

IN THIS GENERATION

Sexual & Reproductive Health Policies for a Youthful World



*Margaret E. Greene, Zohra Rasekh and Kali-Abset Amen
with Nada Chaya and Jenifer Dye*

ACKNOWLEDGEMENTS

We are grateful to the many people who graciously assisted us in reviewing this document, to Carole Ashinkaze for her invaluable editorial support, and to Beverly Johnston for her resource materials.

Our reviewers included Barbara Huberman, Advocates for Youth; María Antonieta Alcalde, Balance; James Rosen, Consultant; Lydia Alpizar, ELIGE; Douglas Kirby, ETR Associates; Jill Sheffield, Family Care International; Lindsay Stewart, FOCUS on Young Adults; Christine Varga, The Futures Group International; Rosalia Rodriguez-Garcia, George Washington University; Emmanuel Avevor, Ghana United Nations Students Association; Susan Pick, IMIFAP; Brian Greenberg, Innovative Resources Management; Rachel Stoler, JSI/PDY Mali; Sarah Brown, Andrea Kane, Isabel Sawhill, National Campaign to Prevent Teen Pregnancy;

Marilyn Keefe, National Family Planning and Reproductive Health Association; Jo Reinders, NISSO; Soraya Tremayne, Oxford University; Jessie Schutt-Ainé, Pan American Health Organization; Rachel Russell, Planned Parenthood Federation of America; KG Santhya, Population Council; Fred Sai, Special Adviser on HIV/AIDS, Republic of Ghana; Pat Donovan, The Alan Guttmacher Institute; Shanti Conly, Barbara Seligman, USAID; and PAI colleagues Sally Ethelston, Amy Coen, Akia Talbot, Bob Engelman, Susan Howells, Terri Bartlett, Nada Chaya, Craig Lasher, Mercedes Mas de Xaxás, Lisa Moreno, Denise Mortimer, Wendy Turnbull, and Carol Wall.

The insights of these reviewers have been essential, but the authors take full responsibility for any and all shortcomings in the final report.

ABOUT POPULATION ACTION INTERNATIONAL

Population Action International (PAI) is an independent policy advocacy group working to strengthen public awareness and political and financial support worldwide for population programs grounded in individual rights. Founded in 1965, PAI is a private, non-profit group and accepts no government funds.

At the heart of Population Action International's mission is its commitment to advance universal access to

family planning and related health services, and to educational and economic opportunities, especially for girls and women. Together, these strategies promise to improve the lives of individual women and their families, while also slowing the world's population growth and helping preserve the environment.



Population Action
INTERNATIONAL

1300 19th Street, NW, Second Floor
Washington, DC 20036 USA

Tel: (+1) 202-557-3400
Fax: (+1) 202-728-4177
www.populationaction.org

Publication requests to pubinq@popact.org

Material from this publication may be reproduced provided Population Action International and the authors are acknowledged as the source.

ISBN: 1-889735-31-0
Library of Congress number: 2002101942
© Population Action International 2002

IN THIS GENERATION

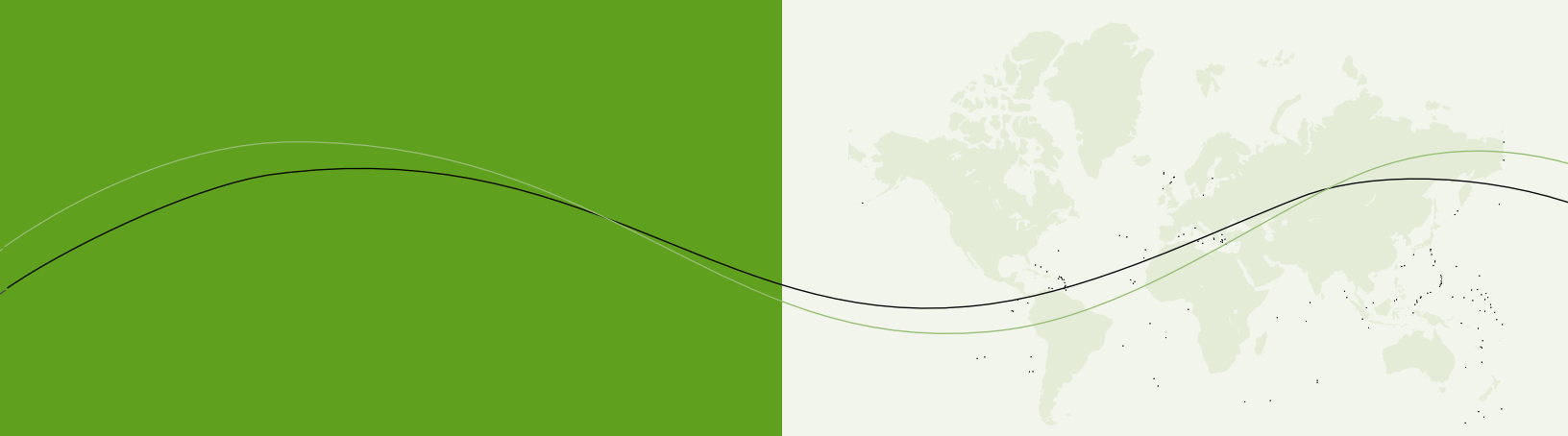
Sexual & Reproductive Health Policies for a Youthful World



*Margaret E. Greene, Zohra Rasekh and Kali-Abset Amen
with Nada Chaya and Jenifer Dye*

CONTENTS

FOREWORD	IV	Youth Perspective: “Empowering Young People” <i>María Antonieta Alcalde Castro, General Coordinator, Balance, Promoción para el Desarrollo y Juventud</i>
CHAPTER ONE	1	Young People’s Sexual and Reproductive Lives: Integral to Development
	2	Why should we care about young people’s sexual and reproductive lives?
	2	The sexual and reproductive experiences of young people
SPECIAL TOPIC	5	Sexual Violence
BOX 1	6	The International Conference on Population and Development (ICPD) and Reproductive Health
BOX 2	7	The ICPD Programme of Action and Youth
BOX 3	8	In This Generation: Summary of Policy Recommendations for a Youthful World
CHAPTER TWO	9	Republic of Ghana: Poised to Implement a National Youth Reproductive Health Policy
	9	Selected Country Statistics
FIGURE 1	10	AIDS in Ghana: Reported Cases of AIDS by Age and Sex through 1998
SPECIAL TOPIC	13	AIDS Declines in Uganda
CHAPTER THREE	17	India: National Discomfort with Sexuality Impedes Youth Reproductive Health Policy
	17	Selected Country Statistics
BOX 4	18	The Evolution of Population Policy in India
BOX 5	20	Illustrative Incentive and Investment Schemes Affecting Girls and Young Women
SPECIAL TOPIC	21	Thailand Increases Girls’ Educational Opportunities
CHAPTER FOUR	25	The Islamic Republic of Iran: Strong Policies Difficult to Document in Practice
	25	Selected Country Statistics



CHAPTER FIVE	3 1	Republic of Mali: Poverty and Poor Health Slow Progress on Youth Reproductive Health
	3 1	Selected Country Statistics
SPECIAL TOPIC	3 3	Female Genital Cutting Banned in Senegal
CHAPTER SIX	3 7	Mexico: NGOs Advance National Discussion of Youth Reproductive Health
	3 7	Selected Country Statistics
BOX 6	4 0	Prominent Mexican Networks for Reproductive Health
SPECIAL TOPIC	4 3	Chile Keeps Pregnant Girls in School
CHAPTER SEVEN	4 5	The Netherlands: Public Health Takes Precedence over Politics
	4 5	Selected Country Statistics
CHAPTER EIGHT	5 1	The United States: Inadequate Programs Leave Youth at Mercy of Mass Media
	5 1	Selected Country Statistics
BOX 7	5 5	Highlights in Sex Education Policy
CHAPTER NINE	5 9	Conclusions: Needs, Numbers and National Commitments
SPECIAL TOPIC	6 1	Parental Involvement - Hopes and Realities
ADVOCACY CHECKLIST	6 3	Advancing Policies for Young People’s Sexual and Reproductive Lives
APPENDIX 1	6 4	Interviews and Conversations
APPENDIX 2	6 6	Acronyms and Definitions
ENDNOTES	6 7	

Youth Perspective: EMPOWERING YOUNG PEOPLE

This report by Population Action International on policies affecting the reproductive lives of youth is a valuable resource in the struggle for the sexual and reproductive rights of young people. It provides key elements for understanding current policies targeting young people's reproductive health. It highlights successes and mistakes, and shows us how individuals, institutions and policymakers committed to youth rights must find innovative ways to address young people's necessities and life circumstances.

An essential element in the promotion of sexual and reproductive health and rights for youth is the recognition of young people as individuals entitled to rights, and as key players in their own development. There is no doubt that young people continue to be viewed as incomplete human beings—physically developed children lacking the capacity for intelligent decision making and in need of adult *protection* from, rather than *preparation* for, the world in which they live. As long as this is the case, we will be unable to create sensible policies and programs that serve their needs and provide them with what they require to live the healthiest and happiest lives possible.

This is not an easy undertaking. It demands asking hard questions about the subordinate roles that young people occupy in society and transforming the collective views

It is only with one's heart that one can see clearly.

What is essential is invisible to the eye.

Antoine de Saint-Exupéry

The Little Prince

we hold of youth—moving from the traditional concepts of young people as trivial and naive to the more accurate and complicated portrait of young people as autonomous and capable.

If we are truly committed to improving young people's lives, we have to incorporate a youth perspective in our work. We need to begin creating more democratic and inclusive spaces of participation where young people have the freedom to talk, learn and work with their elders as well as with each other.

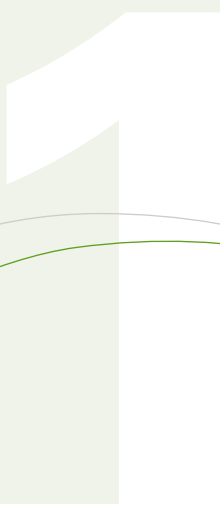
In many parts of the world, young people are organizing themselves and successfully addressing their own needs. This is the time for young people and their elders to work together to construct a better life for young people—and thereby construct a better world.

María Antonieta Alcalde Castro

General Coordinator

Balance, Promoción para el Desarrollo y Juventud

Balance is a Mexican non-governmental organization that works with young people and those who work with young people; it promotes youth rights and gender equity and the incorporation of a youth perspective in programs and policies.



YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE LIVES: INTEGRAL TO DEVELOPMENT

Parents, teachers and other adults widely fail to prepare young people with the information, skills and resources needed to chart a steady, healthy course through the transition to adulthood.

Across the globe, adults in changing societies wring their hands over the behavior of young people, yet are often unable to communicate effectively with them about their sexual and reproductive lives. Parents, teachers and other adults widely fail to prepare young people with the information, skills and resources needed to chart a steady, healthy course through the transition to adulthood. Parents' difficulties in managing their own sexuality, combined with cultural beliefs about parenting, sexuality, and gender all constrain their ability to prepare young people. Failing to provide critical information, skills and support to young people sends them out into the world inadequately prepared for life.

The sexual and reproductive lives of the world's 1.7 billion people between the ages of 10 and 24 are rooted in the values and socioeconomic conditions of their communities and nations. Formulating specific policy requires an awareness of how the youth population varies by age, sex, marital and parenthood status, education, living arrangements, work and migration status.¹ While drawing attention to adolescent fertility as a health issue can legitimize young people's rights to and need for services, this strategy limits policy approaches to their sexual and reproductive lives.² National policies must acknowledge and address the linkages between gender-based expecta-

tions for schooling and pregnancy decision making, for example, and between job prospects and sexual risk taking.

Since the 1994 International Conference on Population and Development (ICPD, *see Box 1*), the effect of an "enabling environment" on individuals' capacity to make healthful decisions has been more clearly understood.³ Reproductive health interventions for adults generally focus on supplying services, but for young people even more than adults, social constraints affect their ability to access services and other supports. We now appreciate that policies play an important role in stimulating use of information and services by removing the social, legal and programmatic obstacles to youth reproductive health.⁴

This report contrasts the ways in which policies in Ghana, India, Iran, Mali, Mexico, the Netherlands and the United States have supported young people's sexual and reproductive lives. Of specific interest here are either expressly formulated youth policies at the national or provincial level, or youth policies incorporated in legislation regulating access to education, social services, marriage, employment, and age of consent, among other things. This report urges countries to explicitly address the sexual and reproductive health needs of young people, preferably in the context of broad policies that take into account the linkages between many aspects of their lives. The report is addressed to national and international

policymakers and non-governmental organizations concerned with the wellbeing of young people.

WHY SHOULD WE CARE ABOUT YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE LIVES?

Young people have a human right to receive the information they need to be able to make healthful decisions about their lives. At the ICPD, 179 countries met to construct an international agreement to protect and support reproductive health and rights. The ICPD Programme of Action called on world leaders to acknowledge the centrality of sexual and reproductive health to health in general, and to respect the rights of young people to lead healthy reproductive lives. Sexual and reproductive decisions affect us for the rest of our lives. Making wise choices depends on adult recognition of young people's right to receive information and guidance and to make decisions accordingly.

The roles and responsibilities of parents sometimes compromise the rights of young people. Girls in much of the world “are having unprotected, unsafe, not fully voluntary (and likely unpleasurable) sex and bearing children soon after marriage, *at the behest of their families.*”⁵ Young people have a right to physical integrity and, where possible, to participate in decisions that will affect them for the rest of their lives. Though the rights and duties of parents are very important, Article 19 of the Universal Declaration of Human Rights provides the international legal basis for young people to claim these fundamental rights without interference.

Health is an important part of human development but, due to taboos related to sex, the reproductive health of young people is usually overlooked or treated as problematic. Young people between the ages of 15 and 24 have the highest rates of sexually transmitted infections (STIs) worldwide, representing over two-thirds of all cases in the developing countries.⁶ But because young people tend not to receive the explicit information or skills they need to deal with their sexuality and reproductive health, they are often unprepared for sexual relations.

The social and developmental consequences of sexual and reproductive decisions are often further reaching than the health consequences. An unintended pregnancy can irrevocably disrupt a young girl's life by standing in the way of further schooling and training. Contracting HIV in an unprotected sexual encounter can bring a young person's prospects for a healthy and productive future to an end. Nations that neglect the sexual and reproductive lives of their young people and fail to help them to remain healthy, in school or at work, may undermine the investments made in other areas of youth development.

Governments must face the reality that there are greater numbers of young people alive now than ever before. There are nearly 1.7 billion young people in the world between the ages of 10 and 24, and another 1.2 billion children under the age of 10 right behind them.⁷ This generation—probably the largest that ever will be—requires significant public and social investment to prepare it for economic and social participation. The timing and number of children borne by these nearly 3 billion young people under age 24—half the world's population—will also have long-lasting consequences for the momentum of population growth, ensuring global population growth in absolute terms even as fertility rates decline in most countries.

The long-neglected reproductive health needs of young people must urgently be addressed. The media, mass culture and the dynamics of globalization and urbanization are influencing how young people see themselves and their prospects—and altering the conditions under which youth sexual and reproductive activity takes place. Families and systems that once trained and protected young people are today unable to prepare them as effectively for their reproductive roles.

THE SEXUAL AND REPRODUCTIVE EXPERIENCES OF YOUNG PEOPLE

The sexual and reproductive experiences of young people vary dramatically by region, age, and sex, but most young people everywhere become sexually active between the

Most young people everywhere become sexually active between the ages of 10 and 20.

ages of 10 and 20.⁸ The available survey data often omit very young adolescents; report overly broad age categories that fail to capture the rapid, year-by-year changes in adolescence; and focus on the fertility status of young women to the neglect of other aspects of their lives.⁹

Expectations that girls will marry and have children at an early age may lead them to have sex early in some places; in others, later marriage is often preceded by premarital sexual activity. The growing gap between earlier puberty and later marriage has extended the period through which most young girls must avoid premarital pregnancy.¹⁰ Although boys tend to marry later, they are often at least as sexually active as girls in their adolescence.

Around the world, most adolescent childbearing occurs within marriage. While sexual and reproductive experience within marriage is socially sanctioned, it exposes girls to health risks such as STIs, HIV, and pregnancy or abortion.¹¹ Early childbearing has lifelong consequences for women and often for men as well, regardless of whether the child is welcomed or considered a liability to young mothers and fathers.¹²

Young parents, especially girls, are often compelled to leave school, resulting in social and economic challenges that negatively affect their wellbeing and that of their children. As the world economy changes, more wage-paying jobs requiring formal education are displacing traditional occupations. Young parents whose education is interrupted have fewer opportunities to earn money for their families.¹³ Schooling has a profound and positive effect in delaying marriage and increasing age at first birth. Yet around the world, schoolgirls who become pregnant struggle with competing pressures from school and home, often leading to poor school performance, expulsion or decisions to drop out.¹⁴ Only recently have education systems considered how to respond to boys who have parented children while in school, or assisted mothers in balancing school and childcare.¹⁵

Social norms defining appropriate sexual and reproductive activity often limit the information, guidance and services to which young people have access. Parents, teachers, community and religious leaders are often “gatekeepers” who regulate transmission of information that can forever impact a young person’s life. By establishing open and meaningful relationships with

young people, these “gatekeepers” can play a key role in protecting them from premature sexual activity and premarital pregnancy. Too often, however, young people feel they have no one to turn to. Reproductive health care providers often show little respect for the young and the unmarried. In many places, pressures to have children early in marriage make it inappropriate for young women to seek out reproductive health services that include contraception. Where premarital sexual activity is common and disapproved of, adults often withhold information, erroneously believing that to provide it may lead young people to have sex.¹⁶ Community and service-provider restrictions on health information and services expose young people to a host of avoidable health risks such as STIs which, untreated, can lead to chronic morbidity, sterility and even death.

Girls are vulnerable to more reproductive health problems than boys for both biological and social reasons, and often have little say over the conditions of sexual relations and childbearing. Very early or frequent pregnancies and exposure to STIs tax the still-developing bodies of young women and can impair their health, exposing them to higher maternal health risks. Early pregnancies often interfere with their opportunities to attend school or obtain job-related skills, and when they occur outside marriage, confront young women with decisions about whether to obtain abortions and how to support their children on their own. The early sexual encounters of many girls and young women are coerced. One-third to two-thirds of sexual assault victims are 15 years old or younger, according to information from Chile, Peru, Malaysia, Mexico, Panama, Papua New Guinea and the United States.¹⁷ Intimidation, forced marriage, trafficking of girls and women to serve men’s sexual desires—all reflect unfavorably on the sexual and reproductive autonomy and health of young women in particular.

Boys are exposed to other risks by ideas of what it means to be a man. Just as some traditional interpretations of femininity promote ignorance, innocence and vir-

Social norms and policies visit unfortunate consequences on many girls who become sexually active.

ginity among women, some ideas of masculinity prescribe sexual conquest, multiple partners, and sexual experimentation.¹⁸ Young men must be pushed to review the health risks to which they may expose themselves and their partners as a result. Newer programs cultivate young men's respect and friendship for girls and women, while also addressing their reproductive health concerns.

Communities generally hold young women—but not young men—responsible for the consequences of unprotected sex. Adults in most places are closely concerned with girls' sexuality and place restrictions on them once they reach puberty.¹⁹ On girls' shoulders ride family honor, responsibility as single parents, and other heavy burdens. Social norms and policies visit unfortunate consequences on many girls who become sexually active.

Because premarital unintended pregnancy can be disastrous for young women's educational and other prospects, they are particularly likely to seek abortions. Abortions to adolescents make up approximately 10 percent of the total, but adolescents have more abortions than older women relative to the number of pregnancies.²⁰ Obtaining safe abortions can be difficult even in countries where it is legal.²¹ Many countries, including Cuba, France, the United States and Turkey, require the consent of parents or spouses to the procedure in some cases, depending on the young woman's age; in others, providers may scold young women or refuse them services. Either situation can lead to delays in obtaining services, increasing the risk of complications.²² Young women may also delay seeking abortions because they are unable to pay, don't know where to obtain services—legal or otherwise—or are in denial about being pregnant.²³ The costs of the medical procedure and other prohibitive conditions at times drive young women to self-induce or to seek out illegal or unqualified practitioners.²⁴ A study of abortion hospitalizations in developing countries found that adolescents accounted for more than half of all admissions for abortion complications.²⁵

Many young women around the world, particularly in sub-Saharan Africa and the Middle East, endure the short- and long-term health and psychological effects of female genital cutting (FGC), a procedure that often takes place just before adolescence.²⁶ The United Nations Population Fund (UNFPA) estimates that between 85 and 115 million women today have under-

gone FGC and 2 million more do so every year.²⁷

Generally performed without a girl's consent, FGC has lifelong implications including painful intercourse, perforations of the urethra, vagina or rectum (fistulae), infections and STI's, including HIV/AIDS, prolonged labor, higher rates of caesarian section, and higher risks of maternal mortality due to tearing and hemorrhage.²⁸

Worldwide, over ten million young people between the ages of 15 and 24 have HIV or AIDS.²⁹ With almost half of all new HIV infections and at least one-third of all new sexually transmitted infections occurring to people younger than 25, efforts to protect and inform youth must take place on a huge scale.³⁰ Their immature reproductive tracts make them more susceptible than adults to acquiring STIs.³¹ Higher infection rates among adolescent girls result in part from sexual relationships—often involving exchanges of money or other resources—with older men who are more likely to have been exposed to the virus.³² Young people tend to consider themselves invulnerable to risk even in countries where HIV is widespread, and the unplanned or secretive nature of many of their sexual encounters makes it difficult for them to protect themselves even when they are aware.³³

Given all that we know about young people's sexual and reproductive lives, what have the world's countries done to support them?

SLOW PROGRESS IN MEETING INTERNATIONALLY AGREED-UPON GOALS

Although the ICPD acknowledged the importance of young people's sexual and reproductive health and rights, few of the 179 countries agreeing to the Programme of Action have translated that commitment into national youth reproductive health policies. The ICPD Programme of Action lays out a framework for the reproductive rights of *everyone* including young people, devotes a section to their specific needs, and calls for the involvement of adolescents in the planning and implementation of



Photograph by Jim Varriale. ©2001 Men Can Stop Rape, Inc.

SPECIAL TOPIC

Sexual Violence

Young people across all cultures, societies and socioeconomic groups experience sexual violence and coercion of one form or another, whether from adults or peers. *Most perpetrators* of sexual violence are known to the victim and *are male*; many are family members. Sexual abuse and violence are vastly underreported around the world, but must be addressed by any national policy for youth sexual and reproductive health.

While sexual violence affects both sexes, worldwide estimates suggest that girls are victimized up to three times more than boys, reflecting women's and girls' subordinate social status. Cultural attitudes toward male and female sexuality—stressing young male sexual prowess and female chastity—often push boys to initiate sex while leaving girls ill-equipped to make informed decisions. The tendency to invest more heavily in boys' schooling and job prospects than in girls' can contribute to child prostitution among girls. Socially sanctioned marriages between young girls and much older men also create conditions for forced or unwanted sex, and are especially traumatic where girls are uninformed about what awaits them.

When young people engage in sexual activities for which they are not developmentally prepared and cannot give informed consent, there are long-term consequences for their social and psychological wellbeing and reproductive health. Their resulting powerlessness reduces their ability to protect themselves from further abuse and sexual risk-taking—leaving them at increased risk for unintended pregnancy, STI/HIV infection, gynecological disorders, sexual dysfunction and depression.

Both the UN Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) lay out agendas for national action to end sexual violence against young people. CEDAW affirms the reproductive rights of women and targets the gender and family relations that contribute to sexual violence. It is important that nations do their part to incorporate the values of these conventions into their national plans, programs, and legislation, inculcating intolerance for sexual abuse and support for young people's social, sexual and reproductive health and wellbeing.

Source:

Heise, L, M Ellsberg, and M Gottemoeller. 1999. *Ending Violence Against Women*. Population Reports: Issues in World Health. XXVII(4) Series L, Number 11. Population Information Program, Center for Communication Programs, The Johns Hopkins University School of Public Health, 13.

The International Conference on Population and Development (ICPD) and Reproductive Health

In 1994, 179 countries met in Cairo at the International Conference on Population and Development (ICPD) to forge an international commitment to improving reproductive health and protecting reproductive rights. At the heart of the Programme of Action's focus on meeting individual reproductive health needs is this definition of reproductive health:

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (Paragraph 7.2)

information, services and other kinds of support. The ICPD also calls for the training of adults who could potentially provide guidance to young people, particularly to "enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health."³⁴

The ICPD Programme of Action made specific promises regarding funding of reproductive health activities overall. Five years later, representatives again met to review progress toward the Programme of Action's goals. The 1999 Hague meeting (part of the ICPD review process) reinforced the ICPD message, and added emphasis on schooling and on youth participation. Yet participants allowed the chance to set spending targets for youth sexual and reproductive health activities to slip away from them. Many governments would argue that the information and services they provide for their citizens

are meant to extend to young people as well, and that establishing a separate line item is not necessary. But adult discomfort with youth sexual activity, whether in the developing world or in industrialized countries, has more often translated into a lack of political will.

Most young people will tell you that their access to guidance on their sexual and reproductive lives is very limited—yet they are rarely asked about what they need and want, and are often unable to advocate on their own behalf. They remain outside the political process due to voting-age restrictions and norms that subordinate young people's status as political actors. Youth involvement is impeded by the sense that young people are incomplete beings, requiring protection even from information. The world's adults need to involve youth directly in policy and program development; such participation would also nurture young people's capacity to make decisions for themselves and their societies.³⁵ The United Nations Convention on the Rights of the Child lays out their right to this participation.

The body of this report focuses on what Ghana, India, Iran, Mali, Mexico, the Netherlands and the United States have done to address the sexual and reproductive health needs of young people. Each country case study includes a description of the country's policy environment for youth sexual and reproductive health, and the factors that have brought youth reproductive health to the focus of national policymakers. A description of policies directly affecting youth reproductive health in each setting looks at coordination across sectors and levels of government. Each case study also analyzes how policies have been implemented, their programmatic focus, key obstacles, and factors that made the development and approval of policies possible. A full list of policy strategies appears at the end of the report. (See Box 3 for a summary.) An advocacy checklist that non-governmental organizations and policymakers can use to advocate for greater support for young people's sexual and reproductive lives rounds out the report.

The ICPD Programme of Action and Youth

Address adolescents' needs

"...address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counseling specifically for that age group..." (Paragraph 7.44)

Promote adolescents' rights

Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies. (Paragraph 7.46)

Respond appropriately to adolescents' needs

Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. Sexually active adolescents will require special family-planning information, counseling and services, and those who become pregnant will require special support from their families and community during pregnancy and early child care. Adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities. (Paragraph 7.47)

Provide training for parents

Programmes should involve and train all who are in a position to provide guidance to adolescents concerning responsible sexual and reproductive behaviour, particularly parents and families, and also communities, religious institutions, schools, the mass media and peer groups. Governments and non-governmental organizations should promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health. (Paragraph 7.48)

BOX 3

In This Generation: Summary of Policy Recommendations for a Youthful World

Political and public health leadership are needed.

Officials at the highest levels of government need to provide leadership that recognizes young people's sexual and reproductive health as central to their overall health and development.

Policymakers' first step toward formulating policy for youth should be to lay out the basic public health or social development principles that underpin all of our sexual and reproductive lives.

Advocates must select specific laws or regulations to influence, whether they concern sex education, clinical services, school expulsion policies, or livelihood opportunities.

Reducing early marriage should be front and center on the policy agenda.

Involve young people, their parents, and other adults and institutions in their communities.

Government and non-governmental advocates must support young people in advocating on their own behalf.

Government needs to enlist NGOs to provide critical support for, and expand on, youth and health initiatives.

Advocacy and programmatic efforts need to involve parents, other adults, and institutions including the religious community.

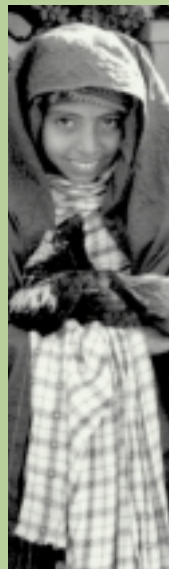
Don't think just about sex, but about all of the other factors that influence young people's sexual and reproductive lives.

Sexual and reproductive health efforts must go beyond family planning to provide skills and information that support healthy relationships, life planning, attending school, and getting training for work—the broader aspects of young people's reproductive lives.

Policies and programs need to work to reduce the gender inequities that expose young people to sexual and reproductive risk.

Coordination of an overall national youth or comprehensive reproductive health policy requires a government institution with the capacity and authority to design and implement policies and programs across sectors, including health, labor force, and education.

Financial objectives and commitments must number among national goals set for youth sexual and reproductive health.



Barbara Horibeck



Margaret E. Greene



Margaret E. Greene

2

Republic of Ghana:



POISED TO IMPLEMENT A NATIONAL YOUTH REPRODUCTIVE HEALTH POLICY

Ghana has often been the first country in sub-Saharan Africa to commit itself to progressive policy changes and, in the early 1990s, took steps to develop a strong adolescent reproductive health policy. Several government ministries collaborated with national organizations and international donor representatives to draft that policy by 1996, but it has not yet been fully implemented. A draft AIDS policy likewise hangs in the balance. The big challenge for Ghana is to implement the visionary policies that varied stakeholders have agreed to and set down on paper.

THE POLICY ENVIRONMENT FOR YOUTH REPRODUCTIVE HEALTH

In 1969, the government of Ghana issued a population policy focusing entirely on family planning. The policy was not a success, and in 1992, then-President Jerry John Rawlings established the National Population Council to review and revise it. The new population policy addresses a broad range of youth issues, including early pregnancy, marriage and gender inequality.³⁶ Perhaps the most impressive aspect of the document, however, is the definition of the institutional framework through which the policy will be implemented. This section lays out a blue-

Total population, year 2000 (in thousands)	19,306
Population ages 0-24 (% of total population)	62%
Population ages 10-24 (% of total population)	34%
Annual population growth rate	2.2%
GNP per capita (PPP US\$, 1999)*	\$1,793
Average births per woman 15-49 (TFR)	4.55
Births to women ages 15-19 (as percent of all births)	15%
Births to women ages 20-24 (as percent of all births)	27%
Percent of 15-24 year-olds ever married (male/female)	13.2% / 48.9%
Young married women (15-19) using any method of contraception (%)	19.2%
HIV prevalence in females 15-24	2.4 - 4.4%
HIV prevalence in males 15-24	0.8 - 2.0%
Years of schooling required	9
Literacy among youth ages 15-24 (male/female)	93% / 86%
Primary Gross Enrollment Ratio (male/female)**	84 / 74
Secondary Gross Enrollment Ratio (male/female)**	44 / 28

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
 ** Total number of children enrolled for every 100 school age children.

