Network

FAMILY HEALTH INTERNATIONAL, VOLUME 20 NUMBER 3, 2000

Adolescent Reproductive Health

News Briefs

HIV Threatens African Youth

Half of today's 15-year-olds in South Africa and Zimbabwe will eventually die of AIDS, where more than a fifth of the adult populations are infected with HIV.

And, according to a recent report by the Joint United Nations Programme on HIV/AIDS (UNAIDS), at least a third of today's 15-year-olds will die of AIDS in another 16 sub-Saharan countries where HIV prevalence is 10 percent or higher. These deaths will occur even if countries can reduce the risk of becoming HIV-infected by half during the next 15 years.

Worldwide, the virus has killed 19 million people and has infected 34 million others, including 5.4 million new infections last year alone, the report says. "The AIDS toll in hard-hit countries is altering the economic and social fabric of society," warned Peter Piot, UNAIDS executive director.

Most HIV-infected people in developing countries die of AIDS by their 30s or 40s, decimating the workforce. More than 13 million children have been orphaned by AIDS, says the report, which was released in June 2000. However, it notes that countries that began fighting the epidemic years ago are experiencing either decreasing or low, stable HIV rates.

Drug May Prevent Many HIV Infections

Some 110,000 HIV-positive births could be prevented in South Africa over the next five years if the relatively inexpensive drug nevirapine were given to all pregnant women during labor and to each newborn, researchers conclude.

Also, life expectancy in South Africa in 2005 would increase by about one year — from 46.6 years without the treatment to 47.5 years, the researchers at University of British Columbia and St. Paul's Hospital in Vancouver, Canada, estimated in a study published in the June 17, 2000 issue of *Lancet*.

Approximately a third of infants born to HIV-positive mothers who do not receive treatment will acquire the infection during birth or through breastmilk, compared to an estimated 13 percent among newborns and mothers who each receive a single dose of nevirapine.

This preventive approach to the AIDS epidemic in South Africa, where 12 percent of the population is infected, would be less expensive than treating HIV-positive infants later in their lives, the authors concluded. In 1999, scientists demonstrated that U.S. $4 in nevirapine per mother and child could be an effective, inexpensive alternative to the drug AZT, which is used in developed countries but costs about U.S. $1,000. FHI managed the 1999 study by scientists at Makerere University in Kampala and the U.S.-based Johns Hopkins University and Fred Hutchinson Cancer Research Center.

Mosquitoes Attracted to Pregnant Women

Mosquitoes, which can carry malaria and other diseases, are far more attracted to pregnant women than non-pregnant women, concludes a small study among 72 women in the West African country of The Gambia.

The pregnant women, about half of the participants, attracted twice as many *Anopheles gambiae* mosquitoes as non-pregnant women. This species of mosquito is the most common malaria-carrying mosquito in Africa. Malaria among pregnant women increases the risk of miscarriage, stillbirth and low weight at birth and can lead to life-threatening anemia.

Two factors seemed to make women more attractive to mosquitoes during pregnancy, said the scientists from the University of Durham and University of Aberdeen in the United Kingdom and Medical Research Council Laboratories in The Gambia. In late pregnancy, women produced 21 percent more exhaled breath than non-pregnant women. Mosquitoes likely use components in exhaled breath to detect a host. Also, blood flow to the skin increased during pregnancy, releasing substances from the skin surface that alert mosquitoes to the presence of a host.

The study found that pregnant women were at increased risk of malaria because they often left the protection of their mosquito nets at night, probably to urinate, twice as frequently as did non-pregnant women.

The findings highlight the "importance of protecting this vulnerable group" against mosquito bites, concluded the authors. The study appeared in the June 3, 2000 issue of *Lancet*.

Norplant Effective Seven Years

Norplant contraceptive implants have been found in two independent studies to be safe and highly effective for seven years, two years longer than the labeling currently allowed by the U.S. Food and Drug Administration.

The studies found that cumulative seven-year pregnancy rates among Norplant users are comparable to rates among women who have undergone surgical sterilization. Furthermore, use of the reversible Norplant was not associated with the regret experienced by a number of women after sterilization.

The studies, conducted by scientists at the New York-based Population Council and the council's International Committee for Contraception Research involved more than 1,200 women in seven countries. In the two studies, the cumulative pregnancy rate was 1.1 per 100 women at five years and 1.9 per

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FAMILY HEALTH INTERNATIONAL, VOLUME 20 NUMBER 3, 2000

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OPINION

DEPARTMENTS

Students gather together on a street in Mérida, Mexico, in the cover photograph by Beryl Goldberg.

Many Youth Face Grim STD Risks

Adolescents need skills and self-confidence to abstain or reduce risks.

Preventing HIV infections among adolescents is an excellent strategy for slowing the AIDS pandemic. About a third of the world's 34 million HIV-positive people are between 10 and 24 years old. In most parts of the world, most new HIV infections are among adolescents, particularly among females. Notably, a substantial number of pregnant adolescents in sub-Saharan Africa are infected. Moreover, about a third of the 333 million new sexually transmitted disease (STD) cases each year — excluding HIV — occur among people younger than 25, and recent data suggest that the adolescent STD epidemic is growing, adds Dr. Willard Cates, Jr., president of FHI and an expert on STDs.[1]

"Younger people are more likely to adopt and maintain safe sexual behaviors than are older people with well-established sexual habits, making youth excellent candidates for prevention efforts," says Dr. Cates. "Reducing adolescent infections will ultimately result in fewer infections among all age groups."

However, many interrelated and complex factors that put adolescents at risk of STDs will not be changed easily or quickly. In many settings, these include poor education, unemployment and poverty. Also, urbanization tends to disrupt family relationships, social networks and traditional mores, while generating more opportunity for sexual encounters.

Adolescents in some places tend to delay their sexual debut, but others begin to have sex quite early. This is important because teenagers who have an early sexual debut are more likely to have sex with high-risk partners or multiple partners and are less likely to use barrier methods of contraception such as latex condoms, which offer STD protection.[2]

In an analysis of studies of adolescent sexual risk-taking in several developing countries, sexual debut as early as nine years was reported in Zimbabwe. In Chile, a third of young people reported having had sex before age 15. In the analysis, today's young people in Cambodia were becoming sexually active at younger ages than in the past. And in Costa Rica and Colombia, a trend among youth to have a wider repertoire of practices (anal and oral sex) was noted.[3]

Also putting both male and female adolescents at risk of STDs is their lack of information about sexual matters, as well as STD prevention, symptoms and treatment.

Approximately one quarter of some 1,000 students surveyed in Karnataka, India, mistakenly thought that a vaccine and a cure for HIV infection existed,[4] while half of 970 secondary-school students surveyed in Nigeria did not know that HIV causes AIDS.[5] In a survey of more than 300 U.S. college students, the majority of students knew little about human papilloma virus (HPV) infection, transmission or prevalence, although HPV infection is the most common STD in this age group and the primary cause of cervical cancer.[6]

Risk perception

Even when adolescents have accurate knowledge about STDs, they often do not heed warnings to reduce risky sexual behaviors. Some adolescents at high risk, for example, do not adopt safer behaviors because they incorrectly perceive their risk as low.

Familiarity with a sexual partner often leads to a perception of decreased risk. In a study from Malawi, girls perceived little risk in having sexual relations with a boy whose mother knew their family.[7] In U.S. studies, adolescents assumed that STD prevalence among their close friends was lower than among other teens and were surprised if they became infected by a close friend.[8] In one U.S. study of some 200 college students, inconsistent condom use was strongly associated with the belief that sexual partners were uninfected with HIV or other STDs. These beliefs were based on individuals' perceptions that they "knew" their partner's sexual history or "just knew" their partner was safe.[9]

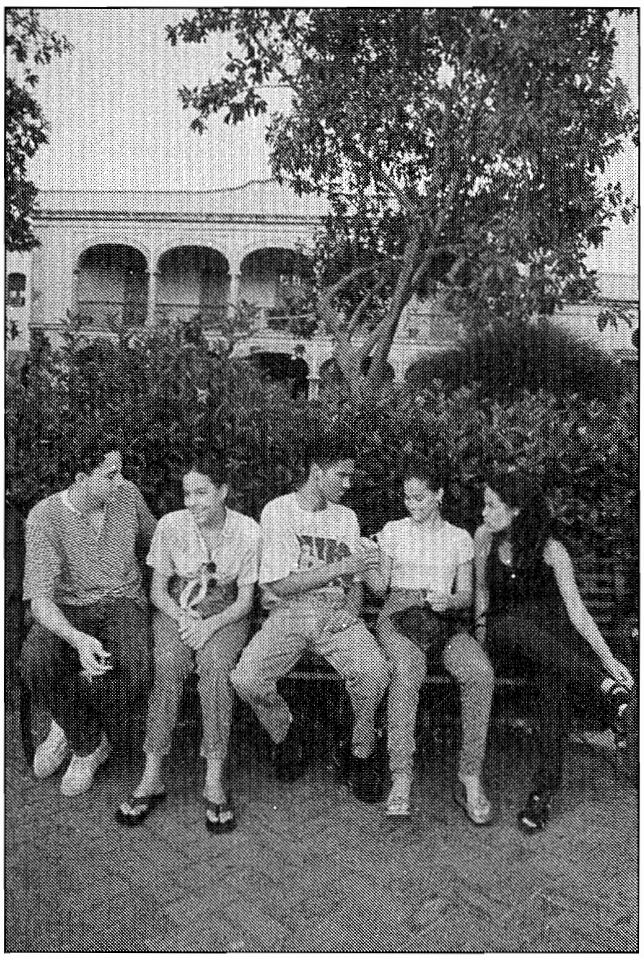
"College students are a highly educated population," says Dr. Diane Civic, author of the report and a research associate at the U.S.-based Center for Health Studies in Seattle, WA. "Clearly, however, 'just knowing' that a partner is safe does not provide factual information on their HIV/STD status. Likewise, knowing a partner's sexual history does not ensure that they are disease-free."

Perceived risk can also decrease as a relationship matures. While half of the 200 U.S. college students in this study reported consistent condom use in the first month of their sexual relationships, condom use decreased as relationships progressed.

Also affecting perceived risk, says FHI's Dr. Cates, "is the tendency for adolescents in steady relationships to be more concerned about preventing pregnancy than the risk of contracting an STD. As oral contraception use increases, condom use decreases. However, dual protection against both STDs and pregnancy is best achieved by using both male condoms and effective female contraceptive methods."

Other adolescents at high risk may not adopt safer behaviors simply because they are passing through a stage of life in which risk-taking is particularly attractive. Many adolescents either feel they have nothing to lose or feel they are invulnerable and cannot lose. Others are strongly influenced by peers. As one respondent in a field study conducted in Kenya commented: "The youngsters of the new generation really look at sex like it is an 'in thing.' You know it is 'macho' now to go to bed with a woman. Even if it is going out for a social drink, you end up in the bedroom. The bottom line is that you will have sex."[10]

BERYL GOLDBERG



YOUNG ADULTS GATHER IN SANTO DOMINGO, DOMINICAN REPUBLIC.

Condom access and skills

To avoid acquiring STDs, adolescents need to have the skills and self-confidence to either abstain from sexual relations or to use condoms consistently and correctly.

"Even boys should learn to say 'no' to risky sex," wrote Fred Otimgu, a student at St. Joseph's College in Layibi, Uganda, in a recent issue of *Straight Talk*, a newspaper for students that encourages youth to wait to have sexual relations or to use condoms. "When I suggested to my girlfriend that we use a condom and she refused, I left her because of my fear of HIV/STDs."

Correct and consistent use of latex condoms is the most effective means of preventing STD infection among sexually active people who are at risk. In many settings, condom use among adolescents has been increasing. However, adolescents may have difficulty obtaining condoms and knowing how to use them correctly.

Most 16- to 22-year-old participants in focus group discussions held in South Africa as part of a commercial marketing initiative said they did not use condoms due to lack of availability. Most of the 78 participants simply did not have the courage to ask for condoms at pharmacies and clinics. "Many said they were tired of being told that they should not be having sex or being refused condoms because the person who is supposed to be distributing them imposed their morality on the youth," says an HIV-positive man who helped conduct the focus groups.

For this reason, he said in an interview, "condoms need to be available wherever youth gather or 'hang out.' Also, most participants reported that they would prefer to purchase their condoms from their peers or younger sales people — not someone who is old enough to be their parent. They would also prefer to get condoms from vending machines in such places as game arcades, public toilets, night clubs, music shops or Internet cafes."

Common Features of Successful STD Programs

Relatively few interventions to prevent sexually transmitted diseases (STDs) among adolescents have been carefully evaluated.[1] However, some common features among programs that have been evaluated and deemed successful (those that seem to produce behavioral changes that protect adolescents) include the following:

Peer education — Adolescents generally prefer having other adolescents to educate them about reproductive health. For example, in Nigeria and Ghana, peer education resulted in adopting such behaviors as abstinence, condom use and limiting the number of sexual partners.[2] Likewise, Kenyan youth educated by their peers limited their number of sexual partners, compared with a similar group not receiving peer education.[3]

Mass media — Mass media messages can influence adolescent sexual attitudes and behavior. A mass media project using television soap operas, radio spots, songs, notebooks and calendars especially created to teach adolescents in Zaire about AIDS issues resulted in more sexual abstinence, mutual fidelity and condom use.[4] A campaign to promote AIDS awareness and prevention among 15- to 30-year-olds in Ghana by using television and radio ads, community meetings, dissemination of promotional materials, and outreach to schools led to a decrease in number of sexual partners and greater condom use.[5]

POPULATION SERVICES INTERNATIONAL (PSI)

VENDING MACHINES HELP MAKE CONDOMS READILY AVAILABLE FOR ADOLESCENTS.

Condom availability — Condoms should be readily available for adolescents. A combination of peer education, an STD referral system and free condom distribution to 15- to 25-year-olds considered high-risk for HIV infection and other STDs in Bali, Indonesia, produced several encouraging results, including a doubling of condom use in two of three cities where the program was conducted. Condom use increased by 50 percent in the third city.[6]

Range of choices — STD prevention initiatives seem to be more successful when offering youth a range of prevention choices — such as abstinence, fidelity and monogamy, and condom use. Providers should remember that adolescents are not a single homogeneous population. That means that no single campaign to prevent STDs among adolescents will be adequate unless it is built upon a respectful recognition of their differences.

Tailored to gender and age — AIDS prevention programs are more effective when tailored to adolescents' gender and age. For example, female adolescents' motivation for using condoms is routinely for pregnancy prevention, while male adolescents' motivation is primarily STD protection. "In one country after another, we find that young unmarried women are not as worried about STDs, which may be asymptomatic for them, as they are about getting pregnant," says Josselyn Neukom of Population Services International, a Washington-based organization that promotes condom use worldwide. "The programmatic implication is that one must consider gender differentials in terms of perceptions of risk and motivations for behavior change when designing HIV/AIDS prevention messages."

— *Kim Best*

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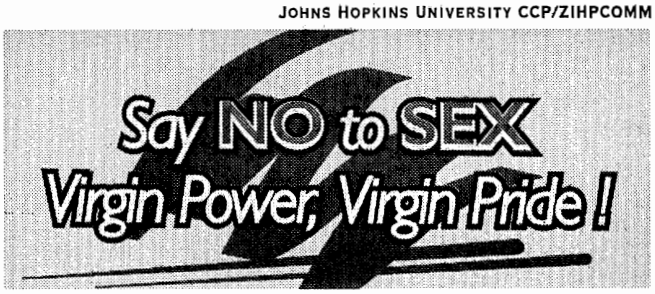

Inexperience with condoms is another problem. Often unfamiliar with condoms and apt to engage in spontaneous sex, adolescents may have problems anticipating intercourse and putting on the condom in a timely manner. Peer-group pressure plays a role, either facilitating or inhibiting condom use. "Issues of image seemed to outweigh risks," says the HIV-positive man who helped conduct the South African focus groups. "If obtaining or using condoms was too embarrassing, boring or silly, they would prefer not to use them."

