Introduction

This package is the second of a series of repackaged products aimed to serve as a vehicle for alerting our users to a wealth of highly valuable educational resources that exist in the field of adolescent reproductive and sexual health. Unfortunately, it is feared that many of these would have never been read simply because they are not easily accessible as very few of those who work in this field probably do not even know where they are located. Or even if they can be accessed, they come in either highly technical and unreadable language; or are so overwhelming in information and unattractive in presentation that the users are discouraged from reading them.

The information consolidation and repackaging strategy of the UNESCO Regional Clearing House addresses this potential waste of resources by reviewing, analysing and selecting the most useful and relevant information, screening out poor information, processing them into more readable language, culling out policy and practice implications and repackaging them into various attractive formats that would render themselves easily readable and applicable to decision-making and programme improvements. To implement this strategy, the Regional Clearing House comes out with series of packages which focus on different topics or areas of importance to adolescents, and which can be used by teachers, trainers, curriculum developers, school administrators and policy markers.

This package is on what research says about adolescent reproductive and sexual health

Objective

The second of a series, this package demonstrates to the users the growing body of research and surveys undertaken by the countries in the region to examine various aspects of adolescent reproductive and sexual health. Just a few years ago, policy makers and practitioners constantly observed that very few benchmark, baseline and evaluative studies had been done to guide them in their policy planning, management and implementation of adolescent reproductive health programmes. After some five years, research studies have started to proliferate, many quite useful while others need further improvements, in terms of quality. The research studies included in this package came from some 15 countries in Asia and the Pacific, most of which arose from UNFPA-funded programmes on adolescent reproductive health. Most are knowledge, attitude and behaviour baseline studies which respond to the initial clamour by the countries for more data about the adolescents in terms of who they are, what they know about
reproductive health and sexuality, how they feel about discussing such topics and what constitutes their sex-related behaviour. A few of these studies even go in-depth into analyzing behavioural patterns among teenagers with regard to sex, dating and teenage pregnancy. A good number of the studies provide data for use as a basis in designing effective IEC and advocacy programmes and strategies. There are also assessment studies to provide information for developing educational programmes and curriculum materials. Reviews of programme approaches are likewise included in this package in order to show experiences and lessons learned in carrying out various programmes on adolescent and reproductive health in a number of countries in the region.

There are a total of 28 studies included in this package. They were recommended by UNFPA country offices for inclusion in this package. They have been summarized and grouped into four sections, namely, (1) general situationer; (2) knowledge, attitude and practices; (3) sexuality; and (4) strategies and approaches. Each study is presented into individual “fact sheet” form for easier reading and manageability.

This package is only the beginning of a continuing series of research briefs. The package will be updated throughout the coming years as countries undertake more and more research and evaluation studies on the topic. Hopefully, the series of packages on the research briefs will show a changing landscape of research in the region in the coming years in terms of type, methodologies and scope.

Countries who might want to contribute their research studies on adolescent reproductive and sexual health for inclusion in next year’s series could please write to:

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UNESCO, Bangkok
920 Sukhumvit Road, Bangkok 10110
Thailand
# Contents

## 1 Situationer

<table>
<thead>
<tr>
<th>Code</th>
<th>Country</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Lao PDR</td>
<td>Survey results call for intense IEC efforts among youth</td>
</tr>
<tr>
<td>002</td>
<td>Malaysia</td>
<td>Nationwide survey hopes to pave way for a national ARH programme</td>
</tr>
<tr>
<td>003</td>
<td>Mongolia</td>
<td>Assessment identifies development needs of Mongolian adolescents</td>
</tr>
<tr>
<td>004</td>
<td>Myanmar</td>
<td>Assessment presents reproductive health needs of young people</td>
</tr>
<tr>
<td>005</td>
<td>Nepal</td>
<td>First comprehensive study reveals state of adolescent reproductive health</td>
</tr>
<tr>
<td>006</td>
<td>Pacific Island Countries</td>
<td>Workshop paper tells how to improve ARH in Pacific Island countries</td>
</tr>
<tr>
<td>007</td>
<td>South Asia</td>
<td>Conference on Adolescents raises reproductive health strategies</td>
</tr>
<tr>
<td>008</td>
<td>Thailand</td>
<td>Reproductive health situation makes progress but leaves room for improvement</td>
</tr>
</tbody>
</table>

## 2 KAP (knowledge, attitude and practices)

<table>
<thead>
<tr>
<th>Code</th>
<th>Country</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>009</td>
<td>Bangladesh</td>
<td>Baseline study explores state of urban youth reproductive health</td>
</tr>
<tr>
<td>010</td>
<td>Cambodia</td>
<td>Reproductive health survey of in-school and out-of-school adolescents</td>
</tr>
<tr>
<td>011</td>
<td>Cambodia</td>
<td>Trends: Baseline data on youth</td>
</tr>
<tr>
<td>012</td>
<td>Lao PDR</td>
<td>Survey shows greater need for quality information on basic reproductive health issues in rural areas</td>
</tr>
<tr>
<td>013</td>
<td>Sri Lanka</td>
<td>Grade nine students show unsatisfactory knowledge of reproductive health issues</td>
</tr>
<tr>
<td>014</td>
<td>Vietnam</td>
<td>Research captures full picture of young Vietnamese lives</td>
</tr>
</tbody>
</table>

## 3 Sexuality

<table>
<thead>
<tr>
<th>Code</th>
<th>Country</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>015</td>
<td>Cambodia</td>
<td>Sexual and reproductive health issues cut across vulnerable youth groups</td>
</tr>
<tr>
<td>016</td>
<td>Lao PDR</td>
<td>Survey bares HIV/AIDS risk behaviour of Vientiane and Savannakket youth</td>
</tr>
<tr>
<td>017</td>
<td>Mongolia</td>
<td>Peer influence spells premarital sex behaviour among school adolescents</td>
</tr>
<tr>
<td>018</td>
<td>Philippines</td>
<td>Looking into adolescent sexuality</td>
</tr>
<tr>
<td>019</td>
<td>Thailand</td>
<td>Double sexual standard operates among rural youth</td>
</tr>
<tr>
<td>020</td>
<td>Vietnam</td>
<td>Sexuality concepts evolve through Vietnam’s history</td>
</tr>
</tbody>
</table>

## 4 Strategies and approaches

<table>
<thead>
<tr>
<th>Code</th>
<th>Country</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>021</td>
<td>Bangladesh</td>
<td>Reviewing strategies that meet adolescents’ health needs</td>
</tr>
<tr>
<td>022</td>
<td>Cambodia</td>
<td>Young factory workers in Phnom Penh talk about work and sexual health</td>
</tr>
<tr>
<td>023</td>
<td>India</td>
<td>Gender and reproductive health messages need to reach more rural learners</td>
</tr>
<tr>
<td>024</td>
<td>India</td>
<td>Madhya Pradesh students want and need sexuality education</td>
</tr>
<tr>
<td>025</td>
<td>Philippines</td>
<td>Sexuality intervention: college youth tell their needs</td>
</tr>
<tr>
<td>026</td>
<td>Vietnam</td>
<td>Evaluation declares two counselling centres as successful models</td>
</tr>
<tr>
<td>027</td>
<td>Vietnam</td>
<td>Window of Love Programme gets good response from listeners</td>
</tr>
<tr>
<td>028</td>
<td>Vietnam</td>
<td>First ARH communication campaign reaps rewards</td>
</tr>
</tbody>
</table>
Research briefs in this section tell how adolescents generally fare at the regional and national levels. Adolescent reproductive health (ARH) needs are highlighted and macro-scale approaches are formulated in response.

A paper outlines the ARH issues in *Pacific Island Countries* and reacts with a set of health care and education interventions to address these issues.

The report from *South Asia* summarises the regional situation in three aspects: adolescent sexuality and reproductive health; literacy and education; and exploitation of and violation against adolescents. It draws strategic responses in these areas.

At the national level, six countries share their own scenarios:

The survey in *Lao PDR* views the low levels of reproductive health knowledge of youth as a call for intense IEC efforts. Sources of information, knowledge rates between subgroups, drug abuse, sexual relationships and contraceptive use are also considered in the report.

*Malaysia* looks at sex-related activities (e.g., dating, cohabitation, abortion) among the youth and the availability of information and counselling support for them. The role of parents and family life on adolescents’ behaviour is weighed. The report also formulates initial strategies for a national programme on ARH.

*Mongolia* explores the comprehensive development needs of adolescents as a framework for a national plan of action. Unmet needs in education, participation, health, information and legal environment are illustrated.

An assessment from *Myanmar* describes inadequacies in information and services for adolescents. It discusses various channels of information for educating adolescents on reproductive health.

A study from *Nepal* examines the knowledge, views and practices of adolescents in the light of designing effective education and information programmes for them. The accessibility of information and services for adolescents is also investigated.

A paper from *Thailand* presents the country’s progress in reproductive health including changing trends, legislation, services and information. It presents basic ways to improve the quality of reproductive health services for adolescents.
Survey results call for intense IEC efforts among youth


Low trends in reproductive health knowledge came out from a national survey conducted among young Laotians in 1999. These seriously compel IEC programmes to be developed as a response.

The Adolescent Reproductive Health Survey was done by the Lao People’s Revolutionary Youth Union and executed by the Japanese Organisation for International Cooperation in Family Planning (JOICFP). Collected from 3,000 households in 18 areas and 1,560 young people aged 15-25, the data from the survey could help programme managers, policymakers and others develop approaches that meet the needs of young people. The major findings are highlighted below.

Reproductive health knowledge

Knowledge on reproductive health issues is generally low. More than half of young Laotians were not aware of contraceptive methods, condom use, sexually transmitted diseases, and harmful drugs (see Figure). But about three quarters of them had some knowledge on HIV/AIDS and the danger of induced abortion.
Young people rely on family and friends for information. The young people’s major sources of information were those close to them (friends, family, relatives), followed by the mass media (TV and radio). Seldom was information received from health workers (7.0 per cent in the case of HIV/AIDS information).

Discrepancies in knowledge exist between subgroups. In most cases, knowledge rates were greater among: (i) youth in urban than in rural areas, (ii) those who were educated than those who were not, (iii) those in the agriculture sector than in other groups (government/private sector or students), and (iv) those in higher age brackets (aged 20-25) than in lower brackets (aged 15-19).

Drug abuse, sex and contraceptives

Drug abuse and sex are not widespread. Use of harmful drugs (1.8 per cent) as well as experience in sex (8.2 per cent) among young people was low. More than half (54.0 per cent) were not in favour of premarital sex. A great majority (80.0 per cent) expressed that sex without consent or sexual harassment is not socially acceptable.

Of those who engaged in sex, 60.0 per cent had their first experience with their girlfriends or boyfriends and 62.5 per cent had sex in homes. The incidence of sexual intercourse with bar girls was 5.0 per cent among all young men.

Contraceptive use is low. Since only 5.4 per cent of all young people had used contraceptives, it appears that a considerable number of those who had had sex did not use a method of contraception. Among the available methods, the condom was the most popularly known (50.4 per cent) and used (3.1 per cent), with the majority of users obtaining their supplies from pharmacies.

What can be done?

Design special IEC programmes. These must emphasise the effective use of mass media, particularly radio and TV, and interpersonal communication to improve adolescent reproductive health knowledge.

Encourage adolescent-friendly reproductive health services. This should be aimed at deterring pregnancies out-of-wedlock and the spread of STD/HIV/AIDS. Although premarital sex is not common, the possibility of rising unsafe sexual relations among the youth, bar girls in particular, must be addressed through programmes that counteract these issues.

Conduct surveys among subgroups. Future surveys should investigate the wide differences among population subgroups particularly the uneducated, the minority and the poor.
Nationwide survey hopes to pave way for a national ARH programme

The National Population and Family Planning Development Board (NPFDB) initiated a national study in 1994 with the aim of formulating a national programme on adolescent reproductive health (ARH). Data were gathered from a series of surveys done from 1994 to 1996 (see Table). The major findings are summarised below:

**Information, education and counselling**

*Education, information counselling and support are lacking.* These are not provided during the stressful period of adolescence – a time when body changes affect behaviour, attitude, personality and lifestyle. Education on physiological and natural processes of the body is lacking, as two thirds of adolescents are afraid to face menstruation. Mothers are unprepared or unable to give sufficient advice and reassurance to their daughters. Fathers do not discuss related issues with their sons. Friends are the main channels of sharing experiences on “wet dreams” and sexual relationships. Some adolescents prefer to receive sex education through their parents but they do not know how the matter can be approached.

*Most adolescents are exposed to inappropriate sexual materials.* More than two thirds of adolescents aged 13-19 had been exposed to various forms of material with explicit or implied sexual connotation in the form of magazines, films, videos and others. The adolescents knew where and how to obtain these materials. They watched pornographic films usually in their friends’ homes or in specific places without their parents’ knowledge. Afterwards, two thirds of them indulged in masturbation or sexual intercourse.

**Dating and sexual activities**

*Dating is an accepted norm among adolescents.* Two thirds of adolescents had started dating by the time they were 13 to 15 years of age. Between 13 and 19 years, more than 80 per cent of the adolescents in the study have begun holding hands, kissing, “necking” and “petting”.

*A number of adolescents engage in sexual intercourse.* More urban than rural adolescents approved of cohabitation and sexual relationships especially among older ones and those who intend to get married later. Eighteen per cent of adolescent respondents from the media survey had experienced sexual intercourse between the ages of 15 and 19.
adolescents, especially Malays, knew it was wrong and some of them felt guilty or ashamed as they had been exposed to religious teachings. Parents likewise disapproved but lacked the confidence and skills to talk to their children. They rely on schools to provide “sex education”.

Pregnancy prevention and termination

Abortion is practiced to some degree. Only 35 per cent of male adolescents had used condoms and six per cent of females had taken pills. Because the rest might have engaged in sex without pregnancy preventive measures, unplanned pregnancies could happen and end in abortions. Unwanted pregnancies were common among Bohsia girls (those who frequented shopping malls), factory girls and those in need of money. Many of the adolescents interviewed knew of someone who had either been pregnant or had had an abortion. They knew where abortion was performed (clinics) and the traditional means of carrying it out (insertion of objects, panadol and Malaria pills, and others). The Bohsia girls did not worry about money for abortion (RM 800 – RM 1,000) as they had “sugar daddies” to pay for them.

Sexuality and family relationships

Adolescents seek sexual relationships to compensate for a poor and unstable family environment. Factors that specifically contribute to this are: lack of parental love and attention, squabbles between father and mother, a lonely and “boring” situation at home and the need to seek “fun and happiness” with friends.

Adolescents have good relationships with parents. Majority of adolescents enjoyed a fairly good relationship with their mothers (93 per cent) and fathers (85 per cent). Most of them rated their mothers to be more ‘moderate and liberal’ and their fathers to be more ‘firm and conservative’. The majority sought approval from their parents when it came to general matters such as going out for activities, clothing, hairstyle and music. Problems appeared in the area of personal and sensitive issues such as sexual changes during puberty, pregnancy and other aspects of reproductive health. Girls had to turn to friends because they did not know how to approach their mothers to talk on these issues. Fathers seemed to be left out or leave the responsibility to mothers.

Recommended strategies and programmes for adolescent reproductive health

<table>
<thead>
<tr>
<th>Strengthen the family institution: Family relationships and support as well as open communication between parents and children must be nurtured. Premarital courses and counselling need to be introduced.</th>
<th>Educate parents: Parents need to understand the physical changes during adolescence for them to provide guidance and support. Parenting courses including child development have to be introduced.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate children and adolescents: Family life education must be introduced to raise awareness of responsibilities, inculcate positive values, and promote healthy lifestyles and family relationships.</td>
<td>Develop curriculum for Family Life Education: Topics and methodologies must be standardised. Personnel must be trained to teach adolescents in various segments of society.</td>
</tr>
<tr>
<td>Expand roles of schools and religious institutions: Religious and moral education in schools must not be limited to only pure religious teachings. Early introduction (at ages 12-13) of family life education is recommended.</td>
<td>Highlight a holistic approach: Youth programmes and activities must include preventive and remedial measures as well as support, guidance and counselling.</td>
</tr>
<tr>
<td>Enforce strict control on pornographic materials: Availability and distribution of pornographic materials must be curbed. Proper classification and labelling of films and advertisements must be implemented.</td>
<td>Seek out all youth groups: Education and counselling services for youth in the work places and rural areas must be introduced.</td>
</tr>
<tr>
<td>Draw a comprehensive multi-sectoral inter-agency strategy and programme: A programme encompassing education, information and counselling services is urgently required to prevent social problems such as the rise of unwanted pregnancies and spread of HIV/AIDS.</td>
<td>Bring the strategy to the attention of top government levels. Based on the findings, the Technical Working Group on Adolescent Reproductive Health and Sexuality should formulate a comprehensive strategy. This must be channelled through the Ministry of National Unity and Social Development.</td>
</tr>
</tbody>
</table>
Assessment identifies development needs of adolescents


Development needs of Mongolian adolescents have been identified through a comprehensive assessment completed in 2000. With the release of the needs assessment report, the basis for a national framework of action for adolescents is now on hand.

The assessment involved a series of activities such as adolescent forums, focus group discussions and a formal survey among 2,083 respondents from five regions across Mongolia. Interviews with government officials, teachers, parents and NGOs and a review of various documents were also conducted.

The survey underscored the unmet needs of adolescents in the areas of education and health among others. Major findings are as follows:

Education

Adolescents perceive schools as uncomfortable and unattractive environments, lacking in the basic tools of learning. Half of the respondents perceived the lack of textbooks and computer equipment as the biggest deficiency in schools. And with no investment in their renovation, school buildings have been deteriorating.

Discriminatory and oppressive school environment poses the biggest obstacle to studying. Teachers discriminate between boys and girls, and between children of different social backgrounds. They treat students on the basis of the rank and wealth of the parents. They fail to create a disciplined environment. More than one third of the respondents indicated that their biggest problem with respect to accessing education is bullying, followed by lack of interest.

A creative environment for learning is indeed lacking. Subjects are not always relevant to the adolescents’ needs or taught in an interesting way. And pupils are not invited to participate in ways that would stimulate them. Child-centred learning methodologies do not appear to be practiced.

Bureaucracy takes precedence over needs and rights. In some cases, the population movement system prevents children from entering school if they have changed location and do not have registration documents.

Extra curricular activities are few and lack variety. Around 15 per cent of the adolescents cited the lack of extra-curricular activities as one of the major deficiencies of the educational system. Only 6.6 per cent of the respondents indicated any participation
in a form of after-school activity. Respondents were frustrated by the gap between their potential capacities and the opportunities to develop those capacities. Many focus group participants cited the lack of initiative on the part of the teachers to organise extra-curricular activities. Given this situation, participants turn to activities that have less constructive focus.

**Adolescents see the value of education.** Most of them see education as an important factor in training for professions that will be useful, stimulating and financially rewarding. But they are not very well informed about the variety of professions available. Fifty-five per cent of the respondents chose white-collar professions like teaching (20 per cent), medicine and engineering.

**Teachers and adolescents have very different perceptions of what the main problems are.** Teachers perceive problems as an end-result of a “lack of demand” while adolescents see them as a product of a “lack of supply”. Adolescents see the school environment as the main problem: bullying in school, lack of interesting classroom content, student illness and the attitude of the teachers. On the other hand, teachers define these problems as mainly household problems: 67 per cent believe that unemployment and poverty are the biggest problem.

