

THE TRUTH ABOUT CONDOMS

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The simple truth is that for sexually active couples at risk for infection condoms are the best means we have of preventing AIDS and other sexually transmitted diseases (STDs). For a man and a woman who are committed to having sexual intercourse and who have any concern regarding any of the STDs, condoms are the best means of preventing infection. Abstinence and a mutually faithful monogamous relationship with an uninfected partner, few would argue, are even more effective; but if sexual intercourse is going to occur, whatever the reasons behind this decision, condoms are the best approach to preventing an infection.

Prevalence of Condom Use

In most societies condom use is minimal. Throughout the world condoms are used by only 5% of reproductive-age couples. Table 1, Condom Use Around the World, documents the lack of dependence of couples on this method of birth control. Clearly, if condom use is going to play a significant role in the prevention of the spread of human immunodeficiency virus (HIV) infection, condom use must increase in the near future. Of the most populous nations in the world, condom use is most extensive in Japan where condoms are used by 43% of married reproductive-age women. This falls to 18% in the United Kingdom and to 10% in the United States. Condoms are used by 2% or less of married couples in Indonesia, Brazil, Bangladesh, Pakistan, Egypt and Nigeria.

The data for Table 1 come from the most recent national survey for each of the countries—the 1982 National Survey of Family Growth (NSFG Cycle III) in the case of the United States. More recent data for the United States are available from a series of Ortho birth control studies which have been carried out annually for almost two decades (Forrest, 1988). The Ortho surveys have included unmarried women for the past decade and 15–17-year-olds since 1985. In the United States, condom use increased by 33% from 12% to 16% from 1982 to 1987. Use of condoms by

married women increased insignificantly from 14% in 1982 to 15% in 1987, but increased from 9% to 16% among unmarried women in the same time span. Even more dramatic was the increase in favorable attitudes toward condoms. From 1977 to 1982 favorable opinions of the condoms remained stable at about 40% (Tanfer, 1985; Forrest, 1988). Favorable opinions of the condom fell to 38–39% from 1982 to 1984. Then, favorable opinions of the condom rose sharply to 60% in 1987 (Forrest, 1988). Increased use of condoms and more favorable attitudes toward condoms appear to be related to growing interest in avoiding sexually transmitted infections.

In his study of condom use in developing nations, Goldberg found that 1% or less of married women aged 15–44 used condoms in 36 of 66 nations, including eight of the 15 nations where 100 or more cases of AIDS have been reported to the World Health Organization as of February, 1988 (Goldberg, 1988). (See Table 2.)

Effectiveness

Condoms are used for two major purposes: to prevent pregnancy and to prevent infection. In neither case is protection 100%. Trussell and Kost's extensive review suggests three failure rates for condoms as contraceptives

Table 1 Condom use and the role of men in family planning:
The 10 most populous nations in the world plus the United Kingdom, Egypt, Turkey and Mexico
Contraceptive Technology: International Edition, 1989

Country	Percent Couples of Reproductive Age Using Condoms	Percent Women with Knowledge of Condoms	Percent Couples of Reproductive Age Using Withdrawal	Spousal Consent Required for Tubal Ligation	Percent Couples of Reproductive Age Protected by Vasectomy
Japan	43	..	1	Yes	3
United Kingdom	17	..	6	No	14
United States	10	..	1	No	11
Turkey	5	..	30	No	—
India	4	54	—	No	>11
China	3	..	—	No	9
Indonesia	2	75	..	Yes	—
Brazil	2	87	5	Yes	1
Bangladesh	2	59	1	No	3
Pakistan	2	20	1	Yes	1
Mexico	2	67	..	Yes	1
Egypt	1	26	—	No	—
Nigeria	—	5	—	..	—
USSR
World	5	..	4	..	5

Your Country,
Region, State,
County or City _____

.. Data not available or not separately reported

— Amount is nil or negligible

Sources: 1. Ross JA, Rich M, Molcan JP, Pensak M. Family Planning and Child Survival: 100 Developing Countries. Center for Population and Family Health, Columbia University 1988; Table 26.
2. London KA, Cushing J, Rustein SO, et al. Fertility and Family Planning Surveys: An Update. Population Reports 1985; Series M(8): 289-348.
3. Gatten ME. Men—New Focus for Family Planning Programs. Population Reports 1986; Series I(32): 889-920.
4. Liskin L. Youth in the 1980s: Social and Health Concerns. Population Reports 1985; Series M(9): 349-367.

in the first year of use (see Table 3). The authors' best estimate of the failure rate among couples using condoms consistently and correctly is 2%. Among typical users the first year failure rate is 12%, while the lowest reported failure rate in first year users is 4%. For typical users of condoms, the failure rate is lower than for typical users of the diaphragm, sponge, cervical cap, spermicides or fertility awareness methods (Trussell & Kost, 1987; Hatcher, 1988). A summary of nine studies of condom failures is presented in Table 4, Summary of Studies of Contraceptive Failure: Condoms (Trussell & Kost, 1987).

Condoms do break and it is important to remember that postcoital contraception may at times be indicated. As long as condoms break; inclination and opportunity unexpectedly converge; men rape women; diaphragms and cervical caps are dislodged; people are so ambivalent about sex that they need to feel "swept away"; IUDs are expelled; and pills are lost or forgotten, we will need morning-after birth control.

In an attempt to determine the likelihood of condom breakage, 282 attendees of family planning and reproductive health conferences; 86 university students; and 89 women attending a municipal hospital family planning clinic were asked several questions about condom use, condom breakage, and pregnancies specifically attributable to a condom that broke. The overall rate of condom breakage was one break per 105 acts of intercourse (see Table 5). However, women seen at the public family planning clinic

had a breakage rate 10 times higher than the reproductive health employees (1:16 vs. 1:161). The university students averaged one break per 92 condom uses, which was intermediate between the other two groups in the study. Compared to family planning clinic patients, the employees working in the reproductive health field were older (mean age 37) and had used condoms more often (an average of 139 times per person). The average clinic patient was 23-years-old and had used a condom only 27 times per person.

In two states, Minnesota and Pennsylvania, more detailed information was collected from 195 individuals working in the field of reproductive health (see Table 6). Condom breakage was more than four times as likely to occur among women who had used condoms less than 100 times than among women who had used condoms more than 250 times. This suggests that frequent condom use teaches women how to use condoms more effectively. Moreover, when condoms did break they were less likely to lead to pregnancy among women who had used condoms more than 250 times (one pregnancy per 31 condom breaks) than in women who had used condoms 100–250 times (one pregnancy per nine condom breaks) or in those women who had used condoms less than 100 times (one pregnancy per 13 condom breaks). This suggests that once a pregnancy results from a broken condom, a woman will not return to the use of condoms, while if pregnancy does not occur, a woman may persist in using condoms. For example, one woman in the study had experienced 15 condom breakages

using condoms 1,250 times, but had not experienced a pregnancy attributable to a broken condom.

How effective are condoms at preventing transmission of the virus which causes AIDS? In one study of heterosexual transmission of the human immunodeficiency virus (HIV), 79% of the couples using condoms experienced condom breakage at least once in the 18-month study period. Another 8% experienced leakage at least once. The heterosexual partners of HIV-positive individuals were least likely to seroconvert if abstinence was employed (0% or zero of 12). Of the 18 couples using condoms consistently, three (17%) seroconverted to become HIV-positive over 18 months. If condoms were not used or were used erratically, as was the case in 17 couples where one person was infected with HIV,

then 82% (14 of 17) became HIV-positive during the study period. Consistent condom use thus helped decrease HIV transmission from 82% to 17% but did not eliminate the risk of HIV transmission (Fischl, 1987). An investigation of prostitutes in Zaire demonstrated an association between condom use and protection against HIV infection (Mann, 1987). Cates concludes that clinical studies suggest "that the protective effect of condoms against many STDs is real and clinically important" (Cates, 1988).

Natural membrane condoms, often called "skin" condoms or "natural skin" condoms, are actually made from the caecum of lamb intestine. Most are produced in Australia. The hepatitis B virus (HBV), which is approximately 42nm (nanometers) in diameter, has been demonstrated to pass

TABLE 2
Percent of Currently Married* Females of Childbearing Age in Developing Countries Reporting Current Use of Condoms, Arranged By World Region**

Current Condom Use	Sub-Saharan Africa	Middle East/ North Africa	Asia	Latin America/ Caribbean
≥ 10%			China-Beijing (25) Singapore (22) Taiwan (17) Hong Kong (15) China-Shanghai (12)	Costa Rica (13) TRINIDAD & TOBAGO (12)
5-9%	Mauritius (9)		S. Korea (7) Fiji (6)	Jamaica (8) Grenada (7) St. Kitts-Nevis (6) BARBADOS (5) VENEZUELA (5)
2-4%		Tunisia (2) Turkey (2)	India (4) Philippines (4) Malaysia (3) Sri Lanka (2) Bangladesh (2) Indonesia (2)	PUERTO RICO (4) Guyana (3) Panama (2) Paraguay (2) BRAZIL (2) COLOMBIA (2) MEXICO (2)
≤ 1%	Ghana (1) ZIMBABWE (1) Botswana (1) ZAIRE-URBAN (<1) KENYA (<1) Senegal (<1) Liberia (<1) Benin (<1) Cameroon (<1) Lesotho (<1) Nigeria (<1) Sudan-North (<1) IVORY COAST (<1) Mauritania (<1) Somalia-Urban (<1) Burkina Faso (<1) RWANDA (<1) BURUNDI (<1) Mali (<1)	Egypt (1) Jordan (1) Morocco (1) Syria (1) N. Yemen (<1)	Thailand (1) China-All (1) Pakistan (1) Nepal (<1)	HAITI (1) Ecuador (1) DOMINICAN REPUBLIC (1) El Salvador (1) Peru (1) Guatemala (1) Honduras (1) Bolivia (<1)

*Generally includes all women living in union, whether legally married or not.

**Ages 15-44 or 15-49.

Note: Countries in capital letters are those which have reported at least 100 AIDS cases to the World Health Organization.

Source: Goldberg, H.I., Lee, N.C., Oberle, M. & Peterson, H.B. Knowledge and use of condoms in less developed countries during the rise of AIDS. Forthcoming in *The Bulletin of the World Health Organization*.

Table 3 Lowest expected, typical, and lowest reported failure rates during the first year of use of a method and first-year continuation rates. United States.^a

Method (1)	% of Women Experiencing an Accidental Pregnancy in the First Year of Use:			% of Women Continuing Use at One Year ^b	
	Lowest Expected ^c (2)	Typical ^d (3)	Lowest Reported ^e (4)	Exc. Preg. (5)	Inc. Preg. (6)
Chance	89	89	0	55	43
Spermicides ^f	3	21	0	84	67
Periodic abstinence		20			
Ovulation method	8		8 ^g		
Sympto-thermal	6		11 ^h		
Calendar	10		14 ⁱ		
Post-ovulation	2		2 ^j		
Withdrawal	4	18	7 ^k		
Cap ^l	5	18	8	77	63
Sponge	5 nullips ≥6 parous	18 nullips ≥28 parous	14 nullips 28 parous	73 73	60 53
Diaphragm ^m	3	18	2	69	57
Condom ⁿ	2	12	4 ^o	73	64
IUD		6		74	70
Medicated	1		0.5		
Non-medicated	2		3		
Pill		3		75	73
Combined	0.1		0		
Progestogen only	0.5		1		
Injectable progestogen				70	70
DMPA	0.3	0.3	0		
NET	0.4	0.4	0		
Implants				88	88
Capsules	0.3	0.3	0.3		
Rods	0.2	0.2	0		
Female sterilization	0.2	0.4	0		
Male sterilization	0.1	0.15	0		

^a Reprinted with the permission of the Population Council, from James Trussell and Kathryn Kost, "Contraceptive failure in the United States: A critical review of the literature," *Studies in Family Planning* 18(5), September/October, 1987: Tables 1 and 2.

^b Among couples who initiate use of a method (not necessarily for the first time) and who use it perfectly (both consistently and correctly), the authors' best guess of the percentage expected to experience an accidental pregnancy during the first year if they do not stop use for any other reason.

^c Among typical couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.

^d In the literature on contraceptive failure, the lowest reported percentage who experienced an accidental pregnancy during the first year following initiation of use (not necessarily for the first time) if they did not stop use for any other reason. However, see Note 8.

^e Among couples attempting to avoid pregnancy, the percentage who continue to use a method, under the alternative assumptions that no one becomes pregnant (col. 5) and that the proportion becoming pregnant is given by col. 2 (col. 6).

^f Foams, creams, jellies, and vaginal suppositories.

^g With spermicidal cream or jelly.

^h Without spermicides.

ⁱ Too low, because rate is based on more than one year of exposure.

through natural membrane condoms (Minuk, 1986). The same investigator found that larger viruses such as the retrovirus causing AIDS (HIV, 100–150nm), cytomegalovirus (CMV, 150–200nm), and herpes simplex virus (HSV, 150–200nm) did not pass through natural membrane condoms (Minuk, 1986). Other investigators have found that the human immunodeficiency virus has passed through pores in natural membrane condoms. At a conference convened in early 1987 to discuss the use of condoms in the prevention of sexually transmitted disease, a number of participants expressed the opinion that they could "see no reason why anyone would recommend natural skin condoms for the prevention of disease." Even stronger was a statement by Malcolm Potts, a longtime student and advocate of condoms, who said, "I would ban the use of natural skin condoms until they have been proven safe." Potts recommends the use of spermicidal latex condoms if the prevention of sexually transmitted infections is a major reason for using condoms (Potts, 1987). Another position is that natural membrane condoms, which act as barriers to all but the smallest viral particles, should not be too strongly discouraged, particularly in view of the finding that natural membrane condoms are the only condoms acceptable to some sexually active men.

A strong word of caution has now been sounded suggesting that clinicians counsel men and women that natural membrane condoms or "skin" condoms are not quite as effective a barrier as latex condoms. Latex condoms, and in particular latex condoms with an effective spermicide added, appear to be the best choice, particularly if the prevention of infection is a high priority for an individual or a couple using condoms.

Why the Debate?

Condom detractors suggest that condom breakage leading to potential spread of the human immunodeficiency virus is too catastrophic an outcome to even consider their recommendation. Do condoms lead to safe sex? No, but most counsellors would suggest that condoms certainly do make sex safer. If condoms are used *when sexual intercourse definitely would have occurred, condoms or no condoms*, then condoms clearly do make sex safer than it otherwise would have been. Organizations providing condoms might consider developing a rejoinder to condom detractors. The boxed message, "Condoms are Effective," suggests some of the ways that programs can promote condom use.

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CONDOMS ARE EFFECTIVE

Condoms are an effective means of preventing sexually transmitted infections with the human immunodeficiency virus (HIV) which causes AIDS. One single act of sexual intercourse or other high risk sexual behavior with an infected individual may lead to transmission of the human immunodeficiency virus (HIV). Condoms should be used by individuals at possible risk for HIV infection and other STDs, even if they are already using sterilization, oral contraceptives or any other means of birth control to prevent unplanned pregnancy.

