accordingly, counseling protocols should explicitly include mentioning to the client the potential effect of each method on sexual relations. Also, history-taking should include a brief section that investigates the dynamics of the client's sexual relations.
- Provide training to family planning service providers on management of simple sexual problems, especially those related to family planning use.
- Develop health education messages to encourage the public to address their sexuality-related questions or concerns with family planning providers.
- Establish links between family planning clinics and university or teaching hospitals for referral of complex cases that are beyond the capabilities of family planning providers.
- Encourage medical schools in Egypt to increase the number of hours assigned to sexology training for undergraduates.
- Work to provide a wider range of barrier methods to family planning clients in Egypt.

The implementation of these recommendations should help to improve existing family planning programs and services in Egypt.

SEXUALITY AND UNDERSERVED  
YOUTH IN COMMUNITIES OF COLOR

**A**dolescents comprise approximately 14 percent of the U.S. population. During the past 20 years the racial and ethnic makeup of this population has significantly shifted. Projections indicate that Hispanic, African-American, American Indian, and Asian adolescents will constitute 56 percent of the adolescent population by the year 2050.<sup>1</sup> This *Fact Sheet* explores the challenges affecting the sexual health and development of these youth of color.

SEXUAL BEHAVIOR

- 49.9 percent of high school students have had sexual intercourse during their lifetime: 52.2 percent of males and 47.7 percent of females.<sup>2</sup>
- 71.2 percent of black, 54.1 percent of Hispanic, and 45.1 percent of white students have had sexual intercourse.<sup>3</sup>
- Among males, 75.7 percent of black, 62.9 percent of Hispanic, and 45.4 percent of white students have had sexual intercourse. Among females, 66.9 percent of black, 45.5 percent of Hispanic, and 44.8 percent of white students have had sexual intercourse.<sup>4</sup>
- 8.3 percent of students have initiated sexual intercourse before the age of 13: males (12.2 percent) were significantly more likely than females (4.4 percent) to have initiated sexual intercourse before the age of 13.<sup>5</sup>
- 20.5 percent of black, 9.2 percent of Hispanic, and 5.5 percent of white students have initiated sexual intercourse before the age of 13.<sup>6</sup>
- Among males, 29.9 percent of black, 14.2 percent of Hispanic, and 7.5 percent of white students have initiated sexual intercourse before the age of 13. Among females, 11.4 percent of black, 4.4 percent of Hispanic, and 3.5 percent of white students have initiated sexual intercourse before the age of 13.<sup>7</sup>
- 16.2 percent of students have had four or more sexual partners: 19.3 percent of males and 13.1 percent of females.<sup>8</sup>
- 34.4 percent of black, 16.6 percent of Hispanic, and 12.4 percent of white students have had four or more sexual partners.<sup>9</sup>

*A study analyzing HIV-related sexual behavior of a sample of 5,385 white and 408 Asian/Pacific Islander (API) high school students who participated in the national school-based Youth Risk Behavior Survey (YRBS 1991) found that:*<sup>10</sup>

- White students were 2.72 times more likely to be sexually experienced than API students; roughly 50.36 percent of white students and 26.84 percent of API students had ever had sexual intercourse.
- After controlling for academic performance, no significant differences were found between white and API students regarding the age of “initiating sex,” the number of lifetime partners, and the proportion of students who reported being currently sexually active (having “had sex” during the past three months).
- The median age reported for “initiating sex” by both white and API students was 15.
- The median number of lifetime partners reported by both white and API students was two.
- Of the students who reported they were sexually active, the number of partners during the past three months differed between white and API students. Among white students, 76.68 percent reported having one partner, 11.90 percent reported having two partners, and 11.42 percent reported having three or more partners. Among API students, 58.62 percent reported having one partner, 25.86 percent reported having two partners, and 15.52 percent reported having three or more partners.

