THEME PAPER

Strategies to Operationalize Innovative Programmes to Address Adolescent Concerns

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* Section 2 of the paper reviewing current approaches, strategies and programmes draws heavily upon the country papers prepared for the Conference. Unfortunately, the Pakistan country paper was not ready at the time this paper was written and, therefore, it does not include information from Pakistan. The framework for ASRH programmes is based on the documented case studies of ICOMP which were reported in its two publications: Innovations Vol. 2 (1995) and Population Manager Vol. 4 (1996). Thanks are also due to Malieca Ratne and Bina Pradhan for their comments on an earlier draft of the paper.

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1. INTRODUCTION

The country papers from the South Asian Region, prepared for this seminar, vividly describe the adolescent needs and their sexual and reproductive health (SRH) problems. The age of menarche has been declining and girls continue to remain ill prepared for this event or understand its significance for reproduction. The age of marriage, although still low in most countries, is gradually increasing thus the period between menarche and marriage is widening which, coupled with the exposure to modernisation influences, places new demands on adolescent sexual behaviour. Despite the increase in age of marriage, the proportion of births to adolescents is high, except for Sri Lanka. Contraceptive use among married adolescents remains low. The recourse to abortions for unwanted pregnancies by unmarried adolescents is high. A large proportion of adolescent girls suffer from anaemia as well as acute and chronic malnutrition, which not only enhances the risk of teenage pregnancy both to mother and child but also adversely affects full development of their human potential. Although varying in intensity, there is concern about prevalence of STDs and HIV/AIDS in this age group. There is evidence of considerable violence, both physical and sexual, against adolescents, albeit inadequately documented. In addition, there are special problems - trafficking and prostitution, dowry, forced marriages, substance abuse etc. Overarching these problems is the low status of girls, including in their adolescent years.

Most countries view the adolescent sexual and reproductive health (ASRH) concerns in the context of their overall socio-economic development. Thus, there are concerns for their education, socialisation and livelihood. In studies elsewhere in the Asian region, these are also highlighted as major concerns of adolescents. Once again, except for Sri Lanka, more than half of all adolescents drop out of school by the age of 15 years. The girls often feel isolated, as opportunities to socialise, except within immediate family circles, are limited although they contribute to household or other economic activities. Special programmes for income generation for adolescents are few except for vocational education and as a part of such income generation activities for women.

Socio-cultural factors are an important determinant of ASRH behaviour and modernisation influences impinge on tradition. Therefore, traditional responses to these problems would not suffice. Despite the recognition of importance of overall developmental perspective and the seriousness of ASRH problems, the programmatic responses have been meagre. There are no comprehensive national programmes. Many NGOs have implemented innovative ASRH activities but both their coverage and scope is limited. Generally developmental programmes of non-formal education (NFE), credit, nutrition and health care serve adolescents but often do not pay special attention to their needs or make their services adolescent-friendly. Post ICPD, ASRH has become an area of concern, as reflected in the formulation of overall RH programmes such as Reproductive and Child Health Programme (RCH) in India and Essential Service Package in the Health and Population Sector Strategy in Bangladesh.

In this paper, we briefly review the current approaches, strategies and programmes to address ASRH concerns (section 2), suggest what is needed (section 3); and develop an operationalization framework to bridge the gap between what is needed and the current status (section 4).

2. REVIEW OF CURRENT APPROACHES, STRATEGIES & PROGRAMMES

Adolescent health concerns are of more recent origin and most programmes are in their infancy. The current approaches and strategies could be classified under four headings: (1) developmental programmes including education and income generation for women; (2) various health programmes such as population education/family life education (FLE), family planning (FP), maternal and child health (MCH), nutrition, and HIV/AIDS; (3) innovative SRH programmes of NGOs; and (4) post-ICPD response of the countries. Given the wide diversity and richness of initiatives as well as lack of information on their coverage and effectiveness, the review is stylistic in nature.

2.1 Developmental Programmes

Adolescent girls are the most vulnerable as women generally have low status. In order to ensure gender equity, equality and empowerment of women, most countries have established legal frameworks and institutional structures, implemented special formal and non-formal education, and vocational education and income generation schemes.

To encourage girls' education at secondary level, a special scholarship scheme has been introduced in Bangladesh. Both Bangladesh and India have made girls schooling free. Non-formal education has been a major approach to address low enrolments in the formal education system. The non-formal and literacy education in Nepal aims at providing educational opportunities to children of 8 – 14 years of age group who have missed primary school. The graduates of these NFE programmes are encouraged to enter regular schools. Similarly, BRAC, an NGO in Bangladesh, operates 34,000 schools having an enrollment of 1.2 million children for NFE where 70% participants are girls. In Maldives, NFE emphasizes educational needs of the large over-age school population through an accelerated educational programme. Bhutan government has used NFE strategy to expand access to functional literacy and 70% of attendees at NFE centres are women. Most of the NFE in Sri Lanka is directed towards skill development. However, a large number of literacy classes are also conducted.

Both government and a large number of NGOs operate vocational skills development and micro-credit systems. However, very few of them have special focus on adolescent girls. While generally they have achieved success, albeit to a varying degree in the countries, the participation rate of adolescents and the benefit derived by them are not clear.