It is therefore recommended that local health departments, family planning programs, and all reproductive health agencies encourage condom use by making condom education and distribution a priority and specifically by undertaking the following actions:

1. Make condoms available to clients free or at the lowest possible cost.
2. Offer clients sufficient quantities of condoms.
3. Instruct clients in the proper use of condoms.
4. Assist clients in enlisting partner cooperation in condom use.
5. Provide community education to overcome barriers to condom use.

TABLE 4: Summary of studies of contraceptive failure : condoms

Reference	Method Brand	N For Analysis	LT 12 Mo.	Failure Rate		Characteristics of the Sample	LFUg	Comments
				Index	Tot. Exp.			
Porter and McDevitt, 1975		397	2.1 (24 mo.)			77% males \geq age 40; all married	4.8c	All couples agreed to exclusive use of spermicidally lubricated condom
Peel, 1972		96	3.9	3698 mo	60 mo	All married	2.9t	Hull Family Survey
Glass, et al., 1974		2057	4.2			Aged 25-39; all married; all white; 66% were previous oral contraceptives users	≤ 1.0v	Oxford/FPA study
John, 1973		85	5.8c	3132 mo	94 mo	All aged \leq 46; all married or living as married	?	Retrospective survey, Britain
Vessey, et al., 1982		?	6.0	4317 yr	24 mo	Aged 25-34; all married; all white; at enrollment, all women were using the diaphragm, IUD, or the Pill successfully for at least 5 months	0.3tv	Oxford/FPA study
Schirm, et al., 1982		1223	9.6s			Aged 15-44; all married	18.2r	NSFG 1973 and 1976
Grady, et al., 1983		1223	9.7sc			Aged 15-44; all married	18.2r	NSFG 1973 and 1976
Vaughan, et al., 1977		696	10.1s			Aged 15-44; all married	19.0t	NSFG 1973
Grady, et al., 1986		526	13.8s			Aged 15-44; all married	20.6r	NSFG 1982
Westoff, et al., 1961		~ 212		13.8c	10062 mo	?	5.7r	EGMA study

NOTES:

- a. Reprinted with the permission of the Population Council, from James Trussell and Kathryn Kost, "Contraceptive Failure in the United States: A Critical Review of the Literature," *Studies in Family Planning* 18(5), September/October, 1987: Tables 1 and 2.
 c. Calculated by Trussell and Kost (1987) from data in the article.
- g. Most of these studies incorrectly report the loss to follow-up rate as the number of women lost at any time during the study divided by the total number of women entering the study. Thus, these are the rates presented in the table. However, the correct measure of LFU would be a gross life table rate. When available, 12-month rates are denoted by the letter "g".
 r. Nonresponse rate of the entire study.
- s. Standardized:
 Vaughan, et al., 1977 (1973 NSFG) — intention (the average of rates for preventers and delayers);
 Grady, et al., 1983 (1973 and 1976 NSFG) — intention. Our calculation (the average of rates for preventers and delayers, as in 1973);
 Schirm, et al., 1982 (1973 and 1976 NSFG) — intention, age, and income;
 Grady, et al., 1986 (1982 NSFG) — intention, age, poverty status, and parity. t. Total for all methods in the study.
- v. The authors report that LFU from "relevant reasons (withdrawal of cooperation or loss of contact)" was .3% per year in the 1982 study and "less than 1%" per year for all reasons in the 1974 study. In the 1982 study, women had on average been followed for 9.5 years; if .3% are LFU per year, then 2.8% would be LFU in 9.5 years. LFU including death and emigration is about twice as high as LFU for "relevant reasons." w. Unless otherwise noted, characteristics refer to females.

TABLE 5: Condom breakage and unplanned pregnancies attributed to broken condoms among individuals working in the field of reproductive health, university students, and women attending a municipal hospital family planning clinic in the United States, 1987-1988

Study Group	Number of Individuals			Total Times Condom Utilized	Number Times Condom Broke	Number Pregnancies Attributed to a Condom Break ^d	Condom Breaks Per Acts of Intercourse
	Ever Used Condoms	Never Used a Condom	Mean Age				
Reproductive Employees ¹	282 (88.1%)	38 (11.9%)	37	39,383	244	9	1:161
University Students ²	86 (57.7%)	63 (42.3%)	19	4,870	53	1	1:92
Women at Family Planning Clinic ³	89 (93.7%)	6 (6.3%)	23	2,404	146	9	1:16
Total	457	107	30	46,657	443	19	1:105

- NOTES:
- Individuals working in family planning, reproductive health, and gynecology and obstetrics were surveyed in the first half of 1987; information was collected at family planning conferences in Ohio, South Dakota, Pennsylvania, and Minnesota.
 - University students completed questionnaires in a health class in a large southeastern community, in 1987.
 - Women were interviewed in a municipal hospital family planning clinic in the southeast, in the summer of 1988.
 - Women from three of the four states, working in the field of reproductive health, were asked if they had experienced an unplanned pregnancy which they attributed to a condom break. Women using condoms 36,047 times experienced 231 condom breaks of which nine led to a pregnancy; thus one pregnancy was attributed to condom breakage for each 4,005 acts of intercourse using condoms and one pregnancy occurred each 26 times a condom broke. Among university students, one pregnancy occurred following 53 condom breaks, while in women interviewed at a municipal hospital family planning clinic, nine pregnancies were attributed to condom breakage following 146 condom breaks or one pregnancy per 16 condom breaks. In toto, there were 19 pregnancies following 430 condom breaks or one pregnancy per 23 condom breaks.

TABLE 6: Condom breakage and unplanned pregnancies among reproductive health care workers in Minnesota and Pennsylvania by total number of acts of intercourse protected using condoms: 1987

Total Number of Acts of Intercourse Protected by Condoms	Number of Women	Total Acts of Intercourse Protected by Condoms	Mean Number of Acts of Intercourse Protected by Condoms Per Person	Number of Times Condom Broke	Condom Breaks Per Acts of Intercourse	Pregnancies Per Condom Breakage
250	34	21,560	634	123	1:175	1:31
100-250	18	2,256	125	17	1:133	1:9
100	143	2,478	17	64	1:39	1:13
TOTAL	195	26,294	776	204	1:129	1:23

USER INSTRUCTIONS

Why should you use condoms?

1. To prevent an unwanted pregnancy.
2. To protect yourself and your partner against sexually transmitted infections, including HIV.
3. To protect the woman against infertility and cervical cancer.
4. To protect the fetus, during pregnancy, against HIV infection, gonorrhea, herpes, chlamydia, trichomoniasis, and genital warts.

When should you use condoms?

Every time you have intercourse and you are afraid that an infection may be spread from one partner to the other, even during pregnancy.

How do you use condoms?

1. Put the condom on the erect penis (either partner can do this) BEFORE the penis is inserted into the vagina or anus.
2. Wait until the vagina is well lubricated, because a condom can tear if the vagina is dry.
3. Roll the condom all the way to the base of the erect penis.
4. Leave 1/2 inch of empty space at the tip of the condom (pinch the tip as you roll it on).
5. Condoms can tear, so be careful.

6. If extra lubrication is needed, use water, K-Y jelly, or contraceptive foam, gel, or cream. Do NOT use petroleum jelly, shortening, or other agents that weaken rubber.
7. For extra protection, use a backup method of birth control such as a diaphragm; contraceptive foam, gel or suppositories; the sponge; the pill.

How do you remove the condom?

1. After intercourse, withdraw the penis immediately, holding on to the rim of the condom to prevent spilling.
2. Check the condom for tears, then throw it away. If the condom has torn, quickly insert spermicidal foam or gel. There is a possibility the woman will still become pregnant, but this reduces the risk. Consult your health care worker as soon as possible; you may be able to obtain postcoital pills.
3. Store condoms in a cool, dry place. Heat—even body heat—may cause the rubber to weaken, so don't store condoms in a place that becomes very hot. If the condoms are kept dry, sealed, and away from heat, sunlight, and fluorescent light, they will probably last five years or more. The date printed on the packaging of some condoms is the date the condom was manufactured; it is not an expiration date.

ADVANTAGES AND NONCONTRACEPTIVE BENEFITS

In addition to protecting against pregnancy, the condom offers several noncontraceptive benefits. Perhaps condoms would be a great deal more popular if some of the noncontraceptive benefits received greater emphasis, thereby offsetting the stigma often associated with condom use (e.g., promiscuity, prostitution).

1. Use of condoms encourages male participation in contraception and protection from infection.
2. Condoms are relatively inexpensive. They may be purchased in large numbers by public family planning programs at very low cost and may even be obtained for free.
3. Condoms are accessible. Their use does not require an examination, prescription, or fitting. They can be obtained by men or women from drugstores, family planning clinics, barbershops, vending machines, gas stations, restaurant toilets, mail order services, or other sources.
4. Some women and men do not wish to have the penis in direct contact with the vagina. The condom is an effective barrier that may make intercourse more pleasurable if this concern exists.
5. Men who have difficulty maintaining an erection may find that the rim of the condom may have a

slight tourniquet effect, helping to maintain an erection.

6. Lubricated condoms can reduce mechanical friction and irritation of the penis or vagina.
7. In some infertile couples, the woman's body makes antibodies to her partner's sperm. In such couples, the use of condoms for three to six months (the length of time depends on the level of the antibody titer and how long it remains elevated) can prevent the release of sperm antigens into the vagina.
8. Women have very occasionally been allergic to their partner's sperm and/or semen; urticarial and even anaphylactic reactions have occurred. Condoms would obviously prevent these allergies.
9. By diminishing sexually transmitted infections, condoms may diminish the likelihood of infertility or cervical cancer in some women.
10. Messy postcoital discharge of semen from the vagina, a very annoying aftermath for some women, is avoided by using condoms.
11. Condom use may prevent the development of or cause the regression of cervical intraepithelial neoplasia.
(Free, 1985; Richardson, 1981; Hatcher, 1982; Sherris, 1982)

DISADVANTAGES AND COMPLICATIONS

The major complaint of condom users is that the condom reduces glans sensitivity, although there is no objective data on whether this is true. In order to provide a perception of increased sensitivity, natural membrane, textured, ribbed, ultrathin, or lubricated condoms may be used. Greater care has to be taken

with thinner condoms because they break and tear more easily. Other users object to interrupting foreplay to put on the condom. In this instance, the woman can be encouraged to put the condom on the man as part of foreplay, although women with long fingernails should be careful.

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If a person who is not HIV-infected is about to have intercourse, far more critical than condom use or the lack of it is the HIV status of the second person with whom the noninfected person is about to be intimate. However, only a small fraction of the U.S. population has been tested for HIV. And the possible window of time it can take before a person becomes HIV antibody-positive keeps getting longer. So knowledge of another person's HIV status is imperfect. Moreover, even when one or both people who are about to enter into an intimate sexual relationship have been tested recently and know their HIV antibody status, there is no guarantee that they will be able to summon the courage to discuss it; or that, if they do discuss it, the information shared between the two people will be honest. In sum, a noninfected individual may not accurately know the HIV antibody status of a person with whom he or she is about to have intercourse.

Condoms For Pregnant Women?

Sexually transmitted infections may complicate pregnancy for a pregnant woman, her partner(s) and/or her child. In the following situations, the provision of condoms to a pregnant woman should be carefully considered:

1. A pregnant woman whose partner is diagnosed as having herpes simplex virus (HSV) infection, chlamydia infection or nongonococcal urethritis (NGU), human immunodeficiency virus (HIV) infection or acquired immunodeficiency disease (AIDS), venereal warts, trichomoniasis, gonorrhea, syphilis, or hepatitis B. (Or if one of the above infections has been strongly suggested.)
2. A woman whose partner is likely to have multiple partners during the course of her pregnancy or whose partner is an intravenous drug abuser.
3. A pregnant woman who is diagnosed, herself, for any of the following infections: HSV infection, HIV infection, chlamydia, pelvic inflammatory disease, mucopurulent cervicitis, venereal warts, trichomoniasis, gonorrhea, syphilis or hepatitis B.
4. A pregnant woman who indicates that she is quite likely to have multiple partners during her pregnancy.

Conclusion

Condoms are not perfect at preventing either pregnancy or HIV infection. For sexually active couples, there are more effective ways of preventing pregnancy. For couples committed to having sexual intercourse where the prevention of HIV transmission is a goal, the best intervention to employ, once the decision to have intercourse has been made, is a condom. In most instances, the condom will not break.

There are many, many couples—throughout the world in different cultures—of different ages and at various degrees

of risk of exposure to HIV infection, who would be much wiser not to have intercourse at all. We, in family planning and sex education programs, have been praising the option of abstinence for the past two decades. Often our "love carefully," "save it for later," "how to say no" or "how to say not now" messages have been appreciated and abstinence has been fostered. But our messages also fall on completely deaf ears, in some instances. Where there is a clear and present danger of possible transmission of HIV infection or any other STD, condoms make extremely good sense. The debate should end. It has gone on too long.

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Dr. Hatcher Suggests

That One Way to Persuade Someone to Use Condoms May Be to Sign a Condom Contract

A Personal Commitment, Pledge, or Contract For

A Safer and Healthier Sexual Life

Introduction: Sexual intercourse and other forms of sexual intimacy are both pleasurable and difficult to discuss. However, careful consideration of this topic is essential because the sexual choices you make today can have life-long consequences.

Consequences of Intimate Sexual Contact May Include:

- AIDS or Acquired Immune Deficiency Syndrome:** Caused by a virus which makes people unable to fight off infection and makes them susceptible to several types of cancer. 1.0 to 1.5 million individuals, both male and female, have been infected and are now capable of transmitting this virus. AIDS adds an entirely new dimension to sexual intercourse. One act of intercourse can now cause a person's death.
- Pregnancy:** In the United States, over 50% of all pregnancies and close to 90% of pregnancies in unmarried teenagers are unintended. Unintended pregnancies are a major reason for young women terminating their education.
- Herpes:** Genital herpes is caused by two types of herpes simplex virus, which may be controlled but not cured. 200,000 new infections and up to 20 million recurrences of herpes occur annually. While the first episode of herpes tends to be the worst, recurrences may be quite painful. Acyclovir, which is used to treat herpes, costs \$50 to \$100 a month.
- Chlamydia:** The most common sexually transmitted disease, chlamydia trachomatis is a bacteria which causes cervicitis, chronic vaginal discharge, pelvic inflammatory disease, and sometimes infertility in women; it causes penile discharge, urethritis, and pain on urination in men. From 10-25% of college and university women test positive for this potentially serious infection.

Commitment, Pledge, or Contract

Your options for a Safer and Healthier Sexual Life:

- ▼ **Abstinence** will be the easiest and safest protection against both pregnancy and sexually transmitted infections for some individuals. For many individuals, abstinence fits best into a person's beliefs about what is right or wrong for that individual to do. A number of other ways of being sexually intimate remain available to the person choosing abstinence.