*A survey of 2,026 ninth to twelfth grade students (186 of which described themselves as API) in a Los Angeles county school district conducted in 1992 found that:*<sup>11</sup>

- 73 percent of API students reported they were virgins (never having had vaginal intercourse) compared to 28 percent of African-American, 43 percent of Latino, and 50 percent of white students, and 48 percent of “other” students.
- 76 of API males and 70 percent of API females reported they were virgins.
- Among non-virgins, API students were less likely than other students to have initiated sexual intercourse at an early age: 17 percent of API non-virgins had had sexual intercourse by 13 years of age compared to 46 percent of African-American, 36 percent of Latino, 28 percent of white, and 28 percent of “other” students.

- API students were less likely than other students to have reported participating in almost all other heterosexual genital activities during the prior year. Other heterosexual genital activities included: masturbation by a partner, masturbation of a partner, fellatio with ejaculation, cunnilingus, and anal intercourse.
- 16 percent of API virgins versus 85 percent of API non-virgins engaged in masturbation by a partner during the prior year.
- 16 percent of API virgins versus 93 percent of API non-virgins engaged in masturbation of a partner during the prior year.
- 4 percent of API virgins versus 69 percent of API non-virgins engaged in fellatio with ejaculation during the prior year.
- 10 percent of API virgins versus 76 percent of API non-virgins engaged in cunnilingus during the prior year.
- Zero percent of API virgins versus 20 percent of API non-virgins engaged in anal intercourse during the prior year.
- API students in homes where English was the primary spoken language were more likely than other API students to report several heterosexual genital sexual activities.
- 49 percent of API students reported engaging in vaginal intercourse more than 10 times during the year compared with 50 percent of African-American, 38 percent of Latino, 51 percent of white, and 34 percent of “other” students.
- Among non-virgins, API students reported the lowest number of lifetime partners for vaginal intercourse: eight percent of API students had had more than five partners, compared with 38 percent of African-American, 21 percent of Latino, 20 percent of white, and 26 percent of “other” students.

*A study reporting the findings of a questionnaire administered from November 1987 through July 1988 to 153 Asian-American students ranging from 18 to 25 years of age attending a Southern California University found that:*<sup>12</sup>

- 44 percent of men and 50 percent of women reported having engaged in heterosexual intercourse at least once in their lives.
- Sexually active young adults began dating at a significantly younger age and had their first serious romantic attachment at a significantly younger age compared to respondents who were not sexually active.
- Students born in the United States were significantly younger (16.6 years of age) at the age of first sexual intercourse than non-U.S.-born students (17.7 years of age).
- Women were found significantly more sexually active than men in both the number of partners in the previous six months and sexual frequency in the previous month.

*A study of 14,000 American Indian/Alaska Native adolescents in the seventh to twelfth grades who participated in the 1998-90 State of Native American Youth Health study found that:*<sup>13</sup>

- 30.9 percent of all students reported having had sexual intercourse: 35.1 percent of males and 27 percent of females.
- The average age of first intercourse was 13.6 years for males and 14.2 years for females.
- 65 percent of males and 56.8 percent of females had had sexual intercourse by the twelfth grade.
- Of students having had sexual intercourse: 14.7 percent of males engaged in sexual intercourse once or twice, 30.6 percent engaged in sexual intercourse rarely (a few times a year or less), 22.6 percent engaged in sexual intercourse sometimes (one to four times per month), and 7.5 percent engaged in sexual intercourse frequently (several times a week). Among females, 16.9 percent engaged in sexual intercourse once or twice, 32.2 percent engaged in sexual intercourse rarely, 20.4 percent engaged in sexual intercourse sometimes, and 9.4 percent engaged in sexual intercourse frequently.
- Students who suffered from physical and sexual abuse were more likely to have reported they had sexual intercourse than non-abused students: 49.3 percent of physically abused students compared with 28.1 percent of non-physically abused students; 50.3 percent of sexually abused students compared with 28.7 percent of non-sexually abused students.
- 24.4 percent of males who reported never having had sexual intercourse reported having had some non-intercourse-based sexual relationships with a female. 16.4 percent of the females who reported never having had sexual intercourse reported having had sexual experiences short of intercourse with a male.

