CONDOM PROMOTION AMONG YOUNG PEOPLE LIVING IN VULNERABLE SITUATIONS

AMITA DHANU AND ARMIN JAMSHEDJI NEOGI

INTRODUCTION

One third of India's population comprising of young people (10-24 years) live in diverse conditions of globalisation, connectivity and consumerism on one side and poverty, lack of access, and lack of choice on the other. A significant proportion are illiterate as indicated by 37% adolescents aged 15-17 years not attending school in urban areas while 56% do not attend school in rural areas. Gender disparities are wide, with twice as many females than males being illiterate¹.

However diverse their conditions, young people in India have commonalities — they lack correct knowledge on SRH issues, have an early sexual debut within or outside marriage, which is overwhelmingly unprotected. While marriage marks the onset of sexual activity among the large majority of young females, especially in rural areas, there is growing evidence of premarital onset of sexual activity particularly among young males from urban areas². Between 20 to 40 percent of sexually active boys reported a casual sexual experience³-⁶. Another study conducted on migrants from Kerala to Mumbai indicated that the average age of sexual debut among never married men was less than twenty years, with 46.4% reporting that it was between 10-19 years of age.⁷ The National Behavioural Surveillance Survey conducted by the National AIDS Control Organisation showed that around 8-10 percent adolescent (15-19 years) boys reported casual sex encounter, while it was just two percent among young girls.⁸ Most of these studies are urban based. Very little evidence-based research is available from rural areas. A study based in rural Rajasthan, revealed the existence of premarital sexual relations among adolescence.⁹

It is difficult to estimate the level of risk among young people as it depends on the types and numbers of partners they have as

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well as the sexual activities of their partners. Where the reach of SRH related information and services are comparatively low due to various social or geographical barriers, the consequences are harsh with increase in HIV infections, deaths due to an unsafe abortion, and irreversible reproductive morbidity among young persons.

To meet the urgent need of prevention and control of HIV/AIDS particularly among the vulnerable population groups of poor young people, the FPA India implemented the condom promotion project at two locations in the high prevalence States of Karnataka and Tamil Nadu.

BACKGROUND OF THE PROJECT

A pilot project was developed to contribute to a decrease in the rate of STI/HIV infection by encouraging safe and healthy sexual and reproductive practices involving young people for the promotion of correct and consistent use of condoms and increase condom use.

Availability and easy access as also affordability are critical factors in condom use. A wide range of strategies to increase access to and use of condoms among sexually active young people in particularly vulnerable circumstances were identified and the project was implemented in five pilot countries – Bolivia (out of school youth), Cambodia (youth fishermen), India (married/unmarried youth), Nepal (youth factory workers), and Zambia (urban youth), through the International Planned Parenthood Federation, London, with financial support from UNFPA.

METHODOLOGY

In India, FPAI carried out this project for thirteen months, up to February 2004, in two villages Kolagad (10,000 population) and Kundithini (12,000 population) at Bellary district, Karnataka, and at KK Nagar and Saligramam Corporation Divisions; with a total slum population of 62,245 at Chennai. The main objectives were to increase knowledge and understanding about SRH (including STI/HIV/AIDS) issues among young people (15-25 years) and to improve access to SRH counselling, including VCT and SRH services, as well as contraception – particularly the condom for dual protection either directly or through referrals. Young people's participation was through the development of 20 peer educators (Yuva Saathi) and ensuring young people's participation in project implementation. The Project was implemented by the Bellary and Chennai Branches of FPA India.

The project included young persons in the community both in and out of school, married as well as unmarried, through a non-institutional, community approach. Realising the need to address a section of a particular type of sex workers, a special group of devadasis (temple girls) was included in the project.

Preproject situation

The State of Karnataka where Bellary is situated has 10 districts with a high HIV prevalence. With 1,849 AIDS cases, the State accounts for 3.2% of the reported AIDS cases in India. The prevalence in antenatal clinics is 1.8% and in STD clinics 13.6%. Bellary has 2,108 persons living with HIV/AIDS and is reported to be the second highest district of Karnataka. There were 56 AIDS cases in Bellary district.