Name(s) _____ Date _____

- ▼ **Absolute monogamy** between partners is safe for those who engage in sexual intimacy, or plan to, assuming that neither is currently infected with the AIDS virus. For some individuals it may be important to be tested for infection prior to engaging in intimate sexual contact. Neither individual can have intercourse outside of this relationship if monogamy is to protect the two individuals from being infected.

Name(s) _____ Date _____

- ▼ **Consistent use of condoms** is the best form of protection for individuals having intercourse outside of a dually monogamous relationship or for couples beginning a new monogamous relationship. Condoms may be used with or without another contraceptive such as birth control pills. Latex condoms are better than natural membrane or "skin" condoms for protection against infections. Condoms may break and are not 100% effective at preventing pregnancy or spreading infection. Spermicides (in foam, suppositories, creams, sponges, and film) may be used with condoms to decrease the risk of both unplanned pregnancy and infection.

Name(s) _____ Date _____

- In addition, If I do become involved in an intimate sexual relationship, I will have the courage to ask that person about his or her past sexual history and will disclose anything in my own history which may place him or her at risk.

Name(s) _____ Date _____

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PROMOTING CONDOM USE TO PREVENT HIV INFECTION

LESSONS FROM HISTORY

Ronald O. Valdiserri, MD

Solving health-related problems can be a complex undertaking, especially if the process intersects other issues which can affect decision-making and implementation. When the health problem under study is associated with behaviors which are controversial, poorly understood, or characterized by conflicting value judgments, solutions may be difficult to come by. Take, for example, the subject of condoms as a means of preventing sexually transmitted diseases, specifically HIV (human immunodeficiency virus) infection. Public health officials have gone on record stating that for persons who are neither celibate nor in a mutually monogamous relationship where both partners are free of HIV infection, condoms are the best means of avoiding sexually acquired HIV infection. Some interpret this recommendation to mean that condom promotion should be given the highest priority as a means of blunting the sexual spread of AIDS. Others take it to mean that condom use should only be advocated as a "last ditch" or "fall-back" alternative, and that the primary emphasis of HIV risk reduction campaigns should be the promotion of celibacy or monogamy.

Different interpretations of this recommendation reflect differences in individual values about sexuality. Persons who believe that sex outside of marriage is wrong may view the promotion of condoms as encouragement for premarital sex, when they believe the solution to AIDS is to discourage this activity. Those who consider sex between two men to be immoral are likely to believe that promoting condom use within this group, as a means of preventing AIDS, is synonymous with endorsing homosexuality, and will probably favor an approach which emphasizes celibacy. Finally, there are those who believe that the HIV-related consequences of condom failure are so great, that rather than promote condom-protected intercourse, they would advocate, instead, for the complete elimination of riskful behavior from the sexual repertoire. Although this solution

is not without reason, it does not coincide with what we have learned from other health promotion experiences, where it has often been found necessary to provide reasonably safe alternatives for persons who are unable to forego completely an unsafe behavior or unhealthy activity.

From a medical and public health perspective, condoms are a highly beneficial product. They are easy to use, reliable if properly used, relatively inexpensive (by western standards), rarely accompanied by negative side effects, and are capable of providing protection against a variety of diseases as well as preventing unwanted pregnancy. But from a social perspective, condoms are often considered an unattractive commodity. Because of their association with one of the most intimate and private aspects of our lives, many find it difficult to consider condoms as promoters of health without remembering that they are adjuncts to intercourse. And thus, the health benefits of condom-protected intercourse often become overshadowed by a debate which has more to do with individual values about sexuality than it does with health.

Many of the same issues we now face about the role of condom promotion in the prevention of HIV infection are similar to earlier, unresolved objections that were raised about condom use as a means of preventing syphilis.¹ Syphilis shares many features in common with HIV infection. Both are sexually transmitted diseases which can result in a variety of life-threatening complications after a long incubation period. Both organisms are bloodborne and can be transmitted from an infected mother to her fetus. The blood test to diagnose syphilis was developed years before curative treatment was available—a situation reminiscent of the current circumstances surrounding HIV infection. Historically, syphilis, like AIDS, was associated with strong, negative cultural values, including the notion that it was an appropriate punishment for sexual misconduct.²

Eighteenth and nineteenth century physicians, writing on the subject of syphilis, thought it absurd that condoms be suggested as a means of preventing the great "pox." In 1737, Joseph Cam, who authored a book on sexually transmitted diseases, wrote: "Surely, Sir, you advise all mankind, which is prompt enough of itself to offend, to use *machinery* and to fight in *armour*. If so, you are not the inventor, but the propagator of wickedness."³

Part of the medical community's reluctance to lend its support to condom promotion as a means of preventing syphilis was justified by the quality of the product at hand. Condoms, or "implements of safety" as they were called,⁴ were handmade from the dried intestines of livestock—usually sheep—and were tied around the base of the penis by a ribbon. No doubt their quality was such that they were often ineffective. In his *Treatise of the Venereal Disease*, translated into English in 1737 by Willian Barrowby, Jean Astruc was particularly pointed in his criticism of condom reliability: "They ought to arm their penis with oak, guarded with a triple plate of brass, instead of trusting to a thin bladder, who are fond of committing a part so capable of receiving infection to the filthy gulph of a harlot."⁵

However, other writings suggest that the reluctance to endorse condoms as syphilis prophylaxis was often related to issues of morality rather than to concerns about efficacy. Although the physiologic understanding of conception was incomplete in the eighteenth century, it was generally acknowledged that condoms could prevent pregnancy. A poem written by White Kennett in 1724 supports this view.

The Machine or, Love's Preservative

Hear and attend; In CUNDUM's praise
I sing and thou, O Venus! aid my Lays
By this machine secure, the willing Maid
Can taste Love's Joys, nor is she more afraid
Her swelling belly should, or squalling Brat,
Betray the luscious Pastime she has been at.⁶

In 1788, when the German venereologist, Christoph Girtanner, described the condom as a "shameful invention which suppresses and annihilates completely the only natural end of cohabitation, namely procreation."⁷ he described an obstacle to sexually transmitted disease prevention which still exists today. Because condoms are both prophylactics and contraceptives, people who are opposed to contraception on moral grounds will have difficulty endorsing the use of condoms for the prevention of sexually transmitted diseases.

The prominent association of condoms with extramarital sexual intercourse, especially intercourse with prostitutes, is another reason why they have come to be considered immoral. Among the most famous of the historical references, associating condom use with prostitution, was that provided by the young James Boswell, who, before his fame as the biographer of Samuel Johnson, kept detailed

diaries of his daily life in eighteenth century London: "At the bottom of the Haymarket, I picked up a strong, jolly, young damsel, and taking her under the arm conducted her to Westminster bridge, and then in *armour* complete did I engage her upon this noble edifice."⁸

In the nineteenth century, condom related technology took a tremendous leap forward. The process of vulcanizing rubber, discovered in 1843 by Goodyear and Hancock⁹ and improved three years later by Alexander Parks,¹⁰ made it possible to mass produce inexpensive condoms for the first time. Although quality control varied among manufacturers, the overall quality of condoms was greatly improved, and presumably, concerns about endorsing a product which was not reliable were somewhat lessened. However, the debate about the morality of endorsing condoms for disease prevention remained just as controversial as it had in the eighteenth century.

When the United States Congress passed the Comstock Act in March of 1873, the definition of obscenity was broadened to include information pertaining to the "prevention of conception."¹¹ Because condoms could be used to prevent pregnancy, information about them was classified as obscene, creating yet another barrier to their promotion for the purpose of preventing disease. In view of legislative barriers and negative public opinion, it is not surprising that advocates of sexually transmitted disease prevention continued to advise abstinence rather than barrier prophylaxis. Many practitioners deliberately emphasized the ravages of syphilis to encourage sexual abstinence. Prince Morrow, who founded the American Society for Sanitary and Moral Prophylaxis in 1905, supported the notion that fear of infection should play a major role in the prevention of sexually transmitted disease: "I have always felt that the doctrine of consequences should be fully expounded as the fear of infection will sometimes restrain men from an evil life when education or moral considerations fail."¹²

It wasn't until 1879 that the bacterium responsible for gonorrhea was isolated, and the cause of syphilis remained unknown until 1905.¹³ The uncertainty which predated these discoveries, and the fact that curative treatment for gonorrhea and for syphilis was unavailable at that time, bolstered the strong emphasis placed on celibacy and monogamy as the mainstays of sexually transmitted disease prophylaxis. But, much as we might empathize with the circumstances of the early twentieth century that predisposed practitioners to advocate abstinence as the primary means of preventing sexually acquired infections, we must also realize that their reluctance to promote condoms as prophylactics was likewise influenced by prevailing social norms which viewed sexual activity outside the confines of marriage as immoral.

The subject of preventing sexually transmitted disease was catapulted to national significance during World War I, when the health of American troops became a major concern

of the United States Army. In its prevention programs, the army stressed sexual continence as the first line of defense. Aggressive promotion of condoms was not undertaken, for fear that it would result in a backlash of sexual activity. Despite a well-planned and implemented media campaign, which admonished "doughboys" to keep in mind the wives, sweethearts, and mothers they had left behind, only 30% of the troops who fought in France managed to abstain from sex, and according to army records, almost seven million days of active duty were lost because of sexually transmitted diseases.¹⁴

An alternate strategy was undertaken during World War II. Learning from its past experience, the United States Army required post exchanges to stock condoms of approved quality, and stressed their utility in preventing disease: "The condom affords the only practical mechanical protection against venereal infection."¹⁵ Lectures about the importance of mechanical and chemical prophylaxis became a routine part of the GI's life, for the American army had discovered what many health promotion studies have subsequently proven: merely discouraging an activity does not necessarily make it unattractive or mean that it will stop.

In the years following World War II, the role of the condom in programs for the prevention of sexually transmitted diseases (STDs) has been minimal. The advent of curative antibiotic therapy for the more common sexually transmitted diseases promoted the development of a public health philosophy of early identification of infection and treatment of contacts. Although health care providers were no longer unsure of the ability of the condom to prevent infections, they realized that it was often more effective, from both an outcome and cost perspective, to identify and treat infected individuals rather than to stress the use of condoms as a means of preventing infection in the first place. This strategy was also influenced by trends in contraceptive technology, and by the perceptions of those at risk, who often viewed the demands of condom use as too great a price to pay for the prevention of infections which could, for the most part, be cured with relative ease.

All of this has changed with the reality of AIDS. Because there is, as yet, no curative treatment for this potentially fatal infection, public health professionals are endorsing condom use among the sexually active as a primary means of defense. And, to a certain extent, the public has responded. Condom sales have skyrocketed, and the subject of condoms would seem to be much on the public's mind. Comedians tell jokes about them; movies feature them as elements of the plot; and magazines, which in years past eschewed such offerings, now carry full-page advertisements proclaiming their worth. These indicators suggest that public attitudes about condoms are changing, but they do not necessarily mean that the condom has found widespread acceptance among everyone in our society. Nor do they imply that the debate about the morality of the condom has been resolved.

It is in the context of sex education programs targeting adolescents that we are likely to encounter the most polarized views about promoting condoms for the prevention of HIV infection. The sensitivity of this subject, and the age-old fear that promoting the use of condoms will result in increased sexual activity, suggests that, in this setting, we are likely to observe a repetition of the debate about the morality of the condom. The subject of adolescent sexuality is highly controversial, and because parents, educators, and adolescents do not share the same perspective about sexuality, it is difficult to reach a consensus on how to educate youth about the prevention of sexually acquired disease without appearing to advocate the initiation or continuation of sexual activity. Because adolescents vary in terms of their sexual experience, it is necessary to provide them with a variety of prevention messages. Although there is an audience for whom the message of abstinence is relevant, there is also the need to address the circumstances of the sexually active. In fact, many adolescents are already placing themselves at risk for sexually transmitted diseases, and unwanted pregnancy, before they even get adequate information about prevention.

There may be no way to resolve the different values which people hold about human sexual behavior, especially in a pluralistic society. But, it is possible to identify a common goal that everyone can support. In discussing the promotion of condoms in response to AIDS, our goal is the prevention of needless suffering and death. It is not the encouragement of irresponsible sexual behavior.

Consumer research tells us that the image associated with a product can exert a great influence on its consumption.¹⁶ If so, in order to effectively encourage sexually active persons to use the condom, we must commit ourselves to upgrading its image. Historically generated, negative images which associate condoms with sexual incontinence, immorality, disease, and risk-taking must be replaced by images associating condoms with prudence, responsibility, and caring for one's partner.

Public health officials are justified in identifying condom use as part of the solution to HIV infection. However, as with many issues pertaining to health, a single action or response is inadequate to address every aspect of the problem. Therefore, condoms are not a panacea. They are only part of the solution to preventing the further spread of HIV infection, no more and no less. But there is no evidence to suggest that they are part of the problem. History warns us to anticipate controversy about the promotion of condoms for the prevention of HIV infection. It does not condemn us to repeat the mistakes of the past.

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Resources About Condoms

THE NATIONAL CONDOM WEEK RESOURCE CENTER wants people to know that they are there to assist individuals and organizations with information, ideas, and resources for organizing National Condom Week activities. They will provide: program ideas and technical assistance; posters (9, some focus on AIDS, on STDs, and on pregnancy prevention); T-shirts, buttons ("You must be putting me on . . . Condom sense"); publications and other resources; a nationwide publicity campaign; and a network of all other NCW participants. They annually produce an 8-page tabloid educational newspaper guide to condoms, **CONDOM SENSE**, which has been researched and developed by a team of educators and writers. It provides information, uses "down-to-earth" language, and incorporates photos and how-to instructions. Articles have included such topics as "AIDS Basics," "The Joys of Outercourse," "Communication is the Best Lubrication," "The Buyer's Guide to Condoms," "How to Use 'Em," and "How to Persuade Your Lover to Use a Condom and Why You Should." A "Start-Up Kit" (\$2 each) is available from the Center that contains more than seventy ideas for condom education and promotions and tips and advice from past NCW participants regarding proven tactics and common roadblocks. There is, in addition, an official NCW song and "Riff-Raff," a rap film public service announcement. One can also obtain information about a variety of new condom-related resources available from the Condom Resource Center for use in condom celebrations.

National Condom Week is a project of Pharmacists Planning Services, Inc.; Mayer Laboratories (makers of Kimono condoms); and Carter-Wallace (makers of Trojan Brand condoms). *NCW Resource Center, 5433 Manila Avenue, Oakland, CA 94618, 415/891-0455.*

ADVICE FROM TEENS ON BUYING CONDOMS

(1988, 5 1/4x8 1/2, foldover pamphlet). This pamphlet, illustrated by cartoonist Shelley Fischman, describes simply and precisely how to buy condoms from start to finish in five easy steps and concludes with "you're smart & you're prepared." It also includes advice on how to use a condom. The pamphlet is based on the results of a survey—conducted by the Teen Council of the Center for Population Options of 60 drug and convenience stores in the District of Columbia—to determine how easy it is for teenagers to obtain nonprescriptive contraceptives. *The Center for Population Options, 1012 14th Street NW, Suite 1200, Washington, DC 20005, 202/347-5700.* Prices: under 40 copies/\$.25 each and over 40 copies/\$.20 plus 15% p/h.

