Communication and advocacy strategies
adolescent reproductive and sexual health

Booklet 2
advocacy and IEC programmes
and strategies
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Although adolescent reproductive and sexual health education is a new programme area when taken under the context of the ICPD POA framework, not a few efforts had been ventured though by a number of forward-looking countries in the region to implement educational, advocacy and communication activities in the areas of human sexuality, HIV/AIDS, and family life/population education, and of course more recently, adolescent reproductive health.

Without doubt, these programmes and activities are characterized by weaknesses and gaps as planners and implementors are usually held back from trying out innovative approaches by opposition and objections from concerned quarters. However, there is also not a dearth of successful innovative strategies and approaches which can documented and shared for others to learn from and even replicate.

Sexuality and reproductive health education is an area that generates misconceptions, confusion, fear and unwarranted caution, to say the least. These can be ascribed by many factors. First, policy makers, community members, parents and teachers are reluctant to confront issues of sexual and reproductive health. Teen-agers often get their information from their peers who may be ignorant of the topic or the mass media which may provide sensational and inaccurate information. In many programmes, curriculum and textbooks continue to limit their focus on biological, demographic, population and development and family life education issues. Sometimes, in spite of a well-designed curriculum, an ill-prepared or uncomfortable teacher can render a programme ineffective. Teaching methods used are often not suited to the sensitive nature of sexual and reproductive health education issues.

However, the developments in this field have not been held back by a few conservatives and traditionalists. Many organizations, especially the non-governmental and voluntary organizations as well as bold government agencies have taken steps to undertake innovative strategies to introduce reproductive and sexual health messages into their programmes to reach the adolescents and influence them into taking responsible decisions regarding their sexual and health behaviours.

These strategies and approaches range from energizing in-school education through co-curricular or community support from out-of-school sector; setting up counselling services inside a school campus; counselling through telephone hotlines; peer group counselling and discussions; development of IEC materials and interactive Internet discussion forum; youth camps and debates and competitions and campaigns in recreational places. Some of these strategies have worked and some failed. How is it that in one country the setting up of counselling centre for youth
within a school campus is acceptable and not in another? Why is it that the use of peer approach in reaching the youth is effective in one cultural setting and not in another? How has religion been an obstacle in the introduction of reproductive and sexual health education in a few countries and how has this been overcome?

Some countries and some sectors of society have raised fears and caution in introducing reproductive and sexual health which could be unwarranted. The perceptions could be emanating from their own perspective alone and may not be shared by other sectors or even the recipients themselves, i.e., adolescents. Or even if these fears are justified, these are not really unsolvable. Bold, innovative strategies and approaches are now called for if the ICPD POA recommendations dealing with adolescent health are to see reality. As Dr. Nafis Sadik, Executive Director of UNFPA states:

"The largest challenge facing us does not lie in resources or delivery systems or even infrastructures, but in the minds of people. We must be sensitive to cultural mores and traditions, but we must not allow them to stand in the way of actions we know are needed. We have to overcome the obstacles of superstitions, prejudices, and stereotypes. These changes may not be easy and we face formidable challenges. They involve questioning entrenched beliefs and attitudes, especially toward girls. Lifelong habits must be given up, but they have to be, because in the end Asia's future depends on all its people: and it will depend as much on adolescents as on adults".

In order to document the experiences of the countries in the planning and implementation of best practices and innovative strategies in the field of adolescent reproductive and sexual health, these series of case studies are being commissioned to selected countries which have accumulated a pool of knowledge and experiences which can be shared with other countries.

To document the experiences of countries engaged in planning and implementing adolescent reproductive and sexual health in the areas of advocacy and IEC (information, education and communication), the UNESCO Regional Clearing House on Population Education carried out an activity whereby selected countries were asked to document their experiences in order to:

1. Identify the profile and characteristics of adolescents in various areas such as demographic profile, fertility, teen pregnancies, sexual behaviour, STDs, contraception, etc.

2. Describe the policy and programme responses of the country to address the problems and issues dealing with adolescent reproductive and sexual health
3. Document the strategies, best practices and innovative approaches used in undertaking advocacy and IEC activities on this topic and the results or impact of these strategies on the target recipients.

4. To examine and bring out the factors/conditions which have contributed to the success of these best practices or failure of some strategies and from these highlight the lessons learned or guidelines for future consideration.

5. To identify organizations which have achieved successes in carrying out programmes/activities on adolescent reproductive and sexual health.

Seven countries were initially selected to document their experiences – Bangladesh, Iran, Malaysia, Mongolia, Philippines, Sri Lanka and Thailand.

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**BOOKLET ONE: Demographic Profile**

This booklet describes the adolescent population of the seven countries in terms of their demographic profile such as their population size, age of marriage, educational attainment, employment, and health, among others. This is followed by an overall picture of the reproductive and sexual health characteristics of the adolescents through their fertility practices, teen pregnancy/childbearing abortion, HIV/AIDS and STDs, family planning and contraception. The last part synthesizes the different knowledge, attitude and practice (KAP) surveys dealing with the youth’s sexual behaviour, knowledge, attitude and behaviour on sexuality, age at first intercourse, and incidence of pre-marital sexual activity. Booklet One thus sets the context, i.e. the problem that the adolescents face for which the succeeding two booklets address their focus on.

**BOOKLET TWO: Advocacy and IEC Programmes and Strategies**

This booklet describes the seven countries' responses to address the problems faced by adolescents by showing the various programmes and activities that the countries are carrying out. Each of the programme included describes the target audiences reached, the scope, type of organizations involved, their objectives, strategies used, outputs or results of such programmes and impact. After describing the overall programme details, this booklet zeroes in on the advocacy and IEC strategies which have been used. These strategies are analysed in terms of their types.
BOOKLET THREE: Lessons Learned and Guidelines

Based on the experiences elaborated in Booklet Two, this booklet draws the implications from them in terms of the lessons that have been learned, highlighting the factors which helped and hindered their successful implementation. Finally, from this wealth of knowledge also arose specific and practical guidelines for consideration by those who are formulating and implementing similar programmes especially as the guidelines deal with policy formulation, programme planning and management, forging alliances and winning support, using more effective strategies, audience segmentation and materials development, innovative approaches, emphasis on life skills ad safe sex behaviour and measurement of impact and use of indicators of success.
Booklet 2
Advocacy and IEC
Programmes and Strategies
POLICIES

GENERAL SITUATION

Of the seven countries covered in this booklet (Bangladesh, Iran, Malaysia, Mongolia, the Philippines, Sri Lanka and Thailand), only three – Sri Lanka, Philippines and Mongolia – have an official and formal policy on adolescent reproductive health (ARH).

At the time this booklet was being written, only one other country – Malaysia – was expected to launch its own official and formal policy soon. The three other countries – Bangladesh, Iran, and Thailand – do not have policies that are specific to ARH. None are expected to be enacted soon. Whatever policies they may have pertain mostly to youth welfare in general.

Sri Lanka

In Sri Lanka, the climate and political leadership are very positive towards reproductive health. In August 1998, the Cabinet of Ministers approved a National Population and Reproductive Health Policy which has eight goals, including one that relates directly to the reproductive health (RH) of youth and adolescents.

Goal 4 of this Policy states: Promote responsible adolescent and youth behaviour.

It spells out the following strategies:

- Ensure adequate information on population, family life, including ethical human behaviour, sexuality and drug abuse in school curricula at the appropriate levels.
- Strengthen youth worker education by including information about drug abuse and sex-related problems at vocational training centres, institutions of higher learning, and workplaces such as free trade zones.
- Encourage counseling on drug and substance abuse, human sexuality and psycho-social problems, especially by nongovernmental organizations (NGOs), community-based organizations and the National Youth Services Council.
- Promote informed and constructive media coverage of youth-related social problems.
- Promote productive employment opportunities for youth.
- Promote programmes, including counseling, to minimize the incidence of suicide among the youth.
- Provide the legal, familial and institutional support to mothers to enable them to protect their children from sexual abuse and harassment.
The high literacy rate of the population (85%-90%) has helped to propagate important messages on RH to the public through the print media. The cultural background of the country also is much more positive towards gender equity than that of other countries in the region: many key posts in government and among NGOs are held by women.

Top-level administrators, including those in the army, also support and promote activities related to RH in their own organizations, knowing there is a general feeling in the country that RH issues and problems need to be taken seriously. The health system from the provincial level down assures quick and effective delivery of services, and a National Health Policy gives priority to both curative and preventive service facilities.

