Communication and advocacy strategies
adolescent reproductive and sexual health

Case Study
Islamic Republic of Iran

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Shadpour, K.  
19 p. (Communication and advocacy strategies: adolescent reproductive and sexual health; series two)


613.951

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Published by the
UNESCO Principal Regional Office for Asia and the Pacific
P.O. Box 967, Prakanong Post Office
Bangkok 10110, Thailand

Printed in Thailand
under UNFPA Project RAS/96/P02

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## CONTENTS

**PREFACE**  

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**DEMOGRAPHIC CHARACTERISTICS OF ADOLESCENTS**

- Population composition of adolescents  
- Age at marriage  
- Educational level  
- Health and nutrition  
- Fertility, teen pregnancy and abortion  
- STDs/HIV/AIDS  
- Practice of contraception and family planning  
- Knowledge, attitude and behaviour on sexuality and reproductive health

---

**PROGRAMME RESPONSES TO ADOLESCENT REPRODUCTIVE HEALTH PROBLEMS**

- Government programmes  
- NGO programmes

---

**ADVOCACY AND IEC STRATEGIES USED TO PROMOTE ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH MESSAGES**

- Advocacy strategies  
- Information, Education and Communication (IEC) strategies

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**LESSONS LEARNED**

- Success/failure factors for advocacy strategies  
- Success/failure factors for IEC strategies  
- Overall listing of lessons learned
<table>
<thead>
<tr>
<th>CONTENTS (continued)</th>
</tr>
</thead>
</table>

GUIDELINES FOR FORMULATING AND IMPLEMENTING ADVOCACY AND IEC PROGRAMMES ON ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

17

Guidelines for advocacy programmes ......................... 17
Guidelines for IEC programmes ............................... 17

REFERENCES ......................................................... 18
Appendix: Directory of Organisations ......................... 19
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 generate 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 and Communication 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.

This volume presents the experiences of Iran in planning and implementing the advocacy and IEC strategies for promoting adolescent reproductive and sexual health programmes. It was compiled by Kamel Shadpour, M.D. MPH, Senior Health Expert from the Ministry of Health and Medical Education.
A. POPULATION COMPOSITION OF ADOLESCENTS

Immediately after the Islamic Revolution of February 1979, early marriage and bearing more offspring were announced to be valued as social assets by the new Islamic government. This resulted in very high fertility rates and a drastic increase in population growth. The outcome of this baby boom in the early 1980s has now become the country’s major social concern with repercussions in education, employment, housing and many other fields.

The proportion of adolescents (ages 10-19) to the total population was 27% in 1996, 23.4% in 1976, and 22.4% in 1986 (Table 1).

Table 1. Change in the Adolescent (ages 10-19) Population Composition of Iran (1976 to 1996)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rural</th>
<th>Urban</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>1976</td>
<td>3,917,242</td>
<td>21.9</td>
<td>3,986,141</td>
</tr>
<tr>
<td>1986</td>
<td>5,370,324</td>
<td>23.8</td>
<td>525,178</td>
</tr>
<tr>
<td>1996</td>
<td>364,583</td>
<td>27.4</td>
<td>9,831,640</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran; National Census of Population and Housing, National Data, 1976 to 1996.

The results of the last national census conducted in 1996 showed that the population aged 10 to 19 had increased by 46% from 1986 and nearly 105% from 1976. The overall population growth rates from 1986 to 1996 and 1976 to 1986 were 21.5% and 78%, respectively. At the same time, the urban adolescent population had increased by 72% and 147%, respectively. The corresponding increase rates for rural adolescents were 18.5% and 62.5%. The rural-urban adolescents’ ratio shrunk from 0.98 in 1976 to 0.65 in 1996. All these reflected the population migration from rural to urban areas.

Although growth rates of adolescents were different in urban and rural areas, the overall age distribution has remained constant over time. This indicates that migration trend in the last two decades has been in the form of whole families moving to the urban centres rather than adults who were merely seeking jobs.

