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SEXUAL HEALTH ISSUES WORLDWIDE

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CALL FOR SUBMISSIONS

The *SIECUS Report* welcomes articles, reviews,or critical analyses from interested individuals.Upcoming issues of the *SIECUS Report* will have the following themes:

- **Contraceptive Update**
  December 2002/January 2003 issue
  Deadline for article submission: September 2,2002

- **Integrating Prevention Efforts: STDs, HIV, and Teen Pregnancy**
  February/March 2003 issue
  Deadline for article submission: November 4, 2002

- **Young People Talk about Sexual Health, Education, and Rights**
  April/May 2003 issue
  Deadline for article submission: January 2,2003

- **The Debate about Sexual Addiction and Compulsion**
  June/July 2003 issue
  Deadline for article submission: March 3, 2003

- **Monitoring Sexuality Education in the United States/Tenth Anniversary**
  August/September 2003 issue
  Deadline for article submission: May 1, 2003

UNDERSTANDING CULTURAL DIVERSITY IS KEY TO EFFECTIVE COMMUNICATION

Mac Edwards

When I first started working in New York City after living in the Washington,DC, area for over 20 years, I was in awe of the ethnic diversity of this enormous city. It is filled with neighborhoods that reflect the cultures of dozens of countries worldwide.

Even after working here for over 10 years, I am still amazed at the variety of cultures that coexist in this city. It is a humbling and exciting experience to try to understand—even to a very small extent—the various habits, beliefs, traditions, and languages of these cultures. I feel very lucky to live here and to have gained a fairly good idea of the cultural diversity of the world without leaving the city.

This issue of the *SIECUS Report* on "Sexual Health Issues Worldwide" emphasizes the importance of understanding various cultures as the foundation for communicating effectively about sexual health and sexual rights issues.

TALKING ABOUT SEXUALITY

Emily Smith, who is a senior science writer and editor for Network magazine at Family Health International in Research Triangle, NC, writes in her article "Discussing Sexuality Fosters Sexual Health" about the importance of providers discussing with their clients aspects of their lives that may impede optimal sexual health. She points out that providing quality reproductive health care is complex and involves an open dialogue between providers and clients about issues that are traditionally not discussed in many cultures.

Part of what makes her article so fascinating is her use of a wealth of research from around the world to make the point that there is still a great deal of work to do in this area. She discusses studies from Brazil, Boliva, India, Nicaragua, Sierra Leone, Indonesia, Pakistan,Bangladesh,Thailand, and Mexico.

PROMOTING SEXUAL HEALTH

The remainder of this *SIECUS Report* focuses on programs worldwide that are helping to promote sexual health in various countries.

Kathy Kirwan,the PASH project coordinator and manager of education services at Family Planning of Western Australia in Perth,Australia, writes about her organization's PASH (Promoting Sexual Health) program, which works with young people on sexuality issues from a holistic peer education perspective. "Respect for the young people and how they are managing their lives and their decisions is paramount in the course," she explains.

Next Denise Kohn, the program coordinator for adolescents of Planned Parenthood Federation's Western Hemisphere Region, writes in "Working with Out-of-School Youth in Belize and Peru" that targeting such youth is particularly challenging for sexual and reproductive health providers.She points out that one of the most important lessons that a provider can learn is to discuss issues in the context of other pressing concerns, such as jobs, or in informal "rap sessions." "Include practical issues—such as decision-making, self-esteem, and development of life goals—in programs so that young people will find them more useful," she adds.

Then Jashodhara Dasgupta, coordinator of SAHAYOG in Lucknow, Uttar Pradesh, India, recaps in "Experiences of Implementing a Sexual Health Strategy in Northern India" the compelling story of his staff's arrest and imprisonment after it published a study on HIV/AIDS in the area."State AIDS organizations and government agencies denied that there was a need to address sexuality in discussions about AIDS and even dismissed the possibility of AIDS cases in the area," he said.

The remaining four articles discuss programs that are underway in four separate countries.They provide important information for individuals interested in similar work.The articles include "Youth Hotlines Succeed in Guatemala and Colombia," "AIDS Infoshare: Russian Public Health and Human Rights," "BBC's *Sexwise* Provides Critical Sexual Health Information Worldwide," "*Lovelife* and Independent Newspapers Join South African Fight Against HIV/AIDS."

POLICY UPDATE

William Smith, SIECUS'director of public policy, makes an excellent point in his article "Bush Administration 'Mission Creep' Affects Global Sexual Health Efforts" that the President is trying to convince the rest of the globe that the only effective way to address sexual and reproductive health issues is to tell people that they should remain abstinent until they marry and that they must remain monogamous and exercise fidelity after they marry.

He also highlights a recent study published in the June

British Medical Journal pointing to the gamble the world will take if it accepts the Bush Administration's premise. The study found that the pregnancy rate among adolescent women in four abstinence programs was higher than in the control group that did not participate.

He also points to recent Bush Administration efforts to advance abstinence-only-until-marriage at the United Nations Children's Summit in May and to the phasing out of U.S. financial support for the United Nations Population Fund in the fiscal year 2003 federal budget. This is why SIECUS believes those gathering in Barcelona this July to assess the global HIV/AIDS epidemic and strategize about how to find solutions will not be looking to the U.S. government for inspired leadership.

NEW CULTURALLY COMPETENT RESOURCES

Finally, this *SIECUS Report* includes the updated SIECUS Annotated Bibliography on "Culturally Competent Sexuality Education Resources." This is a critically important resource for all people working within cultures to help people become sexually healthy adults. It includes books of general interest, books for professionals, books for families, relevant curricula, a list of publishers, and a list of organizations that can provide additional information and resources.

I think that *SIECUS Report* readers will find this issue filled with important information that will help them in their work on sexual health issues worldwide.

UGANDA'S GOVERNMENT-SUPPORTED EDUCATION PROGRAM HELPS TO DRAMATICALLY REDUCE HIV/AIDS CASES

Uganda, devastated by years of dictatorship and war, was once considered the epicenter of the global AIDS epidemic.

After infection rates reached more than 30 percent in the capital city of Kampala in the early 1990s, the Ugandan government, along with a broad group of civic, religious, and other grassroots organizations, started strategizing openly and honestly about HIV/AIDS prevention.

The country's resulting HIV/AIDS prevention program, called "ABC" (for "Abstain, Be Faithful, or Wear a Condom") uses strategies that encourage people to delay sexual intercourse, limit the number of sexual partners, and increase condom use.

In the past decade, the country's comprehensive sexuality education and condom distribution programs have helped reduce the HIV prevalence rate from 14 percent in the early 1990s to eight percent in 2000. In addition, the prevalence rates among teenage women have dropped from 28 percent in 1991 to six percent in 1998.

SIMILAR PROGRAMS CAN HELP YOUTH

Though the AIDS epidemic in Uganda is far from over, figures show that infection has declined among youth and that condom use and the age of sexual initiation have risen sharply as a result of the government-promoted "ABC" program. This provides important evidence that comprehensive sexuality education and condom distribution programs work.

With the implementation of other programs based on Uganda's government-sponsored efforts, the 1.7 billion youth 10 to 24 years of age living in the world today (86 percent of whom live in developing countries) will have hope that the HIV/AIDS epidemic will end.

GOVERNMENTS NEED TO PROVIDE SEXUALITY HEALTH SERVICES TO THEIR CITIZENS

Tamara Kreinin, M.H.S.A.

I am writing to you from the 14th Annual International AIDS Conference in Barcelona, Spain, where more than 10,000 scientists, activists, policymakers, and people living with HIV/AIDS are meeting to discuss ways to prevent and treat this virus and subsequent disease.

This Conference has made one thing crystal clear. With nearly a billion of the world's population between the ages of 15 and 24, it is critical that comprehensive sexuality education programs, including information about both abstinence and condom use, become a key part of any prevention and treatment plan.[1]

The statistics about the spread of AIDS around the world paint a picture of people in desperate need of the information that SIECUS has long encouraged both in the United States and around the world.

CULTURALLY RELEVANT EDUCATION PROGRAMS

When developing such programs outside the United States, it is critical that social service providers and nongovernmental organizations—working in conjunction with government agencies—plan them in a culturally relevant and appropriate manner that address the specific social and cultural issues, contexts, and language needs of the people they are serving.

When programs and services are based on such cultural competencies, they have a significantly increased potential to succeed in meeting people's sexual health needs and concerns as well as promoting safer sexual behavior.

At the same time, providers must work to change the negative—and ultimately harmful—social and community norms relating to sexuality that are prevalent in so many parts of the world. This is critical if they are going to help people see sexuality education both as a way to create a healthy and positive sexual life and prevent disease.

As providers seek to accomplish this important work, they also need to build a foundation of trust with their clients. Discussions relating to sexuality and sexual health are intimate and personal. Providers will succeed only if they have the tools and the training to help their clients feel comfortable, open,and respected.

CONTROVERSIAL SUBJECT

Discussion of sexuality is generally a controversial subject all over the world,particularly when it comes to young people and their access to information. Many societies currently view sex and sexuality as shameful. Many also have strong taboos about open discussions relating to sexuality.

Strong opposition exists about providing people with the tools, knowledge, and skills they need to empower and protect themselves sexually. Fueled more by adult fears than by research or reality, this opposition denies people life-saving and life-enhancing information. Even those who have access to sexuality education or sexual health services find that the programs and curricula are fragmented and limited in scope.

People have the right to information, education, and medical services to safeguard their health. It is the responsibility of governments, with the support and assistance of nongovernmental organizations, to provide and fund such life-saving programs and services.

As advocates, we need to include our policymakers in our work to inform people about sexual health. We need to broaden their understanding of the roles they can play in developing and supporting positive and comprehensive sexual health programs. Policymakers have the potential to be one of our greatest allies. We need to continue to work to achieve this goal.

RECENT U.N. SUMMIT ACTION

We must also listen carefully to our youth as we develop sexuality education and sexual health programs. They are the ones who can provide us with the insight and the perspective we need to make certain that we are providing them with what they need. But there is controversy.

No where was the controversy over sexuality education for young people more apparent than at the recent United Nations Summit on Children this past May. A number of conservative groups worked diligently to include information about abstinence-only-until-marriage programs in the summit's language. While the final document did not include any information about the programs, it still lacks a strong commitment to providing young people the sexual and reproductive health information, resources, and services they need.

Driven by misinformation about sexuality education and sexual health, opponents of comprehensive sexuality education falsely believe that it will promote premature sexual activity and an increase in sexual partners. We know this simply is not true.

The dangerous and misguided attempts by countries like the United States to promote unproven abstinence-only-until-marriage education can only continue to harm and deny young people their right to information and education about sexuality.

SEXUALITY EDUCATION LEADS TO SEXUAL HEALTH

Because many people become sexually active in their teen years, they need to receive information and education at the time when it has the potential to most positively affect their future.

With high rates of pregnancy, sexually transmitted infections (STIs), HIV, and sexual violence currently prevalent among young people, it is critical that they receive the type of sexuality education that will help ensure that they have the social and economic opportunities to succeed in life.

Women are in particular need of this information and education. According to the UNAIDS report just released at Barcelona, women are at particular risk for contracting HIV because of gender inequity, specifically the lack of resources, knowledge, and power because of their gender.[2]

Not surprisingly, the majority of young people 15 through 24 years of age living with HIV/AIDS in Sub-Saharan Africa and Asia are young women.[3] That is because these females often have unsafe sexual relationships with infected older men who seek them out. Because of their diminished power both in these relationships and in society, these young women, in particular, need access to information, education, and services to protect their health.

When sexuality education and sexual health services are more than limited anatomy lessons and are well grounded in providing decision-making skills, they will help people take measures to protect themselves and their partners.

According to the United Nations Joint Programme on AIDS, access to quality, comprehensive education about sexuality and HIV/AIDS will lead to a delay in sexual debut among young people and an increase in contraceptive and condom use among sexually active ones.[4]

COUNTRIES SET STANDARD

We know what we need to do as a global community. We know that prevention programs, comprehensive education, and quality services work to promote healthy sexual behavior and reduce negative sexual health outcomes.

We have excellent models which are supported by governments and taken to scale to reach as many people as possible. It is vital that we look to these models to guide our policymaking and program development.

One example is the work accomplished in Nigeria by nongovernmental organizations and service providers collaborating with the country's Ministry of Education. Recognizing that sexual health information and education is critical in stemming the rise of HIV, the Ministry of Education has recently implemented a national sexuality education policy and curriculum for secondary school-age youth throughout the country.

Another example is the work of the government in Uganda, where comprehensive HIV-prevention programs and condom distribution efforts are supported. As a result, the adult HIV prevalence rate was reduced from 14 percent in the early 1990s to eight percent in 2000, and prevalence rates among teenage women dropped from 28 percent in 1991 to six percent in 1998.[5]

A final example is the work in Thailand. With the strong support of policymakers, Thailand's comprehensive prevention efforts have reduced the number of new HIV infections to 30,000 from a high of 140,000 in 1990.[6]

Country-specific programs like these are setting the standard that the rest of the world should—and must—follow in order to promote healthy sexuality for all people.

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DISCUSSING SEXUALITY FOSTERS SEXUAL HEALTH

Emily J. Smith
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Every woman seeking reproductive health services carries her entire life story with her. It is a story that providers should be prepared to listen to with respect because it may contain information vital to the woman's health and well-being.

Many aspects of a woman's life affect her reproductive health, including her relationship with her partner and her understanding of, and beliefs about, sexuality. Because of this, providers would be wise to consider discussing such issues with clients, says Family Health International (FHI) researcher Dr. Patricia Bailey, whose work has included research on how contraception affects men's and women's quality of life. "The goal of such discussions would be to foster optimal sexual health, an aim that encompasses much more than just the prevention of sexually transmitted infections (STIs) or unplanned pregnancies," Dr. Bailey says.

The World Health Organization (WHO) defines sexual health as "the integration of the physical, emotional, intellectual, and social aspects of sexual being in ways that are enriching and that enhance personality, communication, and love." Furthermore, WHO states: "Fundamental to this concept are the right to sexual information and the right to pleasure."[1]

PROVIDERS CAN HELP WITH OPEN DIALOGUE

Violence, coercion, discrimination, fear, shame, guilt, false beliefs, and lack of knowledge about sexual issues are barriers to sexual health that many women face throughout the world. But providers can help by discussing with clients the aspects of their lives that may impede optimal sexual health.

"Providing quality reproductive health care is complex and involves an open dialogue between providers and clients about issues that traditionally may not have been discussed during medical consultations," Dr. Bailey says.

IN-DEPTH INTERVIEWS WITH BRAZILIAN DOCTORS

In-depth interviews with 15 gynecologists working in primary health care posts in Rio de Janeiro, Brazil, between 1993 and 1995 revealed that these doctors often found it difficult to discuss with female clients issues related to STIs and sexuality. It was particularly difficult for them to explain to a married woman that she had a genital infection and how she might have acquired it, since such an explanation implied marital infidelity.

