Network

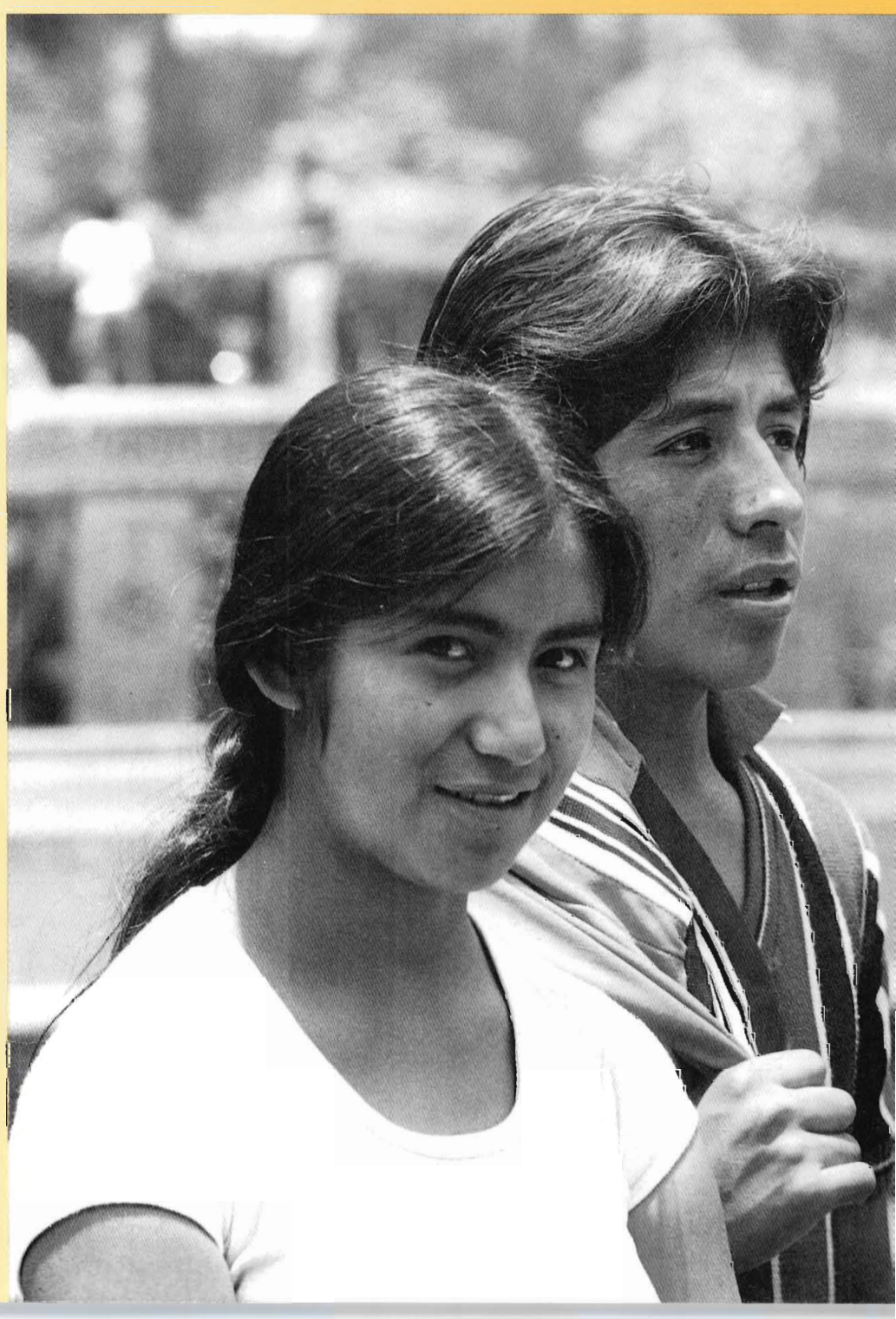
FAMILY HEALTH INTERNATIONAL, VOL. 14 NO. 2, OCTOBER 1993

Adolescents

DOES SEX EDUCATION WORK?

THE TRAGIC COST OF UNSAFE ABORTIONS

TEACHING TEENAGERS ABOUT HIV



News Briefs

U.S. FDA approves longer IUD shelf life

The approved shelf life of two intrauterine devices (IUDs) has been extended three years by the U.S. Food and Drug Administration (FDA).

The Copper T 380A and the Copper T 200B are now considered to have a shelf life of seven years, rather than four, based on tests of physical properties and sterility. The FDA announced the longer shelf life in June.

"Shelf life" refers to how long a product can be stored prior to use and still be safe and effective to use. Some IUDs offer effective contraception for up to eight years during use.

New testing for ST 1435

The Population Council is beginning new clinical trials of ST 1435, a synthetic progestin, after encouraging results from early trials in Finland, the Dominican Republic and Chile. Of 121 women who for two years used subdermal implants containing the drug, none became pregnant.

Given the trade name Nestorone, ST 1435 may be suitable for use in a single-rod subdermal implant. Norplant, a subdermal implant system developed by the Population Council, uses six rods. Inserting and removing one rod would be simpler than doing so for six rods, says Dr. Rosemarie Thau, director of the Population Council's contraceptive development program, which is coordinating the new trials.

New trials will be done in the Dominican Republic, Chile, United States and France. Implants and vaginal rings have been tested most extensively, and injectables, creams and jellies are also being evaluated.

Latex condoms offer HIV protection

New research supports the view that latex condoms, when used consistently and correctly, prevent the spread of HIV and other sexually transmitted diseases, according to the U.S. Centers for Disease Control and Prevention (CDC).

In a study following couples in which only one member was HIV-infected, 123 couples used a condom each time they had sex and none of the uninfected partners became infected. For another group who used condoms inconsistently, 10 percent of the uninfected partners acquired HIV — 12 people among 122 couples. Couples were followed an average of 22 months each in the study, which was conducted by Isabelle DeVincenzi of the European Centre for the Epidemiological Monitoring of AIDS in Paris.

In an Italian study following female partners of HIV-infected men for an average of two years, 2 percent of uninfected partners who used condoms consistently (three of 171 women) became infected, compared with 15 percent among those couples who used condoms inconsistently (eight women among 55). This study was done by Dr. Alberto Saracco of the HIV Center, IRCCS Ospedale San Raffaele, Milano, Italy, and 20 colleagues from a variety of Italian hospitals and health agencies.

"Our first message is to avoid intercourse with an infected partner," says Dr. Bert Peterson, chief of women's health and fertility with the CDC, which cited the studies in an August report. "But for people who will take that risk...condoms will save your life."

Teenage mothers have less healthy infants

Behavioral factors may cause teenage women in urban Sahelian Africa to have less healthy children than older mothers, two researchers concluded from a study of 20,000 births in Mali and Burkina Faso.

Adolescents were 45 percent more likely than older women to have infants of low birth weight, and children of teenagers faced a 35 percent greater risk of dying from the first through the twenty-fourth month of life, even after socioeconomic and demographic factors were taken into account.

"The most important factor is behavior," says Dr. Thomas LeGrand, who co-authored the study published in the May/June 1993 issue of *Studies in Family Planning*. Adolescents are less likely to seek prenatal care, he says. They also wean their infants earlier and are less likely to get complete sets of vaccinations for their children.

School girls facing unwanted pregnancies may diet so their weight gain does not show, potentially harming the fetus, the study says, and young inexperienced mothers may be less able to get health care for their children.

Norplant use among sickle cell patients

Norplant appears to be a safe and appropriate contraceptive for women with mild to moderate sickle cell disease. The subdermal progestin implant did not cause biochemical or hematologic changes in 23 Nigerian women who used it for an average of one year, according to a study published in April in *International Journal of Gynecology & Obstetrics*.

"It seems that progestin-only methods are quite safe for women with sickle cell disease," says Paul Feldblum, an FHI researcher and a co-author of the study. "Some clinicians feel that such methods can improve the clinical status of those women."

Women with sickle cell disease, whose risk of sickling crises and other difficulties increases during pregnancy and delivery, have special contraceptive needs. They often have low red blood cell counts, so methods such as the IUD may be contraindicated because of the possibility of increased menstrual bleeding. High-dose combined oral contraceptives (the pill) may increase their risk of thromboembolism.

Previous research has shown that some progestins provide benefits, including reduced pain, to women with sickle cell disease.

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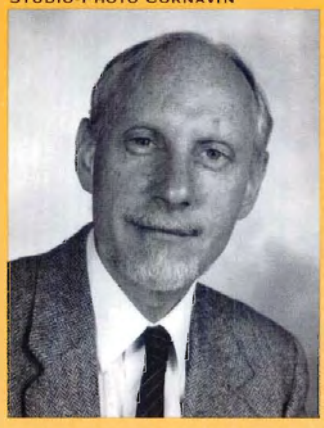
IN THIS ISSUE

Cover photo by Beryl Goldberg of a young couple in Mexico City.

OPINION

STUDIO-PHOTO CORNAVIN



DR. HERBERT L. FRIEDMAN

Overcoming Obstacles to Good Adolescent Health

By Dr. Herbert L. Friedman
World Health Organization
Geneva, Switzerland

The need for action to promote the healthy development of young people has never been more urgent. One-third of the world's population is between 10 and 24 years of age, and four out of five of these young people live in developing countries. They form a great resource for humanity because of their energy, idealism and fresh views, but they are also vulnerable.

The world in which they live has changed rapidly in recent decades. The tremendous flow of population to the cities, the spread of telecommunications across cultural and geographic boundaries, increased travel, a generally earlier beginning of puberty and a later age at marriage, a decrease in the influence and power of the family, the advent of AIDS, an increase in violence, and easier access to potentially harmful tobacco, alcohol and other drugs have had an impact on the behavior and health of young people.

In youth, new patterns of behavior are formed that may last a lifetime. Many things are tried for the first time in adolescence, such as sexual relations and experiments with the use of tobacco, alcohol or other drugs. Risk-taking, a natural part of growing up, can be more hazardous if mixed with alcohol or drugs. For example, using illicit drugs through shared needles carries the double risk of HIV infection from the needle and a loss of judgment about sexual relations, which may lead to unwanted pregnancy or sexually transmitted diseases (STDs).

The behavior of young people can have both short- and long-term consequences. Unprotected sexual relations are at the heart of problems associated with unwanted or too early pregnancy and childbirth, induced abortion, and STDs, including HIV infection leading to AIDS. These actions may also result in maternal and child morbidity, mortality and infertility, not to mention a thwarting of the social and economic development of young people, especially females.

Young people don't live in isolation. Much of what they do is determined by what others do — including key adults in their families, in health and education programs, in the workplace, in the environment generally, and in policy and lawmaking positions. The needs of young people have traditionally been given low priority. While they do not appear as frequently in morbidity and mortality statistics, a longer-term view of their behavior and its consequences leads to a persuasive public health argument for giving the needs of adolescents high priority.

OBSTACLES TO HEALTH

What are the obstacles to good health and health behaviors in young people? There are perhaps four kinds:

- Young people themselves generally don't have adequate knowledge about their own maturation, especially sexuality, and have little useful information about what reproductive health services exist and how to use them.
- People who could provide such help — doctors, nurses, teachers, religious figures, youth leaders and others — are rarely trained in issues of adolescent sexuality or in how to communicate with young people effectively.
- Existing services are rarely designed with young people in mind and almost never

involve youth in planning or evaluating the services.

• Policies and legislation that affect young people are often simply a by-product of other actions and do not express a clear and constructive approach to young people's needs.

These obstacles reflect myths about adolescent sexuality that create fear among adults. Many adults believe that young people are sexually promiscuous — the vast majority are not. Many believe that giving adolescents information and help to prevent pregnancy and STDs will make them more sexually active or promiscuous — the opposite appears to be the case. Young people usually have the same fundamental values as their parents — not opposite values, as most think. Differences are often in surface issues, such as taste in clothes and music.

Another mistaken assumption is that the best way to help adolescents is to tell them what not to do. Also, contrary to what many adults think, simply giving young people information about human biology is not sufficient to determine their sexual behavior. And, people mistakenly think that adults are inherently equipped to talk — and listen — to young people about sexually related matters.

BERYL GOLDBERG

STUDENTS MINGLE AT A CARACAS, VENEZUELA, CAMPUS. INVOLVING YOUTH IN THE PLANNING OF PROGRAMS IS VITAL.

Overcoming obstacles to good adolescent health requires doing away with such myths and clearly articulating other positive ideas for decision-makers. Information from young people themselves is needed to accomplish this, because they know more about their own behavior than adults do. Let me give you one example of how the World Health Organization has tapped into this enormous knowledge base, using an approach called the "narrative research method."

We invited youth leaders from 11 African countries, representing national affiliates of the World Assembly of Youth and the World Organization of the Scout Movement. About 25 youth leaders, aged 18 to 25 and of both sexes, met in two groups, one francophone and one anglophone. Support came from the United Nations Population Fund.

Using role play, each group created a story that they felt was the most typical pattern of behavior between two adolescents that ultimately leads to pregnancy. Then they developed a questionnaire describing the story, designed so that the respondent could modify the story as it developed. For example, when the teenage girl thinks she is pregnant and approaches the boy with this information, how does he react? The respondent can decide that the boy rejects the girl, denies any responsibility or tries to help her.

Back at home, the youth leaders and others in their groups conducted this survey among a total of more than 13,000 young persons, using national samples from urban and rural districts. The two groups of leaders met again and analyzed these responses.

The most important finding was the low level of communication about relationships in general and particularly about sexuality. It was fascinating to see the degree of misunderstanding that could occur between the girl and boy in the story, these two adolescents and their families, and the families and the health-services community. The findings indicated that most serious problems could be avoided by more honest and open communication.

Better communication can only occur, however, when people gain confidence and trust in each other, both adolescents and adults. Earlier this year, the two groups of youth leaders met together in Dakar, Senegal, with representatives of ministries of health from the 11 countries, and began planning projects based on the research findings.

Next steps

There is still a great deal we do not know about how to make reproductive health programs for adolescents more effective. Even so, a consensus is developing about what has been learned in recent efforts.

Youth participation. It is vitally important that young people be invited to help plan, implement and evaluate programs meant for their benefit. Not only is it crucial to success, but for those adults who have experienced it, it is a great pleasure.

Interactive approaches. Using approaches that enable both sides of the human equation to participate is very important. Health workers need to listen and learn from young people as well as give them the benefit of their own experience and wisdom.

People, not problems. A holistic approach that takes into account the adolescent person and not simply the adolescent "problem" is likely to be more effective and more durable than single solutions to single problems.

Links between services. It is essential that adults talk to each other about adolescent programs, as well as to youth. Establishing links between people at the district level working in family planning, education, maternal and child health, STDs and other relevant services should be given high priority. While it is not realistic to expect all such services to work directly together, it is feasible for people to know those in related services who work with adolescents and to work toward formal means of cooperation. Youth organizations themselves might be a natural link for this effort.

In one word, "partnership" is the key. Relationships are the determinants of much of what human beings do. In adolescence, relating to other human beings on many levels is a crucial part of development. Adults, and especially those of us who work in the "helping professions," have very much to gain by letting young people have a real partnership with us and much to lose if we do not.

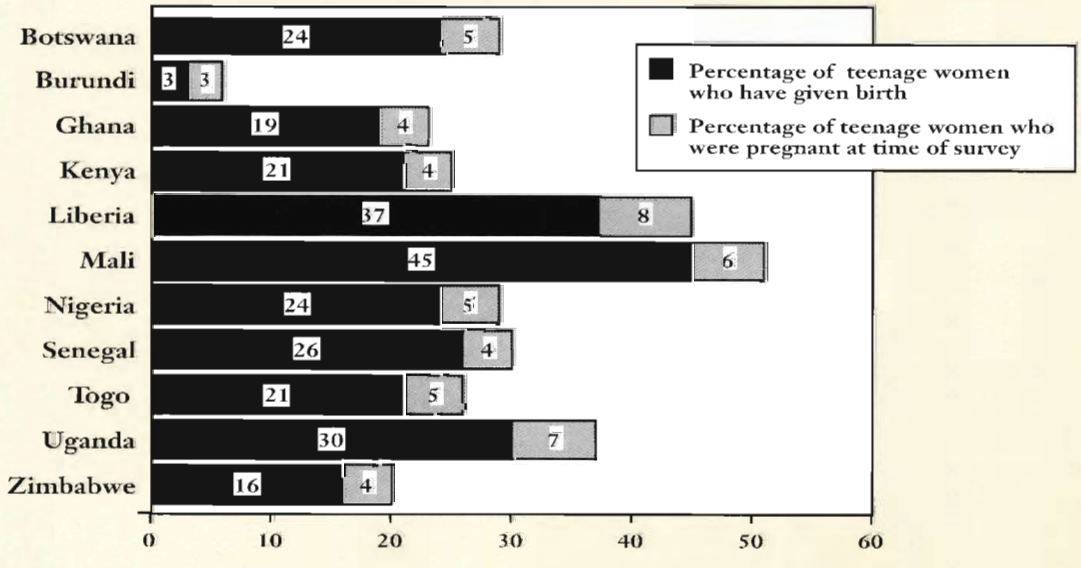
Dr. Friedman is chief of Adolescent Health in the Division of Family Health for the World Health Organization.