But problems remain:

- Some programmes are hindered by the traditional attitudes of some conservative bureaucrats or heads of institutions.
- Procedures for effective monitoring and follow-up are lacking.
- Financial transactions, including payments, are delayed by government red tape.
- The general breakdown of security in the country has dampened the attractiveness of youth programmes and the fun promised by the planned Drop-in Centers.
- Many traditional attitudes at the personal level create bottlenecks in implementation at local levels.

In Mongolia, three policies directly affect adolescents: the Population Policy of 1996, the National Programme on Reproductive Health of 1997, and the Programme on School Teenagers and Adolescent Health of 1998. All three seek to educate and train adolescents on reproductive and sexual health, establish services for ARH, carry out advocacy activities on ARH issues through the mass media, and assist NGOs working on these issues.

In particular, the Population Policy aims to provide information and medical services to prevent early or closely spaced births. Its implementation period is from 1996 to 2000.

The National Programme on Reproductive Health aims to address issues related to ARH, including lack of access to health services, low quality of health assistance, and lack of professionals who specialize in ARH. Its implementation period is from 1998 to 2001.

The Programme on School Teenagers and Adolescent Health seeks to win the support of government, public organizations, economic establishments, parents and teachers for a health system for pupils and adolescents and to build an environment that will allow them to live and grow healthy, not only physically but also morally.

But there are serious problems: to date, the country has no school-based sex education programme. And it has a serious lack of educators – whether teachers, health service providers or parents. But the design for such a programme is under way.

There is also very little data on the nature and magnitude of young people’s sexual health problems, their perceptions and needs, the social context in which their sexual behaviour takes place, and their knowledge and attitudes towards their own sexuality.

The Philippines sets a good model in developing an integrated and coordinated programme for orchestrating the efforts of various agencies carrying out an adolescent reproductive health programme. The overall integrated reproductive health programme strategy is coordinated by a focal point – the Commission on Population. It has five sub-strategies; one of which focuses on
adolescent health and youth development programme that addresses the fertility and sexuality-related needs and problems of the Filipino adolescents. It consolidates the government and NGOs efforts towards the promotion of the total well being of the youth, reduce reproductive health problems, strengthen service delivery programme and instill values of gender equity. A holistic action plan shows objectives, strategies and activities of participating agencies cooperating in the integrated programme.

However, as far as legislations dealing directly with ARSH, there are only two pieces of legislation specific to adolescent reproductive and sexual health: Population and Sex Awareness (PASE) for out-of-school youth and the Teaching of Population Education (POPED) in public and private elementary and secondary schools.

PASE was developed by the Department of Social Welfare and Development (DSWD) to address the problems of early marriage and unemployment among out-of-school youth. It aims to prepare these youth economically and socially to cope with their situation and to live as responsible adults and members of their community. It is backed by an administrative order and integrated into the human resources development programme for the youth of the DSWD’s Bureau of Youth Welfare.

POPED incorporates population sub-units in five subject areas – social studies, science, health, mathematics and home economics – and is backed by a memorandum of the Department of Education, Culture and Sports (DECS). It is part of the overall plans of the country’s Population Education Program.

Currently, the core areas of population education are: (1) Family life and responsible parenthood; (2) Gender and development; (3) Population and reproductive health; and (4) Population resources, environment and sustainable development.

In 1999 the DECS, in recognition of the crucial role of adolescent health in learning, issued a memorandum forming a task force on adolescent health. The task force will strengthen various school health and health-related programmes and services, particularly those that address the physical, social and emotional needs and interests of adolescents.

But in this country, too, there is a problem even in the teaching of population education: Catholic schools that are opposed to teaching sex education and family planning would focus on other topics that are not contrary to their values. In fact, the terms “sex education” and “family planning” are anathema to these schools.

In 1998 the Ministry of Health, together with its partners in government and among NGOs, initiated the formulation of an Adolescent Health Policy. At the time this booklet was being written, this policy was almost ready. Once launched, it will act as a springboard for reproductive and sexual health education and services which can be made available to adolescents.

The Malaysian government is committed to adolescent reproductive and sexual health. Several ministries, including those of education, health, youth and sports, and national unity and development, cater to the needs of the adolescent. In fact, most of the country's social and health policies and programmes which relate to adolescents and to reproductive and sexual health antedate those of the International Conference on Population and Development in Cairo.

The problem, however, is that the government looks on the concern “holistically,” i.e., under social problems of the youth which it terms “social ills.” This approach tends to skirt controversial issues like sexuality, which may be the main issue.

Because most of the programmes for adolescents provide only information but rarely life skills, adolescents are unable to see that they are vulnerable. For example, studies on knowledge, attitudes, practice and
behavior related to HIV/AIDS have shown that Malaysian adolescents are knowledgeable about it. But many could not see that they are also vulnerable to it.

Reproductive rights in Malaysia apply only to couples and married women. Adolescents can be provided RH services but cannot be given contraceptives if they are unmarried.

There also seems to be some misunderstanding about the need to provide adolescents with relevant information to protect them. Result: they are denied education on sex or sexuality. If sex education is allowed, parents would usually say the teaching should be left to teachers of religion or to the schools.

This forces Malaysian youth to turn to other sources like the Internet for information about sex. More often than not, however, what they get when they type the word “sex” on their computers are pornographic sites. These do not give the youth a fair idea of what sex is about.

In Bangladesh, the practice of offering specialized health services to adolescents, whether by government institutions or by NGOs, was begun only recently.

The government’s new five-year health programme recognizes adolescent health as a priority target area and makes it part of the so-called Essential Services Package (ESP). A separate programme, titled “Maternal Nutrition and Adolescent Health,” deals with adolescent health issues which include the following:

- behavioural change through effective information-education-communication,
- postponing first birth or preventing unwanted pregnancy through proper IEC,
- increased use of contraceptives by newly married couples,
- prevention of unsafe abortion due to unwanted pregnancy,
- special antenatal and safe-delivery care to pregnant women aged less than 24 years,
- creation of awareness among adolescents about reproductive tract infections/sexually transmitted diseases (RTI/STD),
- availability of high quality services for management of these infections and diseases,
- involvement of NGOs and the private sector in promoting adolescent health, and
- intersectoral coordination among the various sectors concerned – education, law, labor, social welfare, youth, culture and sports.

The following are other important components of ESP: health education and information on the disadvantages of early marriage, the reproductive process, safe sex, proper nutrition and hygiene, proper sibling care, adolescent contraception, treatment of anemia and certain gynecological problems like dysmenorrhea. Under this programme, all health and family planning service providers in government are expected to deliver adolescent health services as well, as part of the reproductive health component of the ESP.

But, like in practically all the other countries covered in this booklet, there is a serious problem: in Bangladesh, any proposal to introduce sex education or ARH education will face resistance and even active opposition from community leaders. School teachers, parents and even the students themselves will cite violations of their customs, tradition and religion.
In Iran the closest reference to reproductive health is found in the National Youth Policy that was formulated in 1992 by the Supreme Council of the Youth. This council is the official body in charge of coordinating activities of this age group.

Articles 36-42 of the Policy are devoted to family and marriage. None, however, explicitly mentions sexual health.

The country still lacks a systematic and coherent advocacy strategy. Various government ministries and organizations have tried to sensitize influential individuals to critical issues in population, RH and family planning but these efforts have been “mostly ad hoc, sporadic and had no clear focus and strategy.” Nor is there a systematic and institutionalized programme for getting the media involved in advocacy activities for adolescent reproductive and sexual health.

These is also a need to get religious leaders to be more intimately involved in reproductive and sexual health activities, including those for adolescents. What makes this particularly challenging is that certain religious leaders are not in favour of RH and family planning programmes. Given the sensitive nature of advocacy activities for RH and family planning, managers of these programmes have chosen to be cautious and conservative in their approach so as not to get flak from those who are against these programmes.

But efforts made so far have alerted NGOs and community workers and leaders to critical population and development concerns that remain and affect RH and gender equity and equality in the country.

In 1995, a national RH/FP IEC Centre was set up within the Ministry of Health and Medical Education with the assistance of UNFPA. This indicated willingness on the part of national authorities to strengthen educational promotion activities in RH/FP. But there is no evidence that this Centre has accomplished anything specific about the reproductive health of adolescents.

In 1993, the Ministry of Health, faced with a large cohort of the population which was entering reproductive age in 1994, devoted great efforts to increase awareness about RH problems among adolescents. As a first step, it set up an office within the Family Health Department to coordinate programmes aimed at improving adolescent health.