"I tell her how she can avoid complications, but I do not get into how she might have been infected," said one of the gynecologists. "I do not think it would be good for her. We do not know how she got infected, and for her to get ideas….I think it is best just to treat it."

When physicians in the study were asked what they typically said to a woman who had an STI, only half reported informing the client that her infection was transmitted through sexual contact. "Look, I try to be neutral and not get involved in her private life," another physician said. "I have a very medical posture. I give her the results of the test and tell if there is a disease…."

In the same study, in-depth exit interviews with 42 women who had been diagnosed with chlamydia at primary health care posts in Rio de Janeiro, where they sought gynecological and prenatal care, revealed that only two of the women understood that their infection was transmitted through sexual contact.

This suggests that their physicians had not discussed the subject with them. The 15 gynecologists interviewed for the study did not attend to these women and in fact worked at other primary health care posts. But direct observation of gynecologists working at health posts where the 42 women were diagnosed revealed that those physicians' attitudes were similar to those of the 15 interviewed gynecologists, researchers reported.[2]

A clear explanation by a medical professional of the source of STIs is not sufficient to prevent infection, but it does serve as a foundation for the prevention of STIs, including HIV/AIDS. Such explanations can be especially important in settings like Brazil, where heterosexual intimate relations are the primary mode of HIV infection in women. (In Brazil, the female-to-male ratio of reported AIDS cases has increased from one female for every 28 males in 1985 to one female for every three males in 1995.)

In the same Brazilian study, even when clients persisted in attempting to discuss how they might have acquired an STI—such as through a partner's infidelity—some physicians avoided discussing the matter.

According to one doctor, "When the patient expresses suspicion of infidelity, I cut her off….I say, look here, what

is important is that you have a disease. Both you and your husband have to be treated, right?"

BOLIVIAN WOMEN'S STUDY PROJECT

"But providers should be sensitive to women's concerns about infidelity," stresses FHI's Bailey, who, from 1995 to 1996, helped coordinate an FHI Women's Studies Project that examined how contraceptive use affects the sexuality, quality of life, and stability of couples in El Alto, Bolivia. Data for the study were collected from focus group discussions and in-depth interviews with 110 married women and 35 married men from El Alto.

In one focus group, several women discussed the impact of their husbands' infidelities. "No, I don't like sex," a woman said. "He treats me badly and he goes with other women. And now he has these large pustules on him. I don't know what they are. He'll disappear for two or three nights and when I ask him, he always says he was with a friend."[3]

Cultural beliefs about how active a woman should be in sexual relations can influence how a woman feels about her sexuality. One-half of the women interviewed in the El Alto study, for instance, said they did not consider it proper for married women to initiate sexual relations with their spouses. Many Bolivian men expressed the same view. However, the male focus group participants also agreed that one reason they become involved with their extramarital lovers is because, unlike their wives, their girlfriends initiated sex.[4]

"Women need to know that it is normal to be active participants in sex," Dr. Bailey says. "A sympathetic and caring provider who brings up the subject of sexuality with clients and creates an environment where it is comfortable for clients to talk about sex can show clients that it is OK to think about and even articulate these things. Then women might be less nervous about bringing up the subject with their partners."

There is another key reason why providers should consider talking with a woman about her sexuality and relationship with her partner: In some settings, intimate partner violence can limit a woman's access to health care or even prevent her from protecting herself against unplanned pregnancy or STIs.

STUDY OF VIOLENCE IN RELATIONSHIPS IN INDIA

A study from 1995 to 1996 of 6,632 married men living with their wives in Uttar Pradesh, India, found that abusive men were more likely than non-abusive men to have STI symptoms and to engage in extramarital sex. The study also found that unplanned pregnancies were more common in abusive relationships.[5]

"Women do not always have the power to make decisions about when they are going to have sex, how they are going to have sex, and what, if any, contraceptive method or disease-preventing methods they are going to use," says Jane Schueller, FHI's associate director of training and education. "And, if a woman has a partner who has multiple partners outside their marriage, she is at greater risk of an STI or HIV/AIDS."

Even violence that has taken place many years ago can affect the reproductive health of a woman. Research has shown that women who grow up in abusive homes are at higher risk for unplanned pregnancies.[6]

ABUSE IN NICARAGUA, SIERRA LEONE, INDONESIA

The fact that intimate partner violence is common in many settings is reflected in recent research. A 1995 population-based, household study of 488 women aged 15 to 49 years in Leon, Nicaragua, found that 40 percent had been physically abused by a partner at some point in their lives.[7]

Another survey conducted in 1994 among 144 women in Sierra Leone, West Africa, found that two-thirds of the women had been physically abused by a partner and more than half had been forced by their partners to have sexual intercourse. The majority of study participants were recruited from family planning clinics and hospital clinic waiting rooms in Freetown and in the Northern Province, but some were also recruited from marketplaces, a refugee camp, and a teacher's college.[8]

A 1999 study conducted in the Purworejo District of Central Java, Indonesia, among a population-based sample of 765 married women who were recruited from a longitudinal study of health during pregnancy found that one in four had been physically or sexually abused by her husband.[9]

Intimate partner violence can affect a woman's reproductive health in many ways. In addition to being at increased risk of an STI and unplanned pregnancy, abused women are at higher risk for having induced abortions, pre-term labor, low birth-weight babies, and various gynecological problems. For this reason, some experts feel that reproductive health clinics may be an ideal place to screen for intimate partner violence.

CLINICS NEED TRAINING ABOUT PARTNER VIOLENCE

A 1997 FHI survey of 607 women from El Alto and La Paz, Bolivia, supports this premise. Nearly half of some 40 percent of women who reported experiencing intimate partner violence said they had visited a reproductive health clinic within the past year.[10]

"Reproductive health services are well-positioned to screen women for intimate partner violence," says Donna McCarraher, an FHI research associate who coordinated the FHI study. "But programs that intend to provide screening need to ensure that everyone in the clinic is thoroughly trained and committed to preventing intimate partner violence."

Program managers also need to evaluate whether staff have sufficient time to offer such services, she says. And policymakers and program managers need to define what to do if they identify victims of intimate partner violence through screening. If they plan to refer women for counseling or shelter, then program managers need to set up and maintain such a system, McCarraher says.

PROVIDERS NEED TO CONSIDER CULTURAL, SOCIAL FACTORS

Cultural and social factors—some obvious, others less so—strongly influence the reproductive health decisions of women in many settings throughout the world.

A woman's ability to work and earn an income that she can control, for instance, can influence whether she can pay for health services.

Religious prohibitions, expectations about fertility, knowledge and beliefs about contraception, self-esteem, relationships with friends and family members, and freedom of movement all influence their decisions. Providers who understand these influences and establish open and respectful communication about the circumstances of clients' lives and decisions help those clients maintain optimal sexual health.

"Providers should not forget that many women are living in a context where they are not making unilateral decisions about their reproductive health," stresses Dr. Bailey, whose work has included research on contraception and quality-of-life issues.

Research has found, for instance, that social factors can influence a woman's access to reproductive health care and limit her ability to make decisions about reproductive health issues.

STUDY IN PAKISTAN FOCUSES ON SOCIAL SYSTEMS

In Northern Punjab, Pakistan, a 1997 study involving in-depth interviews and focus group discussions with married and unmarried men and women found that village social systems implemented to protect the honor of women and their families limited women's mobility and access to health care.

Unmarried women faced the greatest restrictions and were often kept at home unless medical care was urgent. Several respondents also said unmarried women had to avoid frequent visits to providers, which could suggest a health problem related to sexual activity.[11]

BANGLADESH STUDY ON BARI DWELLINGS

A woman's position within her extended family has also been found to limit women's reproductive health care choices. In rural Bangladesh, where many families live in grouped dwellings known as baris, a 1994 study found that a woman's social position within a bari could limit her access to reversible, modern contraceptive methods.

This study of 2,861 women living in 936 baris found that daughters-in-law and sisters-in-law of bari leaders used reversible, modern contraceptive methods less than wives of bari leaders. Access to those methods may be limited by either the bari leader or his wife, the researchers suggested.[12]

THAILAND STUDY SHOWS FAMILY NETWORKS MATTER

But social factors do not always have a negative effect on women's reproductive health. A recent study in Thailand found that the more external kinship ties households have, the more likely women in those households are to use modern forms of temporary contraception.[13]

Interpersonal communication through household kinship networks, both within and outside the village, may facilitate the spread of information. Kinship networks may provide greater economic resources with which to purchase modern contraceptive methods, the researchers noted.

"Social networks really matter," says Dr. Elaine Murphy, senior program advisor at the U.S.-based Program for Appropriate Technology in Health, whose work has focused on how client-provider interactions affect quality of care. "Clients often hear about family planning services and especially about specific methods from family members and friends."

Research shows that cultural and social factors also influence women's knowledge and beliefs about contraception and reproduction, their self-esteem, and their feelings about sexuality, which in turn affect their reproductive health decisions.

BOLIVIAN STUDY SHOWS NEGATIVITY, MISTRUST

A 1993 study based on in-depth interviews with 30 indigenous Aymaran women in La Paz and El Alto, Bolivia, found that many of the women had ambivalent, if not negative, feelings about sex.[14] "The interviews make clear that the women's reticence to speak of sexuality and reproduction is something that most of them learned at an early age," the study's authors noted. "They grew up in households where sexuality was not discussed and they soon learned that it behooved them not to ask questions or to appear to take any interest in such matters."

The study found that two-thirds of the women were not given clear information about reproduction when they were growing up and many did not understand how pregnancy occurs.

"They learned that sexuality was shameful and dangerous," the researchers said, "and they were told that they needed to 'take care of themselves' and avoid pregnancy, but they were not told how."

Although the study did not specifically address whether

the women disliked sex, the researchers reported "an aversion to sex was apparent." Wives of men who wanted sex infrequently indicated that they considered themselves lucky.

Such feelings may explain why the rhythm method and other forms of family planning involving long periods of abstinence were so popular among the women, the researchers said. More than half used some form of the rhythm method. Four of the 30 relied on a combination of abstinence, prolonged breastfeeding, herbal infusions to induce menstruation, and abortion. Only eight used modern contraceptives.

Mistrust of health care providers may have been another factor influencing the reproductive health choice of these women, the researchers said. Many of the women feared modern contraceptives and a number of them anticipated being discriminated against and receiving poor treatment because they were Aymaran. Several said that providers could not be trusted to tell the truth about contraceptive side effects and reported that providers dismissed their concerns about these effects.

In some cases,the women's mistrust was based on their own past experiences. Two of the women said they had been pressured into continuing the use of an intrauterine device (IUD) although they had asked their providers to remove them because of side effects.A physician told one of the women, "You're fine: Healthy as a girl!""That's all he said," the woman added,"so I just went away."

"When clients do not trust providers,they may be less apt to seek out their services and to obtain from them accurate reproductive health information that is otherwise unavailable.

This was the case in the Bolivian study, where researchers found that reliance on natural methods of family planning in the absence of knowledge about how to correctly use such methods led to many unplanned pregnancies.Two-thirds of the women had had at least one induced abortion or had tried to terminate a pregnancy, the study found. Almost one third reported unplanned pregnancies "that resulted in the birth of infants who subsequently died in unclear circumstances that might be interpreted as passive or active infanticide," the researchers said.

RESPECTFUL COMMUNICATION

Respectful and open discussions between providers and clients can create opportunities for providers to learn about factors influencing clients' decisions. Wisdom of this sort is necessary for providers to be able to offer counseling that is truly applicable to the circumstances of their clients' lives.

"Only interactive and dynamic counseling can identify clients' needs, risks, concerns, and preferences within their life-stage and life-situation," Dr. Murphy noted in a recent analysis of client–provider interactions.[15] The analysis also emphasized the importance of individualizing counseling, treating clients respectfully, counseling on method side effects,and providing clients with the contraceptive method of their choice.

In the case of the Bolivian study, where natural family planning methods were preferred by the majority of the women, the researchers recommended that providers educate clients to use these methods effectively rather than trying to convince them to use other methods.

"Providing clients with the contraceptive method of their choice is an important way that medical practitioners can help women maintain optimal reproductive health," Dr. Bailey agreed."Women who have succeeded in getting to a clinic often have a pretty good idea of what they want. Providers should respect that." In fact, research has shown that a woman who receives her contraceptive of choice is more likely to continue using the method.[16]

MEXICAN STUDY SHOWS COUNSELING HELPS

Providing women with adequate counseling on method side effects can also improve the chances that they will continue using the method, research has shown.[17] Such observations were confirmed in a 2001 study conducted in Merida, Yucatan, Mexico, which found that method continuation rates of injectable depotmedroxyprogesterone acetate (DMPA) were substantially higher among women who received extra counseling on side effects than among those who received only routine counseling: 83 percent and 57 percent, respectively.[18]

"Counseling on side effects is extremely important," Dr. Murphy says. "Providers should talk with clients about how certain contraceptives can affect a woman's body and also about how they can affect a woman's sexual relationship. In some cultures, for example, where there is a taboo on intercourse during times of bleeding, IUD use may be discontinued because heavy bleeding or spotting are frequent side effects of this method. Thus, IUD use may produce a conflict between a woman's desire to delay childbearing and her sexual desires or those of her partner."

Counseling women, especially youth, about how contraceptive use affects health in general might also prevent some women from making unhealthy—even life-threatening—sexual health decisions.

CONCLUSION

Still,few providers make discussions regarding sexuality part of their practice.

But research conducted in Egypt through the Population Council's Frontiers in Reproductive Health project has shown that sexuality counseling can be successfully integrated into services at family planning clinics.

The 1999 study was conducted in four Egyptian Ministry of Health and Population clinics and two private

clinics affiliated with the ministry.

Nurses and physicians for all six clinics attended a two-day contraception training session emphasizing barrier methods. Staff at three of these clinics received three additional days of training on sexuality, gender, and counseling.

The study showed that medical practitioners who went through sexuality training were less inhibited about discussing sexuality-related issues with their clients.

Clients attending the intervention clinics were more likely to have been counseled on how their chosen contraceptive could affect their sexuality than clients in control clinics (41 percent versus 22 percent).

Clients in intervention clinics were also more likely to have had a sexuality-related discussion with their provider unrelated to family planning than clients in control clinics (44 percent versus 18 percent). Sexuality discussions in intervention clinics seemed to promote clients' adoption of barrier contraceptive methods.

"This study challenges the belief that women do not like to talk about their sexual problems," said Population Council researcher Dr. Nahla Abdel-Tawab. "Once rapport is established, they can talk frankly about sexual difficulties with a physician whom they trust."

To continue to improve communication about sexuality-related issues, the study's authors recommended that providers be trained to manage simple sexual problems and to counsel women about how various contraceptive methods can affect sexual relations.