*A study of 3,749 sexually experienced, reservation-based American Indian adolescents of diverse sexual orientations who participated in a national school-based survey conducted with 55 tribes in eight of the 12 Indian Health Service areas from 1988 through 1990 found that:*<sup>14</sup>

- Self-reported gay/bisexual males were more likely to have reported the onset of heterosexual intercourse at 13 years of age or younger (53.3 percent), compared to males unsure of their sexual orientation (46.1 percent) and heterosexually identified males (44.5 percent).
- Self-reported lesbian/bisexual females (40.6 percent) and females unsure of their sexual orientation (44.6 percent) were more likely than their heterosexual female counterparts (28.5 percent) to have reported an age at first sexual intercourse of 13 years or younger.

- Lesbian/bisexual females (16.7 percent) were twice as likely as females unsure of their sexual orientation (7.8 percent) and slightly more likely than heterosexual females (12.7 percent) to report having sexual intercourse several times a week.

### CONTRACEPTIVE USE

- 58 percent of currently sexually active (having had intercourse three months preceding the survey) high school students reported that either they or their partner had used a condom during last sexual intercourse: 65.5 percent of males and 50.7 percent of females.<sup>15</sup>
- 70 percent of black, 55.2 percent of Hispanic, and 55 percent of white students reported condom use during last sexual intercourse.<sup>16</sup>
- Among males, 75.3 percent of black, 66.1 percent of Hispanic, and 63 percent of white students reported condom use during last sexual intercourse. Among females, 64.5 percent of black, 43 percent of Hispanic, and 47.6 percent of white students reported condom use during last sexual intercourse.<sup>17</sup>
- 16.2 percent of currently active high school students reported that either they or their partner had used birth control pills before last sexual intercourse; white students (21 percent) were significantly more likely than Hispanic (7.8 percent) and black (7.7 percent) students to report birth control pill use before last sexual intercourse.<sup>18</sup>

*A survey of 2,026 ninth to twelfth grade students (186 of which described themselves as API) in a Los Angeles county school district conducted in 1992 found that:*<sup>19</sup>

- 66 percent of API students used a condom at first vaginal intercourse compared with 36 percent of African-American, 33 percent of Latino, 58 percent of white, and 45 percent of “other” students.
- Among API students who had engaged in vaginal intercourse during the preceding year, 36 percent used condoms all the time compared with 40 percent of African-American, 23 percent of Latino, 35 percent of white, and 42 percent of “other” students.
- Twenty-six percent of API students who had engaged in vaginal intercourse during the preceding year reported they had never used condoms, compared with 14 percent of African-American, 27 percent of Latino, 16 percent of white, and 19 percent of “other” students.

*A study reporting the findings of a questionnaire administered from November 1987 through July 1988 to 153 Asian-American students, ranging from 18 to 25 years of age attending a Southern California University found that:*<sup>20</sup>

- 31 percent of sexually experienced students reported they always use birth control during sexual intercourse.

- 11 percent of students reported using condoms every time they are sexually active.
- 77 percent of the students reported having used a condom for sexual intercourse at some point.
- 93 percent of students reported engaging in sexual intercourse without condoms.
- 66.7 percent of males and eighty-six percent of females reported they had at some point suggested the use of condoms to a sexual partner.
- 63 percent of males and 86.4 percent of females also reported that a partner had suggested condom use at some point.

*A study of 14,000 American Indian/Alaska Native adolescents in the seventh to twelfth grades who participated in the 1998-90 State of Native American Youth Health study found that:*<sup>21</sup>

- Forty percent of males and half of females who are sexually active reported they always used birth control.
- 48.7 percent of male and 23.6 percent of females reported using condoms only.
- Birth control pills were the second most popular form of contraception for females; 18.3 percent of all sexually active females were using the birth control pill. Older females were twice as likely to use the birth control pill than younger females.
- Withdrawal was the primary contraception for about one-tenth of males and females; older adolescents were somewhat more likely to practice withdrawal.
- Nearly a third of males and one in 5 females who were sexually active indicated that they rarely used birth control.
- Well over a third of males and over half of females in grades seven through nine reported having had sexual intercourse and not using birth control. Percentages for older teens diminished to 25.1 percent for males and 38.6 percent for females.

