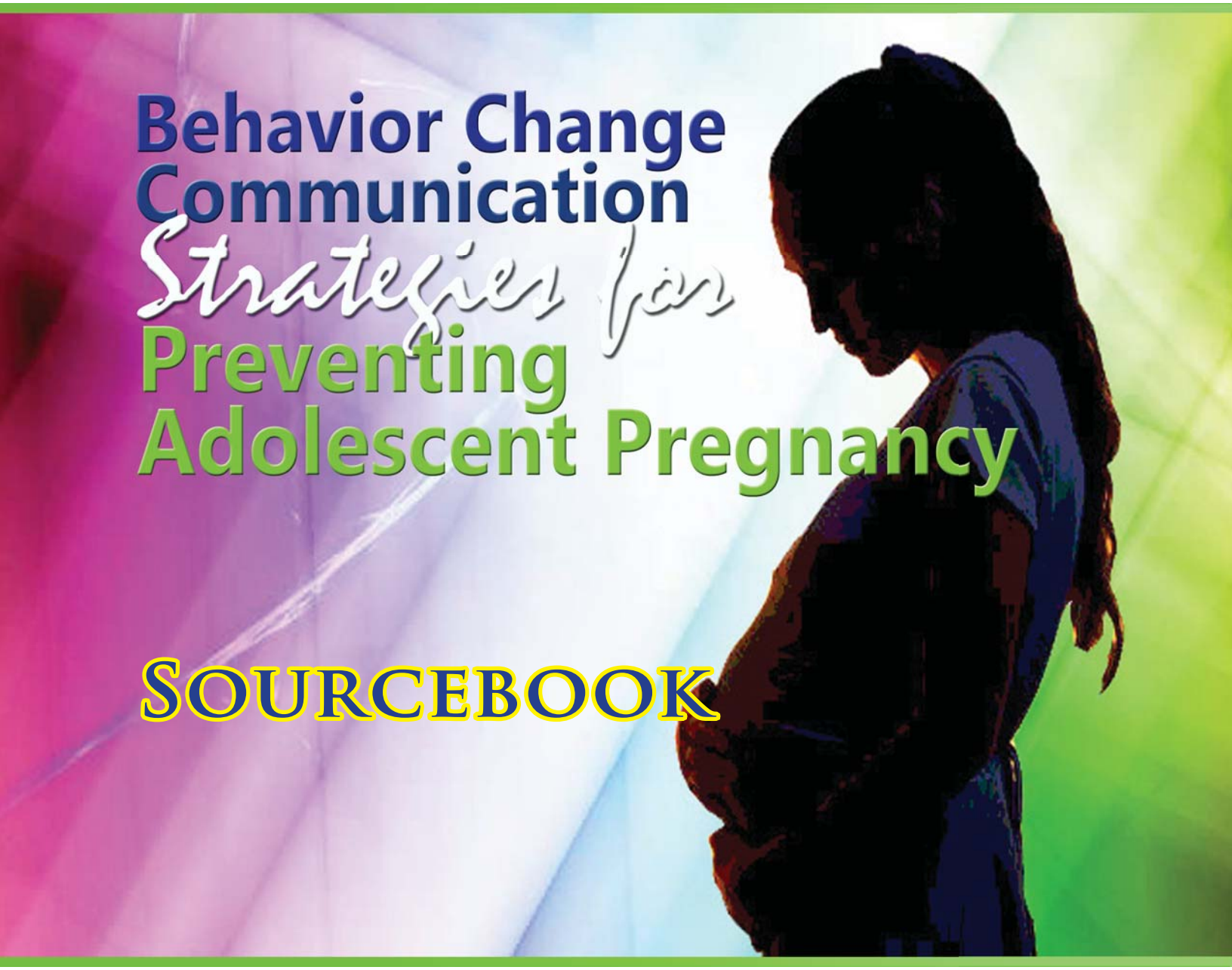
Behavior Change Communication Strategies for Preventing Adolescent Pregnancy



SOURCEBOOK

DEPARTMENT OF HEALTH
2012

Behavior Change Communication Strategies for Preventing Adolescent Pregnancy

Sourcebook

Department of Health
2012

Contents

Acknowledgement
Foreword

1 **SECTION 1. INTRODUCTION**

4 Content of the BCC Sourcebook

5 Methodologies and Processes Involved in the Development of the Sourcebook

6 Using the Sourcebook

6 Limitations of the Sourcebook

9 **SECTION 2. UNDERSTANDING ADOLESCENT PREGNANCY**

10 A. Adolescent Pregnancy as a Development Issue

13 B. Characteristics of Adolescence Stage

17 C. The Filipino Adolescents

19 D. Factors Associated with Adolescent Pregnancy

38 E. Conclusion

40 References

45 **SECTION 3. DESIGNING BEHAVIOR CHANGE COMMUNICATION STRATEGY FOR PREVENTING ADOLESCENT PREGNANCY**

46 A. BCC Strategy for Adolescent Pregnancy

47 B. Considerations for Designing BCC Strategies for Adolescent Pregnancy

50 C. Legal mandates that can guide the design of the BCC Strategies

53 D. Steps in the BCC Planning Process

69 **SECTION 4. BEHAVIOR CHANGE COMMUNICATION STRATEGIES FOR DELAYING SEXUAL INITIATION AMONG ADOLESCENTS**

70 A. The Desired Behavior

74 B. The Target Audiences

75 C. Key Messages to Delay Sexual Initiation

79 D. BCC Strategies to Delay Sexual Initiation

119 E. Monitoring Gains and Gaps

124 References

125 **SECTION 5. BEHAVIOR CHANGE COMMUNICATION STRATEGIES FOR PROMOTING ABSTINENCE FROM SEX AND PROTECTED SEX**

127 A. The Desired Behavior

129 B. The Target Audiences

130 C. Key Messages for Abstinence from Sex and Protected Sex

132 D. BCC Strategies to Promote Abstinence from Sex and Protected Sex

140 E. Advocacy and Social Mobilization Support Activities

141 F. Monitoring Gains and Gaps

144 References

145 **SECTION 6. BEHAVIOR CHANGE COMMUNICATION STRATEGIES TO AVOID MULTIPLE SEX PARTNERS AND COMMERCIAL SEX**

146 A. The Desired Behaviors

148 B. The Target Audiences

149 C. Key Messages for Avoiding Multiple Sex Partners and Commercial Sex

150 D. BCC Strategies for Enabling Adolescents to Avoid Multiple Sex Partners

E. BCC Strategies for Protected Sex among Female Adolescents Engaged in Commercial Sex

154 F. Advocacy and Social Mobilization Support Activities

155 G. Monitoring Gains and Gaps

158 References

159 **SECTION 7. MONITORING AND EVALUATING BCC STRATEGIES**

160 A. Monitoring

161 B. Evaluation

167 C. Developing a Monitoring Scheme

168 D. Other Considerations in Evaluation

171 **SECTION 8. REFERENCE MATERIALS**

173 ANNEX A. Adolescent Pregnancy: Causal and Behavioral Analysis

211 ANNEX B. Focus Questions for Causal and Behavioral Analysis

216 ANNEX C. Frequently Asked Question on Adolescent Sexual and Reproductive Health

218 ANNEX D. Sample Training Design

230 ANNEX E. Things to Consider in Conducting Interpersonal Communication Strategies

232 ANNEX F. Legal Bases for the Provision of Adolescent Health Services in the Philippines

248 ANNEX G. Sample Script for Theater Presentations Dealing with ASRH Issues

264 ANNEX H. Sample Brochure on Adolescent Pregnancy

265 ANNEX I. Sample Posters and Messages on Adolescent Pregnancy

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The Department of Health (DOH) expresses its appreciation and gratitude to the Demographic Research and Development Foundation, Inc. (DRDF) for developing this ***Sourcebook on Behavioral Change Communication (BCC) Strategies for Preventing Adolescent Pregnancy***. The recommended BCC interventions and tools contained in this Sourcebook were developed and synthesized using research-based information and sound theoretical frameworks that were gleaned from research conducted in the Philippines and abroad. The Project Team, headed by Dr. Zelda C. Zablan (Principal Investigator), with the able support and technical skills of Mr. Lolito R. Tacardon (Project Consultant) and Mr. Randy Jay C. Solis (Communications Consultant), worked together to devise the communication strategies and recommend the BCC interventions and tools contained in this Sourcebook. The Project Team was ably assisted by researchers Ms. Angelique Ogena and Ms. Celia Abbago in the execution of the various activities towards the development of the Sourcebook.

Appreciation is also for all the stakeholders from government, and non-government organizations who have participated in consultations and dissemination workshops and have provided inputs in the development, enhancement, and finalization of this Sourcebook. Their inputs have been very valuable in making this Sourcebook relevant to its intended audience.

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Acknowledgement is also given to the members of the National Technical Committee on Adolescent Health and Development (NTCAHD) for their inputs which significantly contributed in the enhancement of the Sourcebook.

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Foreword

The health and well-being of Filipino adolescents and youth form a vital component of the Aquino Health Agenda of providing Universal Health Care (Kalusugang Pangkalahatan). Adolescents and youth are not only the foundation of the future but also a significant contributor to the health and socio-economic development of the country.

Healthy adolescents and youth assure us of a healthy population and a bright prospect for national development. As such, the Department embarked on a pivotal strategy of ensuring the health of adolescents by addressing the issue of increasing adolecent pregnancy. Adolecent pregnancy is not only a health hazard among the youth but also a concern that affects their social, mental, and physical growth and development.

As our response to the prevailing issue of adolescent pregnancy, we pursued the project: "*Development of Behavioral Change Communication (BCC) Strategy for Preventing Adolescent Pregnancy*." This endeavor aimed to design and recommend strategies that can be undertaken not only by DOH but also by all national and local stakeholders to address the behavioral as well as non-behavioral factors associated with adolescent pregnancy. This research-based project sets the framework and platform for converging all efforts to address this encompassing issue.

It is within this context that this ***Sourcebook on BCC for Preventing Adolescent Pregnancy*** was developed. This sourcebook specifically aim to provide health workers, program managers, youth-serving professionals from government and non-government organizations, local officials and program implementers and other institutions and individuals working along adolesent health and youth development with analytical tools, recommended BCC and support communication strategies, and other sample communication messages and materials that can be adopted or can guide the design of communication strategies to prevent adolescent pregnancy.

By using this Sourcebook, we hope that we can be more purposive in our actions towards ensuring the health especially the sexual and reproductive health of our adolescents. We, the adults, brought them into this world, thus, it is our responsibility to provide them with an environment in which they are able to realize their potentials and aspirations. This Sourcebook is a contribution in building an enabling and better world for our adolescents and youth.

ENRIQUE T. ONA, MD, FPCS, FACS
Secretary of Health
Department of Health

SECTION 1

Introduction

WHY DO WE CARE ABOUT ADOLESCENT PREGNANCY?

Our prospect of a bright future and a better society is anchored on the quality of our adolescents today. While many adolescents are positively contributing to national development as demonstrated by their celebrated successes and excellence in various spheres in our society, there are imminent threats and challenges that can undermine their prospect of a bright future. One of these challenges is early and unintended pregnancy.

Motherhood at a very young age entails a risk of maternal death that is much greater than average, and the children of young mothers have higher risks of morbidity and mortality. Early childbearing continues to be an impediment to improvements in the educational, economic, and social status of women. For young women, in general, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life.

Within this context, there is a need to create an enabling environment for adolescent health and development. We need to empower them in developing positive and effective skills and behaviors that could help them protect themselves from the threats within the environment they live in. As a vital component of national growth, we need to enable them to achieve the full realization of their potentials by giving them the necessary information, services, and skills so that they can contribute significantly to national development.

The task, however, is enormously challenging. We need to deal with complex behavioral concern that comes with their current stage of development. Adolescence is a transitional stage of human development where childhood ends and adulthood begins. It is characterized by confusions and changes that impact on their biological, mental, emotional, and cognitive growth.

The onset of puberty during adolescence triggers consciousness on their sexuality. Most often, their quest to get in touch with their sexuality is combined with their pursuit of autonomy, independence, and sense of self-identify pursued through adventurism, exploration, and experimentation. In a positive light, this pursuit also motivates them to thrive on their ideals, dreams, and aspirations.

Behavior Change Communication (BCC) Strategy for Preventing Adolescent Pregnancy. More than ever, adolescents need help, guidance, and empowerment. This is the main purpose for which the Department of Health invested in the project: "**Development of Behavior Change Communication (BCC) Strategy for Adolescent Pregnancy.**" This initiative essentially aims to contribute to the promotion of positive and healthy behaviors that enable adolescents to avoid too early and unintended pregnancy. This initiative is an integral part of the Adolescent and Youth Health and Development (AYHD) Program of the Department of Health. It specifically aims to provide options for effective BCC and other support communication strategies to

various stakeholders at all levels in preventing early and unintended adolescent pregnancy. This initiative also aims to set a framework for harmonizing and converging existing as well as recommended communication strategies for preventing too early and unintended pregnancy among adolescents.

The Sourcebook on BCC Strategies for Preventing Adolescent Pregnancy

This Sourcebook on BCC Strategies for Preventing Adolescent Pregnancy is the main output of this initiative. It was developed to provide all workers and advocates of adolescent health and development with a resource for designing BCC strategies for promoting positive and healthy behaviors among adolescents to specifically prevent too early sexual initiation, unprotected sex, and other risky sexual behaviors. A BCC strategy is the strategic use of communication tools and approaches to promote positive health outcomes, based on proven theories and models of behavior change. Behavior change communication is a set of organized communication interventions and processes aimed at influencing social and community norms and promote individual behavioral change or positive behavior maintenance for a better quality of life. (Chen, 2006).

The Sourcebook is intended specifically for program managers, service providers, youth leaders, youth-serving professionals and institutions, media and communication practitioners, and other stakeholders who are interested in developing BCC interventions for preventing adolescent pregnancy. You can use the document to get ideas and guidance in planning and conceptualizing your BCC strategies for promoting healthy and positive sexual behaviors among adolescents as they relate with your mandates, programs, and responsibilities. This Sourcebook can be relevant to the following interest of various users:.

Type of User	Possible use of the Sourcebook in relation to interest and functions of the User
Program managers	• The Sourcebook can provide information on how to design and monitor BCC communication strategies; • It can also provide some key details on making BCC interventions more effective.
Service providers	• The Sourcebook can be a reference on how specific services and information can contribute to promoting positive sexual development among adolescents • The Sourcebook can also provide information on the key messages in addressing ASRH concerns through appropriate services and in improving the health-seeking behaviors of the adolescents
Youth leaders and youth serving professionals and institutions	• The Sourcebook can provide important details on how to design, implement, and monitor BCC strategies in relation to adolescent health and youth development programs
Media and communication practitioners	• The Sourcebook can provide the key behaviors and the corresponding messages that can be promoted in the media to support healthy and positive behaviors among adolescents and youth

Content of the Sourcebook

The Sourcebook has eight (8) sections consisting of: 1) the introduction which includes the information about this Sourcebook; 2) understanding the causes and behavioural factors associated with adolescent pregnancy; 3) overview of the BCC process; 4) options for BCC strategies on promoting delayed sexual initiation; 5) options for BCC strategies on promoting protected sex; 6) options for BCC strategies on avoiding multiple sex partners and other sexual risky behaviors; 7) monitoring and evaluation of BCC strategies; and 8) additional reference materials.

Section 1. Introduction. The introduction provides you with the rationale and context in which the Sourcebook was developed and the information about this Sourcebook.

Section 2. Understanding Adolescent Pregnancy. Section 2 consists of substantive discussions on the processes and changes occurring during the period of adolescence to give an understanding of the expected behaviors, tensions, and challenges during this stage of human psychosocial development. This section also delves into the various behavioral and non-behavioral factors associated with adolescent pregnancy as the bases of developing BCC strategies. The analysis of the behavioral and non-behavioral factors is based on the Integrative Model of Behavior Change of Fishbein & Cappella (2006).

Section 3. The BCC Planning Process. This Section provides you with information on the basic concepts and the steps in planning BCC strategies and interventions for influencing behaviors related to adolescent pregnancy. The suggested BCC planning process is based on the communication planning framework being promoted by UNFPA which include the following basic steps: a) assessment (causal and behavioral analysis), b) communication analysis, and c) designing communication strategies, and evaluation. You may use this Section to plan your own BCC strategies based on your specific objectives and needs.

Section 4-6. BCC Strategies for Preventing Adolescent Pregnancy. This Section provides options for BCC strategies and programs that you can implement to address the direct determinants of early pregnancy and childbirth. These proximate behavioral determinants include: too early sexual initiation (Section 4), unprotected sex or non-use of contraception (Section 5), and engagement into sexual activities with commercial sex and multiple partners (Section 6). Each section provides the following information:

The desired behavior. An elaboration of the desired behavior for each target audience is provided for a deeper appreciation of the behaviors to be promoted. It also provides the component behaviors that could lead to the main desired behavior.

The intended audiences. A brief review of the characteristics of the target audiences is also provided to contextualize the suggested BCC strategies.

Communicating the right message. Each section for thematic BCC intervention also outlines the key messages which you should communicate to specific target audience to achieve the desired behavior. The recommended BCC strategies are likewise based on these key messages.

BCC actions to deliver the message and to achieve desired behaviors. This outlines the key areas and strategies that can be adopted in promoting the desired behaviors. For each strategy, you are provided with specific activities to be conducted; types and essential contents of communication materials; sample training designs; the stakeholders to be involved; and other considerations to make the strategy more effective.

Monitoring BCC Gains and Gaps. This informs you of the key indicators you can consider in monitoring and assessing the effectiveness of the strategies towards realizing the desired behaviors.

Section 7. Monitoring and Evaluating BCC Strategies. This Section discusses the outcome, output, and input indicators needed in monitoring and evaluating a BCC strategy. These indicators serve as the parameters for ensuring the effective and efficient implementation of the BCC strategies.

Section 8. Reference Materials. This Section provides additional reference materials that can be used in the preparation and conduct of relevant BCC strategies.

Methodologies and Processes Involved in the Development of the Sourcebook

The Sourcebook is a product of consultative and participatory process. In early 2011, the Department of Health collaborated with the Demographic Research and Development Foundation (DRDF) in the design and implementation of the project: Development of BCC Strategies for Adolescent Pregnancy. The project aims to develop BCC strategies that could promote positive behaviours among adolescents for them to prevent adolescent pregnancy.

The first step was the development of a database for adolescent pregnancy which served as the information base for designing the BCC strategies. Review of existing literature, research, and studies were undertaken to consolidate available information pertinent to adolescent pregnancy. To substantiate the literatures, focus-group-discussions (FGDs) and key-informant-interviews (KIIs) in selected areas with high incidence of teenage pregnancy, were conducted. The FGDs and KIIs involved a total of 122 stakeholders including adolescents (male and female), parents, teachers, local officials, guidance counselors, information officers, and members of local media. The data gathering covered the following areas: 1) Baguio City, Benguet; 2) San Juan City, Metro Manila; 3) Legazpi City, Albay; 4) Tagbilaran City, Bohol; 5) Surigao City, Surigao del Norte; and 6) Davao City, Davao del Sur. The areas for the study were selected to capture a range of issues and experiences on adolescent pregnancy across the country as the areas represented the three island groups in the Philippines. The information generated from these data gathering activities served as the basis for the causal and behavioural analysis.

Several consultations with various stakeholders including adolescents, youth leaders, teachers, parents, youth development workers from government and non-government agencies, counsellors, and local officials were also conducted to gather their inputs on the key messages, communication channels, and media that can be adopted to effectively promote positive

behaviours among adolescents. The identification of recommended BCC strategies made use of the information gathered from these stakeholders. The drafting and finalization of this Sourcebook benefited from the inputs of the DOH's National Technical Committee on Adolescent and Youth Health and Development (NTCAYHD) composed of various national government agencies and NGOs. Technical consultants on communication, demography, public health, and adolescent reproductive health were also tapped to enhance this Sourcebook.

Using this Sourcebook

Use the Sourcebook as your reference material for initial information and ideas in conceptualizing, designing, implementing, and monitoring your BCC strategies. Since the Sourcebook is not a complete cookbook but merely a source of major directions and considerations for planning or improving BCC approaches, you need to fill in the gaps with necessary legwork, research, and other relevant activities to complete your BCC planning process. The most important thing about designing BCC strategy is the local and individual context in which identified strategies will be applied. The strategies need to be localized and tailored to the actual needs of the target audiences because of the 'no-one-size-fits-all' principle. Specifically, you may use the Sourcebook to be guided on the following:

- Identifying the problem behaviors and factors associated with the adolescent pregnancy (Section 2);
- Undergoing the essential BCC planning processes (Section 3);
- Getting ideas and suggested specific and concrete BCC strategies that can be adopted to promote behaviors among adolescents as target audience to prevent early and unintended pregnancies (Section 4-6);
- Having an idea on what indicators to monitor and evaluate to ensure that strategies are producing the desired results and objectives (Section 7).

Other references and resources are also provided in the Annexes. You may use them for sample or prototypes of IEC materials, instruments for data gathering, training designs, available modules and manuals, and other references that you may need in your BCC planning activities.

The sections are not dependent on each other. You may use sections that suit your needs without having to read thoroughly the previous sections. However, it is highly recommended that you go through all the Sections since BCC planning process is cohesive, from causal anlysis to monitoring and evaluation. Lastly, you need to test, modify, and reconfigure the recommended BCC strategies based on the actual situation, behaviors, and geographic and cultural environment of the target audiences you will work with.

Limitations of this Sourcebook

The BCC strategies identified in this Sourcebook are generally applicable to all types of adolescents in the country. However, you should be careful and cautious in planning and implementing related interventions among adolescents or target audiences in a specific cultural context. For example, this document does not provide a substantive discussion on adolescent

behaviors related to too early pregnancy in Islamic context and that of the indigenous groups in which culture play an essential role. As such, you need to modify specific strategies according to the prevailing religious and cultural context of your target audiences and stakeholders.

Another major limitation of this document is its focus on the behavioral analysis among adolescents aged 15-19 years. This is because of the limitations in quantitative data for 10-19 years old. However, to fill-in the gaps in the behavior of this specific age group, relevant literature were reviewed. Given this, you should be prepared to substantiate the data on this segment of adolescents to make your interventions more empirically based.

Lastly, many of the empirical data and information from the literature were generated from available nationwide studies and surveys on adolescent sexuality. The most comprehensive of these studies is the *Young Adult Fertility and Sexuality Survey* (YAFSS). The latest YAFSS, however, was conducted ten years ago (2002) which may possibly not be accurately reflective anymore of the actual situation of the Filipino youth. Within this limitation, the data generated from YAFSS were treated as indicative information about the sexuality of the adolescents. To substantiate and support the relevance of the available empirical data, series of FGDs and KIIs were conducted.

SECTION 2

Understanding Adolescent Pregnancy

Before we proceed to design behavior change communication strategies, we need to have a deep understanding of the issue on adolescent pregnancy. Understanding the issue is critical in designing appropriate interventions that can address this important development concern. It is even more important to have a deep understanding of the factors that affect adolescent pregnancy in the context of behavior change communication (BCC) since adolescent pregnancy is essentially a behavioral issue. This Section attempts to provide such understanding by discussing the factors directly and indirectly associated with adolescent pregnancy.

We also discuss in this Section the nature and dynamics of adolescence as stage of human development to contextualize the behaviors and attitudes of adolescents in relation to their sexuality. Appreciating the expected behaviors of adolescents as they go through the adolescence stage helps you understand why they behave as such.

Lastly, this section discusses the immediate and underlying factors affecting the behaviors of adolescents related to unintended pregnancy. Using the Integrative Model of Behavior Change, the direct and indirect determinants of behaviors (e.g. intention, self-efficacy, and environmental factors) causing adolescent pregnancy are also examined in this section.

A. ADOLESCENT PREGNANCY AS A DEVELOPMENT ISSUE

Adolescents (10-19 years old) in the Philippines comprise about 10.5 percent or almost 9.3 million of the country's total household population in 2007 (NSO, 2010). With such number, their positive contribution to the development of the nation is crucial. Given this, their welfare becomes a paramount concern for development.

As previously discussed, early and unintended pregnancy can be a huge constraint to adolescents' health and well-being. It affects the health, psychosocial, mental, and other components of their growth. Without appropriate intervention to address this important concern, our prospect of a better tomorrow may not be realized.

Pregnancy and childbearing among adolescents is a real and an increasingly disturbing concern. Data (in Table 1) shows that about 54 births occurred among 1,000 women aged 15-19 years in 2006. What is more alarming is that the figure is increasing. While fertility decline is happening among older women, adolescent fertility remained at around 50 births per 1,000 women since 1990's (see Table 1). Overall, adolescent fertility contributed about 30 percent of the overall fertility in 2006.

Moreover, the 2008 NDHS data reveal that one out of ten (9.9%) or an estimated 4,702,400 (NSCB) Filipina aged 15-19 years were already mothers in 2006. A significant percentage of young women has already given birth as young as 17 (7%), 18 (14%), and 19 (24%) years of age (Figure 1).

Table 1. Age-specific and total fertility trends from various surveys, Philippines

Age group	1973 NDS1 (1970)	1978 RPFS2 (1975)	1983 NDS3 (1980)	1986 CPS4 (1984)	1993 NDS5 (1991)	1998 NDHS6 (1996)	2003 NDHS7 (2001)	2008 NDHS8 (2006)
15-19	56	50	55	48	50	46	53	54
20-24	228	212	220	192	190	177	178	163
25-29	302	251	258	229	217	210	191	172
30-34	268	240	221	198	181	155	142	136
35-39	212	179	165	140	120	111	95	84
40-44	100	89	78	62	51	40	43	38
45-49	28	27	20	15	8	7	5	6
Total fertility rate	**6.0**	**5.2**	**5.1**	**4.4**	**4.1**	**3.7**	**3.5**	**3.3**

Source: 1 UPPI (1970) National Demographic Survey 1973

2 NCSO, UPPI, POPCOM, NEDA (1975) Republic of the Philippine Fertility Survey 1978

3 UPPI (1980) National Demographic Survey 1983

4 UPPI(1984) Contraceptive Prevalence Survey (1986)

5 NSO and Macro International (MI) (1991) National Demographic Survey 1993

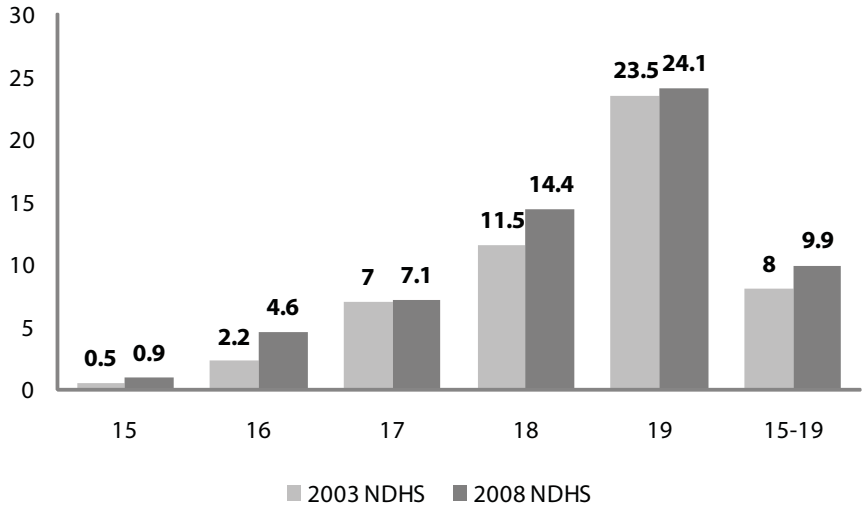
6 NSO , DOH and ICF Macro (1996) National Demographic and Health Survey 1998

7 NSO and ORC Macro (2001) National Demographic and Health Survey 2003

8 NSO and ICF Macro (2006) National Demographic and Health Survey 2008

From National Demographic and Health Survey 2008 (p. 43), by National Statistics Office [Philippines] and ICF Macro, 2009, Calverton, Maryland: National Statistics Office and ICF Macro. Copyright 2009 by National Statistics Office and ICF Macro.

Figure 1. Percent of 15-19 women who have begun child bearing



Source: NSO, 2003 and 2008 NDHS

Unintended Pregnancy and Its Consequences. Our concern for the rising trend in adolescent pregnancy and fertility is anchored primarily on its impact on the health of adolescents. Due to their physiological immaturity, adolescent mothers have an increased risk of premature labor and complications during and after delivery, leading to high morbidity and mortality among mothers and their children.

Based on the 2006 Family Planning Survey, the lifetime risk among women 15-49 years old in the Philippines for 2006 was about 4 for every 1,000 women of reproductive age (Yabut & Bautista, 2007). Lifetime risk of maternal death is the probability that a 15-year-old female will die eventually from a maternal cause assuming that current levels of fertility and mortality (including maternal mortality) do not change in the future, taking into account competing causes of death (Wilmoth 2009).

Pregnancy and childbirth among adolescent mothers are mostly unintended. As the 2008 NDHS revealed, three in ten

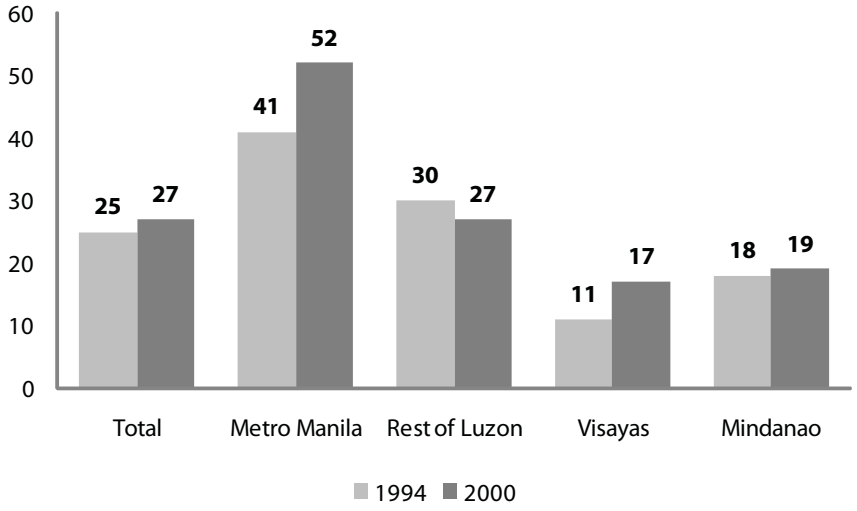
Medical Risk of Adolescent Pregnancy

Pregnant adolescents younger than 17 years have a higher incidence of medical complications involving mother and child than among adult women. The incidence of having a low birth weight infant (<2500 g) among adolescents is more than double the rate for adults, and the neonatal death rate (within 28 days of birth) is almost 3 times higher. The mortality rate for the mother is twice that for adult pregnant women.

Adolescent pregnancy has been associated with other medical problems including poor maternal weight gain, prematurity (birth at <37 weeks' gestation), pregnancy-induced hypertension, anemia, and STIs. Approximately 14% of infants born to adolescents 17 years or younger are preterm versus 6% for women 25 to 29 years of age. Young adolescent mothers (14 years and younger) are more likely than other age groups to give birth to underweight infants, and this is more pronounced among poor adolescents.

Jonathan D. Klein, MD, MPH, and the Committee on Adolescence (2005), *Adolescent Pregnancy: Current Trends and Issues, Pediatrics Vol. 116 No. 1 July 2005,* USA: American Academy of Pediatrics.

Figure 2. Abortion rate in the Philippines: 1994 and 2000



Source: Singh et al. (2006), *Unintended Pregnancy and Induced Abortion in the Philippines*. Manila

(33%) births by adolescent mothers was unwanted at the time of the conception. Unplanned or unwanted pregnancies could lead to self-induced abortion or availing of the services of an untrained birth attendant. The incidence of abortion in the Philippines from hospital records over the 1993-1995 and 1999-2001 periods showed an increasing rate of abortion, from 25 per 1000 women 15-44 years old in 1994 to 27 per 1000 women 15-44 years old in 2000 (Singh, et al., 2006) (see Figure 2).

Too early pregnancy has likewise its demographic implications. Early initiation to childbearing is a major determinant of a large family size as this lengthens the reproductive period of women leading to higher fertility. With longer exposure to reproduction, the population continues to grow rapidly resulting to high proportion of young dependents and the need for more health and nutrition services for infants and children.

Pregnant adolescents especially the unmarried mothers are likewise exposed to negative social consequences including their rejection from the family, friends, and community. Pregnant teens usually drop out from school and ridiculed by the community, which could, in turn, significantly affect their well-being and that of her child. Despite the more liberal perception on sexuality issues in contemporary media, there is still a prevailing stigma within the existing cultural context of the Philippines against out of wedlock pregnancies particularly among teenagers. This conservative and judgmental outlook hinders pregnant adolescents to seek and access appropriate information and services. This partially explains why we have unfavorable policy and program environment for adolescent health and development. All these factors hinder the growth and development of adolescents and youth.

B. CHARACTERISTICS OF THE ADOLESCENCE STAGE

"Adolescents are more than an age group. They are persons in a transitional phase in life. They are living in a critical time of rapid physical, mental, emotional, social, and spiritual development. It is a time of transition that varies across individuals and groups, countries and cultures." - WHO, 2003. As described by literature, adolescence is an important period in the life span of an individual particularly in relation to his/her sexual development. It is a transition stage where rapid physical and psychosocial changes happen. These changes may impact either positively and negatively on the development of adolescents. These changes also redefine the roles adolescents perform, as members of their family, peer group, and the society as they, in turn, perceive these changes (Ogena, 2004).

1. Adolescence as a transition stage

Adolescence is described as a transition stage from childhood to adulthood. The term adolescence comes from the Latin verb adolescere, which means 'to grow up or to grow to maturity' (Ogena, 2004). As such, as children go through adolescence, they are expected to "put away childish things" and learn new patterns and attitudes expected of an adult.

The stress at this stage is relatively intense. During any transitional period, the individual's status is vague and there is confusion as to his/her expected roles. Adults tend to set parameters for adolescents in terms of "maturity" which, in turn, influence the way adults relate with adolescents (Ogena, 2004). This forms part of the social pressure the adolescents are faced with. For example, if adolescents behave like children, they are supposed to 'act their age,' (e.g. *'hindi ka na bata'*) which demands them to be more 'mature' in their behaviors. If they act like an adult, they are reproved for their attempts to act like adults (e.g. *'marami ka pang bigas na kakainin,' 'ang bata-bata mo pa,' 'nagmamadali kang tumanda'*).

2. Adolescence as a period of change

Adolescence is a period of dramatic physical, emotional, attitudinal, and psychosocial changes. It is usually the onset of puberty, which signals their capacity to reproduce. Internal and external bodily changes particularly in terms of height, weight, body proportions, sex organs, and secondary sex characteristics also become manifest during this stage. These physical changes usually trigger some emotional tension among adolescents (Hurlock, 1982).

Adolescents also normally experience emotional intensity brought about by the mix of stress, tensions, and excitements they encounter within their environment and changing relationships. The intensity of these emotional tensions varies among adolescents. Adolescents who cannot cope with these emotional changes usually fall into depression and low self-esteem triggering problems such as suicide. These emotional tensions are mostly experienced during the early adolescence when emotional maturity has yet to take place (10-14 years). Moreover, changes in interests, behavior patterns, and values usually occur during adolescence, giving adolescents mixed feelings of negative and positive emotions.

Many adolescents are ambivalent about changes. While they want and demand independence, they often dread the responsibilities that go with independence and question their ability to cope with their responsibilities.

3. Developmental tasks during adolescence

Adolescents need to master certain essential skills and patterns of behaviors during adolescence. These are called developmental tasks which need to be met during certain stages of life for them to be more successful in undergoing the tasks in the later development phase. Failure to meet these tasks leads to unhappiness and difficulty with later tasks (Havighurst cited in Hurlock, 1982). Developmental tasks are also referred to as social expectations that guide adolescents' behaviors.

According to Havighurst, there are nine (9) major tasks that adolescents should master (1951, cited in Ogena, 2004):

1. Accepting one's physical physique and using one's body effectively;
2. Achieving a masculine or feminine sex role;
3. Developing appropriate and more mature relations with age-mates of both sexes;

4. Becoming emotionally independent of parents and other adults;
5. Achieving the assurance that one will become economically independent;
6. Determining and preparing for economic career;
7. Developing the cognitive skills and concepts necessary for social competence;
8. Understanding and achieving socially responsible behavior;
9. Preparing for marriage and family; and
10. Acquiring a set of values and an ethical system as a guide to behavior – developing an ideology.

4. Search for identity

In the early years of adolescence, conformity to the group or peers is still important to boys and girls. Gradually, they begin to search for their own identity and are no more satisfied to identify with their peers in every respect, as they were in childhood (Hurlock, 1982). The identity of the adolescents seeks to clarify who they are in terms of their role in the society; their gender roles; their own interests, skills, values, and life goals; their sexual preferences and orientations; and other aspects that are important in establishing a concept of themselves and personality. Establishing their identity usually brings emotional tension because of the various conflicting and confusing messages that they encounter within their environment.

5. Sexual development among children and adolescents

Sexual development, as an integral component of individual's maturation throughout life, is likewise an important component of adolescent development. Adolescence covers the period of puberty particularly overlapping the period of late childhood and early adolescence (10-14 years old). Puberty involves the maturation of sexual faculties and reproductive capacity. It is accompanied by changes in somatic growth and psychological perspective (Hurlock, 1982).

Accompanying the physiological changes brought by hormonal growth during puberty are the changes in sexual behaviors among adolescents, Most of these sexual behavioral changes can be better appreciated in the perspective of expected sexual behaviors during childhood. The table below shows the expected sexual behaviors from birth to age 18 (adopted from Family Planning Queensland, 2006, *Sexual Behaviours in Children and Adolescents*, Australia).

Birth to 5 years	5 to 9 years	9 to 12 years	13 to 18 years
• thumb sucking, body stroking and holding of genitals • wanting to touch other children's genitals • asking about or wanting to touch the breasts, bottoms or genitals of familiar adults, eg when in the bath • games –'doctor/ nurse', 'show me yours and I'll show you mine' • enjoyment of being nude • interest in body parts and functions	• masturbation to self soothe • increased curiosity in adult sexuality, eg questions about babies, gender differences • increased curiosity about other children's genitals, eg playing mutual games to see or touch genitals • telling stories or asking questions, using swear words, 'toilet' words or names for private body parts • increased sense of privacy about bodies	• use of sexual language • having girl/ boyfriends • exhibitionism, eg flashing or • mooning amongst same age peers • increased need for privacy • consensual kissing with known peers • use of internet to chat online	• sexually explicit conversations with peers • obscenities and jokes within the cultural norm • flirting • interest in erotica • use of internet to chat online • solitary masturbation • interest and/or participation in a one-on-one relationship (with or without sexual activity) • sexual activity including hugging, kissing, holding hands, foreplay, mutual masturbation • consenting oral sex and/or intercourse with a partner of similar age and developmental ability

6. Cognitive development during adolescence

Another prominent change involved in adolescence are changes in cognitive or thinking skills (abstract thinking ability) and moral thinking (new views about right and wrong) (Ogena, 2004). These changes likewise affect their pursuit of establishing self-identity and their behaviors as they relate with persons within their environment.

Unlike children, adolescents begin to act in a more rational manner - thinking the repercussions of their actions and considering other people's thoughts and views. Adolescents are also able to develop a rational view of the world and tend to express their own opinions and logical views of the realities around them based on the things they learn from experiences and inputs from school. Being capable of abstract thinking, adolescents search for meanings of abstract concepts such as questions on "who am I." These cognitive advances help form the moral thinking and self-identity as well as the way adolescents feels about the biological and developmental changes that they experience (Ogena, 2004). With a more rational mind, adolescents are also able to create an abstract construct of their future – imagining and starting to work on their aspirations and goals in life.

This cognitive development among adolescents likewise leads them to be more critical of established norms. They tend to be more critical of what their parents and other adults are saying as they become more eager to get information from alternative sources. It is during this instance where media becomes increasingly influential among adolescents. With less parental guidance, adolescents screen the information they gather from media and other sources with the moral and values system they have developed and adopted in the earlier stages of their development.

7. Family relationship

With growing identification with their peers, adolescents increasingly prefer the company of their peers than their parents and families. Conflict with parents occurs more often because of generation gap and the changes that adolescents are experiencing. Many parents are unprepared for the assertion of adolescents' independence and autonomy. They tend to treat their adolescent children much as they did when they were younger but at the same time expect their children to "act their age."

The "generation gap" which normally causes conflict between parents and adolescents reflects the difference in the values and standards of behavior held by parents and their adolescent children. Parents tend to impose their standards on their children, whose standards are significantly influenced by modern behavioral norms. Generation gap is most prominent in terms of sexual norms.

The conflict is also sometimes caused by the unpreparedness of parents to accept their adolescent children's objections to the restraints they regard as necessary. Both parents and adolescents feel that they are not understood by each other. Nonetheless, despite the conflict, Filipino adolescents still value the family as their source of support (results from the FGDs).

C. THE FILIPINO ADOLESCENTS

In the Philippines, the term "adolescence" is usually used interchangeably with the word "youth" which is referred to as "*kabataan*" in general. Adolescents are also referred to as "*nagdadalaga*" or "*dalagita*" for females and "*nagbibinata*" or "*binatilyo*" for males (Ogena, 2005). As literature and theories have no definite age-definition of adolescence, institutions in the Philippines variedly define adolescence and youth by age (Ogena, 2005). Various institutions actually use different age ranges to define adolescents mostly for program considerations. Table 2 indicates the institutional definitions of adolescents and youth.

Table 2. Age Definition of Youth by Various Agencies

Institution	Age-range
Department of Health (DOH)	10-24 yrs old
Department of Social Welfare and Development (DSWD)	15-24 yrs old
Department of Labor and Employment (DOLE)	15-24 yrs old
Technical Education and Skills Development Authority (TESDA)	15-24 yrs old
Department of Interior and Local Government (DILG)	15-21 yrs old
Department of Education (DepEd)	7-30 yrs old
Commission on Population (PopCom)	15-24 yrs old
National Youth Commission (NYC) (based on Republic Act 8044)	15-30 yrs old

(Source: Ogena, 2005)

The age definition of adolescents in the country is not only important for targeting and programming interventions but also has significant implications on the behaviors of such group (Ogena, 2005). For example, many policies regulate access to services and behaviors according to age. The 1987 Philippine Constitution and the 1996 Family Code of the Philippines provide the age of majority as 18 years old. In fact, the redefinition of the legal age of marriage under the Family Code from 16 to 18 for females and 21 to 18 for males emanated from the belief of the policymakers that a woman aged 16-17 is not yet prepared to assume marital responsibilities. Legal and customary laws also prohibit minors to access liquors, cigarettes, and even family planning methods (although no law exist explicitly prohibiting minors to access FP methods). These policies have positive and negative implications to forming the sexual behaviors of adolescents in the country. These are also important considerations in identifying BCC strategies for adolescent pregnancy.

Most of the characteristics of adolescents discussed by existing literature mentioned above also apply to Filipino adolescents but in different contexts. Cultural factors and societal institutions play a significant influence on the development of adolescents in the country.

1. Gender roles and expectations

The sexual and gender identity of Filipino adolescents is significantly influenced by prevailing gender issues in the country. Existing gender issues such as stereotyping and double standards define the roles and behaviors of adolescents as they try to form their sexual identity and orientation. Many of these roles put women at the disadvantaged condition. For example, the existing double standards in terms of the behaviors of girls and boys on sexuality create constraints to the sexual development of boys and girls. Girls are expected to be more discreet on their sexual behaviors than boys. Girls are not expected to express nor initiate sexual attractions or they may be perceived and labeled as "*malandi*" or sexually liberated in a negative sense. Being "liberated" is actually considered as someone who has considerable sexual knowledge and

experience and usually does not conform to conservative norms of courting and relationships between men and women. Parents and communities reinforce the double standard by having a more tolerant attitude and treatment towards boys in terms of sexuality. It is often okay for boys to come home late but it is considered a deviant behavior among females (results from the FGDs).

Moreover, Philippine society expects women to be submissive and subordinate to men. Major decisions are usually made by males and are imposed on female partners even against their will. This type of power relations sometimes leads to sexual violence and coercion.

Furthermore, the double standard on sexuality is largely associated with the prevailing concept of masculinity in the Philippines. Masculinity or "*pagkalalake*" is strongly associated with sexual characteristics and concepts such as "sexual potency" and "sexual prowess." Becoming a "man" among Filipino adolescents entails various events which usually include a) *pagpapatuli* (circumcision), b) *pagbibinyag* (first sexual encounter), and c) *panliligaw* (courting). A male adolescent is expected to pass through these events in order to be called "*tunay na lalake*" (real man). Failure to go through these events would lead to negative remarks and labels from peers that consequently affect the adolescents' sense of belongingness and perception of themselves. These expectations have likewise significant impact on the acceptance of one's sexual identity and orientation (i.e. attraction to a particular sex).

These gender issues likewise affect the formation of self-identity and self-efficacy of adolescents. Men are expected to be more emotionally mature than women, thus, they are not expected to show their affection and emotions. Men are not supposed to cry and express their emotions especially in public. Men displaying emotions are perceived to be weak and "gay." As such, adolescent boys are trained and formed to be mentally and emotionally strong or they would be labeled as "*parang babae*" (like a woman) if they exhibit feminine behaviors. Many Filipino adolescents conform to these norms due to peer pressure and societal tolerance.

As an effect of the strong patriarchal concept of masculinity, many Filipino male adolescents develop a sense of irresponsibility when it comes to the repercussions of their sexual behaviors. Boys do not care so much when they impregnate girls because they are just "men" who are supposed to respond impulsively to sexual urges (i.e. "*lalake lang, madaling matukso*"). The blame is put on women as they are labeled as someone who exhibited sexual promiscuity (e.g. *"maagang naglandi*"). In short, the females usually suffer much of the negative consequences of unintended pregnancy.

D. FACTORS ASSOCIATED WITH ADOLESCENT PREGNANCY

The issue of adolescent pregnancy is a result of the interplay of various behavioral and non-behavioral factors within the individual and the environment in which adolescents live. A deep understanding of these factors helps significantly in designing appropriate communication interventions that aim to promote healthy and positive sexual behaviors among this group. Below is a brief but essential discussion on the various determinants of adolescent pregnancy. Refer to

Annex A for a more detailed discussion on the causal and behavioral analysis used for the design and development of this Sourcebook.

1. Direct behavioral causes of adolescent pregnancy

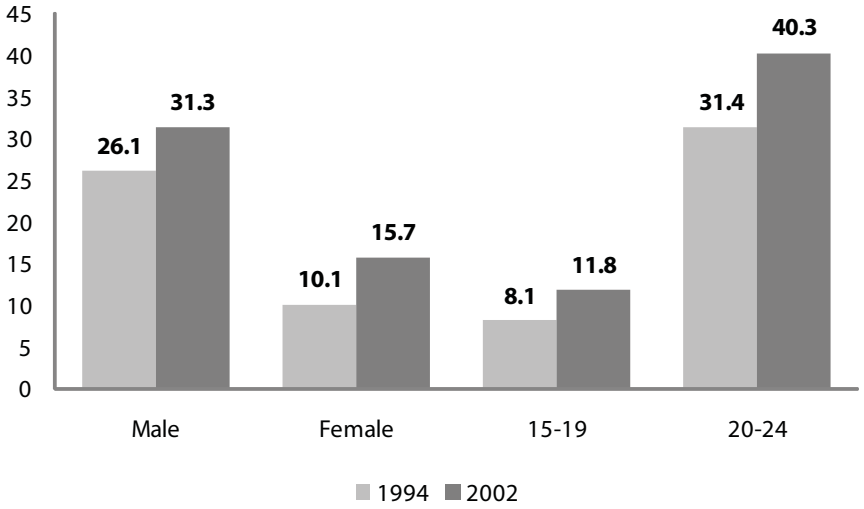
1.1. Too early sexual initiation

Naturally, pregnancy results from sexual intercourse between male and female partners. The initiation to sexual intercourse is a significant event in the physical and psychological development of men and women in all societies. Both the timing of this event and the context within which it occurs can have immediate and long-term consequences for the individual (Singh, Wulf, Samara, and Cuca, 2000). Too early and unintended pregnancy happens when adolescents engage in sexual intercourse in their young age. This is also usually referred to as "premarital sex." Younger exposure to sexual activities will more likely result in pregnancies among the young.

A positive reality about sexual initiation among adolescents is that majority of them have not yet engaged in sexual activities. About 11.8 percent of adolescent aged 15-19 years reported ever having engaged in sex in 2002 (Natividad and Marquez, 2004) implying a larger percentage (89.2%) of those who have not yet sexually debuted.

Nonetheless, the proportion of adolescents who ever engaged in sexual activities is increasing. Data from the 1994 and 2002 Young Adult Fertility and Sexuality Surveys (YAFS II and YAFS III) Figure 3) reveal an increase in the proportion of adolescents (15-19 years) who engaged in early sexual intercourse from 8.1 percent in 1994 to 11.8 percent in 2002 (Natividad and Marquez, 2004). Data from the National Demographic and Health Surveys also showed the incidence of last sexual intercourse among young adult females 15-24 increased from 15.7 percent in 2003 to 16.6 percent in 2008. Those who ever had sex among the 15-19 years old increased more rapidly (from 10.4% in 2003 to 13.6% in 2008) than those 20-24 years (from 54.6% in 2003 to 56.3% in 2008) (NSO, 2009).

Figure 3. Pre-marital sex behaviors, by sex and age group (in percent): Philippines, 1994 and 2002



Source: Data from Natividad and Marquez (2004) in Raymundo and Cruz (2004) Youth Sex and Risk Behaviors in the Philippines

Differentials in Sexual Intercourse. The rising trend in sexual engagement varies between young men and women. Generally, males engage in first sex at younger ages than females (Upadhyay, Hindin and Gultiano, 2006). In 2002, 31.3 percent of males adolescents aged 15-24 years reported having had sexual intercourse which is two times higher than those among their female counterparts (15.7%). However, data from the various YAFSS indicate a more rapid increase in the proportion of females who ever had engaged in sex. There is about 55.4 percent increase (from 10.1% in 1994 to 5.7 in 2002) in the percentage of female young adults who engaged in sex. The increase is only about 20 percent among male adolescents (from 26.1% in 1994 to 31.3% in 2002). Male and female adolescents engage in sexual initiation in almost the same age (18.2 years for males and 18.9 years for females) (Marquez and Galban, 2004).

The prevalence of premarital sexual intercourse is lower among the never married youth (16.7%) than the ever-married (56-58%); those in school (11%) than those not at school (34.9%); and those who never worked (12.8%) than those who ever worked (30-33%). Those who reached college had the highest prevalence (26.6%) while high school undergraduate had the lowest level (17.7%) (Natividad and Marquez, 2004).

Sexual initiation among adolescents is usually unplanned. Most of sexual intercourse among adolescents happened unintentionally. Of all respondents aged 15-19 years who ever had sex experience, only 39.8 percent reported that they wanted it to happen at that time. Nearly one in three (33.3%) adolescents' first sex experiences were not planned and one in four (24.8%) did not want it to happen but just went along with it. More males (43.8%) than females (28.1%) wanted the experience to happen. (Natividad and Marquez, 2004 in Raymundo and Cruz, 2004).

1.2. Engagement in unprotected sexual activities

Early sexual engagement does not necessarily result in pregnancy. The use of contraception may prevent conception and pregnancy. Contraceptive use is apparently not an established normative behavior among adolescents, as implied in the high incidence of too early pregnancies.

The 2002 YAFSS showed that most Filipino adolescents tend to have unprotected sex during their first sexual encounter. During their sexual initiation, only 23.6 percent of the adolescents (15-19 years) reported that they practiced some type of contraception. The percentage of those who practiced contraception is higher among males (32.5%) than among their female counterparts (12.3%). The most commonly used methods during sexual debut were condom and withdrawal, followed by pills. Rhythm was the least used method (Natividad and Marquez, 2004).