OF EVERY 20 TEENAGE WOMEN IN SENEGAL...

FIVE HAVE GIVEN BIRTH

ONE IS PREGNANT

CHILDBEARING AMONG TEENAGE AFRICAN WOMEN



Data refer to women aged 15-19 and may give a low estimate for the number of teenagers who become pregnant, because they do not include pregnancies ending in abortion.

Source: Demographic and Health Surveys, IRD/Macro International. *Adolescent Women in Sub-Saharan Africa: A Chartbook on Marriage and Childbearing.* Washington: Population Reference Bureau, 1992.

Sex Education Leads to Safer Sex

Effective sex education offers accurate information, starts at an early age and recognizes community values.

Many adolescents find their parents and teachers ill-equipped or afraid to teach them about sexual issues, especially in a world where sexual matters and mores seem to change rapidly. In the past, their passage into adulthood was often guided by community leaders designated for the task. But today, many teenagers get their direction from peers or from the media, which often give skewed or sensationalized portrayals of sexuality.

"The vast majority of people who make the decision to become sexually active do so with inadequate information," says Lindsay Stewart, senior program advisor with the International Planned Parenthood Federation's (IPPF) Western Hemisphere office in New York. Sexually active adolescents risk pregnancy and sexually transmitted diseases (STDs), including AIDS, but often lack knowledge about how to prevent them.

"Young people have the right to appropriate information to make decisions and access to the means to help them act responsibly," she says. While some societies forbid giving sex education or contraceptives to adolescents, programs worldwide have developed innovative ways to provide these services to youth.

Evaluations generally show that such programs may improve knowledge about sexuality, delay intercourse and increase contraceptive use. Sex education works best when it reaches youth before their first intercourse. "Providing people with information, even in elementary school, gives them a chance to think through some of the issues," says Dr. Cindy Waszak, an FHI researcher specializing in adolescent programs. "The earlier you start [sex education], the better."

Effective programs offer accurate information, train educators, and combine messages about abstinence and safer sex, health experts say. They make services accessible and operate within community norms. They also address adolescents holistically, not just sexually. "For young people, sexual relationships are one part of their social relationships, and the social relationships are important," says Jane Ferguson, technical officer for the World Health Organization's Adolescent Health Programme. "We have to concentrate on how to assist young people to develop and maintain healthy relationships, not just how to say no to sex."

Education can delay intercourse

Evaluations of adolescent programs can be costly and difficult: data are hard to collect because of the personal nature of questions; programs vary in content and intensity, making comparisons tricky; and experts disagree about what constitutes success.

DRAWINGS FROM THE COMIC BOOK *CAPTAIN CONDOM AND LADY LATEX.*

PATH AND CYS

Sex Education and Behavior

Does sex education hasten sexual activity?

In general, sex education does not seem to cause teenagers to have sex at earlier ages or increase their sexual activity.

Does sex education delay sexual activity?

It can. Especially if youths receive sex education before beginning sexual activity, they may delay sex or practice safer sex. Effective courses include behavioral skills, encourage delaying sexual activity and emphasize practicing safer sex, if adolescents choose to be sexually active.

Does sex education lead to safer sexual activity?

It can. Sex and AIDS education may lead to a reduction in the number of sexual partners and increased use of contraceptives, either to prevent pregnancy or disease transmission.

Primary Sources: This chart is based on a World Health Organization review of 19 studies from around the world and on studies from various countries. See text footnotes 1-7.

Despite the obstacles in obtaining data, scientific evidence shows that many sex education programs seem to change sexual behavior. A World Health Organization (WHO) review of 19 studies found that offering sex education in school often delayed or decreased adolescent sexual activity and led to more contraceptive use.[1] "Available evidence shows that sex and AIDS education do not promote earlier or increased sexual activity in young people," the authors wrote. "More positively, they may lead to an increased uptake of safer sex practices.

"School-based sex education programs were found to be more effective when given before young people become sexually active, and when they emphasized skills and social norms rather than knowledge," according to the review, which also concluded that combining messages about abstinence and safer sex was more effective than emphasizing abstinence alone. In another study, Mexican high school students were no more likely to become sexually active when enrolled in "Planeando Tu Vida," or "Planning Your Life," a sex education program offering contraceptive information and teaching communication skills, than students who weren't enrolled.[2] AIDS education also can help delay sexual intercourse, reduce the number of sexual partners and increase condom use.[3]

In the United States, a school-based course in California, "Reducing the Risk," showed the value of sex education before sex begins. The course advised that students should remain abstinent or use contraceptives; trained them in decision-making and communication skills; and explored the social pressures for having sex.[4]

Eighteen months after the course, almost 10 percent fewer high school student participants had initiated sexual activity than those not enrolled. Participants who had not initiated sex before the course were more likely to use contraceptives when they did start. The course also increased knowledge and parent-child communication among the participants. But teenagers who were sexually active showed less response to the program. Youth sexuality is shaped by the attitudes of society, family and peers, among other factors.

A national study of more than 12,000 young people in the United States found that race, church attendance and parental education — more than sex education — influenced whether girls started having sex at ages 15 or 16.[5] Girls at this age who had sex education were slightly more likely to start having sex than their counterparts, but sex education had no such effect at age 17 or 18. In addition, teenagers who had taken a course were more likely to use contraception and no more likely to become pregnant before age 20 than their peers.

In five Latin American cities — Mexico City; Guatemala City; Quito and Guayaquil, Ecuador; and Santiago, Chile — researchers found that young women who took a sex education course were more likely to delay having sex.[6] In Mexico City, but not other areas, young women and men who took a course before having sex for the first time were more likely to use contraceptives. "The majority of single young adults do not pro-

tect themselves against pregnancy or sexually transmitted diseases at their first intercourse," the authors wrote.

Providing contraceptives

To reach students who are already sexually active, many schools and organizations have decided to provide contraceptives, including condoms and Norplant, as well as education. Evaluations of such efforts indicate that access to contraceptives, like sex education, does not hasten the initiation of sexual activity. The efforts sometimes reduce pregnancy rates as well.

Students at a vocational school in Thailand who received health education training and contraceptive services did not increase sexual activity, but increased contraceptive use when they did have sex.[7] In Baltimore, Maryland, USA, pregnancy rates at a junior and senior high school with a pregnancy prevention program dropped 30 percent, while the rate at comparable schools rose 58 percent over 28 months. High school students exposed for three years to the program, which included education, counseling and contraceptive services, delayed their first intercourse for an average of seven months longer than their counterparts.[8]

A study of six U.S. school-based clinics with reproductive health services showed no increase in or hastening of sexual activity due to the provision of contraceptives from clinics. One clinic showed an increase in the use of contraceptives, but none of the clinics affected pregnancy rates in the schools.[9] Teen pregnancy rates are difficult to measure, because many pregnancies go unreported or end in abortion. An examination of school-based clinics in St. Paul, Minnesota, USA, showed no effect on birth rates.[10]

In San José, California, USA, two high school centers offering contraceptive counseling and other health services reported an increase in contraceptive use among sexually active students after the clinics opened. Male contraceptive use increased more than 50 percent overall and female contraceptive use nearly quadrupled at one school.

The clinics reported no increase in sexual activity among students. Rochelle Sigel, a nurse practitioner, counsels students about reproduction and contraception, including abstinence. "A lot of young women do not think they have any power when it comes to sex," says Sigel. She remembers one 15-year-old student deciding she could postpone having sex with her boyfriend. "To me that's a triumph, for her to feel empowered," she says.

Designing effective programs

Millions of adolescents worldwide are sexually active and at risk for pregnancy, as well as AIDS and other STDs. In some sub-Saharan African countries, for example, as many as 82 percent of young women have been married or had premarital sex before the age of 19.[11] Many youth are sexually active for some time before they seek condoms or other protection. They do not plan for sexual activity, often afraid that obtaining contraceptives means they are being immoral.

Programs to help adolescents address their sexuality are crucial, says Dr. Asha Mohamud, who directs the International Center on Adolescent Fertility, part of the U.S.-based Center for Population Options. Dr. Mohamud has recommended that agencies interested in the welfare of adolescents take steps to improve programs, including supporting integrated services, incorporating the ideas of youth, involving males, linking pregnancy prevention efforts with AIDS prevention, and evaluating existing programs.[12]

For many teenagers, having sex at an early age is associated with other risk factors, such as poverty, poor school performance, smoking, drinking or taking drugs. In addition, many adolescents who become sexually active when they are young come from troubled families where they have been abused.

Offering such youth opportunities to better their lives makes a difference, says Dr. Georgiana Coray, who directs the San José School Health Centers in the United States. Jobs for youth "are the best contraceptive," she says. "Kids who have something to look forward to become much better at either avoiding sexual activity or having safer sexual activity."

The Guyana Responsible Parenthood Association puts this idea into practice with its center for out-of-school youths. It trains teens in vocational skills and academic subjects as well as sex education. But, like some similar programs, the center and the association have met with some resistance.

"Religious leaders think we are encouraging promiscuity" especially by discussing contraceptives, says Claretta DeSouza, the association's acting executive director. But, she says, "We tell [youths] first of all to say no, and then if they can't say no, they need to protect themselves."

BERYL GOLDBERG

A STUDENT LISTENS DURING CLASS IN GHANA. EARLY MARRIAGE AND PREMARITAL SEX ARE COMMON AMONG TEENAGERS IN SUB-SAHARAN AFRICA.

Working with communities is critical to a program's success, says O.J. Sikes, chief of the Education, Communication and Youth branch of the United Nations Population Fund, which funds population education programs in more than 60 countries. Programs that ignore community norms can create unnecessary opposition, he says. "If you do not work hand in hand with teachers, parents and community leaders to discuss what education programs can address, you increase the risk of opposition to your program," he says.

Because what constitutes an acceptable expression of youth sexuality varies so widely around the world, sex education and contraceptive provision must be adapted to each culture, and often each group within a culture. What works with students may not work with street youth, for example.

In U.S. schools, successful programs present a clear message, says Dr. Douglas Kirby, director of research at ETR Associates, a nonprofit organization dedicated to

Contraceptive Methods: A Teenager's Perspective

Most doctors, nurses and community-based providers have little if any training in working with sexually active adolescents, especially unmarried teenagers. Providers generally lack understanding about the barriers that teenagers experience when they consider using contraceptives. An awareness of what adolescents encounter and feel may help providers as they consider the relative advantages and disadvantages of contraceptive methods and services for this age group.

- **Guilt and embarrassment** — Adults generally do not approve of unmarried teenagers being sexually active. Hence, adolescents often feel guilty and embarrassed to admit they are sexually active or to talk about contraception openly. Discussing contraception with adolescents in a private, confidential setting and a non-judgmental way is very important. Helping teenagers become more comfortable talking about sexuality (removing secrecy and shyness) may help also.

- **Lack of knowledge** — Knowledge about sexuality and how contraceptive methods work remains limited among teenagers. Sex education courses, a more open atmosphere about sexuality, the use of peer educators, and explicit information on contraception can help. Providers must be certain that basic facts such as the menstrual cycle are understood, so that methods are more likely to be used properly.

- **Peer pressure** — Peer norms about what is currently fashionable or "cool" influence teenagers significantly. Hence, teenagers worry about being embarrassed by using contraceptives such as condoms when the partner is involved. Messages that help teenagers gain self confidence in their own decisions may help.

- **Communication difficulties** — Many of the contraceptive methods most accessible and most familiar to teenagers require good communication — condoms, periodic abstinence, withdrawal, non-penetrative sex and complete abstinence. Providing teens an opportunity to practice discussing sexuality issues with their peers can be of great assistance.

- **Inexperience** — When an adolescent begins to experiment with sex, certain contraceptive methods, such as withdrawal, will be particularly hard to use correctly. Also, these adolescents may not think of themselves yet as "sexually active" and hence may be more receptive to using a one-time protection (i.e., condoms) than a "family planning" method, such as oral contraceptives or Norplant.

- **Lack of access** — Adolescents often seek contraceptives without their parents' knowledge and, hence, must cope with transportation problems in reaching clinics, the cost of contraceptives, harassment or refusal to be served at pharmacies, and other difficulties. Making contraceptives more easily accessible through outreach efforts would help solve this problem.

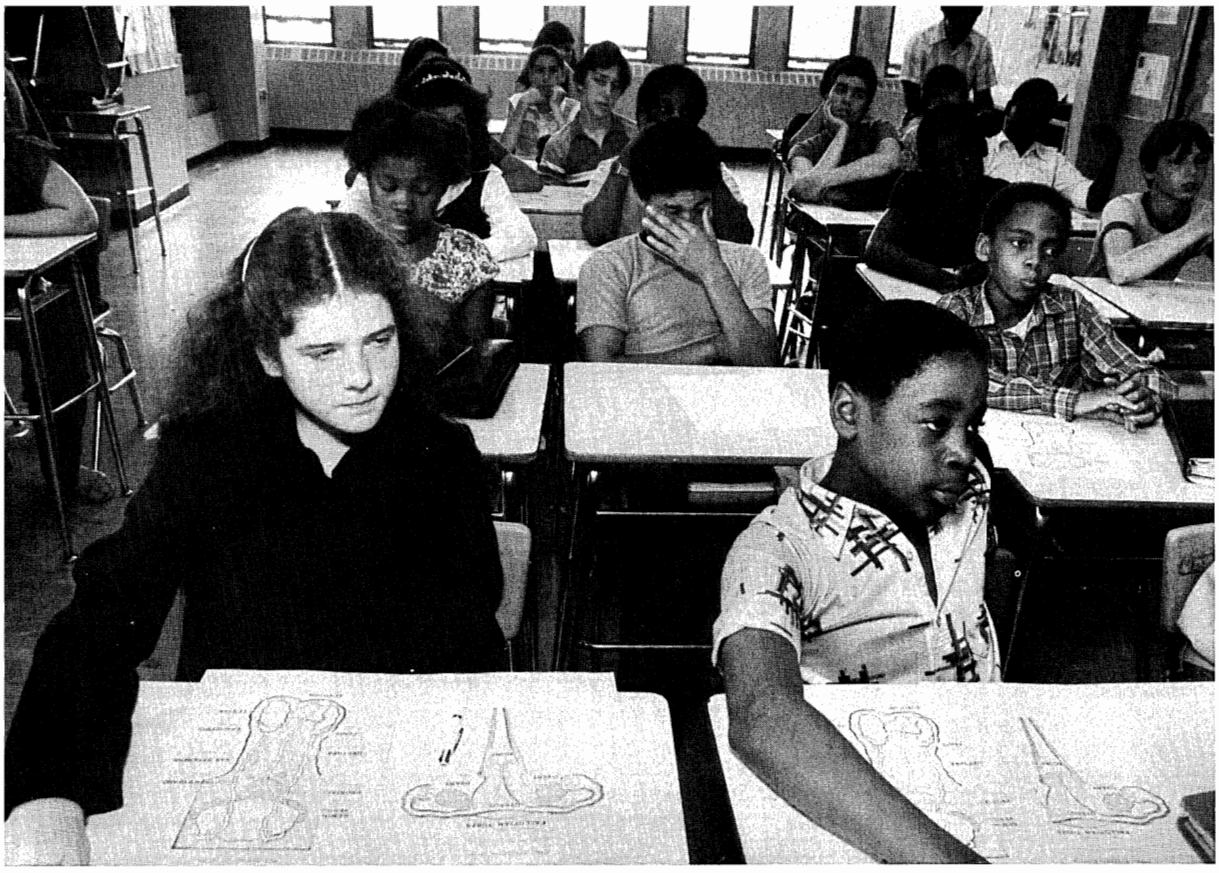
- **Official and cultural barriers** — Some laws, policies, cultural attitudes and traditional medical practices limit services to adolescents or add to fears about an unfamiliar situation. Examples of such barriers include mandatory pelvic exams, prescriptions and parental consent requirements before obtaining oral contraceptives.