**Values and opinions**

**Adolescents feel that their relationships with adults are very significant but not necessarily satisfactory.** They wish to be treated as “future citizens” and be given the same respect as adults. Adolescents feel that parents, teachers and other adults do not have the time or commitment to attend to their emotional, intellectual and spiritual needs.

**Education, hard work and parents’ social status, position and authority are important to the achievement of goals.** Fifty-four per cent of the respondents indicated that these three factors were important in influencing their status in society. In addition, almost all of the respondents cited education (91 per cent) and effort (87 per cent) as factors influencing personal wealth creation.

**Many adolescents are concerned with social issues.** But on average, a third of the sample could not make up their mind about any of the challenging issues presented by the survey. There was a high acceptance (72 per cent of the 15-19 age group) of the right of women to positions of power in society. Many adolescents condemned early marriages (53 per cent), prostitution (62 per cent), suicide (62 per cent) and abortion (53 per cent). On the other hand, 54 per cent approved of child labour.

**Participation**

**Adolescents would like to be involved in the decision making process within families and communities.** Although their opinions are taken into account in some families, they feel that decisions are still being made for them. Around 20 per cent of the respondents felt that their parents do the decision-making. Younger adolescents (10-14 years old) have no participation or a very low level of participation compared to older adolescents.

**Formal channels for expression of adolescent views are limited.** Adolescents do not have enough access to organisations that are set up to cater for their needs, either by government or non-governmental organisations or information groups. Majority of the respondents did not belong to any organisation. Political considerations often take
precedence over the real needs of adolescents when decisions are being made. Twenty-seven per cent of the respondents indicated financial constraints as one of the limitations to greater participation in organisations. On the other hand, 21.6 per cent said organisation activities were far from the needs and interests of the adolescents themselves.

The labour demands made on adolescents exceed a healthy share of family responsibility. This severely restricts their free time to play and to engage in leisure activities. The respondents claimed to spend 46.2 per cent of their free time doing housework. A close second was activities devoted to reading books. The proportion of time spent on housework rises as the area becomes more rural. There is also little choice of leisure activities for adolescents. Organised sports or cultural events are infrequent and unaffordable, especially in rural areas.

Health

Many adolescents are not as physically developed as they should be. There is a high rate or morbidity among adolescents particularly from rural and peri-urban areas. There is also a much higher rate of injury and poisoning among adolescents than among the rest of the population, which suggests that adolescents are particularly vulnerable to accident and are prone to depression and psychological disorders.

Adolescents’ nutrition is well below accepted international recommendation. They do not eat regularly. Anaemia, goitre and digestive disorders are prevalent due to poor nutritional intake among adolescents.

Adolescents face sexual risks. Adolescents are becoming sexually active at a younger age and adolescent pregnancies are increasing. Maternal mortality among adolescent mothers is more than twice the rate in other age groups. There is also a high incidence of abortion among pregnant adolescents. Of the 7,000-8,000 people infected by sexually transmitted diseases each year, about half belong to ages below 25.

Adolescents are eager for information about health and reproductive health. But many do not know how to obtain such information, and many others do not have access to sources of information (see Figure). Forty-five per cent of young adolescents

![Obstacles faced by Mongolian adolescents in obtaining health information](chart.png)
(10-14 years old) and 55 per cent of older adolescents (15-19 years old) did not know where to source such information.

**Accessing health care services is difficult.** Collectively, 61.6 per cent of the respondents said they had some difficulty accessing health care. A third of the respondents felt they do not need medical care. A fifth of them thought that health services in general did not meet their needs. The biggest obstacles to seeking health care were the lack of doctors and the lack of confidentiality in health care centres.

**Information**

**Available information does not adequately meet the needs, interests and expectations of the adolescents.** Some adolescents are overwhelmed with adult, violent and sexually explicit information, while others experience a deficiency of information and a lack of skills in applying received information to their daily life. The content of information tends to be designed by adults and does not adequately reflect the interests and expectations of adolescents.

**There is a marked difference between the levels of information access among adolescents in the rural and urban areas.** Mass media dominated as the major source of information in urban areas while adolescents in rural areas counted more on oral communication. This disparity was attributed to the lack of electricity in the rural areas.

**Legal environment**

**Laws are not strictly implemented.** While the overall legal framework has been set for protecting adolescent rights, the real challenge lies in the implementation and enforcement of these laws. A low level of knowledge of laws and children rights, loose law enforcement and lack of monitoring mechanisms have led to different forms of children rights violations.
What are the reproductive health (RH) needs of young people in Myanmar? How can these needs be met? To answer these questions, an assessment was set by the Ministry of Health, Myanmar, and UNFPA in 1999. To achieve their task, researchers looked at the situation of adolescents through previous studies and through discussions with service providers and community members. They described challenges faced by adolescents and inadequacies in currently available information sources and services. They shared what channels of information were favoured by discussants.

The basic facts: Young people in Myanmar

- 30 per cent of the total population (46 M as of October 1997) are 10-24 years of age (Ministry of Immigration and Population 1997).
- A low fraction of young people are married (MOIP 1998):
  - 15-19 age group:
    - Women, 6.6 per cent
  - 20-25 age group:
    - Men, 2.2 per cent
    - Women, 23.3 per cent
    - Women, 34.8 per cent
- Age of marriage is high (Fertility and Reproductive Health Survey 1999):
  - Men, 27.5 per cent
  - Women, 26.4 per cent
- Teenagers’ rate of pregnancy is twice that of older groups (Thien 1995).
- Pregnant women younger than 19 are more likely to receive care from traditional birth attendants or none at all compared with those over 19 years (MOIP 1998).
- Adolescents need appropriate help in response to the following (Htay and Wai 1997):
  - Young girls face menstrual problems.
  - Most adolescents do not know how conception occurs.
  - Many know about AIDS but very few know about STDs.

Adolescent sexual behaviour

Young people are sexually active to some degree. Service providers and community members believed many boys are engaging in sexual activities, at times with prostitutes, before marriage. They said premarital sex does not happen with girls in their communities. But on further investigations, they cited young unmarried women among the groups at risk of induced abortion.

In Tachileik – a place bordering Thailand – discussants of all ages were much more open to report sexual exposure of young people. They mentioned that after seeking to work in Thailand, young men get into contact with sex workers while young women often end up as prostitutes. Sexual intercourse among couples about to get married was also common.

Knowledge on reproductive health issues

Adolescents lack accurate information. Adolescents were aware of HIV/AIDS and condoms, but less about sexually transmitted diseases (STDs). And their information might not have been accurate. They had heard of contraceptives but did not know the potential side effects or how to use them.
Girls did not know much about menstrual care or the relationship between menarche and fertility. They were emotionally upset by menstrual irregularity, a problem of particular concern among young girls. For this problem, they consulted their grandmothers or mothers and used traditional medicine for treatment or in stubborn cases, injections administered by doctors.

**Access to services**

*Unmarried adolescents are unlikely to seek services from public providers.*

Adolescents reported that contraceptives are easy to acquire from drug stores or private, general practitioners. They preferred private health care providers to public ones because they would like to maintain anonymity and avoid judgmental treatment. Midwives and service providers were said to have judgemental attitudes towards unmarried adolescents with reproductive health problems. Consequently, young people decide to go to private providers or not to seek formal health care at all.

Since service providers were unfamiliar in dealing with unmarried clients, engaged couples planning to delay first births were neither seeking help nor taking contraceptives until their marriage or first sexual encounter.

**Channels of information**

*Adolescents need to be actively provided with information.* Health education should be made accessible to in-school and out-of-school youth through formal channels of communication (see Table 1). The importance of adolescent RH should be explained to parents and teachers for them to support school-based health education, the discussants said. Health personnel on visits, rather than teachers, were deemed more appropriate to handle reproductive health education in schools and even among out-of-school youth. Peer groups and the mass media were marked as other important channels for communicating adolescent reproductive health.

**Table 1. Various channels of adolescent reproductive health (RH) communication and corresponding factors to consider**

<table>
<thead>
<tr>
<th>Communication channels</th>
<th>Some positive and negative factors to consider</th>
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</table>
| □ School teachers      | • Adolescents may not be at ease discussing sensitive issues with someone they meet on a daily basis.  
• Teachers themselves may not be comfortable discussing RH issues with students. |
| □ Health personnel    | • They are perceived to be more credible in handling RH issues. |
| □ Peer groups         | • Adolescents can discuss with peers more openly. |
| □ Mass Media          | • These are popular among teenagers. (magazines, brochures, posters and TV spots) |
First comprehensive study reveals state of adolescent reproductive health


The first comprehensive information on adolescents' knowledge, attitude and practices (KAP) on sexual and reproductive health in Nepal is out, thanks to the efforts of the Valley Research Group. The group’s nationwide study covered 2,025 adolescents aged 15 to 19 as well as 179 key community informants (averaging 38.7 years) from seven districts across Nepal. The sample included mainly unmarried (78.0 per cent), literate (83.0 per cent) adolescents of various ethnic groups (e.g., Brahmin, Chhetri, occupational castes and others). About half (55.9 per cent) of the adolescents were students.

Right age of initiation to sex, marriage and childbirth

Adolescents are against early sexual intercourse, marriage and childbirth.
Adolescents recommended delaying sexual initiation to an average of 21.5 years for boys and 19.4 years for girls. Likewise, they believed that girls and boys should be marrying at ages no younger than 19.9 years and 23.1 years, respectively. They also said newly married couples should be delaying first births for 2.4 years on the average. Nearly half (45.3 per cent) of the adolescents reported 22 to 23 years as an appropriate age for women to give birth. The adolescents cited health considerations for mother and child among their main reasons for delayed childbirth. The recommended ages for sexual initiation, marriage and childbirth increased as the respondent’s level of education increased.

Sexual and reproductive health problems

Adolescents face early sexual initiation. One of every four adolescents claimed to be sexually experienced. First sexual intercourse usually occurred at ages before adolescents finished schooling – a mean of 16.4 years for boys and 16.0 for girls. Males often had premarital sex while female adolescents rarely engaged in sex outside marriage.

Adolescents do not openly discuss sexual problems. Before their first sexual intercourse, about 53.1 per cent of males and 23.2 per cent of females claimed to know about sex mostly from friends. Nearly three quarters (73.1 per cent) of female adolescents suffered physical problems (pain or burning sensation in genitals, urination difficulties and others) from their first sexual experience. Only 33.8 per cent of males admitted the same. Only a quarter of the afflicted adolescents discussed their problems with others.

Teenage pregnancy problems are prevalent. Marriage occurred at 15.6 years for girls and 15.3 for boys. By the age of 17, 46.0 per cent of married adolescent girls had already given birth, indicating that teenage pregnancy is highly prevalent in Nepal. The majority of these girls experienced problems such as prolonged labour, retained placenta and haemorrhage during their first delivery.
Abortion is being practised. A large majority (70 per cent) of the adolescents, particularly females, were aware of abortion. Nearly 41 per cent said modern health practitioners performed it in their communities.

Fertility preferences and family planning

Adolescents prefer having few children. With a slight bias for sons against daughters (1.2 vs. 1.0), the mean ideal number of children preferred by adolescents was 2.2. Although this figure was less than half of the fertility rate then, it did not necessarily denote a leaning for a compact family: 51.6 per cent of adolescents favoured a joint family system over a nuclear type of family. More than half (53.3 per cent) of the adolescents considered it ideal to put a five-year space between births.

Adolescents are aware of family planning but hardly practice it. Almost all adolescents (94.9 per cent) expressed willingness to use family planning methods in the future. About 94 per cent of the adolescents heard of female sterilisation. Male adolescents were very familiar with condoms (96.8 per cent), male sterilisation (94.3 per cent), and female sterilisation (93.5 per cent). But only eight per cent of the adolescents used at least one modern method of contraception. They obtained their contraceptives mainly from health posts, pharmacies and sub-health posts.

Knowledge of reproductive processes and social customs

Adolescents understand basic reproductive processes. Almost all adolescents can define puberty, menstruation, and conception. Ninety-four per cent of the female adolescents experienced menarche at a mean age of 13.9 years. Nearly 60 per cent of them had some knowledge about menstruation before it occurred.

Menstruation is associated with taboos. The majority of adolescents mentioned some social taboos observed during menstruation: isolation as well as restrictions on movement and contact with males.

Knowledge of RTIs/STDs

Knowledge of RTIs and STDs is limited. Only 30.0 per cent of adolescents heard of reproductive tract infections (RTIs), indicating a need for adequately designed education programmes. More than three quarters (77.0 per cent) heard of sexually transmitted diseases (STDs), particularly HIV/AIDS. They cited multiple sex partners (78.4 per cent) and commercial sex workers (52.7 per cent) as sources of STDs.

Illiterate adolescents, followed by those who have attained lower education levels, were least aware of RTIs, STDs and HIV/AIDS.

The majority (85.6 per cent) of the adolescents heard of HIV/AIDS. A remarkably large proportion of them were familiar with the precautionary measures against HIV/AIDS transmission. The most frequently reported measures were the use of condoms (77.2 per cent) and avoidance of unprotected sex with multiple partners (68.0 per cent).

Information and services for adolescents

Radio is a major source of information. Adolescents had reportedly heard about family planning methods, STDs, RTIs and HIV/AIDS through the radio, followed by television and friends. Radio-based programmes were the most appealing forms of information, education and communication (IEC) campaign. Mothers were found to be a major source of information on menstruation.
The community supports RH education for adolescents. A large proportion (74.3 per cent to 99.4 per cent) of key informants were in favour of providing adolescents with education related to sexuality, childbearing and family planning. Around 38 per cent to 61 per cent referred to schools as the appropriate venue for doing so.

Adolescents seldom use health facilities. Almost all adolescents recognised the need for antenatal services during first pregnancies. But only 68.8 per cent of the 157 adolescent mothers had actually received antenatal services. The major reason for not receiving care was lack of knowledge about such services. Adolescents’ knowledge about services available in their nearest health facility is limited to that of curative services.

Only a small portion (4.1 per cent) of the adolescents had visited health facilities for family planning counselling, where most (59.3 per cent) had received advice on contraceptive choices. Of the adolescent parents, only 22 per cent used health facilities for deliveries (16 per cent in hospitals, 3 per cent in health posts and about one per cent in private clinics). More than three quarters delivered at home.

When asked to name their preferred place for obtaining contraceptives and counselling on family planning or infertility, most adolescents specified government hospitals as well as health posts.

A call for action

Based on these research findings, the following were suggested in designing effective education and information programmes for adolescents:

- Strictly enforce legal actions to discourage marriage earlier than the legally approved age of 18.
- Develop educational programmes on healthy sexual behaviour, the right age of sexual intercourse, mutual understanding and safer sex practices using peer education as a strategy.
- Emphasise delay of first births through formal and non-formal education programmes for newly married couples.
- Initiate RH education before the onset of puberty by including relevant topics even in lower secondary curriculum.
- Highlight messages on antenatal care and availability of facilities for such services.
- Share the advantages of contraceptives and eliminate misconceptions such as perceived negative effects on health.
- Develop IEC activities focussing on RTIs, STDS and HIV/AIDS.
- Air a separate radio talk programme on adolescent sexuality.
- Form teenage group forums in the community and school settings.
- Train and actively mobilise community level workers to disseminate information.
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PACIFIC ISLAND COUNTRIES

Workshop paper tells how to improve ARH in the region


The adolescent reproductive health (ARH) issues faced by Pacific Island Countries (PICs) were laid down in a paper presented during an inter-country workshop in 2000. Ways to amend the situation were also suggested. In brief, here is what has been covered:

The situation: teen pregnancy and STIs

**Teen girls account for at least a tenth of all pregnancies.** The respective Ministries of Health declared that about ten per cent of all deliveries in Fiji (1996) and 20 per cent in Marshall Islands (1999) occurred among teenagers.

Estimates of teenage pregnancy incidences increase when abortion rates – unspecified abortions in particular – are factored in. An unspecified abortion (suspected to be an illegal pregnancy termination) refers to a case where a ‘specific diagnosis’ is not medically made. In Fiji, eight per cent of unspecified abortions were performed on adolescent girls in 1999.

UNFPA studies in Cook Islands and Samoa indicated that more adolescent boys than girls had sexual intercourse. However, there were no records of teenage fathers, only mothers. The paper inferred that adolescent boys or girls might be having sex with older people rather than youngsters of their own age.

Data on contraceptive use among adolescents were not available. But a few evidences from clients of the Drop-in Centre in Marshall Islands suggested an increase in the numbers practicing contraception.

**HIV is still rare, but young people’s share on STI rates is alarming.** Between 1989 and 1999, there was only one HIV case among adolescents in Fiji and none in Marshall Islands. But in 1998, adolescents aged 15 to 19 years took up 16.2 per cent of all gonorrhoea cases in Fiji; those aged 20 to 24 years, 40.8 per cent. The corresponding rates for syphilis were lower at 6.2 per cent of the younger age group and 22.2 per cent of the older age group. In the same year, the respective shares of adolescents in syphilis, gonorrhoea, and chlamydia cases among pregnant women in Marshall Islands were estimated at 14 per cent, 15 per cent and 46 per cent.

Barriers to progress

**Progress in ARH meets many constraints.** Through reproductive health studies in PICs, ARH trends that need

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**Box 1. Adolescent reproductive health issues in Pacific Island Countries**

- Lack of information provision
- Low motivation for contraceptive use
- Slow pace of sexuality education
- Lack of safe sex negotiation skills
- Laxity of family discipline
- Peer pressure
- Influence of drugs and alcohol
- Erosion of family, religious and traditional values
- Change of adolescent behaviour and attitude from restrictive to casual
- Sex for money
- Lack of interest in youth programmes and activities
- Increasing number of street kids
- Double standard to male and female sexual behaviour
reversal have been identified. For example, adolescents are not adequately informed about family planning and reproductive and sexual health as well as services available for young people. They have low motivation for preventing pregnancies through contraceptive methods. And sexuality education is going at a slow pace. Other issues were identified as well (see Box 1).

**Strides towards ARH**

**PICs are making progress in ARH policy, programmes and support.** Most PICs have endorsed ARH as a priority component of the family planning and reproductive health programme. With visible efforts, PICs along with international and regional agencies are collectively addressing ARH issues. Drop-in centres are being established successfully across countries in the region. ARH programmes are supported through training of personnel and partnerships with NGOs. Lastly, most religious organisations have somehow recognised ARH as an acceptable concern.

**Improving ARH: recommendations**

**Integrate ARH services into health care systems.** Not finding it feasible to establish separate ARH services, PICs are advised to promote adolescent-friendly programmes and services within established health systems. In this set-up, primary health care systems, such as public hospitals and clinics, need to: a) train health care providers on counselling, appropriate IEC materials, and provision of services specifically for adolescents and b) develop a referral system or protocol that will ensure immediate service for adolescent clients.

Other healthcare systems to tap may include private clinics. Drop-in centres, which are gradually gaining popularity among adolescents, may also serve well for this purpose (see Box 2). Medical professionals should be approached to offer their services on a voluntary basis within drop-in centres.

**Intensify current IEC activities and materials.** Adolescents should be directly involved in the development of IEC materials and the implementation of outreach activities. Efforts should be raised to ensure applicability of IEC materials and activities to local conditions. Different targets – rural and urban adolescents, street kids, and others – should be reached with equal intensity. Teachings should emphasise understanding of one’s own sexuality and “fact, friendship, fellowship” rather than “fear, force, fraud”. Existing IEC programmes should be promoted (for example, YTYIH programme in Marshall Islands; Wol Smol Bag Theatre in Vanuatu, YMCA in Samoa and ARH Information in Fiji). Finally the harmful influences of pornography, TV, video and others should be counteracted. Traditional means of communication (songs, dance, drama) could be promoted as a solution.