For the most recent sex episode, about 24.6 percent of adolescents (15-19) used contraceptives, 27.3 percent for males and 17.1 percent for females. The most common contraception methods used during the last sex for both sexes (15-24) were still condom (38.2%), withdrawal (31.9%) and pills (16.6%). Despite the very low effectiveness of withdrawal as a protection for pregnancy and STIs, almost 32 percent of adolescents used this particular method during their last sex episode and was even the most frequently used method by young females (30.3%) and their partners during their sexual engagement (Natividad and Marquez, 2004 in Raymundo and Cruz, 2004).

Table 4. Contraceptive method mix during the first and last PMS, by sex: 2002

Contraceptives	During First Premarital Sex			During Last Premarital Sex		
Condom	42.1	37.7	40.5	45.2	23.1	38.2
Withdrawal	39.8	37.7	39.0	32.7	30.3	31.9
Pills	8.9	15.1	11.1	11.2	28.5	16.6
Rhythm	5.0	8.2	6.2	7.0	10.8	8.2
Others	4.2	8.2	6.2	4.0	7.2	5.0
Any Method	27.5	14.9	24.7	26.6	21.8	24.8

Source: Natividad and Marquez (2004) in Raymundo and Cruz (2004) Youth Sex and Risk Behaviors in the Philippines

Young Filipino men (15-24 years) are more likely to use condom in their most recent sex episodes if they have used it during their sexual debut. They are also more likely to use condom if their partner was a girlfriend, a friend, or sex worker, as opposed to their spouse. They usually use condom for pregnancy prevention rather than for protection from STI/HIV infections (Manalastas, 2005).

Differentials in contraceptive use. Use of contraception is most prevalent among the never married youth 15-24 years old. About a third (30.5%) of the never married who ever had sexual experience practiced contraception during their first sexual activity. The corresponding figures are much lower among the currently married (13.4%) and among the currently living-in (11.3%) (Natividad and Marquez, 2004).

For the first sexual episode, contraceptive use was higher among those who were currently in school (32.4%) than those who were not in school (18.4%). The use of contraception during sexual initiation also tended to increase with education as those with college education had the highest percentage of users (26.9%) compared to those who had elementary education only (13.3%) (Natividad and Marquez, 2004). Findings of the 2008 UNESCAP Endline Survey showed that despite the high level of sexual exposure among OSYs only 12.3 percent were protected by condom during their last sexual encounter (13.7% among males and 10.2% among females) (Marquez et al., 2009).

Youths (15-24) who were currently working (22.9%) and who never worked (22.4%) have higher rates of contraceptive use than those who ever worked but are not currently working (18.9%). Catholics had slightly higher percentage (21.4%) of contraceptive use than those from other Christian religions (18.1%).

1.3. Engagement in sex with multiple partners

The possibility of getting pregnant during adolescence is enhanced by repeated sexual interactions and engagement in risky sexual behaviors such as having multiple and/or commercial sex partners. The issue becomes a behavioral risk factor because of the prevailing non-use of contraception among adolescents. Females are at the disadvantage end in as much as exposure

to sexual activities heightens the risk of getting pregnant. Females who are forced to have sex for monetary considerations are likewise highly vulnerable to early pregnancy.

Multiple sex partners

Having different partners in a series of sexual episodes is becoming a norm among adolescents who have been initiated to sex. In 2002, more than one-third (35.5%) of adolescents (15-19 years old) had more than one sex partner in a series of sexual activities. Almost half (44.8%) of the male adolescents in 2002 reported having had sex with more than one partner while the comparative percentage for females is only 10.6 percent (Natividad and Marquez, 2004). Data from the 2008 NDHS also showed that prevalence of higher-risk sexual intercourse is high among young, sexually active adolescent women with 15.5 percent having reported sexual intercourse with someone other than their spouse or cohabiting partner in the past 12 months. Interestingly, the percentage of youth (15-24) with multiple sex partner is highest among Catholics (35.2%) (Natividad and Marquez, 2004).

Transactional or Commercial sex

The reported level of commercial sex activity among Filipino adolescents is low but far from negligible because the available data are definitely under-reported. Because commercial sex is illegal making it a hidden phenomenon, available data does not reflect the actual situation.

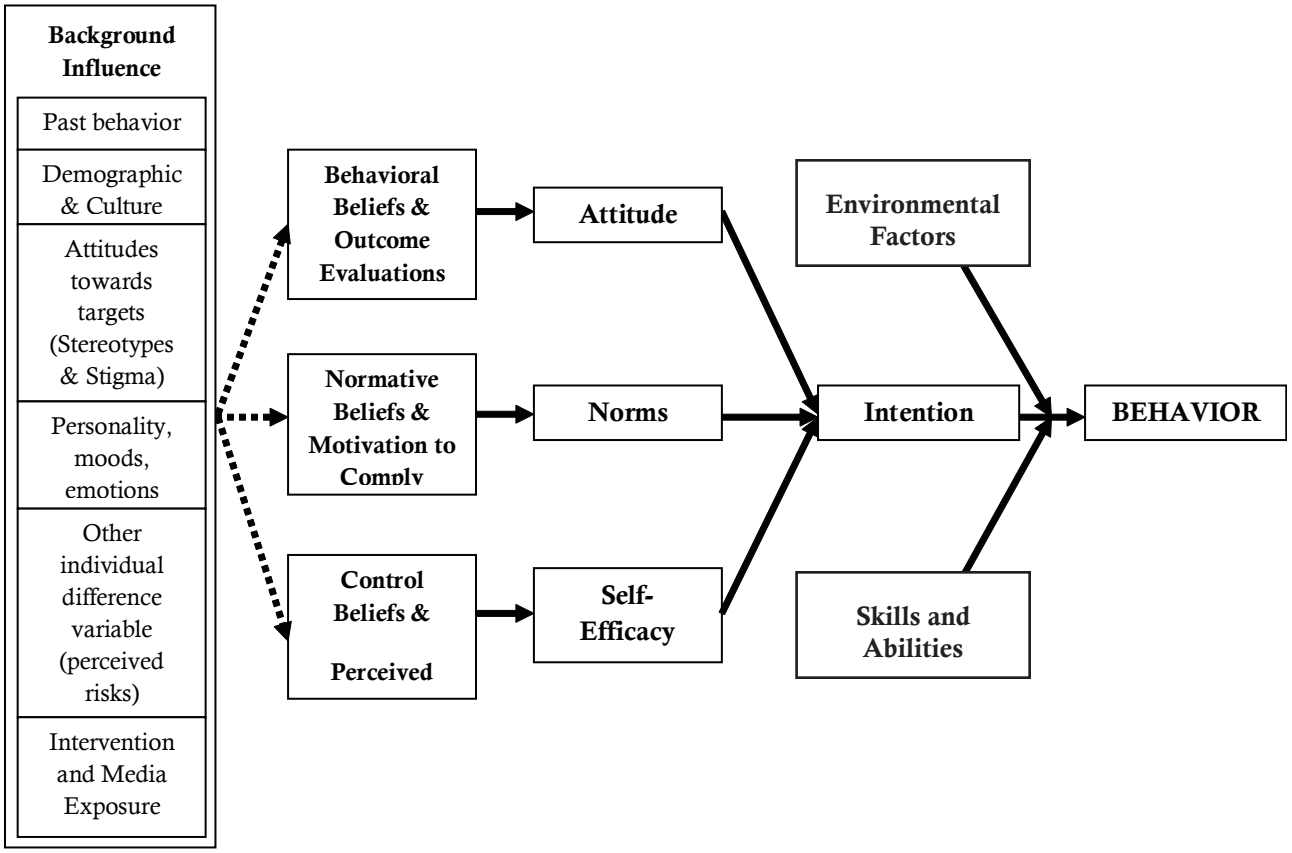
The data from the 2002 YAFSS revealed about 10.2 percent of sexually active adolescents aged 15-19 years who ever been paid for sex and 10.4 percent who ever paid for sex. As expected there were more sexually active males who ever paid for sex (15.6%) than females who have ever been paid for sex (less than 1% based on 30 cases) (Natividad and Marquez, 2004). While the percentage of females who reported to have ever been paid for sex is reportedly low, the actual situation could be observed to be high especially in urban areas where videoke and prostitution houses are flourishing.

Moreover, the result of a study among call centers conducted by the Commission on Population (POPCOM) and UP Population Institute (UPPI) revealed that call center respondents have higher exposure to the following behaviors: casual, non-romantic regular sex, sex with multiple partners, sex with the same sex, commercial sex, unprotected sex, early sex and premarital sex. Among men who paid for sex, 42 percent of call center respondents ever had unprotected sex.

2. Direct and indirect factors causing adolescent pregnancy

In analyzing the underlying behavioral and non-behavioral determinants of adolescent pregnancy, you may use existing conceptual and theoretical models of behavior change. For our purpose, we adopt the Integrative Model of Behavior Prediction of Fishbein and Capella (2006) as illustrated below. The model can serve as an analytical framework for understanding the factors that affect behaviors specifically the intention, environmental factors, and the skills and abilities of an individual.

Figure 3. Integrative Model of Behavior Prediction
(Fishbein and Capella. 2006)



The integrative model illustrated in Figure 3 shows that a **specific behavior** is more likely to be performed when: (1) one intends to engage in that behavior, (2) if they have the requisite skills and abilities to perform the behavior, and (3) if there are no environmental constraints to performing the behavior. The model also suggests that **intentions** are determined by: a) attitude toward performing the behavior, b) perceived norms concerning performance of the behavior, and c) self-efficacy with respect to performing the behavior. The relative importance of these psychosocial variables as determinants of intention will depend upon both the behavior and the population being considered. Thus, for example, one behavior may be primarily determined by attitudes, whereas another may be more strongly influenced by self-efficacy or perceived norms.

As such, in understanding behaviors and intentions, it is important to first determine the degree of influence of attitudes, norms, or self-efficacy control of a subject population. For example, among adolescents, the factors influencing intentions to engage into sex at an early age may be affected more significantly by attitude towards the act (e.g. engaging into sex is OK), or by their capacity to perform the act (e.g. "everybody is doing it, why can't I"), or by existing norms on the behavior (e.g. engaging into sex make one a real man).

The model also shows that attitudes, perceived norms, and self efficacy are determined by underlying beliefs about the outcomes of performing the behavior, the normative proscriptions

and/or behaviors of significant others, and the specific barriers to (or facilitators of) behavioral performance. Thus, for example, the more we believe that delaying sexual initiation will lead to "good" outcomes and prevent "bad" outcomes, the more favorable our attitude would be toward performing the behavior. Similarly, the more we believe that our peers are themselves performing the desired behavior, or that they think that we should perform the behavior, and the more we are motivated to comply with them, the more social pressure we feel (or the stronger the subjective norm) with respect to performing the behavior. Lastly, the more we perceive that we can (have the necessary skills and abilities to) perform the behavior, even in the face of specific barriers or obstacles, the stronger will be our self-efficacy with respect to performing the behavior (Fishbein and Capella, 2006).

The model also illustrates the indirect factors affecting behaviors to include demographic, personality, attitudinal, and other individual difference variables. For example, although men and women may hold different beliefs about performing some behaviors, they may hold very similar beliefs with respect to others. When such demographic, personality, or individual difference variables are systematically related to underlying beliefs, they are likely to be related to the behavior. However, when these "external" or "background" variables are unrelated to behavioral, normative, or control beliefs, they are unlikely to be related to the behavior. The relative importance of each of the variable in the model varies across individuals. Finally, application of the model requires the identification of the behavioral, normative, and control beliefs that are salient in the population being considered (Fishbein, 2008).

The theory's approach to communication planning especially in message development is based on the proposition that communication strategies cater to an audience's needs. These needs determine the particular behavior that a communication intervention seeks to approach (Fishbein, 2008).

2.1. Determinants of adolescents' early engageent in sex

2.1.1. Intentions of adolescents in engaging into sexual activities

Intention indicates readiness to perform a given behavior and it is considered the immediate antecedent of behavior. Intention is based on attitude toward the behavior, subjective norm, and perceived behavioral control, with each predictor having a weighted importance in relation to the behavior and the individual.

In the absence of direct data to reveal the level of intention of adolescents in engaging in sex, we can gauge intentions from data indicating the incidence of sexual activities among this population. The 11.8 percent of adolescents who engaged in sexual activities implies that there is a larger proportion of adolescents who have not yet sexually debuted. Adolescents who have not yet engaged in sexual activities may either have no intention at all or have some degree of intention but may be hindered by some factors.

We can also see that many adolescents even when they engaged in sexual activities have no intention to pursue such activity. As discussed above, a significant percentage of adolescents

expressed that they did not want to engage in sexual activities during the time they did it. To further analyze the level of intention of adolescents to engage in sex, we can look at the factors that affect intentions, namely, attitude, norms, and self-efficacy.

a) Prevailing values and attitudes on sexual initiation

Majority of adolescents do not engage in sexual activity because they generally disapprove of premarital sex. Studies have shown that 60 percent disagreed of premarital sex even if the couple already had marriage plans. Moreover, 70 percent disapproved of sex if there was no emotional relationship between the parties (Cabigon and Zablan 2001; Benares 2001; Cruz and Diaz 2001; IPHC 2001; Badayos 2002, cited in WHO, 2005).

Moreover, adolescents are hesitant to engage in premarital sex because of their fear of its repercussions. They believe that early pregnancy can derail their dreams and aspirations. These adolescents expressed a greater value for education and good future than pleasurable but more temporal and risky behaviors. Many also hold to their fear of disappointing and disobeying their parents or going against their religious beliefs (results from the FGDs). Many young women actually still value virginity and believe that sex should only be done within marriage. Seven out of 10 adolescents surveyed say that virginity was an important consideration in one's choice of a spouse. Almost 50 percent said it was unacceptable for a woman not to be a virgin before marriage (Diaz n.d.). However, a double standard exist among males as they expect to marry a virgin but also want to "devirginize" a girl when given the chance (Perez n.d.; DPF 2001; Zablan 1999, cited in WHO, 2005).

A liberal attitude on sexuality is, however, emerging among adolescents. Based on the available data, youths perceived unwed mothers as acceptable, in general, to society (62.3%), neighbors (75.4 %), girl friends (78.6%) and family (87.6%). There was a marked increase in the acceptance of unmarried mothers during the period from1982 to 1994 (Ogena, 1999).

As substantiated in the FGDs, the sexual liberation brought about by globalization, Westernization of values, and the promotion of a more liberal culture by Western media have promoted more liberal attitude towards sex. While the discussion of sexuality related issues at home is still a taboo, the technological advancements have developed among adolescents significant sexual beliefs and attitudes that run contrary to the conservative sexual values and attitudes of adults, thereby, widening the generation gap in terms of sexual attitudes between older adults and adolescents. For example, for boys, virginity is not anymore a big issue when it comes to relationships as was before.

The increasing number of young people engaging in live-in relationships also manifests the more liberal attitude on sexual activities among adolescents. The proportion of adolescents who are never married decreased during the period 1993-2008. However, for the same period, those in live-in arrangements increased. Data from the National Demographic and Health Surveys revealed that women aged 15-19 who chose to live with their partners has doubled from 2.7 percent in 1993 to 5.1 percent in 2003.

Furthermore, many adolescents consider sex as an expression of love. They expressed that once they enter into a romantic relationship, intimate activities normally becomes part of the relationship. Many adolescents also believe that sex is part of growing up and being curious (results from the FGDs).

b) Subjective norms on sex among adolescents

One of the primary sources of normative beliefs among adolescents is their peers. Adolescents with peers who engage in sexual activities will more likely imitate what they are doing as a process of learning and establishing self-identity and efficacy. As expressed during the FGDs, adolescents engaged in sex because their peers are doing it. The thought that "everybody is doing it" translates into a normative belief that "it is okay" to engage in sex even in their young age.

In addition, peers who may have already had the experience of sex could drum up the curiosity of those who have not yet engaged in sex. Participants in the FGDs shared that sex is something they discuss with friends. Peers give them accounts of their experiences or they consult peers about matters pertaining to sex. It could simply start with sexually active friends relating their experiences and the many pleasures that come with it and later progress to, them wanting to try this out or experience this for themselves. In the process, it becomes a normative behavior among the group members.

The prevailing masculinity concepts in the country also reinforce norms toward early sexual initiation among adolescents. As discussed earlier, much of the concept of masculinity or "manhood" is associated with "sexual potency" and "sexual prowess." Being a man goes with it the need to pass through rites that include "*pagbibinyag*" or sexual initiation in order to be called "*tunay na lalake*" (real man). Failure to go through these events would lead to negative remarks from peers, which eventually would affect the adolescents' perception of themselves. The perceived permissiveness of the society on the sexual "promiscuity" of males has set up social norms that have been passed on through generations. It also created more room for adolescents to explore their sexuality and the capacity to experience sexual pleasure.

The media today is becoming the primary source of normative and acceptable behaviors among the adolescents. Media tend to dictate what is right or wrong in the absence of adult guidance and critical thinking skills. With the advancement in technology and media, access to sexual messages has increased significantly. Media today has enhanced access to pornographies and messages on sexuality that conveys norms favorable to too early sexual engagements among adolescents. Moreover, social networks have facilitated easier interpersonal interactions including sexual activities among adolescents, which also exposed them to risks of sexual abuse. In the FGDs among female adolescents, it was shared that mass media and technology (internet and mobile phones) led to a widespread belief that couples can have sex even if they are not married.

c) Level of self-efficacy among adolescents towards sex

Self-efficacy pertains to the individual's perception that he or she will be able to perform a certain behavior successfully. Perceived behavioral control refers to the degree to which an individual feels that performance or nonperformance of the behavior is under his or her volitional control. People are not likely to form a strong intention to perform a behavior if they believe that they do not have any resources or opportunities to do so even if they hold positive attitudes toward the behavior and believe that important others would approve of the behavior (subjective norm) (Fishbein, 2008).

Engaging in pleasure-seeking behaviors is predicated on the decision to act on one's libidinal urges. However, such decisions are also based on one's capacity to rationalize or carefully assess the repercussions of the actions one will engage in. Rationalization could either lead a person to decide to engage in sex or not. The idea is that if people assess that if there are repercussions involved, there is a greater possibility that they will not engage in that behavior. However, in the case of adolescents, although well aware of repercussions, their desire for sexual pleasure usually prevails. Even adolescents who became pregnant still engaged in unprotected sex.

Curiosity also fuels the self-efficacy of adolescents to engage in sex. Curious about the pleasure that they may derive from engaging into sex as relayed by their peers who already had sexual experience, they become interested to experience sex themselves. Sexual experience enhances the efficacy and confidence of adolescents to repeat a satisfying experience- this is particularly true among male adolescents. Media also reinforces the curiosity of adolescents as it provides visual and more vivid pictures of what they can possibly experience when they engage in such sexual activities.

Curiosity is associated with risk-taking behaviors. Adolescents take sexual risks, which are uncalculated or miscalculated. Risk taking is more of a psychological state, a disposition that allows adolescents to decide to engage in unprotected sex despite the possible negative consequences involved (results from the FGDs).

The curiosity of adolescents to engage in sexual behaviors that may result in pregnancy is negatively influenced by the inadequacy of knowledge on sexual and reproductive health concerns. Due to lack of access to ASRH information, adolescents are deprived of the necessary knowledge and skills that they can use in preventing unplanned pregnancy and its negative consequences.

Self-efficacy is also affected by the will and skill to negotiate, assert, and refuse. Studies have shown that young girls are sexually initiated involuntarily because of their poor leverage to oppose or refuse sexual advances. The existing gender stereotypes and double standards that boxed women into passive and submissive expectations also reinforce this incapacity.

While some adolescents may know the repercussions of their actions, a larger proportion of adolescents have no adequate information on the consequences of early sexual initiation. The lack of information may either pull away or push adolescents into engaging in sex. Many

of adolescents who engaged in sex are curious yet they are not adequately knowledgeable on the repercussions and implications of their actions. In particular, adolescents have very deficient knowledge of reproductive health and rights irrespective of sex and ethnic affiliation. Many adolescents are also misinformed on reproductive health and rights issues and concerns, an unsafe condition that facilitates risky behaviors.

Engaging in a non-protective sexual relationship starts when a partner initiates or shows intent to engage in the sexual act. The sexual act continues when one of the partners responds and reciprocates the initiative. Thus, self-efficacy to engage in sexual activity is also enhanced when acts are reciprocated and mutually desired or consented to by both partners.

2.1.2. Background Influences

Gender, demographic characteristics, physiological make-up, socio-economic conditions, personality traits, culture, and media use (including exposure to sexual messages) are also possible sources of beliefs. The Integrative Model labels these variables as "background" variables.

a) Onset of puberty and increased sex drive

Puberty is a significant event that causes hormonal changes including an increase in sexual drives among adolescents and the onset of the capacity to reproduce. The development of secondary sex characteristics produces either anxiety and tension or increased curiosity to explore in discovering their sexuality. In this period, socially assigned sex roles also become important in the development of attitudes and behaviors of adolescents.

The Sexual Drive

"Sexual behavior is regulated by the brain (parts such as the hypothalamus, the amygdala, and the nucleus accumbens), and other parts of the body, such as the spinal cord and some endocrine glands. The endocrine glands, namely testicles in men, ovaries in women, and adrenal glands in both sexes, secrete so-called sex hormones (also called sex steroids), such as testosterone, estrogen, and progesterone. The secretion of these hormones is partially influenced by the brain, but the hormones also provide information (feedback) to the brain and have an effect on some brain functions.

The regulation of sexual behavior is very complex and not fully understood. An individual can be sexually aroused by a vast array of sensory experiences, and simply by his or her own imagination. Arousal and the sex act itself cause the autonomic nervous system to stimulate many parts of human's anatomy. Women and men experience its effects not simply in their genitals, but also in increased heart rate and breathing, sweating, erect nipples, muscle spasms in various parts of the body, and the pleasure of orgasm.

Modern science has broadened understanding of human sexual functioning. Normal men and women experience a sequence of physiological responses to sexual stimulation. The sexual response cycle is usually divided into four phases: desire, excitement, orgasm, and resolution.

Sexual behavior develops throughout the life cycle. Early sexual experience may involve genital play in infants, which is considered part of normal development. Gender identity ("I am male/female") is established by the age of 2 or 3. Puberty is usually marked by a rapid development of secondary sexual characteristics and the ability to engage in sexual intercourse and reproduction. Sexuality usually peaks in early adulthood and gradually declines thereafter."

(Richard Balon & J. Allan Hobson, *Basic Drives: Eating, Sleeping, and Sex — The Dana Guide.*, November 2007, accessed from http://www.dana.org/news/brainhealth/detail.aspx?id=10068)

b) Gender issues related to sexuality

As discussed earlier, many gender issues are directly associated with the development of sexuality among adolescents. The double standards imposed on male and female, for example, promotes a tolerable sexual liberty among males than females who are expected to be more submissive and passive. Such cultural norms promote differentials in the sexuality of male and female adolescents.

c) Demographic characteristics

Many sexual behaviors are age-defined. This means that there are various sexual behaviors, which are expected among certain ages. For example, it may be too young for 10-14 years old to talk about sexually related matters such as sexual attraction, crushes, and marriage, which are matters more appropriate to older adolescents.

Sexual attitudes, beliefs and behaviors also vary between married and unmarried adolescents. Married adolescents (18-19 years old) are expected to reproduce and enter into sexual relations, as such, pregnancy may be less of concern in relation to the social expectation prescribed to them.

Mobility is another facet of demographic process. Many Filipino adolescents are highly mobile. They move primarily because of education and employment. While it opens for them new opportunities for growth, they are also exposed to serious risky sexual behaviors. Leaving the home moves adolescents away from family and community systems that can promote, reinforce, and monitor norms of appropriate sexual behavior. Access to information and more freedom to do things on their own makes adolescents vulnerable to risky decisions especially about their sexuality. For example, while young people may be exposed to coercion or sexual violence particularly in urban settings, they may also be more likely to engage in consensual, unprotected "survival" sex, especially to ensure their education and basic needs.

d) Personality traits

The psychological make-up, past experiences, and other personality factors influence intentions to engage in sexual activities. An adolescent with low level of confidence may find it more difficult to enter into intimate relationships than someone who is an extrovert or out-going person. An experience of an adolescent or of someone close to him/her might influence an adolescent to engage intentionally or not in sexual activities. For instance, an adolescent with a sibling who was impregnated and suffered rejection from the family might affect her intention to engage in premarital sex.

Adolescents who were victims of sexual violence in their younger years, which dealt them traumatic experience, may also have either negative or positive influence on their sexual behaviors. Some of its psychological effects include low self-esteem, inefficiency to trust and relate with others, tendency to withdraw from triggering situations, and sexual promiscuity (Hurlock, 1982).

e) Socio-economic conditions

The socio-economic conditions of adolescents are also interrelated with their sexual behaviors. As the NDHS consistently showed, pregnancy in the Philippines was prevalent among adolescents who were in poor conditions, among less educated, and among those living in the rural areas (Pedroso, 2010). The relationship between educational attainment and childbearing is reciprocal – education has an impact on childbearing and childbearing has an impact on fulfilling educational goals.

About 26 percent of Philippine youth in 1994 who are no longer in school were sexually active compared with 8 percent of young people who were still in school (Raymundo, Xenos, & Domingo, 1999). Filipino youths who have experienced living away from home and who ever left school exhibited higher (23.8 percent and 25.5 percent) prevalence of premarital sex than their counterparts (12.9 percent & 8.2 percent, respectively) (Laguna, 2003).

The economic capacity of adolescents also influences their intention to engage in sexual activities. Adolescents with more abundant economic sources can have more access to socialization, information, and opportunities that can facilitate early sexual engagement. For instance, adolescents with resources have the capacity to enter entertainment and social establishment (e.g. bars, cafes, and clubs) where they can meet and interact with their partners. They can also pay private rooms or venues to facilitate intimate sexual relationships.

Furthermore, the poor educational and economic conditions of adolescents also contribute to their greater vulnerability to sexual exploitation and abuse in the form of prostitution and trafficking. As teenagers are exposed to the liberal and consumerist culture of the West from the media or social networking sites, some teenagers begin to see their sexuality as a possible escape from their financial woes or as a possible avenue for them to indulge in the lifestyles they desire. Prostitution or sex with monetary considerations has become more rampant with increasing availability of information technology at home and in the community. For instance, media reports and documentations reveal how social networking facilitated dating, sexual encounters, and even sexual abuse involving adolescents.

f) Engagement in non-sexual risk behaviors

The combination of sexual and non-sexual activities is likewise a significant factor in facilitating adolescent pregnancy. A significant increase in the proportion of adolescents who tried drinking alcohol was noted in 2002 (from 54.4 percent in 1994 to 70.1 in 2002). Similarly, drug use among the youth has almost doubled from 5.7 percent in 1994 to 11 percent in 2002. Males had higher prevalence in both drinking and drug use than females. However, the prevalence of non-sexual risk behaviors among females grew faster than among males. Studies have shown that alcohol and substance use have a significant relationship with engagement in casual sex among both male and female adolescents. Substance abuse has also a significant influence on commercial sex among adolescents. (Raymundo and Cruz, 2003)

2.1.3. Environmental and institutional influences

a) Changing family structures and level of parental guidance

The family is the most immediate and influential institution that forms and molds adolescents' behavior. It is the main source of moral, emotional, and financial support of adolescents even when they already have their own families. Moreover, the family also serves as a significant controlling variable in terms of the behaviors of the adolescents (Cruz, Laguna, & Raymundo, 2002).

Many parents prefer that they be the primary source of information about sexuality to their children (UPPI, 2011). Nonetheless, since sexuality concerns remain a taboo among most Filipino families, parents do not usually initiate discussing sexuality issues among adolescents. Even when parents would like to guide their children, parents admitted that their skills are inadequate to guide their adolescent children in matters pertaining to their sexuality (results from the FGDs).

Many parents today find difficulty in parenting their adolescent children because of the complexity of today's time (results from the FGDs). There is an emerging consensus among FGD parent participants that the fast changing social, economic, and technological conditions require greater parental attention, respect, and moral guidance for their adolescent children (results from the FGDs, also in Ogena, 2005).

Family relationships have also significant impact on adolescent behaviors. Issues of broken homes (i.e. separation of parents), marital conflicts between parents, and conflict within the family may motivate adolescents to engage in delinquent behaviors including engagement in sexual activities. Such deviant activities may be adopted by the adolescents as the coping or defense mechanism against these issues.

Changes in family structures and roles likewise have an important influence on adolescent development. Lessened parental guidance due to work and changing family structure (e.g. separation of parents or education of adolescents away from home) affect the behavior and formation of adolescents. Being away from home, far from the panoptic gaze of parents and being at the cusp of adulthood, adolescents feel a certain level of independence from the strictures parents imposed at home. They also see people their age or older who are engaging in behaviors that they may have not been free to do at home. Lastly, male parents assuming responsibilities in household management and rearing of children in the absence of the female parents working abroad also creates tensions on the development of adolescents as most males are not prepared for these roles (results from the FGDs).

b) Existing policy and program environment for ASRH services

Access to information and services is also a vital factor in influencing the behavior of adolescents. However, such access is limited by the lack of policies and programs on ASRH in the community and schools. Moreover, the health facilities are not friendly to adolescents as

many health service providers have judgmental and negative attitude and behaviors towards adolescents accessing information and services on sexuality and reproductive health (results from the FGDs). This also causes reluctance among adolescents to access and demand necessary ASRH information and services.

Many people, including health workers, believe that discussion on the use of condoms with young people promotes promiscuity. This causes young women and men to rely largely on information they get from peers, which is often inaccurate and incomplete.

c) Culture and religion

Although the impact of religion on the behaviors of adolescents has apparently declined nowadays, normative values preached by their religion still guide many adolescents. Many cultural and religious norms and practices directly influence the sexual behaviors of adolescents. For example, pre-arranged and early marriage among Muslims and some indigenous communities exposes female adolescents to risky pregnancy.

2.2. Factors influencing adolescents to engage in unprotected sex

Using contraceptive during sexual initiation and subsequent sexual activities is not an established behavior among adolescents as earlier shown. Data revealed that only about one in ten adolescents aged 15-19 years used condom during their sexual initiation.

2.2.1. Existing attitudes and norms on condom use

Men usually do not use condom because of its perceived effect in reducing sexual sensations during intercourse. About 58 percent of sexually active young adults expressed negative attitudes towards condom use primarily because of reduced sensation and pleasure (WHO, 2005). This is also validated during the FGDs.

Young adults are least likely to use condom with a spouse or steady partner because of a psychosocial belief that condoms are merely for casual ("one-night stands) and commercial sex. They practice unprotected sex with steady partners, which they have perceived to be "safe" and "healthy" in a steady sexual relationship. Moreover, condom use may signify "promiscuity" such that it may be inappropriate for "serious" relationships (Manalastas, 2005).

2.2.2. Efficacy of adolescents in protected sex

Many adolescents have inadequate knowledge and skills on exercising their sexual rights including access and use of contraception. They have inadequate knowledge on what contraception they can use and how to use such contraception, thus, the low use of contraception among them.

Young males used the condom mainly for preventing pregnancy (Manalastas, 2005) rather than as a protection from STI/HIV infection. This implies that they may not be aware that they can get STI and HIV/AIDS even with their steady partners.

Adolescents usually do not the use condom or any contraceptive because of the spontaneity of the act. Since many sexual initiations were unplanned or unintended, having a condom before sex is unlikely. Partners do not usually talk about using a protection because of the impetuosity of the act (results from the FGDs).

Female adolescents usually do not have the ability to refuse sex without any protection. Even if they are willing to engage in protected sex, they find it awkward to proposed or initiate the use of protection (results from the FGDs). Unprotected sex is imposed usually in sexual abuse and violence.

2.2.3. Background influences

a) Previous experience in using condom

While sexually active adolescents are more likely to use contraception in subsequent sexual activities if they used it in their sexual initiation, others may have negative experience in using condom and this may affect their behavior in subsequent sexual activities. Condom use also usually decreases with age (Natividad and Marquez, 2004).

b) Effect of perceived gender roles

Male adolescents can insist his objection in using condom or contraception to his partner because of his perceived superiority over women. Female adolescents usually submit to unprotected sex partners for fear of offending their partners and as expression of their love to their partner (results from the FGDs).

c) Demographic factors

Use of contraception is most prevalent among the never married youth 15-24 years old. About a third (30.5%) of the never married who ever had sex experience practiced contraception during their first sexual activity. The corresponding figures are much lower among the currently married (13.4%) and among the currently living-in (11.3%) (Natividad and Marquez, 2004).

Unmet need for family planning among adolescents. Unmet need for family planning is defined as the percentage of married women who either want to stop having children or want to wait for their next birth but are not using any method of family planning (NDHS, 2008). According to the latest NDHS (2008), about one in four (22%) Filipino women has an unmet need for family planning (NDHS, 2008) with the adolescents aged 15-19 having the highest unmet need for family planning (36%). Unmet need is slightly higher in rural areas than in urban areas (24% vs. 21%), differs among regions, and is higher among lower educational levels and among poorer women.

d) Socio-economic variables

Contraceptive use was higher among those who were currently in school (32.4%) than those who were not in school (18.4%). The use of contraception tended to increase with education

as those with college education had the highest percentage of users (26.9%) compared to those who had elementary education only (13.3%) (Natividad & Marquez, 2004). Findings of the 2008 UNESCAP End-line Survey showed that despite the high level of sexual exposure among OSYs only 12.3 percent were protected by condom in their last sexual encounter (13.7% among males and 10.2% among females) (Marquez et al., 2009).

Youths who were currently working (22.9%) and who never worked (22.4%) have higher rates of contraceptive use than those who ever worked but are not currently working (18.9%) (Natividad & Marquez, 2004).

2.2.4. Environmental and institutional factors

Religion is a significant barrier to contraceptive behavior among Filipinos especially to the young. The Catholic hierarchy strongly opposes the promotion of condoms because it propagates contraceptive mentality, which they consider as anti-life and violation of the Church's teachings. They also argued that promoting condom use could promote promiscuity among adolescents – the same reason that they object to sexuality education in schools. Interestingly, however, many (21.4%) Catholics and other Christian religions (18.1%) have used contraceptives (2008 NDHS). This means that Catholic opposition contraceptive use lies more on the accessibility of contraceptives rather than on the individual intentions of the adolescents.

Due to its controversial nature, adolescents have no access to condoms especially from public health facilities. Health workers from public and even private health facilities and outlets tend to be judgmental and unfriendly among adolescents who seek condom or other family planning methods. There are also inadequate programs and policies at the local level to promote the sexual and reproductive health of adolescents. No officials at the national and local level are openly supporting the provision of contraceptives among sexually active adolescents.

2.3. Factors influencing adolescents to engage in sex with multiple sex partners and in commercial sex

Generally, sexually active young Filipinos stick to one sexual partner. However, a significant proportion of them have multiple partners in their series of sexual activities. This is more prevalent among male adolescents. As expressed during the FGDs, once adolescents sexually debuted, it is more likely that sex becomes part of their subsequent relationships. Thus, having a multiple sex partner increases significantly the chance of getting pregnant among female adolescents.

The negative impact of commercial sex mostly falls on women. Female adolescents are forced to engage in sex with pay and it exposes them not only to early and unintended pregnancy but to sexual exploitation and abuse and health risks such as STI and HIV infections. They are not only exposed to sexually active adolescents but also to sexual advances of adults, which makes them more vulnerable than their fellow adolescents who are not in same circumstance.

2.3.1. Existing attitudes and norms on multiple sex partners and engagement in commercial sex

a) Multiple sex partners as a norm for macho male

There are limited studies on the factors associated with multiple sex partners among adolescents. However, studies abroad indicate that the most significant factors that influence multiple sex partners are associated with gender issues (Santelli, et.al, 1998; Durbin, et.al, 1993). The perceived masculinity of men implies superiority over women especially in terms of sexuality. Having multiple sex partners is a symbol of such assertion of superiority.

In the Philippines, anecdotal evidences showed that men, which include adolescents, are typically inclined to have sexual partners because of double standards and societal tolerance of multiple sex partners among men than among women. Since they cannot be pregnant, it is okay for male to have multiple sexual partners even if they have to pay for it (results from FGDs).

Moreover, "manhood" is falsely measured by the number of sexual partners and exploits and not by men's faithfulness on relationships. Men who have many sexual experiences with various women are regarded as "*matinik*," "*lalaking lalaki*," and "*magaling sa babae*" which actually enhances their self-ego and confidence (results from FGDs).

b) Double standard on faithfulness and loyalty

Faithfulness is also subjected to double standards. Women are supposed to be faithful to their partners but males are justified to engage in extramarital affairs ("*lalake lang"* or *"tao lang na madaling matukso*").

c) Transactional sex as a source of income

Female adolescents are sometimes enticed by sex worker friends from whom they can see visible financial gains from engaging in such activity. Given their poor economic condition, prostitution offers an problemopportunity to achieve their financial objectives (results from the FGDs).

2.3.2. Efficacy in multiple sex partners

Sexual initiation usually leads to subsequent sexual relationships and, thus, having multiple sex partners. The confidence of the adolescents to explore sexually with other partners is enhanced once adolescents sexually debuted. Multiple sex partners may be part of adolescents' sexual experimentation.

The physical attributes and appearances of adolescents may also either enhance or diminish the efficacy of adolescents to enter into sexual relationships. The capacity to engage in multiple sex partners sometimes indicate the "desirability" and "appeal" of an adolescent. The more sexual partners that adolescents had the more that they feel confident about themselves.

On the other hand, adolescents who are not being "dated," courted, or with less sexual activities are labeled by their peers as "physically undesirable" or unattractive (results from the FGD). This consequently lowers the self-esteem of adolescents especially in terms of their sexuality

The motivation to escape poverty and financial problems or to help the family survive economically enhances the efficacy of adolescents to engage in commercial sex. They gain further confidence to engage in such activity as their experience increases and they are able to realize their expected gains from the activity. They also become motivated when they see other adolescents engaged in such act.

2.3.3. Background influences

a) Previous experience in multiple sex partners

The pleasures adolescents personally derive from engaging in sexual activities tend to escalate to the desire to experience it with other partners. Unintended pregnancy among females, however, can more likely hinder adolescents from engaging in sexual activity with other partner.

Sexual abuse and exploitations are also reasons for adolescents to engage in commercial sex. Adolescents who experienced these abuses may psychologically develop sexual promiscuity and permissiveness either as defense mechanism or means to cope with the negative experience.

b) Gender issues

As discussed earlier, multiple sex partners among adolescents is deeply rooted in prevailing gender issues in the county. The differential treatment, standards, and expectations between males and females support the false concept of masculinity and femininity that allow males to have multiple sexual partners and compel women to be submissive. Historically, gender inequalities related to sexuality has likewise resulted in the objectification and commercialization of women.

c) Demographic factors

The incidence of having multiple sex partners increases with age. Younger adolescents are more focused in maintaining intimate relationships with steady partners while older adolescents are already more confident to experiment with other partners their sexuality and intimacies.

There is a high proportion of never been married adolescents who received payment for sex (Natividad & Marquez, 2004). Moreover, the FGDs also found that many of adolescents who entered sex work have already begun childbearing. They were forced into sex work to support their children. This reflects multiple risks among prostituted adolescents. For one, they have to struggle to support their children, and for another, they run the risk of getting pregnant with another child to support.

d. Socio-economic variables

As mentioned above, poverty is the main reason why adolescents receive payment for sex. There is also an indication that some students and currently working youth received payment for sex (Natividad & Marquez, 2004) probably to support their educational and basic needs. Adolescents and young adults also enter into commercial sex because of curiosity, envy of a sex worker friend earning money, search for a job that pays well, parents who are unemployed, and abandonment of parents (Abaya, 1997 cited in Batangan, 2003). Their lack of needed education for employment also pushes them to engage in such type of work.

2.3.4. Environmental and institutional factors

The proliferation of bars and massage parlors catering sexual pleasure indicates the growing access of adolescents to commercial sex trade in the country (Natividad & Marquez, 2004). While there is an existing law prohibiting prostitution, the access of minors and continuing sex trade reflect the weak enforcement of such laws and policies.

The lack of socio-economic opportunities for female adolescents forces them to enter into risky commercial sex work. There are no available programs and projects at all levels that address the economic concerns of these young people.

Adolescents' access to reproductive health information and services are perennially lacking. There are no ASRH programs that provide guidance and counseling to adolescents in order to avoid sexually risky behaviors.

E. CONCLUSION

Adolescent pregnancy is a complex phenomenon and it is an important development concern. The issue is part of the intricate events and processes involved in adolescence and it needs to be given appropriate and effective interventions to lead adolescents towards the realization of their potentials.

Adolescent pregnancy is directly caused by early sexual initiation, unprotected sex, and multiple sex partners including commercial sex. As shown above, there are a lot of interrelated factors associated with the attitudes, values, norms, beliefs, intentions, efficacy, and environment of the adolescents that expose them to early and unintended pregnancy. The lack of knowledge and access to information about the sexuality and reproductive health and rights concerns are likewise significant issues that affect the well-being of adolescents and their capacity to protect themselves from unitended pregnancy. These factors operate differently between male and female adolescents because of the prevailing gender issues in the country. More importantly, these explanatory variables provide us with important clues for designing appropriate BCC strategies for adolescent pregnancy.

The causal and behavioral analysis provides us with a general description of the factors associated with adolescent pregnancy. The important thing about behaviors is that they are unique to every individual. Behaviors are highly dependent on the specific individual and environmental context of the target audience. As such, it is necessary for you to conduct your own causal and behavioral analysis using existing BCC frameworks to make your strategies more responsive and effective. This Section is an attempt to provide you with the areas which you need to look into in undertaking your own analysis. You can use them in the design of your analytical design including the framework, variables to be studied, development of data gathering instruments and methodologies, and the analysis.

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SECTION 3

Designing BCC Strategies for Preventing Adolescent Pregnancy

After having an understanding of the nature and issues and factors related to adolescent pregnancy, you can now delve into the basic concepts of designing Behavior Change Communication (BCC) strategies. Having a deep understanding of the problem behavior enables you to appreciate more the steps involved in BCC planning and strategizing. By careful and deliberate BCC planning, you can ensure that the factors identified in the situational and behavioral analysis are taken into consideration.

BCC is a critical strategy in promoting healthy and responsible sexual behaviors to prevent early and unintended pregnancy among adolescents. BCC is a set of organized communication interventions and processes aimed at influencing social and community norms and promote individual behavioral change or positive behavior maintenance for a better quality of life (Chen, 2006). BCC involves the design and implementation of communication tools and approaches that promote positive behavioral outcomes based on proven theories and models of behavior change.

This Section provides you with key concepts and basic steps in designing BCC strategies for preventing adolescent pregnancy. You need to consider this critical information to make your BCC interventions more relevant and effective. It also provides you with some legal foundations related to adolescent development from which you can contextualize you BCC strategies.

A. BCC STRATEGY FOR ADOLESCENT PREGNANCY

Adolescent pregnancy is essentially a behavioral issue. As such, it demands interventions that can address the web of problem behaviors associated with the undesirable condition. It is in this context that BCC interventions become relevant and an effective strategy for addressing early and unintended pregnancy among adolescents. In promoting positive and healthy sexual behaviors, the role of communication is indispensable because of the strategic and vital role of information in behavior formation and change.

Designing behavioral change strategies requires a proper understanding of the behavior problem and the application of effective methods to change and promote behaviors through communication. BCC interventions are crucial to increase the demand for and access to quality health services and to foster healthy behaviors that prevent undesirable health and development conditions. For example, sexuality and life-skills education in formal and informal settings provide information leading to improved health-seeking behaviors and attitudes among adolescents. Such information enables them to make informed choice decisions particularly on sexuality, a skill or information that they can also transmit to their peers. Effective BCC strategies can increase knowledge, stimulate community dialogue, promote essential attitude change, reduce prevailing stigma and discrimination, create a demand for information and services, advocate, promote services for prevention, care and support, and improve skills and sense of self-efficacy.

1. Objectives of BCC Strategies for Adolescent Pregnancy

The BCC strategies particularly aim to promote positive and healthy behaviors that discourages or prevent too early sexual initiation and pregnancy among adolescents. Through effective BCC strategies, it is hoped that adolescents, as the primary target audiences, will be able to acquire and develop knowledge, attitudes, norms, behaviors, and life-skills or competencies necessary to avoid too early and unintended pregnancy as they progress towards the realization of their full potential. One important BCC strategy is to work in partnership with the stakeholders such as families, schools, health services and communities to influence the social norms and policy environment within which adolescents function. Specifically, the BCC initiatives identified in this Sourcebook aim to:

- Identify and analyze behavioral as well as relevant non-behavioral problems associated with too early and unintended pregnancy as basis for communication planning;
- Formulate right messages targeted to specific and appropriate audiences using the most appropriate communication media and channels;
- Design appropriate communication strategies that influence young people's and other stakeholders' attitudes, behaviors and decision-making skills that, in turn, enable young people to delay sexual initiation, abstain from sex, practice protected sex, and avoid multiple sex partners.

The options for BCC strategies are basically identified according to the desired behavior of different types of intended audiences and the most effective communication messages and media that can influence their behaviors. The communication interventions are likewise identified to address the major factors (attitude, norms, self-efficacy, values) affecting the behaviors of these target audiences as identified in the conceptual framework in the previous Section. Options for interventions focusing on behaviors of secondary audiences to address the environmental and background factors through other communication strategies such as advocacy and social mobilization activities are likewise provided to support specific BCC interventions.

B. CONSIDERATIONS IN DESIGNING BCC STRATEGIES FOR ADOLESCENT PREGNANCY

The issue on adolescent pregnancy is a highly sensitive and controversial issue especially within the cultural context of the country. While it is recognized as a development concern among adolescents as it impact on their well-being, the proposal to promote contraceptives among adolescents is not yet well accepted. Moreover, with the prevailing conservative treatment on matters regarding sexuality among Filipinos despite the modern times, educating adolescents on sexuality remains a challenging strategy because of oppositions particularly from the religious and conservative groups. Given this, keep in mind the following basic principles for your BCC interventions.

Have a deep understanding on the web of factors affecting problem behaviors

While existing literature substantially discusses factors that affect adolescent behaviors related to adolescent pregnancy, it is highly recommended that you gather primary data on the problem behaviors from your target audiences. The contexts in which various audiences behave significantly vary in terms of prevailing social and cultural norms, political dynamics, and other local conditions that may need to be considered in the design of appropriate BCC strategies. Interact with your target audience so you can understand their behaviors and get their perspectives on the strategies that suit their conditions. Conduct research to provide you with information on the extent and causes of adolescent problem behaviors and which will give you a guide in designing and implementing BCC strategies. Lastly, adopt or develop a theoretical or conceptual framework that can guide you in identifying the needed information in your research or studies.

Involve the adolescents in the design and implementation of the BCC strategies

Ensure youth participation in the entire BCC planning and implementation process to make the interventions more relevant and effective. Adolescents know their needs and the corresponding interventions. The most you can do is to facilitate, mentor, and catalyze actions that need to be done in order to address their problem conditions. By their participation, you can ensure their ownership of the interventions. You can take advantage of the idealism and positive energies of the young people in leading their fellow adolescents to take the appropriate road towards the achievement of their aspirations and potentials.

Mobilize the community

The parents, relatives, community leaders, local officials, and all the stakeholders need to be mobilized. These stakeholders have direct and indirect impact on the adolescents' behavior as they live in the same environment where they interact with each other. As such, assess the role of each element of the community and identify what they can contribute to the initiative. A BCC strategy directly influencing the adolescents' behavior may not be effective when their environment remains unfavorable for the desired behavior among adolescents.

Focus on what matters most rather than on a wide range of interventions that may not be effective at all

Since adolescent pregnancy is caused by a web of causal and behavioral factors, the tendency for program managers and planners is to attempt to address all these factors at the same time. Given the limitation in funds, careful and intelligent planning can help you appropriately and effectively invest in high impact activities. Deliver the message right and straight to the appropriate target audience; involve the right target audience; and focus on factors that can be controlled and managed. Do not be satisfied by the number of activities that you have conducted but be more concerned of the number of adolescents who benefited from such activities. In short, the quality of the interventions is what matters.

Have a detailed communication plan

An action is more likely to succeed if it is carefully planned. You may use the plan not only for identifying the programs and interventions to be implemented but also for ensuring the performance of the roles of each stakeholder. The plan is also important in meeting schedules and in programming resources. Without the detailed communication plan, you may come up with interventions that are less effective.

Undertake the rigors of the BCC planning process to make initiatives more effective

There is no shortcut to effective planning and designing of BCC strategies. BCC planning is a meticulous process but it ensures that all important aspects are covered. Its processes are not merely procedural but are designed to allow the communication planners and program managers to identify the salient factors that can serve as the clues for appropriate strategies. While there may be no standard steps to follow in designing BCC strategies, it is important that communication planning follows a systematic and organized process to effectively design effective strategies and to efficiently allocate available resources. As the cliché goes, "half of the work is done with effective planning."

Do not reinvent the wheel

There are always some interventions that are successful in promoting healthy sexual behaviors among adolescents. Check on these existing interventions, study them if they can be adopted depending on your analysis of the causes and behavioral factors that affect your targeted behaviors. These good practices demonstrate concrete examples of how successful BCC interventions should be. There are also existing training materials and manuals from various agencies that you can refer to in filling-in the substance or content of your strategies.

Always test BCC interventions

Testing of BCC interventions is a necessity. It informs you of the intervention's effectiveness and areas that can be strengthened. Testing is actually cost-beneficial because it enables you to have a preview on the impact of the initiative before it can even be implemented in a larger scale, thus, mitigating waste of resources. By enabling you to avoid undesirable or low impact component of the project, you can be more effective in your strategies.

Always document, monitor, and evaluate interventions

Documentation, monitoring, and evaluation are important steps and integral parts of any BCC strategy. A good intervention cannot be considered to have happened at all when undocumented. Documentation, monitoring, and evaluation provide bases for identifying emerging and important issues that need to be addressed in order make the intervention more effective and efficient. These steps help you check whether or not you are achieving your goals and objectives. Otherwise, you may repeat interventions that do not have an impact resulting in lost of opportunities and waste of resources.

Be persistent and unwavering in your desire to develop positive behaviors

Working with behavior change entails unwavering and persistent desire and enthusiasm to promote the desired behavior. Many of the factors associated with adolescent pregnancy are deeply rooted. It may take time to change them and establish new patterns of healthy and positive normative behaviors among the target audiences. You need to be persistent and not be discouraged by unintended results of your intervention. Take stock of the lessons that you have learned from your experience and consider them in enhancing your interventions. Always bear in mind that a single adolescent who developed the desired behavior through your intervention can serve as the seed that can multiply in hundred folds.

C. LEGAL MANDATES THAT CAN GUIDE THE DESIGN OF THE BCC STRATEGIES

The legal foundation of any program intervention is a critical aspect of designing BCC strategies particularly for preventing adolescent pregnancy. These legal mandates justify certain strategies and provide basis for undertaking certain actions. They solidify the acceptability of designed strategies. As such, in designing BCC strategies, you need to familiarize yourself with some of the important legal frameworks to rationalize your strategies.

In March 2010, the inter-agency National Technical Committee on Adolescent and Youth Health and Development (NTCAYHD) of the Department of Health prepared the Primer on the Legal bases for Adolescent Health Services in the Philippines to provide health service providers and stakeholders ready reference on existing legal mandates dealing with adolescent health and development. You may refer to this in Annex F.

In brief, the following relevant laws provide for the welfare and well-being of the children, adolescents, and youth:

1. International Agreements

1.1. The Convention on the Rights of the Child

This international treaty recognizes the human rights of children, defined as persons up to the age of 18 years. The Convention establishes in international law that states parties must ensure that all children—without discrimination in any form—benefit from special protection measures and assistance; have access to services such as education and health care; can develop their personalities, abilities and talents to the fullest potential; grow up in an environment of happiness, love and understanding; and are informed about and participate in, achieving their rights in an accessible and active manner.