All governments also have programmes for youth development, which mainly focus on their socialization and involvement in community development activities. In Maldives, the Maldives Youth Centre conducts education and training, sports and recreation and social and cultural programmes. The Bhutan Youth Development Association aims to channel energies of adolescents/youths through promotion of sports activities, organizing social services and supporting youth guidance centres. Department of Youth Affairs, Government of India also mobilizes youth through its centres called "Nehru Yuva Kendras". In Sri Lanka, the National Youth Services Council trains youth leaders in youth clubs and other such networks. It has incorporated RH education and counselling services in its programmes.

There are very few integrated programmes. One such example is UNFPA supported Haryana Integrated Women's Empowerment and Development Scheme in India (UNFPA 1998). The adolescent girls' component includes life skills development and imparts practical competencies including basic literacy and maths, health, sanitation and nutrition, and RH and reproductive rights.

There has been steady increase in education levels of adolescent girls, the female participation in organized sectors of economic activity has been increasing and generally the legal and institutional frameworks have become more favourable for gender equity and equality. However, much more needs to be done.

It is also worth noting that there have been no special programmes for adolescent boys. If gender equity and equality are to be internalized, it is important that such values are imparted to and internalized by them.

2.2 Health Programmes

Most countries, largely with UNFPA assistance, have been implementing population education for more than a decade. Earlier population education largely covered population and development, population growth, and family planning. The main aim was to institutionalize it at all levels of school education. These programmes had some impact. More recently, their scope has been broadened to include emerging concerns including family life education (FLE), HIV/AIDS and drug abuse, although considerable effort will be required for its effective integration into curriculum, material development and teachers training. In Sri Lanka, as a successor to Population Education/FLE, a programme on RH education is being introduced. It incorporates both social and medical aspects, and will sensitize parents and test peer education on a pilot basis. Building on earlier population education efforts, Nepal has recently implemented a project in 20 of its 75 districts which aims to create awareness of benefits of late marriage, delay first pregnancy, use of FP methods, birth spacing and MCH care. In Bangladesh, some NGOs are implementing innovative FLE models. Adolescents in all the countries of the region have expressed a need for FLE.

Malnutrition as well as anemia not only limit development of full human potential but also increase the risks associated with teenage pregnancies. It is not clear how many countries have programmes to address this issue. However, it is worthy to note that the Integrated Child Development Scheme (ICDS) in India has extended its activities to adolescent girls in the age group 11–18 years. This programme operates through Girls' Clubs and provides health and nutrition supplementation. It is an extension of such a programme for pre-school children and pregnant mothers. However, innovative and cost-effective ways to address this problem are yet to emerge.

Until recently family planning programmes in the region were guided mainly by demographic considerations of reducing fertility to decrease population growth rate. Consequently, they did not pay special attention to contraceptive education and service needs of married, let alone unmarried, adolescents. As fertility rates have begun to decline, the realization has grown that population momentum would be a leading cause of future population growth. Therefore, some attention is now given to delaying the age of marriage and of the first birth. Since social norms generally do not favour delaying the birth after marriage, emphasis is being placed on delaying the age of marriage. Most countries have laws on minimum legal age of marriage although in rural areas these may not be strictly enforced. Consequently, the extent of unmet need for contraception, unwanted pregnancies and abortions among adolescents seem high. Many factors determine the age of marriage and alternative social and economic options need to be made available through multi-pronged strategies.

Although the pregnancy-related risks associated with teenage pregnancy are higher, MCH programmes in the region do not pay special attention to them. Despite some IEC activities, communities also do not seem to be aware of these higher risks.

Most national AIDS programmes have carried out a variety of IEC activities. Although adolescents are at higher risk, these are not specifically directed at them. This has resulted in either lack of or only a superficial knowledge of HIV/AIDS. The knowledge about STDs is even lower, as the country papers have documented. Most societies seem to have underestimated pre-marital sex, especially among boys. The evidence is growing that a significant proportion of young boys may have visited commercial sex workers and generally indulged in unsafe sex. There is a need to evolve methods and IEC materials to reach young persons. Special efforts also need to be made to encourage use of condoms to ensure safe sex.

Many NGOs and most governments have shelters for women and some legal framework to address violence against women. Recently laws related to rape have been strengthened in most countries. Despite many women's NGOs having taken up this issue, both the documentation of and responses to violence remain grossly inadequate. Similarly, there are sporadic attempts to address problems of adolescents who face difficult circumstances such as refugees and migrants. Away from the traditional social support systems, they are particularly vulnerable to exploitation.

2.3 NGOs' SRH Programmes

Generally NGOs have been more at the forefront than governments in addressing ASRH concerns. A large number of NGO programmes in India are described in the country paper for India. For instance, the Better Life Option Programmes of CEDPA fosters self esteem among adolescent girls through increased access to NFE, FLE and RH education and services, and skills and vocational training. The Family Planning Association of India (FPAI) provides health counselling and information services for adolescents. Several organizations are working towards ways to respond to and prevent sexual abuse. Some NGOs work with legal ramifications of abuses such as dowry, divorce, child custody and rape. Yet a few others have programmes to rehabilitate commercial sex workers and many organizations have been working with street children. Many NGOs are also working on programmes to prevent HIV/AIDS. In addition, NGOs have carried out advocacy activities.

In Nepal, FPAN has implemented FLE programmes and a few NGOs are actively involved in AIDS awareness programmes. The projects and programmes of NGOs in RH include FP, MCH, prevention education of HIV/AIDS and STDs, condom promotion and diagnosis and treatment of RTIs. Since 1994, NGOs have been particularly active in the needs assessment, research and advocacy for ASRH. Some are active in advocating against violence and girls trafficking.