Chennai the capital city of Tamil Nadu State was where the first case of AIDS was detected in India. The State has seven of the 49 districts identified with a high prevalence of HIV. With 24,667 AIDS cases in the State it accounts for 45% of all AIDS cases in India. The prevalence in antenatal
Condom Promotion Among Young People Living in Vulnerable Situations

clinics is 1% and in STD clinics 15%. Chennai had 24,680 persons living with HIV/AIDS and 2,923 AIDS cases.

As in other parts of India sexuality is not discussed between seniors and adolescents. The needs assessment at Bellary revealed that premarital sex was prevalent with about 75-80 percent of the boys having contact with devadasis (temple girls), they reported to have multiple sex partners, men having sex with men was common before marriage and a few continued the relationships after marriage. In one village having a large proportion of shepherd community, bestiality is commonly practiced. Although females did report premarital sexual activity, it was relatively less than that among males. A large proportion of both men and women did not know how to use the condom and its dual protective use. Around three fourth of them had heard of AIDS with a wide range of myths and misconceptions. It was estimated that three fifth of the young people in the community are infected with a sexually transmitted infection, however, were unaware of where to avail services for treatment. Some of the other reasons for not seeking health care services were inaccessibility of free/subsidised services, no treatment available at the PHC, social stigma, and incorrect information on treatment through traditional healers and others. The basic issues at Chennai were similar. However, they were more aware of HIV/AIDS and dual protection of the condom.

Project Strategies

The project established various strategies to reach its objectives. Advocacy was carried out with opinion leaders, decision makers, parents, mothers-in-law, government officials, youth leaders. In one instance to overcome opposition from a prominent religious leader, the peer educators invited him to a number of educational and cultural programmes, at one prestigious function he was made the chief guest where he openly declared the need for such educational programmes for youth.

The involvement of already established local voluntary groups at Chennai was for creating an enabling environment for the project. Although the senior members of the LVGs did not approve of sexual activities outside marriage they did recognise that it happens in society and that they have to be well prepared as young persons have a right to correct information to protect themselves.

Project Liaison Committee

Project Liaison Committees were set up at each of the two project locations with prominent and interested members of the community. They helped identify space within the community for establishing Youth Centres, set the criteria for identifying and recruiting Peer Educators and to a large extent monitored the Project activities.

Peer Educators

At each of the project locations more than 10 Peer Educators were identified and established. Formal training was provided to only 20 Peer Educators (10-Bellarly; 10-Chennai). Apart from providing information on STI/HIV/AIDS, training included general health issues, sexuality, family life education, etc. A Peer Educator Training Manual was developed in the local language and Peer Educators were provided with education kits. While this training was provided free of charge to the Peer Educator, there was demand from out of the project area for training additional Peer Educators at Bellary. One Peer Educator from outside the project area was trained through sponsorship provided by the other Peer Educators. The previous
projects related to sexual health by FPA India at Chennai, helped in identifying Peer Educators who were selected with past experience or knowledge on SRH, those who showed an interest in social issues, and those who had a good rapport with others in the community. Other groups that were effectively woven into the project activities through their past experience were local voluntary groups and community leaders as CBDS. In addition to the Project requirement, 18 Peer Educators acted as supporting the trained Peer Educators, to take care of turnover.

All the Peer Educators were young below 25 years of age, both married and unmarried, boys and girls. They were paid out of pocket expenditure for travel or other incidental expenditure.

Peer Educators went through a process of empowerment from knowledge gain in psycho-social issues, sexuality and sexual behaviour, medical issues and counselling — all related to STI/HIV/AIDS, to the level of condom demonstration using penis models and providing basic counselling to their peers.

The Peer Educators themselves perceived their effectiveness as having good communication skills, courageous, ability to establish rapport, good listener, with feelings for his fellowmen, advice only good things to friends to lead a good quality life. They were comfortable doing community level counselling and being known in the community as peer educators. People started respecting them and coming forward to find solutions to their doubts and problems.

Youth Centres

Where recreation facilities were not existing, especially in the villages, two Youth Centres were established, one for girls and one for boys at each of the four project locations. One additional centre was established at Chennai. Games and condom distribution was the mainstay of these Centres. Condom registers were maintained, however, no identity of the person taking the condom was maintained. Membership was free T-shirts and ID cards lent additional value to the members. Educational programmes were organised at these Centres as also confidential counselling carried out by the Peer Educators in privacy. These Youth Centres were managed by the youth themselves.