1.2. The International Conference on Population and Development

The ICPD Program of Action (PoA) is a milestone international agreement forged by about 179 countries including the Philippines in 1994 (Cairo, Egypt). This spells out the strategies that promote reproductive health and the integration of population in sustainable development. It also promotes the reproductive health of adolescents by recommending to all participating country to:

- meet the special needs of adolescents and youth, especially young women, with due regard for their own creative capabilities, for social, family and community support, employment opportunities, participation in the political process, and access to education, health, counselling and high-quality reproductive health services;

- encourage children, adolescents and youth, particularly young women, to continue their education in order to equip them for a better life, to increase their human potential, to help prevent early marriages and high-risk child-bearing and to reduce associated mortality and morbidity;

- provide active and open discussion of the need to protect women, youth and children from any abuse, including sexual abuse, exploitation, trafficking and violence to be supported by educational programmes at both national and community levels. Governments should set the necessary conditions and procedures to encourage victims to report violations of their rights. Laws addressing those concerns should be enacted where they do not exist, made explicit, strengthened and enforced, and appropriate rehabilitation services provided. Governments should also prohibit the production and the trade of child pornography.

- provision of information that helps them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction. This effort is uniquely important for the health of young women and their children, for women's self-determination and, in many countries, for efforts to slow the momentum of population growth.

1.3. The Convention on the Elimination of Discrimination Against Women (CEDAW) Treaty

The CEDAW provides the blueprint for promoting basic human rights, achieving progress and overcoming barriers of discrimination against women and girls. This is reinforced by the Beijing Platform for Action which provides for the affirmative action that the State has to perform in order to address the inadequacies and unequal access to health care and related services of women, children, and adolescents. Likewise, the Recommendation No. 15 of the CEDAW Committee provides that the State should intensify efforts in disseminating information to increase public awareness of the risk and effects of HIV infection and AIDS, especially among women and children. The reproductive and subordinate role that women and children occupy in the society must be given special attention.

2. National and local laws and policies

2.1. The 1987 Philippine Constitution

The Constitution provides that "(t)he State recognizes the vital role of the youth in nation-building and shall promote and protect their physical, moral, spiritual, intellectual and social well-being. It shall inculcate in the youth patriotism and nationalism; and encourage their involvement in public and civic affairs."

2.2. The Youth in Nation-Building Act (Republic Act No. 8044)

This law provides for the establishment of a National Comprehensive and Coordinated Program on Youth Development based on the principles of promoting and protecting Filipino youth's physical, moral, spiritual, intellectual and social well-being; inculcation of patriotism, nationalism and other basic desirable values to the youth; encourage the youth to be involve in character-building and development activities; and mobilization of the youth's abilities, talents and skills and redirecting their creativity, inventive genius and wellspring of enthusiasm and hope for the freedom of our people from fear, hunger and injustice.

2.3. The Magna Carta of Women (Republic Act 9710)

This is a comprehensive women's human rights law that seeks to eliminate discrimination against women by recognizing, protecting, fulfilling and promoting the rights of Filipino women, especially those in the marginalized sectors. It specifically provides for the provision of comprehensive, culture-sensitive, and gender responsive health services and programs covering all stages of a woman's life cycle and which addresses the major causes of women's mortality and morbidity must be provided by the State at all times. Access to the following services must be ensured: (a) family and State collaboration in youth sexuality education and health services without prejudice to the primary right and duty of parents to educate their children; (b) prevention and management of reproductive tract infections, including sexually transmitted diseases, HIV, and AIDS; and (c) prevention of abortion and management of pregnancy-related complications. In addition, women in all sectors must be provided by the State with appropriate, timely, complete, and accurate information and education on all aspects of women's health in government education and training programs.

2.4. The Philippine AIDS and Control Act of 1998 (Republic Act No. 8504)

The law provides for the prevention of HIV/AIDS through provision of accurate information and data on the disease specifically in school curricula and in health facilities and services.

2.5. The Trafficking in Persons Act of 2003 (Republic Act No. 9208)

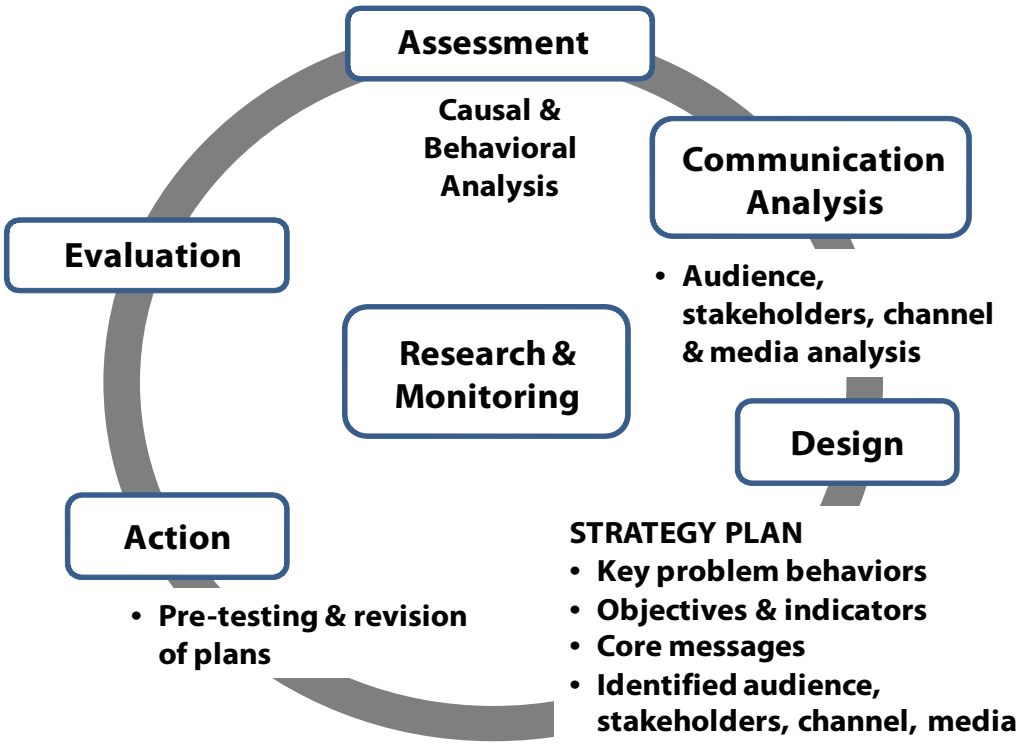
This law provides protection for women and children against acts related to trafficking in persons.

In rationalizing your BCC strategies, you may also cite or refer to local ordinances that provides for policies and programs related to adolescent health and development. These ordinances or local policies may also provide inputs on the gaps in the policies and programs that may be advocated.

D. STEPS IN THE BCC PLANNING PROCESS

In designing BCC strategies, you can use the systematic planning process as illustrated below. The framework is adopted from the processes applied in UNFPA BCC programming (Chen, 2006) for reproductive health concerns. It consist of a) assessment (i.e. causality and behavior analysis); b) communication analysis (i.e. stakeholders, audience, channel and media analyses), and c) designing and implementing actions. This process is also called as the ACADAE communication planning process (Chen, 2006). The ACADAE process is an iterative cyclical process.

Figure 2. The BCC Planning Process



Source: Peter Chen (2006)

1. PREPARATORY ACTIVITIES

1.1. Assessment: Causal and Behavioral Analysis

Your design of BCC strategies for adolescent pregnancy starts from understanding the dynamics of the development and health issue. You need to have a deep understanding of the

problem behaviors and its proximate and underlying causes to be able to identify the areas of interventions. The causal and behavioral analysis answer the questions: "What is the behavior problem?" and "Why are some people behaving this way?" (Chen, 2006). An in-depth analysis of the causes and the factors affecting the problem behaviors can provide a picture of what responsive and appropriate strategies to take.

In causal analysis, include the assessment of factors directly or indirectly influencing early and unintended pregnancy among adolescents. Indirect factors are those that have direct impact on adolescent pregnancy while indirect factors are those that determine the direct determinants but have underlying impact on the problem behavior. Root causes or those factors that are already embedded or ingrained in the culture and society which would need radical interventions and change in societal norms, values, environment, and policies are also analyzed in relation to their impacts on adolescent pregnancy.

1.1.1. Theories that can guide the causal and behavioral analysis

To guide conceptually the behavioral analysis, you can adopt existing theoretical and conceptual frameworks on behavior change. Since behavior change is generally complex, theories are important because it identifies patterns and causal relationships among beliefs, attitudes, and actions as key elements of behaviors. An established framework can help you in explaining behaviors and behavior change at the individual, interpersonal, community, and ecological levels. Depending on the desired behavior of your target audience, you may use existing theories to focus on factors that hinder such desired behaviors. This Section provides you with a brief description of the behavioral change theories but it is highly recommended that you read other pertinent literature to deepen you understanding and appreciation of these various models. Each model has their own strengths and limitations depending on the strategies that you would want to adopt. With deep understanding of these theoretical frameworks, you can select the most applicable model for your project. These theoretical frameworks include:

a) The Health Belief Model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. The model focuses on the attitudes and beliefs of individuals. It was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services to respond to the failure of a free tuberculosis (TB) health screening program. It eventually evolved as tool in exploring a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS.

The HBM postulates that a person will take a health-related action if that person: 1) feels that a negative health condition can be avoided, 2) has a positive expectation that by taking a recommended action, he or she will avoid a negative health condition, and 3) believes that he or she can successfully take a recommended health action.

The HBM uses the following constructs to account for the readiness of an individual to act: a) perceived susceptibility, b) perceived severity, c) perceived benefits, and d) perceived barriers.

The "cues to action" activates such readiness and stimulate overt behavior. The concept of 'self efficacy' is likewise central to HBM. Self efficacy looks at a person's belief in his or her ability to make a health related change. One's ability to do something has an enormous impact on his or her actual ability to do it.

b) Stages of Change Model

The Transtheoretical or Stages of Change Model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997) describes how people modify a problem behavior or acquire a positive behavior. The model construes change as a process involving progress through a series of five stages.

1. **Precontemplation** is the stage in which people are not intending to take action in the future to change certain problem behavior. People do not intend to discontinue the behavior because they may be uninformed or under-informed about the consequences of their behavior; or they may have tried not to engage into such behavior but are pressured by their peers.

2. **Contemplation** is the stage where people are intending to change their behaviors. They are more aware of the advantages and disadvantages of changing their behaviors but are not yet taking action to effect the desired change. These people are likewise not ready for traditional action oriented programs.

3. **Preparation** is the stage in which people are intending to take action in the immediate future. People in this stage have already taken action such as gathering of information, and participation in relevant activities to appreciate planned actions to facilitate further the change in behavior.

4. **Action** is the stage in which people have made specific overt modifications in their behaviors and life-styles. Since action is observable, behavior change often has been equated with action.

5. **Maintenance** is the stage in which people sustain their changed behavior and are working to prevent relapse but they do not apply change processes as frequently as do people in the action stage. They are less tempted to relapse and increasingly more confident that they can continue their change.

c) Social Cognitive (Learning) Theory

The Social Learning Theory (SLT; Bandura,1969, 1973, 1977a, 1986; Bandura & Walters, 1963) postulates that portions of an individual's knowledge acquisition can be directly related to observing others within the context of social interactions, experiences, and outside media influences. It also holds that behavior is influenced by environmental factors, and not just psychological or cognitive factors. Thus, social learning theory assumes that psychological and environmental factors combined influence the development of specific behaviors.

Theoretically, the SLT explains external factors such as peer pressures and media to adolescents behavior towards early pregnancy. If an individual never observed problem behaviors, such as adolescents engaging in sex, then those behaviors would never be learned. Once it is adopted, the behavior leads to positive consequences or outcomes, e.g., acceptance by the group, sense of power, attention of peers, establishment of a group role that instills a sense of pride, and others. The degree of positive reinforcement will determine whether the behavior is continued. Group norms become a power base for this reinforcement.

Another factor that influences behavior is self-efficacy. Self-efficacy is the belief that one can successfully engage in a behavior that is required to produce a desired outcome. Self-efficacy is a critical factor in cognitive and behavioral change since it determines the execution of learned cognitive and behavioral coping skills.

d) Theory of Reasoned and Planned Action

The theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) assumes that individuals are usually quite rational and make systematic use of information available to them. People consider the implications of their actions before they decide to engage or not to engage in a given behavior. The intention (motivation) to perform a certain behavior is dependent on whether individuals evaluate the behavior as positive (attitude), and if they judge others as wanting them to perform the behavior (subjective norm).

This theory is extended into the theory of planned action (Ajzen, 1989, 1991, 2001) which holds that no behavior is executed under purposeful control and that behaviors can be on a continuum from total control to complete lack of control. Both internal factors (cognitive skills, knowledge, emotions) and external factors (situations or environment) determine the degree of control.

The theory of planned action is based on the connection of attitudes and behaviors. Behavior is guided by three kinds of beliefs and cognitive outcomes. The first is the behavioral beliefs which pertain to the subjective probability that the behavior will produce a given outcome. The second type is the normative beliefs which pertain to perceived behavioral expectations of others on the desired behavior. It is assumed that these normative beliefs result in the degree of social pressure to comply (outcome) or subjective norm (they think others, e.g., peers, want them to perform the behavior). The third kind of belief is the control beliefs which have to do with the perceived presence of factors that may facilitate or impede performance of a behavior. These control beliefs (in combination with the perceived power of each control factor) determine the prevailing perceived behavioral control. Specifically, the perceived power of each control factor to hinder or facilitate performance of the behavior contributes to perceived behavioral control in direct proportion to the person's subjective probability that the control factor is present.

e) Problem Behavior Theory

The Problem Behavior Theory (Jessor, 1987, 1991, 1998; Jessor & Jessor, 1977) explains primarily the dysfunction and maladaptation in adolescence. The theory holds that all behavior emerges out of the structure and interaction of three systems of psychosocial components - the personality system, perceived environmental system, and the behavior system.

When the personality system and perceived environment system clash, behavioral problems become manifest (Jessor, 1987). The most prominent features of the adolescent personality include: impulsivity; risk-taking; perceived invulnerability ("can't happen to me"); struggling to find personality identity; errors in thinking due to being locked into normative peer culture ("everybody does it"); and rebellion towards authority. These features, coupled with the disturbances in psychosocial adjustment, clash with the norms and expectations of the culture and society (e.g. engage in sex only during marriage) resulting in problem behavior (e.g. early engagement in sexual activities). It is important to recognize that early adolescent pregnancy is part of a behavioral system that interacts with the personality and environment, and, therefore, can contribute to designing effective interventions to prevent adolescent pregnancy.

f) Integrative Model of Behavior Prediction

Recall that we used the Integrative Model for Behavior Prediction of Fishbein and Capella (2006) in the causal and behavioral analysis in Section 2. A brief discussion was supplied in that Section for you to appreciate the factors that need to be considered in analyzing the problem behaviors related to adolescent pregnancy. You may refer back to Section 2 for the description of this behavior change model.

1.1.2. Conducting the causal and behavioral analysis

a) Doing the Causal Analysis

In conducting the causal analysis, you need to find out the proximate or immediate cause of the situation; the underlying causes or the factors that directly influenced the immediate cause; and the root causes. For this analysis, you may ask the following questions:

Resulting condition: (e.g. adolescent pregnancy)		
Levels of causes	**Behavior-related causes**	**Non-behavior related causes**
Immediate cause *(What did the intended audience do or did that resulted in the situation?)*	**Example:** • *Early sexual initiation* • *Unprotected sex* • *Multiple sex partners*	**Example:** • *No available contraceptive during the sexual intercourse*
Underlying cause *(What factors pushed or caused the intended audience to do such action or behavior that resulted in the situation?)*	• *The female adolescent was not able to refuse sexual advances of male partner* • *The peers influenced the adolescent to engage in such activity*	• *No access to contraceptive* • *Parents are not present* • *Open access to pornographic materials* • *Lack of access to counseling*
Root cause *(What factors in the environment of the intended audience that facilitated the factors that pushed or caused the action of the intended audience that resulted in the situation?)*	• *It is taboo to discuss sexuality at home and in school* • *Double standards (and other gender issues) on sexuality among male and female adolescents*	• *Poor-socio economic conditions* • *Lack of political will among SK and local officials* • *Lack of policies and programs for youth*

Source: Chen, 2006

b) Doing the behavioral analysis

For behavioral analysis, you can be guided by the following key questions:

Problem behavior	Consequences	Desired behaviors	Barriers to the desired behaviors	Factors the encourage desired behaviors
(What is the problem behavior that needs to be addressed?)	*(What are the consequences of the problem behavior?)*	*(What are the desired behaviors?)*	*(What are the barriers to the desired behaviors?)*	*(What existing factors can encourage desired behaviors?)*
Example: • *Early sexual involvement*	• *Early and unintended pregnancy* • *Abortion* • *Dropping-out from school*	• *Abstinence and delayed sexual initiation*	• *Lack of control over sexual urges* • *Lack of skills to refuse sex*	• *Opportunities for diverting sexual energies into more productive endeavors*

Source: Chen, 2006

You can also gather other relevant information that can deepen or substantiate the behavioral analysis. This may include:

- Do male and female adolescents have different behavioral patterns related to their sexuality?

- What are the prevailing social norms on sexual initiation and activities among adolescents?
- What are the prevailing attitudes on sexual initiation among adolescents?
- What do adolescents currently know about the consequences of sexual initiation and activities?
- What are the prevailing gender stereotypes and expectations affecting adolescent sexual behaviors?
- What are the demographic and individual factors that influence the problem behaviors?
- What information and messages being conveyed in the media that are influencing the problem behaviors?

In gathering the needed information, you may first refer to the available data within your reach. You may gather relevant literature and secondary data that supplies information about your problem behaviors. There may also be some primary data (i.e. datasets) that were conducted by certain agencies that you can use for your analysis. Consolidate them and include them in the your database.

After you have gathered relevant literature and secondary data, assess the information gaps using your theoretical or analytical framework. You may further gather data that focus on the information gaps which you have identified. In this way, you can focus your data gathering on information that can substantiate your available data to make it more comprehensive. Equally important, focusing on information gaps can be a more efficient way of allocating limited resources for your data gathering.

1.2. Conducting the communication analysis

The communication analysis entails the identification and assessment of the most appropriate audiences and stakeholders who should be targeted and involved in a communication strategy. The analytical process also involves the formulation of appropriate messages for specific target audiences and the medium and channels through which these messages are effectively conveyed.

1.3. Identfying the target audiences

Effective communication messages and strategies are targeted to appropriate audiences. Target audiences for BCC interventions on adolescent pregnancy are the groups of people who are expected to demonstrate specific desired behavior through specific communication strategies. They are categorized into primary and secondary audiences.

Your primary audiences are those behaviorfrom whom specific behaviors are being desired or to whom desired behaviors are being promoted. It is their behavior which you would want to ultimately influence. Your secondary audiences are those that can influence the behaviors of the primary audience. You could advocate to or mobilize these people to help or support the communication intervention.

An understanding of the behaviors, attitudes, and beliefs of the audiences helps you in determining the appropriate BCC strategies. Bear in mind that various types of audiences exhibit different behavioral patterns as well as differ in the context or environment in which they live. Being very specific in targeting appropriate type of audience can help significantly in making communication strategies more effective. Segmenting various types of audiences within groups can also focus communication interventions to those who actually need the intervention. For example, while the adolescents are the primary audience in the BCC for preventing adolescent pregnancy, behavioral patterns, attitudes, norms, and behaviors towards preventing sexual initiation may be different between males and females. Moreover, the environment of adolescents in the rural areas may be different from that of those in the urban areas. Consider all these differentials among groups of adolescents to make the communication messages and interventions more responsive and effective. Profile each target audience with the description of their background characteristics and other behavioral factors. Some of the questions you can use in understanding your audience more deeply include:

- Who are the primary audiences for the BCC interventions?
- Who are the audiences whom you could target to influence the behavior of the adolescents? (secondary audience)
- What are their knowledge, attitude, beliefs, and normative behaviors on adolescent pregnancy?
- What factors affect their existing knowledge, beliefs, attitude, and behaviors?
- What are their media habits?
- What access do they have to information?
- Who are the persons who can develop or enact policies and programs for adolescent health and development concerns in the locality? (for advocacy)
- Who are the persons and institutions who can be mobilized to raise public awareness and generate support for specific communication objectives? (for social mobilization)

1.4. Identifying the Stakeholders

Identifying the appropriate stakeholders to a BCC issue is important in making specific communication strategies effective. The stakeholders to a BCC strategy are those that have interests and involvement in the problem behavior that affects the development and welfare of the adolescents as the primary audience. Identifying the stakeholders can help in mobilizing individuals, agencies, and institutions in undertaking support interventions to promote the desired behaviors among adolescents. Identify stakeholders as primary and secondary stakeholders or in order of priority in influencing or affecting the behavior of the intended audience. Determine the roles of each group of stakeholders. For this purpose, you may use the matrix to guide you in stakeholders analysis:

Desired behavior	Stakeholders	Role in BCC Strategy
Delayed sexual initiation among adolescents	**Primary Stakeholders**	
	Adolescents (10-19)	• *They are directly targeted as they are expected to perform the desired behavior to enable them to pursue their education and aspirations*
	Secondary Stakeholders	
	Parents	• *They can reinforce the desired behavior by directly influencing the behaviors, attitudes, and values of adolescents*
	Peers	• *They can exert pressure to their peer adolescents to engage in certain activities and behaviors as part of their task to belong*
	Teachers	• *They can influence in the cognitive as well as psycho-social development of the adolescents*
	Health workers	• *They can provide information and needed services to adolescents*
	NGOs	• *They can provide necessary ASRH information and services especially in the community level*

Source: Chen, 2006

Ideally, target audiences and stakeholders should be segmented further into more detailed characteristics such as experience in sexual intercourse (e.g. those with sexual experience versus those who have not) and socio-economic conditions (e.g. poor adolescents versus those with adequate income), among others, to make the interventions to be more effective. Where applicable, the segmentation and stratification of target audiences and stakeholders should be done.

1.5. Developing appropriate messages

An essential element of a BCC strategy is the message for the target audiences. Your message is what you would want your audience to believe, consider, and act. Right message produces the right and desired behavior.

Convey your messages to each specific audience to make it more personal and relevant. Tap into the existing values of each target audience that helps to overcome the barriers or misconceptions they may have. By connecting with each audience's existing values, you can create common ground and more easily motivate the audience to act. Think about the issue from your audience's perspective. Where is your audience when it comes to your issue? Are they ready for what you want to tell them? The most effective messages are designed to meet your audience where they are, and move them toward your point of view.

Focus and make a few strong and memorable points to make your message more effective. Do not convey multiple messages and leave your audience to decide which one is the most important because this may not be effective. Your message should contain no more than four

points. Each point may include sub-points, but the main points need to be both concise and compelling. You may frame your message in the following ways:

1.5.1. Connecting with the values of the target audience

Framing the message to connect it with the existing values of the target audience makes the message more personal to them. This framing aims to develop a personal connection to the issue or message so they care. Thus, make the issue relevant by appealing to their values and lifestyle, or by connecting the issue to their family, friends or community. Emphasize the benefits of believing and doing the message as they relate with their current lifestyles, values, and personal circumstances. For example, you may connect the values attached to education and the advantages of delaying sexual initiation.

1.5.2. Informing and breaking the barrier

You may also frame your message to inform or communicate information that overcomes a key barrier that could prevent the audience from buying into your message. Building the will to act means overcoming the barriers or misconceptions your audience may have. In breaking the barrier, you are not only sharing information to correct misconception or misinformation but you are also trying to ease the audience's perceived risk and disadvantages about the issue. You can overcome the barriers by respecting the audience's comfort zone and asking them to take a manageable action that fits their lifestyle. You can also position the action as the social norm. You must offer hope for positive change, and show that the benefits of taking action outweigh the risks. For example, you may emphasize that it is okay to delay sexual initiation even when their peers do not because in the end they can have better lives; or more positively, you may emphasize the fact that "everybody is not doing it" (sexual initiation), there are more Filipino adolescents who remain committed to their aspirations than those engaging in risky behaviors.

1.5.3. Asking the audience to do something

A message can also focus on getting the target audience to do something in order to achieve the desired behavior. Actions required may not be directly the desired behavior but may include basic steps or behaviors that can lead them towards the desired behavior. The requested action or behavior should be specific and doable. For example: "Consult your peer counselor!"

You may use each of the sample message frames (in Sections 5.1 to 5.3 above) as the basic element of your message or use any of the frames. This is why it is important for you to analyze their behaviors deeply so that you may know what specific component of the problem behavior you would want to influence.

1.6. Identifying the Communication Channel

Selecting the right communication channel is as important as your message. Communication channels pertain to the person or personality that you may use to convey the

message to the intended audience. You can consider the guide questions below in selecting your appropriate communication channel:

Target Audience	Group Affiliation	Location of the Target Audience	Persons to whom adolescents confide or consult	Persons who can influence the target audience
Who is the target audience?	*To what organizations or groups (social, civic, religious, economic) the target audience is currently affiliated?*	*Where does the target audience spend most of his time?*	*Who does the target consult or confide with most of the time?*	*Who can influence the target audience?*
Example: • *Adolescents who have not yet sexually debuted*	• *Sanggunian Kabataan* • *School clubs* • *Fraternities and sororities* • *Youth organizations*	• *Computer shops* • *Malls* • *Schools* • *Tambayans*	• *Parents* • *Peers/ friends* • *Teachers* • *Siblings*	• *Parents* • *Peers/ friends* • *Teachers* • *Siblings*

Source: Chen, 2006

1.7. Developing and choosing communication media or materials to use

Communication media and materials pertain to the forms and equipment by which messages can be conveyed. To be cost-effective, you need to have a comparative analysis of the various types of media and materials that could be used in conveying messages for adolescent pregnancy in terms of their effectiveness, advantages, disadvantages, limitations, cost, reach and accessibility among the target audience. Some materials may be more effective in transmitting one type of message better than others. Some materials are best suited for transmitting general information, while others are better at creating an image or atmosphere. Consider the following:

Media	Advantages	Limitations
GRAPHICS AND PRINTED MEDIA	• The least costly among other types of media • Ready reference, retrievable, and reusable • Many audiences prefer text (reading) in learning over visuals • May be used and distributed in variety of settings • May be produced locally	• Audience should be literate • Sometimes, the health workers or distributor of the materials need training to explain the content of the material
• Posters	• Cheap and can be posted in conspicuous places • Can reach to a number of audiences at the same time	• Good only for limited messages • Limited to audiences who are in areas where it is posted

Media	Advantages	Limitations
• Handouts/ Leaflets/ Brochures	• The materials can be taken home, kept in the bag, and to be read when intended audience is convenient • Cheap and handy	• Limited to individual reader • Can contain limited information
• Flip Charts	• Useful in training • Can also serve as poster	• It needs instructor to explain its content
• Magazines	• Can reach many readers • Can be graphically appealing • Can contain substantial information • Appealing to adolescents	• Not all audiences have time to fully read the materials especially when too textual • More expensive especially in full colors
• Newspapers	• Dailies reach wide number of audiences • Factual and can keep audiences abreast with real situations	• Limited reach in rural areas and among the poor since it has a cost
ELECTRONIC MEDIA	• Used widely and are more popular	• Needs electricity and can be expensive
• Radio	• Can reach to a number of audiences at the same time • Less costly than television airtime	• Usually popular in the rural areas • Dependent on electricity and battery
• Television	• Simulates real life situations through display of visuals and sounds • Most popular media • Has the widest reach	• Airtime is too expensive • Poor families usually do not have televisions
• VCR/DVD/Films	• Same as TV • It can be replayed	• Sensitive and can be easily scratched and destroyed • Needs electronic player
• Internet and On-line media	• Open and most accessible source of information on about anything • Getting popular among adolescents • Can be accessed anywhere	• Can be a sourced of conflicting messages • Largely dependent on internet connection • Poor families have no access to internet
• Phone (text and call)	• Accessible and effective means of connecting people • Can personally reach the audience	• Dependent on line connection • May be expensive
INNOVATIVE AND CREATIVE MEDIA		
• Folk-media	• Low cost and acceptable among local audience • Entertaining	• Folk media is a "dying" medium • Requires constant financial inputs for sustainability

2. ACTUAL DESIGNING AND DEVELOPMENT OF BCC STRATEGIES

Based on the information generated from the causal, behavioral, and communication analyses, you can now begin to identify and design a coherent BCC strategies for adolescent pregnancy. You may develop and implement various options that can reach out to various target audiences towards the achievement of your BCC goals or desired behaviors.

In addition to BCC strategies, identify and plan for other communication strategies that could complement the promotion of the desired behavior among adolescents. These communication strategies include: Advocacy, Social Mobilization, and Information, Education, and Communication (IEC). Below is the basic difference of these various communication strategies.

2.1. Advocacy

Advocacy is set of targeted actions directed at decision-makers in support of a specific policy or program issue. As a process, advocacy is creating support, strengthening that support through consensus building, and fostering a favorable climate and a supportive or enabling environment toward a specific cause or issue (POPCOM, 2001). Your intended audiences for advocacy are usually the legislators, executives, program managers, and their gatekeepers. The usual outputs of an advocacy effort are the enactment of relevant policies or laws, development of specific programs, allocation of budgets, and commitment from the decision-makers on the cause.

The same with BCC, advocacy entails a planning process which involves: a) data collection; b) identification of advocacy issues, goals, and objectives; c) stakeholders analysis; d) developing advocacy messages and communication channels; e) establishing advocacy networks/coalitions; f) policy advocacy; g) resource generation; and h) monitoring and evaluation (POPCOM, 2001).

2.2. Social Mobilization

Social mobilization is the process of gathering and bringing together all potential partners and allies to carry out a common goal, express a common sentiment, or raise public awareness on certain cause or issue (Chen, 2001 & UNICEF, 2006). It involves the identification of groups, organizations, agencies, networks, and individuals who can work collectively towards a common objective and are willing to share their resources and expertise. Since it involves multi-sectoral groups collectively moved into single action, you need consultative and participatory planning and development of social mobilization activities. You may also mobilize these organizations to support advocacy and BCC initiatives.

2.3. Information, Education, and Communication (IEC) Materials

IEC originally pertains to a broad range of communication strategies aimed specifically at informing the public and individuals. It covers printed and interpersonal communication strategies. However, for purposes of this Sourcebook, IEC pertains specifically and exclusively to communication materials aimed at disseminating information to specific target audience.

3. Monitoring and evaluating BCC Strategies

Monitoring and Evaluation (M&E) are important components of any intervention program since they tell you if and how program activities are working. You need to monitor and evaluate communication strategies for you to know whether your desired results are achieved or not; what areas are working and which are not; and, what needs to be done to rectify some bottlenecks in the process of implementation.

You need to assess the quality of activities and/or services and the extent to which the strategies are reaching its intended audience. With adequate data, you can set priorities for strategic planning, assess implementation needs and obtain feedback from the target audience or program participants. You can then prioritize resource allocation, inform future interventions, and decide to sustain effective program components.

3.1. Monitoring

You conduct monitoring regularly to assess whether or not your BCC strategies are going on the right track. You need to know in an ongoing basis whether planned activities are being carried out. Monitoring results reveal whether program activities are being implemented according to plan, and assess the extent to which communication activities are being delivered.

In monitoring, you usually look for input and process indicators. This may include information on the various inputs, resources, and processes needed in the achievement of the desired outputs. You may look into the number of communication media materials produced and disseminated (posters, flip charts, TV/Radio spots, etc); number and types of training workshops conducted (TOT, peer education, etc); amount of resources mobilized; number and type of communication activities conducted and the number of its beneficiaries, among others.

3.2. Evaluation

You measure behavior change by the performance of the desired behavior among your target audiences. You measure such level of change through evaluation. You may evaluate the extent to which expected outcomes are achieved, and to assess the impact of the communication strategies in the target audience. Conduct outcome evaluation when you want to determine whether the desired behavior is being effected. Conduct impact evaluation when you want to determine how the desired behavior impacted on the desired condition among the target audiences.

Section 7 provides you with more detailed information on the indicators that you should measure for your monitoring and evaluation activities. You may refer to such section in designing your monitoring and evaluation schemes.

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4

SECTION

BCC Strategies for Delaying Sexual Initiation among Adolescents

This Section and the two succeeding sections provide options for BCC strategies that promote healthy and positive behaviors for preventing early and unintended adolescent pregnancy. You may adopt these strategies as part of your larger program on adolescent and youth development at the national or local levels or as independent initiatives depending on your objectives.

A. THE DESIRED BEHAVIOR

Sexuality is a significant component of adolescents' development and well-being. Their relationships with the opposite sex, their perception of their roles and behaviors as male and female, and their sexual behaviors or expressions of their sexuality, among others, are an integral part of their growth. Their capacity to understand and nurture their sexuality in a healthy manner can lead them in achieving their developmental tasks.

Healthy and positive sexual behaviors among adolescents consist of behaviors that, in and of themselves, have no negative health effects, and that such behaviors enable adolescents for healthy adolescent sexual development. In the context of early and unintended pregnancy, healthy sexual behaviors involve choices, decisions, and overt actions that can prevent them from getting pregnant and acquiring sexually transmitted diseases. For purposes of this Sourcebook, the key healthy and positive sexual behaviors include: a) delaying sexual initiation; b) using contraception during penetrative sex; and c) abstinence from sexual intercourse.

Delaying sexual initiation is refraining from sexual intercourse at a young age. More than the age factor, delaying sexual initiation promotes restraint to penetrative sexual activities in the context of the risk of unintended pregnancy. Specifically, delaying sexual debutentails suspending sexual intercourse until such time that adolescents are already prepared to physically, mentally, psychologically, socially, and financially assume the responsibilities and demands of pregnancy, childbirth, and childrearing. While level of preparedness is relative, it is to be understood in the context of an individual's capacity to have healthy pregnancy and childbirth, and to provide all the needs of the child and that of the mother to ensure their welfare and well-being. Preparedness assumes that adolescents have already achieved their aspirations and desired development conditions.

Delaying sexual initiation also involves the management of sexual urges and avoiding circumstances and activities that can lead them into unintended sexual intercourse.

1. What behaviors can support delayed sexual initiation

1.1. Recognition and Healthy Expression of Sexual Urges and Intimacies

As discussed in Section 2, sexual drive during adolescence increases dramatically and it pushes adolescents to engage in sexual activities. While sexual urges are biological processes and cannot be consciously and willingly controlled, they can be managed and diverted to healthy avenues. Adolescents need to be aware of their sexual urges and to recognize that these are part of their sexuality. It is important that they do not repress these feelings and sexual energies so that they do not become sexual issues during the later years of their development.

As part of delaying sexual initiation, sexual urges and feelings may be expressed as healthy behaviors or in a manner that it does not expose the individual or his or her partner to health and psycho-social risks. Healthy sexual behaviors include expression of intimacies and affections through spending time with another person, holding hands, kissing, petting, and other acts of sexual intimacies and expressions done within sexual boundaries (i.e. outside of forced sex and penetrative sex that can result to unintended pregnancy).

Adolescents may maintain sexual intimacies and affections but limited to actions that cannot lead them to sexual intercourse. Diverting sexual urges entail having firm positive values, discipline, psycho-social maturity, life-skills or competencies, and enabling environment such as supportive parents and peers.

1.2. Assessing readiness and capacity to act on the implications of one's sexual decisions

Adolescents should be able to decide for themselves when and how to engage in sexual activities as part of their sexual rights. However, their decision to engage in sexual activities should be based on adequate knowledge and information especially about the consequences and implications of their actions – on their own well-being and that of their partner. This also entails a deep self-awareness especially on their sexual intentions and their capacity to responsibly assume the consequences of their actions. It is, therefore, necessary that adolescents are able to access or be provided with adequate and relevant information on matters related to their sexuality concerns as bases for their sexual decisions.

1.3. Focusing on aspirations despite negative peer pressure

Both male and female adolescents should be clear and firm on thethe realization of their aspirations and decision to delay sexual initiation. They should seek and satisfy the need to belong as part of their growth in a manner that enhances their ability to achieve their individual potentials rather than to gain false recognition and sense of belongingness. An enabling group respects the decisions and choices of their members and facilitates their growth rather than creating hindrance to their goals and dreams in life. Adolescents should only identify with groups that can help them grow.

1.4. Demanding information and being critical of messages from media

Adolescents should also be knowledgeable and fully informed on matters pertaining to their sexuality to enable them to express their sexuality in a healthy manner. Demanding and seeking relevant information from concerned agencies and institutions should be pursued by adolescents themselves through organized and individual actions. Adolescents should also be critical of the messages and information they receive from media and other sources of information.

1.5. Demanding necessary services

Adolescents should exercise positive health-seeking behavior which involves demanding appropriate ASRH information and services from public and private health facilities. Adolescents should also seek information from people who could provide the accurate information on their ASRH concerns. These people include their parents, health services providers, peer counselors and educators, teachers, health professionals, trained youth leaders, and other possible sources of correct information.

2. Behaviors of Secondary Audiences that can support delay sexual initiation among adolescents

Secondary audiences are the persons who you can approach to directly influence the behaviors of the adolescents as your primary audience. These people are within the immediate circle of the adolescents from whom adolescents get information and support. Secondary audiences should be included in your BCC planning to make your strategies more comprehensive and effective.

2.1. Parents and guardians

Parents are the closest person who can influence the attitude and behaviors of the adolescents. They are the primary sources of information especially during the formative years of the adolescents. Parenting styles and disciplinary measures significantly influence the formation of the adolescents' values and moral foundation.

Parents can educate their children and encourage their adolescents to decide for themselves and support their decisions especially in delaying sexual engagement. Parents should be effective role models especially on behaviors regarding sexuality. They should also be able to initiate discussions on sexuality and relationships and must be prepared to respond constructively to inquiries raised by their adolescents. They should be effective in communicating with and informing their adolescent children about accurate information on sexuality concerns to guide them in making responsible decisions. There is a need for openness and honesty to build a safe environment that will nurture trust and respect.

2.2. Peers and friends

Peers can strongly influence adolescents because of their need to belong. As mentioned in Section 2, peers become the primary sources of information and role models in the absence of parental or adult guidance. Capitalizing on their direct influence on their peers, adolescents may guide and support each other to make healthy and responsible decisions about their sexuality through role modeling and providing accurate and relevant advice.

2.3. Teachers and mentors

Teachers are primarily responsible in forming and enhancing the cognitive faculties of adolescents. The information they get from school are necessary tools that they can use in dealing with the real world. As such, teachers can play a significant role in influencing the sexual behaviors of adolescents through the provision of accurate and relevant information. Teachers can also create venues for adolescents to communicate their sexual issues such as the sexual changes happening in their bodies, sexual relationships, and other concerns related to their sexual development so that they can be guided accordingly. As secondary parents and formator, they should be objective in responding to adolescents' sexual issues that students may consult with them. In such situations, they should be understanding and not judgmental of the situations of the adolescents who are seeking help.

Teachers are also expected to be aware about their values and attitudes towards issues on sex and sexuality to be able to recognize and respond appropriately to adolescents concerns without bias or judgment.

2.4. Religious leaders

Religious leaders can be instrumental in values formation and in building capacities of the adolescents particularly in deepening their spirituality. Religious leaders have to be knowledgeable on the development and sexuality issues and concerns of the adolescents so they may effectively guide them in developing healthy and responsible behaviors. Religious leaders should not be judgmental but caring on the welfare of the adolescents especially in their sexual development.

B. THE TARGET AUDIENCES

Type of Target Audience	Behavioral Component to be Addressed
Primary Audience	
Children aged 0-7 years	• *Values and moral conscience* • *Cognitive capacity (well-founded concept of what is right and wrong in a given circumstances)* • *Attitudes* • *Subjective norms* • *Life-skills (delayed gratification, patience, caring, etc.)*
Children aged 8-14	• *Awareness on the physiological changes happening in their bodies and skills in dealing positively with these changes* • *Values and attitudes* • *Personality development including gender identify and sexual development* • *Self-efficacy or life-skills (delayed gratification, life-planning, refusal, etc.)* • *Normative beliefs on sexuality concerns*
Adolescents aged 15-19	• *Knowledge on sexual rights and ASRH concerns and skills in dealing with related issues* • *Values and attitudes on engaging in sexual activities* • *Self-efficacy or life-skills (critical thinking, life-planning, refusal, negotiating, etc.)* • *Capacity for well-informed choices and decisions* • *Normative beliefs about sexual initiation*
Secondary Audience	
Parents and guardians	• *Knowledge and attitudes towards adolescent sexuality and reproductive health* • *Attitude and skills on communicating or discussing ASRH issues with their adolescent children* • *Awareness of their own sexuality and positive sexual behaviors*
Teachers	• *Awareness of their own sexuality and positive sexual behaviors* • *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Attitude and skills on communicating or counseling adolescents on ASRH issues*
Peers	• *Knowledge and attitudes towards ASRH* • *Skills on counseling adolescents on ASRH issues*
Religious leaders	• *Awareness of their own sexuality and positive sexual behaviors* • *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Skills on counseling adolescents on ASRH issues*
Local officials, NGOs, and youth leaders	• *Awareness of their own sexuality and positive sexual behaviors* • *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Behavior on supporting adolescent health and development related programs and services*

C. KEY MESSAGES TO PROMOTE DELAYED SEXUAL INITIATION

In conceptualizing the message to adolescents for them to delay sexual initiation, we can refer back to the Integrative Behavior Change Model and look at the components of behaviors that can be influenced by appropriate messages. From the model, we learned the three key elements that affect behaviors – a) intention, b) environmental factors, c) skills and abilities. These factors can also be used in identifying and framing the key messages of your BCC interventions.

Within the context of delaying sexual initiation, you have to do the following steps to develop your key messages for this desired behavior:

- Review the profile and characteristics of the target audiences;
- Identify the current level of their intention to delay sexual initiation;
- Identify crucial attitude, norms and social pressure, and self-efficacy factors and the degree of their influence to the intention; and
- Identify the key messages in influencing these key areas.

To complement your message development, you can also use other BCC theoretical models discussed in Section 3. These models have their advantages that can be used depending on your context (i.e. desired behaviors and factors affecting such behavior). For example, the Health Belief Model can emphasize behaviors that can be addressed towards seeking health services; the Social Cognitive Theory can be used to study how peer pressure can be addressed; the Stages of Behavior Change can be used in developing messages in each step of behavior change; the Theory of Reasoned and Planned Action can be adopted to determine necessary information to influence cognitive aspects of behavioral issues, among others.

1. Messages to promote intention to delaying sexual initiation

The table below provides you with some messages that address existing attitude, norms, and self-efficacy as direct determinants of the intention to delay sexual initiation.

1. 1. Messages to Promote Positive Attitude

Target Audience: ***Male and Female Adolescents aged 10-19 (especially those who have not yet sexually debuted whether in school or out-of-school***

Existing Attitude	Core Messages

• A more liberal attitude towards sexual initiation among adolescents
  • Sexual initiation is perceived as an increasingly normal behavior in relationships
  • Unwed mother is increasingly acceptable in the society
  • Live-in relationship is increasingly being accepted
	• Sexuality is an integral part of the personhood of every human being. For this reason, a favorable environment in which everyone may enjoy all sexual rights as part of the process of development must be created (IPPF, 2006)
	• Intimacies and affections can be expressed in healthy sexual behaviors that may not necessarily lead to sexual intercourse.
	• Love can be expressed in various means and not necessarily through sex
	• Sexual development entails self-awareness and the self-assessment of one's readiness to engage in sexual activities and to responsibly stand by its consequences

• False sense of masculinity and expected submissiveness of female adolescents • Being masculine is being sexually active or having sexual experience	• Masculinity is not about sexual prowess and exploits. It is about men's capacity to care, respect, and empower women. Modern men practices healthy and responsible sexual behavior.

• Lack of information on ASRH and adolescent pregnancy
  • Some adolescents believe that one-time sex cannot get them pregnant.
  • Some of them also believe that first-time sex cannot result to pregnancy
	• Pregnancy is conceived through the fertilization of the sperm and egg and its implantation in the uterus whether or not sexual intercourse is done for the first time or just once.
	• Being aware and knowledgeable of reproductive processes can empower adolescents to take healthy sexual behaviors
	• All persons have the right to sufficient education and information to ensure that any decisions they make related to their sexual and reproductive life are made with full, free and informed consent (IPPF, 2006)
	• Information on ASRH are vital in exercising health and positive sexual behaviors
	• Be involved and exposed to ASRH activities to know more.
	• Get information on ASRH from reliable sources (e.g. parents, health workers in school and in communities, trained peer counselors and youth leaders, teachers, and other health professionals) to make healthy and responsible sexual behavior.

1. 2. Messages to promote positive normative behavior

Target Audience: ***Adolescents 10-19 years old***

Existing Attitude	Core Messages

• Sex is perceived as a increasingly acceptable behavior among adolescents
  • Adolescents believe that 'everybody is doing it'
  • Media portrays sex and pregnancy as a normative behavior among adolescents
• Peers pressure some adolescents to engage in sexual activities
	• Not all adolescents are engaging in sexual activities. In fact, three out of four adolescents aged 15-19 years have never been engaged in sex (YAFSS, 2002). More adolescents chose to prioritize their education than engaging in sexual activities (MTYDP).
	• True friends respect the decision of their peers and guide them towards their aspirations.
	• Saying 'NO' to peers especially in unhealthy activities is a healthy choice and behavior.

• Sex is a 'condition' rather than an 'expression' of love as expressed in "kung mahal mo ko, ibibigay mo lahat sa akin!"	• In expressing ones's emotions conditions should not be imposed on another as proof thereof. • There are other ways to express one's love or affection.
• 'Manhood' and masculinity entails sexual initiation and strengthened by number of sexual encounters and exploits	• Masculinity is not about sexual prowess and exploits. It is about men's capacity to care, respect, and empower women. Modern men practices healthy and responsible sexual behavior. • Men and women are equal in sexual rights. Respect is a key to the exercise of these rights.

1. 3. Messages to promote self-efficacy

Target Audience: ***Adolescents 10-14 years old***

Existing Attitude	Core Messages
• Adolescents do not have adequate knowledge to deal with changes and tensions during the onset of puberty	• Adolescence is a exciting stage of life. Enjoy adolescence by knowing the changes occurring during this stage. • Get the right information to be well informed and to be able to choose and decide wisely. • Approach people who can provide the correct information. • Communicate with youth parents about sexuality.

Target Audience: ***Adolescents 15-19 years old***

Existing Attitude	Core Messages
• Many female adolescents cannot refuse sexual intentions and impositions of partners	• Ensuring sexual rights for all includes a commitment to freedom and protection from harm (IPPF, 2006) • All children and adolescents are entitled to enjoy the right to special protection from all forms of exploitation and coercion. • Healthy relationship entails respect of the partner's decision and individual's choices especially in terms of their sexuality • Refusing sex does not at all diminish love. Love and intimacies can be expressed in healthy sexual behaviors which does not necessarily involve sex. • Sex should not be imposed as a condition of love.
• Adolescents are exposed to risk behaviors due to their lack of accurate knowledge • Adolescents lack accurate information to make informed decision	• Adolescence is a joyful and exciting stage in life. Adolescents should grow while enjoying the experience. • Engaging in sex is a life-defining decision. It entails readiness to assume the consequences of it. Get information about ASRH to be guided. • Sexual rights have also its inherently attached responsibilities.

1. 4. Messages to address the background and environmental factors affecting behaviors

Target Audience: ***Adolescents aged 10-19 in school***

Existing Attitude	Core Messages
• Many adolescents value their education • Education is disrupted by unintended pregnancy • Adolescents engage in sex due to strong and uninformed peer pressure	• Adolescents need life skills for them to have a purpose-driven life • Delaying sexual initiation can help in preventing unintended pregnancy • Education is a key to the achievement of one's aspirations and dreams. • Setting and holding unto one's priorities entails determination to limit sexual activities that may result to unintended pregnancy • Education empowers adolescents to realize their dreams and achieve their reproductive and sexual rights; • Adolescents have the right to information, education, and services

Target Audience: ***Working adolescents and those in poor socio-economic conditions***

Existing Attitude	Core Messages
• Poor and less educated adolescents have high fertility and unmet need for family planning	• Completing education and exercising responsible sexual behaviors can help adolescents improve their socio-economic conditions • Voice out and demand your ASRH needs. Join advocacy and ASRH activities. • Adolescents have the right to access ASRH information and services they need for their healthy sexual development. • There are health services and information available in public as well as private health facilities, exercise the right to access these services.

D. BCC STRATEGIES TO DELAY SEXUAL INITIATION

Delaying sexual initiation is essentially a preventive BCC strategy. It promotes actions and behaviors that aim to enable adolescents to delay or abstain from sexual initiation. The table below provides you with BCC strategies that you may undertake in delaying sexual initiation. Again, you may adopt the strategy as a component of a larger initiative or as an independent intervention depending on your purpose and objectives.

A summary of the BCC strategies and activities as well as the corresponding advocacy and social mobilization support activities are provided below which you may adopt in promoting delayed sexual initiation.

Main BCC Strategies	Specific BCC interventions	Advocacy & Social Mobilization Strategies
Target Audience: Children aged 0-7 years		
• Building the Life-Skills and Competencies and Positive Values of Children in Formative Years to Achieve their Developmental Tasks	• Building the competencies of parents, guardians, and care givers in guiding infants and children (0-7) to achieve their developmental tasks during infancy and early childhood	• Networking and collaboration with NGOs, private sector, and academe in capacitating parents for effective parenting
Target Audience: Elementary children (8-12)		

• Building the Life-Skills and Competencies and Positive Values of School-Age Children to Achieve their Developmental Tasks	• Educating grade school children (7-12) on values necessary for delaying sexual initiation
	  • Strengthening modules and classroom-based values education
	  • Development of interactive and sustainable values education modules for out-of-school children
		• Networking and collaboration with NGOs, private sector, and academe in values education for grade school children and for out-of-school children

Main BCC Strategies	Specific BCC interventions	Advocacy & Social Mobilization Strategies
Target Audience: Adolescent aged 9-14 years		

• Building the Life-Skills and Competencies and Positive Values of Children and Adolescents to Achieve their Developmental Tasks	• Promoting and strengthening values education and formation of pre-adolescents (9-14 Years)
	  • Strengthening of modules for values education with life skills concepts in school
	  • Development of values education and ASRH Program for out-of-school pre-adolescents
	  • Classroom-based values education
	  • Development of relevant information, education, and communication (IEC) materials
		• Advocacy for the development and implementation of ASRH programs in the SK and government programs with corresponding budget
		  • Integration of ASRH trainings and IEC in SK programs and projects
		  • Development of ASRH program in the barangay and municipal level

Target Audience: Adolescents aged 15-19 years (especially for those who have not sexually debuted)		

• Promoting Life Skills-Based Adolescent Sexual and Reproductive Health (for high school and college student)	• Building the knowledge of adolescents on ASRH and other relevant issues
	  • Conduct of symposiums, forums, debates, conventions, conferences, and public discussions and discourses on ASRH issues involving adolescents especially those in high school
	  • Using creative, entertaining, and innovative activities or communication strategies to present and discuss ASRH issues and concerns in school and communities
	  • Dissemination of ASRH information using the radio, internet or on-line sites, texting, hotlines, or phones
	  • Development, production, and dissemination of Information, Education, and Communication (IEC) Materials
		• Advocacy for the development and implementation of ASRH programs in the SK and government programs with corresponding budget to include:
		  • Design and implementation of communication strategies on ASRH
		  • Mobilization of youth and health workers in communication strategies

Main BCC Strategies	Specific BCC interventions	Advocacy & Social Mobilization Strategies

	• Building and sustaining the life-skills and self-efficacy of adolescents
	  • Training of trainers an roll-out trainings on Life Skills for adolescents for both in school and out-of-school
	  • Interactive Youth Camps, Summits, and Conventions
	  • Provision of Counseling Services
	  • Peer Counseling
	  • Counseling in Health Facilities (i.e. health centers and school-based health facilities)
	  • Counseling through hotlines and on-line access
	• Conduct of entertain-educate-empower strategies such as theater presentations, brain and skills competition, script writing, and other innovative strategies in school and communities
	• Recognition of successful and model adolescents and youth in various fields
		Advocacy
		• Advocacy for the development of programs that involve the youth
		  • Entrepreneurship, livelihood, and employment
		  • Sports activities with educational component
		  • Cultural activities
		  • Youth development planning and other political activities
		  • Outreach and charity programs by the barangay or municipal government;
		  • Environmental programs
		• Advocacy for the strict prohibition of selling of liquors and illegal substances to minors
		• Advocacy for the strict regulation or prohibition of minors entering entertainment (e.g. videoke) establishments with obscene shows
		• Advocacy for the strict enforcement of laws on anti-pornography and prostitution

		Social Mobilization
		• Mobilization of adolescent and youth groups and organizations in school and communities in the following campaigns:
		  • Promotion of delayed sexual initiation and prevention of pregnancy
		  • Environmental preservation activities
		  • Enforcement of policies on anti-pornography, substance abuse, and prostitution
		  • Conduct of special events to promote ASRH messages
		• Mobilization of NGOs and community organizations for ASRH and life-skills development

1. Building the Life-Skills and Competencies and Positive Values of Children to Achieve their Developmental Tasks

1.1. Starting the BCC during the formative years

Risk factors for behavior problems occur throughout children's development, and children face new risks as they mature and encounter new challenges. Some early risks have been repeatedly tied to many behavior problems in the later childhood. Reducing these risks can possibly prevent the development of multiple problems.