Sri Lanka has relied on pioneering FP NGOs such as the Family Planning Association of Sri Lanka (FPASL) to cater to the reproductive health needs of adolescents including in-school RH education. Pre-marital counselling in SRH is addressed in the education programmes of NGOs. The government and NGOs work closely to facilitate implementation of laws against sexual abuse and violence.

NGOs have played an important role in the family planning programme in Bangladesh. Several NGOs provide FLE and operate youth clubs. Jatiyo Tarun Shangh (JTS) operates a large number of youth clubs that are active in population work. Recently some of them have begun adding other ASRH activities.

Thus, the review shows that NGOs have developed innovative ways to address specific RH concerns. They have generally worked on a few specific aspects of RH, rather than addressing comprehensive concerns of adolescents. Many also do not have comprehensive ASRH programmes to cover specific geographic areas. They would have to develop and pilot test such approaches which can lay the foundation for future programmes to improve ASRH.

2.4 Post-ICPD Response

Post-ICPD, most countries have either planned or begun implementing adolescent health as a part of overall reproductive health. In Bangladesh, ASRH is included under

the overall essential service package in the Health and Population Sector Strategy. It will address nutritional deficiency, early and unwanted pregnancy, maternal services, complications of unsafe abortions, RTI/STDs, addiction to substance abuse, accident, violence and sexual abuses. Behaviour change communication and IEC, training to service providers, involvement of private and NGO sectors and inter-sectoral coordination are the major strategies. Similarly the RCH service package in India aims to enhance RH knowledge of adolescents and improve self health-care as well as health care seeking behaviour of adolescents and enhance awareness of communities to their SRH needs. Nepal's RH strategy encompasses inter-divisional within MOH and inter-sectoral coordination, which will deliver RH education services at family, community, and health service levels. It will improve gender perspectives and empowerment of women. Counselling, sex education, contraceptive education and services and STD/HIV/AIDS prevention would be specially targetted at adolescents. In Bhutan, the programme would focus on improving quality of RH care and include various RH services for adolescents. The RH education will also be emphasized in schools and NFE activities. In Maldives, attempts will be made to make services friendly to adolescents. MOH and Ministry of Education will coordinate SRH education in schools. Sri Lanka had undertaken various SRH activities and a policy is being finalized. Preventive strategies have been started through youth counselling centres and vocational training centres. Post-ICPD, the governments have also encouraged greater involvement of NGOs and other civil society organizations. They are participating in a task force to formulate national policies. Both India and Bangladesh have formalized mechanisms for enhanced NGO involvement.

These activities are of recent origin and therefore, it is difficult to predict their impact. Although some actions are based on previously tested government or NGO experiences, many are new. However, post-ICPD most governments have established a framework in which ASRH education and services can take place.

3. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES: WHAT IS NEEDED?

The review shows that the ASRH programmes are generally small scale except for family life education in schools or AIDS awareness campaigns. Although post-ICPD many countries are incorporating ASRH activities in their overall RH programmes, there is a need to recognise that adolescents constitute a separate group which cannot be treated in the same manner as adults, and even among adolescents, needs differ depending on the socio-economic status and sexual behaviour. Often even married adolescents are not able to access the family planning services because of either social or economic barriers. Adolescents would generally like to be informed by their peers, would like services which are friendly, and ensure privacy and confidentiality. They are often not at places where adults may go for services. So the channels to reach them would need to differ. Therefore, special ASRH programmes would be needed.

3.1 A Societal Vision for ASRH

However, before ASRH programmes can be launched, there is a need to create social acceptability for them. ASRH is a sensitive issue in most communities. Therefore, social acceptability needs to be created by analysing problems, carrying out advocacy through communication and addressing those problems which are widely recognised as those requiring action. All the stakeholders need to have commitment to ASRH. For instance, if in-school ASRH education activities are to be implemented, the stakeholders – Ministry of Education, district education officers, school principals, teachers and parents – need to be sensitised and their commitment sought. Failure to get social acceptability can also cause difficulty as it is easy to spread rumours about the nature and intent of these programmes through media or otherwise.

In many South Asian countries, NGOs have begun to advocate for ASRH (see box 1). In Sri Lanka, for instance, NGOs, human rights groups and government officials engaged in probation and childcare services have been in the forefront in advocating preventive strategies and legal reforms. The mass media has also played a useful role in bringing to focus incidents of exploitation and violence against children to create a public opinion to enforce social control on these issues.

Box 1. Advocacy for ASRH in Nepal

Various NGOs, particularly the Family Planning Association of Nepal, are organizing workshops/seminars for parliamentarians, the media, women leaders and social workers on advocating the RH sexuality needs of adolescents. Debate and essay competitions among secondary level school students on the needs of adolescents have been an on-going process.

Other NGOs such as ABC Nepal, Asia Foundation, Shtri Shakti, SHATHI, WOREC and WICOM are advocating against violence and sexual abuse as well as for the cause of women.

(From Nepal country paper)

Although the recognition of the need for ASRH programmes is growing, continuing advocacy is necessary. First, many believe that ASRH may encourage an early onset of sexual activities among adolescents. Therefore, one needs to demonstrate that ASRH programmes will actually lead to more responsible sexual behaviour among adolescents and that the harmful effects on their health will decline. Second, sensitising policy makers and generating their commitment should be a priority. Third, there is a need to demonstrate that ASRH programmes can be implemented in diverse cultural settings.