Girls more vulnerable

In developing countries, up to 60 percent of new HIV infections are among 15- to 24-year-olds, with generally twice as many new infections in young women than young men.[11] Recent studies in several African populations indicate that 15- to 19-year-old girls are five or six times more likely to be HIV-positive than boys their own age. In one area of Kenya, 22 percent of 15- to 19-year-old girls in the general population were HIV-infected, compared with just 4 percent of boys of the same age.[12]

Similarly, the reported incidence of syphilis, gonorrhea and particularly chlamydia has been generally higher among female teenagers than among males the same age throughout 16 developed countries (the United States, Canada, and 14 in Europe).[13] For developing countries, very little age- or sex-specific data are available for STDs other than HIV.[14]

Why are young women more vulnerable than young men — or older women — to STD infection? In the adolescent female, a specific type of cell lining the inside of the cervical canal extends onto the outer surface of the cervix, where exposure to sexually transmitted pathogens is greater. These cells are more vulnerable to infections such as chlamydia and gonorrhea. As women age, this vulnerable tissue recedes and usually no longer extends onto the outer surface of the cervix.

Adolescent girls are also infected with HIV more often than are adolescent boys because many have sex with older men, who are more likely to be infected than adolescent men.[15] Older men are more likely than younger men to be able to give gifts, money or favors. "The girl's friends can tell her that John bought shoes for her, Peter bought lipsticks, Lawrence bought earrings," says a participant in adolescent focus group discussions held in Benin City, Nigeria. "They will then say if she was going out with only Lawrence, who would have bought her the shoes and lipsticks?"[16] Also, surveys show that young women are less likely than males of the same age to report condom use.[17]

Young male adolescents also face risks. In developing countries, older men, family members or peers often encouraged young men to begin having sex, often with potentially high-risk partners: sex workers, other men or older women.[18] In Uganda, older women appear to seek younger boys for sexual favors[19] and, in Malawi, younger boys seek older women.[20] In Mexico, Guatemala and Jamaica, most of young males' first sexual relationships have been reported to be with older women. In Mumbai, India, research indicated that older married women are sexual partners of some young male adolescents from the neighborhood.[21] In addition, some young boys have sex with men. Often, relations involve unprotected anal sex, which can cause abrasions and cuts through which HIV can pass into the receptive partner's bloodstream.

In-depth interviews in Karachi, Pakistan, by a group promoting sexual health, called Aahung (an Urdu word meaning "harmony"), suggest that adolescent boys from low-income communities are at least as vulnerable to STDs as are girls. "Boys have much more freedom to experiment," said Shazia Premjee of Aahung in an interview.

"Boys also have more access to information about sex," she says, "much of which is filled with myths and misconceptions that lead to unhealthy behaviors. Unlike girls — who generally are not allowed to leave the home unaccompanied after puberty and receive guidance from older, female members of the family — boys do not talk about sexual health with adults in their households. Sexual misconceptions, therefore, are not corrected. Also, many of the boys we interviewed had had various sexual experiences with members of the same sex."

PANELS FROM AN FHI COMIC BOOK ENTITLED *ROSE GETS TREATED* EMPHASIZE THE NEED TO USE CONDOMS.

Young Women Reporting Coerced Sex

Country	Percentage	Study population
India	26%	133 postgraduate, middle- and upper-class students
Mali	22%	500 women 15 to 25 years old
Tanzania	30%	549 secondary school students
Zimbabwe	20%	410 primary and secondary school students

Sources: Castelino CT. Child sexual abuse: a retrospective study: Bombay, India. Unpublished paper. Tata Institute of Social Sciences, 1985; Connaissances, attitudes et comportements des jeunes (15-25 ans) vis-à-vis de la santé de la reproduction. Unpublished paper. Ministère de la Santé, des Personnes Agees et de la Solidarité, Direction Nationale de l'Action Sociale, Centre National d'Information, d'Éducation et de Communication pour la Santé (CNIECS), 1999:35; Matasha E, Ntembelea T, Mayaud P, et al. Sexual and reproductive health among primary and secondary school pupils in Mwanza, Tanzania: need for intervention. *AIDS Care* 1998;10(5):571-82; Khan N. Sexual and physical abuse: a threat to reproductive and sexual health. *Sexual Health Exchange* 1998;1.

Both young men and women sell sex. But, unlike male adolescents who often become prostitutes voluntarily, girls usually do so against their wishes. In Thailand, young girls most commonly sell sex because their parents urgently need money.[22] Young sex workers are at a higher risk of acquiring an STD than older prostitutes because they have less power to negotiate condom use with partners. The consequences can be grim. In Cambodia, for example, nearly a third of sex workers ages 13 to 19 years are infected with HIV.[23]

Meanwhile, a substantial number of girls have sexual relations because they are physically coerced: In various populations, between a quarter and a third of young women report having experienced coerced sexual relations (see table, this page). The plight of the world's 100 million street children — most of whom are between 11- and 14-years-old and live in the large cities of developing countries — is even more bleak. In Guatemala, 95 percent of street girls had experienced sexual abuse. In Brazil, street youth are considered to be at high risk of HIV or STDs in part because of very early sexual debut, frequently the result of coercion.[24]

Anal intercourse presents the greatest risk of sexual HIV transmission.[25] However, in numerous studies, heterosexuals have been found to use condoms less often for anal sex than for vaginal sex.[26] Furthermore, a study among 800 sexually active New York City adolescents ages 13 to 21 years showed that females practicing anal sex (about 14 percent of the 483 women in the study) were less likely to use condoms with a non-steady — and potentially more risky — partner. Of young women who practiced anal intercourse, 84 percent never used condoms with steady partners, but even more — 96 percent — never used condoms with casual partners.[27]

STD complications

STD treatment for adolescents is often inadequate for a variety of reasons, including the fact that many adolescents do not know about available services. Services may also be inaccessible because clinics are far away or have limited hours; tests and drugs may be too expensive; female adolescents may fear pelvic examinations (even though such exams may not be necessary); young people may be too embarrassed or feel too guilty to seek treatment; and health providers may be reluctant to serve adolescents. Health facilities in places as diverse as Antigua, Senegal and Thailand have been found to deny adolescents privacy and confidentiality, and staff have been rude in some places.[28]

Not surprisingly, many adolescents with STD symptoms avoid established clinics. Adolescents from Benin City participating in focus group discussions reported that they first sought care from traditional healers or patent medicine dealers. Locally available herbs, roots, soda, and combinations of salt, potash, gin, lime and pepper fruit were mentioned more frequently than antibiotics as ways of treating STDs, especially by males.

Correct diagnosis and treatment of STDs is particularly challenging among young women, since such STDs as gonorrhea and chlamydia are often asymptomatic. Female adolescents with symptoms tend to delay seeking help, compared with older women.[29]

Delay or lack of treatment of STDs can have serious, even fatal, consequences. Untreated STDs — particularly chlamydia and gonorrhea — can cause pelvic inflammatory disease (PID) throughout the upper genital tract. Inflammation and scarring from this infection can either block the fallopian tubes or damage the tubal lining. Long-term consequences include chronic pain, tubal infertility or life-threatening ectopic pregnancy.

Not only is PID more common among sexually active female adolescents than older sexually active women, but female adolescents are more likely to be infected again and to experience a recurrence of PID. This is because, by beginning sexual activity early, they have more time to be infected. Repeated infections increase the risk of infertility.[30]

Given PID's potentially severe consequences, including infertility and death, physicians should start treatment in all

Pregnant Adolescents Who Are HIV-Positive

Percentage (15-19 years of age)

Botswana	28%
Kenya	21%
South Africa	13%
Uganda	11%
Zimbabwe	30%

Sources: World Health Organization; Joint United Nations Programme on HIV/AIDS; Kenya Girl Guides Association.

sexually active adolescents with presumed PID — those experiencing lower abdominal pain with adnexal and cervical motion tenderness — if other causes are not identified. Additional symptoms that support the diagnosis of PID include a fever (an oral temperature greater than 38 C or 100.4 F), leukorrhea (greater than 10 white blood cells/high-power field), and laboratory documentation of cervical infection with *C. trachomatis* or *N. gonorrhoeae*.[31]

If an STD-infected adolescent becomes pregnant, the disease can be transmitted to her fetus or infant. Bacterial vaginosis and trichomoniasis are related to preterm delivery and low-birthweight infants.

The following STDs can cause a variety of diseases in infants — gonorrhea can cause conjunctivitis, sepsis and meningitis; chlamydia can cause conjunctivitis, pneumonia, bronchiolitis and otitis media; syphilis can result in congenital syphilis and neonatal death; hepatitis B can cause hepatitis and cirrhosis; herpes simplex virus can cause disseminated, central nervous system and localized lesions; and human papilloma virus can cause laryngeal papillomatosis. HIV can cause pediatric AIDS. Up to one in every three pregnant adolescents in some settings is HIV-infected (see table, page 8).

— Kim Best

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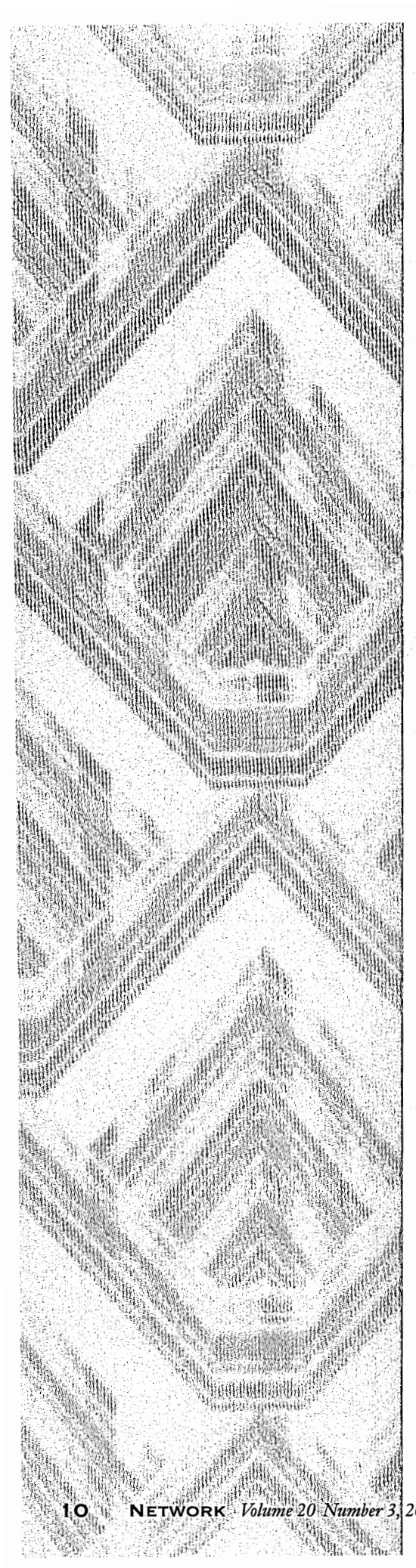


Sex Education Helps Prepare Young Adults

Reproductive health education can succeed in various settings, including schools and community centers.

Sex education can result in young adults delaying first intercourse or, if they are already sexually active, in using contraception. Virtually all studies conclude that sex education does not lead to earlier or increased sexual activity.

"Youth are interested in sex because of biological reasons, hormones," says Dr. Cynthia Waszak, an FHI senior scientist who focuses on adolescent health. "Suggestions about sex in music, radio, advertisements, films and television reinforce that interest. Kids talk about sex and have questions about it. We should find ways to give youth the right information so they can make better, informed decisions about their sexual behavior."

Learning about reproductive health is part of the larger developmental process as children become adults. Developing self-esteem, a sense of hope and goals for the future, and respect for others are also part of the process. Aspects of education on sexuality are incorporated into various types of programs, sometimes called family life skills or family life education in many developing countries. Married as well as unmarried adolescents need education, on contraception in particular, especially in countries such as Bangladesh and India where 50 to 75 percent of women under age 18 are married.

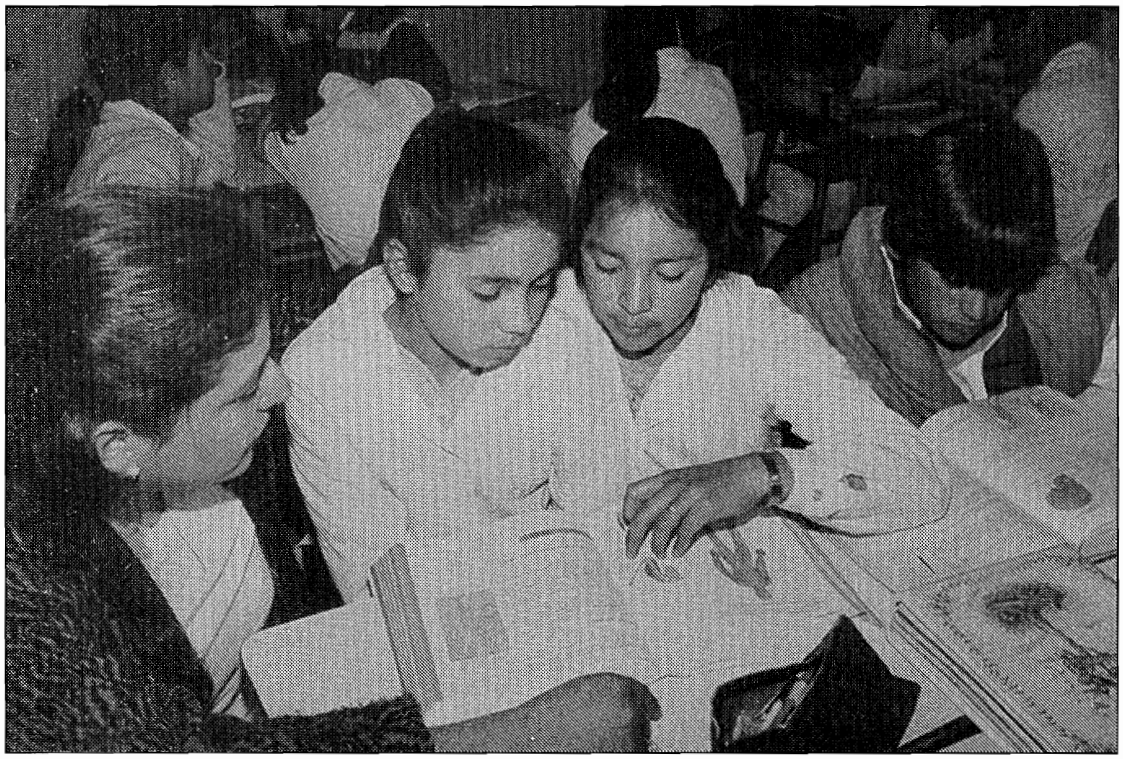
Sex education programs have been successful in various settings, including schools, community centers, youth groups and the workplace, explains Judith Senderowitz, a U.S.-based consultant who has written extensively on adolescence. The programs often include peer-based approaches and media activities to reach more people. A characteristic of programs that appears critical to success is "an interactive and experiential learning environment where young people can comfortably and safely explore issues and concerns and develop skills to practice safer sexual behavior," reports Senderowitz in one analysis.[1]

Elements for success

Successful sex education programs have common elements that can be adapted to various cultural situations. These common elements include certain features in curriculum and adequate teacher training.

Dr. Douglas Kirby, an analyst for ETR Associates, a U.S.-based educational research company, reviewed sex education programs and found 10 common elements of the most effective programs.[2] Giving a clear, consistent message is critical. "The programs that give the pros and cons to having sex or using condoms and then implicitly say, 'Choose what is best for you,' were not as effective at changing behaviors as the ones that consistently made a specific case. A common effective message was 'always avoid unprotected sex.' Abstinence is the best way — if you have sex, always use a condom."

CARLOS D. CONDE/INTER-AMERICAN DEVELOPMENT BANK



STUDENTS IN ARGENTINA LEARN ABOUT REPRODUCTIVE HEALTH.

Making the message appropriate to the age and sexual experience of the participants is also essential. "If few of the participants are having sex, focusing almost entirely on abstinence may be appropriate," he says. The most effective programs concentrated on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.

Another important component, he says, is to identify what should change. "The successful programs," Dr. Kirby says, "all look at the factors that affect sexual behavior — beliefs, attitudes, norms and skills — and design a curriculum to address those factors." Effective programs also provided opportunities for students to practice communication and negotiation skills, and had them personalize the information.

Traditionally, sex education messages are targeted to one of two groups: those who are sexually active or those who are not. A study suggests that messages could be tailored to address four groups instead: those who do not anticipate having sex in the next year (delayers), those who anticipate initiating sex in the next year (anticipators), those who have had one sexual partner (singles) and those who have had two or more partners (multiples).