Each stage of human development is interdependent and interrelated. The foundation laid during babyhood and childhood are important for some reasons. First, children do not outgrow undesirable traits as they grow older. Patterns established early in life persist regardless of whether they are good or bad, harmful or beneficial. Second, if undesirable patterns of behavior or unfavorable beliefs and attitudes have started to develop, the sooner they can be corrected the easier it will be for the child. Third, because early foundations quickly develop into habits through repetition, they will have a life-long influence on a child's personal and social adjustments. And, fourth, because learning and experience play dominant roles in development, they can be directed and controlled so that the development will be along lines that will make good personal and social adjustments possible. (Hurlock, 1982)

Children build their values and attitudes through their life experiences, observations, and interactions with significant others within their world. As they start to develop their cognitive and rational capabilities, their values are also formed through positive and negative reinforcements (right values are positively reinforced and wrong or undesirable values are negatively reinforced).

Values are important in delaying sexual initiation since they serve as the controlling variables that keep adolescents from engaging into sexual initiation. Values set the focus of adolescents towards their aspirations and motivate them to decide responsibly. They also mitigate the influence of sexual drive among adolescents by letting them prioritize their aspirations over short-lived gratifications.

To ensure that adolescents have positive and healthy values and functioning moral conscience, it is very important that these moral compass and values be formed properly during childhood or preadolescence years. The quality of values that children acquire during the formative years determines the type of decisions and behaviors that they take when they reach adolescence. As such, the most critical aspect of behavioral formation or BCC strategy among children is the formation of beliefs, attitudes, norms, values, and skills that enable them to delay sexual debut when they reach adolescence. These areas can be the focus of preventive BCC interventions.

1.2. SPECIFIC BCC INTERVENTIONS

1.2.1. Capacitating parents, guardians, relatives, and significant others on 'Effective Parenting'

Parents, guardians, and other significant others who have the responsibility of providing care for chidren are the primary target audience for BCC interventions for children in formative years. Your interventions should be centered on building the capacities of parents and even would-be parents on effective parenting with the end goal of enabling children to develop the developmental tasks necessary for them to effectively cope with the tasks during the later stages of development.

You may implement capacity building for parents on effective parenting through:

- Intensive training;
- Parent's classes (in staggered basis);
- Integration of effective parenting sessions and messages in Pre-Marriage Counseling (PMC) and communication strategies for maternal and child health (i.e. MNCHN);
- Production and dissemination of IEC materials (i.e. fact sheet, brochures, and primers); and
- Utilizing the media (i.e. talk shows on effective parenting).

1.2.2. Developing appropriate values and attitudes among children for delayed sexual initiation

In order to ensure the formation of socially acceptable and morally sound values, attitudes, and behavioral guideposts among children and preadolescents, you can support the strengthening of the values education and formation programs in formal education. Character building among children should be given equal importance as that of cognitive and skills development. Promoting and strengthening values education and formation among grade school children and preadolescents strategically provides the necessary character tools such as proper values, attitudes, and beliefs which could influence them to delay sexual initiation until they are physiologically, mentally, socially, psychologically, and financially ready.

Values formation and education are, nonetheless, confined in the four walls of the school. Much of the experiences and messages influencing the behaviors and attitudes of children are found in the home and in their community. For that reason, values education and formation programs should be extended at home or outside the school. Values education should not only be school-based but be connected with the family and home as institutional support to values formation. Community-based values education and formation programs should likewise be an integral component of the broader program to mold out-of-school children into responsible and productive individuals amidst socio-economic difficulties.

a) Key concepts and compentencies children should learn and develop

Psychologically, children need to master the following developmental tasks to be able to perform effectively the tasks during adolescence (Hurlock, 1982). Parents have a key role in achieving these developmental tasks.

Developmental Tasks during Babyhood and Childhood

Babyhood & Early Childhood Tasks	Importance to developing healthy sexual behaviors
• Learning to take solid foods • Learning to walk • Learning to talk • Learning to control the elimination of body wastes	• The physical development, nutritional, and health status of children are important in their cognitive development and in turn their overall well-being • Inadequate diet prenatally and after birth may result in retarded brain development and mental retardation (www.scribd.com)
• Learning sex differences and sexual modesty	• Gender roles are important component of sexuality. Teaching children to become gender-sensitive can develop among them proper respect to the opposite sex in the context of their sexuality. • Learning sex differences and sexual modesty are critical component of appreciating one's sexuality including sexual orientation and sexuality.
• Getting ready to read	• Getting ready to read forms part of the cognitive development of children which is important in their well-being
• Learning to distinguish right and wrong and beginning to develop a conscience	• The type of moral conscience developed during childhood forms part of the attitude, judgment, and behaviors during the later stages of life • With proper perspective of right and wrong, children will be guided in defining and nurturing proper values (what are important to them) which are critical aspect of sexuality

Developmental Tasks during Late Childhood

Developmental tasks during late childhood	Importance to developing healthy sexual behaviors
• Learning physical skills necessary for ordinary games	• Learning physical skills and capacity to play form part of developing the psychomotor skills of children which are important component of their psychological and psychosocial development
• Building a wholesome attitude toward oneself as a growing organism	• Having a wholesome attitude toward oneself is part of developing self-awareness and self-esteem which are critical element of one's personality and sexuality development
• Learning to get along with age-mates • Developing attitudes toward social groups and institutions	• The capacity to get along with age-mates forms part of the psychosocial development of individuals which in turn are critical in their personality and sexuality development
• Beginning to develop appropriate masculine or feminine social roles	• A more stable appreciation of their sexual identity provides adolescents with proper perspective of gender roles and relationships
• Developing fundamental skills in reading, writing, calculating • Develop concepts necessary for everyday living	• This is part of the cognitive development of children which is a foundation of sound moral conscience and sexuality development

Developmental tasks during late childhood	Importance to developing healthy sexual behaviors
• Developing a conscience, a sense of morality, and a scale of values	• Acquiring a more stable concept of morality and proper values helps children to develop their skills in visioning and life-planning and sound decision-making which they need in developing responsible sexual behaviors
• Achieving personal independence	• As children become more independent, they need to acquire necessary life skills which they need to survive in everyday life and in developing their sexuality and personality

In forming the values and core competencies of school grade children, you may also emphasize the virtues and competencies listed below to enable them to delay sexual debut when they reach adolescence. These virtues and competencies are identified by various literature as fundamental to human development.

Values and Virtues	Relevance to delaying sexual initiation
Self-caring	• Self-caring enables children to value and appreciate their lives and health and to protect themselves from adults' abuses. Children should learn how to recognize and verbalize abuses and advances and seek for help from trusted adults. • Adolescents who have developed self-caring value and appreciate their health. They avoid behaviors that can harm and compromise their health such as some reproductive health problems.
Kindness, Empathy, Respect and Sensitivity	• Sensitivity pertains to being concerned and sensitive to the needs of others in given circumstances. Children should be able to appreciate and be more critical on the repercussion of their actions towards others. Sensitivity is also empathizing with the circumstances of others and being able to be conscious of the things that may hurt the feelings and conditions of others. • Kindness means having affective, affable and helpful attitudes towards others. • If children have developed the virtue and values of being sensitive, as adolescents they may be able to have respect for the decision of others; be more prudent and considerate of the conditions of others; and be more sensitive to the repercussions of their actions and decisions.
Capacity to express thoughts and feelings	• Children should be encouraged and empowered to express emotions, views, and ideas in healthy manner. Constant communication with children is vital in defining what is "right" and "wrong" values, attitudes, and behaviors and in encouraging children to express themselves effectively. • The capacity of children to express thoughts and feelings is the foundation of self-confidence and negotiating skills. This skill is needed in effectively refusing sexual advances and proposals and in communicating healthy sexual feelings with partner.
Moral judgment or the capacity to distinguish what is good from what is bad	• Children need to acquire a good level of social consciousness and an adequate ethical and moral criterion. It means to internalize a right value system which may be a function of religion or any institutional influence. Such value system defines the moral compass that guides overt actions and behaviors. Without a grounded and clear moral compass, children and adolescents may internalize and perform acts that may run contrary to good customs and norms.

Values and Virtues	Relevance to delaying sexual initiation
Patience, delaying gratification, and capacity for reflection	• Patience is a critical aspect of delaying sexual debut. It entails learning how to wait for rewards and anticipated gratifications. Patience is an indispensable necessity for training and fulfillment of any kind of achievements or skills. • Taking time to reflect implies the capacity of individuals to be more critical of the consequences and implications of one's actions.
Independence	• When children live in healthy environment they become independent as they grow up. It implies taking care of oneself (according to the age), to establish relationships and cooperate with others without losing their own values. • Independence is part of the development tasks needed to be achieved during childhood. Independence necessitates a strong values and moral foundation since seeking independence means less external control such as those from parents and other significant others. In such event, the ingrained values and moral conscience of an individual become the primary controlling factor in his/her behavior and overt actions.
Adaptation and flexibility	• Adaptation and flexibility pertains to the capacity of an individual to adapt and react positively in a given condition. Such skills are basically important in survival and in going through difficult circumstances. • In relation to delaying sexual debut, this competency is necessary in order for an individual to recognize intelligently the dangers, risks, and meanings of certain conditions for them to act accordingly.
High self-esteem	• Self-esteem pertains to being worthy, lovable and important. Children should feel that their own personality is respected and valued and that they are important. • Self-esteem facilitates self-efficacy or the capacity of individuals to take certain actions or skills. Self-esteem is needed in maintaining actions and behaviors that can delay sexual initiation.
Love of God	• Having a sense of a Supreme Being who created the world and someone to whom people can pray for their needs helps in controlling and regulating behaviors. Love of God is a strong motivation to pursue godly virtues that helps form values aligned to responsible sexual behaviors in the later years of human development. It is not the type of religion that matters but the impact of the teachings and beliefs on the behavior of humans that is important. In the Philippines, religion plays a key influence in the behaviors of its members.

The abovementioned values help individuals make responsible decisions in terms of their sexual behaviors in the later stage of their development. They build the moral foundation that could later on guide adolescents to delay sexual initiation until they think they are responsible enough to assume its consequences. For example, a child who is formed to be respectful of others can more likely have a respectful attitude and behavior towards women and the choices and decisions of others. A child who exhibits the virtue of kindness can become more sensitive to the situations and circumstances of others and learn not to take advantages of situations that put down or harm others.

The Rights of Children. Moreover, in forming positive and healthy attitude among children, it is also important to integrate in behavioral strategies the promotion and protection of the rights of the child. Observing and protecting these rights are essential in promoting the welfare of children and in developing positive values related to preventing adolescent pregnancy. These rights should

also provide the framework for any program for children. The following are the rights of the child as enshrined in the Convention on the Rights of the Child and explicitly mandated by the Children and Youth Welfare Code of the Philippines (Presidential Decree 603):

- *Every child is endowed with the dignity and worth of a human being from the moment of his conception, as generally accepted in medical parlance, and has, therefore, the right to be born well.*
- *Every child has the right to a wholesome family life that will provide him with love, care and understanding, guidance and counseling, and moral and material security.*
- *The dependent or abandoned child shall be provided with the nearest substitute for a home.*
- *Every child has the right to a well-rounded development of his personality to the end that he may become a happy, useful and active member of society.*
- *The gifted child shall be given opportunity and encouragement to develop his special talents.*
- *The emotionally disturbed or socially maladjusted child shall be treated with sympathy and understanding, and shall be entitled to treatment and competent care.*
- *The physically or mentally handicapped child shall be given the treatment, education and care required by his particular condition.*
- *Every child has the right to a balanced diet, adequate clothing, sufficient shelter, proper medical attention, and all the basic physical requirements of a healthy and vigorous life.*
- *Every child has the right to be brought up in an atmosphere of morality and rectitude for the enrichment and the strengthening of his character.*
- *Every child has the right to an education commensurate with his abilities and to the development of his skills for the improvement of his capacity for service to himself and to his fellowmen.*
- *Every child has the right to full opportunities for safe and wholesome recreation and activities, individual as well as social, for the wholesome use of his leisure hours.*
- *Every child has the right to protection against exploitation, improper influences, hazards, and other conditions or circumstances prejudicial to his physical, mental, emotional, social and moral development.*
- *Every child has the right to live in a community and a society that can offer him an environment free from pernicious influences and conducive to the promotion of his health and the cultivation of his desirable traits and attributes.*

Consistency of Values

The vital component of values education in the context of forming patterns of behavior is consistency. The consistent reinforcement of positive messages and values will more likely send clear message to children and can more easily develop patterns of behavior.

Given this, values education implies consistency of messages from school to the home – the two worlds in which children primarily live. The values taught in school should be applied at home and protected against conflicting messages coming from other external sources of information such as media. Media serves as the "proxy" parents when real parents or guardians are not around. Many empirical studies have shown the significant influence of media to the behaviors not only of children but individuals. The impact of media, however, is more powerful among children who still lack cognitive and rational faculties that let them judge or screen positive and negative messages before they are assimilated into one's behavior. Media exposure, therefore, needs timely and accurate parental guidance to reinforce consistency of positive values and attitudes. Parents need to process the information adolescents get from media to ensure consistency of behaviors.

- *Every child has the right to the care, assistance, and protection of the State, particularly when his parents or guardians fail or are unable to provide him with his fundamental needs for growth, development, and improvement.*
- *Every child has the right to an efficient and honest government that will deepen his faith in democracy and inspire him with the morality of the constituted authorities both in their public and private lives.*
- *Every child has the right to grow up as a free individual, in an atmosphere of peace, understanding, tolerance, and universal brotherhood, and with the determination to contribute his share in the building of a better world.*

The same national policy also specifies the responsibilities of the child. These responsibilities may form part of behavioral strategies that aim to provide welfare and growth for children.

- *Strive to lead an upright and virtuous life in accordance with the tenets of his religion, the teachings of his elders and mentors, and the biddings of a clean conscience;*
- *Love, respect and obey his parents, and cooperate with them in the strengthening of the family;*
- *Extend to his brothers and sisters his love, thoughtfulness, and helpfulness, and endeavor with them to keep the family harmonious and united;*
- *Exert his utmost to develop his potentialities for service, particularly by undergoing a formal education suited to his abilities, in order that he may become an asset to himself and to society;*
- *Respect not only his elders but also the customs and traditions of our people, the memory of our heroes, the duly constituted authorities, the laws of our country, and the principles and institutions of democracy;*
- *Participate actively in civic affairs and in the promotion of the general welfare, always bearing in mind that it is the youth who will eventually be called upon to discharge the responsibility of leadership in shaping the nation's future; and*
- *Help in the observance of individual human rights, the strengthening of freedom everywhere, the fostering of cooperation among nations in the pursuit of their common aspirations for programs and prosperity, and the furtherance of world peace.*

b) Specific activities under this BCC strategy (delay sexual initiation)

Under this BCC strategy, you may pursue the following activities:

b.1) Strengthen Values Education in school

Support or initiate curriculum, modules and lessons plans review and revisions to integrate the lessons on values, competencies, and virtues mentioned above. Emphasize values and skills that would enable adolescents to develop positive attitudes and make responsible and values-consistent decisions in the later stages of their development.

b.2) Classroom-based values education through experiential learning methodologies

Support or promote the integration of values education in the school curriculum for elementary. Values educations should focus on the development of skills and competencies and values mentioned above using experiential learning methodologies.

b.3) Conduct Values Education for out-of-school children

Support or initiate the development of module and communication programs on values education among out-of-school children. Involve NGOs, civic organizations, and other agencies working with out-of-school children in the development and implementation of these modules and programs.

Keep in mind that the development of this specific module for out-of-school children is rather challenging because of the strong external factors that influences the attitude and normative beliefs of this specific group of target audience. These external factors include the community, media, and family. The limited mechanism (e.g. school setting) to process the messages that children are exposed to leads them to acquire moral parameters – of what is right and wrong - the way they experience interactions and reality in these institutions. These realities (e.g. early pregnancy) become the norms that children subsequently follow. As such, community-based BCC initiatives for out-of-school children should be integrated in strategies that aim to change the attitude and normative beliefs of the community.

1.3. Communication medium for children

Children are like sponges, taking in information of all kinds. Some children learn best by sound, while other learns best visually. Visual learners acquire information best by seeing it. Children who benefit from this are good at remembering people's faces but not their names. These children may also think in pictures and learn best from visual displays. Illustrations, diagrams, flipcharts, overhead transparencies and video will help visual learners grasp concepts quickly. Teachers can identify visual learners by those children who like to read quietly and often observe rather than talking. A final key method to teach visual learners is to have them memorize what they have seen.

Auditory learners gather information best by repetition. These children like to read aloud and are generally not afraid to speak in class. Repetition is the best practice for learning. Listening to the voice helps reinforce knowledge. Children who are auditory learners should practice reciting information to themselves. These learners can also teach themselves to complete a task by reciting instructions aloud. Use words along with actions and pictures to help children who learn by auditory methods.

In fostering the values and virtues mentioned above, you can design audio and visual materials to aid learning among children and pre-adolescents. Comic book, cartoons, videos, and interactive interpersonal and experiential learning activities are the customary means of

communication among children. Actual life situations could also be an opportunity for instilling learning among children since they learn best from modeling and what they see and observe around them. Modeling the virtues can help them to grasp what do these values mean and how these can be acted in real life.

Proper teachings and guidance in understanding the implications and proper values and attitudes toward certain actions and events can be carried out through interpersonal communication strategies with children. Interpersonal communication with children should be primarily taken on by parents, guardians, siblings, and other relatives within the circle of influence of the children.

1.4. Advocacy and social mobilization support strategies

To support the BCC strategies for promoting and strengthening values education and formation for children in formative and grade school age, you may conduct the following:

1.4.1. Networking and collaboration with NGOs, private sector, and academe in values education for formative and grade school children and for out-of-school children

To strengthen the modules and to conduct school- and community-based values education, you need to network and collaborate with NGOs, the private sector, and the academe. You can connect with NGOs who are working with children in the community in developing and implementing modular sessions on values formation among children with emphasis on the skills mentioned aboved. You can also collaborate with private sector through their corporate social responsibility (CSR) programs.

You may also mobilize these organizations in the conduct of advocacy among national government agencies (i.e. Department of Education) and local governments for the conduct of the BCC strategies. You should target the government agencies concerned since they have the mandates and resources for sustainable strategies.

1.4.2. Advocacy for the design and implementation of sustainable programs for responsible parenting at the barangay level

You may also launch advocacy strategies towards the development of sustainable programs for forming effective and responsible parents. Such programs may be advocated among barangay officials as their regular projects which can also mobilize parent organizations in the community. You may advocate specifically for the funding of relevant programs.

1.4.3. Advocacy for the design and implementation of programs for promoting biological functioning throughout the development of children and adolescents

From the earliest stages of development, the biological influences that come from the child's brain and physiology can increase or decrease their risk for behavior problems. For

example, maternal health during pregnancy includes children's nutritional status which are linked to increased risk for child behavior problems. Given this, BCC strategies should also be connected with nutrition and health programs that aim to foster and support healthy biological functioning necessary for developing and adopting positive behaviors.

2. Developing Positive Values and Attitudes and Age-Appropriate Sexuality Skills among Pre-Adolescents (9-14 Years Old)

For Grade 5 and 6 students, which also can extend up to first to second year high school, some concepts on sexuality can already be integrated. To some preadolescents, puberty may have begun, as such, you may focus your strategies and messages in helping preadolescents cope with the stress and tensions in this phase of growth. This strategy can be adopted to address the following specific problem behaviors:

- Lack of knowledge and awareness among adolescents on the physical and social changes happening in their bodies;
- Tendency of adolescents to take risk, to be extremely curious, and willing to experiment particulary about their sexuality regardless of the consequences;
- Adolescents engage in non-sexual risky behaviors such as substance abuse;
- Adolescents are overcome by sexual urge and ignore or overlook the possible consequences of their actions; and
- Exposure to conflicting and unguided messages on sexuality from the media.

2.1. Information that pre-adolescents need to know

In addition to the topics on values that need to be integrated in the curriculum for elementary and secondary education curriculum, you may also include specific topics on sexuality as those provided below. These topics should lead to critical competencies that pre-adolescents should develop in order to delay sexual debut.

Topics	Expected competencies and learning
Physiological changes and development among boys and girls • The biological and physical changes occurring during preadolescence • Healthy and proper behaviors when these changes are happening • Puberty and fertility awareness	• Preadolescent boys and girls have accurate knowledge and awareness on the changes that is happening on their bodies • Preadolescent boys and girls know what to expect and how to deal with certain changes in their bodies • Preadolescents do not engage in sexual activities that leads to pregnancy

Topics	Expected competencies and learning
Healthy sexual feelings and expressions	• Preadolescent boys and girls know and understand the feelings and sensations happening in their bodies when they are sexually aroused or attracted to their peers. Adolescents are able to recognize these feelings and understand these to better cope and respond to these feeling and better express these feelings in a positive and healthy manner. • It is also important that they understand these feelings and sensations to protect themselves from abusive sexual advances and harrassment acts from adults and their peers • Preadolescent boys and girls understand the moral, psychological, and health implications of masturbation. There is a need to understand that masturbation is a natural phenomena and is a healthy option for safer sex practices.
Gender roles and issues	• Preadolescents know the discriminating gender roles attached to their being boys and girls • Preadolescents boys and girls respect and treat each other as equals in roles, responsibilities, capabilities, and opportunities at home, in schol, and in the society • Preadolescents boys are critical of gender stereotypes they encounter at home and in school
Love, empathy, respect, trust and commitment	• Preadolescents are able to appreciate and actualize values of love, respect, trust, and commitment especially in relation to their sexuality
Protection from sexual abuse	• Boys and girls know and avoid inappropriate body touches and favors and advances from adults
Life Skills • Conscious decision-making and effective problem solving • Creative and critical thinking • Effective communication, negotiation, refusal and interpersonal relationships • Self-awareness and empathy • Ability to manage emotions and ability to manage stress	• Boys and girls make conscious decision-making and effective problem solving; • Boys and girls think creatively and critically especially towards messages they get from media; • Boys and girls can express and assert themselves articulately; • Boys and girls can negotiate and refuse sexual advances; • Boys and girls maintain good interpersonal relationships with their significant others; • Boys and girls are conscious of what is happening in their body and in their personality; • Boys and girls empathize with their peers and people in their environment especially in difficult circumstances; • Boys and girls manage emotions and stress effectively and productively.

You may support the integration of these topics in the school curriculum or you may conduct other effective communication strategies such as forums, video showing, or other relevant classroom activities. You can reach out to out-of-school preadolescents through existing outreach programs of NGOs and government institutions.

2.2. Specific activities under this strategy

2.2.1. Values Education with Life Skills Formation in school

Support curriculum, modules and lessons plans review and revisions to integrate the lessons on values, competencies, virtues, and life skills mentioned above.

2.2.2. Development of Values Education and ASRH Program for out-of-school pre-Adolescents

Support the development of module and communication programs on values education and age-appropriate topics on ASRH among out-of-school children. Involve NGOs, civic organizations, and other agencies working with out-of-school pre-adolescents in the development and implementation of the modules.

Ensure that stakeholders and your implementing partners on this specific BCC activity are trained on life-skills ASRH and other relevant topics.

2.2.3. Classroom-based Values Education

Support the integration of values education and ASRH relevant topics in the school curriculum for elementary. Such education should focus on the development of core skills and competencies and topics mentioned above using experiential learning methodologies.

You may also integrate the modules in regular symposiums, seminar, and special classroom discussions. You may likewise integrate it in the school's counseling program. Ensure that training of teachers and guidance counselors in school are trained on ASRH.

2.2.4. Development of Relevant IEC Materials

Initiate the development and dissemination of appropriate IEC materials that can effectively relay the messages to the target audience. Such material should be appealing to the preadolescents. For this purpose, the IEC materials may be in the form of comics, video presentations, posters, brochures, and other interactive methodologies (e.g. social networks or interpersonal communication activities)

2.3. Communication medium for pre-adolescents

Preadolescents start to assimilate in their behaviors prevailing norms and instructions from people they consider as authoritative in specific aspects of life. They are still children but they now start to connect with peers and distance themselves from their parents. They now spend more time with peers and with media away from home. They usually spend time in tambayans, computer shops, malls, and areas where they can congregate.

Given this, you may develop IEC materials capitalizing their eagerness to learn and socialize away from home and tendency to congregate with peers. You may capture them in places where they visit frequently for the distribution of IEC materials. The IEC materials may be in the form of comics, brochures, posters, video presentations, and other interactive materials and communication methodologies. You may also optimize on-line or internet-based communication strategies to disseminate the key messages on ASRH among this group of adolescents. You may specifically use the social networks utilizing its free features such as blogs, chat rooms, and messaging to trigger discussions and provide accurate information on sexuality that is appropriate to their age.

2.4. Advocacy and social mobilization support strategies

To support the BCC initiatives for pre-adolescents, you may focus advocacy efforts in development and conduct of programs that can inform and capacitate preadolescents on ASRH issues appropriate to their age as mentioned above. You can direct advocacy efforts towards the Sanggunian Kabataan (SK) to take advantage of their structure and available resources. You may work with the SK in the development of relevant communication and education programs and projects and its integration in their regular plans and programs. You may advocate for the utilization of their allocation on ASRH-related initiatives.

For sustainability, you may also mobilize the SK to initiate the enactment of resolutions or policies that create and institutionalize ASRH programs specifically for enabling preadolescents to prevent ASRH-related issues and problems. Projects may be best implemented at the barangay and municipal level to ensure that adolescents in the community benefit from the said project.

3. Promoting Life Skills-Based Adolescent Sexual and Reproductive Health (for 15-19 Years Old)

The highest incidence of pregnancy and childbirth is occurring among adolescents aged 15-19 years. Through every means possible, it is important that you segment the interventions for adolescents according to their sexual experience to make the strategies more effective. Preventive measures are for those who have not yet engaged on sexual initiation. And, there are much more of them than those who already have been sexually initiated.

Many of the existing adolescent health and development programs in the country have targeted the 15-19 years old. You may review these programs and identify which of them can be replicated or what part of them can be adopted based on your objectives. This document does not provide all the applied interventions in the country but provides some framework in which existing interventions can be integrated to make these strategies cohesive towards a common BCC goal and objectives.

The core strategy for preventing sexual initiation among this segment of adolescence is the promotion of life skills. Life skills pertain to the abilities, skills, and behaviors that enable individuals to deal or cope with the demands and challenges of everyday life (POPCOM). By providing these skills to adolescents, they can effectively go through the challenges and tasks of adolescence particularly those related to their sexuality towards the realization of their potentials.

3.1. Information that adolescents aged 15-19 years need to know

Developing life skills entails the formation of well-grounded knowledge on adolescent sexual and reproductive health and concerns. This will inform the adolescents on their decisions and actions related to their sexuality. The specific information that adolescents need to know include:

3.1.1. Human Sexuality

Adolescents need to understand human sexuality so they can appreciate the things and changes that are happening in their bodies physically and psychologically. They should also need to understand that understanding one's sexuality is an inherent part of and individual's sexual rights. Specifically, the adolescents need to know about:

- The definition of sexuality as part of human development;
- The components of sexuality to include:

  - **Sex** – the physical characteristics of being male or female. It includes the biological elements and functions of reproductive anatomy and physiology.
  - **The human (male and female) reproductive system** – particularly its parts, processes, and functions;
  - **Sexual orientation and preferences** – refer to the sex of the person to whom one is sexually attracted (heterosexual, homosexual, and bisexual);
  - **Sexual behaviors, its consequences, and its health, cultural, and moral implications.** Sexual behaviors pertain to any physical activity involving the body as a means of expressing erotic feelings. The discussion of its consequences, health perspective as well as its cultural and moral dimensions is also important for the adolescents for them to know the implications when they engage into sexual behaviors.
  - **Gender identity** – refers to the physiological sense of being male or female consisting of personal and social norms for feminine or masculine behavior.
  - **Desired sexual values, attitudes, feelings, and emotions** – pertain to what values should be nurtured sexually and how to express their sexual attitudes, feelings, and emotions including sexual urges in healthy and responsible manner.
  - **Sexual rights as human rights related to sexuality.**
    - Sexual Rights - set of enshrined and inalienable entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people

- **The principles of sexual rights (IPPF, 2006)**
  - Sexuality is an integral part of the personhood of every human being, for this reason a favourable environment in which everyone may enjoy all sexual rights as part of the process of development must be created;
  - The rights and protections guaranteed to people under age eighteen differ from those of adults, and must take into account the evolving capacities of the individual child to exercise rights on his or her own behalf;
  - Non-discrimination underlines all human rights protection and promotion;
  - Sexuality, and pleasure deriving from it, is a central aspect of being human, whether or not a person chooses to reproduce.
  - Ensuring sexual rights for all includes a commitment to freedom and protection from harm;
  - Sexual rights may be subject only to those limitations determined by law for the purpose of securing due recognition and respect for the rights and freedoms of others and the general welfare in a democratic society;
  - The obligations to respect, protect and fulfill apply to all sexual rights and freedoms.

- **Sexual Rights**
  - Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender;
  - The right to participation for all persons, regardless of sex, sexuality or gender;
  - The rights to life, liberty, security of the person and bodily integrity;
  - Right to privacy;
  - Right to personal autonomy and recognition before the law
  - Right to freedom of thought, opinion and expression; right to association;
  - Right to health and to the benefits of scientific progress;
  - Right to education and information;
  - Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children; and
  - Right to accountability and redress.

In informing adolescents about sexuality, it is important to ensure that they are able to differentiate sexual behaviors from human sexuality. Based on the pilot testing of interpersonal communication skills, adolescents usually refer to sexuality as "sex" or the "sexual act." It is important that adolescents understand the difference to avoid the misconception that topics on sexuality are promoting sex education (i.e. pertaining to the sexual act).

3.1.2. Adolescent Sexuality and Reproductive Health Issues and Concerns

Knowledge of sexuality and reproductive health issues and concerns provide adolescents with information that they can use in making responsible decisions on their sexuality. Adolescents must have an understanding of the following:

- **The expected physiological growth, changes, and process involved during the adolescent period.** Adolescents need to understand the growth processes during adolescence so that they can prepare and cope with the stresses and changes that go with the processes of growth.
- **Fertility awareness.** Adolescents need to know the processes involved in human reproduction and how pregnancy can be conceived. An understanding of their fertility enables them to realize the repercussions of engaging into sexual activities.
- **Responsible sexuality and dimensions and issues in sexual relationships.** Adolescents need to have an understanding and appreciation of healthy romantic relationship. It includes appreciation of being responsible in expressing their sexuality particularly in related activities such as dating, courting, and engaging into intimate and exclusive relationships. These should provide adolescents with information on how these activities lead to sexual initiation so that they can set and communicate their limitations.

3.1.3. The THREATS and RISKS that adolescents are facing today

Adolescents should also know the various sexual and socio-economic threats that they are facing in today's time so that they may know how to cope and avoid these situations. These threats may include, among others:

- **Too early sexual involvement.** This refers to the implications of engaging too early in sexual activities.
- **HIV/AIDS and STI.** This may include the description of the diseases; who are at risk; how are they acquired or transmitted; and how can they be treated.
- **Sexual Violence.** This pertains to the understanding of the conditions in which adolescents are exposed to risk of sexual violence including rape, sexual harassment, sexual abuse and molestation, incest, and other forms of sexual violence.
- **Early marriage.** This provides information to adolescents on the implications and demands of early marriage.
- **Abortion.** This topic should open the eyes of adolescents to think twice before engaging into sexual activities as this may result in unintended pregnancy and consequently in abortion. Abortion may lead not only to the death of the fetus but of the mother as well.
- **Trafficking, prostitution, and exploitation.** Adolescents should be aware of their vulnerability and protection from acts of trafficking, prostitution, and exploitation, which is also directly connected with unintended pregnancy.
- **Dysfuntional families.** Many adolescents enter into intimate relationships because they lack attention and love from their family due to some dysfunctions and problems in the home. Thus, adolescents need to know how to cope positively with family problems to avoid risky behaviors.
- **Rising violence, delinquency, and criminality.** Violent and delinquent behaviors lead to criminality among adolescents. These behaviors are likewise directly connected with

sexual behaviors. As such, adolescents need to equip themselves with information on how to divert their energies and emotions positively and productively to avoid violence. Adolescents also need information on the repercussions of their violent behaviors.

- **Poverty and unemployment.** Adolescents also have to understand that poverty is a constraining factor to their development but it is not a reason for them to engage in promiscuous activities. By understanding the factors affecting poverty, they can strive to set their priorities (i.e. education, training, and employment) straight.
- **Substance abuse.** Adolescents should also realize that substance use and abuse could push them to engage in too early and unintended sexual engagement. Knowing the risk and impact of substance abuse on their development could help them avoid these unwanted behaviors
- **Materialism and spiritual emptiness.** Adolescents should realize the need to balance life with spirituality. As part of their values formation, a deep spirituality is a strong controlling variable that keeps adolescents from delinquent behaviors including sexual promiscuity.

Some considerations in discussing the concept of 'Sexuality' among adolescents

In teaching the concepts of responsible sexuality, it is very important to focus on explaining sexuality in the most understandable concepts among the target audience. As experienced in the pilot-testing and other related interpersonal communication strategies on sexual and reproductive health, sexuality is considered as an abstract concept. Many adolescents equate sexuality with 'sex' or 'sexual act.' Thus, it is important that the concept be explained in its proper context. Likewise, observe sensitivities and reactions from the audience on concepts related to sexuality. Ensure that a learning environment is maintained in the course of discussing these concepts.

3.2. Skills and behaviors adolescents need to develop

As previously discussed, adolescents are constantly exposed to various threats and challenges including too early and unintended pregnancy. In order to deal with these challenges effectively, adolescents need to acquire life skills and develop positive behaviors that can keep them towards their aspirations. The life skills that need to be promoted in your BCC strategies include:

3.2.1. Self Awareness and high self-esteem

Adolescents need to be in touch with themselves especially their strengths and weaknesses as well as their values and attitudes in life (POPCOM,2010).

Having a high self-esteem makes adolescents confident, assertive, and optimistic. Self-esteem is an important factor for adolescents to control and restrain themselves from engaging in sexual initiation. It is also a significant factor that can lead adolescents in the achievement of their aspirations

3.2.1. Visioning and life planning skills

Adolescents should be visionaries and full of aspirations. They should be able to create their own vision or desired condition in the future which guides their actions and behaviors. Having a vision or aspiration and sticking to the achievement of that desired future enables adolescents to focus on things that can help them attain their aspirations. Pregnancy is considered as hindrance to aspirations if adolescents focus on their vision.

3.2.3. Effective communication, refusal and negotiating skills

Adolescents can better express their feelings, refuse sexual advances, and negotiate with their partners if they have effective communication skills. Effective communication is essential in building healthy interpersonal relationships. This is also essential in the ability of the adolescents in saying "No" to sex and to abuses. Open and effective communication is the basic skill in agreeing to certain terms including not engaging or delaying sexual initiation.

3.2.4. Critical thinking

Adolescents need to be critical of the messages and situations that they encounter from their environment. Being critical is not accepting things at its face value but understanding all dimensions of a given situation. This is important in controlling sexual urges and in making decisions.

3.2.5. Making sound and intelligent decisions

Delaying sexual initiation is a decision that an adolescent should make. In coming up with this decision, adolescents should have a rational and intelligent process of decision-making which involves considerations of all dimensions or consequences of actions to be taken.

3.2.6. Interpersonal communication and relationship skills

As part of their psychosocial development, adolescents should be able to have a harmonious and healthy relationship and interactions with people within the circle of their significant persons. Adolescents should be able to relate and interact with their parents, relatives, peers, and friends. As such, even when peer pressure is strong, a sound interpersonal relationship enables adolescents to negotiate and do things differently from the peers without losing the sense of respect and belongingness.

Effective interpersonal relationship is also important in maintaining harmonious relationship with family members who form the most immediate environment of the adolescents.

A supportive and effective relationship with parents can help adolescents go through their personal development.

3.2.7. Effective expression and management of emotions and feelings

The capacity to express emotions coupled with rational thinking equates to sound decision-making. Adolescents need to be able to express their emotions in healthy and productive manner for them to agree mutually not to engage in sexual activities. Effective management of emotions also involves the capacity to control anger and express it in endeavors that are more productive.

3.2.8. Gender sensitivity

Understanding the differentials in the societal and normative roles of men and women helps adolescents appreciate the need to be more sensitive to these gender differences. It also helps develop among adolescents gender sensitive values and attitudes especially in relation to their sexuality.

3.2.9. Deep spirituality

Spirituality is essentially the level of relationship of an individual with his/her God. A deep sense of spirituality makes adolescents avoid actions that may run contrary to their religious beliefs including avoiding premarital sex. Spirituality and religious beliefs strongly guides decisions.

3.3. Specific strategies and activities in promoting life-skills

In promoting life-skills-based ASRH, you may adopt and implement the following key BCC activities:

3.3.1. Building the knowledge of adolescents on ASRH and related issues

Knowledge and understanding of ASRH issues and processes are key elements in making responsible decisions and behaviors on sexuality. You may include raising knowledge and appreciation on ASRH issues and concepts as one of the major components of your BCC strategy for preventing adolescent pregnancy. Such strategy may include the following activities and methodologies proven for effectively raising knowledge and awareness on ASRH issues and concerns:

a) Conduct of symposiums, forums, debates, conventions, conferences, and public discussions and discourses on ASRH issues involving adolescents especially those in high school

Ensure that these activities provide the venue for disseminating accurate information on ASRH rather than confusion among the target audience. Likewise, ensure that trained counselors, health workers, youth development professionals, psychologists, and other credible resource persons are tasked to discuss relevant topics to ensure consistency and accuracy of information.

You may consider the capacity building of health workers, youth leaders from government (e.g. Sanggunian Kabataan), NGOs or civic organizations on ASRH to create a pool of resource persons who can help in the discussion of relevant topics during the abovementioned activities.

What to consider in the organization and conduct of public symposiums, forums, and discussions?

- The most challenging aspect of these types of activities is sustaining the attention of the adolescent audiences. Adolescents can be easily distracted when they are with their peers and their attention span is too short especially in topics that do not interest them. However, the best thing about adolescent audiences is that they are highly energized and can actively participate in discussions when their attention is captured.

  Given this, you should design and apply interactive and participative approaches during these public gatherings to capture most of their attention. You may integrate video showing, creative and artistic presentation, entertain-educate strategies, and other entertaining methodologies. You may also use celebrities and popular personalities who are knowledgeable on the topic and supportive of ASRH to help ensure their attention.
- To ensure the attention of the school-based adolescents, you may collaborate with the school officials and teachers to make the forum part of their classroom learning exercises by conducting exams on the subject after certain activities. This is also to deepen their internalization of the topics discussed during the forum. It is then helpful to give handouts and discussion papers to the teachers as their reference in developing examination questionnaires.
- In the design of the programme, you should always allot enough time for open forum to provide opportunities for adolescents to clarify issues. Usually, adolescents learn more when their personal interests and issues are addressed rather than merely listening to topics academically discussed. Encourage the audience to raise questions to make the information more relevant to the actual conditions of the adolescent audiences.
- Make the venue conducive to learning and discussion during these activities. Limit participants into manageable level (e.g. at most 50 participants) to minimize distractions and ensure participation. This can give more opportunity for most of the participants to express their concerns making the discussion more personally relevant for them. More than 50 participants creates more distractions since the concentration span of adolescents are relatively low.
- Always support the activities with IEC materials for more information. These can serve as take home materials that adolescents can readily read during their spare time. The take home materials are also useful for those adolescents who were not able to express their queries and interests during such public gathering. It can also be used or disseminated to other adolescent members of the households who were not able to attend the symposium or forum.
- Also ensure that the symposiums, forums, or other big gatherings for disseminating ASRH information should leave adolescents with the names and contacts of individuals or organizations within their reach for their further queries. Encourage them to seek more information from persons and facilities accessible to them.
- It may also help improve the succeeding similar activities if the current activity is fully documented especially during the open forum. You can use the documentation to review the most common concerns and queries so that in the succeeding symposiums or forums, these issues will be highlighted in the lectures and presentations. You can also integrate an assessment or feedback mechanism in these activities to identify areas for improvement.

b) Using creative, entertaining, and innovative activities or communication strategies to present and discuss ASRH issues and concerns in school and communities.

Since adolescents has high interest in entertainment, you can use strategies that entertain at the same time provide opportunities to present ASRH issues. Entertainment-education uses mass media as well as folk media in popular format such as music, theater presentation, and variety shows to transmit messages with an experiential and emotional appeal. They can effectively persuade and motivate young audiences to engage in healthy behaviors because they can easily relate with the characters. These may include:

- Theater groups composed of adolescents;
- Conduct of contests and competitions such as:
  - *beauty pageant;*
  - *battle of the bands;*
  - *poster-making contest;*
  - *essay contest;*
  - *battle-of-the-brains or quiz-bees;*
  - *speech choral;*
  - *and other similar activities that may feature ASRH issues.*

Ensure that these activities can communicate the key messages on ASRH. Highlight the educative and informative aspect of the activity on ASRH issues and concerns with equal substance as its entertainment value.

In activities that have limited participants such as poster-making, choral, essay contests and the like; ensure that the positive messages expressed through the outputs of these contests should be disseminated further to larger audience. For example, you can post in conspicuous places in school and communities the winning posters so more people can view and appreciate the message. You can also send to dailies or newspapers, feature magazines, newsletters, and other publications the winning essay pieces so more people can read the article. Winning choral or song presentations may be presented during gatherings of adolescents in the school and in the community. The same can also be done with the outputs of other competitions.

c) Dissemination of ASRH information using the radio, internet or on-line sites, texting, hotlines, or phones

Many NGOs and LGUs have successfully reached out to adolescents through radio, internet, and phones (text and calls) through "hotlines" and counseling programs. These mediums are effective in as much as they provide accurate, confidential, and personalized information. Counseling and providing information through radio, on-line, and hotlines can also reach-out to more clients than symposiums and forums without fear of embarrassment or repercussions.

The challenge in maintaining radio spot is the cost of the airtime. You can reduce the cost if you can collaborate with the radio station in terms of the sharing of the cost. In all these strategies,

you need a full time counselor who is knowledgeable and credible in providing accurate advice on ASRH issues.

d) Development, production, and dissemination of Information, Education, and Communication (IEC) Materials

IEC materials are indispensable in the effort to build knowledge and awareness on ASRH issues and concerns, although costly. These IEC materials convey directly to the audience the key messages that you want to impart to the target audience to foster positive behaviors such as delaying sexual engagement. Effective IEC materials may include:

- Prints (e.g. brochure, comics, posters, primers, streamers, billboards, stickers, etc.);
- Radio and television advertisements and programs;
- Campaign collaterals (e.g. t-shirt, caps, mugs, etc.); and
- On-line materials and sites (e.g. social networks, blogs, chats, and other on-line discussions accessible to adolescents).

In developing an effective IEC material, you need to gather information on the following as basis for designing the material:

- Audience characteristics and problem behaviors;
- Existing knowledge, attitude, beliefs, and behaviors;
- Most accessible sources of information; and
- Most appealing type of IEC.

Equally important, you should also consider the available budget of your Project. Partnering and collaborating with the private sector or other agencies in the production of the IEC materials may help.

Generally, you should post and disseminate IEC materials in areas where adolescents and other target audiences frequently convene or congregate.

IEC materials can support all BCC strategies. They can help in reinforcing knowledge and skills imparted in training or other communication strategies. As such, you may distribute these materials in activities with interpersonal communication strategies such as symposiums and forums.

3.3.1. Building and sustaining the life-skills and self-efficacy of adolescents

You may focus on capacitating and developing the life skills of the adolescents as one of the main BCC strategies. These life skills are important behaviors that can help adolescents delay sexual initiation. In implementing this specific BCC intervention, you may consider the following:

- Depending on the coverage and budget of your project, you may organize the structure of the training by various levels of training. Trainers may be subjected to training first. The trained trainers will then facilitate the roll-out trainings.

- In terms of the design of the training, you may divide the training into two parts. The first part would focus on grounding the adolescents on ASRH issues. The second part would be the training on the various life-skills.
- Ensure that experiential learning approaches are applied during the training. Structured learning activities are proven effective methodologies in instilling insights and messages.
- You may involve youth leaders in the pool of resource persons during the trainings. They can relate more to the experiences of the young participants, thus, they can open more in terms of their experiences. Just ensure that the youth leader is trained and able to handle related issues. A professional should always be present in these activities to ensure support information especially in topics that require technical responses from professionals.
- Building skills needs practice. In teaching life skills, you need to create opportunities where they can apply these skills effectively in appropriate situations. Thus, life skills should be taught in real life situations in which adolescents can apply the skills. A monitoring mechanism that can ensure that such skills are applied can also help in reinforcing the application of the learned skills. Counseling whether by individual or group can provide feedbacking mechanism.

3.3.3. Provision of counseling services

Counseling is an effective BCC strategy for enabling adolescents to decide rationally and responsibly in matters regarding their sexuality. Counseling services assist adolescents to resolve personal difficulties and acquiring the information, skills, attitude, and proper perspective in looking at their problems and solving them on their own. In providing counseling services, you may adopt the following strategies:

a) Peer education and counseling

- **Peer education** — tapping adolescents to help educate one another — is one way to harness the many positive aspects of peer influence. If adolescents really do exist mostly in a world of their own making, why not make that an informed, educated world, from within?

- Peer counseling in the context of ASRH is assisting an adolescent (counselee) by a fellow adolescent (counselor) to resolve issues or come up with healthy and responsible choices and decisions on his/her own on matters related to his/her sexuality and reproductive health by providing him/her with accurate information, guidance, skills, and alternatives.

- Peer counseling has many advantages to the adolescent counselees, the counselors, and the community.

    - The counselees are given the opportunity to model after someone whom they have reached out to voluntarily. They are given the opportunity to develop coping skills that presumably work because they work with the peer counselor they are relating to. They can learn to advocate on their own behalf. Their feelings of self-worth can be

enhanced because they have a counselor who truly understands and can relate with their experience.

- The peer counselors gain in feelings of self-worth for they have the opportunity to share a valuable and worthwhile experience. This in turn can motivate the counselors to reach out to others and to perfect their skills. For many peer counselors this position can be a vehicle for career development.

- The community, of course, is helped to form a positive image of the adolescents. More importantly, the service to adolescents is improved allowing these persons to take up a more meaningful role in the community. The development of peer counselors would appear to be the grassroots answer to a growing technology, allowing people to grow closer together rather than apart.

- A major component of peer counseling is the capacity building of counselors. Counselors need to be intensively trained on ASRH issues and concerns; concepts, techniques, and ethical standards in counseling; and follow-up counseling services.

  - Given the critical role of the peer counselor, ensure that appropriate participants are trained as peer counselors. Not all adolescents can be peer counselors. A good counselor is a person who can show empathy toward other people's problems, be able to listen, communicate, be direct, sincere, be able to share personal experiences, be trusting, and have knowledge and skill that would be helpful. In addition, a peer counselor must have an in-depth appreciation of ASRH issues. Thus, a counselor should have a broad range of good personal characteristics and conceptually prepared to deal with ASRH issues of their fellow peers.

  - Ensure that the peer counselors know the philosophy and policies of the place she/he is working. It is highly important that the counselor know his/her abilities and limitations. It is important to know when and when not to act.

  - The issue of confidentiality is important. The counselor must know the difference between being a support person and being a 'protector' or 'rescuer'. They have to recognize that adolescents have a right to make their own decisions and to live with the consequences of that decision.

- As a strategy, you can also organize adolescents into support groups whose members support each other to achieve their goals and objectives particularly in relation to their sexuality and reproductive health. Members may be trained in peer counseling on ASRH issues so they continuously support each other in guiding and enabling their members to delay sexual initiation until they are already ready to cope with the demands of pregnancy and childbirth.

- For the specific activities under peer counseling, you may conduct the following activities:

  - Selection and training of peer counselors (with in depth practicum);
  - Provision of peer counseling in informal settings in the community;
  - Setting-up of counseling or youth center in the barangay or community;
  - Campaign for the promotion of peer counseling in the barangay or community.

b) Provision of counseling services in health facilities

Counseling services may also be provided in health facilities by health workers. Health workers may reach out to adolescents in the provision of accurate information about pregnancy and childbirth and its health implications.

- As counselors they should be objective, non-judgmental, and discriminatory especially in dealing with adolescents who may be at the same age as their own children. Adolescents have passive health-seeking behavior particularly for counseling services from health facilities because of the judgmental attitude of health workers.

- Health workers can help adolescents in dealing with the sexual changes happening in their bodies. They can also provide credible advice on the repercussions of engaging too early in sexual activities.

- A campaign to promote access of counseling services in health facilities among adolescents may be undertaken. The campaign can revolve in promoting the health center or facility as an adolescent-friendly source of information and needed services.

For the specific activities under counseling in health facilities, you may conduct the following activities:

- Training of health workers in counseling ASRH issues;
- Provision of counseling in the health facility;
  - Hiring and deployment of youth counselor to cater to the counseling needs of the adolescents;
  - Setting-up of counseling or youth unit or corner in the health facility;
- Campaign for the promotion of counseling services in the barangay or community.

c) Referral to Professional Help for Sexual Deviations and Behaviors needing psychiatric and clinical interventions

In circumstances where adolescents need advice on serious sexual deviations and disorders, as a counselor, you should refer them to professional help. Avoid trying to give information and advices that may only reinforce or add additional confusion to the client rather than enabling them

to take healthy actions. Sexual deviations are sexual disorders characterized by recurrent intense sexual urges, sexually arousing fantasies, or behavior involving use of a nonhuman object, the suffering or humiliation of oneself or one's partner, or children or other non-consenting partners *(accesed from http://medical-dictionary.thefreedictionary.com/sexual+deviation*). Some of sexual deviant behaviors include:

- Sadism – the derivation of pleasure as a result of inflicting pain or watching pain inflicted on others.
- Masochism – the condition in which sexual gratification depends on suffering physical pain or humiliation.
- Fetishism – the sexual arousal a person receives from a physical object, or from a specific situation.
- Rape – type of sexual assault usually involving sexual intercourse, which is initiated by one or more persons against another person without that person's consent.
- Paedophilia (pedophilia) – a psychiatric disorder in adults or late adolescents typically characterized by a primary or exclusive sexual interest in prepubescent children (generally age 13 years or younger, though onset of puberty may vary).
- Exhibitionism – refers to a desire or compulsion to expose parts of one's body – specifically the genitals or buttocks of a man or woman, or the breasts of a woman – in a public or semi-public circumstance, in crowds or groups of friends or acquaintances, or to strangers.
- Voyeurism –the sexual interest in or practice of spying on people engaged in intimate behaviors, such as undressing, sexual activity, or other actions usually considered to be of a private nature.