However, to develop a common societal vision, one must move beyond advocacy and sensitisation to a broader participatory process (box 2). Sensitisation of key stakeholders requires identification of and discussions on problems with them. Advocacy efforts require intensive communication and dialogue with various stakeholders. The participation of stakeholders in programme formulation would increase their support to the programme. Commitment to a common vision would go beyond these stages and provide appropriate roles to key stakeholders in programme implementation.

Box 2
Commitment to Common Vision:
Four Stages

Sensitisation
☒
Advocacy
☒
Participation in programming
☒
Common vision

A participatory process implemented by the Government of Uganda and UNFPA in the development and implementation of Programme for Enhancing Adolescent Reproductive Life (PEARL) illustrates how a common societal vision can be created. The guiding principle was the approach that focused on the tasks, was inclusive and participatory. The task focus implied that instead of discussing conflicting positions about sexuality and reproductive health of adolescents, groups and representatives of social and religious institutions should identify a problem to solve or an issue to address. Inclusiveness means making room for all social partners including the youths themselves as part of the process. The participatory process implies that each group can contribute according to their strengths and mandate and complement each other in addressing ASRH concerns (Farah and Nalwadda 1996). The PEARL programme has been implemented on a pilot basis in four of Uganda's 39 districts. Its objectives are to (a) promote district and community support among leaders, positive cultural practices, and responsible sexual behaviour among adolescents; (b) increase interpersonal communication between parents, children and adolescents; (c) provide accessible, acceptable and affordable RH services to adolescents; (d) develop skills of adolescents; and (e) strengthen management capacity with a view to ensure programme sustainability.

3.2. Creating an Enabling Environment for ASRH Programming

Currently governments do not have an explicit policy regarding the reproductive rights of adolescents and ASRH programmes, although most governments have included these activities as part of their broader approach to RH. The views regarding the desirability of an explicit policy differ among the ASRH advocates. Some feel that it may be better to let the programmes develop and demonstrate what can be done and the policy will follow. They fear that a premature policy discussion could actually place barriers to ASRH programmes. Others feel that a conducive policy environment can accelerate implementation of ASRH programmes. Clearly the situation will differ from country to country.

3.3. A Framework for ASRH Programming

Programming for ASRH activities suffer from two serious lacunas. First, the research base on understanding the ASRH behaviour and its causes is weak. As Jejeebhoy (1996) remarks, " Unfortunately for programme planners, the paucity of reliable information is less conducive to recommendations for adolescents programmes than to research recommendations". Second, the knowledge base on effectiveness of ASRH programmes is inadequate. As Hughes and McCauley (1998) remark, "First, there is broad and strong consensus on many elements of what constitutes 'best practice' based on practice, not science. Second, the research knowledge base about programme effectiveness is quite weak."

Reflecting the current state of art, many authors have described the best practices for ASRH (Amana, Population Manager Vol. 4). These usually address key elements of programming such as (a) needs assessment, (b) addressing holistic needs of adolescents, (c) creating a common vision, (d) programme strategies (peer education, linkages with other agencies, segmenting the groups according to their needs, comprehensive range of services), (e) implementation processes including adolescent friendly education and services, and monitoring and evaluation, (f) appropriate IEC strategies and materials, (g) importance to gender concerns, and (h) building capacity for sustainability.

A study group jointly convened by WHO, UNFPA and UNICEF (1997) also proposed a framework for country programming for adolescent health. According to the framework, the programmes need to (a) promote development to meet needs; (b) build competencies; and (c) prevent and respond to health problems. Its major interventions are to create a safe and supportive environment, provide information and counselling, build skills and improve health services. It recommends use of all settings where adolescents may be found and all actors who may come in contact with them. Four major challenges identified are to (a) building political commitment, (b) identifying priorities for action, (c) maintaining implementation and (d) monitoring and evaluation.

The process of ASRH programming is important. The youth must be at the centre stage and should be involved in programme planning, implementation and evaluation. The programme design should begin with the identification of target segments - which age groups, who and where. Then it is necessary to carry out a situation analysis through surveys, focus group discussions, narrative research and/or other methodologies. This exercise is necessary both to ensure that the real needs of target segments are addressed and to serve as a basis for dialogue with the stakeholders which should follow in order to determine the problems to be addressed as well as to generate commitment to address them. The interventions should be based on an understanding of why the behaviour that is sought to be changed persists. It is known that knowledge alone is often not sufficient to cause change. Therefore, key determinants of behaviour need to be addressed through programme interventions. Once the range of interventions and

activities have been identified, implementation arrangements would need to be worked out. Ultimately the programmes should not only cause the desired behaviour change but also empower the youth and the community to ensure programme sustainability.