- **Physiological considerations** — Young, nulliparous females have relatively small uteruses, making an intrauterine device (IUD) an inappropriate method due to the likelihood of excessive pain and bleeding.

- **Coercion and philosophical issues** — Adolescents may be particularly vulnerable to provider coercion regarding such methods as Norplant and IUDs; some providers believe that sexually active teenagers need these long-acting, low-compliance devices, which only clinicians have the final authority to remove. Also, sterilization, a permanent method, is not appropriate for adolescents.

— Dr. Cindy Waszak

Dr. Waszak is a research associate at FHI and co-chair of FHI's Working Group on Adolescents.



BERYL GOLDBERG

STUDENTS ATTEND A SEX EDUCATION CLASS AT A NEW YORK CITY SCHOOL.

improving the health of young people. "Particularly in the age of AIDS, there are things kids need to be doing," he says. "We know enough about the realities of HIV, pregnancy and STDs that we should be encouraging them to make the decision" to delay sex or use condoms.

Effective programs offer accurate information, depend on role-playing and other types of active learning, and adequately train the educators who work with teens, he says. They also work to change adolescents' perception of social norms regarding sexual activity and contraceptive use, making safer sex or abstinence more acceptable.

"We're making abstinence valuable, but we're not judging those who decide not to be abstinent," says Dr. Mohamud of the Center for Population Options. "What we try to avoid is saying to adolescents 'You cannot have sex' or 'You must use contraception.' They make the decision ultimately."

In addition to making programs and contraceptives available, they must be accessible to teens, says Kirstan Hawkins, a research officer with IPPF. A program's success may depend on whether parental permission is required, how understanding the staff is, the accessibility of the site, and other factors. Young people may have limited money and means of transportation, and are often embarrassed to ask for information on sexuality.

"The staff must be trained in working with young people and really sensitive to the issues of young people," Hawkins says. "If they look at how young people feel about [sexuality], then they can begin to address the real issues."

— Carol Lynn Blaney

FOOTNOTES

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Youth Often Risk Unsafe Abortions

Infertility, crippling handicaps and death are among the sad consequences of unsafe abortions.

Fearful of parental disapproval and expulsion from school, a Nigerian girl seeks an abortion from a woman who advises her to drink cow's milk with bitter herbs.

A young Brazilian prostitute tries to induce abortion by swallowing misoprostol, a drug that causes uterine contractions.

A Bangladeshi youth seeks an abortion from a village midwife, who uses roots cut from a neem tree to dilate the cervix.

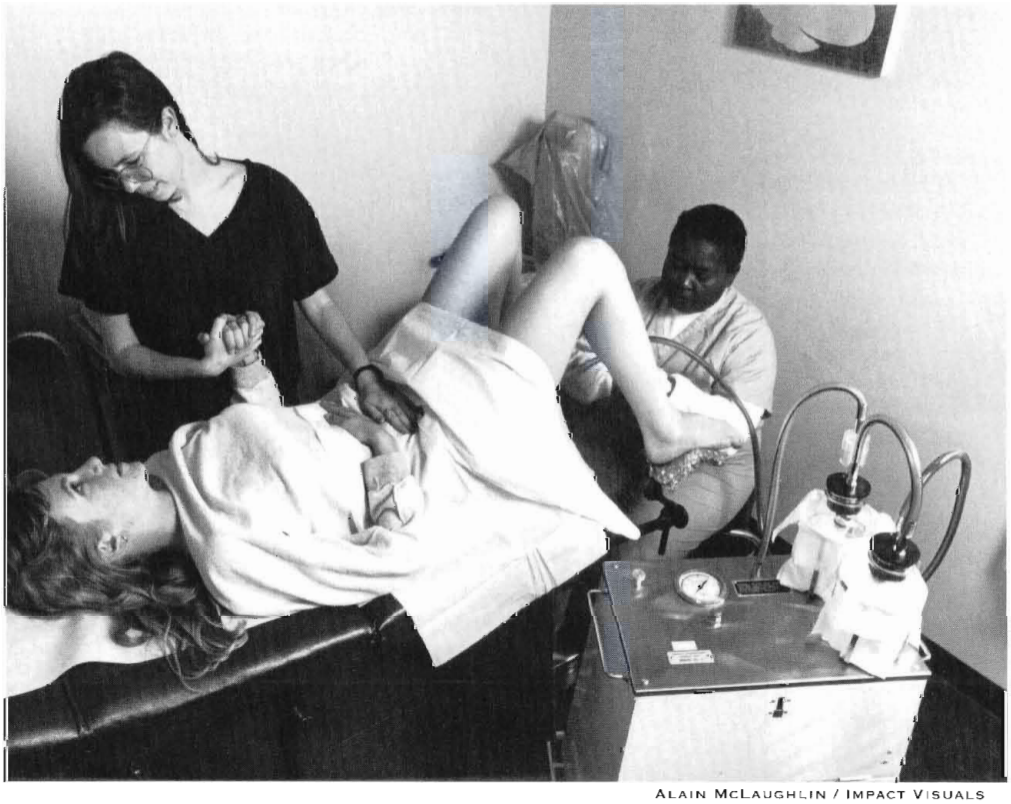
Each year, millions of young women in developing and industrialized countries seek similar unsafe abortions as a remedy for unwanted pregnancies. By doing so, they put themselves at risk for serious health problems, including infection, hemorrhage, infertility — even death. Because many of these girls come to hospital emergency rooms and clinics for treatment of abortion complications, they also strain health-care systems. The World Health Organization (WHO) estimates that at least one-third of all women seeking hospital care for abortion complications are under age 20. Of the estimated 50 million induced abortions worldwide each year, more than one-third are illegal, and nearly half of all abortions take place outside the health-care system.[1]

For girls and women who have unsafe abortions, two types of short-term health problems can occur: injuries from the procedure itself, such as perforation of the uterus, cervical lacerations or hemorrhage; and bleeding and infection, caused by incomplete abortion or introduction of bacteria into the uterus. Long-term complications include increased risk of ectopic pregnancy, chronic pelvic infection and possible infertility.

The death rate for unsafe abortion is estimated in one study to be as high as 1,000 per 100,000 procedures. When performed by experienced providers using aseptic techniques, the abortion death rate drops dramatically, to less than one death (0.6) per 100,000.[2]

"A woman has about 30 years of fertility," says Francine M. Coeytaux, co-director of the Pacific Institute for Women's Health in the United States and author of a study of unsafe abortion in sub-Saharan Africa. "If

A YOUNG WOMAN RECEIVES A SAFE ABORTION IN A CALIFORNIA, USA, CLINIC.



ALAIN MCLAUGHLIN / IMPACT VISUALS

she starts off early with an unwanted pregnancy and an unsafe abortion, she's risking her whole reproductive future. The way some societies deal with infertile women is they become outcasts, they can't marry, and they are forced into prostitution."

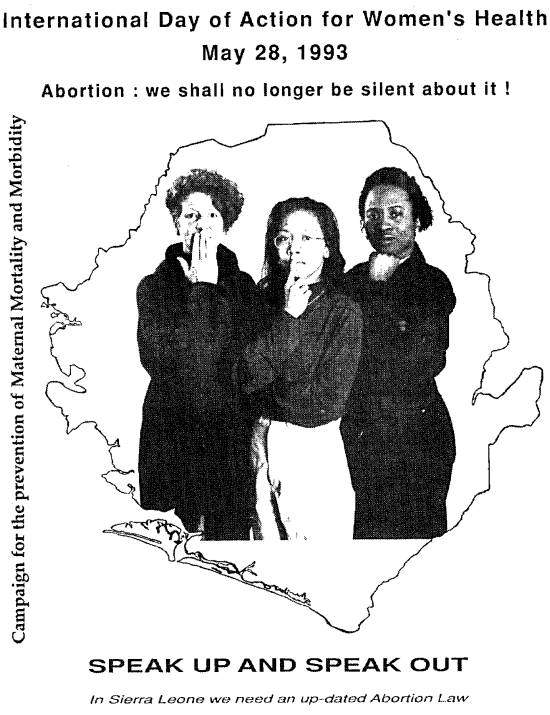
More risky for adolescents

While the risks of mortality and morbidity from unsafe abortion are high for women of all ages, they are especially high for adolescents. "The complications and problems are greater for this age group than any other group," says Dr. Douglas Huber, medical director of Pathfinder International, based in the United States. "Adolescents don't seek out care early on. They wait until later in their pregnancies when the health risks are greater. Often, they don't have the knowledge of where to go for an abortion. When the complications do come, their fear of going for treatment is greater."

Joan Healy, director of program management at International Projects Assistance Services (IPAS), a U.S. group that trains providers in safe abortion techniques, agrees. "Adolescents are particularly at risk because of their lack of knowledge and their lack of resources. The information they get from their peers tends to be limited and inadequate. They often get bad advice."

Several studies illustrate the impact of unsafe abortion on individuals and on health-care systems.

- In an FHI study in Bolivia of patients hospitalized for complications from induced abortions, about 39 percent of the women under 18 years old had illegally provoked abortions; the figure was 30 percent for women ages 18 to 19. The proportion decreased steadily with age.[3]
- In Zaire, a study of 2,465 women hospitalized for abortion complications showed that the proportion of induced abortions was greatest among women under 20. Among patients 18 or younger, 58 percent were treated for complications of induced abortion, and among patients 18 to 19, the number was 41 percent. This compares with less than 10 percent of women in the 30 or older age group.[4]
- A study at the University of Calabar Teaching Hospital in Nigeria found that 72 percent of the patients hospitalized for abortion complications were under 20. Fifty-eight percent were students, and 11 percent had undergone a previous unsafe abortion. Only five percent of the patients had used contraceptives.[5]
- In Cameroon, 32 percent of emergency admissions at a local hospital were due to abortion-related complications. Nearly 39 percent of the patients with abortion-related complications were ages 11 to 19.[6]
- In Russia, 15.2 percent of all illegal abortions performed on childless women involved girls 17 and under, according to 1989 estimates.[7]



A POSTER FROM SIERRA LEONE PROMOTES ACCESS TO SAFE ABORTION.

Hospitalizations, however, "are only the tip of the iceberg," says Dr. O.A. Ladipo, executive secretary and program director of the South to South Cooperation in Reproductive Health in Bahia, Brazil, and author of studies on adolescent abortion in Africa. "Many don't make it to the hospital. They die at home or on the way. Unsafe abortion is a major health problem responsible for deaths in the prime of life."

Numerous barriers

In spite of the odds of illness, infertility or death, for many girls the risks of unsafe abortion are outweighed by the fears generated from an unplanned pregnancy: fear of parental disapproval, abandonment by a boyfriend or husband, financial and emotional responsibilities of child rearing, expulsion from school, or inability to marry if they have a child out of wedlock.

Obtaining a safe abortion — or obtaining medical services after an unsafe procedure — is not easy for adolescents, who may encounter medical, cultural and legal barriers.

Significant barriers, family planning officials say, are laws and policies that prohibit or restrict abortion. In Nigeria, for example, abortion must be certified or approved by two qualified registered physicians. Anyone who illegally performs an abortion is subject to 14 years in prison. In Turkey, abortion is legal until the tenth week of pregnancy, but it must be performed by a gynecologist, not another health-care provider. In Bangladesh, abortion is illegal except to save the life of the mother. However, menstrual regulation, a technique that uses vacuum aspiration, can be performed legally as soon as a woman misses her period.

International Planned Parenthood Federation (IPPF) reports that most of the world's countries — more than 90 — have "strict" or "very strict" abortion policies.[8] (See related chart, p. 15.)

In countries where legal abortion is available upon request, adolescents face barriers as well. Dr. Cindy Waszak of FHI says in the United States, where legal abortions have been available upon request since 1973, data from focus groups indicate many girls don't know abortion is legal or don't have the money or transportation necessary to obtain the procedure. Some state governments require parental consent, which can be a deterrent, she says. A 1991 study of more than 1,500 adolescents who underwent abortion showed that approximately one-third did not tell their parents. Among the most common reasons for secrecy were fear of hurting or disappointing parents; fear of parental anger; fear the parents would make the girl stop seeing her boyfriend; and concern that the parents were under too much stress.[9]

In India, where abortion has been legal for more than 20 years, adolescents encounter numerous barriers to safe abortions, says Sudha Tewari, who works with Parivar Seva Sanstha, an affiliate of Marie Stopes International. Some health policies restrict abortion for minors unless they obtain parental

consent. Although abortion is free in public hospitals, adolescents may face long waits and lack of confidentiality. In private hospitals, the costs of abortion services are related to marital status and are typically higher for unmarried women, Tewari reports.

For adolescents seeking treatment for abortion complications, fear that providers will be judgmental or callous is also a barrier. "Young people are often scared to go to hospitals," says Dr. Malika Ladjali of IPPF, which coordinates the Youth for Youth Project, an international effort that involves WHO and the United Nations Population Fund. "Adolescents are scared of not finding helpful people, scared of moral judgments and lectures. They are scared of the white coats.... The [provider's] attitude is 'if it's bad enough, you'll remember it all your life.' "

Lack of adequately trained medical personnel and lack of supplies can hinder teenagers' attempts to obtain safe abortions. For example, in Cameroon, there is one doctor to provide care for every 15,000 people; one nurse to provide care for every 12,000 people.[10] In India, 70 percent of the country's 900 million people live in rural areas, but the majority of India's doctors live in urban areas, with only 1,000 of the doctors who are trained to perform abortions practicing in rural communities.[11]

A NEED FOR EDUCATION

Legalizing abortion and training more providers to perform abortions correctly would help reduce adolescent mortality and morbidity, family planning officials say. Yet, efforts to prevent unsafe abortions also must focus on prevention of unwanted pregnancies. Adolescents must be educated about sexuality and reproductive health, must have easy access to contraceptives and must be informed about the dangers of unsafe abortion.

Several such efforts are under way. In Sierra Leone, family planning and women's groups have begun a campaign to educate the public about unsafe abortion with the theme "Abortion: We Shall No Longer Be Silent About It." The education effort includes a song with the lyrics, "We the women/We the girls/ We are the ones suffering/ We don't think we should die from abortion."

In addition, the campaign has developed a 40-minute video, which is being shown to groups on request, including students at a Catholic school, traditional birth attendants, local village chiefs and women shopping in markets. The video tells the stories of four people: a schoolgirl who, following an illegal abortion, seeks hospital care and receives family planning counseling; a pregnant teenager involved with a "sugar daddy" who does not want to lose his standing in the church or community by admitting he is her baby's father; a youth who explains to a friend that it's better to use condoms to prevent pregnancy than to end a pregnancy by unsafe abortion; and a married woman whose husband agrees to an abortion only if she will have it done in a hospital.

In Senegal, the Xall Yoon project focuses part of its effort on educating youth about unsafe abortion. A chorus from a Xall Yoon song says: "Come girls and boys/Together we'll learn how to prevent unwanted pregnancies/Together we'll learn how to prevent abortion."

In Sri Lanka, Buddhist priests, volunteers, and health educators are trained to teach rural youth about reproductive health. Among the topics discussed are preparation for marriage and the health consequences of unsafe abortion.

Post-abortion counseling about family planning is critical in preventing subsequent unsafe abortions, family planners say. In Mexico, where abortion is illegal except in cases where the mother's life is in danger or the woman has been raped, adolescents who come to several Mexico City hospitals to give birth or to recover from unsafe abortions receive family planning counseling, says Anameli Monroy, board president of the Centro de Orientación para Adolescentes (CORA). Begun in 1978, the program was started when health and family planning officials realized "the girls who were hospitalized for pregnancy or an abortion would come back pretty soon because they didn't have any [contraceptive] information," Dr. Monroy says.