3.3.4. Building leaders and young champions on ASRH

Forming young leaders ensures behaviors that can delay sexual initiations. Leaders know their priorities and have high level of self-awareness, determination, and control over their urges. They know what is important to them and concentrate on what pushes them to their goals rather than venturing on risky behaviors that hinder them towards their goals. More importantly, young leaders understand the issues on ASRH and its implications on their development.

Capitalizing on their idealism and optimism, you may form and nurture leadership values to build behaviors that prevent them from engaging in actions such as sexual initiation that hinder their aspirations. Forming adolescents as leaders also helps in educating their peers on ASRH. Building adolescents as leaders entails the creation of opportunities in which they can exercise their leadership. Participation in Sanggunian Kabataan and other youth organizations can give them the venue to be leaders and diversion from sexual preoccupations.

This strategy may include the following activities:

- Training or workshops on leadership values and skills;
- Training on analyzing youth situations and development of appropriate ASRH policies and programs;

- Participation to leadership conferences and conventions, and educational field trips;
- Visits to good practices on ASRH and leadership;
- Participation in youth program development, planning, implementation, and monitoring particularly on ASRH issues and concerns;
- Training on governance, project development, effective communication, and other skills that can enhance leadership skills;
- Creation and participation in youth organizations;
- Participation in development-oriented initiatives in the community.

3.3.5. Information campaign against sexual non-risky behaviors (substance use and abuse)

You may integrate the promotion of sexual risky behaviors with the campaign against substance use and abuse and other non-sexual risky behaviors among adolescents. You may promote the following key messages for this:

- Substance use and abuse may facilitate sexual promiscuity and early pregnancy;
- Substance use diminishes your control and volition over your actions;
- The use of alcohol and drugs and sex is the recipe to unwanted pregnancy and to broken dreams.

This strategy may include the following activities:

- Massive orientation on the substance use and abuse focusing on the types of substances (drugs), signs and consequences of substance abuse, and means to prevent substance use and abuse;
- Media campaign against substance abuse among adolescents;
- Development and dissemination of IEC for the campaign; and
- Peer counseling against substance abuse.

3.3.5. Males' involvement in ASRH

Perceived as the more aggressive party in sexual relationships, males can contribute significantly in promoting delayed sexual initiation. Training and mobilizing male adolescents in the campaign for delayed initiation, development of life skills, and healthy sexual behaviors can be an effective strategy for behavior change communication. Males as counselors on ASRH can also effectively influence the behavior of their peers.

Differentiating the Emphasis on the Messages of BCC Strategies for Male and Female Adolescents

As discussed in the previous sections, there are differentials in the factors attendant to the behaviors of males and females in relation to sexual initiation. These differentials are rooted from the prevailing double standards and norms particularly in terms of sexuality. Given this, you may design specific strategies or modify content of activities to address these differentials. Consider the following differentials in the emphasis of the content and messages for male and female adolescents under certain BCC strategies:

For Male Adolescents	For Female Adolescents
Messages under the strategy of Building the knowledge of adolescents on ASRH and other relevant issues	
• Being usually the more aggressive party in sexual activities, you need more control over your sexual urges. Your will should be stronger than your emotions. • Sex is never the initiation into "manhood." Real men know how to control themselves and wait until they are ready for the demands of pregnancy and rearing children. • Not everybody is doing it! You do not need sex in order to belong to the group. True friends respect your decisions and your aspirations. • Sex is not love. Love can be experienced, enjoyed, and nurtured without sex. So you cannot demand sex from your partner to prove her love for you. • Sex is an important aspect of human sexuality. One should be able to enjoy it free from coercion, harms and health risks.Think first before you act. Impulsive behaviors lead you to broken dreams. • Males do not have the advantage in sexual relationships. It is not as if "you have nothing to lose" when you impregnate women. You actually have everything to lose – your studies, relationships, confidence, and prospects for bright future, among others. • Sex is not reversible. Once you did it, there are irreversible consequences.	• Once you enter the age of menarche, you can already get pregnant. • Pregnancy is too risky at your age because your body is not yet ready and mature enough. • Do not exchange adolescence with motherhood. Motherhood can be best enjoyed when you are ready. • Know and avoid circumstances where you are forced to engage into sex. • Not everybody is doing it! You do not need sex in order to belong to the group. True friends respect your decisions and your aspirations. • Sex is not love. Love can be experienced, enjoyed, and nurtured without sex. So you do not need to engage in sex to prove your love for your partner. • Early sex puts young girls at more risk for health problems such as early pregnancy and STI.

For Male Adolescents	For Female Adolescents
Messages under the strategy of Building and sustain the life-skills of adolescents	
• Self-awareness and high self-esteem enables you to know yourself and work on your weaknesses that can constrain you from your goals. • Effective communication is being able to listen to others and empathize with what they feel. Respect the decision of your partner when she refuses to have sex with you. • Critical thinking enables you to think first before you act. It gives you space to think of the consequences of your actions vis-à-vis your readiness to assume the responsibility attached to them. It also enables you to screen the messages you can get from media and refuse peer pressure when it leads you to negative consequences. • Making sound and intelligent decisions is a skill you need to avoid actions and behaviors that keep you from your aspirations. • Visioning and life planning provides you the options that you would want to take to fully realize your potentials. Without direction, you can never achieve anything in your life. • Effective expression and management of emotions and feelings enables you to be more controlling of the unconscious energies including sexual urges that drive your behavior. It involves expressing emotions and urges in healthy outlets. • Deep spirituality also helps you to take actions that are morally right and acceptable as define by your relationship with your God. It also guides you to live a good life.	• Self-awareness and high self-esteem enables you to know yourself and work on your weaknesses that can constrain you from your goals. • Effective communication means that you are able to refuse sexual proposals and advances. It also your skill in negotiating your feelings and position with your partner. • Critical thinking enables you to think first before you act. It lets you question and refuse peer pressure when it leads you to negative consequences. • Making sound and intelligent decisions is a skill you need to avoid actions and behaviors that keep you from your aspirations. • Visioning and life planning provides you the options that you would want to take to fully realize your potentials. Without direction, you can never achieve anything in your life. • Effective expression and management of emotions and feelings enables you to be more controlling of the unconscious energies including sexual urges that drive your behavior. It involves expressing emotions and urges in healthy outlets. • Deep spirituality also help you to take actions that are morally right and acceptable as define by your relationship with your God. It also guides you to live a good life.
Messages under the strategy of provision of counseling services	
• It is okay to seek help from your friends or somebody whom you trust and who have the accurate information you need. • It helps when you are able to express your emotions and problems to somebody who is willing to listen. • You may seek advice from your parents, teachers, health workers, and somebody you has accurate information on your issues.	• You may seek advice from your parents, teachers, health workers, and somebody you has accurate information on your issues

3.4. Communication medium for adolescents (15-19 years old)

Adolescents aged 15-19 years have higher exposure to media than their younger counterparts. As such, you may use the media in its various forms as the major medium through which messages for their desired behavior can be conveyed. Depending on your budget, you may use the television, radio, internet, or phones. You may also connect with them through the social networks utilizing its free features such as blogs, chat rooms, and messaging to trigger discussions and provide accurate information on sexuality that is appropriate to their age.

Interpersonal communication methodologies are also effective means to convey the messages of responsible sexuality. Trainings, sessions, and activities which include interpersonal communication strategies provide a more personal means of conveying messages. It provides greater chance of gaining deeper information as there is more time for discussions and elaboration of core messages. Face-to-face interactions with co-participants and resource persons can also facilitate more experiential process of learning.

Printed materials are still relevant but they should be appealing enough for the adolescents to render their time to read fully the materials. These printed materials may be posted in areas where they frequently congregate such as homes, tambayans, schools, malls, internet shops, parks, and teen health centers.

3.5. Support Advocacy and Social Mobilization Strategies

The life skills development of adolescents can be institutionalized with appropriate policies and programs at the local level. You can work with the SK and other youth organizations in the locality to advocate for the development and implementation of ASRH programs in SK and local government programs with corresponding budget. The programs may include:

- Creation and sustainable operation of youth centers or corners in the barangay that will serve as outlets for adolescents for ASRH information and services;
- Development of adolescents-led mobile resource centers on ASRH for adolescents in remote or difficult-to-reach areas;
- Development and operationalization of adolescents-led mobile ASRH IEC Resource Center;
- Establishment and utilization of adolescents and youth demographic and socio-economic database for programming and planning;
- Institutionalization of IEC and BCC strategies especially the training programs in SK or local government programs through its integration in the local development plans;
- Organization and mobilization of youth councils for the development and implementation of programs for adolescents and youth.

Other advocacy initiatives may be pursued towards the creation of other programs that can divert the energies, skills, and time of adolescents to more productive endeavors. These programs

may limit the opportunities for performing problem behaviors. They may include mobilization and involvement of adolescents in:

- Entrepreneurship, livelihood, employment, and other income generating projects;
- Sports activities with educational component;
- Cultural and social activities;
- Youth development planning and other political activities;
- Outreach and charity programs by the barangay or municipal government; and
- Environmental programs and project.

To support healthy and positive behaviors among adolescents, you may also pursue advocacy for the strict regulation and enforcement of laws on:

- Prohibition of selling of liquors and illegal substances to minors;
- Regulation or prohibition of minors from entering entertainment (e.g. videoke) establishments with obscene shows; and
- Anti-pornography and prostitution.

For social mobilization, you may collaborate with and mobilize adolescent and youth groups and organizations in school and communities in the following campaigns:

- Promotion of delayed sexual initiation and prevention of pregnancy;
- Environmental preservation activities;
- Enforcement of policies on anti-pornography, substance abuse, and prostitution; and
- Conduct of special events to promote ASRH messages.

The creation of policies that regulate adolescents' non-sexual behavior can effectively help in promoting positive and healthy sexual behaviors among the primary target audiences. Among the proven local policies, include:

- *Implementing curfew hours.* This imposes limitations on the allowable time that adolescents can spend up to the night to discourage them to congregate and impulsively undertake risky behaviors. Adolescents tend to congregate during the night and it gives them opportunity to experiment and explore in activities that put them at risk including sexual initiation.
- *Adolescents-led intensive and sustainable campaign against substance abuse (i.e. alcohol and illegal drugs).* This policy is obviously necessary to protect the adolescents from the negative impact of substance abuse, which facilitates sexual initiation and unprotected sex.
- *Placement and endorsement of performing and model adolescents in employment opportunities.* This policy aims to employ adolescents who exhibited exemplary behaviors in school and in the community as an incentive for adolescents to sustain healthy and responsible sexual behaviors.

You can mobilize community organizations, NGOs, and youth associations in the development and implementation of the abovementioned policies. Ensure substantive involvement of adolescents in the development and implementation of these policies to ensure the ownership of adolescents on these initiatives.

4. Support BCC Strategies to delay sexual initiation for Secondary Audiences

As discussed earlier, the main secondary audiences for BCC strategies for adolescents include the parents, relatives, teachers, religious leaders, and youth leaders. By targeting these audiences, you can influence indirectly the behaviors of the adolescents.

4.1. Building the Capability of Parents, Guardians, and Relatives in Guiding the Sexuality Development of Children and Adolescents

Parents play a critical role in the values formation and sexuality development of their children. Most of the attitudes, beliefs, and behaviors of adolescents are learned from their homes through the teachings of parents and their interactions with family members. What they teach to children forms the character of the children, which they carry up to adulthood. Whether they like it or not, parents also serve as the role model of their children.

Capitalizing on the indispensable role of parents in children's values formation and sexual development, your BCC strategy may include capability-building initiatives for parents to raise effectively their children into responsible adolescents and adults. Parents should be equipped with necessary skills in building a solid foundation of information and values regarding sexual behavior and attitudes among their children. Children and adolescents will then be better equipped for managing the constant stream of unsolicited content on sexuality and other issues to which they are exposed from media and peers given the timely and accurate guidance from their parents.

4.1.1. Information parents need to learn in forming positive values of their children

In forming the values of their children during their formative years, parents should be able to perform their roles in the following areas of their children's development:

Areas of Child Development	Parents' Role and Needed Skills
Learning trust	• Provision of care and nurturance needed by the child to developed sense of trust and security
Learning autonomy	• Nurturance of the child to be sure of himself, elated over his or her new found control, and proud rather than ashamed
Learning initiative	• Provision of support for a healthy developing child learning to imagine, broaden his skills to active play, cooperate with others, and lead as well as follow
Forming fundamental values necessary for an emotionally and cognitively effective child	• Provision of role modeling and support for the child to imbibe and learn positive values of self-caring , sensitivity, capacity to express thoughts and feelings, capacity to distinguish what is good from what is bad, patience, independence , adaptation and flexibility, sense of reality, kindness, high self-esteem, goodness and generosity, compassion, and love of God.
Learning gender equality	• As children start to adopt gender roles and expectations, parents need to instill the concept of gender equality. This can be done by promoting equal importance for the role of boys and girls at home and their accomplishments; shared responsibility in household chores; respect for each other; and, equal treatment. • This should also emphasize the need to provide equal opportunities for girls and boys regardless of their gender identity, sexual orientation and sexual preference. Learning about gender should enable one to transform harmful, discriminating and oppressing gender roles to help build a more tolerant society.

4.1.2. What should parents know about ASRH

To be effective mentor to their adolescent children on ASRH matters, parents need to know the concepts and issues related to ASRH. Parents need to know the following:

a) Definition and elements of Adolescent Sexual and Reproductive Health (ASRH)

Parents should know the elements and aspects of reproductive health especially among adolescents so they may understand the sexual behaviors of their adolescent children and so that they can guide them properly. The specific topics that parents should know about ASRH include:

- The development, functions, and processes of the reproductive health system;
- Fertility processes and its determinants;
- RH issues including family planning and maternal health;
- Violence against women and children; and
- Adolescent pregnancy and its consequences, among others.

b) Understanding and appreciating their own sexuality

Parents need to understand their own sexuality to be effective role models and mentors to their children on sexual and reproductive health concerns. Parents should be able to resolve their sexual issues before they can effectively lead their adolescent children to responsible sexual behaviors.

c) Physical growth and changes occurring during adolescence

Parents should know the biological changes occurring among adolescents so that they can give them appropriate advice on what to do and should not do when these changes are happening. With appropriate knowledge of these changes, parents can also guide their adolescents in protecting themselves from unwanted sexual advances.

d) Psychosocial development among adolescents

Parents should also know the changes occurring among their adolescent children as part of their psychosocial development so they can understand changes in their actions and behaviors. It is important that parents know the processes in this aspect of their development so they can help them cope with the stress and issues that come along the way.

Having significant role in the psychosocial development of adolescents, parents can positively perform their roles when they are informed. They can also maintain harmonious relationship with their children when they understand where the adolescents' actions are coming from. They can support their adolescents more effectively in coming up with decisions that can affect their development. For example, if parents know that socialization is part of the growth process among adolescents, parents can be supportive in developing the socialization skills of their adolescent children.

e) Sexual development of adolescents

Parents should also know the processes involved in the sexual development of the adolescents. They should be able to guide adolescents in issues related to their sexuality so they can properly assist them in the behaviors.

Parents should also understand the gender dimensions in the psychosexual development of adolescents and their role in forming normative behaviors in sexuality. They should avoid actions and behaviors toward their children that reflect double standard for their male and female children. More importantly, they should be able to guide their adolescent boys to develop a healthy normative behavior in relation to their sexuality. Parents especially the father can guide adolescents in forming a healthy concept and appreciation of masculinity.

f) The role of parents in building the life skills of the adolescents

Parents should have an appreciation of the developmental tasks during adolescents so they can assist them in developing needed skills to achieve such tasks. Parents should appreciate their part and provide supportive environment for adolescents to develop these life skills as discussed above.

Consider the following in gathering and convening parents:

- Inviting both parents to the training is ideal. Both parents should be supportive of the values formation of their children.
- Parents may be gathered in a community to participate in two- or three-day training or seminar. Since parents from the community, have responsibilities at home and in their work, you can conduct the training in series until all the topics have been discussed.
- Involve the community leaders in organizing and conducting the activity to ensure ownership.
- Focus on the skills development. Apply experiential learning activities not only to engage parents but to bring insights into their emotions.
- You may organize parents into support groups so that they can help each other in applying the concepts they learn. The support group can also exchange experiences from which other parents can also learn.
- If they are organized, you may federate them with other organizations in other communities to form a movement. In this way, responsible parenting can be promoted as a normative behavior. Members of these federations or organizations may be invited as resource persons in other trainings.

4.1.3. Specific Strategies in Capacitating Parents

a) Capability-building of Parents, Guardians, and Relatives on Responsible Parenting and Positive Values Formation for Children

In terms of the content, you may train parents (both the father and the mother) on responsible parenting with emphasis on the following:

- Concepts of responsible parenthood;
- Responsibilities of parents;
- Psycho-social development of the child;
- Rights of the child;
- Positive Filipino values; and
- Effective techniques in disciplining children.

b) Conducting Regular Parents' or Couples' Classes on Effective Parenting

You may also conduct regular classes of couples in the community to equip parents with information necessary for helping them practice responsible parenting. This may be integrated in regular classes for mothers in the community.

c) Integrating Effective Parenting Concepts in the Programs of Religious and Community Groups and Organizations

You may also collaborate with religious organizations (e.g. Couple's for Christ; Parish Renewal Experience) and civic groups or associations (e.g. Rotary Club, Parents-Teachers Associations)

in which both parents are members in the conduct of sessions for parents. These groups may integrate as part of their special projects the conduct of parenting sessions for responsible parenthood and ASRH.

Some Effective Methodologies during the Sessions for Parents

- You may tap resource persons who are parents themselves to provide inputs or discuss some topics not only to establish credibility but to make the concepts more experiential and relevant to the emotions of the participants. You can involve somebody whom the participants know and have reputation of being an effective parent.
- You can also apply experiential learning methodologies in capacitating parents to make them interact with other parents and deepen their learning. The activities can likewise foster partnership between couples and let them mutually appreciate the concepts and insights to be learned. Tailor learning activities based on their actual situation to make the topics more relevant. Use example that are known to them.
- You can also include testimonies from participants in relation to the topics for the participants to get a visual picture of how the topics can be practically applied.
- Ensure the conduciveness of the venue for learning. The training or session should be able to provide the venue and opportunity for the sharing of experiences among parents to foster peer learning.

d) Capacitating Parents on ASRH

To provide information and skills among parents on educating their adolescent children on sexuality and reproductive health concerns, you can also conduct capacity building among parents, especially among those with adolescent children, on ASRH as part of effective parenting. Your BCC strategy for parents should aim to enable parents to:

- Recognize their responsibility to talk to their children about relationships and sexuality;
- Not assume that young people's knowledge of sexuality and relationships is accurate, thorough or even sufficient;
- Ensure that conversations about relationships and sex are ongoing, and their children feel comfortable in asking questions on the subject as they arise;
- Recognize young people's sensibilities in discussing sexual matters, but this should not impede their educational role in equipping their children with essential knowledge about sexuality;
- Be able to appraise when their adolescent is in a romantic relationship
- Provide moral guidance for their children in a manner that does not turn adolescents to close down communication;
- Communicate with one another to be consistent with their messages;
- Avoid reinforcing double standard on sexual norms and behaviors between their sons and daughters

e) Integrating Capability Building Strategies for Effective Parenting Adolescents in Existing Programs

To sustain capability building for effective parenting, you may also work with government agencies and NGOs, which have already existing programs on capacitating parents for effective parenting. These programs include:

- Pre-Marriage Counseling (PMC) Program in LGUs;
- ERPAT of DSWD;
- Kalalakihang Tumutugon sa Responsibilidad at Obligasyon PA (KATROPA) para sa Kalusugan ng Ina at Anak of POPCOM;
- Parent Education on Adolescent Health and Development of POPCOM; and
- Parenting Adolescent Module of DSWD;

Topics that can be included in Parents' Classes

- **Clarifying values as parent -** This topic helps parents to understand themselves better and reflect on their personality, strengths, and weaknesses, in relation to their being parents.
- **Threats and challenges facing Filipino families of today -** This topic helps parents to identify and understand the threats and challenges facing the Filipino families. It also provides information on how to strengthen the family relationships.
- **Understanding adolescence as stage of human development -** This topic helps parents understand the processes, changes, and challenges facing adolescents as they go about their current stage of human growth and development.
- **How to communicate with adolescents on matters regarding sexuality -** This topic provides techniques for parents in helping and educating their adolescent children in matters of sexuality and reproductive health.
- **Roles of parents in forming life skills of adolescents** - This topic provides parents with understanding and skills in helping their adolescent children develop and exercise effective life skills.

4.2. Capacitating Teachers on ASRH

As second parents to adolescents, teachers do not only contribute to the cognitive and intellectual development of adolescents but also in their psychosocial development. As adolescents spend more time in school than home, teachers have greater and strategic opportunity to educate adolescents on ASRH issues and concerns. To make them more effective in assisting adolescents in their growth and develop behaviors that enable them to delay sexual initiation, teachers especially those teaching social sciences subjects need to acquire the necessary knowledge and skills. Teachers need to be trained on the following:

4.2.1. ASRH issues and concerns

Teachers should have a deep appreciation of the ASRH issues and concerns so they can integrate it in their respective subjects to promote healthy sexual behaviors.

4.2.2. Supporting Adolescents in Developing Life Skills

Teachers as mentors can effectively support the development of life skills among adolescents through interpersonal relationships and interactions. Since adolescents also usually consult teachers about their personal life, teachers have the opportunity to provide advice that

motivates adolescents to adopt healthy sexual behaviors. It is therefore important for teachers to gain the necessary skills in supporting adolescents in developing life skills.

4.3. Mobilizing Religious Leaders and Organizations in Values Formation and Promotion of Health Sexual Behaviors among Young People

As proven in various good practices, partnership and collaboration with the religious leaders and organizations can contribute effectively in forming the values and life skills of adolescents. Religious leaders can specifically help in deepening the spirituality of the adolescent, which can lead them in setting their priorities and visions straight; preventing promiscuous and delinquent behaviors; instilling respect to others; and other formation of values, attitudes, and behaviors that keep them from the intention to engage in sexual initiation.

You may mobilize religious leaders in promoting delayed sexual initiation through:

- Conduct of retreats, recollections, and religious activities that deepen the spirituality of the adolescents;
- Integration of human sexuality in regular seminars and orientations of the parish for young people;
- Involvement of adolescents in church services and other religious activities such as catechism and outreach programs;
- Involvement of religious leaders in government health and education programs for adolescents;
- Development, production, and dissemination of IEC materials on healthy sexual behaviors (e.g. delaying sexual initiation) among adolescent parishioners; and
- Integration of healthy sexual behaviors in pre-marriage seminars and counseling services of the parishes (i.e. Pre-Cana Seminar for would-be-couples).

E. MONITORING GAINS AND GAPS

In order to ensure that your BCC, advocacy, and social mobilization strategies are achieving its objectives, there is a need to monitor the implementation of these interventions. Below are the key indicators that you should monitor and evaluate to measure the effectiveness of communication strategies for delaying sexual initiation. The indicators are arranged according to the factors that affect behaviors as illustrated by the integrated framework for behavior change used in Section 2. These factors include knowledge; attitudes, beliefs, and values; self-efficacy; skills; and actual sexual practice or behavior. It would also help if the indicators will be categorized by sex to determine the significant differentials for further programming. Measure only indicators that are relevant and workable based on your program objectives and available resources.

Indicators for BCC Strategies for Delaying Sexual Initiation

I. Outcome Indicators

1.1. Indicators for measuring KNOWLEDGE ON ASRH

- % of adolescents who know the consequences of early sexual initiation
- % of adolescents who know the functions and processes of their reproductive systems
- % of adolescents who know the various threats and issues affecting their development
- % of adolescents who can identify risk-taking behaviors
- % of adolescents who know options to delay sexual initiation
- % of adolescents who know how to avoid risk-taking behaviors
- % of adolescents who know the necessary skills they need to delay sexual initiation
- % of parents, teachers, peers, and stakeholders who know the functions and processes of their reproductive systems
- % of parents, teachers, peers, and stakeholders who know various threats and issues affecting adolescent development

1.2. Indicators for measuring ATTITUDES, BELIEFS, AND VALUES

- % of adolescents, parents, teachers, and stakeholders who have particular attitudes and beliefs about key health-related behaviors, influences, and issues:

    - Getting pregnant
    - Delaying sexual initiation
    - Relationships, marriage
    - Gender roles, masculinity, and gender issues
    - Age at first sexual intercourse
    - Abstinence
    - Achieving education and aspirations
    - Premarital sex as a behavioral norm among peers
    - Communicating sexuality and ASRH issues between their parents and adolescent children
    - Responsible sexuality among parents

1.3. Indicators for measuring INTENTIONS

- % who believe that adolescents should only engage in sex when they are already ready to assume the demands of pregnancy and childbirth
- % of males and females who believe that it is okay to engage in premarital sex during adolescents
- % of adolescents who intend to have sex before marriage
- % of adolescents who have intention to do the following:
    - Consult a peer counselor
    - Consult parents for advice on RH
    - Delay onset of sexual activity

    - Consult a health service provider for wellness and health promotion, prevention of illness and disability, or for information on health related issues
- % of parents who intend to provide information and guidance to their children on ASRH issues and concerns

1.4. Indicators for measuring SELF EFFICACY

- % of adolescents who believe they can express one'es sexuality and feelings in positive and healthy manner
- % of adolescents who believe they could refuse sex if they did not want it
- % of adolescents who feel responsible for their actions toward others
- % of adolescents who believe they are able to act upon their decision and priorities e.g. completing their education
- % of adolescents who believe they can refuse peer pressure on sexual initiation
- % of adolescents who believe that can advocate healthy behaviors among adolescents
- % of parents who believe they can provide information and guidance to their children on ASRH issues and concerns

1.5. Indicators for measuring ACQUIRED SKILLS

- % of adolescents who acquired proficiency in any of the following particular skills after attending a course on life skills or ASRH:

    - Self-awareness and high self-esteem
    - Visioning and life planning
    - Effective communication
    - Refusal
    - Negotiating
    - Critical thinking
    - Making sound and intelligent decisions
    - Interpersonal relationships
    - Effective expression and management of emotions and feelings
    - Gender sensitivity

- % of adolescents who feel comfortable discussing SRH issues with parents, adults, health providers, counselors
- % of parents who are skilled and able to provide information and guidance to their children on ASRH issues and concerns

1.6. Indicators for measuring SEXUAL BEHAVIORS

- % of adolescents who ever had sexual intercourse
- Age at first sexual intercourse by sex and other background characteristics
- % of adolescents who had sex within a specified time period
- % of adolescents who expressed that the sexual intercourse was wanted or intended

- % of parents who provided and discussed information and guidance to their children on ASRH issues and concerns

1.7. Indicators for ADVOCACY OUTCOMES

- No. of policies and programs related to ASRH developed and implemented in the locality (by type)
- Amount of funds allocated and spent for ASR- related programs and policies

2. Output and Input Indicators

Output Indicators	Input Indicators
For BCC Strategies	
• No. of trained adolescents, parents, and stakeholders on ASRH and other types of training and capability building activities (by sex and by type of training) • No. of adolescents, parents, and stakeholders who participated/ attended interpersonal communication activities (by sex and by type of activities)	• No. of ASRH-capability building activities conducted (by type and type of audience) • No. of symposiums, forums, and public gatherings conducted (by type and type of audience) • Number of orientations and symposiums conducted for campaign against substance abuse and non-sexual risky behaviors (by type and type of audience)
• No. of adolescents who received counseling services (by sex and by type of counselor)	• No. of counselors trained on peer counseling and ASRH and life skills (by sex) • No. of counseling sessions conducted
• No. of adolescents who received information and services from health facility and from parents	• Types of programs offered in health facilities • No. of parents who provided ASRH information to their adolescent children
• No. of adolescents who received IEC materials (by sex and by type of materials) • No. of audiences who recall ASRH messages from IEC materials (by type of audience)	• No. of IEC products produced and disseminated (by type)
• No. of adolescents trained on leadership trainings (by sex)	• No. of leadership training and activities conducted
• No. of adolescents involved or who received services and information through ASRH programs (by sex and type of programs)	• No. of programs developed and implemented (by type and locality) • No. of ASRH-related policies enacted • No. of NGOs and organizations mobilized for ASRH (by level) • Amount spent versus allocation on ASRH-related activities by source of funds • No. of adolescents who attended skills development trainings (by sex) • No. of decision-makers mobilized for ASRH
• No. of adolescents who received SRH information from school	• No. of SRH curriculum-related sessions conducted and developed

Output Indicators	Input Indicators
• No. of adolescents who received information on SRH through radio, hotlines, text, and on-line counseling services	• No. and frequency of radio, hotlines, text, and on-line counseling services provided
• No. of parents, teachers, and other stakeholders who were trained, oriented, and informed on ASRH	• No. of communication activities conducted for parents, teachers, and other stakeholders (by type of activity)
For Advoccay and Social Mobilization Strategies	
• No. of local champions, advocates, and stakeholders (e.g. parents and community organizations) mobilized for ASRH • No. of local networks, NGOs, and government officials mobilized • No. of youth and community leaders mobilized	• No. of advocacy activities conducted (by type) • No. of policies drafted and filed related to ASRH programs and policies (by type)

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SECTION 5

BCC Strategies for Promoting Abstinence and Protected Sex

As data have shown, almost one in four (23%) young people aged 15-19 years have already engaged in penetrative sexual activities. Most of these happened unintentionally and without using any contraceptive resulting in too early and risky pregnancy. This implies the need to promote protected sex among adolescents who already have sexually debuted and are currently engaging in sexual activities as well as among those who are intending to initiate sexual activity for them to avoid unintended and too early pregnancy and its concomitant consequences.

Promoting protected sex among sexually active adolescents is difficult because of its controversial nature. In designing BCC strategies for this specific behavior, there is a need for you to conduct a broad consultation among stakeholders in order to ensure the acceptability of the approaches and interventions to be designed and implemented. You should also consult the intended audiences particularly the adolescents exhibiting the problem behavior so that they can express their needs and demand corresponding interventions.

As discussed earlier, the primary BCC strategies for adolescent pregnancy are for those who aim to prevent sexual initiation. However, recognizing that there are adolescents who are already engaging in sexual activities, prevention strategies may no longer be applicable to them. As such, the next best strategy for this segment of adolescents is to let them use contraceptives to prevent pregnancy.

Who are the sexually active adolescents?

The BCC strategies under this Section are primarily intended for adolescents who are already sexually active. Sexually active adolescents are those who ever had engaged and are currently engaging in series of sexual activities. These may include adolescents who regularly or less frequently engage in sexual activities with a steady or multiple sex partners.

However, as indicated in Section 2, most of sexual initiations were unprotected, thus, exposing sexually debuting adolescents to unintended pregnancy. As such, protected sex should also be promoted during sexual initiation. This means that protected sex should also be promoted among adolescents who have high intentions to engage in sexual activity for the first time.

What to consider in promoting protected sex?

While this strategy is intended for those who are sexually active, the cultural acceptability of interventions both in terms of their methodologies and in terms of content should be carefully designed and implemented. The most ideal, safest, and priority strategy for sexually active adolescents is abstinence or refraining from sexual activities. Prevention or abstinence is still more effective than any other strategy to prevent adolescent pregnancy.

However, you need to carefully study your audience and identify those who are actually sexually active to avoid sending the wrong message to adolescents who have not yet engaged in any sexual activity. It is also important to study the intentions of those who already have engaged in sexual activities to identify appropriate messages and interventions.

Promoting protected sex is not only for avoiding pregnancy but also for protection against contracting sexually transmitted infections (STIs) and HIV/AIDS. Promoting protected sex within the context of avoiding these diseases may also help in promoting the use of contraceptives to avoid pregnancy.

What contraceptives should be promoted among sexually active adolescents?

An important question along this BCC strategy is: what type of contraceptive methods should be promoted among sexually active adolescents? As a policy and program principle, the Department of Health promotes family planning methods or contraceptives under the context of the family planning (FP), maternal health, and prevention of STI and HIV/AIDS infection programs. Under the Family Planning program, contraceptive methods are primarily promoted among couples who are married and cohabiting or in union for limiting and spacing births. FP methods are also promoted as an intervention for maternal health particularly to ensure birth spacing. Lastly, condom is also promoted to prevent STI and HIV/AIDS infection especially for most-at-risk-population.

In the context of adolescent sexual and reproductive health, pills, condom, injectables, and other legal and safe temporary methods can be promoted for preventing pregnancy and STI and HIV/AIDS infection among sexually active adolescents. Permanent methods are not recommended to adolescents in as much as these methods are for those who want to limit the number of their children permanently. Adolescents, obviously, would still want to have their own children and family in the future.

However, promoting these contraceptives strictly requires counseling to provide adolescents with personally tailored informed and appropriate choice of method. Since abstinence should be promoted as the primary option for adolescents, contraceptives may be promoted in accordance to existing family planning standards as the "last resort" for preventing pregnancy among adolescents.

A. THE DESIRED BEHAVIOR

1. Abstinence from Sex

The safest way not to get pregnant is to abstain from sex. This, however, entails a strong will and discipline to control sexual urges and channeling of energies to more positive and productive endeavors. Abstinence is refraining from subsequent sexual activities after their sexual initiation so as not to be exposed to early pregnancy.

2. Going for Counseling and Contraceptive Use

If abstinence fails, sexually active adolescents should ensure protected sex. Male adolescents should use condom properly to avoid pregnancy and protect themselves and their partners from STI and HIV infection. Condom use should be practiced during all sexual engagements including sexual initiation and subsequent sexual activities.

Female adolescents can also consult health service providers for contraceptive methods most appropriate to their health conditions. Pills and injectables strictly require medical advice to make the method more effective and to avoid unintended side effects. As such, adolescents should also practice positive health-seeking behavior especially in matters regarding their sexual and reproductive health.

Male and female adolescents should make it a habit to seek counseling services for their sexual and reproductive health concerns. They should seek appropriate information and services to protect them from unintended pregnancy.

3. Support behaviors to promote abstinence and protected sex

The desired behaviors for delaying sexual initiation mentioned in Section 4 are also relevant for abstaining from sexual activities. Controlling and managing sexual drive, focusing on priorities, and being critical of the messages from media are all behaviors that can support adolescents to refrain from sexual activities. Practicing the needed life skills and efficacies can also effectively support abstinence.

4. Desired behaviors among Secondary Audiences

4.1. Parents and Guardians

Again, parents should effectively communicate ASRH issues and concerns with their children particularly on the repercussions of their sexual activities. Parents should effectively encourage their adolescent children to abstain from sex and to focus on the achievement of their aspirations. If parents are morally constrained to instruct their children on protected sex, they should encourage their adolescent children to seek guidance from counselors and health service providers about reproductive health issues.

4.2. The Peers

Peers can guide and support each other to make healthy and responsible decisions about their sexuality by role modeling and encouraging them to abstain or practice protected sex. Peers can be a source of pressure for positive behavior among adolescents.

4.3. Counselors

Teachers, guidance counselors, and health workers should have an open and understanding attitude towards sexually active adolescents. They should guide them to abstain from sex and to use protection against pregnancy if intimacies lead to sexual intercourse.

4.4. Health workers

Health workers need to be objective and non-judgmental in treating adolescents' sexuality concerns. They should be effective in counseling adolescents to abstain from sex and provide them with informed choice and access to appropriate contraceptive methods when needed. They should be able to make adolescents feel comfortable in seeking necessary health services that ensure their sexual and reproductive health.

B. THE TARGET AUDIENCES

Type of Target Audience	Behavioral Component to be Addressed
Primary Audience	
Adolescents 14-19 who are about to engage in sexual initiation	• *Values and moral conscience* • *Cognitive capacity (well-founded concept of what is right and wrong in a given circumstances)* • *Attitudes* • *Subjective norms* • *Life-skills (delayed gratification, patience, caring, etc.)*
Adolescents who already engaged in sexual activities	• *Values and attitudes* • *Self-efficacy or life-skills (delayed gratification, life-planning, refusal, etc.)* • *Normative beliefs on sexuality concerns especially on condom use*
Secondary Audience	
Parents and guardians	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Attitude and skills on communicating or discussing ASRH issues with their adolescent children especially on abstaining and using condom*
Teachers and guidance counselors	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Attitude and skills on communicating or counseling adolescents on ASRH issues*
Peers	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Skills on counseling adolescents on ASRH issues*
Health workers	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Skills on counseling adolescents on ASRH issues*
Local officials, NGOs, and youth leaders	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Behavior on supporting adolescent health and development related programs and services*

C. KEY MESSAGES FOR ABSTINENCE AND PROTECTED SEX

In promoting abstinence, you may also use the messages developed for delaying sexual initiation and in preventive strategies identified in the previous section. This time, the focus is to convince adolescents not to engage in subsequent sexual behaviors to prevent pregnancy. In promoting contraception, you may adopt the following messages:

1. Messages to promote positive attitude towards protected sex

Existing Attitude	Core Messages

• Men usually do not use condom because of its perceived effect in reducing sexual sensations during intercourse.	• Condom helps prevent unintended pregnancy
	• Condom protects adolescents from STI and HIV
	  • Studies have shown that condoms are highly effective in preventing HIV transmission when used properly. These studies looked at uninfected people in sexual relationships with HIV-infected partners.
	  • Studies found that even with repeated sexual contact, 98 to 100 percent of those people who used latex condoms correctly and consistently did not become infected.
	• Condom increases sexual satisfaction because it removes the fear of pregnancy and STI and HIV infections.
	• There are types of condoms in the market that are made of thinner latex which can get equal sensation as that of unprotected sex.
	• Other advantages of condom
	  • Convenient and easy to obtain
	  • Inexpensive
	  • Do not require a prescription
	• Know the facts about protected sex and STI and HIV/AIDS!
	  • Get the right information so you will be informed and you can choose and decide wisely.
	  • Approach people (e.g. health workers) who can provide the correct information.

Existing Attitude	Core Messages

• Condom is considered as only for casual ("one-night stands) and commercial sex and not for steady partners.
• Adolescents lack knowledge on STI and HIV/AIDS
	• Condom is for protection from pregnancy and disease infection. Protected sex can show couples that they care about the welfare of each other.
	• Know the facts about protected sex and STI and HIV/AIDS!
	  • Get the right information so you will be informed and you can choose and decide wisely.
	  • Approach people (e.g. health workers) who can provide the correct information.

• Condom promotes promiscuity.	• Condom use promotes responsible sexuality as it makes adolescents become rational and critical of the ramifications of their actions. • Condom use is only promoted among the sexually active adolescents who have developed tendencies to engage into sexual activities. Abstinence is still the priority behavior that is promoted among adolescents, however, once adolescents are "helpless" to control their sexual urges, they need to use condom.

2. Messages to promote positive norms on protected sex

Existing Attitude	Core Messages
• Men usually do not use condom because of its perceived effect in reducing sexual sensation during intercourse.	• Condom increases sexual satisfaction because it removes the fear of pregnancy and STI and HIV infections. • There are types of condoms in the market that are made of thinner latex which can get equal sensation as that of unprotected sex.

• Condom is used only for for casual ("one-night stands) and commercial sex and not for steady partners.
• Adolescents lack knowledge on STI and HIV/AIDS
	• Condom is for protection from pregnancy and disease infection.
	• Protected sex can show couples that they care about the welfare of each other.
	• Know the facts about protected sex and STI and HIV/AIDS!
	  • Get the right information so you will be informed and you can choose and decide wisely.
	  • Approach people (e.g. health workers) who can provide the correct information.

3. Messages to build self-efficacy on protected sex

Existing Attitude	Core Messages
• Female adolescents usually do not have the ability to refuse sex without any protection.	• Refusing unprotected sex can save female adolescents from unintended pregnancy and STI and HIV/AIDS infection • Regularly consulting health workers leads to safe sexual behaviors
• Adolescents usually do not use condom or any contraceptive because of the spontaneity of the act.	• Engaging in sex is a defining behavior among adolescents. They should act in accordance with their readiness and commitment to assume the responsibility attached to its consequences.

D. BCC STRATEGIES TO PROMOTE ABSTINENCE FROM SEX AND PROTECTES SEX

The preventive strategies enumerated in Section 4 can also be used to promote abstinence from sexual activities. You can adopt them as your primary strategies to prevent adolescents from repeated sexual engagements.

The BCC strategies for promoting protected sex aim to address the following barriers to desired behaviors:

- Negative attitude towards condom and protected sex;
- Adolescents' belief that condom is only for casual and commercial sex and not for steady romantic relationships;
- Lack of information on the consequences and risks of unprotected sex;
- Unintended and unplanned sexual intercourse;
- Incapacity of female adolescents to refuse unprotected sex;
- False sense of masculinity and submissiveness of female adolescents to unprotected; and
- Lack of access to contraceptives.

Below is a summary of the BCC strategies and activities as well as the advocacy and social mobilization support activities that you may adopt in promoting condom use:

Main BCC Strategies	Specific BCC interventions	Advocacy & Social Mobilization Strategies
Target Audience: Adolescents 15-19 (have not yet engaged in sex and those who are sexually active)		
• Raising the Awareness of Adolescents on the Negative Consequences of Unprotected Sex	• Development, production, and dissemination of IEC materials • Counseling on condom use (e.g. peer counseling and in health facilities) • Integration of messages on condom use in television and radio programs • Entertain-educate on condom use • Campaign on protected sex through symposiums, forum, round-table discussions, debates, and other interpersonal communication strategies	• Mobilization of health workers in providing counseling and info-dissemination activities on protected sex among adolescents • Mobilization of youth leaders in the campaign for protected sex • Mobilization of NGOs, communities, and government agencies in the campaign for protected sex
Target Audience: Sexually active adolescents aged 15-19 years		
• Provision of Counseling Services and Effective Contraceptives for Protected Sex among Adolescents	• Training of health service providers on ASRH and effective counseling of adolescents • Training of peers on counseling fellow adolescents on protected sex • Provision of counseling and appropriate contraceptives among sexually active adolescents	• Advocacy for the development of adolescent responsive health services including provision of appropriate contraceptives • Mobilization of health workers in providing counseling and info-dissemination activities on protected sex among sexually active adolescents • Mobilization of youth leaders in the promotion of protected sex • Mobilization of NGOs, communities, and government agencies in the promotion of protected sex

I. Provision of Counseling Services among Sexually Active Adolescents

The promotion of protected sex among adolescents is a highly controversial. As such, you need to carefully design your BCC strategies for promoting protected sex to avoid misconception that your strategy is promoting sexual promiscuity. The first challenge that you have to consider is: how to identify the sexually active adolescents? This is important to ensure that information and appropriate services are given to appropriate audiences. Otherwise, when information on protected sex are given in a "shotgun" or "generic" approach by which even those not intending to engage in sex are covered, the message may be interpreted wrongly. It may send a wrong message among adolescents that sex is okay as long as it is protected. This is the reason why symposiums, forums, or other activities that aim to raise the knowledge and appreciation of the adolescents is not recommended for promoting protected sex. You need to dissect your target audience and seek out to the sexually active to fit in your strategies.

The most effective way to identify sexually active adolescents is through counseling. Counseling can help identify and locate the sexually active adolescents through personal interactions between the counselor and the adolescent client. With open and enabling discussion on adolescents problems and concerns, the counselor may be able to know and understand the sexual reproductive health concerns of the adolescents which he or she can use in empowering adolescents to take appropriate actions. As such, this should be the first step in any strategy that aims to promote protected sex.

1.1. Counseling in Health Facilities

Counseling can help adolescents become aware of the repercussions of their sexual behaviors and make informed choices in matters related to their sexuality and reproductive health. You may establish the source of counseling services in the public as well as private health facilities. Health workers should be friendly to adolescents so they can open-up and express their needs. Adolescents are hesitant to seek advice and services from the health center because of the judgmental attitude of the health workers on behavior of adolescents. Such attitudinal barrier must be removed to promote a more positive health-seeking behavior among adolescents.

As an innovative strategy, you may hire or train younger health service providers who can relate more effectively with adolescents. Set-up a youth friendly corner or special service unit allotted for adolescents to make them more comfortable in accessing information and services specifically in health facilities. Likewise, conduct campaign to inform the public on the availability of these services to increase demand and improve health-seeking behaviors among adolescents.

1.2. Peer Counseling

Peer counseling is also important in promoting protected sex. Peers can relate more intimately with their fellow adolescents. The similarity of their world and experiences motivates adolescents to open up to friends whom they know can help them with their concerns. Adolescent counselors speak the same language as their peers so they can relate with them in a more personal basis. Peer counselors can let their peers open up without fear of being judged by adults. The confidence to open-up is critical in enabling adolescents to take appropriate action towards their concerns.

Peer counseling is also effective in terms of role modeling positive attitudes. Peer counselors can be living examples of the desired behaviors. Adolescents may be motivated to abstain or engage in protected sex when they know and see somebody from among their peers exhibiting such behavior. This facilitates adopting condom use as a normative behavior among the members of their group.

Peer counseling should be extended from schools to the community to also address the ASRH concerns of the out-of-school adolescents. This segment of adolescents needs counseling services as they more vulnerable and exposed to various factors that can undermine their sexual

and reproductive health. They also do not have the necessary resources to access service necessary for protected sex.

2. Developing the Refusal and Negotiating Skills of Female Adolescents for Protected Sex

Female adolescents should be protected from the unintended consequences of protected sex. They should be able to refuse sexual proposals by their male partners especially when their male partners refuse to use condom. Both male and female adolescents should be able to communicate their desires and sexuality to arrive at healthy and positive behaviors. They should be able to reach an agreement to delay or abstain from sex, or use condom or protection when they mutually consent to do the act.

In view of this, you may integrate the promotion of condom use in your life skills training as recommended in Section 4. You can specifically develop among female adolescents the skill to refuse and negotiate especially on matters regarding their sexuality. The refusal and negotiating skills may be applied in refusing to have sex at all (abstain) or to have protection when both partners resort to doing the sexual act. This skill can also protect women from sexual advances from their partners.

3. Development, Production, and Dissemination of IEC Materials

You may focus the content of the IEC materials on the messages identified above. For promoting abstinence, you may adopt the materials that could be designed for promoting delayed sexual initiation. These materials should emphasize the need to abstain from sex as the safest way of preventing pregnancy and STI and HIV infections. IEC materials for protected sex should only be disseminated during counseling sessions to reinforce adolescents' knowledge on ASRH related concerns.

The development and dissemination of IEC materials for promoting protected should be carefully undertaken taking into consideration the critical cultural sensitivities existing within the environment of the target audience. Moreover, you need to carefully and patiently identify the target audiences so that correct information and messages could be imparted. You need to encourage appropriate guidance to adolescents through the parents or counselors in understanding the message and correct context of the content of the IEC materials. You should avoid promoting messages that may promote promiscuity and obscenely hurt religious feelings and cultural sensitivities.

In developing the IEC materials for condom use among adolescents, you may consider the following:

- Avoid explicit and obscene illustrations of sexual activities. This may offend sensitivities.
- Avoid vulgar words or text as this would also offend the readers.
- Be factual. Mention facts with empirical and credible evidences.
- Simplify texts. Capture the message effectively in the IEC materials in an appealing and understandable manner.
- Translate the messages into the language that the target audiences use in daily living. These include the use of appropriate dialect and of simple concepts and terminologies.
- Access of the target audiences to the IEC materials to be produced.

Each IEC materials has their own advantages and disadvantages. Consider them in choosing the most appropriate IEC materials that you can develop and disseminate. Always pre-test the materials before printing them so that you can preview the acceptability and effectiveness of such materials to your intended audiences. The specific activities you need to do in the development of IEC materials include:

Steps in Developing IEC Materials	Description
1. Conceptualize your IEC material • Define the problem	• Go back to your causal and behavioral analysis. Identify which of the components of the behavioral problem you should address.
• Set your objectives	• What is your purpose in developing the material? Do you want to influence knowledge or attitude, level of access to condoms, or availability of information and services. Do you want to inform, motivate, or change behaviors?
• Identify the type of materials to be developed	• What materials should you develop and produce? In selecting the type of IEC materials to be produced, take into consideration the characteristics of the audience, the potential accessibility of the materials among the intended audiences, and the cost-effectiveness of the preferred IEC material.
2. Develop your message • Determine and write the content	• Based on the messages identified above, you need to select which message you would want to convey through your choice of IEC materials based on your analysis of your audience. • Unify the text around a central theme. Simplify or clarify this theme in terms of its impact upon the target audience. You may use illustrative incidents, empirical facts, and other credible information to amplify your main message.

Steps in Developing IEC Materials	Description
• Make Visual Choices for the IEC mater	• You may work with your lay-out artist in designing the visuals of the IEC materials. Basic considerations in the visuals of an IEC materials include: a) simplicity; b) visual appeal or attractiveness; c) use of texts or letterings; and, d) clarity and effectiveness of illustrations (e.g. picture versus cliparts or drawings).
3. Produce your IEC materials	• Print your materials in limited copies for the pre-testing.
4. Pre-test your materials	• It is important to pretest the materials to see if they are appropriate for the intended audiences and that they will help achieve the desired impact. It can also help identify other factors that can affect the acceptability and relevance of the materials.
5. Print, produce, and disseminate your materials in quantity	• After revising the materials after the pretest, you may now finalize the layout of your materials, after which, you may then print and produce the material in larger quantity. • Set-up a distribution mechanism to determine the beneficiaries for such interventions. It is important to know if the intended audience actually received the materials so they can be subjected to assessment later on.
6. Assess and evaluate the materials for its effectiveness	• You must subject the materials to assessment and evaluation in order to determine the level of effectiveness and impact of the IEC materials vis-à-vis its objectives. Assessment can also provide you with information on the areas to be improved.

Making condom use as a behavioral norm among men in television, radio, and other media programs (Lee, 2009)

Increasing the proportion of Filipino males especially among adolescents is indeed a challenging task, but it is a doable and achievable target. One pivotal action that can be done is to establish condom use as a normative behavior, that is, make it a routine and regular practice among sexually active men to prevent their partners and themselves from acquiring infections and unintended pregnancy.

The use of television is appropriate for condom use because of its power to create social realities and norms. However, while stand-alone commercials on condoms have merits, they entail limiting budgetary considerations. As such, we need alternative inexpensive strategy for the normalization of condom use especially for young people and sexually active males.

One way of doing this is to embed the idea and practice of condom use in appropriate television shows, such as on-going or future sex, drama, and comedy programs. For example, the idea and practice of using condoms can be integrated by finding or establishing niches in actors' dialogue, actions or situations in the shows. For instance, if an actor discovers that she is pregnant and she is confiding to a friend, the following dialogue may be infused:

"Buntis ka? Sinabi ko naman sayong gumamit ka ng proteksyon. Alam mo namang ganyan ang kahihinatnan ng gingawa nyo ng boyfriend mo pero dapat pinagamit mo siya ng condom."

Also, with an appropriate camera angle, an actor in a program may be shown with a condom pack well-outlined in his jean's pockets or placed somewhere in the room. Or, while an actor is having sex scene in a television program, the following dialogue may be included in the script:

Scene: Couple seen kissing and then suddenly stops:

Partner: *"Saan punta mo?*

Actor: *"Sandali, may kukunin lang ako"*

Partner: *"Ano?"*

Actor: *"Condom (sabay ngiti). Mabuti na 'yong ligtas. Mahirap na."*

Or an actor may be asked to wear a t-shirt with condom-related messages, or hand condom packs to his girlfriend in a show. The whole strategy aims to promote condom use in less glaring ways. This strategy does not require a long broadcast air time (a few seconds will do), and it does not have to be restricted in television alone. Movies, radio programs, and the internet and other forms of mass media can be utilized as well. This approach requires forming and maintaining close working relationships with mass media owners and professionals, some of whom – coming from a different generation – are supportive of social changes, such as the one being proposed.

To reinforce the socio-cultural embeddedness of condom use, role models are needed. People tend to adopt and sustain new behavior when they are given credible models who display that behavior. Credible role models have to practice what they preach.

Moreover, condom use as it is embedded socially and culturally should be promoted and marketed with emotional appeal. This means that when men use the method, they feel and experience positive emotions.