They also recommended that the government develop a referral system with teaching or university hospitals for women with more complex sexual problems as well as public health messages encouraging women to ask family planning providers about their sexuality-related concerns.[19] All in the name discussing sexuality to foster sexual health.

This article was adapted from three articles titled, "Discussing Sexuality Fosters Sexual Health," "Life Circumstances Influence Decisions," and "Training Providers to Talk about Sex," which appeared in volume 21, number 4 of Network, *published by Family Health International in Research Triangle Park, NC* ***–Editor***

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BBC'S *SEXWISE* PROVIDES CRITICAL SEXUAL HEALTH INFORMATION WORLDWIDE

The British Broadcasting Corporation (BBC) and International Planned Parenthood Federation (IPPF) are working together in different regions of the world to speak to people in their own languages about sexual health and reproductive rights through a new project called *Sexwise*.

The project consists of a Web site, books, and radio programs from the BBC. In collaboration with the IPPF and national Family Planning Associations (FPAs), the BBC has adapted and translated the radio programs, books, and Web site into 22 languages.

It has spanned the globe in three phases. Phase 1 was completed in 1996 in South Asia; Phase 2 took place in 1998 throughout Europe, Eastern Europe, and Central Asia; and Phase 3 was launched in June 2000 across Africa, the Arab region, Southeast Asia,and Latin America.

Sexwise aims to:

- Improve people's knowledge and understanding of their bodies and emotions
- Increase discussion of specific sexual and social concerns among individuals and communities
- Raise awareness about safer sex and STDs such as HIV/AIDS
- Respond to people's anxieties about sexual health
- Help people make more informed choices about their sexuality
- Dispel myths about sex and sexuality

Sexwise radio programs are designed to meet the needs of and raise issues relevant to regional audiences.They feature people describing their personal aspirations, experiences, and concerns. Topics include puberty changes, attitudes and responsibilities relating to sexual relationships, contraception,and gender issues.

Following the broadcast of radio programs, the FPAs offer advice and services to those people who want more support on particular issues.They also provide cassettes of the programs and the books in health centers,clinics,schools, and other venues.

Radio is a particularly useful format for sexuality education because it is an easily accessible and far-reaching medium. Poverty and high rates of illiteracy make radio the cheapest and most accessible source of information in many countries.

This collaboration between the BBC and IPPF is an example of how industry and NGOs can successfully link their missions to promote public health and well being.

For more information contact: BBC World Service, Bush House, Strand, London UC2B 4PH, United Kingdom. Phone: (+44) 20 7240 3456. Fax: (+44) 20 7557 1258. Visit their Web site at:http://www.bbc.co.uk/worldservice/aci_tech/features/health/sexwise

PASH PROMOTES ADOLESCENT SEXUAL HEALTH

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Imagine you are part of a small team asked to design and conduct a course for young people about sexuality and sexual health. The funding body wants a course with 15 to 16 weekly sessions, each lasting about two and a half hours. What approach would you take? What would you include? How would you structure it?

For most of us who work as sexuality educators, we would want to approach sexual health in a holistic manner. We would like to guide young people toward a positive experience of their sexuality, not just help them avoid unplanned pregnancies or sexually transmissible infections (STIs).

This means looking at sexuality in the context of the young person's life. It means getting the chance to include things like communication skills, assertiveness, conflict resolution, and risk taking, as well as being able to talk about things like anatomy, conception, contraception, and STIs. We have developed a peer education program that does all that.

THE PASH CONCEPT

The Family Planning Association of Western Australia (FPWA) developed and implemented the PASH (Promoting Adolescent Sexual Health) program during the past 10 years. The concept arose from the desire to work with young people on sexuality from a holistic peer education perspective, and it has now been used widely throughout Western Australia. In Australia, the word "PASH" has a slang meaning somewhat akin to "making out" or perhaps "kissing and cuddling passionately."

The PASH format is flexible. It is a course that young people attend voluntarily even when it is "done by the book." The young people, from culturally and linguistically diverse backgrounds, are recruited from schools, homeless accommodation services, juvenile detention centres, and universities—basically from any walk of life.

Using a group work- and activity-based approach, the course usually includes approximately five to 20 participants. The facilitators aim to create a place of physical and emotional safety, with large doses of fun to keep it attractive. As one young participant replied when asked what was the best thing about PASH:

> *Oh you'll have fun. I mean, you'll get to know yourself better, and you'll have fun. It doesn't get any better than that.*

Respect for the young people and how they are managing their lives and their decisions is paramount in the course. It is recognized that whatever is happening in their lives, they are doing the very best they can.

The formal aims of the project are to reduce unplanned pregnancies, to stop the spread of STIs, and to delay first intercourse, but this is not a "just say no" program. Having a respectful environment in which to learn, to explore fundamental values, to get to know themselves better, to have an opportunity to clarify decisions, and to learn useful skills all underpin the process of making positive decisions about physical health.

Two people facilitate the group, usually a male and a female if the group is mixed-gender. While the facilitators hold the responsibility to run the group, there is no teacher/student dynamic. Where appropriate, for instance, the facilitators share personal experiences.

One of the most wonderful outcomes for me in running a PASH was in the last "closing" session, when one of the young men came up to me to thank me. When I asked what he was thanking me for, he said he had been finding things very difficult and had been thinking it was all too hard. But when I shared some of the things from my own past, he had decided that life will get better if he just hangs in there.

PASH ITSELF

PASH itself is supported by a manual, which has the 16 sessions written as 'lesson plans,' many with alternative sessions or activities. The movement during these 16 sessions is from information-based to more personal or challenging issues to allow stronger group formation. The manual offers a framework rather than a set program, and facilitators are expected to adapt it to suit the needs of their particular group.

The first session is group formation. The next session, on anatomy, conception and contraception, is about teaching these things in a way that is memorable, fun and relevant, involving moving human models and discussions of reproductive systems.

A session on STIs clarifies basic information, seeking to teach the practical things people need to know as well as exploring how one would feel about getting an STI and what to do if a friend had a concern. A separate or combined session on HIV/AIDS is available. During this time, the young people and the facilitators are getting to know and trust each other more.

When we explore teenage pregnancy and teenage parenting, we invite a young person affected by a teenage pregnancy to talk about her or his experience. What makes it real is that it is not usually a "grim warning" session. The young mothers/parents love their child in the same way older people do. Having a child has often added an important dimension to their lives. They are candid, however, about the work involved, the loss of freedom, and the responsibilities that raising children implies.

We learn by taking risks. With adolescence being a time of learning, this is an important issue. The program explores risk taking by going into the purposes it can serve. This helps the participants better understand some of their own decisions (and think about future decisions). It also assists them to be better peer educators—to help them be less judgemental of others who take risks.

There is an entire session on sexuality. We cover communication skills, assertiveness, relationships, sexual assault, and conflict resolution. We look at gender roles and their impact on our lives and decisions. The fifteenth session is a "speak out" where we have a guest speaker on the topic of choice by the young people. This speaker is frequently a young gay person, or a speaker who is HIV positive. As with the teenage mother guest speakers, these sessions have a tremendous impact.

FPWA is a strongly pro-choice agency. This means that all ranges of views need to be supported and respected. Young people who are anti-abortion find their views as supported as, for instance, those of someone who has chosen to have a termination. In exploring sexuality with young people, we also explore issues of sexual orientation—looking at the impact of homophobia on the lives of young people. PASH has been run by a wide range of people, all carrying that same respect for young people in their group who hold different values than they do.

Disclosures of sexual abuse in the latter stages of the program are not uncommon. We have had young people "come out" as gay and have had to work with resulting family issues. Some facilitators and agencies obviously have concerns about these sorts of disclosures. It is our belief, however, that the young people should not be left to manage these issues by themselves. Knowing what we, as the facilitators, will do when it happens is essential.

Evaluations from the young people have shown increased confidence and self-efficacy, greater clarity about decisions, and, depending on the group, increased knowledge. More convincing still is the passion and enthusiasm of the young people for PASH. As a facilitator, it is very rewarding. Seeing the changes in confidence and assertiveness, the creation of friendships, the trust and respect between participants and between participants and facilitators is enormously satisfying. It makes all the work very worthwhile.

WHY PASH IS WHAT IT IS

As with any long-term project, a lot of people helped PASH become what it is—the ideas people, the coordinators, the many facilitators.

It also happened because FPWA was committed to the program. PASH would never have been possible without a supportive funding body. Healthway, the Western Australian Health Promotion Foundation, is a statutory body that initially utilized a percentage of taxes on tobacco (prior to the changes in state taxing) to (1) sponsor sports, arts, and racing to promote health and (2) fund health promotion programs and research. PASH was one of the early health-promotion projects funded by Healthway.

Healthway funded PASH in 1992-93 to pilot the program and write the manual. It was very successful, training many young people as peer educators. Having seen PASH's success, FPWA was committed to its continuing. But with limited funding, this was accomplished in a restricted manner.

Healthway approached FPWA in 1996 with the idea of starter-grants. In this program, Healthway provides a grant to FPWA. One portion provides small grants to communities for them to run PASH. FPWA uses the other portion to provide free training to the communities receiving the grant and to support them as they run their groups.

The groups may be run for 10 weeks, rather than 16, if that suits the agency's work. They may hold a camp for three to five days, or have a couple of full days with some single sessions. FPWA works from a philosophy of respecting that local people know their circumstances and people best, and that the local facilitators need the ability to take responsibility for their group. They can phone us at any time!

The Starter-Grant Project was run in 1996, 1998, and 1999/2000. It has allowed PASH to take place in communities all over Western Australia. This is a significant achievement, as Western Australia is a huge area, with a major population in the capital city, and the rest of the population spread widely. (It is approximately three and a half times the size of the state of Texas, with a population of approximately two million.) The starter grant concept is how so many young people from such diverse backgrounds have had the opportunity of participating in PASH.

WHERE TO FROM HERE?

Where to from here? The PASH manual is now in its third edition, with more updates in the pipeline. Training for PASH is an ongoing, core part of the work of FPWA. We hope to continue offering small grants to local communities with starter-grant funding.

The success of PASH with indigenous young people has led to requests to create a program for a younger age group. We are currently looking into creating a totally new program for young people 11 to 14 years of age. We continue to grow.

AIDS INFOSHARE: RUSSIAN PUBLIC HEALTH AND HUMAN RIGHTS

AIDS Infoshare is a Russian nongovernmental organization (NGO) founded in 1993 to provide individuals and organizations with the tools that they need to fight HIV/AIDS and STDs as well as human rights violations in the health care system.

It was started in Moscow when a small group of people discovered that very few Russians had access to information needed to take action against these issues.

As Russia has transitioned over the past decade into a market economy, it has experienced several new health crises: epidemics of infectious diseases, rising rates of alcoholism and drug abuse, increased rates of abortion and infant mortality, declining life span, and countless health problems as a result of the civil war in Chechnya.

Therefore, it has become increasingly important to educate the public about sexuality and reproductive health. It is also important that individuals know their rights before entering into a relationship with medical professionals or the public health system.

RUSSIAN HEALTH PROBLEMS

According to the U.S. Centers for Disease Control and Prevention (CDC), the infant mortality rate in Russia is still seven times the rate of the United States, despite a recent decline. Almost a quarter of all maternal deaths were related to abortions in 1995, the vast majority due to illegal abortions.

HIV/AIDS is also on the rise. Russia now has the fastest-rising rates of HIV infection in the world, with the number of HIV-positive Russians growing 15-fold in the past three years, the United Nations reported in December 2001.

While the official registered number of HIV-infected people has reached 163,000, the actual figure may be five to 10 times larger, according to the chief of the Russian Health Ministry's AIDS Department. By 2015, it is estimated that five to 10 million Russians will die from AIDS.

HUMAN RIGHTS AND HEALTH

One of AIDS Infoshare's recently-launched programs is designed to produce a set of guidelines for improving the observance of human rights and medical ethics in Russia's health care system.

Titled "Human Rights and Health in Russia," the program brings together NGOs,journalists,medical professionals, and policymakers to begin to look at practical ways to close the gap between the concept of human rights and the situation as it now exists in Russia.

The project includes researching the public health realities of 13 target groups; creating a comprehensive document of recommendations to present to the Duma, the governing body in Russia; a newsletter; and a possible six-part television series to introduce and explain concepts of human rights and medical ethics to a larger audience.

Another project titled "Infoexchange: STDs/HIV/AIDS Prevention among Women" works closely with 10 organizations to assist and support them in conducting their own projects, providing computer equipment and training, project management skills, small project grants, and partnerships with American/European organizations doing the same work.

To date, there has been no attempt to begin discussion on the interaction of human rights and public health in Russia. Infoshare understands these matters are not separate and is working to educate policymakers on human rights and their place in public health promotion, to seek input from doctors and NGOs working with vulnerable populations on how to improve the health status of the nation and not instill fear and distrust in those they are trying to help, and,finally, to work with the media to inform the public of their rights regarding their health.

Infoshare's programs are helping to create true change in Russia's health care system.

For more information, contact: Infoshare International, 584 Castro Street, Suite 671, San Francisco, CA 94114. Phone:415/437-1873. Fax:510/843-4066.E-mail: infoshare1@aol.com

WORKING WITH OUT-OF-SCHOOL YOUTH IN BELIZE AND PERU

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Urban youth in Belize and Peru face a number of common concerns, including high pregnancy rates, lack of knowledge and negative attitudes about sexual and reproductive health, low self-esteem, poor decision-making skills,and limited economic opportunities.

For example, teen pregnancy rates in Belize have been as high as 20 percent. Out-of-school youth are particularly vulnerable to such difficulties, but reaching these youth can be challenging.

FINDING WAYS TO PROVIDE SERVICES

Family planning associations must find creative ways to attract out-of-school youth to services and to provide them with the information and skills they need for improved sexual and reproductive health and quality of life.

Successful strategies have included, in the case of Belize, using arts and entertainment to communicate important sexual and reproductive health information, and, in the case of Peru, linking out-of-school youth's economic concerns with sexual and reproductive health.

In 1995, the Belize Family Life Association (BFLA) initiated a series of discussions with its youth groups throughout the country and with the Society for the Promotion of Education and Research (SPEAR), a local organization that had successfully worked with inner-city youth, to identify ways to effectively work with out-of-school adolescents.

As a result of these consultations, BFLA developed a project that combined both education and entertainment in targeting urban youth in Belize City. The drama/dance peer-counseling project, which received funding from the Hewlett Foundation for a two-year period (1996-98), was intended to serve as a model for reaching out-of-school youth with information and education on sexual and reproductive health issues.

The Peruvian Institute for Responsible Parenthood (INPPARES) focused on enhancing urban youth's opportunities for income generation while improving their knowledge and attitudes related to sexual and reproductive health. The two-and-a-half-year project (May 1997 through October 1999) was based on the premise that when young people lack opportunities to become productive members of society, their self-esteem, relationships, and health suffer.