Sources:

United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
 World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank.
 Ghana Statistical Service (GSS), Macro International Inc (MI). 1999. *Ghana Demographic and Health Survey 1998*. Calverton, MD, USA: MI.
 UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
 UNESCO. 1995. *Statistical Yearbook*. Paris: UNESCO.
 UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.
 United Nations. 1997. *Report on the World Social Situation*. New York: United Nations.

print of the ministries to be involved, coordinating committees, and their composition.

Ghana's National Reproductive Health Service Policy, completed soon after the 1994 ICPD, mandates comprehensive reproductive health care, including counseling and sex education, for all Ghanaians without respect to age. It also calls for the active discouragement of female genital cutting, and outlines provisions for adolescent reproductive health.³⁷ A 1996 National Youth Policy, coordinated by the Ministries of Youth and Sports and of Education, also touches upon reproductive health. A Third Country Programme (1996-2000) initiates a Population Planning and Family Life Education program for adolescents in and out of school.³⁸ Thus, adolescent issues are addressed at the policy level across several sectors beyond health—providing for vocational training, literacy and agricultural development, among other things.

The government report on HIV/AIDS points to children aged 5 to 14 as Ghana’s “window of hope,” for whom sexuality and health education can really make a difference.

However, disapproval of youth sexual activity poses an important challenge to youth reproductive health efforts. Ghana is a multi-ethnic society, with substantial proportions of Christians, Muslims, and practitioners of indigenous beliefs.³⁹ The relative lack of tension among religious groups in Ghana prevents this diversity from becoming a major political factor in national debate over reproductive health policy. Nonetheless, adults across religious groups tend to judge youth sexual activity harshly, adversely affecting the openness of policy dialogue.

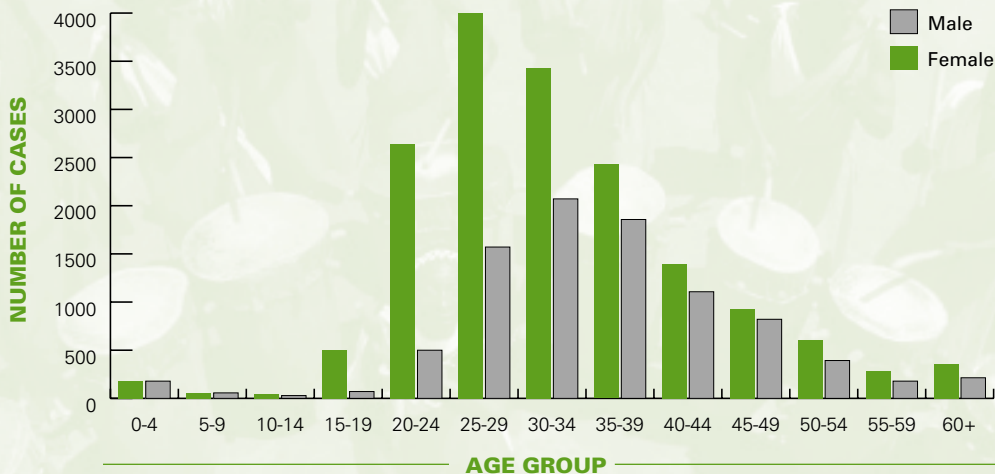
WHAT REALITIES HAVE BROUGHT YOUTH REPRODUCTIVE HEALTH TO THE FOCUS OF THE NATION?

Patterns of HIV/AIDS and high levels of teenage pregnancy and abortion complications have drawn national atten-

tion to youth reproductive health in Ghana. Current estimates indicate that 500,000 Ghanaians are infected with the AIDS virus, more than half of them between the ages of 10 and 29.⁴⁰ The data shown in Figure 1 below have galvanized many Ghanaian policymakers to focus on youth reproductive health over the past few years. High infection rates among people in their twenties suggest that they contracted HIV in early sexual encounters, when they were still teenagers or in their early twenties. The huge discrepancy in the numbers of women and men with AIDS is evidence that girls are having sex with sexually experienced older men who are more likely to be HIV-positive, and that women are more likely to contract the virus upon exposure. The government report on HIV/AIDS points to children aged 5 to 14 as Ghana’s “window of hope,” for whom sexuality and health education can really make a difference.⁴¹

Teenage pregnancy and complications of unsafe abortion, a leading cause of maternal death among Ghana’s young, are also critical concerns.⁴² By age 20, more than 85 percent of young women are sexually active, and 30 percent of all births are to women aged 15 to 24.⁴³ But young people’s access to reproductive health information and guidance is limited, particularly if they are unmar-

FIGURE 1 AIDS in Ghana: Reported Cases of AIDS by Age and Sex through 1998



Source: Ghana Ministry of Health National AIDS/STD Control Programme, 1999. *HIV/AIDS in Ghana*.



Zohra Rasekh

By age 20, more than 85 percent of young women are sexually active, and 30 percent of all births are to women aged 15 to 24.

ried, by disapproving parents and service providers as well as by legal age restrictions. Adolescent girls are more likely to seek out abortions than older women and are more likely to go to illegal providers. Hospital staff, the police, and women themselves are often unfamiliar with the laws regarding access to safe abortion, and girls and women are sometimes turned over to the police for requesting services to which they are legally entitled.⁴⁴

IS THERE A YOUTH REPRODUCTIVE HEALTH POLICY?

A thoughtful adolescent reproductive health policy has existed in draft form since 1996.⁴⁵ Its approval is seen largely as a formality since most stakeholders have already agreed to it.⁴⁶ The Adolescent Reproductive Health Policy reflects the spirit of the ICPD Programme of Action, referring explicitly to the right of young people to information, services and involvement in planning, and provides guidelines for government and non-governmental agencies implementing programs across sectors with specific targets for youth wellbeing: percentage reductions in early marriage, childbirth and dropping out of school, and increases in exposure to sex education, out-of-school programs, youth-friendly services and girls' schooling.⁴⁷ A

secondary focus is on the institutions and parents, caretakers, teachers, religious leaders, service providers, and policymakers who influence the upbringing of youth.

The National Population Council led the Ministries of Health, Education, Youth and Sports and others in its development, with the participation of the National Youth Council, non-governmental organizations (NGOs) and researchers, and technical assistance from the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID). The Ministry of Health will take the lead in programmatic implementation.

WHAT KEY FACTORS MADE THE DEVELOPMENT OF THIS POLICY POSSIBLE?

Several important coalitions have played a role in the development of the Adolescent Reproductive Health Policy. Religious organizations were also involved from the outset, and the government took care to inform people and seek their approval: an adolescent reproductive health needs assessment and forum were conducted nationally in 1997 to stimulate regional discussions and address objections.⁴⁸

Government initiative, the coordination efforts of the National Population Council, and donor pressure also aided policy development across sectors. Ghana's openness to constructive involvement of international donors in the policy development process is unusual. As a Member of Parliament stated, "We as a nation need partners ... and we welcome help."⁴⁹

Remarkable in many of Ghana's policy documents is the acknowledgement of the broad range of policies, laws, and programs that form the context for youth sexual and reproductive health. A 1996 Adolescent Reproductive Health Summit in Accra identified the government agencies that oversee activities relating to young people. Participants also identified gaps needing to be addressed and the need for a coalition of advocates who could lobby

at the highest levels of government.⁵⁰ A government brief notes the role of government beyond service provision, and the need to improve the degree of law enforcement.⁵¹ The government has beautifully articulated a vision, and must now carry through by implementing it.

FOCUS OF PROGRAMMATIC EFFORTS RELATING TO YOUTH REPRODUCTIVE HEALTH

Even before the Adolescent Reproductive Health Policy has been formally implemented, several participating ministries are moving toward doing so, sure that its approval is only a matter of time. The policy calls explicitly on the Ministry of Youth and Sports to strengthen the National Youth Council so that reproductive health can be promoted among its member institutions. It urges the Ministry, and Ghana's National Commission on Children, to link with the Ministries of Employment and Social Welfare in the development of youth centers with diverse facilities for young people.⁵² The Ministry of Health is working to sensitize its staff to the needs of young people, a daunting task, particularly as it has tended to favor the clinical aspects of young people's reproductive lives to the neglect of educational and social aspects.^{53,54} In keeping with the policy's emphasis on creating a favorable environment for prevention and treatment of AIDS and sexually transmitted infections, the National AIDS/STD Control Programme launched a huge AIDS campaign in February 2000.⁵⁵ While early response to the HIV epidemic was concentrated in the Ministry of Health, other ministries, NGOs, and HIV-positive groups have become involved in program implementation.⁵⁶

UNFPA is providing technical assistance for the expansion of reproductive health information and services to adolescents at the national level, and is also making efforts to integrate population and sex education into the curricula of primary and secondary schools and teacher training colleges. The government has also established a degree program at Cape Coast University in population and family life education. However, not all of those trained will teach, and many are uncomfortable with the material.⁵⁷ Large NGOs, including the Young Men's and Young Women's Christian Associations, Planned Parenthood Association of Ghana, Muslim Family Counseling Services

and Ghana Social Marketing Foundation (GSMF), also provide significant prevention-oriented information and services to young people.

Current programmatic efforts also emphasize contraceptive social marketing and peer education. GSMF has been particularly successful in promoting and selling condoms to young men, though it's not clear how many con-

"You have a bigger job to do in working on reproductive health, and that's why it shouldn't stay only with the Ministry of Health. Very few people are talking about reproductive health as a *rights* issue influenced by other factors. A family planning orientation keeps people from seeing the other motivations adolescents have."

—Yaa Amekudzi, Centre for the Development of People

doms are actually used. An awareness campaign targets nightclubs and dance houses in both urban and rural areas, distributing free condoms with each ticket.⁵⁸ The problem with such social marketing in Ghana, as in many other settings, is its neglect of messages promoting either respect for partners or girls' ability to negotiate condom use.

Reflecting disapproval of youth sexual activity, some youth reproductive health messages aim to frighten, and stress the dire consequences of poor decisions rather than how to avoid them in the first place. Because adult objections to youth sexual activity can stand in the way of sexual and reproductive health efforts, educating influential adults, including religious leaders, teachers, and especially parents will be critical to the success of the youth reproductive health policy. Between 1996 and 2000, UNFPA supported advocacy campaigns for 3,840 priests, imams and other religious leaders, and a parents' guide was prepared on how to discuss sexuality with children. GSMF has organized media campaigns about sex education, FGC, rape, HIV/AIDS and condom use, and to help

SPECIAL TOPIC

AIDS Declines in Uganda

Uganda is to date the only country in Africa to successfully reverse an upward spiral of infection with HIV/AIDS. Like other sub-Saharan countries, it began to feel the effects of the AIDS epidemic in the 1980s. In 1992, HIV prevalence peaked at 30 percent among adults in the capital, Kampala, and at 10 percent in the country as a whole. President Yaweri Kaguti Museveni responded by bombarding the country with radio, TV and print advertisements about AIDS, and recruited political leaders, religious centers and schools to sound the alarm. The effectiveness of the campaign rested on Museveni's ability to create a social climate supportive of education and prevention.

One of Uganda's most successful social marketing efforts was the tabloid, *Straight Talk*, distributed as an insert in the daily government newspaper. *Straight Talk*, designed for adolescents, provides information and advice about sex and sexuality, self-esteem, HIV/AIDS, and the rights of children to avoid exploitative relationships. The innovative publication focuses heavily on questions from Ugandan youth, relying on testimonials and powerful visual images to make its impact. Most of *Straight Talk's* content comes from young readers, and is supplemented by contributions from a sociologist and a physician.

Uganda now boasts a reduction in HIV infections among young pregnant women and adolescent girls, an increase in age at first intercourse, and a high level of HIV/AIDS awareness, as well as increased demand for counseling, testing and condoms. Kampala's HIV prevalence has dropped from 30 to 12 percent, while the country's overall prevalence dropped from 10 to 7 percent. Uganda's experience demonstrates that strong political will, the involvement of local institutions, and open communication about HIV/AIDS transmission and prevention can have an enormous impact on controlling the epidemic.

Sources:

Agence France-Presse, "AIDS-Uganda: Openness About HIV/AIDS slows infection rate in Uganda," at <http://www.aegis.com/news/afp/1999/AF990910.html>. Internet; accessed 21 December 2001.

Afrol.com News, "President Museveni Explains Uganda's Success in Combating AIDS," at http://www.afrol.com/News/uga003_aids_success.htm. Internet; accessed 21 December 2001.

AIDScaptions, "Straight Talk for Youth: Ugandan Girls and Boys Learning to Escape Gender Stereotypes," at <http://www.fhi.org/en/aids/aidschap/aidspubs/serial/captions/v2%2D3/cp2310.html>. Internet; accessed 21 December 2001.

Cynthia Greenlee, "Straight Talk: Using Newspapers for AIDS Prevention in Uganda," at <http://excellent.com.utk.edu/greenlee.html>. Internet; accessed 21 December 2001.

The Dallas Morning News, "Uganda Reversing Deadly AIDS Spiral," at <http://www.dallasnews.com/specials/aids/1017aids2uganda.htm>. Internet; accessed 21 December 2001.

parents think through the challenges their children face.⁵⁹ Muslim Family Counseling Services has found that educating imams and teachers allows it to organize much of its work through mosques and Muslim schools.

CHALLENGES AND RESPONSES

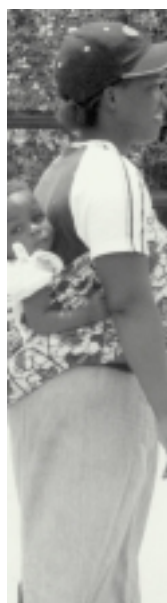
Efforts to implement these policy changes have been slow and face obstacles resulting from the effects of decentralization, a lack of resources, gender inequities and a reluctance to acknowledge youth sexual activity. Ghana's decentralization process calls for replication of many departments, including reproductive health, at the district level but the transition has not been smooth. With twice the per capita income of some of its West African neighbors, Ghana nonetheless depends significantly on international financial and technical support for health and development programs.⁶⁰ Though the country is deeply committed to basic education and has increased its education budget severalfold since 1987, the costs of schooling have implications for youth development and reproductive health.⁶¹ Families unable to pay school fees for all children most often send sons and not daughters to secondary school, pushing some girls into sexual relationships with older men to pay their expenses.⁶² A lack of funding has limited the development of youth-friendly centers and clinics, and some donors are uncomfortable supporting income-generation for youth as part of a reproductive health program—yet many youth cannot afford nominal clinic costs.

Cultural mores pose an obstacle to the implementation of reproductive health policies and protective laws in Ghana.⁶³ Adults are not comfortable with educating youth about sexual issues, and many believe this information will lead to promiscuity and immoral behavior. But adults hold the keys to successful implementation of services addressing young people's most important needs. Low expectations for girls contribute to early marriage and high fertility; births to young women ages 15 to 24 account for approximately one-third of all births. Though a 1985 law liberalized abortion, girls often seek out illicit services, and maternal deaths from septic abortion are reportedly much higher among adolescents than among adult women.⁶⁴

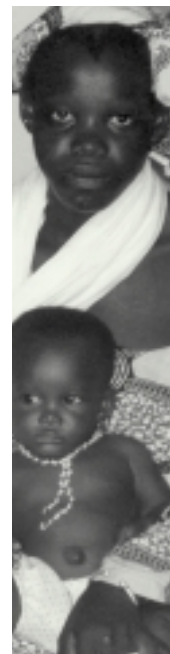
The Adolescent Reproductive Health Policy should be seen as a large step in the process of addressing youth reproductive health rather than as the final result.

Conflict with traditional practices also stands in the way of implementation. The solemnization of the majority of marriages through customary or Muslim law goes against the Marriage Ordinance's requirement that parties to marriage be at least 21 years of age.⁶⁵ Female religious slavery (*trocosi*) is illegal, but the practice persists with approximately 4,500 women currently in bondage.⁶⁶ Few believe that banning female genital cutting in 1994 has substantially reduced the practice.

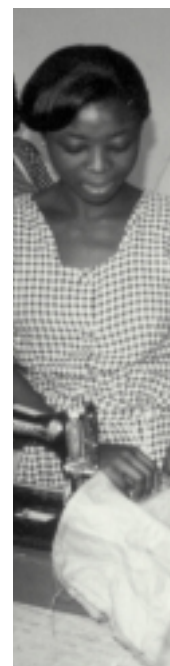
After involvement in the policy process early on, the youth voice has dwindled in Ghana, and the coalition that developed the Adolescent Reproductive Health Policy has lost steam since completing the draft. The *de facto* dissolution of the coalition worries some NGO representatives, since the policy doesn't fully address all practical details and would benefit from further leadership through



Zohra Rasekh



Zohra Rasekh



Robert Engelman



Zohra Rasekh

implementation. Though the policy emphasizes sex education, for example, there are few trained and qualified teachers, and plenty of debate about the age at which these courses should be provided.⁶⁷

Although approval of the Adolescent Reproductive Health Policy appears to be a foregone conclusion, full implementation has not yet occurred. The reasons for this halting process are diffuse, ranging from the practical realities of government decentralization to scarcity of human, material and financial resources, and the lack of experience with practical implementation across sectors.⁶⁸ However, there is enthusiasm in Parliament, and the new government has strongly supported programs for young people.⁶⁹

LESSONS LEARNED AND RECOMMENDATIONS

The Adolescent Reproductive Health Policy should be seen as a large step in the process of addressing youth reproductive health rather than as the final result. The long period over which the policy has been developed has led some to regard the document as the end of the road rather than the beginning.

Broad-based participation in development of the adolescent reproductive health policy made for a wide sense of ownership. The policy development process kept many people involved. Participants are happy to take credit for their contributions; now the challenge is to build on that ownership for implementation.

Extensive donor participation in the policy process, particularly by USAID and UNFPA, seems to have been constructive and reinforcing of government efforts. Ghana's openness to outside support has worked to its advantage.

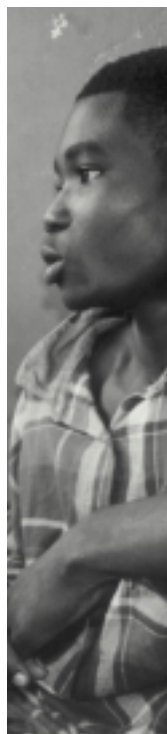
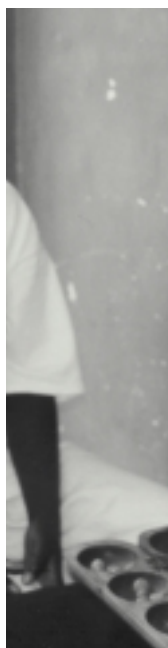
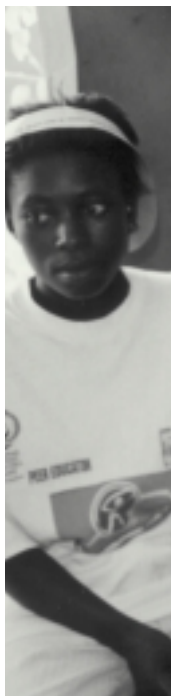
The National Population Council needs to show leadership in urging formal implementation of the policy. Multi-sectoral policies get delayed in as many ministries as they involve, and the Adolescent Reproductive Health Policy has remained in draft form for years now. The NPC should take the opportunity to gain its approval with the country's new president and administration.

Moving the creative thinking reflected in several of Ghana's policies to action will require close attention to how these policies are implemented. For example, the adolescent reproductive health policy recognizes that gender inequities constrain young women at every turn; devising programs and activities that reflect this concern will be more of a challenge, as they must work on changing social norms.

The peer education program should be re-assessed so that it is not just promoting condom purchases, but also communicating important social messages.

Adolescents get most reproductive health information from their peers and the media.⁷⁰ The educational approaches of NGO-administered programs should broaden the scope of peer outreach and multi-media efforts to influence the social dynamics affecting sexual intercourse and relationships.

Ghana should publicize the availability of abortion services where they are legal in order to avoid some of the public health consequences of illegal abortions. Health practitioners and counselors need training in when to provide services, counseling and referral. The incidence of abortion among young girls is high, and post-abortion care at Ghanaian hospitals is very costly.



Robert Engelman

The implementation of the Adolescent Reproductive Health Policy must continue to include advocacy and educational activities by both government and non-governmental players. Further advocacy is needed at the national level, and with prominent public figures, including chiefs and religious leaders at the regional and local levels.

Just as it is attending to teacher training for family life education in schools, Ghana needs to invest in sensitizing health care providers to be more receptive to young people who dare to seek services from them. Ghana will reap the benefits of the services it offers by making sure that everyone who tries to use them is well received.

Ghana has been and continues to be on the forefront of progressive legislative change for health and development. The Adolescent Reproductive Health Policy is a case in point. However, Ghana's experience also illustrates the need to maintain the enthusiasm for the policy development process right through implementation. Ghana's collaborative, multi-sectoral approach to lawmaking suggests it will do what it must to support the reproductive health of this generation of young people.

India:



NATIONAL DISCOMFORT WITH SEXUALITY IMPEDES YOUTH REPRODUCTIVE HEALTH POLICY

National discomfort with the realities of sexual behavior in India, including youth sexual activity, has sharply constrained India's ability to address the sexual and reproductive health needs of young people. Accurate information on sexuality is scarce, and health care of any kind is hard to come by for young people in India, who are seen as essentially healthy and not in need of services. Those who seek reproductive health services often are met by judgmental health providers, and are afforded little or no privacy in which to discuss their problems.

Cultural expectations in India place heavy constraints on girls, with son preference, sex-selective abortion, and discriminatory nutritional and health care practices contributing to their subordinate status. More than 50 percent of girls marry before age 18, and have at least one child by age 20.⁷¹ Even within marriage, they are often unprepared for sexual intercourse and prevented by their husbands' families from using contraception. Boys and young men marry later but are tremendously anxious about their sexuality and also make up the majority of young clients seen at STI clinics.

Pre-marital sexual activity and pregnancy are more common than generally acknowledged, and reproductive tract infections are widespread among young women.⁷² Unmarried girls who seek out health services are stigma-

Total population, year 2000 (in thousands)	1,008,937
Population ages 0-24 (% of total population)	52%
Population ages 10-24 (% of total population)	30%
Annual population growth rate	1.69%
GNP per capita (PPP US\$, 1999)*	\$2,149
Average births per woman 15-49 (TFR)	2.9
Births to women ages 15-19 (as percent of all births)	9%
Births to women ages 20-24 (as percent of all births)	40%
Percent of 15-19 year-olds ever married (male/female)	10% / 36%
Percent of 20-24 year-olds ever married (male/female)	40% / 83%
Young married women (15-19) using any method of contraception (%)	8%
HIV prevalence in females 15-24	0.4 - 0.8%
HIV prevalence in males 15-24	0.1 - 0.6%
Years of schooling required	NA
Literacy among youth ages 15-24 (male/female)	79% / 59%
Primary Gross Enrollment Ratio (male/female)**	109 / 90
Secondary Gross Enrollment Ratio (male/female)**	59 / 39

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
** Total number of children enrolled for every 100 school age children.

Sources:

United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank.
International Institute for Population Sciences (IIPS) and ORC Macro. 2000. *National Family Health Survey (NFHS-2), 1998-99: India*. Mumbai: IIPS.
United Nations Population Division. 2000. *World Marriage Patterns 2000* [Wallchart]. New York: United Nations.
UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.

tized, affecting their chances for marriage. Both girls and boys often seek out less legitimate services out of worry about the lack of confidentiality, inability to pay, and fear of being discovered by parents or scolded by service providers.⁷³

BRIEF OVERVIEW OF THE POLICY ENVIRONMENT FOR YOUTH REPRODUCTIVE HEALTH

Reproductive health services provided by India's Family Welfare Program reach a remarkable number of people in far-flung areas, but have little to offer young people. Rooted in concern with population growth, they have long focused on long-term or permanent contraceptive methods for adult married women, to the detriment of

BOX 4

The Evolution of Population Policy in India

- 1952 Family Planning Program launched.
- 1976 Statement of National Population Policy.*
- 1977 Policy Statement on Family Welfare Program.*
- 1983 National Health Policy refers to need to secure small family norm; while adopting the policy, Parliament emphasizes need for a separate population policy.
- 1991 Committee on Population appointed by National Development Council recommends the formulation and adoption of a national population policy.
- 1994 Swaminathan Commission reports on national population policy.
- 1997 National Population Policy drafted.
- 2000 National Population Policy passed.

* Neither of these statements was discussed or adopted by Parliament.

Source:

Government of India. 2000. *National Population Policy*. New Delhi, India: Ministry of Health and Family Welfare.

those seeking other services or simply wanting to space births.⁷⁴ Over the past five years, the system has shifted toward more client-centered, integrated services. Still, other aspects of reproductive health—education, diagnosis and treatment of STIs, and services for the young, unmarried and men—have been neglected. Where services exist, social constraints pose enormous obstacles for young people who try to access them.⁷⁵

India's National Population Policy of 2000 acknowledges past failures to serve young people and proposes a wide range of remedies, including increased access to information and services, and enforcement of the Child Marriage Restraint Act of 1976.⁷⁶ A working group set up by the National Population Commission to contribute to India's 10th Five-Year Plan also focuses on women, children and adolescents.

The Family Welfare Department took its first steps toward addressing adolescent reproductive health in 2000, and is working with secondary schools and NGOs to set up clinics for students and out-of-school youths respectively. These efforts would eventually be integrated into India's huge national Reproductive and Child Health program.⁷⁷

WHAT REALITIES HAVE BROUGHT YOUTH REPRODUCTIVE HEALTH TO THE FOCUS OF THE NATION?

Concern with population momentum has driven interest in marriage and fertility among young people for a number of years. More recently, HIV has compelled the Government of India to pay closer attention to the sexual and reproductive health education of the young: about half of all people who contract HIV in India are under age 25.⁷⁸ Officials have acknowledged a need for adolescent counseling, public education and preventive measures.⁷⁹ A final factor reinforcing the focus on young people has been the integrated approach to reproductive health articulated at ICPD, including an emphasis on the individual wellbeing of youth.⁸⁰

It will take a while for proposed legislative changes to make the educational and public health systems friendly to youth.

IS THERE A YOUTH REPRODUCTIVE HEALTH POLICY?

The sexual and reproductive health needs of young people now figure prominently in the National Population Policy, and in India's draft National Youth Policy. The Indian government's enormous public health system and decades of experience in implementing population and family planning policies make it by far the largest player in the sexual and reproductive health arena. But it will take a while for proposed legislative changes to make the educational and public health systems friendly to youth.

Youth are viewed as needing what the state decides will be best for them.⁸¹ The Department of Youth Affairs and Sports (DYAS), established in 1985, formulated a national youth policy in 1988, but limited itself "to typical areas such as sports, education and vocational training," omitting health issues related to sexuality, sexual abuse and violence against young adults.⁸² In 1999, the DYAS became a Ministry, overseeing three major programs for youth. The National Service Scheme recruits university students to provide community service and reaches about 170,000 youth.⁸³ The Nehru Yuvak Kendra Sangathan (Nehru Youth Center Association) is a system of local youth clubs offering vocational training, awareness campaigns, and health fairs to 8 million out-of-school youth, ages 15-35.⁸⁴ The National Reconstruction Corps engages young volunteers in "nation-building activities" when fully operational.⁸⁵ These have all mobilized young people, but generally not on their own behalf.

The draft National Youth Policy, aimed at people ages 15 to 35, calls for the establishment of coordinating mechanisms among various ministries of the central government and the states.⁸⁶ However, this document has been in draft form for at least four years, and advocates hope that it will not follow the path of the visionary 1997 AIDS policy that has not yet been taken up by Parliament. The Planning Commission has in hand a new youth strategy for the 10th Five-Year Plan, but to date this very recent document has not been widely disseminated.

Complicating youth sexual and reproductive health efforts in India are conflicting and inconsistent state policies. Madhya Pradesh's state population policy directly addresses adolescent and family life education and notes the need to sensitize parents.⁸⁷ Uttar Pradesh's policy tries

to increase age at marriage by increasing awareness of the legal limits, involving advocacy groups, and denying government jobs to people who marry before the legal minimum.⁸⁸ Rajasthan's approach is more narrowly focused on reducing fertility and increasing age at marriage for women, now just above 15 on average.⁸⁹

Some states have sought to increase the value of daughters through monetary investment in eligible girls as determined by poverty and family size (*see Box 5*). Girls are allowed access to this money only when they reach a certain age and have not yet married or have achieved other educational requirements. These innovative schemes could have significant effects in the long run, yet women's advocates worry that government payments to families with daughters may reinforce a sense of girls' lesser worth.



Margaret E. Greene

Illustrative Incentive and Investment Schemes Affecting Girls and Young Women

National programs

Balika Samridhi Yojana (Young Women's Development Plan): A plan launched at the national level in 1997 to provide cash to poor mothers giving birth to first or second daughters.

Maternity Benefit Scheme: 500 Rupees to mothers who have their first child after age 19, for birth of first or second child only, contingent on ante-natal care checkups, and institutional delivery by trained birth attendant.

Fertility Reduction Scheme: "Couples below the poverty line who marry after the legal age of marriage, register the marriage, have the first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child, will be rewarded."⁹⁰

State programs

State of Andhra Pradesh: The only daughter or one of two children of a couple adopting sterilization will get a series of monetary benefits until she is 20 years old, and a lump sum amount at 20 if she remains unmarried until age 18.

State of Haryana: Cash gift recognizing and honoring mothers of girl children at the time of birth; long-term monetary investment that each daughter can claim at age 18, if unmarried. Additional sums may be given to girls who further delay marriage. The states of Kerala and Rajasthan have similar schemes.

State of Gujarat: Bicycle scheme offers new bicycles to girls who have completed the tenth grade, capitalizing on the relative mobility of girls and women in Gujarat. The gift rewards girls for their accomplishments and increases their mobility.

Sources:

- Government of India. 2000. *National Population Policy*.
 Department of Family Welfare, Government of Andhra Pradesh. 1997. *Andhra Pradesh State Population Policy*. Hyderabad, Andhra Pradesh: Government of Andhra Pradesh.
 Mathur, N. 1999. *Our Daughters, Our Wealth: Investing in Young Girls*. New Delhi, India: Population Council.
 Greene, M. 1996. *Watering the Neighbour's Garden*.

FOCUS OF PROGRAMMATIC EFFORTS RELATING TO REPRODUCTIVE HEALTH

Basic information about reproductive health is difficult for anyone in India to find, let alone young people. The inclusion of girls in the early 1990s in the nationwide Integrated Child Development Scheme was the government's first attempt to integrate adolescents into an existing broad-based program, with the potential to reach millions of girls. One project taught girls how to run childcare centers. Another sought to develop the health, literacy and skills of girls who have dropped out of school. In 1994, about 450,000 11 to 18 year-old girls around the country were participating in this program.⁹¹ A recent evaluation noted increased confidence among the girls, and improvements in the delivery of health services but criticized, among other things, its potentially exploitative recruitment of adolescent girls as volunteer workers.⁹²

Persistent ambivalence about sex education has also impeded the full implementation of a population and family life education program begun in the early 1980s. Some say the political will to implement a national sex education program is lacking at the top.⁹³ AIDS programs also sideline sexuality and sex education. Sex education has recently been included in India's National Curriculum, with segments on adolescent education and life skills. But messages displeasing to state officials are diluted, and teachers skip certain topics out of discomfort. As a United Nations Population Fund (UNFPA) staff member explained, the only strategy that works in the long run is to motivate teachers, as "teachers are gatekeepers more than parents."⁹⁴

The national government and several states run separate HIV/AIDS awareness programs in secondary schools, with the potential to reach over 6.5 million young people, but these have not been fully implemented.⁹⁵ Only Tamil Nadu has gone ahead with sexual health education, while Maharashtra actually banned AIDS education in public schools, despite having the worst epidemic of any state.⁹⁶ The objectives of population, family life and AIDS education are ostensibly quite different, and many gaps remain in what they cover, yet policymakers and school administrators point to whatever they are doing as proof that sexual and reproductive health are being taught in schools.