(Adopted from Lee, Romeo, "Filipino Men and Condom Use: An Action Priority," ICPD at 15 Magazine, POPCOM, 2009)

4. Building the Capacity of Health Service Providers on ASRH on Counseling Adolescents

As mentioned in a number of times in this document, the attitude of health service providers towards adolescent pregnancy and sexual behaviors significantly affect the health-seeking behaviors of adolescents. Just like with their parents, adolescents have an issue on the "generation gap" between the health workers and adolescents. Adolescents seldom go to health facilities not only because there are no specific ASRH services offered to them but also because of the negative attitude of health workers towards them.

To encourage more positive health-seeking behaviors among adolescents in terms of their ASRH concerns, specifically for their needs in protected sex, the health workers need to be more understanding of the situations and needs of the adolescents. Health workers should be able to empower adolescents to choose and act responsibly in terms of their sexuality by providing accurate information and needed services.

The challenge for health workers is to make the adolescent client open-up and freely express their problems and issues without fear of being ridiculed or ostracized. The health worker and the client should be able to overcome the "generation gap" which is serving as a barrier for the adolescent to open-up. The health workers should have the following basic knowledge and skills:

Core competencies among Health Workers in addressing ASRH issues	Relevance of skills in promoting protected sex

• Deep understanding on ASRH specifically on the following:
  • Reproductive health needs of adolescents
  • Developmental tasks during adolescents
  • Factors causing adolescent pregnancy
  • Developmental processes and expected behaviors during adolescence
	• An understanding of ASRH issues helps health workers to understand sexuality-related issues being confided by the adolescents. It gives health workers with proper perspective and information that can guide adolescents to pinpoint the obstacles in their own way and take responsible and appropriate actions in relation to their sexual and reproductive health issues.

Core competencies among Health Workers in addressing ASRH issues	Relevance of skills in promoting protected sex
• Ability to listen to adolescents without bias or judgment	• Health workers should know how to listen to what the adolescents have to say. Good listening generates empathy and understanding on the emotions involved in the shared experiences and problems of the adolescents. Sometimes, counselors do not even need to say something; adolescents just need somebody to understand and empathize with them. • Health workers need to distance themselves from any emotion that they may feel in connection with the issue. They should remain objective and unaffected emotionally.
• Ability to guide the adolescents understand their problems and pin point the obstacles as well as the potential solutions on their own	• Health workers should be able to guide adolescents in analyzing and understanding their issue and take appropriate actions. They should be able to guide adolescents surface the issues in relation to their problems and let them connect these factors to understand their situation on their own. By letting them understand the problem, they may be able to pinpoint the obstacles and by doing so identify actions that can respond to these issues.
• Ability to guide adolescents realize the opportunities that they can optimize during their struggles and tensions	• Health workers should be able to lead the adolescents in finding the lessons to be learned from their experiences and using such learning to empower them to take actions.

E. ADVOCACY AND SOCIAL MOBILIZATION SUPPORT STRATEGIES

1. Advocacy for the development of adolescent responsive health services including the provision of condoms

The BCC strategies identified above need important advocacy support to complement the promotion of the desired behavior among sexually active adolescents. You need to collaborate with existing networks, organizations, and other stakeholders in the advocacy for the design and implementation of responsive health services including the provision of condoms among sexually active adolescents. This entails the enactment of ASRH related policies or development of related programs to ensure access of adolescents to counseling and contraceptive services. These services are needed to address the demand of adolescents who would seek necessary information and services to enable them exercise healthy and responsible sexual behaviors. Your advocacy should also work for the allocation of budgets and resources to implement and sustain the ASRH related policies and programs.

2. Mobilization of youth leaders in the promotion of protected sex

The participation of the youth themselves in promoting abstinence and condom use is critical. Youth leaders should be able to lead the way towards healthy and responsible sexual behaviors among their fellow adolescents. They can mobilize their peers to contribute in the

campaign. In this way, their participation in related ASRH activities can be in itself a strategy in making opportunity for the adolescents to get away from chances of unprotected sex. Adolescents participation in social mobilization activities can also build leadership skills and social consciousness among them which they need in exercising responsible decisions and behaviors. Adolescents' involvement can actually jumpstart a movement for responsible and health sexual behavior.

3. Mobilization of NGOs, communities, and government agencies in the promotion of protected sex

Appropriate agencies and organizations at all levels should also be involved in the campaign. You can undertake advocacy initiatives to mobilize various stakeholders in implementing ASRH-related programs and projects and allocating adequate funds for sustainability.

4. Mobilization of the private sector in the promotion of protected sex

The private sector is a critical partner in the campaign for healthy sexual behaviors among adolescents. They can help in ensuring necessary ASRH services including condoms among the working adolescents and also in undertaking school and community-based information drive and service provision. You may collaborate with the private sector under their corporate social responsibility (CSR) initiatives.

F. MONITORING GAINS AND GAPS

You may use the following indicators in monitoring the effectiveness and impact of your strategies for abstinence and condom use:

1. Outcome Indicators

1.1. Indicators for measuring KNOWLEDGE on Condom Use

- % of adolescents who knows the consequences of unprotected sex
- % of adolescents who knows various methods to prevent pregnancy
- % of adolescents who knows the various STIs (modes of transmission and prevention)
- % of adolescents who knows HIV and AIDS (modes of transmission and prevention)

1.2. Indicators for measuring ATTITUDES, BELIEFS, AND VALUES

- % of adolescents who have particular attitudes and beliefs about key health-related behaviors, influences, and issues:

- Abstinence
- Protected sex (using condom)
- Getting pregnant
- STI and HIV/AIDS
- Exchange of money for sex

- % of adolescents who believe that unprotected sex is the prevailing norm among adolescents

1.3. Indicators for measuring SELF EFFICACY

- % of adolescents who believe that they can control their sexual urges
- % of adolescents who believe they could refuse sex if the partner do not use condom
- % of adolescents who put importance on studies or employment more than sexual activities
- % of adolescents who believe they can refuse peer pressure on sexual activities
- % of adolescents who believe they can advocate healthy behaviors among adolescents

1.4. Indicators for measuring SEXUAL BEHAVIORS

- % of adolescents who abstain from sex in the last 12 months
- % of adolescents who used condom during their sexual initiation and subsequent sexual activities
- % of adolescents who seek information and consultation/services at health facilities
- % of adolescents who are able decide about their sexual behaviors - whether or not to engage in sex
- % of adolescents who engage in safer sex practices

1.5. Indicators for ADVOCACY and SOCIAL MOBILIZATION ACTIVITIES

- No. of relevant policies and programs enacted and implemented to promote protected sex (by type of policy and program and by type of implementing agency)

Output Indicators	Input Indicators
• No. of trained adolescents on ASRH and other types of training and capability building activities (by sex and by type of training) • No. of adolescents who participated/ attended interpersonal communication activities (by sex and by type of activities)	• No. of ASRH-capability building activities conducted (by type) • No. of orientations and symposiums conducted to promote protected sex
• No. of adolescents who received counseling services (by sex and by type of counselor)	• No. of counselors trained on peer counseling and ASRH and life skills (by sex) • No. of counseling sessions conducted
• No. of adolescents who received information and services from health facility • No. of adolescents who received condom	• Types of programs offered in health facilities
• No. of adolescents who received IEC materials (by sex and by type of materials) • No. of audiences who recall ASRH messages from IEC materials (by type of audience)	• No. of IEC products produced and disseminated (by type)
• No. of adolescents involved or who received services and information through ASRH programs (by sex and type of programs)	• No. of programs developed and implemented (by type and locality) • No. of ASRH-related policies enacted • No. of NGOs and organizations mobilized for ASRH (by level) • Amount spent versus allocation on ASRH-related activities by source of funds • No. of adolescents who attended skills development trainings (by sex) • No. of decision-makers mobilized for ASRH
• No. of adolescents who received information on SRH through radio, hotlines, text, and on-line counseling services	• No. and frequency of radio, hotlines, text, and on-line counseling services provided
• No. of local champions and advocates mobilized and supportive of advocacy for protected sex • No. of community organizations mobilized for advocacy for protected sex	• No. of advocacy and social mobilization activities conducted (by type and by implementing partner – public and private) • No. of agencies, networks, and alliances mobilized and involved in advocacy and social mobilization activities

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SECTION 6

BCC Strategies for Avoiding Multiple Sex Partners & Commercial Sex

Risky sexual behaviors such as engaging in sex with multiple and commercial sex partners enhance the chance of an adolescent to impregnate or to get pregnant. As discussed in Section 2, a significant proportion of male adolescents have engaged in sex with multiple sex partners and many female adolescents are caught in commercial sex against their will. These behaviors and conditions become a behavioral risk factor because of the low prevalence of contraceptive use among adolescents. Males who are actively engaging in sex with different partners have higher chances of impregnating several female partners. Prostituted women, on the other hand, are left vulnerable to pregnancy and sexually transmitted diseases because of their active exposure to sexual engagement as means of survival. Multiple and commercial sex behaviors should also be addressed by corresponding BCC strategy to prevent adolescent pregnancy.

A. THE DESIRED BEHAVIORS

1. Avoiding Multiple Sex Partners

Avoiding multiple sex partners is actually refraining or abstaining from sexual activities not only with their regular sex partners but also with other sex partners. Avoiding active sex life entails controlling sexual urge. It is not about being faithful to one partner but about absolutely avoiding sexual activities until adolescents are prepared to take on the responsibilities associated with pregnancy and childbirth. As such, avoiding multiple sex partners is the same behavior as abstinence. When sexual abstinence is not observed, adolescents are expected to use protection when they engage in sexual activities.

2. Protected Sex among Adolescent Engaging in Transactional Sex

The issue of transactional sex is closely associated with poverty and scarcity. Transactional sex includes engagement in sexual activities for consideration of payment either in ther form of money or in kind. However, while we recognize the socio-economic conditions that force adolescents to engage in commercial or transactional sex, especially among female adolescents, the BCC strategies in this Sourcebook are not intended to address such conditions. The BCC strategies cannot address the non-behavioral concerns but it can promote the prevention of unintended pregnancy and sexually transmitted diseases as consequences that aggravate their poor conditions. As such, the BCC strategies for female engaging in transactional or commercial sex focus on promting protected sex.

Female adolescents and their partners are expected to use contraception whenever they engage in transactional sex. They should always compel their paying partners to use condom and refuse sex if they would not use one.

3. Support behaviors to achieve the desired behaviors

Again, managing sexual drive, focusing on priorities, and being critical of the messages from media are all behaviors that can support adolescents to refrain from sexual activities that lead them to different partners. Practicing the needed life skills and efficacies can also effectively support adolescents in avoiding multiple sex partners.

For female adolescents engaged in transactional sex, their skills in refusing and negotiating with their partners can help them ensure protected sex, thus, avoiding unintended pregnancy. They should be able to refuse sexual advances and exploitation from their paying partners.

4. Desired behaviors of Secondary Audiences

4.1. Parents and Guardians

Parents should be able to guide their adolescent children in their sexual activities particularly enabling them to prevent early and unintended pregnancy through constant communication with their children about ASRH issues. Whatever relationships children engage in, parents should be there to reinforce healthy and positive sexual behaviors including protected sex.

4.2. The Peers

Peers can influence their fellow adolescents to refrain from sex in romantic relationships. The peers should establish behavioral norms that discourage the false concept of masculinity in which having multiple sex partners enhances one's self-ego and status as a man.

4.3. Counselors

Teachers, guidance counselors, and health workers can influence adolescent behaviors through appropriate information and guidance. They can enable adolescents to resolve their issues through informed decisions.

4.4. Health Workers

Health workers can be sources of information and services that adolescents, especially those in the commercial sex trade, can use to avoid unintended pregnancy and sexually transmitted diseases.

4.5. Managers of Establishment-based and Freelance Sex Workers

The managers or handlers of sex workers, establishment-based or freelance, can help in nurturing the desired behaviors to the women under their care through their guidance. They can give the adolescents the necessary information that they can use in protecting themselves from pregnancy and sexually transmitted diseases.

B. THE TARGET AUDIENCES

Type of Target Audience	Behavioral Component to be Addressed
Primary Audience	
Male adolescents who are sexually active (with one or more sexual partners)	• *Values and attitudes* • *Self-efficacy or life-skills (delayed gratification, life-planning, refusal, etc.)* • *Normative beliefs on sexuality concerns especially on condom use*
Female adolescents engaged in paid or commercial sex	• *Values and attitudes* • *Self-efficacy or life-skills (refusal and negotiation skills)* • *Normative beliefs on sexuality concerns especially on condom use*
Secondary Audience	
Parents and guardians	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Attitude and skills on communicating or discussing ASRH issues with their adolescent children especially on abstaining and using condom*
Teachers and guidance counselors	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Attitude and skills on communicating or counseling adolescents on ASRH issues*
Peers	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Skills on counseling adolescents on ASRH issues*
Health workers	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Skills on counseling adolescents on ASRH issues*
Local officials, NGOs, and youth leaders	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Behavior on supporting adolescent health and development-related programs and services*
Managers of Establishment-based and Freelance Sex Workers	• *Knowledge and attitudes on adolescent sexuality and reproductive health* • *Skills on counseling adolescents on ASRH issues*

Focus the BCC strategy on the male adolescents because of their higher tendency to engage in sex with multiple partners than their female counterpart. The strategy specifically addresses their false sense of and attitude toward their masculinity which makes them feel confident and proud of their sexual conquest with little regard to the consequences of their behaviors. Females are at the receiving end of these negative consequences. As such, we target the risky behaviors among males to prevent pregnancy among females.

For transactional or commercial sex, our focus should be towards protecting female adolescents from unintended pregnancy as well as from STI and HIV infections. The engagement of male adolescents in commercial sex is also an important issue in so far as their reproductive health is concerned. However, the female involvement in commercial sex is more critical and relevant in terms of adolescent pregnancy. It is the female who is exposed to pregnancy during paid sex rather than the males. They are exposed to the sexual behaviors not only of males of their age but more of the behaviors of their adult clients. Thus, females engaged in this risky sexual behavior need more attention.

C. KEY MESSAGES FOR AVOIDING MULTIPLE SEX PARTNERS AND COMMERCIAL SEX

The messages developed for delaying sexual initiation and abstinence are also relevant for discouraging multiple sex partners behaviors. The focus is to convince adolescents not to engage in subsequent sexual behaviors with different partners to prevent pregnancy and disease. Or, if they engage in sexual relations, they should ensure protected sex.

1. Messages to promote positive attitude towards protected sex

Recall that the main factor that influences male adolescents to take risky behaviors such as multiple sex partners is their feeling of pride with their sexual conquest and the lack of control over their sexual urges. As we want them to abstain from sex in their multiple relationships, you can emphasize the consequences of their actions in relation to their health and aspirations. You may pin point the benefits of having a faithful relationship with no sex involved. Or, if they are really bent on engaging in sex, show them the advantages of protected sex. The core messages and sample slogans we identified in Sections 4 and 5 are actually relevant in preventing adolescents to engage in risky behaviors. You may refer back to these Sections.

Existing Attitude	Core Messages

• Male adolescents believe that masculinity is measured by the number of women he had sex with
  • The more sex partners an adolescent has, the more desirable and masculine he is
  • It is normal for men to have multiple sex partners.
	• Having multiple sex parters especially when its unprotected exposes adolescents to unintended pregnancy and STI and HIV/AIDS infections
	• Masculinity is not in any way measured by number of sexual exploits or adventures. Real men are those who can create opportunity for their partner to grow and develop. This entails avoiding activities that may lead them to unintended pregnancy and STI and HIV/AIDS infection.
	• Engaging in sex has its consequences for the adolescent and his partner. It entails commitment and readiness to assume these consequences.
	• Adolescents should know more about ASRH
	  • Seek information from health workers, teachers, and counselors
	  • Communicate with your parents!
	  • Join ASRH activities in your community!

For females engaging in commercial sex, your messages should encourage your target audience to protect themselves at all times when they are caught in uncompromising situation. They should also make as a habit their regular check-up with health service providers not only for sexually transmitted diseases but also for unexpected pregnancy so they can be given appropriate care and services. They should ultimately be able to have the confidence to explore other less risky alternatives to aspire for a better life.

While this group of female adolescents is primarily forced by circumstances to engage in paid sex, many of them have still a certain degree of choice and capacity to refuse sex. Anecdotal evidences reveal that not all women who exchange sex with monetary considerations are doing it for their survival. Some of them engage in paid sex to sustain a costly lifestyle. This means that some of these adolescents can still decide to free themselves from such situation if they so desire. Among this group of women, the desired behavior is for them to refrain from such risky sexual behavior and find other alternative and legitimate sources of income.

D. BCC STRATEGIES FOR ENABLING ADOLESCENTS TO AVOID MULTIPLE SEX PARTNERS

Preventive strategies enumerated in Sections 4 and 5 (abstinence) remain the most effective strategy that you can adopt to address problem behaviors related to having multiple sex partners. Their purpose is to enable adolescents to abstain from sex whenever they are in serious or casual romantic relationships. If they are really inclined towards performing the act, then protected sex should be ensured. You may again review these strategies and adopt them as you deem fit and appropriate to your program and objectives.

1. Building and Nurturing Gender Sensitive and Sexually Responsible Male Adolescents

The tendency of male adolescents to explore their sexuality through risky sexual behaviors is essentially rooted in their false sense of masculinity. Male adolescents who engage with multiple sex partners build their self-egos through their sexual exploits and conquest. The more partners they have, the more esteem they get from their peers and even the society at large.

Within this context, our main strategy in addressing this false sense of values, attitudes and behavioral norms is to build the appreciation and understanding of male adolescents on gender concepts and issues as they relate with their sexuality. Male adolescents should realize that there are gender constructs that lead to gender issues such as stereotyping, discrimination, and violence against women that put women at a disadvantage. These gender issues hinder adolescent women to grow and develop to the fullest. As a man, male adolescents have a significant and critical role in perpetuating undesirable gender concepts, and at the same time in addressing these issues.

You may conduct the following activities to enhance the gender sensitivity and responsiveness of male adolescents:

1.1. Gender Sensitivity Training among Male Adolescents	
Objectives	**Content**
For the male adolescents to: • appreciate and understand the prevailing gender issues including the issue on masculinity in the country; • realize their role in the formation and institutionalization of these gender issues; • appreciate how these gender issues affect their sense of masculinity and their sexuality; and • appreciate their roles in promoting gender equality and responsible sexuality.	Gender concepts and issues • What is gender as compared to sex? • What are the gender issues and their manifestations? • What is masculinity and patriarchy? How is it manifested in behaviors? • What is human sexuality? • What are the impacts of the culture of masculinity on the sexuality of adolescents? • What can adolescents do to address gender issues and patriarchy? • How can adolescents express their sexuality responsibly?

Organizing and mobilizing the male adolescents into a group of advocates serve a dual purpose. One is to let them be exposed to real gender issues that promote risky sexual behaviors and let them appreciate their role in perpetuating these undesirable behaviors. Another is, let them realize and appreciate that they can be agents of change by giving them the responsibility to promote gender equality and responsible sexuality. The goal is to transform their idealism and enthusiasm into a more productive endeavors.

Lastly, this strategy can be effective because adolescents can better relate to the issues faced by their fellow adolescents. As such, they can propose responsive solutions to these issues. Adults should only be there to guide them.

You may also involve the female adolescents in this strategy. However, experiences have shown that putting both the male and female participants in one venue for gender sensitivity training or orientation only creates a further divide as both groups become defensive of the gender issues. Moreover, females are not comfortable discussing personal gender issues when males are around and vice-versa. Given this, you may subject the female adolescents to gender sensitivity trainings separately by sex to encourage more open and active participation. To avoid gender division among male and female adolescents, you can put them together after they have undergone the training and jointly work for mobilization and advocacy activities.

2. Peer Counseling among Male Adolescents

Peer counseling is an effective communication strategy for all adolescent health and development issues. As such, you may also adopt this strategy to guide adolescents in their sexual behaviors particularly in enabling them to avoid risky sexual behaviors such as engaging with multiple sex partners. However, to make this strategy effective, mobilize male peer counselors to talk with their fellow male peers (e.g. usapang lalake). A male talking to another male on matters related to gender issues and adolescent sexuality is an effective strategy as it encourages males to open-up; the counselor can relate with the counselee as they have basically the same issues, experience, and behavioral tendencies; and, the male counselee becomes more comfortable talking on sexuality with someone whom he knows.

The challenge in counseling male adolescents is their difficulty in opening up during counseling. Males do not usually like to talk about personal matters with a counselor because they are socially trained not to be emotional; not to be expressive of what they feel; not to expose their weakness; and, not to confide at all, especially with a fellow male. All these barriers can be minimized by proper training of male peer counselors for an appreciation of the gender issues.

3. Developing Life and Leadership Skills among Male Adolescents

You may modify your life skills training and interventions, as discussed in Section 4, to focus on male adolescents. Enabling them to have effective skills on decision making, critical thinking, interpersonal communication, deep spirituality, and other relevant skills can prevent male adolescents engage in risky behaviors. These skills can give a male adolescent a sense of direction that enables him to be preoccupied on the things that can help him achieve his aspirations rather than on pleasurable but hindering activities. You may adopt the same modules as you used in Section 4.

To build their leadership, adolescents may be mobilized to lead ASRH related activities in their community. They can also actively participate in other community activities that channel their sexual energies into more worthwhile and productive endeavors.

E. BCC STRATEGIES FOR PROTECTED SEX AMONG FEMALE ADOLESCENTS ENGAGED IN TRANSACTIONAL SEX

1. Strengthening the Life Skills especially Refusal and Negotiating Skills among Female Adolescents

As discussed earlier, the main concern among female adolescents engaged in commercial sex is protecting them from pregnancy and sexually transmitted infections. Female adolescents are often caught with uncompromising paying partners and who would not want to use condom. As such, there is a need for adolescents in this situation to be able to negotiate for the use of condom with their partners and refuse sex if they would not want to use a condom for protection. This entails effective negotiating and refusal skills. As such, you may subject concerned adolescents to relevant life skills training and capacity building.

Other life skills or competencies may also be developed among this group of adolescents. They may use these life skills to protect themselves from unexpected harm and abuses given their precarious situations, and, more importantly, could enable them to find alternative and less risky sources of income. Firm life skills can also help female adolescents who are engaging in paid sex merely to support costly lifestyle to come up with more responsible sexual decisions and behaviors. Their level of agency towards persevering in more worthwhile undertakings such as studying and working in other alternative employments can be strengthened through proper life skills.

2. Peer Counseling

Women trapped in paid sex need constant support and encouragement. Adolescents in this type of situation have deep and complex psychological issues that should be dealt with appropriately. Many of them have low self-esteem because of feeling guilty and dirty because of their activities and the stigma and discrimination attached to their activities. Some have been forced to mature earlier than their fellow adolescents because of the responsibility that they have to carry for their family. In the process, they have missed some developmental tasks during adolescence, which they need in effectively performing the tasks of adulthood.

This group of adolescents needs counseling to enable them to cope with their situation and ensure their growth. Somebody should guide them in their development in the context of the limiting conditions that they have. Peer counselors can help them cope with the psychological, mental, and emotional ordeals that they are experiencing. They need to feel loved and cared for as they experience stigma and judgmental attitude from the persons around them.

To provide counseling among this type of audiences, you may train counselors from among them. Choose somebody who has the required qualification of a counselor to provide them quality counseling information and services. You may also recruit and train their managers and "handlers" as counselors on ASRH issues to guide and protect the adolescents under their care.

Undertaking this type of intervention is rather challenging. The conditions of the intended audiences require strategies that can effectively reach out to them. You need for example to consider:

- where they can be reached or found (especially the freelance sex worker);
- when to approach them without fear that they may be apprehended;
- how to provide the counseling service without interrupting their work; and
- other considerations that may affect the effectiveness of your strategies.

As such, you need to work with various NGOs, the local government, and other key stakeholders who can help you in your intervention. You have to coordinate with them to ensure collaboration and resource sharing.

F. SUPPORT ADVOCACY AND SOCIAL MOBILIZATION STRATEGIES

1. For Avoiding Multiple Sex Partners

1.1. Advocacy for the Integration of Gender Sensitivity Concepts and Skills in the School Curriculum and Community Programs for Out-of-School Youth

You may pursue an advocacy initiative among local officials, the SK Officials, and to concerned national government agencies to integrate gender sensitivity trainings or capacity building in the school curriculum in elementary and high school and also in the community. This will ensure that adolescents develop and adopt more appropriate and responsible gender roles and sexual behaviors.

1.2. Advocacy for a Sustainable Life-Skills-Based ASRH Program

You can also advocate among local government units for the development and implementation of a comprehensive adolescent health and youth development program that caters for the ASRH needs of the adolescents and youth. This program should also include capacity building activities for life skills among adolescents.

2. For Protecting Female Adolescents engaged in Transactional Sex

2.1.Advocacy for the development and implementation of youth development programs that provide education and employment opportunities for adolescents so they would not be forced in sex work

A comprehensive youth development program can help adolescents cope with their socio-economic needs thereby saving them from illegal and risky activities. This youth development program should also provide necessary health and counseling services to women forced in paid sex.

2.2. Mobilization of youth groups to help in enabling women engaged in paid sex against discrimination and stigma

Youth can effectively reach out to their fellow youth in distress or undesirable circumstances to let them feel that they are loved and cared for. Adolescents engaged in sex work need to feel that they are not stigmatized and discriminated. And, they can feel this more sincerely when their fellow adolescents provide them with this kind of feeling or environment.

G. MONITORING GAINS AND GAPS

1. Outcome Indicators

1.1. Indicators for measuring KNOWLEDGE ON ASRH

- % of adolescents who knows the consequences of commercial sex and multiple sex partners
- % of adolescents who knows the various threats and issues affecting their development
- % of adolescents who can identify risk-taking behaviors
- % of adolescents who knows methods for protected sex
- % of adolescents who knows how to avoid risk-taking behaviors
- % of adolescents who knows the necessary skills they need for abstinence and protected sex

1.2. Indicators for measuring ATTITUDES, BELIEFS, AND VALUES

- % of adolescents who have particular attitudes and beliefs about key health-related behaviors, influences, and issues:

    - Multiple partners
    - Abstinence
    - Getting pregnant
    - STI and HIV/AIDS
    - Sex in exchange for fee

- % of adolescents who believe that having multiple sex partner is the prevailing norm among adolescents

1.3. Indicators for measuring INTENTIONS

- % of adolescents who intend to have sex with various partners
- % of adolescents who have intention to do the following:
  - Consult a peer counselor
  - Consult parents for advice on RH
  - Use condom
  - Engage in commercial sex

1.4. Indicators for measuring SELF EFFICACY

- % of adolescents who believe that they can control their sexual urges
- % of adolescents who believe they could refuse sex if they did not want it
- % of adolescents who feel responsible for their actions toward others
- % of adolescents who put importance on studies or employment more than sexual activities
- % of adolescents who believe they can refuse peer pressure on sexual initiation
- % of adolescents who believe that can advocate healthy behaviors among adolescents

1.5. Indicators for measuring ACQUIRED SKILLS

- % of adolescents who acquired proficiency in a particular skill during the course of a life skills or ASRH interventions:
  - *Self-awareness, Empathy, Interpersonal relationships, Decision making, Critical thinking, problem solving, Negotiation, Coping with stress, Coping with emotions, Communication, Visioning and goal setting*

- % of adolescents who feel comfortable discussing SRH issues with parents, adults, health providers, counselors

1.6. Indicators for measuring SEXUAL BEHAVIORS

- % of adolescents who ever had sexual intercourse
- Age at first sexual intercourse by sex and other background characteristics
- % of adolescents who had sex within a specified time period
- % of adolescents who expressed that the sexual intercourse was wanted or intended
- No. of adolescents who paid for sex
- No. of adolescents who received payment for sex

Output Indicators	Input Indicators
• No. of trained adolescents on ASRH and other types of training and capability building activities (by sex and by type of training) • No. of adolescents who participated/ attended interpersonal communication activities (by sex and by type of activities)	• No. of ASRH-capability building activities conducted (by type) • No. of symposiums, forums, and public gatherings conducted • Number of orientations and symposiums conducted
• No. of adolescents who received counseling services (by sex and by type of counselor)	• No. of counselors trained on peer counseling and ASRH and life skills (by sex) • No. of counseling sessions conducted
• No. of adolescents who received information and services from health facility • No. of adolescents who received condom	• Types of programs offered in health facilities
• No. of adolescents who received IEC materials (by sex and by type of materials) • No. of audiences who recall ASRH messages from IEC materials (by type of audience)	• No. of IEC products produced and disseminated (by type)
• No. of adolescents involved or who received services and information through ASRH programs (by sex and type of programs)	• No. of programs developed and implemented (by type and locality) • No. of ASRH-related policies enacted • No. of NGOs and organizations mobilized for ASRH (by level) • Amount spent versus allocation on ASRH-related activities by source of funds • No. of adolescents who attended skills development trainings (by sex) • No. of decision-makers mobilized for ASRH
• No. of adolescents who received information on SRH through radio, hotlines, text, and on-line counseling services	• No. and frequency of radio, hotlines, text, and on-line counseling services provided
• No. of commercial sex workers who received information on SRH through radio, hotlines, text, and on-line counseling services	• No. and frequency of radio, hotlines, text, and on-line counseling services provided
• No. of local champions and advocates mobilized and supportive of advocacy for protected sex • No. of community organizations mobilized for advocacy for protected sex	• No. of advocacy and social mobilization activities conducted (by type and by implementing partner – public and private) • No. of agencies, networks, and alliances mobilized and involved in advocacy and social mobilization activities

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SECTION 7

Monitoring & Evaluating Behavior Change Communication Strategies

Knowing whether your strategies and activities are producing the desired results is a very important aspect of planning and implementing BCC strategies. Did my strategies work? What difference did my interventions make? All these questions give meaning to all the efforts that you have poured in in making a better life for adolescents.

Monitoring and Evaluation (M&E) are important components of any intervention program. In the perspective of our BCC strategies, it can tell us if and how our communication interventions and activities are working in view of the desired behaviors that we have set. It enables us to appreciate how effective our strategies are particularly in terms of its messages, media, and activities in fostering healthy and responsible sexual behaviors among adolescents to enable them to prevent early and unintended pregnancy.

Monitoring and evaluation aim to determine and measure the results of any program. However, these are two distinct but complementary concepts that we need to understand and integrate in our planning process so that we can have a sense of what we are doing.

A. MONITORING

To assess if your BCC interventions are going on the right track, you conduct monitoring activities. Monitoring is the systematic, timely, and regular gathering of feedback and information about the progress of a program or initiative to provide timely and appropriate support intervention. Monitoring usually looks into the input, processes, and outputs of a given intervention.

1. Why monitor BCC strategies

Monitoring helps in the immediate identification of strengths that can be replicated in current and future projects. It enables you to determine the weaknesses, gaps, errors, bottlenecks, and problems in the course of implementation as your bases for formulating timely solutions or interventions. It also provides insights and lessons from the present intervention to be used in the development of future projects.

When we are able to provide timely and appropriate support or intervention to emerging issues in the implementation process, we can promptly check problems at an early stage, thus, preventing their recurrence and waste of resources and their possible damaging effects on the program.

Typically, monitoring gathers data on process indicators. This includes: number and types of communication media materials produced and disseminated or number of training workshops conducted, for example. Monitoring can also check whether the tools and materials for use of trainers, peer educators, counselors, and program implementers are in sufficient quantities and/or displayed with easy access for relevant groups. As part of monitoring, you can also conduct process evaluation to measure the quality of program implementation and the extent to which services are being used by the intended target population.

B. EVALUATION

To determine the relevance, efficiency, effectiveness, impact, and sustainability of your interventions, you conduct an evaluation. Evaluation aims to measure the changes in knowledge, attitudes, behaviors, skills, community norms, and health and development status. When you want to determine whether the changes or outcomes that you want to influence are changing among the target audience, you conduct an outcome evaluation. When you are interested to know how much of the observed changes in the outcomes is due to your intervention, you do an impact evaluation.

1. Difference between monitoring and evaluation

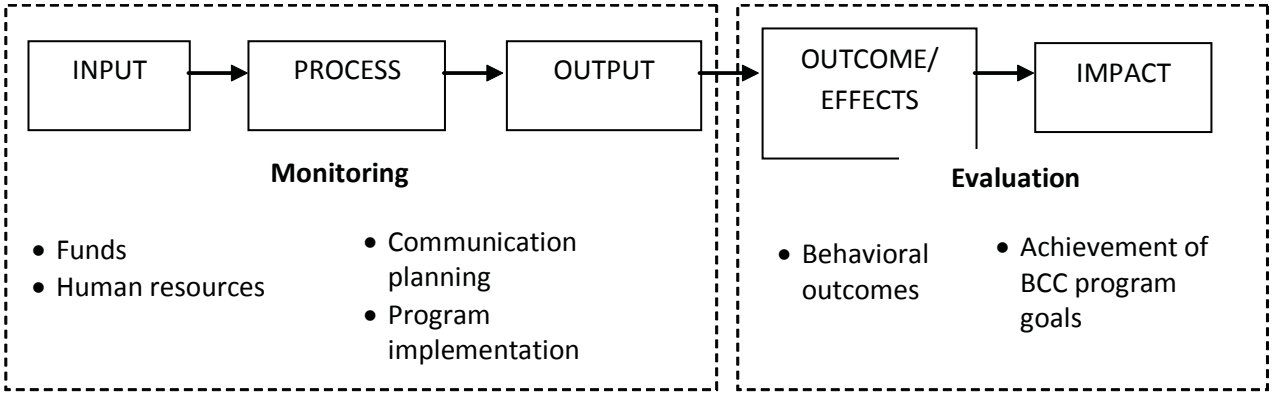
Monitoring and evaluation are two interrelated processes of program development and implementation. They are both important elements of program management. They also require baseline information as their basis of measuring changes and progress. Finally, they both provide insights and lessons for use in the next programming. There are a few basic differences between these two processes.

Output Indicators	Input Indicators
• Monitoring focuses on operations – the relationships among inputs, process, activities, strategies, and outputs. • It asks the question: How is the project running?	• Evaluation focuses on the effects of interventions. • It asks the question: What difference did the project make?
• Monitoring is conducted continuously from the start of implementation.	• Impact evaluation is done after the completion of the project or after a certain stage of it (e.g. mid-term).
• The person in-charge of the monitoring is actively concerned with the conduct and outcomes of the project.	• The project evaluator usually is not involved in the day-to-day operations of the project. The evaluator maintains a detached and impartial view of the intervention.

2. What should be Monitored and Evaluated?

Monitoring and evaluation make use of indicators to reflect the status of results. Indicators are information on a particular circumstance that is measurable in some form (UNICEF, 2006). It approximates or shows the status or levels of conditions to be reached or achieved at the outcome, output, and input levels. It also indicates the magnitude and direction of change (i.e increasing or declining) over time.

In monitoring and evaluating BCC strategies, you can develop or make use of different indicators for a hierarchy of various results. You may categorize your indicators into: a) input indicators; b) process indicators; c) output indicators; d) outcome indicators; and e) impact indicators. You can monitor the input, process, and output indicators while you can evaluate the outcome effects and impact indicators (see illustration below).



Input Indicators. Use input indicators to approximate or describe the quality and quantity of the various inputs to the development of interventions. Inputs include the physical resources such as raw materials, financial, and human resources; and technology, including equipment, management systems.

Output Indicators. These indicators measure the quantity and quality of the results produced by activities or the process and inputs.

Outcome Indicators. These indicators measure the qualitative and quantitative results of the intervention in the short run (effects).

Impact Indicators. These measure the qualitative and quantitative results of the intervention in the long run.

2.1. Specific Indicators to Monitor and Evaluate

To provide you with an idea of the specific indicators that you need to monitor and evaluate for the BCC strategies for preventing adolescent pregnancy as specified in this Sourcebook, we provide below the set of M&E indicators for each strategy. As discussed in the introductory section, the ultimate goal or the desired impact of all the BCC strategies identified in this Sourcebook is the reduction of the incidence of pregnancy among adolescents 10-19 years old. The expected outcome pertains to the achievement of the desired behaviors that directly influence adolescent pregnancy.

In measuring the indicators, you may focus on the respondents among those covered by your interventions. As mentioned earlier, you need baseline data for these indicators to measure the change among the target audience. For comparative purposes, you may also compare the indicators among those not covered by your intervention (control group). Lastly, you may compare the indicators by background characteristics such as sex, age, education, and employment, where applicable.

BCC IMPACT INDICATORS:

- Pregnancy rate of women 15-19 years
- Age specific fertility rate among women 15-19 years

Main BCC Strategies	Specific BCC Strategies & Activities	Input Indicators	Output Indicators	Outcome Indicators
Developing appropriate values and core competencies among school children	Educating Grade School Children on Values Necessary for Delaying Sexual Initiation	• No. & type of modules developed for values education in school • No. & type of modules for values education for out-of-school children • No. of values education classes conducted • No. of training conducted for teachers on the VE modules	• % of grade school children who attended values education classes using VE modules • No. of teachers trained on VE modules • No. of parents trained on responsible parenthood (based on the modules)	• Incidence of delinquent behaviors among school children • % of children who asked parents about proper hygiene • % of children who knows abusive touches by adults
	Promoting and Strengthening Values Education and Formation for Pre-Adolescents (9-14 Years	• Type of modules developed • Type of values and ASRH programs for OSY designed and implemented • No. of classes on values education conducted • No.& types of IEC materials developed	• % of preadolescents who attended modular classes on ASRH • % of preadolescents who received IEC materials (by type) • % of preadolescents who attended classes or sessions in life skills	• % of preadolescents who know about the RH processes happening among them (fertility awareness) • % of adolescents asking parents/teachers about ASRH issues • % of parents discussing ASRH concerns among preadolescents • Incidence of delinquent behaviors among preadolescents
Promoting Life Skills-Based Adolescent Sexual and Reproductive Health (for 15-19 Years Old)	Building the knowledge of adolescents on ASRH and other relevant issues	• No. of communication activities conducted (by type) • No. of IEC materials on ASRH developed (by type) • No. of communication campaigns on ASRH in media (by type)	• % of adolescents who attended communication activities (by type) • % of adolescents who received IEC materials (by type) • % of adolescents (in & out-of-school) who received information about ASRH (by source)	• % of adolescents who have negative attitudes towards: • *Early sexual initiation among adolescents* • *Unprotected sex* • *Early marriage* • Adolescent pregnancy • % of adolescents who are aware of their fertility • % of adolescents who intend to delay sexual initiation • % of adolescents who know the various factors affecting early sexual initiation • % of adolescents who know the effect of early sexual initiation

Main BCC Strategies	Specific BCC Strategies & Activities	Input Indicators	Output Indicators	Outcome Indicators
	Building and Sustaining the Life-Skills and Self-Efficacy of Adolescents	• No. of training on life skills conducted • No. of communication activities conducted (by type) • No. of counseling sessions conducted (by location) • No. of entertain-educate strategies conducted • No. of recognition events conducted	• % of adolescents who attended life skills training • No. of adolescents who participated in communication activities (by type) • No. of adolescents who received counseling services (by type of source) • No. of adolescents who recognized for exemplary achievements • No. of peer counselors trained • No. of health workers trained on peer counseling • No. of counseling services established in health center (by type)	• % of adolescents who believe that they are able to practice life skills • % of adolescents who intend to delay sexual initiation • % of adolescents who value and prioritize completion of education • % of adolescents who resolved ASRH issues through counseling • % of adolescents who believe that they can promote ASRH
	Building youth leaders and champions on ASRH	• No. of leadership training and workshops conducted • No. of youth programs developed and implemented • Amount of budget allocation for youth programs • No. of youth mobilized for conduct and organization of community events • No. of youth-oriented activities conducted in the community • No. of programs integrated in local development plans (by type)	• No. of adolescent leaders trained on leadership • No. of adolescents benefited and participated in youth programs • No. of adolescent involved in the implementation of ASRH programs (by type)	• % of adolescents who believe that they are able to practice life skills • % of adolescents who intend to delay sexual initiation • % of adolescents who have the leadership skills for ASRH
Campaign against sexual non-risky behaviors (substance use and abuse)	Massive campaign against substance use and abuse Development and dissemination of IEC for the campaign Counseling services	• No. of communication activities conducted (by type) • No. of IEC materials against substance abuse developed (by type) • No. of communication campaigns against substance abuse in media (by type)	• % of adolescents who attended communication activities (by type) • % of adolescents who received IEC materials (by type) • % of adolescents (in & out-of-school) who received information against substance abuse (by source)	• % of adolescents who engaged in non-sexual risky behaviors (substance abuse) • % of adolescents who believe they can influence their fellow adolescents to refrain from substance abuse • % of adolescents who engaged in substance use and in sexual activity

Main BCC Strategies	Specific BCC Strategies & Activities	Input Indicators	Output Indicators	Outcome Indicators
Building the Capability of Parents, Guardians, and Relatives in Guiding the Sexuality Development of Adolescents	Capability-building of Parents, Guardians, and Relatives on Responsible Parenting and Positive Values Formation for Children Conduct of Couples' Classes on Effective Parenting Integrating Effective Parenting Concepts in the Programs of Religious and Community Groups and Organizations	• No. of trainings and seminars on ASRH and 'parenting adolescents' conducted • No. and type of IEC materials for parents produced and disseminated • No. of parents who acted as resource persons during training	• No. of parents who participated in ASRH and 'parenting adolescents' sessions • No. of parents mobilized and organized in ASRH-related activities	• No. or % of parents who discussed ASRH concerns with their adolescent children • No. of adolescents who consulted their parents on ASRH concerns • % of adolescents who delayed sex because of parental advice • % of adolescents who developed life skills because of parental guidance • % of parents who believe that they have the knowledge and skills to guide adolescents on ASRH issues
Capacitating Teachers on ASRH	Training on ASRH among teachers	• No. of training on ASRH for teachers conducted • No. of training design and modules developed	• No. of teachers who participated in training on ASRH	• % or No. of teachers teaching ASRH concerns in classroom • % of teachers with negative attitude on pregnant adolescents • % of teachers who provided ASRH information to adolescents • % of adolescents who received ASRH information from teachers
Mobilizing Religious Leaders and Organizations in Values Formation and Promotion of Healthy Sexual Behaviors among Young People	Conduct of youth-oriented religious activities	• No. of trainings and seminars on values formation and spiritual training or sessions conducted by religious groups	• No. of adolescents who attended values formation and spiritual training or sessions • No. of religious leaders involved • No. of IEC materials produced by religious groups	• No. of religious leaders with negative attitude on ASRH • % or no. of adolescents who believe they can control their sexual urges • % or no. of adolescents who prioritize education • % or no. of adolescents who intend to delay sexual initiation

Main BCC Strategies	Specific BCC Strategies & Activities	Input Indicators	Output Indicators	Outcome Indicators
BCC Strategies for Condom Use	Raising the Awareness of Adolescents on the Negative Consequences of Unprotected Sex Provision of Counseling Services and Effective Contraceptives for Protected Sex among Adolescents	• No. of communication activities conducted (by type) • No. of IEC materials developed, produced, and disseminated • No. of counseling sessions conducted • No. of life skills training conducted • No. of condoms distributed (by source) • No. of peer counseling training conducted	• No. of peer counselors trained • No. of health workers as counselors trained • No. of sexually active adolescents who attended the communication activities • No. of adolescents who received counseling sessions • No. of adolescents who received condom (by source) • No. of health workers who dispensed condom to sexually active adolescents • % of adolescents who received guidance from teachers & parents	• % of adolescents who know how to prevent pregnancy • % of adolescents who used condom in sexual activities • % of adolescents who intend to use condom • % of adolescents who intend to abstain from sex in certain period • % of adolescents who refused sex because there is no condom • % of adolescents who prioritized studies over sex • % of health workers with positive attitude on providing condom to sexually active adolescents • % of health workers who have proper skills in counseling adolescents
BCC Strategies for Avoiding Multiple Sex Partners	Building and Nurturing Gender Sensitive and Sexually Responsible Male Adolescents Peer Counseling Developing Life and Leadership Skills among Male Adolescents	• No. of gender sensitivity or related trainings or sessions conducted • No. of IEC materials produced	• No. of male adolescents who participated in gender sensitivity training or sessions	• % of adolescents who have positive attitude s towards respecting women's rights • % of adolescents who have positive attitude on gender equality • % of adolescents who believe that masculinity is not about having multiple sex partners • % of adolescents who intend to respect women who refuse sex • % of adolescents who intends to abstain from sex • % of adolescents who intend to use condom

Main BCC Strategies	Specific BCC Strategies & Activities	Input Indicators	Output Indicators	Outcome Indicators
BCC Strategies for Promoting Protected Sex among Female Adolescents who engaged in paid sex	Strengthening the Life Skills especially Refusal and Negotiating Skills among Female Adolescents Peer Counseling	• No. of life skills training among female adolescents • No. of IEC materials produced and disseminated • No. of peer counseling sessions conducted	• No. of female adolescents who attended the life skills training • No. of female adolescents who received IEC materials • No. of female adolescents engaging in paid sex who received counseling	• % of female adolescents who refused paid sex • % of female adolescents who believe that they have capacity to refuse paid sex • % of female adolescents who refused sex without condom • % of female adolescents who knows the consequences of unprotected sex • % of female adolescents who were able to convince their partner to use condom during sex • % of female adolescents who refused paid sex • % of female adolescents who used condom during paid sex

C. DEVELOPING A MONITORING SCHEME

Planning your monitoring scheme is as important as its content. It is important that you organize your steps in monitoring to ensure that this important activity produces its intended objectives. Planning the monitoring scheme is not yet the monitoring activity itself. It only involves organizing the needed steps prior to undertaking the actual monitoring activity. Planning the monitoring scheme helps significantly in effectively allocating the resources for this specific activity by identifying what indicators to gather, how to gather, who will be involved, what offices to consult, what methodologies to employ, and other factors to consider in making the monitoring process effective. You may use the simple matrix below to guide you in planning your monitoring scheme.

Monitoring Objectives. You should be clear on the purpose for undertaking your monitoring

Monitoring Objectives	Project Expected Outputs	Project Inputs (activities)	Monitoring Points	Information Source	Monitoring activities	Schedule	Responsible Persons

activities. You may state in broad strokes the data that you want to gather and for what purpose.

Project Expected Outputs. These are what the intervention is expected to produce or result to after a certain period. You may be guided by the enumerated sample indicators above.

Project Inputs. These are the planned activities that need to be undertaken to produce the desired outputs. It also includes the structures to be set-up as well as other mechanisms needed in the implementation of the initiatives.

Monitoring Points. Monitoring points pertain to the various aspects or details which you want to monitor pertaining to the project. You may include concerns such as timeliness, quality, and quantity, financial efficiency, and issues encountered during the implementation.

Information Source. This pertains to the offices or prospective institutions that can provide the needed data. They may be individuals, documents, databases, or structures.

Monitoring Activities, Schedules, and Responsible Persons. These are the activities that need to be undertaken to implement the actual monitoring processes. It may involve meetings, briefings, review of documents, and other necessary activities. It is also important to identify when these activities will be conducted and who will be the lead person to undertake specific activities.

D. OTHER CONSIDERATIONS IN MONITORING

1. Collecting the Needed Data

There are various methods you can use in collecting data for monitoring and evaluation of BCC strategies. Some of the standard methods include interviewing, focus group discussions, observations, surveys, workshops, community or stakeholders meetings, structured questionnaires, and document analysis, among others. Most of the sample indicators provided above need primary data. This means that you have to produce the information directly from the concerned respondents rather from secondary sources.

In choosing the method to use, you also consider whether you need qualitative or quantitative data. Quantitative data are information that are expressed through numerical values (i.e. numbers, proportions, rate, and percentages). Qualitative data are descriptions of conditions and status in terms of their attributes.

2. Analyzing the Information

Analyzing information for monitoring purposes generally involves comparing the actual performance or accomplishments with those intended or planned, and then finding the reasons for and correcting any discrepancies – whether the deviations are reasonable and beneficial or unjustified and harmful to the project. You may do the following in analyzing the information.

- Compare the actual performance or conduct of a project with the project plans specifically inputs, outputs, and finance (as indicated in the project work and financial plans);
- Identify discrepancies (whether over or under performance) between the actual data and the plans;

- Identify problems and situations which could have led to the discrepancies; and
- Analyze causes and factors that contribute to the discrepancies.

In monitoring BCC activities, it is critically important to look into the following:

- appropriateness of the target audiences or participants;
- what messages were delivered;
- how were the messages delivered;
- conduciveness of the venue;
- modules and medium of instruction used; and
- feedback from the participants.

E. CONSIDERATIONS IN EVALUATION

1. Integrating Evaluation Mechanisms in Communication Activities

Since BCC strategies deal with behaviors, evaluation is a critical method to determine whether such strategies are effective. Change in behavior is an outcome indicator, as such, it can only be measured by evaluation. To make evaluation an integral process of the implementation of BCC strategies, ensure the following:

- Establish baseline data as basis for evaluating changes in behavior;
- Conduct evaluation or assessment for every activity to measure increase in knowledge and change in attitudes, values, and intentions of the participants (i.e. pre- and post-test questionnaires);
- Conduct mid-term evaluation to determine how interventions are shaping up towards achieving various communication goals (for BC, advocacy, social mobilization); and
- Establish end-line database to measure results of the communication strategies among various target audiences.

REFERENCES

Adamchak, S., Bond, K., MacLaren, L., Magnani, R., Nelson, K., Seltzer, J., (2000). A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs, The Focus on Young Adults, Tool Series 5. USA: Pathfinder International.

SECTION 8

Reference Materials

Introduction

This Section provides additional reference materials for the preparation and implementation of the BCC strategies discussed in the previous sections. It contains more detailed information that can be used by the users of the Sourcebook or those interested in designing appropriate BCC strategies for adolesent health and youth development and in preparing and undertaking relevant activities.

The reference materials contained in this compilation were developed by the Project Team and some were adopted from various agencies who have implemented good practices on adolescent health and youth development.

Specifically, it provides the following information on:

- The causal and behavioral analysis of adolescent pregnancy
- Focus questions for causal and behavioral analysis
- Frequently asked questions on adolescent sexual and reproductive health
- Sample training designs
- Things to consider in conducting trainings and communication strategies
- Legal mandates on adolescent health and youth development
- Sample script for theater presentation dealing with ASRH issues
- Sample posters for preventing adolescent pregnancy

Annex A Adolescent Pregnancy: Causal and Behavioral Analysis

This causal and behavioral analysis was undertaken by the BCC Project Team as part of the design of the Sourcebook particularly in the undergoing the BCC planning process. The analysis was based on the review of relevant literature and results of the focus-group-discussions and key informant interviews

You may use this material in planning your causal and behavioral analysis particularly in identifying relevant behaviors that should be addressed by your BCC interventions. This material can also help in designing your instruments for data gathering

Adolescent Fertility and Pregnancy in the Philippines

The Philippines' total fertility rate over the 30 year period showed a declining trend from 6 children per woman in 1973 to 3.3 children in 2008. However, in the more recent period (1998-2008), adolescent fertility showed a significant increase (17.4 percent) while fertility among older women declined. The same trend can be seen in 2003-2008 period. Moreover, the 2008 National Demographic and Health Survey revealed that one out of ten (9.9 percent) or an estimated 4,702,400 (by NSCB) Filipina aged 15-19 is already a mother. As shown in Figure 1, a substantial percentage of young women has given birth as young as 17 (7 percent), 18 (14 percent), and 19 (24 percent) years.