*A study of 3,749 sexually experienced, reservation-based American Indian adolescents of diverse sexual orientations who participated in a national school-based survey conducted with 55 tribes in eight of the 12 Indian Health Service areas from 1988 through 1990 found that:*<sup>22</sup>

- Gay/bisexual males and males unsure of their sexual orientation were more likely to have reported they rarely used contraceptives than their heterosexual male counterparts.
- More than one in three gay/bisexual males (35.5 percent) and males unsure of their sexual orientation (37.5 percent) reported rarely using birth control as compared to 28 percent of heterosexual males.

- Males unsure of their sexual orientation were more likely to have reported using unreliable methods of birth control (withdrawal, rhythm method, or no contraception).
- Heterosexual females were most likely to have reported frequent contraceptive use while females unsure of their sexual orientation were least likely to do so.
- Two out of three sexually experienced heterosexual females reported use of birth control often or always while half of lesbian/bisexual females and 44.7 percent of females unsure of their sexual orientation reported the same.
- Nearly two out of five lesbian/bisexual females reported they rarely to never used birth control while one of five heterosexual females reported doing the same.
- Two of three females unsure of their sexual orientation (66.2 percent) reported using unreliable methods of birth control (withdrawal, rhythm method, or no method), compared to just over half of heterosexual (51.7 percent) and lesbian/bisexual females (54.5 percent).

## SEXUALLY TRANSMITTED DISEASES

- Approximately one-fourth of the 15 million new STD cases in the United States occur among adolescents.<sup>23</sup>
- Chlamydia and gonorrhea are the most common STDs among adolescents. 40 percent of chlamydia cases are reported among 15 to 19 year old adolescents.<sup>24</sup>
- Adolescent females 15 to 19 years of age had the highest rate of gonorrhea in 1999. African-American females of this age group reported a gonorrhea rate of 3,691 cases per 100,000, a rate 19 times greater than their non-Hispanic white counterparts. African-American males of this age group reported a gonorrhea rate of 1,996.5 per 100,000, a rate 52 times greater than their non-Hispanic white counterparts.<sup>25</sup>
- 20 to 24 year old males have the highest gonorrhea rates and the third highest rates of primary and secondary syphilis.<sup>26</sup>
- In 1998, over 11,500 new cases of STDs were reported among Asian Americans and Pacific Islanders. Among 15 to 24 year old Asian American and Pacific Islander females, chlamydia cases increased by 32.9 percent in 1998.<sup>27</sup>
- Rates for all three STDs were highest among African-American students. Native American females had the next highest rates of gonorrhea and chlamydia.
- Among female respondents who tested positive for gonorrhea, 4.3 percent were African-American, 1.9 were Native American, 0.9 percent were white, 0.7 percent were Hispanic, and 0 percent were API.
- Among female respondents who tested positive for chlamydia, 12 percent were African-American, 11.3 percent were Native American, 5.8 percent were white, 5.3 percent were Hispanic, and seven percent were API.
- Half of all new HIV infections are thought to occur in young people under 25 years of age. It is estimated that young people between the ages of 13 to 25 are contracting HIV at the rate of two per hour.<sup>29</sup>
- African-American and Hispanic young people make up roughly 15 percent of the U.S. adolescent population. However, African-American young people account for 60 percent of new AIDS cases, and Hispanic youth account for 24 percent of new cases.<sup>30</sup>
- African-American adolescent females between the ages of 13 and 19 represent 15 percent of all U.S. adolescent females, yet they account for 66 percent of all AIDS cases reported among young women.<sup>31</sup>
- A sample of 15- to 22-year-old young men who have sex with men in seven urban cities found HIV prevalence rates highest among young men of color: 14.1 percent among black, 13.4 percent among mixed, 6.9 percent among Hispanic, 6.7 percent among American Indian/Alaska Native, 3 percent among API, and 3.3 percent among white.<sup>32</sup>
- Among Asian and Pacific Islander males and females, AIDS case reported through December 1998 were concentrated among the 25 to 44 year olds, 73 percent for males and 64 percent for females.<sup>33</sup>