With local funds and contributions from International Planned Parenthood Federation (IPPF)/Western Hemisphere Region and UNICEF, INPPARES teamed with the Center for Integral Development (CID), a local nongovernmental organization (NGO) specializing in income generation and micro-enterprise development. Together, we provided "Quality of Life" training,integrating sexual and reproductive health education and the development of income-generating strategies and skills for primarily out-of-school youth 16 to 28 years of age in three Peruvian cities (Lima, Huancayo, and Cusco).

PROJECT GOALS, OBJECTIVES

The overall goal of the drama/dance peer-counseling project in Belize was to equip out-of-school youth with the skills and knowledge needed to better manage their sexuality, leading to improved relationships and sexual and reproductive health.

The specific objectives of the project were to increase the ability of adolescents to negotiate safer sexual practices, including the use of condoms, and to improve attitudes among out-of-school youth regarding gender equity.

The goal of the "Quality of Life" program in Peru was to improve the situation of youth in poor urban areas by means of sexual and reproductive health education and skills development for income generation.

The main objectives were to improve adolescents' knowledge and attitudes related to sexual and reproductive health, to increase their capacity to implement income-generating activities, and to build their self-esteem and leadership skills.

PROJECT ACTIVITIES

Youth involvement in project design was a key strategy in working with out-of-school youth in both Belize and Peru. In Belize, members of BFLA's Youth Advocacy Movement provided input during the design phase of the project, and in Peru, project staff conducted needs assessments and

involved youth in the design of project activities.

The drama/dance peer-counseling project in Belize successfully recruited and trained 28 out-of-school youth volunteers to serve as peer counselors and members of the Astrals Entertainment Group. The youth received training in drama and dance as well as sexual and reproductive health and life skills. Twenty-one of these youth remained for the life of the project, resulting in a retention rate of 75 percent.

The comprehensive training program for these peer counselors focused on building their personal value system and self-esteem. Improving the peer counselors' own decision-making skills related to sexuality and sexual relations and increasing their understanding of the responsibilities of parenthood and employment were also key components of the training.

Most of the training was based on a "life skills" curriculum called *Life Planning Education* developed by the Center for Population Options. After this preparation, the youth were able to provide sexual and reproductive health information and counseling in communication/negotiation skills to their peers through drama and dance performances, rap sessions, and counseling sessions.

The drama and dance performances relied on out-of-school youth's attraction to crowds and loud music in the streets, while the rap sessions utilized a "talk show" format and encouraged sharing and discussion among youth who might not do so in a more formal setting.

The peer educators also provided individual counseling and used a referral card system to direct out-of-school youth to clinical and other reproductive health services at BFLA's Teen Center.

The "Quality of Life" training course consisted of 20 hours of instruction over the course of a week, split between sexual and reproductive health and skills for income generation. Specific topics that were covered included skills assessment, small business planning, entrepreneurial culture, self-esteem, sexuality, human anatomy and physiology, sexually transmitted infections, family and personal relationships, and family planning. After course facilitators found that many of the young men had *machista* attitudes, additional time was spent covering gender issues.

Workshops and talks were also held at high schools and youth groups, and individual counseling was made available to address participants' vocational and sexual and reproductive health needs. The project sponsored two nationwide small business competitions, with winners receiving small grants to implement and evaluate their business plans. Other project outputs included a manual called "Sexual and Reproductive Health," which was developed and distributed to all course participants, as well as a pamphlet series on a variety of SRH topics.

EVALUATION STRATEGIES

The projects used a variety of methods to monitor and evaluate their efforts.

In Belize, project staff designed a plan for monitoring and evaluation, which included pre- and post-test examinations of peer counselor trainees. Peer counselors were also asked to provide feedback on their perceptions of the training sessions.

In Peru, project staff employed both quantitative and qualitative methods to evaluate the effectiveness of the intervention. Pre- and post-test questionnaires were administered to 360 youth participating in the "Quality of Life" courses, and a series of focus groups were held with other youth.

KEY RESULTS

The drama/dance peer-counseling model in Belize and the Peruvian model, which combined sexual and reproductive health and small business training, both proved to be effective in reaching out-of-school youth. The projects brought positive changes in youth's knowledge and attitudes as well as an increase in their use of sexual and reproductive health clinical services.

In Belize, not surprisingly, the project had the greatest effect on those young people who participated directly in the project as peer counselors. Training session evaluations revealed that youth were satisfied with the level of their training.

Furthermore, pre- and post-test results revealed that before the training, 45 percent of youth had correct knowledge of sexual and reproductive health and appropriate communication/negotiation skills. Following the training, the percentage increased to 91 percent.

Another project success was an increase in youth's use of clinical services. Fifteen sexually active peer counselors became family planning users following their involvement in the project, and 176 out-of-school youth utilized the clinical services of BFLA's Teen Center, an increase of more than 10 percent from the period before the project was initiated.

In addition to the 28 youth who received training as peer counselors and another 24 drop-in youth who received training on an informal basis, the project reached nearly 3,000 young people through various activities. There were 24 community presentations, involving 729 out-of-school youth, 21 rap sessions with 394 out-of-school youth, and six peer education/outreach sessions involving 198 out-of-school youth. Through 32 school presentations held at five high schools in Belize City, more than 1,500 in-school youth were also reached.

In Peru, the "Quality of Life" training project touched the lives of thousands of youth. More than 15,000 were reached through 213 talks, 32 workshops, and 22 "Quality of Life" trainings in the three project cities. In addition, 1,681 youth received individual counseling, the majority for inter-

personal problems such as communicating with a partner or parent. Based on the project evaluation results, participating youth's self-esteem improved by 89 percent on the Stanley Cooper Smith Scale for Self-Esteem, a self-administered test consisting of 58 yes/no questions. There were also increases in knowledge about sexual and reproductive health themes covered in the courses, and improved attitudes related to sexuality. Furthermore, many participants said that prior to participating in the course, they lacked the skills to resolve interpersonal conflicts. During the project period, there was also an increase in youth seeking sexual and reproductive health services and counseling at INPPARES clinics.

More than 2,000 youth registered for the project's small-business project design competitions, with more than 400 projects submitted. Many youth were able to develop successful businesses, such as bakeries, tailor shops, or agricultural projects, which in some cases became the principal source of income for the family, according to project staff.

The project also had a positive effect on INPPARES as an organization. Vocational issues were successfully integrated into the topics covered in counseling sessions with young people at INPPARES' Youth Center in Lima, including skills assessment and help in creating a personal plan for finding employment or starting an income-generating project.

LESSONS LEARNED

Reaching out-of-school youth is particularly challenging for sexual and reproductive health care providers. Developing successful strategies often requires targeting other important youth needs, such as generating income, or finding innovative ways—such as drama and dance—to present information.

IPPF of the Western Hemisphere Region has identified a number of key lessons to consider when designing programs for out-of-school youth:

- Work with other organizations to address topics not usually in the scope of sexual and reproductive health to expand the association's reach and contribute to an improvement in adolescents' overall quality of life.
- Include a component in programs targeting out-of-school youth that involves income generation. These young people consider their economic situation to be more pressing than the risk of HIV/STIs and pregnancy.
- Develop a flexible program with a realistic pace so that out-of-school youth can fit it into their work schedules. Peru's "Quality of Life" program offered classes at flexible times to make attendance easier for participants.
- Discuss sexual and reproductive health concerns in the context of other pressing concerns, such as jobs, or in informal settings such as the "rap sessions" utilized in Belize.
- Include practical issues—such as decision-making, self-esteem, and development of life goals—in programs so that young people will find them more useful. This was true of Peru's "Quality of Life" project.

DEVELOPING GUIDELINES FOR COMPREHENSIVE SEXUALITY EDUCATION

SIECUS has worked with organizations in Brazil, India, Nigeria, and Russia since 1995 to develop a consensus on the components of comprehensive sexuality education.

During that time, participants have learned that simply translating the SIECUS *Guidelines* is not appropriate because of the culturally specific aspects of sexuality.

SIECUS' International Department has therefore published a booklet titled *Developing Guidelines for Comprehensive Sexuality Education* that answers questions educators, service providers, and policymakers worldwide have about the development of guidelines in their own countries.

Specifically, the booklet outlines a 14-step approach to developing country-specific guidelines based on SIECUS' work in the United States and internationally.

The booklet is available for $10 by writing to SIECUS Publications, SIECUS, 130 West 42nd Street, Suite 350, New York, NY 10036-7802. All orders must be accompanied by a check made payable to SIECUS and drawn on a U.S. bank.

YOUTH HOTLINES SUCCEED IN GUATEMALA AND COLOMBIA

Early childbearing, unsafe abortion, HIV/AIDS, sexually transmitted infections (STIs), sexual violence, drug and alcohol addiction, family tensions, and psychological distress are all common problems among youth in Guatemala and Colombia.

PHONE HOTLINES

Youth phone hotlines were established in both of these countries in order to provide an anonymous and free point of first contact for adolescents in need of sexual and reproductive health information,counseling, and referral.

In Guatemala, the Asociación Pro-Bienestar de la Familía (APROFAM) ran a phone counseling and referral service in Guatemala City for 16 years (1980-1996), fielding 40 to 100 calls a day, or 7,000 per year. In 1999, the organization sought to capitalize on this expertise and focus on adolescents, establishing a youth hotline with funding from The Netherlands Trust Fund.

In Colombia, PROFAMILIA has successfully operated a nationwide phone information service since 1991, with the annual call volume increasing from 15,600 to 132,000 in the first five years. Due to the growing demand among youth for this service as well as the need to provide them with free and confidential access to accurate information on sexual and reproductive health, PROFAMILIA launched a three-year Youth Hotline Project in 1996 with funding from the Hewlett Foundation.

PROJECT GOALS AND OBJECTIVES

The goal of the Guatemalan youth hotline was to improve adolescents'sexual, reproductive, and mental health by offering anonymous emergency counseling and referral to clinical and psychological services.In Colombia, the goal was to offer counseling to those adolescents with questions or problems related to sexual and reproductive health but without direct access to services,and to provide referral to appropriate services as needed. Both young men and women were served through the hotlines.

PROJECT ACTIVITIES

In Guatemala, APROFAM surveyed youth prior to implementation so that the project could be better tailored to youth needs and preferences.The service was offered nationwide and was free to anyone with a phone line. The hotline was staffed by two trained female psychologists who provided counseling and referral to a wide range of agencies, such as drug and alcohol detoxification centers,Alcoholics Anonymous, cultural and sports clubs, and homeless shelters, as well as health clinics, including APROFAM's own youth clinic. The psychologists were also prepared to help victims of sexual harassment or domestic violence.

Marketing strategies were an important component of both projects. In Guatemala, the hotline was marketed through newspaper, television,and radio announcements, at kiosks,and on posters and flyers distributed at schools and youth hangouts.The project was also promoted through APROFAM's other youth projects, such as the organization's cyber center. Most of the callers indicated that they had heard about the service through friends (41 percent), schools (19 percent), flyers (19 percent), newspapers (10 percent), and radio (8 percent).

In Colombia, PROFAMILIA launched a widespread marketing campaign for the youth hotline on several fronts. Promotional materials were distributed through universities, high schools, community centers, health centers, and other places frequented by youth. The hotline number was printed on PROFAMILIA's letterhead, on all papers distributed to clinic users, and on posters hanging in PROFAMILIA facilities. The Youth Hotline also served as one of the sponsors of a nationwide youth meeting, making contacts with municipal authorities, youth groups, and local and national governmental agencies involved in health, education, and youth issues. T-shirts were printed with the hotline number and worn by PROFAMILIA staff at the event.

In addition, a radio marketing campaign was broadcast in numerous cities in and around Colombia with information about the youth hotline as well as informational spots on sexual and reproductive health topics, such as HIV/AIDS, STIs, adolescent pregnancy, family planning, condom use, sexual abuse, emergency contraception, and so forth. These radio spots were designed using young people's own language and the specific context of the geographical area in which they were to be aired. A special effort was also made to market the service directly to young men, since in the past 90 percent of youth callers to the hotline were female.

Youth hotline staff received training in sexual and reproductive health,including specialized information on adolescent health, as well as information related to accessing services at PROFAMILIA and other service providers within the Colombian health system.

KEY RESULTS

Guatemala's Youth Hotline project received a total of 954 calls during the initial 18-month period of the project, mostly from the Guatemala City metropolitan area.Youth called seeking information or counseling on a variety of concerns, including contraception (15 percent), abortion (13 percent), fear of pregnancy (12 percent),information about youth services (12 percent), HIV/AIDS/STIs (6 percent), self-esteem (4 percent), and emotional crisis (4 percent).Approximately 30 adults also called with concerns about adolescents.

According to the results of APROFAM's caller survey, all users were either very satisfied (50 percent) or satisfied (50 percent) with the hotline service. Some 90 percent of callers were referred to APROFAM's youth clinic, which registered 366 visits directly attributable to hotline referral (14 percent of all visits during the project period).

Colombia's youth hotline project also proved to be a success. Calls from adolescents increased 139 percent from a monthly average of 144 calls at the beginning of the project to 345 calls per month, and the average proportion of young male callers increased from 10 to 15 percent. Calls came from youth around the country, including large urban centers, smaller cities, and rural areas. Nearly 9,000 calls were received through the youth hotline during the three-year project period. The majority of requests for information were related to family planning methods, especially emergency contraception and injectables,pregnancy risk,STIs, and couple relations.

LESSONS LEARNED

These two projects have shown that youth hotlines can serve as an important point of first contact for youth seeking sexual and reproductive health information, counseling, and related services. Some of the key lessons learned were:

- Ongoing marketing is important.Radio campaigns proved especially fruitful for PROFAMILIA in Colombia.
- Strategic alliances with other organizations can help in the dissemination of information. PROFAMILIA in Colombia developed ties with a variety of youth-serving agencies that helped to promote the hotline.
- Adequate staffing is important in handling calls in an efficient manner. These calls can sometimes prove difficult and time consuming because young people find it hard to discuss issues relating to sexuality.
- Hotline staff must have access to current information on services available to youth.This is especially important when the hotline service is offered nationwide and young people need referrals to services in multiple areas.
- Hotline staff should receive training on a broad range of topics, such as adolescent development, sexual and reproductive health, drug and alcohol abuse, sexual harassment, and referrals.
- Since hotlines are usually free, organizations will find it difficult to operate without donor funding. They should consider cross-subsidization from clinical services as a possible strategy.

EXPERIENCES OF IMPLEMENTING A SEXUAL HEALTH STRATEGY IN NORTHERN INDIA

Jashodhara Dasgupta, M.A.
Coordinator, SAHAYOG
Lucknow, Uttar Pradesh, India

A sudden furor arose in Northern Indian in April 2000 after the arrest and imprisonment of 11 workers of a nongovernmental organization (NGO) over charges of publication and distribution of pornography and inciting the armed forces to mutiny.