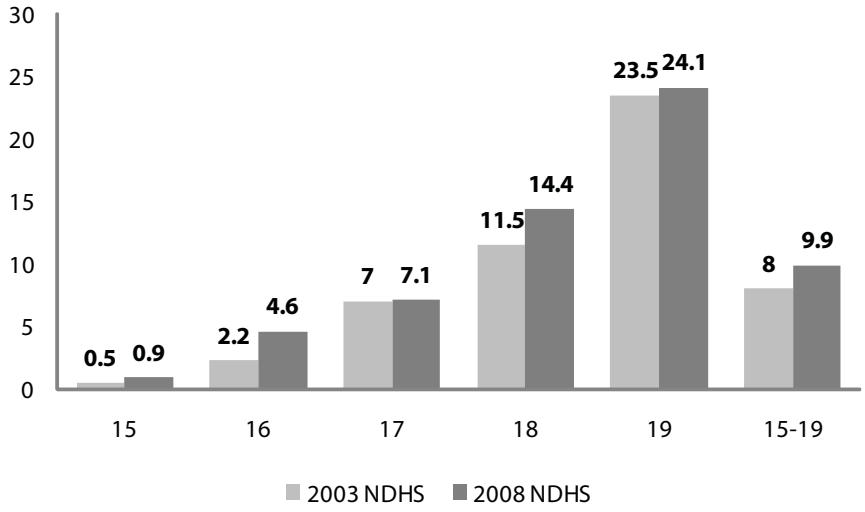
Table 1. Age-specific and total fertility trends from various surveys, Philippines

Age group	1973 NDS[1] (1970)	1978 RPFS[2] (1975)	1983 NDS[3] (1980)	1986 CPS[4] (1984)	1993 NDS[5] (1991)	1998 NDHS[6] (1996)	2003 NDHS[7] (2001)	2008 NDHS[8] (2006)
15-19	56	50	55	48	50	46	53	54
20-24	228	212	220	192	190	177	178	163
25-29	302	251	258	229	217	210	191	172
30-34	268	240	221	198	181	155	142	136
35-39	212	179	165	140	120	111	95	84
40-44	100	89	78	62	51	40	43	38
45-49	28	27	20	15	8	7	5	6
Total fertility rate	**6.0**	**5.2**	**5.1**	**4.4**	**4.1**	**3.7**	**3.5**	**3.3**

Source: [1] UPPI (1970) *National Demographic Survey 1973*
[2] NCSO, UPPI, POPCOM, NEDA (1975) *Republic of the Philippine Fertility Survey 1978*
[3] UPPI (1980) *National Demographic Survey 1983*
[4] UPPI(1984) *Contraceptive Prevalence Survey (1986)*
[5] NSO and Macro International (MI) (1991) *National Demographic Survey 1993*
[6] NSO , DOH and ICF Macro (1996) *National Demographic and Health Survey 1998*
[7] NSO and ORC Macro (2001) *National Demographic and Health Survey 2003*
[8] NSO and ICF Macro (2006) *National Demographic and Health Survey 2008*

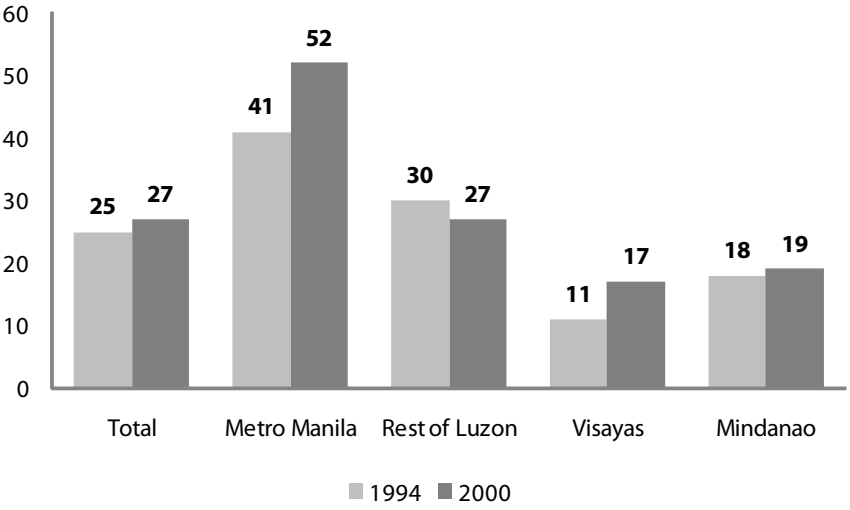
From *National Demographic and Health Survey 2008* (p. 43), by National Statistics Office [Philippines] and ICF Macro, 2009, Calverton, Maryland: National Statistics Office and ICF Macro. Copyright 2009 by National Statistics Office and ICF Macro.

Figure 1. Percent of 15-19 women who have begun child bearing: 2003 and 2008 NDHS



Unintended Pregnancies and Its Consequences. Many pregnancies among adolescent mothers are unintended. As the 2008 NDHS revealed, one third (33%) of births by adolescent mothers were unwanted at the time of the conception. Unplanned or unwanted pregnancies could lead to self-induced abortion or availing of the services of an untrained birth attendant. The incidence of abortion in the Philippines from hospital records over the 1993-1995 and 1999-2001 period showed an increasing rate of abortion, from 25 per 1000 women 15-44 years old in 1994 to 27 per 1000 women 15-44 years old in 2000 (Singh, et al., 2006) (see Table 2).

Figure 2. Abortion rate in the Philippines: 1994 and 2000
Source: Singh et al. (2006) *Unintended Pregnancy and Induced Abortion in the Philippines*



Abortion rates were highest for Metro Manila in both periods. Abortion rates were highest in Luzon and lowest in Visayas (see Table 2 and Figure 2). In the study of Singh et.al., almost half (46 percent) of abortion attempts occurred among young women aged 20 to 24 and 16 percent among 15-19 years old (Singh, 2004). Furthermore, 8 percent of the 15-19 young women and 14 percent of those 20-24 years old had induced abortion (Cabigon, 2004). In addition, Juarez et al., (2005) using

the 2004 National Survey of Women found that 46 percent of abortion attempts occur among young women: some 30 percent among women aged 20-24, and 16 percent among teenagers (15-19 years old).

Table 2. Estimated abortion rate, by survey year and region

Region	Estimate abortion rate*	
	1994	2000
TOTAL	25	27
METRO MANILA	41	52
REST OF LUZON	30	27
Bicol	20	25
Cagayan Valley	30	34
CAR	33	34
Central Luzon	39	27
Ilocos Region	27	38
Southern Tagalog	27	22
VISAYAS	11	17
Central Visayas	6	24
Eastern Visayas	16	17
Western Visayas	12	10
MINDANAO	18	18
ARMM	8	7
CARAGA	4	13
Central Mindanao	29	26
Northern Mindanao	11	25
Southern Mindanao	23	20
Western Mindanao	24	13

Source: Singh et al. (2006) *Unintended Pregnancy and Induced Abortion in the Philippines*

Too early pregnancy likewise has demographic implications. Early initiation to childbearing is a major determinant of large family as this lengthens the reproductive period of women. With longer exposure to reproduction, the population continues to grow rapidly resulting to a high proportion of young dependents and the need for more health and nutrition services for infants and children.

Adolescents and unmarried mothers are likewise exposed to unfavorable social consequences including their rejection from the family, friends, and community which could in turn, significantly affect their well-being and that of their child. Despite the more liberal perception on sexuality issues in contemporary media, there is still a prevailing stigma within the existing cultural context of the Philippines against pregnancies out of wedlock particularly among adolescents (Kabamalan, 2006).

ANALYSIS OF THE CAUSES AND BEHAVIORAL FACTORS OF ADOLESCENT PREGNANCY

I. Evidence from the National Demographic and Health Surveys, Young Adult Fertility and Sexuality Survey, and other data sources

A. Immediate Determinants

There are three main problem behaviors related to adolescent pregnancy that are the focus of the causal and behavioral analysis. These include 1) too early engagement in sexual acts; 2) non-use of contraception or also labeled as unprotected sex; and 3) engagement in sex with multiple partners. These behaviors can be considered as the direct or proximate behavioral determinants or causes of adolescent pregnancy.

1. Early Sexual Involvement

Increase in Incidence of Premarital sex (PMS). Data shown in Table 6 from the 1994 and 2002 Young Adult Fertility and Sexuality Surveys (YAFS II and YAFS III) reveal an increase in the percentage of adolescents who engaged in early sexual behaviors from 8.1 percent in 1994 to 11.8 percent in 2002.

Moreover, data on recent sexual behavior from the National Demographic and Health Surveys showed the incidence of last sexual intercourse among adolescent women increased from 6.7 percent in 2003 to 8.1 percent in 2008. Those who ever had sex among the 15-19 years increased more rapidly (at 29.5% from 10.5% in 2003 to 13.6% in 2008) than those 20-24 years (at 31% from 54.6% in 2003 to 56.3% in 2008).

Table 3. Percent of youth who have ever engaged in pre-marital sex, by sex and age group: Philippines, 1994 and 2002

Sex and Age	Ever had Pre-marital Sex	
Sex	**1994**	**2002**
Male	26.1	31.3
Female	10.1	15.7
Age		
15-19	8.1	11.8
20-24	31.4	40.3
Total	**17.8**	**23.1**
N	**10,879**	**16,311**

Source: Data from Natividad and Marquez (2004) in Raymundo and Cruz (2004) *Youth Sex and Risk Behaviors in the Philippines*

The increase in pre-marital sex varies between young men and women. Generally, males engage in precoital physical behaviors and first sex at younger ages than females (Upadhyay, Hindin and Gultiano, 2006). Thirty one percent (31.3%) of male Filipino youth admitted to an early sexual

experience in 2002 representing a 20 percent increase from a 26.1 percent level in 1994. In contrast, 15.7 percent of young women admitted to a pre-marital sex experience in 2002 compared to only 10.1 percent in 1994 representing a 55.4 percent increase (see Table 3). Although, pre-marital sex experience is higher among the males than the females in both periods, the data point to a more rapid increase among the females. The age of sexual initiation was also found to be slightly lower among males (18.2 years on the average) than females (18.9 years on the average) (Marquez and Galban, 2004). The prevalence of premarital sexual activity of youth 15-24 years in the Philippines over the 1994 and 2002 period increased from 17.8 percent to 23.1 percent. The magnitude of change was however higher among the 15-19 year olds (45 percent change) than the 20-24 year olds (28 percent change), and higher among females (55 percent change) than among males (20 percent change).

Pre-marital sex is also seen to increase with age. Prevalence of ever having PMS experience increased by age as both 15-19 and 20-24 year olds in 2002 reported higher prevalence than their age counterparts in 1994. The percent change among the younger (15-19 years) adolescents was higher (45.6%) compared to the rate of change among the older ones (28.3%) (Natividad and Marquez, 2004 in Raymundo and Cruz, 2004).

Differentials of premarital sex (PMS) across some characteristics. In 2002, 11.8 percent 15 to 19 years old in the Philippines reported having had premarital sexual intercourse with nearly three times as many males (17.8%) than females (6.0%).

The prevalence of premarital sex is lower among the never married youth 15-24 (17%) than the ever-married (56-58%); those in school (11 percent) than those not at school (35%); and those who never worked (13 percent) than those who ever worked (30-33%). Those who reached college had the highest prevalence (27%) while high school undergraduate had the lowest level (18%).

2. Engagement in Risky Sexual Behaviors

Many adolescents exhibit risky sexual behaviors. In 2002, over a third (35.5%) had sex with more than one premarital sex partner. Almost half of the male adolescents in 2002 reported more than one partner (44.8%) while the comparative percentage for females is only 10.6 percent. The percentage of youth (15-24) with multiple PMS partner is highest among Catholics (35.2%).

The 2008, data from the NDHS showed that prevalence of higher-risk sexual intercourse is high among young, sexually active adolescent women with 15.5 percent having reported sexual intercourse with someone other than their spouse or cohabiting partner in the past 12 months.

Casual and commercial sex. The result of a study among call centers commissioned by the Commission on Population revealed that call center respondents have higher exposure to the following behaviors: casual, non-romantic regular sex (FUBU), sex with multiple partners, sex with the same sex, commercial sex, unprotected sex, early sex and premarital sex. Moreover, of the male call center respondents who were paid to have sex, three out of four said they were paid to have sex with another man, 30 percent of whom had unprotected sex. Among men who paid for sex, 42 percent of call center respondents ever had unprotected sex (UP Population Institute, 2010).

3. Engagement in Unprotected Sex

Use of contraceptive among the sexually active. The 2002 YAFS survey showed that most Filipino adolescents tend to have unprotected sex during their first sexual encounter. Only 21 percent of those who ever had PMS used a contraceptive during their first sexual encounter. During the first PMS experience among young adults (15-24), only 21 percent said they practiced some type of contraception. This is highest among adolescents (15-19) at 23.6 percent, declining monotonically with age. The proportion who practiced contraception is higher among the 15-19 year old (32.5%) males than the 15-19 year old females (12.3%).

Contraceptive method used. Using data from the 2002 YAFS, Table 4 shows that 24.7 percent of Filipino youth 15-24 years old used contraceptives during the first premarital sex (PMS). The most commonly used methods were condom and withdrawal, pills second and with rhythm as the least used. The used of condom and withdrawal were more popular among the males while pills and rhythm use was higher among the females.

Table 4. Contraceptive method mix during the first and last PMS, by sex: 2002

Contraceptives	During first Pre-marital Sex			During last Pre-marital Sex		
	Male	Female	Both Sexes	Male	Female	Both Sexes
Condom	42.1	37.7	40.5	45.2	23.1	38.2
Withdrawal	39.8	37.7	39.0	32.7	30.3	31.9
Pills	8.9	15.1	11.1	11.2	28.5	16.6
Rhythm	5.0	8.2	6.2	7.0	10.8	8.2
Others	4.2	8.2	6.2	4.0	7.2	5.0
Any method	**27.5**	**14.9**	**24.7**	**26.6**	**21.8**	**24.8**

Source: Natividad and Marquez (2004) in Raymundo and Cruz (2004) *Youth Sex and Risk Behaviors in the Philippines*

Differentials in contraceptive use. One out of two or 53.4 percent of adolescents who practiced contraception during their first premarital sex experience used a condom in 2002 (Natividad and Marquez, 2004 in Raymundo and Cruz, 2004). This is higher compared to their older counterparts (20-24 years old) with only 37.7 percent adolescents using condom on their first premarital sexual intercourse. The same pattern is evident with condom use during the last premarital sexual experience with 22.5 percent among adolescents (15-19 years old) and only 18.0 percent among the young adults (20-24 years old).

Use of contraception was most prevalent among the never married youth 15-24 years old. About a third of the never married (30.5%) who ever had PMS experience practiced contraception during their first PMS activity. The corresponding figures are much lower among the currently married (13.4%) and among the currently living-in (11.3%).

Also for the last sex episode, almost 73.4 percent of males and 78.2 percent of females reported not using any method. The most common method for the last pre-marital sex for both sexes is still condom, with 38.2 percent, withdrawal (31.9%) and pills (16.6%). For males, condom was still the most commonly used method (45.2%) during their last sex encounter. An alarming information from the data in Table 4 points to the continued popularity of withdrawal as a contraceptive method among

adolescents. Despite the very low effectiveness of withdrawal as a protection for pregnancy and STIs, almost 32 percent of adolescents used this particular method during their last PMS episode and was even the most method used by young females (30.3% of women) and their partners during their sexual engagement (Natividad and Marquez, 2004 in Raymundo and Cruz, 2004).

Contraceptive use was higher among those who were currently in school (32.4%) than those who were not in school (18.4%). The use of contraception tended to increase with education as those with college education had the highest percentage of users (26.9%) compared to those who had elementary education only (13.3 percent). Youth who were currently working (22.9%) and who never worked (22.4%) have higher rates of contraceptive use than those who ever worked but are not currently working (18.9%). Catholics had slightly higher percentage (21.4%) of contraceptive use than those from other Christian religions (18.1%).

Findings of the 2008 UNESCAP Endline Survey showed that despite the high level of sexual exposure among OSYs only 12.3 percent were protected by condom in their last sexual encounter (13.7% among males and 10.2% among females) (Marquez et al., 2009).

B. Underlying Determinants

1. Behavioral Underlying Factors

(a) Lack of accurate information on adolescent sexuality

Adolescent Sexuality studies have shown that adolescents engage in sexual intercourse for the first time for various reasons. These include exploration, adventure, experience, curiosity, expression of love or mere sexual urge (Cabigon and Zablan, 2001 and Cabigon and Sumagaysay, 2006). Other studies have also shown specified factors that affect the sexual behavior of young girls such as their poor leverage to oppose sexual advances and their inadequate knowledge of contraceptives should these advances lead to sexual intercourse. On the other hand, young men have been found to be driven to sex largely for pleasure and out of peer pressure and curiosity. The general lack of a sense of responsibility perhaps as a result of the lack of knowledge, awareness, and appreciation of their sexuality leading to the lack of control over their sexual behavior is proving to be a serious barrier to improving adolescent sexual and reproductive health (Roque, 2001).

The lack of accurate information on adolescent sexuality often includes the limited knowledge of youth and adolescents on reproductive rights and contraception. A study by Cabaraban and Linog in 2005 showed that in general, the adolescents have very deficient knowledge of RH irrespective of sex and ethnic affiliation. Their understanding is not only too generic; it is sometimes off-tangent. "*Respondents' knowledge of reproductive rights is deficient, the range and scope of which are seen in a myopic perspective. Quite a number of respondents/participants affirmed not having any idea about the concept. In fact, some are candid to admit, it is their first time to hear the term 'reproductive rights*." Moreover, the same study, showed some misconceptions of the respondents about contraceptives, to wit:

- *"Taking pills will result to giving birth to an abnormal child"*
- *"Use of Depo will make a woman feel faint"*
- *"Condom use is not acceptable to men; they find it unsatisfying to use"*

- *"Pills have lots of side effects—either weight gain or weight loss"*
- *"Condom is not effective because it leaks"*
- *"Rhythm is unreliable, too taxing for a couple to count and determine the safe period"*
- *"IUD is believed to cause cancer of the vagina and the ovary"*

(b) Longer exposure to sexual initiation

Age at menarche. Age of menarche is one of the determinants of fertility as it indicates the onset for women's capacity to reproduce. In the Philippines, the age of menarche is getting younger. In 2003 the age of menarche among Filipino women aged 15-49 was 13.3 years and 13.2 years in 2008. The mean age at menarche for women 15-19 was 12.8 years in both 2003 and 2008. However, among women age 20-24, mean age at menarche was higher at 13.1 years in 2003 and 13.0 years in 2008. Moreover, early puberty was found to be associated with earlier age of alcohol use and sexual initiation, which in turn predicted early pregnancy (Deardorff, Gonzales, Christopher, Roosa, and Millsap, 2005).

Delayed age at marriage and increasing live-in arrangements. The adolescents of today are more likely to delay marriage. Data from the National Demographic and Health Surveys from 1993 to 2008 reveals that more and more adolescents are postponing marriage and choosing to be in live-in arrangements. Postponing marriage provides longer years of exposure to sexual engagement before marriage.

Table 5. Marital status of Filipino women, by age: 1993, 1998, and 2003

Marital status	15-19	20-24
Never married		
1993[1]	92.2	54.6
1998[2]	91.5	56.3
2003[3]	90.6	48.7
2008[4]	88.8	50.9
Married		
1993[1]	4.7	38.4
1998[2]	4.8	34.5
2003[3]	3.9	36.9
2008[4]	2.9	26.8
Living together		
1993[1]	2.7	6
1998[2]	3.6	7.6
2003[3]	5.1	12.7
2008[4]	7.4	19.8

Source: [1] NSO and Macro International Inc. (1994) *National Demographic Survey 1993*
[2] NSO, DOH and Macro International Inc. (1999) *National Demographic and Health Survey 1998*
[3] NSO and ICF Macro (2004) *National Demographic and Health Survey 2003*
[4] NSO and ICF Macro (2009) *National Demographic and Health Survey 2008*

Nationwide surveys of adolescents 15-24 years in the Philippines showed a decrease in the proportion of those who are formally married, from 12 percent in 1994 to 9.6 percent in 2002. However, the same nationwide surveys showed that live-in arrangement among those 15-24 increased from 4.7 percent in 1994 to 6.0 percent in 2002.

Table 6. Marital status of Filipino youth 15-19 by sex: 1994 and 2002

Marital status	1994	2002
Never married		
Male	98.4	98.7
Female	91.9	92.5
Both	95.1	95.6
Currently married		
Male	(0.6)	0.3
Female	4.1	2.5
Both	2.4	1.4
Living together		
Male	(0.9)	1.0
Female	3.9	4.8
Both	2.4	2.9
Div/Sep/Widowed		
Male	(0.0)	0.0
Female	(0.2)	0.1
Both	(0.1)	0.1

Source: Berja and Ogena (2004) in Raymundo and Cruz (2009) *Youth Sex and Risk Behaviors in the Philippines*

The proportion of adolescents who are never married decreased during the period 1993-2008. However, for the same period, those in live-in arrangements increased. Data from the National Demographic and Health Surveys revealed that women aged 15-19 who chose to live with their partners has doubled from 2.7 percent in 1993 to 5.1 percent in 2003 (see Table 5). This is also true for those in the older age group 20-24 from 6 to 12.7 percent. The YAFSS in 2002 also showed an increasing trend of adolescents living-in from 1994 to 2002 (see Table 6). A similar trend was found using census data (Kabamalan, 2006).

Majority of the youth (15-24) who are already in union and are not living with their parents, 65.5 percent among those married formally and 62.6 percent among those living-in together. However, a significant proportion of married adolescents (23.0 percent among currently married and 25.3 percent among those cohabiting) reported that they are currently living with both parents. Meanwhile, nearly three quarters of out-of-school youths (OSYs) reside with their parents and only 3.2 percent live independently in their own homes (Marquez et al., 2009).

(c) Engagement in non-sexual risk behaviors

The combination of sexual and non-sexual activities is likewise a significant factor in facilitating adolescent pregnancy. The number of youth ages 15-24 who have engaged in non-sexual risky behaviors was found to have increased. A significant increase in the proportion of adolescents who tried drinking alcohol was noted in 2002 (from 54.4% in 1994 to 70.1% in 2002). Similarly, drug use among the youth has almost doubled from 5.7 percent in 1994 to 11 percent in 2002. Data in Table 7 also show that males had higher prevalence in both drinking and drug use than females. However, the prevalence of non-sexual risk behaviors among females grew faster than among males.

Table 7. Filipino youth's alcohol drinking and drug use by sex (in percent): 1994 and 2002

Non-sexual risky behaviors	1994			2002		
	Females	Males	BS	Females	Males	BS
Ever Drunk Alcohol	36.5	73.6	54.4	60.2	81.0	70.1
Ever Used Drug	1.0	10.9	5.7	3.2	19.7	11.0

Source: Cruz and Berja (2004) in Raymundo and Cruz (2009) *Youth Sex and Risk Behaviors in the Philippines*

Alcohol use. Cruz & Berja (2004) using the 2002 YAFS found that drinking is almost universal among the young adult males 20-24 years with 93.9 percent admitting they have ever tried drinking alcoholic beverages compared to 73.2 percent among males 15-19 with 81 percent for all ages. Drinking among females was lower (60.2%) for all ages, 70.2 percent for 20-24 and 52.4 percent for those 15-19 years old. Within a span of eight years, the prevalence of those who ever drank alcohol increased from 54.4 percent to 70.1 percent .

Out-of-school youths (15-24) are more likely to venture into drinking alcohol than smoking. About nine in 10 OSYs have ever tried alcoholic beverages with no apparent differences across respondent type (Marquez et al., 2009). They are initiated to drinking almost at the same time they start smoking at a mean age of 16 years. For most of them, drinking is mostly for socialization, relaxation and other reasons such as something to do whenever there are social occasions, to induce sleep or simply as a pastime (Marquez et al., 2009). Their peers have a dominant role to play in the drinking behavior of OSYs as suggested by the finding that most of them were initiated to drinking due to peer pressure. More females than males tried drinking out of curiosity (Marquez et al., 2009).

Meanwhile, a study by University of the Philippines Population Institute (UPPI) in 2010 on the *Lifestyle, Health Status and Behavior of Young Workers in Call Centers and Other Industries in Metro Manila and Bohol* showed that there is a highly significant association between drinking alcohol and having casual sex among young call center workers who are current alcohol drinkers. Moreover, engaging in sex with multiple partners was found to be significantly related drinking alcohol among young call center workers who are current drinkers (UPPI, 2010). Regardless of sex and place of work, drinking alcohol was significantly associated with engagement in any risky sexual behavior 12 months prior to the survey among young workers who are current drinkers (UPPI, 2010).

Drug use. Cruz & Berja (2004) likewise found that in 2002, 2.8 percent of Filipino youth admitted to be currently using dangerous drugs, which is twice the 1.4 percent level reported in 1994. There is also an apparent rise in the proportion of Filipino youth who have ever been exposed to drugs. Females are less likely to be on drugs than males (3.2% vs. 19.7% have ever tried drugs; 0.6% vs. 5.2% are currently using drugs, respectively). Females exhibit a faster rate of increase compared to males.

In 2002, 6.4 percent Filipino adolescents reported that they ever tried using drugs. Nearly three times more male adolescents (11.2 percent) than their female counterparts (1.8%) reported that they ever tried using drugs (Cruz and Berja in Raymundo and Cruz, 2004).

Marijuana and methamphetamine or shabu are the most commonly used drugs with no significant differences observed across sex and respondent type. It is the OSY's friends, peers and classmates who figured as the dominant influential to the respondent's introduction to drugs (Marquez et al., 2009). Like drinking, drug use is a momentary phase in the lives of many OSYs. Over three quarters (78.9 percent) of those who ever tried were not currently using drugs at the time of the study (Marquez et al., 2009).

Based on the timing of exposure to risk behaviors it appears that OSYs get initiated to smoking and drinking prior to drug use. The average age they started to use drugs is 16.7 years a year later the average they start smoking and drinking (Marquez et al., 2009).

In 2010, UPPI found that drugs or substance use is has an equally significant relationship with engagement to casual sex among both male and female workers regardless of place of work. There is also a significance found between drug use and engagement to commercial sex among non-call center young workers who ever used drugs. Moreover, engaging in sex with multiple partners was found to be significantly related to drug use among young call center workers who ever tried using drugs (UPPI, 2010). The same study showed that there is an association between drug use and engagement in any sexual risky behavior 12 months prior to the survey among young call center and non-call center workers regardless of sex.

(d) Parental Involvement

Lack of open discussion about sex and sexuality in families and communities puts adolescents at high risk of unwanted pregnancy and sexually transmitted infections, including HIV/AIDS. In 1994, premarital sex among Filipino youth was found to be lower (17.4%) among those who were raised by both their biological parents compared to those who grew up in a different family set-up (20.0%) (Laguna, 2003). Growing up with both parents protects females from engaging in PMS but it serves as a risk factor for older males. Most of the respondents in the 1994 YAFS study grew up with their natural parents, although a significant percentage spent their growing up years without the supervision of both their parents. Study results showed that about 84 percent of respondents were raised by both parents until the age of 15 (Laguna, 2003).

Meanwhile, a 2006 study in Cebu showed that where parents make household decisions jointly, sons report delaying first sex. In households in which mothers have higher status, daughters report delayed first sex. The results demonstrate that long-term positive effects on children, particularly delaying first sex, occur in families in which parental decision-making is cooperative and in which women have high status (Upadhyay and Hindin, 2006).

In a study by Galay (2010) on parent-child connectedness among the youth, it was revealed that the level of attachment of children to their parents may serve as a factor to for children to engage into sexual intercourse. Children who had sexual intercourse proved to have lower level of attachment to their parents than those who never had sex (Galay, 2010). Moreover, Galay (2010) found a negative relationship between premarital sexual behavior and the quality of parenting of fathers therefore, the probability of having premarital sex decreases as quality of fathering improves.

In Bohol and NCR, a study on parents in 2011 showed that overall, the proportion who said they discussed sex at home is low at 15.8 percent. More respondents reported sex was discussed at home

in late adolescence and early adulthood (17.5%, 17.0%) than middle adolescence (12.8%) (Cruz and Berja, 2011).

The same parental study showed that more female than male children reported discussing sex at home. More children with tertiary education reported sex was discussed at home than those who attained primary and secondary education (Cruz and Berja, 2011).

(e) Conflicting messages from the Media

With the advancement in technology and media including the access to social networks which serves as outlets of information among the young on sexuality, access to sexual messages has increased significantly. Coupled with their attitude of exploration and experimentation, access to sexual messages facilitates too early sexual engagements. Without proper guidance, adolescents tend to conform to what is socially acceptable as perpetuated by media.

Of the media sources reported in the 1994 YAFS Survey, 92 percent of young people had listened to the radio, whether on a regular basis or occasionally. Eighty-five percent watched television while 72 percent read the newspaper (Laguna, 2003). For the same year, Laguna (2003) found that more males (70.3 percent) compared with females (55.1 percent) were exposed to movies. On the other hand, 29.8 percent of young males admitted to have watched x-rated or pornographic films either in movies or videos with only 6.4 percent among young females had similar exposure (Laguna, 2003). Viewing x-rated films significantly influences PMS experience among the young people ages 15-24. Those without exposure showed 14.2 percent PMS compared to 34.9 percent among those exposed (Laguna, 2003).

Meanwhile in 2011, parents in Bohol and NCR reported that watching TV was the most common activity of their adolescent sons although there were more parents in Bohol (46 percent) than in NCR (41 percent) who reported this (Cruz and Berja , 2011).

Non-Behavioral Factors

(a) School participation and sexual activity

About 26 percent of Philippine youth in 1994 who are no longer in school were sexually active compared with 8 percent of young people who were still in school (Raymundo, Xenos, & Domingo, 1999). Laguna (2003) found that Filipino youths who have experienced living away from home and who ever left school exhibited higher (23.8% and 25.5%) PMS prevalence than their counterparts (12.9% & 8.2%, respectively).

(b) Educational attainment and childbearing

One of the most consistent findings of analyses on fertility behavior in developing countries is a strong correlation between the level of women's education and fertility behavior. The relationship between educational attainment and childbearing is reciprocal – level of education has an impact on childbearing and childbearing has an impact on completed level of education.

Studies in the United States indicate that adolescent childbearing has a long-term causal impact on educational attainment, welfare dependency, and career success (Nort et. Al., 1992). Over 20 percent of teen mothers drop out of school when they become pregnant. Teen women with children are less likely to return to school and are more likely to face limited career and economic opportunities compared to women whose first children are born after age 20 (Plotnick and Butler cited in Pedroso, 2010).

In a further analysis of the 2008 NDHS data, the study done by Pedroso (2010) revealed that pregnancy in the Philippines were prevalent among adolescents who were in poor conditions, among less-educated, and among those living in the rural areas.

(c) Lack of enabling policy and program environment for the promotion of responsible and positive sexual behavior among adolescents

Today, existing development policies and programs neglect the reproductive health needs of the young. Even when the role of the young is recognized and the need to empower them is at consensus, in real terms, few government services address the specific health needs and concerns of this segment of the population. Of the limited services available for young people, most are provided by NGOs. The teen-center models are gradually expanding in other areas but many are no longer functioning due to budgetary constraints. The expansion and sustainability of these efforts is a continuing challenge which youth development workers are facing.

Many mechanisms have been put in place to harness youth's role in nation building through participation in planning and policy-making. The *Sangguniang Kabataan (SK)* has been a promising ground for forming adolescents and the youth into effective leaders. However, many stakeholders have criticized its effectiveness citing its highly politicized processes and mechanisms. Many of the projects of the SK have been concentrated on "clean and green," sports and other short-term projects.

Many of the adolescent FGD respondents commonly pointed out that adolescents, particularly the out-of-school youths, engage in pre-marital sex because of lack of other activities that they can focus on and get them busy. Much of their time is concentrated on socialization with peers and the opposite sex which lead them to sexual experimentation and exploration. The lack of activities to which they can divert their attention, effort, and skills causes adolescents to focus on sexually-related matters.

Integrating ASRH concerns in the curriculum could have been a bold and radical move to ensure attainment of vital information that the adolescent and youth need to nurture and develop positive sexual and reproductive health attitudes. However, the curricular integration, training of teachers, printing of manuals and core messages have been held in abeyance due to the association of these ASRH instructional materials with "sex education".

(d) Lack of timely and comparable data base on adolescent sexuality

Serious data gaps on adolescent sexuality and reproductive health still exist. The YAFS, the most comprehensive data on adolescent sexuality in the country have not been updated since 2002 making it difficult for planners and policy-makers to design appropriate interventions. There is, indeed, a need to strengthen the database for adolescent health and youth development in order to capture

their fast-changing needs and to formulate appropriate policy and program interventions could be formulated.

3. Root Causes

(a) Poor socio-economic condition of adolescents

The poor economic conditions of adolescents prevent them from accessing education and necessary information to make them aware of their reproductive heath and sexuality. Moreover, their poor educational and economic conditions contribute to their greater vulnerability to sexual exploitation and abuse. Many adolescents and youth who are out-of-school due mainly to economic reasons are looking for work but many are left unemployed. Even among graduates, their lack of experience prevents them from finding work and forces them to join the unemployed segment of the labor force.

In 2008, women ages 15-24 who belong to the lowest wealth quintile had the highest percentage that has begun childbearing compared to female adolescents belonging to the higher wealth quintiles (NSO and Macro International, Inc., 2009). The percentage of female adolescents who have begun childbearing among those who belong in the lowest wealth quintile is at 44.1 percent. This proportion decreases as the wealth quintile increases (see Table 8).

Table 8. Percentage of young women who have begun childbearing by wealth quintile

Wealth Quintile	Percentage of women age 15-24 who have begun childbearing	Number of women
Lowest	44.1	698
Second	34.6	861
Middle	27.3	917
Fourth	22.9	1078
Highest	13.1	1343
Total	26.1	4896

Source: NSO and Macro International, Inc. (2009) *National Demographic and Health Survey*

Although educational attainment of female adolescents is higher than their male counterparts, the number of adolescent females 15-24 years old (2.5 million) in the Philippine labor force is much lower than adolescent males (4.6 million) (Varga, 2003). Moreover, the unemployment rate of adolescent females was higher (23 percent) than that of males (19 percent). Of the young women who worked, over 75 percent were self-employed (NSO, Department of Health, Macro International, Inc., 1999).

Slow Philippine economic performance has been associated with rapid population growth, high dependency, few investments and low productivity. Over one out of five (20.9 percent) Filipino families and over one-fourth (26.5 percent) of the population were classified as poor in 2009 (National Statistical Coordination Board, 2011).

In the Baseline Study for the Joint Programme on Youth, Employment and Migration, it was found that almost 9.5 percent of the total Overseas Filipino Workers (OFW) are youth (ages 15-24) in

2003 (Ogena, Cabigon, Kabamalan, Lotivio, Cruz, Ogena, 2011). There was a higher proportion of female youth OFWs (14 percent) observed compared to males (5 percent). Females Remittance of overseas workers (OFW) to their families in the Philippines amounted to PhP 138.5 billion in 2009. Around 1.9 million Filipinos in 2009 were legally or illegally working overseas, employed as domestic workers, factory workers, or night club dancers in Japan and other countries (National Statistics Office, 2010).

(b) Socio-Cultural Context

The socio-cultural environment of adolescents has is also shaped by broad global factors such as: role of religion (Christianity), political subjugation (by Spain and United States of America), the worldwide trend of "globalization" through inter-country trade and industrial relations, and the rapidly expanding telecommunications. The spread of Western influences is hastened by modern media (radio, TV, internet) which constitute the major information sources and behavioral influence on sexual and reproductive matters of Filipino Youth (Varga and Feranil, 2003).

(c) Religion

The Catholic Church has tremendous sway in government, particularly on which pieces of legislation (e.g. the Reproductive Health Bill) receive attention and are ultimately passed. The Church is traditionally opposed to sexuality and RH education in schools and prefers parents to educate their children on these matters, thus affecting the quality of information imparted to young people. Moreover, most parents feel inadequate to impart sexuality and RH information to their children due to lack of education and training.

(d) Gender Dynamics and Sexual Double Standards

Cultural value is placed on virginity prior to marriage and fertility after marriage. From a woman's view point, sex is assumed to lead to marriage. Social norms uphold the acceptability of childbearing after marriage, thus it is important to have a child as soon as possible after marriage. Both cultural values have implications on sexual and reproductive health.

It is acceptable or even expected of Filipino men to be sexually experienced prior to marriage and for women to be virgins. Young girls are supposed to control the pace of relationship prior to marriages, and the burden to say "no" to sex is upon her. For girls, premarital sex is done in anticipation of marriage. After marriage, girls are supposed to be sexually available to their husbands whenever he wants sex.

After marriage, the sexual double standard subjugating the female to her husband, render her powerless to gender-based violence, and the recognition that divorce in the Philippines is not officially recognized, largely as a result of the objections of the Catholic church (Varga and Feranil, 2003).

II. Evidence from Focus Group Discussions and Key Informant Interviews

A. Personal Push Factors

A.1 Sexual Maturation and the Greater Freedom to Express One's Sexuality

The FGD results showed that adolescents are aware that a female can get pregnant once she starts having her menstruation. Parents who participated in the FGDs were able to observe that the children today are becoming physically and mentally mature earlier than the usual, which validates the pattern of the "younging" age at menarche. As such, a parent from San Juan City said:

> *"May bata pong maaga siya nagiging dalaga (There are children who mature at an early age.) "*

Participants recognize that the teenage years is a time for such changes. For instance, a father from Baguio relates that with his children's increasing interest in the opposite sex, he has to make sure that he channels this energy to other activities to prevent them from engaging in unwarranted sexual activities:

> *Ako pag naki-jamming or yung friends ng mga anak mo eh kaya i-ano mo yung talent nila for example sa guitar siguro doon. OK din na para ma-ano nila yung interest nila rather having the interest with the opposite sex.* (When I bond with my children or with their friends, I encourage them to focus on their talents rather than on the opposite sex to divert their attention.)

There is also recognition from participants that teenagers have become increasingly able to express their sexuality freely. For instance, a male adolescent respondent from San Juan says:

> *Kasi ang mga bata ngayon mostly…kagaya ng mga sinabi na mapupusok ang mga kabataan ngayon para bang ginagawang habit na [ang pagiging mapusok]. Yung pag-ibig ba gingagawa nilang parang libangan nalang ngayon, hindi na katulad noon.* (Children today are aggressive… It's like being aggressive is becoming a habit to them. Love is an entertainment (or leisure activity) for them, unlike before.)

However, while this urge may be innate in the sense that it is physiological, this can either be enabled or disabled by social norms and socio-historical currents in society. The sharing of the participant refers to the crucial difference between teenagers from the past and present day teenagers, whom respondents say have more leeway in expressing their sexuality. And this of course cannot be divorced from societal attitudes towards sex.

This difference is borne by the greater sexual strictures imposed on people in the past. For instance, the Church, which promotes chastity and sexual purity, held a lot of sway in the lives of individuals in the past. Moreover, sex was a taboo subject. However, with the sexual revolution in the late 60s and 70s and the explosion of globalization with the concomitant sharing of cultures, Westernization of values, the promotion of a more liberal culture by Western media, sexual norms, the strictures of the past and the authority of the Church have been undermined. Perhaps, it is not accurate to say that the younger generation now has more intense physiological sexual urges compared to teenagers in the past. The difference lies in the greater freedom to express one's sexuality because structural factors have been changed or eroded over the past few decades.

However, this does not imply that libido alone would predispose adolescents to early pregnancy. It is the decision to satisfy the rising libido through pleasure seeking behaviors with the opposite sex that can lead to this eventuality. While this could be satisfied through self gratification (i.e. masturbation) or channeled via engagement in non-sexual activities, there are those who take this a step further by engaging in unprotected sex. Because the larger society has become more permissive about sex, there is now more room to explore one's sexuality and the capacity to experience sexual pleasure. A female adolescent respondent from Bohol says:

> *Para sa akin iyong pleasure because mayroon ako mga kakilala na tinanong ko why they engaged into such kind of activity and they said, 'it's the pleasure it brings.' Naging habit-forming na nila hanggang parang 'once you tasted, you always wanted.'(sic*). (For me, it's the pleasure. I know of someone whom I asked why they engaged into such kind of activity and they said, it's the pleasure it brings.' It becomes habit-forming that once you tasted it you always wanted.)

A.2 Gratification vs. Rationalization

As discussed in the previous section, engaging in pleasure seeking behaviors is predicated on the decision to act on one's libidinal urges. However, such decisions are also predicated on one's capacity to rationalize or carefully assess the repercussions of the actions one will engage in. Rationalization could either lead a person to decide to engage in sex or not. The idea is that if people assess that if there are repercussions involved, there is a greater possibility that they will not engage in that behavior.

Interestingly, although well aware of repercussions, adolescents who became pregnant still engaged in unprotected sex. According to Susan, a guidance counselor from the University of the Philippines-Baguio, she counseled a girl who knew the consequences of her and her boyfriend's decision to have sex, but she and her boyfriend conveniently ignored or overlooked these possible consequences. According to the guidance counselor, these adolescents have allowed their urges or feelings to overtake their reason. She says:

> Susan: *They can not control their feelings. Like, I've talked to one student who came and was pregnant at the end of the semester. How did this happen? Because in the counseling process we have to dwell into (sic) this, the factors that contributed…And this girl was honest to tell me, she went home, her boyfriend met her, two of them went out on a date, it was even in an open air, and it [sex] happened …*
>
> Anna: *(Is this) Curiosity? Well because there is, I mean both of them were curious, but did they know the consequences, did they step a little bit ahead of what was…*
>
> Susan: *They forgot the consequences. They just dwell (sic) on that immediate feeling that both had at the moment they met…*

Junking reason at the crucial moment thrust the girl and her boyfriend into an unwanted situation. When asked do the adolescents know the repercussions of their actions, Carla, 25 years old, student and a mother to one child, said: "*Alam nila ma'am, pero ginagawa pa rin*." ("They know ma'am, but still they do it)".

This is validated by the sharing of a female participant from Baguio, Jake, 20 years old, who got pregnant early on and is now an out-of-school youth mother of two children. Although she knew how to protect herself via the use of the contraceptives and despite the availability of contraceptives in her community, she went on and dove into the sexual act with her boyfriend. In the heat of things, the couple brushed off possible consequences: "*Minsan kasi sinasabi na bahala na*." In a sense, couples leave their fate to chance. They push worrying about the situation up to the point when the possible consequences of their actions would have already appeared. It also appears that at that moment both have given more premium to the gratification of the sexual urge more than the possible negative outcomes of their behaviors and actions.

Thus, Jimmy, a male adolescent participant from San Juan shares how adolescents prioritize gratification over thinking of the posible negative outcomes of their decisión to have sex:

> *Alam nila yon (referring to the consequences of engaging in unprotected sex) pag naga-ano na, pero pag nabuntis na saka na itanggi na yan. Kasi mga kabataan sabik lang yan pero pag andyan na yung responsabilidad natatakot na yan….Syempre pagdating sa ganung bagay iisipin mo ba yung ano… ang iniisip nila yung sarap. Syempre pag nabuo na iisipin mo problema*. (They know it (referring to the consequences of engaging in unprotected sex) when they're doing it but when the girl is already conceiving, they will deny it. Adolescents are eager but if responsibility is already there, they dont wouldn't want to face it because they are scared. Of course when it's already there, you'll think of it as a problem.)

A.3 The Bane of Curiosity

Adolescence is also a time for curiosity, especially for things the adolescents have yet to experience. Interestingly, a number of the respondents from Luzon to Mindanao attributed early pregnancy to adolescents' tendency to be curious. Curiosity in itself is harmless. However, once curiosity is coupled with the greater freedoms adolescents attain with their approach to adulthood, the undermining of parents as chief authority figures in their lives, and the increasing liberal attitudes towards sex, all these can result to behaviors that could compromise their well being.

Jimmy, a respondent from San Juan, for instance, describes the experience as adolescents progress to adulthood and gain the capacity to make their own decisions and to do things they could never do as children:

> *Kasi pag first year ka palang parang ina-ano mo lang yung pagka childish mo eh, habang umaakyat ka sa fourth year lalong nagma-mature tapos pagdating mo ng college… kasi di ba doon mo mararanasan yung lahat ng kalokohan pag akyat mo ng college.* (If you are still in your first year of high school, you're still childish. As advance to fourth year, you become more mature up to the time when you become college…that's the time when you'll experience all foolishness/ escapade when you are in college.)

Romeo and Arthur, participants from the Baguio FGD attribute this to the thirst for new experiences and adventure:

> Romeo: *Pag teenager po siguro Ma'am,parang sabik sa … (If you are teenager maybe you are more eager/aggressive)*

Arthur: *Kumbaga adventure (It's like an adventure)*
Romeo: *Pero yung consequence pagkatapos, hindi nai-isip… (But the consequences after, you don't think of it)*
Facilitator: *But the thing here is, you must experience it yourselves.*

Amor, a male criminology student who participated in the Bohol FGD, on the other, adds another dimension to the curiosity of adolescents. He says that curiosity could be fanned by peer influence: He says,

> *Para sa akin Ma'am, merong mga barkada na pangit ang impluwensya, meron din namang good influence. Kung meron kang mga barkada, talagang ipapagawa mo, ikaw naman na wala pang alam, magiging curious ka, hahantong sa "once tasted, always wanted." Kapag nakakatikim ka na, palagi mo ng babalik balikan, kaya kung meyron kang kaibigan na gumagawa ng ganyan, pag susunod ka, babalik balikan mo na.* (For me Ma'am there are friends that are bad influence, there are also friends that are of good influences. If you have friends/peers who really, you will be curious since you don't know anything about it and it will end up to "once tasted, always wanted". Once you've tasted it, you'll always go look for it if you have friends doing that. If you follow them, you'll surely look for it and do it again.)

James, also a male participant from Bohol, agrees with Amor. He says,

> *…kahit mga bata pa, nagsisimula ng magka-gf o bf, at makikipagtalik sila dahil sa curious sila, gagaya sa mga barkada at sila rin ay makasanayan na, ang kahihinatnan ay mabuntis. Kahit bata pa, naging buntis na.* (Even if they are still young, they begin to have girfriends or boyfriends, and they will have sex because they are curious. They will do what their friends are doing and they themselves will be used to it and it turns out that they may become pregnant. Even though they are still young, they may become pregnant.)

The sharing of Amor and James shows that peers who may have already had the experience of sex could drum up the curiousity of those who have not yet had sex. Participants in the FGD in other localities share that sex is something they discuss with friends. Peers give them accounts of their experiences or they consult peers about matters pertaining to sex. It could simply start with sexually active friends relating their experiences and the many pleasures that come with it and later progress to, them wanting to try this out or experience this for themselves.

The sharing of Diana, a female participant from the FGDs in Davao, allows us to understand how talk about sex could fan the curiosity of teenagers:

> *Another is our schoolmates or classmates. Because like in our division, you can just hear the topic sex everywhere. Then you become curious. Eventhough you're not that close, you will get interested and join in the discussion. Our classmates and schoolmates are big contributors when in comes to that thing.*

Or it could even escalate to friends actually bringing their "virgin" friends to have their first taste of sex as Amor implied in his sharing. Unfortunately, as the two respondents relate, the first taste of sex could already lead to an addiction of sorts.

The parents from Baguio, yet add another dimension. Carmen, a parent participant from Baguio said that the overt and covert sexual images teenagers see in the media could stir up their curiosity. Jane, also a parent from Baguio, agrees. She said that once curiosity is piqued, some teenagers want to experience what they have seen.

A.4 Adolescents as Risk Takers

Adolescents usually take sexual risks which are sometimes uncalculated or miscalculated. Risk taking is more of a psychological state, a disposition that allows a teenager to decide to engage in unprotected sex despite the possible negative consequences involved. Annie, a Baguio-based Project coordinator of the BCYA and peer educator volunteer and key informant interview of this research said that adolescents, in a sense, have lost their sense of hesitation, even fear of doing things they would not have done when they were younger and when they were still at home with their parents. In high school, adolescents are cautious even timid but when they reach college and attain a level of independence from their parents, they lose this sense of reluctance and begin to take risks.

This risk taking behavior although of a psychological state, of course, is affected by societal factors. UP Baguio is home to students from all over the Philippines who, for the first time, may be living independently from their parents. Being away from home, far from the panoptic gaze of parents and being at the cusp of adulthood, these teenagers feel a certain level of independence from the strictures parents imposed at home. They also see people their age or older who are engaging in behaviors that they may have not been free to do at home. Annie could not have put the situation any better:

> *They are really risk takers na, and since it is open to the public like it's almost open na OK lang mag live-in, OK mag boyfriend. So for them talking about high school meron pa silang pagiging mahinhin… ng konti, but when we go out (sic) to college that's when you never realized (sic) that they will do it kasi parang kahit sabihin mo dito palang sa Baguio taboo pa rin eh.* (They are really risk takers, and since it is open to the public like it's almost open and its OK to live-in, to have boyfriend. So for them talking about high school there are still those decent/self conscious, but when we go out (sic) to college that's when you never realized (sic) that they will do it even if you tell that here in Baguio that is still a taboo.)

Despite societal strictures with people in the community frowning upon early pregnancy, the adolescents are unperturbed. They still dive head on to satisfy their urge without any regard for protecting themselves. This is because they see others who engage in relationships and co-habit with their boyfriends or girlfriends. It has become in some ways normative or acceptable.

A.5 Giving in to Temptation involves mutual consent

Engaging in a non-protective sexual relationship starts when a partner initiates or shows intent to engage in the sexual act. As Jimmy, a male adolescent participant from San Juan says, "*Ano lang parang tukso, kasi sa totoo lang isa lang naman sa inyo ang gagalaw eh. Pag isa sa inyo nagpakita ng motibo siguraduhin mo yan.*"

The problem according to Jimmy starts, when one of the partners responds and reciprocates the initiative. The initiative will not progress to the act if there is no mutual consent. Jimmy says, "*Depende, pwede kasi sa babae o sa lalake, pero pakitaan mo ng ganyan na motibo kung ayaw ng babae di hindi.*

Kung magpakita man ang babae kung ayaw ng lalake hindi rin." He further adds, "*Hindi nila pwedeng sabihin na hindi naiwasan, talagang silang dalawa ginusto kaya nga nila nagawa parehas nilang gusto*." Jimmy's statement of course, assumes that the relationship is always consensual, which might not always be the case. But there are two important things about Jimmy's sharing: one) in matters about pregnancy, it takes two to tango, the female cannot be solely blamed for getting pregnant, two) if one of the partners is level-headed enough to say no, then pre-marital sex can be averted.

A.6. Not Having the Right Information

The focus group discussion (FGD) results showed the lack of knowledge and control over the sexuality of adolescents. The participants expressed that while adolescents are aware of the repercussions of engaging in sexual activities, their desire for sexual pleasure usually prevails. It would seem that the decision and behavior of adolescents to engage or not to engage in sexual activities largely depends on their knowledge, values, and their attitude toward their sexuality coupled with their negotiating skills. The intimate nature of sexual interaction between an adolescent couple appears to depend less on external influences and more on those that are inherently within the individual including values, psycho-sexual make-up, and behavioral factors.

The FGD results of other adolescent groups however revealed that early pregnancy is a result of adolescents' experimentation as influenced by their **social environment** (i.e. peer pressure, curiosity, excitement, being in love). Adolescents engage in sexual intercourse when they become tempted to have sex since couples are always together. Adolescents said that sexual intercourse is a way to prove their love.

While some teenagers know the consequences of having unprotected sex, there are those who may be aware of the consequences but their knowledge is encumbered by misconceptions. Take for instance the sharing of a group of girls studying in a university in Manila who are aged 17-20 years old. We quote below the exchange of ideas during the FGD:

Moderator: *So is early pregnancy of a young girl due to having sex with a single guy or many other guys?*
F1: *Maybe with many other guys.*
Mod: *So do you know things on (sic) how to prevent these pregnancies?*
F1: *Pills*
F2: *Using condoms*
Mod: *Okay, contraceptives*
F3: *Using withdrawal method*
Mod: *Withdrawal? But we already told you that it is not a safe way of preventing pregnancy?*
F1: *Yes, but others still do it.*
Mod: *Okay, before the guy ejaculates, the sex organ is removed [from the vagina].*
F1: *Others let the woman urinate after having sex.*
F2: *Others let the woman bounce around.*
Mod: *Okay so…who do you think decides to use these measures?*
F1: *The guy.*
F2: *Sometimes both.*
Mod: *Okay both.*
F3: *Okay but usually, they say that it's the guy*

From the conversation above, we can see that the girls know how girls end up pregnant. They also have an idea regarding the use of contraceptives to prevent pregnancy. However, the information they have is either incomplete or is peppered with fallacies and misconceptions. For instance, F (the names were inaudible) said that a girl would get pregnant if she sleeps with many men, little realizing that it just takes one male and her fertile period for her to get pregnant. They also have misinformed beliefs that the withdrawal method protects them from pregnancy when in fact it is the most unreliable way to prevent pregnancy. Worse, they also have fallacious beliefs based on fish wives' tales that urinating or bouncing around after sex can prevent pregnancy.