As a group, the anticipators showed riskier behaviors and looser ties to family, school and church when compared with the delayers. Youth with multiple sex partners also reported more risks, compared with those who have had only one partner. Health educators should "address the social and psychological context in which sexual experiences occur," recommended researchers from the U.S. Centers for Disease Control and Prevention, which studied 900 students ages 15 to 18 in the United States and Puerto Rico.[3]

The U.S.-based Sexuality Information and Education Council (SIECUS) has developed sex education guidelines. They emphasize beginning early, when children are in primary school, and continuing through adolescence. Teachers need to be trained, and programs should involve the community, parents, administrators and religious leaders. The curriculum should include information on human development, reproductive anatomy, relationships, personal skills, sexual behavior and health, and gender roles.[4]

As countries begin to implement sex education programs, they are drawing to some extent on international guidelines and acknowledged common elements for success. Brazil, for example, has mandated that sex education begin with primary school children. In Mexico, a course developed by the Instituto Mexicano de Investigación de Familia y Población (IMIFAP) called "Planning Your Life" incorporates sex in the larger context of life development. A study by IMIFAP and the New York-based Population Council showed that the course can increase students' knowledge and, among sexually active students, increase contraceptive use.[5]

In Nigeria, a new curriculum emphasizes the development of skills, teacher training and community involvement. A national task force has developed guidelines for comprehensive sex education, working with the SIECUS model. Using the Nigerian guide, the Association for Reproductive and Family Health (ARFH), a Nigerian nongovernmental organization working with the Oyo state government, has developed a curriculum being implemented in 26 schools for 10- to 18-year-olds.

"A needs assessment and baseline survey revealed that, since first sexual experience occurred between ages 13 and 16, youth more than ever before require sexual and reproductive health information as well as some life-building skills — negotiation skills, values clarification, refusal skills, decision-making and goal setting. These skills will enable youth to cope with the demands and challenges of growing up, self-management and other transitions," explains Grace Delano, ARFH executive director. ARFH is also emphasizing training that helps teachers clarify their own values of sexuality. Modifying youths' sexual behavior requires a multidimensional approach, says Delano. "Mass media involvement, advocacy and community involvement are some of the

Do Youth Need Information?

Studies have consistently found that youth lack basic knowledge about sexuality and contraception.

- In a survey of nearly 3,000 youth in Senegal, only one-third of those 15- to 19-years-old could correctly identify the fertile time in the menstrual cycle, and 80 percent incorrectly thought that oral contraceptives could cause sterility. Those youth who had participated in a family life education program had more knowledge about contraception and used contraception more often.[1]
- A study of sex education programs in South Africa found that youth want more information, including help with decision-making and coping skills, and the opportunity for individual counseling with someone they trust. In focus groups with 60 students, youth said their parents ought to be the main source of information on sex education but were not giving them what they needed.[2]
- In a survey among 2,460 students 14- to 19-years-old in Nigeria, just one in three could correctly identify when conception was most likely to occur. In focus groups, "students expressed a strong desire for better education about contraception and the consequences of sexual intercourse, and recommended that both schools and parents participate in educating young people about reproductive health."[3]
- In nearby Guinea, a survey of more than 3,600 unmarried men and women 15- to 24-years-old found that one of four women had been pregnant and 22 percent of these pregnancies ended in an abortion. The average age at first intercourse was 16.3 years for girls and 15.6 years for boys, but more than half of those who were sexually active had never used contraception. "School-based sexuality education could benefit even out-of-school youths because their partners often are students," the study concluded.[4]

— William R. Finger

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strategies adopted to ensure that the teachings in the school are complemented by the community."

Educators agree on the importance of curricula helping youth to develop and practice decision-making skills. "Sex education is not just about sex," says Hally Mahler, a trainer at FHI who has facilitated sessions on sex education for teachers, guidance counselors, parents and youth in Asia, Africa and Latin America. "Self-esteem, decision-making skills, feeling you have options and can control things — that is what the curriculum needs to emphasize." For kids to learn skills about negotiating safe sex, teachers have to be comfortable with the content of the curriculum and make it interesting for youth. "We have to get them excited and answer their questions in a real way. So we use music that is popular with kids and exercises that will help people talk about taboo subjects."

One exercise Mahler is incorporating into a new curriculum in Senegal is what she calls a condom fashion show. "Kids, teachers and parents open the condoms and make them into belts, bracelets and earrings. It desensitizes them to this subject, and they can then talk more honestly and openly."

Government and nongovernmental organizations are working with FHI to develop the curriculum for use with 10- to 19-year-olds. The Frontiers in Reproductive Health project coordinates this work by the New York-based Population Council.

Little research on sex education among newlyweds exists, and what is available focuses on contraceptive use. China and Bangladesh have used family planning field workers successfully among married adolescents. In Bangladesh, when family planning field workers targeted newlyweds with letters of congratulations and motivational talks, contraception use among newlyweds increased from 19 percent in 1993 to 42 percent in 1997. In Indonesia, counselors use marriage registries to contact newlyweds. Attending talks on family planning is a prerequisite to a civil marriage in several states in Mexico. And in Bangladesh and Taiwan, media campaigns have focused on reaching newlyweds.[6]

Education can help

In the most comprehensive analysis of sex education, the Joint United Nations Programme on HIV/AIDS (UNAIDS) examined 68 evaluations of sex education projects, 53 of which evaluated specific interventions.

Of these 53 interventions, 22 "delayed the onset of sexual activity, reduced the number of sexual partners or reduced unplanned pregnancy and STD rates," the UNAIDS analysis concluded. There were neither increases nor decreases in sexual activity and attendant rates of pregnancy and STDs in nearly all of the other interventions evaluated. In one of the few exceptions, a program that included only abstinence in the curriculum resulted in an increase in noncoital sexual activity such as breast touching.[7]

In the United States, a review of nearly 80 sex education programs also found that "programs that focus upon sexuality, including sex and HIV education programs, school-based clinics, and condom availability programs, do not increase any measure of

sexual activity." While nearly all of the programs increased knowledge among youth about sexuality, only a few resulted in measurable reductions in sexual risk-taking, such as delayed onset or reduced frequency of sex, reduced number of sexual partners, or increased use of condoms or other forms of contraception.[8]

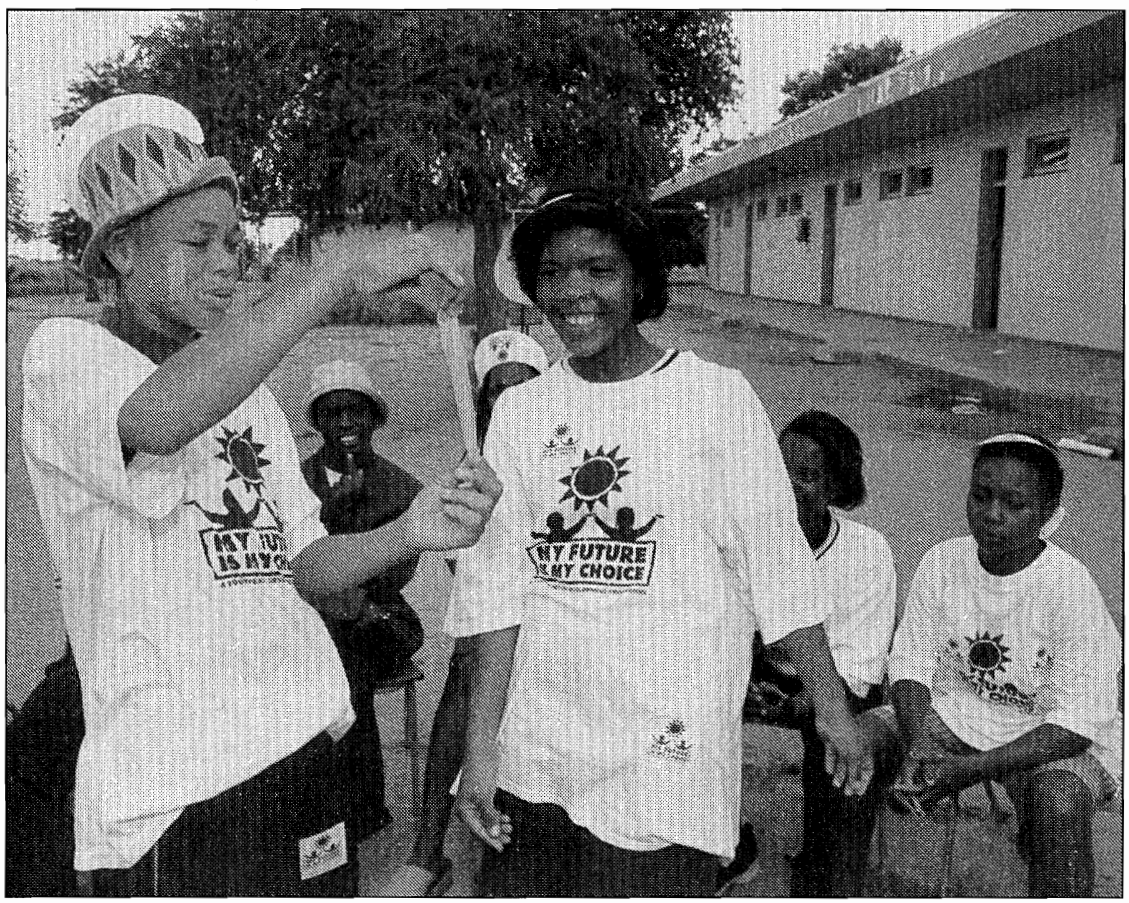
Most of the successful programs have included strong community involvement and clear messages about avoiding pregnancy or sexually transmitted diseases (STDs). A study in Senegal found that family life education programs needed to put more emphasis on skill development. The study used focus groups and surveys with 225 boys and girls 14- to 18-years-old who participated in the programs at schools, youth clubs and sports associations. "This [education] allows us to be more mature and to be able to face some of life's problems," said one boy.[9]

The youth also brought up issues involving respect and responsibility. "Discussions about what boys and girls want from each other in relationships suggest a lack of respect between the sexes," the study found. Boys thought that girls were primarily interested in money and other material things from boys, while boys and girls mentioned "the possibility of beatings or rape if a woman refuses to have sexual relations. Values that instill respect for women while teaching that violence is never acceptable need to be emphasized." The Institut de Sciences et l'Environment Université Cheikh Anta Diop de Dakar and FHI conducted the study, working with several ministry offices and nongovernmental organizations.

In a rural, low-income area of the United States, sexual health education for students 5- to 18-years-old involved community agencies, religious leaders, parents, media messages and health promotion. After three years, annual pregnancies fell from 60 to 25 pregnancies per 1,000 young women 14- to 17-years-old. In two control areas with no intervention, annual pregnancies in the same age group increased. The program taught about reproductive anatomy and contraception, and focused on ways to improve decision-making, interpersonal communication skills and self-esteem. It emphasized the need to balance personal values with those of the family, religious institutions and community.[10]

Simply providing educational materials without other key elements, such as community involvement, can be counterproductive. A study in Nicaragua found that placing health education materials in motel rooms used by commercial sex workers actually lowered the frequency of condom use.[11]

GIACOMO PIROZZI/UNICEF/HQ00-0104



YOUNG ADULTS IN OKAKARA, NAMIBIA, TAKE PART IN AN EDUCATIONAL EXERCISE ABOUT THE PROPER USE OF CONDOMS IN A PROGRAM CALLED "MY FUTURE IS MY CHOICE," WHICH RECEIVES ASSISTANCE FROM THE UNITED NATIONS CHILDREN'S FUND. THE PROGRAM INVOLVES GROUP DISCUSSIONS, ROLE-PLAYING AND OTHER ACTIVITIES.

TEACHER TRAINING

Other factors critical for good sex education programs include adequate teacher training and resources for implementing the program. "Training teachers is a key element of successful sex education programs, and the lack of good training has been a big problem," says Dr. Waszak of FHI. "The teachers do not get trained, so they ignore the

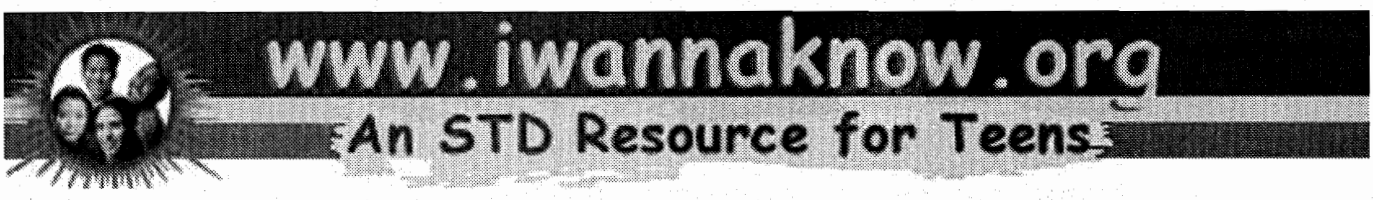
curriculum or do not know how to deal with it. The training has to desensitize the discomfort the teachers feel in talking about subjects that were taboo when they grew up. And, once you start talking about sexual health with youth, you have to listen to them. You have to deal with their questions, and often, that is not comfortable for teachers."

A recent evaluation of the Peru sex education program suggests the potential limitations of training and resources. "There is still resistance by some teachers asked to implement the program, which undercuts its effectiveness," says Dr. Robert Magnani of Tulane University, who works with FOCUS on Young Adults, a U.S.-based research program. "Not enough time and resources had been committed to gain the support of teachers and principals. This is a big issue in conservative societies."

In South Africa, life-skills training is mandated in all schools by 2005. "But life-skills training curricula and teaching methods vary significantly," says Dr. Magnani. "It is fairly well done in some schools but not done well in others." While recommended national guidelines are important, he says, local provinces have to make financial and other commitments to implement the guidelines.

Good training requires creative approaches. In Jamaica, FHI has worked with the Ministry of Education to train guidance counselors to teach family life skills using a manual called *Preparing for the VIBES in the World of Sexuality*. It teaches counselors how to guide youth in developing skits, dances, songs and other theatrical expressions of their questions, concerns, fears and scenarios for sexual situations, working with the Ashe Performing Arts Academy and Ensemble (see related article, page 28). An evaluation of the program is under way, following for two years youth who participated in the family life skills course at age 12.

The need for good training goes beyond school-based curricula. Involving parents and community leaders is also important. Working in Jamaica with the National Family Planning Board and Ashe, FHI is developing an adolescent reproductive health program for parents. It includes a training manual and video to help parents communicate better with their teenagers.



Reproductive Health Web Sites for Youth

Today's Internet technology allows adolescents, parents and providers to find helpful information quickly and easily about sexually transmitted diseases, contraception and other reproductive health topics. Among the Web sites offering adolescent reproductive health information are the following:

http://www.iwannaknow.org
The American Social Health Association site includes a guide to help adults discuss sensitive matters with their children. Daily stories of fictional characters facing sexual health issues are given in soap opera fashion.

http://www.ama-assn.org/adolhlth/adolhlth.htm
The American Medical Association offers information about adolescent health services. The site also offers fact sheets to help providers discuss specific topics with parents.

http://www.talkingwithkids.org
This site, by Children Now and the Kaiser Family Foundation, encourages parents to talk with their children about sexual health, violence and drug abuse. Information is available in English and Spanish.

http://www.teenwire.com
Planned Parenthood Federation of America's "Teenwire" provides information about teen sexuality, sexual health and relationships. Answers to commonly asked questions about sexual health and a magazine written by teens for teens are available.

http://www.bbc.co.uk/worldservice/sci_tech/features/health/sexwise
The International Planned Parenthood Federation and the BBC World Service provide adolescent reproductive health information from various national family planning programs and educational radio reports, offered in 22 languages at the BBC's "Sexwise" page.

http:www.unicef.org/voy/
This United Nations Children's Fund site provides an online forum for young adults to discuss a number of topics, including reproductive health. The Web site is available in English, Spanish and French. ■

Using the manual, a group of parents will be trained to work with other parents. In an initial needs assessment, about 90 parents expressed concerns about STDs, rape, pregnancy and homosexuality. Reflecting on their own adolescent experiences and concerns for their children, they identified what they thought should go into the manual.

The AIDS epidemic has generated many ways to reinforce sex education messages, including mass media campaigns, hotlines and computers. A campaign in the Philippines targeted young people by using popular music groups and advertising an information hotline. An evaluation of the project found that half of those recalling the music changed their sexual behavior, and 44 percent talked with friends or parents about sex-related information.[12] With the help of young people, the International Planned Parenthood Federation (IPPF) is preparing a Web site with sex education materials. IPPF currently cosponsors a Web site with the BBC World Service called "Sexwise" (see related article, page 14).