LOVE IN THE 1980s: NOBODY'S TAKING CHANCES ANYMORE

(1988, 4 1/2x4 1/2, foldover pamphlet). "A whole new ballgame, with new rules. And Rule #1 is, you deal with the risks of sex—or you don't have sex. . . . Buying condoms and foam says you think the future's worth thinking about ahead of time. Using them together says you think responsibility, like love, is better when it's shared." Covers using and choosing condoms and foam and making them work for you; what to know when you shop; and how they work to prevent pregnancy. The publication was made possible by a grant from the maker of Trojan Brand condoms. *Planned Parenthood of New York City, Inc., 380 Second Avenue, New York, NY 10010, 212/677-6474.* Prices: free in New York City; single copy, \$.50; 100/\$20; 1000/\$150, plus 15% p/h.

CHANGING THE CLIMATE

Debra W. Haffner, SIECUS Executive Director

Tsuguo Shimazaki, secretary general of the Japanese Association For Sex Education, recently visited SIECUS and we discussed mutual concerns about sexuality education, family planning, and reproductive health. Mr. Shimazaki told me that in Japan condom use is almost universal and that it is the pill that is considered unnatural.

I was struck by how far we have to go in the United States before we approach universal use of condoms. Despite the increases in the percentage of people having favorable attitudes about condoms, (see Hatcher article), less than one in six sexually active Americans presently use them. A recent survey, conducted by the National Center for Health Statistics, reported that less than one third of Americans knew that condoms were very effective in preventing the transmission of HIV.

There is no question that we have seen a change in a willingness to be open about condoms. Condom machines have been installed in universities' restrooms and bookstores, bars, and airports. One hotel chain reports that they now include a package of condoms with their complimentary toiletries. Two of the television networks have finally decided to accept public service advertisements about condoms, newscasters talk about condoms on the nightly news, and even comic strips refer to them.

Unfortunately, this increase in the willingness to discuss condoms hasn't necessarily translated into a large increase in the number of people using condoms nor in a change in our attitudes about condoms. When I ask professionals or teenagers to complete the sentence, "Girls who carry condoms in their wallets are . . ." with the first word that comes into their minds, the almost universal answer is "sluts." Teenage boys respond that boys who carry condoms are both "studs" (e.g. they are probably having sexual intercourse) or "wimps" (real men don't use condoms). And all of us who work with men of any age know that the belief, "it's like taking a shower with a raincoat on," is still often the prevailing point of view. Little wonder that more people do not use condoms or that more teenagers are not prepared.

Condoms are not perfect at preventing pregnancies and they are not perfect at preventing sexually transmitted diseases, including HIV transmission. However, for sexually involved individuals who are not part of mutually monogamous relationships where the serostatus of the partner is known, they are the *only* protection against sexually transmitted diseases and HIV transmission.

In my mind, public pronouncements by medical experts, that condom use is unlikely to halt the spread of AIDS, do significant harm. Given public sentiment about condoms, information that says that condom use may not be effective will actually discourage their use. Students have told me, "if it's not really going to work, and it's a drag to use or talk about or obtain, then why bother?"

I have suggested that everyone—teenagers and adults—begin to carry condoms "just in case" or "for a friend." Couples should not have to discuss whether or not to use condoms—their use should be assumed. Everyone should be prepared, either in regard to themselves or in order to help out someone who might have forgotten their supply.

Those of us who are educators, health professionals, and counselors have a major role to play in promoting the concept that all sexually active people must use condoms each and every time they have any kind of intercourse. We need to advocate for widespread availability of condoms at low cost. We need to assure that our neighborhood drug-stores and food stores will bring condoms from behind the counter, will offer a wide assortment, and will be supportive of young people who come to buy them. We need to use the very good posters and brochures that have been developed to promote condom use. We need to examine our own feelings about condom use, and we need to learn to talk about the positive role—indeed, even the erotic role—they can play in sexual relationships. Only then can we expect to see any significant change in the number of people who are protected.

QUESTIONS ASKED

By Clients of Planned Parenthood of Bergen County, NJ

ABOUT CONDOMS

While clients were waiting for their appointments, Planned Parenthood of Bergen County (PPBC) gave them a questionnaire titled, "Tell Us What You Want to Know!!!" Noting that the condom is the best way for sexually active people to avoid the risks of sexually transmitted diseases, including AIDS, PPBC asked their clients to "Ask the questions that you would like to have answered about Condoms and Safer Sex!" The following are the questions they asked.

1. If your partner uses condoms, is it necessary to use any other method of birth control?
2. A friend of mine got pregnant; her partner used a condom. What guarantee is there that it will help the risk of disease?
3. If a person has AIDS and has intercourse with a person without AIDS, will the person automatically transmit it to the other person?
4. Does the condom feel any different for the male or the female than without? Does it detract any sensation?
5. How is the best way to bring up the subject in conversation?
6. What is the best kind of condom, lamb, etc.? Do name brands really mean better quality?
7. Are condoms 100% effective in every way, especially AIDS?
8. I would like to know how to use them and when to use them.
9. What should I do if a condom breaks while my partner is still inside me?
10. What can I do to ease the soreness condoms cause me?
11. If it falls off? Why does it fall off?
12. Are there condoms that feel like the real thing?
13. Isn't there another method besides not having sex to prevent the risk of getting sexually transmitted diseases.
14. Is that the safest?
15. What if you are married and have no disease?
16. I think that most people have a problem talking to their partner. How do you ask your partner to use condoms without insulting them?
17. Are lambskin condoms safer in preventing AIDS?
18. Why do some condoms break?
19. Do condoms come in different sizes?
20. Do they break often?
21. Can you tell if there is a small hole?
22. Why are condoms uncomfortable to the male and female?
23. Why do most men refuse to use a condom?
24. Are there different types of condoms?
25. What is the percentage of condoms preventing these diseases?
26. If a condom breaks after ejaculation occurs, can the sperm still fertilize the ovary?
27. What goes better with a condom: film, douche, gel, or anything?
28. Could they break if you are not careful?
29. How could younger girls or guys get condoms for nothing?
30. Can you still get pregnant if you use a condom?
31. After testing the condom for pinholes, is there an easier way of putting it on?
32. Is there one that will be made in double layers in case one breaks?
33. What are the best kind of condoms to use?
34. If you or your partner have none of the above mentioned diseases, is a condom still necessary?
35. Can condoms cause infections? Allergic reactions?
36. Are they safe to use alone?
37. What is the most popular condom?
38. Is there any difference between lubricated and nonlubricated?
39. How effective are they in preventing pregnancy?
40. How effective are they in prevention of transmission of AIDS?
41. Why do they sometimes cause irritation on the female during intercourse (like burning)?

News . . .



A Continued Commitment To Sexual Health & Education

SIECUS Introduces New Logo Celebrating Its 25th Anniversary

SIECUS begins the celebration of its 25th anniversary in 1989. To highlight this important year, the special logo shown above will soon appear on all SIECUS stationery and printed materials.

Debra W. Haffner, executive director of SIECUS, commenting on the logo, said: "We are very excited about our 25th Anniversary celebration. It represents a milestone in our development and it affirms our longtime leadership commitment to the promotion of sexual health and education." She added: "It also represents the establishment of a solid 25-year-old organization, an organization created and inspired by the remarkable pioneering vision and dedication of its founders and one enhanced by the continuous foresight, support, and hard work of a dedicated board of directors and staff; an excellent network of associated professionals and

organizations; special friends, donors, foundations, members, and others. These people have all believed in, and extended, the ideals, principles, positions, and goals that SIECUS has stood for and has taken—and they have done so on local, national, and international levels.

"I am very pleased with our new logo as I feel it emphasizes this continued, important commitment of SIECUS and its members and friends to a very essential part of human life. Our sexuality influences, and is influenced by, everything we think and do and it is an area that has increasingly been in the public eye because of its crucial importance to the positive well-being of the people of this country and world. People should be better educated about their sexuality and should have continuous access to excellent information that will help them to lead happy, sexually-positive lives. SIECUS will continue in its leadership and advocacy role, in this respect, and will offer its resources wherever it can be of benefit."

Haffner added, "I look forward to this exciting year of celebration. I am very happy to be here at this particular time and to be able to contribute to the ongoing development of SIECUS' important activities. I know how critically important SIECUS has been since its inception—and how critically important it will continue to be—as a support to everyone working in this, and related, areas."

The logo was designed by Corporate Communicators, a full service advertising and public relations firm in Norwalk, Connecticut. Corporate Communicators donated the design of the logo to SIECUS to demonstrate their support for the organization and its activities. Jayme Rolls, president of the firm said,

"We are delighted to be working with SIECUS during its 25th year and to be supporting the work of this important organization."

Among Unmarried Women Who Are Having Sex, Condom Use Increasing But Limited

According to the Alan Guttmacher Institute, despite messages to teenagers to "just say no" to sex and popular concerns over contracting AIDS, the percentage of single women aged 18-44 who were having sex *increased* from 68% to 76% between 1982 and 1987 and few women indicated that they have had sex less frequently now than in earlier years. Nonetheless, publicity about the condom's effectiveness in preventing the spread of many sexually transmitted diseases (STDs), especially AIDS, apparently has had an impact on attitudes toward the condom and, to a lesser extent, on condom use.

Overall condom use increased between 1982 and 1987, from 12% to 16% among all women at risk of unintended pregnancy (those women of childbearing age who are fertile, sexually active, and not pregnant or seeking pregnancy). Almost all of the increase, however, was attributable to the growing use of condoms by unmarried women, among whom use nearly doubled—from 9% to 16%. Use by married women, on the other hand, remained stable at around 15%. In spite of the percentage increase, condom use is still quite low, contrary to what might be expected in response to the changing attitudes toward condoms. From 1982 to 1985, favorable opinion of the condom rose sharply, from 38% to 60%. Nearly all of this increase occurred in 1986 and early 1987 when discussion about AIDS, and

recommendations regarding condom use, became more common.

Between 1982 and 1987, favorable opinion of oral contraceptives also increased among women aged 18–44, continuing the steady rise in approval of the pill seen since the late 1970s. In 1987, three-quarters of all women reported a favorable opinion of the pill and 95% of pill users were satisfied with this method of contraception. Levels of pill use increased among both married and unmarried women from 1982 to 1987 in line with these changing attitudes. A total of 13.2 million women aged 15–44 used the pill in 1987—almost half of unmarried women and more than one-fifth of married women at risk of unintended pregnancy. The greater use of oral contraceptives and the steady rise in approval of the pill suggest that educational attempts to provide consistent, accurate information on the benefits as well as the risks of the pill may be starting to dispel some of the fears and misinformation about this birth control method.

These are among the most striking findings of a recent study, "U.S. Women's Contraceptive Attitudes and Practice: How Have They Changed in the 1980s?", by Jacqueline Darroch Forrest, PhD, vice president of research for The Alan Guttmacher Institute and Richard R. Fordyce, executive director of marketing services of the Ortho Pharmaceutical Corporation. The study presents new data about sexual activity and contraceptive attitudes and use from a 1987 nationwide survey, published in the May/June 1988 issue of the Institute's bimonthly professional journal, *Family Planning Perspectives*.

The study is based on a national survey which has been conducted annually for nearly two decades, initially among married women aged 18–44 and, for the last decade, among both married and unmarried women. Since 1985, 15–17-year-old women have also been included in the survey. In 1987, more than 7,000 women aged 18–44 and 3,000 young women aged 15–17 were surveyed. Data from the survey reflect the age, marital status, and geographic distribution of women in the United States, but underrepresent nonwhite women.

According to the study, in the half-decade between 1982 and 1987, the proportion of American women in sexual relationships increased. Of the approximately 57 million women aged 15–44 in 1987, nearly 49 million were having sex, including 32 million married women and some 17 million unmarried women. The authors note that there is reason for concern about how well sexually active women are protected against STDs and unintended pregnancy. Most of the increase in sexual activity occurred among unmarried women at risk of unintended pregnancy, a significant proportion of whom were not using a contraceptive method, and many more of whom were not using a birth control method affording STD protection.

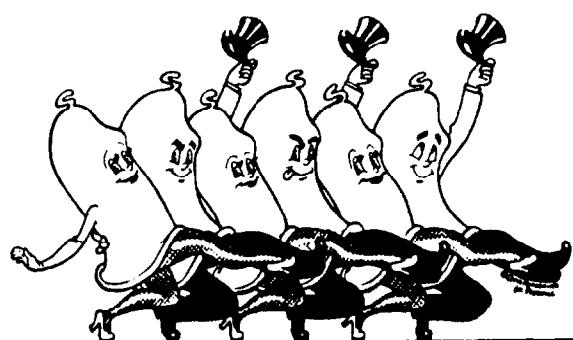
Overall, levels of contraceptive use were about the same in 1987 as in 1982. (Higher levels of condom use, primarily among unmarried women, did not significantly impact overall levels of contraceptive use). In 1982, 68% of women exposed to the risk of unintended pregnancy relied on sterilization, the pill or the IUD; in 1987, the level was

71%. Despite the small increase in the use of these most effective contraceptive methods, the researchers estimate that 3.3 million women aged 15–44, who are fertile and sexually active, are not using a contraceptive even though they do not want to become pregnant.

The slight increase in the use of the most effective contraceptive methods by women aged 18–44 at risk of unintended pregnancy reflects an increase in pill use (from 27% to 32%), a small increase in sterilization (from 34% to 36%), and a drop in IUD use (from 7% to 3%). Most of the overall increase in the use of the most effective methods is attributable to greater reliance on sterilization (from 46% to 51%) and the pill (from 17% to 22%) by married women.

National Condom Week

The goal of National Condom Week (NCW) since its inception in 1978 has been to reduce the incidence of unintended pregnancy, sexually transmitted diseases, and AIDS by increasing the proportion of sexually active 18–24-year-olds who use condoms correctly and consistently. "The bulk of unintended pregnancies and new cases of chlamydia, gonorrhea, herpes, syphilis and venereal warts occur in the 18–24-year-old age group." For the past ten years, the National Condom Week Resource Center has been providing the annual framework for local organizations to develop NCW events which meet the needs, interests, and values of their communities. In 1986, 16 organizations held events during National Condom Week; in 1987, more than 100; and in 1988, 250. The majority of people participating in NCW are from colleges, public and private health agencies, and communities. The activities are designed to be informative, visual, and humorous—and can last for one day or an entire week. They state with humor: "Condoms don't deserve the bad rap they've had for so long. Someone has to speak out on their behalf!" Although the events can take place in traditional clinics and educational settings, NCW



NATIONAL CONDOM WEEK

February 14-21st

has encouraged participants to hold them in central campus plazas, residence areas, and on the streets—as “close to people’s daily experience as possible.” The fact that it is held annually on the week of Valentine’s Day is also intentional. NCW feels that “using condoms promotes honest and direct communication between sexual partners.”