**Introduce sexuality education.** In-school and out-of-school adolescents should equally receive sexuality education. Peer education and counselling should be an integral part of this programme.

**Identify cultural and religious entry points for intervention.** Cultural and religious beliefs should be adapted to support the ARH agenda. For example, the Pacific way of raising a family in an attitude of care, sharing, love and respect should be promoted and used to the advantage of ARH programmes. Likewise, the religious concept of purity in love, sex and marriage could justify interventions of education, parenting, counselling and promotion of safe and responsible sex.
Conference on adolescents raises reproductive health strategies


The three-day South Asia Conference on Adolescents was organized in 1998 as a follow-up to the implementation of the International Conference on Population Development (ICPD) Programme of Action. The conference concluded with a set of national and regional strategies under three broad thematic areas: sexual and reproductive health; literacy and education; and exploitation and violence.

Government representatives and selected adolescents from countries under the South Asian Association of Regional Cooperation (SAARC), NGOs and UN agencies participated in the conference. They reviewed and assessed the progress made, lessons learned as well as the constraints encountered in the ICPD Programme of Action for adolescents. The following is a brief summary of what has been discussed:

Adolescent sexual and reproductive health

Adolescent fertility is rising. Despite the decreasing trend in the total fertility rate in Bangladesh, the fertility rate among adolescents has increased. There is also a rising proportion of teenage mothers among all mothers. A similar situation is occurring in Bhutan where 11 per cent of all births occur to adolescent girls. In Maldives, late adolescents (15-19 years) contribute 30 per cent to the country’s total fertility. The age-specific fertility rate of adolescents is 1.3 where most girls and women conceive and bear children within their first year of marriage. Age-specific fertility rates in Nepal indicate a shift to younger age groups (15-24 years). In Pakistan, a large share of births occurs to girls aged 15-19 years. Ninety per cent of adolescent girls preferred to give birth early as insurance against rejection, isolation and threat of the second wife.

Adolescents are becoming sexually active at an earlier age. The fairly tolerant attitude towards sex and sexuality has led to an increasing occurrence of pre-marital sex among this age group. In Bhutan and Maldives, there is considerable freedom of choice of sex partners. The mean age of first sexual contact in Nepal is 18 years old. On the other hand, 11 per cent of all illegitimate births in Sri Lanka are by adolescent girls.

"We adolescents are not only conscious of our rights but we also feel responsible for moving away from the “me” decade in which we are living, to a decade where adolescents will prove to be an important human resource for the betterment of the region. We pledge to make this a reality.”

— Preamble of Delhi Declaration, The South Asia Conference on Adolescents 1999
More adolescents are getting married at a younger age. The lowest average age of marriage is in Maldives at 16 years of age. In Bangladesh, it is 18 years. In Pakistan, it is 21 years but a significant proportion of the populations marry by 17. About 60 per cent of marriages in Nepal involve adolescent brides. The mean age of marriage is 18 and child marriages are on the rise in Nepal. In India, 50 per cent of adolescent girls (aged 15-19) are already married. Most adolescent girls are married by the age of 20. There is a wide difference between ages of spouses among adolescent marriages in these countries.

Mortality among mothers, infants and children is rising. Early conception and birth among adolescents result in a higher risk of maternal mortality. Most countries report an increase in maternal mortality rates (MMR). Nepal has the highest MMR in the region (539 deaths per 100,000 live births). And among its adolescent girls, MMR is 864 deaths per 100,000 live births. Girls aged 15-19 take the biggest fraction (19 per cent) of reproductive age deaths. MMR among adolescents in Pakistan is 341 deaths per 100,000 live births.

The incidence of abortion among adolescents is increasing. Twelve per cent of spontaneous abortions in India occurs among the 13-14 age group while nine per cent among the 15-19 age group. In Nepal, seven per cent of all abortion cases occur among adolescents younger than 20 years of age. An alarming proportion of maternal deaths in Pakistan are attributed to unsafe abortion practices. In Sri Lanka, abortions among adolescents (15-19 years) are as many as 750 abortions per day.

STDs/HIV/AIDS are becoming more prevalent among adolescents. Because of unprotected sexual practices, STDs (especially gonorrhoea) are spreading in Bhutan. In 1994, the World Health Organization estimated that 2.5 million Indians are HIV positive. It is suspected that they acquired HIV during adolescence. In Nepal, half of female adolescent STD patients are commercial sex workers. About one in five of these patients is HIV positive. Around 50,000 to 80,000 cases of HIV/AIDS have been reported in Pakistan.

Literacy and education

Literacy and educational levels are still low. Other than Sri Lanka, a significant proportion of the adolescent population is illiterate. Most adolescents in Bangladesh are illiterate. At the primary education level, the enrolment rate is high (87 per cent) but only half reach the final grade. Gross primary school enrolment rate in Bhutan is 72 per cent but the literacy rate among adolescent girls is less than 10 per cent. In Nepal, adolescent literacy is low (less than 40 per cent).

There are still gender disparities in the enrolment rates at higher levels. In Bangladesh, only 23 per cent of the girls have seven years of schooling. Adolescent girls in Bhutan are over five times less likely to be literate than boys. In India, there is a 20 per cent gap in literacy between boys and girls aged 10-19. The mean year of schooling for Pakistani adolescent boys is 2.9 years while the girls’ schooling averages only one-fourth of this (0.7 year). There are fewer educational opportunities open to female adolescents since most schools are highly sex-segregated.
School dropout rates among girls are significantly higher among girls. This is true in India since girls assume domestic and sibling care responsibilities at a young age. More adolescent girls (38 per cent) dropped out of the secondary and post-secondary levels in Bhutan.

Exploitation of and violation against adolescents

Common forms of adolescent exploitation in the SAARC region include:
- Use of students, especially boys, for political protests and violence
- Adolescent employment in hazardous and non-remunerative jobs for unequal wages
- Conscription of children, youth and adolescents into military/ethnic conflicts
- Substance abuse
- Child labour practices

Violent acts committed against adolescents include:
- Rape
- Physical and sexual abuse
- Courtship violence and dowry-related abuse (i.e. accidental burning or “chula” homicide, dowry killing)
- Economically-coerced sexual abuse
- Sexual harassment
- Forced prostitution and cross-border trafficking of women
- Murder

Policies and programmes for adolescents

Most countries have been able to make headway in incorporating adolescent concerns into their national policies on health. Only Pakistan has not been able to do so. Programmes such as Family Life Education (FLE) and Population Education (PE) have been integrated into the formal and non-formal school curricula in some countries. The 5th Health and Population Programme of Bangladesh outlines specific adolescent sexual and reproductive health (ASRH) services. The 8th Five-Year Plan of the Royal Bhutan Government specifies the inclusion of specific target groups within the framework of reproductive health, family planning, STD/HIV/AIDS prevention services and school health services. In India, the National Reproduction and Child Health programme, a major comprehensive package on maternal and child health care service, supports special projects for adolescents from urban slum, tribal and disadvantaged groups. In Maldives, the Health Master Plan (1996-2005) identifies goals and strategies to address adolescent needs including the empowerment of women and adolescents.

UNFPA programmes in the region include:
- Financial support for the improvement of access to quality RH services
- Support KAP surveys and population education programmes
- Population, development and environmental courses in schools
- Information dissemination programmes (RH information and services)
- Collaborative efforts with NGOs
Strategic Recommendations:

Over-all Strategy

- Adopt an SAARC Declaration on the Rights of Adolescents.
- Strengthen national capacity in the collection, compilation, updating and analysis of qualitative and quantitative data on all aspects of adolescent life.
- Sensitise politicians, policy makers, parents, teachers and members of the press on their needs and problems.
- Formulate a comprehensive national strategy and programme of action addressing adolescents’ multi-dimensional needs.
- Incorporate adolescent concerns into existing development programmes for adolescents.
- Establish a Centre of Excellence for Adolescents.
- Foster inter-ministerial collaboration to address adolescent needs.
- Hold country-level conferences on adolescents (as a follow-up on the conference).
- Form a network of adolescent group.
- Establish counselling and career guidance centre.
- Ban the involvement of students in partisan politics.
- Eliminate discriminating practices against female children.

Sexual and Reproductive Health

- Sensitise politicians, policy makers, community leaders, parents and teachers to the uniqueness of adolescent needs.
- Collect, analyse and disseminate data on all aspects of adolescents’ sexual and reproductive health on a regular and systematic manner.
- Formulate country specific comprehensive ASRH programmes for specific target groups (i.e. married and unmarried, sexual active and non-active adolescents, urban and rural settings).
- Improve the sexual and reproductive health knowledge of adolescents in issues such as sexuality, reproduction and unsafe sexual practices.
- Ensure the accessibility and quality of RH services for all.
- Lobby for increasing the legal age of marriage and, at the same time, take the necessary steps against early marriage and teenage pregnancy.
- Incorporate ASRH concerns into existing development programmes.

Strategic Recommendations: Literacy and Education

- Make primary education compulsory for all primary school age children.
- Enhance the quality of education with updated curricula reflecting the needs of the adolescents, properly trained teachers, increased student participation in education programmes, improved environmental facilities.
- Update existing programmes on ASRH education on a continuing basis in light of new research findings and best practices.
- Inculcate moral and religious values through education programmes.
- Develop a holistic education plan for out-of-school adolescents that will give them functional literacy and income generation skills.
- Develop appropriate educational materials to orient parents and teachers on the RH needs of adolescents.
- Increase the budgetary allocation for education.
- Increase the participation and role of NGOs and the private sector in education.

Strategic Recommendations: Violence Against Adolescents

- Sensitise all law enforcement personnel, politicians, policy makers, parents, teachers and the press on the needs and problems of the adolescents particularly the pervasiveness of violence and exploitation against adolescents.
- Formulate a comprehensive national strategy and programme of action to address social, economic and domestic exploitation of, and violence against adolescents.
- Establish a national coordination council to strengthen and coordinate intra-country efforts to eliminate all types of exploitation of and violence against adolescents.
- Review existing laws and identify gaps and take necessary corrective legal steps.
- Set-up rehabilitation centres for drug addicts and sexually abused adolescents, both boys and girls.
A report in 1998 paints progress, but also points out pitfalls, in the adolescent reproductive health situation in Thailand. The report was delivered with the hopes of developing and improving ARH counselling and services in the country. It was also designed to help in identifying problems, target groups, factors affecting health behaviour and relevant institutional responses. It employed three major strategies in reaching its objectives. A review of relevant research activities was conducted to come up with a multi-dimensional picture of the adolescent situation in Thailand (see Figure). A grid workshop was organised, gathering 32 knowledgeable persons and practitioners. Focus group discussions were carried out to identify reproductive health needs among adolescents and youth. The findings of the study follow.

Country demographics

**Population trends are promising.** The population growth rate is decreasing. The annual growth rate is 1.1 per cent. The fertility rate is declining as well. The total fertility rate has decreased to 1.95 from the value of 6.30 in 1964-65. The population structure is shifting towards a younger age.

**Education**

**Literacy rate is quite high.** In 1991, 47.5 per cent of the children and youth were in educational institutions. More than 60 per cent of them had completed compulsory primary education, 14.2 per cent finished secondary level while 1.8 per cent had university degrees.

Average dropout age among students is between 12 and 14 years. In this age group, 67 per cent left school while only 14.4 per cent of those aged 15-19 did the same. Those residing outside city districts dropped out at earlier ages compared with those in city districts.

Status of policy and legislation for adolescents

**An adolescent health plan and a number of laws are in place.** An adolescent health plan has been integrated into the Eighth Five-Year National Health Plan (1997-2001). The plan carefully reflected the weight given to the health needs of adolescents. Relevant activities are currently being carried out as part of the regular programmes of the Ministry of Public Health. In addition, important laws and regulations have been developed in the areas of marriage, adoption, education, labour protection, school lunch fund and suppression of commercial sex.
Adolescent sexuality and reproduction health

The median age at first sexual encounter is between 16 and 18 years. The median age for girls was higher compared to that of boys. More than half of all who ever had sex had unprotected first sexual intercourse. Moreover, it was found that relatively small proportions of males had commercial sex workers (CSWs) as their first partners.

Sexual tendency of young people is towards early and premarital sex with non-commercial sex partners. Several studies on sexual behaviour pointed out that they were inclined to have premarital sex at a young age and frequently with non-commercial sex workers (girlfriends/boyfriends). This was attributed to the belief that it is safer. Research studies also indicated that adolescents have higher rate of condom use in sexual encounters with CSWs.

The STD situation among adolescents is distressing. Information from service statistics showed that half of all patients seeking treatment for STDs (excluding HIV/AIDS) belonged to the 10-24 years old age group. Although the number of STD patients decreases in older age groups, the number of those infected under 15 years old has gradually increased. It was also observed that female patients aged 10-24 has outnumbered their male counterparts.

HIV/AIDS is still considered a problem among adolescents. Those aged 20-24 years old were found to constitute the highest proportion of HIV positive patients. Common mode of transmission in this age group was through unprotected sexual encounters.

Levels of knowledge on STD/HIV/AIDS issues vary by age, sex, levels of education and areas of residence. The older and higher educated male adolescents living in urban areas are more knowledgeable compared to other groups. Among different adolescent groups, commercial sex workers were found to have fairly good knowledge while military draftees were virtually afraid of AIDS but less aware of its mode of transmission.

Marriage culture is changing. The average age at first marriage was pegged at 20.5 years while the average age at first birth was 23 years old. The desired number of children was 2.4.

Abortion rates among the young are increasing. The number treated for complications from illegal abortions has increased. In 1984, more than half of these complication cases were among patients aged 24 and younger. Of all illegal abortion cases among single women, 48.6 per cent were performed on those aged 20-24 and 40.5 per cent on those aged 15-19.

Services and information

RH services for adolescents need to increase. Workshop participants pointed out the lack of special clinics available to young people. Few counselling clinics existed while hotline counselling services were mostly provided by the private sector.

Studies need to target a wider age range. To date, no study has been conducted where adolescents aged 10-24 years old served as the target population. Most of the studies have involved respondents aged 10-19 years old or youth 15-24 years old. Studies often focused on different respondents and different settings. In addition, these researches have not been able to examine or investigate all aspects of adolescent health.

The availability of information on HIV/AIDS cases is outstanding. The reporting system on HIV/AIDS reflected information from both the GOs and NGOs in the country. But for other STDs, only information from the Department of Communicable Diseases Control is widely available.
adolescent reproductive health

KAP studies give representations of particular target groups. They are invaluable in planning and designing target-specific programme interventions. They are also useful in monitoring and evaluating the success of future programmes. This section contains the following KAP studies:

A baseline study from Bangladesh sketches its urban target in terms of education, employment, age of marriage and childbirth, family planning knowledge and practice, teenage pregnancy, STD/HIV/AIDS knowledge, and risk behaviours such as smoking and alcohol and drug use. It also explores adolescent-parent relationships and identifies parents’ perceptions and concerns about adolescent’s reproductive health needs. The information is meant to help the development of adolescent static clinics.

Demographic, listenership and disease profiles of youth are derived from the baseline data gathered from four areas in Cambodia. The knowledge of youth on reproductive and sexual health, their sources of information as well as their social and life skills are also described. The outcome will be used in the preparation of an interactive radio programme on reproductive health. Still in Cambodia, baseline studies among school-going and out-of-school youth cover: communication on sexual matters, reproductive health knowledge, sexual practices, STD/HIV/AIDS information and risks and family planning practices. Based on these findings, important components of peer education programmes and services are identified.

The report from Sri Lanka depicts Grade Nine students’ knowledge of population, adolescence and reproductive health, family life and reproductive physiology, and sexuality and responsible behaviour.

Youth’s knowledge of reproductive physiology, contraception, STDs/AIDS and their perceptions on sexual behaviour and unwanted pregnancy are covered in the Lao PDR survey of young people from villages. Also discussed are the roles played by education and geographic isolation with respect to reproductive health knowledge and degree of conservatism.

The research report from Vietnam presents a general picture of the lives of young people in Vietnam. Aspects outside the reproductive health arena are well represented – education, time use and life activity, employment and social attitude, migration and gender roles.
Baseline study explores state of urban youth reproductive health

Source: Islam, Ariful, Quamrun Nahar and Cristobal Tunon. Adolescents and reproductive health: a baseline study from selected urban areas of Bangladesh: abstract. s.l.:UFHP-ICDDR, B-ACPR, November 2000.

In early 1999, the Urban Family Health Partnership (UFHP) began a pilot scheme for an Adolescent Health Programme. UFHP aims to develop a comprehensive programme focused on reproductive health needs of adolescents through static clinics that provide services and counselling to adolescents that ‘walk in’ or are ‘referred’ through educational activities in schools and the community at large.

A baseline study was commissioned to assess the current knowledge, attitudes and behaviour of adolescents; explore adolescent-parent relationships; and identify parents’ perceptions and concerns about reproductive health needs of adolescents. A total of 3,047 adolescents aged 13-19 (mean: 15.6 years) and 1,540 parents from Chittagong, Khulna and Darsana were interviewed using two separate questionnaires to arrive at the following trends:

Education and employment
- One out of ten adolescents had never attended school.
- Among school-going adolescents, 18 per cent of males and one in ten females declared having worked for earnings.
- Among out-of-school adolescents, 63 per cent of males and 19 per cent of females were employed in some form of paid work.

Age of marriage and childbirth
- The perceived ideal age for marriage was 18.8 years for females and 23.8 years for males.
- Approximately a fifth of the females (aged 13-19) and one per cent of males were married for an average duration of 2.7 years. The average duration of marriage was two years for females and 0.77 years for males.
- The mean age at first pregnancy was 14.5 years for married female adolescents. Nearly 60 per cent of married female adolescents and about 20 per cent of the wives of the married male adolescents had been pregnant.
- The perceived ideal age for females to have children was 21.8 years and for men to become fathers was 26.7 years.

Family planning knowledge and practice
- About one in five adolescents did not know when a female could get pregnant. Even in the group of over 15 years, one in eight reported lack of knowledge on this subject.
- Oral contraceptives and condoms were the best-known contraceptive methods among respondents.
- Over 60 per cent of married females were not using family planning methods. Around 46 per cent of the married male adolescents were not using family planning methods.
About 70 per cent of married female adolescents reported that they had received antenatal care during pregnancy.

Teenage pregnancy

- If premarital pregnancy occurred, 55 per cent of the guardians recommended that parents should arrange for abortion. Around 52 per cent favoured the idea of arranging marriage with the responsible boy. Almost a quarter (23.3 per cent) suggested taking legal action.
- About three quarters (73.6 per cent) suggested that parents should arrange a marriage if their son is responsible for premarital pregnancy.

STD/HIV/AIDS knowledge

- Between a quarter and one third of all boys had heard of STDs. Girls, particularly in small municipalities, were less knowledgeable. A smaller proportion of older adolescent girls reported knowledge of STDs.
- As perceived by adolescents, HIV is transmitted through sexual activity (53.8 per cent of females and 38.7 per cent of males), use of non-sterile needles and syringes (26.8 per cent of females and 37.6 per cent of males), blood transfusion (21.4 per cent), and sexual activity with commercial sex workers (16.8 per cent of females and 51.9 per cent of males).

Smoking, alcohol and drug use

- Only five per cent of girls and 37 per cent of boys smoked at least once. Before the age of 16, the difference in smoking habits between sexes is less pronounced than at later stages.
- Adolescent boys had taken at least once fencidil/alcohol (5.1 per cent) and drugs (6.3 per cent). The greater number was in the cities of the Khulna division. There is strong association between smoking and the probability of drinking alcohol or fencidil.