Many community organizations have taken an interest in sex education. FHI has worked with the World Association of Girl Guides and Girl Scouts to provide sex education to adolescents in several African countries and India (see related article, page 30). The Arab-based boy scouts organization has been training youth in peer counseling skills and sensitization about gender and sexual health. In Ghana, the Young Women's Christian Association is working with the U.S.-based Centre for Development and Population Activities to involve parents and church leaders in counseling.

Peer education programs are particularly popular with HIV-prevention projects. An evaluation of 21 peer-based projects supported by FHI in 10 countries (Brazil, Cameroon, Dominican Republic, Ethiopia, Haiti, Jamaica, Nigeria, Tanzania, Thailand and Zimbabwe) found that 81 percent of the target audience said they preferred getting information on HIV/AIDS from peer educators. A student peer educator in Zimbabwe said, "With someone your own age, you will be serious. You'll feel at ease. With someone older, you do not want to discuss some things, problems, what is in your heart."[13]

— William R. Finger

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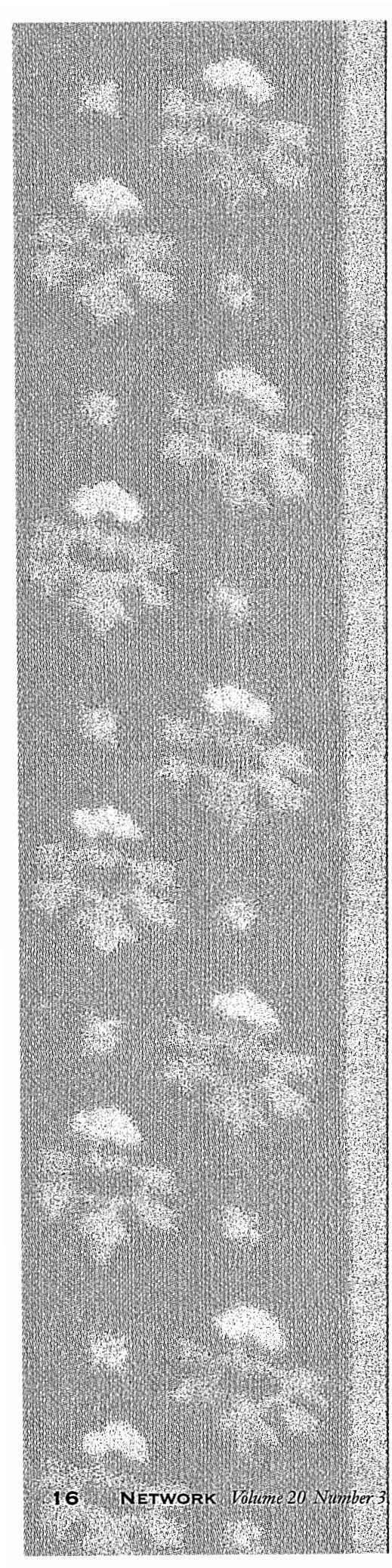

Better Services Can Reduce Abortion Risks

Fear, shame and desperation lead some young women to end a pregnancy, often under unsafe conditions.

For an adolescent girl, an unplanned pregnancy can have severe consequences: abandonment by her partner, expulsion from school, loss of a job, dishonor for her family if she is unmarried, disease or death.

Because they are afraid, ashamed or desperate, many young women are willing to risk their lives to end an unplanned pregnancy. They seek an illegal abortion, often from an untrained person under unsafe conditions, or they try dangerous ways to induce an abortion themselves by drinking gasoline or detergent, taking drug overdoses, douching with bleaches, or inserting objects into their vaginas.

"When an adolescent girl wants to interrupt a pregnancy, she always goes where she should not, in the most isolated places where she knows no one will see her. She goes to places where there are no gynecologists," says one West African health worker.[1]

Worldwide, clandestine abortion is an all-too-common occurrence among adolescents. The World Health Organization (WHO) estimates that between 1 million and 4.4 million abortions are performed each year among young women (ages 10 to 24 years), and that most of these are unsafe because they are performed illegally under hazardous conditions by unskilled providers.[2]

"Adolescents are more likely than adults to deny they are pregnant, not recognize the signs of pregnancy, delay decision-making and seek abortion later in the pregnancy, which puts them at greater risk," said Ashley Montague, a program associate for the U.S.-based Ipas, a reproductive health organization that concentrates on preventing unsafe abortions.

Although not all clandestine abortions are unsafe, they are associated with high rates of illness and death. Unsafe abortion can result in hemorrhage, infection and cuts or chemical burns to the genitals or reproductive organs. Treatment can require hospitalization, blood transfusions, antibiotics and other drugs.

Long-term consequences include chronic pain, ectopic pregnancy and infertility due to infections in the upper genital tract. Infertility can carry serious socioeconomic consequences for women, including abandonment by partners and ostracism by the community. Women who are infertile may not be able to marry, and without marriage, they have little hope of being financially secure or respected by their peers. In addition, many young women who become pregnant are expelled from school or fired from their jobs, further limiting their opportunities to earn income.

To help reduce the numbers of deaths and illnesses caused by abortion, health experts recommend several strategies: make family planning information and services more widely available to adolescents; offer emergency contraception to adolescents who have unprotected sex or who are worried about contraceptive failure; and improve

postabortion care, including contraceptive services for women hospitalized due to abortion complications.

Contraceptives for young people

Some of the reasons for unsafe abortion can be traced to a lack of contraceptives and other reproductive health services for young people.

Family planning programs are most often designed for married women, not for young, single women or men. Young people may not know how or where to obtain family planning services; those who do may be discouraged by health workers' judgmental attitudes.

In Dakar, Senegal, 12 young people posing as clients in an FHI study visited family planning clinics and were told "you are too young for that" and "focus more on your studies because these methods are bad for your health."[3] In Ghana, family planning workers said marriage was a mandatory requirement for family planning.[4]

Young adults typically know less about family planning than older people, and when they do use contraception, they tend to use less effective methods, use them incorrectly or abandon contraception altogether.

Lack of access to contraceptive services is one reason for increasing rates of abortion among young women in Vietnam, where abortion is legal and widely available. In Hanoi, 90 percent of 259 women who had undergone abortion were ages 15 to 24 years, one study found. Although 78 percent of the young women knew about family planning, only 26 percent had used a method — predominantly condoms or withdrawal — and they used those methods inconsistently or incorrectly.

When asked why they had not used contraception, some of the Vietnamese women explained that they are expected to be virgins when they marry — seeking family planning would disclose that they are sexually active. Also, not using contraception was perceived as a sign of fidelity and confidence that a relationship would lead to marriage. Some young women explained that they did not know that condoms protect against pregnancy as well as sexually transmitted diseases, while others thought that oral contraceptives cause permanent infertility. Ninety-three percent said they could have avoided pregnancy if they had been better informed about sexuality and contraception.[5]

PETER ARMENIA

WOMEN VISIT ON A STREET IN HANOI, VIETNAM. LACK OF ACCESS TO CONTRACEPTIVE SERVICES IS ONE REASON FOR INCREASING RATES OF ABORTION IN SOME COUNTRIES, INCLUDING VIETNAM.

Better family life education in schools could help young people delay sexual activity or use contraception correctly when they do become sexually active. "To prevent abortion, you also have to consider the right to education, to information, and to family planning and reproductive health services in general," says Luisa Cabal, an attorney for the Center for Reproductive Law and Policy in the United States. "Access to information and education should be linked with access to services." In addition to quality family planning services, she says, young adults need related services, such as HIV testing and counseling for sexual violence.

"We need to develop adolescent-friendly clinics and policies, with convenient hours and locations, affordable services," says Montague of Ipas. "We need providers who are nonjudgmental and who have received special training in working with adolescents. We must ensure confidentiality and ask adolescents what would help them use contraception effectively.

"Health programs should provide a range of methods, including female condoms and emergency contraception. Providers should explore whether a young woman needs a method that does not require her partner's cooperation or whether she needs a method she can easily conceal from family members. Providers must be sure to address myths and concerns about contraception. And they should expect to provide more outreach — in schools and in nonclinic settings — and more follow-up for younger clients."

Improving adolescents' knowledge of and access to emergency contraception could help reduce unplanned pregnancies and abortion, says Montague. While emergency contraception should not be used as a regular contraceptive method, young people may not know it is available, how to obtain it or how to use it correctly.

In Nigeria, a survey was conducted among 156 young women who had previously undergone a clandestine abortion. Most of them had heard of emergency contraception, but fewer than one-third knew about emergency contraceptive pills.[6] A study at a New York center for young adults found only 30 percent knew about emergency contraception.[7]

Friends, Family Influence Abortion Decisions

For many young women, research shows that encouragement to seek an abortion comes from friends, parents and sexual partners.

• An FHI study in Brazil among 563 young women seeking prenatal or postabortion care found half of the teenagers in both groups said someone close to them had recommended that they end their pregnancies. For teenagers seeking prenatal care, the suggestions came from friends (48 percent), mothers (20 percent), other relatives (23 percent) and their sexual partners (9 percent). For the young women with induced abortions, suggestions came from friends (29 percent), mothers (27 percent), partners (24 percent) and other relatives (20 percent).[1]

• Studies in Africa have shown that social and family networks are an important source of information about abortion, particularly for young unmarried women. In an FHI study in Guinea, a young woman explained, "I went to see my girlfriend, who showed me one of her friends. ... Her mother is a midwife. ... She said OK. She gave me the price." Once an adolescent girl is pregnant, parents' attitudes can affect young women's attitudes about pregnancy and abortion. In Guinea and Côte d'Ivoire, study participants said a young woman might have an abortion to save her family from embarrassment. Some suggested a girl would not have an abortion if her parents approved of the pregnancy.[2]

• In Senegal, young women who become pregnant may be shunned by their parents and forced to leave home. Instead of supporting the girl, one male adolescent told researchers that parents "banish her or chase her from the house." Or if she stays "they ignore her as if she were not part of the family."[3]

• The views of male partners often influence women's decisions about whether to keep or terminate a pregnancy. In Tanzania, of 150 adolescents who underwent abortion, 46 percent said they told their male partners before anyone else, and 27 percent told male partners after telling a friend or relative. Two-thirds of the men who knew about their partners' pregnancies advised them to abort. While only 31 percent of men helped women find someone to perform the abortion, nearly 50 percent were prepared to pay for the procedure.[4]

Partners influenced women's decisions to seek abortion as well as their initial decisions to use family planning. One 20-year-old woman in Kenya who sought an abortion said she did not want children until after she was married but did not use family planning. She was afraid oral contraceptives would cause permanent infertility, and her partner did not want to use condoms. Whenever she suggested condoms, he gave her a piece of candy and asked her to eat it with the wrapping on, telling her that is how it felt for him to use condoms.[5]

— Barbara Barnett

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Some health experts recommend that emergency contraceptive pills be provided in advance to young people who are sexually active. Pills should be given with written instructions on how and when to take them. Pills can also be given to couples who use condoms, in case a condom breaks or fails.

Postabortion Care

For young people who have undergone an abortion, postabortion care, including family planning counseling, is critical in preventing repeat abortions. Young women need to know that fertility can return quickly after an abortion and to understand which contraceptive methods are available to them.

If no complications arise after a woman has had a first trimester abortion, she can use any contraceptive method except periodic abstinence, which is not recommended until her regular menstrual cycle returns. If she has had a second trimester abortion, the fitting of diaphragms or cervical caps should be delayed four to six weeks until uterine size has returned to normal. Intrauterine device (IUD) insertion also should be postponed until four to six weeks after abortion unless the provider is trained in immediate postabortion insertion. Women with infection should not use IUDs or undergo sterilization until the infection is gone (usually about three months). Women with severe injury to the genital tract should not use IUDs, spermicides, diaphragms, cervical caps or sterilization until the injury has healed. Those with severe bleeding and related anemia should not use IUDs or sterilization until the condition has been

resolved. Women should not resume sexual intercourse until postabortion bleeding stops — usually five to seven days — and until any complications or problems are resolved.[8]

In many countries, efforts have focused on improving postabortion services. In Kenya, the Population Council, Ipas and the Ministry of Health evaluated different ways of delivering postabortion services. One system offered services at gynecology wards through gynecology staff members. Another offered services at the ward, but given by family planning and maternal health providers. And a third system offered services at family planning clinics.

The evaluation found that the first system, in which gynecology staff provided family planning services on the gynecology ward, was the most effective, the most acceptable to clients and the easiest to administer. Offering contraceptive services on the gynecology ward also gave the hospital staff a chance to counsel male partners when they visited the women.

Before the study, hospitals offered contraceptives to women treated for postabortion complications, but family planning services were located away from the wards, and there were no formal links between the wards and the family planning clinics. Postabortion family planning counseling helped increase women's use of contraception, researchers found. More than two-thirds of postabortion clients decided to use family planning, and more than 70 percent of those received a method before they left the hospital. Before the study, only 22 percent said they would use family planning, and 3 percent received a method before they left the hospital.[9]

In Bolivia, the Population Council worked with the Ministry of Health in a pilot study to improve postabortion care. Before the study, hospital staff had questioned postabortion patients to identify cases of illegal abortion and had charged higher fees to patients with symptoms of induced abortion. Abortion patients were offered emergency care then quickly discharged with no counseling.

During the study, staff established a special treatment and counseling area for postabortion patients, stressed interpersonal communications, and established a referral system for women needing other reproductive health services, including contraception. Hospital staff members' technical knowledge improved, as did their counseling skills.

Acceptance of contraception increased substantially. In 1995, postabortion contraceptive use was less than 15 percent in La Paz, Santa Cruz and Sucre. By 1997, acceptance had risen to more than 60 percent in Sucre and more than 80 percent in La Paz and Santa Cruz. One consequence of the changes was that the hospital began to treat more adolescent patients with postabortion family planning services as word spread.[10]

Another strategy to improve postabortion care is to make communities aware of services. In Zimbabwe, the POLICY Project educates young people about the dangers of clandestine abortion. The Amakhosi Theatre Group produced a play about an adolescent couple who succumb to peer pressure and have sex. The young man leaves when he finds out his girlfriend is pregnant, and the young woman seeks an abortion from a commerical sex worker. Complications occur and the young woman's parents take her to the hospital. She survives but cannot have children. The play ends with the mother warning the audience about the dangers of unsafe abortion, the need for immediate medical attention if problems arise and the importance of family planning counseling.

More than 2,500 people have seen the drama, which is used to generate discussions among community members, including city officials, health-care workers, village chiefs, traditional healers and clergy. Based on these discussions, researchers have recommended that adolescents receive more information about family planning and unsafe abortion.[11]

Because unwanted pregnancy can be the result of unwanted sex, provider training on partner violence, rape and assault is useful. In Mexico City, Ipas conducted workshops at three hospitals to make health providers aware of victims' needs, and Ipas launched a media campaign to encourage rape victims to report their assaults. Both activities are part of a larger effort to increase access to abortion among women who have been victims of violence.

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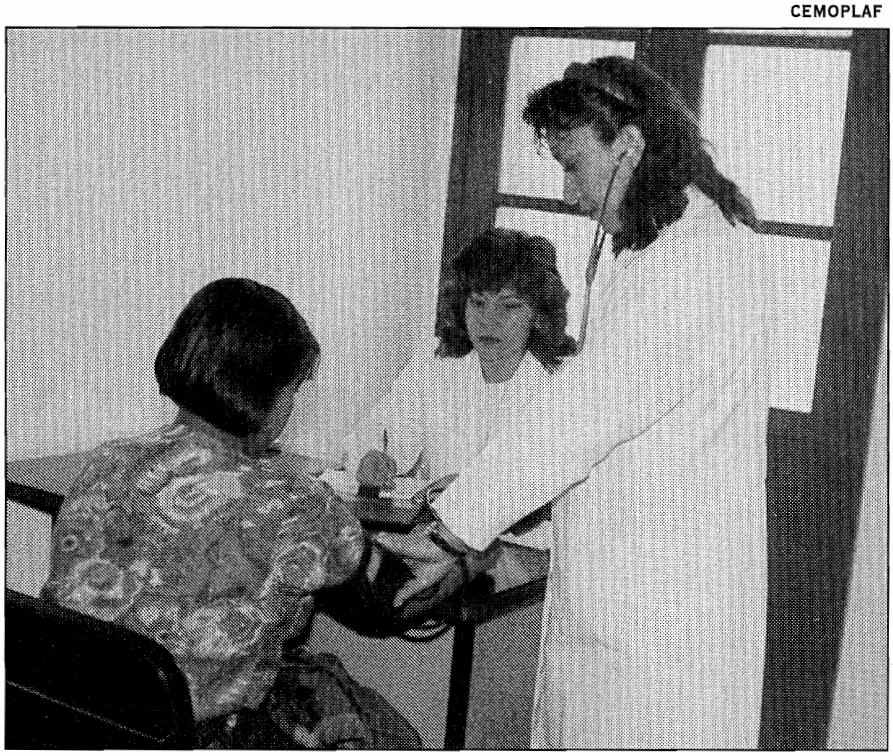

PROVIDERS AT A CLINIC IN QUITO, ECUADOR, TAKE INFORMATION FROM A CLIENT DURING HER INITIAL VISIT.