Comprehensive ASRH Programmes

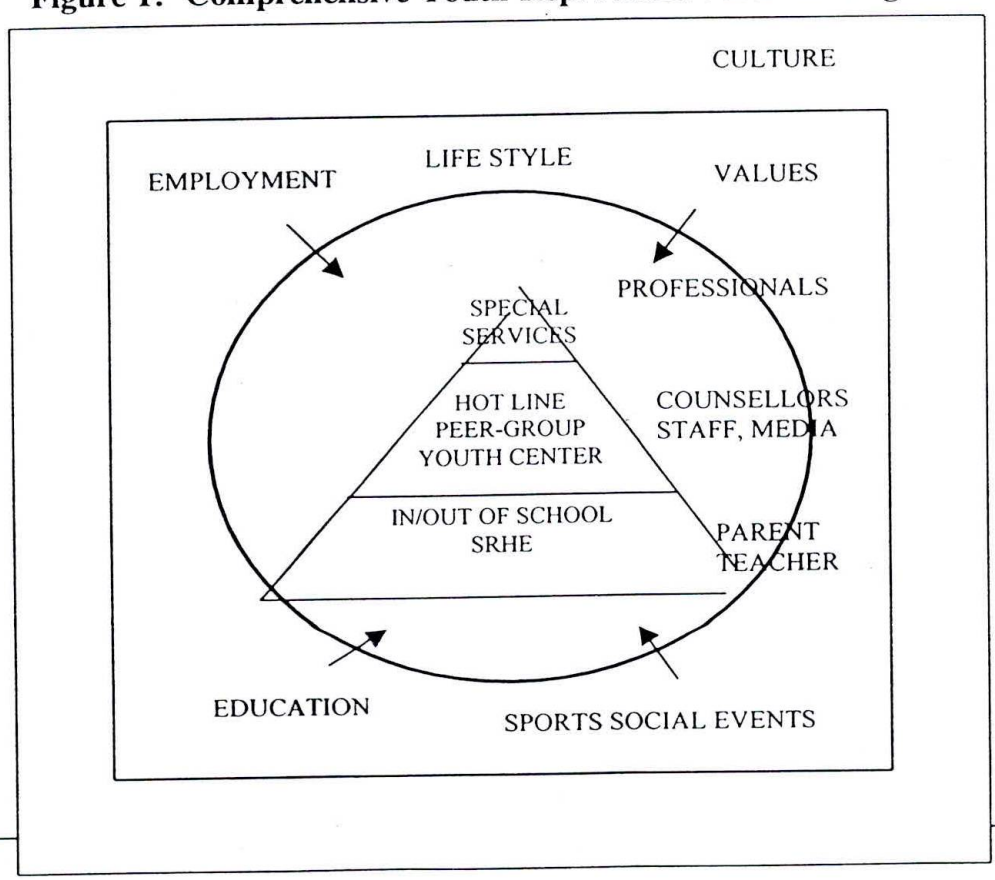
Although the ASRH programmes would have to be appropriate to their cultural context and need to continuously learn and adapt as the knowledge base strengthens, a contour of such programmes emerges (figure 1) through an analysis of documented innovations (Innovations Vol. 2 1994. Population Manager Vol. 4 1996). A comprehensive ASRH programme would have three components:

1. Sexual and reproductive health education for in-school and out of school adolescents through parents, teachers and mass media;
2. Youth centres supporting a peer group network, telephone counselling and personal counselling; and
3. A referral network for promotion and provision of special services, although some services may be incorporated in the above components.

These components would have to be supplemented to address special programmes such as those for violence against women and trafficking for prostitution or street children.

The life styles of adolescents have great influence on their sexual and reproductive behaviours. The promotion of values, opportunities for employment and education as well as the provision of social events (sports, outdoor activity etc.) can further strengthen a comprehensive ASRH programme. Since ASRH is a sensitive issue, the cultural context must be given adequate attention during the process of programme design and implementation.

Figure 1. Comprehensive Youth Reproductive Health Programmes



3.4. In-school programmes

Our review had shown that population education and its successor family life education programmes are being offered in almost all the countries. However, their coverage and impact are not clear. An innovative example of ASRH education in schools in Sri Lanka is shown in box 3.

Box 3 In-school Programme
Family Planning Association of Sri Lanka

This innovative programme was started in 1992. Its objective is to provide youth with information on growing up process, reproductive system, sexuality, STDs including HIV/AIDS, and create opportunities for counselling

On the basis of a request from the school, a three-hour multi-media presentation is organised by a team of a former teacher and an organiser. It includes lectures, films, question-answer sessions, pre-test and post test. To ensure follow up as well as to institutionalise the programme, teachers, who volunteered, are trained to provide in-school sexual and reproductive health education as a regular part of curriculum.

The major lesson is that commitment within the Ministry of Education and among school principles was created through a process of dialogues and advocacy. Linkages were established with selected youth organisations and other NGOs. Initially the publicity about the programme was kept to a minimum so as not to risk adverse public opinion.

More than 200,000 students were covered in the programme by 1994. Now in collaboration with the government, the programme is extended to 18 districts.

Although the programme initially used special teams, there is debate as to whether such education should be included in regular curriculum and taught through teachers. The former is more costly but the latter may dilute the emphasis and quality of education.

It is estimated to cost US $0.84 per student or US $ 300,000 per year if extended to whole of Sri Lanka.

(Basnayake and Andersson 1995)

Teachers and parents play an important role in in-school programme. Although some programmes also educate parents, the activities to improve the interaction between parents and adolescents to nurture and support the process of maturation have not been emphasised. A programme in Indonesia organises families into small groups, which meet periodically to discuss adolescent problems/issues. Through these group meetings, facilitated by trained cadres, families are exposed to ways of addressing adolescent problems and needs.