Adolescent-parent relationship

- Around 30 per cent of girls and nine per cent of boys found it difficult to discuss personal matters. On the other hand, only seven per cent of girls and three per cent of boys found it difficult to discuss important matters with their mothers.
- Over 96 per cent of the adolescents did not discuss reproductive health matters like marriage, family planning, pregnancy and sex with their fathers. Most adolescents said ‘shyness’ was the main reason for not being able to discuss these issues with their fathers. For the same reason, nearly half of the girls and 91 per cent of boys did not discuss such matters with their mothers.

Parents’ perceptions and concerns

- Over three quarters of the guardians felt comfortable discussing sexual matters and reproductive health with adolescents.
- Around 41 per cent discuss about reproductive health and sexual matters with adolescents.
- Parents wanted to know more about STDs (67.5 per cent), HIV/AIDS (57.9 per cent) and contraceptives (44 per cent).
- Nearly 90 per cent of the parents agreed with the idea that information about reproductive health and sexuality should be available for adolescents from clinics. There was less support for this type of information to be made available for adolescents at pharmacies.
Reproductive health survey of in-school and out-of-school adolescents

Sources: Reproductive Health Association of Cambodia. Adolescent reproductive health survey, a baseline study: school going adolescents in Phnom Penh. n.d. 21 p.

Peer education programmes and youth-friendly clinic services for school and out-of-school adolescents in Phnom Penh will soon be designed according to the results of two baseline studies. The Reproductive Health Association of Cambodia (RHAC), under the EC/UNFPA Asia Initiative, has now released the results of these studies, reflecting similarities and differences in the outlook and experiences of the two adolescent subgroups.

Adolescents in the study numbered 1,197 Grade 8 to 12 students from three high schools and 407 out-of-school youngsters aged 12 to 25. Research highlights are featured below:

Communication on sexual and reproductive health

Adolescents seldom discuss sexuality and reproductive health matters among themselves. More than three quarters of adolescents reported that they do not discuss with peers topics such as: how to avoid pregnancy, relationships with the opposite sex, whether or not to have sex with someone, unwanted pregnancy or abortion and where to get condoms. This lack of openness among adolescents could be a challenge to future peer education programmes.

Reproductive health knowledge

Levels of reproductive health knowledge are low among in-school adolescents in particular. Over 70 per cent of school adolescents did not know when pregnancy is likely to occur. The corresponding rates for out-of-school adolescents were 58.1 per cent of the females and 67.6 per cent of the males.

Adolescent girls learned about menstruation from their mothers and sisters; adolescent boys, from the media. Both sexes relied on the media and their friends for information on matters such as wet dreams – a topic that was less known to most girls or school adolescents. Less than a fifth of girls and only 44 per cent of school adolescents knew about it. More than two thirds (67.6 per cent) of out-of-school adolescent boys were aware of it.

Sexual experience

Sexual experience among out-of-school adolescents is about ten times that of in-school adolescents. The respective percentages of out-of-school and in-school adolescents who had had sexual intercourse are 37.3 per cent and 3.8 per cent. The difference is partly
explained by the higher percentage of married out-of-school adolescents. The incidence of sexual intercourse started rising at the age between 16 and 17 years.

Sex among adolescents may involve multiple partners, prostitutes, alcohol and drugs. Of the school adolescents who had experienced sex, about four of every ten claimed to have more than one sexual partner in their lifetime. Among out-of-school adolescents, about three of every ten boys had had multiple partners while girls were usually dedicated to one partner.

Nearly half (49.1 per cent) of the out-of-school boys had their first sexual encounter with prostitutes, 40.7 per cent with girlfriends. Among in-school boys, only 35 per cent had prostitutes for their first sexual partner. Most (60 per cent) had their first sex with girlfriends.

Most out-of-school adolescents reported their partners to be under the influence of alcohol or drugs during the first time they had sex, although they themselves were not. But with school adolescents, neither alcohol nor drugs seemed to play a role in sexual initiation.

Many adolescents do not discuss or use protection during their first sex act. In 70 per cent or more of first time sex experiences, protection from pregnancy was not discussed between partners. Only 60 per cent used some form of contraception, usually condoms, during their first sex act. Those that did not use any method reasoned that they did not know how or they did not expect to have sexual intercourse. In the case of some out-of-school adolescents, they simply wanted a pregnancy.

STDs/HIV/AIDS

Adolescents hear about STDs/HIV/AIDS from the media and other sources. About half of adolescents had heard of STDs. More in-school than out-of-school adolescents had heard of HIV/AIDS (78.9 per cent against 61.7 per cent). Adolescents reported more than one source of information. The media, particularly TV and radio, was a more significant source for school adolescents (88.8 per cent) than for their out-of-school counterparts (43 per cent). More than 90 per cent of adolescents cited the media also as their source of HIV/AIDS information. Other sources were: health workers, family members, friends and teachers.

Those who have heard about STDs and HIV/AIDS are generally well informed although some misunderstandings remain. The most common of these are the possibility of STD infection through sharing of meals or clothes as believed by about a tenth or more of all adolescents.

A number of adolescents do not seek treatment for STDs. Of the adolescents who have heard about STDs, 5.2 per cent of in-school and 11 per cent of out-of-school adolescents reported to have had an infection. Of those who knew of being infected, nearly 40 per cent did not seek treatment. Those who sought help usually went to a clinic or a hospital or a traditional nurse. Most needed to see multiple service providers for treatment.

A number of adolescents are at risk of HIV/AIDS. Nine per cent of in-school and 12.4 per cent of out-of-school adolescents believed their own chances of becoming HIV/AIDS infected within the next year are moderate or high. Adolescents see HIV/AIDS as a serious problem: more than 70 per cent of adolescents believed they should be told about it so they can prevent becoming infected.

At least 30 per cent of respondents with sexual experience did not use a condom to prevent STDs/HIV/AIDS the last time they had intercourse for the following reasons: they did not know how to use it, they did not expect to have intercourse, they were embarrassed, they believed their partner did not have the disease, or they thought it was harmful to their health.
Family planning

Most adolescents are aware of family planning. Only less than a fifth of adolescents (18.5 per cent are in school and 16 per cent are out of school) had never heard of family planning. The mass media was once again cited as a main source of family planning information by more than 85 per cent of adolescents who were aware of family planning. Although greater than 80 per cent of adolescents claimed to be aware of family planning, this figure is relatively low for out-of-school adolescents who are much more sexually experienced than their in-school counterparts.

There is a gap between knowledge and practice. Adolescents who had had sexual intercourse used a family planning method in only 50.3 per cent and 35.0 per cent of cases among in-school and out-of-school adolescents, respectively. Condoms were the most popular among the methods used. Those that failed to use any method either did not know how to use one or had unexpected sexual intercourse. Other reasons included shyness and embarrassment.

Adolescents have misconceptions on family planning. Eighty per cent or more of adolescents believed that family planning is dangerous to one’s health. Other misconceptions included the following: sex before marriage or the age of 20 cannot result in pregnancy; and adolescents, unlike married couples, do not need family planning because they have sex only now and then.

Adolescents face problems of access to contraceptives. Nine per cent of in-school adolescents and 26.7 of out-of-school adolescents who had sexual intercourse considered it difficult to acquire a family planning method. Of these adolescents, about half or more thought it could be embarrassing to buy contraceptives. A fourth to a third of them cited cost and the possibility of being given a bad reputation as other barriers to acquisition.

Attitudes on condom use put girls at a disadvantage. Buying condoms was perceived embarrassing by at least half of adolescents, particularly girls. The double standard towards condom use does not help. Both sexes (50.7 per cent to 88.4 per cent) believed that boys carrying condoms are responsible. A lesser percentage (36.9 per cent to 63.5 per cent) believed this to be true for girls.

Designing a reproductive health programme for adolescents

Based on the gaps discovered from these studies, the following should be considered as important components of future education programmes and services for in-school and out-of-school adolescents:

- Training of peers should focus on methods and techniques of opening discussions.
- Increasing the knowledge of condom use, advocating double use (pills and condoms) and advocating preparedness need to be important characteristics of the future programme.
- It seems important to assure adolescents of immediate and correct treatment for STDs and to inform them of possible places for treatment.
- Instruction on condom use, condom negotiation and awareness would seem to be able to prevent STD infections.
- Education of adolescents should focus on correcting family planning misconceptions such as perceived negative effects on health.
- Making contraceptives easily and cheaply available in non-threatening setting would possibly help them in avoiding unwanted pregnancies.
Trends: Baseline data on youth


The Cambodia Health Education Media Service has recently completed its baseline survey among the youth sector. Survey results were compiled and analyzed to serve as the foundation for the preparation of an interactive radio programme on reproductive health.

The survey was designed to assess the levels of knowledge, attitude, belief and practices related to general health information. It covered the areas of Phnom Penh, Kampot, Kratie and Battambang. Although the information gathered was found to be incomplete, there were interesting trends worth noting. These are as follows:

Demographic profile

- People are more likely to be married when they reach 20-24 years old.
- Marriage is more common in the urban areas as compared to the rural areas.
- Factors that determine marriage include parents, personal interest, educational attainment and standard of living.
- The mean number of household size is six.
- A larger proportion of the rural youth cannot read compared to their urban counterparts.
- The male-female ratio in higher education is virtually equal.
- A greater majority of the urban youth are students.
- Average household weekly income is 26,081 riel (US$ 6.86).
- Women tend to belong to lower income brackets compared to the men.
- TV ownership is higher among urban households compared to radio ownership.

Listenership profile

- There is a higher degree of station loyalty in the rural areas due to the lack of choice.
- There is a wide audience base in Kratie and Kampot for FM 95 while people in Battambang listen to FM 91.
- FM 95 have a lot of male listeners while FM 103 have a lot of female listeners.
- People devote 1-2 hours a day to listening to the radio.
- More women listen to the radio but men listen for longer periods compared to women.
- Among the rural youth, noon is the most popular time for radio listening.
- The urban youth prefer to listen to the radio in the early morning.
- The most popular place for listening to the radio is at home.
- Most of the rural youth listen to the radio with their families while those in the urban areas listen by themselves.
- Programmes, which have song requests, are the most popular among the young people.
Health information and services

- TV and radio are the primary sources of health information.
- Men source their information from newspapers and books while women get more from magazines.
- For health advice, the youth prefer to seek their parents’ advice.
- For most people, the nearest clinic is less than one kilometer away.

Disease profile

- The most common diseases are malaria, diarrhea, tuberculosis, typhoid, hepatitis, acute gastritis, malnutrition, fever, dengue fever and AIDS.
- In the rural areas, malaria is considered as the most serious health problem.
- Typhoid and hepatitis are considered most serious in urban areas.
- There is much negative feeling towards sick people.

Reproductive health

- There is a low level of knowledge and a lot of misconceptions about menstruation and its physical manifestations.
- The pill is the most well known form of contraceptive method.
- There is still a high level of misconception on the effects of contraceptives (i.e. infertility).
- People in Battambang are the most sexually active among the four provinces.
- Women are more sexually active compared to the men. Reasons behind the high incidence of premarital sex among women include love, trust in their partner and fear that parents will not grant them permission to marry.
- Vast majority of the people do not have an idea about what happens in the abortion procedure.
- With regards to birth spacing, they prefer to have a two- to three-year gap between deliveries.
- There is a very low level of awareness on breastfeeding.
- There is still a lot of misconception about fertility including the belief that fertility is affected by “sitting on small mill and steps or sitting for a long time”, “sleeping at midday and getting up early in the morning” or “saying bad words or laughing at a disabled person”.

Sexual health

- Among the STDs, syphilis is the most well known followed by HIV/AIDS and gonorrhea.
- There is a high level of awareness on the mode of transmission of HIV/AIDS where knowledge is higher in urban areas compared to rural areas.
- In the aspect of protection against HIV/AIDS infection, people are generally aware of the different means of protection (use of condoms, monogamy, and others).

Social and life skills

- Dating age is pegged at 16-19 years old although urban residents start dating at an earlier age compared to their rural counterparts.
- The most common problem among the young people is the lack of money, followed by critical parents and lack of job/occupation.
- The most popular pastime among the young people is meeting friends followed by shopping, sport activities and daydreaming.
- The young people espouse equality between genders but this is not reflected in practice. Men receive a higher level of education than girls do. There is also a preference for male children.
Survey shows greater need for quality information on basic reproductive health issues in rural areas


Young Laotians in rural areas have limited knowledge of basic reproductive health (RH) issues according to a 1999 survey. This gives good reason to disseminate quality information among the youth. Conducted under the EC/UNFPA Reproductive Health Initiative, the survey used peer research and focus group discussions among 190 respondents aged 15-23. One third of the respondents were from two villages in Vientiane Municipality while the rest were from Sayaboury Province (Thadeua, Namone villages and the Sayaboury High School).

Results showed that more educated respondents demonstrated greater RH knowledge. Those living in relatively more isolated areas were less knowledgeable on RH issues and were more conservative in their views. Other significant survey results included:

Reproductive physiology

Respondents from villages are less knowledgeable of reproductive physiology. Most respondents from villages were unable to name internal reproductive organs compared to the high school students. The latter possessed a wider vocabulary and broader understanding of reproductive physiology. They were better informed on the physical and emotional changes associated with puberty and reproduction. This can be attributed to the study of human reproduction during their biology classes.

Knowledge of the menstrual cycle and fertility is equally poor for males and females. The women (28 per cent) were more accurate than the men (12 per cent) in identifying the correct length of the menstrual cycle. But the reverse trend emerged in identifying the correct average length of the menstrual period – more than half of the women failed to do so. Only 15 per cent of the respondents correctly identified the most fertile period during menstruation. Less than one third of all respondents (23 per cent of the women; 33 per cent of the men) were aware that pregnancy was possible during menstruation.

Contraception and birth spacing

Levels of knowledge on contraception are correlated with the areas of residence. In the remote area of Namone, 44 per cent of the married women were unable to name any birth control method. In Thadeua, there were higher levels of knowledge on contraceptives for both women and men. Unlike Namone, Thadeua has a village dispensary and four village health volunteers.

Contraceptive knowledge is loaded with misinformation. Many female respondents believed that missing one pill does not lower their protection against pregnancy. Fifty-five per cent of the women also believed that antibiotics offer the same protection as the pill. Most of the male respondents (71 per cent) believed that condom use reduces sexual pleasure. More than half of the respondents believed that vasectomy makes men weaker.
Young people prefer small-size families. The preferred number of children ranged from two to four children. How this relates to actual fertility rates remains to be seen.

Sexual behaviour and preferences

Males think premarital sex is a common practice. Ninety-seven per cent of the men and 24 per cent of the women in the two villages of Vientiane Municipality believed that premarital sex is common. Agreeing to this were 42 per cent of the male high school students and 17 per cent of their female counterparts.

Most of the respondents said it was important for men to have premarital sexual experiences. Around one third of the male respondents believed in the importance of premarital sex even among women.

Responses of single and married men and women were also different. In the Sayaboury province, almost all of the women in Namone find premarital sex uncommon. The married women in Thadeua believed that premarital sex is common while only half of the single women agreed. On the other hand, 87 per cent of the single men in the Sayaboury province found premarital sex common. A similar percentage of married men found it uncommon.

Most respondents perceive homosexual relations negatively. Most of the respondents described homosexual relations as “sin” and “against Lao culture”. More than 80 per cent of the respondents were unaware of the existence of homosexual practices.

Unwanted pregnancy

Unwanted pregnancy is unacceptable. Responses to questions related to this indicated that those living in rural communities were conservative on this issue. A number of respondents in Namone said they would want to kill their sister if this happened to her. Pregnancies outside marriage were seen to cause great shame.

Abortion is viewed as an acceptable solution to unwanted pregnancies. A surprising finding was the notion (by 84 per cent of the women and 60 per cent of the men) that abortion is a safe alternative to contraception. Among the high school students, abortion was widely perceived to be a viable option for pregnant unmarried women (see Figure). The other alternative is marriage.

STDs/HIV/AIDS awareness

Misconceptions on STDs/AIDS are prevalent. Compared with their counterparts in the villages, the high school students fared best in knowledge of STD/HIV/AIDS. But almost all of the respondents had misconceptions about STDs/AIDS particularly on transmission and prevention. Among the male respondents in the four villages, around half believed that touching an infected person can transmit AIDS. Almost two thirds of the female respondents in the villages agreed that taking birth control pills protects them against STDs. A similar trend was also apparent among the responses of the high school students.
Grade nine students show unsatisfactory knowledge of reproductive health issues


A baseline survey conducted in 1999 revealed that most Grade Nine students in Sri Lanka were unaware or misinformed about reproductive health and sexuality. Likewise, they were not fully aware of the changes that are taking place within the modern family in particular and the global village in general. This justifies the inclusion of population, family life and reproductive health modules into the secondary school curriculum.

The survey was conducted among respondents averaging 14 years of age. Using a structured questionnaire, the study investigated 1,031 boys and 1,183 girls from 217 schools. These included all-girls, all-boys and mixed schools; Sinhala, Tamil and Muslim schools; and 1AB, 1C and T-2 schools in rural and urban settings. The summary of the findings is as follows:

Knowledge on population

As a whole, knowledge about the Sri Lankan population is low. Only a tenth of the respondents were able to correctly identify the population size. With respect to its structure, one third of the respondents recognised the correct proportion of the adolescent population while only a fourth were able to identify the aged population. Students in 1AB schools, female schools and Sinhala schools fared better than others. Students from 1C schools, T-2 schools and Tamil schools had relatively lower levels of awareness.

Adolescence and reproductive health

Students reach puberty around ages 13 to 14. Most students (61 per cent) reached puberty between these ages; only 34 per cent said otherwise. Puberty has been reached by most of the students in 1AB schools (66 per cent) and T-2 schools (55 per cent). Forty-four per cent of the students from 1C schools indicated not having reached puberty while 26 per cent were not sure.
Students have average levels of awareness about puberty and the changes it brings. Forty-one per cent of the respondents were able to indicate the changes that occur during puberty while 43 per cent gave incorrect answers. When asked to name three changes that take place in early adolescence, more than 80 per cent of the students gave at least one correct answer. Above average levels of knowledge were recorded among students in 1AB schools, male schools and Sinhala schools. Students in Tamil schools consistently showed lower levels of knowledge.

Students relate puberty with marriage. More than half (68 per cent) of the students held the attitude that puberty qualifies girls for marriage. A large proportion (62 per cent) of the students in female schools agreed. Thus, it is not surprising that they were unable to relate marriage to other social, economic and cultural considerations.

Students have poor knowledge on childbirth issues. Eighty-two per cent of the students were unable to identify the appropriate age for women to conceive. The level of knowledge on child spacing was also low (18 per cent).

Adolescents are still governed by social customs and taboos. Although there was a relatively high level of awareness on the biological characteristics of menstruation, only 35 per cent of the respondents were able to respond correctly to questions on taboos related to it. For example, 31 per cent believed that bathing is prohibited during the menstrual period while 35 per cent were not sure.

Family life

The family dining affair tends to favour males. More than 60 per cent of the respondents in most subgroups believed that cooking meals in the house is the responsibility of the mother or any other female. Only 11 per cent of the students disagreed with this statement. On the average, 55 per cent of the students agreed with the statement, “When having meals more attention should be given to the father and other male children.” More female respondents agreed with the statement.

Adolescents prefer less interference from parents. Three quarters of the students agreed that parents should not inquire on the whereabouts of adolescents.