Another suggestion for improving postabortion care is decentralizing services, so that postabortion care is offered at health centers, in addition to hospitals. Ipas also recommends health workers be trained in manual vacuum aspiration, which uses suction to remove contents remaining in the uterus after an abortion, while the traditional method of dilation and curettage involves scraping the uterine wall. Aspiration can avoid the need for a hospital stay.

While maintaining good services is important, simple economic pressures play a role in a young woman's decision to keep a pregnancy or have an abortion — and even whether she can afford a safe abortion.

In Guinea and Côte d'Ivoire, young people told FHI researchers that a pregnant girl would consider whether she could afford visits to the hospital for checkups, medicine and better food, in addition to the long-term costs of raising a child and the father's willingness to assume financial responsibility. If she decided to have an abortion, costs often determine the method used. "Where they do not have enough money, I think that she will rely on indigenous means," one young man explained, referring to dangerous substances to induce an abortion or using falls and blows to the lower abdomen.[12]

— *Barbara Barnett*

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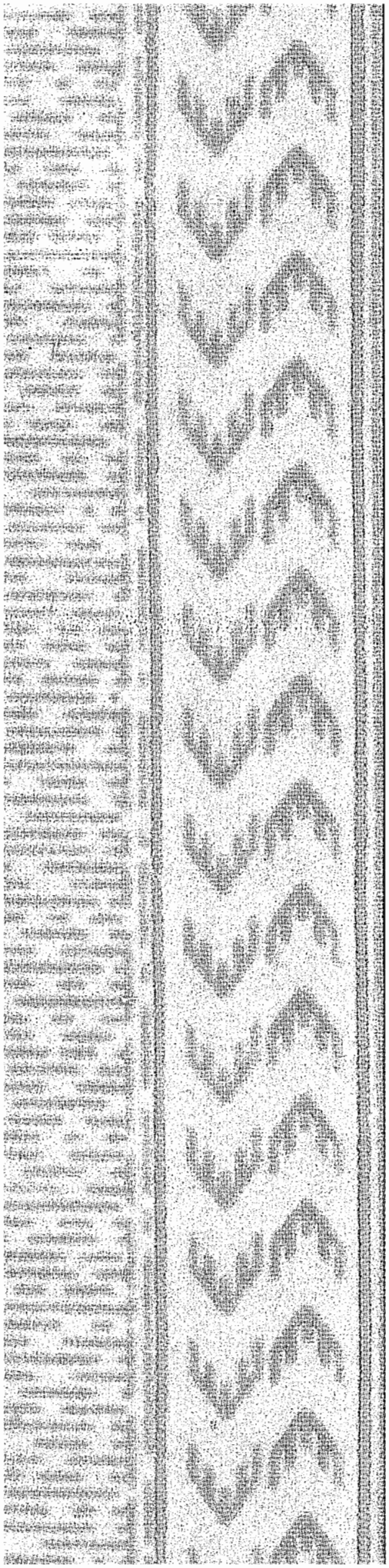


Some Cultures Tolerate Risky Male Behaviors

Risky behaviors among adolescent males can affect women negatively in many ways.

Boys generally engage in more risky sexual behaviors than girls, and many cultures are more tolerant of male adolescent sexual activity or may even encourage it. Also, adolescent boys tend to use alcohol and drugs more often than girls, which can lead to sexual risk-taking.

The role of manhood promoted in many societies may discourage young men from showing affection or other emotions while encouraging them to seek control, success and power. Such pressures may prompt boys to act aggressively, leading to injuries, accidents and homicides.[1]

In Mexico, for example, mortality rates for males and females are about equal until age 14, when male mortality begins to increase. Mortality is twice as high for males as for females among people 15- to 24-years-old. The leading causes of death for young men in Mexico are accidents and homicide.[2]

Many men feel stress as a result of not being able to live up to the expected norms of manhood. "There are clear patterns of sex differences in substance use and suicide rates, with boys in developing countries generally reporting higher rates of substance use and boys completing suicide at much higher rates than young women," concludes a World Health Organization (WHO) review of research on adolescent boys.[3]

These risky male behaviors affect women negatively, encouraging some men to have sex only for physical gratification, to have multiple partners and to treat women with little respect or even violence. Boys generally begin sexual relationships at an earlier age, have more partners and are more sexually active before marriage than girls. Also, boys frequently see irresponsible or abusive behavior toward women and girls, often within their own families, which can encourage them to act irresponsibly. As men grow older, these unhealthy behaviors may become more difficult to change.[4]

What boys need

Encouraging young men to avoid risky sexual behaviors can result in better reproductive health for everyone. In a larger context, helping young men to develop self-esteem and a sense of purpose in life can lead to better treatment of women and less risky behavior. But how can health programs help achieve these goals?

"Many views on adolescent boys have emerged out of a deficit perspective, looking at boys negatively and trying to get them to take more responsibility," says Paul Bloem, who directs a WHO project for adolescent males. "Instead of a negative, deficit-oriented view, we [at WHO] are trying to understand boys the way they are and see what they need for HIV prevention and for their health and development. By having healthy adolescent boys, you influence the health of girls as well."

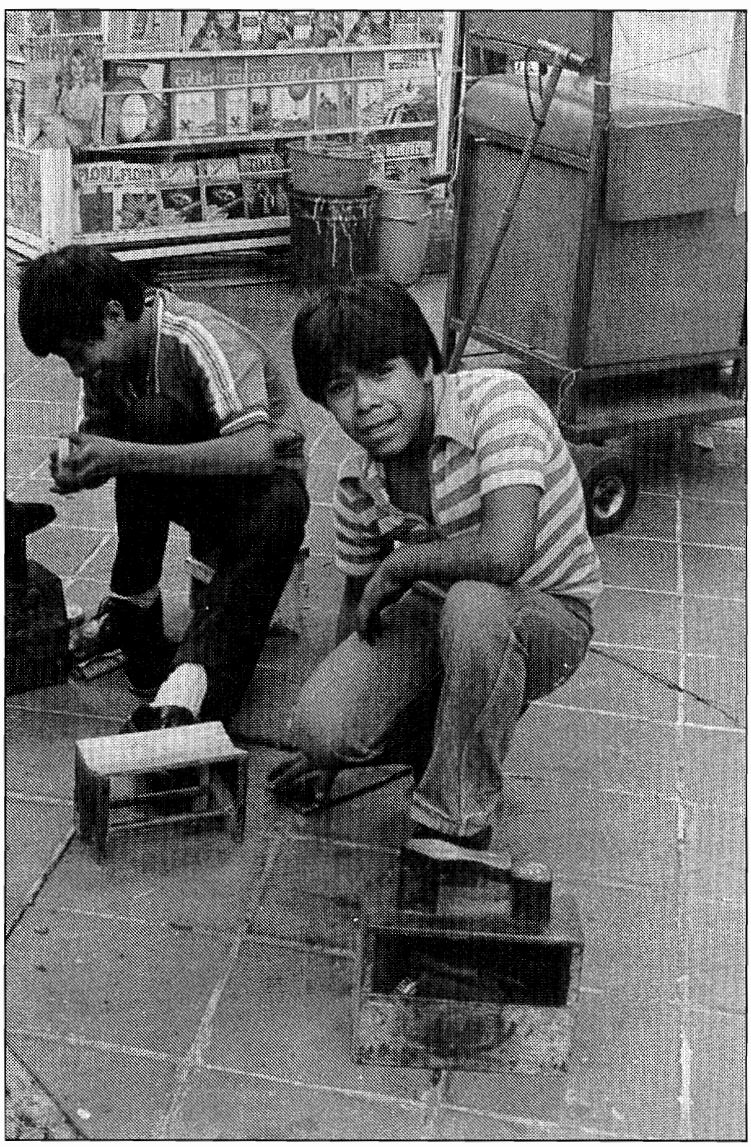
The best way to reach boys is to go where they are in the community. For example, the Gente Joven program of the Mexican Family Planning Association (Mexfam) initially opened three centers for

adolescents. But the program soon began using peer educators, youth councils, media and other techniques in order to reach boys in street gangs, in sports clubs, at work and in school. More than 1,500 peer promoters distribute information to other young men and women.[5]

"Young men have a lot to contribute and we should spend more time listening to them," says Errol Alexis of the Margaret Sanger Center International. "If they come with an idea and identify a way to achieve something, they are more likely to give their support." Based on his work in training peer educators in Namibia, Zambia and the Caribbean, Alexis believes boys are often willing to support women's rights to contraception. The peer educators worked through soccer clubs, military and police forces, and church groups.

In a low-income area of Rio de Janeiro, a year-long effort by Instituto PROMUNDO identified beneficial behaviors toward women, such as seeking relationships based on equality rather than sexual conquest. While none of the 25 young men in the study (ages 15 to 21) showed all characteristics all the time, several demonstrated some of the behaviors. Such activities as a mentor program and peer groups were used to nurture beneficial behaviors.

BERYL GOLDBERG



BOYS WORK ON THE STREETS OF MEXICO CITY. THE ROLE OF MANHOOD IN MANY CULTURES EMPHASIZES TAKING CONTROL AND BEING SUCCESSFUL, WHICH MAY ENCOURAGE SOME BOYS TO ENGAGE IN RISKY SEXUAL BEHAVIORS.

In the central India city of Jabalpur, CARE International is working with boys as part of an effort to improve the health care of adolescent girls in urban slums. Early in the project, CARE realized the need to reach boys as well. "They constituted an important influential category in decision-making," says Dr. Y.P. Gupta of CARE, who supervises the Jabalpur project. Boys often need information, counseling and reproductive health services as much as girls. Getting boys involved, however, was more difficult than reaching girls, he says. Very few boys participated initially but eventually were recruited through schools and youth groups. A Youth Health Convention for boys has promoted better reproductive health through posters, slogans and essays, quiz programs and street plays. More than 2,700 boys from slums and another 2,600 boys in schools have participated.

One important need of adolescent boys is basic knowledge of reproductive health issues. In the slums of Lucknow, a city in north India where premarital sex is traditionally taboo, a survey of unmarried boys ages 15 to 21 found that 8 percent were sexually active, but most had little knowledge of sexually transmitted diseases (STDs).[6] Another study found that sexually active rural and urban boys in the Indian state of Gujarat know little about STDs or how to use condoms correctly.[7]

USING MEDIA

Communication messages may be more effective if adapted to address male and female concerns, one study concludes.[8] In rural India, the Child in Need Institute has developed a kit that tells the story of Shankar, a 13-year-old boy. It uses flip charts and activities to educate adolescent boys about puberty, self-esteem, responsibility, contraception, safer sex, hygiene, STDs and childbirth. Kits with different topics are used with different age groups, but all of them focus on the theme of men being responsible for their sexual behavior.

Advertisements in Zambia, developed with a 35-person youth advisory group, include different messages designed to reach boys and girls. "The messages for girls emphasize abstinence more and helping girls negotiate condom use," says Elizabeth Serlemitsos, coordinator of the project.

"For boys, the emphasis is that safer behavior — abstinence or using condoms — makes you cooler or more desirable."

In one advertisement, a boy sees a pretty girl and says "with her I could even go live," referring to sex without a condom. His friends try to talk him out of it. Later, he has an STD, and the message says: "Guess who didn't use a condom?" The nationwide project, called Helping Each Other Act Responsibly Together (HEART), uses posters and broadcast advertising to encourage unmarried youth to abstain from sex or to use a condom.

Integrating reproductive health with other services may offer a way to reach adolescent boys. In a survey of health programs working with boys, managers reported vocational education as the primary need for boys, followed by counseling, places for boys to discuss their reproductive health concerns, and reproductive and sexual health services. The report recommended more research on "ways to expand integrated health and health promotion for adolescent boys that include the full range of their expressed needs."[9]

A study of 23 U.S. programs that involved young men in preventing teenage pregnancy summarized practical advice and philosophies of practitioners. Be knowledgeable about the community and find out what the participants know and are interested in learning, the study says. Using male staff was essential; offering employment training or recreation helped pave the way for providing reproductive counseling; and a playful, entertaining and nonthreatening approach to pregnancy prevention worked best. "Preaching responsibility can turn males off," the report says. "Instead, these programs try to change males' attitudes towards themselves, their relationships with women, and their futures."[10]

"Men are individuals with their own sexual and reproductive health needs," says Freya Sonenstein of the U.S.-based Urban Institute, which recently reviewed programs working with young men in the United States. "If we can empower men in this area, it will lead to greater gender equality." The review concluded that a comprehensive reproductive health strategy for young men should convey necessary information, foster skills development, provide access to clinical health care as appropriate, and promote self-esteem.[11]

— William R. Finger

JOHNS HOPKINS UNIVERSITY CCP/ZIHPCOMM

A STICKER DISTRIBUTED IN ZAMBIA BY A PROJECT CALLED HELPING EACH OTHER ACT RESPONSIBLY TOGETHER (HEART).

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Neighborhood Peer Educators in Mali

SÉGOU, Mali — The Ségou bus station, not far from the aquamarine waters of the Niger River, is a bustling transportation hub ringed by small shops and a colorful sea of traders carrying wares to market. It is also home to the only program that provides contraceptives and reproductive health services to adolescents in this small city and its surrounding rural region.

In a small but clean office on the second floor of the bus depot, two health educators greet young people who come by to ask questions, buy condoms or seek information on sexually transmitted diseases (STDs). "The office has become something of a drop-in center," says Boncana Haidara, a former midwife and now one of three professional health educators who staff the Programme des Adolescents (PRADO) office in the depot. "It is easier for a girl to tell us that she is worried about not getting her period than to tell her mother."

PRADO is an activity of the Association de Soutien au Développement des Activités de Population (ASDAP), based in the capital city of Bamako. In 1995, ASDAP became the first organization in Mali to develop contraceptive and reproductive health services targeting young adults.

Adolescents desperately needed these services, says Fatoumata Traoré Toure, ASDAP president. "We started as a pilot project for a year with support from the Centre for Development and Population Activities" (CEDPA), she says. "We trained peer educators and we found that it was an excellent approach." With support for a more comprehensive program, the effort has since been expanded to involve rural and urban zones such as Koulikoro, Koutiala and Ségou.

Girls and boys trained in counseling and other educational activities help promote contraceptive use among their peers.

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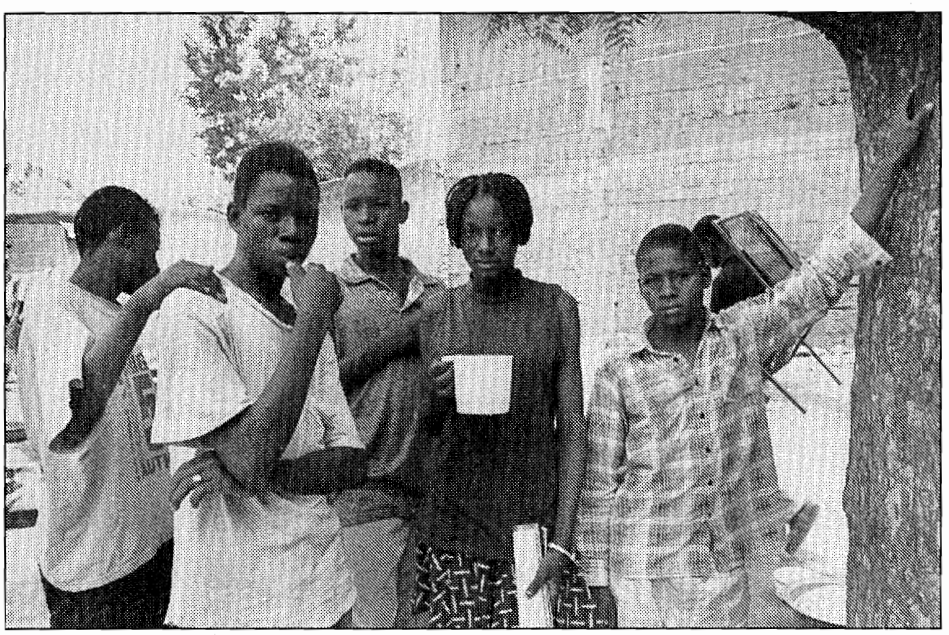


TEENAGERS GATHER AT A FAMILY COMPOUND IN BAMAKO, MALI.