## PREGNANCY

*A study in the Journal of Adolescent Health evaluating the medical records of 12,881 racial/ethnically diverse 16- to 24-year-old adolescents enrolled in 54 U.S. Job Corps training centers in 1996 found that:*<sup>28</sup>

- Among female adolescents, an estimated 9.2 percent tested positive for chlamydia, 2.7 percent tested positive for gonorrhea, and 0.4 percent tested positive for syphilis. Among male adolescents who were tested for gonorrhea and chlamydia, 14 percent tested positive for gonorrhea and 19 percent tested positive for chlamydia.
- More than 900,000 adolescents become pregnant annually.<sup>34</sup>
- Adolescent pregnancy rates have declined nationwide since the 1990s: the rate for 15 to 19 year olds dropped 19 percent from its peak in 1991 of 116.5 per 1,000 to 94.3 per 1,000 in 1997.<sup>35</sup>
- Among black 15- to 19-year-old adolescents, the nationwide pregnancy rate declined 20 percent between 1990 and 1996; for white adolescents of the same age group, the pregnancy rate declined 16 percent between 1990 and 1996.<sup>36</sup>
- For Hispanic adolescents, pregnancy rates have declined only since 1994; an 11 percent decline occurred from 1994 to 1997.<sup>37</sup>



- In 1996, adolescent pregnancy rates were more than twice as high among non-Hispanic black and Hispanic adolescents than non-Hispanic white adolescents.<sup>38</sup>
- Nationally, birth rates for adolescents 15 to 19 years of age declined 18 percent between 1991 and 1998 (51.1 live births per 1,000) for all racial/ethnic populations.<sup>39</sup>
- Birth rates have sharply declined for black adolescents since 1991: 26 percent, from 115.5 per 1,000 in 1991 to 85.4 per 1,000 in 1998.<sup>40</sup>
- For Hispanic adolescents, steady declines in birth rates have occurred only since 1994: from 107.7 per 1,000 in 1991 to 93.6 per 1,000 in 1998, a thirteen percent decline in four years.<sup>41</sup>
- Despite recent declines, birth rates for black and Hispanic adolescents are still higher than for other racial/ethnic groups: birth rates for non-Hispanic white adolescents declined 19 percent from 1991 to 1998 to 35.2 births per 1,000 in 1998; for American Indian adolescents, birth rates declined 15 percent from 1991 to 1998 to 72.1 births per 1,000 in 1998; and API adolescents, birth rates declined 16 percent from 1991 to 1998 to 23.1 births per 1,000 in 1998.<sup>42</sup>
- API adolescents had the lowest birth rate in 1998, 23.1 per 1,000 births.<sup>43</sup>

***A study of 14,000 American Indian/Alaska Native adolescents in the seventh to twelfth grades who participated in the 1998-90 State of Native American Youth Health study found that:*<sup>44</sup>**

- 5 percent of sexually active males reported they were aware of ever having caused a pregnancy.
- Over half of males who had caused a pregnancy reported they “had sex” at least monthly and one fifth reported having “had sex” several times a weeks.
- 7.2 percent of sexually active females have been pregnant at least once.
- 43 percent of females who had been pregnant reported having “had sex” at least once a month and 18 percent reported having “had sex” several times a week.
- Pregnancy appeared more likely among students who reported having been physically and sexually abused: 13.5 percent of physically abused adolescents compared to five percent of non-physically abused adolescents have been pregnant; 11.7 percent of sexually abused teens compared to 5.5 percent of non-sexually abused adolescents have been pregnant.