The projected population size of adolescents shows that they will eventually decrease in number and percentage by the year 2020 (Table 2).
Table 3. Mean Age at First Marriage in Iran (1956 to 1996)

<table>
<thead>
<tr>
<th>Year</th>
<th>Age at first marriage (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
</tr>
<tr>
<td>1956</td>
<td>24.4</td>
</tr>
<tr>
<td>1966</td>
<td>22.6</td>
</tr>
<tr>
<td>1976</td>
<td>22.6</td>
</tr>
<tr>
<td>1986</td>
<td>24.5</td>
</tr>
</tbody>
</table>


B. AGE AT MARRIAGE

Early marriage and universal conjugal unity have continued to be emphasised and promoted as fundamental Islamic values. Despite these efforts, there is sufficient evidence on a marked rise in age at first marriage particularly in recent years.

The average age at marriage in females rose from 19.8 in 1986 to 22.4 in 1996 and in males, from 23.6 to 25.6 during the same period (Table 3). This rise is equally observed in rural and urban areas. Socio-economic development and an increase in literacy and educational attainment have played an important role in the postponement of marriage, especially among females. Parents are encouraging their daughters to continue secondary school and higher education levels.

Traditional Islamic jurisprudence (Sharia) and the Civil Code, adopted by the government, favour and encourage early marriage as a social value. But in recent years, the Civil Code raised the minimum age for legal marriage to 15 and 18 for girls and boys, respectively.

In 1996, the rate of married adolescents (4.9%) was significantly lower compared with 9.8% in 1986 (Table 4). The decrease in proportion of married adolescents applied similarly to males and females and reflected the postponement in marriage and delay in family formation throughout the country. The rise in age at marriage has been attributed to recent economic hardships such as shortage in housing, unemployment and the rise in cost of living.
Table 4. Adolescent Marital Status (1976 to 1996)

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>1976</td>
<td>117,527</td>
<td>2.9</td>
<td>610,518</td>
</tr>
<tr>
<td>1986</td>
<td>194,064</td>
<td>3.4</td>
<td>929,482</td>
</tr>
<tr>
<td>1996</td>
<td>111,807</td>
<td>1.4</td>
<td>679,279</td>
</tr>
</tbody>
</table>


Table 5. Rate of Marriage in the Male Population aged 15-29 in Iran

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rural</th>
<th>Urban</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>20-24</td>
<td>332,618</td>
<td>33.08</td>
<td>664,402</td>
<td>66.07</td>
</tr>
<tr>
<td>25-29</td>
<td>651,852</td>
<td>79.85</td>
<td>158,964</td>
<td>19.47</td>
</tr>
<tr>
<td>Total</td>
<td>32.24</td>
<td>66.89</td>
<td>28.36</td>
<td>71.80</td>
</tr>
</tbody>
</table>


Table 6. Rate of Marriage in the Female Population aged 15-29 in Iran

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rural</th>
<th>Urban</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>15-19</td>
<td>276,726</td>
<td>19.74</td>
<td>1,108,419</td>
<td>79.09</td>
</tr>
<tr>
<td>20-24</td>
<td>610,654</td>
<td>58.45</td>
<td>419,192</td>
<td>40.16</td>
</tr>
<tr>
<td>25-29</td>
<td>670,971</td>
<td>81.82</td>
<td>134,647</td>
<td>16.14</td>
</tr>
<tr>
<td>Total</td>
<td>47.71</td>
<td>50.91</td>
<td>49.33</td>
<td>71.80</td>
</tr>
</tbody>
</table>

C. EDUCATIONAL LEVEL

The literacy rate of the adolescent population jumped from merely 60% in 1976 to over 95% in 1996 (Table 7). This rise was greater among females, reflecting a significant reduction in gender disparities in education over the recent years. The literacy rate increased from 47.8% in 1976 to 91.5% in 1996 among females, and from 71.2% to 97.8% among males. The rise in literacy rate was even more impressive in rural areas, from 43.8% to 93.9% during the same period. Most of these gains in literacy could be traced to the vastly expanded opportunities for formal education, especially for rural females.