The Department has also activated a multidisciplinary committee on adolescent health, worked for intersectoral cooperation for implementing its action plan, and carried out the following activities: production of educational materials on adolescent health, compilation of information about adolescents, provision of health facilities with educational modules on counseling on reproductive health and population issues; facilitation and conduct of knowledge/attitude/practice surveys on puberty in urban and rural areas, and conduct of an educational workshop attended by most of the key authorities from different bodies involved in adolescent reproductive health.

Recently it published the following books on adolescent health in Farsi: A guidebook for parents and teachers, a guidebook for boys, a guidebook for girls, physical aspects of adolescent education (a Unesco book, translated from English), and a guidebook on adolescents’ health for health managers and personnel (also a translation from English).

The Department of Health reports that there is not yet a strong strategy for adolescent reproductive health in Thailand and the services and IEC efforts are fragmented. However, while strategies may be fragmented, there are nevertheless various programmes that the government implements. It was claimed that the strategies and activities of the NGOs are more focused.

For the last 15 years, the Planned Parenthood Association of Thailand (PPAT) has been advocating the inclusion of sex
education, which does not exist in any effective form, in public schools. The course is needed not only by secondary school students but also by students at higher levels of education and by out-of-school youth, because sex education is generally not provided by parents in Thailand: cultural norms forbid communication about sex between parents and children.

Towards this end, PPAT has conducted seminars for administrators, trained teachers, developed suitable IEC materials, organized related research with Chiang Mai University, and conveyed its results to the Ministry of Education through seminars.

The Ministry has responded with a number of announcements of its plans to introduce a new curriculum that would include sex education. But it has failed to do so, citing, among other reasons, lack of funds for the needed change. The PPAT believes the real reasons are twofold: teachers are reluctant to handle the course, and parents will react adversely.

An outspoken legislator, Senator Saisuree Chutikul, has said the government sector is “too cowardly to undertake this type of action.” The senator cited as well the problems of lack of trained teachers, lack of trainers for teachers of sex education, and the inadequacy of mechanisms to ensure that teachers impart useful knowledge effectively.

Many schools in the private education sector, however, now have sex education courses for secondary students. An NGO, the Population Council, intends to advocate the teaching of sex education in schools and tertiary institutions, a move that is supported by another NGO, the Foundation for Women (FFW). The Population Council aims to work with the Ministry of Education and the Ministry of Public Health in developing curricula for courses on gender, sexuality and reproductive health.

The Family Planning and Population Division of the Department of Health believes there is no strong strategy yet for ARH in the country and that IEC and services efforts are fragmented. But it also believes that the efforts of NGOs are more focused.

The department says adolescents in the school sector are important, but it also points out that out-of-school adolescents are just as important because they make up two-thirds of the target population.

Another reproductive health need of adolescents in the country is safe and responsible sex. There is evidence that adolescents and youth in general who are sexually active, and not just members of specific groups such as migrants and factory workers, are at high risk of sexually transmitted disease and HIV/AIDS. Government and NGOs have responded to the need with programmes that promote safe and responsible sex.
PROGRAMMES

- For Advocacy

- The programmes for advocacy which are most frequently used in most of the countries under study employ seminars and other public forums, meetings and consultations, packaging and dissemination of information, and publication of a newsletter in order to obtain support from its target audiences. These are usually used in combination with one another. All require relatively less preparation than other types of programmes activities and do not entail as great an expense, but they have limited effectiveness.

- Less used but found by users to be more interesting and effective among target audiences are the following programme activities: development of policy papers and advocacy materials, publication of studies or findings from research, training of ARH advocates, political lobbying, meetings for networking or the building of coalitions, briefing and training of media, and running special programmes on radio and television.

- Another type of advocacy programme is the media campaign. It is not conducted often and is used in only a few countries because its costs can be prohibitive.

- Most of these programmes are carried out by NGOs, some with government support or cooperation, and most with support from a funding agency. The most common funder is the United Nations Population Fund, followed by private donor agencies such as the International Planned Parenthood Federation (IPPF) and locally based funding agencies.

- In-country funders include the national and local governments, the private sector, and locally based NGOs and donor agencies.

- For IEC

- The most common types of IEC programmes being carried out by most of the countries under study include population or family life education for youth in school, out of school or at work reproductive health services or health-based programmes; counseling programmes, community-based programmes, and media and IEC materials development; and training on IEC strategies.

- In these programmes, the following activities were used but to a lesser degree: individual counseling, peer or youth-to-youth counseling, training of individual counselors and peer counselors, referrals, exhibitions, youth camps, use of information technology, teaching of life skills, teen and youth centers, hotline service, folk media, special media, mobilization of clubs, delivery of services, research, innovative and youth club-related approaches, drama and folk songs, and production and dissemination of print materials.
These programmes seek to promote a wide range of objectives, including getting support from those who can push for the formulation or adoption of a national policy on ARH and the teaching of sex education in schools. Other objectives target behavioural changes such as reduction of the risk of unwanted pregnancies and unsafe abortion, delaying marriage, practicing safe and responsible sex, reduction of the risk of sexually transmitted diseases and HIV/AIDS, development or strengthening of skills of those who serve in programmes for adolescents, and widening or strengthening of the base of support for these programmes.

For the most part, objectives that address specific needs are balanced and well covered. What needs to be explicitly stated in more countries, however, is an objective for the adoption of a formal and official policy on adolescent reproductive and sexual health as well as for the teaching of sex education. This is a real challenge, particularly in countries where the pursuit of such an objective faces strong cultural, religious or political opposition.

Most programme objectives are measurable and quantifiable, but their impact, particularly on overall programme goals, is long-term and, therefore, not immediately apparent. The following goals or objectives are common to many countries:

**For Advocacy**

- work for the adoption of a national policy on adolescent reproductive and sexual health
- work for the inclusion of sex education in the school curriculum
- build coalitions
- train ARH advocates
- win media support for all ARH-related efforts
- promote coordination and networking
- strengthen delivery of programme services for the youth through coordinated and synchronized efforts of government and nongovernmental organizations and key influential persons
- convince parents, teachers and other community leaders to favour and support adolescent reproductive health programmes
- obtain support from the private sector
- encourage adolescents to adopt healthy behaviour and avoid risky activities
- improve and promote adolescents’ total well-being and self-esteem
- reduce the incidence of reproductive health and other problems among the youth
For IEC

- improve and promote adolescents' total well-being and self-esteem
- reduce the incidence of reproductive health and other problems among the youth
- prevent unwanted pregnancies
- reduce adolescent pregnancies
- prevent and reduce the incidence of unsafe abortion
- prevent and reduce the incidence of sexually transmitted diseases and HIV/AIDS
- reduce the incidence of early marriage
- generate information on adolescents' attitudes, behaviour and practices related to fertility
- respond to the social, emotional, intellectual and reproductive needs of adolescents
- provide information, counseling and referrals related to sexuality and contraception
- test alternative venues for reaching young workers and out-of-school youth
- reduce the incidence of death among mothers during pregnancy, delivery and the period after birth
- prepare youth for responsible adulthood by addressing their needs related to adolescent sexuality within the context of a healthy and wholesome adolescent development
- provide sexuality-related information to adolescents through peer counselors and telephone services
- develop materials specific to adolescent fertility
- train potential counselors and information providers
- provide technical assistance to information and service providers
- provide in-school youth knowledge of the implications of a rapidly growing population on socioeconomic development
- provide students the concept of and knowledge on responsible parenthood
- persuade couples to favour small families

Of these programmes' targets, the best covered are legislators, policy planners, programme managers, teachers and school administrators, and the youth who are in school, female, urban and married. Most programmes for adolescents carried out by government organizations and NGOs are confined to the urban areas; only a few focus on the rural areas.

In other countries, special groups such as soldiers in the army, migrants, and workers in factories, estates or industrial zones are also programme targets.

Most neglected are youths who are sexually active, in prison or in other dangerous and difficult circumstances such as on the streets or engaged in commercial sex. Those who should be reached more are youth who are out of school, male, in a rural setting, at work and unmarried; parents, and cultural or religious groups.

Of these targets, only the youth appear to have received, and continue to receive, some attention in terms of their information needs and preferences. Most
others like the service providers and IEC workers and counselors, seem to be not well-defined, not segmented, not studied in terms of their needs, little involved in programme planning and implementation, and not as well-assessed as targets or audiences. It is mainly the youth who are involved in programme planning and implementation in Malaysia, the Philippines, Sri Lanka and Thailand.