Awareness generation

Education and communication through mass programmes, group activities, interactive games, street plays, media (print and TV), training of peer educators, etc were intensive. Concepts such as “Talking Condom” created interest among the public while desensitising them on condoms. The media, particularly the TV was involved at the inception of the Project. Influential local persons spoke on the need for “safeguarding our youth” through projects such as these. The media also highlighted project activities from time to time. One highlight of the project was a question answer programme on the local Chennai TV network with peer educators telecast on World AIDS Day 2003. This increased the confidence of the participating peer educators as well as of other peer educators. It also increased their status in the community.

Accessibility to services

Access to condoms was through Community Based Distributors (CBDs) who were situated within half a kilometre away in the rural areas and a five-minute walk in the urban areas, all within easy walking distance of prospective users. Retail shops also had condoms on sale. These shops received condoms from the CBDs. A marginal amount of Re 0.25 was their incentive, however, they reasoned that
distributing condoms at no profit is also a social service.

CBDs were provided training in condom supplies, storage, demonstration and also to make referrals in particular cases either for counselling or for providing more accurate information. The CBDs at Chennai were oriented in marketing as well. Apart from learning how to sell, they were taught condom demonstration. Marketing strategies such as 'buy one get one free' were adopted in Chennai. Although the CBDs were knowledgeable to talk about SRH issues, the women were not comfortable to talk about these issues with men.

Clients from the community were referred for either counselling only or for both counselling and testing at established VCT (voluntary testing and counselling) Centres.

Project Implementation and Outputs

At the end of the project period, an evaluation of the project was carried out which included desk review of the processes through monitoring visits, statistical and descriptive reports as well as the findings of the evaluation team through focus group discussions. The specific objectives were met through the strategies adopted by the project.

Knowledge building and behaviour change

The level of knowledge among 17,425 (about 13% youth of the project area) young people reached a stage of knowing the modes of HIV/AIDS transmission, the 'window period', STDs, and precautions to be taken including the correct and consistent use of condoms. Behaviour change communication was directed towards single faithful partners and correct and consistent use of condoms. Concerns revolved around the window period and blood transfusion, and issues on treatment.

The young girls and boys also gained knowledge on allied areas such as menstrual hygiene, conception and infertility, and a range of sexuality and family life issues.

The need for knowledge building was expressed by one young girl in one of the group discussions "there is a need for such activities in other villages also." The group felt that the Project was reaching out to only 30% of the youth population in their area and that there is a need for expanding this project to cover other youth.

Instances of transfer of knowledge were cited and behaviour changed. A young girl who learnt about menstrual hygiene counselled her elder sister to follow the hygienic procedures, diet restrictions during menstruation were stopped, a boy whose friend was having sexual relations with a girl who was shared among his two other friends was informed of the dangers of having multiple partners and having sex with those who have multiple partners.

Ripple effect was noted as a Muslim community, encouraged by the activities happening in the project areas, requested to have a peer educator among them. Since the project had no funds to train another peer educator, the other trained peer educators contributed Rs. 25 each towards her training. This was after a Muslim couple found to be HIV+ had been restrained from entering the village two years back. The husband died leaving the wife alone in an isolated hut. A close relative was unintentionally selected as a peer educator who convinced the family members to bring her back home.

The dynamics of social change due to the project were narrated such as girls going out and learning about more things other than the routine. Discussing condom use with their husband was indicated by a girl, who was not literate and a member of the Youth Centre, who explained to her
husband with the IEC material provided by the Centre. Another instance was of a young unmarried young girl who was about to commit suicide was rescued by a member of the Youth Centre and was referred for safe abortion. Mothers who could not discuss sensitive sexual issues with their children requested the Peer Educators to do so, since their children would relate more easily to girls of the same age.

A group of devadasis were encouraged to form an association to help themselves, they insisted that their non-regular clients use condoms. However, with their regular clients they did not insist on condom use. Condoms were readily available with them or at a shop nearby. They guided their client to the shop in case they ran short of condoms. This group was aware of sexually transmitted diseases, but had not heard of particular diseases and HIV before the project. They were willing for HIV testing.