SPECIAL TOPIC

Thailand Increases Girls' Educational Opportunities

Combating child prostitution became a high priority for the Thai government in 1992. Although prostitution was illegal and punishable by imprisonment, child exploitation was steadily rising. Without educational and employment options, many young girls have no other way to support themselves and their families. The rise in HIV prevalence among sex workers from 3.5 percent in 1989 to 29 percent in 1996 prompted the government to launch a national effort to assist youth at risk of entering the sex industry. Preventive measures guaranteed nine years of quality basic education to all children, gave girls and boys equal access to formal and non-formal education and vocational training, and set up a surveillance system to prevent coercion or deception of children into becoming prostitutes.

Projects include the Sema Life Development Project, which has provided secondary-school scholarships for disadvantaged girls since 1994. Teachers are trained to identify girls at high risk of being exploited and to intervene with them and their parents for their continued education. Target areas include eight provinces in northern Thailand with high rates of HIV/AIDS and high percentages of girls who drop out of school after grade six. The Thai Women of Tomorrow project, initiated in 1992, places a greater emphasis on changing attitudes of parents and daughters toward prostitution and on vocational training as an alternative to school. Both programs prove that through education, adolescents can develop the maturity, knowledge and skills to protect them from deception and acquire better jobs. The Education Loan Fund Project was also designed to assist disadvantaged families, but focuses on children who finish grade 9 and cannot afford to enter upper-level secondary school, or secondary school graduates who wish to continue to vocational school or university training. Keeping children in school three more years further decreases their risk of entering the sex trade.

The Ministry of Public Health offers 50 to 80 nursing college places with guaranteed public hospital positions per year to Sema scholarship participants who finish secondary school. Seven companies offer training and jobs to Thai Women of Tomorrow girls. Those participating in vocational training are assisted with job opportunities in computers, modern fashion and design, and gem-cutting where girls earn relatively good wages. The Thai Government and State Lottery proceeds fund these programs and are committed to them over the long haul. The positive results of linking education and reproductive health ensure the ongoing involvement of Ministries of Education and Health.

Sources:

UNAIDS Best Practice Collection, "Reducing Girls' Vulnerability to HIV/AIDS: The Thai Approach," at <http://www.unaids.org/publications/documents/children/young/reducingcse.pdf>. Internet; accessed 21 December 2001.

Royal Thai Embassy in Washington, D.C., "Children Prostitution," at <http://www.thaiembdc.org/socials/childprs.htm>. Internet; accessed 21 December 2001.



Kym Bills

“Health services don’t look at adolescents specifically. You’re either a child and need vitamins, or you’re married and need obstetric care.”

—UNFPA official

The most interesting programs and services for young people are implemented by NGOs.⁹⁷ While the government sees the need to train young people to be responsible, NGOs are more likely to believe that young people *are* responsible and simply need information and support to make healthful decisions.⁹⁸

One non-governmental effort is the Bharat Scouts and Guides’ Healthy Adolescent Project in India program, which provides training in physiological aspects of reproductive health and promotes discussions of gender relations, confidence, and relationships.⁹⁹ Another program offers counseling to engaged and recently married young people, and free services to married couples in hopes of drawing first-time parents into greater use of services.¹⁰⁰ The Family Planning Association of India’s Sex Education, Counselling, Research and Training/Therapy program provides counseling for engaged and recently married young people, and free services to married couples. Other important NGO providers of reproductive health services and information are Parivar Seva Sanstha (Family Services Organization) and Marie Stopes.

WHAT WERE THE KEY FACTORS THAT MADE THE DEVELOPMENT OF THESE POLICIES POSSIBLE?

India’s shift from family planning to a reproductive health approach since 1997, with “more comprehensive ... services and a focus on client choice, service quality, gender issues and underserved groups, including adolescents,” has challenged programs to broaden their focus.¹⁰¹ However, ambivalence about the reproductive health agenda, particularly within programs on the ground, has slowed the evolution of services.

Another important factor has been the steady work of numerous non-governmental organizations that advocate for or do research on sexual and reproductive health and rights. Advocacy and education organizations include Tarshi (originally an acronym for Talking About Reproductive and Sexual Health Issues) and Naz (Pride), which have educated and promoted broader dialogue on sexual health, including HIV/AIDS. Those involved in research include the Population Council, doing programmatic research on interventions for young people, and HealthWatch, which tends more to engage in research for advocacy purposes, to ensure that the ICPD agenda is being implemented in India’s family welfare programs.

CHALLENGES AND RESPONSES

The political climate in India is unfavorable to the development and implementation of youth reproductive health policies. India’s diverse religious and cultural practices, beliefs and conditions hinder the implementation of existing laws. The need to enforce minimum age at marriage, for example, is rediscovered as an important issue over and over.

While population education efforts focus on demography and development, AIDS education efforts focus on the disease organism.¹⁰² Both narrow approaches sideline broader sexuality education. Sex education in schools and colleges and open discussions in the press are easily blocked by conservative opposition, censorship and pornography laws, as an analysis of the HIV epidemic in India found.¹⁰³ One atypical organization, Parivar Seva Sanstha, promotes sex education in Orissa state as a need and not a problem. The organization not only delivers services, but works with media and government representatives.

The national response to HIV/AIDS has been undermined by India’s ongoing denial that India’s young people could ever suffer from a full-blown AIDS epidemic.¹⁰⁴ The government bureaucracy separates HIV from other aspects of reproductive health, rarely addressing the more complicated social and personal factors that also shape reproductive health in general. This has also been true of



Margaret E. Greene

counselors based in the schools. UNFPA, itself newly recommitted to adolescents, will over the next two years be tailing off its support of population education and emphasizing sexuality and HIV/AIDS counseling.¹⁰⁵

LESSONS LEARNED AND RECOMMENDATIONS

India must overcome its discomfort with sexuality and face up to the reality of youth sexual activity, changing norms, and the AIDS pandemic. India's response to both HIV/AIDS and youth reproductive health needs is impeded by a "society-wide taboo on discussing sexuality."¹⁰⁶ There are almost no settings where it is appropriate and comfortable for anyone to learn about healthy sexuality, reproductive health, and disease prevention.

India needs urgently to develop its own broad, non-disease-driven approach to sexuality. India's biological approach to sex education and HIV education tends to address not gender roles and sexuality, but parenting, disease, and abstinence; nor does the Indian system of education facilitate active participation and interaction. Sex education should build on the experi-

India's response to both HIV/AIDS and youth reproductive health needs is impeded by a "society-wide taboo on discussing sexuality," says Siddarth Dube.

ences—and materials—of organizations that have been working to empower women and improve their health.¹⁰⁷

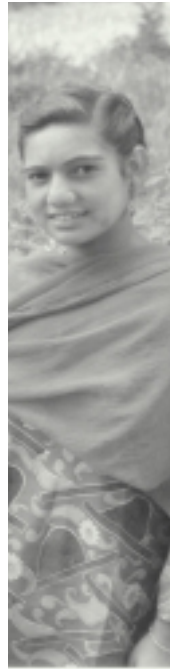
Widespread illiteracy underlines the importance of being able to talk about sexuality comfortably in one forum or another. Reaching out to young people for educational purposes will require further training in communication skills for educators and health personnel.

Strong leadership from the very top is critical to break the silence in India. Policymakers tend to assume that their constituents will be scandalized by any decisive moves they might make in this area; many seek political advantage by wrapping themselves in "cultural" and "traditional" values rather than by trying to dispel people's fears with correct information.¹⁰⁸

The government of India has missed important opportunities to work with youth in existing Family Welfare programs. The government needs to separate reproductive health, including HIV, from its demographic objectives, especially where young people are concerned. The confusion of these two national agendas has led to an unnecessarily narrow emphasis on family planning.

Few in either the government or NGOs are listening to young people themselves. There is little solicitation of young people as to what they might want or need, and there are few settings where they can discuss their own experiences and concerns. India has been very slow in coming to terms with its large youth population.

Although policymakers generally agree that investments in youth development need to cut across sectors, few activities draw on more than the health sector to address young people's sexual and reproductive lives. Poverty, illiteracy, the lack of health care, rural to urban migration, the low status of women, and many other factors contribute to poor reproductive health and the spread of HIV. Addressing such wide-ranging social obstacles to health will require going beyond the health system.¹⁰⁹



Margaret E. Greene

*Integrating sex education into school curricula will benefit young people directly, and may also improve the social environment in which state-run and NGO health programs operate.*¹¹⁰ Teachers can be important community leaders, and providing them with extensive non-judgmental training in sex education would be a useful starting point. Parents likewise need information, and parent-teacher associations might provide the means for them to learn.

Advocacy on the right of young people to reproductive health information and services is desperately needed in India. As long as youth rights are not taken seriously, young people's access to education and competent and respectful services will not be assured.

The government will benefit from listening more to non-governmental organizations, as they tend to have more experience working on youth reproductive health. Most NGOs find themselves outside the policy process, with little actual input into policy documents and implementation.

Activists on youth reproductive health in India must join forces and establish networks that focus on improving specific policies and programs. Networks such as HealthWatch, a collaboration among NGOs, researchers and activists that has sparked national debate on population policy and reproductive health programs, can play a larger role in promoting sexuality education as an important right of every Indian.

The government needs to complete the thoughtful draft National Youth Policy and act on it! The most recent proposal by the Planning Commission to include young people in the 10th Five-Year Plan may provide the structure and funds needed in the absence of such a policy.

The question now is whether India's leadership will make sure that the content of programs and educational efforts meets the enormous need for clear, nonjudgmental information and services for young people, indeed, for the entire population. The creation of new curricular materials for adolescents represents an important opportunity for India. A strong national youth policy, once passed, could provide the legislative backing for these changes at the programmatic level.

The Islamic Republic of Iran:

STRONG POLICIES DIFFICULT TO DOCUMENT IN PRACTICE

The Islamic Republic of Iran drew international attention in the 1990s for having implemented one of the world's most successful policies to stabilize population growth. A policy reversal in the late 1980s that led to the implementation of new population and family planning activities caused fertility to drop precipitously, and contributed to delays in marriage and longer spaces between births.

A disproportionately youthful population focused political and social concern on the needs of the young.¹¹¹ Iran's wealth relative to other countries in south-central Asia, due largely to its significant oil reserves, provided resources for addressing those needs. Young people ages 10 to 24 make up 37 percent of Iran's population of over 67 million.¹¹² Their literacy rate exceeds 95 percent, with rates for young women almost doubling from 48 percent to 92 percent over the past two decades, and rates among young men rising from 71 percent to 98 percent. These patterns are particularly marked in rural areas, where literacy rose from 27 to 89 percent for adolescent girls, and from 60 percent to 98 percent among adolescent boys following vastly expanded formal education opportunities.¹¹³

Iran's constitution is based on *Shari'a* or Islamic Law, and government policies and actions are guided by Islamic principles. Shi'a Muslims comprise 91 percent and Sunni



Total population, year 2000 (in thousands)	70,330
Population ages 0-24 (% of total population)	59%
Population ages 10-24 (% of total population)	36%
Annual population growth rate	1.69%
GNP per capita (PPP US\$, 1999)*	\$5,163
Average births per woman 15-49 (TFR)	2.6
Births to women ages 15-19 (as percent of all births)	9%
Births to women ages 20-24 (as percent of all births)	27%
Percent of 15-19 year-olds ever married (male/female)	5% / 26%
Percent of 20-24 year-olds ever married (male/female)	34% / 69%
Young married women (15-19) using any method of contraception (%)	34%
HIV prevalence in females 15-24	No Data
HIV prevalence in males 15-24	No Data
Years of schooling required	5
Literacy among youth ages 15-24 (male/female)	96% / 92%
Primary Gross Enrollment Ratio (male/female)**	102 / 95
Secondary Gross Enrollment Ratio (male/female)**	81 / 73

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
** Total number of children enrolled for every 100 school age children.

Sources:

United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank.
Ministry of Health and Medical Education. 1997. *Results of the 1997 Family Planning Survey of Iran*. Tehran: MOHME.
United Nations Population Division. 2000. *World Marriage Patterns 2000* [Wallchart]. New York: United Nations.
Population Reference Bureau (PRB). 2000. *The World's Youth 2000*. Washington, DC: PRB.
UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
UNESCO. 1995. *Statistical Yearbook*. Paris: UNESCO.
UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.
United Nations. 1997. *Report on the World Social Situation*. New York: United Nations.

Muslims 8 percent of the total population; others are Christian, Jewish, Zoroastrian and Baha'i (the latter a religious group not recognized by the government). A substantial population of Afghan refugees also lives within Iran's borders. In contrast with many other Muslim countries, Iran has often tempered *Shari'a* with a pragmatic approach to modern social demands, including the reproductive health needs of its people. This assessment of Iran's response to the ICPD mandate on youth sexual and reproductive health is based heavily on official documents and educational materials—reflecting Iran's stated intentions toward its young people, rather than extensive evidence of success or failure. Little research exists on what is actually happening, particularly where that reality departs from the government's intentions or from social norms.

THE POLICY ENVIRONMENT FOR YOUTH REPRODUCTIVE HEALTH

In 1979, an Islamic revolution replaced the semi-secular monarchy with an Islamic regime. The new constitution established mandates for the various branches of government under the supervision of the top spiritual leader, with significant consequences for the country's population and reproductive health policies and laws. Uncertainty regarding the role of family planning within Islam contributed to a lack of support by the new government, though both the public and private sectors continued providing services on a modest scale.¹¹⁴ Though some within government were concerned with population and family planning all along, policy overall promoted high fertility to maximize supporters of the Revolution, make up for the enormous loss of life in the Iran-Iraq war, and out of a sense of international isolation reinforced by the U.S. embargo.¹¹⁵ The pro-natalist strategy included lowering the age at marriage to 9 for girls and 14 for boys, offering incentives for families to have more children, and outlawing abortion. These policies, as well as immigration from Afghanistan in particular, resulted in a population boom from 34 million to 50 million between 1976 and 1986, an average annual growth rate of over 3 percent over a 10-year period.¹¹⁶

The 1986 census, which showed very rapid population growth and migration to the cities, was initially cause for elation and then for alarm. The Plan and Budget Organization, and the Ministry of Health and Medical Education (MOHME) resolved to launch a campaign to convince other policymakers of the need for a population policy and family planning program.¹¹⁷ Two important seminars held in the city of Mashad, one in 1988 on population and development, and the second in 1989 on Islam and population policy—organized for high-level clergy—were instrumental to this effort. The High Judicial Council announced that “family planning does not have any Islamic barriers” and the government doubled its population budget and established a new population policy and family planning program, the latter the responsibility of the MOHME.¹¹⁸ In 1990, the cross-sectoral Family Limitation Commission was created to coordinate and supervise all government activities relating to population policy, including promoting a small-family norm

The Islamic government faced a huge challenge in explaining this dramatic turnabout to its people and launched a national consensus-building campaign to make clear the negative consequences of rapid population growth, and the benefits of birth limitation for society and for women's health.

through the media, abolishing maternity leave after four or more children, increasing women's educational and employment opportunities, and expanding retirement benefits. The Islamic government faced a huge challenge in explaining this dramatic turnabout to its people and launched a national consensus-building campaign to make clear the negative consequences of rapid population growth, and the benefits of birth limitation for society and for women's health.¹¹⁹

Religious figures at the highest levels supported the campaign through radio, television, newspaper and Friday prayers. A hallmark of advocacy efforts was an emphasis on the role of family planning as essential to women's health. Iran's leader Ayatollah Khomeini spoke in favor of child spacing, and many others issued proclamations (*fatwas*) in support of specific methods of birth control and of breastfeeding and government officials cited the prophet Mohammed as stating that “small families bring greater ease.”¹²⁰ The prominent religious leader Ayatollah Shirazi exhorted Iranians to think about the quality rather than the quantity of Muslims.¹²¹ A 1993 law discontinued the entire pro-natalist policy, and a census showed that between 1986 and 1996, the average annual population growth rate dropped from 2.5 to 1.5 percent.¹²² Socioeconomic changes may have initiated the decline, but it was certainly catalyzed by the government's intense efforts between 1988 and 1991.¹²³

WHAT HAS BROUGHT YOUTH REPRODUCTIVE HEALTH TO NATIONAL ATTENTION?

Iran's baby boom and population growth became the focus of national dialogue about new approaches to education,

health, and other areas of social policy and how they could be implemented on the enormous scale needed. Parental concern expressed as pressure on the government to increase its attention to youth wellbeing was also an important factor.

IS THERE A YOUTH REPRODUCTIVE HEALTH POLICY?

No comprehensive policy specifically addresses youth sexual and reproductive health needs, and young people's sexuality has been a subject not comfortably discussed in the public domain. However, a National Population Policy, Family Planning Law, National Development Policy and National Health Policy all include youth-specific provisions. And a National Population and Family Planning Law mandates that the Ministries of Education, Culture and Health take responsibility for promoting student awareness of population and development and incorporate population education issues into school curricula.

The High Council for Youth, established in 1993, developed a National Youth Policy to raise awareness of the needs of young people but did not explicitly address youth reproductive health, even in sections devoted to family and marriage.¹²⁴ The National Health Policy mandates delivery of free and comprehensive health services, which include reproductive health, for all. Services are provided through a primary health care network serving over 90 percent of the population; this system is especially active in rural areas. While in theory a 16-year-old might be able to obtain reproductive health care without being questioned about marital status, age or parental approval, records will include all of this information and often determine the services and information he or she receives.¹²⁵

Similar contradictions exist with regard to marriage. The government's fertility decline campaign supported a movement by reformist parliamentarians to raise the legal minimum age at marriage from 9 to 15 for girls and from 17 to 18 for boys. Unfortunately, this effort has been blocked by the Guardian Council, the conservative body that must vet all legislation and candidates for compliance with its view of Islamic precepts. Nonetheless, socioeconomic development and higher educational attainment

"The problem of boys is more complicated because girls talk with their mothers about personal issues. Boys don't talk to their mothers, and fathers are not attending to their children. For boys we give a booklet to read and also we have a counselor to guide and answer questions."

—Ministry of Health representative

contributed to a rise in average age at marriage between 1986 and 2000 for both men and women (to 25 and 22, respectively).¹²⁶

Since the 1994 ICPD, increased public awareness of youth reproductive health issues has made it easier for the government to provide reproductive health education, counseling and services within conservative Iranian society. But it has proceeded cautiously, considering each community's sensitivity and putting religious leaders at the forefront of public education efforts. Despite the absence of a single overarching policy in this area, the political influence of experts and religious leaders within the ranks of government has played a critical role in bringing youth sexual and reproductive health to the attention of political leaders. While a number of non-governmental organizations have provided some advocacy, technical support and research, their influence is limited.¹²⁷



Zohra Rasekh

The government's more recent emphasis is to provide age-appropriate information through the formal education system. The government's attention to female literacy in recent years has made dissemination of materials much easier.

FOCUS OF PROGRAMMATIC EFFORTS RELATING TO YOUTH REPRODUCTIVE HEALTH

In many respects, an explicit youth reproductive health policy has not been missed in Iran.¹²⁸ A strong health system, commitment to serving everyone, and efforts to change public attitudes have served young people well. The Islamic government has coordinated and funded numerous projects and almost all services are provided free of charge.

The Ministry of Health and Medical Education and the National Youth Council are the two main coordinating bodies of multi-sectoral work aimed at improving young people's sexual and reproductive knowledge and health. In 1994, the ministry established a Youth Office within its Family Health Department to work with schools, teachers and parents on the medical and social consequences of youth sexuality.¹²⁹

One innovative program provides mandatory premarital courses for engaged couples; to obtain a marriage license, each couple must attend a half-day course on sexual and reproductive health issues, including family planning, and undergo medical tests for syphilis infection and drug use. Though the low limits on age at marriage mean that premarital counseling officials often find themselves having to prepare ten to fifteen year-old boys and girls for marriage, the counseling is regarded as effective and culturally accepted. The MOHME administers nearly 500 counseling centers nationwide, as well as many mobile teams in rural areas, and is trying to expand its services further with the assistance of a charity group, the Imam's Relief Committee.

A booklet, "The Message of Happiness for Young Couples," published by the MOHME, emphasizes love,

caring, and spiritual connection in the sexual relationship, and advises a young man to ensure the consent and readiness of the woman before having sex.¹³⁰ The text goes so far as to explain physiological responses to sexual arousal, and contains very explicit information on the enjoyment of each partner, sexual foreplay, hygiene, STI prevention, and the reality that AIDS can happen to anyone, particularly people with multiple partners. It discourages pregnancy before age 18 as a health risk, explains the signs of pregnancy, and recommends three years' spacing between births. Like many reproductive health publications in Iran, publications often include Muslim teachings that legitimize talking about sex-related topics.¹³¹

The government's more recent emphasis is to provide age-appropriate information through the formal education system. The government's attention to female literacy in recent years has made dissemination of materials much easier. Books for parents, and married and unmarried youth are now being tested in three different provinces.¹³² The MOHME also provides health information for a multi-sectoral program aimed at involving young Iranians in the nation's development.¹³³

The Ministry of Education (MOE) has also established a Curriculum Development Committee to develop educational materials for more than 1,000 pilot school projects in five provinces. The MOE made reproductive health education part of the school curriculum in September 2001, and existing materials will be integrated into school textbooks for senior high school students.¹³⁴ Though some population education and family planning materials have already been provided in schools, they have not been integrated into any required course.¹³⁵ UNFPA offers teacher training on adolescent health issues, and assists the Family Planning Association of the Islamic Republic of Iran (FPAIRI) and the education ministry in developing and producing educational materials to help parents communicate with their children.

Education is also the main focus of national NGOs working in reproductive health. The Parent Teacher Association (PTA), an independent NGO and long-time partner of the Ministry of Education, has published several manuals on youth reproductive health, family relationships, and gender, and an educational journal, Payvand (Connection), for parents. A FPAIRI project has

A remarkable aspect of Iran's approach to reproductive health in general is its attention to male education, awareness and participation.

provided training to adults who work with young people in a variety of settings including juvenile prisons, schools, cultural centers, PTAs and mosques.¹³⁶

Another FPAIRI program has produced age-appropriate materials for boys, girls and engaged couples. Materials for the youngest adolescents focus on physiology and hygiene; older girls and boys learn about STDs, pregnancy, and family planning. A booklet for girls presents the physical and psychological aspects of puberty, encourages seeing the beauty in womanhood and instructs girls to consult women in their families as well as their health practitioners for further information.¹³⁷ The content of the book for boys is quite different and more explicit than the one for girls, covering sexuality and sexual behavior, the importance of penis size, the psychology of interest and lack of interest in the opposite sex, masturbation, and other topics.¹³⁸ Only in materials for young engaged or married couples is information about sexual relationships and sexuality presented.¹³⁹

A remarkable aspect of Iran's approach to reproductive health in general is its attention to male education, awareness and participation. The government builds on evidence that men's involvement has an important effect on women's health and uses Islamic teachings that encourage men to take responsibility for their sexual behavior and to negotiate family planning with their wives.¹⁴⁰ The health ministry is finalizing a National Plan of Action for male involvement in reproductive health matters and the education ministry is expanding its sex education program to military bases and other workplaces with technical assistance from UNFPA.¹⁴¹

CHALLENGES AND RESPONSES

Discrepancies exist between the Guardian Council's views, government health policies, and local practices. For example, no official records are kept on the sexual health, pregnancies or abortions of girls under age 15 because they are considered children and are not supposed to be sexually active. And early marriages and high fertility are permitted, in spite of the recognition that these practices are harmful. The National Education Policy mandates schooling for married pregnant girls, but in

rural areas such schools are scarce and pregnant girls have to attend school in nearby cities or provinces.¹⁴²

Moreover, although Iran's policy achievements regarding youth are admirable, there has been little research into what is actually happening. This is where NGOs could potentially play a bigger role. In 2000, for example, with funding from UNICEF and the International Planned Parenthood Federation, FPAIRI surveyed 4,320 boys and girls in Tehran to assess the effectiveness of a series of sex education modules.¹⁴³ Such assessments are very much needed.

Indeed, the inadequacy of educational materials is another challenge to the success of Iran's youth program. On the one hand, textbooks and manuals are surprisingly open in their explanations of the body and sexual organs. On the other hand, most materials speak euphemistically of sexuality and relationship issues, and discussion of the sexual behavior of young people, even within marriage, is censored.¹⁴⁴ Few NGOs are involved in youth reproductive health in Iran: cultural, social and political conditions are not favorable to independent work by NGOs on the reproductive and sexual health of young people.

While it is clear that access to health facilities has greatly improved the health status of Iranians overall, few data are available about people aged 10 to 24.¹⁴⁵ Iran produces little information on the conditions young people face in accessing information or services, or in making sexual or reproductive decisions that differ from prevailing norms. For example, although there are no valid data on abortion (which is illegal except when the mother's health is at risk) and early pregnancy, experts estimate that approximately 100,000 young women undergo abortion each year, most of it illicit and/or self-induced.¹⁴⁶ Increased public awareness of the importance of young people to Iran's development has led to the collection of some data on their health status, but more needs to occur.

LESSONS LEARNED AND RECOMMENDATIONS

Factors favoring youth reproductive health efforts in Iran have included concern with the large youth population and its needs, strong government commitment to health, the support of high-level religious leaders, a well-educated society, cooperation between schools and parents, adequate national funds, and collaboration among various government sectors and civil society in policy planning and implementation. While Iran is unique in many respects, its experience is relevant to the development of youth sexual and reproductive health policy in other settings.

The government has enjoyed economic, political and religious support in addressing the needs of youth. Political conditions are such in Iran that it was possible to improve reproductive health information and services for citizens of all ages while pursuing the goal of reducing population growth. Iran's efforts toward population stabilization have occurred without the kind of human rights abuses that have occurred elsewhere; for example, the country explicitly avoided repeating India's experience with coerced vasectomy in the 1970s.¹⁴⁷

Changes in reproductive health policy have benefited hugely from the close association between political and religious leaders in Iran. Iranian Shi'ism has shown itself open to change, and to interpreting the Qur'an according to the time, place and people—providing a useful example for other countries in which religion has an important influence in policy development.

Iran's government has recognized that the leadership must be active in changing attitudes toward the provision of sexual and reproductive health information and services to young people. The need for an explicit youth reproductive health policy may be less acute when the political will to improve the reproductive lives of young people exists. But that political will exists among only some policymakers in Iran, and in only some sectors, requiring further advocacy on youth sexual and reproductive health.

Though sex and reproduction are sensitive topics, the government is working through culturally acceptable channels to facilitate access to accurate

information and the creation of safe contexts for open discussion of these issues. Tentative government reproductive health education programs in schools have been reinforced by PTA activities. The PTA has emerged as a powerful venue for discussing and producing materials on youth reproductive health issues. Iran has a long way to go before age-appropriate reproductive health information is integrated into curricular materials for anyone but the oldest students.

Government programmatic initiatives on behalf of young people's sexual and reproductive lives would be strengthened considerably by the development of a national policy in this area. The existence of such a document would assist in making Iran's policies affecting young people more consistent, and in facilitating cross-sectoral coordination.

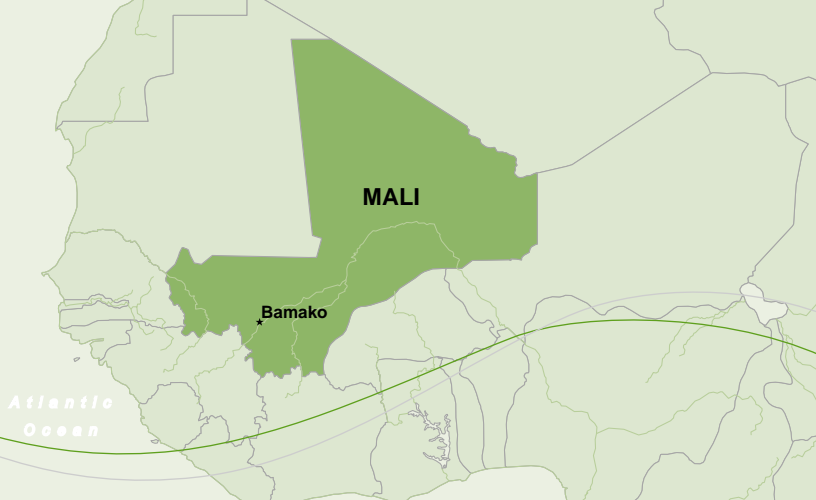
A commitment to youth development makes it possible for married and pregnant girls to continue their schooling after marriage. Iran's commitment to girls' education and development has led to the creation of special schools for these girls.

NGOs in Iran could play a more active role in informing policy-makers about local realities. The circumstances and consequences of very early marriage and pregnancy are often overlooked in the face of cultural conventions at the local level. The impact of pregnancy complications and abortion among young girls must not be denied. Civil society could play an important role in documenting what is happening on the ground and the effectiveness of various interventions.

Iran seems politically ready to formulate a culturally sensitive youth reproductive health policy, and has already been implementing several very promising programs. To the surprise of many outside Iran, some in the country's conservative government and religious leadership have been responsive to the reproductive health needs of young Iranians. Still, much remains to be done to educate policymakers and program implementers, and to develop more realistic policies for young people. The government must respond to the sexual and reproductive health needs of young people and approach the realities of their lives with greater frankness.