Generally the content of such education includes (a) personal: human physiology, primary health care, changes at puberty, child/parent conflict, nutrition, hygiene, self esteem and problems and options of adolescents; (b) societal: relationships, responsibilities, family planning, love

life styles, parenthood; and (c) social problems: smoking/alcoholism, prostitution, STDs and HIV/AIDS, drug abuse and child abuse.

The Bangladesh Rural Advancement Committee (BRAC) in Bangladesh has pilot tested a FLE curriculum in its NFE schools as well as in selected government schools. It is currently being evaluated. Once refined, BRAC plans to make it more widely available in the country and assist in upscaling it in the schools.

Most such programmes emphasise provision of information. However, theories of social influence suggest that this may not lead to behaviour change. They suggest that adolescents need to acquire "life skills" such as planning ahead, decision making, problem solving, negotiating and forming positive relationships if their behaviour is to change. Some groups have now embraced the centrality of skills building for adolescents in their programmes (Hughes and McCauley 1998, Population Manager Vol. 4 1996).

3.5. Reaching Out of School Adolescents

Unfortunately, in most of the South Asian countries (Sri Lanka is an exception), many adolescents are out of school by the age of 15, particularly in rural areas. They need to be reached through special means. These have included youth guidance centres in Sri Lanka, vocational training centres in India, Sri Lanka and Bhutan, youth clubs in India, Bangladesh (box 4) and Maldives or work place programmes such as in export processing zones in Sri Lanka. Unfortunately the data on the scope, coverage or effectiveness of such activities are not available. One innovative mechanisms used by many NGOs has been a camp approach (box 5).

Box 4
Youth Clubs in Bangladesh

A UNFPA supported project on involvement of youth in population and family welfare activities through the Department of Youth Development of the Ministry of Youth and Sports in Bangladesh, aims to train the youths in the training centers on family welfare education, and develop leadership qualities and appropriate skills in population education activities for the organizers of the local level voluntary youth clubs. After the training, the organizers mobilize the members and the community for population activities.

(Department of Youth Development 1996)

Box 5
Camps for adolescents

The Society for Education, Action and Research in Community Health (SEARCH) in India, as an extension of its community-based health programmes, started giving lectures on sexuality and sex education to adolescents in nearby schools. A similar programme was organized for parents and teachers. Because of high demand, "Family Life Education and Personality Development" camps are being organized regularly. The five and a half-day residential camps (separate for boys and girls) focus not only on sexuality education but also on personality and skills development (such as repairs at home, and use of telephone). To address the cause of sexual exploitation of girls, gender issues are addressed. In addition, each participant receives a medical examination. The cost per trainee is estimated to be about US $ 15.

(Mavlankar et al. 1998)

3.6 Peer group networks and youth centres

Adolescents get information or seem to learn about SRH issues through their peers and many would prefer peers to the parents or teachers for such knowledge. Therefore, many programmes rely on peer educators. Typically, in such a programme, peer educators are trained and supported by a counsellor in their activities.

Box 6 *Peer Educator Networks*

The Lucknow Centre of the Sex Education, Counselling, Research, Training and Therapy (SECRT) Programme of the Family Planning Association of India has trained peer educators through a three-day workshop. The training covers information on sexuality, preparing for marriage and planned parenthood, sexual behaviour development, drugs, STD and HIV/AIDS, and counselling and leadership skills. The peer educators (called 'young inspirers') carry out a variety of outreach activities as well as counsel their peers at school and in their residential neighbourhood.

(Chakraborty et. al. 1995)

A project supported by UNFPA to improve health care for adolescent girls living in urban slums of Jabalpur, in Madhya Pradesh, India uses a cadre of adolescent girls as health guides to provide continuing education about ARH and information on where to obtain services for adolescent girls. The project objectives were to reach adolescent girls who have RH problems with medical care and appropriate treatment, to improve maternal care, to increase the use of family planning and to provide a range of quality RH services and information to them. The service delivery network was also expanded by training providers about the special needs of adolescents.

(UNFPA 1998)

In many countries, youth centers (box 7) have been opened with objectives of not only ASRH activities but also training for leadership and voluntarism. They usually support a peer educator network and counselling services, but also include a whole range of outreach activities such as talks, dialogues etc., youth camps, education sessions for youths in factories, talks and poster competitions. They may also include other services for adolescents such as legal advice, career guidance, and referral services.

Box 7

The Rural Women Social Education Center (RUWSEC), India

RUWSEC is a community-based NGO that focuses on the rights of women in their households, including reproductive rights and their overall well being. Its ASRH programme comprises of (a) separate in-school workshops for girls and boys of class VIII; (b) health festivals or "Melas" for adolescent girls; (c) educational programmes for young women factory workers; and (d) youth center for adolescent boys.

RUWSEC recognized that adolescent boys (11-18 years of age) had remained in the periphery of its programmes. The issues of career and employment, in addition to all the other concerns that they share with adolescent girls, are their major concerns. Failure in examinations and unemployment push potentially productive male youth to anti-social behaviour out of frustration. So RUWSEC set up a youth center in a large village, which provides facilities for recreation, education and assistance with school examinations and choice of career. Sex education and health care counseling are also provided. The Center conducts weekly half-day workshops on gender sensitisation, gender relations within marriage, sexuality and responsible safe sexual behaviour.