***A study of 3,749 sexually experienced, reservation-based American Indian adolescents of diverse sexual orientations who participated in a national school-based survey conducted with 55 tribes in eight of the 12 Indian Health Service areas from 1988 through 1990 found that:*<sup>45</sup>**

- Nearly one in five gay/bisexual males (18.6 percent) reported having caused a pregnancy, compared to 11.8 percent of heterosexual males, and 10.4 percent of males unsure of their sexual orientation.
- 25 percent of lesbian/bisexual females, 21.9 percent of heterosexual females, and 22.1 percent of females unsure of their sexual orientation reported a history of one or more pregnancies.
- For younger females unsure of their sexual orientation, frequency of contraceptive use was significantly associated with pregnancy; those who reported they used contraceptives sometimes were 10 times more likely to report a pregnancy as compared to those who used contraceptives often to always (60 percent, sometimes; 19 percent, rarely; 6.7 percent, often/always).
- For older females unsure of their sexual orientation, an earlier age at onset of heterosexual intercourse was significantly associated with pregnancy. Half of unsure females who reported an age of first intercourse at 13 years or younger had been pregnant, compared to 21.1 percent of unsure females whose first heterosexual intercourse occurred between 14 to 16 years of age, and 16.7 percent of unsure females whose first heterosexual intercourse occurred at 17 years of age or older.
- For heterosexual females, age, frequency of intercourse, and physical abuse were significantly associated with pregnancy. History of pregnancy increased with age from 7.1 percent of 12-year-olds to 39.6 percent of 18-year-olds.
- Among younger heterosexual females, 7.1 percent who seldom had intercourse reported a pregnancy; females who had intercourse sometimes were three times as likely (21.3 percent) as females who seldom had intercourse to report pregnancy; and females who had intercourse several times a week were twice as likely to report a pregnancy (14.8 percent).
- Among older heterosexual females, one in five females who seldom had intercourse had been pregnant (19.7 percent) compared to more than one in four females who sometimes had intercourse (27.9 percent) and half of females who reported intercourse several times a week (49.5 percent).
- Both older and younger heterosexual females with a history of physical abuse were more likely to report pregnancy: 27.6 percent of females who had been physically abused reported a pregnancy compared to 19.7 percent of females who had not been abused.

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### Submitting Articles and Book and Audiovisual Reviews for Publication in the *SIECUS Report*

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Manuscripts are read with the understanding that they are not under consideration elsewhere and have not been published previously. Manuscripts not accepted for publication will not be returned. Upon acceptance, all manuscripts will be edited for grammar, conciseness, organization, and clarity.

To expedite production, submissions should adhere to the following guidelines:

#### PREPARATION OF MANUSCRIPTS

Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

All disks should be clearly labeled with the title of submission, author's name, type of computer or word processor used, and type of software used.

The following guidelines summarize the information that should appear in all manuscripts. Authors should refer to the current issue of the *SIECUS Report* as a guide to our style for punctuation, capitalization, and reference format.

#### Articles

The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

Articles may incorporate sidebars, lists of special resources, and other supplementary information of interest. Charts should be included only if necessary and should be submitted in camera-ready form. References should be numbered consecutively throughout the manuscript and listed at the end.

#### Book Reviews

The beginning of a book review should include the title of the book, author's or editor's name, place of publication (city and state), publisher's name, copyright date, number of pages, and price for hardcover and paperback editions.

#### Audiovisual Reviews

The beginning of an audiovisual review should include the title of the work, producer's name, year, running time, name and address of distributor, and price.

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On request, authors of articles receive three copies of the issue in which their article appears, and reviewers receive two copies. Larger quantities are available to authors and reviewers at half price if requested prior to printing.

#### INQUIRIES AND SUBMISSIONS

All questions and submissions should be addressed to the editor, by telephone, at 212/819-9770, by E-mail to [medwards@siecus.org](mailto:medwards@siecus.org), or by mail to *SIECUS Report*, SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802.

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### M i s s i o n

SIECUS affirms that sexuality is a natural and healthy part of living. SIECUS develops, collects, and disseminates information; promotes comprehensive education about sexuality; and advocates the right of individuals to make responsible sexual choices.