Smithsonian to Acquire Panels from the AIDS Memorial Quilt

The Smithsonian’s National Museum of American History will acquire several commemorative panels collected by the NAMES Project for its AIDS Memorial Quilt.

The acquisition will take place over a period of time in an effort to document the diversity of those who have died from acquired immune deficiency syndrome (AIDS). The quilt panels will be added to the collections of the Division of Medical Sciences which has an ongoing interest in issues related to the history of public health in the United States.

Museum Director Roger G. Kennedy, in speaking about this acquisition, said, “The AIDS Memorial Quilt is significant not only as a symbol of those who have died, but also as one aspect of the country’s response to that loss.”

The quilt currently consists of nearly 9,000 panels, each commemorating a person who has died from AIDS. Each of the 3-foot by 6-foot panels—many created by family groups and friends—is distinctive in its design and reflects the personality and interests of the person memorialized in the panel.

Since 1981, when the first cases of AIDS were reported, more than 40,000 Americans have died from the effects of the virus according to the U.S. Surgeon General’s Report. By the end of 1991, that figure is expected to increase to 179,000 deaths from an estimated 270,000 cases.

During the coming year, the museum’s Division of Medical Sciences, in cooperation with the NAMES Project, will identify and select a number of panels

based on the design, message, gender, and age of the individual depicted. The selected panels will join other objects, graphics, and educational materials in the collections documenting the medical and social history of AIDS.

The division is an active member of the newly formed AIDS History Group, a national organization whose aim is to coordinate efforts to preserve and document the history of AIDS.

1988 Survey on the Sexual Development of Young Japanese Completed

The Japanese Sex Education Association has done three surveys on the sexual development and behavior of young people, one in 1974, one in 1981, and the most recent survey, conducted between November 1987 and August 1988. The current survey covers the present situation of junior high to college students (this is the first time junior high school students have been included). Replies from 8,681 (4317 males, 4364 females) were randomly selected and analyzed.

The surveys have had three main objectives:

To make clear at what age various sexual experiences occur, physiological, psychological, and behavioral; to show how they develop with age; and to show how such experiences change with the times.

To show the many factors which bring about individual differences in sexual awareness, especially social factors.

To clarify those aspects which were not sufficiently analyzed in previous surveys, and to clarify the relationship between social factors and sex education.

To take into account regional variations, nine sites were chosen in Japan: three large and three medium-sized cities, and three small towns or villages. Within these, one hundred and fifty schools were selected, and in each school several classes were surveyed. The survey found, contrary to expectation, that the gap between different geographical areas was, in the majority of cases, small. However, there was a

lower frequency in dating in small town or village areas. “This just indicates that there is a difference in the strength of influence of social pressure between small towns and villages and larger towns, and this pressure reduces the rate of those sexual activities which are visible to the public.”

The survey indicates that by the first year of junior high school (12 to 13-year-olds) 54-63% of the girls had begun menstruation and 19-27% of the boys had experienced ejaculation; by age 16, 95% of the girls and 82% of the boys; and by age 22, 99% of the girls and 96% of the boys. The “previous survey (1981) showed that ejaculation is experienced mainly through masturbation and this survey shows the same result.”

The survey indicates that many first year junior high school students had already experienced “an interest in sex” and that by college age (19-22) nearly all women “have had such experience”: “Wanting to be friendly with the opposite sex, wanting to touch the body of the opposite sex, feeling sexual excitement, wanting to kiss, etc.” As far as “wanting to be friendly with the opposite sex,” the survey indicated “almost no difference in the rate of experience between males and females. But in regard to touching the body of the opposite sex, feeling sexual excitement, and wanting to kiss are concerned, there is a considerable gap between males and females, males having such experiences ahead of females.”

Sexual activity at junior high school age “is virtually zero,” but after that it begins to rise and increases very rapidly for those 18 and above (university age). At the age of 22, about half have had sexual intercourse.

A question was asked concerning the participants’ “image” of sex. Males and females varied considerably: males answered that sex is “joyous,” “clean,” and “not embarrassing,” which shows that “they have a strong tendency to have a positive image of sex.” For females, “even in the most positive group” (college students), the image they had of sex was that it was “dirty” and “embarrassing.” However, the

The Day After—November 9, 1988

Debra W. Haffner, SIECUS Executive Director

I am feeling this morning much the same way I did in November 1980 and November 1984. I am tired from having stayed up too late flipping channels for the last minutes of election night coverage, and I am both depressed and frightened by the outcome.

Like many of you, I felt a deep sense of disappointment in the negativity of this year's campaign and the glossing over of the issues. I was disheartened by the fact that the disparagement of the "L" word became one of the hallmarks of the campaign. I am proud to be a progressive liberal and proud of the traditions that represents. I am proud of the leadership of people like the SIECUS members who helped lead the fights for civil rights, women's rights, gay rights, the legalization of abortion, and sexuality education for our children. I am proud that SIECUS has been associated throughout its history with the work of the American Civil Liberties Union. I am proud of our commitment to a more enlightened republic.

And I am worried about four more years of an agenda that is opposed to a progressive view of America. One of my friends recently commented, "we were really scared in 1980, but nothing that bad has really happened to reproductive rights since then." She is right . . . and wrong. We have had to continuously struggle to stay in place. Reproductive rights activists have fought back countless constitutional amendments to outlaw abortion, the squeal rule that would have required clinics to notify parents of their daughters use of contraception, the Bork nomination, continuous attacks on the national family planning program, proposals to ban pro-

grams that even mention homosexuality, and so on. The other side has been effective in reducing U.S. support for international family planning programs. Perhaps most horrifying are the years that the Reagan administration ignored the growing AIDS epidemic and their reluctance to adopt even the recommendations of their own commission.

I think I am most frightened by the possibility that we will once again lose the right to choose safe and legal abortions during the next four years. Three of the current members of the Supreme Court are over 80, and we have at best a 5-4 pro-choice majority at present. The Reagan administration was able to put in place over half of the nation's federal judges, often using an abortion litmus test. The possibility that a case overturning *Roe vs. Wade* will come before a new Supreme Court is both real and horrifying.

All of us—sexuality educators, counselors, therapists, health professionals, religious leaders, and consumers—must become more political during the coming years in order to stop future assaults and to continue to press for a more progressive America for our children. We must seek new coalitions so that we can work together to protect our rights on a local, state, and national level. We must begin to know and communicate with our school boards, state legislators, and national representatives. I am committed to developing an advocacy program for SIECUS and to developing public policy education materials for members. We need to work together to assure that sexual rights are protected and that all people have access to quality sexuality information and education.

survey indicated that both sexes have a more positive view of sex as they get older. Their view that sex is "serious" also increases with age.

The sexual concerns of those participating in the survey ranged from whether their body was perfect or not to sexual intercourse, contraception and sexually transmitted diseases. But even more, they wished to know about "how to associate with the opposite sex" and

the "differences in behavior or psychology of males and females"—in other words they have worries about the psychological or social sides of sexual behavior."

When asked, "What do you feel has most strongly influenced you as far as sexual behavior and consciousness are concerned?" they answered a "friend" and "mass media." A very small number responded, "parents," "teachers," or

"school classes." This "trend," relying mainly on friends and mass media, was common to all young people regardless of sex, age, area and so forth.

The Association said that, according to recent opinion polls in Japan, increasing expectations are put on school education and especially sex education, but the results show, at least as far as sex education at the present is concerned, that to fulfill such expectations is difficult."

New Institute Opens at Golden Valley Health Center

The Golden Valley Institute for Behavioral Medicine, one of few such organizations in the United States, recently opened in Golden Valley, Minnesota. The Institute will provide ongoing professional training, educational materials (a series of videotapes and training manuals), and research and development resources (outcome studies, statistical reviews, literature searches, and position papers) to the behavioral medicine community. It will be located adjacent to the 110-acre campus of the Golden Valley Center, a Joint Commission on Accreditation of Healthcare Organizations-accredited hospital which specializes in behavioral medicine for children, adolescents, and adults.

Steven R. Kamber, chief executive officer of the Center, said: "As a leader in behavioral medicine, we at Golden Valley Health Center have not only an opportunity, but an obligation, to share our expertise in helping people. The field of addictions and behavioral disorders is expanding as people learn more about the negative effects of unhealthy behaviors on their lives. By drawing from expert resources in the professional community, the Institute will meet the growing need for specialized training and education in emerging fields of behavioral medicine."

Sarah Sandberg is the new Institute's executive director. She will design and manage all of the Institute's activities which will focus on a wide range of behavioral medicine subjects, including eating disorders, sexual addiction, and couples' recovery. She is the former community relations coordinator and an adjunctive therapist for the Center and has worked closely with the Golden Valley Health Center's inpatient Sexual Dependency Unit, which provides both inpatient and outpatient treatment to sexually dependent individuals. Sexual dependency or addiction is defined by the Center and Institute as "engaging in obsessive/compulsive sexual behaviors which cause severe distress for the individual and/or his or her family. The sexually-addicted person is unable to control his or her sexual behaviors and lives in constant fear of discovery."

Sandberg said that the subject of sexual addiction is attracting national attention and that the demand for information about developing fields of study within behavioral medicine is also increasing. Among its other activities, therefore, the Institute will provide current information about sexual dependency and will bring health care professionals from across the country to the Twin Cities area "for training and study about this and other addictions." Seminars will be held throughout the year.

Sexual Addiction Survey Results Released

Patrick Carnes, PhD, nationally known addiction expert, revealed the results of his yearlong national survey of sexually addicted persons at the Second National Conference on Sexual Compulsivity and Addiction, which was sponsored by the Program in Human Sexuality, Department of Family Practice and Community Health, University of Minnesota Medical School. Speaking before several hundred professionals, including sexologists and mental health experts, he reported his finding on the causes of sexual addiction, patient types, and recovery patterns. His survey included more than 600 "sexually addicted persons" who have entered or completed recovery programs. Dr. Carnes estimates that 6% of the population is affected by sexual addiction.

Most significant among his finding is "the overwhelming correlation between childhood abuse and sexual addiction in adulthood." Eighty-three percent of those surveyed reported having been sexually abused as children, 73%

physically abused, 97% emotionally abused. Dr. Carnes said that previously he and others had suspected that a relationship existed between childhood abuse and sexual addiction, but until this survey there had been no substantial proof to confirm their suspicions. "The data uncovered in the survey," said Dr. Carnes, "will provide invaluable assistance in treating the sexual addict."

In general, women report more severe abuse patterns, especially where violence is involved. Men have more trouble identifying abuse patterns in their childhood, according to the survey. The profile of the sexual addict that has emerged from the survey indicates that he/she is a person with a college or graduate degree (65%) and another addiction of some type (only 17% of those surveyed report sexual addiction as their sole addiction). Alcoholism, chemical abuse, eating disorders, compulsive working, spending, and gambling are the most common co-addictions. Most sexual addicts, the survey revealed, come from severely dysfunctional families. Usually these families have other addicts—of some type—within the family as well (87%).

Sexual addicts in the recovery process experience their greatest degree of distress during the second six months of treatment. Typically, they feel most acutely the sense of loss of their prior sexual behavior during that time period. Their second and third years of recovery show dramatic improvements in their finances, careers, and ability to cope with stress. Healthy sexuality and family relationships generally improve only after completion of the third year of recovery.

SIECUS OFFERS NEW PUBLICATION

SIECUS has just published a new fact sheet, "Sex Education and the Schools: Issues and Answers." This attractive two-page flyer answers the most common questions about sexuality education and seeks to dispel common myths.

Single copies are free. Send a self-addressed, stamped envelope to Publications, SIECUS, 32 Washington Place, New York, N.Y. 10003. Bulk rates are available upon request.

STATE UPDATE ON SEXUALITY EDUCATION AND AIDS EDUCATION

Diane de Mauro
SIECUS Director of Program Services

This year is turning out to be an extremely important one for the adopting and implementing of state mandates for sexuality education and AIDS education. Less than 2 years ago, only two states, plus the District of Columbia, had mandated sexuality education. Now 13 states, plus Washington DC, have mandates: Delaware, Georgia, Iowa, Illinois, Kansas, Kentucky, Maryland, Nevada,¹ New Jersey, Rhode Island, South Carolina, Vermont, and Virginia. Michigan has proposed a mandate pending final approval.

As the chart which accompanies this article indicates, at least 21 states have recommendations or guidelines for school health programs which include sexuality education as an integral component. Although many of these recommendations have stipulations that preclude the teaching of such subjects as intercourse, abortion, masturbation, and homosexuality, this certainly is a beginning step!

A systematic study of these state guidelines indicates that states strongly support local autonomy, strong involvement of parents in the planning of programs, public review of materials, periodic evaluations, special teacher training, and the integration of instruction into grades and courses.² Many states have successfully implemented sexuality education programs, with the assistance of curriculum advisory committees, which are designed to reflect community attitudes and standards and include not only parents but also religious and community leaders, physicians, and members of the helping professions.³

There is a growing interest among educators and state legislators to provide some form of AIDS education for their students. The most recent tally indicates at least 28 states have mandates for AIDS education, with an additional 19 states making recommendations for one.

Definitions

State mandate is a requirement that all school districts provide sexuality education and/or AIDS education to their students, K-12, usually in the form of family life education programs or comprehensive health education. Mandates are usually accompanied by suggested curricula to be implemented at the local level. Nevada is the sole exception to this. (See footnote no. 1.)

Recommendations refer to any provisions by state legislatures or state departments of education that support sexuality education and/or AIDS education but do not

	MANDATES		RECOMMENDATIONS		CURRICULA	
	SEX ED	AIDS	SEX ED	AIDS	SEX ED	AIDS
Alabama		•				•
Alaska				•		
Arizona				•		•
Arkansas			•	•	•	•
California			•	•	•	•
Colorado				•		•
Connecticut				•		•
Delaware	•	•			•	•
Dist. of Col.	•	•			•	•
Florida		•	•			•
Georgia	•	•			•	•
Hawaii		•	•		•	•
Idaho				•		•
Illinois	•	•			•	•
Indiana		•	•			•
Iowa	•	•				•
Kansas	•	•			•	•
Kentucky	•	•			•	•
Louisiana				•	•	
Maine			•	•		
Maryland	•	•			•	•
Massachusetts					•	
Michigan		•	•		•	
Minnesota		•	•		•	•
Mississippi					•	
Missouri					•	
Montana				•		
Nebraska					•	
Nevada	•	•				•
New Hampshire			•	•		
New Jersey	•			•	•	•
New Mexico		•	•			
New York	•	•			•	•
North Carolina		•				
North Dakota				•	•	
Ohio		•				
Oklahoma		•				
Oregon	•	•			•	•
Pennsylvania	•	•				
Rhode Island	•	•			•	•
South Carolina	•					•
South Dakota		•				
Tennessee		•				
Texas				•	•	
Utah		•	•			
Vermont	•					
Virginia	•	•				
Washington		•	•			
West Virginia				•	•	
Wisconsin				•	•	
Wyoming						

require it. While curricula may be suggested, it is left up to the local districts to design and implement such programs.