Girls are invited to attend an in-hospital workshop that focuses on contraceptive use. They're invited to return to the hospital two weeks later with their baby, boyfriend, husband or other family member to learn more about health care and CORA's job training programs.

While unsafe abortion is dangerous, adolescent pregnancy carries its own set of risks. "Even when pregnancy is wanted, it's very dangerous — even life-threatening," says Dr. Ladipo of the South to South Cooperation.

Pregnant teens may suffer from anemia, miscarriage, pregnancy-induced hypertension (toxemia), or eclampsia, an advanced stage of toxemia that is life-threatening for mother and baby. Because their bodies are not fully grown, young girls may suffer from prolonged or obstructed labor, which can lead to ruptured uterus and death for the mother and fetus, as well as infection or damage to the bladder or bowels. Husbands and family members frequently reject girls who sustain bowel or bladder injuries, and they may become social outcasts or prostitutes, says Dr. Ladipo.

Infants born to teenage mothers may suffer from complications due to low birth weight or prematurity. The incidence of stillbirth is higher among teens who are less likely to seek prenatal care because of economic or geographic barriers. A study of women in rural Bangladesh, where 69 percent of girls marry between ages 15 and 19, showed a maternal mortality rate three times higher for girls age 13 to 17 than women 18 to 23.[12]

BY YOUTH, FOR YOUTH

To reduce the risks of mortality and morbidity from adolescent pregnancy and unsafe abortion, health providers, program managers, and policy-makers must develop family planning programs that address the unique needs of young people, family planning experts say.

"Teens are not planning their families," advises Ms. Healy of IPAS. "They're avoiding pregnancy." The strategies for education must be different than for older women, who may want to space the births of their children.

Programs should seek to remove barriers to safe abortion, family planners say, but programs also must seek to remove medical, legal and social barriers to adolescent contraception. For example, many African and Asian countries dispense contraceptive services only to married women. To make contraceptives more accessible and to involve men in family planning, the CORA program distributes condoms in settings where young people congregate, such as schools, parks, factories, clubs and CORA education centers.

Education of adults, including parents, teachers and health providers, is as important as education of adolescents, experts say. Many family planning programs reflect adult staff's discomfort with adolescent sexuality. Consequently, adolescents do not feel welcome or encouraged to seek services.

Sexual abstinence is "what society expects of young people, but it is not what society practices," Dr. Ladipo says. "Often they [youth] are looked down upon by the adults or by the health-care workers themselves."

To design family planning services for adolescents, providers, program managers, and policy-makers must involve young people in the discussions.

"The most important thing to do is to accept that young people have sexual lives," says Dr. Ladjali of IPPF. "We have to change our minds and change our attitudes. We have to consider young people a partner in family planning, not a target."

— *Barbara Barnett*

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Access to Legal Abortion

On Demand

About 40 percent of the world's population[1] have access to early abortion upon request. Laws, however, may require parental consent, approval of state committees or physician consent.

These countries include:
- 22 countries in Europe, including Bulgaria and Romania
- 12 countries in the former Soviet Union, including Armenia and Russia
- 4 countries in Asia, including China and Vietnam
- 4 countries in the Americas, including Cuba and the United States
- 1 in the Middle East, Turkey
- 1 in Africa, Tunisia

For Social Reasons

Another 21 percent of the world's population live in countries that permit abortion for social or economic reasons, such as age or low income.

These countries include:
- 5 countries in Asia, including India and North Korea
- 3 countries in Europe, Great Britain, Finland and Hungary
- 1 country in Africa, Zambia

For Health Reasons

16 percent of the world's population live in countries that permit abortion when a woman's health is at risk or in cases of rape, incest or fetal defects.

These countries include:
- 21 countries in Africa, including Cameroon, Kenya and Togo
- 8 countries in the Americas, including Bolivia, Peru and Ecuador
- 7 countries in Asia, including Pakistan and Papua New Guinea
- 5 countries in Europe, including Germany and Poland
- 4 countries in the Middle East, including Kuwait

For Rape, Incest or to Save Mother's Life

5 percent of the world's population live in countries that permit abortion only in cases of rape or incest or when the mother's life is in danger.

These three countries are:
- Brazil, Mexico and Sudan

Only to Save Mother's Life

18 percent of the world's population live in countries that permit abortion only when the mother's life is in danger.

These include:
- 19 countries in Africa, including Burkina Faso, Mali and Senegal
- 11 countries in the Americas, including Chile and the Dominican Republic
- 9 countries in Asia, including the Philippines and Sri Lanka
- 7 countries in the Middle East, including Iran and Yemen
- 1 country in Europe, Ireland

Source: Abortion laws worldwide. *Expanding Access to Safe Abortion: Key Policy Issues.* Washington: Population Action International; Sept. 1993.

1. Excluding countries with fewer than 1 million people.

Seeking Better Ways to Teach Youth about AIDS

Preventing HIV's spread is especially difficult among youth, who account for many of the world's victims.

Many children in the developing world struggle daily just to survive. A disease like AIDS that may strike years in the future can easily seem meaningless compared to an empty belly or a cold stove, thus making successful prevention efforts unusually difficult to achieve.

Yet the need for prevention strategies for youth is clear: About half of the HIV infections worldwide now occur among people younger than age 25, estimates the World Health Organization, and rates of sexually transmitted diseases (STDs) are higher among adolescents than for any other age group.

Some community-based programs are seeking to prevent AIDS in the larger context of poverty, education, jobs and feelings of self worth. The AIDS epidemic has also prompted more discussions about sex among young persons, their parents and the community. But efforts to decrease HIV transmission among young people still face major barriers.

"The ambivalent attitude of adults toward young people's sexuality is a major obstacle to HIV and STD prevention programs," says Dr. Mariella Baldo, who works with youth programs for the World Health Organization's Global Programme on AIDS (WHO/GPA). "As a consequence, information and education do not reach the youth with effective messages and programs, which need to be centered on safe sexual practices."

Many adults and policy-makers worry that sex education may encourage young people to have sex earlier or become promiscuous. "Evaluation studies provide ample evidence to the contrary," says Dr. Baldo. "Sex and AIDS education do not promote earlier or increased sexual activity in young people but rather may lead to an increase of safer sex practices," she says.[1]

Young people's behaviors also present a challenge to AIDS prevention. Unmarried youth are sexually active at a younger age than in past generations, are marrying at older ages, have expanded educational opportunities, and are migrating to cities where they face more decisions away from traditional family units. "All of this means there are increasing numbers of adolescents who are sexually active and single for many years, for whom the message of 'no sex before marriage' is not relevant," says Dr. Baldo.

Dr. Lacka Piya-Ajariya, a senior national officer for United Nations Children's Fund (UNICEF) in Thailand, formerly with the Thai Ministry of Education, points to an additional barrier. "Limited economic opportunities for young people, particularly girls, is a major challenge that affects the AIDS epidemic here. The low status of women is a cultural issue and needs structural changes to help increase the bargaining power of women," he says.

IN A DRAWING ON A T-SHIRT DESIGNED BY TEENS FOR AIDS PREVENTION, A CONDOM ADVISES: "AIDS IS REAL. YOU DECIDE."

CENTER FOR POPULATION OPTIONS

Opening the Gates

The obstacles are indeed immense — but so are the possibilities for change. As youth have shown a genuine concern about their own sexual health and that of their peers, both adults and other young people have taken notice. In the west African country of Senegal, for example, Catholic parents and village leaders have sought assistance from Xall Yoon ("Opening the Gates"). The project trains youth to provide information to other youth on STDs, sexual health, contraception and safe abortion, and to distribute condoms.

"Officials do not support some of our work, such as distributing condoms, but they accept it," says Lamine Diawara, who directs the project. "They know that STDs and unwanted pregnancies are very widespread in the community and that our work can help."

Even before AIDS, many countries had curricula for sex education. "But these were not being implemented, partly because of real constraints such as lack of funds and training and partly because it was a controversial topic," says Dr. Baldo. "When AIDS appeared, it forced people to reconsider the whole issue of sex education. Because of AIDS, sex education is moving again."

In the mid-1980s, Ugandan officials recognized the dangers of AIDS and began a large-scale AIDS education program in secondary schools. The program sought to provide accurate information on the virus and its transmission and to dispel the many myths about how a person could get HIV. By 1993, HIV infection rates ranged from 5 percent in rural areas to as high as 29 percent in some urban areas of Uganda, one of the worst infection rates in the world.

In villages of the most affected regions, six times the number of girls as boys between the ages 15 and 19 are infected with HIV. This pattern is true in many parts of Africa and for many reasons, including the greater physiological risk of transmission among women compared with the risk for men.

During the time the AIDS education program was beginning, the Uganda Adolescent Fertility Survey questioned 4,510 youth ages 15 to 24. The findings, released in 1992, suggest that youth had learned basic information about HIV, but the knowledge was not affecting their actions. Ninety-five percent of those surveyed had heard about STDs, and most knew condoms prevented STDs. Even so, most had a negative attitude toward the use of condoms, and substantial numbers reported having had an STD (21 percent of males, 8 percent of females).

"The gap between knowledge and practice is rather wide," the researchers reported. "Sex education offered in the school system comes rather late and may be inappropriate to meet the needs of the adolescents and young adults." Instead, the researchers recommended, information in the schools should reach young people before they become sexually active.[2]

To help meet this need for getting information to younger children, UNICEF recently began Safeguard Youth from AIDS, or SYFA (pronounced see-fa), which means "I don't want to die" in the main language in southern Uganda. Coordinating with Ugandan ministry officials and other local groups, such as the Health Education Network and the School Health Education Project, SYFA is focusing on children ages 5 to 14, whom they call the "window of hope," while also helping expand services to those ages 15 to 20.

POSTER PRODUCED BY SIERRA LEONE'S YOUTH FOR YOUTH PROJECT.

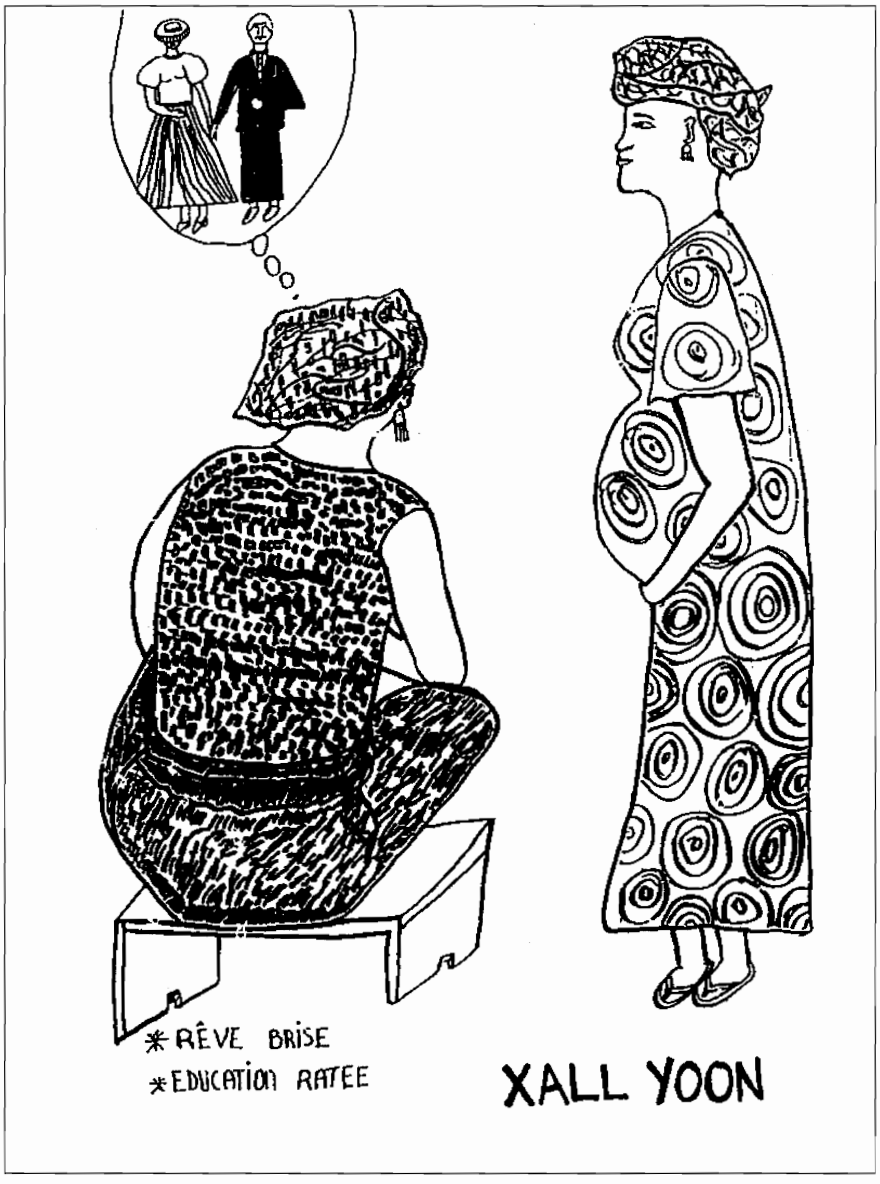
Finding the Sugar Daddy

To the south in Zimbabwe, where the virus has also hit hard, school materials incorporating HIV information are being developed for children ages 8 and 9. Plans are under way now to train 55,000 teachers in this country of 10 million. Materials for secondary schools are frank about subjects once considered strictly taboo. The New Generation newspaper produced for Zimbabwean school children includes a page called "Body Talk in the Age of AIDS."

Last March, the page ran a competition asking young people to identify "Who is a Sugar Daddy?", the phrase used loosely to describe an older man having sex with a younger woman in exchange for gifts, money or other favors. The contest presented three situations and asked readers if the man described was a sugar daddy, and why or why not. The circumstances were subtle, not clear-cut, much like daily life. The competition sought to stimulate young people to think about such issues. Another column on the page is entitled "Talk, Listen, Lead by Example — Teenagers Talk to Parents."

Across the Indian Ocean in Thailand, where the epidemic has also found a major foothold, information on HIV/AIDS has been incorporated into primary-level curricula called "Life Experience" and "Character and Development," which address building positive attitudes and solving personal and social problems. The secondary-level health education materials address how students can protect themselves and inform others about AIDS prevention.

Last year, more than 100 Thai schools held AIDS-awareness competitions for writing essays, songs, cartoon scripts, slogans and drawings. "An important lesson learned in Thailand is that when working with young



POSTER BY SENEGALESE YOUTH SHOWS A WOMAN THINKING REGRETFULLY THAT HER PREGNANT FRIEND'S DREAMS ARE SHATTERED.

people, it is necessary to undertake reinforcing activities such as competitions and contests, exhibitions and public awareness events, involving movie stars, public singers and others of influence with young people," says Dr. Piya-Ajariya of UNICEF.

Approaches to in-school AIDS information efforts vary significantly, and evaluations of these efforts have begun. Some programs focus on avoidance of disease and prevention of unwanted pregnancy, while others emphasize life skills necessary for developing into a sexually healthy adult.

Evaluations of seven projects that incorporated AIDS information into sex education found that discussions about AIDS within families increased after the projects began and that school officials recognized the value that condom use can have. WHO and UNESCO established and evaluated these projects in Ethiopia, Mauritius, Sierra Leone, Tanzania, Jamaica and Venezuela, plus a regional project among several small countries in the Pacific.[3]

Negotiating safer sex

Increasingly, experts recommend that in-school programs should not only convey information but also teach skills. These should include how to identify risk situations and behaviors, negotiate safer sex or no sex, recognize potentially sexually abusive or violent situations, and how to find and use existing services.

Ideally, such skills would be learned in a context of human relations and value development, says Dr. Peter Aggleton, chief of WHO/GPA's social and behavioral studies and support unit. Young people need to learn to express love and intimacy in appropriate ways, take responsibility for their own behavior, promote the rights of all people to accurate information on sexuality and interact with both genders in respectful ways.

The most successful programs at teaching these skills begin with the expressed needs of young people themselves, says Dr. Aggleton. To achieve sustained behavior change, he adds, programs need to offer a range of risk reduction options and differentiate between the needs of adolescents in school or the workforce, living separately or with their family, and other factors.[4]

Many of the most successful AIDS prevention programs for youth rely on the young people for ideas, for talking with their peers and for educating the larger community. But resources must be available to give these young people a chance to write plays, tape music and distribute educational materials and sometimes condoms.