This accusation was based on the report of a study on HIV/AIDS that SAHAYOG, the NGO, had published nine months earlier. Six of the workers, including a visiting guest, were imprisoned for 40 days, denied access to lawyers, and not allowed bail. Four of them were detained under the National Security Act (usually applied only to retaining terrorists) so they could not receive bail for a year.

National media coverage and hot debates ensued on the appropriateness of working on AIDS or on sexuality and sexual health issues. Ethics and rights questions were raised regarding community rights to privacy of sexual behavior as well as the ethics of publishing research on high-risk behavior or of using quotations of experiences of sexual violation and abuse.

State AIDS organizations and government agencies denied that there was a need to address sexuality in discussions about AIDS and even dismissed the possibility of AIDS cases in the area.

The following is an attempt to describe the factors that contributed to the incident and to analyze this NGO's experience of implementing a sexual health education strategy in northern India.

BACKGROUND

SAHAYOG is a voluntary organization that has worked from a rights-based perspective since 1992 in the northern part of India in the state of Uttar Pradesh.

It was started by a team that included a medical doctor and a women's activist. Gradually, it attracted a dedicated team of health workers,social activists, and grassroots workers.The core areas of SAHAYOG's work involved women's health, rights, and empowerment. Within this framework, it also worked with men to promote responsible partnering and support for women's rights.

SAHAYOG's strategies included research, training, information development and dissemination, networking, and advocacy, apart from community organization and awareness-raising.

SAHAYOG usually advocates new issues after conducting studies to understand them; one of its unwritten agendas was to simplify the difficult concepts and information regarding health, gender, and rights into language that could be easily understood and used by ordinary people.The target groups were mainly women, youth, *dalits* (the "lower caste"), and other voluntary organizations working in the state.

The empowerment work with women and *dalits* at the community level led to a reaction from the local vested interests whose control over political, economic, and social processes was threatened by the activities of the community groups formed by SAHAYOG. Almost every year there were attempts to force SAHAYOG to leave the area, through staff harassment,petitions to the administration,and other strategies.

By the late 1990s, SAHAYOG had emerged as a well-known organization working on reproductive health and rights, partly because two of its staff had been awarded the MacArthur Fellowship for Population Innovations for 1995 through 1998. SAHAYOG had been implementing an innovative, gender-sensitive, and women-controlled reproductive health care program from a rights-based approach in 60 villages of one district, and is also well known for the gender and health trainings it was able to provide for staff of other NGOs and government employees.

SAHAYOG was also hosting the secretariat of a network called HealthWatch Uttar Pradesh-Bihar that advocated and monitored work on sexual and reproductive health and rights. Apart from this, it was associated with the women's movement and with health and rights networks.

THE AREA

SAHAYOG works primarily in the northern part of the Uttar Pradesh state, in the mountainous zone of the central Himalayas.

The region has difficult terrain, with mountains and forests, poor communication, and poor outreach of state health services. The problems of the area are compounded by high male migration and a 'money order' economy.

Men who are fortunate are able to join the army; others have to make do with unreliable private sector jobs, or become domestic help such as cooks or guards. Others simply become unskilled migrant laborers in tourist areas of the region, or work as cleaners with the transport industry.

Women generally do not migrate but stay in the area to work in the fields and forests. Apparently enjoying mobility and freedoms denied to women in the plains regions of the same state, these hill women are also subject to strict controls and sanctions from a rigidly patriarchal society. They do not make any significant decisions without the male heads of the home.

Although settlements usually consist of scattered hamlets separated by terraced fields, ravines and forests, communities tend to close ranks completely in cases of gender-based violence or sexual "misdemeanors," and cover up all evidence to prevent any information leaking to the outside world.

SAHAYOG worked in one district with women and *dalits*, and organized community level groups of women, adolescents, or youth to promote local leadership and awareness-raising activities. One of the groups consisted of dalit men and women performers trained in Theatre of the Oppressed who usually worked on public awareness campaigns on people's rights, combining education with mobilization work.

THE INCIDENT

SAHAYOG has been concerned with the effect of male migration on women's reproductive health since its earlier documentation exercise in 1996 across the 10 districts of the region. In 1998, a study was planned to document the incidence of high-risk behavior related to the spread of HIV/AIDS in the region. The study looked at knowledge, attitudes, and practices related to different modes of transmission such as the use of needles/syringes, blood transfusions, and heterosexual and homosexual contact. The study was subsequently conducted with the help of resource persons working with a premiere HIV/AIDS project elsewhere,* and in collaboration with another NGO that had previously worked on AIDS-related issues in the same state.

The key findings of the study showed that all routes for transmission for HIV/AIDS were open in the region. There was no sterilization of needles during routine vaccination programs or at health clinics. No blood-banking facility existed with HIV-testing services at the district hospital. Evidence was found of commercial sex worker blood donors.

There was also evidence of coerced unprotected sexual relations, including sexual exploitation of single women, such as widows; informal commercial sex-work in rural areas; and sexual abuse within families. Young men reported having multiple sex partners, including same-sex partners and commercial sex workers.

The report of the study was prepared by September 1999 in two different formats, both with the objective of sharing the information and analyses with groups who normally do not have access to such reports, as study reports are usually published in English.

One version of the report was in local-dialect theatre so that the community could understand the data that it provided. The second was a written document in the language of the area (Hindi), to enable the local NGOs to understand the seriousness and complexity of the issue.

The theatre sessions were very successful, enabling community youth and women to comprehend their vulnerability and prompting them to make community plans for preventive education with the help of SAHAYOG health workers. As a follow up to this, a male health worker started a community youth group to work specifically on peer education strategies for sexuality and health issues.

The Hindi report was printed and disseminated to a few hundred NGOs and individuals working on health issues. It was hoped that the report would lead to a rethinking of health program strategies among government and NGOs to include issues of sexual health and sexual violence for both men and women.

Almost nine months after the publication and dissemination of the report, a newspaper article appeared condemning it as inflammatory and inaccurate. This was followed by similar articles. Within a day or two, the SAHAYOG offices were attacked by groups of belligerent youth protesting against "the disrespect to the dignity and culture of the area." There were physical attacks on the staff, the smashing and looting of property, obscene behavior toward female workers, and sloganeering and picketing, all in the presence of the police.

The staff was arbitrarily arrested and produced in court the next day but denied lawyers. Those lawyers who tried to represent them were threatened with their lives. The staff were imprisoned and denied bail for 40 days. At the same time, the district town issued an order forbidding SAHAYOG from carrying out any activities in the district. The district magistrate (who is the administrative head) also instructed the local bank to freeze the organization's accounts as well as the personal bank accounts of its key staff.

Activists from other places who rushed to the defense of the SAHAYOG staff were attacked and even heckled in court. The police refused to register any reports of attacks on the staff and the offices or of the theft of organizational property. Newspapers continued to cover the issue, including grossly false statements with banner headlines.

The local media published completely one-sided reports of the incident for months. They refused to publish any press statements of SAHAYOG staff, the apology issued by the organization for "hurting or offending local sentiments or culture," or the repeated attempts made by community

women and *dalits* to submit petitions to the district administrations in defense of the organization and its past work.

Multiple copies were made of the four pages of the SAHAYOG study report which gave quotations from respondents describing experiences of sexual violations and abuse. These were systematically distributed to even the remotest mountain villages in the region, which had never even seen a newspaper.

After some days, as bail appeared likely as the result of the actions of a higher court, the district administration imposed the National Security Act (NSA) upon four staff members, thus preventing them from obtaining bail for at least one year. At the same time, there was national mobilization and advocacy by activists working on human rights, women's rights,sexual rights,and health rights.

The national government issued a statement condemning the attack,the NSA was removed,and,after 40 days,the higher court granted bail. The *dalits* of the community, where SAHAYOG had worked, including dalit women, came forward to stand as guarantors for bail.

ANALYSIS

Until the imposition of the NSA, even those who had spoken in defense of SAHAYOG at the national and state level were wary about the "pornographic" content of the Hindi report and continued to debate whether SAHAYOG deserved the attack or the public "outrage."

After the NSA, it became clear that the issue was not whether the NGO had done anything to deserve the attack but that some forces were trying to ensure that the NGO was wiped out using the "violation of culture and dignity of the region" as an excuse to do so.

It also became obvious that the "voice of the outraged public" was actually a carefully orchestrated collection of a few vocal and influential voices of the more powerful sections of society. Dalit voices and community women's voices were missing.

The experience is also worth analyzing from the standpoint of the implementation of a sexual health strategy. Sexual health largely depends on the ability to negotiate safe and pleasurable sexual activity in conjunction with one's sexual identity. Inherent in this is negotiation of the power structures of the relationships in which a person is involved.

Strategies for sexual health become especially difficult in the case of disempowered people like single women, poor or dalit youth, or young women sexually abused by family members and close relatives. In fact, even allowing the expression of what has so far been kept hidden disturbs the power balance.

CONCLUSION

While SAHAYOG's sexual health strategy was not comprehensively designed (as is evident from the posting of copies of the report to people without any formal presentation and discussion), it is clear that the implied "disclosure" and the disruption of the "culture of silence" provoked a violent reaction from the powerful elements in the community.

Today SAHAYOG is continuing its work on sexual and reproductive rights and health through its trainings for NGOs, for government staff, and especially for men. It continues to encourage "unpacking" of the silences and myths surrounding sexuality through discussions in more protected spaces like workshops and trainings, mostly done outside the region where the incident took place. At the community level, it is carrying on its work in new areas by developing a "rights"perspective.

In the future, SAHAYOG plans to conduct a study on *Violence Against Women in the Uttaranchal Region* by using a much more strategic approach.Apart from that, it will also work in other regions with men on the subjects of violence against women, on male identity and sexuality, and on sexual and reproductive rights and health.

In order to overcome the problems which SAHAYOG faced, it recommends that other groups develop a well thought-out strategy when deciding to make public statements on issues that have strong cultural connotations.

For example, key players like government agency officials, media persons/spokespersons, or senior academicians should endorse and support the information before it is finalized and released.

In addition, it is important for organizations like SAHAYOG to a have strong supportive networks—especially with groups that work from a human rights perspective.

⋆ *Sonagachi Project with Commercial Sex Workers of Kolkata, West Bengal,India.*

LOVELIFE AND INDEPENDENT NEWSPAPERS JOIN SOUTH AFRICAN FIGHT AGAINST HIV/AIDS

Despite the advances in treatment of HIV/AIDS and prevention efforts, sub-Saharan Africa is still overwhelmed and burdened by the epidemic. South Africa, in particular, has suffered. Consider these statistics:

- South Africa has the largest number of people living with HIV/AIDS in the world, officially estimated at 4.2 million
- One in four South African women 20 to 29 years of age is infected with HIV
- Over 420,000 South African children are orphans as a result of AIDS
- In South Africa,AIDS is expected to shrink the national economy by as much as $22 billion by 2010
- Over 40 percent of South African teachers have died from HIV/AIDS

LOVELIFE PEER EDUCATION

LoveLife is a peer education program designed to substantially reduce the incidence of HIV, STDs, and unwanted pregnancy among 15- to 20-year-old South Africans through positive messages on sexual behavior through television,radio, publications, entertainment, and sports.

Launched only two years ago, *LoveLife* has quickly gained recognition as a new lifestyle motto for young South Africans.Already more than 70 percent can readily identify the *LoveLife* image and can accurately describe its purpose.

LoveLife employs a multimedia campaign to reach youth with HIV-prevention messages, combined with a nationwide drive to build prevention awareness. It accomplishes this by stimulating open and informed communication about sex, sexuality, and gender relations, as well as by developing adolescent sexual health services,outreach, and support programs.

FIVE-YEAR PARTNERSHIP WITH INDEPENDENT NEWSPAPERS

Independent Newspapers, South Africa's largest newspaper publishing company, has joined *LoveLife* in a five-year partnership to help the group fight the nation's HIV/AIDS epidemic.

A biweekly newsletter targeted to youth titled *Thetha Nathi (Speak to Us)*, is the centerpiece of the partnership. It will assist *LoveLife* in expanding its media reach and educational efforts.

In addition to *Thetha Nathi*, *LoveLife*'s other major programs include *S'camta* (slang for "Talk about It"), a weekly television program. It encourages teens throughout the country to talk openly about sex and relationships, both with their peers and their parents. The program is part road movie, part documentary, and part music program, with hosts traveling throughout South Africa sharing stories about life, sex, and being young.

LoveLife also reaches youth through *LoveLife* radio, which partners with three commercial radio stations and six public services radio stations in South Africa. It has established youth-friendly health services in public clinics, a free sexual health help line, and sexual health education programs in the most remote parts of South Africa.

Resources from *LoveLife* include:

- *The Impending Catastrophe*, a resource book on the emerging HIV/AIDS epidemic in South Africa
- *Loud and Clear*, tips on talking to children about difficult things
- *Talking and Listening*, helping parents and teenagers work together
- *Tell Me More!*
- Xunhua News Agency

For the post-apartheid generation, which is exposed to the global economy and a pervasive media, *LoveLife* has become a national movement calling South African youth to both community and personal action.

A poignant comment by a teenager in a recent survey was:"When we drive past the billboards, we feel so proud because they give us a sense of belonging."

For more information: LoveLife, *P. O. Box 45, Parklands 2121. Phone: +27 11 771 6800. Fax: +27 11 771 6801. Web site: http://www.LoveLife.org.za. E-mail: talk@LoveLife.org.za*

BUSH ADMINISTRATION "MISSION CREEP" AFFECTS GLOBAL SEXUAL HEALTH EFFORTS

William Smith
SIECUS Public Policy Director

This issue of the *SIECUS Report* addresses a gamut of international issues related to sexual and reproductive health. In many ways, they are the product of in-country dynamics. But more recently, we have seen the ideological and religiously conservative disposition toward sexuality in the United States become a product for export. For advocates of sound public health policies, this phenomenon of "mission creep" has become a source of deep concern.

For all intent and purpose, the Bush Administration has launched an all-out campaign to convince the rest of the globe that the only effective way to permanently address sexual and reproductive health issues is rather simple: first, all people—regardless of age—should remain abstinent until they marry; second, those who are married must remain monogamous and exercise fidelity. Coupled with this philosophy is an Administration willing to provide assistance to those in need, but only if they are willing to gamble—as we ourselves are domestically—that the approach is sufficient and workable.

RESEARCH POINTS TO GAMBLE

The most recent research underscores just how much of a gamble it is. *The British Medical Journal* released a study in June that found three abstinence programs in which the pregnancy rate among female partners of males was significantly higher than among those who did not take part in the program. The study also found that the pregnancy rate among adolescent women in four abstinence programs was higher than in the control group. None of the programs defined as "abstinence programs" in the study taught about any forms of prevention, such as contraception.