Curricula range from suggested resource materials, teaching guides, bibliographies of books, articles, and videos to comprehensive teaching lessons on the subject of sexuality education or AIDS. Curricula may be thorough and cover such subjects as sexual development, reproductive health, interpersonal relationships, sex and gender roles, etc., or for some states, it may be limited to material that strictly pertains to sexually transmitted diseases. Most states that have mandates have also developed curricula, but some states that have distributed curricula to their school districts have no mandate or recommendation. Also, some of the curricula are only appropriate for use at the secondary level.

Sources: Responses to SIECUS request of April 29, 1988 to all state education departments for current laws, rules, regulations, and mandates regarding sexuality education and/or AIDS education; National Association of State Boards of Education; and Planned Parenthood Federation of America.

Footnotes

1. Unlike the other states, Nevada's mandate is not age or content specific.
2. Kirby, D. and Scales, P. An analysis of state guidelines for sex education instruction in public schools. *Family Relations*, 1981, 2, 237.
3. Dickman, I. & Gordon, S. *Schools and sex education: New perspectives*. New York: Public Affairs Committee, Inc., 1988, 8.

Conference / Seminar Calendar

THE WOMEN'S THERAPY CENTRE INSTITUTE Lecture Series 1988-89, "Sexual Violence in the Lives of Women." Workshops: "Lesbian Psychosexual Development and Therapeutic Process"; "Exploring Difference: A Lesbian Perspective"; "The Intersection of Society, Gender, and Psychology." Experimental Groups: "Women's Eating Problems and Body Image" (6 weeks); "Mastectomy and Your Feelings" (8 weeks); "Infertility and Its Consequences" (half-day); and "In Search of a Lost Libido: An Inquiry Into the Vicissitudes of Lesbian Sexuality" (half-day). Contact: The Women's Therapy Centre Institute, 80 East 11 Street, Room 101, New York, NY 10003, 212/420-1974.

UNIVERSITY OF MINNESOTA, PROGRAM IN HUMAN SEXUALITY CONFERENCE, "CHEMICAL DEPENDENCY AND INTIMACY DYSFUNCTION," (CEUs will be awarded), January 23-24, 1989. Noted speakers include Sue Evans, Sondra Smalley, Eli Coleman, and Susan Schaefer. A special session on the "Alkali Indian Tribe's phenomenally successful chemical dependency treatment and prevention project will be part of the conference." The program is designed for counselors concerned about the role of intimacy functioning in the total recovery of their chemically dependent clients. Current research and clinical methods will be presented. Radisson University Hotel, University of Minnesota East Bank campus. Contact: Diane Campbell, Conference Coordinator, 3920 Woodview Court, Vadnais Heights, MN 55127, 612/484-8090.

2ND ANNUAL WHITE MOUNTAINS FAMILY THERAPY WINTERFEST, (CEUs will be awarded), January 26-28, 1989. Sponsored by the American Association for Marriage and Family Therapy and the Clearview Center of New England. Program will include "Treatment Modalities of Compulsive Sexual Behavior." Fox Ridge Resort, North Conway, New Hampshire. Contact: Laura N. Jacobs, The Clearview Center, Inc., 404 Middlesex Road #4, Tyngsboro, MA 01879.

CONTRACEPTIVE TECHNOLOGY, February 10-11, 1989 (San Francisco) and February 16-17, 1989 (Washington, DC). Sponsored by Contemporary Forums and coordinated by Robert A. Hatcher,

MD, MPH. "These national conferences will address the most current and relevant topics related to the prevention of AIDS, unplanned pregnancies and infertility. Appropriate interventions and treatment modalities for common clinical situations will be presented and discussed in-depth by a clinically experienced faculty specializing in women's health care." Participants will be given three books: *Contraceptive Technology*, *The AIDS Answer Book*, and *Understanding Your Body*. Hyatt Regency San Francisco and Grand Hyatt Washington. Contact: Contemporary Forums, 530 La Gonda Way, Suite E, Danville, California 94526, 415/820-2800.

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION 17TH ANNUAL MEETING, "OPPORTUNITIES '89: BACK TO THE FUTURE, February 22-24, 1989. Those attending represent state health departments, public health clinics, hospitals, and private nonprofit agencies from across the country. Mayflower Hotel, Washington, DC. Contact: NFPRA, 122 C Street, NW, #380, Washington, DC 20001, 202/628-3535.

ORTHO 1989: ORTHOPSYCHIATRIC ASSOCIATION 66TH ANNUAL MEETING, "CHANGING FAMILIES, CHANGING RESPONSES: REORIENTING SERVICES AND PROGRAMS," March 31-April 4, 1989. Will provide an opportunity for mental health professionals (6000 expected to attend) to share knowledge and experience of major current mental health concerns. More than 200 program events will be devoted to children, adults, the aging, families, schools, and the community. Will discuss Women and Their Breasts; The Adult Male Experience Through Music and Film; Integrating AIDS Prevention Into Clinical Practice; Working With Children, Minorities and Inner City Families Affected by AIDS; Clinical Issues of Sexuality; Incest Recovery in Adult Women: A Feminist Perspective; Lesbian and Gay Therapists Working Together; and Countertransference (racism, sexism, homophobia, ageism, treating disabled persons). The New York Hilton. Contact: The American Orthopsychiatric Association, 19 West 44th Street, Suite 1616, New York, NY 10036, 212/354-5770.

Book Reviews • Book Reviews • Book Reviews •

CONFIDENT PARENTING

Dr. Mel Silberman. New York: Warner Books, 1988 (130 pp.; \$6.95).

Confident Parenting is a practical guide for helping parents to acquire or to improve their childraising skills. Moreover, it can be a very useful "textbook" for educators in classes on child-care and parent/child sexual communication. Speaking in a straightforward manner, Dr. Silberman authoritatively helps the parent to pinpoint parent/child conflicts and to approach them with flexibility, calmness, and common sense for the benefit of both the parent and the child. Dr. Silberman's approach is particularly effective in enabling the reader to separate out the dual roles of parenting—the caring, affectionate parent *vs.* the directive, in-charge, executive parent—and in explaining how to avoid the problematic roles of the rigid, confusing, entangled or distant parent.

The Confident Parenting program is presented in four distinct parts—each a thorough guide with definitions, illustrative cases, and key discussion points. The four areas and each of their strengths are as follows:

1) *Get clear what you want.* This is an especially important section as many parents often find it difficult to determine exactly what it is that they want their child to do or be, and how to communicate this.

2) *Remain calm and confident.*

Dr. Silberman assists parents in differentiating between the pleading, angry, and confident parental voice; in becoming aware of their body language; and in dealing with their children's protesting of parental requests or decisions. Much of this material can be effectively applied to building skills for sexual communication between caretaker and child as well.

3) *Select a plan of action.* He encourages parents to experiment with new approaches and offers ten basic options that can be implemented, including monitoring behavior, rewarding, encouraging, and backing off. Good distinctions are made between what constitutes encouraging *vs.* teaching and ignoring *vs.* penalizing (no corporal punishment here, thank goodness, instead the emphasis is on "time out").

4) *Obtain support from other adults.* Dr. Silberman wisely provides guidelines for avoiding conflict between the parents or the caretakers. Welcomed portions of this discussion on team parenting include an emphasis on emotional support and constructive criticism, as well as how to be aware of those tendencies which limit team effectiveness, i.e., interfering with the other, maintaining rigid role division, and allowing inappropriate others to parent the child, etc.

The drawbacks of Dr. Silberman's book are few. One is his overriding emphasis on "difficult children." The first sentence of the book opens with, "All children can be difficult." Although he provides a good section on *why* children can be difficult (poor control, lack of understanding or self-worth, etc.), with an important emphasis on "don't worry, your child can change," his book seems to target the parent who is at his or her wit's end and the child who is totally out of control. Furthermore, the book would have been more useful had he provided more age-specific advice. There are only a few instances in which the discussion is divided into points that pertain to early childhood, middle childhood, and adolescence. The rest of the book is apparently addressed to parents of younger children. All in all, however, Dr. Silberman does a great service in providing practical, comprehensive advice that can certainly assist

his readers in transforming their parenting experience from an uncertain negative one to a confident positive one.

Reviewed by Diane de Mauro, PhD,
director of program services for SIECUS.

SAFE ENCOUNTERS: HOW WOMEN CAN SAY YES TO PLEASURE AND NO TO UNSAFE SEX

Beverly Whipple and Gina Ogden. McGraw-Hill Book Company (222 pp.; \$16.95).

Safe Encounters may sound vaguely sci-fi but the subtitle explains that it is a practical guide to "How Women Can Say Yes to Pleasure and No to Unsafe Sex."

This is a much needed and valuable book—the kind many parents want their daughters to read (daughters who are already somewhat sexually experienced, I would venture, since the book is very erotically explicit).

It is this very explicitness which is the book's strength. It makes safer sex sound loving, sexy, creative, and fun! In this sense it follows in the tradition of the gay community's most effective safe-sex "campaigns" where it has been learned that eroticizing safer sex helps motivate people to practice less risky behaviors.

Part of the book is devoted to self-help exercises, with labels such as "Undoing Blame," "Giving Yourself Strokes," "The Women in the Mirror," and "Pleasure Mantra." I found these the least satisfying sections in the book because, while the authors are surely correct that self-esteem and assertiveness will enhance a woman's ability to put safer-sex into practice, I do not think these slightly gimmicky exercises

will significantly affect self-esteem or assertiveness.

The book is at its best when it is most down-to-earth. The phrase guide which divides possible phrases into two categories, "To Turn a Partner ON" and "To Turn a Partner OFF," is funny and helpful. For example, for the turn-off question, "Can't you think of anything but intercourse?" the authors suggest the alternative, "I'd like to flirt outrageously with you—for hours and hours."

Flirting outrageously, and variations thereof, are what Whipple and Ogden stress. There are many ways to make love that do not require penis insertion into orifices. They use a word to describe all these activities, which is one of my favorite words, "outercourse." It makes people think.

This book also teaches some of the fine points of safer sex which I, for one, did not know. For example, did you realize that adding water to water soluble lubricants (which are excellent for manual stimulation) makes them slippery again? The authors suggest a bowl of warm water, a squeeze bottle or a squirt gun!

There is a fairly good section on talking to kids about AIDS. I do object to one suggestion—that five to eight-year-olds be told "that diseases can get into the blood through cuts in the body." That would surely be terrifying to a child in the context of discussing AIDS.

I have some concerns about the accuracy of all the factual information in the book. There is a reference to an "incubation period" for HIV of ten to twenty years which has not been proved and some of the material is already out-of-date. For example, the new diagnostic category of an HIV positive test in combination with dementia is not included in the authors list of what constitutes AIDS. However, almost any book on AIDS will be a bit outdated by the time it is published, and this book's primary purpose is not to offer facts.

A more serious problem with this book is that it takes a very strict view of what is safer sex. Kissing and cunnilingus are

OUT. They describe, in detail, how to use a rubber dam for cunnilingus. I tried this section out on a few young women, aged 18 to 20, and their reaction was very negative. They thought this was "going too far"—and I worried that it might cause them to dismiss the idea of safer sex altogether. "After all, if kissing is risky and I know I am going to kiss, then why bother with other precautions?"

I sympathize with the author's predicament about cautioning against behaviors with even a fairly remote risk of AIDS transmission. Every professional, indeed every parent, struggles with giving the information which is most likely to promote less risky sexual behavior and we know that straight facts alone are not the answer.

We must somehow give women—particularly young women—a sense that there is something they can do to protect themselves against AIDS without hopelessly truncating their sexuality. By-and-large, I think—I hope!—this book contributes to that urgent cause.

Reviewed by Lorna Sarrel, co-director of the Human Sexuality Program at Yale University and chairperson of SIECUS' board of directors.

TERRIFIC SEX IN FEARFUL TIMES

Brooks Peters. New York: St. Martin's Press, 1988 (205 pp.; \$14.95).

In an era when sex negativity and "eretophobia" are running rampant in reaction to the fact that AIDS can be transmitted sexually, *Terrific Sex in Fearful Times* is a welcome addition to the literature. It is a little treasure of a book that attempts to teach basic sexual enhancement to people of both genders, and all sexual orientations, while instructing about safer sex. The author most deftly accomplishes his goal with creativity, humor, and a communicated sense of sexual adventures and possibilities, despite these being "plague years." While realistic and instructional about the dangers of high-risk sexual activities,

he is never preachy nor does he attempt to instill unnecessary fear.

Peters is completely unapologetic about loving sex and refuses to allow AIDS or other sexually transmitted diseases to interfere with a satisfying and exciting, but risk-free, sex life. However, people who are more sexually conservative will be offended by the book's content and tone.

One of the book's strong points is that it is nonhomophobic and is not heterosexually or homosexually biased. Most of the examples are heterosexual, but there are enough gay male examples and nontraditionally heterosexual male activities, like anal insertion, that the book will, undoubtedly, help many people stretch their sexual limits and expand their sexual repertoires, if they so desire.

There are several small, yet important, omissions that need to be pointed out. In the excellent section on how to use a condom, the author forgets to instruct users to always milk all air out of the condom once it is completely unrolled on the penis. This helps prevent breakage. In another section, he discusses the pleasures of having hot wax dripped on the skin of the body as a sexual stimulant. This is pleasurable for some people but only if paraffin candles are used; beeswax burns at a considerably higher temperature and can cause a serious burn if it comes in contact with the skin. His other noticeable omission is the pleasure that two men can get from using well-worked-out and defined pectoral muscles as an area of erotic stimulation.

All in all, this book is a useful and well-thought-out way to help educate all people about how to eroticize safer sex. It would be a perfect gift for an adolescent who is newly becoming sexually active or who needs to become prepared for sexual activity.

Michael Shernoff, CSW, ACSW, is co-director of Chelsea Psychotherapy Associates in Manhattan. He is also co-chair of the AIDS Task Force of the Society for the Scientific Study of Sex.

BOOK BRIEFS

AIDS: A SELF-CARE MANUAL

AIDS Project Los Angeles. Moffatt, Spiegel, Parrish, Helquist (eds.). Santa Monica, CA: IBS Press, 1987 (306 pp., \$12.95).