**For Advocacy**

Targets of advocacy programmes include parents, legislators and policymakers, political and religious leaders, programme managers, professionals working with youth (such as teachers, counselors and health care providers); influential individuals, sectors or organizations; sectoral groups, including those in education, health, youth, labour, NGOs and voluntary groups; decision-makers at different levels of administration and management, and the mass media.

**For IEC**

In IEC, programmes and projects are directed at youth in various settings and situations – in school, out of school, male, female, urban, rural, at work, in prison or in an estate, married, unmarried, with children, in a dangerous or difficult situation (such as street children and commercial sex workers); parents; representatives of mass media, decision-makers such as local government officials, and cultural or religious groups such as Muslims whose cultural constraints are perceived to be different from those of other groups as well as the professionals working with the youth.

Many of these programmes and projects are being carried out by government such as the Ministries of Health, Education, Labour, Social Welfare, Youth and Sports, apex bodies of population or family planning programmes, etc. or by NGOs, or by government in partnership with NGOs. In some countries, some programmes are carried out by private organizations or institutions or, in some rare cases, by universities and even by the army.

Compared to NGOs, government organizations offer fewer and more traditional services. But they have more extensive reach, cover more rural areas, enjoy longer-term support, can more easily institutionalize programmes, and have greater clout. Many of their service providers, however, are perceived to be less user-friendly than NGOs.

NGOs, on the other hand, are more innovative, more proactive and more flexible; can respond faster and more meaningfully; can cover the most vulnerable; and can offer a far wider range of services.
Government organizations and NGOs carry out a wide range of strategies and activities for their advocacy and IEC programmes related to adolescent health. Among these are:

A. For Advocacy

1. Strategies Used

A variety of strategies are employed to promote advocacy of adolescent reproductive health (ARH). In the countries covered by this booklet – Malaysia, the Philippines, Thailand, Bangladesh, Sri Lanka, Mongolia and Iran – the mix of strategies differ. Two factors appear to account for most of the differences: the innovativeness of the participating organizations or institutions, and the resources at their command.

Those which are advocacy specific include political lobbying, building alliances with other sectors, including the mass media, training of media representatives; talks and lectures, including those on radio and television; conduct of meetings and conferences, research, training of those who serve the youth as well as training of the youth themselves, development of advocacy materials; and exhibitions.

Other strategies include the conduct of research and dissemination of research findings; development, production and dissemination of materials; building of alliances; leadership training; peer training; recreational activities; and promotion of collaboration and cooperation among sectors.

2. Target Audiences

These strategies are used to reach various sectors who are regarded as the major stakeholders in adolescent programmes – legislators, policymakers, programme managers and implementors, donor representatives, school administrators and teachers, national and local officials, influential members of communities, parents and youth.

B. For IEC

1. Strategies Used

Most of the strategies employed in advocacy are used for information-education-communication (IEC) as well.

These include the traditional lectures, presentations and seminars are the most common and the easiest to implement. However, they can be with certain target audiences (particularly adolescents), the most boring and least effective. Even with adults, such strategies, if carried out in isolation and with little imagination, have very limited results.

Other strategies, however, are popular and bring immediate results. Among adolescents in countries where these strategies are employed, the standouts are peer counselors, telephone hotlines, adolescent centres and youth camps.

Peer counselors are particularly effective because the young prefer to talk with fellow youth. If such peers are trained, they can reach out to, and help, other youths.

3. Outcomes/Outputs

Among the outcomes or outputs of these strategies are policies developed, legislations enacted, advocacy materials developed, people trained on advocacy, conduct of meetings and conferences, more systematic involvement and participation of other sectors, media support, media programmes, and mobilization of the non-governmental organizations and the private sector.

Outcomes or outputs that appear to be more difficult or take longer to accomplish are the acceptance of the issue of reproductive health (RH) specially for adolescents, enactment of laws and policies, changes in audience attitude and behaviour, and acceptance or initiation of sex education programmes.
Telephone hotlines offer easy access, anonymity and confidentiality. Equally important, they provide a person at the other end of the line who is willing to listen but yet is neither threatening nor judgmental. It is perhaps for these same reasons that these hotlines attract not only adolescents but an even wider range of users as well.

As for adolescent centres, these facilities offer youth places where they can be by themselves.

And, as for youth camps, these harness the energy of adolescents, enable them to interact and compete with one another, learn life skills and have fun.

Organizations working with youth have found that the strategies that work best with these youth are those that reach them where they are (such as in malls and shopping centers), provide them access to non-threatening, nonjudgmental trained service providers; build on their interest, use modern technology (such as the Internet), and communicate with them through multimedia.

WHERE AND HOW TO REACH THE YOUTH

IEC strategies to reach the youth can be clustered under eight headings: school-based, health center-based, hospital-based, community-based, drop-in youth center, telephone hotline, mall-based youth center.

School-Based Strategies
These are carried out in coordination with the guidance programme in schools and include the integration of adolescent reproductive health issues in selected academic subjects. They also call for work with student organizations. Their targets are students and service providers, including guidance counselors, teachers and peer counselors.

Activities or outputs include lecture series, symposiums, film forums, mini-libraries, counseling, referrals, parenting sessions, and leadership and peer training programmes.

Health Center-Based Strategies
Meant for walk-in clients of adolescent clinics, these strategies provide counseling that is integrated with medical consultation. It is run by counselors and trained doctors, nurses and midwives who staff government health centers.

Hospital-Based Strategies
These are for adolescents who are walk-in or admitted patients of private hospitals. Private medical consultants and resident physicians provide counseling integrated with medical consultation.

Community-Based Strategies
Directed at both out-of-school and in-school youth, these are run by counselors and peer counselors who plan and conduct lecture series, symposiums, film forums, parenting sessions, counseling and referrals.

Drop-In Youth Centres
These are both for students and out-of-school youth. They are run by counselors who plan lecture series, film discussions, counseling, referrals, training, library services and recreation activities.

Telephone Hotlines
Aimed at the general public and adolescents, these services are staffed by professional counselors and trained volunteer counselors who provide counseling and referrals.

Mall-Based Youth Centres
Located in malls, such centers target youth aged 12 to 19 and are staffed by trained volunteer counselors and resource speakers. Their offerings may include computer-based Internet education, film showings, training in leadership and peer counseling, lectures and interactive plays.

Newsletters
These are published for adolescents and, in some cases, are youth editions of newsletters for older readers.
All of these strategies, however, require careful planning, trained staff, promotion and effective implementation. They are also more successful if the youth are represented and involved in such planning and implementation (including of materials to be developed or activities to be undertaken), and if such representation and participation are not merely token but real and meaningful.

Another requirement of such strategies, of course, is funding. For many organizations, particularly nongovernmental organizations (NGOs), funding is a problem. But some NGOs have found creative and innovative ways of solving this problem, including soliciting financial support from the private sector and from business corporations, asking for counterpart resources for projects (such as office space) from local governments, and making projects self-paying.

Other essential strategies for IEC are the conduct of research; development, production and dissemination of materials; building of alliances; and promotion of collaboration and cooperation among the health and education sectors.

2. Targets

The main target of IEC strategies include the various categories of youth – pre-school, in-school and out-of-school; male or female; urban or rural; working or not working; married or unmarried; sexually active or inactive; adolescent parents, and vulnerable and marginalized youth.

Of these, the best-covered in most of the countries are the urban, in-school youth, programme managers and the mass media. They appear to be the most accessible and most receptive. Other principal targets are parents, providers of health care, counselors, policy planners, programme managers, influential persons and organizations, and mass media.

The most-neglected categories which require urgent attention are the out-of-school, whether urban or rural; working youth; and vulnerable or marginalized youth such as street children, commercial sex workers, estate workers, and the like.

These targets are more or less defined but rarely segmented. In most cases, their needs and characteristics are not well studied, and their involvement in programme planning and implementation are more the exception than the rule.

3. Outcomes/Outputs

The principal outcomes or outputs of these strategies are informed and educated stakeholders who are favourably disposed to the issue of reproductive and sexual health for adolescents, and are supportive of programmes, projects and other efforts that spring from these issues.