Access to condoms and its use

Condom use was perceived by young people mostly as prevention of STI out of marriage and within marriage as a contraceptive. It was also perceived as being used only among the educated classes. Some groups strongly felt that to increase condom use the prospective client needs counselling as well as confidence in the person who is educating him. They also felt that advertisements on TV, posters and pamphlets do not show how it can be used. The most effective mode of communication to promote condom use they felt is through one-to-one communication.

Young persons frequently procured condoms from the Youth Centre on the pretext of playing games, while sign language was used to avail condoms especially from retail distributors such as shops. Unmarried boys and girls did procure condoms. Newly married girls were provided information and education on the correct use of condom and its importance of use during every sexual intercourse.

Some boys shared a packet of condoms, one packet containing three condoms. It was also stated by a group of boys that 90% of the boys who visited sex workers used condoms regularly. They also said that around 20% men having sex with men use condoms. They got to know this through close friends who confide in them. One young about to be married girl was coerced by her finance for sexual intercourse. Aware of the consequences, the next time she used condoms.

The community passed the level of condom sensitisation such as feeling, touching and talking about condoms, reached a level of using free condoms but has not yet reached a level of choosing branded condoms.

A total of 65,238 condom pieces were distributed during the project period to 6,146 young married and unmarried persons including sex workers and devadasis.

Counselling

Counselling was provided on issues related to sexuality, HIV/AIDS, RTI/STIs, contraceptives, as well as on other psychosocial matters. Appropriate referrals were made for further counselling, testing or treatment. Confidentiality and privacy was strictly maintained.

With their status, Peer Educators were able to tackle cases of domestic violence and other social issues. An illiterate man who got into the habit of bestiality got injuries through this act. Knowing that Peer Educators of the village were around to find solutions to his intimate sexual
problem approached a Peer Educator. On being advised a safer sexual option is now deriving sexual satisfaction by masturbating.

An unmarried young labour girl was undergoing repeat abortions through a local quack. Getting to know of the activities of the Youth Centre, she approached a Peer Educator and opted for a safer measure of using condoms. Another young girl, who was compelled to marry early, refused to have intercourse with her husband. The marriage was on the brink of break-up. However, with the intervention of the Youth Centres for boys and girls an understanding was reached and the marriage saved. A girl who was coerced by her husband for oral sex underwent counselling. She in turn counselled three other girls who were facing the same problem. A young boy having premarital sex took counsel of a Peer Educator and took his girl friend for emergency contraception.

Along with the support of project staff, the peer educators provided counselling to 4,260 young persons (including 367 referrals).

**Sustainability**

Peer Educators expressed that they would continue being counsellors at the community level, however, they did show concern for a place where they could provide counselling in seclusion. They were also concerned about the other youth activities at the Youth Centre, which would have to close at the end of the project period. Procuring condoms was a difficulty expressed by all, as there are problems and delays in getting condom supplies from the government and other sources are expensive.

This project was not completely sustainable since time was short. However, important linkages with other organisations were established for the youth to avail of services and Peer Educators would continue imparting information and counselling.

**Lessons Learnt**

- Involvement of local community leaders in the process of implementation gained credibility for project activities.
- The effective role of Peer Educators is accepted in the community by gatekeepers and built the confidence of Peer Educators as Counsellors.
- Youth Centre was easily identified as a place for youth activities with privacy and confidentiality maintained for getting information and services.
- Partnerships with other agencies working in HIV/AIDS in providing services and training is a cost-effective method.
- Media leverage to project activities boosted the morale of all involved with the project.
- One-to-one interactions for counselling and condom promotion ensures correct use of condoms.
- Knowledge building among community members allays stigma and discrimination.

**Acknowledgements**

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6. National AIDS Control Organisation (NACO) and UNICEF. Knowledge, attitudes and practices of young adults (15-24 years), New Delhi, 2002.