In one six-country collaborative project called "Youth for Youth," the International Planned Parenthood Federation (IPPF), the United Nations Population Fund (UNFPA) and WHO are working with local organizations to promote adolescent reproductive health. The idea for the project emerged from two international conferences in the late 1980s seeking ways to improve the health of women and children. Several of the projects have made AIDS prevention a central part of their work, including Xall Yoon in Senegal.

The backbone of the project has been the training of more than 700 youth, many of them as peer educators. Other activities have included the formation of a music group, which has helped take AIDS prevention messages to rural areas and to street children. The president of Senegal has provided funds for this group. This summer, Xall Yoon began training an additional 140 young counselors, who are scheduled to distribute condoms and explain how to use them properly.

"We would like to cover 10 regions before 1996," says Diawara, the project director. "UNFPA has just given us funds to record some cassettes and a video clip," he says. "It will mix traditional African rhythms and modern rap music. We want it to have a proper style to attract the youth." Other support for the project comes from Comic Relief, a United Kingdom-based nonprofit group, and the local IPPF affiliate, Association Sénégalaise pour le Bien-Etre Familial (ASBEF).

The invisible enemy

Just as a multi-agency program can unleash the power of youth to help prevent AIDS, so can a single dedicated person. About four years ago, Carmen Milagros Velez, a social worker in a low-income housing authority in Bayamón, Puerto Rico, realized that many of the youth where she worked were in danger of becoming infected with HIV. A message of "just say no" to sex was not realistic, with surveys showing that one of every four males ages 14 to 16 was sexually active.

Velez learned about a training program relying on peer education called Teens for AIDS Prevention (TAP), developed by the Center for Population Options, a U.S.-based nonprofit organization. Despite resistance from parents, who assumed the effort would encourage teens to become sexually active, 11 youths completed an initial training program and began to educate other youth, encouraging condom use only for those who were already sexually active. The project has continued to grow, now into San Juan, and the youth have designed T-shirts, posters, brochures, and buttons with their own messages. Working with PROFAMILIA, the local IPPF affiliate, the project has developed a center with recreational activities and clinical services. One T-shirt features a condom with sunglasses saying, "AIDS is real. You decide."[5]

In the city of Recife, on the eastern tip of Brazil, a charismatic woman named Ana Vasconcelos has also made a difference. She calls AIDS "the invisible enemy." AIDS prevention campaigns face particularly difficult challenges among youth who have little, if any, self-esteem or hope, such as the vast numbers of street children in her city, where she began to work with girls on the street. "These prostitutes have nothing," says Vasconcelos. "As one said, 'I am nothing. If I am nothing, I have no rules, no limits.' "

In 1988, Vasconcelos started a program called Casa de Passagem (Passage House) as a way to help street girls understand their realities and become active in changing their environment. Counselors began working on the street, gaining the trust of the girls. Passage House offers basic education, food and shelter, medical attention, and most important, says Vasconcelos, affection.[6]

To help the invisible danger of HIV become more tangible, the staff got a microscope and showed the girls slides of sewer water. "Amazed at the number of apparently invisible creatures they saw under the lens, the girls began to believe that the HIV virus could in fact exist," explains Vasconcelos. "Now we don't need the lens anymore. Many girls are being educators for others."

The discussions about AIDS gave them a new way of viewing their sexuality and enhanced their sense of self-worth, says Vasconcelos. "Self-love was related to protecting their bodies."

Both community-based and in-school AIDS prevention efforts have the potential to reduce HIV transmission. But these efforts must take into account larger issues, especially poverty, discrimination against women and lack of job opportunities.

Before Passage House, the street girls in Recife were as invisible as the virus. "Nobody could see them, so we became the microscope," says Vasconcelos.

— William R. Finger

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YOUTH AND SEXUALITY

THE FOLLOWING ACCOUNTS BY YOUNG PEOPLE FROM AROUND THE WORLD DESCRIBE INTRIGUING WAYS THEY LEARN OR TEACH ABOUT SEXUALITY.

Using Drama to Teach Sex Education

By Dervan Malcolm, Age 17

KINGSTON, Jamaica — Adolescents need to be taught that sex must be done out of love by two people who care about each other, and they must be prepared to share the consequences. And this is where the teachers come in. Every teacher needs to be trained to act as a counselor.

The members of Calabar High School's Drama Club were fortunate to have had such teachers. At first, some of us were afraid of speaking about sex in their presence, since they might think of us as rude. Mrs. Pauline Lawrence-Matthie, our teacher, had to relate personal experiences with her son to get us to talk. We eventually spoke, and she wrote a realistic skit about two sex education tutors and a class of curious boys, which we performed.

Ms. Prim, the first tutor, does not take kindly to the boys' colloquial terms for sex and the male sex organ. She eventually leaves the class out of disgust. The new teacher, Ms. Easy, is totally different from Ms. Prim. She is tolerant, attentive and understanding. She listens to what the boys have to say about sex and the male organ and encourages them to use the biological terms instead of the colloquial terms. The important thing is that she listens.

The people who saw the skit were awed by its boldness. But the real beneficiaries were the performers — the boys. We learned that having sexual feelings is normal, and in instances where we get sexual urges it is important that we exercise self-control.

Parents usually tell their children in a very stern way to abstain from sex — without telling them why. And of course, adolescents, especially boys, will try to find out why. If the information can't come to the boys, then the boys will go in search of the information, getting it from sexually oriented movies, magazines and songs. There is also ever-present peer pressure. All this will lead ultimately to the real thing — sexual intercourse.

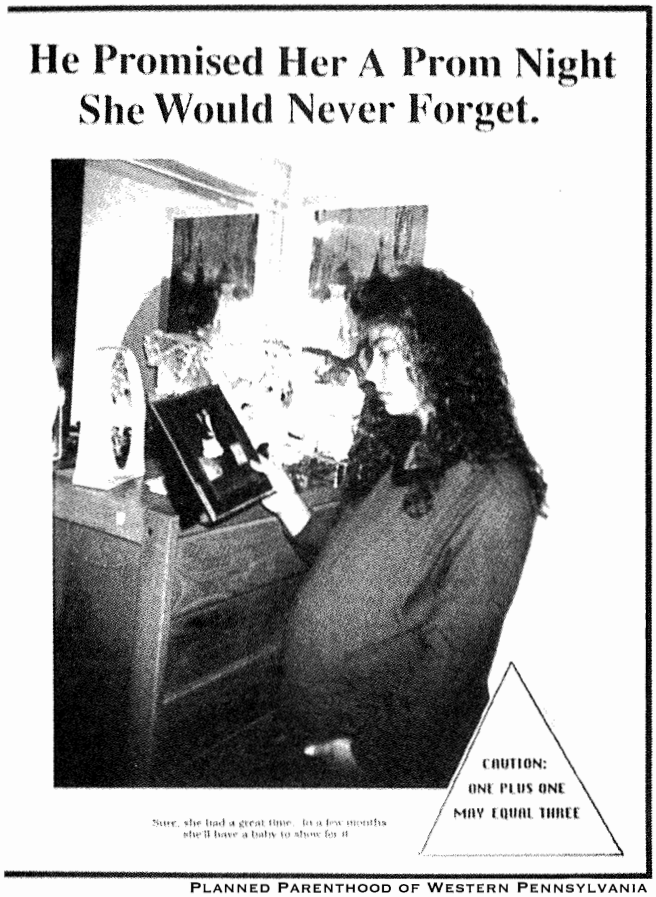
According to the National Family Planning Board of Jamaica, 58 percent of Jamaican males have their first sexual experience before they are 14 years old. Preaching abstinence only complicates the subject of sex. It does not help the situation. Obviously, we cannot prevent boys from having sexual intercourse. What we can do is what the sexually explicit movies don't do, and that is to teach boys how to practice safe sex.

"PEOPLE WHO SAW THE SKIT WERE AWED BY ITS BOLDNESS."

Dervan Malcolm is a member of the Calabar High School Drama Club in Kingston.

ABID ASLAM/UNFPA

DRAMA CLASS AT CALABAR HIGH SCHOOL IN JAMAICA.



PLANNED PARENTHOOD OF WESTERN PENNSYLVANIA

JOHNSTOWN HIGH *TROJAN TIMES* INCLUDES THIS PUBLIC SERVICE NOTICE.

Coping with an Unplanned Pregnancy

By Becky Smolen, Age 15

JOHNSTOWN, Pa., USA — Last May I found out that I was pregnant. I knew something was wrong when I was 18 days late with my period. I was really scared to get a pregnancy test, but I asked my neighbor, who's a nurse, to give me a home pregnancy test. She agreed, and when the results came, they were positive.

Right away I started to cry. So many thoughts went through my mind. I thought that my parents were going to kill me and that I'd have to move out of my house. I also wondered what was I going to do? I'm only 15 and I'm going to have a baby.

I told my dad and he turned pale. He asked who the father was and if he was on drugs or not. My dad told my mom. We talked about it, and she asked really personal questions. Some of them I couldn't even feel comfortable answering.

It was really tense around the house for awhile. I was depressed, because I didn't know how to deal with being pregnant so young and because the one person who should have cared didn't. My parents were upset because I hurt them. They wanted me to do so much and to go so far and now, well, I was going to be responsible for another person in their lives.

After awhile things got back to normal. My parents accepted my decision to keep the baby. I'm lucky that they support me 100 percent. I realize that I could have had an abortion, or that I could have had the baby and given it up for adoption, but it was my baby and my choice and it was the right decision for me. Keeping and raising this baby will be the best thing I ever do.

The morning sickness and initial humiliation are over now. I'm having my baby, and I'm going to love her. (Yes, I've found out she's a girl.)

The first day of school, my journalism teacher, Mr. Scott McCloud, told our classes, "We're going to love Becky, respect her for her courageous decision, support her and do everything we can to help her." The support of my friends and family are the most important aspects of my life right now.

Becky Smolen, now 17, will graduate next year from Johnstown High School in Pennsylvania. This column and others about her pregnancy appeared in the school newspaper, the Trojan Times.

Peer Counseling Helps Fellow Students

By Mojisola Opabunmi, Age 22

IBADAN, Nigeria — I became a peer counselor three years ago when a fourth-year medical student almost lost her life as the result of an unsafe abortion. I got involved because I was convinced we needed such a program on campus, and I saw it as an opportunity to be a source of information and assistance to my fellow students.

About 360 of us from the University of Ibadan took four days of peer promoter training, which taught us about decision-making, family planning methods, adolescent sexuality, counseling and other topics. For the first time in my life, I learned that "sexuality" does not refer only to having sexual intercourse. The training made me understand better the changes that take place in my body and their effect on my behavior, and most importantly, how I can cope with them. Knowing myself better made me more prepared to help others cope with their sexual problems.

We learned about contraceptive methods, especially the non-prescription ones appropriate for youths — such as condoms and foaming tablets. We also learned how to use and dispense them correctly. The training taught us to give information on family planning, present talks for youth programs and refer cases that need special attention to the appropriate people.

Being a peer promoter is important because youths feel more comfortable sharing their problems, joys and experiences with each other than with adults. Furthermore, being a peer promoter improves your relationships and brings you popularity and dignity. The peer promoter program also makes services more acceptable and accessible than health centers, which are located away from the easy reach of students and, in most cases, manned by adults. Most peer promoters have been of immense help to their brothers and sisters as well as their parents on the issue of adolescent sexuality.

"YOUTHS FEEL MORE COMFORTABLE SHARING THEIR PROBLEMS, JOYS AND EXPERIENCES WITH EACH OTHER."

Mojisola Opabunmi is an undergraduate student at the University of Ibadan. She is a peer counselor for Multi-Dimensional Approach to Young Adult Fertility Management (MUDAFEM), a program operated by the Association for Reproductive and Family Health in Ibadan in collaboration with the University College Hospital and the University Health Services, Ibadan.

FOUNDATION FOR ADOLESCENT DEVELOPMENT

DIAL-A-FRIEND IN MANILA USES YOUNG COUNSELORS TO GIVE ADOLESCENTS ACCURATE INFORMATION.

Telephone Provides "Instant Friend"

By Rodel Aguilar, Age 22

MANILA, Philippines — For six months, I have volunteered to answer phones at Dial-A-Friend. You just dial seven numbers and you have an instant friend who will listen to you and help you solve your problems.

Callers ask mostly about relationships with their families, their boyfriends, their girlfriends. They ask about their difficulties and anxieties. We also get calls about contraception. When I was a neophyte counselor, I was quite nervous, but our self-confidence eventually develops and our morale gets boosted once we help someone.

Dial-A-Friend keeps callers anonymous. They either call from public phones or from home when their parents are not around. Sometimes even their best friends don't know about their deep secrets.

"SOMETIMES EVEN THEIR BEST FRIENDS DON'T KNOW ABOUT THEIR DEEP SECRETS."

We give them assurance that their cases will be confidential, especially if the problem is something that they don't want their families to know. They feel more comfortable, and they think the person they're talking to is someone they can trust. Clients don't have to see counselors personally and there's a sense of security in guarding their identity. They don't want to get ridiculed.

At Dial-A-Friend, we stress the consequences of teenage pregnancy. If the problem is actual pregnancy, we refer them to a pregnancy counseling service, and we advise them to reveal the situation to their parents. Abortion is illegal in the Philippines, and we do not believe it is the solution to their problem. For sexually transmitted diseases, we refer them to the AIDS hotline.

We try to listen to their problems and they really appreciate that. They feel they are not alone and their problems are not abnormal. We try to talk with them in a non-judgmental manner, and we give them alternatives.

Seven out of 10 are female callers, mostly 13 to 19 years old. They are students from different universities in Manila, and we occasionally get long distance calls from the provinces. They find out about us through our lectures in schools, performing artists who support us and our promotions — advertisements on television, radio and flyers.

We receive return calls from adolescents saying they were glad they called Dial-A-Friend — it made a difference in their lives. There's someone willing to listen, and we all know that people are too busy and everybody needs someone to talk to. At the end of the day, I sleep well because I know I've helped someone.

Rodel Aguilar recently graduated from San Sebastian College in Manila. Dial-A-Friend is operated by the nonprofit Foundation for Adolescent Development.

Sex Education Promotes Safer Behavior

By Messan Buaben-Moevi, Age 17

LOMÉ, Togo —I started having sexual relations at 10 with a girl at the same school who was almost my age. We did not have anything to protect against pregnancy or diseases. I did not know about contraceptive methods then. I learned about these methods in a sex education program. It helped me control myself and show my school buddies what to do to avoid sexually transmitted diseases and pregnancies.

After the training, I lost my shame about things that would have seemed forbidden before. I am no longer afraid to express myself about sexuality, a subject that was taboo during my childhood.

I learned about family planning centers through the training too. At one clinic, it is easy to get condoms because the person who serves there is young and we can trust him. With older people, one is not so at ease asking for condoms. Before that, I got condoms at the pharmacy, but I did not get them myself. I asked someone who is a little older and could buy them without fear to get them. Someone as young as me is not well thought of in pharmacies, and one fears running into family members or friends of the family.

A year ago when I used a condom, the girl thought I wanted to humiliate her. Another time, I had some condoms but I did not use them because I did not have enough courage to propose that. With another girl, I asked her the first day of her period to find out if she was fertile or not. That was a little difficult for me.

Now that I have been in the training, I found out that it is normal to use a condom

"I DID NOT KNOW ABOUT CONTRACEPTIVE METHODS THEN."

and it is good to protect oneself against disease. It may be that I am the one who carries the disease. It's also good to protect against pregnancy, because I go out with girls my age. Now when I am with a girl, I propose using a condom. I try to convince her, and if she refuses, I don't have sex with her. So I'm no longer afraid of pregnancy or disease.

Messan Buaben-Moevi is a student at the College D'Enseignement General Tokoin-Est in Lomé. He was interviewed for this article by Dr. Komlan Edah, a statistician-demographer with Togo's Division of Family Health. His sex education was provided by the division to members of Comité d'Action pour la Coopération Internationale et l'Epanouissement de la Jeunesse (CACIEJ).