Other outcomes are the development of IEC and media programmes and materials, adolescents practising safe sex, better counseling methods, teachers more equipped with knowledge and skills in teaching on reproductive health, support from parents and community as well as the mass media, personnel trained, and more systematic intersectoral involvement and participation.
ANALYSIS OF IEC AND ADVOCACY STRATEGIES USED

Of the various IEC strategies employed, the following stand out and have been most successful because they are suitable, participatory, youth-oriented and appropriate to their targets:

**Youth Camps**

Organized in Malaysia, the Philippines and Thailand, these attract adolescents because they provide a venue where young people can be with friends and be free to express themselves. These camps have been used most effectively to impart knowledge of reproductive and sexual health. Activities at camp may include role-playing, case discussions and quizzes that are non-threatening and actually promote learning. Camps can also be organized for special groups like handicapped adolescents who likewise need training and information on reproductive health.

**Teaching of Life and Life Planning Skills**

Done in Bangladesh, Malaysia and the Philippines, these rate highly among adolescents because these enable them to examine their values, provide them correct information on adolescent health and sexuality problems, improve their communication skills, and help in goal-setting and decision-making.

In Bangladesh, for example, most NGO programmes for adolescents provide adolescent family life education (AFLE) for both in-school and out-of-school youth. The curriculum for the AFLE course covers all the main interests of adolescents and includes the following reproductive health-related components: awareness-building, adolescent life/future life, health and hygiene, preparation for safe motherhood, avoiding abuse of adolescents, avoiding early marriage, and population planning. AFLE has attracted wide attention because girls who have gone through it are more knowledgeable and vocal about maternal and child health and gender issues than girls who have not. The way it is taught, however, has one weakness: it is lecture-oriented and not very participatory.

In the Philippines, the Foundation for Adolescent Development (FAD), an NGO, makes life planning education more interesting and useful to high school dropouts in urban poor communities by combining it with vocational skills training. Skills offered include computer technology, automotive mechanics, installation of building wiring, hotel and restaurant services, radio electronics, refrigeration and air conditioning, dressmaking and cooking. The project is supported by big private companies.

**Hotlines**

Set up in Bangladesh, Malaysia, the Philippines and Thailand, these provide immediate, anonymous, non-threatening, nonjudgmental and professional assistance to adolescents. Aside from the telephone, other means of communication can also serve as hotlines, such as the mail and mobile units, as is done in Bangladesh. Hotlines, however, attract not only adolescents but also the general public.

One such telephone hotline service in Thailand was set up by the Programme for Appropriate Technology in Health (PATH). It uses students from the Prince of Songkla University as volunteer counselors because
adolescents appear to have more respect for advice from these university students than those that come from their peers.

These counselors go through three days of training on the physical and emotional changes which occur during adolescence, differences in the thought processes of young men and young women; outcomes and consequences of pregnancy, STDs and HIV/AIDS; and communication skills.

Teen or Youth Centres

Set up in Malaysia, the Philippines and Thailand, these meet a need among youth for a place where they can simply hang out. Many of these centres are designed to provide adolescent-friendly programmes, give factual information on reproductive and sexual health, increase these adolescents' receptiveness to counseling and other reproductive health services, offer them a venue for harnessing their creativity without subjecting them to coercion or discrimination, provide a place for training responsible youth leaders to become peer facilitators or counselors, develop adult role models for youth, strengthen individual and group values against risky behaviour, promote responsible sexual behaviour to prevent unplanned pregnancy and delay sexual activities, and help the youth to express and understand their feelings so they can make responsible decisions later in life.

Examples are the Multi-Service Youth Centres established by the Philippine Center for Population and Development for 15-24 age group with goals of providing information, counseling and referral services on adolescent health and development, human sexuality, life planning education, parent-child/boy-girl/peer relationships within the context of a “drop-in, stand-alone, multi-service youth centre facility”.

Education and Counseling Programmes

The better-known forms of these are peer education and peer counseling. In Bangladesh, for example, at least three NGOs with varied objectives offer peer and individual counseling: Breaking the Silence seeks to build awareness of child abuse and adolescent drug abuse; Marie Stopes Clinic Centre promotes family planning, prevention of STD/AIDS, safe abortion and male participation in family planning activities; and the Family Planning Association of Bangladesh (FPAB) promotes family planning and prevention of STD/AIDS, and provides AFLE and capacity building.

In Malaysia, the AIDS unit of the Disease Control Division launched a programme to train a cadre of youths knowledgeable in HIV/AIDS and, through these youths, to educate others in the country. The programme is known as PROSTAR – “Program Sihat Tanpa AIDS untuk Remaja” (Healthy Adolescents Without AIDS). It is aimed at adolescents aged 13 to 25 and covers secondary school children, those attending college and university, young people involved in the “Rakan Muda” (Young Friends or Partners) programme of the Ministry of Youth and Sports, members of organizations like the Red Crescent, Scouts and Girl Guides, St. Johns Ambulance, and youth in factories.

Programmes for School Counselors

Also in Malaysia, an initiative taken recently by the Malaysian AIDS Council to train school counselors in HIV/AIDS was met with great enthusiasm by the counselors who expressed the need to be equipped with such knowledge. Such training included adolescent sexual health issues.

Youth Club-Related Programmes

One such programme carried out in Bangladesh between 1995 and 1997 sought to involve the youth in population and family welfare activities through the youth club. It was carried out by the Directorate of Youth Development under the Ministry of Youth and Sports. Another programme begun five years ago by the Family Planning Association of Bangladesh and still running, seeks to promote RH, sex education and personal hygiene among youths aged nine to 19 through group discussions, seminars and voluntary agencies in population.
Participation of Youth in Programme Planning and Decision-Making

Programmes that are planned with the meaningful participation of the youth have a better chance of succeeding. In Malaysia, for example, the Penang Family Planning Association has included a representative of the youth in its executive committee to involve this sector in the association’s decision-making.

In early 1999, the Federation of Family Planning Associations of Malaysia (FFPAM) initiated the establishment of the Malaysian Steering Committee to assess the extent to which the ICPD Plan of Action has been achieved. It included in the committee two youth members – one representing the Federation and the other, the Malaysian AIDS Council. The committee continues to be the focal point for NGOs for initiating, implementing and monitoring the ICPD Plan of Action, including those portions on reproductive and sexual health of adolescents.

Strategies and activities, which are often comfortably about emotion-laden sexual issues in a language the audience can understand. Because speakers are afraid of reactions from conservative members of the audience, they often merely raise awareness and convey facts during their talk.

Other strategies are notable for their innovativeness. Examples:

Setting up of Integrated Model of Delivering Information, Counseling and Contraceptive Services in Places Where Adolescents Can Be Reached

In the Philippines, a government-run maternity hospital called Fabella Hospital adopted a nearby elementary school to provide reproductive health assessment as part of its annual physical examination of pre-pubertal pupils (grades 4-6, 9-12 years old).

The Confidential Approach to AIDS Prevention (CAAP) in Bangladesh is another good example. A centre runs this on HIV/AIDS information, counseling and action research. It was set up to establish confidential channels of information dissemination and education on HIV/AIDS prevention, provide short-term crisis or situation counseling, provide referral for anonymous blood testing, and supplement government efforts to combat HIV/AIDS.

The center is open from 9 a.m. to 5 p.m. Sunday to Thursday to receive calls through its hotline from anywhere in the country. Its mobile team disseminates preventive education messages and provides counseling to communities, slum dwellers, students, garment factory workers, organizations and institutions, and those who cannot establish contact through post or the telephone. The center itself can provide in-house counseling, education or information, group presentations, face-to-face communications and slide presentations.

Sharing of Skills, Knowledge and Expertise

Also in Bangladesh, NGOs, the private sector and government institutions set up the
South-South Center to facilitate and coordinate in-country and intercountry sharing of skills, knowledge, expertise, lessons from experience, success stories, and innovative approaches to reproductive health, family planning, adolescent reproductive health, STD-HIV/AIDS, maternal health and morbidity, and gender and development.

**Use of Information Technology**

In Malaysia, the Federation of Family Planning Associations of Malaysia (FFPAM) organized a workshop on the development of a youth website or home page which eventually could contain information on reproductive and sexual health. Participants agreed to set up a special chat room (where “free speech” is allowed) where they can discuss matters of interest to them, including reproductive and sexual health. Although its results have yet to be seen, this is one programme in which the youth got together to design a sex education programme for themselves. The youth are very interested in this, so it should be harnessed in the effort to reach out to them.

**Promoting Emergency Contraception**

In Thailand, the Bangkok office of the Population Council, an NGO, has initiated an activity to make emergency contraception known and available in Thailand. This is mainly an advocacy activity, aimed at the mass media and policy planners. Ultimately, it aims to make emergency contraception available over the counters of drugstores, together with accurate and up-to-date information and advice that the method should only be used in emergency situations.