Reproductive physiology

Students fare poorly in knowledge of reproductive systems. Only 35 per cent of the respondents correctly named the parts of the female reproductive system. Students in Tamil and Muslim schools had lower levels of knowledge on this. Only 15 per cent of the respondents were able to identify the parts of the male reproductive system. Students in female schools had the highest percentage of correct answers followed by students in mixed and male schools. Other school categories had extremely low levels of knowledge.
On average, those in male schools had the highest level of knowledge on reproductive physiology. The students from female schools also fared better than those from other schools. Students in 1AB and Sinhala schools had slightly better levels of knowledge on reproductive health than those in 1C, T-2, Mix, Tamil and Muslim schools.

**Knowledge levels on conception and contraceptives are low.** There was a high percentage of “don’t know” answers for questions related to these subjects. Over half of the students did not know that women are unlikely to conceive during menstruation and that there is a difference between intercourse and conception. Nearly 30 per cent expressed not knowing about contraceptives, and the effects of early conception and marriage with relatives.

**Sexuality and responsible behaviour**

**Students are split in openness to sexuality discussions.** Those open to such discussions were 52 per cent of students in male schools, 47 per cent in female schools, 44 per cent in 1AB schools and 44 per cent in Sinhala schools. Around one fourth of the students from Tamil and Muslim schools disapproved of open discussions on sexuality. A higher percentage declined to respond.

**Emerging trends on sexuality challenge traditional views.** Majority of the adolescents indicated that intercourse should be limited to married couples only. But views shifting away from conservatism were also observed. Thirty-nine per cent of the adolescents believed that intercourse is permissible outside marriage and 35 per cent did not have objections to having sex during adolescence. More than a quarter (27 per cent) did not think that self-stimulation is harmful and 13 per cent approved of homosexuality.

**Awareness of STD/HIV/AIDS is quite low.** Less than a tenth of the students were able to identify two or more STDs. Majority of the students (64 per cent) were only able to name one. Despite the extensive information campaign on AIDS, less than half were able to name the AIDS virus. Out of all students, 63 per cent were unable to state even one mode of AIDS transmission. An alarming level of 76 per cent could not name even one preventive action against HIV/AIDS. A little over half of the students agreed that the spread of AIDS could be checked by legally keeping the patients out of society.
Research captures full picture of young people’s lives


The need to take adolescent issues beyond reproductive health areas has been realised in the survey, “Adolescents and Social Change in Vietnam” (VASC’99). This survey promised a full picture of the experiences of Vietnamese adolescents in all domains of their lives.

Covered by the survey were young people aged 13-22 in six provinces, namely Lai Chau, Quang Ninh, Ha Tay, Quang Nam – Da Nang, Ho Chi Minh City, and Kien Giang. The survey also focused on sex differentials to illustrate how girls are disadvantaged today. Although researchers cautioned against interpreting the results as nationally representative, the major findings highlighted below merit consideration.

Education

Younger adolescents, males, and those in urban provinces have some educational advantage. These three groups have better education than their older, female, and rural counterparts. Younger students have greater desires for higher levels of education compared with their older counterparts. Girls receive more tutoring and vocational training than boys. They tend to believe that their schooling expenses are high relative to what their families are able to pay.

Time use and life activity

Girls work harder in the home. This is true with respect to their studies, chores, and household economic activities. Boys spend more time in recreation.

Adolescents in the six provinces differently apportion their time. For example, youth in Quang Ninh and Kien Giang devote an equally great deal of time on chores, household economic activities and recreation but not on outside jobs. In contrast, youth in Ho Chi Minh City and Quang Nam – Da Nang perform relatively few household chores and economic activities while they spend a relatively large amount of time doing outside jobs. They study a great deal of time but spend a below-average amount of time on recreation. Differences among provinces were also observed in the degree of participation in religious activities, exposure to media, and involvement in organised groups or societies.

Children of educated mothers tend to study more, be more actively involved in organised groups, have better exposure to media, and spend less amount on household chores and economic activities but more on recreation.

Employment and social attitude

Boys and girls take part in economic life inside and outside the house. Both begin working at approximately the same age. Rural adolescents are largely self-employed in agricultural jobs including forestry and fishing while a bulk of adolescents in Ho Chi Minh City engage in commerce and services. Rural adolescents are likely to carry out unpaid work for families while urban ones are likely to participate in paid jobs. Income generated by urban youth and boys are higher than that by rural youth or girls reflecting the gap in living standards and the levels of income between urban and rural areas.
Adolescents show fairly universal concerns about their future. They worry most about employment, followed by education and health. The societal problems that they are most concerned about are social evils, unemployment and environmental pollution.

Spatial mobility and migration

Adolescents are more unlikely to migrate between provinces or far distances than between communities. Adolescents’ migration, which usually happen for family or job reasons are often decided by parents. Education and employment were the reasons stated by three quarters of adolescents who wanted to migrate. But unfavourable living and working conditions may have contributed to the hardly improved health of urbanward migrants compared with those who migrated to rural areas.

Puberty and sexual initiation

Significant differences in the age of menarche exist across provinces. This suggests differences in nutritional status, with girls in Lai Chau apparently less nourished than elsewhere. These girls, along with those in Quang Ninh, received less information about puberty than their peers in other provinces.

Current reported rates of premarital sex are extremely low. The rates are ten per cent among boys and five per cent among girls. Considering that underreporting is likely in this study and elsewhere, the rates are still low compared with Southeast Asian neighbours.

Contraception and reproductive health knowledge

Familiarity with contraceptives does not reflect level of practice or fertility knowledge. On average, adolescents are familiar with two to three methods of contraception with nearly two thirds familiar with the condom – the most popular method among others. However, less than half (41 per cent) of the boys and half of the girls who had premarital sex used a modern method of contraception. Furthermore, only a few adolescents – seven per cent of boys and 13 per cent of girls – were found to be aware of the most fertile period during the menstrual cycle. Adolescents are familiar with HIV/AIDS but they know more about its transmission than its prevention. A number of girls aged 18-22 (5 per cent of in Quang Nam-Da Tay and 38 per cent in Lai Chau) believed that they have had a reproductive tract infection.

Marriage and childbearing

Adolescents believe they should be involved in the choice of a spouse. Common criteria in choosing a spouse include a good job for the husband and a pretty look for the wife. Most believe that a husband should be older than the wife.

Childbearing is important for married adolescents. Pregnancy followed soon after marriage. The vast majority of adolescents want to have two children.

Gender roles and equality

Youth are much more likely to favour joint decision-making than sharing of household tasks. Most believe in gender segregated household roles. Youth from Quang Nam – Da Nang were least likely to hold traditional role attitudes than young people elsewhere.

Smoking, alcohol consumption and drug use is more prevalent among males. These practices were examined as that may portend future behaviour, including reproductive health, labour force participation, domestic life of men and women as well as marital relationships. Cigarette smoking was reported by nearly half of the boys (46 per cent) but only by 4 per cent of the girls. Boys with educated mothers seem less likely to smoke. Alcohol consumption is higher in rural than in urban areas. Compared with girls, boys were about 1.5 or 2.7 times likely to have tried beer or liquor, respectively. Cocaine or heroine use was extremely low (one per cent for boys and less than one per cent for girls) but is believed to have been underreported.
In this section, the sexual behaviour and attitudes of men and women are examined. Characterisation of a target group includes identification of priority issues and sexual risks faced by the subjects. It may involve explanations of sexual decision-making processes. All these are often prerequisites to the development of reproductive health programmes and responses that best fit a target group.

To achieve a better understanding of its target groups, a study in Cambodia identifies the sexual and reproductive issues (e.g., sexual activity, sexual abuse, prostitution, pregnancy, abortion and others) that cut across vulnerable youth groups, namely commercial sex workers, street children and poor provincial youth.

A survey in Lao PDR looks at young people’s views and practices that put them at high risk of HIV/AIDS. HIV/AIDS knowledge, condom use, extramarital sex, multiplicity of partners, sex with prostitutes, risk perception and homosexual relations are among the concerns of the survey.

Significant factors, particularly peer influences, which drive school adolescents into premarital sex are listed in a statistical study in Mongolia. The effect of these factors on males and females is differentiated.

A report from the Philippines profiles young people’s dating behaviour, types of sexual relationships, incidence of reproductive health problems among sexually active youth and HIV/AIDS risk behaviours. Channels for reaching the youth and appropriate interventions including policy recommendations are presented.

A study from Thailand exposes the double standard that dictates young men and women’s different sexual behaviour patterns and affects decision-making on sexual matters. Premarital sex, sex with commercial sex workers, contraceptive use, and outlook on STDs are discussed.

Sexuality thinking through different eras is revisited in the research study from Vietnam. It shows the struggle of youth with the old and new concepts of love and sexuality. The report also covers present trends in sexuality studies and ends with a set of recommendations for a research agenda.
Sexual and reproductive health issues
cut across vulnerable youth groups

Source: Pharmaciens San Frontiers, Operation Enfants de Battambang and Mth SamlanvFriends. KAP survey on 
reproductive health among vulnerable youth. Phnom Penh: EC/UNFPA Initiative for Reproductive Health in 

Interviews with vulnerable youth groups in Cambodia revealed a unique set of reproductive 
health problems that must be taken up. The target of a project under the EC/UNFPA Initiative 
for Reproductive Health in Asia, these groups were represented by: (i) 150 female commercial 
sex workers (CSWs) from Phnom Penh, (ii) 210 vulnerable youth (e.g., out-of-school youth with 
very poor economic backgrounds) from the province (Battambang City), and (iii) 256 street 
children (or former street children) in urban areas.

The study was done to help the various project teams gain a better understanding of their 
target groups. The findings are as follows:

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<th>Characterising the vulnerable youth groups in Cambodia</th>
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<td>Commercial sex workers (CSWs)</td>
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<td>Provincial youth Male 12-25</td>
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<td>Provincial youth Male 17</td>
</tr>
<tr>
<td>Female 14</td>
</tr>
<tr>
<td>Street children Male 37</td>
</tr>
<tr>
<td>Female 43</td>
</tr>
</tbody>
</table>

*Additional source of income

Sexuality

Vulnerable youth groups are sexually active. CSWs were the most sexually active 
with 68 per cent having more than three sexual partners the week before the survey. This was 
followed by street children and older youth (aged 20-25) from the province. Sexual activity begins 
at 16 for street children and at 17 for girls from the province.

Sexual abuse is common. A very high rate of sexual abuse (82 per cent) was reported 
among commercial sex workers: 42 per cent had been sold into prostitution, 24 per cent had 
been raped, and 10 per cent were victims of incest. Although hesitant to talk about it, other 
vulnerable youth groups also reported cases of abuse, particularly rape. At least a quarter of 
provincial girls aged 15-25 and 41 per cent of male street children aged 15-19 had been raped.

Prostitution is not limited to commercial sex workers. In the provincial group, nearly a 
third of the girls aged 15-25 and a quarter of the boys aged 15-19 had exchanged sex for 
money. Prostitution among street children was particularly high at 61 per cent of the boys aged 
20-25.
Pregnancy and abortion

*Pregnancy is rampant among CSWs and street children.* CSWs generated high rates of pregnancy (50 per cent). Medical follow-up among them was not much and the incidence of motherhood was low. Pregnancy was even more widespread among street children (86 to 93 per cent of the 15-25 age group).

*CSWs face a high incidence of abortion.* Rates of abortion (28 per cent) and complications were high among CSWs. Thus, CSWs were highly interested in knowing more about abortion. Few of the non-CSWs admitted to having an abortion, reflecting the unacceptability of this practice among other youth groups. The latter were aware that abortion is dangerous. They showed only mild interest in this topic.

Contraception and birth spacing

*Vulnerable youth groups demonstrate various levels of contraceptive use.* Among CSWs, only 23 per cent showed consistent use of contraceptives. Around the time of the interview among the provincial youth group, only one to four per cent of the girls in the 15-25 age group and only six per cent of the boys in the 15-19 age group were using contraceptives. The figures were more promising for street children as more than 50 per cent of the 15-25 age group were using contraceptives. Most respondents expressed a keen interest to learn more about birth spacing.

STDs/HIV/AIDS

*Reported STD rates are low.* Researchers believe that STD infections have spread to half of all CSWs but only 24 per cent of this group claimed having STDs. About half of them did not even know what are STDs. Among the provincial youth, infection rates ranged from only four to 12 per cent. The highest rate of infection (32 per cent) was found among female street children.

*HIV/AIDS awareness and interest are high but risk perception is low.* Almost all had heard of HIV/AIDS. Awareness of modes of transmission and protection were likewise high among all groups. A large number of youth (40 to 74 per cent) were confident of not catching AIDS because of condom use, faithfulness to one partner or lack of sexual experience. More than a third of the CSWs (36 per cent) did not think they would contract AIDS.

*Reactions towards AIDS-infected persons are generally positive.* Most of the subjects interviewed would continue to visit relatives and other acquaintances afflicted with AIDS. However, about a quarter did not agree.

Reproductive health messages

*Vulnerable youth groups show interest in a wide range of topics.* These are birth spacing, male and female anatomy, female hygiene, newborn hygiene, gender, domestic violence, sexual problems and nutrition. Female hygiene was a topic equally popular for both sexes. Younger age groups (12-14) were less interested in topics such as sexual problems.

*A variety of communication channels are welcome.* Most groups highly favoured meetings as a way of receiving reproductive health messages. Other channels such as videos and shows were also acceptable.
The high level of knowledge on HIV/AIDS has not translated to changes in behaviour and attitude among the youth in Vientiane and Savannakhet provinces. This was revealed in a study conducted by the Australian Red Cross among 1,050 respondents, 60 per cent of whom were men. Half of the respondents belonged to the 20 to 25 age bracket; 18.4 per cent were 15 to 19 years of age; 30.6 per cent were 26 to 30. Almost three quarters (72 per cent) of the respondents were not married. Summarised below are the major findings of the survey:

**HIV/AIDS knowledge**

*Young people have misconceptions on HIV transmission and progress.* Although 95 per cent were able to identify heterosexual intercourse as a mode of HIV transmission, 80 per cent erroneously claimed that being a blood donor could cause one to contract HIV. Over a quarter of all respondents (26 per cent) did not know that there are Lao people infected with HIV. More than half (51 per cent) said that an HIV-positive person could not look healthy. Young men and women assessed their risk of contracting HIV/AIDS on the basis of many factors, a few of which were not necessarily valid (e.g. “I have self-confidence.”).

*Mass media is the preferred source of information on sex and AIDS.* Eighty-nine per cent preferred to receive information through television, 76 per cent preferred printed materials (posters, pamphlets, leaflets) and 75 per cent through the radio. On the other hand, 65 per cent said they preferred to learn about AIDS through the workplace. Construction workers, factory workers and teachers were more likely to have this preference. Forty per cent of the respondents said they learned about sex from their family members while 57 per cent said they would prefer to learn from their families.

**Condom use**

*Young people are familiar with the use of condoms for HIV prevention.* Most of the people in Vientiane (84 per cent) and Savannakhet (71 per cent) provinces knew what a condom is. Seventy per cent of all respondents knew that condoms could prevent HIV infection. But 66 per cent of the men admitted having sex without condoms. Of these men, about three quarters were unmarried. Forty per cent of the women admitted having sex without condoms. Of these women, half were not married.

Thirty per cent thought condom practice should not be difficult to introduce since it serves as a protection against diseases. Thirteen per cent of the respondents believed that there will be no difficulty in explaining condom use between sexual partners since there is “love and understanding” between them. Seventy per cent of the men and 62 per cent of the women would advocate condom use during intercourse. But 10 per cent of the men who agreed to condom use qualified their answers. They said they would do so when having sex with prostitutes, but not with their wife or girlfriend. Some thought they could justify condom use based on their partner’s physical appearance.

Eleven per cent believed that it would be difficult to use condoms since they have not used it before. Seventeen per cent of the men and three per cent of the women said condoms
caused “loss of feeling”. Twelve per cent of the women thought condoms were bad for their health.

Gender relations

**Half of young people hold traditional views on equality between sexes.** Fifty-two per cent of women and 49 per cent of men said that Lao men and women are not given equal freedom in relationships with the opposite sex. Almost a fifth of both men and women said that it was against Lao culture for women to have equal freedom with men. Eleven per cent said that men had more social rights than women. Seven per cent of the respondents believed that Lao women must uphold traditions while a further six per cent said women should be self-respecting and honourable.

Sexual behaviour and risks

**First sexual encounter occurs between ages 17 and 21.** Forty-four per cent of the men and 24 per cent of the women had their first sexual intercourse during this period. Respondents who never had sex numbered one third of the men and 62 per cent of the women.

**Extramarital sex is more common among men.** Almost half of the respondents believed it common for Lao men to have sexual relationships outside of marriage. Therefore, it is not surprising that almost 30 per cent of the married women in Savannakhet said they were at risk of HIV infection since their husbands “play around”. On the other hand, only about one fourth of the respondents said Lao women have sexual relationships outside marriage.

**Those with multiple sex partners do not see themselves at risk.** A tenth of the men and less than two per cent of the women admitted to having more than ten previous sexual partners (see Figure). Yet, 66 per cent of these people rated their chances of HIV infection as “none” to “very small.” Male respondents commonly had a range of one to four sexual partners while women had only one.

**Sex with prostitutes: Young men knowingly put themselves at risk.** A large proportion of the respondents thought that prostitutes were most likely to become infected with STDs such as HIV/AIDS. One third thought clients of prostitutes were most likely to become infected with HIV/AIDS. Despite this thinking, 37 per cent of the male respondents had sex with prostitutes. Seventeen per cent of the men also admitted sharing a prostitute with friends.

**A number put themselves at risk of HIV through homosexual relations.** Almost 60 per cent of all respondents did not know that HIV could be transmitted from one male to another during sexual relations. Nine per cent of the men said they have engaged in same-sex intercourse.
Peer influence spells premarital sexual behaviour of school adolescents

In-school adolescents in Mongolia are led to engage in premarital sex largely by their friends’ behaviour – particularly those pertaining to sexual activities and alcohol use. Five other factors were also found to correlate with sexual initiation among school adolescents (see Table). Contrary to previous reports, age of adolescents and their parents living together at home were not relevant. These were among the conclusions of a research designed to find out whether individual, family and peer characteristics affected the tendency among students aged 13-18 to get into premarital sex.

The data used for statistical analyses came from the Baseline Survey on Adolescent Sexuality 1999. The findings are summarised below:

Profile: In-school adolescents

A number of students, mostly males, engage in premarital sex. Of the 1,343 respondents (543 males and 800 females) 16.2 per cent of the males and 3.8 per cent of the females had premarital sex.

Few students communicate well with their parents. Less than a quarter of students rated parent-child communication on sexual and reproductive health (SRH) good; the rest rated this from poor (16.2 per cent) to moderate (55.0 per cent). In fact, almost all adolescents claimed to get their SRH information mainly from mass media.

The failure of almost a fifth of adolescents to identify their parents’ level of education again pointed to poor communication lines. In spite of this, almost two thirds of the adolescents characterised a good relationship with their parents.

Factors to sexual initiation

Different factors predispose male and female students to premarital sex. The factors that were positively tested to have an effect on sexual initiation among in-school male adolescents did not necessarily affect females.
Most likely to engage in premarital sex were males who:
(a) got their information on SRH from mass media rather than non-media sources,
(b) had poor levels of knowledge on SRH,
(c) perceived poor parent-child communication on SRH,
(d) had more than one girlfriend over time,
(e) used alcohol, and
(f) had many sexually experienced friends.