5

Republic of Mali:



POVERTY AND POOR HEALTH SLOW PROGRESS

West African cultural values combined with Islam give Malian women little say over much of their lives. Cultural factors that impede reproductive health include a sexual double standard, and extensive and yet stigmatized pre-marital sexual activity. Although women often support their families and households, their low levels of education and difficulty in accessing financial resources limit the kind of work they can do. School enrollment is very low, particularly among girls; no more than one in five girls in rural areas ever attends school.¹⁴⁸ Despite some achievements in reproductive health care provision since the ICPD, Malian women and adolescent girls experience high levels of early marriage and pregnancy, receive limited sex education in school, and have no legal access to abortion. In the mid-1990s, 42 percent of girls aged 15 to 19—69 percent of 19-year-olds—were pregnant or had already given birth, the great majority within marriage.¹⁴⁹ Twenty-two percent of women are married—illegally—by age 15, and 93 percent of women aged 25 to 49 were already married by age 22. Ninety-four percent of women of childbearing age have experienced female genital cutting (FGC).¹⁵⁰

Approximately 30 percent of the population have access to primary health care in Mali, one of the poorest countries in the world.¹⁵¹ Government-subsidized public health care is free only for pregnant women and children

Total population, year 2000 (in thousands)	11,351
Population ages 0-24 (% of total population)	66%
Population ages 10-24 (% of total population)	32%
Annual population growth rate	2.68%
GNP per capita (PPP US\$, 1999)*	\$693
Average births per woman 15-49 (TFR)	7
Births to women ages 15-19 (as percent of all births)	21%
Births to women ages 20-24 (as percent of all births)	28%
Percent of 15-19 year-olds ever married (male/female)	5% / 50%
Percent of 20-24 year-olds ever married (male/female)	29% / 88%
Young married women (15-19) using any method of contraception (%)	5%
HIV prevalence in females 15-24	1.7 - 2.4%
HIV prevalence in males 15-24	1.0 - 1.6%
Years of schooling required	9
Literacy among youth ages 15-24 (male/female)	71% / 58%
Primary Gross Enrollment Ratio (male/female)**	58 / 40
Secondary Gross Enrollment Ratio (male/female)**	17 / 8

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
 ** Total number of children enrolled for every 100 school age children.

Sources:

United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
 World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank.
 United Nations Population Division. 2000. *World Marriage Patterns 2000* [Wallchart]. New York: United Nations.
 Population Reference Bureau (PRB). 2000. *The World's Youth 2000*. Washington, DC: PRB.
 UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
 UNESCO. 1995. *Statistical Yearbook*. Paris: UNESCO
 UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.
 United Nations. 1997. *Report on the World Social Situation*. New York: United Nations.

up to 12 years of age. Universal coverage is impeded by the modest though increasing portion of the budget set aside for health care, the dispersion of the rural population, and the large share of the population at risk of poor health.¹⁵²

The sexual and reproductive lives of young Malians are not well addressed by current policies. Some early efforts are being made to train health providers how to treat young people, and mention of their needs appears in national guidelines for reproductive health services.¹⁵³ But Mali needs to draw its ministries together to formulate a national strategy to address the many constraints to young people's sexual and reproductive lives: gender inequities, social and political norms, the views of parents and other adults, and unfavorable social and economic conditions.

Most young people are not in school, which limits the impact of any school-based sex education program.

THE POLICY ENVIRONMENT FOR YOUTH REPRODUCTIVE HEALTH

In Mali, as in much of the developing world, population and health policies address reproductive health and rights. The ICPD definition of reproductive health as a state of wellbeing rather than just the absence of illness officially guides Mali's policies, though programs have moved forward in fits and starts. The government began to promote birth spacing for improved maternal and child health in 1972, and integrated reproductive health into maternal and infant health services in 1978.¹⁵⁴ In 1991 it adopted a national population policy statement emphasizing the protection of the family, the right of couples to decide the number and spacing of their children, respect for the rights of children, and the need to integrate women into the development process.¹⁵⁵ This policy refers specifically to the need to raise awareness of the detrimental effects of early marriage; to protect adolescents against early and unwanted pregnancies; to combat traditional practices harmful to girls' health, including female genital cutting; and to liberate women and adolescents from having to obtain spousal or parental consent in order to obtain services.¹⁵⁶

Most people working in reproductive health agree that since the ICPD, national policymaking has become more transparent, and youth reproductive health has received more attention. A 1996 government report to the United Nations specifically stated that health services for children are not meant to address sexual and reproductive health, but Mali's decentralization can potentially make the health system more responsive at the local level.¹⁵⁷

Female genital cutting is strongly supported throughout Malian society for a broad range of reasons including custom, religion, and beliefs about hygiene and the preservation of morality. However, an increased awareness of its negative effects led the government to develop a plan to eradicate FGC by 2008 through education and sensitization efforts and led by a National Committee to Eradicate Practices Harmful to the Health of Women and Children. Several organizations and networks, including Groupe Pivot/Santé Population and the U.S.-based Centre for Development and Population Activities, have teamed up on anti-FGC campaigns.

Sexuality education in Mali is not required, and when it is taught offers little more than basic concepts of reproductive biology.¹⁵⁸ Reference to sex education at the policy level emphasizes the need to instill awareness of the risks and disadvantages of early and unwanted pregnancy. Support from the United Nations Population Fund's (UNFPA) for sex and population education program in schools may help expand how the material is taught, and help move sexuality education efforts toward providing young people with the information and services they need to reduce risks. However, most young people are not in school, which limits the impact of any school-based sex education program. The fact that so many young Malians are not in school increases the likelihood of early sexual activity or risk taking, given the lack of opportunities for paid employment. Sadly, even those who have completed school do not necessarily have a better chance of finding work than their unschooled peers.

The political parties have a tremendous influence on youth, filling their heads with hopes and their pockets with money or other small favors, in exchange for their allegiance.¹⁵⁹ Every party has its youth wing, and is recruiting young people in preparation for elections in June 2002.

WHAT HAS BROUGHT YOUTH REPRODUCTIVE HEALTH TO NATIONAL ATTENTION?

Two realities have brought youth reproductive health to the attention of policymakers and program designers: high levels of pregnancy and unsafe abortion among young girls, and concern about the spread of HIV/AIDS. Pregnancy is not an issue simply because it conflicts with school, which so many girls do not attend; rather, when pregnancy occurs outside of marriage, as it does for many young women, it is seen as scandalous and disruptive behavior and may cause them to be thrown out of their homes.

SPECIAL TOPIC

Female Genital Cutting Banned in Senegal

Female genital cutting, long practiced in Senegal, has finally been outlawed. The 1999 legislation making this dangerous practice a criminal offense set punishment at up to six years in prison for offenders. Offenders are defined not only as the person performing the procedure but also parents and others ordering it.

The new law was strongly supported by President Abdou Diouf, who credits women at the grassroots with initiating the change. At the core of the movement was a group of newly literate women from the village of Malicounda, who had been trained by the non-governmental organization TOSTAN. The program—literally, “breaking out of the egg”—combined basic education in native languages with development issues. Upon completing this course, the Malicounda women were better equipped to make informed decisions about their own health and wellbeing, and that of their children.

Extending their newly acquired knowledge to neighboring communities, with support from TOSTAN and UNICEF, they brought FGC to public attention by performing a play illustrating their reasons for wanting to end the practice. Their next step was to establish a coalition with two neighboring villages. One, in which women had also recently completed TOSTAN training, readily accepted the “oath of Malicounda.” The other village, however, decided that consulting with kin in neighboring villages would be a prerequisite for abolishing FGC. Two male villagers who had been participants in the TOSTAN program, a facilitator and a senior Muslim mullah, traveled from village to village to discuss the negative effects of FGC, and to explain that Islam does not require FGC. As a result, many tribes decided that circumcision was no longer central to their cultural identity.

The community was then free to make its own decision regarding customary law. Convinced of the importance of their activism, the men returned eager to assist the women of the first three villages in organizing intervillage conferences for interested parties. This wave of community involvement begun in 1998 grew steadily, and eventually had a profound impact on Senegal’s legislation, even surprising outside activists who had been largely unsuccessful in their anti-FGC campaigns. The movement demonstrated that even a basic education gives people the tools to decide for themselves that harmful practices must cease. By mid-1999, 28 other villages had also renounced the practice of FGC. Senegal joins Sudan, Somalia, Kenya, Togo, Ghana and Burkina Faso in banning female genital cutting.

In other African countries such as Kenya, communities are embracing alternative rites of passage. Circumcision Through Words, for example, brings together young candidates for a week-long program of counseling, confirmation, and celebration. During a week spent in seclusion, the young girls absorb traditional teachings about their roles as adult women and parents in their communities. The program also develops their knowledge of health, reproductive issues, and hygiene and their communication skills and self-esteem. The eradication of FGC does not come without its problems. Advocates for ending this harmful practice are exploring new ways in which former circumcisers can earn a living.

Sources:

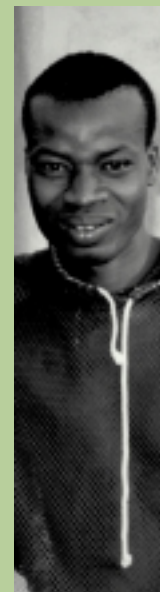
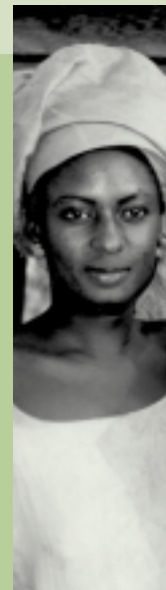
African News Service, “Alternative Rite to Female Circumcision,” at <http://allafrica.com/stories/199711190060.html>

CNN.com, “Female Circumcision outlawed in Senegal,” at <http://www.cnn.com/WORLD/africa/9901/15/senegal.01/>

UNFPA, “Senegal Bans Female Genital Mutilation,” at <http://www.unfpa.org/modules/dispatch/issues99/feb99/senegal.htm>

The Christian Science Publishing Society, “Standing Up To Ancient Custom,” at <http://www.csmonitor.com/durable/1998/06/03/p1s4.htm>

“Senegalese Women Remake Their Culture.” (No. 3, Dec. 1998) World Bank: Washington D.C.



Terri Bartlett

A national debate about the public health impact of unsafe abortion—especially for girls—is desperately needed.

Malian law does not recognize any grounds for abortion, though parts of the National Population Policy support an interpretation that would allow it if a woman's life were at risk.¹⁶⁰ A busy doctor at one reproductive health clinic stated that while health reasons might justify his performing an abortion, he would not provide the service in cases of rape or incest. One out of every 20 maternal deaths in Mali is estimated to result from unsafe abortion, but punishments for seeking or performing abortions are severe, and girls with complications often wait until their situation is desperate before seeking out legitimate health care.¹⁶¹ Even when a woman dies as a result of abortion, it is rarely discussed.¹⁶² A national debate about the public health impact of unsafe abortion—especially for girls—is desperately needed.

The prevalence of HIV is lower in Mali than in neighboring countries, but it is increasing and almost two-thirds of HIV-positive people are young, between ages 20 and 35. Among women ages 15-24, estimates of those infected range from 1.7 to 2.4 percent, while for men in the same age group, estimates range from 1.0 to 1.6 percent, below the lower estimate for women.¹⁶³ A National AIDS Prevention Program tries to strengthen organizational capacity, and knowledge of HIV among young people is high, but this has had little demonstrated effect on behavior, including condom use.¹⁶⁴ Half of women in one study had not changed their sexual behavior after learning about HIV, perhaps reflecting the difficulties young women face in negotiating sex or condom use.¹⁶⁵

WHAT YOUTH REPRODUCTIVE HEALTH POLICY IS THERE?

The government recognizes the importance of youth reproductive health, but has yet to develop a policy with clearly defined roles and responsibilities. Several ten-year plans in specific sectors demonstrate a capacity for long-term planning, but the additional challenge of coordination across multiple sectors—a requirement for youth

policy—has not been met. And while the Ministries of Youth and Sports, Health, and Women, Family and Children have joined forces to consider youth reproductive health, it isn't clear who should lead; the Ministry of Health is currently playing this role. It is also unclear whether any one of these ministries has the capacity to coordinate efforts across sectors.

Any meaningful multi-sectoral policy for young people in Mali needs to address the links between low rates of school attendance, especially among girls, reproductive roles, and aspirations and opportunities for work. Although pregnancy is not the principal reason girls drop out of school in Mali, it nonetheless almost always leads to an exit from school. An interesting mentoring program matches schoolgirls whose female family members have not attended school with older girls who are in more advanced grades, and provides other resources to keep them in school.¹⁶⁶

Many foreign donors have been working in Mali, and some NGOs there fault foreign donors for a narrow, single-sector approach to youth reproductive health. Others blame the heavy emphasis on a purely health sector approach on the lack of a national locus for youth policy initiatives. Some efforts have recently been made to “harmonize” their activities at the programmatic level; these include a USAID-funded NGO collaboration to prepare a unified training guide for peer educators.¹⁶⁷



Terri Bartlett

The extensive influence of international donor agencies makes Mali more vulnerable to externally initiated programmatic shifts. Given the lack of leadership for multi-sectoral coordination from within the government, the single-sector approach of international donor agencies becomes more of a problem. Because of its considerable involvement and influence in Mali, USAID's difficulty in combining its activities in education and health is especially disappointing.

FOCUS OF PROGRAMMATIC EFFORTS RELATING TO YOUTH REPRODUCTIVE HEALTH

Programmatic approaches focus on the training and deployment of peer educators, the social marketing of condoms, and the creation of youth centers. Few organizations are trying to address gender inequities and how they affect the sexual and reproductive lives of young people.

Although peer education offers access to a broad range of young people, particularly in urban areas, it is difficult to offer sufficient training, participants drop out at a high rate, and young people are not themselves involved in program planning.¹⁶⁸ Peer education efforts in Mali have also tried to change young people's behavior without addressing the circumstances that constrain their choices and decisions, and these programs often face initial opposition from parents, teachers, religious and community leaders.

Youth social marketing efforts focus on increasing condom sales and improving attitudes toward condom use. Social marketing efforts must take into account that it is socially unacceptable for girls to negotiate condom use, women's health advocates point out. The accompanying messages need development in order to increase their social impact, and indeed, some are starting to address FGC.¹⁶⁹

Youth centers provide sports and cultural activities as well as health services and information, youth facilitators and peer educators, and sometimes access to computers (for those who read French). UNFPA is supporting youth reproductive health activities through several youth centers in a five-year project through 2002.¹⁷⁰ The word from some donors and NGOs, however, is that youth centers are not reaching many young people and have little impact on their sexual and reproductive behavior and health.¹⁷¹

CHALLENGES AND RESPONSES

In spite of extensive programmatic activities taking place in Mali around youth sexual and reproductive health, the situation at the policy level is discouraging. The lack of coordination between ministries has prevented the rise of a multi-sectoral policy. Both the government and NGOs consider youth reproductive health a priority, yet have been unable to develop a comprehensive long-term strategy of support for young people in their sexual and reproductive lives.

For example, while girls officially have the same rights to reproductive health care as adult women, social obstacles discourage them from seeking out such care.¹⁷² The government's weak health care and education systems are currently not up to the task of serving young people. Recently published government guidelines refer explicitly to the need to adapt information and services to the needs of young people.¹⁷³ In a procedural manual, however, the instructions on the needs of young people generally simply refer the reader to the text on adults.¹⁷⁴ On the positive side, confidentiality and protection from backlash from parents are covered, a training manual exists, and at least 60 health care providers have now been trained.¹⁷⁵ In spite of their limitations, these procedures need to be validated by the government and widely disseminated so that some standards for quality of reproductive health care can be established.¹⁷⁶

Early marriage and childbearing undermine girls' reproductive health and schooling, and the existence of Mali's own National Girls' Education Agency, established in 1990, shows that the need to remove obstacles to girls' school attendance is recognized.¹⁷⁷ Yet few health information and services demonstrate real effort to reduce gender inequities. Mali's National Population Policy proposes to increase public awareness of the harmful effects of early marriage, give girls access to education, and give all young people information about the risks of pregnancy and how to gain access to contraceptives. Also under discussion is a new family code that would make the legal age at marriage the same for boys and girls.

Linking activities to eliminate female genital cutting more closely to reproductive health services could be a productive way to bring about change.¹⁷⁸ The Association for Support for the Development of Population Activities

“Here the government tolerates NGOs, but does not support them.”

—Malian veteran of international development work

believes that the most effective strategy is to present medical arguments against FGC to service providers and citizens. After seeing some of their materials in January 1999, the Ministry of Health wrote a letter to all regional public health and hospital directors stating that the practice of excision would not be tolerated in any health institution, and Mali’s president appears committed to developing a meaningful response to the problem.¹⁷⁹

An inter-sectoral working group is currently developing a National Youth Promotion Policy with the support and participation of UNFPA and the Population Council, but the process has been politically charged and kept under wraps. Many NGOs are too weak to participate actively, while the government is often unreceptive to NGO input, resulting in few opportunities for exchanges of perspectives.¹⁸⁰

LESSONS LEARNED AND RECOMMENDATIONS

Ensuring good sexual and reproductive health for Mali’s youth will require coordinated efforts to address young people’s many and interrelated development needs.

Getting a coordinated policy on paper will be an important step toward improving the reproductive health of young people in Mali. Mali’s heavy reliance on foreign donors reinforces the urgent need for such a policy, as donors’ programmatic emphases determine youth reproductive health activities.¹⁸¹ With no policy formally outlined, youth reproductive health activities are vulnerable when sympathetic individuals leave office. Donors could help by further contributing to the policy development process in Mali.

The government needs to build on the strengths of donors and non-governmental organizations to develop its own capacity for addressing the reproductive health needs of youth. The Ministry of Youth and Sports, where leadership would ideally reside, should be reinforced and given a coordinating role.

Given the daunting task of reaching Malian young people and the shortage of resources available for the job, the government should recognize and mobilize the talents and resources of non-governmental organizations. As a Malian veteran of international development work said, “Here the government tolerates NGOs, but does not support them.”

Non-governmental organizations have an important role to play in advocating with the government to prioritize youth development, including reproductive health. In other settings, NGOs have overcome the relative disinterest of government by joining together to form coalitions or networks. Mali’s women’s movement, for example, could provide rights-based rationale and language that would strengthen the less developed reproductive health movement. The opportunities for strategic collaboration on advocacy between women’s human rights organizations and reproductive health groups are enormous.

Community demand, financial support and commitment to programs can be more easily sustained if parents are encouraged to participate. A degree of social change needs to occur for young people to be able to seek out reproductive health care. Cultural norms that impede good sexual and reproductive health require working not only with young people but also with influential adults, teachers, and parents to change attitudes.

Efforts to improve the reproductive health of young people should extend beyond the important one of access to contraception. An overemphasis on contraception is too narrow an approach to youth sexual and reproductive health.

Commercial and social messages should be directed to young people and to young women in particular. Mali’s young people face significant social obstacles in accessing information, guidance and services. Prevailing social norms make it difficult for women to buy condoms or even make decisions about sexual relations. As long as girls’ contraceptive use is widely seen as a sign of promiscuity, straightforward social marketing efforts that sell condoms to boys will not significantly improve girls’ reproductive health.

The Malian government should reconsider the legal status of abortion, since illegal abortions are among the major public health threats to unmarried girls. One government strategy has been to conduct a public education campaign about the dangers of abortion, but this does not get at the root causes of unintended pregnancy among young people, and serves only to frighten them without providing alternatives.

Mexico:

NGOS ADVANCE NATIONAL DISCUSSION OF YOUTH REPRODUCTIVE HEALTH

Mexico's dynamic civil society movement makes for lively public debate on a variety of issues, including youth sexual and reproductive health. The strands of this debate include young people's rights and access to information and services, the balancing of parental and child rights, and of a developmental versus a problem-oriented approach to youth reproductive health. The focus of this analysis is on the powerful advocacy of Mexican non-governmental organizations, how they have moved the debate, and the strategies they have used.

THE POLICY ENVIRONMENT FOR YOUTH REPRODUCTIVE HEALTH

The concerns of Mexico's National Population Council (CONAPO) extend well beyond population growth to the reproductive health and wellbeing of the populace. Approximately 57 percent of Mexico's population of about 98 million are under the age of 25, and median age at sexual initiation is 15 for young men and 16 for young women.¹⁸² Yet public policies for the most part pay little attention to youth, and reproductive health policies have for 25 years focused on the needs of adult women. The needs of young people, for whom sexuality and reproduction are not always linked, have been neglected.



Total population, year 2000 (in thousands)	98,872
Population ages 0-24 (% of total population)	53%
Population ages 10-24 (% of total population)	31%
Annual population growth rate	1.63%
GNP per capita (PPP US\$, 1999)*	\$7,719
Average births per woman 15-49 (TFR)	2.8
Births to women ages 15-19 (as percent of all births)	15%
Births to women ages 20-24 (as percent of all births)	32%
Percent of 15-19 year-olds ever married (male/female)	6% / 16%
Percent of 20-24 year-olds ever married (male/female)	39% / 55%
Young married women (15-19) using any method of contraception (%)	30%
HIV prevalence in females 15-24	0.1 - 0.1%
HIV prevalence in males 15-24	0.3 - 0.5%
Years of schooling required	6
Literacy among youth ages 15-24 (male/female)	97% / 96%
Primary Gross Enrollment Ratio (male/female)**	116 / 113
Secondary Gross Enrollment Ratio (male/female)**	64 / 64

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
** Total number of children enrolled for every 100 school age children.

Sources:

United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank.
United Nations Population Division. 2000. *World Marriage Patterns 2000* [Wallchart]. New York: United Nations.
Population Reference Bureau (PRB). 2000. *The World's Youth 2000*. Washington, DC: PRB.
UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
UNESCO. 1995. *Statistical Yearbook*. Paris: UNESCO.
UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.
United Nations. 1997. *Report on the World Social Situation*. New York: United Nations.

Mexico was one of the first countries in Latin America to implement a government program for adolescents, even before the 1994 ICPD. In 1993, Mexico's Ministry of Health invited government bodies, NGOs, and international agencies working on health to a meeting to define strategies for adolescent reproductive health.¹⁸³ The "Declaration of Monterrey" that emerged from this meeting aimed to consolidate separate government activities and reinforce NGO support for adolescent health. In 1994, the Ministry of Health began a national program to address the health needs of young people, putting in place measures aimed at protecting their rights to information, communication and health services. The program was to be based on "an integrated vision that would encourage responsible attitudes and behaviors so that adolescents would assume their sexuality in an autonomous way, responsibly and without risks."¹⁸⁴

Family planning tends to be the focus of activities in the health sector, an emphasis that many people describe as either inappropriate or too narrow.

WHAT REALITIES HAVE BROUGHT YOUTH REPRODUCTIVE HEALTH TO THE FOCUS OF THE GOVERNMENT?

Government and NGO attention to young people together shape what is happening in Mexico, motivated by quite different factors. The government, pushed by adolescent pregnancy, population growth and the spread of HIV/AIDS, aims to reduce all three through education and family planning. CONAPO has stated its intentions to provide young people with the information and services that can enable them to make healthful decisions about their sexual and reproductive lives.¹⁸⁵

The most outspoken NGOs, in contrast, tend to be motivated by a broad concern for youth development and the rights of young people to information and support for their sexual and reproductive lives.¹⁸⁶ They invoke international agreements such as the ICPD Programme of Action and the Platform for Action of the Fourth World Conference on Women (Beijing, 1995), and have organized national events that explicitly lay out points of official agreement.

IS THERE A YOUTH REPRODUCTIVE HEALTH POLICY?

No overarching government policy addresses the sexual and reproductive health of young people in Mexico.¹⁸⁷ A central goal of Mexico's Reproductive Health and Family Planning Program (1995-2000) was to provide for the sexual and reproductive health needs of adolescents through the establishment of more than 100 centers in hospitals or clinics around the country.¹⁸⁸ Family planning tends to be the focus of activities in the health sector, an emphasis that many people describe as either inappropriate or too narrow. And insufficient training and

sensitization of providers make young people vulnerable to the whims of particular providers.

The Mexican Institute of Social Security (IMSS), which provides national health insurance and health coverage to workers, has widely implemented reproductive health programs in its clinics and hospitals, and is trying to be more welcoming to young people. IMSS reaches some 47 million people in mostly urban areas of the country.¹⁸⁹ The government reaches out to rural and indigenous youth through IMSS-Solidaridad, part of the larger IMSS system.

IMSS-Solidaridad, the largest government program in reproductive health and part of the larger IMSS system, serves more than 10 million people in rural areas and has a system of rural adolescent centers to address young people's health generally, and to encourage self-care based on an understanding of options and risks.¹⁹⁰ All of IMSS's programs have been hard-hit by federal budget cuts; between 1993 and 1996, federal reproductive health expenditures dropped by 33 percent, and health expenditures by 37 percent.¹⁹¹

The previously independent Integrated Development of the Family system (DIF), now located within the Ministry of Social Development, is best positioned to lead youth development activities nationwide. DIF focuses on basic health, legal assistance and educational programs for youth, families and women, and together with IMSS-Solidaridad is probably the most trusted government institution from the perspective of the population at large. However, both national and state DIFs are traditionally headed by the wives of elected officials, making leadership dependent on politics and the often inconsistent efforts of well-intentioned laypersons who turn over every few years.

Despite their collaboration, each institution and ministry has its own priorities and infrastructure. These organizations have met to discuss coordinated approaches and to reconcile their divergent visions of what needs to happen. The Mexican Youth Institute and the DIF, which have tended to trip over one another on matters relating to youth reproductive health, could work together to coordinate activities across multiple sectors.

FOCUS OF PROGRAMMATIC EFFORTS ON YOUTH REPRODUCTIVE HEALTH

Two approaches predominate in Mexico's policy arena: sexuality education; and services for young people who are sexually active, or have had a first pregnancy. Specific programs that link young people's health to other needs, such as schooling and employment, are rare. Sexuality education was not required in Mexico until recently, and sex education had historically been addressed—or not—at the whim of local school administrators. Teachers received no training, so other groups, such as the women's branch of the Legionnaires of Christ, stepped in, offering their services free of charge.

Mexico's recent progress in incorporating sexuality education into the national school system is due in large part to NGO advocacy efforts. Ten years ago, parents in a nationwide Gallup poll overwhelmingly expressed their support for sex education and their personal reluctance to address this issue with their children.¹⁹² Widespread dissemination of these findings led to the first collaboration between progressive NGOs and the government on a sexuality education program for ninth-graders in 1993, which in 1998 was extended to cover seventh and eighth graders.¹⁹³ Over this period, the program changed names several times, beginning with "adolescence and sexuality," and ending up as "civics and ethics." In 1998, fifth- and sixth-graders were introduced to a new required textbook on human biology and life skills. This has been followed by the more recent development of texts on health, sexuality, birth control and STIs.¹⁹⁴ In 1999, the Ministry of Education invited NGOs to compete to produce textbooks for use in the mandatory eighth-grade course.

However, the million teachers who should cover the material are still untrained. As a result, they often continue to skip sexuality education, or limit open communication and discussion.¹⁹⁵ Furthermore, since state secretaries of education often decide which books to use, a conservative official can profoundly limit the exposure of young people to information about sex and reproduction. The prominent, conservative National Union of Parents would like sex education programs for young people to be submitted for its endorsement.¹⁹⁶

A key challenge to youth sexual and reproductive health services in Mexico is the need to address the

Mexico's recent progress in incorporating sexuality education into the national school system is due in large part to NGO advocacy efforts.

HIV/AIDS pandemic. In 2000, the National Council for the Prevention and Control of HIV/AIDS (CONASIDA) focused on the important role of young men in influencing the course of the disease.¹⁹⁷ Charged with all aspects of dealing with the pandemic, CONASIDA has not focused particularly on working with young people, but has produced widely useful educational materials.

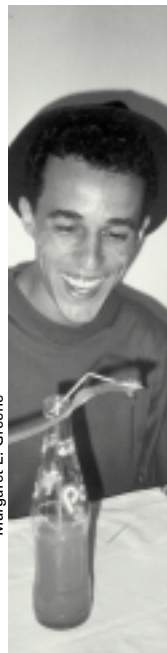
Mexfam (Mexican Foundation for Family Planning), the largest non-governmental source of reproductive health information and services in Mexico, has slowly been moving away from a demographic orientation to address broader issues of sexuality and gender. Volunteers in its adolescent health program, Gente Joven (Young People), conduct educational activities, distribute materials and non-medical contraceptives, and make referrals to Mexfam clinics.¹⁹⁸ Parents and teachers also participate in its activities.



Margaret E. Greene



Margaret E. Greene



Margaret E. Greene

BOX 6

Prominent Mexican Networks for Reproductive Health

Coordinación Nacional de Mujeres de Organizaciones Civiles por un Milenio Feminista—Brings together women's organizations for advocacy in several areas including reproductive health and rights; largest network in the country.

GIRE (Grupo de Información para la Reproducción Elegida, AC)—Collects, processes and publicizes information related to reproductive rights; conducts research, training and advocacy.

Demysex (Democracia y Sexualidad)—Dedicated to strengthening sexuality education and sexual rights and to promoting gender equity, all in the interests of building a democratic society; works nationwide.

ELIGE (Red de Jóvenes por los Derechos Sexuales y Reproductivos, AC)—Brings together young people to work mostly in Mexico City on training, advocacy and research; works to promote independent youth organizing around sexual and reproductive rights in different states of the country.

Foro Mexicano de Mujer y Políticas de Población—Gathers diverse organizations from around the country to follow up on implementation of the ICPD Programme of Action.

Sistema Nacional de Promoción y Capacitación en Salud Sexual—Brings together community-based organizations and individuals teaching sexuality, sexual and reproductive rights

Red de Salud de las Mujeres del Distrito Federal—Works to achieve full respect for women's right to health, and to strengthen the capacity of their members in health care provision; works in Mexico City

Comité Nacional Promotor por una Maternidad sin Riesgos—Organizes at the state level to promote safe motherhood; conducts advocacy at the national level on reproductive health and rights.

Entre ONGs—Convenes more than 50 NGOs that exchange information and training on life skills and sexuality education, and work with the government.

WHAT WERE THE KEY FACTORS MAKING THE DEVELOPMENT AND APPROVAL OF THESE POLICIES POSSIBLE?

Government institutions are increasingly attuned to the responsibility they have to prepare young people for their sexual and reproductive lives. Aside from the explicit youth-focused activities these institutions have undertaken, they now demonstrate a greater awareness of the shortcomings of public services where young people are concerned. The National Crusade for Quality in Health Services, for example, has drawn attention to the neglect of adolescents in most health services.

Advocacy by Mexican NGOs promoting the Cairo agenda has been key to improving the sexual and reproductive lives of young people. Especially notable here are youth advocacy efforts that build on the work and strategies of the women's movement to hold the government accountable for protecting the health and rights of young people. Civil society is strong in Mexico, and has increased its power by creating networks of organizations around various themes. The Ministry of Health and other government bodies have become ever more open to outside input.