The program in Ségou trains two or three young people in each neighborhood it serves to become peer educators. These educators are 10 to 20 years old, and of the 65 trained so far, two-thirds are females. "Girls talk more among themselves," says Haidara, who is convinced that working through girls is the way to reach other girls, and the earlier the better.

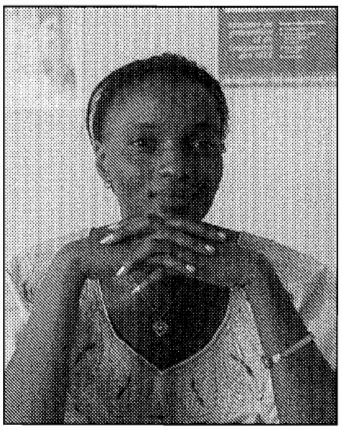
A 1999 survey confirms that young women want to know more, earlier. "If you could change the past," the survey asked, "which information would you have wanted to have about sex?" The most common response — by 41 percent of women surveyed — was that they wished that as adolescents they had known better how to prevent pregnancy and STDs and cited age 12 as the appropriate age to begin receiving information. Survey participants reported that lack of information was one obstacle to reproductive health in the Ségou region; other obstacles included distance to health services, lack of contraceptive methods and cost.[1]

Dr. Mohamadou Hachimi, health director for the Ségou region, points to the survey as evidence that new strategies are needed to serve young adults. But he says traditional values and societal pressures for recently married girls to prove their fertility discourage formal health services from reaching adolescents effectively. "In general, it is taboo to talk to young people about sexuality or reproductive health," Dr. Hachimi says. "Here it is taken badly if you talk about family planning with young people, but we need to, considering the problems of undesired pregnancies and STDs."

Another 1999 survey in Mali, conducted by CEDPA and the Futures Group International, found that about one in every four unmarried young adults in the Ségou

region reported having had intercourse at least once (23 percent of women and 27 percent of men ages 15 to 24). One in five (22 percent women, 19 percent men) reported having had a sexually transmitted infection in the prior 12 months, yet fewer than one out of 13 reported that they were currently using contraception.[2] "By 18 years old, 81 percent of adolescents in Mali have already initiated sexual activity," reported a nationwide Demographic and Health Survey.[3]

ELIZABETH T. ROBINSON/FHI



BONCANA HAIDARA OF PRADO.

TEA AND NOTEBOOKS

When PRADO peer educators organize discussion groups in their neighborhoods, they usually ask one of the three professional health educators to assist, primarily to provide support when difficult questions are posed. "They serve traditional tea with mint," Haidara explains and smiles. "ASDAP provides the tea."

Incidental expenses such as providing drinks for gatherings or gasoline for transportation can add up, and programs such as this often wrestle with issues of sustainability. To curtail expenses and provide an incentive for peer educators, PRADO encourages educators to sell condoms during discussion groups and similar events. Peer educators keep half of the proceeds for themselves, returning the rest to ASDAP. Young people who seek services in the office above the bus depot receive free counseling and pay a small fee to obtain condoms, spermicidal tablets or oral contraceptives.

Each peer educator keeps a notebook, recording useful details about home visits, discussion groups, or counseling sessions — themes discussed, number of female and male participants, how many were younger than 25 years old. Such information helps staff strengthen and focus their assistance.

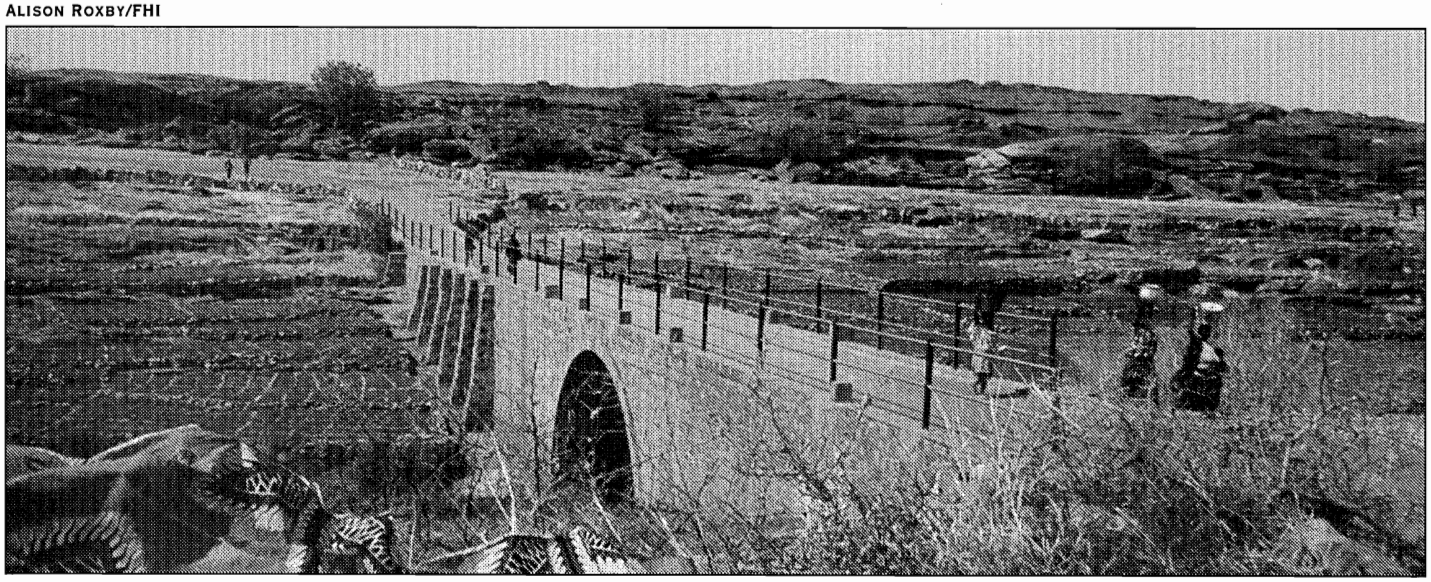
Certain health concerns, such as the health risks of female circumcision, are difficult to discuss. More than 83 percent of young women and men in Ségou report being willing to have their girl children circumcised.[4] The Bamako office provides audiocassette tapes on female circumcision to help initiate discussions. ASDAP also publishes an attractive magazine on adolescent reproductive health that targets young people, and is partly written by young people.

"You have to involve adolescents in everything you do," says Traoré, the ASDAP president. "You should not propose all the strategies. Young people themselves have a lot to add. You have to know how to listen to them. Young people do not like people to tell them what to do. Involve them, listen to them. If you arrive with preconceived ideas, you will not advance."

Many components of the PRADO program are consonant with World Health Organization (WHO) recommendations on action for adolescent health. For example, WHO's framework for country programming recommends providing information in a safe and supportive environment for young people and involving youth systematically.[5] The PRADO program offers young people a convenient place to access services, with both male and female educators at the bus depot office. The program is built on a framework of youth involvement, yet also sponsors events that involve parents and the community, including the school system.

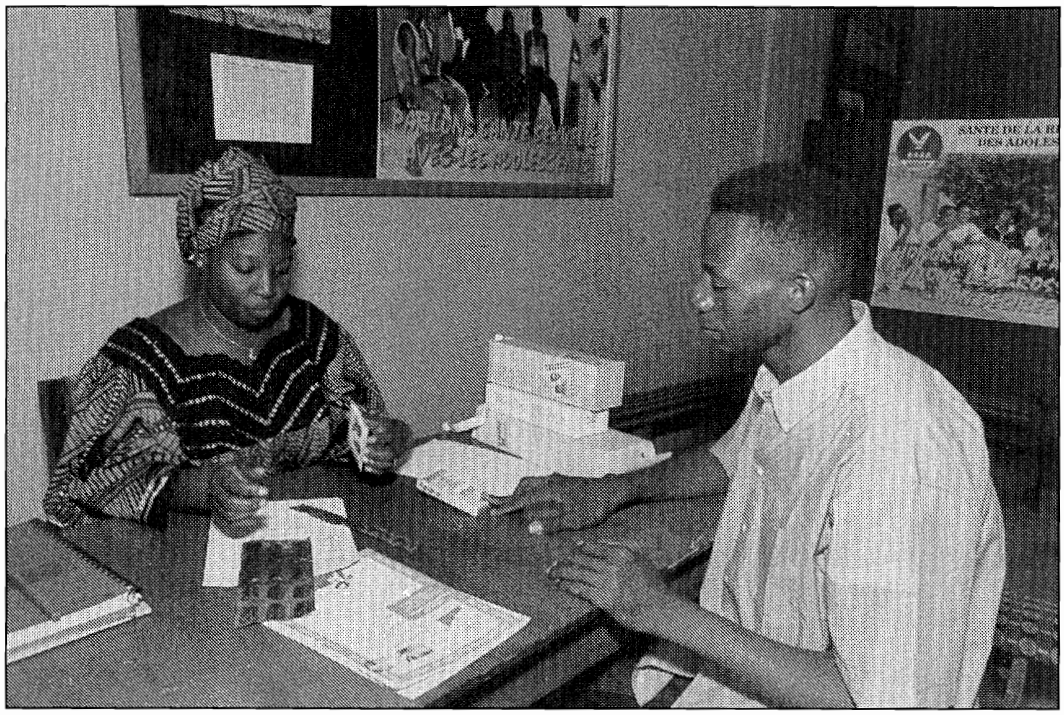
"Each month we go to the schools to explain what reproductive health is," says Haidara. "First we ask, 'What do you know about AIDS?' Then we point out which of their comments are true, and we get into more detailed explanations of points that need better understanding." In this traditional ethnic Bambara town, Haidara says,

ALISON ROXBY/FHI



WOMEN CROSS A BRIDGE IN RURAL MALI. A PEER EDUCATION PROGRAM IN MALI CALLED PROGRAMME DES ADOLESCENTS (PRADO) HAS EXPANDED TO SERVE YOUNG ADULTS IN BOTH URBAN AND RURAL LOCATIONS.

BERYL GOLDBERG



FAMILY PLANNING COUNSELING IN A BAMAKO, MALI, CLINIC IS AN ACTIVITY OF ASSOCIATION DE SOUTIEN AU DÉVELOPPEMENT DES ACTIVITÉS DE POPULATION (ASDAP), WHICH ALSO OPERATES THE PROGRAMME DES ADOLESCENTS (PRADO).

the subjects of reproductive health, family planning, STDs and sexuality are taboo in family discussions. But young people are hungry for information. "Some students ask about monthly periods, consequences of abortion, STDs, and how to take pills," she says.

Haidara says being an effective health educator takes persistence and a high level of comfort in talking about sensitive issues. "I think you really have to work at *continuing* to communicate and raise awareness of the issues," she emphasizes. "The staff have to be very comfortable with young people and with the subject of reproductive health. Every single day you see a new face, so you have to keep working."

NEIGHBORHOOD WOMEN

Even in Bamako, where health services are more widely available than in Ségou, there is an urgent need for adolescent services. In some neighborhoods, individual women pick up the slack, often addressing a range of needs including health, education, employment and recreation.

Aminata Barry Toure, who organizes biweekly discussion groups on reproductive health for adolescents in the Doumanzana neighborhood of Bamako, says young people need information to make responsible choices. "There is a lot of boredom," says Barry, president of the Association Malienne pour la Sauvegarde du Bien-être Familial. "Young people initiate sexual activity even at 15 or 16 years old. ... There are no cinemas, no places for games. There is nothing to do but have sex."

Barry is known among young people in her neighborhood for her activism. She raised funds to purchase a donkey, allowing teenagers to earn money by carting away neighborhood trash. She spearheaded the establishment of a dispensary in Doumanzana, possibly the only neighborhood clinic in Bamako with laboratory facilities and reagents to do tests for gonorrhea, syphilis and sickle cell anemia.

"Here we do not talk in the family about sexuality," continues Barry, a professional accountant and mother of six. "It is thought that if you do this, you are pushing them into making love. We think it is best if they wait until they are married. But kids are sexually active anyway. They just hide it."

It is a hot afternoon, and the dusty streets are filled with young people. Barry sends out the word, and soon a group of teenagers assembles in a simple, dirt-floored preschool her organization built for children of market women. They speak openly about sex and reveal fears stemming from both lack of information and misinformation, such as the incorrect notion that condom use can cause a woman to hemorrhage.

One student wants to know whether a woman can get pregnant if a man's preejaculatory fluid and a woman's natural lubrication touch outside the body. The young people laugh at each other's questions but listen intently to the answers. "How can you withdraw without leaving the condom inside the woman?" a boy asks. "How long does it take for a woman's fertility to return after using oral contraceptives or Depo [Provera]?" a girl asks.

Many of their questions are practical. Others address deeply ingrained cultural perceptions, such as the notion that forced sex is a matter of passion, not violence.

When a young woman says she has friends who have been raped, boys jump in and say "men cannot control themselves" and "between men and women it is fire and gas: if they get together everything catches fire!" It is clear that many of the young people in the group are aware of forced sex, and attitudes towards it vary along gender lines. Nationwide, one out of five young women reported that their first experience with intercourse was not consensual.[6]

"The important thing is opening the channels of communication with young people," Barry says. Not many adolescents come to the dispensary for contraception, she says, but many others seem interested in the discussion groups. Many participants purchase condoms after such talks, when she has them.

Sitting in her office, her normally cheerful face is pinched. She mentions that a young girl she knows recently died from an abortion. "The news has really hit me hard," she says. "She was so beautiful. Really beautiful."

Barry wants to create "listening centers" for young people, where trained adults and peer leaders would listen and give advice, including referrals for medical care. She envisions renting or building a youth center with a video machine and conference room where young people could get together. Perhaps if mixed groups of boys and girls learn to begin talking at an early age about relationships and how to prevent pregnancy and STDs, she muses, the stage will be set to discuss reproductive health decisions as couples.

In this context of widespread poverty and insufficient health services, women leaders such as Barry are playing an important role in identifying and filling the gaps. "Health, family planning, legal aspects of female circumcision, small commerce and income generation, gardening, the care of young children and girls, environment, reforestation," Barry lists, and sighs. "Women do everything."

— Elizabeth T. Robinson

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News Briefs

Continued from page 2

100 women at seven years, the investigators wrote in the March 2000 issue of *Contraception.*

These studies also support previous observations that risk of pregnancy among Norplant users increases with weight and decreases with age. Over seven years, there were no pregnancies among women who weighed less than 50 kilograms (110 pounds) upon admission. A small number of pregnancies increased with higher weight groups and decreased by older age groups.

Contraceptive Patch

A study involving 610 women has found that an experimental contraceptive patch applied to the abdomen suppresses ovulation as effectively as oral contraception.

The study by U.S.-based Robert Wood Johnson Research Institute, a subsidiary of the pharmaceutical firm Johnson & Johnson, compared the degree to which ovarian activity was suppressed over four menstrual cycles by patches containing norelgestromin and ethinyl estradiol versus pills containing norgestimate and ethinyl estradiol. A 20-square centimeter patch was as effective as the pill in suppressing ovarian activity, which was determined by measuring serum progesterone levels and ovarian follicle size.