Female adolescents whose fathers have higher than secondary education were less likely to have premarital sex. Those who had more than one boyfriend were more likely to have premarital sex.

Response: Steps to be taken

The study recommends the following initiatives:

<table>
<thead>
<tr>
<th>Characteristics of Mongolian school adolescents aged 13-18 (1999)</th>
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<tbody>
<tr>
<td>❑ Nine per cent had premarital sex experience.</td>
</tr>
<tr>
<td>❑ Very few (5.3 per cent) had poor academic performance; the rest were almost equally divided between having medium and good academic records.</td>
</tr>
<tr>
<td>❑ Two fifths had poor knowledge on sexual and reproductive health (SRH) issues.</td>
</tr>
<tr>
<td>❑ A strong majority (91.5 per cent) relied on the mass media as their main source of SRH information.</td>
</tr>
<tr>
<td>❑ About half had parents with an education beyond the secondary level.</td>
</tr>
<tr>
<td>❑ Most (71.5 per cent) did not have boyfriends or girlfriends; the rest had either one or more over time.</td>
</tr>
<tr>
<td>❑ 15.5 per cent had used alcohol.</td>
</tr>
<tr>
<td>❑ About 40 per cent of their friends were sexually experienced.</td>
</tr>
</tbody>
</table>

Improve SRH sources of information and services at school, family and community levels.

Ensure that mass media disseminates correct and appropriate information.

Encourage parents to take interest in and to watch for signs of alcohol use and sexual activity among their children’s friends.

Take a gender-specific approach to sex education with emphasis on decision-making and values clarification to control early and unsafe sex, particularly among male adolescents and their friends. Empower female adolescents with sex-related life and negotiation skills.

Expand behavioural studies on sex to address experiences of youth in different settings (e.g., out-of-school youth). Study further the decision-making process of young women on sexual and reproductive health.
Looking into adolescent sexuality

The 1994 Young Adult Fertility and Sexuality Survey (YAFS-II) covering Filipino males and females aged 15-24 aimed to provide greater understanding of the knowledge, attitudes and behaviour of young Filipinos in sex-related issues. Before YAFS-II, it was felt that there had been information gaps about adolescent sexuality. Updated information on various aspects of adolescent life has become necessary in order to justify changes in population education as well as implementation of appropriate adolescent sexuality programmes. The significant findings from the survey results are discussed below:

Modern profile of youth

*Important transformations: marriage is being delayed and school enrolment is rising.* Not only has the mean average of marriage risen. The percentage of single youth has also markedly moved upward. Delayed marriages have indicated longer duration of schooling, hence, higher educational attainment. There are also evidences of high social and geographic mobility of the youth, particularly with respect to rural-to-urban migration.

Dating behaviour

*Adolescents face earlier initiation into dating.* Filipino adolescents now go through dating (single or group) and related events (e.g., having crushes, admiring the opposite sex or having admirers, having boyfriends or girlfriends) at younger ages compared a decade ago. These changes can be attributed to a number of developments: improved communication and transportation systems facilitating interaction outside of the home; changing life styles and more options for living arrangements that keep adolescents away from parents’ and relatives’ supervision; and greater liberty of adolescents over the choice of dating partners and the place of dates.

Various factors affect dating behaviour. Adolescents who have been exposed to city life, have lived away from parents or have lived in dormitories, or have studied in private schools are more inclined to date than other groups. Analysis of survey results also implied greater dating tendency for children whose parents are economically better off, not strict, and with unstable marriages.

Union formation and premarital sex

*Three kinds of premarital sexual experiences are identified.* First is committed sexual experience, which means sex with a partner who subsequently becomes the marital partner. Majority of the married youth, both males and females in the YAFS-II sample reported sexual experience with their partner before formal union. Second is commercial sex experience for which a monetary transaction is involved. Survey results reported 7.7 per cent of males aged 15-24 engaging in this kind of sexual experience. Third is casual sex experience, which is sex with a partner who has not become the marital partner, and does not involve any monetary transaction. The overall level of sexual experience among unmarried male youth is higher than females, specifically in casual sex.
Childbearing

Childbearing patterns vary across groups. Evidence from YAFS-II suggests that many young Filipino women have started bearing children at a young age: more than one quarter of respondents by age 20, more than 50 per cent by age 24. Rural women and those who are less educated start childbearing at younger ages than their urban and better-educated counterparts. More than 50 per cent of women married for at least one year gave birth to their first child within the first year of marriage. The duration from marriage to first child is shorter for urban and wealthier women than rural and poor women. Educated women start childbearing at older ages but the spacing between births has been observed to be shorter than that of less educated women.

Reproductive health

Many adolescents face a host of untreated problems. The high incidence of reproductive health problems (e.g., painful urination, penile and vaginal discharge, and others) is closely related to the high level of sexual activity among adolescents (see Figure). Despite the prevalence of these problems, treatment and health service utilisation has been observed to be low. Of the survey respondents who claimed to have had reproductive health problems, only 16 per cent sought treatment. According to YAFS-II results, the use of contraceptive and other family planning practices has been low among Filipino adolescents.

Smoking, drinking and drug use

Significant levels of drinking, smoking and drug use are observed. On average, adolescents are initiated into these practices at age 16 or 17. It has also been found that these risk behaviours are closely linked with one another; that is, an adolescent engaged in one activity is more likely to engage in another activity than one who is not involved in any at all.

A number of factors influence smoking, drinking and drug use. Among these are socio-economic background, family and peer influences and exposure to information. The influence of the family has been particularly strong with regard to smoking. Children tend to follow their parents’ attitudes and behaviour.

HIV/AIDS

Young males face a high risk of contracting HIV. This is a result of high levels of premarital sexual activity with more than one partner. However, their self-perception of risk is low. Only a third think that men engaged in commercial sex without condoms will likely contract HIV. Abstinence and monogamy, which are effective means of preventing HIV transmission aside from condoms, are not being observed by a significant number of young Filipino males. This makes condom use an important alternative in curbing the spread of HIV. However, not a significant percentage of male respondents agree that proper use of condoms can prevent virus transmission.
Avenues for reaching the youth

Channels of influence bring different impacts on risk-taking attitudes of youth. Deemed vital in designing programmes are knowledge or awareness of the composition of youth in various demographic subgroups and how these numbers have been dramatically changing, and an assessment of the reach of communication channels to these groups. Three channels of influence have been considered: school, church and the media. Schools provide an advantage in terms of improved reproductive health and health-related behaviour especially for girls. Churches provide venues for relaying messages and activities in which the youth can participate. The mass media, being relatively well developed in the Philippines can reach a wide range of youth groups. For males reached by the various channels of influence, risk-taking is least prevalent for those enrolled in school but not connected to churches or the media and most prevalent for those connected to media but not to schools or churches. The same pattern for females was borne out by the survey results.

Recommendations: promotion of reproductive health, overall health and development of adolescents

Create a proper socio-economic environment that promotes adolescent development in all fronts. Three major institutions – family, school and religion – play an important role in the socialisation of the youth. Education on sexuality and reproductive health must start at home and should be reinforced in school and by the religious sector. These institutions must incorporate the sexual and reproductive health needs of the young people in a more proactive manner.

Deal appropriately and adequately with young people’s sexual and reproductive health needs. Adolescents have age-appropriate sexual and reproductive health needs. Programmes to meet these needs must involve a creative and caring approach. These programmes may integrate sex and health education through the school curriculum that is attentive to the real needs of the young people. Counselling and service delivery must be designed setting clear principles and guidelines.

Improve the fit between adolescents’ needs and future programmes. The dynamic nature of sexual behaviour of adolescents requires an equally dynamic set of programmes responding to their needs. Future research should continue tracking down the attitudes and behaviour of the young people as they adjust to their changing environment. Programme implementers must be informed of these changing trends in order to customise their activities.

Develop appropriate and adequate multi-sectoral policy responses. There is an increasing realisation of the interconnectedness of sexual behaviour and reproductive health, and the stages of social development of youth. The following are policy areas that need review:

- Early and appropriate sex education in the school system and in other programmes designed to reach out-of-school youth
- Programmes through various forms of media and types of organisations to reach and inform parents of the needs and difficulties being encountered by the youth
- Ensuring that laws, policies and practices that prohibit the access of young people to vital reproductive health services are relaxed or amended
- Support for policies and programmes that expand opportunities for education and employment of the youth
- Enactment of laws and establishing mechanisms that will protect adolescents from being sexually exploited
- Support and protective programmes to reach youth in especially-difficult situations such as street children, parent-absent homes and prostitutes
- Ensuring that the national population policies include promotion of youth sexual health
Double sexual standard operates among rural youth


An underlying double standard to the sexual behaviour of men and women was brought out in a report published in 2000. Major differences in the way young rural men and women think about sex were documented as well. Respondents, aged 15-24, included 623 men and 605 women from the rural areas of North and Northeast Thailand. Of these respondents, 44 males and 88 females were married. Research highlights are found below:

Sexuality attitudes

Permissive attitudes are held for premarital sexual behaviour of males. Almost 40 per cent of both sexes held the double standard that premarital sex is legitimate for males but not for females. The female youth, however, held more conservative attitudes toward premarital sex: about 60 per cent believed in abstinence before marriage compared with only 27 per cent of males.

The rural youth perceived their parents to be more accepting of premarital sexual behaviour among male than among female children. According to 39.2 per cent of the male respondents and 59.6 per cent of the female respondents, the most common parental reaction to discovery of premarital sexual relationships among children is to push for marriage. Given the same situation, more male respondents (32.5 per cent) than females (8.9 per cent) believed their parents would simply accept their premarital sexual behaviour.

Premarital sexual behaviour

Males have more experience in sex-related behaviour long before they are married. From masturbation to kissing to sexual intercourse, males are ahead of females. While half of unmarried males admitted having premarital sex, only two per cent of their female counterparts did. The reported rate increased almost two-fold (89.1 per cent) for married males and almost ten-fold (19 per cent) for married females. It appeared that married females were no longer reluctant to admit having premarital sexual relationships with their present spouses.

Males experience their first intercourse at a younger age than females do. By the age of 15, 28 per cent of rural males had already engaged in sex. By the end of their teenage years, almost all rural youth were sexually experienced. The difference between the age at first intercourse and marriage was 2.8 years for males but only 1.0 year for females. The report explained that premarital sex among females often ended in marriage soon afterwards as a cultural mechanism to protect their reputation or chastity.

Males who are older, married, out of school, working or living away from home were more likely to engage in premarital sex. The region of residence (North vs Northeast) and parents’ premarital status were not associated with adolescents’ sexual behaviour before marriage.
Young men and women engage in premarital sex for different reasons. Almost half of unmarried males had prostitutes as their first sexual partners. All females had boyfriends as their first partners. It emerged that young men see prostitutes to gain pleasure and sexual experience. They viewed sex as an end in itself, but females viewed it along with commitment and emotional intimacy. Curiosity was the main motivation cited by 87.2 per cent of males for their first intercourse while love and surrender to pressure were the reasons cited by females.

Sex with prostitutes and use of condoms

Male sexual patterns bring risks. The fact that a number of men are sexually active with prostitutes coupled with low condom use puts not only themselves but also the lives of their future children and wives at risk. Almost half (44.5 per cent) of all the male respondents had visited prostitutes. By the age of 18, 80 per cent had made their first visit. But 58 per cent of them stopped visiting at least six months before the survey.

Approximately two thirds of the sexually experienced unmarried men continued their sexual activities during the past six months. Prostitutes were their most common sexual partners among others (see Figure). While 22 per cent of the married men had extramarital sex with prostitutes or non-prostitutes, only two of the 88 married females admitted the same, with a lover in both cases.

Male respondents had positive attitudes toward condom use, agreeing that condoms are inexpensive and accessible. But those who had visited prostitutes were more likely to point out the inconvenience and reduction of sexual pleasure with the use of condoms. Almost a quarter (22.4 per cent) either failed to consistently use condoms or never used condoms during sex with prostitutes.

Contraception

The high level of contraceptive knowledge is not linked to contraceptive use. The rural youth knew about different contraceptive methods, particularly the pill (82 per cent). Females were more knowledgeable about the methods except for the condom. Despite these high knowledge rates, almost a third of the males and half of the females did not use any contraception at first intercourse. The higher failure rate in females was said to have stemmed from an unplanned first intercourse.

The youth think family planning is only for married couples. A minority held the view that any couple, married or not, may practice family planning. Many believed that reproductive decision-making (e.g., planning the number of children) is a shared task between spouses but at the same time, most thought the responsibility of birth control lies on the wife alone.

STDs

The youth are knowledgeable on STDs. More than 80 per cent cited AIDS as a venereal disease. Respondents also cited gonorrhoea and syphilis. Males were more knowledgeable
about the specific names of STDs. Young people were most likely to learn about STDs from the mass media (TV and radio). Health personnel, teachers and friends were other significant sources of information. Knowledge of transmission and prevention of STDs were equally high but almost 30 per cent were not sure whether AIDS is curable.

**The youth do not see themselves at risk of STDs.** The majority (68 per cent of males and 75 per cent of females) did not perceive themselves at risk of STDs mainly because they had not been sexually active (40 per cent of males and 68 per cent of females). For males, condom use is the next cited reason.

**STD-infected males do not necessarily seek treatment from doctors.** Twelve per cent of the males had STDs. Many of them sought a combination of treatments. About half saw a doctor or tried self-medication or both; 17 per cent visited health personnel; and eight per cent had no treatment at all.

**Counteracting the double standard**

These results confirm a strong sexual double standard that views sexuality of females as passive and that of males as active. Sexual innocence among women is valued and overt display of sexual potency, shown through numbers of sex partners, among men is tolerated.

The social expectation on women could undermine safe sex practices among unmarried youth. Because Thai women are socialised to value virginity and sexual innocence, they hesitate to discuss the need for contraception as it may convey an image of being sexually experienced. Therefore, the very few unmarried rural women having premarital sex are at great risk of getting pregnant and contracting STDs.

The report concluded with policy options to counteract the negative outcomes of this double standard in Thai society:

- **More studies:** Find out how young people are socialised, how they construct attitudes on sex, and how they alter their attitudes and behaviour.

- **Early intervention:** Introduce any intervention programme while the youth are in school, before the onset of sexual activity. Compared to out-of-school youth, students are less likely to have casual sex or sex with prostitutes.

- **Changing high-risk behaviour:** Increase HIV awareness among young men with multiple sexual partners as they are the most likely agents for the spread of HIV. Target to change their behaviour and to increase the use of protection among them. Emphasise the devastating impact of HIV infection on their families and future spouses.

- **Gender-specific programmes:** Develop gender-specific programmes that stress males’ responsibility to young women and enhance females’ self esteem and negotiation skills. Programmes should inform women of the risks of sexual activities, provide them with resources to reduce their risks, and teach them to resist unprotected sex.

- **Condom strategy:** Promote the dual purpose of condom use during intercourse: (i) as a barrier against STDs and (ii) as a contraceptive method. This strategy would enhance the health of young men and their current and future partners, both prostitutes and non-prostitutes.
Sexuality concepts and trends evolve through history


Changes in concepts, attitudes and behaviour on sexuality over different historical periods were explored in a research completed in 1998 (Hong). This study was done to identify issues for designing a research agenda on sexuality and reproductive health in Vietnam. The researcher used documents, statistical data and focus group discussions to reach these findings:

Sexuality until 1945

Relics, rituals and games of the past speak of openness to sexuality. Archaeological relics with carvings of couples in sexual intercourse (e.g., Dao Thinh bronze jar, believed to belong to the Bronze Age and the Lu bronze drum) indicated a fairly liberal concept of sexuality in the past. Lunar-based festivals in the early times included worship rituals and games that allowed, if not encouraged, sexual contact between men and women (see Box). These were practised even at a time when Confucian ethics would have dictated otherwise.

A ritual and a game in Vietnam’s past:
A reflection of sexuality

The No Nuong worship ritual:
People kept the bamboo symbol No resembling a male sexual organ and the Nuong resembling a female sexual organ. On the eve of the Lunar New Year, villagers would gather in a procession where they carry the symbols and rhythmically strike them against each other. Young girls and boys chanted to the drumbeat and were paired off afterwards to perform their “striking game.” Any couple that later married were assured to receive divine luck.

The game of grabbing eels from a jar:
A team of one young man and one young woman had to catch an eel inside a jar without looking into the jar. The young man had to keep one hand on the woman’s breast. At the same time, judges closely watched along with fellow villagers who called out and teased the couple.

Confucianism pervades sexuality thinking. Confucianism, which arrived in the 10th century and flourished between the 15th and 18th centuries, introduced a strict concept and secretiveness to sexuality such that contradictory trends of thinking simultaneously existed in Vietnam’s past. While official literature supported the austere views toward sexuality and female morality, folklore and sayings challenged the descriptions of shy, virtuous women or the controlled passions of men.

In contrast to Confucianism and traditional Vietnamese culture, the arrival of French culture during the mid-19th century to the early 20th century made inconsequential impact to the thinking of peasants living in rural areas. But literary and philosophical works of French writers influenced Vietnamese literature, which began to criticise arranged marriages and harsh feudal ethics.
Socialist construction and wartime

**Most restrictive views on sexual relations were embraced.** The 1945 Revolution and the following Pre-renovation Period supported the sacrifice of individual sentiments for the utmost contribution to the nation’s construction and defence. Literary works adopted pure, faithful love and restraint of natural desires as common themes and idealised revolutionary heroism.

Concealment of information, chastisement and imposing heavy punishments characterised the concepts of gender and sexual relations during the pre-renovation period in Vietnam. Equality between sexes fought to actually eliminate gender differences. Fashion was politicised: any style of Western origin or resemblance was criticised. Severe punishment was meted out for premarital and extramarital affairs, especially among women. Only today do people dare expose the reality that love, sexuality and children born out of wedlock did exist in the midst of bombings and selfless labour in that period.

The extreme concepts of sexuality then dictated absolutely no sex education – families and the society avoided their responsibilities to the younger generation. As a result, succeeding generations were ill equipped to balance the changing concepts of freedom and gender relations.

Renovation period

**Sexual views sow confusion.** Exploratory discussions with a small group of young people revealed that today’s youth struggle with the old and new concepts of love, the value of virginity, and premarital and extramarital sexual relations. The youth view sex with an important role in life and in mutual understanding and harmony. They have more liberal ideas on premarital sex and adultery. At the same time, their lack of understanding of reproductive health and sexuality has led to increased abortions, early marriages and other psychological traumas as revealed by studies in this field.

Sexuality research and publications today

**Studies in the 90s reveal new trends in sexual issues.** In the light of the HIV/AIDS epidemic, prostitution and homosexuality are now emerging areas of study. The most recent development of prostitution in Vietnam has been closely associated with social and economic changes. The discovery of high-risk behaviour among sex workers and their customers raises the concern that HIV/AIDS will soon spread to the larger community. Some foreign researchers have examined homosexuality but it remains a new subject for domestic researchers.

Increasing incidences of premarital sex and abortions are also under investigation as more and more young people consider sex a part of love. The necessity of providing sex and reproductive health information is clear. The results of studies conducted in schools are more reserved but show that students of all ages need this information. Issues such as the content of sex education programmes and who will teach this subject were raised but have not been resolved.