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
<th>Both Sexes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
<td>Total</td>
<td>Rural</td>
<td>Urban</td>
<td>Total</td>
</tr>
<tr>
<td>1976*</td>
<td>59.5</td>
<td>82.7</td>
<td>71.2</td>
<td>27.3</td>
<td>70.7</td>
<td>47.8</td>
</tr>
<tr>
<td>1986</td>
<td>82.9</td>
<td>94.3</td>
<td>88.8</td>
<td>59.6</td>
<td>89.0</td>
<td>74.8</td>
</tr>
<tr>
<td>1996</td>
<td>97.5</td>
<td>98.2</td>
<td>97.8</td>
<td>88.5</td>
<td>94.8</td>
<td>91.5</td>
</tr>
</tbody>
</table>

* Population aged 7-19

Source: Statistical Centre of Iran; National Census of Population and Housing, National Data, 1976 to 1996.

D. HEALTH AND NUTRITION

The overall health status of the Iranian population has changed significantly in the past two decades following the Islamic Revolution. The most prominent health indicators such as infant mortality rate, maternal mortality ratio, immunisation coverage and universal access to health facilities has improved a lot in both urban and rural areas. Though no specific data is available on adolescent health, it is likely that the overall trends in health in Iran apply to adolescents as well.

Registration for marriage in Iran requires engaged couples to undergo medical tests for contagious diseases particularly STDs (sexually transmitted diseases) and drug abuse. Implementation of Iran’s health system uses this law requirement to compel such couples to attend premarital courses. This allows for the incorporation of sex education and sexual health into reproductive health programmes.
Fertility remained high in Iran up to 1986 and then it subsequently declined. The factors leading to this decline include the adoption of an official family planning programme, legitimisation of birth control by the government and religious leaders, and improvement in levels of education, health and living standards.

A study limited to the single metropolitan area of Shiraz showed that in 1996 the fertility of women aged 15-19 was 56 per thousand, and highest among the merely literate (160), the economically inactive (74), and those born in the rural areas (151). It was lowest among those with secondary education (11), the economically active (5), those born in the urban areas (48), and those with higher education (0).

Traditionally, Islam and the Iranian society have greatly emphasised family formation and have restricted sexual activities to the confines of wedlock. Premarital sexual activity and reproduction among adolescents (particularly among unmarried girls) is strictly censured and subject to severe punishment.

There is no available information on abortion and teen pregnancy.

Contrary to the organised approach established for HIV infections, other sexually transmitted diseases (STDs) so far lack a specific programme for follow up in Iran’s health care system. Taboos surrounding the subject of STDs, predictably reduce the likelihood of patients calling upon peripheral health facilities especially in rural settings. Social and cultural considerations have brought most of these patients to prefer treatment through the private sector. Educating the private sector has consequently been emphasised in the hopes of increasing its contribution toward follow up and reporting incidents.

VDRL test used to be routinely conducted for the diagnosis of syphilis in all clients under family health and prenatal care programmes. Recently, this practice has been dropped in view of the scarcity of positive test results.

Following the ceasefire with Iraq in 1988, the Ministry of Health and Medical Education initiated in bringing the problem of unprecedented rapid population growth to the attention of the leader of the Islamic Revolution, the late Imam Khomeini. The Imam’s blessing sparked discussions on population and family planning and led to organising a seminar in Mashad in 1988. A principal conclusion of this seminar was the need for a multi-dimensional policy for population control.
Despite the emphasis of Islam on the values of family formation and procreation, most of Islam’s religious leaders have accepted in principle the right of couples to limit or space their pregnancies using the barrier methods or withdrawal provided both partners consent to the practice.

Since the reactivation of the national family planning programme in 1989, the Ministry has been able to secure written proclamations (Fatwa) from the incumbent supreme spiritual leader and several other prominent Ayatollahs regarding specific methods such as vasectomy, tubectomy, condoms, pills, IUD and withdrawal.

Today, there is no major legal or religious obstacle to the promotion and delivery of family planning methods and services except abortion, which is not recognised as a proper means for birth control. However, abortion can be resorted to at the recommendation of a qualified physician once the mother’s life is at stake.

**H. KNOWLEDGE, ATTITUDE AND BEHAVIOUR ON SEXUALITY AND REPRODUCTIVE HEALTH**

In 1998, the Family Planning Association, an Iranian NGO, conducted two separate studies on the knowledge and attitude of 757 young boys and 1,565 girls about puberty and reproductive health. A summary of the results of both studies is shown in Table 8.