Perspectives on youth sexual and reproductive health and education range widely. One end of the spectrum is represented by Elige, Letra S, and Demysex (*see Box 6 for details*), as reflected in an August 2000 meeting on young people's "right to have rights" in Tlaxcala.¹⁹⁹ These organizations and activities help maintain a high level of philosophical integrity in discussions of young people's rights to information and care. The National Union of Parents, in contrast, emphasizes parents' rights to regulate their children's exposure to information and is a locus for opposition to sex education. They and others have criticized the promotion of "sexual rights" by people they call "leaders of the 'Sexual Revolution'."²⁰⁰ Conservatives have generally been more willing to sit down and negotiate with the government than those on the left, leading to missed opportunities to strengthen sexuality education.²⁰¹

Several recent unplanned and unrelated developments have been useful in moving reproductive health issues forward: In 2000, a hospital in Baja California Sur refused to provide an abortion to a 14-year-old girl who had

became pregnant as a result of rape, although she was legally entitled to have one. And the Guanajuato state senate tried to make abortion illegal even in cases of rape.²⁰² Though state governments (rather than the federal government) determine the legality of abortion, these cases led to increased demands for decriminalization of abortion around the country. More recently, the Secretary of Labor refused to let his daughter read a book by noted author Carlos Fuentes, contributing to a lively national debate over parental control of information.²⁰³

CHALLENGES AND RESPONSES

Reproductive health and youth advocates see this as an exciting and unpredictable time in Mexico's history. The Independent Revolutionary Party or PRI, in power for 70 years, has been replaced by the conservative National Action Party or PAN, exacerbating tensions between conservatives and liberals over the best way to approach social issues.

A lack of sustained funding for training, services, materials, advocacy and evaluation of youth sexual and reproductive health projects threatens Mexico's capacity to build on its positive experiences. Decentralization further subjects reproductive health policy to the opinions and beliefs of governors and local officials, leading to inconsistent implementation of national health policy; continuity is lost, as programs are started and stopped.

The Ministry of Health's youth program, just evaluated, was coordinated by an alphabet soup of government agencies, including IMSS-Solidaridad, the Government Workers' Insurance Institute (ISSSTE), DIF, and the Mexican Youth Institute (IMJ). But norms for treatment of young people by healthcare providers are not strict, and insufficient training and sensitization of providers make young people vulnerable to the whims of particular providers. IMSS, ISSSTE and the hospitals of the Ministry of Health are trying to coordinate work in the big hospitals, building the capacity of medical personnel to deal with youth.

The government's sexual and reproductive health efforts for young people need to expand in scale. For example, one national program to prevent unwanted pregnancies, the spread of STIs and drug addiction has

"You can be sure the social side isn't being dealt with by most of these programs."

—High-ranking government official

only 248 centers for 22 million adolescents. Many have insufficient and poorly trained staff as well as inadequate supplies of condoms.²⁰⁴ Lack of insurance coverage is another major obstacle to youth reproductive health, as pregnant girls can't obtain insurance coverage unless they are children of insured people or are insured themselves as workers. National reproductive health services need to expand their efforts away from an exclusive focus on adult women.

Many opportunities are missed or only taken by chance rather than through careful planning. For instance, the conservative new director of the national DIF recruited Ana Cristina Fox, the daughter of Mexico's president, to launch an abstinence campaign to reduce adolescent pregnancy. Not until outraged reproductive rights advocates argued against basing a campaign on religious ideology, and social scientists were conferred with were other options considered.²⁰⁵ Better use of data and expertise inside and outside government could help turn things around.

Gender inequities greatly affect sexual and reproductive health in Mexico, yet the government's approach to reproductive health tends to be clinical, to the neglect of the social, economic and personal aspects of sexual relationships.²⁰⁶ As one high-level government official observed about youth reproductive health services, "You can be sure the social side isn't being dealt with by most of these programs." For example, schools are not making enough effort to increase and support the enrollment of girls, and no national law guarantees the schooling of pregnant girls.²⁰⁷

Problems differ in those urban and rural areas where Mexico's indigenous population is concentrated.²⁰⁸ In marginal urban populations, sexuality education and access to birth control must be linked to efforts to change socioeconomic conditions. In rural areas, there are few roles for childless women, and becoming a mother elevates a woman's social and community status. In order to reduce early pregnancy there, public education about the importance of schooling, scholarships to keep girls in

“We young people have the right to have rights.”

—Foro Nacional de Jóvenes por los Derechos Sexuales (National Youth Forum for Sexual Rights)

school, and support in delaying marriage must be the primary interventions.²⁰⁹

Public sector programs strongly emphasize birth control for married, heterosexual couples, slighting the many other sexual and reproductive health needs of young people. Government services in rural areas with high adolescent pregnancy rates offer nothing for young people until *after* pregnancy—perhaps because the approach has been to treat the young woman as a *mother* rather than as a *woman* or *person*. An exception is the program (developed with non-governmental support)—“Si yo estoy bien, mi familia también” (If I am well, my family is too)—which promotes empowerment and health, first for young women, and then for their children. After 18 months of providing young women with knowledge and skills to care for their own physical and mental health, the program introduces elements of how to care for their children. The program has reached 40,000 families in Oaxaca.²¹⁰ The recent creation of a coordinating body for social development (Coordinación de Desarrollo Social) that would include both Health and Education may expand programmatic approaches to human development and citizenship and integrate sex education more fully.

Many government agencies and NGOs are pursuing ICPD and Beijing objectives, but there has been little coordination of their activities, or evaluation of their impact.²¹¹ Civil society organizations often provide more coherent approaches and advocacy.²¹² For example, when the state of Guanajuato threatened to criminalize abortion even in cases of rape (in 2000), several NGOs worked to mobilize community members in opposition. As part of their efforts, they conducted a survey of public opinion on abortion, and then successfully used the finding that most people believed a woman who had been raped should not be jailed for seeking an abortion to prevent its criminalization.²¹³

LESSONS LEARNED AND RECOMMENDATIONS

The civil society movement in Mexico is powerful and dynamic and has the potential to extend significantly both the nature and scale of government work in youth sexual and reproductive health. Its advocacy of sex education in schools, in particular, has been important when policymakers and parents have been uncertain about how to move forward.

By joining forces through networks, NGOs augment their influence in national discussions of youth sexual and reproductive health. NGO networks have greatly strengthened reproductive health advocacy in Mexico; women’s health advocates have been particularly powerful in shifting public policy.

By boldly invoking rights language to promote sexuality education for young people, Mexican NGOs have taken advantage of a powerful ideological tool for their advocacy. They have used the language of international agreements to craft a vision of what youth reproductive health and rights should look like—providing not only the framework for their efforts, but the moral authority for urging the government to reshape its programs.

Advocacy by young people on their own behalf in Mexico provides an authority that is lacking in much youth reproductive health advocacy elsewhere. The youth movement is well represented and very active in Mexico. Women’s organizations that have advanced women’s sexual and reproductive health have provided important support for groups promoting young people’s sexual rights.

NGO networks working on youth rights should seek out opportunities to work in small groups with their opponents, including government officials. The unwillingness of progressive NGOs to negotiate compromises with the government has contributed to the disproportionate influence of a vocal minority of conservatives, bolstered by the unifying influence of the Catholic Church.

SPECIAL TOPIC

Chile Keeps Pregnant Girls in School

Latin America faces high adolescent pregnancy rates. In some countries, as many as 25 percent of all children are born to mothers under 19 years of age. Many of these young women face ostracism by their families, their peers and even school administrators, and the stigma attached to early and out-of-wedlock childbearing prevents them from completing their schooling. To prevent school dropout and additional unintended pregnancies, abortion and poverty, Chile has initiated an innovative program to keep pregnant girls in school.

Private donors and UNFPA funded a model school for pregnant teens called UNOPEC—incorporating in-school daycare facilities, training in specific job skills and most importantly, an environment free of the prejudice that young pregnant girls normally face in school. The school also helps them to find work. A recent assessment showed that this educational model achieves greater scholastic continuity, contributes to birth spacing, and increases access to better jobs.

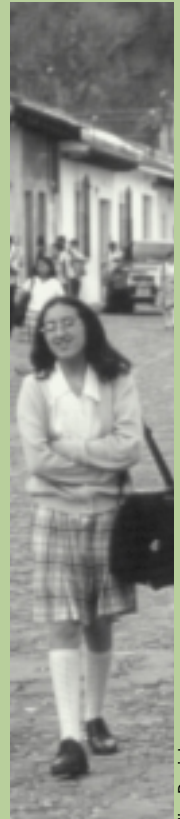
As a result, Chile's Department of Education and the Municipality of Conchali have incorporated the model into the public sector. The program continues under the name of Holy Maria of Conchali High School, offering sex education, hands-on learning and education for the children of the students. The model demonstrates the influence small programs can have on countrywide issues.

Sources:

WomensNet Headlines, "Chile: Keeping Pregnant Teenagers in School," at <http://headlines.igc.apc.org:8080/wnheadlines/964198005/index.html>. Internet; accessed 21 December 2001.

Todita.com, "Las Escuelas Ante el Embarazo Adolescente," at <http://todito.com/paginas/noticias/44573.html>. Internet; accessed 21 December 2001.

Proyectol.cal, "Liceo Holy Maria of Conchali," at http://www.fjguzman.cl/contenido/fundacion/publicaciones/proyecto/proy_local_mayo.html#top. Internet; accessed 21 December 2001.



Jim Daniels



Robert Engelman

Mexico needs to move beyond its clinical approach to youth reproductive health and address the social and economic conditions that shape young people's reproductive lives. The health sector has worked with young people, but its efforts are generally limited to service provision and come late in the game.

The approaches of diverse government institutions and NGOs and their networks require more coordination to be effective. A shared body of research on young people's lives may facilitate this process. Several recent studies—by the National Population Council, an attitudinal study by Mexfam, and a study on general youth behavior by the Mexican Youth Institute—have pointed to the importance of coordination as a goal of policy development.²¹⁴

Institutional leadership is important to the development of longer-term policies for youth. This leadership provides continuity in the delivery of key social services and education, and is essential to coordinating these efforts.

Specific advocacy with church-related groups to address the HIV epidemic may be a useful strategy. There is an urgent need to develop a vigorous policy of prevention, detection and treatment of HIV/AIDS without moralizing, which implies facing up to the opposition of the powerful hierarchy of Mexico's Catholic Church.²¹⁵

Mexico's experience with youth reproductive health offers many useful lessons for other countries. The immeasurable contributions that non-governmental organizations make are key to ongoing policy development, and ensure both citizen participation as well as government accountability.

North Sea

Amsterdam

NETHERLANDS

The Netherlands:

PUBLIC HEALTH TAKES PRECEDENCE OVER POLITICS

For more than four decades, the Dutch government has worked to change attitudes toward sexuality for the good of public health. Young people in particular have benefited from an emphasis on their right to the information needed to make healthful and responsible decisions. Numbering just under 16 million, the population of the Netherlands is one of the youngest in Western Europe, with 18 percent of its people aged 10 to 24.²¹⁶ Although many young people are sexually active, rates of unintended pregnancy and abortion are exceptionally low, due mainly to the society's realistic approach to youth sexuality and reproductive health. The Netherlands provides an excellent example of what can be achieved with a clear-eyed public-health focus. With an outstanding tradition of consensus building in policy development, this prosperous country places great value on quality of life for all citizens. Government cooperation with the public and civil society has been key.

Before World War II, Dutch society was traditional and religious, with Catholics, Protestants and Jews all sharing similar attitudes. Premarital sex was strongly discouraged, and there was no sexuality education in schools. Contraception was prohibited until the mid-1960s and, as a consequence, the Netherlands had one of the highest birth rates in Western Europe until the early 1970s.²¹⁷ The large families of the 1950s and 1960s led to social and

Total population, year 2000 (in thousands)	15,987
Population ages 0-24 (% of total population)	30%
Population ages 10-24 (% of total population)	18%
Annual population growth rate	0.52%
GNP per capita (PPP US\$, 1999)*	\$23,052
Average births per woman 15-49 (TFR)	1.5
Births to women ages 15-19 (as percent of all births)	1%
Births to women ages 20-24 (as percent of all births)	9%
Percent of 15-19 year-olds ever married (male/female)	0.2% / 2%
Percent of 20-24 year-olds ever married (male/female)	7% / 26%
Young married women (15-19) using any method of contraception (%)	NA
HIV prevalence in females 15-24	0.1 - 0.1%
HIV prevalence in males 15-24	0.1 - 0.3%
Years of schooling required	11
Literacy among youth ages 15-24 (male/female)	NA
Primary Gross Enrollment Ratio (male/female)**	109 / 107
Secondary Gross Enrollment Ratio (male/female)**	134 / 129

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
 ** Total number of children enrolled for every 100 school age children.

Sources:

Netherlands Central Bureau of Statistics (CBS). "Population: Key Figures." Statline.
 United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
 World Bank. *World Development Report 2000/2001: Attacking Poverty*. Washington, DC: World Bank.
 United Nations Population Division. 2000. *World Marriage Patterns 2000* [Wallchart]. New York: United Nations.
 UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
 UNESCO. 1995. *Statistical Yearbook*. Paris: UNESCO.
 UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.
 United Nations. 1997. *Report on the World Social Situation*. New York: United Nations.

political discussions of the country's high population density, a concern that later facilitated acceptance of family planning. One of the most conservative countries in the region at that time, the Netherlands' sober Calvinist roots still shape a cautious enjoyment of life and sexuality as something to be "earned."²¹⁸

Over the past 30 to 40 years, however, secularization has resulted in greatly increased openness with regard to sexuality and sexual and reproductive health. During the post-war reconstruction in the late 1940s and early 1950s, rapid urbanization and industrialization brought about substantial social and economic change, with significant consequences for social values and the family. In the late 1950s, the Ministry of Education sponsored national NGOs to conduct surveys on young people's sexual behavior, spurring a national dialogue.²¹⁹ While no discrete reproductive health goals were set, the government

The 1980s witnessed a “second sexual revolution” in Dutch attitudes, with the appearance of AIDS fostering public acceptance of all prevention activities, especially condom use.

invested in programs fostering personal responsibility and life skills.

From the early 1960s through the mid-1970s, Dutch society underwent a “sexual revolution,” brought on by a reexamination of socio-religious values, the women’s movement, heightened mass media exposure, gay rights efforts, and an awareness of the population growth that had resulted from fertility and immigration. Industrialization, economic growth, and a decline in the influence of the church also helped spur these changes. Large families became less appealing in this wealthier, more educated society, and contraception and sterilization gained increasing acceptance.

Citizen action in the 1960s gave rise to organizations such as the Netherlands Association for Sexual Reform, the Protestant Society for Responsible Family Planning, and the Catholic Bureau for Sexuality and Relations, all of which lobbied the government to legalize contraceptives.²²⁰ By the late 1960s, family planning was accepted by the Dutch Society of Family Doctors. By the late 1970s, a potent mix of forces, including the emerging feminist and gay liberation movements, had contributed to a transformation of sexual norms in the Netherlands.

The 1980s witnessed a “second sexual revolution” in Dutch attitudes, with the appearance of AIDS fostering public acceptance of all prevention activities, especially condom use. Improved funding of research drove thoughtful interventions. The media played an important role, and “Double Dutch”—using condoms *and* the pill—became the primary message, especially for young people. Far-reaching campaigns stressed the mantra “Safer sex or NO sex,” and condom use was promoted as a way for young men to share responsibility. New research in the 1980s raised awareness of sexual harassment and abuse and highlighted the need to look critically at the roles of boys and men in ensuring that sex is “safer” from unintended pregnancy and STIs, including HIV, and is not forced.²²¹

Respect for people’s wishes and boundaries is central to Dutch norms around sexuality.²²²

Policymakers also considered the public health consequences of unintended pregnancy among adolescents and took decisive action, leading to an astounding drop in the rate of unwanted pregnancies among unmarried adolescent girls from 100 per 1000 girls in the late 1960s to 16 by the end of the 1980s.²²³ Tremendous political support for the prevention of unwanted pregnancies inspired new campaigns to improve sex education and promote contraceptive use. The Netherlands has since spent more per capita than most other countries on reproductive health programs and research.²²⁴ In 1981, two-thirds of sexually active adolescents were on the pill, and even though ever more young people are now sexually active, the number of adolescent pregnancies has declined steadily since the 1960s, except for a slight increase among immigrant girls from the Dutch Antilles.²²⁵

WHAT BROUGHT YOUTH REPRODUCTIVE HEALTH TO NATIONAL ATTENTION?

In response to the United Nations Declaration on the Rights of the Child in 1959, the government developed a policy prioritizing the needs of young people and entitling them to “opportunities and facilities, by law and by other means, to enable them to develop physically, mentally, spiritually and socially in a healthy and normal manner.”²²⁶ This holistic approach to youth development highlighted the shortcomings of compartmentalizing government efforts by sector and the need to work across sectors.

By 1995 the national government directive was simple: Make life easier for young people and strengthen their contribution to society by working through multiple government departments and devolving decision making to localities.²²⁷ The central government’s hands-off approach minimized bureaucratic intervention and eased the integration of youth services at the regional level.

The Ministry of Health, Welfare and Sport emphasizes social and political participation as central to youth policy. Policymakers and youth advocates support a view of sexual development as a social learning process, an empowerment concept mainstreamed in the 1970s and 1980s, and believe that “learning to negotiate and communicate about

safe sex are ... important developmental tasks.”²²⁸ Local youth inform municipal policies through student councils and youth organizations. The national umbrella organization Dutch Youth Group advises the government on key youth issues, further blurring the typical hard lines between adult and youth expertise.

IS THERE A YOUTH REPRODUCTIVE HEALTH POLICY?

There is no one national policy document dedicated to youth reproductive health, which is addressed by a broad range of laws and policies in multiple sectors. Basic reproductive health care is provided under the universal health care system without charge. The national health insurance plan provides for a “dual contraceptive delivery system,” wherein contraception is available from private clinics that don’t require parental notification or consent for young people who also have their own doctors.

Youth involvement and programmatic activities in sexual and reproductive health are shaped by three laws which place equality, tolerance and respect at the center of social and political life. The Child and Youth Care Act (1989) addresses the implementation and financing of most youth services, including education, employment, childcare, early childhood education, mental and physical health, safety, sport and culture. The Education Participation Act (1992) regulates youth and community involvement in secondary schools. The Social Welfare Act (1994) addresses citizens in disadvantaged situations and stimulates their participation in society.

By the late 1970s, sex education had moved beyond the school system to the mass media, community centers, and youth fairs. Because AIDS arose in the 1980s while the government was instituting its first comprehensive sexual and reproductive health programs for young people, AIDS and STIs were integrated into sex education programs from the outset. This integration occurred thanks in part to Rutgers Stichting, a private non-profit organization funded entirely by the Dutch government until the end of the 1990s. In 1993, the national health promotion program “Living Together” was introduced into secondary schools to advance an even broader concept of sexual health including “safer sex, skills such as talking

Youth involvement and programmatic activities in sexual and reproductive health are shaped by three laws which place equality, tolerance and respect at the center of social and political life.

about and negotiating safer sex, and buying, carrying and using condoms.”²²⁹

With an emphasis on prevention, the national AIDS policy aims to promote solidarity with HIV-positive people and people living with AIDS, prevent risky sexual behavior, and promote scientific research that informs policy. The government also funds and cooperates closely with the AIDS Fund, an organization with an exceptional record of combating HIV/AIDS through research, preventive care, social integration, and advocacy initiatives.²³⁰ The Netherlands Foundation for STD Control, founded in 1973, is the main provider of STI and HIV services.²³¹

In the mid-1960s, the legalization of abortion became a central topic of public debate, leading to the development of a nationwide network of abortion clinics in 1971.²³² Stimezo Nederland (a network of non-profit abortion clinics) was organized to galvanize the support of the medical community and to encourage public support of



Barbara Huberman

A second key factor in the Netherlands' success is a belief that laws should address reality, not ideology. In simple terms, law follows practice.

abortion as a community health imperative. Stimezo successfully organized a movement that developed into a nationwide network of abortion clinics in 1971. Later legislation set standards for abortion services; free services under the national health insurance plan encourage clients to seek care early in pregnancy, and doctors have no fear of being sued.

FOCUS OF PROGRAMMATIC EFFORTS RELATING TO REPRODUCTIVE HEALTH

The Dutch place great value on education and encourage diverse pathways to learning and full adulthood. The Netherlands' Ministry of Education, Culture and Science, with one of the largest budgets of any government department, mandates instruction on relationships and sexual development, sexual harassment and abuse for both primary and secondary schools.²³³ Teachers' knowledge and ability to communicate material is regularly reinforced through training.

Schools are expected—though not required—to include sexuality education in their curricula; 95 percent of secondary schools and about 50 percent of primary schools do so.²³⁴ Schools can choose the materials, methods, approach and time spent on each objective but pregnancy, STIs, sexual orientation and homophobia, value clarification, respect for differences in attitudes, and skills for healthy sexuality are obligatory topics. The core message is that young people should take responsibility if they decide to have sex, and the underlying goal is that they learn to distinguish between safer and unsafe sexual practices and to care for their health and wellbeing. Students are taught the life skills they need to negotiate these practices.

But sex education is not perceived as primarily a school responsibility, and school-based efforts are supported by the provision of quality information to parents, family doctors, youth-friendly clinics, and the media. Information and services are easily accessible from pri-

mary care physicians and clinics on a confidential basis, at little or no cost.

A great deal of collaboration takes place between government departments, NGOs and private industry to promote and preserve an extensive network of institutional supports for youth. The Department of Health, Welfare and Sport largely funds the Netherlands Institute of Social Sexological Research (NISSO), for example, an independent research institute that addresses sexuality, intimate relationships and gender issues. NISSO has provided much of the scientific and sociological basis for ongoing national campaigns to promote good reproductive health. Its Youth Incentives division, staffed by a team of researchers, educational specialists, trainers, and medical and non-medical consultants promotes and disseminates sexual and reproductive health programs for young people. Through its international operations, NISSO endeavors to share the Dutch approach to youth sexual and reproductive health in the developing world.

WHAT WERE THE KEY FACTORS THAT MADE THE DEVELOPMENT OF THESE POLICIES POSSIBLE?

Working from agreed-upon core objectives allowed the government to take a hands-off approach, relying on shared values of integrity, citizenship, and responsibility of young people to guide programs. Rather than making detailed demands regarding the specific content of programs, the government closely monitors institutions to establish whether they are fulfilling their role in society.²³⁵

A second key factor in the success of the Netherlands in addressing youth sexual and reproductive health needs is a belief that laws should address reality, not ideology.²³⁶ In simple terms, law follows practice. When the philosophies of the Catholic Church were hostile to the modern family planning movement, Dutch society created avenues for reconciling the discord. Observing that its traditional morality was out of step with the increasing acceptability of premarital sex, the Dutch Church adapted its philosophy and made important concessions, promoting adherence to family values while acknowledging the changing character of young people's sexual lives.

Another important factor is an exceptional national capacity for achieving political consensus in the

Netherlands—the “Polder model”—that facilitates the search for common ground on difficult topics. A long-term coalition between Christian Democrats and Socialists has facilitated the passage of some important legislation, including, for example the legalization of abortion in the mid-1980s.²³⁷ Imbedded in the Termination of Pregnancy Act is a required five-day lapse time between a woman’s first consultation with a doctor or clinician and the actual procedure. Most women oppose the lapse time but it was included as a political compromise between competing party factions in Parliament upon passage of the law. The experience of the Netherlands represents “tolerance in a consciously pluralistic society [that believes in] accommodation rather than confrontation.”²³⁸

Mass media campaigns have also been a very strong force for changing public attitudes about sex, relationships, and decision-making. Television until recently was all government sponsored, and so access and acceptance of public health content was much easier there than in the private, commercial networks of many other countries. Subject to ongoing evaluation, mass media campaigns are research- and theory-based, “long-term, coordinated, implemented through multiple channels, and delivered on a large scale.”²³⁹ NGOs such as the Netherlands Association for Sexual Reform (NVSH) and Rutgers Stichting have mobilized the mass media for frank, explicit and often humorous education campaigns funded by the government. Through issue campaigns and a barrage of condom commercials, the media have explicitly situated reproductive health in the center of overall public health. And campaigns run intensively for several years, exhausting an issue so that it is thoroughly understood. Young people are flooded with advice on the meaning of their sexuality and how to keep it safe.

A final factor has been the positive involvement of parents and communities, who have adjusted to the realities of youth sexuality with an attitude of “restrictive permissiveness.”²⁴⁰ Restrictive permissiveness enables parents to pace youth in sexual development while educating them, communicating a positive outlook toward sexuality, and encouraging them to exercise their personal choice in informed and healthy ways.²⁴¹ Young people are very likely to live at home throughout adolescence and delay marriage until almost age 30. The reason for marriage is

By recognizing family planning as an important aspect of general practice, for example, the Netherlands Society of General Medical Practitioners made confidential birth control counselling a part of primary health care services for young people and adults.

most often to have children; until people are ready to take this step, it is acceptable for them to have responsible non-marital relationships. Laws, institutions and norms have adjusted, in the pragmatic Dutch way, to the new economic units brought about by cohabitation.²⁴²

CHALLENGES AND RESPONSES

The Netherlands has aimed key policy initiatives at reducing structural barriers to services and information. By recognizing family planning as an important aspect of general practice, for example, the Netherlands Society of General Medical Practitioners made confidential birth control counselling a part of primary health care services for young people and adults. Legislative and programmatic changes expanded youth access to contraception, abortion and other family planning services that had previously been illegal or inaccessible.

Public-private partnerships in the Netherlands have helped increase reproductive health options. The government maintains some distance in reproductive health care provision because direct and extensive government involvement is politically unacceptable there.²⁴³ With the support of advocacy groups throughout the country, the government committed the funds needed to establish family planning centers and to support clinics run by non-governmental organizations. Rutgers Stichting arose in 1969 and focused on providing and expanding access to reproductive health services, supplies, counseling and information. Designed as an alternative to family doctor care, its conveniently located walk-in clinics are the mainstay of the Dutch system of reproductive health clinics, especially for youth. Initially including 60 sites, Rutgers clinics declined in number as people increasingly took questions about sexuality and contraception to their

The Dutch approach to youth sexual and reproductive health “is practical. It is wise public health policy. It is respect for young people. It is a realistic focus on responsibility, not stigma. And it’s about living in the 21st century when relationships are defined in terms of pleasure, safety, trust, commitment, and mutual honesty. Is that Utopia? Then I want to find it for my children.”

—Barbara Huberman, Advocates for Youth

general practitioners. Today, low pregnancy and abortion rates, and expansion of services by family doctors and other health care practitioners have led to a perception that clinics are not needed as much as they were in the past, and by the end of the 1990s, only seven clinics remained. The Ministry of Health has resolved to keep these open to serve special groups and to try out innovative approaches.²⁴⁴

LESSONS LEARNED AND RECOMMENDATIONS—MOSTLY FOR OTHER SETTINGS

The government of the Netherlands catalyzed social change for public health purposes. A major public health goal has been to build young people’s capacity for responsible sexuality by expanding their knowledge and skills.

Youth reproductive health in the Netherlands is about the development, rights and needs of young people rather than the views of parents, other adults, religious figures and society. As a result, policies and the messages they convey are consistent, and programs reinforce one another.

The government has supported massive, long-term educational campaigns through the media. Its partnership with the media has shaped Dutch society’s views of sexuality and expanded people’s skills for dealing with sexuality.

Although the government has been centrally involved in supporting youth reproductive health by changing public attitudes and funding educational

and service provision institutions, it has carved out a supporting role for itself, rather than a dominant one.

The government’s monitoring of core principles rather than specific guidelines has allowed for considerable flexibility at the local level, flexibility that has avoided some of the confrontation one sees in other settings.

Parents and other adults accept young people as sexual beings and see intimate relationships as a natural part of development and the process of emotional maturation. This is absolutely not to say that the shift toward ‘restrictive permissiveness’ was easy and automatic for all parents. But parents’ attitudes toward sexuality have been shifted and their knowledge increased by the government public health campaign.

Young people in the Netherlands benefit from easy access to reproductive health information and services through family doctors, a model that could be applied in many other settings. Providing information and care for young people on sexuality and reproductive health is a responsibility of primary care physicians, often people whom adolescents have known since childhood.

There is little patience in the Netherlands for the hypocrisy that arises when abstract values are promoted in the face of contradictory life realities. This capacity for self-assessment has made it possible even for religious groups to take a hands-off approach to youth sexuality. The church and the state are sharply separated, and ethical behavior is seen as an individual’s responsibility rather than a religious one. Like many other institutions, churches have been supportive of sex education and awareness for young people because they see its importance to health and development.

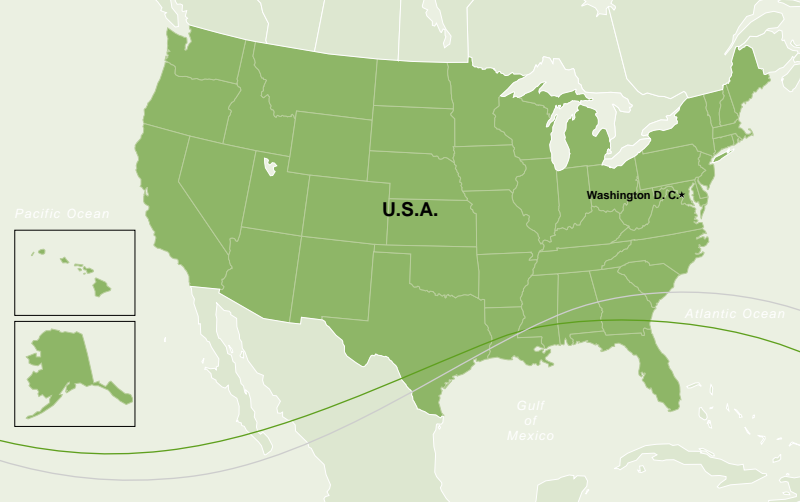
The Netherlands is among a handful of countries that routinely adhere to international agreements on social development and human rights. This dedication features prominently in the Dutch success story on youth reproductive health. Although the government has become increasingly lax in maintaining the high level of input that previously characterized its extensive programs, the progressive youth development framework has been thoroughly institutionalized, ensuring young people’s health and welfare. These laws, and the sum of youth-oriented policies at all tiers of government, are grounded in an ethic the whole of society has embraced, one that places equality, tolerance and respect at the center of social and political life.

The United States:

INADEQUATE PROGRAMS LEAVE YOUTH AT MERCY OF MASS MEDIA

The United States has considerable work to do to support young people's sexual and reproductive lives, particularly in comparison with other developed countries. Public debate on the issue is often polarized between those who espouse moralistic approaches and those who view the issue in strict public health terms, the perfect "recipe for stalemate."²⁴⁵ Too often, young people are left without the guidance or the skills to make healthful decisions about their sexuality, at the mercy of a mass media that glorifies sexual activity.