Socially conservative groups criticized on the study. Focus on the Family described its "poor quality" and encouraged abstinence-until-marriage proponents to "take this report lightly." In addition, one of their analysts suggested that researchers should look at the largest program run by the Southern Baptist Church that focuses on pledging abstinence until marriage. Focus on the Family says the program run by the Ugandan government is an example of an effective application of the pledge program.

According to UNAIDS, Uganda's overall infection rate has fallen from eight percent in 1999 to five percent in 2001. But crediting the overall drop to pledge programs, as Focus on the Family does, is decidedly misleading. In fact, on June 21 at a meeting of the President's Advisory Council on HIV/AIDS—now co-chaired by abstinence-only champion and former Congressman Tom Coburn—Dr. Ann Peterson, assistant administrator for the United States Agency for International Development's Bureau for Global Health, presented data on Uganda's strategy to reduce its HIV-infection rates.

In reality, Uganda's approach is multifaceted in that it stresses both abstinence and faithfulness while also promoting condom use for those who are sexually active. Proponents of abstinence-only-until-marriage conveniently leave off the last part of the strategy in their propaganda to sell abstinence-only-until-marriage interventions in the international context. In addition, a study of the pledge card program's application in the United States found harm associated with the intervention. Those young people who broke the pledge were a third less likely to use contraception when they did have intercourse.

"MISSION CREEP" AT U.N. CHILDREN'S SUMMIT

And yet, the lack of scientific support has not swayed the Bush Administration's purposeful "mission creep" in advancing abstinence-only-until-marriage beyond our own domestic prevention portfolio.

At the United Nations Children's Summit this past May, the United States was in the embarrassing position of being ideologically akin to such totalitarian and theistic states as Iran, Sudan, Libya, and Iraq in denying language to a consensus document that sought to provide young people around the world with access to reproductive health care services.

During a speech at the Summit, U.S. Secretary of Health and Human Services Tommy Thompson reiterated unwavering support for the Bush doctrine that abstinence from "non-marital sexual activity" is the panacea for solving all matters related to sexual and reproductive health. Even Concerned Women for America was forced to report that the Secretary's speech "received tepid applause."

Additional evidence of the Bush Administration's "mission creep" comes on its own views regarding HIV/AIDS preven-

tion. Already, the United States is conducting a domestic review of those receiving HIV/AIDS-prevention funding. The Bush Administration insists this is designed to curb waste, but direct service providers fear that the review is really an effort to expunge programs not in sync with the Administration's abstinence-only philosophy on prevention.

It is no coincidence that the Bush Administration's high-profile decision on June 18 to allocate $500 million over the next three years to the international HIV/AIDS initiative was so narrowly focused as to provide funding only for medicine that prevents mother-to-child transmission of HIV.

While direly needed, the act gave the impression of leadership while entirely skirting the delicate issues involved in prevention—such as sex. In addition, it provided significantly less money than advocates had anticipated. One estimate found that the allocation aimed to prevent 30,000 infants from infection annually even though 800,000 infants are born HIV positive each year according to UNAIDS. This outermost indication from the Bush Administration on how best to prevent HIV in the developing world, while discouraging, perhaps indicates at the very least that the Administration is fully aware that a global abstinence-only-until-marriage campaign headed by the United States remains a hard sell.

UNFPA-FUNDING PHASE OUT

Finally, the Bush Administration's relentless attack on family planning continues to defy rational thinking in terms of preventing unintended pregnancy and protecting the health of women.

Domestically, the President has proposed flat funding for family planning for fiscal year 2003. But internationally, the President's budget blueprint entirely phases out support for the United Nations Population Fund (UNFPA).

The lack of forward-looking support for UNFPA is hardly surprising. In the last week of June, *The Washington Post* reported that "Bush aides directed State Department officials in recent days to devise a plan to eliminate"the $34 million allocated in the current fiscal year to UNFPA.

Under pressure from domestic groups opposed to family planning, the President has held up the release of the money citing allegations that it is used to enforce China's coercive abortion practice under that country's "one-child" policy. To date, no facts have been found to corroborate the allegations.

CONCLUSION

Separately, these examples might prove indicative of politics as usual—a President taking the opportunity to appease a particular constituency. But taken together, they are battles in the war to champion an ideology of hyper-moralism over sound public health policies designed to promote and secure sexual and reproductive health.

That this is an issue for the United States is abundantly clear. Yet, in spite of the loss of nearly a half million lives due to AIDS since 1981, the epidemic has slowed here and our access to anti-retroviral therapies is prolonging life and mercifully postponing our experience with deaths. It's telling that a recent estimate of HIV infections in Africa originated in an arm of the U.S. intelligence apparatus. That study estimated that 60 million Africans will become infected with HIV in next five years. A UNAIDS report in early July estimates that 70 million people will die of AIDS in the developing world over the next 20 years. Imagine watching an entire quarter of the United States population die a horrid death over the next 20 years. We cannot. Yet we couch it in terms that deal with global stability and stability of regimes, not in effective public health strategies to prevent infection.

That is why SIECUS hopes those gathering in Barcelona this July to asses the global HIV/AIDS epidemic and strategize about how to find solutions will not count on the United States government for inspired leadership. Unfortunately, our own government's strategy is a politically- and ideologically driven domestic experiment whose early indications suggest more harm than good.

XVI WORLD CONGRESS OF SEXOLOGY SET FOR MARCH 10-14 IN HAVANA, CUBA

The XVI World Congress of Sexology is scheduled for March 10-14, 2003, in Havana, Cuba, under the auspices of the World Health Organization and the Pan-American Health Organization.

World Congress topics will include sexuality education;public policies related to sexuality;sexuality and violence; sexually transmitted infections; reproductive and sexual health;and gender and sexuality.

Registration fees until December 31 are $400, participants;$275,students; and $90, accompanying persons. Registration fees after December 31 are $500, participants;$300,students; and $100, accompanying persons.

For more information, contact cubasexologia@colombus.cu or visit the Web site www.cubasexologia.com/16congreso/

CULTURALLY COMPETENT SEXUALITY EDUCATION RESOURCES

A SIECUS Annotated Bibliography

Educators,service providers, health professionals, and individuals worldwide are working to provide people with comprehensive sexuality education to help them become sexually healthy adults as well as to help them practice safer sexual behaviors, delay the onset of sexual intercourse, and reduce both unplanned pregnancy and sexually transmitted disease rates.

As they develop these programs, these individuals must target their messages to people of different cultures, races, socioeconomic backgrounds, ages, genders, and sexual orientations.This bibliography includes resources that reflect the diverse cultures and backgrounds of such groups as Latinos; African Americans; Asians and Pacific Islanders; Native Americans; gays,lesbians,bisexuals, and transgendered people;and others.

It includes culturally competent resources for professionals, individuals, and families specifically related to sexuality. It also includes resources related to other fields that are adaptable to discussions about sexuality, and provides ordering information for as well as contact information on organizations with more resources.

As with all materials, SIECUS recommends that readers screen them to make certain they are relevant to their target audience.

SIECUS does not sell or distribute the publications listed in this bibliography. They are, however, available for use in our Mary S. Calderone Library. Readers can order copies by checking the order information provided in the bibliography.

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This bibliography was compiled by Amy Levine, librarian; Darlene Torres, associate librarian; and Johanna Novales, data assistant.

* These books were in SIECUS' annotated bibliography on *Culturally Competent Sexuality Education Resources* (1996). They are still relevant.

Disclaimer: *Most of the books in this bibliography contain current, positive images about sexuality; others may need updating.*

GENERAL RESOURCES

Bodies and Biases: Sexualities in Hispanic Cultures and Literatures*

David William Foster and Roberto Reis, Editors

Looking at a broad spectrum of popular culture, this book addresses how sexual behavior and collective identity, homosexuality, and gender are represented in historical and contemporary Hispanic literature.
1996;$21.95; ISBN 0816627711; University of Minnesota Press.

Encyclopedia of AIDS

Raymond A. Smith, Editor

This book provides the reader with a thorough look at AIDS and its effects on culture, politics, law, and the individual. To help increase awareness of AIDS, this resource offers information on transmission and prevention, basic science and epidemiology, and pathology and treatment.
2001; $25; ISBN 0140514864; Penguin Putnam Inc.

Gender Diversity: Crosscultural Variations

Serena Nanda

This book is an introduction to the subject of gender diversity and is based on ethnographic data of gender diversity in numerous cultures. All the cultures described in the book provide spaces for sex and gender roles beyond the binary opposites of male and female, man and woman.Chapters include "Multiple Genders among North American Indians," "Hijra and Sadhin: Neither Man Nor Woman in India," "Men and Not-Men: Sexuality and Gender in Brazil," and "Transgendered Males in Thailand and the Philippines."
2000;$10.95;ISBN 1577660749; Waveland Press, Inc.

Nuestros Cuperos, Nuestros Vidas

The Boston Women's Health Book Collective

This Spanish version of *Our Bodies, Ourselves* is an easy-to-use resource that addresses the social, spiritual, and health issues of Latina-American heterosexual,lesbian, and bisexual women. Chapters include "Knowledge Is Power," "Taking Care of Our Health," "Relationships and Sexuality," "Health and Reproductive Rights," and "Maternity."
1998;$24; ISBN 0684842319; Seven Stories Press.

Salud: A Latina's Guide to Total Health

Jane Delgado, Ph.D.

Written by and for Latina women, this revised edition has 24 chapters that cover a broad range of health issues. Topics include prevention and treatment of the diseases that most commonly affect Latinas, such as diabetes, cervical cancer, and depression. It also discusses sexuality and reproductive health issues as well as religious and spiritual traditions that affect the way Latinas view their health. A Spanish version, *Salud: Guía para la salud integral de la mujer Latina*, is also available.
2002; $19.95; ISBN 0060006218; Harper Collins.

FOR PROFESSIONALS

AIDS Education: Reaching Diverse Populations*

Melinda K. Moore and Martin L. Forst, Editors

This book describes how to tailor HIV/AIDS education and prevention efforts to specific cultural and ethnic groups,including gay men, lesbians, African Americans, Asian American and Pacific Islanders,Latinos, sexual assault survivors, and homeless youth. Chapters include "HIV/AIDS Education and Prevention in the Asian American and Pacific Islander Communities," "Evolution of a Model of Popular Health Education for Environmental Change in the Latino Community," and "MAESTRO: A Cross-Cultural HIV/AIDS Training Curriculum."
1996; $64.95; ISBN 0275949044; Praeger Publishers.

Clinician's Guide to Working with Asians and Pacific Islanders Living with HIV

Daniel D. Yu, M.S.W.

This guide is designed to help medical providers overcome the cultural challenges of working with Asian and Pacific Islanders living with HIV. It discusses three questions: (1) What cultural factors amplify the difficulties faced by Asians and Pacific Islanders with HIV? (2) How do these cultural amplifiers affect a patient's access to services? (3) What can a medical provider do to address language and cultural barriers and to help empower Asian and Pacific Islander patients living with HIV?
1999; free online at http://www.apiwellness.org/v20/physician/physunder.html;Asian & Pacific Islander Wellness Center.

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

Robert W. Cole, Editor

Although not specifically focused on sexuality education, this book serves as a practical guide to developing a variety of school programs that can improve the performance of students from diverse cultural, ethnic, linguistic, and socioeconomic backgrounds. While some of the instruction is designed to increase student achievement in reading,writing,mathematics, and oral communication skills, other strategies apply in any subject.
1995;$25.95; ISBN 0871202379;Association for Supervision and Curriculum Development.

First Talk: A Teen Pregnancy Prevention Dialogue among Latinos

Bronwyn Mayden, Wendy Castro, and Megan Annitto

This book was published following a national symposium sponsored by the Child Welfare League of America and the National Council of Latino Executives. Chapters include "Characteristics of the Latino Population," "Factors Contributing to Latino Adolescent Pregnancy," "Sexual Activity, Contraceptive Use, and Sexually Transmitted Diseases," "Marriage and Childbearing," and "Latino Adolescent Pregnancy Prevention."
Appendices include "Principles Underlying Program Development," "Focus Groups," "Principles in the Latino Adolescent Pregnancy Symposium," and "Resources." This book is also available in Spanish.
1999; $14.95; ISBN 0878687610; The Child Welfare League of America.

Guidelines for Comprehensive Sexuality Education for Hispanic/Latino Youth

This booklet is an adaptation of SIECUS' *Guidelines for Comprehensive Sexuality Education Kindergarten-12th Grade* specifically designed for use with Hispanic/Latino youth. It provides a framework for comprehensive sexuality education including key concepts and developmental message for early childhood, pre-adolescence, early adolescence, and adolescence. The text, in both Spanish and English, includes a resource section on materials for Hispanic/Latino youth.
1995;$8;SIECUS.

Health-Promoting and Heath-Compromising Behaviors among Minority Adolescents

Dawn K. Wilson, James R. Rodriguez, and Wendell C. Taylor, Editors

This is part of the *Application and Practice in Health Psychology* series and is designed for clinical and counseling professionals working with minority adolescents. It addresses developmental, biological, and sociocultural issues and focuses on specific health-promoting and health-compromising behaviors that need targeting such as drug abuse, violence, sexually transmitted diseases, female health issues, and chronic health risks. Chapters include "Preventing Drug Abuse and Violence," "Health Promotion in Minority Adolescents: Emphasis on Sexually Transmitted Diseases and the Human Immunodeficiency Virus," "Community-based Interventions," and "Health Care and Health Policy for Adolescents."
1997;$24.95;ISBN 1557983976;American Psychological Association.

Hip-Hop's Influence within Youth Popular Culture: A Catalyst for Reaching America's Youth with Substance Abuse Prevention Messages

Patricia Thandi Hicks Harper, Ph.D., and Billo Mahmood Harper

This report provides a practical and theoretical framework for understanding and utilizing youth popular culture, particularly Hip-Hop culture, in substance abuse prevention programs. The discussions are also relevant for sexuality education and sexual health programs. The report includes models, ideas, and case studies designed to help professionals fully integrate youth-friendly, culturally competent approaches into their prevention work. Chapters include "Conceptual and Theoretical Framework for a New Prevention Approach," "Understanding the Youth Culture Phenomenon," and "Youth Popular Culture for Prevention."
1999;$32.50;ISBN 0966994205; McFarland & Associates.

The Multicultural Challenge in Health Education

Ana Consuelo Matiella, Editor

In this book, 28 of the nation's top health educators offer strategies to make health education culturally relevant. The book focuses on the needs of those responsible for educating young people in increasingly diverse communities. Topics include: the acculturation process and implications for education, ethnicity and heath belief systems, multiethnic perspectives on comprehensive health education, integration of multicultural health education into the curriculum, and staff development for multicultural competency.
1994; ISBN 1560713550; out of print but may be available in bookstores or libraries.