<table>
<thead>
<tr>
<th>KNOWLEDGE/ATTITUDE</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>On puberty:</strong></td>
<td></td>
</tr>
<tr>
<td>Considered puberty to be a happy or fortunate period and a step towards social maturity</td>
<td>19</td>
</tr>
<tr>
<td>Shame, preoccupation with mind and body and changes in behaviour during puberty</td>
<td>69</td>
</tr>
<tr>
<td><strong>On appropriate age for parenthood:</strong></td>
<td></td>
</tr>
<tr>
<td>Male = 25-29</td>
<td>55</td>
</tr>
<tr>
<td>Female = 20-24</td>
<td></td>
</tr>
<tr>
<td><strong>On contraception:</strong></td>
<td></td>
</tr>
<tr>
<td>Knowledgeable about contraception</td>
<td>54</td>
</tr>
<tr>
<td>Expressed the need for being taught about contraceptive methods prior to marriage</td>
<td>85</td>
</tr>
<tr>
<td>Considered ages 15-29 as appropriate for education on contraceptives</td>
<td>70</td>
</tr>
<tr>
<td><strong>On sexually transmitted diseases:</strong></td>
<td></td>
</tr>
<tr>
<td>Knowledgeable about STDs and their mode of transmission</td>
<td>66</td>
</tr>
<tr>
<td>Knowledge of AIDS at least by name</td>
<td>50</td>
</tr>
</tbody>
</table>
Other results from the survey were:

- 83% of the girls were quite familiar with menstruation but only half of them considered it an indicator of well-being and health. 35% of the girls aged 15-19 believed that taking a shower is not advisable during menstruation.

- Most of those knowledgeable about contraception were aware of methods used only by females. Their general sources of information were friends, literature, parents, teachers, radio and television. The favoured resources for information on health during puberty were parents, teachers, sisters and other boys in that order.

- 57% of the male correspondents believe that contraception is a mutual responsibility of man and woman. The rest were equally divided between those in favour of trusting sole responsibility with the husband or the wife.

Although adolescents are well aware of the proper age of marriage and value of limiting the number of offspring, they still adhere to the concept of gender preference and are not familiar with the mental and social implications of puberty. They are neither adequately acquainted with the available methods of contraception, nor at ease with the attitude of mutual responsibility in sexual life and have no information about sexually transmitted diseases.

Another study carried out by the Ministry of Health and Medical Education in 1996 on reproductive knowledge, attitudes and practice in girls aged 12-25 at both rural and urban areas indicated a fairly good knowledge about signs of physical growth and maturation. It also showed that two out of five girls (41.5%) who had begun menstruating had not received any information about it beforehand, and half of them had been terrified by their first experience. For those who did receive some advice or information in advance about puberty and menarche, their main sources were their mothers (32%), friends (16%), an elder sister (15%) or a teacher (12%). An overwhelming majority (92%) of the respondents mentioned that some knowledge about family planning and familiarity with birth control methods is essential before marriage.

There is no information available on a number of parameters such as age at first intercourse and premarital sex.
1. The Supreme Council of the Youth

The Council established in 1992 and administered under the Presidential Office, is the official body in charge of coordinating endeavours for the young. The first and foremost action taken by the Council was to develop a sound National Youth Policy (NYP) as a result of the efforts of scholars, experts, authorities and government officials. This policy has been formulated according to the Educational Charter of the Younger Generation. The Charter and the Policy, comprising 14 Fields and 98 Articles, were ratified by the President and issued to all departments and government organisations.

Articles 36 to 42 of the NYP, being devoted to family and marriage, are the closest fields to reproductive health. None of the articles explicitly deal with sexual health, and almost all of them cover only the very broad and most general concepts of family formation and marriage.

The Council has recently come to be known as the National Centre for Youth. It is hoped that in its new capacity, it will be able to fulfil much more important missions for the youth.

2. Youth Department, Ministry of Health and Medical Education (MOHME)

Five years ago, the Ministry of Health faced the large population born after the Revolution at the verge of fertility and entering reproductive age. The Ministry has devoted great efforts to increase awareness about reproductive health problems among adolescents. As its first step, an exclusive office was established within the Family Health Department and is currently working with the General Directorate for School Health, coordinating the variety of programmes aimed at improving adolescent health.