The method makes use of high-dose hormonal preparations after intercourse to keep a pregnancy from taking place. It is believed that the method is already widely used, but there is almost complete absence of public information about how to use it. A committee in the country’s Food and Drug Administration has opposed publicity about the method because it could encourage adolescents to engage in sexual experimentation.

**Adopting Available IEC Materials**

Instead of re-inventing the wheel and duplicating existing successful IEC materials, resulting in unnecessary wastage of funds, such IEC materials which had become a hit could instead be reprinted by those other organizations. In Thailand for example, under the USAID/AIDSCAP Service Worker Outreach Project, a pair of booklets entitled “The Male Formula for Love” and “Women Do Know How to Love” were found very effective and had been reprinted ten times by various other organizations and provincial health offices. In Sri Lanka, the culture, customs and tradition do not allow free and open talk about sexuality and reproductive health discussion of sexuality. These issues are opposed by political and religious leaders, and teachers and parents themselves.

In Sri Lanka, the culture, customs and tradition do not allow free and open discussion of sexuality.

In Mongolia, parents traditionally do not talk about sexuality and reproductive health issues with their children. These issues are
not included in formal education programmes, either. Parents themselves have limited knowledge of these issues because conversation between young and old is discouraged or even not allowed.

In Malaysia parents, lawmakers and politicians tread with caution on the issue of sex. Some mistakenly equate reproductive and sexual health of adolescents with sex education. Giving adolescents sex education, they say, is tantamount to giving them approval to engage in premarital sex.

In early 1999, for example, the Malaysian Minister of National Unity and National Development, prompted by the discovery of “social ills” affecting the country’s adolescents, announced that 60 schools around the federal capital would be taking part in a pilot project to teach sex education. The announcement, however, was denied by the Minister of Education who said at the time that there were no such plans. Parent-teacher associations also objected to the idea.

In September 1999 the same Minister announced that the Cabinet Committee on Social Ills had agreed to include reproductive health education in co-curriculum activities and that her ministry was working on a teaching module to be submitted to the committee for approval. Since her announcement was reported in the press, the Ministry of Education has not commented on it.

Despite media campaigns in the recent past, advocacy of adolescent reproductive and sexual health information in Malaysia has not been very successful. As Dr. S.P. Choong, former chair of FPPAM put it, politicians “who often duck the problem involving human sexuality often give the excuse that the people are not quite ready. But if leaders are not ready to face these issues, when will the people be?”

In Thailand sex education is generally not provided by parents. Cultural norms forbid communication about sex between parents and children.

In Iran both Islam and Iranian society emphasize family formation and restrict sexual activity to married couples. Premarital sex and reproduction among adolescents, particularly unmarried young girls, is strictly censured and severely punished.

In the Philippines there are problems in the teaching of population education: it is not taught as a separate subject but is merely integrated into other subjects. It is left to the teacher when and where to integrate POPED. The programme also takes only 2% of the total 220 school days, materials are not specific enough on what topics to discuss and what materials to use, reading materials about the core areas leave much to the teacher’s interpretation, and Catholic schools that are opposed to teaching sex education and family planning would focus on other topics that are not contrary to their values. In fact, the terms “sex education” and “family planning” are anathema to these schools.

In Bangladesh any proposal to introduce sex education or ARH education will face resistance and even active opposition from community leaders. School teachers, parents and even the students themselves will cite violations of their customs, tradition and religion.
Some strategies and activities are known for their appropriateness to their target audiences or “clients.” These include:

**Youth Counseling Centres**

In Thailand, the Planned Parenthood Association of Thailand (PPAT) provides services and information to both and female adolescents on adolescent health, sex education and HIV/AIDS. It provides these through its youth counseling centres in Bangkok, Chiang Mai, Khon Kaen and Songkhla. Its activities are aimed at adolescents in school (secondary, vocational and university levels), those out of school, in densely populated areas, in prisons and in urban areas.

**Women Organizations**

In Thailand also, the Foundation for Women (FFW), a long-established NGO, provides information and support to women, promotes their rights particularly in negotiations with government, and conducts research on issues that concern women, with the participation of women most directly affected. Adolescents make up 71 per cent of its clients. These include victims of rape, unintended pregnancy, premarital pregnancy, and lack of male responsibility for the consequences of sexual relationships. They receive counseling as well as referral services.

**Radio and Television**

In Thailand, the Population Council uses radio and television through Talk Shows to place the reproductive and sexual health issues in the public arena after finding out that the most preferred medium by teenagers is the television talk shows. Studies done by university students in Malaysia show that these media are the most important sources of knowledge on HIV/AIDS among Malaysian adolescents.

They are used to air commercials, drama programmes, counseling programmes and public affairs programmes where ARH advocates can serve or appear as resource persons.

But these media have their limitations. In Malaysia itself, the government is very cautious about the programmes aired over the electronic media. Programmes on alcohol abuse, drugs, child health care, reproductive and sexual health and adolescents are shown on TV and published in newspapers, imparting moral values on the consequences of premarital sex and lack of adherence to religious teachings. But they do not deal directly with sexuality issues faced by adolescents.

TV stations have special programmes for adolescents but these do not deal exclusively with reproductive and sexual health, either. Rather, speakers are invited from time to time to speak on issues affecting the young, such as dating and premarital sex. But the effectiveness of these programmes is blunted because speakers are cautioned about what they may or may not say over the air, including words they may not mention. They are also reminded that family planning should be for married couples only.

**Parents/Teachers Association**

Having sex education in schools in Iran is impossible. Only parents and fellow members of the family may provide such education. Messages on reproductive and sexual health, therefore, are communicated to parents by the Parents/Teachers Association (PTA) which collaborates closely with the Ministry of Education, interacts with parents all over the country and, through these parents, with students at different levels of education.

Main channels for communicating with these parents are the journal and books published by the Association, including one on the sexual problems of children and an educational analysis of the relationship between boys and girls in Iran.
The country studies showed various strategies used in order to reach other types of clientele not normally reached through the normal channels.

In Thailand, the Foundation for Women, in addition to targeting adolescents from squatter settlements and street children, is now embarking on a new project called Building Rural Network on Human Rights, with focus on young people in rural villages and their responsibilities to protect their friends from reproductive health risk through the provision of information on this topic to young people.

In the Philippines, the adolescents working in factories are reached through their workplace under the programme, “Information and Counseling Program on Sexuality for the Young at the Export Processing Zone where peer counselors and company health staff are given training who later on become the service providers as well. The same strategy is being carried out in Sri Lanka through the Labour Department where orientation programmes of “big sisters” attached to industries, worker leaders, supervisors and female workers are being provided.

NGOs in a few countries, like Bangladesh, have developed strategies and activities to reach marginalized groups. These include the setting up of satellite clinics for adolescents, done by the Organization of Mothers and Infants (OMI); the holding of periodic health clinics at garment factories, done by Nari Maitre, a women’s organization; holding of a special clinic hour, done by the Concerned Women for Family Planning (CWFP) at a project site in Chittagong; and the setting up of separate health clinics for adolescents, done by Marie Stopes Clinic Society.

In Mongolia, services for adolescents began to be provided in 1997 through the “adolescent gynecology cabinets.” Set up by the Ministry of Health and Social Welfare, these cabinets have as their main task to monitor the physical and sexual development of young women. Doctors who run these cabinets conduct outreach services in secondary schools, where they hold classes in sex education. Services are provided as well by the Adolescent Hospital which is run by Marie Stopes.

In the Philippines, the Foundation for Adolescent Development (FAD) runs centres for urban poor and community-based youth. Known as Teen Health Quarters, these centres offer a wide range of services, including personal hygiene, skin care, pregnancy test, self-breast examination, consultation on menstruation, counseling on HIV/AIDS, referrals, consultation on painful urination, diagnosis of STDs, consultation on cases of drug abuse, Pap smear, family planning counseling, immunization, pre and postnatal care, circumcision, blood pressure checkup and monitoring, and even nebulization, ear piercing and blood typing.
A number of other advocacy and IEC strategies and activities are employed by countries. These include:

**Exhibitions**

By themselves, these can only create awareness. But they can attract audience attention if accompanied by other programmes, such as the distribution of printed materials, stage shows and quizzes to impart knowledge, hosted by celebrities who are popular with the young.

**Printed Materials**

These include posters, promotional materials, bulletins, brochures, resource books, training modules, flyers, primers, leaflets, bookmarks, booklets and comic magazines. In general, printed materials produced by NGOs tend to give adolescents more focus than those produced by government departments which turn out mainly factual pamphlets, leaflets and posters.