Title: Approaches to researching women's reproductive health.
Website: http://www.popcouncil.org/pdfs/popbriefs/pb1002.pdf
Abstract: Since the late 1980s, comprehensive studies from Egypt, India, Nigeria, and Turkey have revealed the widespread prevalence of reproductive tract and other gynecologic disorders. These findings have prompted researchers to expand this work to explore the pervasiveness of these illnesses and to shed light on factors that place women at risk. But what are the best ways to conduct this type of research? Population Council senior program associate Shireen Jejeebhoy; Michael Koenig, associate professor, Bloomberg School of Public Health, Johns Hopkins University; and Christopher Elias, president, Program for Appropriate Technology in Health (PATH), have collaborated on a book, Reproductive Tract Infections and Other Gynaecological Disorders: A Multidisciplinary Research Approach, that tackles this question. The editors draw upon the considerable experience of their contributing authors and provide a synthesis of the best approaches for studying this topic. A spectrum of reproductive ailments can affect women. Reproductive tract infections (RTIs) are some of the most common. They can be transmitted sexually, produced by an overgrowth of normal microorganisms, or result from infections related to abortion, childbirth, sterilization, or the insertion of an intrauterine device. Women may also develop gynecologic cancers, endocrine disorders, genital prolapse (a painful condition in which the uterus or vagina is displaced downward), obstetric fistulae (a loss of tissue between the vagina and bladder and/or rectum caused by obstructed labor), infertility, sexual dysfunction, and menopausal symptoms. Discomfort caused by these conditions can impair a woman's ability to engage in a wide range of activities and can damage marital and sexual relationships and psychological well-being. (excerpt)

Title: Meeting the health needs of men: Ensure that your facility stacks up!
Survey shows there is room for improvement in reaching young males.
Abstract: Review the number of services offered at your family planning agency, then check off the number that address the reproductive health needs of men. If your agency is like most of the facilities participating in a recently published survey, you may be serving some male patients, but doing very little to recruit more. By the late 1990s, 87% of agencies providing publicly funded family planning services in the United States served at least some male patients, primarily through condom provision, contraceptive counseling, and testing and treatment for sexually transmitted diseases (STDs). Most of the facilities surveyed expressed interest in serving more men in the future; however, only one in five conducted activities to recruit more men, according to a report of the survey's results. (excerpt)

Title: Caught in a dilemma? HIV/AIDS, gender and the media.
Source: Media and Gender. 2004 Feb; (14): [8] p..
Abstract: Over 22 millions people have died of AIDS related illnesses in the last 20 years and more than 42 million people are currently infected with a virus which was unknown 1980. While HIV/AIDS is the largest health issue currently facing the world, the epidemic is a gender issue. Statistics prove that both the spread and impact of HIV/AIDS is not random. Disproportionately affects women and adolescent girls who are socially, culturally, biologically and economically more vulnerable than their male counterparts. These power imbalances between men and women are accentuated by various traditional practices that contribute to the spread of the disease such as female genital mutilation, and the early or forced marriages of girls. It is clear that gender roles and relations have a significant influence on the course
and impact of the HIV/AIDS epidemic in every region of the world. In short, HIV/AIDS not only driven by gender inequality, it entrenches gender inequality and, as Noleen Heyzer, Executive Director of UNIFEM has said, in the case of HIV/AIDS, “gender inequality is fatal”.

(excerpt)

Language: English


Abstract: The 1994 International Conference on Population and Development (ICPD) articulated a bold new vision about the relationships between population, development and individual well-being. At the ICPD, 179 countries adopted a 20-year forward-looking Programme of Action (ICPD PoA), which built on the success of population, maternal health and family planning programmes of the previous decades while addressing, with a new perspective, the needs of the early years of the twenty-first century. As the ICPD is reaching its mid-point in 2004, it is fitting that countries take stock of progress that has been made so far in achieving the Cairo goals. UNFPA is mandated to assist countries in their review of operational experiences in implementing the ICPD PoA, and to that end, conducted a Global Survey in 2003 to appraise national experiences ten years after Cairo. An overall response rate of 92 per cent was achieved for developing and countries in transition. For donor countries, the response rate was 82 per cent. The objectives of this report are to: (a) describe, from an operational perspective, the progress that has been made, and the constraints that have been encountered, by countries in their efforts to implement specific actions of the ICPD PoA and the MDGs; (b) present measures taken with some regional highlights; and (c) summarize the major conclusions arising from the 2003 Global Survey and assess the way forward. The various chapters of the report present the findings and conclusions emanating from the analysis of the Survey. (excerpt)

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Language: English

Source: POPLINE.org
The Journal of Family Welfare

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