Fragmented policies reflect this polarization of views, while inadequate funding leaves both government and non-governmental programs without the resources to meet young people's needs for guidance and opportunity.²⁴⁶ This figures among the reasons for exceptionally low use of healthcare services by youth.²⁴⁷ At the same time, early sexual debut and later marriage, if marriage takes place at all, mean that young people are spending more time sexually active yet unmarried.²⁴⁸ The absence of public health and other policies that support America's 59 million young people as informed and responsible actors in their own sexual and reproductive lives reflects a distressing mismatch between the oft-espoused and actual commitments to youth development.²⁴⁹



Total population, year 2000 (in thousands)	285,556
Population ages 0-24 (% of total population)	35%
Population ages 10-24 (% of total population)	21%
Annual population growth rate	1.05%
GNP per capita (PPP US\$, 1999)*	\$33,833
Average births per woman 15-49 (TFR)	2.1
Births to women ages 15-19 (as percent of all births)	12.4%
Births to women ages 20-24 (as percent of all births)	25%
Percent of 15-19 year-olds ever married (male/female)	1% / 4%
Percent of 20-24 year-olds ever married (male/female)	19% / 33%
Young women (15-19) using any method of contraception (%)	29.8%
HIV prevalence in females 15-24	0.2 - 0.3%
HIV prevalence in males 15-24	0.3 - 0.8%
Years of schooling required	10
Literacy among youth ages 15-24 (male/female)	NA
Primary Gross Enrollment Ratio (male/female)**	102 / 101
Secondary Gross Enrollment Ratio (male/female)**	98 / 97

Notes:

* A measure of per capita income that takes into account relative purchasing power across countries.
 ** Total number of children enrolled for every 100 school age children.

Sources:

United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision*. New York: United Nations.
 U.S. Census Bureau. "USA Statistics in Brief." 2000 Census estimate.
 U.S. Census Bureau. "USA Statistics in Brief." 1999 Census estimate.
 U.S. Census Bureau. 2001. International Data Base (IDB).
 National Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. 1995 estimate.
 UNAIDS. 2000. *Report on the Global HIV/AIDS Epidemic: June 2000*. Geneva: UNAIDS.
 UNESCO. 1995. *Statistical Yearbook*. Paris: UNESCO
 UNESCO. 1999. *Statistical Yearbook*. Paris: UNESCO.
 United Nations. 1997. *Report on the World Social Situation*. New York: United Nations.



Margaret E. Greene/DC Campaign to Prevent Teen Pregnancy

The feminization of poverty in America has reinforced attention to out-of-wedlock early pregnancies, in large part out of concern with the burden young mothers might place on the welfare system.

THE POLICY ENVIRONMENT FOR YOUTH REPRODUCTIVE HEALTH

While there is no comprehensive reproductive health policy for either young people or adults, the United States has a long legislative history of addressing and then sidestepping reproductive health issues, especially contraception. In the 1870s, the Comstock Laws outlawed the production of “lewd” or “indecent” materials, classifying even contraceptive information as obscene. The Supreme Court rejected the Comstock Laws in 1939, the result of a growing political movement to legalize contraception. Margaret Sanger, who coined the phrase “birth control,” pioneered this movement, earning renown for her “radical” pamphlets on the use of contraception, founding the first family planning clinics, and laying the groundwork for the establishment of the Planned Parenthood Federation of America.

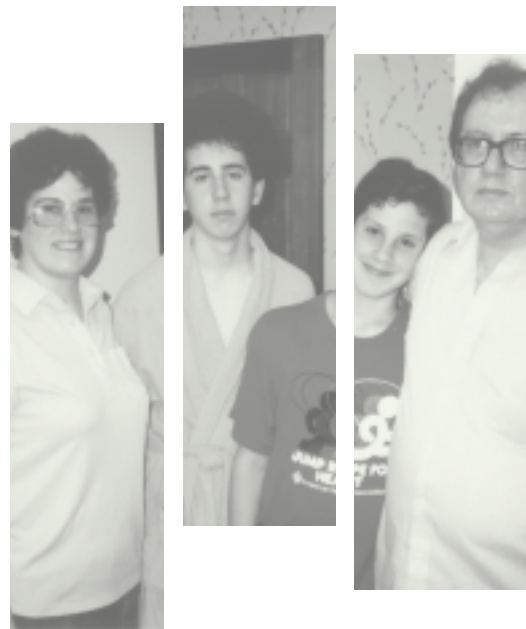
National debate on reproductive health and choices gained considerable attention with the advent of the birth control pill in the 1960s. Women’s demands for safe, reliable and convenient means to control their childbearing and national debates on welfare resulted in the enactment in 1970 of Title X of the Public Health Service Act, which provided funding for the establishment of clinics and services that have served women ever since. In 1973, abortion was legalized with the Supreme Court’s ruling in *Roe v. Wade*.

Opening the door to family planning and abortion services in the 1960s and 1970s gave an increasingly sexually active adolescent population access to confidential contraceptive services, but controversy over appropriate support for young people’s sexual and reproductive lives persists today. At the federal, state and community level, politicians, citizens’ groups, health professionals, and parents all continue to exert influence over youth reproductive health policy.

WHAT REALITIES HAVE BROUGHT YOUTH SEXUAL AND REPRODUCTIVE HEALTH TO NATIONAL ATTENTION?

Increasing STI prevalence and the AIDS crisis sparked a ‘safe sex’ movement starting in the 1980s that has broadened national discussion of young people’s sexuality and reproductive health. Despite sustained declines in adolescent pregnancies in the 1990s, almost one million occur annually, indicating a significant unmet need for reproductive health care, information and guidance.²⁵⁰

The feminization of poverty in America has reinforced attention to out-of-wedlock early pregnancies, in large part out of concern with the burden young mothers might place on the welfare system. Almost all federal money for young people—outside of education—is for programs targeting “at risk” youth, reflecting America’s problem-driven approach to addressing the sexual and reproductive lives of its young people.



Margaret E. Greene

IS THERE A YOUTH REPRODUCTIVE HEALTH POLICY?

A broad array of legislation factors into the policy backdrop for youth sexual and reproductive health in the United States. These divergent laws and regulations form an only sporadically supportive environment for young people's sexual and reproductive health.

Title XIX of the Social Security Act, Medicaid (1965), authorized states to use state and federal funds to provide health coverage and family planning services and supplies for low-income families, including sexually active minors. A national and state program that helps cover medical costs for people with low incomes, federal Medicaid dollars may not be used to pay for abortions except in cases of rape, incest or to save a woman's life, though states may elect to provide abortion services with their own funds.

Title X of the Public Health Service Act, the National Family Planning Program (1970), channels funds to an array of agencies that provide reproductive health services, making confidential and subsidized contraceptive and gynecological care available to adolescents.²⁵¹ A "gag rule" promulgated by the Reagan Administration in 1988 would have prohibited Title X programs from discussing abortion with clients unless their lives or health were threatened, but court challenges prevented its implementation, and President Bill Clinton rescinded it in 1993.

Title XX of the Public Health Service Act, The Adolescent Family Life Act (AFLA) (1981), funds demonstration projects by health agencies, school systems and other institutions that provide services specifically to young people. Projects are required to provide comprehensive health, education and social services, operate within various settings, and include youth development programs.²⁵² In recent years, a portion of Title XX programs have funded "abstinence-only education." AFLA's goal is to promote chastity, self-discipline and adoption among adolescents rather than to provide contraceptive services.²⁵³

Title V of the Social Security Act, the Maternal and Child Health Services Block Grant (1981), seeks to improve the health of mothers, children and youth through coordination of care and the building of community capacity. These funds can also be used to pay for

The hodgepodge and sometimes even contradictory policies governing youth sexual and reproductive health in the United States reflect limited active interest in youth sexual concerns and strong societal views about the need to "protect youth" from information that some mistakenly believe may lead to early sexual activity.

family planning services. This legislation has been amended several times since its adoption in 1935, and was converted to block grants in 1981.²⁵⁴ Section 510 of Title V, enacted as part of a much larger effort to reform the U.S. welfare system, establishes a separate abstinence education program apart from the block grants, "to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out of wedlock." Title V also supports the development of community-based abstinence education programs for youth, ages 12-18, through the Special Projects of Regional and National Significance (SPRANS) program. SPRANS provides modest support (\$40 million in fiscal year 2002) to both public and private entities for the development and implementation of such programs.

Personal Responsibility and Work Opportunity Reconciliation Act / Welfare Reform Act (1996), overhauled the nation's welfare system and also placed strong emphasis on reducing out-of-wedlock pregnancies, especially among adolescents. Unmarried minor parents are required to complete high school and live in adult-supervised settings to receive public assistance; child support and the establishment of paternity are strengthened, but opportunities for higher education and training are limited.²⁵⁵

Title XXI of the Social Security Act, The State Children's Health Insurance Program (CHIP), (1997), makes \$40 billion available to states for medical insurance of children under age 19 in low-income families. States have to fulfill only minimum federal requirements, and as a result, while reproductive health services are covered for youth in some states, they include only prenatal care or pre-pregnancy family planning services in others.²⁵⁶

The existing approach to youth sexual and reproductive health in the United States is medical and problem-driven, underestimating both young people’s needs and their competencies.

Since the 1973 Supreme Court *Roe v. Wade* decision legalizing abortion, adult women have had the right to obtain first-trimester abortions without restriction. However, laws in 35 states require young women to obtain consent or notify one or both parents before obtaining an abortion; 26 states enforce these measures.²⁵⁷ Waiting periods and a host of other restrictions also apply. Funding restrictions also limit the use of federal Medicaid funds for abortion services for low-income women.

WHAT KEY FACTORS MADE THE DEVELOPMENT OF THESE POLICIES POSSIBLE?

The hodgepodge and sometimes even contradictory policies governing youth sexual and reproductive health in the United States reflect limited active interest in youth sexual concerns and strong societal views about the need to “protect youth” from information that some mistakenly believe may lead to early sexual activity. Overall, both youth policies and the allocation of funds for youth are conservative. The rise of the religious right, increasing support for a conservative legislative agenda, and an unwillingness among Members of Congress to oppose abstinence-only sex education have also shaped the policy environment in the United States. Twenty years of growing support for “states’ rights” in the country has allowed state-by-state differentiation of objectives and outcomes. So while plenty of legislation affects the sexual and reproductive health of young people, it has often been compromised by a lack of resources and little attention to monitoring implementation.

An indication of the sad state of affairs in the United States has been the casting aside by a conservative administration of a carefully crafted national report on sexual and reproductive health. Written by Surgeon General David Satcher, the “Call to Action to Promote Sexual Health and Responsible Behavior” was released in July

2001 and quickly disappeared.²⁵⁸ This document assembles the facts and lays the basis for national dialogue on sexuality and sexual health and how to address them.

MAIN FOCUS OF PROGRAMMATIC EFFORTS RELATING TO YOUTH REPRODUCTIVE HEALTH

The existing approach to youth sexual and reproductive health in the United States is medical and problem-driven, underestimating both young people’s needs and their competencies. Focused mainly on medical care and services on one hand, and social programming to reduce out-of-wedlock childbearing on the other, programs are predominantly oriented toward women. Sexuality education is widely available in schools, but its content and structure differ widely depending on the setting.

CHALLENGES AND RESPONSES

Laws governing young people’s reproductive health and access rights are contained in a patchwork of Constitutional provisions, federal, state and local statutes and policies, and Supreme Court decisions. Decisions made at various levels are not well coordinated, and the jostling among them adversely affects reproductive health outcomes for youth.²⁵⁹

For example, although several Supreme Court rulings limit the power of states to regulate or ban abortion, nearly every state limits abortion services in one way or another—leading many young women to delay obtaining services and to seek more dangerous alternatives.²⁶⁰ States may be forced to impose restrictions in order to qualify for certain funds. Restrictions may also stem from a governor’s leanings on reproductive rights and health, which typically reflect party platform.²⁶¹ Thus, although abortion is generally legal in the United States, anti-choice politicians have limited abortion information and access through parental consent requirements, counseling and referral bans, and complicated restrictions on funding, among other strategies.

Contradictions exist between state and federal priorities. For example, the *federal* Medicaid mandate stipulates that enrollees of childbearing age have access to family

planning services, yet only one-third of *state* Medicaid programs routinely provide information about contraceptive coverage. Most plans generally do not give such information to those under 18 years old, effectively denying youth access to *legally covered services*.²⁶²

Close to 1400 school-based health centers (SBHCs) in 45 states and the District of Columbia provide affordable, convenient and confidential services to adolescents.²⁶³ However, most sidestep reproductive health issues, including contraception and abortion counseling, and community or state opposition has compelled some to drop reproductive health services. School district policy may prevent them from dispensing contraception on site.²⁶⁴

Approximately half of all adolescents using reproductive health services obtain them from no- or low-cost public clinics. Still, many young people are not getting the full range of reproductive health care services they need.²⁶⁵ Only half of all physicians report providing any counseling to adolescents on reproductive health issues, and fewer than 3 percent report providing counseling on STIs or HIV.²⁶⁶ Embarrassment and discomfort about interaction with physicians are substantial considerations for adolescents.

Fear of legal liability inhibits some American doctors from providing complete information and care. Although doctors are legally protected, their concern with parental reactions sometimes impedes their relationship with young patients. Most states set the age of consent at 16, though some set it as early as 13. Whatever a young person that age or above confides in a pediatrician must remain confidential and doctors are protected from liability by confidentiality clauses. If an under-age youth seeks reproductive health information or services, the pediatrician must by law tell the child if parental permission is required to discuss the topic.²⁶⁷ Pediatricians generally encourage parental involvement.

Youth themselves often do not seek care for fear their parents will be informed.²⁶⁸ Another major obstacle to youth access to sexual and reproductive health services is that young people often lack insurance or face other financial obstacles. Uninsured, low-income and minority youth are particularly at risk of not obtaining the health care they need for financial reasons, underlining the importance of Title X and CHIP.

State laws increasingly recognize minors' ability to make appropriate decisions regarding their own health

BOX 7

Highlights in Sex Education Policy

- Early 1900s** Sex education begins as an effort to reinforce sexual restraint and the procreative character of sex.
- 1919** White House Conference on Child Welfare supports sex education in public schools.
- 1920** U.S. Public Health Service publishes the Manual on Sex Education in High School.
- 1940s** National associations call for an improved, more progressive curriculum. While maintaining a moralistic focus, curricula now promote information about healthy sexuality, reproductive issues, "normal" sexuality and "venereal diseases".
- 1950s** The American Medical Association and the National Education Association jointly publish a sexuality curriculum focused on family life education.
- 1960s** The Sex Information and Education Council of the United States (SIECUS) is chartered with the goal of promoting healthy sex attitudes and the spread of factual information. Opposition groups begin to fight aggressively at state and local levels against sex education in schools.
- Early 1970s** Twenty states vote to restrict or abolish sex education.
- Late 1970s** Only three states and the District of Columbia require sex education.
- Mid 1980s** Recognition of the sexual transmission of HIV/AIDS dramatically changes the argument against sex education. Surgeon General C. Everett Koop calls for sex education in schools as early as the third grade. States begin to require instruction on HIV and other STIs, with some states establishing sex education requirements.
- 1988** The Centers for Disease Control and Prevention offer financial and technical assistance to state and local education agencies, national organizations and other institutions to improve HIV education in schools.
- 1996** Federal funding for abstinence-only sex education included in welfare reform.
- 1997** Nineteen states and the District of Columbia establish laws or policies requiring schools to provide sex education, with 34 states plus the District of Columbia mandating instruction about HIV/AIDS and other STIs.
- 2001** Surgeon General David Satcher issues a national "Call to Action" to promote sexual health and responsibility as a major public health priority. An endorsement of comprehensive sex education, Satcher's declaration stresses full access to developmentally and culturally appropriate information.

Social and cultural norms tend to push pregnant and parenting girls out of school ... or to alternatives of lower academic quality. Girls may not even be told that they are entitled to tutoring and childcare under Title IX.

care, yet minors do not have full autonomy when it comes to accessing confidential care.²⁶⁹ Debates over parental consent continue at congressional and state levels, and state policies regarding minors' authority over health care decisions extend to STI/HIV testing, prenatal care and delivery services, abortion, and contraceptive services.²⁷⁰ Only about half of the 50 states give minors the explicit right to consent to their own contraceptive care.²⁷¹

Several youth populations face significant barriers to obtaining sexual and reproductive health information, care and guidance. These include young people living in underserved, rural areas, the nearly half a million living in foster care, group homes or residential living situations, and homeless youth and runaways.²⁷² Surviving on the margins of traditional school and health care systems,

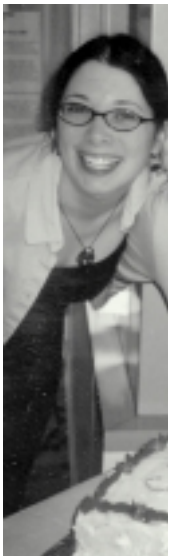
these young people often have complex sexual histories, including high rates of abuse, pregnancy and STI/HIV infection.

Title IX of the Education Amendments of 1972 prohibits school discrimination based on gender, marital, pregnancy or parenting status, and requires that absences due to childbirth be treated as any other absence from “temporary disabilities,” but social and cultural norms tend to push pregnant and parenting girls out of school, particularly in southern and rural school districts, or to alternatives of lower academic quality.²⁷³ Girls may not even be told that they are entitled to tutoring and childcare under Title IX.

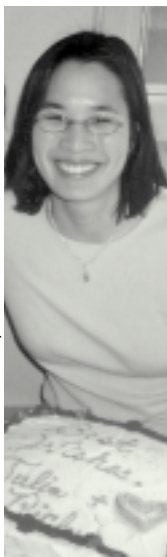
More than 90 percent of Americans support teaching sexuality education in high school and 84 percent support teaching it in junior high school.²⁷⁴ Seventy percent of Americans oppose federal funding for abstinence-only education. But these overwhelming majorities have been underrepresented in the national policymaking arena. Thus, the content of such courses falls short of a comprehensive approach to healthy sexual behavior.

Policies and financial commitments to sexuality education have zigzagged wildly over the past few years. There is no national law on sexuality education, although almost all states require or encourage some form of it in the public school curriculum, and there is enormous state-by-state variance (*see Box 7*).²⁷⁵ Even the medical accuracy of sex education materials is unreliable and varies from school to school. While it is true that a huge amount of information is available to youth—just look at any magazine for girls—well-informed and non-judgmental parents, teachers, and health personnel are often scarce in young people's lives, and youth views do not figure in the cacophony of voices holding forth on youth reproductive health.

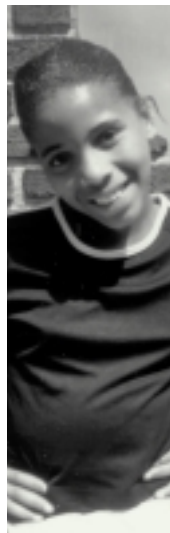
Some responses to these challenges include efforts to involve young men, the establishment of school-based health clinics, and policy and programmatic efforts to address the broad developmental needs of young people. Young men remain largely outside the system, and the few who seek health care receive little or no information about sexuality or reproduction from providers.²⁷⁶ Concerns over adolescent pregnancy rates and increases



Sarah Reidy



Sarah Reidy



Margaret E. Greene



Sally Ethelston

in the numbers of men fathering children outside of marriage have prompted agencies and advocacy groups to establish state and local initiatives to encourage responsible fatherhood.²⁷⁷

School-based health clinics in middle and high schools are increasingly providing services that include treatment of STIs (73 percent), HIV/AIDS counseling (77 percent) and diagnostic services such as pregnancy testing (85 percent).²⁷⁸ School-linked health centers (SLHCs) are a newer approach to dealing with the restrictions that parents and school boards often impose on SBHCs, and may help to end the stalemate over school-based services. They are offsite yet maintain formal and informal linkages to schools; every SLHC has a presence in its affiliated schools through one or more health, social or youth workers.²⁷⁹ SLHCs provide more comprehensive medical services including reproductive health care, counseling, social services designed for adolescents, and sometimes even pediatric care for children of young patients.

The Family Life Education Act, introduced in Congress in December 2001, responds to many of the shortcomings of sex education in U.S. schools.²⁸⁰ It carefully defines family life programs as, among other things, being age-appropriate and medically accurate, and stressing the value of abstinence while not ignoring young people who are already sexually active.

The Younger Americans Act recently introduced in Congress would strengthen the coordination and evaluation of youth-oriented services. Supported by over 40 national organizations, the legislation would mandate a nationwide network of supportive services for youth access “to the competencies and character development they need to be fully prepared as adults and effective citizens.”²⁸¹ Youth Development Programs (YDPs) exemplify the approach that could arise from this broad legislation. They do not focus on stopping “bad behavior,” but rather offer young people the support they need to be competent, well-functioning adults.²⁸² Evaluations of YDPs suggest that such multi-sectoral programs addressing education, employment and life options for young people also reduce early pregnancy.²⁸³

More than 90 percent of Americans support teaching sexuality education in high school and 84 percent support teaching it in junior high school.²⁷⁴ Seventy percent of Americans oppose federal funding for abstinence-only education.

LESSONS LEARNED AND RECOMMENDATIONS

National discourse on their sexual and reproductive development has too often been reduced to getting young people to avoid non-marital intercourse. There is a lack of vision in American society about the broad range of skills, knowledge, and services young people need to lead healthy sexual and reproductive lives and for overall development.

Educators, researchers, healthcare providers and advocates should join forces to support the establishment of a National Office of Youth Policy and passage of the Younger Americans Act. This act could establish mechanisms for coordination across sectors, program monitoring and evaluation, and the participation of youth in policy formulation.

Policymakers and youth advocates need to agree on some basic public health principles as the basis for youth sexual and reproductive health policy. Sound legislation would include language on a shared vision of what needs to happen.

Fund comprehensive—not abstinence-only—sexuality education nationwide, and monitor its implementation. The Family Life Education Act provides an excellent framework for making this happen. Current guidelines are not carefully monitored, and ongoing controversy makes sex education vulnerable to politics. The federal government should incorporate the American Medical Association’s definition of medical accuracy into all federally-funded sex education programs.

Campaigns to make youth more visible should rely heavily on the media, and address aspects of popular culture that directly affect their sexual and reproductive lives. Media campaigns to date have been too small to have state or national impact.²⁸⁴



State legislators need to eliminate policies that restrict minors' rights to services and information.

Every state gives minors the right to consent to STI services, but this right does not always extend to contraceptive use or abortion.

Integrate reproductive health services into pediatrics so pediatricians can take a more active role in supporting the sexual and reproductive lives of their young patients.

Relax limits on doctors' ability to speak freely with their patients, and educate them about what the limits really are; fear of legal reprisal interferes with doctors' ability to guide and support them.

Increasing the comfort of medical personnel with sexual and reproductive matters through training both in school and on the job should be an emphasis of clinical efforts to improve youth sexual and reproductive health.

Provide strong oversight of federal policies as they are implemented locally.

State and school policies on sexual and reproductive health are highly variable. A coordinating Office of Youth Policy and state-level committees that would include boards of education, health, and labor, could help to guide and monitor states in implementing and evaluating programs.

Increase quality health and development programs for out-of-school youth.

Non-governmental job training programs, public-private partnerships and the welfare system itself all represent potential opportunities to connect with youth in comprehensive ways.

Provide age-appropriate sexual and reproductive health information and services to everyone, including boys and young men.

Existing fatherhood initiatives try to bolster young men's supporting roles, but often do not meet their sexual and reproductive health needs.

Policies affecting youth reproductive health in the United States lack the ICPD Programme of Action's broader vision for the development of young people.

America's young people need policies that place public health and development goals before political ideology. Such efforts will involve multi-sectoral planning, changes in the way health information and services are delivered to youth, and additional supports for family and community roles in the sexual and reproductive lives of young people.

9



Conclusions:

NEEDS, NUMBERS AND NATIONAL COMMITMENTS

Give young people the proper information, opportunity and skills, and they will use and build on them throughout their lives.

Young people are often invisible to policymakers—and their sexual and reproductive health side-stepped—because they appear generally healthy, because addressing sexuality can be awkward, and because many if not most young people cannot vote or otherwise influence policymakers. This report shows it is essential to increase the visibility of people aged 10 to 24, and the priority accorded to their very real needs.

Young people rightly express frustration at being told they are incapable of making decisions for themselves—while not being provided the health and developmental tools they need to do so. This self-fulfilling prophecy and its emphasis on adult control reflect a vision of young people as less than fully human, and as undeserving of important rights. The health and success adults want for young people is what the young also want for themselves throughout their lives. Give young people the proper information, opportunity and skills, and they will use and build on them throughout their lives.

Providing for youth sexual and reproductive health must go beyond the transmission of *information* to the transmission of *capacity*: young people's capacity to take responsibility for their health, their relationships, and their roles in community life. This must be provided along with the expectation that they will do well. By providing a broad range of skills, information, and resources, we can

make it possible for young people to make informed and positive decisions—and to advocate—on their own behalf and on behalf of their peers. We must think about young people as growing in competency and capacity to make the countless decisions for which parents and other adults will not be present.

The need for policies that enhance the capacities of young people is underscored by the existence of 1.7 billion youth aged 10 to 24, with another 1.2 billion age 9 and younger following right behind them. The largest generation in human history needs every support as its young people move into adulthood. Government commitments to schooling, health, and employment are essential for individual and national development. The governments of most nations around the world have agreed to the Convention on the Rights of the Child, the Programme of Action of the International Conference on Population and Development, and the Beijing Platform for Action. Now what will they do for their young?

WHAT IS TO BE DONE?

Governments need to support healthy options for young people's sexual and reproductive lives. In places as diverse as Uganda and the Netherlands, governments have waded

into the arena of youth sexual and reproductive health because they so clearly understand the urgent public health mandate for doing so.

Policymakers' first step toward formulating policy for youth should be to lay out basic public health and social development principles—for example, the need to provide sound information in a non-judgmental way. These principles and the framework for youth policy they establish, help shape a nation's approach to youth and health. As the experiences of individual countries show, these principles can inform policies that support the healthy sexual and reproductive lives of young people, and can provide for local implementation without excessive oversight. The media can play an important role in disseminating these public health messages and educating the public.

Advocates will need to prioritize specific laws to target in their efforts. In almost every setting, a first priority is to encourage and fund high-quality sexuality and lifeskills education nationwide from the earliest ages. Teachers and health care providers must be given the knowledge and the skills to communicate comfortably about sexual and reproductive health with young people. A second priority is to adapt services and standards to the specific needs of youth. The major health threat that unsafe abortion poses to young women in many settings challenges countries to reconsider the status of abortion if it is illegal, and to expand access to safe services if it is legal. A third important focus is to strengthen laws that mandate freedom from sexual abuse and discrimination. Pregnant girls are often denied their right to continued education; guaranteeing schooling for pregnant girls is an investment in many lives and futures, and contributes to family and public health.

Reducing early marriage should be front and center on the policy agenda. Early marriage is an expression of girls' and women's low status in society and may violate their human rights.²⁸⁵ Minimum age-at-marriage laws are important for the promotion of gender equity and the health of women. Where such laws exist, government and community leaders must educate about and enforce them.

Policies must go beyond the health sector in supporting young people's reproductive lives. A concept of sexual and reproductive health that is strongly focused on

fertility control has limited relevance to the lives of young people. A consensus has arisen on the need to go beyond the individual needs of young people and address the family, community, cultural and economic conditions that constrain their health and life choices. A strictly health-centered approach to the reproductive lives of young people tends to lead to narrowly programmatic activities rather than to the broader youth development approach that is needed. Youth development policy requires an institutional home and the authority to resolve debates over strategy and resource allocation, to coordinate activities across sectors, and to assess compliance with youth-oriented protocols by health, education, employment and other sectors.

Reducing the gender inequities that expose young people to sexual and reproductive risk is key to any strategy for improving the wellbeing and health of youth. Girls experience sexual coercion, female genital cutting, botched abortion, risky pregnancy, and STIs, due in large part to gender inequities that condition their sexual encounters. Boys are urged into experimentation and 'scoring' by expectations about manhood that lead to increased sexual risk taking. Yet sexual and reproductive health policies tend to focus on the biological aspects of reproductive health to the neglect of these social aspects.

Set financial objectives and commitments among the goals for youth sexual and reproductive health. A comprehensive study of global investment in young people's sexual and reproductive lives—including the priorities of governments, the private sector, and donors—is needed. Such an analysis, though difficult to realize, would test commitment to youth concerns at global meetings and in policy development and implementation. Accounting mechanisms for health care often do not track funds spent on specific population groups, nor across multiple sectors. For example, a youth-only clinic would be easily recognized as a youth reproductive health program; but a school program that teaches self-esteem may not be seen as contributing to better reproductive health.

Policies and programs should involve parents, religious leaders, and other adults in the community in advocating for young people and providing them with what they need. Governments must ensure that parents' opinions are shaped by a solid understanding of what is at stake rather than by unrealistic fears about what

Parental Involvement—Hopes and Realities

Parents and families are critical influences on young people's sexual behavior and attitudes. Communication between parents and children can transmit the values that help young people negotiate their sexual and reproductive lives.

Yet many parents themselves are not well informed and fear that talking about sex will be awkward and may contribute to undesirable sexual behavior. Children themselves may discourage parents from talking about sex, since often they too feel awkward discussing the topic with their mother or father. Older children, especially, will often insist "I already know all that."

It is the task of parents, regardless, to find their way to this difficult conversation, just as they find ways to teach their children not to play with fire or dash in front of moving vehicles. Thus, some of the most important steps parents can take are to become better informed about reproductive health, facilitate open, honest and ongoing communication about sexuality, and encourage their children to focus on planning for the future.

Parents should also play a steady role in shaping public policy to serve the best interests of youth. As advocates, parents can raise awareness and influence policy by

- being informed voters;
- urging policymakers to recognize the importance of youth reproductive health;
- tapping into or creating support networks that advocate for and ensure implementation of sound policies;
- starting discussion in their communities around youth sexual and reproductive health with local religious leaders, the media and other community members; and
- working in other coalitions that focus more broadly on youth development.

Young people in most societies receive ambiguous messages from parents and the larger community about reproductive health and sexuality; this ambiguity can impede the development of healthy and responsible sexuality. In a few exceptional settings, coherent messages and health-motivated attitudes about sexuality are expressed in both private and public spheres, reinforcing the practical values needed to negotiate healthful sexual and reproductive lives. At the root of these different approaches are conflicting beliefs about adolescents' sexuality and about their capacity to make responsible decisions.

Parents play an important role not only in imparting biological knowledge about reproduction to their children, but also in the development of self-esteem, confidence, and the ability to negotiate sexual relationships. By listening to children's questions and issues, while articulating their own values, parents can enhance young people's capacity to cope with social demands relating to sexuality. However, few parents are equipped with accurate information about sexual health or the realities of adolescent sexual behavior.

Supporting youth reproductive health and rights while respecting parental concerns continues to be one of the greatest political challenges policymakers face. At times, parents' desire to know or control a child's sexual behavior may not be in her best interest. Indeed, most providers of reproductive health services to young people believe that confidentiality is a necessary aspect of their relationship with the young, though they also encourage youth to be open and honest with their parents.

Sources:

Strategic Planning Work Group, A community Strategic Plan for Preventing Teen Pregnancies and Sexually Transmitted Diseases (September 1999). The Council on Adolescent Pregnancy Prevention Charlottesville, VA.

SIECUS Community Action Kit <http://www.siecus.org/advocacy/kits0002.html>. Internet; accessed 26 September 2001.

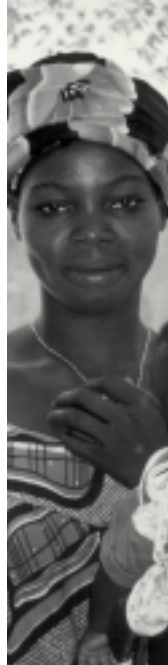
“Will you be concerned with us for who we are now, not just for the adults we will become?”