The main objective of the Youth Department is to promote physical, mental and social well being of young males and females aged 10-19 in both urban and rural parts of Iran.

The specific objectives include the following:

- To promote healthy behaviour of adolescents facing puberty
- To improve the knowledge and behaviour of adolescents, parents, teachers and health personnel towards sexuality and puberty
and its potential mental and behavioural consequences

- To promote a healthy lifestyle for adolescents as well as their parents and teachers
- To increase the knowledge of adolescents about reproductive health and family planning
- To promote a general knowledge about STDs and other prevailing health problems of the youth
- To carry out advocacy programmes for the key decision-makers of the society on adolescence, reproductive health and other needs of this age group

Besides the reactivation of a multidisciplinary committee on adolescent health and coordination of intersectoral cooperation to implement the Action Plan, the Youth Department has also carried out the following activities:

- Facilitating and conducting KAP surveys on puberty in urban and rural areas
- Compiling a mass of information about adolescents
- Providing health facilities with educational modules on counselling about reproductive health and population issues
- Conducting educational workshops attended by most of the key authorities from different bodies involved in the reproductive health of adolescents

The Youth Department has produced several educational materials on adolescent health. These materials have been distributed in thousands and their impact is being investigated in three pilot provinces. The following books were published and distributed in Farsi:


### B. NGO PROGRAMMES

Iranian NGOs recently organised gatherings with the participation of the government and United Nations agencies to promote mutual cooperation and institutionalisation of their activities. The government, on the other hand, had organised task forces to study legislature and policies with respect to the NGOs registration procedures, their participatory needs, the requirements for capacity building, and knowledge sharing and networking. The Family Planning Association and Iranian Women’s NGOs participated in the planning, management, and implementing population and development policies and programmes.

The Parents-Teachers Association (PTA) has half a century of successful
service. It functions as an independent non-governmental organisation in collaboration with the Ministry of Education. The PTA interacts with parents all over the country and through them, the students at different levels of education. Though a very small proportion (if any) of the subject on reproductive and sexual health of students are discussed by the PTA, other messages are efficiently communicated to the parents through this route. The Association has publications on:

- Sexual problems of children
- Parents and population education problems
- Getting acquainted with the Parents-Teachers Association
- An education analysis of the relationship between girls and boys in Iran
- Family and children for pre-school, primary school, guidance school and high school age groups
1. Political lobbying

A systematic and coherent advocacy strategy is lacking in Iran. A number of activities have been attempted by various government ministries and organisations to sensitize influential personalities on critical issues in the field of population studies, reproductive health and family planning. These have been more or less ad-hoc and sporadic, with no clear focus and defined strategy. However, such activities have been instrumental in alerting personnel and representatives of NGOs and community leaders about critical population and development concerns. Often times, these have been organised concurrently with the celebration of the World Population Day and similar events.

2. Passing of legislations

By ratifying the family planning law in 1993, the Iranian parliament showed that it has a clear understanding of rapid population growth and its adverse effects on the socio-economic situation of the country. Nonetheless, it is necessary to encourage closer cooperation between parliamentarians and government officials in charge of implementing the reproductive health and family planning programmes. Recently, UNFPA’s support and strong advocacy efforts led to the establishment of a Population Division under the Ministry of Education. The Division is tasked to oversee and coordinate population activities.

3. Use of mass media

The country has an extensive communication network. More than 90% of the country is covered by national and provincial television networks, radio coverage is nation-wide and printed media include over 700 dailies and periodicals. There is no existing systematic and institutionalised programme to involve the Iranian media in advocacy activities of reproductive health and family planning.

The monthly publication Payvand (meaning connection or link in Persian) is an educational journal published by the Parents-Teachers Association to establish and maintain connection with families and parents. It is used as a tool for advocacy and may be purchased by anyone interested. The Association has also published the books “Family and Sexual Problems in Children” in 5,000 copies for the latest edition, “An Educational Analysis of Relationship Between Girls and Boys in Iran” and “Family and Children” series aimed at four different levels of education.