(Subramanian 1998)

Telephone counselling in urban areas or those with good access to phone services has proved useful in many settings. For instance, the Foundation for Adolescent Development in Philippines operates a programme called 'DIAL-A-FRIEND'. Most of the telephone counsellors are volunteers and are selected based on their age, education, personality characteristics and counselling skills. The counsellors also have to undergo practical training. Continuing education to counsellors is provided through case conferencing to share experiences and case consultations with professional counsellors.

3.7. Special services

Some adolescents may require special services (box 8) requiring professional assistance (contraceptive services, professional counselling, legal aid etc.). It may not be possible to offer such services in a programme and perhaps the best way to organise it is through an informal or a formal referral network. The professionals need to be provided training in addressing special problems of adolescents in friendly and non-judgemental manner. Some programmes have incorporated special services for key ASRH issues. For instance, some NGOs in Africa have included programmes for unmarried teenage mothers including facilities for adoption, continuation of their education, and assistance in income generating activities (Population Manager Vol. 4).

Box 8

Special Services

- Professional counseling and therapy
- Contraceptive and other RH services
- Legal services
- Shelter
- Referral to rehabilitation programmes
- Referral to other youth-oriented programmes

The health centres need to become adolescent friendly if they are to meet their needs. This would not only require community support and participation of adolescents but also a review of policies, procedures, staff and physical environment.

Special services are also required to meet the needs of adolescents in difficult circumstances such as refugees or migrants, particularly, in the age group 14-19, where they are must vulnerable to exploitation. Such programmes would have to incorporate an integrated package of services aimed at making them socially and economically self-reliant and responsible.

4. OPERATIONALIZING ASRH PROGRAMMES

Above, we have discussed a framework for a comprehensive ASRH programmes. However, it may neither be feasible nor desirable to implement such a comprehensive programme at the outset. Instead it may be useful to use an incremental approach building on what already exists and utilising all opportunities for ASRH activities. Based on a review of programme experiences. Hughes and McCauley (1998) suggest following programming principles for ASRH programmes:

- Recognise and address the fact that the programme needs of young people differ according to their sexual experience and other key characteristics.
- Start with what young people want, and what they are already doing to obtain sexual and reproductive health information and services.

- Include building skills (both generic and specific to SRH) as a core intervention.
- Engage adults in creating a safer and more supportive environment in which young people can develop and manage their lives, including their sexual and reproductive health.
- Use a greater variety of settings and providers – private and public, clinical and non-clinical – to provide SRH information and services.
- Make the most of what exists. Build upon and link existing programmes and services in new and flexible ways so that they reach many more young people,

4.1. Issues in Operationalization

Several issues would need to be addressed for effective operationalization of ASRH programmes: involvement of adolescents, paucity of resources, inadequate organisational framework, need for cultural harmonisation and gaps in the knowledge base.

Involvement of adolescents. It is widely recognised that adolescents themselves should be involved in planning, implementation and evaluation if ASRH programmes are to be effective. However, most programmes tend to be developed by experts who are generally adults. Although many NGOs consulted adolescents to identify their concerns or in evaluating their programmes, it is not clear how many government programmes had explicitly involved them in formulation of programmes or envisage their active involvement as peer educators.

Paucity of resources. Adolescents constitute a large group, comprising nearly a fifth of the population. If comprehensive ASRH programmes are to be implemented then their resource requirements are likely to be large. Therefore, programmes need to ensure their cost effectiveness through use of existing facilities and human resources, harnessing the energy of adolescents, and reorienting some of the existing programmes to serve adolescents better. In addition, where contraceptive prevalence is high, some of the IEC resources in the FP programme could be diverted to the ASRH programmes.

Inadequate organisational framework. A multi-sectoral and multi-disciplinary approach is necessary to implement ASRH programmes. For instance, typically Ministry of Education, Ministry of Information, Ministry of Youth and Sports and Ministries of Health and Population would have to work together. Similarly, a coalition would need to be formed of government, NGOs, youth organisations, women's NGOs and training and research institutions to address ASRH issues. Such a coalition does not seem to exist in any country. However, multi-sectoral approaches used in population field can be utilised to build such a coalition.

Need for cultural harmonisation. Recognising that ASRH issues are culturally sensitive, the approaches used should be harmonised with the culture. For instance, successful reduction in FGM practices in Uganda through REACH programme

separated basic cultural value of girls' initiation from FGM and succeeded in involving religious leaders as well as community elders leading to significant and rapid reduction in the incidence of FGM.

Gaps in the knowledge base. The researches in the ASRH area are rapidly growing. However, many issues still require careful study. As one is dealing with sensitive issues, innovative research methodologies need to be used. However, ASRH programmes themselves should encourage continuous learning from their own experiences through careful periodic review, reflection and evaluation. There is also a need to share experiences both more rapidly and widely.

4.2. Strategies for Operationalization

Our review of the current status of ASRH programmes had indicated the need to place ASRH programmes in a developmental perspective. Therefore, existing developmental programmes – particularly education, income generation and employment – should have specific components for adolescents. Many health programmes also have hitherto neglected adolescent needs. Therefore, these programmes need to be enabled and motivated to meet those needs. Many innovations in ASRH programmes have taken place. These need to be upscaled. However, comprehensive adolescent programme designs have not yet emerged and these need to be pilot tested before they can be upscaled. Finally, research needs to be encouraged to build a reliable database on adolescent needs, concerns and behaviour.