Family Planning Education Helps Build Self-Esteem

By Poonam Choudhary, Age 21

AALI GAON, India — I got married at the age of 20. In our community, generally girls are married off at 15 or 16, but my marriage was delayed according to my father's and my wishes. I did not desire to have my first child immediately. My husband and I are very young and I did not want to assume maternal responsibilities so early in life. Picking up courage, I spoke to my husband. On learning that he had similar views, I was very relieved.

"I DID NOT WANT TO ASSUME MATERNAL RESPONSIBILITIES SO EARLY IN LIFE."

I belong to a middle-class family. Due to an absence of a high school in the village, I was forced to drop out of school. Young girls in our community are not allowed to move freely within the village, much less the outside world. But when I was 19, I got the opportunity to gain a lot of information on family planning, health, personal hygiene and good nutrition as part of the Better Life Project. I also learned beauty skills, embroidery, knitting and video film-making.

Often I share the information and skills I learned with others. I have even advised my brothers' wives about proper child care and immunization. Now that I have a good relationship with the unmarried sister of my husband, I sometimes tell her whatever I have learned.

I have felt a great change in myself. My earlier inhibitions in talking to people have dropped, and I can entertain and speak freely with guests who come home. I am more confident about traveling outside my village to other places alone or with company. Learning to operate a video camera and producing a film was my favorite experience. I discovered that I can do what is normally said to be the work of boys only.

Sometimes I think that if I had not learned new skills, I would not have been able to share my feelings about family planning with my husband. My mother-in-law is also agreeable to our decision about waiting to have children because both my brothers-in-law have large families. However, I have to face my sisters-in-law who taunt me about my childless status. The problem now is that my husband is not satisfied using condoms. I have decided to consult the doctor at the mobile clinic about taking pills or other methods of contraception.

Poonam Choudhary lives in the village of Aali Gaon, near New Delhi. The Prerana-Associate CEDPA Better Life Project is supported by the U.S.-based Centre for Development and Population Activities (CEDPA).

CEDPA

TEENAGE GIRLS IN INDIA TAKE PART IN BETTER LIFE PROJECT.

Manila Street Children Face Many Sexual Risks

The avoidable death of a street youth sparks new efforts to help Filipino teenagers.

MANILA, Philippines — In late June, the two main streets through the Ermita district were teeming with tourists. Bikini-clad girls danced on stages next to open doors, while prostitutes as young as 14 openly solicited business. Boys hung around street corners with shoe shine kits and hands well-trained to pick wallets from unbuttoned pockets.

But the next day, the bordellos and bars were boarded up with hand-painted signs throughout the area, "Closed by order of Mayor." The tourists with their money were gone, and so were the street children that lived off of them.

ALAN DEJECACION

MANY STREET YOUTHS, PERHAPS ONE IN THREE, ARE GIRLS.

The new mayor of Manila had warned he would close Ermita. "We may be in big trouble if he does it without providing alternatives for the kids," Teresita Marie Bagasao said before the closing. Bagasao directs a nonprofit group called Kabalikat ng Pamilyang Pilipino (Partnership with Filipino Families). "Otherwise, this will just drive the kids underground and will make it even harder for us to reach them for our prevention and support activities."

Kabalikat operates a reproductive health clinic a few blocks from the heart of the district, treating sexually transmitted diseases (STDs), distributing condoms and offering other basic health information and services.

A few weeks after the closing, however, Bagasao has surprising news. "Most of the kids are still coming to the clinics," she says. The street kids walk 20 minutes from another red-light area that is developing outside the Manila city limits, back to the Ermita clinic. Their loyalty to the clinic encourages Bagasao.

These children owe a lot to a boy named Allan and the people who noticed him. Four years ago, Allan, about 11, suffered from malnutrition and a badly infected wound resulting from a severe beating by his father. An outreach worker from a local agency tried to help Allan, but the hospital would only treat him if his father gave permission. The father refused and the hospital put Allan out on the street. That night he died.

Allan's death triggered an analysis of the population of street children in Manila. Coordinated by eight social service agencies, the study found that none of the existing services addressed the needs of these children in a consistent or comprehensive way. The group decided to form a network called the Metro Manila Health Action Program for Street Kids, which has grown to include about 20 advocacy organizations.

Today, a referral system matches youth with the appropriate service. Policy changes have also resulted. A youngster in Allan's situation could get help at two public health centers or a public hospital, even without an adult's permission.

There are an estimated 50,000 to 75,000 street children in Manila, concentrated in two large slum areas and the new

red-light district. "My friends are still out there," says a 14-year-old boy. "I want to help." He survived on the streets through its well-known prostitution business, which includes pedophilia. Then he learned about Kabalikat from an outreach worker called a street educator.

Recently, the boy completed training to be a street educator and joined the paid staff. Another boy in the same training group quit his lucrative, often illegal work in Ermita. The street educators go through in-depth sex education training, designed to help them reflect on their own sexuality before returning to the streets to educate others.

If street educators can get five or six boys or girls away from scavenging, watching cars, begging or prostitution, they talk to them on a street corner or go to a nearby park, offering coconuts or colas for refreshment. They listen as much as they talk, reflecting the philosophy of Kabalikat.

"We inspire trust among the children," says Bagasao, the director, because the program is "not out to reform them or turn them over to an institution or do anything against their will. Only then are we able to initiate sessions on health, substance abuse, sexual health and condom use, nutrition, counseling and referrals for structured care and support."

Of the streets

Experts estimate that as many as 100 million children ages 5 to 18 live or work on the streets of urban areas throughout the world. The root cause of this phenomenon is poverty, with migration from rural villages into sprawling urban areas making the problem worse.

About 70 percent are considered children "on the street," meaning they return at night to live with their families, some even trying to stay in school. The rest are "of the street," with perhaps 20 to 25 percent still knowing where their families are and 5 to 10 percent totally on their own. About one-fourth to one-third of the street children are female.[1]

Like Allan, these young people tend to fall outside of conventional health-care systems, while at the same time facing severe health hazards. The leading illnesses among street children are respiratory infections, skin diseases, gastrointestinal problems and trauma. Many programs around the world working with street children also report that sexual abuse, exploitation, unwanted pregnancies and STDs are common. The most common STDs are gonorrhea and syphilis.

Some street children are beginning to be aware of the dangers of AIDS, even in the face of other massive problems. In Kenya, a recent study shows that nearly four of five street children know about AIDS. The Undugu Society of Kenya reports that "HIV/AIDS is a major issue among street children because they are subject to a lot of [sexual] relationships for purposes of survival."[2]

In India, fewer street children are aware of AIDS. "AIDS has still not become a major health issue among street and working children," says Rita Panicker, founder and director of the Butterflies Program for Street Children in New Delhi. A young man living on the streets of Bombay adds, "We have too many problems already. Even if AIDS started to kill us, it wouldn't be a problem. We die anyway." Violence threatens many street children daily, including injuries and even murder.

The numbers of street kids and the scope of their problems are growing but so are efforts to address their health-care needs. In the mid-1980s, people began setting up networks in cities in the Philippines to coordinate services for street children. The Metro Manila program, which became a model for networks in other cities, works whenever possible with families of street youth. Protection and rehabilitation activities provide health, nutritional, counseling and other services while referring more specialized problems to clinics and hospitals. The network includes art, sports and vocational training committees. Youth participate in the planning of activities.

Both in the Philippines and worldwide, several common themes have emerged among programs working with street youth.[3]

- Male dominance within most societies and most programs working with street youth limit young women's access to health services, education, training and other opportunities.
- Sex education and reproductive health services are not usually a strong component of these programs' health-care interventions and need to become a higher priority.
- Child-to-child and youth-to-youth education activities are often the most successful.
- Developing decision-making skills and income-generating activities help address other health-care problems, especially many kinds of substance abuse.

Many people working with street children emphasize the importance of enhancing self-esteem, pointing out that street youth feel worthless or devalued. At the same time, street children have in many cases developed "the capacity to face life far from their family," says Hector León of UNICEF-Mexico, who works with street youth programs there. "They are self-sufficient and can survive by solving problems." Researchers have found that many street children establish relationships among themselves and with adults and, in the process, find protection and trust, affection and solidarity.

— Mark Connolly and Chi Nguyen Franchet

Mr. Connolly works for the United Nations Children's Fund (UNICEF) in New York. Dr. Franchet, who helped initiate the Metro Manila Health Action Program for Street Children, is with the Institut d'Epidémiologie at the Université Claude Bernard, Lyon, France.

Footnotes

1. Barker GK, Rocky M, Van Horn L, eds. *Reaching the hard-to-reach: health strategies for serving urban young women.* Childhope-USA, Inc., Working Paper Number 3, Conference Report, December 3-4, 1991, Washington, D.C., 7-8.

2. Connolly M. *The health of street children and youth.* UNICEF, unpublished.

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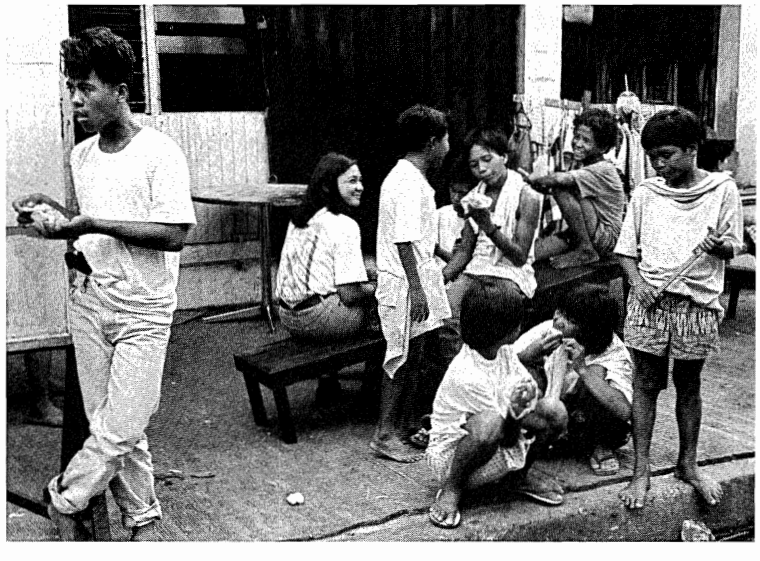
ALAN DEJECACION



MANILA STREETS ARE HOME TO MORE THAN 50,000 YOUTHS.

Chilean Clinic Serves More than Medical Needs

Lack of education and nutrition needs are among formidable problems facing pregnant teenagers.

Young women come to the Santiago, Chile clinic from the city's schools and on buses from the surrounding countryside, staff members say. The teenagers enter holding the hands of their friends or in the care of their mothers. Many are pregnant and single, poor and afraid.

At the Centro de Medicina Reproductiva del Adolescente (CEMERA), they find a team of specialists who strive to help solve the formidable problems many of them face during their pregnancies, including medical troubles, lack of education, poor nutrition and emotional difficulties.

PEDRO PEREIRA

WOMEN WAIT TO BE SEEN AT CEMERA CLINIC IN SANTIAGO.

Mariela, 15, was sent by one of her teachers to CEMERA when she was two months pregnant. She says she feels at ease at the clinic because of her relationships with the other pregnant adolescents and the staff. "I have friends here," she says. "We're very comfortable together."

A decade ago, adolescents in Chile had few places to turn if they were pregnant or in need of contraception or information about their sexuality. Their fertility rates and health risks in pregnancy were high compared to older Chilean women.

So a team of Chilean doctors, social workers and other specialists set out to provide family planning services to youth, treating not only their medical needs, but their social, emotional and psychological troubles as well. "It's very important to have the comprehensive approach," says Dr. Ramiro Molina, CEMERA's director. "We can see that any kind of [sexual] problem is only a consequence of social or psychological or family problems."

Adolescent reproductive health has grown in importance as teenagers become a larger percentage of the world's population and as earlier onset of menses and delayed marriage extend the period of adolescence, Dr. Molina says. Three years ago, he organized the CEMERA center, whose staff now treats about 1,800 low-income adolescents annually, 80 percent of whom are female. CEMERA's services are needed. A 1988 survey of young adults in Santiago, ages 15 to 24, showed that 20 percent or fewer used contraceptives at first premarital intercourse, and that 70 percent of first births in this age group were conceived out of wedlock.[1]

CEMERA started by giving prenatal care to adolescents, and has since branched out to include workshops and assistance for their partners and their parents. In addition, it offers workshops and contraceptive counseling to young men and women. Most services are free.

"One of the important things is that they don't deal only with teenage pregnancy but also focus on adolescent reproductive health," says Dr. José Solís, coordinator of the growth, development and human reproduction unit of the Pan American

PEDRO PEREIRA

A PREGNANT WOMAN RECEIVES FAMILY PLANNING COUNSELING AT CEMERA.

Health Organization (PAHO) in Washington. The center draws adolescent health care out of the hospital setting, making adolescents more comfortable, emphasizing prevention of repeat pregnancies and medical problems, and saving money, he says.

In 1981, only two centers addressed adolescent reproductive health in Chile, Dr. Molina says. As of last year, more than 95 groups and institutions were working in adolescent reproductive health, and most of their personnel were trained at CEMERA, he says.

Worried and afraid

While CEMERA has well-developed technical expertise, the center strives to be informal, to make itself less threatening to adolescents. Staff often shun medical white in favor of more casual clothes, and CEMERA is housed in a cluster of renovated homes in downtown Santiago. The red-block clinic building is what most young women see first when they come for help with their pregnancies.

Inside, a nurse who was herself an adolescent mother greets young women. They are often referred by teachers, judges in juvenile court or other teenagers. A social worker interviews them, asking about their family and personal histories. "We use the first interview to lower their anxiety a little and to make them feel comfortable," says Electra Gonzalez, CEMERA's social worker. "In general, they arrive very scared and very worried.

"We need to assure them we are going to respect their privacy," she says. "The ones that come seeking contraceptives — their families don't know they are sexually active. We keep the adolescent's confidence even though we know their family doesn't know."

In Chile, adolescents can receive health care without parental permission. Still, most pregnant adolescents at CEMERA have told their families about their situations.

After interviewing the young women, Gonzalez directs them for medical, nutritional or psychological counseling to CEMERA's team of health professionals, which includes obstetrician/gynecologists, a psychiatrist, a family counselor and a midwife.

The young women learn how to care for themselves during their pregnancies and how to care for their newborns. They also have the opportunity to ask questions about motherhood and what disturbs many of them — the pain of labor.

Pregnant teenagers need plenty of support, because they face tremendous difficulties. About 90 percent of CEMERA's pregnant clients didn't want or plan their pregnancies. Eight percent of them are victims of sexual abuse. Many more require counseling for other reasons.

"They are confronted with problems they didn't know they'd have," says Dr. Virginia Toledo, CEMERA's adolescent psychiatrist. "This leads to mental health problems."

Often, teens come to the center from abusive or broken families. They learn healthy ways to communicate and express affection at CEMERA. Workshop leaders teach about adolescent sexuality and attempt to dispel myths about promiscuity and other issues, passing this information on to parents who can work with their other children as well.

Besides medical and emotional care, adolescents also will get help with their education through a program scheduled to begin this year. Many single young women drop out of school when they become pregnant. Loss of an education often begins a cycle of poverty.

CEMERA plans to open a school program in northern Santiago for 200 pregnant teenagers. Known as "Enseñando para La Vida," or "Teaching for Life," the pilot program will offer academic and vocational training, sex education and skills that the young women need to take care of themselves and their children.

At CEMERA, clients get contraceptives and counseling, to help them avoid another unplanned pregnancy. "We show them choices in an objective way without telling them what to do," says Lucía Lobos, the family counselor at CEMERA. "We give them the opportunity to express their feelings. They feel so good talking with us, they even come back after they have the baby."

Meeting a need

The CEMERA program began in 1981, the offspring of a unit set up to do adolescent research at the Universidad de Chile; it became a center and part of the faculty of medicine in 1990. Dr. Molina spearheaded the research, after realizing that few services were available for pregnant adolescents, who are at higher medical risk than pregnant adults.

"When pregnant adolescents have good medical care, the risks are not so high," he says, adding that adolescents' children are also at risk. "Single mothers don't get medical care for their children. When the children become competition for the freedom of teenagers, the problems start. They don't complete the vaccines and they don't give care for diseases."