Developers and disseminators of these publications are enthusiastic about them. But there is no data to represent the impact of these materials on their target audience and their recipients’ attitude.
B. INFORMATION, EDUCATION AND COMMUNICATION (IEC) STRATEGIES

1. In-school education programme

The issue of population education has received special attention in the Family Planning Law adopted in 1993. In this regard, the Ministry of Culture and Higher Education and the Ministry of Education have been mandated with the responsibility of promoting students' awareness about population and development. Some efforts have been made by the Ministry of Education to incorporate population education issues into formal and informal school curricula. These projects, however, were not done in a professional and systematic manner.

A Curriculum Development Committee has also been set up to develop educational materials for use in over 1,000 pilot schools in five selected provinces. Population education messages were developed by the Committee and was published in the form of booklets. These materials will be integrated into school textbooks at the national level. Due to cultural sensitivities and religious considerations, the content of the schoolbook is purely limited to the issue of population and development and no information on reproductive health or family planning is provided.

The Youth Department of the Ministry of Health has published the series, “Guidelines on Reproductive Health” in three books, each one for parents, girls and boys. The books are now being tested in a pilot project, in three different provinces.

The main aim of the government is to increase knowledge, understanding and commitment of the target group toward reproductive health and family planning and enable couples to change their attitudes and behaviour in favour of smaller family and higher standards of reproductive health and family planning.

The establishment of a national reproductive health/family planning IEC Centre in 1995, under the Ministry of Health and the Ministry of Education with the assistance of UNFPA, indicated the willingness of national authorities to strengthen educational promotion activities of the reproductive health and family planning programme. However, there is no specific evidence as yet of the accomplishments of the Centre.

2. Training of communicators and health care providers on IEC

Currently, efforts are being made to convey issues on critical reproductive health and family planning to students through the Parents-Teachers Association. Fifty (50) schoolteachers have undergone special training and are expected to serve as trainers to convey necessary information to parents. A booklet containing important issues on population, reproductive health and family planning has also been developed. The government will evaluate the impact of such activity and must try to expand the PTA's scope of activity at the national level.

In recent years, some steps have been taken to educate health personnel
working in both public and private sectors on the subject of HIV and AIDS. These efforts have been expanded to include students, teachers, clergy, judges, military personnel and law enforcement officers. STDs are not yet officially a priority concern of Iran's public health system. Experience and resources gained by the National AIDS Committee can and should be extended to cover other STDs.

3. Religious influence and campaign

In view of the particular characteristics of Iranian political fabric and governance, religious leaders play a critical role in guiding and influencing public behaviour with regard to population, reproductive health and family planning matters.

The supreme spiritual leader has used his periodic visit to provinces to spread the message and advise parents against early child marriages, which affect the spiritual and mental health and education of the young. The parents themselves usually arrange such marriages.

Religious leaders have also made or allowed use of public occasions like Friday prayers for local and national public health and family planning authorities to share their views with the public. Iran’s spectacular progress in promoting family planning, immunisation and breast-feeding owes much to such support.

Even the charity organisation, “Imam’s Relief Committee,” has established a carefully developed premarital family planning education and counselling service for the prospective parents among economically deprived youth under its care. The Committee periodically organises mass marriage ceremonies for these youth.
1. Support of religious leaders

In Iran, where religious leaders are also policymakers, planners or managers, the Ministry of Health and Medical Education had little trouble getting approval or support for various public health policies, including reproductive health.

2. Support of government

Despite all the daunting problems it has faced over most of the past two decades, the Iranian government has managed to maintain its investments in health, education and social services at a comparatively high level. The share of the social services and welfare from the annual public budget has continued to grow at a high rate under the First and Second Five Year Development Plans. The plans placed emphasis on development and implementation of an effective family planning and reproductive health programme in the country.

3. Socio-cultural orientation of society

The conservatism of Iranian society and its sensitivity to sexual and reproduction-related matters have caused advocates, programme implementers, workers, and religious leaders to proceed slowly or have kept them from fully participating in advocacy efforts. This is demonstrated by the following:

- The Iranian delegation to the Cairo Conference on Population and Development (ICPD, 1994) did not endorse a few issues in the Agenda and Programme of Action. It expressed reservations on some concepts, terms and recommendations during the conference.

- Existing policies for youth do not deal directly with sexual health.