Multicultural Human Services or AIDS Treatment and Prevention: Policy Perspectives and Planning*

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

This book discusses specific suggestions for prevention,education, and behavioral change strategies that are culturally relevant to African Americans,Native Americans,Native Hawaiians,Puerto Ricans, and Mexicans.
1992;$18.95; ISBN 156023038;The Haworth Press, Inc.

Perceptions of Risk: An Assessment of the Factors Influencing Use of Reproductive and Sexual Health Services

by Asian American Women National Asian Women's Health Organization*

This report includes the findings of interviews with health care advocates,practitioners, and focus groups with Asian American women. It discusses how misinformation, poverty, sexism, and privacy issues severely limit Asian American women's access to health services. It includes specific recommendations for educators and counselors working with this population.
1995; $10; National Asian Women's Health Organization.

Sexual Cultures and the Construction of Adolescent Identities*

Janice M. Irvine, Editor

This book explores how a teenager's race, class, gender, sexual orientation, religion, and family relationships affect the development of his or her sexual identity. It discusses the relationship between ethnic background and adolescent sexual behaviors, desires, and body image. With a specific focus on Asian, African-American, Latino, gay and lesbian, and physically disabled teenagers, this book challenges common generalizations about cultural groups to help educators develop culturally competent sexuality education curricula.
1994; $24.95; ISBN 1566391369; Temple University Press.

Sexuality Education Across Cultures: Working with Differences*

Janice M. Irvine

Using social-constructionist theory as a tool for understanding cultural diversity and sexuality, this book describes how culture shapes the ways that individuals may differ in their sexual thoughts, feelings, and behaviors. The author acknowledges that there is usually no single blueprint for developing effective multicultural sexuality education. The book provides insight into research and examples of problems sexuality educators may face.
1995; ISBN 0787901547; out of print but may be available in bookstores or libraries.

Sexuality, Poverty, and the Inner City*

Elijah Anderson, Ph.D.

This report from the seminar series, "Sexuality and American Social Policy," focuses on the effects poverty has had on the sexual behavior and gender roles of urban youth. It also compares the sexual attitudes and experiences of poor white teenagers with those of minority youth.
1994; Free; ISBN 0944525199; Kaiser Family Foundation.

¡Sí, Se Puede! Yes We Can!

Angela Ginorio and Michelle Huston

This book explores the experiences of Latinas in the U.S. educational system. The first section provides an overview of governing concepts and trends. The second section provides an in-depth discussion of communities, including families,peers, and schools and

their relationship to the educational process. The third section focuses on individual traits, such as self confidence, and explores how they are shaped by educational variables. The book concludes with recommendations for school personnel, families, and policymakers. It is also available in Spanish.
2001;$12.95;ISBN 187992224X; American Association of University Women Educational Foundation.

Troubling Intersections of Race and Sexuality: Queer Students of Color and Anti-Oppressive Education

Kevin K. Kumashiro, Editor

Through autobiographical accounts of gay, lesbian, and bisexual students of different racial backgrounds, this book offers theoretical insights and educational strategies for educators. Essays include "Undressing the Normal: Community Efforts for Queer Asian and Asian American Youth," "Adolescent Sexual Orientation, Race and Ethnicity, and School Environments," "Race and Sexual Orientation in Multicultural Feminist Teacher Education."
2001;$26.95; ISBN 0742501906; Rowman & Littlefield Publishers, Inc.

Working with Latino Youth

Luis A. Vargas and Joan D. Koss-Chioino, Editors

This book provides a model for working with Latino youth that takes into account individuals within the context of their families, their communities, and their culture. Using research materials and case studies, it provides strategies that are culturally responsive and effective for professionals who interact with Latino youth. Chapters include "Arenas for Therapeutic Intervention," "Latino Youth in Personal Contexts," and "Contextual Approaches: Practical Implications."
1999; $40; ISBN 0787943258; Jossey-Bass.

A Youth Leader's Guide to Building Cultural Competence*

Susan A. Messina

This resource is designed to help educators, health care professionals, and other service providers meet the challenges of teaching HIV and sexuality education to culturally diverse groups. Using a four-step model, it helps build the knowledge, attitudes, and skills necessary to reach young people from a variety of backgrounds, with a specific focus on African-American,Latino, gay, lesbian,and bisexual teenagers.
1994;$10;Advocates for Youth.

PUBLICATIONS FOR FAMILIES

How to Talk to Your Children about AIDS*

This booklet is designed to help parents talk to their children about HIV/AIDS. It offers basic information about and guidelines for specific age levels: preschool, young children, preteens, and teenagers. A Spanish version, *Como Hablar Con Sus Hijos Sobre el SIDA*, is also available.
1997;$2;SIECUS.

Finding Our Voices: Talking with Our Children about Sexuality and AIDS

This booklet provides parents with support and suggestions for talking with children about sexuality issues. It addresses values, developmental stages, and sexual behavior. It also includes an extensive list of resources. A Spanish version, *En Busca de Nuestras Voces: Hablando con Nuestros Hijos Acerca de la Sexualidad y el SIDA*, is also available.
1998;$5;Mothers' Voices.

CURRICULA

Be Proud! Be Responsible! Strategies to Empower Youth to Reduce Their Risk for AIDS

Loretta Sweet Jemmott, Ph.D., John B. Jemmott III, Ph.D. and Konstance A. McCaffree, Ph.D.

This six-session curriculum was originally targeted to African American male adolescents 13 to 18 years of age. It is now used to disseminate HIV-prevention information to all adolescents. The skills-based lessons focus on participants' needs to adapt responsible and safer sexual behaviors to prevent the sexual transmission of HIV. It includes a video. The U.S. Centers for Disease Control and Prevention's (CDC) Division of Adolescent and School Health identifies this curriculum as one that has shown credible evidence of effectiveness.
1996;$95;Select Media.

Becoming a Responsible Teen: An HIV Risk Reduction Intervention Program for Adolescents (B.A.R.T.)*

Janet S. St. Lawrence, Ph.D.

The Centers for Disease Control and Prevention has named this HIV/AIDS-prevention curriculum as a "program that works." Originally designed for African-American adolescents in non-school settings, it provides information about HIV/AIDS and involves teen participants in building the skills they need to clarify their own values about sexual activity and learn how to avoid the risk of becoming infected with HIV. For adolescents in grades nine through 12, the curriculum consists of eight sessions. Students are segregated by gender to focus on skill development.
1998;$49.95;ISBN 1560715723; ETR Associates.

Can We Talk? Helping Families Talk About Self-Esteem, Sex and Peer Pressure

This program helps parents of children in grades four through eight enhance their role as sexuality educators of their children. It is a four-part workshop series on self-esteem, puberty, sexuality, mixed messages, and peer pressure. Each class contains information for a one-hour interactive discussion, home activities between parents and children, and videos that focus on communication. The set includes a planning and training manual, a family activity book, and a video. A Spanish version, *¿Conversamos?*, is also available.
1998;$75;NEA Professional Library.

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

Written in English, this 12-module curriculum takes an empowerment approach to sexuality education for Latinas/Hispanic women. The lessons include information on HIV/AIDS prevention and transmission as well as exercises for examining the role of Latinas/Hispanic women in preventing HIV infection. The curriculum includes a participant's manual, a trainer's manual, and evaluation materials.
1991; National Coalition of Hispanic Health and Human Services Organizations (COSSMHO); out of print but may be available in bookstores or libraries.

Focus on Kids: Adolescent HIV Risk Prevention

University of Maryland Department of Pediatrics

The Centers for Disease Control and Prevention has identified this curriculum as a "program that works." Originally developed for African American urban youth, this program provides information to help reduce the risk of HIV infection among young people nine to 15 years of age through various interactive activities including games, role plays, discussions, and community projects. It also uses "friendship groups" to strengthen peer support. Topics covered in this curriculum are HIV and other STDs, condom use, abstinence, and sex and drug pressures that youth face. It also offers practice in decision-making, communication, and refusal and advocacy skills.
1998; $29.95; ISBN 156071591X; ETR Associates.

Growing Together: A Sexuality Education Program for Girls Ages 9-11 and Their Parents

Girls Inc.

This revised and updated curriculum is a component of Girls Incorporated's *Preventing Adolescent Pregnancy* program. It consists of five one-and-a-half- to two-hour sessions to help parents and their daughters nine to 11 years of age learn new information and develop the skills they need to talk about sexuality issues. Topics include anatomy, puberty, and communication. A Spanish version, *Crecer Juntas*, is also available.
2001; ISBN 1576790614; available to affiliated organizations and to licensees—non-member organizations should call for more information; Girls Incorporated National Resource Center.

HIV Prevention for Latinos: Interactive Bilingual HIV Education for English as a Second Language Programs

Asistencia Para Latinos

This curriculum is designed to teach Latinos factual and culturally competent HIV/AIDS information. Lesson plans are in English and Spanish. Topics include "HIV 101 for ESL Classrooms," "Understanding HIV and the Body," "Sexual Relationships," "Needle Sharing," and "Reproduction and Prenatal Care."
1998; Asistencia Para Latinos.

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

Henry Lesnick

This curriculum provides five hours of HIV/AIDS instruction for high school and young adult students who speak English as a second language (ESL). Using exercises which require students to use listening, reading, writing, speaking, and critical thinking skills, this curriculum helps them develop English language skills while learning how HIV is transmitted and prevented. Background materials, exercises, and activities come with each lesson. The curriculum also includes a list of international HIV/AIDS education and support service providers.
1995; available free of charge at www.hostos.cuny.edu/homepages/lesnick/; Hostos Community College Department of English, City University of New York.

Let the Circle Be Unbroken: A Model Curriculum for "Rites of Passage" Activities and Programs

Theresa Montgomery Okwumabua

This program translates the theories of an Afrocentric conceptual model into a prevention program. It teaches adolescents the knowledge and skills necessary to build self esteem; enhance self image; develop leadership skills, cultural awareness and appreciation; and make healthy, productive, and self-affirming life choices. Targeted to young people 10 to 18 years of age, this curriculum consists of 16 units covering such subjects as "Knowing Self and Others," "Conflict Resolution and Violence Prevention," "HIV/AIDS and Other Life Threatening Conditions," and "Spirituality: The Journey Within."
1996; $120; NIA Psychological & Health Consultants, Inc.

Nosotras Viviremos

The National Coalition of Advocates for Students

Updated in 1996 by the National Coalition of Advocates for Students, this curriculum consists of two parallel training manuals:one addressing the issues and concerns of farm-working mothers/mentors and the other addressing the issues of pre-adolescent and adolescent farm-working girls. Each consists of six units, including basic HIV/AIDS/STD information,exercises,stories, and handouts. The curricula are designed to help participants explore self-identity and to use self-reflection to address the reality of sexuality, HIV, and STDs in their lives. The intervention is designed for implementation in four sessions, with each session lasting between two and three hours. The curriculum is also available in Spanish.

2001; ISBN 1880002205; for more information contact the National Coalition of Advocates for Students.

S.T.A.T.S.: Sex, Teens, AIDS: Take 'Em Serious

March of Dimes and Alpha Phi Alpha Fraternity, Inc.

Originally developed for a male responsibility program, this video and curriculum and activities guide has recently been revised to address sexuality issues facing male and female adolescents between the ages of 12 and 17. The twenty-minute video--the center piece of the program--consists of mini-dramas including discussion of peer pressure, intimate relationships, safer sex, abstinence, HIV and other STDs, and teen pregnancy. The guide, which can be used in single or multiple sessions,covers five areas: "The Three R's: Responsibility, Respect, Relationships," "Adolescent Pregnancy and Parenthood," "Protecting Yourself," "Sexually Transmitted Diseases," and "Intimate Violence in Relationships."

2000;$95;March of Dimes.

Tackling Gay Issues in School: A Resource Module

Leif Mitchell, Editor

This resource for educators, administrators, counselors, trainers, and others working to create safe and inclusive school environments includes a rationale for including lesbian,gay, bisexual,and transgender issues in schools, recommended curriculum and staff development activities, and resource lists. A Spanish version, Abordondo La Temática Gay en la Escuela,is also available.

1999; $20; Gay, Lesbian, and Straight Education Network (GLSEN).

Viviremos! On the Road to Healthy Living

Villarreal Analytical Management and Organizational Services (VAMOS) and The National Coalition of Advocates for Students

This bilingual curriculum on HIV/AIDS is for migrant students in grades six through 12. The curriculum helps farm worker teens delay sexual intercourse by practicing assertiveness and decision-making skills in potentially high-risk situations. It also teaches them how to use condoms. It consists of five lessons including "Basic Facts about HIV and AIDS," "Risk Assessment," "Assertiveness," "Decision Making," and "Problem Solving."

1996; $19.95; ISBN 1880002124; National Coalition of Advocates for Students.

Will Power/Won't Power: A Sexuality Education Program for Girls Ages 12-14

Girls Inc.

This updated curriculum is a component of Girls Incorporated's *Preventing Adolescent Pregnancy* program. It consists of 10 90-minute sessions for girls 12 to 14 years of age on reproductive health, assertiveness, sexual pressures, values, abstinence, and decision making. Originally designed to help girls who were likely to be facing decisions about sexual intercourse but who had not yet become sexually active, it has been revised to address sexual decision making for girls who are sexually experienced.A Spanish version, *Querer/Poder Decir "No,"* is also available.

2001; ISBN 1576790622; available to affiliated organizations and to licensees—non-member organizations should call for more information; Girls Incorporated National Resource Center.