The patch regimen for each menstrual cycle consisted of three consecutive seven-day patches, followed by a patch-free week. The contraceptive pill regimen consisted of 21 days of pills, followed by a pill-free week. The institute's findings were presented at the May 2000 meeting of the American College of Obstetricians and Gynecologists in San Francisco. □

The "Ashe" Experience in Jamaica

By Michael Holgate
Ashe Performing Arts Academy and Ensemble

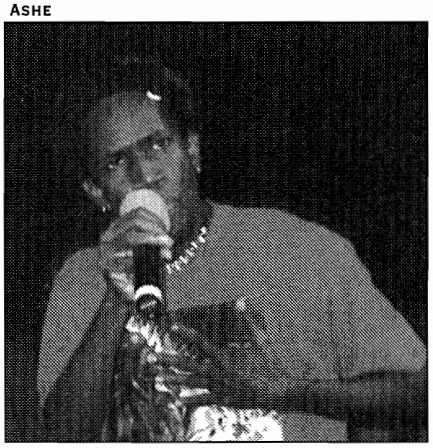
KINGSTON, Jamaica — Think back to that time when you seemed to have so much on your mind about becoming an adult and how unprepared you were to deal with so many issues, especially those involving sex.

That time is fraught with challenges, uncertainties, unfounded fears, internal conflicts and being confronted with a new you, in a new body, with new feelings — and often with little help. This is adolescence.

Worse, instead of getting constructive help through reliable information and supportive comments from others, you may receive just the opposite — incorrect information and discouraging comments that only promote unfounded fears. This only deepens your confusion.

Now, try to imagine yourself in a dark room with so many pent-up emotions, frustrations and ignorance. Someone comes inside and turns on the light, and fears dissipate with correct information. That is the Ashe experience.

ASHE



MICHAEL HOLGATE OF ASHE.

Ashe is a performing arts company whose mission is peer education and personal development. "Ashe" is an African word that means many things, but fundamentally refers to one's inner strength and self-respect.

As an Ashe performer since my teenage years, I know that we operate on two levels. As actors, performing is vital to our own personal growth, just as we hope our performances and interactive workshops help participants with their personal development.

I have been privileged to understand my own sexual development so much better by performing theater through Ashe, and I believe our performances inform and inspire the many people who come to watch — other youth, parents and adults who work with youth among them.

I am a product of this personal development experience, which uses a model built upon three ideas described in the letters "EIC:"

- "E" stands for "excite the youth," which Ashe does very well, as one of the most prominent and popular performing arts companies in Jamaica.
- "I" stands for "involve the youth." This idea refers to the training Ashe conducts in singing, dancing and acting, as well as its performances and workshops.
- "C" stands for the "commitment" youth make.

As young people explore sexuality and develop into young adults, it is not enough for teachers, parents and others to let them fend for themselves, especially in a world with AIDS and other sexually transmitted diseases (STDs) running freely like mad dogs.

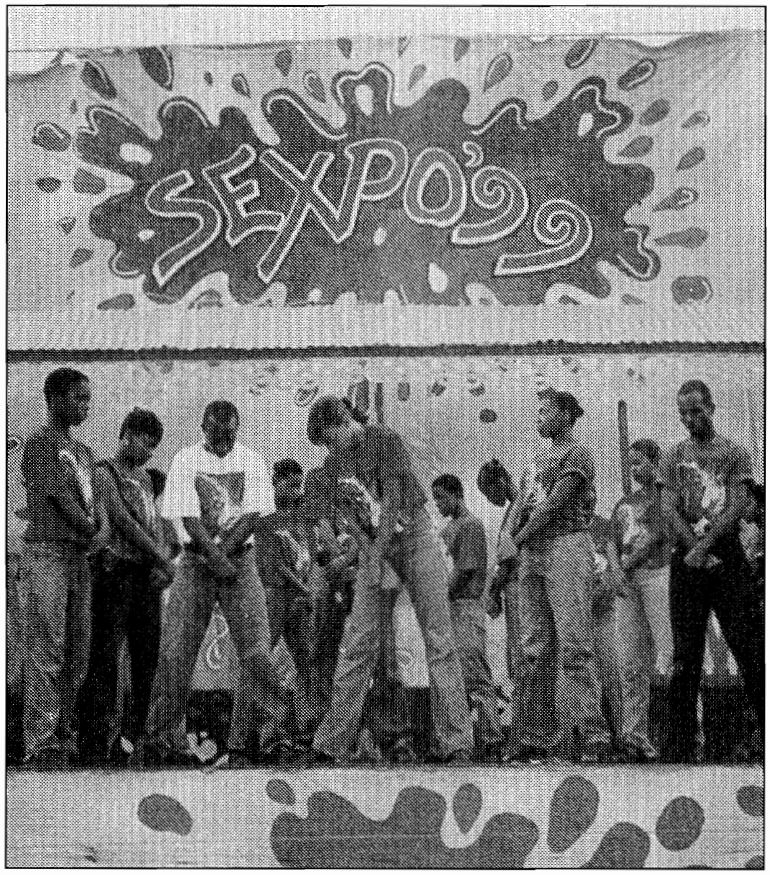
Cultural taboos against open discussion, repressive beliefs and any number of personal insecurities can place a muzzle upon the mouths of parents and teachers, even when they would like to help young adults protect themselves from disease or unplanned pregnancy. Risky sexual behavior is so much more likely within the dark room of ignorance where so many young people find themselves as they begin their passage into sexual maturity.

When the light is turned on through the Ashe experience, there is freedom to share ideas, information and truths about the sexual world. Ashe helped me accept my sexuality and accept myself as a sexual being. It made me aware of the importance of protection against STDs before I became sexually active with another person. Ashe empowered me as an individual, helping me understand that the love and appreciation of myself are necessary parts of my decision to protect myself.

BUILDING SELF-ESTEEM

Building self-esteem is an important part of the Ashe experience. Self-esteem can become a binding thread in the fabric of everyday life, interwoven into so many activities and attitudes. In the performing arts, your body and mind shape the patterns that

HALLY MAHLER/FHI



AN ASHE PERFORMANCE IN JAMAICA INVOLVES MANY YOUNG ACTORS.

become the fabric of your craft, but it is self-esteem that must run throughout this pattern to make it strong. Personal development is needed in order to excel because the craft of performing is YOU.

A good way to learn something is to teach it. That is how I gained my own self-esteem. I learned the language of self-esteem on stage. I learned what it takes to express self-esteem in my own life. At Ashe, the love and appreciation of self is integrated into how we function as a unit. It is like a child learning to speak, learning language in order to understand other people better. If I had not learned the language of self-esteem, I would not have become the performer I wanted to be.

Sex education through the performing arts easily communicates with the core of a person's being. I played the role of "Uncontrollable Urge" in our musical called *Vibes in a World of Sexuality.* Even in playing a negative character or role, important feelings and information can sink down deep into your core. What sinks down is "look at the havoc I am wreaking as Uncontrollable Urge — is this really how uncontrollable urges affect my peers, my friends ... me?"

This kind of performance leads to self-analysis, which in turn leads to action. At this stage of my life, I can say I have avoided certain consequences associated with unsafe sexual practices. But what of all the many young people told about the dangers of the sexual world? Why do some still take risks and suffer the consequences? Well, that is just it — they have been "told."

There is a stark difference between being told something is so and knowing it. Young adults are preached to about any number of things. We learn to deal with this early — we simply tune out. But I never have the option of tuning out from something I must perform. In order to present it to the best of my ability, I must pay attention.

An important aspect of the Ashe approach is discussion sessions with the audiences, usually our peers, after we perform. This allows performers and audience members to communicate one-on-one about reproductive health. It offers an opportunity to think about all the things we are learning, because we can hear how these issues affect other lives.

It also allows us to break many barriers, to be more comfortable with our own sexuality. For example, the whole issue of masturbation can be an embarrassing thing to talk about, perhaps because there is only one person involved in this activity and hence, one person to take responsibility.

In Ashe discussions, we change the word associated with this activity to make it easier to discuss. All teenagers want to drive a car and get their license, so "masturbation" can be described as "driving." And so young adults can more freely discuss driving, and their concerns about driving, yet know that we are really talking about masturbation.

As a performer and facilitator during discussion sessions and workshops, I am keenly aware that my own levels of comfort and self-respect are important. Any insecurity participants sense from me as a facilitator will only make them less willing to share their experiences and concerns, and will limit their ability to benefit from the experience.

The most beautiful thing about the Ashe experience is that it is so transferable — those of us who perform build a level of comfort and understanding, and we share this with our peers. Young adults who attend our performances and workshops build upon their own self-respect and expand their knowledge about a range of reproductive health matters.

Ashe performer Michael Holgate, 27, has been a member of the Jamaican theater group since he was a teenager. The troupe addresses reproductive health issues through performances, audience discussions and workshops. □

Reproductive Health Merit Badge for Scouts

Because they often lack autonomy, decision-making skills and access to information and services, adolescents are vulnerable to a host of reproductive health problems.

For adolescent refugees, this vulnerability is compounded by violence, separation from family and poor living conditions. Health programs typically focus on the provision of emergency services, such as clean water and sanitation, and reproductive health programs are usually designed for pregnant women and their infants. Little attention is given to young people who have questions about puberty, menstruation, sexuality or relationships.

To address the unique health needs of adolescent refugees, the World Association of Girl Guides and Girl Scouts (WAGGGS) and FHI developed a comprehensive training and peer education project. The Health of Adolescent Refugees Project (HARP) allows young women to earn a merit badge by completing a series of activities that include teaching others about reproductive health. A two-year pilot project in Uganda, Zambia and Egypt, financed by the United Nations Population Fund, concluded in 2000, and an evaluation by FHI found the program was successful in improving young girls' use of health-care services and their self-esteem. Using local funding, scouts continue to earn the badge in each of the three countries.

"One of the most important things we accomplished is that we proved you can offer reproductive health education to adolescent refugees," says Lindsay Gilbert, a WAGGGS project and program development executive. "We proved you can provide education that can change knowledge and behavior. The girls who participated in the project told us they had ambitions and hopes for the future. Families were also able to learn from their daughters."

In each country, 10 women, most of them refugees, were trained to be group leaders. In Uganda and Zambia, 600 girls living in refugee camps initially participated in HARP, while in Egypt, 100 refugee girls living throughout Cairo participated.

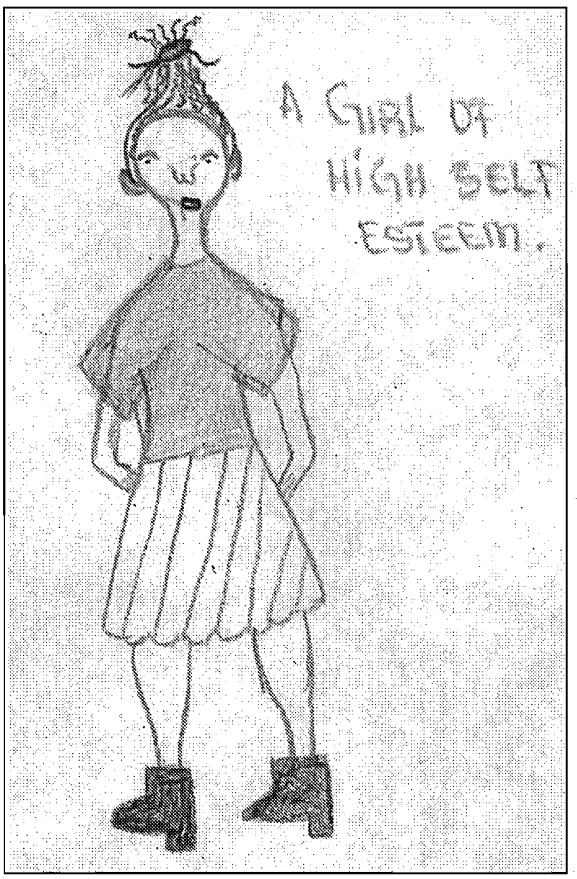
To earn the badge, girls participate in educational activities and attend sessions where they discuss health topics, including the female reproductive system, physical and emotional changes during puberty, relationships, the human body, nutrition, hygiene and disease prevention. Three different curricula were developed: one for girls ages seven to 10, one for ages 11 to 14, and one for ages 15 and older. Topics vary by age, with girls ages seven to 10 learning about physical and emotional changes during adolescence, girls ages 11 to 14 learning about sexually transmitted diseases and pregnancy prevention, and girls ages 15 and older learning about healthy pregnancies and baby care.

Girls must complete other compulsory and optional activities to earn their badges.[1] Compulsory activities vary by age but center on developing a notebook of drawings girls prepare to share with friends. For example, during HARP, girls ages seven to 10 were asked to draw pictures of the human body, while girls ages 15 and older were asked to draw illustrations of maternal-child health. In addition, girls used the notebook to store materials from other HARP activities, including journals about their menstrual cycles, songs or poems written to honor an important woman in their lives, or a quiz for peers on HIV transmission.

To earn their badges, girls serve as peer educators in their communities and must reach at least 25 other girls through informal group discussions, one-on-one visits, distribution of educational materials or formal talks.

CYNTHIA WASZAK/FHI

GIRL GUIDES PARTICIPATE IN THE HEALTH OF ADOLESCENT REFUGEES PROJECT (HARP) IN MEHEBA REFUGEE CAMP, ZAMBIA.



A DRAWING FROM A GIRL'S NOTEBOOK IN THE HEALTH OF ADOLESCENT REFUGEES PROJECT (HARP).

Girls can also earn bronze, silver or gold certificates for additional tasks, such as planning and preparing a healthy meal, performing a drama based on health themes or developing a list of recommendations for health agencies that work with adolescent refugees. All tasks focus on passing knowledge along to others.

In evaluating HARP, FHI found that participants understood general health messages about puberty, personal hygiene, sanitation and nutrition. However, girls had a harder time comprehending more complex topics. For example, some girls did not understand the "safe" period of the menstrual cycle. Reasons for this may have been that educational materials were printed in English, not local languages, and that text was rarely illustrated. Also, guide leaders had experience with teaching methods that emphasized rote learning rather than student participation. In addition, concepts such as "gender" and "self-esteem" were new to the girls and difficult to explain.[2]

Besides increasing girls' knowledge about health, HARP gave participants a safe place to gather, an outlet for creativity and an opportunity to have fun — elements often missing from the lives of young female refugees. Also, HARP gave young women a chance to interact with older women who are caring, nurturing role models.

A problem in implementing the project was that many adolescents were reluctant to discuss some reproductive health issues. Some girls in Zambia were embarrassed by drawings of the uterus. Others were embarrassed when boys made comments about their notebooks. Some did not want to take the notebooks home for their families to see.

HARP also benefited adults who worked with adolescents. One project coordinator gained new knowledge about reproductive health. "It is a shame that I did not know some of these things until I was 30 years old, but at least I know them now," she says. Others say HARP participation increased their status in the community. "I am famous in my village now," says one of the leaders in Uganda. And national coordinators working with the project say they gained empathy for refugees. Says one trainer in Egypt, "I never saw these people in our communities before, but now they are visible to me. Now they see me in the market and call out to me, and I know they are here."

Although HARP was designed exclusively for girls, an important lesson learned was the need to develop activities for adolescent boys. "It became clear that the communities wanted the boys involved as well," says Gilbert. "As a girl learned about family planning, it was difficult to put what she learned into action if she didn't have the understanding of her male partner."

Male involvement will be a central component of a new project by WAGGGS and FHI. The Healthy Adolescent Project in India (HAPI) will work with the Bharat Scouts and Guides Association to adapt the HARP curriculum for boys and girls, offering different programs for ages 10 to 13 and ages 14 and older. The project, which will be conducted at seven sites in West Bengal, is funded by the David and Lucile Packard Foundation.

HAPI hopes to reach thousands of youth through peer education. Health providers also will work with scout and guide groups, giving talks during meetings, promoting adolescent health at special events, and conducting tours of local health clinics for young people.

"What is most exciting about these programs is that we are reaching adolescents with health information just as they are forming life-long attitudes and habits," says Matthew Tiedemann of FHI, who works with HARP and HAPI. "We are reaching them through an established, trusted network — guides and scouts — and we are applying the lessons learned from HARP to the HAPI project. We hope there will be opportunities to adapt the program in even more countries."

— Barbara Barnett

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Encouraging Youth-friendly Clinics

Inconvenient hours or location, unfriendly staff and lack of privacy are among reasons many young adults give for not using reproductive health clinics.

A campaign in South Africa is trying to address such concerns through a certification process in which clinics that meet certain standards that help youth will receive recognition.

Plans for the project draw on such models as the "gold star" campaign used in Egypt to indicate family planning clinics that meet national standards for good service quality. The Egyptian campaign uses television messages and posters to promote the gold star clinics. The South African campaign plans to use the stars to help adolescents identify clinics that might be more friendly to their needs.