- Reproductive health and family planning managers and workers have opted for a conservative and reserved approach in order to avoid attack from those opposing implementation of their programmes.

- Despite the support of religious leaders on population and family planning programmes, they address the issue with caution and act conservatively. Some are not in favour of family planning and reproductive health programmes.
1. Support of religious leaders

Ever since the government started to launch its population and family planning programme, religious leaders have supported and backed the programme. The full support of top religious leaders has gone a long way in legitimising family planning and encouraging Iranian couples to utilise various methods of birth control.

2. Concerted support of government, schools and parents

The government, schools and parents support educational promotion activities on reproductive health and family planning programme at the local and national levels. The government has established programmes for schools. The PTA has been used as a powerful venue to discuss issues related to students and has been instrumental in the production of several IEC materials including journals and books.

3. Impediments to NGOs involvement

It is emphasised that non-governmental organisations have taken steps to undertake innovative strategies to introduce reproductive and sexual health messages into their programmes to reach adolescents and influence them in making responsible decisions regarding their sexual and health behaviours. However, in the Islamic Republic of Iran, this action is confronted by two serious impediments.

First, there are very few NGOs in the country. Though there is no shortage of charity organisations (most of which have religious alignment), NGOs as is known today had only been introduced in the country in the past few years. Because of Iran’s unique contemporary cultural, social and political conditions, these few NGOs do not prefer to approach heated subjects such as reproductive and sexual health.

Second, the NGOs are required to work within the framework of their host nation’s cultural context and observe its social code. The considerable sensitivity and controversy surrounding these subjects are not expected to give any NGO freedom to act out or improvise programmes.

4. Taboos on sexuality issues

Abortion, premarital sex, promiscuity, and prostitution are taboos in Iranian society. As a result, it is difficult to obtain data on parameters such as teen pregnancy and STDs/HIV. The trauma of facing socio-cultural condemnation makes it impossible to report these cases. No study will even dare to discuss these issues making it difficult to assess the magnitude of the problem and draw up responses to it.

Social, cultural and religious pressures have kept people from facing issues related to reproductive and sexual health. Discussions about these are not being done openly.
5. Insufficient content of IEC materials

Because of the sensitivity of the culture to messages on reproduction and sexuality, only a few IEC materials for public dissemination directly address these topics. Others present closely related topics such as health, relationships, family life and marriage.

C. OVERALL LISTING OF LESSONS LEARNED

1. On using the influence of religious leaders

Tap the influence of religious leaders on society to address priority issues in adolescent reproductive and sexual health. Get the support and involvement of these leaders in the formulation and implementation of appropriate reproductive health policies.

2. Aligning with government priorities

Determine the appropriate government priorities that may be used as entry points for advocating adolescent reproductive and sexual health. In Iran, the financial support and emphasis of government on effective family planning and reproductive health programme has been a springboard for further developing related programmes targeting the youth.

3. On sensitivity

Respect socio-cultural sensitivities in using any advocacy or IEC strategy.

4. On supporting IEC activities

Consolidate efforts of government, schools and parents to jointly support any IEC activity done in the academic setting.

5. On NGOs involvement

Build up the few NGOs willing to go into reproductive and sexual health activities despite the impediments.

6. On research data

Consider all data valuable. In a society where the subject of reproductive and sexual health is not open, it is frustrating to survey the situation among adolescents. Therefore, any available piece of information should be used to analyse the needs of adolescents.
A. GUIDELINES FOR ADVOCACY PROGRAMMES

- Take steps towards a national advocacy strategy.
- Tap the right leaders to influence public behaviour. They can be the religious leaders of the country.
- Sustain government policies that will ensure the involvement of civil society and NGOs on country population and development policies.
- Conduct more and varied researches to obtain more reliable data targeted for advocacy of adolescent reproductive and sexual health.

B. GUIDELINES FOR IEC PROGRAMMES

- Sensitise and involve the media. As media can play an effective and indispensable role in successful implementation of these programmes, its sensitisation and systematic involvement in population reproductive health and family planning advocacy should be given special attention.
- Formulate and distribute guidelines on reproductive health for parents and children.
- Conduct studies on content analysis of IEC materials to determine whether the target audience is being reached effectively.
REFERENCES


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