Zohra Pasekh



Barbara Horibeck



Terri Bartlett

could be. Parental involvement should focus on the ways families and communities can empower young people. Parents form the backbone of young people’s social networks and social capital. As citizens, they have an important role to play in reinforcing and sustaining commitment to policies for young people. Religious institutions often play significant development roles within communities, and influence social norms. Church groups should be encouraged to enhance their services for young persons and to build on often successful youth groups to disseminate information, and provide alternative venues for young people’s social interactions.

Enlist NGOs to provide critical support for, and expand on, government youth and health initiatives.

In countries where the government welcomes the participation of civil society in national debate and programmatic work, NGOs have played a vitalizing role in work on youth reproductive health. Responding to the needs of young people is not the responsibility of government alone; communities, parents, churches and civil society need to join in efforts to reach young people. NGOs, including women’s advocacy groups, have an important role to play in advocating with government and with the public, and in shaping the implementation of youth reproductive health policies.

In 15 years—less than a single generation—the world’s 1.7 billion people aged 10 to 24 will have come fully into their adulthood. Much of the blueprint for supporting the sexual and reproductive lives of young people is set forth in the visionary Programme of Action that the world’s nations crafted at the ICPD in 1994. Eight years later, these same nations must answer the question young people the world over have posed to their elders: “Will you be concerned with us for who we are now, not just for the adults we will become?” Our answer should be, “Yes, we will rise to the promise of our vision in Cairo, we will fulfill our commitments, and we will address your needs, *in this generation.*”

ADVANCING POLICIES FOR YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE LIVES

Identify key areas for youth sexual and reproductive health advocacy.

- Collect and analyze information in order to prioritize areas for action.

Inform the debate on youth sexual and reproductive health. Good information can bring together unexpected allies by establishing common ground in the facts.

- Use information about young people as a tool to mobilize people in support of sexual and reproductive health programs.
- Identify community members who should especially have this information.

Mobilize your community.

- Marshal concerns at the local level.
- Describe the local challenges and problems of young people to community members.

Identify important constituencies on whom to focus.

- Look for common ground in public health and social development objectives.
- Identify, educate, and sensitize key social groups—parents, teachers, religious figures, traditional leaders, politicians, elders—about the health and development needs of young people.
- Meet early and often with people who don't agree with you. You should work with them, too.
- Agree to disagree. If underlying principles can be agreed upon, then specific approaches can often be worked out.

Involve young people, the most powerful advocates for their own wellbeing.

- Continually involve young people in assessing priorities, designing, planning, and evaluation.
- Foster adult-youth partnerships.
- Work with young people to combat stereotypes about youth sexual behavior and inclinations.
- Mobilize the youth vote.

Assess what your own organization or institution can do.

- Assess your own organization's commitment to youth sexual and reproductive health: How will advocacy and networking further your work for young people?
- Assess your capacity to work with other organizations. Build capacity if needed.

Form networks and strategic alliances.

- Identify and bring together a broad range of organizations interested in young people's wellbeing.
- With which organizations could you collaborate to further youth reproductive health? Women's groups? Youth development groups? Health advocacy groups?
- Work together to develop strategies for increasing and sustaining attention to young people.
- Look for outside assistance from donors, international agencies, and other organizations working locally or nationally.
- Be willing to compromise. The outcome may not be all you wished for, but it may help young people.

Sources: This checklist draws on our own analysis and work by the following organizations: Focus on Young Adults, The Futures Group International, The Pan American Health Organization, The Panos Institute, the United Nations Population Fund, the United Nations Children's Fund, and the World Health Organization.

APPENDIX 1

INTERVIEWS AND CONVERSATIONS

Many of the most interesting ideas in this report originated with the many people who graciously agreed to be interviewed or to discuss the issues with the authors.

Ghana: Yaa Amekudzi, Centre for the Development of People; Staffan I. Lindberg, Ghana Parliamentary Caucus on Population and Development, Parliamentarians for Global Action; Alex Banful, Mabel Tsibu-Nyarko, Ghana Social Marketing Foundation; Emmanuel Avevor, Ebenezer Malcom, Myra Togobo, Ghana United Nations Students and Youth Association; Wisdom Mensah, International Needs; Gloria Nikoi, former Minister of Foreign Affairs; Jamila Abdullah, Ali Al-Hassan, Joseph Ankrah, Ahmad Dau, Baba Issa, Kasim Larri and others, Muslim Family Counselling Services; National Council on Women and Development; Richard Turkson, National Population Council; Honorable Alban S.K. Bagbin, Honorable Grace Coleman, Honorable Osei-Adjei, Honorable Theresa A. Tagoe, Parliament of Ghana; Matthew Ashun, Audrey Augustus, Salorme Azumah, Abraham Nyako, Mr. Yankey, Planned Parenthood Association of Ghana; John S. Nabilah Wulugunaba, Population Impact Project, University of Ghana, Legon; Rejoice Nutakor, Ministry of Health of Ghana; Amon Nikoi, former Director of State Bank of Ghana; Benedicta Ababio, The Futures Group Policy Project; Moses Mukasa, UNFPA; Urban Aid, a clinic of the Salvation Army; Esther Owusu, Young Women's Christian Association of Ghana.

India: Sudhansh Malhotra, Adolescent Section, Ministry of Health and Family Welfare; Arundhati Mishra, CEDPA; O.P. Yadav, Family Planning Association of India; Manmohan Sharma, Indian Association of Parliamentarians on Population and Development; Ravi Narayan, Indian Committee of Youth Organizations, and Youth & Family

Planning Programme Council; P.L. Joshi, National AIDS Control Organization (NACO); J.L. Pandey, National Population Education Project, National Council of Educational Research and Training (NCERT); Dr. Rachana, Naveen Sangwan, K.M. Sathyanarayana, The Futures Group Policy Project; Gunjan Sharma, The Naz Project (India) Trust; Saroj Pachauri, K.G. Santhya, Anjali Widge, The Population Council; Sunita Arora, Sharmila Ghosh Neogi, The Population Foundation of India; Sumita Taneja, Sudha Tewari, Parivar Seva Sanstha; Radhika Chandiramani, Tarshi—Talking About Reproductive and Sexual Health Issues; Dinesh Agarwal and Mridula Seth, UNFPA

Iran: Ms. Moofeedi, Ms. Qasimi, Association of Muslim Women Lawyers; Tom Greene, Consultant; Amir Hussein Barmaki, Mojgan Darbi, Hassan Mohtashami, Pedram Moosavi, Hooria Milani Shamshiri, Zakia Shirafkan, Nijan Yasrebi, FPAIRI; Ms. Shams, Green Outlook; Hossein Malek Afzali Ardakani, M.T. Cheroghchi Bashi, Mansour Safaie Farahani, Hameed Setayesh, MOHME; Mehdi Sedghazar, Shaid Jafari Health Center; Khadeja Neizary, Women's Center for Support of Social Activities, Ministry of Education; Tahereh Taherian, Women's Sports Federation of the Islamic Republic of Iran; Sharareh Amirkhalili, Monire Basire, M. Mosleh-Uddin, UNFPA; Mandana Askarinasab, UNICEF.

Mali: Ibrahima Kotié Diakité, Samba Touré, Fadima Drave Traoré, Association Malienne pour la Promotion et Protection de la Famille (AMPPF); Dr. Osmane, Fatimata Traoré, Association de Soutien au Développement des Activités de Population (ASDAP); Hadja Assa Diallo Soumaré, Comité d'Action Pour Les Droits de l'Enfant et de la Femme; Issa Sidibe, CEDPA; Abdoukadri Zeinou, Cabinet de Recherche Action pour le Développement

APPENDIX 1

Endogène (CRADE); Suleymane Dolo, Modibo Maiga, Mariam Kassambara Sow, Groupe Pivot/Santé Population; Houleymata Diarra, Arkea Dupre, Dandara Kanté, Suzanne Reier, René Rovira, Rachel Stoler, JSI/PDY—Programme Démissènya Yiriwali; Sidiki Kone, Projet Promotion des Jeunes, Sports et Santé, Sogoniko; Susan McLucas, Sahel Initiative Troisième Millénaire; Lynn Lederer, Save the Children; Yacine Diallo, UNDP; Rokia Traoré Ly, Boubacar Monzon Traoré, UNFPA; Mohammad Diarra, Salif Koulibaly, Aida Lô, Ursula Nadolny, United States Agency for International Development.

Mexico: Gabriela Rodriguez, Afluentes; María Antonieta Alcalde, Balance; Daniel Gonzalez, Eduardo Liendo, Colectivo de Hombres por Relaciones Igualitarias; Lydia Alpizar, ELIGE; Beatriz Cabazos, Foro de Población; Susan Pick, IMIFAP; Jesús Garcia, Esmeralda Ponce de Leon, Araceli Prieto Alvarez, Instituto Mexicano de la Juventud; Ana Luisa Liguori, John D. and Catherine T. MacArthur Foundation; Alejandro Brito, Letra S; Simon Javier Garcia Moreno, Rosalva Segura Nolasco, Programa Estatal de la Mujer, Subsecretaria de Asuntos Jurídicos y Participación Ciudadana, Gobierno del Estado de Veracruz; Jose Alberto Elizalde Bonilla, Programa de Prevención y Atención Integral del Embarazo en

Adolescentes; Pilar Denegri, Protección a la Infancia; Jose Luis Navarro P., Riesgos Sociales en la Infancia, Sistema Nacional—Desarrollo Integral de la Familia; Olivia Aguilar, Carmen Flores, Benno de Keijzer, Emma Reyes, Salud y Género; Araceli Gonzalez Saavedra, Claudia Pena Cabrera, Xochiquetzal.

The Netherlands: Barbara Huberman, Advocates for Youth; Doortje Braeken, Catalyst Project, IPPF Western Hemisphere Region; Bart Wijnberg, Ministry of Health, Welfare and Sport; Sarah Maso, Jo Reinders, Netherlands Institute for Social Sexological Research (NISSO); Annette Van Den Berg, World Population Foundation.

United States: Glenda Partee, Donna Walker James, American Youth Policy Forum; Wendy Wolfe, Center for Assessment and Policy Development; Douglas Kirby, ETR Associates; Susan Moskosky, DHHS; Linda Juszcak, Division of Adolescent Medicine, North Shore University Hospital; Patrick Sheeran, Office of Adolescent Pregnancy Programs; Smita Pamar, Bill Smith, SIECUS; Alexandra Ashbrook, Teen Parents and the Law Program, Street Law Inc.; Cynthia Dailard, Heather Boonstra, The Alan Guttmacher Institute; Hilandia Neuta-Rendon, Women's Educational Equity Act, Equity Resource Center.

APPENDIX 2

ACRONYMS AND DEFINITIONS

CHIP	State Children's Health Insurance Program (U.S.), also SCHIP
CONAPO	National Population Council (Mexico)
DIF	Desarrollo Integral de la Familia (Integral Development of the Family, Mexico)
DYAS	Department of Youth and Sports (India)
FGC	Female Genital Cutting
FPAIRI	Family Planning Association of the Islamic Republic of Iran
GSMF	Ghana Social Marketing Foundation
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population and Development (Cairo 1994)
IMSS	Instituto Mexicano de Seguro Social (Mexican Institute of Social Security)
ISSSTE	Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (Mexico)
IMJ	Instituto Mexicano de la Juventud
Medicaid	A national and state program that helps cover medical costs for people with low incomes (U.S.)
MOHME	Ministry of Health and Medical Education (Iran)
NVSH	Netherlands Association for Sexual Reform
NGO	Non-Governmental Organization
ONG	Non-Governmental Organization in Spanish
PPAG	Planned Parenthood Association of Ghana
PTA	Parent Teacher Association (Iran)
SBHC	School-Based Health Center
SCHIP	State Children's Health Insurance Program (U.S.), also CHIP
Shari'a	Islamic law
SLHC	School-Linked Health Center
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
YDP	Youth Development Program

APPENDIX 3

ENDNOTES

- 1 Bruce, J. 2001. "Recognizing Adolescent Diversity in Policy and Programs: Highlighting Neglected Issues." Presentation to the Population Council, 24 January.
- 2 Bruce, J, and BS Mensch. 1999. "Taking Back Young Lives: Policy Issues for Adolescent Girls in the Developing World." *JAMWA* 54(3), 153-155.
- 3 United Nations Population Fund. 1999. *A Time Between: Health, Sexuality and Reproductive Rights of Young People*. New York, NY, USA: UNFPA.
- 4 De Bruyn, M. 1999. "Young Lives at Risk: Adolescents and Sexual Health." *Panos Media Briefing* 35 (July). Available from http://www.oneworld.org/panos/briefing/young_lives_at_risk.htm; Internet; accessed 5 November 2001.
- 5 Bruce, J, and BS Mensch. 1999. "Taking Back Young Lives." *Emphasis added*.
- 6 Morell, V. 1995. "Attacking the Causes of 'Silent' Infertility." *Science* 269, 11 August.
- 7 United Nations Population Division. 2001. *World Population Prospects: The 2000 Revision, vol. II, Sex and Age Distribution of the World Population*. New York, NY, USA: United Nations.
- 8 Mensch, BS, J Bruce and ME Greene. 1998. *The Uncharted Passage: Girls' Adolescence in the Developing World*. New York, NY, USA: The Population Council; The Alan Guttmacher Institute (AGI). 1998. *Into A New World: Young Women's Sexual and Reproductive Lives*. New York, NY, USA: AGI.
- 9 Mensch, BS, J Bruce and ME Greene. 1998. *The Uncharted Passage*.
- 10 Bledsoe, CH, and Barney Cohen. 1993. *Social Dynamics of Adolescent Fertility in Sub-Saharan Africa*. Washington, DC, USA: National Academy Press.
- 11 UNICEF. 2001. "Early Marriage, Child Spouses." *Innocenti Digest* 7. Florence, Italy: UNICEF.
- 12 McCauley, AP, and C Salter. 1995. "Meeting the Needs of Young Adults." *Population Reports*. Baltimore, MD, USA: Population Information Program, Johns Hopkins University.
- 13 Mensch, BS, J Bruce, and ME Greene. 1998. *The Uncharted Passage*.
- 14 Panis, CW, LA Lillard and DM Upchurch. 1995. "Implications of Family Formation for Educational Attainment among Young Women" [unpublished paper]. Presented at the Annual Meeting of the Population Association of America, San Francisco, California, USA (April 6-8): 23.
- 15 McCauley, AP and C Salter. 1995. "Meeting the Needs of Young Adults."
- 16 Joint United Nations Programme on HIV/AIDS Press Release. 1997. "Sexual Health Education Does Lead to Safer Sexual Behaviour-UNAIDS Review." 22 October.
- 17 Heise, L, M Ellsberg and M Gottemoeller. 1999. *Ending Violence against Women*. Baltimore, MD, USA: Johns Hopkins University School of Public Health, Population Information Program.
- 18 Rivers, K, and P Aggleton. 1999. "Adolescent Sexuality, Gender and the HIV Epidemic." *Panos Briefing* 35 (July). Available from <http://www.undp.org/hiv/publications/gender/adolesce.htm>; Internet; accessed 16 April 2001; Weiss, E, D Whelan, and G Gupta. 1996. *Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World*. Washington, DC, USA: International Center for Research on Women (ICRW).
- 19 Ibid., 155.
- 20 de Bruyn, M. 1999. "Intersecting Health Risk: Adolescent Unwanted Pregnancy, Unsafe Abortion and AIDS." *Initiatives in Reproductive Health Policy* 3: 4-5; AGI. 1999. *Sharing Responsibility. Women, Society and Abortion Worldwide*. New York: AGI.
- 21 Westoff, C. 2000. "The Substitution of Contraception for Abortion in Kazakhstan in the 1990s." *DHS Analytical Studies* 1. Calverton, MD, USA: Macro International (December).
- 22 AGI. 1999. *Sharing Responsibility*, de Bruyn, M. 1999. "Intersecting Health Risk."
- 23 McCauley, AP, and C Salter. 1995. "Meeting the Needs of Young Adults."
- 24 AGI. 1999. *Sharing Responsibility*.
- 25 Mensch, BS, J Bruce and ME Greene. 1998. *The Uncharted Passage*.
- 26 Amnesty International. 1998. "Female Genital Mutilation." Available from <http://www.amnesty.org/ailib/intcan/femgen/fgm1.htm>; Internet; accessed 5 November 2001.
- 27 UNFPA. 2000. *Lives Together, Worlds Apart: Men and Women in a Time of Change*. New York, NY, USA: UNFPA, 15.
- 28 Senderowitz, J. 1995. "Adolescent Health: Reassessing the Passage to Adulthood." *World Bank Discussion Paper* 272. Washington, DC, USA: World Bank.
- 29 UNAIDS. 1999. *Young People and HIV/AIDS*. Geneva, Switzerland: UNAIDS.
- 30 UNAIDS. 1999. *Facts and Figures: 1999 World AIDS Campaign*. Geneva, Switzerland: UNAIDS.
- 31 Erickson, K and T Brunette. 1996. "Patterns and Predictors of Infertility among African Women: A Cross-National Survey of Twenty-seven Nations." *Social Science and Medicine* 42(2).
- 32 Luke, N. 2001. "Cross-generational and Transactional Sexual Relations in Sub-Saharan Africa: A Review of the Evidence on Prevalence and Implications for Negotiation of Safe Sexual Practices for Adolescent Girls" [unpublished paper]. Prepared for the International Center for Research on Women as part of the AIDSMark Project (26 September); UNAIDS. 2000. *Report on the Global HIV/AIDS epidemic: June 2000*. Geneva: UNAIDS.
- 33 Agence France Press. 2001. "More than 10 million 15-to-24 year-olds living with HIV/AIDS: UNICEF." Geneva, Switzerland (June 12).
- 34 UNFPA. 1994. *Report of the International Conference on Population and Development, Cairo*, 5-13 September 1994. Paragraph 7.48.
- 35 Hughes, J, and AP McCauley. 1995. "Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries." *Studies in Family Planning* 29(2): 233-245.
- 36 National Population Council, Ministry of Health. 1994. *National Population Policy (Revised Edition, 1994)*. Accra, Ghana: Government of Ghana.
- 37 Ministry of Health, Republic of Ghana. 1996. *National Reproductive Health Service Policy and Standards*. Accra, Ghana: Ministry of Health (April).
- 38 Center for Reproductive Law and Policy (CRLP). 1997. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, Anglophone Africa*. New York, NY, USA: CRLP.
- 39 US Department of State, Bureau of African Affairs. 1998. *Background Note: Ghana*. Available from <http://www.state.gov/r/pa/bgn/index.cfm?docid=2860#people>; Internet; accessed 31 July 2001.
- 40 National AIDS/STD Control Programme, Ministry of Health. 1999. *HIV/AIDS in Ghana: Background, Projections, Impacts, Interventions*. Accra, Ghana: Ministry of Health.
- 41 Ibid.
- 42 Reproductive and Child Health Unit. 2001. "Brief on Adolescent Health Programme in Ghana." Accra, Ghana: Ministry of Health.
- 43 Fayorsey, C. 1995. *Adolescent Reproductive Health Issues in Ghana*. Legon, Ghana: Sociology Department, University of Ghana; Population Impact Project, University of Ghana. 1995. *Adolescent Fertility and Reproductive Health in Ghana*. Legon, Ghana: Population Impact Project, University of Ghana (December).

- 44 CRLP. 1997. *Women of the World*.
- 45 National Population Council. 1996. *Draft Adolescent Reproductive Health Policy*. Accra, Ghana: Government of Ghana.
- 46 Interview with representatives of Planned Parenthood Association of Ghana, Accra, Ghana, March 2001.
- 47 Luke, N. 1998. *Reproductive Health Case Study: Ghana*. Washington, DC, USA: The Policy Project, The Futures Group International; National Population Council. 1996. *Draft: Government of Ghana: Adolescent Reproductive Health Policy*.
- 48 Hardee, K and others. 1998. *Post-Cairo Reproductive Health Policies and Programs: A Comparative Study of Eight Countries*. Washington, DC: The Policy Project; Luke, N. 1998. *Reproductive Health Case Study*.
- 49 Honorable Osei-Adjei, Member of Parliament, Republic of Ghana. 2001. Interview by author, Accra, Ghana, 21 March.
- 50 Ampomah, K. 1996. "Draft: Proceedings of the Adolescent Reproductive Health Summit" [unpublished paper]. Accra, Ghana: National Population Council, Ministry of Health.
- 51 Reproductive and Child Health Unit. 2001. "Brief on Adolescent Health Programme."
- 52 National Population Council. 1996. *Draft Adolescent Reproductive Health Policy*.
- 53 Ministry of Health, Republic of Ghana. 1996. *National Reproductive Health Service Policy and Standards*.
- 54 Luke, N. 1998. *Reproductive Health Case Study*.
- 55 National AIDS/STD Control Programme (NACP). 1996. "Draft Policy Document on HIV/AIDS." Accra, Ghana: NACP.
- 56 NACP. 1999. *HIV/AIDS in Ghana: Background, Projections, Impacts, Interventions*. Accra, Ghana: Ministry of Health.
- 57 Yankey, F, Planned Parenthood Association of Ghana (PPAG). 2001. Interview by author, Accra, Ghana, 20 March.
- 58 Futures Group International. 2001. "Social Marketing Campaigns." Available from www.ftgi.com/Adols1.asp; Internet; accessed 2 August 2001.
- 59 Banful, Ghana Social Marketing Foundation. 2001. Interview by author, Accra, Ghana, 13 March.
- 60 Population Reference Bureau (PRB). 2000. *2000 World Population Data Sheet*. Available from www.measurecommunication.org, or www.prb.org; Internet.
- 61 US Department of State, Bureau of African Affairs. 1998. *Background Note: Ghana*.
- 62 Notes from CEDEP interview, Accra, Ghana, March 2001.
- 63 Hardee, K and others. 1998. *Post-Cairo Reproductive Health Policies*.
- 64 CRLP. 1997. *Women of the World*.
- 65 Ibid.
- 66 Ibid, 47.
- 67 Honorable Osei-Adjei, Member of Parliament, Republic of Ghana. 2001. Interview by author, Accra, Ghana, 21 March.
- 68 Honorable Coleman, Member of Parliament, Republic of Ghana. 2001. Interview by author, Accra, Ghana, 21 March.
- 69 Honorable Osei-Adjei, Member of Parliament, Republic of Ghana. 2001. Interview by author, Accra, Ghana, 21 March.
- 70 Nabila, JS, C Fayorsey and M Pappoe. 1996. *Adolescent Reproductive Health Needs: Ghana Country Assessment, Key Findings Report*. Accra, Ghana: Population Impact Project, 4-5.
- 71 Department of Family Welfare, Ministry of Health and Family Welfare. 2000. *National Population Policy 2000*. New Delhi, India: Government of India, 35.
- 72 Mamdani, M. 1999. "Adolescent Reproductive Health: Experience of Community-Based Programmes," 261-311. In S. Pachauri (ed.) *Implementing a Reproductive Health Agenda in India: The Beginning*. New Delhi, India: Population Council, 302; Anand, A. 1999. "Let's Talk About Sex." *People and the Planet* 8(1), 4.
- 73 Ganatra, B and SS Hirve. 2000. "Induced Abortions: Decision Making, Provider Choice and Morbidity Experience in Rural Adolescents" [unpublished paper]. Prepared for the International Conference on Adolescent Reproductive Health, IRR/WHO, Mumbai, India (1-4 November).
- 74 Measham, AR and RA Heaver. 1996. *India's Family Welfare Program: Moving to a Reproductive and Child Health Approach*. Washington, DC, USA: The World Bank, 21.
- 75 CRLP. 1995. *Women of the World: Formal Laws and Policies Affecting Their Reproductive Lives*. New York: CRLP.
- 76 Department of Family Welfare, Ministry of Health and Family Welfare. 2000. *National Population Policy 2000*, 8.
- 77 Malhotra, S, Department of Family Welfare, Ministry of Health and Family Welfare. 2001. Interview by author, New Delhi, India, 8 May.
- 78 Dube, S. 2000. *Sex, Lies and AIDS*. New Delhi: HarperCollins, 45.
- 79 Chaturvedi, YN, Secretary, Department of Family Welfare, Government of India. 1999. Statement to the Commission on Population and Development, Acting as Preparatory Committee for the Special Session of the General Assembly, New York, NY, USA, Para. 19; Ezhilmalai, D, Minister of State for Health and Family Welfare, Government of India. 1999. Statement at the Twenty-first Special Session of the General Assembly on Overall Review and Appraisal of the Implementation of the Programme of Action on the International Conference on Population and Development. New York, NY, USA, Para. 12.
- 80 Singh, S. "Youth: A Resource for Today and Tomorrow," 235-259. In S. Pachauri (ed.) 1999. *Implementing A Reproductive Health Agenda in India: The Beginning*. New Delhi, India: Population Council, 250.
- 81 Ibid., 239.
- 82 United Nations Department of Economic and Social Affairs. 1999-2001. "Country Profiles on the Situation of Youth." Available from <http://esa.un.org/socdev/unyin/country4.asp?countrycode=in>; Internet; accessed 14 June 2001; Urivi Vikram Charitable Trust. "National Policy for Young Adults: Advocacy Document" [unpublished paper]. New Delhi, India: UVCT, 36.
- 83 Ministry of Youth Affairs and Sports, Government of India. 2000. *Background Note for the Consideration of Working Group on Youth Affairs and Sports for Formulation of X Five Year Plan (2002-2007) for the Ministry of Youth Affairs and Sports*. New Delhi, India: Government of India, 1.
- 84 For more information on Nehru Yuvak Kendra Sangathan, see <http://www.nyks-india.org/genesis.htm>; Internet; accessed 6 August 2001.
- 85 Department of Youth Affairs and Sports, Government of India. 1997. *Annual Report 1997*. New Delhi: Government of India; Ministry of Youth Affairs and Sports. 2000. *Background Note*.
- 86 Ministry of Youth Affairs and Sports. 2000. *Draft: National Youth Policy*. New Delhi, India: Government of India.
- 87 Department of Health and Family Welfare, Government of Madhya Pradesh. 2000. *Madhya Pradesh Population Policy*. Bhopal, Madhya Pradesh: Government of Madhya Pradesh, 16.
- 88 Department of Family Welfare, Government of Uttar Pradesh. 2000. *Uttar Pradesh Population Policy*. Lucknow, Uttar Pradesh: Government of Uttar Pradesh, 9.
- 89 Department of Family Welfare, Government of Rajasthan. 1999. *Population Policy of Rajasthan*. Jaipur, Rajasthan: Government of Rajasthan.
- 90 Government of India. 2000. *National Population Policy*, 14.
- 91 Greene, ME. 1996. *Watering the Neighbour's Garden*, 24-25.
- 92 National Institute of Public Cooperation and Child Development (NIPCCD). 2000. *Adolescent Girls' Scheme: An Evaluation*. New Delhi, India: NIPCCD.
- 93 Pandey, JL, National Council of Educational Research and Training (NCERT). 2001. Interview by author, New Delhi, India, 8 May.
- 94 Agarwal, D, UNFPA. 2001. Interview by author, New Delhi, India, 9 May.
- 95 Singh, S. 1999. "Youth: A Resource for Today and Tomorrow"; National AIDS Control Organisation. 2000. *Combating HIV/AIDS in India 1999-2000*. New Delhi, India: Ministry of Health and Family Welfare, Government of India, 45.
- 96 Dube, S. 2000. *Sex, Lies and AIDS*, 99.
- 97 Mamdani, M. 1999. "Adolescent Reproductive Health," 281.
- 98 See, for example, National Population Education Project. "Adolescence Education: Knowledge Base," in Pandey, J, SB Yadav, and KK Sadhu (eds.) 1999. *Adolescence Education in Schools, Part II*. New Delhi, India: NCERT, 35.
- 99 For more information on the Healthy Adolescent Project in India, see Bharat Scouts and Guides Website. Available from <http://www.tbsgi.org/HAPI.htm>; Internet; accessed 17 December 2001.
- 100 Santhya, GK, The Population Council. 2001. Interview by author, New Delhi, India, 7 May.