**Video Materials**

In Malaysia, for example, FPPAM has produced a videotape titled “One Unintended Moment. A Thousand Miseries.” This can be used as a starter for a discussion on teenage pregnancy. The Federation will distribute it to its affiliates involved in reproductive and sexual health of adolescents. In the Philippines, the Foundation for Adolescent Development and the PCPD produced several video films tackling issues on youth sexuality and an MTV style song rendered by a well-known singer in the country.

**Research**

Some organizations, such as Bangladesh’s International Centre for Diarrhoeal Disease Research and its Voluntary Health Services Society, conduct research on adolescent reproductive health. The first did an assessment of the reproductive health needs of adolescents in the country; the second, an assessment of the Adolescent Family Life Education programme in Bangladesh.

**Folk Media**

From the experience of ARH advocates in Sri Lanka, folk literature, folk songs and other folk media such as the drama and street play are specially effective in reaching less-educated and high-risk audiences.

**Print Media Material**

These include press releases, news stories, feature stories and reprinting of news clippings.

**Special Media**

These include T-shirts, caps, streamers, billboards, theater and contests.
COORDINATION

Most ARH programmes in most countries are largely uncoordinated although programmes of government agencies appear to be less so. NGOs usually form a loose network but cooperate on issues which cannot be handled by only one organization. One such issue is sex education.

A notable exception is Sri Lanka. There, government agencies and NGOs with ARH programmes coordinate their efforts and resources so they are able to make the best use of their strengths and resources. The government sectors which are important to RH – health, education, social services and labour – are effectively networked and share material, expertise and resources. All of them also contribute to improving the efficiency of RH interventions. Result: administrative delays and red tape have been minimized because representatives of these sectors working in the field are now directly linked.

In Mongolia, programmes in the formal education sector are being coordinated and monitored by the Ministry of Health and Social Welfare, Ministry of Enlightenment and other related organizations. In the nonformal education sector, NGOs provide assistance and collaboration.

Efforts, however, continue to be made in the other countries to forge some cooperation with one another. Some have gotten together to share learning from experience. But if their efforts at cooperation are limited to this, their overall impact will continue to be diffused and minimal.
Following are the outputs or products of advocacy programmes and examples of such outputs or products from specific countries:

### Outputs of Advocacy Programmes

1. Acceptance of the need for attention to adolescent reproductive health
2. Formulation of policies
3. Passage of laws
4. Development and dissemination of advocacy materials
5. Training of Personnel
6. Conduct of meetings and conferences
7. Winning over more sectors
8. Winning of media support
9. Changes in audience attitudes and behavior

### Acceptance of the Need for Attention to Adolescent Reproductive Health

In Malaysia, advocates of ARH found that politicians were forced to face the facts after the results of two studies were published. One, on Malaysian students and youth “loafing” in streets and shopping complexes instead of being in school, and the other, on ARH in the country, led to the establishment of special Cabinet committees to look into social problems, including adolescent health, and forced relevant ministries to plan and carry out special programmes to address the problems.

The study on loafing was initiated and sponsored by Malaysia’s Ministry of Youth and Sports and carried out by local universities. A major finding of the study was, the problem stemmed from limited and poor quality time that parents spent with their children at home. The study warned that if nothing were done, adolescents would be exposed to dangers to health arising from high-risk behavior.

In Iran, Islam’s emphasis on early marriage and the country’s large number of adolescent couples required that both their families and the health system pay serious attention to their reproductive health needs. For this reason, the country’s Family Health Department officially announced that its main goal is to promote the physical, mental and social well being of youths aged 10-19 in the urban and rural areas.

Its specific objectives are to improve the knowledge and behaviour of adolescents, parents, teachers and health personnel towards sexuality and puberty and the potential consequences of these on the mind and behaviour; promote healthy behaviour among youth entering puberty, promote a healthy lifestyle not only among adolescents but also among their parents and teachers, increase adolescents’ knowledge of reproductive health and family planning,
promote general knowledge about sexually transmitted diseases and prevailing health problems among the youth, and carry out advocacy programmes among decision-makers about adolescence, reproductive health and the unique needs of this age group.

In Mongolia, the government approved in June 1977 the first-ever Adolescents’ Reproductive Health Programme. Its priority activities included a study of the sexual behavior of adolescents, development of an appropriate school-based sex education programme, and extension of family planning programmes to rural areas.

In Sri Lanka, members of Parliament expressed willingness to support RH programmes in their constituencies and came up with suggestions to overcome health problems in their areas.

As early as 1993, the Malaysian government identified adolescent health as an area of concern. A year later, the Ministry of Health outlined several strategies and activities to provide health care for adolescents. In 1995 it came out with a plan of action to actually carry out these activities under its adolescents health programme. These activities include participation in the study done by the National Family Planning and Development Board on reproductive and sexual health among adolescents, production of modules covering adolescent health, training of health personnel who would provide adolescent health services, and pilot projects on peer education and information through “youth club” activities.

In 1998, an Adolescent Health Policy was drawn up with the participation of various government and nongovernmental organizations involved in adolescent health. This policy is waiting to be launched.

In Sri Lanka, a number of new laws have been enacted and existing laws have been amended to address new and emerging adolescent problems and issues. These include laws pertaining to child rights, punishment for rape, defilement of girls aged between 12 and 14, and acts of gross indecency between males.

TV and radio spots, talk shows

In Bangladesh, TV spots and talk shows to raise awareness of RH issues have been developed and broadcast in the country for the first time. The spots include one on underage brides and another on the hazards of early marriage. One TV talk show, titled “Problems of Adolescents and Youths in Bangladesh,” introduces sex education to adolescents and young adults. The show has five episodes: the first on growing up, the second on “Eve-teasing,” the third on gender discrimination, the fourth on boy-girl relationships, and the fifth on drug abuse.

In Mongolia, radio and TV spots and programmes related to youth as well as local
journal and newspaper articles focusing on the youth are being developed with the assistance of the Margaret Sanger Centre International.

In Sri Lanka, the following have been produced: a TV spot on unwanted pregnancies, a teledrama on abortion and safe pregnancy, and a pamphlet on preparation for marriage.

**Film for television**

Still another product for television in Bangladesh is a short film titled “Life at Nayanjuli,” with messages on the consequences of early marriage, early pregnancy, proper care of the reproductive organs, and role of parents and the elderly. The film is a good resource material for training.

**Training manual**

In Malaysia in the mid-seventies, the Federation of Family Planning Associations of Malaysia (FFPAM) initiated a programme for the training of trainers in Family Life Education and produced a Family Life Education Manual to facilitate educational programmes for both in-school and out-of-school youth and for youths who worked in factories. This manual is updated continuously and now has sections on HIV/AIDS.

**Pamphlets and leaflets**

In Malaysia also, FFPAM has produced a series of specially designed Family Life Education pamphlets, leaflets and comic magazines on adolescent reproductive and sexual health. These cover physical and psychosocial changes in adolescents, sexual rights, gender, masturbation, and relationship with parents and peers.

Two booklets – “The Best Years of Your Life” and its sequel, “The Best Years of Your Life and More” – are very well received. Covering life skills, they use simple language and a lot of illustrations. They are published in English and Bahasa Malaysia.

**Publication for adolescents**

The Malaysian AIDS Council also produces leaflets and posters on HIV but devotes one special publication, named *Vital*, to adolescents. The publication’s format, contents and language are tailored to young people. It even contains questions adolescents want answered, but dare not ask. And, because Malaysia is a multiracial society, *Vital* is published in all the major languages in the country.

**Video drama**

In Bangladesh, a video drama covering all the RH components and women’s rights has been developed. Titled “Right for Better Living,” it was conceived by the Bangladesh Centre for Communication Programmes (BCCP).

**Folk songs**

Since these are an important and appropriate medium for reaching people particularly in the rural areas, some NGOs in Bangladesh, notably the Family Planning Association of Bangladesh and BCCP, have produced folk songs on audio.

**Materials for teachers and trainers**

In Mongolia, handouts and textbooks to help teachers and trainers in adolescent family life were published by the Mongolian Family Welfare Association, the Mongolian Open Society Foundation and the Ministry of Health and Social Welfare. The effectiveness of these materials, however, have yet to be evaluated.