This guide covers "many of the concerns and needs of people exposed to the AIDS virus, diagnosed with AIDS symptoms, worried about AIDS, and grieving for those who have been diagnosed with the disease." It is divided into 10 sections: AIDS: An Overview; A Socio-Psychological Perspective; A Medical Perspective; Treatment: A Therapeutic Perspective; Prevention: A Socio-Sexual Perspective; A Self-Care Perspective; A Practical Perspective; A Spiritual Perspective; A Healing Perspective; and Self-Care Resources. "We believe that this book can help you better care for yourself and your loved ones, feel more in control of your own life, and help you work with health care providers to obtain the best care possible."

DANGEROUS SEXUALITIES: MEDICO-MORAL POLITICS IN ENGLAND SINCE 1830

Frank Mort. New York: Routledge & Kegan Paul, Inc. in association with Methuen Inc., 1987 (280 pp., \$14.95).

"This book [which begins with a narrative on AIDS] is about unravelling the narratives which link our beliefs about health and disease to moral and immoral notions of sex... The book has a double axis. First, a detailed account of the relation between systems of medical knowledge and power. Second, an analysis of the way medical and other discourses have produced a distinct regime of sex, targeting sensitive or dangerous groups and generating forms of resistance. Historically, our main focus is on the nineteenth and early twentieth century, but in conclusion we shall return with some urgency to our own situation now.... Two influences have been paramount. The revival of marxist and marxist-influenced theory and history, and the impact of feminisms.... Much of the initial impetus for tackling the medico-moral domain came from the work of the French philosopher and historian Michel Foucault."

INTIMATE RELATIONSHIPS: SOME SOCIAL WORK PERSPECTIVES ON LOVE

Wendell Ricketts and Harvey L. Gochros (eds.). New York, London: The Haworth Press, 1987 (140 pp., \$14.95).

"Although social workers frequently explore and treat interpersonal problems, in and out of families, and emphasize the primacy of the worker-client relationship, social work literature infrequently deals directly

with love, and the word rarely appears in social work research... love is being rediscovered by the helping professions and recognized as an essential ingredient of individual and collective social functioning. Efforts are underway to legitimize the study of the complexities, problems, and characteristics of ultimate human relationships." The book covers love in three broad categories: love of self; love toward others; and love between client and therapist. It is a hard-cover edition of an issue of the *Journal of Social Work & Human Sexuality* (Vol. 5, No. 2, Spring/Summer 1987).

SEDUCTION LINES HEARD 'ROUND THE WORLD AND ANSWERS YOU CAN GIVE: A WORLD BOOK OF LINES

Sol Gordon. Buffalo, NY: Prometheus Books, 1987 (176 pp., \$7.95).

"This book of lines is for your amusement. It will help you appreciate that sex is never a test or a proof of love. There are cultural and ethnic differences in lines.... Every semester during my fifteen years at Syracuse University, I have taught a class on Human Sexuality to about five hundred students from all fifty states and many countries of the world. My students helped me to collect thousands of lines." The book includes special sections entitled, "How Can You Tell If You're in Love?" and "AIDS Alert."

STRATEGIES FOR SURVIVAL: A GAY MEN'S HEALTH MANUAL FOR THE AGE OF AIDS

Delaney and Peter Goldblum with Joseph Brewer. New York: St. Martin's Press, 1987 (320 pp., \$10.95).

This book is designed to help gay men accomplish several objectives: to better understand what health is and how to maintain it; to evaluate their personal risk for contracting AIDS; to help decide what changes, if any, they want to make in those key aspects of their lives which affect their health; to learn a planning process for implementing change; to better recognize the threat of AIDS to themselves and their communities, and to encourage them to take a stand in facing that threat. Written by gay people for gay people, it presents a step-by-step approach to the goal of overall health maintenance. The subjects addressed include: sexual behavior, stress management, emotions and attitudes, social support, nutrition and exercise, substance use and abuse, and resource development. It has a workbook format, with charts and questionnaires to help one analyze one's health status; to identify underlying behaviors; and to develop a personal plan for changing behaviors that conflict with the goal of sustained health.

Jim Jackson

Reproductive Anatomy Models

Ideal for
AIDS Education
Special Education
Condom & Foam Demonstrations
SOFT • DURABLE • SIMPLE
EXPLICIT • PORTABLE
REALISTIC

jim jackson and company
33 richdale avenue
cambridge, massachusetts 02140
(617) 864-9063 free brochure

Choices: In Sexuality with Physical Disability

(16 mm & Video/Color/60 Mins.)

Produced for:
Institute of Rehabilitation Medicine
New York University Medical Center
Joan L. Bardach Ph.D., Project Director
Frank Padrone Ph.D., Co-Director

... Choices is a film which can be used time and time again in rehabilitation facilities human sexuality programs and in any group where issues of sexual interaction and adjustment to a disability are being discussed. If both parts cannot be purchased, Part 1 is a tremendously good discussion starter and should not be missed.

Pam Boyle, Coordinator: Reproductive Health and Disabilities Program of the Margaret Sanger Center of Planned Parenthood, NYC.

MERCURY

Mercury Productions
7 West 18th Street, 2nd flr
NYC 10011 (212) 869-4073

Audiovisual Reviews • Audiovisual Reviews

ON BECOMING A WOMAN: Mothers and Daughters Talking Together

Executive Producer: National Black Women's Health Project. Directed by Cheryl Chisholm. 1987, 90 min. Purchase: (16mm) \$950, (video) \$195; rental (16mm) \$150, (video) \$80. Each of the three segments are also sold or rented separately. Women Make Movies, 225 Lafayette Street, Suite 211, New York, NY 10012, 212/925-0606.

The three segments of *On Being a Woman* bring together mothers and their daughters in a moving and intimate exploration of their experiences as adult women and maturing adolescent girls. Filmed on consecutive occasions, the approximately 10 mother-daughter pairs share their thoughts on a number of female development subjects: menstruation and physical maturation, sexual awakening, self-image, birth control, parent-child communication, and that old classic, the "generation gap." The exchange is, for the most part, casual, poignant, and frank. Occasionally, it is tense or melancholic, particularly when heart-to-heart conversations take place between parent and child. At all times, the viewer is in the privileged seat of that of a "fly on the wall," a non-participating observer trusted with female emotions, feelings, and sensitivities.

Whereas nothing in this video makes it a video for women only, it is first and foremost a film about, and for, females of all ages. It would be equally as appropriate for a girls' health class as it would be for a training workshop for professionals. Becoming a woman is about maturing and recognizing commonalities, differences, and their subtleties—not only for the daughters but for the mothers as well. It is a coming to terms with the female experience, in all of its changes, manifestations, and complexities.

In addressing what it means, physically, emotionally, and psychologically to

become a woman, the participants slowly reveal themselves to the viewer and to themselves and to each other. Learning about oneself, one's child or mother, and the other, slowly unfolds as the film progresses and encourages the process of identification between individual participants and viewers.

It is the consensus of the review committee that each 30-minute segment of the video can be viewed on separate occasions but should be viewed in order, as each segment will not stand alone without the other two. This is not only because references are made to previous discussions that would leave the viewer guessing if something was bypassed but, more importantly, because the transformation of the participants as they go through this group process would be missed—and this is an important highlight of the video.

In the first segment, the mothers and daughters are seated in upright positions: the mothers sitting in chairs and on couches, the daughters sitting on the floor. Their conversation is giggly and chatty. There is an informative emphasis, in the form of testimonials, on first experiences of menstruation and a discussion takes place on developmental changes during puberty.

In this portion of the video, a welcome diversion from the usual anatomy chart are photographs of nude models demonstrating "average looking" body parts. By the last segment, the participants' body language indicates a much more relaxed atmosphere, with mothers and daughters equally sprawled around the room, stretched out on the floor and on couches. The conversation has become more reflective and introspective and now centers on issues of empowerment, fears, and communication. At this point, there are few giggles. There is more probing, and there are some difficult moments as mother and child come to terms with their communication and relationship problems.

The experiential process of the film is nicely juxtaposed with informative segments about puberty, development, sexuality, and birth control. Although the narrator, at times, rushes through the information, giving too much in too short a time, too quickly. The discussion of birth control methods among the group is particularly well done. Mothers and daughters are viewed passing around the contraceptives with a playful approach to knowing them firsthand.

On the negative side, the review committee thought that the video was much too long to be viewed at one sitting. It possibly overextended itself in trying to cover too much at one time and to capture every moment of the conversations. Moreover, seeing all three components together emphasized the disparity in the video production—the sound, lighting, and photography varied greatly between segments and, at some points, seemed somewhat amateurish. One inadequacy was noted in the segment which focused on contraceptive methods. Little information was provided on the side effects and risk factors, and appropriate use by adolescents was not addressed. An error was also made in the demonstration of how contraceptive jelly is used with a diaphragm: the jelly was put only on the rim and not inside. However, judged in its entirety, the positive attributes of this videotape greatly outweigh the negative. The review committee highly recommends this sensitive and fine film.

Reviewed by Diane de Mauro, director of program services at SIECUS.

YOU'RE WHAT?! A STORY OF TEENAGE PREGNANCY

Directed by Patty Collinge and Karen Winkler. VHS or Beta, color, 28 min. 1986. Purchase price: \$250 for institutions, \$75 for community groups, 3-day rental for \$30. Boston Women's Health Collective, 47 Nichols Avenue, Watertown, MA 02172 (617) 924-0304.

You're What? is about unplanned teenage pregnancy and the choices open to the pregnant teenager. It is specifically about counseling teenage women who are considering abortion in Massachusetts where a parental consent law is in effect.

Using local Planned Parenthood staff and area adolescents, the video follows one young woman as she discovers she is pregnant. Renee, a pregnant fifteen-year-old feels that she can't tell her parents about her pregnancy, let alone obtain their consent for an abortion. Like many in similar situations, she feels that telling her parents would "kill" them. Her boyfriend is too immature to be of any assistance. Her female friends, who have been pregnant, also have varied responses to her situation. Some have had abortions. Some have not. Some have kept their children and are enjoying them, while others have found the pressures of raising their children onerous. Renee visits her local Planned Parenthood counselor. The counselor goes over the options with her: Renee could keep the child, place it for adoption, or have an abortion. Renee decides to explore the decision to have an abortion. The counselor explains the judicial procedures required for a minor to obtain legal consent for abortion should she so choose. The viewer then accompanies Renee and her counselor as she appears before the judge.

When the panel viewed the video they felt that the parental consent portion would limit the video's relevancy to a national audience. However, the recent appellate court decision upholding Minnesota's parental consent law has made this video very relevant to family planning agencies and pregnant minors, especially in the 25 states that have similar laws.

Although the video is realistic in its portrayal of emotions and the problems pregnant adolescents face, the panel noticed an obvious lack of male involvement in much of the video. It is possible that because the lack of male responsibility and involvement is not uncommon the video was trying to emphasize the point. However, in an educational setting, one might want to stop the video periodically and address the males in the audience with ques-

tions about responsibility and maturity, rather than let the attitudes that are presented in the video pass as models.

As a video, *You're What?* suffers from poor sound quality and nonprofessional actors who, although contributing to the video's realism, display some self consciousness, slowing the pace of an already overlong script.

You're What? ends with Renee leaving the court with permission to abort her fetus. We don't know what her final decision will be. The point of the video is that the decision is hers and is hers alone.

The video was funded by grants from the Ms. Foundation for Women and other organizations. The Collective is willing to make arrangements for the distribution of the film by other groups. They can be contacted for details.

Reviewed by Fred Nesta, former manager of SIECUS' Mary S. Calderone Library.

Members of the SIECUS Audiovisual Review Panel for this issue were:

Michelle Gittens, BA, New York City Department of Health, Community Associate/STD Education; David McAllister, MA, public health educator, New York City Department of Health; Dr. Nabila S. Salib, social worker, and from SIECUS—David Boyd, BA, former administrative assistant; Raquel Burgos, membership coordinator; Diane de Mauro, PhD, director of program services; Janet Jamar, BS, manager of publications and public relations; Fred Nesta, MS, former manager of SIECUS' Mary S. Calderone Library; and Jeannette Reyes, membership assistant.

subject up with a partner. *Condom Talk* has been designed by the Center for Family Life Education, Planned Parenthood of Bergen County (PPBC), New Jersey, to help people imagine and discuss various ways to approach the subject of condom use with a partner. In the video, the female character imagines herself in six different scenarios initiating "condom talk" with her partner. The tape comes with a complete lesson plan for communicating with a partner about safer sex that has been taken from the manual, *Teaching Safer Sex*, which is also available from PPBC (\$15.95).

THE NEW TRADITION: SAFER SEX COUNSELING IN FAMILY PLANNING CLINICS

A 30-minute training video. Planned Parenthood of Bergen County, 575 Main Street, Hackensack, NJ 07601, 201/489-1265. Price: \$89, plus \$3 p/h.

This video is part of a complete package designed to help agencies integrate education about safer sex into their regular clinic procedures. The video shows the step-by-step process counselors are using at the clinic in Hackensack, N.J., to help women protect themselves from chlamydia and other sexually transmitted diseases, and from AIDS.

Four role-play scenarios demonstrate how staff can rehearse talking with women in varying life situations. The scenes show one woman who believes she is not at risk because she is in a relationship that is currently monogamous; another who is pregnant and wonders whether she should be tested for HIV antibodies; one whose cultural and religious background makes talking about safer sex unthinkable; and a fourth who simply wants to know how she can communicate with her partner about using condoms.

The video features actual interviews with four clients. These women are extremely supportive of the "safer sex" counseling procedure and are typical of the clients the agency has surveyed in assessing its new program.

The New Tradition package also includes an outline and materials for a three-hour staff training session as well as forms for use with clients: a confidential risk-assessment form, "Check Yourself Out," and two questionnaires. One questionnaire asks clients the questions they have about using condoms. The other assesses client attitudes toward safer sex education procedures in a clinic. Books, pamphlets, and articles on safer sex, plus a condom sampler, "The Threesome: You, Me and the Condom," complete the kit. These combined materials are sufficient for an agency to begin a safer sex tradition of its own.

MEDIA RESOURCES

CONDOM TALK

A four-minute trigger tape and lesson plan. Planned Parenthood of Bergen County, 575 Main Street, Hackensack, NJ 07601, 201/489-1265. Price: \$29.95, plus \$2 p/h.

Perhaps one of the most difficult things about using a condom is bringing the

Other Information Resources

DOES AIDS HURT? EDUCATING YOUNG CHILDREN ABOUT AIDS (1988, 143 pp., 7x9½, book) by Marcia Quackenbush, MS, and Sylvia Villarreal, MD. Designed for teachers, parents, and other care providers, this book provides suggestions for educating young children (preschool to age 10). It provides "simple, honest, age-appropriate information about AIDS." Recommendations are keyed to the developmental stages of children. The book emphasizes the importance of a solid health education program to give children the tools they need to understand basic concepts about disease transmission. Among the information provided is: when to bring up the topic of AIDS; troubleshooting; anticipating problems that might arise in discussing AIDS with young children; special circumstances: when a child, family or friends are at risk for or infected with HIV; the school with HIV-infected students or staff; and how to stay updated on AIDS information. *Network Publications, P.O. Box 1830, 408/438-4080.* Price: \$14.95.