- 101 Visaria, L, S Jejeebhoy and T Merrick. 1999. "Comment: From Family Planning to Reproductive Health: Challenges Facing India." *International Family Planning Perspectives* 25 Supplement (January): S44.
- 102 Yadav, SB and KK Sadhu. 1994. "Status of Adolescence Education in the School Curricula," in *Adolescence Education: Report of the National Seminar*. New Delhi, India: National Population Education Project, National Council of Educational Research and Training, 33-38.
- 103 Dube, S. 2000. *Sex, Lies and AIDS*, 45.
- 104 Ibid., 92.
- 105 UNDP, UNFPA. 1997. "United Nations Population Fund Proposed Projects and Programmes: Recommendation by the Executive Director, Assistance to the Government of India." New York, NY, USA: United Nations, 5.
- 106 Dube, S. 2000. *Sex, Lies and AIDS*, 45.
- 107 Mamdani, M. 1999. "Adolescent Reproductive Health," 283.
- 108 Santhya, GK, The Population Council. 2001. Interview by author, New Delhi, India, 7 May.
- 109 Dube, S. 2000. *Sex, Lies and AIDS*.
- 110 Mamdani, M. 1999. "Adolescent Reproductive Health," 300.
- 111 Hakimian H. 2000. "Population Dynamics in Post-Revolutionary Iran: A Re-examination of Evidence." in P Alizadeh (ed.) 2000. *The Economy of Iran: Dilemmas of an Islamic State*. London: IB Tauris.
- 112 Population Reference Bureau (PRB). 2000. *2000 World Population Data Sheet: Iran Demographic Highlights*. Washington, DC, USA: PRB.
- 113 UNESCO. 1997. *Demographic Profile of Adolescents in Asia and Pacific*. Bangkok, Thailand: UNESCO.
- 114 Mehryar, AH, and others. 2000. "Repression and Revival of the Family Planning Program and its Impact on the Fertility Levels and Demographic Transition in the Islamic Republic of Iran" [unpublished paper]. Prepared for the 7th Annual Conference of the Economic Research Forum, Amman, Jordan (26-29 October).
- 115 Wright, R. 2000. *The Last Great Revolution: Turmoil and Transformation in Iran*. New York, NY, USA: Alfred A Knopf.
- 116 Hakimian, H. 2000. "Population Dynamics in Post-Revolutionary Iran: A Re-examination of Evidence," in P Alizadeh (ed.) 2000. *The Economy of Iran*.
- 117 Mehryar and others. 2000. "Repression and Revival."
- 118 UNFPA. 2000. *Country Population Assessment: The Islamic Republic of Iran*. Tehran, Iran: UNFPA; Musleh-Uddin, PM and M Bassir. 2001. *Fertility Trends in Post Revolutionary Iran*. Tehran, Iran: UNFPA.
- 119 Mohtashimi, H, Global Population Council. 2001. Interview by author, Tehran, Iran, 5 May.
- 120 Murphy, C. 1992. "Iran Promoting Birth Control in Policy Switch." *The Washington Post* (8 May).
- 121 MacFarquhar, N. 1996. "With Iran Population Boom, Vasectomy Receives Blessing." *New York Times* (8 September).
- 122 Statistical Centre of Iran. 1999. "Table 1.4 Average Annual Growth Rate of Population, by Urban/Rural Areas: 1956-1996." *Population Indicators of Iran, 1956-96*. Tehran, Iran: Statistical Centre of Iran, 6.
- 123 Aghajanian, Akbar. 1995. "A New Direction in Population Policy and Family Planning in the Islamic Republic of Iran." *Asia Pacific Journal* 10, 1.
- 124 Malek-Afzali, H, Ministry of Health and Medical Education. 2001. Interview by author, Tehran, Iran, 14 May.
- 125 Cheroghchi, B, Ministry of Health and Medical Education. 2001. Interview by author, Tehran, Iran, 7 May.
- 126 UNESCO. 1997. *Demographic Profile*.
- 127 Milani, H, Family Planning Association Islamic Republic of Iran. 2001. Interview by author, Tehran, Iran, 7 May.
- 128 Milani, H, Family Planning Association Islamic Republic of Iran. 2001. Interview by author, Tehran, Iran, 7 May.
- 129 UNFPA. 2000. *Country Population Assessment*.
- 130 FPAIRI, IPPF. 2000. "A Guide on Reproductive Health for Newly Married Couples." Tehran, Iran: FPAIRI.
- 131 Wright, R. 2000. *The Last Great Revolution*.
- 132 UNFPA. 1999. *Annual Report on the Islamic Republic of Iran*. Tehran: UNFPA.
- 133 Malek-Afzali, H, Ministry of Health and Medical Education. 2001. Interview by author, Tehran, Iran, 14 May.
- 134 Naizary, M, Ministry of Education. 2001. Interview by author, Tehran, Iran, 5 May.
- 135 Mohtashami, H, Global Population Council. 2001. Personal communication, Email. 23 December.
- 136 UNFPA. 2000. *Country Population Assessment*.
- 137 Population Education Project, Ministry of Education. (n.d.) *Health of Adolescent Girls*. Ministry of Education, Islamic Republic of Iran and UNFPA.
- 138 UNFPA, IPPF, and FPAIRI. 2001. "Pubertal Health of Boys." Tehran, Iran: FPAIRI.
- 139 FPAIRI, IPPF. (n.d.) "A Guide on Reproductive Health for Newly Married Couples"; FPAIRI. (n.d.) *Marriage Guide on Reproductive Health*. Tehran, Iran: FPAIRI and IPPF.
- 140 Cheroghchi, B, Ministry of Health and Medical Education. 2001. Interview by author, Tehran, Iran, 7 May.
- 141 Family Health Department, Under Secretary for Public Health, MOHME, Islamic Republic of Iran and UNFPA. 1998. *Country Report on Population, Reproductive Health and Family Planning Program in the Islamic Republic of Iran*. Tehran, Iran: MOHME and UNFPA (February).
- 142 Askarinasab, M, UNICEF. 2001. Interview by author, Tehran, Iran, 7 May.
- 143 UNFPA. 2000. *Country Population Assessment*.
- 144 Tremayne, S, Oxford University. 2001. Personal communication, Email. 5 October.
- 145 Ministry of Health and Medical Education (MOHME). 2001. *Health Situation and Trends in the Islamic Republic of Iran*. Tehran: MOHME.
- 146 Malek-Afzali, H, Ministry of Health and Medical Education. 2001. Interview by author, Tehran, Iran, 14 May.
- 147 Wright, R. 2000. *The Last Great Revolution*.
- 148 Seligman, B, L Weiss, and S Pacque Margolis. 2000. *Mali Youth Profile*. Washington, DC, USA: FOCUS on Young Adults.
- 149 Demographic and Health Surveys, Macro International, Inc. 1996. *Enquête Démographique et de Santé 1995-1996*. Calverton, MD: Macro International.
- 150 Ministère de la Promotion de la Femme, de l'Enfant et de la Famille (MPF). 1998. *Plan National d'Eradication de l'Excision a l'Horizon 2007*. Bamako, MALI: MPF.
- 151 UNFPA. 1998. *The State of World Population*. New York, NY, USA: UNFPA, 70.
- 152 Ministère de la Santé, République du Mali. 1998. *Plan Décennal de Développement Sanitaire et Social, 1998-2007*. Bamako, Mali: Ministère de la Santé, 37; CRLP, Groupe de Recherche Femmes et Lois au Sénégal. 1999. *Women of the World: Laws and Policies Affecting Their Reproductive Lives: Francophone Africa*. New York, NY, USA: CRLP.
- 153 Ministère de la Santé, République du Mali. 2000. *Politique et Normes des Services de Santé de la Reproduction*. Bamako, Mali: Ministère de la Santé, 26.
- 154 Ibid.
- 155 Ministère de la Santé, de la Solidarité et des Personnes Agées. 1995. *Déclaration de la Politique Sectorielle de Santé et de Population*. Bamako, Mali: Ministère de la Santé; CRLP, Groupe de Recherche Femmes et Lois au Sénégal. 1999. *Women of the World*.
- 156 Ibid; Women's Environment and Development Organization (WEDO). 1999. *Risks, Rights and Reforms: A 50-Country Survey Assessing Government Actions Five Years After the International Conference on Population and Development*. New York, NY, USA: WEDO.
- 157 CRLP, Groupe de Recherche Femmes et Lois au Sénégal. 1999. *Women of the World*.
- 158 CRLP, Association of Jurists of Mali. 1999. *Reproductive Rights of Young Girls and Adolescents in Mali*. New York, NY, USA: CRLP.
- 159 Stoler, R, John Snow, Inc. (JSI). 2001. Interview by author, Bamako, Mali, 29 March.
- 160 Ibid; Ministry of Economy, Planning and Integration. 1991. *Declaration of National Policy on Population in Mali*. Bamako, Mali: Ministry of Economy, Planning and Integration.
- 161 UNICEF. 1997. *Analyse de la Situation des Enfants et des Femmes au Mali*. New York: UNICEF (July).
- 162 CRLP, Groupe de Recherche Femmes et Lois au Sénégal. 1999. *Women of the World*.

- 163 UNAIDS. "Table of Country-specific HIV/AIDS Estimates and Data." Available from http://www.unaids.org/epidemic_update/report/index.html#table; Internet; accessed 30 May 2001.
- 164 CRLP, Groupe de Recherche Femmes et Lois au Sénégal. 1999. *Women of the World*.
- 165 Demographic and Health Surveys, Macro International, Inc. 1996. *Enquête Démographique et de Santé 1995-1996*.
- 166 Seligman, B, USAID. 2001. Interview by author, Washington, DC, USA, 7 August.
- 167 Stoler, R, JSI. 2001. Interview by author, Bamako, Mali, 29 March.
- 168 Gorsline-Flamm, E. 2000. *Mali's Young Adult Reproductive Health Inventory (YARH): Workshop Report, Bamako, Mali*. Washington, DC: FOCUS on Young Adults; Marikani, L. and Castle Consultants. 2000. *Report 2: Educators' Activities, Efficacy and Impact: Qualitative Evidence from a Survey of 148 Peer Educators*. Report prepared for CEDPA. Washington, DC, USA: CEDPA (November).
- 169 Diallo, H. 2001. Interview by author, Bamako, Mali, 28 March.
- 170 UNFPA. 2000. *Jeunes, Sports et Santé*. Bamako, Mali: UNFPA; UNFPA. 2000. Reproductive Health Program in Mali. Bamako, Mali: UNFPA.
- 171 Stewart, L, FOCUS on Young Adults. 2001. Interview by author, Washington, DC, USA, 24 September.
- 172 Ministère de la Santé, République du Mali. 2000. *Politique et Normes des Services de Santé de la Reproduction*, 26; Ministère de la Santé, République du Mali. 2000. *Procédures des Services de Santé de la Reproduction*.
- 173 Ministère de la Santé, République du Mali. 2000. *Politique et Normes*, 26.
- 174 Ministère de la Santé, République du Mali. 2000. *Procédures des Services*.
- 175 Stoler, R, JSI. 2001. Interview by author, Bamako, Mali, 29 March.
- 176 Gorsline-Flamm, E. 2000. *Mali's Young Adult Reproductive Health Inventory*.
- 177 CRLP, Groupe de Recherche Femmes et Lois au Sénégal. 1999. *Women of the World*.
- 178 Dawit, S. 1998. "Needs Assessment," 12-13.
- 179 Letter reproduced in Ministère de la Santé, République du Mali. 2000. *Politique et Normes des Services*, 102; McLucas, S. Sahel Initiative Troisième Millénaire. 2001. Interview by author, Bamako, Mali, 30 March.
- 180 Dawit, S. 1998. "Needs Assessment," 13.
- 181 Debay, M and B Seligman. 1998. *Draft: Mali Youth Assessment Report*. Washington, DC, USA: FOCUS on Young Adults.
- 182 Consejo Nacional de Población (CONAPO). "Indicadores Sociodemográficos." Available from <http://www.conapo.gob.mx/indicaso/index.htm>; Internet; accessed 7 June 2001.
- 183 Secretaría de Salud, Dirección General de Salud Reproductiva. 2000. "Evaluación del Programa de Salud Sexual y Reproductiva para Adolescentes." Mexico City, Mexico: Secretaría de Salud (November).
- 184 Ibid, 9.
- 185 CONAPO. "Ley General de Población y Reglamento, Artículo 19." Available from <http://www.conapo.gob.mx/polpobla/reglamento1.htm>; Internet; accessed 7 June 2001.
- 186 Montes, SG. 1999. "Las Organizaciones No Gubernamentales Mexicanas y la Salud Reproductiva." Mexico, D.F.: El Colegio de México, Centro de Estudios Demográficos y de Desarrollo Urbano, Programa Salud Reproductiva y Sociedad.
- 187 Rodríguez-García, R and others. 1999. *The Legislative and Policy Environment for Adolescent Health in Latin America and the Caribbean*. Washington, DC, USA: Pan American Health Organization (PAHO), W.K. Kellogg Foundation.
- 188 CRLP, DEMUS, Estudio para la Defensa de los Derechos de la Mujer. 1997. *Women of the World: Laws and Policies Affecting Their Reproductive Lives, Latin America and the Caribbean*. New York, NY, USA: CRLP.
- 189 IMSS. "Seguridad y Solidaridad Social." <http://www.imss.gob.mx/IMSS/ofDirector/discursos/2001/01.htm>; Internet; accessed 19 December 2001.
- 190 IMSS. <http://www.imss.gob.mx/IMSS/default.htm>; Internet; accessed 19 December 2001; Cabral Soto, J. 2000. "Una Perspectiva del Estado: Modelo de Atención Integral a la Salud del Adolescente en el Medio Rural" [unpublished paper]. Presented at "Trabajando con Hombres Jóvenes: Salud, Sexualidad, Género y Prevención de Violencia." Queretaro, Mexico (March).
- 191 Espinosa, G, L Paz Paredes and V Rodríguez. 1999. *Salud Sexual y Reproductiva en México: Los Programas, Los Procesos, Los Recursos Financieros*. Mexico City, Mexico: Foro Nacional de Mujeres y Políticas de Población (March).
- 192 IMIFAP. 1993. "First National Poll About Sexuality Education." Report presented to Prospect Hill, Moriah and Merck Foundations; Mexfam. "Encuesta Para el Programa 'Gente Joven' de Mexfam: Informe de Resultados." Available from <http://www.mexfam.org.mx/pathfind/sld052.htm>; Internet; accessed 5 June 2001.
- 193 Pick, S, IMIFAP. 2001. Interview by author, Mexico City, Mexico, 19 April.
- 194 CRLP, DEMUS, Estudio para la Defensa de los Derechos de la Mujer. 2001. *Mujeres del Mundo: Leyes y Políticas que Afectan Sus Vidas Reproductivas, America Latina y el Caribe, Suplemento 2000*. New York, NY, USA: CRLP.
- 195 Pick, S, IMIFAP. 2001. Interview by author, Mexico City, Mexico, 19 April.
- 196 Union Nacional de Padres de Familia A.C. (UNPF). "Derechos Ignorados." <http://www.familia.com.mx/correoestrategico-017.htm>; Internet; accessed 21 December 2001.
- 197 Centro Nacional para la Prevención y Control del VIH/SIDA. <http://www.ssa.gob.mx/conasida/>; Internet; accessed 19 December 2001.
- 198 Mexfam. "Gente Joven Program." Available from http://www.mexfam.org.mx/gj_intro_i.htm; Internet; accessed 4 June 2001.
- 199 Fronjosá Aguilar, CF, A Mercado Gurrola, and HM Villaseñor Hernández (eds.) 2000. "Memoria, Foro Nacional de Jóvenes por los Derechos Sexuales." Tlaxcala, Mexico: Instituto Mexicano de la Juventud (13-17 August).
- 200 Union Nacional de Padres de Familia A.C. UNPF. Available from <http://www.familia.com.mx/articulosUG-002.htm>; Internet; accessed 5 June 2001.
- 201 Pick, S, IMIFAP. 2001. Interview by author, Mexico City, Mexico, 19 April.
- 202 Cruz, A. 2000. "Rechaza la Ley Antiaborto 63% de Guanajuatenses: Encuesta." *La Jornada*. Mexico City, 26 August.
- 203 Ravelo, R. 2001. "Es Abascal el que Necesita Leer a Ciceron y Educarse: Fuentes." *La Jornada*. Mexico City, 18 April: 8.
- 204 Damián, GE. 1999. *Avances y Retos de la Salud Reproductiva en Mexico: Discurso, Financiamiento y Praxis*. Mexico City, Mexico: Foro Nacional de Mujeres y Políticas de Población, 47.
- 205 Pick, S, IMIFAP. 2001. Interview by author, Mexico City, Mexico, 19 April.
- 206 Sistema Nacional para el Desarrollo Integral de la Familia, Comisión Nacional de la Mujer, DIF-DF, Comisión de Derechos Humanos del Distrito Federal (n.d.). *Guía de Orientación Jurídica para Madres y Padres Adolescentes*. Mexico City, Mexico: DIF. Available from http://www.unicef.org/mexico/programas/Guia_Orientacion.PDF; Internet; accessed 5 December 2001; Rodríguez Ramirez, G and BM Hernandez. 2000. *Manual de Capacitación de Sexualidad e Infecciones de Transmisión Sexual para Jóvenes Campesinas y Campesinos*. Mexico City, Mexico: Consejo Nacional para la Prevención y Control del SIDA.
- 207 González Butrón, MA. 2000. *Las Mujeres Mexicanas en el Tercer Milenio*. Morelia, Michoacan, Mexico: Coordinación Nacional de Mujeres de Organizaciones Civiles Por un Milenio Feminista, 206.
- 208 Fernandez Ham, P and DE Avila Garcia. 1999. "Análisis Comparativo Entre Jóvenes Rurales y Urbanos: Una Relación Indisoluble." *Revista de Estudios sobre Juventud, Nueva Epoca* 3(9): 8-23.
- 209 Stern, C. 1995. "Embarazo Adolescente: Significado e Implicaciones para Distintos Sectores Sociales." *Demos: Carta Demográfica sobre México* 8: 11-12.
- 210 Venguer, T and others. 2001. "Si yo estoy bien, mi familia tambien." Report presented to Smith Kline and Beecham; "Series of promotional and educational materials for rural and indigenous areas. Mexico City, Mexico: Editorial IDEAME.
- 211 González Butrón, MA. 2000. *Las Mujeres Mexicanas en el Tercer Milenio*, 214.
- 212 Herrera Carnevale, C. 2000. *Experiencias Viables de Colaboración entre ONG de Mujeres e Instancias Gubernamentales en Mexico*. Mexico City, Mexico: Foro Nacional de Mujeres y Políticas de Población, 43.
- 213 Rodríguez, G. 2000. "El Aborto: Encuesta en Guanajuato." *Demos: Carta Demográfica sobre México* 13: 37-38.
- 214 Instituto Mexicano de la Juventud. 2001. *Encuesta Nacional de Juventud 2000 (Resultados Preliminares)*. Mexico City, Mexico: Instituto Mexicano de la Juventud.

- 215 Damián, GE. 1999. *Avances y Retos*, 18-19.
- 216 United Nations Population Division. 2001. *World Population Prospects*.
- 217 Ketting, E. 1983. "Contraception and Fertility in the Netherlands." *Family Planning Perspectives* 15: 19-25.
- 218 Reinders, J, NISSO. 2001. Interview by author, Washington, DC, USA, 9 October.
- 219 Du Bio-Reymond, M and others (eds.). 1995. *Childhood and Youth in Germany and The Netherlands: Transition and Coping of Adolescents*. Berlin, New York: Walter De Gruyter & Co.
- 220 Ketting, E. 1998. "The Family Planning And Sexual Health Revolution in The Netherlands." Utrecht, The Netherlands: Netherlands Institute of Social Sexological Research (NISSO).
- 221 For more information, see the work of Nel Draijer and others.
- 222 Reinders, J, NISSO. 2001. Interview by author, Washington, DC, USA, 9 October.
- 223 Ketting E. 1994. "Contraception in the Netherlands: The Low Abortion Rate Explained." *Patient Education and Counseling*. 23(3): 161-171.
- 224 United Nations Population Division. 2001. *World Population Prospects*.
- 225 Reinders, J, NISSO. 2001. Personal communication, Email. Washington, DC, USA, 23 August.
- 226 United Nations High Commission for Refugees (UNHCR). 1959. *Declaration Of The Rights Of The Child*. Proclaimed By General Assembly Resolution 1386(XIV): UNHCR.
- 227 International Center of the Netherlands Institute of Care and Welfare (NIZW). 2001. *Youth Participation in The Netherlands*. Available from <http://www.nizw.nl/fr-zoek1.htm>; Internet; accessed October 2001.
- 228 Du Bio-Reymond, M and others (eds.). 1995. *Childhood and Youth*; Rademakers, J. 1999. *Cross-Cultural Differences in Adolescent Sexual Behavior and Attitudes to Contraception*. Utrecht, The Netherlands: NISSO.
- 229 Poelman, J, J Reinders. 2000. "AIDS as Impetus for Sex Education." *STD Bulletin*. 20(4/98). Utrecht, the Netherlands Foundation for STD Control, January, 16-21.
- 230 AIDS Fonds. 2001. "Stichting AIDS Fonds." Available from <http://www.aidsfonds.nl>; Internet; accessed 16 October 2001.
- 231 Stichting soa-bestrijding. 2001. "The Stichting soa-bestrijding." Available from <http://www.soa.nl>; Internet; accessed 16 October 2001.
- 232 David, HP and J Rademakers. 1996. "Lessons from the Dutch Abortion Experience." *Studies in Family Planning* 27: 341-343.
- 233 Wijnberg, B, The Ministry of Health, Welfare and Sport. 2001. Interview by author, The Hague, The Netherlands, 1 May.
- 234 Reinders, J, NISSO. 2001. Personal communication, Email. Washington, DC, 9 October.
- 235 Hermans and Adelmund, Dutch Ministry of Education, Culture and Science, Information Department. 2000. "Giving Institutions Room to Deliver Quality." Available from <http://www.minocw.nl/english/p20000711.htm>; Internet; accessed 13 December 2001.
- 236 Ketting, E. 1994. "Is the Dutch Abortion Rate Really That Low?" *Planned Parenthood in Europe* 23(3): 29-32. Utrecht, The Netherlands: NISSO.
- 237 Reinders, J. 2001. Personal communication, Email. Washington, DC, USA, 9 October.
- 238 Trussell, J. 1998. "Contraceptive Technology Conference Coverage: Why Is Teen Pregnancy Rate in The Netherlands So Low?" *Contraceptive Technology Update* (May). Princeton, NJ, USA: Office of Population Research, Princeton University.
- 239 Berne, L and B Huberman. 1999. *European Approaches to Adolescent Sexual Behavior & Responsibility*. Washington, DC, USA: Advocates for Youth.
- 240 Reinders, J, NISSO. 2001. Personal communication, Email. Washington, DC, USA, 4 December
- 241 Trussell, J. 1998. "Contraceptive Technology Conference Coverage."
- 242 Reinders, J, NISSO. 2001. Personal communication, Email. Washington, DC, USA, 4 December.
- 243 Trussell, J. 1998. "Contraceptive Technology Conference Coverage."
- 244 Reinders, J, NISSO. Personal communication, Email. Washington, DC, USA, 4 December, 2001.
- 245 The National Campaign to Prevent Teen Pregnancy. 2001. *Halfway There: A Prescription for Continued Progress in Preventing Teen Pregnancy*. Washington, DC, USA: The National Campaign to Prevent Teen Pregnancy.
- 246 Youth Development Directions Project. 2000. *Youth Development: Issues, Challenges and Directions*. "Introduction and Overview." Philadelphia, PA, USA: Public/Private Ventures, 10.
- 247 Ozer, EM and others. 1998. *America's Adolescents: Are They Healthy?* San Francisco, CA, USA: University of California, San Francisco, National Adolescent Health Information, 12.
- 248 Ozer, EM and others. 1998. *America's Adolescents*, 38; Dailard, Cynthia with Rachel Benson Gold. 2000. *Fulfilling the Promise: Public Policy and US Family Planning Clinics*. New York, NY, USA: The Alan Guttmacher Institute (AGI), 10.
- 249 US Census Bureau. 2000. *Resident Population Estimates of the United States by Age and Sex: April 1, 1990 to July 1, 1999 with Short-Term Projection to November 1, 2000*. Washington, DC, USA: Population Estimates Program, Population Division, US Census Bureau.
- 250 Darroch, JE and S Singh. 1999. "Why is Teenage Pregnancy Declining? The Roles of Abstinence, Sexual Activity and Contraceptive Use." *AGI Occasional Report 1* (December); National Abortion and Reproductive Rights Action League (NARAL) Fact Sheet. 2001. "Online Newsroom: The Need for Comprehensive Sexuality Education." Available from http://www.naral.org/mediaresources/fact/sexed.html#N_11_; Internet; accessed 15 May 2001.
- 251 Gold, RB. 2001. "Title X: Three Decades of Accomplishment." *The Guttmacher Report on Public Policy* 4(1) (February), 6.
- 252 Office of Adolescent Pregnancy Programs. 2001. Available from <http://www.hhs.gov/opa/titlexx/oapp.html>; Internet; accessed 4 June 2001.
- 253 Saul, R. 1998. "Whatever Happened to the Adolescent Family Life Act?" *The Guttmacher Report on Public Policy* 1(2) (April).
- 254 Title V of the Social Security Act became a block grant as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), PL 97-35.
- 255 Bernstein, J and M Greenberg. 2001. "Reforming Welfare Reform." *The American Prospect* 12(1), 1-15 January.
- 256 Gold, RB. 2000. "Adolescent Care Standards and State CHIP Efforts." *Issues in Brief*, 2000 Series (1). New York and Washington, USA: AGI, 1.
- 257 CRLP. 1995. *Women of the World: Formal Laws and Policies Affecting Their Reproductive Lives*. New York, NY, USA: The International Program, CRLP, 36-37.
- 258 Satcher, D. 2001. "The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior." Washington, DC: Department of Health and Human Services. Available at <http://www.surgeongeneral.gov/library/sexualhealth/call.htm>.
- 259 Lieberman, D and J Feierman. 1999. "Legal Issues in the Reproductive Health Care of Adolescents." *Journal of the American Medical Women's Association* 54(3).
- 260 American Academy of Pediatrics, Committee on Adolescence. 1996. "The Adolescent's Right to Confidential Care When Considering Abortion" [Policy Statement]. *Pediatrics* 97(5): 746-751.
- 261 NARAL. 1999. *Who Decides? A State-by-State Review of Abortion and Reproductive Rights*. Washington, DC, USA: NARAL, pvii.
- 262 Gold, RB and A Sonfield. 2001. "Reproductive Health Services for Adolescents under the State Children's Health Insurance Program." *Family Planning Perspectives* 33(1).
- 263 Center for Health and Health Care in Schools. "School-Based Health Centers: Results from a 50-State Survey, School Year 1999-2000." Available from <http://www.healthinschools.org/sbhcs/survey2000.htm>; Internet; accessed 2 May 2001.
- 264 Fothergill, K and B Orlick. 1997. "The School-Linked Health Center: A Promising Model of Community-Based Care for Adolescents." *Issues at a Glance*. Advocates for Youth, Support Center for School-Based & School-Linked Health Care. Available from www.advocatesforyouth.org/publications/iag/SLHC_MDL.HTM; Internet; accessed 2 May 2001; National Assembly on School-Based Health Care News Release. 2000. "School-Based Health Centers Play an Increasingly Important Role in Children's Health, National Survey Shows", 11 August. Available from <http://nasbhc.org/censusnews.html>; Internet; accessed 6 June 2001; National Assembly on School-Based Health Care. 2000. *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999*. Washington, DC, USA: NASBHC.
- 265 Dailard, Cynthia with Rachel Benson Gold. 2000. *Fulfilling the Promise: Public Policy and US Family Planning Clinics*. New York, NY, USA: AGI, 16.

ENDNOTES

- 266 Gold, Rachel Benson. 2000. "Adolescent Care Standards," 2.
- 267 Hurley, T. American Academy of Pediatrics. 2001. Interview by author, Washington, DC, USA, 4 October.
- 268 The Commonwealth Fund. 1997. *The Commonwealth Fund Survey of the Health of Adolescent Girls: Facts on Access to Health Care*. Available from <http://www.cmwf.org/programs/women/acesfact.asp>; Internet; accessed 24 April 2001.
- 269 Medenwald, J. 1998. "Legal Issues and School-Based and School-Linked Health Centers." *Issues at a Glance*. Advocates for Youth. Available from www.advocatesforyouth.org/publications/iag/SBHCSLHC.HTM; Internet; accessed 2 May 2001.
- 270 Boonstra, H and E Nash. 2000. "Minors and the Right to Consent to Health Care." *The Guttmacher Report on Public Policy* 3(4).
- 271 Ibid.
- 272 Yawn, BP and RA Yawn. 1993. "Adolescent Pregnancies in Rural America: A Review of the Literature and Strategies for Primary Prevention." *Family and Community Health* 16: 36-45; F eijoo, AN and AP Taylor. 2000. *Measuring Up: Assessing State Policies to Promote Adolescent Sexual and Reproductive Health, An Assessment of Policies in All 50 States* 1(3). Washington, DC, USA: Advocates for Youth, xii-xiii.
- 273 Wolf, WC. 2000. "Using Title IX to Protect the Rights of Pregnant and Parenting Teens." *PPFY Network Newsletter: Pregnancy Prevention for Youth* (March).
- 274 NARAL Online Newsroom. 2000. "House Approves Additional \$50 Million for Abstinence-Only Programs: Bush Supports Efforts to Censor Critical Information to Teens." 14 June. Available from http://www.naral.org/mediareources/press/pr061400_abstinence.html; Internet; accessed 3 May 2001.
- 275 CRLP. 1995. *Women of the World*, 38-39; Donovan, P. 1998. "School-Based Sexuality Education: The Issues and Challenges." *Family Planning Perspectives* 30(4): 188-193.
- 276 Porter, LE and L Ku. 2000. "Use of Reproductive Health Services among Young Men, 1995" *Journal of Adolescent Health* 27 (3): 186-194.
- 277 Sonenstein, FL (ed.). 2000. *Young Men's Sexual and Reproductive Health Toward a National Strategy: Framework and Recommendations*. Washington, DC, USA: The Urban Institute, 14; Bernard, SN and JK Knitzer. 1999. *Map and Track State Initiatives to Encourage Responsible Fatherhood*. New York, NY, USA: National Center for Children in Poverty.
- 278 National Assembly on School-Based Health Care. 2000. "School-Based Health Centers"; National Assembly on School-Based Health Care. 2000. *Creating Access*.
- 279 Juszcak, L, Division of Adolescent Medicine, North Shore University Hospital. 2001. Interview by author, Washington, DC, USA, 24 July.
- 280 H.R. 3469 is available at <http://thomas.loc.gov>; Internet; accessed 21 December 2001.
- 281 National Youth Development Information Center, National Collaboration for Youth. "The Younger Americans Act Fact Sheet." Available from <http://www.nydic.org/nydic/YAA.html>; Internet; accessed 5 June 2001.
- 282 Partee, G, American Youth Policy Forum. 2001. Interview by author, Washington, DC, USA, 4 May.
- 283 Kirby, D and K Coyle. 1997. "Youth Development Programs." *Children and Youth Services Review* 19(5/6): 437-54 [journal on-line]. Available from <http://www.aei.org/sw/swkirbycoyle2.htm>; Internet; accessed 3 May 2001.
- 284 Sawhill, I. 2001. "What Can Be Done to Reduce Teen Pregnancy and Out-of-Wedlock Births?" *Welfare Reform and Beyond Policy Brief 8* (October). Washington, DC, USA: The Brookings Institution.
- 285 UNICEF. 2001. *Early Marriage, Child Spouses. Innocenti Digest 7*. Florence, Italy: UNICEF.

BOARD OF DIRECTORS

Constance Spahn, *Chair*

Victoria P. Sant, *First Vice Chair*

William H. Draper, III, *Second Vice Chair*

Robin Chandler Duke, *Chair Emeritus*

Scott M. Spangler, *Treasurer*

Phyllis Tilson Piotrow, *Secretary*

William H. Draper, Jr., *Honorary Chair (1965-1974)*

Amy Coen, *President*

Vincent Anku

Vicki-Ann E. Assevero

Harriet Babbitt

Kenneth H. Bacon

Anthony C. Beilenson

Pouru P. Bhiwandi

Marnie Dawson Carr

William Clark, Jr.

Melissa Draper

Bill Green

Kaval Gullhati

Jonathan Lash

Yolonda Richardson

Barbara Roberts

Allan Rosenfield

Fred T. Sai

Isabel V. Sawhill

Timothy L. Towell

Joseph C. Wheeler

William D. Zabel

THE COUNCIL

Joseph D. Tydings, *Chair*

C. Payne Lucas, *Vice Chair*

Robert Fearey, *Secretary*

Norman E. Borlaug

Sharon L. Camp

A. W. Clausen

Barber B. Conable

Julia J. Henderson

Lawrence R. Kegan

Robert S. McNamara

Wendy B. Morgan

Thomas H. Roberts, Jr.

Nafis Sadik

Elmer Boyd Staats

Publications Team: Sally Ethelston, Brian Hewitt, Julie Witherell

Designer: Hasten Design Studio, Washington, DC

Printer: Image Graphics Incorporated

Cover/page i photos: © Jim Daniels

Printed on recycled paper with soy inks.



Population Action
INTERNATIONAL

1300 19th Street, NW, Second Floor

Washington, DC 20036 USA

www.populationaction.org