**The educational significance of publications on sexuality is limited.** In recent years, the quantity of publications on sexuality and gender education has rapidly increased reflecting societal changes in concepts, consciousness and attitudes about these issues. However, most publications provide simple information that does not answer many people’s questions. Most of these works draw on documents by foreign authors, making minimal use of domestic research results to put issues within the context of Vietnamese society.
Newspapers are taking up new issues. Newspapers have recently begun to address the issues of forced sex, sexual harassment, sexual abuse and rape. These problems are indicative of the changes in concepts and behaviour on sexuality. Defining the limit of these phenomena within Vietnamese culture is difficult.

Suggestions for a research programme

Wide-scale qualitative research is feasible. This exploratory study revealed that the Vietnamese people are ready to supply personal information on their sexual concepts and behaviour. However, not all Vietnamese researchers take advantage of this willingness. Most researches to date rely exclusively on quantitative methods, which do not provide enough information. Some have begun to use qualitative methods but not all of them do so properly. Thus, research skills need to improve so that sexuality studies could be carried out in bigger scale. Information generated from such studies will ensure formulation of appropriate policies and measures for effective interventions.

Research on AIDS epidemic and changes in sexual relations is critical. The AIDS epidemic in Vietnam has entered a stage of rapid development and is spreading throughout the community. It deserves special attention.

Recent research trends must continue. Methodological problems in research on premarital sex, abortion, prostitution, homosexuality and high-risk sexual behaviours need to be solved. More in-depth studies should be conducted with sex workers and homosexuals. The history and development of prostitution and homosexuality should be examined.

Youth sexuality research is urgent. Young people are engaging in sexual activities earlier than ever. Changing concepts and attitudes on sexuality and the diminishing control of parents on their children reinforce early sexual involvement of young people. The increasing rate of premarital abortion and proportion of young people infected with HIV/AIDS emphasise the importance of studying youth sexuality.

Research targets need to widen. Most studies on sexuality have been conducted in cities. Research has to include people in rural areas as they constitute 80 per cent of the country’s population. Likewise, research targets should expand to central and southern provinces as well as ethnic minority groups.

Gender relation is the key to interpretation. Traditional concepts of gender and changes in gender roles should receive primary attention in research on sexuality and related topics. Without examining gender relations, it is impossible to thoroughly understand sexual behaviour and dynamics in sexual relationships. Research on forced sex, harassment, abuse and rape will strengthen the understanding of gender issues.
Sexual and reproductive health needs can be met through different means. This section presents strategies and approaches that have been recommended or implemented by various countries based on national as well as target-specific needs. In general, these are covered: school-based approaches, health services, education and counselling outreach, and the use of mass media.

A review from Bangladesh sweeps through the impact of government and NGO programmes and activities on reproductive health. The availability of information needed to carry out these responses is likewise assessed and corresponding suggestions are proposed.

An outline for sexual health education among factory workers in Cambodia is introduced in consideration to every sexual health issue identified. These issues are revealed from discussions that portray work in the factories, health and sexual health concerns, and attitudinal contexts to sex and relationships.

Two studies in India plea for sexuality and reproductive health education among school adolescents and neo-literate learners because the state of knowledge among these two groups reflects this need. One study demonstrates that school adolescents themselves are in favour of sex education. Another study shows that rural adolescents under the literacy campaign lag behind their urban counterparts and should receive even more reproductive health messages.

A qualitative research in the Philippines explores the acceptability of counselling services; information dissemination formats and topics; and student organisations’ involvement in a future campus-based programme on sexuality.

Three studies from Vietnam evaluate the effectiveness of various programmes, which have been designed and implemented for adolescents: two counselling centres, an adolescent reproductive health campaign and a radio broadcast. The lessons learned from these strategies are noted for the improvement of the programmes and other similar endeavours elsewhere.
Reviewing strategies that meet adolescents’ health needs

Under the current Health and Population Sector Programme (HPSP) of the Government of Bangladesh and the National Integrated Population and Health Programme (NIPHP), adolescents have been identified as a priority target group. The Operations Research Project of NIPHP has done an extensive review of information to facilitate the development of strategies relating to adolescent reproductive health. Different initiatives that have been undertaken in Bangladesh and other developing countries to address the health needs of adolescent were also reviewed.

Adolescent health: the available information

Progress has been made but more efforts will be required. Review of the existing information on adolescent health suggests that progress has been made with respect to schooling, age at first marriage, adolescent fertility and conception. But there is a scarcity of data on the reproductive health knowledge of adolescents. Only a few studies exist, and these are on knowledge and practices concerning menstruation. Similarly, little is known about the sexual behaviour of this age group. One study has suggested that premarital sex is substantially high between both males and females and higher in urban than rural areas. Information on how adolescents in Bangladesh make decisions about reproductive health behaviour is also lacking. And, in general, information on the reproductive health needs of adolescents is not available.

There is paucity of data among adolescent girls on the prevalence of medical problems attributed to maternal causes. Maternal mortality is estimated, in fact, to be three to four times higher among adolescent as among adults. About half of married adolescent girls suffer from undernutrition. The limited nature of the information available on the use of health care facilities by adolescents suggests that access to, and utilisation of health services by this population group is very limited.

General strategies

The existing literature suggests that at the global level, four different approaches have been tried to address the reproductive health needs of adolescents: (i) school based programmes, (ii) outreach programmes, (iii) clinic-based programmes and (iv) social marketing and mass media programmes.

Strategies in Bangladesh

Government programmes are shifting to accommodate adolescents. In the past, the health and family planning programme of the government primarily targeted married women of reproductive age and children, thereby largely ignoring the health needs of adolescents. In the current HPSP, adolescent health has been included, as part of the Essential Services Package.
and a separate programme called maternal Nutrition and Adolescent Health has been created to deal with adolescent health issues.

**NGOs are active but activities have limited impact.** There have been an impressive number of activities addressing reproductive health and other needs of adolescents during the past decade. However, these activities are mostly community-based, relatively small-scale, pilot efforts with limited impact. Moreover, these efforts have primarily focused on adolescent girls. These programmes tend to be poorly documented and evaluated.

In spite of the above-mentioned limitations with regard to adolescent initiatives, the successes made by these projects should not be overlooked. Although difficulties in programme planning and documentation prevent the measurement of project impact, effectiveness could be partly judged by the level of community mobilization brought about by these programmes. Other accomplishments, which could also be regarded as milestones in addressing adolescent health issues in Bangladesh include: holding different meetings, formation of adolescent forums, development of AFLE curriculum and IEC materials; and development of training curriculum especially for adolescents.

**Tackling other areas**

Other aspects of adolescent health needs have to be taken up:

- Identification of the reproductive health needs of adolescents through quantitative and qualitative studies
- Documentation and evaluation of existing adolescent programmes to use lessons learned form these projects
- Designing and testing various approaches to address the health needs of adolescents
- Involving adolescents in designing, planning, and implementing programmes for their own age group
- Upgrading the health care system to address the health needs of adolescents
- Ensuring the involvement of community groups in these programmes
- Conducting operations research in designing, implementing and evaluating adolescent programmes
Young factory workers in Phnom Penh talk about work and sexual health


Seventy-seven young workers from three garment factories in Phnom Penh discussed their plight in a 1999 study conducted by CARE International in Cambodia. Sexual and reproductive health issues emerging from these discussions were then considered point by point in proposing the contents of sexual health education sessions for this target group.

Three quarters of the participants were women, reflecting the workforce composition in the factories. Workers, ranging from 15 to 24 years of age, were put into same-sex groups of five to seven for a series of discussions that lasted two or three days. They talked about working conditions and terms in the factories. They shared deep concerns on sexual health as well as socio-economic and attitudinal contexts to sexual decisions. Here is what can be inferred from what they said:

Work in the factories

Work is difficult: low wages, long hours, many hazards. Workers spend at least US$20 each month for their rent, food and utilities in Phnom Penh. Although reported income in the factories is US$30–40 per month, some young people earn only US$7 per month. Wage deductions are made for workers' mistake and sick leave. Some do not know how their wages are calculated. Many routinely work 12-hour days, seven days a week. They often describe overtime as compulsory. They perceive their work to be full of hazards, such as electric shocks from machinery and injuries from needles.

Many workers believe their working conditions to be socially unjust but none directly refer to their legal rights. Many fear dismissal due to sick leave without permission, failure to work overtime required or raising of complaint with manager. Better relationships between workers and management exits when workers have an organised system of representation.

Health and sexual health

Young workers are extremely concerned about their health. Poverty, working large amounts of overtime and poor working conditions are widely perceived to be damaging to health. Workers are also concerned that minor illnesses can potentially progress to very serious or fatal illnesses.
Treatment-seeking behaviour is affected by many factors. Cost is a big consideration in seeking treatment for illnesses of young garment factory workers. Most think of Western medicine as more effective than traditional Cambodian medicine for most illnesses and young women have some concerns in approaching male doctors. These factors and others (see Box) should be taken into account if clinical services for young workers are provided or existing services are supported.

Factors affecting health-seeking behaviour of young factory workers

- Cost of services
- Accessibility in terms of transport costs and opening hours
- Confidentiality
- Non-judgemental and welcoming attitudes of clinical staff
- Possibility of providing counselling or other supporting services

Suggested age of marriage depends on individual’s maturity and sense of responsibility. Girls reach puberty between 14 and 18 years of age; boys, between 15 and 20. Many workers believe that young men begin to access commercial sex by this time. Young women claim that a woman is old enough to marry and give birth at 18. But many recommend that women delay marriage to the early 20s, when they are expected to have more earning capacity and greater maturity to raise children and cope with the demands of a family. Young men do not share these women’s perceptions on safe ages for childbirth and desirable ages for marriage.

Many young women underscore the importance of parental involvement in the choice of a husband. They reason that parents take responsibility for them should their marriages fail. However, it is undesirable for parents to force their daughters into marriages.

Contraceptive methods are widespread; so are the misconceptions. Participants listed a number of contraceptive methods, notably IUD, Norplant, pills, injections and condoms. More women than men prefer condoms as their contraceptive choice. Young women are particularly knowledgeable on contraceptive methods, although their information is not always accurate. Some women think condoms are not contraceptives. When a method doesn’t suit an individual woman, it is often perceived potentially damaging to health. Young workers also incorrectly believe that a woman can conceive only during her menstrual period or shortly afterwards.

AIDS and STD awareness is substantial, but understanding is limited. Young workers know that HIV/AIDS exists in Cambodia, often from among people they know. They are aware of its transmission through sex and other modes. Many know that it is incurable and terminal, but some change their opinion upon hearing anecdotes of effective cures from other participants. Although they may know of blood testing as the only means of detecting HIV/AIDS, they cannot distinguish the test timing and frequency that gives a reliable diagnosis. Generally, there is limited understanding or confusion on HIV/AIDS progression.

Participants do not link HIV/AIDS to STD transmission. They are familiar with a number of STDs but cannot fully assess the risk of different sexual activities. They claim these diseases are potentially serious, but easy and cheap to cure with traditional medicine.

Commercial sex workers are considered the source and cause of infections in men. Workers think married women are at risk of being infected by their husbands. They strongly perceive that having sex with someone trusted poses no risk of infection.

Sex and relationships

Young women face vulnerabilities in their reputation and in freedom from violence. For example, many young men believe they can identify a virgin woman by her physical appearance alone. And the family of a prospective husband is likely to investigate a woman’s
reputation. Thus, women feel the need to guard themselves against any hint of sexual misconduct.

Women are perceived at risk of sexual violence and coercion because they could be drugged by men or kidnapped and sold into the sex industry. The city is considered a dangerous place for women. Many young women are indeed afraid of being sexually violated. *Seduction scripts put men in control and make safe sex negotiations difficult.* Sex is not discussed verbally. Men initiate sexual relationships. Many assume that a woman’s silent response to a man’s advances means wanting to have sex with him. A woman agrees to sex only when she trusts and believes her partner’s declaration of love. Since an inexperienced woman is expected to be shy during sex, it would be awkward for her initiate negotiations for safe sex. In situations where people “trust” each other, it might be very difficult for either partner to suggest the use of condoms. The same is true for married workers.

**Closing the gaps**

Respondents were found to enjoy the participatory method used in this study. The report suggested that the same method could be adapted for sexual health education purposes. Its recommendations (see Table) are designed to respond to the gaps in sexual health understanding among young factory workers.

<table>
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<tr>
<th>Problem</th>
<th>Recommendation</th>
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| Participants do not have sufficient knowledge to assess which sexual activities carry a risk of infection. | Specifically address:  
  - How HIV/AIDS infections are transmitted through sex  
  - Factors which increase the likelihood of HIV/AIDS transmission |
| Lack of knowledge about the progression of HIV/AIDS and STDs may lead young people to believe that an infected person is free of infection or has been cured. | Emphasise:  
  - Progression of HIV/AIDS, including stages likely to be symptom-free  
  - Information about the possibility of asymptomatic infection with STDs |
| Young people may not differentiate between condoms that offer a high level of protection from sexual infections and those with unsafe features. | Highlight:  
  - Positive quality indicators of condom use  
  - Particular features that are likely to make condoms unsafe |
| The stigma of HIV/AIDS is likely to:  
  - Deter people from openly discussing HIV infection and prevention  
  - Negatively affect the quality of life of people living with HIV/AIDS | Ensure that:  
  - No project activities inadvertently reinforce stigma  
  - Address directly:  
    - The issue of stigma |
| Young people, particularly women, may be afraid to discuss their sexual well-being or seek advice or support. | Enable young people:  
  - To explore ways of supporting each other in maximising their sexual health and well-being, possibly forming mutual support groups |
| Young people may be deterred from seeking medical advice or treatment for sexual health problems by a sense of embarrassment, shyness or shame. | Support young people:  
  - To speak openly about sexual health issues  
  - Environments which will continuously enable young people to openly discuss issues |
| Young people are frightened of pregnancy, disease and ruined reputations as a result of having sex. | Support young people in:  
  - Exploring issues of trust  
  - Identifying and role-playing strategies of open communication on sex  
  - Developing negotiation skills and confidence, particularly in safe sex and contraceptive use |

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**Recommended inclusions for participatory sessions on sexual health education**

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<th>Problem</th>
<th>Recommendation</th>
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Rural learners need to hear more messages on gender equality and reproductive health as concluded in a study by Singh et al. (1998). This study was done to help the development of population education training and materials for adolescents enrolled in literacy programmes. The 363 neo-literate respondents included boys aged 15-22 and girls aged 13-18 under the Total Literacy Campaign in Raebareli District, India.

The details below demonstrate how rural learners, compared with their urban counterparts, lag behind in knowledge, attitude and practices affecting: (i) the size of their families, (ii) their reproductive health and rights and (iii) the role that females play in their families. All these call for gender and reproductive health education with a particular emphasis on the needs of rural learners.

**Family size: determining factors**

*Child marriage is more prevalent among rural learners.* More than half (56.7 per cent) of married learners came from rural rather than urban areas. More girls than boys were married and girls usually married before the legal age of 18. Except for urban males, child marriage was mainly confined to lower castes.

*More urban adolescents prefer a small family size.* About two thirds (65.8 per cent) of adolescents preferred a family size of two children. Of those who preferred having four or more children, 62.7 per cent were rural learners.

*More urban spouses jointly decide the number of children.* Most married learners (63.9 per cent) said both spouses decided on their desired family size. This pattern is even more pronounced among urban respondents (73.7 per cent) against rural ones (55.6 per cent).

*Most rural learners do not know about family planning and its methods.* Despite wide promotion of family planning, only 40.1 per cent of adolescent learners in rural areas heard
of the programme. In urban areas, 59.1 per cent were aware of it. Of those aware of family planning, 62.6 per cent of urban learners but only 37.0 per cent of rural ones knew of contraceptive methods (mostly condoms and pills). The actual use of contraceptives among married learners was quite low (10.8 per cent). Half of the non-users claimed to lack knowledge about contraceptives.

**Son preference is strongly dominant among learners.** Preference for sons is the usual cause of high birth rates in rural areas, where preference was observed at 92.9 per cent compared with 87.8 per cent in urban areas. Even after the hypothetical scenario of the preceding birth of two daughters, son preference prevailed at 87.6 per cent among learners. Most learners wanted sons to sustain their hereditary lines or provide support and care for ageing parents.

**Reproductive health and rights**

**Few learners are aware of STDs and AIDS.** Only 13.5 per cent of learners heard about sexually transmitted diseases (STDs) while 19.6 per cent heard of AIDS. Owing to their greater exposure to TV and radio, more urban (33.1 per cent) than rural (6.0 per cent) learners heard of AIDS. Adolescents were made aware of STDs mainly through neighbours and friends; AIDS, mostly through by electronic media.

**More urban learners believe in spouses’ equal rights to intercourse.** Among married learners, 47.4 per cent from urban areas and 35.6 per cent from rural areas thought wives have as much right to intercourse as husbands. They reasoned that everyone has a sexual desire. But most thought this right belonged to the husband alone.

**Infertility of women is unknown to most learners.** Only 39.9 per cent knew about infertility among females. Many (40.7 per cent) did not know the cause and only a few were aware that it is curable.

**Gender issues**

**Women have low status in the family.** More than half of learners (53.5 per cent) said women are given comparatively low status in the family. And these learners reported that for women to improve their status, they have to work to earn money. The less popular suggestion was to give women the same education opportunities as men.

Female learners (62.4 per cent) thought girls are treated as a burden to the family, mostly because of dowry arrangements. A less percentage of males recognised any burden imposed by girls.

**Learners are not aware of women’s rights in the family.** A majority of 67.7 per cent incorrectly thought that only sons have rights to inherit their parents’ property. This was true, regardless of sex, in rural and urban areas. Rural females (64.1 per cent) thought of themselves to have no personal right because they are considered husband’s property. Only 42.0 per cent of urban females agreed.

**Rural females are less aware of their greater roles in the family.** Most rural females (80.8 per cent) said women should be confined to household work only; 62.8 per cent said males are better in dealing with family matters. Fewer urban females agreed to these two views.

More females than males favoured giving decision-making power to both husband and wife in family matters and children’s marriages and education. More urban females (65.5 per cent) than rural ones (46.2 per cent) were convinced that both sexes have equal rights to decision-making on property matters as well.
Madhya Pradesh students want and need sexuality education


Students in Madhya Pradesh do not only want, but also need sexuality education. This was according to a survey that sampled three per cent of the 9th- to 12th-grader population. The following responses to survey questionnaires attested to the students’ need to improve their knowledge on adolescence, reproductive health and sexuality:

**Attitude on sex education and topics**

- **Students think sex education is necessary.** An overwhelming majority of students (87.6 per cent) agreed to the necessity of sex education. Most students (64.6 per cent) thought it should be part of school education.

- **Sex-related subjects remain a taboo.** About two thirds of students felt awkward hearing talks on sex or discussing their own body changes with their parents. More girls than boys felt this way. Nevertheless, many (73.7 per cent) acknowledged their own need to share problems with parents and teachers.

- Although more than half (58 per cent) of students favoured broadcasting advertisements related to contraceptives and STDs, a greater number (67.0 per cent) were embarrassed to watch such. They thought the modes of presentation were too vulgar.

**Knowledge of puberty**

- **Students have poor knowledge of their own body changes.** Less than half of students were able to correctly define puberty, wet dreams and ages of secondary growth changes. But almost all (90 per cent) knew that hormones were responsible for secondary growth. More than 70 per cent were also aware of the body changes expected for both sexes.

- Only 38 per cent understood why menstruation occurs. Some rural students even simply took it as a curse from god.

**Knowledge of pregnancy, contraception and abortion**

- **Not all students understand the biological process of conception.** For example, about half did not know where fertilisation occurs. Only 32.9-48.1 per cent were aware of infertile couples’ options for conception, such as artificial insemination and in vitro fertilisation (test tube baby).