ORDERING INFORMATION

Advocates for Youth
1025 Vermont Avenue N.W., Suite 200
Washington, DC 20005
Phone:202/347-5700
Fax:202/347-2263
Web site: www.advocatesforyouth.org

The American Association of University Women Education Foundation
Sales Department
8543 Grovemont Circle
Gaithersburg, MD 20877-4179
Phone:800/225-9998
Fax:301/948-6233
Web site: www.aauw.org

American Psychological Association
Order Department
750 First Street, N.E.
Washington, DC 20002
Phone: 800/374-2721 or 202/336-5500
Fax:202/336-5502
Web site: www.apa.org

Asian & Pacific Islander Wellness Center
730 Polk Street, Fourth Floor
San Francisco, CA 94109
Phone:415/292-3400
Fax: 415/292-3404
Web site: www.apiwellness.org

Asistencia Para Latinos
c/o Deborah Schoeberlein
RAD Educational Programs
P. O. Box 1433
Carbondale, CO 81623
Phone:970/963-1727
Fax:970/963-2037

Association for Supervision and Curriculum Development
1703 N. Beauregard Street
Alexandria, VA 22311
Phone:800/933-2723
Fax:703/575-5400
Web site: www.ascd.org

The Child Welfare League of America
P. O. Box 2019
Annapolis Junction, MD 20701-2019
Phone:800/407-6273
Fax:301/206-9789
Web site: www.cwla.org

ETR Associates
4 Carbonero Way
Scotts Valley, CA 95066-4200
Phone:800/321-4407
Fax:800/435-8433
Web site: www.etr.org

Gay, Lesbian, and Straight Education Network (GLSEN)
Bookmasters Inc.
P. O. Box 388
Ashlin, OH 44805
Phone:212/727-0135
Fax:212/727-0254
Web site: www.glsen.org

Girls Incorporated National Resource Center
441 West Michigan Street
Indianapolis, IN 46202
Phone:317/634-7546
Fax:317/634-3024
Web site: www.girlsinc.org

Harper Collins
P. O. Box 360846
Pittsburg, PA 15251-6846
Phone:800/242-7737
Fax:800/822-4090
Web site: www.harpercollins.com

The Haworth Press,Inc.
10 Alice Street
Binghamton, NY 13904-1580
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Fax:800/895-0582
Web site: www.haworthpressinc.com

Hostos Community College
Henry Lesnick
Department of English
City University of New York
Bronx, NY 10451
Phone:718/518-6597
Web site:
www.hostos.cuny.edu/homepages/lesnick/

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Indianapolis, IN 46256
Phone:800/956-7739
Fax:800/605-2665
Web site: www.josseybass.com

Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
Phone:800/656-4533
Fax:650/854-4800
Web site: www.kff.org

March of Dimes
P.O. Box 1657
Wilkes-Barre, PA 18703-1657
Phone:800/367-6630
Fax:570/825-1987
Web site: www.modimes.org

McFarland & Associates
8601 Georgia Avenue, Suite 601
Silver Spring, MD 20910
Phone:301/589-0780
Fax:301/589-2567
Web site:
www.hiphop4kids.com/html/maincontent.html

National Asian Women's Health Organization
250 Montgomery Street, Suite 900
San Francisco, CA 94104
Phone:415/989-9747
Fax:415/989-9758
Web site: www.nawho.org

National Coalition of Advocates for Students
100 Boylston Street, Suite 815
Boston, MA 02116-4610
Phone:617/357-8507
Fax:617/357-9549
Web site: www.ncasboston.org

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286 North Avalon
Memphis, TN 38112
Phone:901/272-2469
Fax:901/272-2469

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East Rutherford, NJ 07073
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West Port, CT 06881
Phone:800/225-5800
Fax:603/431-2214
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Charlotte, NC 28289
Phone:800/462-6420
Fax: 800/338-4550
Web site: www.rowmanlittlefield.com

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Web site: www.pressuchicago.edu

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Web site: www.waveland.com

University of Minnesota Press
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Fax:800/621-8476
Web site: www.upress.umn.edu

MORE RESOURCES

Advocates for Youth

This organization works to prevent pregnancy, STDs, and HIV infection among adolescents.
1025 Vermont Avenue, N.W.; Suite 200, Washington, DC 20005; Phone: 202/347-5700; Fax: 202/347-2263; Web site: www.advocatesforyouth.org

African American AIDS Policy and Training Institute

This organization works to fight AIDS among people of African descent.
1833 W. 8th St, Suite 200, Los Angeles, CA 90057-4257;Phone:213/353-3610; Fax: 213/989-0181;Web site: www.blackaids.org

Asian & Pacific Islander Coalition on HIV/AIDS

This organization provides HIV/AIDS-related services, education, and research to Asian and Pacific Islander communities in New York City.
150 Lafayette Street, Sixth Floor, New York, NY 10013; Phone: 212/334-7940; Fax: 212/334-7956;Web site:www.apicha.org

Asian & Pacific Islander Wellness Center

This center aims to educate, support, empower, and advocate for Asian and Pacific Islander (A&PI) communities—particularly A&PIs living with or at-risk for HIV/AIDS.
730 Polk Street, Fourth Floor, San Francisco, CA 94109; Phone: 415/292-3400; Fax: 415/292-3404; Web site: www.apiwellness.org

The Balm in Gilead

This organization works to stop the spread of HIV/AIDS throughout the African-American community by building the capacity of faith communities to provide AIDS education and support networks for all people living and affected by HIV/AIDS.
130 West 42nd Street, Suite 450, New York, NY 10036; Phone: 212/730-7381 or 888/225-6243; Fax: 212/730-2551; Web site:www.balmingilead.org

Blacks Educating Blacks about Sexual Health Issues

This organization is the largest AIDS service agency providing education, HIV-prevention counseling, HIV antibody testing, and case management services to the African American community in Pennsylvania.
1217 Spring Garden Street, First Floor, Philadelphia, PA 19123; Phone: 215-769-3561; Fax: 215-769-3860; Web site: www.bebashi.org

The Center for Cross Cultural Health

This organization works to integrate the role of culture in improving health and to ensure that diverse populations receive culturally competent and sensitive health and human services.Through information sharing, training, and research the Center works to increase cultural competency among individuals,organizations,systems, and societies.
1313 S.E. Fifth Street, Suite 100B, Minneapolis, MN 55414; Phone: 612/379-3573; Fax: 612/623-3002; Web site: www.crosshealth.com

Child Welfare League of America

This organization is committed to engaging all Americans in promoting the well being of children, young people, and their families as well as in protecting every child from harm.
440 First Street, N.W., Third Floor, Washington, DC 20001-2085; Phone: 202/638-2952; Fax: 202/638-4004; Web site:www.cwla.org

Cross Cultural Health Care Program

Through a combination of cultural competency trainings, interpreter trainings, research projects, community coalition building,and other services,CCHCP serves as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate.
2821 Beacon Avenue South, Seattle, WA 98144; Phone: 206.860-0329; Fax: 206/860-0334;Web site:www.xculture.org

Diversity Rx

This Web site, supported by the National Conference of State Legislatures (NCSL), Resources for Cross Cultural Health Care (RCCHC), and the Henry J. Kaiser Family Foundation, promotes language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities.

Web site:www.diversityrx.org

Diversity Web

This Web site, designed by the Association of American Colleges and Universities and the University of Maryland at College Park,aims to connect,amplify, and multiply campus diversity efforts through a central location on the Web.

Web site:www.diversityweb.org

ETR Associates

This organization seeks to enhance the well being of individuals, families, and communities by providing leadership, educational resources, training, and research in health promotion with an emphasis on sexuality and health education.

P. O. Box 1830, Santa Cruz, CA 95061-1830;Phone:800/321-4407; Fax:800/435-8433;Web site:www.etr.org

Girls Incorporated

This national youth organization is dedicated to helping every girl become strong, smart,and bold through advocacy, research, and education.

120 Wall Street, Third Floor, New York, NY 10005; Phone: 212/509-2000; Fax: 212/509-8708; National Resource Center, 441 West Michigan Street, Indianapolis, IN 46202-3233; Phone: 317/634-7546; Fax: 317/634-3024;Web site:www.girlsinc.org

Latina Health Project

This is a series of programs and events designed to explore and explain disparities in health status and in access to medical care affecting Hispanic women in Philadelphia, PA;Delaware; and South New Jersey.

Minority Women's Health Initiative, WHYY, Inc, 150 North Sixth Street, Philadelphia, PA 19106; Phone: 215/351-2003; Fax: 215/351-3347; Web site: www.latinasalud.org

Latino Commission on AIDS

This membership organization is dedicated to improving and expanding AIDS prevention, research, treatment and other services in the Latino community through organizing, education, model program development and training. Using its extensive network of members, the Commission works to mobilize an effective Latino community response to the health crisis created by HIV/AIDS.

24 West 25th Street, Ninth Floor, New York, NY 10010; Phone: 212/675-3288; Fax: 212/675-3466; Web site: www.latinoaids.org

Multi-cultural Pavilion

This Web site provides resources for educators, students, and activists to explore and discuss multicultural education; facilitate opportunities for educators to work toward self-awareness and development; and provide forums for educators to interact and collaborate with each other to develop a critical, transformative approach to multicultural education.

Web site: curry.edschool.virginia.edu/go/multicultural

National Alliance for Hispanic Health

This network seeks to improve the health and well being of Hispanics in the United States.

1501 Sixteenth Street, N.W., Washington, DC 20036;Phone:202/387-5000; Fax:202/797-4353;Web site: www.hispanichealth.org

National Asian Women's Health Organization

This organization works to achieve health equity for Asian women and families.

250 Montgomery Street, Suite 900, San Francisco CA 94104; Phone:415/989-9747; Fax: 415/989-9758; Web site: www.nawho.org

National Association for the Advancement of Colored People

This organization works at the national, regional, and local levels for the protection and enhancement of African Americans and other minorities.

4805 Mt. Hope Drive, Baltimore, MD 21215; Phone: 877/622-2798; Fax: 410/358-3818; Web site: www.naacp.org

National Black Women's Health Project

This organization seeks to improve the health of black women by providing wellness education and services, health information, and advocacy.

600 Pennsylvania Avenue, S.E., Suite 310, Washington DC 20003; Phone:202/543-9311; Fax:202/543-9743;www.nbwhp.org

National Center for Cultural Competence

This center works to increase the capacity of health care and mental health programs to design,implement,and evaluate culturally and linguistically competent service delivery systems.

Georgetown University Center for Child and Human Development, 3307 M Street, N.W., Suite 401, Washington, DC 20007-3935; Phone: 800/788-2066 or 202/687-5387; Fax:202/687-8899; Web site: www.georgetown.edu/research/gucdc/nccc/

National Council of La Raza

This organization works to reduce poverty and discrimination as well as to improve life opportunities for Hispanic Americans through two approaches: capacity-building assistance to support and strengthen Hispanic community-based organizations, and applied research, policy analysis, and advocacy.

1111 19th, N.W., Suite 1000, Washington, DC 20036; Phone: 202/785-1670; Fax: 202/776-1792;Web site: www.ndr.org

National Latina Health Network

This network is dedicated to strengthening and developing collaborations between Latina leaders in public health and building local and national community health partnerships which enhance the quality of life for

Latinas and their families across the nation.
1680 Wisconsin Avenue, N.W., Second Floor, Washington, DC 20007; Phone:202/966-9633 or 9637; Web site: www.nationallatinahealthnetwork.com

National Latina Institute for Reproductive Health

The mission of NLIRH is to ensure the right to reproductive health for Latinas, their families and communities through education,advocacy and coalition building.
P.O. Box 610456; Queens, NY 11361; Phone: 718/229-7045; Fax: 718/229-7112; Web site:www.latinainstitute.org

National Latina/o Lesbian, Gay, Bisexual and Transgender Organization

This organization represents lesbian, gay, bisexual and transgendered Latinas/os. LLEGÓ works to overcome social, health, and political barriers that individuals face due to their sexual orientation and ethnicity.
1420 K Street, N.W., Suite 200, Washington, DC 20005; Phone: 202/408-5380; Fax: 202/408-8478;Web site:www.llego.org

National Minority AIDS Council

This organization is dedicated to developing leadership within communities of color to address the challenges of HIV/AIDS.
1931 13th Street, N.W., Washington, DC 20009; Phone: 202/483-6622; Fax: 202/483-1135;Web site: www.nmac.org

National Multi-Cultural Institute

This organization works with individuals, organizations, and communities to create a society that is strengthened and empowered by its diversity.Through its initiatives,NMCI leads efforts to increase communication, understanding, and respect among people of diverse backgrounds and addresses some of the important issues of multiculturalism facing our society.
3000 Connecticut Avenue, N.W., Suite 438, Washington, DC 20008-2556; Phone: 202/483-0700; Fax: 202/483-5233; Web site:www.nmci.org

National Native American AIDS Prevention Center

This is a network of concerned Native Americans willing to speak publicly on the need for HIV-prevention education by and for Native Americans.
436 14th Street, Suite 1020, Oakland, CA 94610; Phone: 510/444-2051; Fax: 510/444-1593;Web site:www.nnaapc.org

National Urban League

This organization helps African Americans to secure economic self-reliance, parity and power, and civil rights.
120 Wall Street, New York, NY 10005; Phone:212/558-5300; Fax: 212/558-5332; Web site:www.nul.org

National Youth Advocacy Coalition

This organization advocates for and with young people who are gay, lesbian,bisexual, or transgender in an effort to end discrimination against them and to ensure their physical and emotional well-being.
1638 R Street, N.W., Suite 300, Washington, DC 20009; Phone: 202/319-7596 or 800/541-6922; Fax: 202/319-7365; Web site:www.nyacyouth.org

The Native American Women's Health Education Resource Center

This organization addresses the issues of health,education, land and water rights,and economic development as they relate to Native American people. It offers many programs benefiting people locally, nationally, and internationally.
P. O. Box 572, Lake Andes, SD 57356-0572l; Phone: 605/487-7072; Fax: 605/487-7964; Web site: www.nativeshop.org

Office of Minority and Women's Health

This office of the Bureau of Primary Health Care (BPHC) promotes activities that reduce disparities in the health status of women as well as racial and ethnic populations. It stimulates collaborative partnerships to ensure coordinated health care that responds to unique cultural and linguistic needs.
4350 East-West Highway, Bethesda, MD 20814;Phone:301-594-4490; Fax:301/594-0089;Web site: www.bphc.hrsa.gov/omwh

Office of Minority Health Resource Center

Established by the U.S. Department of Health and Human Services Office of Minority Health, OMHRC serves as a national resource and referral service on minority health issues.
P. O. Box 37337, Washington, DC 20013-7337;Phone:800/444/6472; Fax:301/230-7198;Web site: www.omhrc.gov/omhr

Planned Parenthood Federation of America

This organization believes in the fundamental right of individuals to manage their own fertility regardless of income, marital status, race, age, sexual orientation, and national origin.
810 Seventh Avenue, New York, NY 10019; Phone: 212/541-7800; 800/230-PLAN refers to local Planned Parenthoods; Fax: 212/245-1845; 1780 Massachusetts Avenue, N.W., Washington, DC 20036; Phone: 202/973-4800; Fax: 202/296-3242; Web site:www.plannedparenthood.org

YWCA of the USA

The YWCA empowers women and girls by offering a wide range of services and programs that enrich and transform their lives.
Empire State Building, 350 Fifth Avenue, Suite 301, New York, NY 10118; Phone: 212/273-7800; Fax: 212/ 465-2281; Web site:www.ywca.org

SIECUS sexuality information and education council of the united states

INSTRUCTIONS FOR AUTHORS

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

Each issue of the *SIECUS Report* features groundbreaking articles and commentary by leaders and front-line professionals in the field of sexuality and education, along with news, special bibliographies on varied topics, book and audiovisual reviews, recommended resources, and advocacy updates. All of this comes to members and other subscribers six times each year.

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

SIECUS Board of Directors 2002

Mission

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.

SIECUS sexuality information and education council of the united states

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