"We need accessible clinics with nonjudgmental, friendly staff and reduced waiting times," says Kim Dickson-Tetteh, who is coordinating the initiative through the Reproductive Health Research Unit (RHRU), University of the Witwatersrand in Soweto, and the South Africa Department of Health. The campaign seeks to make health-care services more accessible and acceptable to adolescents, to establish national standards and criteria for adolescent health care in clinics throughout the country, and to help health-care providers improve their delivery of adolescent-friendly services. Called the National Adolescent-Friendly Clinic Initiative (NAFCI), it is funded by the Henry J. Kaiser Family Foundation and is part of a public education program called Initiative Lovelife.

What adolescents like

Adolescents have indicated what they would like to have in clinic services. A study by the Washington-based International Center for Research on Women, based on research with adolescents in Africa, Asia, Latin America and the Caribbean, recommends that reproductive health services for youth be private, confidential, affordable, accessible and staffed with sensitive providers.[1] At a youth information center set up by the Planned Parenthood Association of South Africa, youth said the most important factors determining their choice of a clinic were staff attitudes, location and atmosphere, contraceptive methods available and clinic hours, in that order.[2]

"The circumstances vary extensively regarding what kinds of clinical services will best serve youth," says Dr. Cynthia Waszak of FHI, who has evaluated adolescent programs throughout the world. "Sometimes youth want service centers just for youth. Other times they want them integrated into existing clinics. The most important thing is to ask youth and providers in a particular community what they want and what will work best for them."

In many countries, the attitudes of providers have discouraged even married adolescents. One study of services for married teenage women found that providers in some countries refuse to provide services until the young wives have given birth.[3] In countries where women typically marry in their teenage years, another study found that it is often difficult for teenage married women to reach clinics, emphasizing the need for outreach workers who can assist newlyweds.[4]

FOCUS on Young Adults, implemented by the U.S.-based Pathfinder International, has developed workbooks to score clinics on the quality of their services to youth. The workbooks examine four areas: the facility itself, including operating hours, location and privacy; staff performance, including respect shown to clients, confidentiality and adequate time for interaction; administrative procedures, such as whether fees are affordable and whether drop-in clients are welcome; and how youth perceive the clinic's services.[5]

"Evaluation is still very limited on how effective such projects [to attract young adults] are — or can be," reports Judith Senderowitz, a consultant for the FOCUS project. "Furthermore, most demonstration activities have looked mainly at the overall effects of the program design and, therefore, cannot attribute results to specific youth-friendly components."[6]

The FOCUS review identified efforts to promote youth-friendly efforts in prenatal, postpartum and postabortion programs, primarily in hospitals, in Brazil, Chile, Ghana, Kenya, Mexico and Nigeria. In Brazil, when a hospital offered specific hours, counseling, education and contraceptives through outpatient services to adolescents, 50 percent of the young women patients returned after birth or abortion for these services.[7]

Innovative services for youth have been developed in general clinical settings in many other countries. In Zambia, for example, the Lusaka Urban Youth-Friendly Health Services project used participatory needs assessments and learning exercises to involve community leaders and parents. The project provided education on contraception and prenatal care at seven clinics, two of which also had peer educators. The number of youth using the clinics doubled as a result of the project, with significantly more nonpregnant teenage girls seeking counseling and contraceptive services.[8]

The South Africa certification program has developed what it calls an "essential service package of adolescent-friendly services" drawing upon World Health Organization recommendations for primary health care services. Standards have been developed based on research of what adolescents say

they want in clinical services. The standards include policies and processes that support adolescents' rights, a physical environment conducive to the provision of adolescent-friendly services, and the provision of psychosocial and physical assessments of youth.

An innovative aspect of the South Africa effort is that the clinics themselves determine how to make their services more youth-friendly. "If the clinic staff members find that they do not meet the standards, then they determine what they should do to move in that direction — such as reducing waiting time or training staff to provide adolescent-friendly services," says Dickson-Tetteh of RHRU.

Involvement in the steps toward certification means the staff understand what they need to do and become more invested in the outcome. "Using this self-assessment approach gives the clinics the opportunity to look at themselves and their operations," says FHI's Tara Nutley, who participated in a meeting of international experts who helped plan the project. "It is a valuable part of the process."

While helping clinics to be friendly to youth is important, some analysts emphasize that clinic-based services alone cannot serve the needs of all youth. "We have to design services that reach out into the community, to where the youth are. Otherwise, many adolescents will never get the services they need," says Nutley.

Developing community-based programs that provide such services as contraceptives and counseling is challenging, however. Annabel Erulkar and colleagues at the New York-based Population Council recently evaluated 14 community-based youth centers in Kenya, Zimbabwe and Ghana. Centers typically offered recreation, vocational education or a library along with reproductive health services.

By offering other activities, centers attempt to be more attractive to youth. However, youth centers are often stigmatized by the community and youth themselves. "Many youth, especially girls, do not want to be associated with family planning organizations because it suggests sexual activity or because young people brand them as places for those with sexually transmitted diseases," concludes an evaluation. Those who do visit the centers are older youth, averaging 21 years of age in Zimbabwe. In Kenya, about nine of every 10 clients were over age 20 with a quarter of them older than the upper limit of 24.

The evaluations also found that staff are highly knowledgeable but are often judgmental. Asked how he would respond to an unmarried girl seeking contraception, a Kenyan provider said, "I would reverse her mind and tell her not to have sex," an attitude that would discourage sexually active young adults from using contraception.[9]

— William R. Finger

GISELLE WULFSOHN/PANOS PICTURES

A PROJECT IN SOUTH AFRICA IS PLANNING WAYS CLINICS CAN BE MORE APPEALING TO YOUNG ADULTS. THESE COLLEGE STUDENTS RELAX AT A POPULAR GATHERING PLACE NEAR THEIR CAMPUS IN SUBURBAN JOHANNESBURG, SOUTH AFRICA.

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OPINION

The Need to Evaluate Youth Programs

By Nancy E. Williamson, PhD
Senior Associate for Global Operations Research
Frontiers in Reproductive Health

Today's young adults are our future. Their energy, leadership and wisdom will shape the world during this new century. They will care for our own generation as we grow older and they will nurture the next generation to come.

Consequently, protecting their good health is a vital concern for all of us. Effective strategies and programs to protect the reproductive health of young adults are needed in every country, but are especially urgent for youth in developing countries.

Around the world, thousands of young women die each year from complications due to an unplanned pregnancy, many of them resulting from clandestine abortions (see article, page 16). And in 18 African countries, at least a third of today's 15-year-olds are expected to become infected with HIV during their adult lives and will die from this terrible disease (see page 2).

For developing-country adolescents to avoid unplanned pregnancies, disease and other serious reproductive health problems, they need accurate information and services. We need a variety of carefully designed school-based programs, community efforts and responsible mass media messages to help educate youth.

In the abstract, what youth need for good reproductive health is easy to identify. Young adults need a basic understanding of how their bodies work and the reproductive health concerns they face, as can be provided through family life education (see article, page 10). They need ways to develop stronger interpersonal skills (for example, how to avoid unprotected sex). They should know about specific health services available to them (treatment for sexually transmitted diseases, contraception and postabortion care) and how to obtain commodities (condoms and other contraceptives, drugs for treatment and educational materials). They should be aware that the choices they make today could help or harm them and those they love, perhaps with lasting consequences.

However, specific approaches to meeting adolescent reproductive health needs vary considerably. Some programs take a holistic approach to youth development while others favor a more targeted approach to reproductive health. Approaches include family life education in schools, media campaigns (print and broadcast media), peer education programs, youth centers, telephone hotlines, theater groups and postabortion or postpartum programs. Some religious-based programs and sports programs are involved in reproductive health strategies for youth, as are a variety of other projects: social marketing of condoms to youth, HIV counseling and testing, efforts to keep youth in schools, job training, discouragement of early marriage, and premarital counseling

among them. Most current programs are on a small scale. (A recent review of youth programs in developing countries has been prepared by Judith Senderowitz, a consultant who has written extensively on adolescence.)[1]

Only a tiny percentage of the world's resources is devoted to helping youth in developing countries realize their potential. Given the huge numbers of youth and the seriousness of the problems, there is a temptation to commit all available resources to action programs and just "get on with it." Evaluation may seem like a luxury.

Limited resources

But get on with what? Hard decisions must be made about how to allocate very limited resources. Many programs reach youth long after they need the information rather than when the information is most crucial. Other programs may not deal with the most pressing concerns facing youth. Health professionals and program managers lack adequate information on cost-effective ways to reach the largest number of youth, including both boys and girls, different age groups, in-school and out-of-school youth, and unmarried and married youth.

Jerry Markatos/FHI

Nancy Williamson of FHI and Frontiers in Reproductive Health.

Take the example of youth centers, places where adolescents can congregate for recreation and also have access to reproductive health services or information. At first glance, this seems like a reasonable approach. But a recent evaluation of 14 centers in Africa found that youth centers typically serve small numbers of youth (often older males), are not particularly good places to deliver reproductive health information and services, and are relatively expensive.[2]

Other researchers have found that youth centers in Mexico were less cost-effective than a community youth program in recruiting family planning users.[3] On the other hand, postpartum programs such as one in Jamaica and another in Mexico have been quite successful in encouraging adolescent mothers to postpone a second pregnancy.[4] Regrettably, information on cost-effectiveness is lacking for most adolescent programs in developing countries.

How can program managers monitor the impacts of different approaches and the resources required? How does one choose which approaches are more successful and should be expanded? Below are key questions managers might ask:

- What behaviors is the program trying to change? Is the program preventive, curative, or both? Once these key features are identified, meaningful core indicators can be developed.
- Are the planned activities targeted toward changing those behaviors?
- Is the program targeted to all youth in a geographical area or is it focused on a specific group (e.g., older or younger youth, boys or girls, in-school or out-of-school youth, married or unmarried youth)? Will it serve only the youth who come to the site?
- Is the program having an impact beyond the changes that one would expect as young people mature?
- Is the program having an impact beyond other changes occurring in the project area? (Comparing the area being served with a similar "control" area that is not being served will help determine this.)
- What are the additional costs required to implement the program?
- Would the money be better spent on another kind of program?
- If the program does have an impact, can it be sustained?
- If successful, can the program be expanded?

The Frontiers in Reproductive Health project of the Population Council and its partners, FHI and Tulane University, are addressing these questions for youth programs in Mexico, Bangladesh, Kenya and Senegal. A strategy to improve the environment for adolescent reproductive health and to make services more youth-friendly is being compared with a strategy that includes both of those elements plus a school-based program. The cost-effectiveness of the two strategies is included in the evaluation.

Careful monitoring and evaluation are urgently needed precisely because the needs of our youth are so important.

Dr. Williamson is seconded from FHI to the Population Council to work on the Washington-based Frontiers in Reproductive Health. The U.S. Agency for International Development supports this worldwide operations research project.

Additional reading

Two recent publications to help evaluate youth programs are: *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs* by Susan Adamchak, Katherine Bond, Laurel MacLaren, et al. and *Getting to Scale in Young Adult Reproductive Health Programs* by Janet Smith and Charlotte Colvin. Both are available from: FOCUS on Young Adults, Pathfinder International, Attn: Communications Advisor, 1201 Connecticut Avenue NW, Suite 501, Washington, DC 20036, USA. E-mail: focus@pathfind.org.

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3. Townsend JW, Diáz de May E, Sepúlveda Y, et al. Sex education and family planning services for young adults: alternative urban strategies in Mexico. *Stud Fam Plann* 1987;18(2):103-8.

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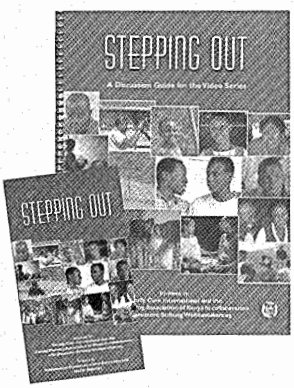
Resources

Stepping Out Videos for Youth

Family Care International (*http://www.familycareintl.org*) is offering reproductive health education videos and handbooks for adolescents in English-speaking Africa. *Stepping Out*, a set of six videos, covers themes ranging from human growth and development to consequences of unprotected sex. An accompanying discussion guide for peer educators and counselors outlines activities for young adults ages 12 to 19. *You, Your Life, Your Dreams*, a handbook for adolescents, covers such topics as puberty, relationships, contraception, unwanted sexual activity, substance abuse and planning for the future. It includes cartoons, illustrations and quotations from African young people. The materials are free to organizations based in developing countries. For prices to others or to obtain a copy, please contact: Family Care International, 588 Broadway, Suite 503, New York, NY 10012, USA. Telephone: (212) 941-5300. Fax: (212) 941-5563. E-mail: fcipubs@familycareintl.org. In Africa, contact: Family Care International/Kenya, P.O. Box 45763, Nairobi, Kenya. Telephone (254-2) 443167. Fax: (254-2) 441743. E-mail: fcikenya@africaonline.co.ke.



FHI Adolescent Handbook

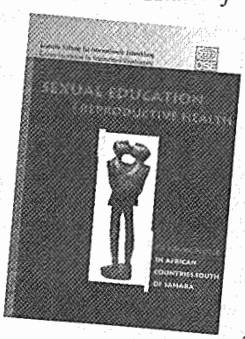
Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents is a handbook for providers, program managers, educators and others who work with adolescents. It outlines the critical need for reproductive health services for young women and men, focusing on prevention of unplanned pregnancies and sexually transmitted diseases, including HIV. The 100-page handbook contains role-plays that providers can use to help young people negotiate condom use and say "no" to sex. Published by FHI, it is free to those working in developing countries. To obtain a copy, write to: Publications Coordinator, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709, USA. Telephone: (919) 544-7040. Fax: (919) 544-7261. E-mail: publications@fhi.org.

Cultural View of Contraception

Contraception Across Cultures: Technologies, Choices, Constraints explores the impact of contraception on specific societies and how those societies influence the use of contraception. Case studies from Mexico, Haiti, Israel, Zimbabwe, Uzbekistan, Bangladesh and Tonga examine the development, dissemination and use of new contraceptive technologies. To obtain a paperback copy for U.S. $19.50, please contact: NYU Press, 838 Broadway, New York, NY 10003-4812, USA. Telephone: (800) 996-6987. Fax: (212) 505-9183. E-mail: nyupress.orders@nyu.edu.

Sex Education Programs in Africa

Sexual Education and Reproductive Health of Young People in African Countries South of Sahara compares adolescent sexual and reproductive health programs in various African countries, Germany and the Netherlands. It analyzes why adolescents are at risk for unwanted pregnancies and HIV/AIDS, describes strengths and weaknesses of programs, and gives strategies for better adolescent services. Based on a seminar for health professionals and policy-makers in Kenya, Tanzania, Uganda, Ghana and Zimbabwe, the 222-page paperback book is free for developing country providers. It can be obtained by contacting: Deutsche Stiftun für internationale Entwicklung (DSE), Zentralstelle für Gesundheit, Heussallee 2-10, 53113 Bonn, Germany. Telephone: (49) 228-2434-801. Fax: (49) 228-2434-844. E-mail: zg@dse.org.



MEASURE Report on Adolescents

A social marketing project that encouraged youth to protect themselves from reproductive health problems is described in *Social Marketing for Adolescent Sexual Health*. The 28-page report presents the major activities of the project, which was directed by Population Services International and conducted in major cities in Botswana, Cameroon, Guinea and South Africa. The report also describes how the activities were evaluated and provides lessons learned for future adolescent health programs. Free copies are available to those working in developing countries. To obtain a copy, please contact: Donna Clifton, MEASURE Communication, Population Reference Bureau, 1875 Connecticut Avenue NW, Suite 520, Washington, DC 20009, USA. Telephone: (202) 483-1100. Fax: (202) 328-3937. E-mail: prborders@prb.org.

FHI Training Module on Reproductive Health of Young Adults

Reproductive health issues affecting young adults, including important considerations when choosing a contraceptive method, are discussed in a slide lecture module produced by FHI. *Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Diseases* is part of FHI's Contraceptive Technology Update Series, designed for health-care providers, program managers and policy-makers. Available in English, French and Spanish, the module is free or at cost to trainers and educators in developing countries and is online at *http://www.fhi.org/en/ctu/adoltpm/main.html*. To obtain a copy, please contact: Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709, USA. Telephone: (919) 544-7040. Fax: (919) 544-7261. E-mail: publications@fhi.org.