Radio and TV spots and programmes related to youth as well as local journal and newspaper articles focusing on the youth are being developed with the assistance of the Margaret Sanger Centre International.
Sri Lanka

In Sri Lanka, a project advocating male participation in RH for gender equity was conducted among soldiers in the Sri Lanka Army. Thirty high-ranking officers went through an orientation seminar and about 100,000 soldiers were addressed through the project.

The project’s other achievements: production of a training manual that was sent to training centres for integration in courses; production by the army on its own of a leaflet on RH for soldiers; conduct of a workshop on male participation in RH for instructors who will train new soldiers on RH issues, including prevention of STD/AIDS; and provision by medical units of face-to-face education and leaflets on STD/AIDS to soldiers on home leave from the war zone.

In the same country, another project has trained 26 teachers to function as counselors to adolescents in their own schools. Yet another project has trained 100 youth leaders in youth clubs on RH and sexuality.

Mongolia

In Mongolia, activities in the nonformal education sector include the training of parents and adolescents through radio and television; development of syllabus, lessons and books for parents; conduct of nonformal and distance training for adolescents who are unemployed, not studying and living in a difficult situation (such as street children and as commercial sex workers), conduct of workshops and surveys on sexual life and sex education, and production of advocacy material like pamphlets, posters and leaflets.

Malaysia

In Malaysia, the AIDS Unit of the government’s Disease Control Division launched a programme to train a cadre of youths knowledgeable in HIV/AIDS and, through these youths, to educate other youths in the country. The programme is known as PROSTAR – “Program Sihat Tanpa AIDS untuk Remaja” (Healthy Adolescents Without AIDS). It is aimed at adolescents aged 13 to 25 and covers secondary school children, those attending college and university, young people involved in the “Rakan Muda” (Young Friends or Partners) programme of the Ministry of Youth and Sports, and members of organizations like the Red Crescent, Scouts and Girl Guides, St. Johns Ambulance, and youth in factories.

Still in Malaysia, the Malaysian AIDS Council took the initiative recently to train school counselors in HIV/AIDS. The effort was met with great enthusiasm by the counselors who expressed the need to be equipped with such knowledge. Such training included adolescent sexual health issues.

Philippines

In the Philippines, the Manila Center for Young Adults operated by the Foundation for Adolescent Development (FAD) trains school-based peer counselors, serves as a resource for universities for school symposiums on teen issues, provides library service in adolescent health and sexuality, provides a practicum site for students of psychology and social work, and serves as a resource center for HIV/AIDS education and prevention.

Bangladesh

Since parents or adults in Bangladesh find it difficult to teach adolescents about sexuality, NGOs there have found other ways to meet this need. These include the adolescent family life education programme (AFLE) developed and introduced in 1997 by the Bangladesh Rural Advancement Committee (BRAC) for adolescents in secondary and nonformal primary school, and out of school (the Kishoree Pathagar system).
Issues taken up with students in the nonformal primary schools are basic health, hygiene and nutrition (which includes personal hygiene, environment, water and sanitation, intestinal parasites and goitre, infectious disease and food and nutrition) and reproductive health (which includes reproductive health and menstruation, marriage and pregnancy, RTI/STD, and family planning).

Issues discussed in secondary school are food and nutrition of adolescents, expanded programme of immunization and growth monitoring, helminthiasis and goitre, reproductive health and menstruation, marriage and pregnancy, RTI/STD, and family planning.

**Mongolia**

The Margaret Sanger Centre International is helping to ensure that clinic services in the country are “youth responsive” through health staff that are trained to counsel and care for both male and female adolescents in need of reproductive health advice, contraception and treatment of sexually transmitted infections.

**Bangladesh**

In October 1998, Bangladesh’s Ministry of Health and Family Welfare and the Operations Research Project of the International Centre for Diarrhoeal Disease Research (OPR – ICDDR,B) jointly organized the first stock-taking workshop on adolescent health activities in the country. In that workshop, key issues related to the design of the government’s future programme for the reproductive health of adolescents in schools and communities were discussed, along with important lessons from the experience of NGOs conducting initiatives for adolescents.

**Malaysia**

In 1997, the Federation of Family Planning Associations of Malaysia (FFPAM) held a seminar on “Challenges and Future Directions in Reproductive Health for the 21st Century.” That seminar called on the Federation to take the lead in advocating that (1) sexuality education be introduced systematically and effectively in schools and in the curriculum of all organizations for the youth, (2) education up to Form Five (end of high school) be made available to all unwed mothers, (3) youth clinics be set up as part of government health services or get NGOs to do this with financial support from government, (4) young people be provided appropriate sexual and reproductive and sexual health services, and adequate publicity be generated to keep young people informed, (5) premarital courses be provided to all soon-to-be-wed couples and (6) parenting courses be made available.

These recommendations have been made part of the three-year plan of the Federation and its 13 member associations. The Federation has been involved in adolescent reproductive and sexual health since the early seventies when migration from the rural to the urban areas led to a host of social problems in the area of boy-girl relationships as well as drugs. State family planning associations set up youth centres to ensure that the youth had a place of their own to go to for their activities. They avoided being seen at family planning clinics lest they be mistaken to be there for contraceptive services.

**Mongolia**

To focus attention on the issues of adolescent reproductive health, sex education, sexual and reproductive rights and gender and family, six “One World” conferences have been called since 1998 by the Mongolian Women’s Social Progressive Movement.
For the last three years, an action group in Bangladesh that calls itself Breaking the Silence have been working to create awareness among people at all levels of society against sexual abuse and torture of children. Their targets include legislators, decision-makers and programme managers.

In Malaysia, 32 NGOs involved in HIV/AIDS education and in care and support for people living with HIV/AIDS have formed an umbrella organization known as the Malaysian Aids Council. It has been advocating that sex education be made available to all adolescents as part of the effort to arrest the HIV/AIDS epidemic. Since its formation in 1992, it has been making funds available to affiliates for educational programmes. Youth organizations in the same country such as the Red Crescent, the Girl Guides and Scouts and St. John’s Ambulance and adult groups like the Soroptomist International and religious organizations also run educational programmes on HIV/AIDS prevention.

In Mongolia, several specialized agencies of the United Nations and local and international government and nongovernmental organizations have also planned their programmes and project activities so that these would support the country’s IEC programmes on adolescent reproductive health. These include educational approaches (such as peer counseling and parent-adolescent education) that combine use of mass media with more one-to-one and group learning in settings in school or out-of-school; and getting clinical staff of the Ministry of Health and Social Welfare to provide a more user-friendly environment that will make contraceptive services more accessible to young men and women.

Mongolian NGOs which have done various kinds of training, advocacy and surveys on adolescent reproductive and sexual health include the Mongolian Family Welfare Association, Scout Association of Mongolia, Adolescent Future Centre, National Centre against Violence, Women’s Movement for Social Progress, Good Neighbor Association, Family Planning Association, and the National Centre for Children.

Malaysia

ARH advocates in Malaysia have won and kept the support of the mass media by sensitizing their representatives, providing training, and keeping them informed of developments through materials and briefings.

Such support has had significant benefits. For example, after stories appeared in the mass media about unwed teenage pregnancies, newborn babies being left outside mosques and in bus stops, and loitering of teenage groups in shopping complexes when they should be in school, government authorities were moved to formulate needed policies.

Sri Lanka

After going through orientation seminars and receiving press kits on RH, representatives of mass media have allotted more time and space to messages on population and RH issues. Even the Sri Lanka Broadcasting Corporation has started a series of sex education programmes for the youth and panel discussions where specialists answer questions from listeners.

Thailand

For the Population Council’s effort to make emergency contraception known and available, advocacy has so far included a
In Bangladesh, the women's organization Nari Maitree reported that adolescent girls who have completed its programme on adolescent family life education (AFLE) have become more aware of their health, reproductive rights and human rights; now talk more openly and freely about health and other issues with doctors, organizers and even their own mothers; and have developed a sense of responsibility.

In 1992 in the same country, the ICDDR, B completed a two-year project which provided training to women and adolescent girls in interpersonal skills, basic literacy, legal awareness and basic knowledge in reproductive health. A reproductive health curriculum was developed specially for the project.

In the Philippines, the impact of the country's population education programme is not easy to determine because indicators in terms of changes in behavior cannot be immediately measured. Changes in premarital sex behavior, early pregnancy and decline in fertility cannot be directly attributed to it. But a study (Young Adults Fertility Survey-II) showed that there is a significant inverse relationship between population education and premarital sex.
Bangladesh

Iran

Malaysia
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Mongolia

Philippines

Sri Lanka

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