"EDUCATING ADOLESCENTS ABOUT AIDS," Journal of Home Economics (Winter 1987, 6 pp., article available as reprint) written by Sally A. Koblinsky, Janet E. Preston, and Gladys Gary Vaughn. "In response to increasing interest in AIDS education curricula and teaching methods, the American Home Economics Association recently published a handpicked list of 45 resources for use in teaching adolescents about AIDS." Each of the resources (curricula, posters, films, videos, brochures, books, bibliographies, and hotlines) is described, target audience identified, and "each has proven successful in schools or community outreach campaigns." Accompanying the list is an explanation of the AIDS problem, answers to 11 frequently asked questions about AIDS, and 12 tips for teaching about AIDS. "To protect the health and welfare of American youth," they state, "home economics must assume responsibility for providing AIDS education to adolescents." *American Home Economics Association, Accounting Office, Publication Sales, 2010 Massachusetts Avenue NW, Washington, DC 20036-1028.* Price: \$3.50.

BRIDGES OF RESPECT: CREATING SUPPORT FOR LESBIAN AND GAY YOUTH (1988, 5½x8, 97 pp. resource guide) invites adults who work with youth to: recognize the existence and needs of a substantial—but neglected and largely invisible—population of gay and lesbian young people; learn more about how homophobia harms everyone by maintaining barriers of silence and by fostering emotional, verbal, and physical violence; replace the harmful lessons of homophobia with an affirmation of the intrinsic dignity and worth of every

person. It has been designed especially for parents, educators, religious leaders, community workers, health and human service providers. The guide offers creative ideas and approaches for affecting constructive change, and an annotated directory of useful organizations, educational resources, and program models. *Community Relations Division, American Friends Service Committee, 1501 Cherry Street, Philadelphia, PA 19102.* Price: \$7.50; discounts available for quantity orders.

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SEXUALITY AND THE DEVELOPMENTALLY DISABLED

An Annotated SIECUS Bibliography of Resources

The sexuality needs of the developmentally disabled are too often ignored. SIECUS supports the sexual rights of people with disabilities, including access to high quality specialized information and education. The SIECUS staff compiled this bibliography to assist professionals and parents in educating this population.

Please note that, other than its own publications, SIECUS does not sell or distribute any of these publications. However, most of the print materials are available for use at SIECUS' Mary S. Calderone Library, New York University, 32 Washington Place, Room 52, New York, NY 10003; 212/673-3850.

One to four copies of this bibliography are available from SIECUS on receipt of \$2.50 per copy and a stamped, self-addressed, business-sized envelope. In bulk, they are \$2.00 each for 5-49 copies and \$1.25 for 50 copies or more. Please add 15% to cover postage and handling (p/h).

The bibliography was prepared by Fred Nesta, former manager, Mary S. Calderone Library; Daniel Donohue, manager, Mary S. Calderone Library;

Mark Bigler, graduate assistant; Kathy Putnam, MPH candidate, Hunter College; and Lori Abrams, volunteer assistant, November, 1988.

BOOKS

BEHAVIORAL INTERVENTION IN THE SEXUAL PROBLEMS OF MENTALLY HANDICAPPED INDIVIDUALS

Lynda K. Mitchell

This book presents a wide range of problems, and intervention methods for dealing with them. It is an excellent resource book for professionals. (1985, 106 pp.; \$24.00, 10% discount for libraries.)

Charles C. Thomas, 2600 South First St., Springfield, IL 62708-4709; 217/789-8980.

AN EASY GUIDE TO LOVING CAREFULLY FOR MEN AND WOMEN.

Lyn McKee, Winifred Kempton, and Lynne Stiggall

This book includes basic information on sexual anatomy, reproduction and contraception. It is suitable for those with limited reading skills to read on their own or with a parent or teacher. (1987, Rev. ed., 71 pp.; \$6.95 plus 15% postage and handling.)

Planned Parenthood of Contra Costa, 1291 Oakland Boulevard, Walnut Creek, CA 94596; 415/935-4066.

GROWING UP: A SOCIAL AND SEXUAL EDUCATION PICTURE BOOK FOR YOUNG PEOPLE WITH MENTAL RETARDATION

Victor Shea and Betty Gordon

This book is designed to be read by moderately through severely mentally handicapped students aged 12 and up, although many parts may be suitable for younger students with mild learning problems. Basic information and illustrations are on right-hand pages, and ideas for discussion and further learning activities are on the left. The material is in a looseleaf format to allow for tailoring the program to one's own needs. (1984, 147 pp.; \$20 + \$1.50 postage and handling.)

Division for Disorders of Development and Learning, BSRC 22H, University of North Carolina, Chapel Hill, NC 27514; 919/966-5171.

LOVE, SEX AND BIRTH CONTROL FOR MENTALLY HANDICAPPED PEOPLE: A GUIDE FOR PARENTS

Winifred Kempton, Medora S. Bass, and Sol Gordon, eds.

This is a parent's guide covering socialization, puberty, abuse, contraception, and

sexual responsibility. (1985, 7th revised edition, 36 pp.; \$2.95, bulk rates available.)

Planned Parenthood of Southeastern Pennsylvania, 1144 Locust St., Philadelphia, PA 19107-5740; 215/351-5590.

THE NEED TO KNOW: SEXUALITY AND THE DISABLED CHILD FOR PARENTS OF CHILDREN WITH PHYSICAL, SENSORY, OR DEVELOPMENTAL DISABILITIES

Phil Way

This booklet for parents stresses the importance of sexuality education for children with physical or developmental disabilities. (1982, 28 pp.; \$1.25 plus 15% postage and handling. Bulk rates on request.)

Six Rivers Planned Parenthood, 2316 Harrison Ave., Eureka, CA 95501; 707/442-2961.

SURVIVOR: FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES WHO HAVE BEEN SEXUALLY ASSAULTED

Nora J. Baladerian, Krysia Dankowski, and Tawnya Jackson

This is a two booklet set. The first booklet is designed for persons with a minimal reading level and is to be read with the assistance of a teacher or parent. A second booklet is intended to assist parents, teachers, advocates, and others in helping the readers of the first booklet. A third booklet, written for fourth grade reading level, is being prepared. (1986, 2 booklets; The booklets are free, but there is a \$1.50 charge for postage and handling.)

Los Angeles Commission on Assaults Against Women, 543 North Fairfax Ave., Los Angeles, CA 90036; 213/655-4235.

CURRICULA

BECOMING ME: A PERSONAL ADJUSTMENT GUIDE FOR SECONDARY STUDENTS

Theresa Throckmorton

This curriculum includes units on personal and social development, health and self

care, and human growth and development, all focused on nurturing the practical skills needed for everyday life. Content outline, behavior objectives, learning activities, and resources are given for each topic. (1980, 83 pp.; \$12.00.)

Grand Rapids Public Schools, 143 Bostwick, NE, Grand Rapids, MI 49503; 616/456-4700.

BEING ME HUMAN AWARENESS PROGRAM

Jean Edwards and Suzan Wapnick

There are four elements in this program that may be used together as a complete curriculum or individually to supplement an existing program. This program approaches a broad population, from the mildly disabled to the severely handicapped; from children (age 6) through older persons. It includes:

Being Me: The Teachers Guidebook.
Covers all phases of sex education.
Includes examples of curricula and lesson plans from a variety of sources.

Sex Education Slides. Intended to supplement the guidebook.

Assessment Scale and Photo Cards. Also to supplement the main text. There 40 pre-and post-test questions, with 80 photos, which are designed to assess the social/sexual skills of both verbal and nonverbal students.

Just Between Us: A Social/Sexual Guide for Parents and Professionals, by Jean P. Edwards and Thomas E. Elkins.
Designed to help parents and professionals openly deal with the sexual needs of the developmentally disabled.

(1988; total package, \$120; guidebook, \$30.00; slides, \$40.00; assessment scale and photo cards, \$40.00; *Just Between Us*, \$12.00.)

Ednick Communications, Box 3612, Portland, OR 97208; 503/246-4601.

CIRCLES

Marklyn Champagne and Leslie Walker-Hirsch

This three-part multimedia series is designed so that each part can be used independently of each other. Circles I deals with intimacy and relationships. Abuse prevention is covered in Circles II. Circles III is concerned with communicable diseases, including

AIDS and STDs. (1983, mixed media [slides, sound cassettes, photos, wall chart, and guide]; \$399 each, discounts available if purchased in sets.)

James Stanfield Publishing Co., P.O. Box 1983, Santa Monica, CA 90406; 800/421-6534 or 213/395-7466.

EDUCATION FOR ADULTHOOD: A CURRICULUM FOR THE MENTALLY RETARDED WHO NEED A BETTER UNDERSTANDING OF LIFE'S PROCESSES AND A TRAINING GUIDE FOR THOSE WHO WILL TEACH THE CURRICULUM

Madeline Greenbaum and Sandra Noll

Designed for adolescents and adults to help them understand and deal with sexuality, aging, death, disabilities, and expressing feelings. It includes a training program for educators. (1982, 254 pp.; \$34.00)

Elizabeth W. Pouch Center for Special People, 657 Castleton Ave., Staten Island, NY 10301; 718/448-9775.

LIFE HORIZONS

Winifred Kempton

This new edition of Kempton's classic *Sexuality and the Mentally Handicapped*, includes a section on AIDS and an additional section, Life Horizons II, which deals with the psychosocial aspects of sexuality. Life Horizons I contains over 500 slides and covers anatomy, puberty and aging, reproduction, contraception, AIDS and STDs. Part II, with over 600 slides, covers self-esteem, moral, legal and social issues, dating, marriage, parenting, and sexual abuse. (1988; both sets, \$599; Life Horizons I, \$399; Life Horizons II, \$399.)

James Stanfield Publishing Co., P.O. Box 1983, Santa Monica, CA 90406; 800/421-6534 or 213/395-7466.

PREVENTING SEXUAL ABUSE OF PERSONS WITH DISABILITIES: A CURRICULUM FOR HEARING IMPAIRED, PHYSICALLY DISABLED, BLIND AND MENTALLY RETARDED STUDENTS

This 175-page curriculum includes separate lesson plans for each of the four populations named in the title. Topics covered include positive and negative touch, vocabulary, myths and facts about sexual abuse,

avoidance techniques, and assertive behavior. (1983, 173 pp.; \$19.95.)

Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/438-4284.

SEX EDUCATION FOR PERSONS WITH DISABILITIES THAT HINDER LEARNING: A TEACHER'S GUIDE

Winifred Kempton

This invaluable resource for educators is newly revised and expanded. It covers effective teaching techniques and strategies and defines the major components of a good sexuality education program. A comprehensive bibliography is provided. (1988, 200 pp.; \$19.95.)

James Stanfield Publishing Co., P.O. Box 1983, Santa Monica, Ca 90406; 800/421-6534 or 213/395-7466.

AUDIOVISUALS

AIDS: HOW TO PROTECT YOURSELF

An explicit video presenting basic information on AIDS and demonstrating condom use. Through role playing, responses to pressures to have unprotected intercourse are demonstrated. It is accompanied by a manual, *AIDS: Training People with Disabilities to Better Protect Themselves*. (1987, 17 min.; \$149.00, including postage and handling.)

Young Adult Institute, 460 W. 34th St., New York, NY 10001; 212/563-7474.

SEXUAL ABUSE PREVENTION: FIVE SAFETY RULES FOR MENTALLY HANDICAPPED PERSONS. A VIDEOTAPE ON PREVENTING SEXUAL ABUSE FOR MENTALLY RETARDED PERSONS

Produced by the Planned Parenthood Association of Cincinnati, this video features young developmentally disabled actors depicting the five rules of safety: your body belongs to you, keep your clothes on in public, say "no", get away, tell someone. This is an excellent video, simple, realistic, and useful. It includes a printed guide with

a chapter on involving parents. (1987, 24 min.; Purchase \$180, rental \$35.)

Agency for Instructional Technology, Box A, Bloomington, IN 47402; 800/457-4509 or 812/339-2203.

TEACHING AIDS

DOLLS

Planned Parenthood of Minnesota produces life size (5'6" and 5'5") heavy paper male and female dolls with detachable sexual parts to demonstrate erection, ejaculation, urination, menstruation, pelvic examinations, fertility, and fetal development. (\$75.00 plus 10% postage and handling for prepaid orders.)

Planned Parenthood of Minnesota, 1965 Ford Parkway, St. Paul, MN 55116; 612/698-2401.

MODELS

Female pelvic and male penis models. A rubber female model includes vagina, labia, clitoris, urethra, rectum, and uterus. It can be used to demonstrate diaphragm use and pelvic examinations. Rubber male penis models are also available. The flacid model shows circumcised penis, scrotum, with the reverse side revealing the vas deferens, prostate, bladder, and anus. An erect penis model is also available. This model can be used with the vaginal model to demonstrate intercourse. All models come with painted, unpainted, or stitched pubic hair. (Female: Unpainted, \$312, painted, \$360, stitched pubic hair, \$408; Male (Flacid): Unpainted, \$264, painted \$312, stitched pubic hair, \$360; Male (Erect): unpainted, \$168, painted \$216, stitched pubic hair, \$288.)

Jim Jackson and Co., 33 Richdale Ave., Cambridge, MA 02140; 617/864-9063.

PENIS MODEL

A molded, flexible erect penis with scrotum and a suction cup base is available for use in condom demonstrations. (\$34.95)

Adam and Eve, Apple Court, P.O. Box 800, Carrboro, NC 27510; 800/334-5474.

DATABASES

CYDLINE

Produced by the National Center for Youth With Disabilities

Contains bibliographic file of articles and a program file of institutions and agencies that provide educational or other services. Available in menu driven or command mode, the database provides searching on several fields, including state and affiliation in the program database.

National Center for Youth With Disabilities, Adolescent Health Program, Box 721, University of Minnesota Hospital and Clinic, Minneapolis, MN 55455; 800/333-6293.

EXCEPTIONAL CHILD EDUCATION RESOURCES

Produced by the Council for Exceptional Children

Citations with abstracts to articles, books, and symposia dealing with the education of the gifted and physically, mentally or developmentally disabled. Available on BRS and DIALOG, it contains records from 1966 to date.

Council for Exceptional Children, 1920 Association Drive, Arlington, Va 22091.

ORGANIZATIONS

Association for Retarded Citizens, 2501 Avenue J, Arlington, TX 76011; 817/640-0204.

Coalition on Sexuality and Disability, Inc., 380 Second Ave., New York, NY 10010; 212/242-3900.

National Center for Youth With Disabilities, Adolescent Health Program, Box 721, University of Minnesota Hospital and Clinic, Minneapolis, MN 55455; 800/333-6293.

National Information Center for Handicapped Children and Youth, P.O. Box 1492, Washington, DC 20013; 703/893-6061.

SIECUS, 32 Washington Pl., New York, NY 10003; 212/673-3850.