Dr. Molina started his work with a core group of health professionals and has expanded the staff to 14. Many work part-time, enabling the center to operate on a yearly budget of about U.S. $95,000. Most funding has come from grants by the United Nations Population Fund (UNFPA), the World Health Organization (WHO), PAHO, the Universidad de Chile, the Asociación Chilena de Protección de la Familia and other organizations.

Besides helping adolescents directly, CEMERA conducts research, trains medical students and offers courses in adolescent reproductive health and sex education to specialists. CEMERA is also developing a sex education program. Germán Jara, the sex education specialist at CEMERA, recommends sex education be started "at the earliest possible time — we hope, in kindergarten.

"We are born sexual beings," he says. "We feel it's possible for young people to learn a language that will orient and guide them so that they can express themselves."

— Carol Lynn Blaney

Footnote

1. Herold JM, Valenzuela MS, Morris L. Premarital sexual activity and contraceptive use in Santiago, Chile. *Stud Fam Plann* 1992; 23(2): 128-36.

Project Helps Build Sexual Responsibility

Radio plays and teacher-student teams are among ways an Ethiopian project encourages sexual education.

ADDIS ABABA, Ethiopia — Abeba Mulugeta, 19, first learned about the youth center from a newspaper article. After sending her boyfriend to investigate, she traveled with him to the small office surrounded by huge cypress and eucalyptus trees in this teeming city of 3 million.

"At first, I was very tense and reserved, but once I discovered that the counselors here are very polite, understanding and easy to talk to, I developed the confidence to tell them even my very intimate secrets," says Abeba. "My only regret is that I didn't know about this place early enough to avoid the humiliation I went through."

ABEBA MULUGETA, 19, AND HER SON, EYOB.

TAMERAT ASEFA

Abeba was a mother at age 15. When she became pregnant, she didn't even realize it. Her neighbors and relatives began making remarks about how big her belly had become. "I didn't even get a hint when I missed my period," she says. "I thought it would reappear."

No longer naive about sexual matters, Abeba feels more secure about avoiding another unwanted pregnancy — and committed to helping other girls as well. While she still does not feel relaxed talking openly with her parents about these issues, she does talk regularly with her friends. Abeba, the youngest mother who has worked with the project, is one of many volunteers who help distribute information about adolescent sexuality.

Named the Youth Counseling Services and Family Planning Education Project, it was established in 1990 by the Family Guidance Association of Ethiopia (FGAE). A staff of five, plus a twice-a-week visit from a doctor, operate from the project's two locations. They have distributed condoms, spermicides and other non-medical contraceptives to about 5,300 youth and provided medical consultations to about 500 adolescents.

Films on adolescent sexuality and methods of contraceptives are shown, and 14,000 booklets on family life education and contraception have been distributed.

DRAMA TROUPE

The staff members also oversee an ambitious outreach effort: a drama troupe that performs in schools, city theaters and on the radio; family life education programs in 10 schools, which include condom distribution; and peer education and other efforts to out-of-school youth.

"The youth project focuses on improving the reproductive health of adolescents," says Wondayehou Kassa, executive director of FGAE, the national affiliate of the International Planned Parenthood Federation (IPPF). "This includes prevention and treatment of sexually transmitted diseases (STDs) and HIV/AIDS and making readily accessible and available family planning services for youth." The program is working with influential community leaders, school teachers

and youth "to break the cultural barriers that hinder youth from obtaining services."

Ethiopia is predominantly rural, but urban migration is increasing. About one million people ages 10 to 24 live in Addis Ababa, where teenage pregnancy, unsafe abortion and STDs are major problems. An estimated 50 percent of sexually active youth have an STD infection. The youth project has worked only in the capital city thus far, lacking funds to expand into the rural areas.

In the project's first week of operations, Abraham Tsegaye was one of 30 youths who watched a film about a young girl who had an unwanted pregnancy. "Ever since that day, I developed a strong commitment to work toward alleviating the social evils of unwanted pregnancy and STDs," says Abraham, an articulate, earnest young actor and playwright, now 21.

He wrote a play for the youth project about teenage pregnancy, called "Yetwatwa Chorka" (meaning literally the "Morning Budding Flower"). The youth project organized a drama troupe, which began performing the play before adolescents and parents, with discussions often following. The troupe has performed in high schools throughout the city as well as in neighborhood settings for out-of-school youth. The play has been produced into a video film and is beginning to be shown outside Addis Ababa.

For the last year, the troupe has been performing a second play at the City Hall Theatre in Addis, widening its audience. A third play, called "Shemgay" (a traditional elder), has been playing weekly on the national radio. Illustrating the conflict in a family between traditional and modern values, the play has attracted a large audience. Members of the drama troupe also present short dialogues on topics related to contraception and family life issues on national radio and make announcements about condoms and HIV transmission in media advertisements.

Serawit Fikre, 24, the producer-director and main actor in the troupe, has become a household name in the country as "Abiye Zergaw" ("old man Zergaw"), the role he plays in the new stage and radio plays. Tasteful presentations address such subjects as birth control methods and prevention of STDs.

Another FGAE effort involves 10 high schools. In each school, a male and female student are selected to work under the guidance of a teacher to design and implement projects in their schools. Some of these groups distribute condoms, both to teachers and students.

"They distribute condoms among their peer groups, making every effort that such activities do not create unnecessary controversies," says Wondayehou, the FGAE director. Many people, including school authorities and teachers, "have the attitude that family life and sex education for adolescents induce promiscuity," he adds. Studies have shown, however, that sex education does not promote earlier or increased sexual activity in young people and may instead lead to an increase in safer sexual practices.[1]

The project hopes to open new centers in more easily accessible areas, says Wondayehou. A major frustration, he adds, concerns STDs: "Due to lack of facilities and funds for drugs and clinical equipment, it has not been possible to integrate treatment of STDs for the youth at the center."

The project also hopes to do more work with the 850,000 out-of-school young people in Addis Ababa. Those who have benefited from the center's activities can lead this outreach effort as volunteers — people such as Azeb Kebede. "The counseling at the center has lessened the pain from separating from a boyfriend I stayed with a long time," says Azeb, now 23. At the center, she received free oral contraceptive pills and participated in educational programs. She has stopped taking the pills for now because she does not want another boyfriend for awhile.

"The fashion is that once you have tea or coffee with one, he asks you to go to bed straight away," she says. "I know many men in the area where I live, some of them married, who go out with many girls, some too young to comprehend the consequences of what they are doing." Azeb has begun to pass along information on preventing pregnancy and HIV transmission.

A 1992 evaluation of the project suggested that it expand its outreach to youth who are not in school and seek cost-effective strategies for reaching out-of-school youth in the communities through approaches such as peer education. The report also underscored the importance of counseling at the centers "to empower young people" to make appropriate decisions involving sexual matters.[2]

No one better demonstrates the impact such counseling can have than Abeba, smiling with her four-year-old. She worries about the many women in the slum area where she lives who have to sell themselves for sex in order to survive.

"They go to bed with any man who pays them," says Abeba, adding that many women would be unable to eat or pay rent if they refused. "This youth center is doing a worthwhile job, but considering the enormity of its mission, the job cannot be left only to it. There must be a society-wide mobilization. A lot remains to be done to change the entrenched traditional attitudes to sexual relations. Traditions die hard."

— Awol Endris

Mr. Awol teaches English at Addis Ababa University and is a freelance writer.

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TAMERAT ASEFA

FGAE PROJECT INCLUDES DRAMA TROUPE THAT ADDRESSES FAMILY PLANNING TOPICS.

"Under 20" Clubs Offer Straight Talk about Sex

Clubs in 12 Caribbean nations help teenagers avoid pregnancies by learning about sexual responsibility.

ST. GEORGE'S, Grenada — On a summer evening in a Catholic school classroom in rural Grenada, 24 adolescents and adults gather to discuss a subject that interests all of them: teenage sexuality.

The group, which includes six teenage mothers, talks and sometimes argues about a variety of questions: Do adolescents understand that sexual activity carries certain responsibilities? Are girls less likely to get pregnant if they have life goals or plans? How can the incidence of teenage pregnancy be reduced when cultural attitudes revere boys who have numerous sexual partners?

The group discussion is one of the activities of the Under 20 Club, an innovative family planning project in Grenada and 11 other Caribbean nations. "There's a widely held belief young people cannot behave responsibly," says Tyrone Buckmire, an Under 20 Club counselor who led the group discussion in Grenada. "We feel the problem of teenage pregnancy could be controlled if young people were educated about sexuality and responsibility very early in life."

Begun less than a decade ago, Under 20 Clubs are part of a regional strategy to address the growing problem of teenage pregnancy. In the late 1980s, half of all first births in the Caribbean were to teenage mothers. Family planning associations decided that, in order for programs to reach adolescents, their programs must not only target young people; the programs also must involve youth in program planning and service delivery. The clubs provide factual information about human reproduction to teens and dispense contraceptives to sexually active youth.

"Traditionally, family planning associations have been primarily oriented to providing contraceptive services, with a special focus on married couples and older persons," says program advisor Lucella Campbell, who works in the New York office of International Planned Parenthood Federation (IPPF), one of the project's sponsors. "The Under 20 Club hopes to encourage young people to view family planning associations as a resource for information and counseling."

In Grenada, a small West Indies island nation with a population of 98,000, there are five active chapters of the Under 20 Club. In this primarily rural country, the clubs are an important source of information, friendships and emotional support for young people. Club members frequently congregate at the youth center, operated by the Grenada Planned Parenthood Association, where they can socialize and play games. The center also houses a family planning clinic where a nurse and counselor answer adolescents' questions and distribute condoms, spermicides and oral contraceptives.

"I think education is the key to addressing any problem," says Clint Williams, a 17-year-old who is the former president of the St. George's chapter of the Under 20 Club in Grenada. "If we educate young people, and tell them the consequences of their actions and give them alternatives, we'll be better off."

One of the goals of the Under 20 Clubs is to encourage young people to communicate openly about sexuality — a topic many

of them are too shy or too embarrassed to talk about with their friends, their girlfriends or boyfriends, and especially, their parents. A sign at the youth center urges adolescents: "Stay away from sex if you're not ready. Wait until you are ready." The sign, club members say, is a catalyst to help young people begin talking to each other and to adults.

"Parents avoid these topics, so what we do is we train our members to approach their parents," says Michael Grant, 20, president of the St. Andrew's chapter of the club. "We explain to them the world has changed, and they need to help us. We also advise them against getting angry with us when we seek to discuss the issue of sexuality, just the same as we urge our members against getting angry when their parents speak. It's like we're helping them, and they're helping us."

Juanita Collins, 15, a member of the National Under 20 Club's executive committee, agrees that parental involvement is crucial for teens. "If we work at the Parent-Teacher Association meetings, which we intend to do, and address the problem from the root, which is the home, we can find solutions."

Under 20 Clubs throughout the Caribbean region seek not only to educate young people about sexuality but also to encourage youth to help their peers. For example, Under 20 Clubs in Belize, a country with a population of some 200,000, work with delinquent youth and stage an annual drama festival, which focuses on the prevention of teenage pregnancy and sexually transmitted diseases. Under 20 Clubs in Grenada raise money to buy books and uniforms for poor students, and at Christmas they raise money to help the needy and disabled. In addition to Belize and Grenada, Under 20 Clubs also are active in Anguilla, Antigua, the Bahamas, Barbados, Dominica, Guyana, Montserrat, St. Kitts, St. Lucia and St. Vincent.

Peer counselors also work with adolescents to help them learn skills that will aid them in developing values, self-esteem and life goals. Nigel, a 15-year-old club member in Belize, explains: "Because the Under 20 Club is associated with family planning, some of my peers think that we only talk about contraceptives and sex. So what I do is to inform them that our club deals with other life planning issues, such as self-esteem values, decision-making, goal setting and so on."

Elroy, a 17-year-old peer counselor in Belize, says participating in the Under 20 Club has helped him better understand the physical and emotional changes adolescence can bring. "Before I became a peer counselor, I was faced with problems of my own. I was puzzled, and lost and had mixed feelings. I was confused and didn't know what to do when making a decision. Now I can handle my own problems and help others to solve their problems."

Part of the Under 20 Club's holistic approach to adolescent family planning services is to stress that the decisions young people make can have a tremendous impact on their adult lives. One of the Under 20 Club goals is to make adolescents aware that pregnancy prevention, either through abstinence or contraceptive use, is essential if young people are to become productive members of adult society. Counselors try to make adolescents aware that teen pregnancy carries distinct disadvantages, especially for girls.

"Life deals out successes according to one's ability to reach for higher goals," says Campbell of IPPF. "In the Caribbean, the accompanying loss of educational opportunity makes teenage pregnancy the number one deterrent to success for the young girl."

Jeannine Sylvester, an 18-year-old member of Grenada's National Under 20 Club, hopes the clubs can change some of the old attitudes. "Some people believe that by letting [adolescent mothers] back into school, they are promoting the idea that it's all right to get pregnant, but that's not it. By letting them back into school, they are an example of what teenage mothers have to go through and it's not easy. I think the teenage mother should be given an opportunity to at least further her education so she can help herself and her baby."

Prevention of adolescent pregnancy is a "major priority" for Caribbean family planning associations, according to Campbell.

At a recent region-wide conference, family planning experts discussed strategies for adolescent family planning programs. Under 20 Club members participated in the meetings, offering their experience and perspectives in the primarily adult audience.

Conference participants emphasized that to be effective family planning programs for adolescents must be more "client-focused." Young people's unique needs must be incorporated into the planning of programs and service delivery. Young people must be able to share their ideas directly with board members, participants agreed, and young people should be considered for board membership as well.

— Odette Campbell

Ms. Campbell is a journalist with the Grenada Broadcasting Corporation.

NASH HERNDON/FHI

FAMILY PLANNING PROGRAMS SHOULD INVOLVE YOUTH IN DESIGNING SERVICES.

Progestin-only Methods Safe During Lactation

While non-hormonal methods are the first choice, progestin-only pills, implants and injections are safe for mother and child.

In developing countries, an estimated 90 percent of women depend on breastfeeding as the primary way to nourish their infants.[1] Breastfeeding, which offers excellent nutrition and protects infants from disease, also provides a natural contraceptive for women.

The duration of this contraceptive protection is variable. Breastfeeding is considered to be an effective contraceptive method only until the child is six months old, and then only if the mother has not yet resumed her menses and has not begun to supplement breastfeeding with significant amounts of other food or milk.[2] Many breastfeeding mothers, however, need dependable contraception for longer than six months.

Mothers may need to achieve better birth spacing, for example. Giving birth less than two years after a previous birth imposes greater health risks on both the mother and infant.[3] Most methods of contraception, with the exception of those containing estrogen, provide breastfeeding mothers with safe and effective protection against pregnancy while doing no harm to the breastmilk or infant.[4]

First Choice

Non-hormonal methods of contraception, including the intrauterine device (IUD), barrier methods, spermicides and sterilization, do not affect breastmilk and are safe for mother and infant. International health organizations generally recommend that these methods be considered first by women who are breastfeeding. "Non-hormonal contraception should be the first choice for lactating women if it is acceptable to the user and is not contraindicated for other medical reasons," according to the International Planned Parenthood Federation (IPPF).[5]

But some women prefer hormonal methods, such as injectables or oral contraceptives, because of their convenience and effectiveness. Combined oral contraceptives (the pill), which contain estrogen and progestin, are very effective in preventing pregnancy but are not recommended for breastfeeding women. Combined oral contraceptives decrease breast milk supply and may alter milk composition. Estrogen appears primarily responsible for these effects.

For those breastfeeding women who prefer hormonal contraception, progestin-only methods are the methods of choice. "Oral contraceptives that use only progestins are appropriate and safe to use during breastfeeding," says Dr. Roberto Rivera, FHI corporate director of international medical affairs. "Only oral contraceptives that contain estrogen should be avoided."

Progestin-only methods include the progestin-only pill (POP), also known as the "minipill"; the subdermal implant known as Norplant; and some injectable drugs, norethisterone enanthate (NET-EN) and depot-medroxyprogesterone acetate (DMPA). They contain progestins but no estrogens. Progestin-only methods prevent pregnancy

in several ways: by thickening cervical mucus, making sperm penetration more difficult; by thinning the uterine lining; and, for some methods, by blocking ovulation.