Therefore, operationalization strategy should have five components: (i) incorporating adolescent concerns in the relevant development programmes, (ii) orienting existing health programmes to be adolescent-friendly, (iii) upscaling ASRH innovations; (iv) pilot testing models of comprehensive ASRH programmes in specific geographic areas; and (v) encouraging research in ASRH.

Incorporating adolescent concerns in existing developmental programmes

As discussed earlier, the developmental programmes of NFE and credit include adolescents but often do not have special component to meet their needs. Such programmes, to meet these special needs, may need to link up with other programmes. For instance, NFE programmes have established linkages with formal school programmes so that adolescents can either join schools or are able to complete schooling through self-study. Similarly, credit programmes may need to link up with vocational training and/or entrepreneurship development programmes so that adolescents are able to access an integrated package of services.

Many programmes of youth development such as sports and youth clubs do not often incorporate ASRH education and referrals for services. Although the current coverage

of such programmes may be limited, the participants could be provided not only ASRH education but also be trained to be peer educators in their community.

Reorienting health programmes to be adolescent-friendly

There are many barriers to the use of existing services by adolescents – they may be ill informed, they do not have resources to access services, they are shy or worried bout being 'found out', providers may scold them or be judgmental. In short, the programmes may not be adolescent-friendly. The health services are delivered by health workers and health centers. Typically they do not consider adolescents as target groups. The task here is to orient them to be more 'adolescent-friendly' and reach them. This would require training providers, flexible hours, assurance of privacy and confidentiality, and development of a referral network. The monitoring system would have to include indicators related to services provided to adolescents.

Upscaling ASRH innovations

The previous two strategies, that of reorienting existing programmes, would not suffice as adolescents are as a group distinct from adults, the size of adolescent group is large, and they have many and varying ASRH needs. Therefore, it would be necessary to upscale proven ASRH innovations. These innovations have largely been implemented by NGOs, and given the current cultural and policy environment, the governments may want NGOs to upscale them. In some countries, governments may also be able to provide financial support as well as set standards for quality and content.

The upscaling process could be in several ways: (a) an NGO may upscale its own innovation through expanding coverage. For instance BRAC may expand FLE programme, after the pilot test is completed, to cover its NFE schools; (b) other NGOs may implement tested models such as youth camps or outreach activities; (c) Government and NGOs may collaborate for instance to expand in-school FLE programmes; and (d) the mass media activities could be expanded after their tests at small scale.

An organizational framework is needed, as the upscaling process is not autonomous. Government ministries and NGOs may wish to form a coalition to catalyze the upscaling process.

Pilot testing comprehensive programmes as models

Most of the innovative programmes have implemented piecemeal approaches and have not taken a comprehensive health approach. Different components of ASRH Programme interventions interact and would have a synergistic impact. As a result, they can neither be evaluated nor provide a generic design for comprehensive ASRH

programming. It would be useful to implement pilot demonstration projects in several countries to learn how they respond to diverse cultural settings. Although the generic design of these programmes may be similar to that outlined in Section 3.4, each pilot project would have to adapt itself to local conditions. Each pilot project would also have to follow the process of programme development comprising needs assessment, stakeholder dialogue, agreement on ASRH problems/issues to be addressed, design of the content for interventions, implementation arrangements, and monitoring and evaluation procedures to be followed. Thus situation analysis will be part of the pilot test programmes which can use operations research methodologies. It should be emphasized that adolescents should be involved in all the phases of pilot testing.

Encouraging Research in ASRH

It was mentioned earlier that there are many gaps both in terms of understanding ASRH behaviour as well as in development of cost-effective interventions. Therefore, ASRH researches need to span community-based, behavioural, biomedical and programme intervention/action research. An illustrative list of research needs arising out of Jejeebhoy's (1996) review of researches, is as follows:

- RH needs and decision making authority among girls.
- Pre-marital sexual behaviour awareness and attitudes among boys and girls.
- Levels, patterns and context of abortion behaviour among unmarried and married girls.
- Community-based studies on RH morbidity in obstetric, gynecological and RTIs.
- Access to health care and barriers in its use.

The above research needs to be an input into policies and programming for ASRH. In addition, intervention research is needed in various components of ASRH as well as sharing of experiences through careful documentation. Given its sensitivity, researchers would need to both innovate new methodologies as well as acquire skills in using existing methodologies for ASRH research.

5. CONCLUSION

To date, programmatic responses to adolescent needs and their SRH concerns have been limited. However, there is growing recognition of the need for ASRH programmes and post-ICPD most countries have incorporated ASRH activities as part of broader reproductive health programmes.

The paper argues that adolescents constitute a group separate from adults and, therefore, special ASRH programmes will be needed. These would require developing a societal vision for ASRH and a framework for programming. Comprehensive ASRH programmes would comprise of in-school and out-of-school SRH education; youth

centers supporting peer groups network, telephone and personal counselling, and a referral network for promotion and provision of special services.

Several issues need be addressed for effective operationalization of ASRH programmes: involvement of adolescents, paucity of resources, inadequate organizational framework, need for cultural harmonization and gaps in the knowledge base. The strategies for operationalization should be situated in a developmental framework and would include (i) incorporating adolescent concerns in the relevant development programmes; (ii) orienting existing health programmes to be adolescent-friendly; (iii) upscaling ASRH interventions; (iv) pilot testing models of comprehensive ASRH programmes; (v) encouraging research in ASRH. Addressing ASRH problems is the key to improving sexual and reproductive health status in the Region and the world.

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