- **Contraception and abortion are not clear concepts to a number of students.** Around 30 per cent of the students could not certainly define contraception or abortion. On the other hand, almost everyone (95 per cent) believed that frequent abortion is harmful to a woman’s health.
Knowledge of AIDS and STDs

Students do not know beyond the basics of AIDS and STDs. Most students knew what the acronym AIDS stood for, how AIDS is spread in general, and what organism is responsible for it. But not many students went beyond this knowledge. About half were confused as to why an AIDS-infected person dies. Only a quarter (25.5 per cent) knew that AIDS could spread through non-sexual contact as well. Thus almost two thirds agreed that advertising causes and consequences of AIDS is the best way to raise awareness.

Only 39.6 per cent of the students know what the acronym STD stands for. Less than this percentage could name STDs other than AIDS.

Parents and teachers’ knowledge on sexuality

Parents and teachers also need to improve their reproductive health knowledge. As sources of information, parents and teachers need to be much better equipped than their current state of knowledge. While the scores achieved by students on sexuality questions peaked at 60-70 per cent correct answers, those for parents and teachers strongly leaned towards 60 per cent or less correct answers (see Figure). Very few students, parents and teachers achieved greater than 80 per cent correct answers.
Adolescent reproductive health
UNESCO RECHPEC

Sexuality intervention: college youth tell their needs


A hundred students, aged 16-20, from five college and university campuses in Manila talked about their sexual lifestyles, information and counselling needs, and the potential role of student organisations in school-based programmes on sexuality and reproductive health. The results of these focus group discussions and in-depth interviews with school officials are revealed:

Adolescent sexual behaviour

Adolescents engage in physical intimacies for various reasons. Unmarried campus-based adolescents enter dating and heterosexual relationships that may develop to sexual intercourse through time. Sexual activities may also occur outside the context of love relationships, for example, when adolescents join fraternities, are high on drugs or in need of money.

To explain their engagement in sexual intercourse, adolescents cited a broad range of reasons: social (e.g., exposure to sexually explicit media, peer group pressure); familial (e.g., strict household rules, lack of parental care); interpersonal (e.g., love for partner, increased frequency of dating); and individual or psychological (e.g., curiosity, sexual urge). Peer groups were identified to strongly influence the inclination towards premarital sex because peers often share sexual exploits, challenge the sexually inexperienced to try sex, or display sexual behaviour in view of their peers.

Adolescents perceive themselves at risk. Adolescents perceived their group at risk of unwanted pregnancies and, to a much lesser extent, STD infections.

Information and counselling needs

Students and authorities acknowledge the need for services. Adolescents agreed on the need for information and counselling services to cut the incidence of unwanted pregnancies and STD infections and their consequences. School authorities agreed too. But students and school authorities were opposed to the idea of providing adolescents with contraceptives as it might encourage people to initiate sexual activity or become more active in it.

Students share what topics will benefit them. Male and female students listed a similar range of topics of interest to them (see Box 1). The report emphasised that formation of knowledge, appropriate attitudes and values are desirable, but development of skills (for example, self-esteem, refusal techniques and sexual risk recognition) should be pursued more.

Information sources and activities

Individuals have different preferences for information sources. Some thought parents are ideal sources because they are ultimately responsible for their children, but others thought parents lack understanding of the youth culture and have a tendency to moralise. Peers were trusted best by the youth but were perceived to lack the maturity, experience, knowledge and
credibility possessed by adult educators and counsellors. The researcher suggested using trained peers, under the supervision of adult counsellors, to deal only with minor adolescent concerns only.

The characteristics of a counsellor are critical. The respondents were willing to avail of counselling services. They specified what they thought were the ideal qualities of a counsellor (see Box 2). While the outward appearance of a counsellor (e.g., not so young or old, always smiling, approachable, ‘angelic look’) makes an impression, actual interaction skills and attitudes are equally important for adolescents. The report said counsellors need re-training to help them understand their young clients.

A combination of activities works best. Different ways to get adolescents to know about sex issues were suggested by the respondents themselves (see Box 3). Since every activity has its own strengths and weaknesses, the report concluded it best to use more than one format for information dissemination.

Under exploration: student organisations’ role

Student organisations have a potential role. Discussants were receptive to the use of student organisations to spearhead relevant activities in the campus. Others had apprehensions that the approach could discourage participation from non-members. Besides, some organisations were thought to be seriously political or religious. Should student organisations play an active role, school officials pointed the need to recognise sexuality concerns in the organisations’ goals, to train their student leaders, and to have educators and counsellors supervise their activities. The report stated that organisations should be carefully selected taking into account their reputation, credibility and concerns. Student discussants identified two to four organisations in their campuses that seemed to fit these criteria.
Evaluation declares two counselling centres as successful models


Two centres in Ho Chi Minh City and Hanoi demonstrated an effective counselling model on reproductive health (RH) for youth and adolescents. This model is worth duplicating through local funding schemes and close coordination with the national RH program and through the technical assistance of UNFPA and other donors. This was concluded after a quantitative and qualitative evaluation by the Population Research Consultants under the support of UNFPA.

Covered by this evaluation were the Counselling Centre for Youth and Happiness in Hanoi and the Counselling Centre for Love, Marriage and Family in Ho Chi Minh City. Research subjects included the centre’s managers and counsellors as well as clients. Also included among the 200 respondents were youth and adolescents aged 15-24 living near the two centres. In their two years of operation, the centres provided face-to-face, community-based, telephone and correspondence counselling. These centres and their services were evaluated as follows:

What do young people say about the counselling centres in Hanoi and Ho Chi Minh City?

**On the counsellors:**
- **The educational level of the counsellors is quite good. Every one has a firm understanding of laws, no need for further knowledge. The most important thing is that they are all kind, enthusiastic and smiling.**
  - Can, 28, Ho Chi Minh
- **They are all smiling, hospitable, gentle and even better than my mother at home. It was the first time I came but I had a great trust on them.**
  - Lan, 19 Ho Chi Minh

**On mode of counselling:**
- **[A demonstration of one disadvantage of face-to-face counselling:]** Sometimes my friend... [went to the centre] in hiding as if he had committed a crime.
  - Male respondent, 20, Hanoi
- **Telephoning is convenient because I don’t want to let myself [be] seen or my name and age known to the counsellor. Some sensitive issues are easier to be talked over the telephone for the feeling of shyness or worries can be removed.**
  - Female respondent, 26, Hanoi

**On counselling charges:**
- **I have been to the centre two times and got humanitarian counselling, so I do not have to pay. I am grateful to the counsellors.**
  - Linh, 18 years old Ho Chi Minh
- **Charging counselling service is a right thing to do, but the unit cost of VND 1,500 is very expensive. We are students so we don’t have much money. The appropriate charge should be about VND 1,200 a minute.**
  - Tuan, 22 Ho Chi Minh

**Mode of counselling**

*Hotline counselling is the most popular mode of counselling.* Almost 95 per cent of the clients of both centres reached them by telephone. By calling, adolescents from the farther sections of the city were able to contact the centre. Since the centres operated in two to three shifts a day, most of the calls came in outside state working hours. Generally, people tend to believe that counselling over the telephone is more advantageous because callers can be helped immediately. Relatively few clients chose face-to-face counselling because of shyness, lack of time and distance from the centres. Some respondents even perceived a “stigma” in being seen in the vicinity of the centres.

**Counselling charges**

*Clients are likely to value the quality of the counselling more than mind the fees they pay.* Generally, there were no complaints about the fees charged for face-to-face
counselling. Charges are flexible and dependent on the time spent, the complexity of the topic and the clients’ capacity to pay. Some got free counselling while others were charged an average of VND 5,000. Some of the respondents/clients were even surprised with the low fees they paid. This indicated that charges did not prevent clients from getting face-to-face counselling. Telephone counselling charges are fixed at VND 1,500 per minute. The Post and Telecommunication Service collects the whole payment and turns over 60 per cent of it to the centres. Most, but not all, are happy with this rate.

Counsellors

The counsellor is considered a crucial factor to the success of the project. Although the centres have counsellors from different walks of life (i.e. law, educators, health professionals), the training they received as well as the amount of information they possess played an important role during their interactions with the clients. Youth and adolescent clients appreciated their dedication, positive attitude and warmth. The sincerity and enthusiasm from the counsellors not only helped the clients solve their problems but also made them feel good and made life more meaningful for them. These qualities encouraged clients to return in person to the centre or continue calling when in trouble.

Public awareness of the centre

The centres have been ineffective in attracting clients. Most youth and adolescents adjacent to the centres knew of their existence (65.4 per cent), but failed to indicate their actual location. The centres have not been actively formulating concrete plans to create more demand among the youth and adolescents. Awareness among the target clientele needs to be increased.

Resources

The centres have a limited supply of materials. Difficulties were encountered with respect to the provision of documentation (printed materials) for counselling. This was attributed to the lack of funding to support this endeavour. The revenues generated from counselling services were not sufficient.

UNFPA support plays an important role in sustaining the centres’ activities. According to the experience of the Ho Chi Minh City counselling centre, these resources were highly effective when used in combination with the centre’s resources for the development of IEC materials and provision of facilities for community-based counselling services.

Recommendations: Improving the counselling centres in Vietnam

- Expand the counselling model to other areas in Hanoi, Ho Chi Minh City and large cities such as Haiphong, Danang, Nha Trang, and Can Tho. By 2005, counselling centres should be set up in all cities and provinces.
- Hire full-time managers and counsellors to ensure efficient service. And more part-time staff should be made available to respond to clients at all times.
- Coordinate with activities of other programmes. The centres’ services should be promoted through other reproductive health programmes. At the same time, clients should be made aware of other counselling and information channels.
- Encourage the government to support the centres through infrastructure, legislation, and tax exemptions.
- Obtain stable resources to finance the centres’ activities. While UNFPA funding is vital, centres should develop their capacity to generate resources to achieve sustainability.
- Study the feasibility of expanding community-based counselling because there is a high demand for this in cities, computer-base counselling (e.g., e-mail and Internet forums) should be encouraged.
- Coordinate with youth branches at grassroots level or in schools to promote counselling services, especially community-based counselling, among youth and adolescents.
- Request for direct telephone lines so that clients do not have to go through the Post and Telecommunication Service operators.
- Implement pipeline projects such as health examinations and others related to safe sex as well as prevention of STDs and unwanted pregnancies.
Window of Love Programme gets good response from listeners


The audience response to the phone-in radio programme Window of Love has been positive in the first year of broadcast. The programme has enjoyed wide support and has been recognized socially for its important role in the provision of knowledge aimed at changing the reproductive health attitude and behaviour among the youth and adolescents. This was the conclusion reached by the audience research study conducted by the Population Research Consultants under the support of UNFPA.

The research was conducted to identify the difficulties and barriers preventing the youth and adolescents from listening to or participating in the Window of Love Programme. It was designed to initially evaluate the programme’s impacts on behavioural and attitudinal changes among the youth with respect to reproductive health. Most respondents were 14 to 18 years, although there were older respondents (26 to 31 years) too. Of the 1,309 respondents from North, Midland and South Vietnam, only a third have learned about the programme or have listened to its broadcast. This audience of 432 was further investigated to assess the points of the programme.

Data for the study were gathered from in-depth interviews and focus group discussions as well as from letters sent in by the listeners. In addition, newspaper clippings about the programme were also reviewed. The major findings of the study are as follows:

Audience characteristics

A large audience share comes from the northern part of Vietnam. Out of the 162 people who phoned into the programme, 41 per cent of the callers were from the north. Callers from Central Vietnam had the lowest proportion. The same pattern was observed for the letter senders. Almost half other letter senders were from the north.

Most of the letter senders are adolescents and youth. Writers aged 17-24 comprised 75 per cent of the total letters received by the programme. Only 22 per cent of the letter senders belonged to the 25-29 years old age group and 3 per cent for those beyond 30 years old.

Audience response to the programme

Recall of programme details is high. About two thirds of the audience were able to remember the broadcast time. There is no large difference between men and women with regards to identifying the schedule of the programme.

Urban residents are more aware about the day, time and duration of the radio broadcast. This was contrary to the projection that rural audiences would be more interested since they have fewer opportunities to access RH information.

Educated listeners seek to access more RH information. More student/listeners from the higher secondary group (10th grade upward) recalled the broadcast day, time and duration compared to the younger listeners. The listenership rate among the latter group was 10 per cent lower than the former.
Adolescents are more interested in the programme as compared to other age groups. Respondents aged 14-18 years old were more aware about the programme’s broadcast history (34 per cent), day of broadcast (84 per cent), time of broadcast (69 per cent) and the length of broadcast (67 per cent) as compared to the other age groups.

Broadcast day, but not time, is convenient for listeners. Almost three quarters of the 342 respondents found Sunday to be convenient for them. But almost half of the respondents found the 10:00 a.m. broadcast to be inconvenient. Some respondents attributed this to conflicts with household chores and homework. Opinion on the ideal broadcast time was divided. Forty-eight per cent wanted the programme aired between 6:00 – 12:00 in the morning while 47 per cent wanted it in the evening (between 7:00 and 10:00 p.m.).

The thirty-minute format is sufficient to meet the audience’s needs. More than half (56 per cent) of the respondents were satisfied with the programme duration. But a significant proportion of the responses (22 per cent) indicated that the programme was too short. Due to limitations posed by the 30-minute time slot, questions posed to the programme counsellors were not answered satisfactorily.

**Audience response to programme content**

The current programme format generates only mild interest among its target audience. Majority of the respondents were infrequent listeners of the programme. They account for 78 per cent of the listening respondents. With respect to age groups, 87 per cent of the respondents in the 26-31 years old age group and 78 per cent of those in the younger age bracket (14-25 years old) were infrequent listeners.

Most of the listeners are not keenly interested in the programme content. Although 84 per cent of the respondents showed interest in the programme’s content, only 23.3 per cent were very interested in it. The rest expressed only mild interest.

Compared to other youth programmes, the “Window of Love” is generating more interest among its target audience. Infrequent listeners of the programme comprised 79 per cent of the audience as against 72 per cent for other programmes. On the other hand, 14.3 per cent of the audience were frequent listeners of the programme as compared to 11.3 per cent for other programmes.

Love, puberty and sexuality issues are the topics of interest to the audience. Almost 70 per cent of the letters and responses to the survey indicated that issues on love generated the most interest among the audience. Issues related to puberty and sexuality (42 per cent) ranked second. Adolescents showed more interest on puberty and sexuality-related topics. On the other hand, respondents and letter writers from the older age brackets (21-35 years old) were more concerned and interested in love-related topics.

The programme is able to generate an increase in RH knowledge among its listeners. Among those who listened to the programme at least once, 69 per cent believed that they have gained a better understanding of RH issues. 56 per cent of them gained a better perspective on pure friendship and love while 27 per cent learned more about puberty issues. There was a low level of interest in other RH-related topics like contraceptives (7.3 per cent), abortion (4.3 per cent) and STDs (9.3 per cent). 91 per cent of the respondents felt that the information they get from the programme is useful. Almost all of the adolescent respondents believed that the programme content is useful.

The programme helps desensitise adolescents on RH issues. Issues tackled in the programme are considered to be taboo and too sensitive to be discussed openly. Now, there is a shift in the youth’s perception. Majority of the respondents (75 per cent) did not feel that the programme’s contents were too private to be discussed on air. A high rate of respondents (80 per cent) aged 14-18 years old shared this opinion. This rate is 28 per cent higher than the older respondents (26-31 years old).
First ARH communication campaign reaps rewards


After only four months, remarkable results have been achieved in the first Information, Education and Communication (IEC) campaign on adolescent reproductive health (ARH). This was the verdict reached by a study that evaluated the urban-based campaign of the Vietnam Youth Union. As part of this evaluation, the effectiveness of the IEC messages as well as the IEC channels and media used during the campaign were assessed. A total of 390 people (224 men and 166 women) in Hanoi City and Nghe An province were interviewed. Of these, 164 were 18 years and below while the rest were 19 years and above.

The IEC campaign involved nine messages about friendship, love, safe sex, STDs and pregnancy prevention (see Box). These messages were disseminated through mass media such as advertisements on radio, TV, newspaper, IEC posters, garments and others. Additionally, messages were advocated directly through broadcasting media in wards, youth clubs/counselling centres and through teachers and parents. The major findings of the study are as follows:

Awareness of ARH messages

Awareness on ARH messages is very high. Ninety-seven per cent of the respondents had read or heard the messages. But the rate of spontaneous recall of the messages was lower compared to instances when the interviewers prompted the respondents.

Recall of message content varies across age groups and sexes. Messages advocating friendship and studying for the future were more easily remembered by respondents aged 18 years and below. Respondents over 19 years often remembered messages about love, safe sex and STD prevention. On the average, half of the men could spontaneously remember the messages while only 40 per cent of the women could. But a higher proportion of women remembered messages related to love and premarital sex (e.g., “I love your virtue and soul, and your saying ‘don’t’.”). This indicated that women still valued traditional culture.

Shorter and favourable messages are more readily remembered. More than 60 per cent of the respondents were able to remember shorter messages (e.g., “Friendship is sacred and valued if cared”). The longer messages were difficult to remember and understand deeply. Respondents also remembered the messages they favoured most. The most preferred message (67 per cent) was “It is important for us to study now for our future living.” Recall of this message rated at 62 per cent. One of the least preferred messages was the one on condoms and safe sex. The rate of recall for this message was 40.5 per cent.
Effect of IEC channels

Television is the main IEC channel. Majority of the respondents (91 per cent) got the IEC messages through television, which is often part of the urban household. On the other hand, 63 per cent of the message reception was through radio advertisements. This lower rate could be due to broadcast interference as well as unfavourable schedule of the broadcast.

Preference of IEC channels differs between age groups and sexes. Television was the most preferred IEC channel (see Figure). This was followed by youth clubs/counselling centres (70 per cent) and newspaper and radio advertisements. The lowest rating (20 per cent) went to IEC through garments. Respondents under 19 preferred receiving information through clubs or counselling centres and people close to them (teachers, parents and friends). For respondents above 19 years, newspapers had the highest preference rating (69 per cent). Compared to the men, a larger proportion of the women preferred television to other channels. Males favoured channels like youth clubs, personal talks as well as radio broadcasts in the commune.

Men are exposed to more information channels than women are. More than half (54 per cent) of the men knew about the “The Youth and Happiness” journal as compared to only 36 per cent of the women. Young men received more ARH messages through youth clubs and counselling centres (68 per cent) than women (48 per cent). On the other hand, female respondents more frequently cited books and newspapers as information channels.

Popular mass media cannot convey all aspects of the communication campaign. Short messages were better recalled when heard through the television or radio. But long and difficult messages were recalled more frequently through channels like newspapers, youth clubs or interpersonal communication (teachers, parents, and friends).

Knowledge, perception and attitude on ARH

Knowledge and understanding of ARH issues varies across geographic locations, sexes and ages. In Nghe An, 83 per cent of the interviewees knew at least one ARH issue but only 6.7 per cent had a good understanding of this issue. On the other hand, only 68 per cent of the interviewees in Hanoi knew at least one issue. Seventy-six per cent of the respondents over 19 years of age knew more about ARH than those below 19 years old. Only 24 per cent of the males were unaware of ARH. Women had slightly lower levels of awareness.

A number of respondents want more ARH information. Nearly half of the interviewees (45 per cent) wished to gain a deeper understanding about ARH. Interviewees aged 18 years old and below desired to understand more about friendship and love. The older age group wanted to know more about puberty psychology, STD prevention, and marriage and spouses’ relations.