The World Health Organization (WHO), which has completed studies on hormonal contraceptive use by breastfeeding women, has found that progestin-only methods are safe during lactation. "WHO considers progestin-only methods appropriate hormonal methods for breastfeeding women," writes Dr. Giuseppe Benagiano, director of the Special Programme of Research, Development and Research Training in Human Reproduction.[6]

Progestins are safe

Studies have shown that progestin-only contraceptives taken by breastfeeding women do not harm their children. In general, they do not affect the quantity of breast milk. They have no known adverse effects on growth or development of the infant.

The timing of when to initiate progestin-only contraceptive use, however, has not been settled. Some health organizations, such as the London-based IPPF, recommend that breastfeeding women may begin using the method six weeks after delivery.[7] The timing of initiation may be of particular concern with injectables, which initially give a higher dose than do progestin-only oral contraceptives or implants. Other experts recommend waiting periods ranging up to four months, but one study in Argentina showed no harm to infants when progestin-only oral contraceptives were begun one week postpartum.[8]

Besides health issues, clients and their providers must consider other aspects of timing. If a woman cannot return to a clinic to obtain contraceptives, providing them immediately postpartum may be reasonable.

While steroids can pass to infants through breast milk, researchers have found the amount of progestins transmitted this way to be very small or undetectable. The levels are particularly low with progestin-only pills.

In a Swedish study, no progestin could be detected in breast milk of women who took a progestin-only pill containing d-Norgestrel.[9] In addition, no steroid could be detected in the blood of a breastfed infant whose mother used this pill. These results suggest that infants metabolize the steroid and their bodies do not accumulate it.

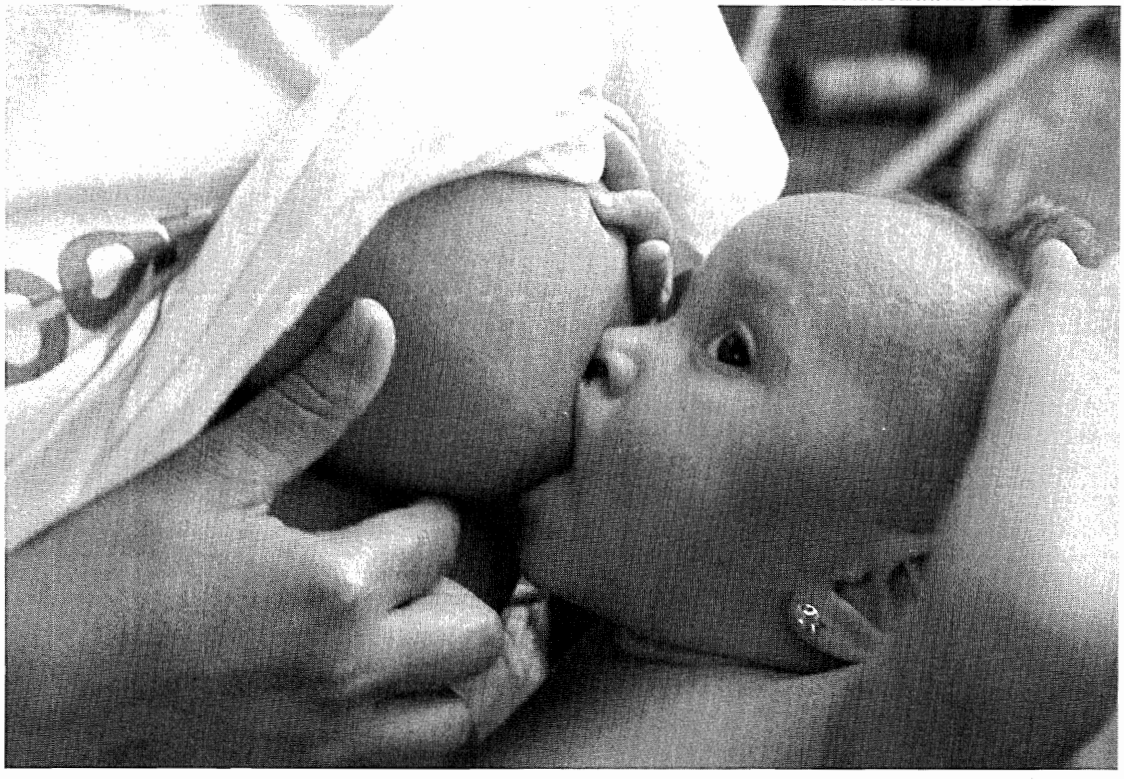
Progestin-only methods do not decrease, and may enhance, breastmilk production. At least 21 studies show no adverse effect on breastmilk volume or duration of breastfeeding in women using progestin-only contraceptives.[10]

Some studies show that progestin-only methods do not affect milk composition, while others point to slight changes.[11] DMPA may alter the concentration of lactose, calories and nitrogen in breast milk, according to one WHO study. These changes are not likely to cause difficulties in regions where women are adequately nourished but should be studied in populations with less than ideal nutrition levels, the study's authors concluded.

In the same WHO study, infants of Thai and Hungarian mothers who used progestin-only pills or DMPA while breastfeeding did not differ significantly from other infants in weight or other measures of growth.[12] Other studies of oral, injectable and implant progestins have shown similar results.[13]

The long-term effects of progestins have not been studied thoroughly in humans, but the results from initial studies indicate that they cause no harm. A study in Chile found that children exposed to progestin in breast milk showed no adverse response in growth or development through age four, although they weighed an average of about a pound less than the control group. The difference in weight could have been caused by differences in parity or the length of breastfeeding, the authors concluded.[14] A cohort study in Thailand following children through puberty found that breastfeeding by women on DMPA did not affect children's growth.[15]

Sean Sprague/Impact Visuals



Progestin-only methods are safe to use during breastfeeding.

PROGESTIN-ONLY METHODS

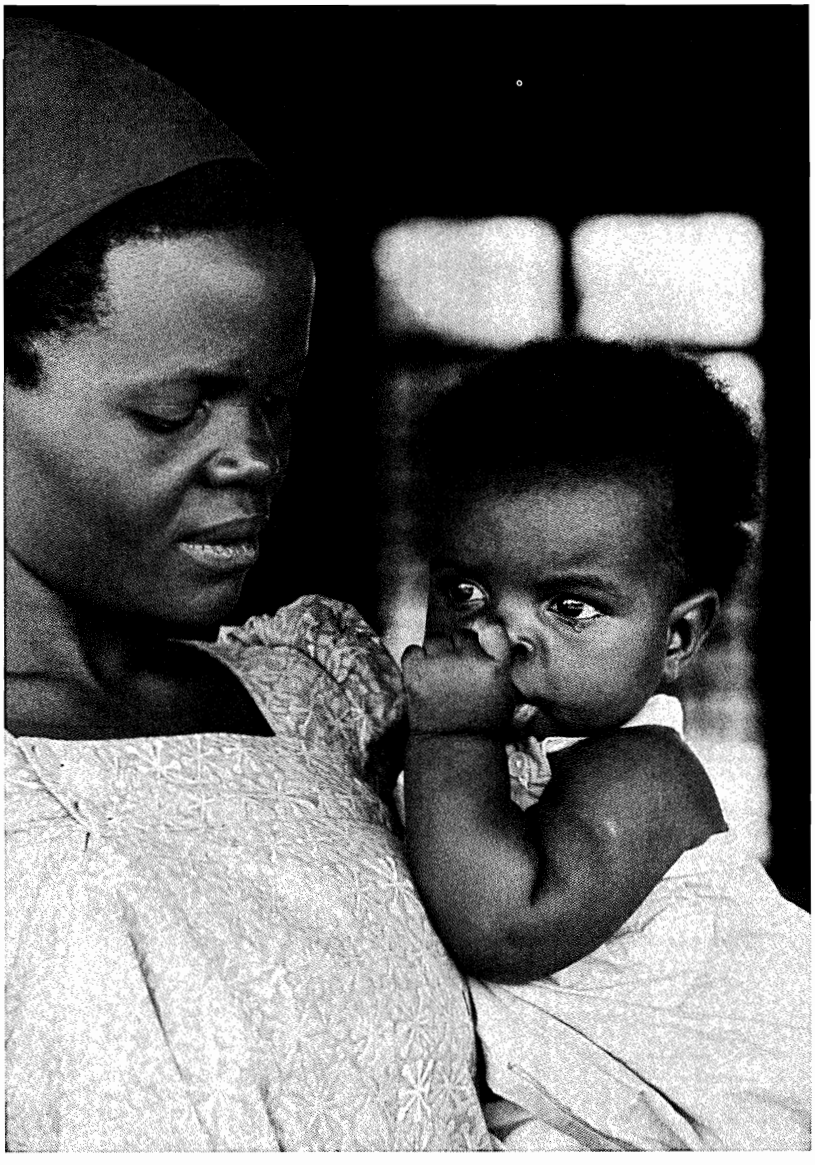
Progestin-only methods have several advantages. They use low doses of hormones, are reversible, don't interrupt lovemaking and are very effective. But there are some difficulties. Progestin-only methods are not readily available in many areas, and they often cause disturbances in menstrual bleeding patterns. While some, such as Norplant, have long-term effectiveness and require little user compliance, others, such as progestin-only pills, require adherence to a relatively strict schedule.

Critics of progestin-only methods for use during breastfeeding point out that the U.S. Food and Drug Administration (FDA) has not approved progestin-only pills for use by breastfeeding women. But the FDA is revising information to be provided in the package inserts for the pills. Current package inserts were written for estrogen-containing pills.

According to Dr. Solomon Sobel, director of the FDA's division of metabolism and endocrine drug products, the agency will revise labeling for progestin-only pills to reflect a worldwide consensus that they are safe for breastfeeding mothers and their infants. "We expect that the revised labeling for progestin-only contraceptives will not contain warnings that were found to be appropriate for contraceptive methods that contain estrogen," he writes.[16] Labeling in many European countries, such as the United Kingdom and Sweden, already reflects this assessment of progestin-only contraceptives.

— Carol Lynn Blaney

UNITED NATIONS



PROGESTIN-ONLY METHODS DO NOT HARM INFANTS OR CHILDREN OF BREASTFEEDING MOTHERS.

FOOTNOTES

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2. Kennedy K, Rivera R, McNeilly A. Consensus statement on the use of breastfeeding as a family planning method, Bellagio, Italy, August 1988. *Contraception* 1989; 39(5): 477-96.

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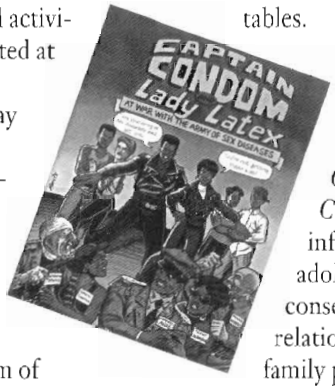
16. U.S. Food and Drug Administration letter to U.S. Agency for International Development. July 1993.

Resources

PATH Comic Book Aims at Teenagers

Captain Condom and Lady Latex at War with the Army of Sex Diseases is a comic book intended to teach teenagers about sexually transmitted diseases and safer sexual activity. While directed at U.S. inner-city teenagers, it may be adapted for teenagers in developing countries. Available in English, it costs U.S. $1 per copy, with a minimum of five copies per order. Those requesting it from developing countries may obtain five free copies. To order, write: Program for Appropriate Technology in Health (PATH), 1990 M Street, NW, Suite 700, Washington, DC 20036, USA.



Report Examines Safe Abortion Issues

Population Action International has published *Expanding Access to Safe Abortion: Key Policy Issues*, a report geared to policy-makers and family planning service providers in developing countries.

The eight-page report, which includes pull-out charts, covers essential elements of abortion care, abortion laws, modern abortion methods and post-abortion contraceptive use. Available in English, French and Spanish, the booklet is free in developing countries, costs U.S. $3 elsewhere, and can be obtained by writing: Population Action International, 1120 19th Street, NW, Suite 550, Washington DC, 20036-3605 USA. FAX: 202-293-1795.

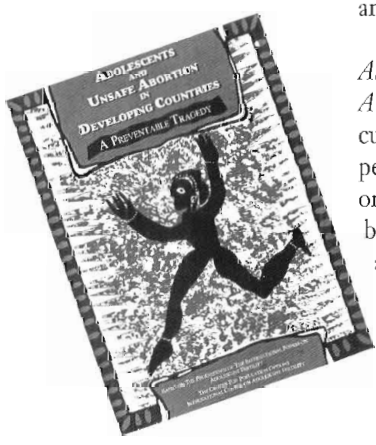
Booklets Profile Adolescent Fertility

Two booklets provide data on adolescent fertility from Demographic and Health Surveys around the world. Both detail the information with graphs, charts and tables.

• *Adolescent Sexual Activity and Childbearing in Latin America and the Caribbean: Risks & Consequences* provides information on adolescent fertility, its consequences and its relationship to education, family planning, and marriage. The 24-page booklet, available in English and Spanish, suggests policy options on the issue.

• *Adolescent Women in Sub-Saharan Africa: A Chartbook on Marriage and Childbearing* is a compilation of data from 11 countries. The 24-page booklet includes graphics about birth rates, fertility trends, sexual experience, family planning and infant mortality. It is available in French and English.

Both booklets are free to developing countries and agencies working with them and may be obtained by writing: International Programs, Population Reference Bureau, 1875 Connecticut Ave., NW, Suite 520, Washington, DC 20009, USA.



Video Helps Asian Teens Discuss Sex

The Japanese Organization for International Cooperation in Family Planning has produced a 13-minute animated video about adolescent sexual behavior, sexually transmitted diseases, family planning and pregnancy. *My Way* depicts four young women approaching sexual relationships in different ways.

Produced in 1992, the film contains no dialogue but has captions in Thai or English. It is available on several types of video and on 16mm film. For information on obtaining *My Way*, the cost of which ranges between 10,000 and 13,000 yen plus shipping, contact: Sakura Motion Picture Co., 1-57-1 Yoyogi, Shibuya-ku, Tokyo 151, Japan. Fax: 81-3-3320-7666.

CPO Series Focuses on Adolescents

The Center for Population Options (CPO) has published a series of materials for people and agencies working with adolescents. The materials are free in developing countries; prices listed are for orders from elsewhere in the world.

• *Adolescent Fertility in Sub-Sahara Africa: Strategies for a New Generation* is a 35-page booklet in English outlining the cultural and social context of early childbearing and programmatic responses to it. Designed for program managers and advocates, it was published in 1992 and costs U.S. $10.

• *Adolescents and Unsafe Abortions in Developing Countries: A Preventable Tragedy* addresses cultural, legal and medical aspects and provides recent data on the topic. The 68-page booklet, published in 1992, is available in English. It costs U.S. $15.

• CPO also produces a series of fact sheets, summarizing information on a variety of issues. They are available in English for U.S. $1 each, or as "fact packs" covering 19 topics for U.S. $10. The topics include: adolescent contraceptive use, teenage pregnancy in Africa (also available in French), teenage pregnancy and sexually transmitted diseases in Latin America (also in Spanish), and young women and AIDS.

To order, write the Center for Population Options, Publications, 1025 Vermont Avenue, NW, Suite 210, Washington, DC 20005, USA.

IPAS Publishes Abortion Care Monographs

International Projects Assistance Services (IPAS) has produced two monographs for family planning managers or policy-makers in its *Issues in Abortion Care* series. Each publication is available in English and costs U.S. $4.95, plus shipping and handling, in developing countries; and U.S. $9.95, plus shipping and handling, elsewhere.

• *Meeting Women's Needs for Post-Abortion Family Planning: Framing the Questions* explores the obstacles keeping women from receiving the family planning services they need. The 70-page publication, which is also available in Spanish, covers health system design, contraceptive method use, quality of care and policy issues, among other topics.

• *Health Systems' Role in Abortion Care: The Need for a Pro-Active Approach* examines service delivery barriers to abortion care and discusses ways that health systems can prevent deaths and injuries from unsafe abortions. The 34-page monograph was published in 1991.

To obtain the publications, write: IPAS, P.O. Box 100, Carrboro, NC 27510, USA.

New FHI Publications

To request any of the following publications, write to: Publications Assistant, Family Health International, P.O. Box 13950, Research Triangle Park, NC, USA 27709. Please request publications by number.

93-15 Hubacher D, Potter LS. Adherence to oral contraceptive regimens in four countries. *Int Fam Plann Perspect* 1993 Jun; 19(2):49-53.

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