From their sharing, we also see that it is possible that the woman is not empowered to decide which contraceptives to use. Thus, their pregnancy or the prevention of pregnancy is dependent on the male who has to decide on the form of contraception to use.

B. The Decision to Say No

In the discussions above, some reasons why adolescents decide to have sex were discussed. However, it is also crucial to understand why adolescents decide to say no to sex or at least say no to unprotected pre-marital sex that could lead to early pregnancy. This section focuses on what respondents have said as to how some teenagers have managed to say no to pre-marital sex or to postpone it for a later time.

B.1 Negative Modeling

Sometimes, the decision not to engage in sex early on rests on a negative model, a model that poses off-putting outcomes and therefore instead of encouraging a person to follow it, it leads to the opposite effect. Aida who was part of the Baguio FGD is a mother of two unmarried boys aged 23 and 27. Aida shares a humorous but bittersweet story that illustrates the principle of negative modeling:

> *Sabi nga ng anak ko yung friend daw nya lagi daw mainit ang ulo sa trabaho. Sabi ko, "Bakit laging mainit ang ulo nya?" "Ikaw ba naman mommy kung ang makikita mo bago ka matulog eh ay ang pangit na babae, pag gising mo pangit pa rin di syempre mag-iinit ang ulo mo." Kasi nga hindi niya napili talaga yung napangasawa nya. By accident lang daw na nag-asawa sila kasi nabuntis niya kaya pinakasalan. Pero ngayon daw nagkakaroon na sya ng realization na ang napangasawa nya ay hindi nga ganun kaganda, sabi niya kaya laging mainit ang ulo niya sa trabaho nila.* (My son told me that his friend is always grumpy at work and I asked him why. He answered "If you were in his shoes and you'll wake up every morning seeing your wife's ugly face, wouldn't you get mad as well?" He did not have a choice that time and he had to marry his wife because he got her pregnant. He already came to a realization that he married a girl who's not beautiful.)

The story of the Aida's son's officemate has discouraged Aida's son from engaging in pre-marital sex or, at the very least, made him carefully weigh his decision to engage in it or not because of the possible dire consequences that it carries. However, the plight of the officemate only echoes what Aida has been telling her sons all along. Aida has always impressed upon her children to engage in sex within the bounds of marriage and has always issued them this fair warning:

"*Para sa akin, ang lagi kong sinasabi, basta sex will be (sic) done within the bound (sic) of marriage kasi once na naka-disgrasya kayo, what if kung hindi mo gusto yan? Eh di pagsisisihan mo.*" (I've always told them, sex should be done within marriage because if you accidentally got somebody pregnant, what (happens) if you don't like her? You'll regret it.)

The story of the officemate allowed Aida's son to validate the truth in the admonitions of Aida. It drove home the point regarding the importance of protecting oneself from the possibility of accidentally impregnating a woman and ending up marrying a woman he does not love.

B.2 Exercising Control

Some adolescents are pragmatic when it comes to engaging in relationships. They do not rush into one, instead they think that relationships will come at the right time. David, a male participant from San Juan, explains this:

Ako naman hindi naman ako nagmamadaling magka GF kasi sinasabi ko sa sarili ko darating din naman yan eh. Pero OK lang naman yung pa-link-link lang, pa crush-crush lang. OK lang yon wala naman kayong ginagawang masama. (I'm not hurrying myself into having a girlfriend because I told myself that in time, it will come. But it's fine with me to have links, crushes. It's fine because you're not doing anything bad anyway.)

We can glean from David's sharing hat he is willing to wait for the relationship to happen. There are other pre-occupations that occupy him at the moment and thus he does not give too much premium on engaging in relationship yet. In so doing, he is able to avoid the occasions, opportunities, or temptations to engage in a sexual relationship.

Although Jasmine from Davao has a boyfriend she is well aware of the need to control what she calls the excitement:

Kanang gina aware gud mi niya na "kailangan ninyo kung dili man mapugngan ang ninyong kanang sa puberty age ninyo excitement dapat aware mo unsa gani pangbuhaton, unsay mga consequences ana, ug dapat responsible enough mo na magtake sa action (They [teachers] told us that we need to control our excitement, especially during the puberty stage, and we should always be aware of our actions and its consequences and finally, we should be responsible enough to make an action)

She attributes these to teachers from her elementary years who taught them reproductive health and the need to control their sexual urges to prevent any untoward consequences. Here we see that lessons from school have been ingrained properly, which in turn has been used by Jasmine as a guiding principle during her adolescent years. However, we should offer the caveat that learning this from school is not always an assurance that adolescents would react in the same way Jasmine did. As pointed out earlier, some adolescents knew the consequences of their actions but still went on engaging in unprotected sex.

C. Structural Factors

While decisions seem to be private and personal in nature, we cannot deny that external forces also come into play when people make their decisions. This is because inevitably, we are part of society and whatever happens to society affects the private lives of individuals. As the eminent American sociologist, C. Wright Mills says, the biography of an individual is always influenced by the history of society. Thus, we cannot divorce private decisions from the social contexts they were made in.

C.1 The Opportunity and Context to Engage in Sexual Exploration

A number of the participants said that adolescents engage in both non-sexual and sexual risk behaviors because they are presented with the opportunity to do so especially with the absence of adult supervision. This opportunity could come when adult/parental supervision (as in the case of teenagers who study in another locality for college) is unavailable or when they have time alone at home or in a secluded unsupervised place with their partner. This time alone presents the opportunity for the adolescents to be intimate with each other. Aida, a parent from Baguio recounts her experience with her favorite nephew:

> *Ako yung pamangkin ko na anak-anakan ko, he was 19 nagkaroon siya ng girlfriend 19 din actually pamangkin ng ka-klase ko nung high school. Inuuwi niya yung babae sa bahay nila tapos yung tatay niya is a military man di nasa trabaho siya. Eh yung mother is a teacher…di syempre walang tao. Inuuwi niya yung girlfriend when the parents are away. Sa gabi pinapapasok niya sa loob ng kwarto niya kapag tulog na silang lahat lalo na yung mama niya. Tapos pag nag check yung mama niya it's either itatago niya under the bed or sa cabinet niya itatago yung babae. One time parang na-sense ng mama niya itinago niya sa cabinet. Nung mag-check ang mama niya at binuksan yung cabinet andun yung babae at yung babae nakuha pang ngumiti sa mama ng pamangkin ko*. (My nephew whom I also treat as my son, he was 19 when he had a girlfriend who's also 19 and my high school classmate's niece. He brought the girl to their house, his father is a military and was at work that time while her mother is teacher and was also at work that time. Nobody was there. He always brought the girl to their house when his parents are away and at night, he lets the girl go inside his room when his parents are asleep, especially his mother. There was one time that the mother felt the boy was hiding something in his cabinet and when she opened the cabinet, she saw the girl inside who even had the nerve to smile at her.)

Here we see that although the mother ensures that she checks on her child, the adolescent son still found a way to evade his mother's scrutiny and to create a space and opportunity for him and his girlfriend to do what they want to do.

The FGD results also revealed that engaging into non-sexual risk behaviors such as drinking alcohol is triggers one's libido and presents an opportunity to adolescents to engage into sexual acts as mentioned by female adolescent FGD participants in Baguio City:

> *"….natri-trigger yung libido ng (drinking alcohol) ang isang tao…"*
> *"Pag mga lasing nakikipag ano* (When they are drunk, they engage into sex)*"*
> *"[Kung]…naka drugs po [nakikipag-sex]* (when intoxicated with drugs, they have sex)*"*

The situation of Eddie, a parent from Baguio, is similar to the situation of the parents of Aida's nephew. Ben and his wife were busy with work and hence were not always home to oversee their children. The opportunities to be alone were grabbed by his 13 year old son to engage in sexual exploration at home.

> *…And the 13 year old boy is my problem that's why hindi na ako babalik sa trabaho ko kaysa naman mapariwara pa yung bata, problema. One day napansin ko kasi na nag-uwi na siya ng babae sa bahay at the age of 13 imagine…when I was 13 hindi ako sexually active na ganun.* (… And the 13 year old boy is my problem that's why I will no longer go back to my work if the consequence of it is my son's welfare. One day I noticed that she brought home a girl, imagine he was only 13. When I was his age, I'm not that sexually active.)

But adolescents need not even be alone at home to do it. Sexual exploration can even happen in the context of a home-based group activity even when parents are at home. But because parents at a certain point cannot watch all the activities of the teenagers, unwanted things between girls and boys happen. Perhaps, parents naively think that in a group situation like this, there is little opportunity for sexual exploration. Jane, a parent from Baguio, shows how this may not be the case especially when alcohol consumption is already involved:

> *Yun kasi yung mga sleep over ng mga teenagers, pupunta kami sa bahay niyo ngayong gabi ganyan. Tapos, party party. Tapos may sleep over but within that hindi mo na alam pag ano nakainom na di ba nangyayari (iyang mga bagay na iyan).* (That's how they do sleepovers, then they'll have parties later on. After that, you wouldn't know if your child drank alcohol during the sleepover, things like that.)

A different situation is presented by Amy, a parent from San Juan, who says that sexual exploration happens when parents do not exercise parental control and allow their teenagers to leave the house with their friends as much as they want to. For Amy, their 12 and 15 year old neighbors got pregnant because the parents failed to stop their children from roaming the streets and joining their peers until the wee hours of the morning. She says:

> *Sa amin ha, wag niya pababayaang umaabot ng ganung oras sa kalye ang anak niya. Para sa akin, kasi yun ang kinalakihan ko eh hindi ako pwedeng abutin ng ganung oras sa kalye. Pinababayaan niya anak niya. Kahit lalaki yan, or babae dapat yan pagpalo ng 8 or 9 [pm] nasa bahay na yan. Dapat na yan maipasok.* (In our opinion, don't let your children stay late in streets. I grew up being prohibited to stay late in the streets. They're (parents) are not taking care of their children. When the clock hits 8:00 or 9:00 pm, the children should be home already, regardless if your child is a boy or a girl.)

Lastly, because the child may be studying in another locality, the child boldly engages in things he or she might not have done had their parents been around to guide and oversee them. It is not uncommon in Baguio to see teenagers get pregnant, conceal the pregnancy from their parents, and live-in with their boyfriend or girlfriend also unknown to their parents. Ben shares this:

> *Although boyfriend, girlfriend naman sila eh pero they engage into (sic) premarital sex and then they ended up (sic) with one child ganun.Tapos hangga't makaupa na sila ng maliit na kwarto, nangyari na yan sa akin eh pinikot ako ng misis ko when I was 17. High school kami noon pero tuloy pa rin kami, hanggang ngayon kami pa rin*. (Although they are boyfriend, girlfriend, they engage

into premarital sex and then they ended up with one child. Until such time, they'll start renting a small room. It happened to me, my wife seduced me when I was 17. We were still in high school that time but we still continued together, and up to now we are still together.)

C.2. The Family: Parental Guidance does not always mean they will not do it

In the cultural context of the Philippines, the guidance of parents remains a major influential factor in the behavior of adolescents and youth. Parents play a key role in forming the attitude, behavior, and values of adolescents particularly in relation to their sexuality. However, "sex" and "sexuality" matters are considered "taboo" in the discussions in the family and even in the community. As such, parents find it "offensive," "awkward" and even "dirty" to discuss sexuality matters with their children (Commission on Population, 2002).

The FGD results showed that adolescents are embarrassed to seek help or to consult with their parents. Parents are also likely to get angry at their children when asked or even consulted about early pregnancy.

"Pagagalitan sila [pag nagtanong tungkol sa early pregnancy] (They will be scolded when they ask their parents about early pregnancy)…" –FGD Female Adolescent, Baguio

*"Nahihiya siguro sa magulang (*Maybe they're embarrassed to ask their parents about it)…" –FGD Female Adolescent, Baguio

The FGD results of parents showed the reluctance of some parents to an open discussion on courtship, sex, pregnancy and marriage with their children because they are "conservative or traditional". However FGD results showed that for some couples, it is the mother who is more open to a discussion on sexuality with their male or female children.

A Baguio mother knew her 4th year high school girl was pregnant but did not talk to her about it until after graduation for fear she might drop out of school. It was after graduation then that the mother brought her pregnant child to the doctor for check-up.

There is a general agreement among the respondents that parental guidance is needed to stave off the possibility of early pre-marital sexual encounters among teenagers. Guidance, according to conventional wisdom, begins at home with the parents doing the guiding. Guidance Counselor Susan says: "First and foremost, I think it begins from home…Parenting, for example." She relates that most of the cases they handle related to early pregnancy involves the absence of one parent, usually the mother. She shares, that the absence "could contribute greatly to teenagers who would look for a relationship, meaningful relationship, which is not found in the home."

Dina, a registered nurse connected with the Philippine Red Cross, believes that parental guidance is a must if parents are to raise responsible children. She also says that communication between parents and children is a necessity. When asked how she thinks adolescents can avoid problems related to their sexuality, she replied:

Siguro, pinakamalaki na factor ang parenting, o yung parental guidance. Kasi kung iisipin mo, maaring hindi napalaki ng maayos ang isang bata kung wala nito. At dahil dito, napakadaling

maimpluwensyahan ng bata galing sa kanyang mga nakakasalamuha sa labas ng bahay. Kaya malaki talaga ang impluwensya ng parental guidance. Mahirap din talaga, kasi, sa pagitan ng isang magulang at kanyang anak, mahirap din ang pakikipag-usap. Maaring hindi "open" ang isa't isa na pag usapan ang mga bagay-bagay, ang iba, mas nakakapag usap pa ng masinsinan sa kanilang mga kaibigan kaysa sa kanilang mga magulang. (Maybe the biggest factor is parenting or the parental guidance. If you think of it, maybe you could not rear a good child without parental guidance. And because of this, its easy for them to be influenced by people outside your home. This is the reason why parental guidance. It's really difficult because between parents and the child, communication is hard. It could be that they're not "open" to talk about things with each other. For others, they find it easier to have serious talks with their friends than with their parents.)

At the start, the family plays this important role of influencing the lives of children. As adolescents grow-up, they encounter various reference groups that influence their lives and act as a source of information, even guidance sometimes. Thus, the authority and influence of the family are undermined or are no longer given that much importance. This is especially true, when children start to spend majority of their time outside the family. The school, peers, even media come to have an important place in the lives of adolescents. Sometimes, these groups even become more influential in their lives especially when there are existing problems in the relationship between parents and children.

Hence, experts and parents think that parents should continually involve themselves in the lives of their children, to supervise them closely, to keep communication lines open, and to establish friendship with them. This is the context of Aida's sharing, a parent participant from Baguio. She underscores the importance of knowing who her sons' girlfriends are:

Ako sa mga anak ko talaga, I encourage them to introduce their girlfriend to me at saka inaalam ko kung ano naman ang family background ng mga GF nila. I love them to come to my house pag lalabas sila sinasabi kasama ko si ganito so ganun lang, kung sasabihin nilang magsisimba at isasama yung GF nila OK lang sa akin. So hindi naman very permissive so at least alam ko and I have to make it a point na nami-meet ko yung family ng GF nila para alam ko pinagsasabihan din yung mga anak nila na babae. (In my case, I encourage my children to introduce their girlfriend to me and I really check the family background of the girl. I love them to come to my house and its fine with me for my children to go out with their girlfriends, but not very permissive. At least I know where they are and I make sure that I meet the girl's family so I will know that the parents are also looking after their daughter.)

Some are also inclined to think that disciplining children and keeping an eagle eye on them could avert the possibility of early pregnancy. However, this does not work all the time. In fact, keeping an eagle watch on adolescents could actually boomerang and pose the opposite effect as some participants believe. Jimmy of San Juan puts it this way: "…*pag lagi mong pinoprotektahan yung bata lalo lang sila magrerebelde kasi hindi nila natitikman kung ano yung tunay na buhay, kasi lagi lang sila sa poder ng magulang*."

The sharing of Carmen, a parent participant and population officer from Baguio, belies the commonly held belief that a healthy dose of parental guidance and communication would ensure that the teenagers would help avoid problems such as teenage pregnancy. Carmen laments that despite

trying to guide her children properly and despite trying to build a close and trusting relationship with her daughters, her fourth year high school daughter still ended up pregnant. She relates how she has tried to be communicative to her children:

> *Hindi rin natin masasabi na yung pagaaral also [helps teenagers] avoid pregnancy…kasi na-experience ko na yan although I always advice them (her children) na every morning magkakasama kami naglalakad or pag lumabas sila hinahatid ganito. Tapos, "you should go home on time," sinusundo pa noon ng husband ko tapos nangyari pa rin. May time limit (sic) din yan when they will arrive at home.* (You cannot tell if studying also avoid teenage pregnancy…because I've already experienced that. Although I always advice them (my children) every morning when we're all walking together or when I accompany them somewhere. I tell them that they should go home on time, my husband even fetched them from school but still it happened. There is also a time limit when they arrive at home.)

Carmen further shares that it was not even her daughter's boyfriend who got her pregnant but a friend who regularly visited their house. The man was 29 years old, while her daughter then was 15 years old. Apparently, the man would pay their home a visit whenever Carmen and her husband were away. Olga, a parent from Davao, reflects on her experiences with her adolescents:

> "I can say that because I experienced that myself. No matter how you advice them that these are the things that you should do, these are the things that you should not do, you should not engage in romantic relationships while you are still studying because your Ateneo education will go to waste, still it doesn't matter (sic)."

From her sharing, we see that while parents talk to their children or give them advice, somehow the advice gets lost along the way as she has experienced with her own adolescent. There seems to be a disconnect between the messages the parents send and how the young adults take these messages in. All parents can hope for is when they talk to their children, the young adults would take their advice and be guided by them. Rose, a parent from Davao, makes this important point:

> "We cannot follow all the time the footsteps of our children. We can talk to our children, but then we do not know what is happening to them in school and to whom do they associate with. Unless they come to us and introduce the person whom they spend most of the time with, we (won't know)."

Jane, a parent from Baguio, agrees that there is really no assurance that talks with her children regarding ways they could protect themselves from adolescent pregnancy would be effective to avert them from engaging in pre-marital or unprotected sex. She says,

> *Sometimes, I have the feeling na baka itong sinasabi kong correct information but still baka they will try it out. Although sasabihin natin para [mabigyan sila] ng correct information but still you do not know kung ano na yung nangyayari pag wala na tayo*. (Sometimes, I have the feeling that maybe even if I tell them the correct information, they'll be tempted to try it out. Although we're giving them the correct information, we still wouldn't know what happens when we're no longer around.)

Experts suggest that parents should keep an open line of communication with their children when it comes to matters about relationships, even sex. This is to establish a trusting relationship between the parent and the child. Moreover, it helps parents know what is happening with their children and whether they would need to help them out with possible problems the teenagers are experiencing. Keeping a trusting relationship with parents also compels the children to protect the trust between them and their parents. However, the question is how open should the relationship be? Should parents be open enough to discuss matters about sex? Jane, for instance, raises doubts over her openness to her children regarding matters about sex. She says, "*mahirap pa rin pala na pag tinuro mo sa anak mo baka i-try naman ng mga anak namin. (It's still difficult when you're teaching it to your own child, maybe they'll be encouraged to try it).*"

Perhaps, there will really be no hard and fast answers as to the questions or to the dilemma about whether parents should openly talk about sex with their children. In some instances, talking to children work but in others the messages are not received properly by children or they choose a course of action that is opposite of what the parents are expecting them to do. And yet in other instances, parents who have not talked to children have not had problems with their children engaging in pre-marital sex. However, Melanie, a female participant from Davao, makes a sensible advice to parents when they deal with their children:

> *Give them freedom. Ask them if they want this or they want the other way around, like that. As I said earlier, do not restrict the person to a single thing. Give her choices and let her decide.*

By giving the adolescents choices, they feel like they are adults who are now responsible for the trajectory of their lives. In the end, talking to the children may be a better option than suppressing the issue completely. Perhaps, the challenge to the parents is how to get their message across and how to make children listen and accept these messages. Because teenagers are in the cusp of adulthood and would want to assert their individuality and capacity to decide for themselves, perhaps, the better tact is really to give them options and to make them realize the repercussions of their actions.

Or perhaps, rather than being in denial that their children are sexual beings who are already engaged in sexual relations it would be better to discuss protective options (e.g. contraceptives). Parents should also let go of notions that sex is "dirty" and that it is not something that parents should talk about with their children. They should be open to the fact that the world has changed and that sex issues are faced by teenagers at an ever younger age. But this last item of course would be a source of debate in a country like the Philippines, where people still regard themselves as conservative Christians/ Catholics. As Jane who works for the Population Commission says about her husband:

> *Yes, kasi traditional yung asawa ko, ayaw niya na napaguusapan yung mga ganung bagay, even nga yung mgaterials ko sa sexuality yung mga picture ng penis, vagina ganun minsan mga modules ko nandun pagagalitan niya ako pag nakakalat yung mga materials ko baka basahin ng mga bata. Conservative yung asawa ko.* (Yes, because my husband is traditional (conservative), he does not want to talk about those things, even my visual aid materials on sexuality with picture of a penis and vagina. Sometimes he gets mad at me over my modules that are scattered inside the house, he's afraid that our children will see it and read it. My husband is conservative.)

C.3 The Small Group: The Influence of Peers

The sharing of Alex, a male adolescent participant from the University of Mindanao in Davao, illustrates why peers serve as one of the most influential groups in the lives of teenagers. He explains that this is because a huge part of their daily lives is spent with peers. Adolescents also think that fellow youngsters can understand them better than adults, including their parents, because they face similar issues as cohorts. This is also said in the context that sometimes, parents explode right away in anger when their children confess that they have done something wrong, as one of the adolescent participants of the FGD pointed out.

Alex admits that peers serve as one of the principal sources of information on issues about sex and sexuality. And this is a common sharing that we found out from the various FGDs with youths all over the country. Alex says,

> *For me the biggest influence is still the peers. Like sa amin na estudyante, most of our time is spent in school and mostly we spend it with our friends. Ang mga kaibigan namin ang parating nakakausap at mas nakakaintindi sa amin. May panahon talaga na na o-open talaga yung mga topics patungkol sa sex and sexuality. Kaibigan pa rin talaga yung nagbibigay ng information or idea about sex and sexuality sa isip ng mga kabataan* (For me the biggest influence is still the peers. Like for us student, most of our time is spent in school and mostly we spend it with our friends. Our friends are the ones we talk to often times and the ones who understand us. There are times that topics about sex and sexuality are brought up in conversations. Friends or peers are the ones giving information or idea about sex and sexuality on the minds of the youth.)

Peer pressure comes in the direct or indirect forms. Indirect forms are when teenagers try to conform to a certain norm they see among their peers. Their peers may not necessarily force them to do something they do not want to do, but comparing their situation to the situation of their peers, the teenager may feel compelled to measure up to the group norm. Because teenagers are still in the process of developing their personality, they want to fit in with the group. Jane, a parent from Baguio explains this:

> *Then isa pa is yung peer pressure yung mga batang anak natin although may control sila pag yung barkada nila ang nag-ano sa kanila na gawin para feeling nila hindi sila maiwan gagawin nila kahit ayaw nila. Kasi kulang pa sila sa decision-making or wise decision making*….(Another thing is peer pressure, our adolescent children although they have control over themselves when their peers are the ones pushing them to do something against their will so they wont be left out, they'll be forced to do it. They still lack decision-making skills.)

Andrew from San Juan talks about the pressure to have a girlfriend just because all his friends already have girlfriends. He says, "*syempre yung ka tropa syempre sabihin niya may bago na naman akong GF siempre naiisip mo sa sarili, ako kaya kalian kaya ako magkagirlfriend*? (Of course your friend will tell you "I have a new GF again" and you think to yourself, "How about me, when will I have a GF?)".

The direct form of pressure on the other hand is an unequivocal form of demand to do something for the group. One form of such direct pressure is initiation to a fraternity or sorority where the person is required to undergo through a rite of solidarity.

Jimmy, a male respondent from San Juan shares a story that illustrates a direct form of peer pressure. He discloses the experience of his friend who is a fraternity member since he was a freshman in high school and who had to initiate a girl who was joining the sister sorority of the fraternity. According to Jimmy, to be part of the sorority, the girl had to willingly submit herself sexually to a member of the fraternity. Jimmy's friend was assigned to initiate the applicant. He shares:

> *Oo, yung barkada ko kasi first year high school pa lang eh nag member ng fraternity. Tapos ano, syempre initiation ng sorority, so ayun na nga, kailangan mong (the girl) ibigay (herself sexually). Di syempre ikaw yung mag-iinitiate doon sa babae….Tapos ngayon pagka-graduate niya (male friend) ng high school tinext ako, ang text nya sa akin bigla pare pumunta ka sa simbahan tapos pag punta ko doon ninong na pala ako.*(Yes, my friend became a member of a fraternity when he was just a first year highschool student. After that, of course they have sorority initiations and with that, the girls have to give their virginity to the guys. As a guy, of course you'll be the one to initiate. Then after my friend's graduation in high school he texted me and told me to go to the church. When I got their, I was shocked to know that I was already the godfather of his child.)

For a number of adolescents, peer pressure is difficult to evade because it has repercussions on one's sense of belonging and therefore one's identity as a person as well because the peer group serves as a source of social identity. It therefore becomes important for them to conform to group expectations Similarities in characteristics and experiences bond members of a group together and allow them to claim a group based identity. This is important to members of the group because the bond not only acts as a source of solidarity but also as a support structure. Jasmine from Davao shares the seeming inevitability of conformity to the group:

> *They (friends) really influence us. For example, you are expected only to do certain things which your friends do as well. Then if you do something different from what your friends has (sic) been practicing, then they will also treat you differently. You will then be taken out of their group.*

Jimmy from San Juan, on the other hand, explains the kind of mindset adolescents may have hence their desire to conform: "*Kung ang kabataan noon ay Maria Clara, ngayon hindi na. Kumbaga, kung hindi sumasabay sa agos ngayon talo ka eh. Kumbaga sa ating mga kabataan…sumasabay na lang sa agos eh*." Jimmy's idea is that adolescents aside from conforming to their actual peers may also be conforming to the larger stream of young people worldwide or cohorts who share the same ideals, behaviors, and ways of viewing things.

From the sharing of the respondents, we will see how the family as a support structure and source of direction for adolescents has been overtaken by peers. The peer group now serves as a potent source of information especially as regards experiences that teenagers may not be comfortable discussing with their parents. Peers are also perceived as an authoritative source of guidance for how to act and what to do about certain experiences and situations because they can relate with the experiences of a fellow adolescent.

A participant in one of the FGDs shares the horrifying experience of her son under the hands of his supposed friends who brought him to a brothel for his first sexual initiation (devirginization):

> *Isa sa mga anak ko, nagsabi sa akin na meron daw siyang tulo. Sabi ko pumunta tayo sa doctor. Sabi ko anak, papaano mo nakuha iyan? Sabi niya, "Tuturuan daw nila (friends) ako kung paano mag-*

sex. Binigyan nila ako ng babae na may sakit para magkaroon ako ng sakit." Mabuti wala pang HIV. Kaya yung pagbinyag, yung mga binibinyagan daw, binibigyan ng mga babaeng bayaran. Ganun nakuha niya. Sabi ko anak, iwasan mo na yang mga kaibigan mo na yan. (One of my children told me that he has gonorrhea (tulo). I told him to see a doctor. I ask him how he got that? He said, one of his friends told him that they'll teach him how to have sex. They gave me a woman who's infected for me to get infected as well. Good thing there's no HIV during that time yet. They call it their 'baptism into adulthood or masculinity' by going to a prostitute for their first sexual experience. So I told him to avoid his friends.)

The friends of the participants' son, it turns out had less than noble intentions for him. Instead of protecting him, they brought him in harm's way. This underscores the dangers of ending up with the wrong peers because instead of serving as a support structure, they could even thrust the dangers to compromising situations.

C.4. Poverty or Financial/Material Need

Parents from Baguio think that one of the reasons that drive young people to engage in pre-marital sex is poverty. There are young girls, who for financial reasons, hook up with older males in exchange for money or financial support. Ben, a parent from Baguio, shares what he has seen from his neighbors:

I will tell you one thing ha, alam mo sa bahay namin yung neighbor namin is a Sommalian pero may mga Filipina, tapos ilan sila doon. They are renting [an] apartment. Tapos, sometimes, naririnig ko sa gabi yan sumisigaw yung babae tapos pag gising ko sa umaga may condom doon sa pagitan ng bahay namin natapon doon. Pero yung mga babaeng yon mga high school, kaya nga kawawa yung mga parents nila….Ang alam ko financial ang reason doon kasi kung hindi, hindi ka papatol sa itsura palang ng lalaki sasabihin mo bang hindi dahil sa pera kasi ang ganda ng babae. Kasi minsan naririnig ko na nag-aaway sila. (I will tell you one thing, we have a Sommalian neighbor, but there are Filipinas there as well. They are renting an apartment. Sometimes during the night, you will hear them shouting at each other then the next morning, we'll see a condom between our houses thrown there. And those girls are only high school students, I pity their parents. From what I know, it's for financial reasons. Judging from the looks of the guy, you'll know that the girl is going out with him for the money. The girl looks beautiful. I hear them fight sometimes.)

But it could be more than poverty. As adolescents get exposed to the liberal and consumerist culture of the West from the media or social networking sites, some adolescents begin to see their sexuality as a possible escape from their financial woes or as a possible avenue for them to indulge in the lifestyles they desire. Aida, a parent participant from Baguio, provides her opinion on this:

Sometimes it's not really poverty, but it could be a reason. Kasi nga yon ngang mabigyan sila ng magandang damit, sapatos, and everything and…young adults [think] gusto nilang pumorma di ba. Iyon ang gusto niya, pumorma para "in" sya sa tropa niya kaya gusto niyang pumorma hindi basta-bastang bag ang gusto niya, yung mga signatures ang gusto niyang isuot. Another reason for that is para makakuha sila ng better than their partner now ganun. Kaya sila kung minsan eh ang ina-ano pa ng retired navy man yung mga nag ii-schooling dito. They could easily find a girlfriend because they could give everything kaya ang daming kumakabit talaga sa mga navy man, yung

mga may pera talaga na kahit married or what they don't care.(Sometimes it's not really poverty, but it could be a reason. Cause if you give them good clothings, shoes and everything, young adults wants to have a good image so they'll be in the fad with their friends. They don't want cheap bags, they want signature bags. Another reason is that they want to get a better partner than what they have right now. That's why sometimes, retired navy men heare go out with girls who are still in school. They can easily find a girlfriend because they have the capacity to give the girls what they want that's why many girls want to be with retired navy men. There are navy men who already have wives but they don't care.)

C.5 Media

An FGD among the adolescent males revealed their recognition of television, films, internet ability to set the trend in sexual behavior. Meanwhile, in another FGD among female adolescents, it was reported that mass media and technology (internet and mobile phones) led to a widespread belief that couples can have sex even if they are not married.

A number of the participants have also attribute the adolescents' early exploration of their sexuality and for engaging in early pe-marital sex to media. Some have pointed out, for instance, that the sexually charged images adolescents see on TV, the internet, movies, and pornographic materials make them think this is normative, that early sex is acceptable. The tendency for media to glamorize sex, stirrs the curiosity of adolescents, which makes them want to experience it. Samuel, male participant who works in the UP Mindanao, comments, "I think that sex as an idea has become common today worldwide. We can see it in the movies, TV. Teenagers all over the world do it and know about it."

With the proliferation of these images on the media, the messages of parents and educators on the need to wait for marriage before having sex or at least the need to protect oneself from the possibility of pregnancy or from STIs/HIV are drowned out. Sometimes, media makes it appear that sex is attractive, stylish, and usual while doing little to counterbalance these with messages on the dangers and negative consequences of sex.

This is exacerbated by the fact that some parents deny the possibility that their children may be engaging in early sex already. Hence, parents would rather remain in their safe bubbles denying the possibility that their children could be doing it or else, parents just choose to remain ignorant about it as if remaining ignorant about it would dispel the possibility the children are engaging in early sex. Juanita, a mother participant from San Juan, says, "*Hanggang ngayon po wala naman po akong ganoon na pag-uusap (i.e. matters about sex and sexuality). Kasi 15 pa lang po siya e."(*Up to now we don't have any conversation (matters about sex and sexuality). Her assumption is that because her child is only 15 years old, there is no need to discuss these matters with her because she is too young to engage in these acts little realizing that some girls as early as 12 year old have already ended up pregnant. Thus, Rosalie prefers to limit the mother-child conversation to conversations about school or the curfew she imposes on her children ("*tamang oras ng pag-uwi*").

Perhaps, many parents also share the mindset of Jeanette that talking about sex with their children would only embolden their children to try it out all the more. Samuel makes this important comment:

But in our own house where most people feel safe and comfortable, sex is a topic that is not talked about....So para sa akin malaking factor yun na ang sex hindi pinag-uusapan sa bahay (So for me it's a big factor that you never discuss sex at home). *Parents are usually withdrawn about the topic.*

In another FGD with parents from San Juan City, they said that mass media influence the youth by arousing their curiosity and entice them to try what they see or hear from the media as one of them shared:

Malaki [ang impluwensiya ng media] kasi nakakapanuod 'yung bata e. Curious po sila. Na-eengganyo sila [na gayahin ang nakikita nila sa media]. (Mass media greatly influences the children. They're curious, they are attracted to do what they see in the mass media.)

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Annex B Focus Questions for Causal and Behavioral Analyis

This material provides sample questions that can be included in your instruments for data gathering in relation to your causal and behavioral analysis. These were used by the Project Team to gather relevant information for the analysis of the factors associated with adolescent pregnancy as well as for the communication analysis.

You may adopt these questions in the formulation of your questionnaires or FGD designs. However, it is necessary that you review existing literature to focus on areas that need qualitative data.

FOCUS GROUP DISCUSSION QUESTIONS

Respondents: MALE and FEMALE adolescents

A. Knowledge and attitude on sexuality and adolescent pregnancy

- *Ang isyu ba ng maagang pagbubuntis ay laganap sa inyong lugar?*
- *Ano ang inyong pagkakaintindi sa "sex"? "sexuality"? Ano sa tingin ninyo ang kanilang pagkakaiba? (Ano ang pumapasok sa isipan ninyo kung nabanggit ang salitang "sekswalidad"?)*
- *Paano ipinapahayag ng mga kabataan sa inyong lugar ang kanilang sekswalidad?*
- *Saan kayo nakakakuha ng impormasyon tungkol sa sekswalidad? Ito ba ay itinuturo sa inyong paaralan, komunidad, at sa health center?*
- *Ano sa tingin ninyo ang mga bagay-bagay na kailangan ninyong malaman tungkol sa inyong sekswalidad?*
- *Ano ang katangian ng isang kabataang responsable sa pagpapahayag sa kanyang sekswalidad?*
- *Ang pakikipagrelasyong sekswal ba ay masama o mabuti para sa kabataan? Bakit?*
- *Sa inyong opinyon, tanggap na ba ng komunidad ang maagang pakikipagtalik sa mga kabataan? Ito ba ay madalas na ginagawa na ng mga kabataang inyong kakilala?*
- *Sa anong klaseng relasyon madalas nangyayari ang pagtatalik? (sa mag-nobya o casual lamang)?*
- *May nalalaman ba ang mga kabataan ngayon (babae at lalaki) sa mga pamamaraan sa pag-iwas ng pagbubuntis? Anu-ano ang mga ito?*
- *Sino sa mag-partner (babae o lalaki) ang karaniwang magpasya kung gagamit sila o hindi ng kontraseptiba?*
    - *Anu-ano ang dahilan kung bakit hindi gumagamit ang mga kabataan ng kontraseptiba?*

- *Sa inyong kaalaman, anong kontraseptiba ang kadalasang ginagamit ng mga kabataan? Bakit?*
- *Sa inyong pagkakaalam, saan pwedeng makakuha o kumukuha ang mga kabataan ng impormasyon at kontraseptiba?*
- *Sa inyong kaalaman, anu-ano ang mga dahilan kung bakit ayaw gumamit ng mga kabataan ng kontraseptiba?*

- *Sa inyong palagay, maari bang mabuntis ang kabataan sa minsang pakikipag-sex?*
- *Anu-ano ang maaring resulta ng maagang pakikipagtalik?*
- *Alam ba ng kabataan (babae o lalaki) na may paraan para hindi mabuntis ang babae kahit makipagsex (makipagtalik)? Sa mga hindi kasal, ang paggamit ba ng kontraseptiba ay katanggap-tangap?*
- *Ano ang nalalaman ninyong palatandaan sa isang babae na pwede nang mabuntis? Sa anong edad ang karaniwang pagdating ng unang regla sa isang babae? Ito ba ay nagbabago sa mga nakababatang babae kumpara sa mga nakakatanda sa kanila? Anu-ano ang dahilan ng pagbabago?*
- *Pwede bang mabuntis ang isang babae na hindi pa nagregla?*
- *Anu-ano ang dahilang ng maagang pag-aasawa?*
- *Ang pakikipag-sex ba ay isang karapatan? Bakit?*
- *May kakilala ba kayong kabataan na nagtangkang magpalaglag o nagpalaglag ng sanggol sa sinapupunan?*
  - *Sino at ano sa tingin ninyo ang nagtutulak sa isang kabataan na babae na magpalaglag ng bata? Sa inyong palagay, alam ba ng kabataan kung ano ang mga panganib na maidudulot ng pagpapalaglag?*
  - *Saan pwedeng nakakakuha ng impormasyon ukol sa pagpapalaglag? (e.g. health centers, media, priests, parents, school, etc.)*

B. Causes of Early Sexual Engagement (Underlying factors).

Pag-uusapan natin ang mga mas malalim na kadahilanan ng maagang pagbubuntis.

- *Ano sa tingin ninyo ang mga dahilan kung bakit may mga kabataang nabubuntis sa murang gulang?*
- *Sa inyong opinyon, ang sex ba ay bahagi ng pagmamahalan o pakikipagrelasyon? Maari bang magmahal ng lubos kahit walang sex?*
- *Sino ang madalas nagyaya ng sex?*
- *Sa inyong palagay, iniisip ba ng mga kabataan ang maaring kahihinatnan ng kanilang maagang pakikipagsex? Ano ang mga dahilan kung bakit nauuwi sa sex ang pakikipagrelasyon ng mga kabataan?*
- *Ano ang tingin ng inyong mga kabarkada sa mga kabataang wala pang karanasan sa sex? Ang pakikipagsex ba ay may relasyon sa inyong pagkalalake? o pagkababae?*

- *Ang paninigarilyo, pag-iinom o pagdrodroga ay pag-uugali ba ng mga kabataan ngayon? Dumadami ba o kumokonti ba ang may ganitong pag-uugali? Ang mga bisyo na ito ba ay may kinalaman sa maagang pakikipagtalik? Sa anong paraan?*

C. Institutional Factors Influencing the Open Discussion of Sex and Sexuality

- *Malaya bang napapag-usapan sa inyong pamilya at paaralan ang panliligaw, pag-ibig, palkikipagtalik, pagbubuntis at pag-aasawa?*
- *Kung may problema ang kabataan sa mga bagay ukol sa pakikipagtalik, pagbubuntis at pag-aasawa, sino ang kanilang madalas kinukunsolta? Bakit?*
  - *Anong impormasyon ang kanilang nakukuha sa mga ito?*
- *Anong impormasyon ukol sa sex at sekswalidad ang madalas tinatalakay sa media (sa radyo, telebisyon, pelikula/video, dyaryo at internet). Alin-alin sa mga nabanggit na media: (1) ang pinakamadalas na nakakarating sa kabataan? (2) ang madalas na paniniwalaan? Ito ba ay dumadami o kumokonti o parehas lang? (3) ang pinakamaimpluwensya sa pagdedesisyon ng kabataan ukol sa sex at sekswalidad?*
- *Ano ang epekto ng media sa desisyon ng mga kabataang makipagrelasyon at makipagtalik sa kanilang karelasyon?*
- *May polisiya (policy) o' programang lokal ba kayong nalalaman na tumatalakay sa problema ng kabataan ukol sa pagbubuntis at mga problema na dulot nito? Anu-anong polisiya (policy) o programa ang mga ito?*
- *Ito ba ay polisiya (policy) o' program ng gobyerno? Pribadong sektor (industrial/pangangalakal), relihiyon, at iba pa?*
- *Nakikisali ba kayo at ang mga residente ng inyong barangay/bayan/siyudad sa mga programang ito? Ano ang inyong papel sa programang ito?*
- *Ang mga programang ASRH na ito ba ay nakapagbibigay sapat na serbisyo para sa kabataan?*
- *Epektibo ba ang mga programang ito para maimpluwensiyahan (sa mabuting paraan) ang mga kabataan? Sa anong paraan?*

D. Questions on Communication Analysis

- *Saan madalas nakakakuha ang mga kabataan ng impormasyon tungkol sa kanilang kalusugan at sekswalidad? Anong klase ng media ang napagkukuhana ng impormasyon ng mga kabataan? Anu-anong impormasyon ang kanilang nakukuha?*
- *Epektibo ba ang mga sumusunod na pamamaraan para makapagbigay ng impormasyon sa ng mga kabataan:*
  - *Brochure*
  - *Poster*
  - *TV program*
  - *Radio program*

- *Interpersonal communication strategies (e.g. seminar, counseling, training, etc.)*
- *Newpaper advertisement*

- *Ano sa mga ito ay pinaka-epektibong pamamaraan ng komunikasyon sa mga kabataan?*
- *Anu-ano ang mga grupong sinasalihan ng mga kabataan? Ano ang epekto ng grupong ito sa pag-uugali at sekswalidad ng isang kabataan?*
- *Kanino madalas kumonsulta o humingi ng payo ang mga kabataan tungkol sa kanilang isyu sa sekwalidad katulad ng pagbubuntis, pagreregla at pakikipagrelasyon?*
  - *Sino dapat ang magpangaral sa mga kabataan tungkol sa kanilang sekswalidad (e.g. pagbubuntis, paggamit ng contraceptives, pakikipagrelasyon)*
  - *Tama bang nakikialam ang magulang sa pakikipagrelasyon ng mga kabataan?*
  - *Dapat bang isama ang mga impormasyon tungkol sa sekswalidad sa paaralan?*
- *Sino ang may pinakamalaking impluwensya o pinapakinggan ng mga kabataan sa mga desisyon at pag-uugali nila tungkol sa kanilang sekswalidad? Bakit?*
- *Anu-anong impormasyon ang dapat malaman ng kabataan upang maiwasan ang maagang pagbubuntis?*
- *Anu-anong mga stratehiya ang pwedeng gawin upang makuha ang partisipasyong ng mga kabataan sa programa ng goberyno?*

FGD QUESTIONS ON ASRH FOR PARENTS

- *Anu-ano ang mga isyung kinakaharap ng mga kabataan ngayon. (PROBE for the following issues)*
  - *Maagang pakikipagtalik (early sexual engagement)?*
  - *Maagang pagbubuntis o pagkaimpeksyon (Pagkahawa) ng STI/HIV/AIDS gawa ng di paggamit ng kontraceptiba (early pregnancy, STI/HIV/AIDS)?*
  - *Pagkakaroon ng maraming "partner" sa sex (boy-girl and MSM, both sequential or simultaneous partnerships)?*
- *Alin sa mga nabanggit ang pinakalaganap na problema ng kabataan dito sa komunidad ninyo?*
- *Anu-ano ba ang dahilan kung bakit ang mga kabataan ay:*
  - *nakikipagtalik sa murang gulang?*
  - *hindi gumagamit ng paraan para maiwasan ang hindi inaasahan/gustong pagbubuntis (unintended/unwanted pregnancy) at mga inpeksyon (STI/HIV/AIDS)?*
  - *nakikipagtalik sa higit sa isang partner (multiple sex), o nagbabayad o nagpapabayad para sa pakikipagtalik?*
- *Ang mga paksa na ukol sa (1) pakikipaligawan, (2) pakikipagtalik (3) pagbubuntis, at (4) pag-aasawa ay karaniwan bang pinag-uusapan ng mga magulang at ng kanilang mga anak? Sa anong edad ng bata unang pinag-uusapan ito?*
- *Ang mga pag-uusap sa mga paksang ito (1-4 in Q1) ba ay parehong nagaganap sa anak na babae at lalaki? Sino sa mga mag-asawa (nanay/tatay) ang madalas na tumatalakay sa mga paksang ito sa mga anak ng teenager (kabataan)?*

- *Nalalaman ba ng isang magulang kung may problema ang kanilang anak na teenager ukol sa mga paksang ito (1-4 in Q1)? Ito ba ay kusang inilalapit sa kanila ng kanilang anak? O sa iba nilang nalaman? Sino sa mga magulang ang mas madalas nilalapitan?*
- *Ano ba ang karaniwang pangaral ng isang magulang sa:*
  - *Edad na pwede makipagtalik ang kanilang (babaeng/lalaking) anak?*
  - *Kanino/kailan pwede makipagtalik (boyfriend/husband; premarital/postmarital)?*
- *Ano ang karaniwang pangaral ng magulang ukol sa relasyong sekswal ng mag-asawa?*
- *Ano ang pwedeng gawin ng magulang para mapagpaliban ang pag-aasawa ng maaga ng kanilang mga anak? (inform, educate, family household arrangement, economic stability of family)*
- *Ano ang pwedeng gawin ng magulang para masigurong nasa tamang paga-agwat ang panganganak ng kanilang mga anak? (teach children proper births spacing, husband-wife communication , use of FP)*
- *Ano ang pwedeng gawin ng magulang para masigurong matatag ang pamumuhay pinansyal ng kanilang mga anak? (provide adequate education, assist in job-seeking, ensure stability in work performance, keeping healthy living and lifestyle).*

Annex C Frequently Asked Questions on ASRH

This material is a consolidation of the questions often asked by adolescents about their sexuality and reproductive health. These questions were gathered from those collected by the Commission on Population-NCR from their communication activities and from other relevant materials.

You can develop your own IEC materials containing information based on these questions.

Question	Answer
1. Is pregnancy possible if the male partner is uncircumcised?	• Yes. Pregnancy has nothing to do with circumcision. It is the sperm cell released, fertilized by the egg cell, and implanted in the female uterus that causes pregnancy.
2. Can one get pregnant even if they engage in sex only once?	• Yes. Pregnancy can happen when the woman is fertile. A woman is fertile when she is ovulating and for a few days before ovulation when fertile cervical mucus is present.
3. What are the negative effects of early pregnancy among adolescents?	• Adolescent pregnancy is associated with higher rates of illness and death for both the mother and infant. o The younger a mother, the greater is the risk of her infant dying during the first year of life. o Pregnant adolescents are at much higher risk of having serious medical complications. • Early marriage • Dropping out from school
4. Why is sex discouraged among adolescents?	• Early sexual initiation results to unintended pregnancy, which in turn, puts pregnant adolescents into risky health conditions. • Early and unintended pregnancy has many negative consequences and these hinder an adolescent to achieve her aspirations. • Engaging in sex too early can also expose adolescents to sexually transmitted infections and HIV/AIDS.
5. Is masturbation bad?	• Most religions refer to it as a sinful act. It is best to seek counsel or advice from a priest or a minister. • Biologically, it does not pose negative repercussion on the health of a person. • Psychologically, when masturbation becomes an addiction, it may affect the sexual behaviors and even self-esteem of an individual. It is best to seek help from a trained counselor.

Question	Answer
6. What is STI?	• A Sexually Transmitted Infection (STI) is an infection which has been transmitted through sexual activity. Some well known examples of STIs are syphilis, AIDS, herpes, and gonorrhea. Doctors prefer the use of the term "STI" rather than Sexually Transmitted Disease (STD), because it is possible for someone to be infected without showing signs of disease, which means that the infection can be passed along by people who are asymptomatic. STIs are a serious issue in many parts of the world since they can be difficult to prevent and treat without access to the proper materials.
7. What is HIV and AIDS?	• Accute Immunodeficiency Syndrome (AIDS) is caused by the human immunodeficiency virus (HIV), which damages the body's defense system. • AIDS is an incurable but preventable disease. HIV spreads through unprotected sex, transfusions of unscreened blood, contaminated needles and syringes (most often those used for injecting drugs), and from an infected woman to her child during pregnancy, childbirth, or breastfeeding. • The risk of getting HIV through sex can be reduced if people don't have sex, if they reduce the number of sex partners, if uninfected partners have sex only with each other, or if people have safer sex – sex without penetration or while using condom.

Annex D Sample Training Design

These materials provide sample training design which contain the essential topics to be discussed in specific type of communication strategy. It also includes the time duration for each topic and the content of each major topics.

These designs aimed to address the causal and behavioral factors identified in the Sourcebook. You may adopt these designs based on your needs.

A. Building Awareness and Appreciation on Adolescent Sexuality and Reproductive Health (ASRH) Issues and Concerns

Option 1. Orientation/Forum on ASRH Issues and Concerns

Participants: Male and female adolescents aged 15-19 years
Number of days: 1 day
Objectives:
- To enhance the knowledge and awareness of participants on ASRH issues and concerns

No. of Hours	Main Topic	Contents
0.5	Preliminaries	• Invocation, national anthem, messages, pre-test
2	What is Adolescent Reproductive Health (RH)?	• Definition of RH o What does RH imply? o What are the elements of RH? • Definition and implications of Adolescent Reproductive Health • Open Forum
2	What is Human Sexuality?	• Definition of Sexuality • Elements of Sexuality o Sex and gender concepts and issues o Sexual identity and orientation o Sexual behaviors • Open Forum
1	ASRH Issues and Concerns: In Figures (Situationer)	• Empirical data related to ASRH (national/ regional/ local data) • Open Forum
0.5	Synthesis	• Summary of learning • Post-test, evaluation/activity assessment

Option 2. Orientation/Forum on Adolescent Pregnancy

Participants: Male and female adolescents aged 15-19 years

Number of days: 1 day

Objectives:
- To enhance the knowledge and awareness of participants on adolescent pregnancy

No. of Hours	Main Topic	Contents
0.5	Preliminaries	• Invocation, national anthem, messages, pre-test
1	Situationer on Adolescent Pregnancy (e.g. national, regional, local)	• Facts and figures on adolescent pregnancy o Incidence of adolescent pregnancy o Consequences of adolescent pregnancy
1	Fertility Awareness	• The male and female reproductive system functions and processes • Open Forum
2.5	Determinants (behavioral, institutional, and individual) of adolescent pregnancy	• Direct causes of adolescent pregnancy o Behavioral causes o Attitudes and normative beliefs on sexuality and beliefs o Institutional factors (family, peers, media, government, church/religion, etc.) o Socio-economic factors • Consequences of adolescent pregnancy o Health-related o Socio-economic implications o Behavioral and individual implications
1	How to prevent adolescent pregnancy?	• Ways to prevent too early and unintended pregnancy
0.5	Synthesis	• Summary of learning • Post-test, evaluation/activity assessment

Option 3. Orientation on Adolescent Sexuality

Participants: Male and female adolescents aged 15-19 years (may be in separate groups)

Number of days: 1 day

Objectives:
- To deepen the awareness and appreciation of participants on adolescent sexuality

No. of Hours	Main Topic	Contents
0.5	Preliminaries	• Invocation, national anthem, messages, pre-test
2	What is Sexuality?	• Definition of Sexuality • Elements of Sexuality o Sex and gender concepts and issues o Sexual identity and orientation o Sexual behaviors • Open Forum
2	Gender and Sexuality	• Definition of gender as compared to sex • Gender issues related to sexuality • Open Forum
1	Fertility Awareness	• The male and female reproductive system functions and processes • Open Forum
2	Healthy Sexuality	• How to express and nurture one's sexuality in healthy way?
0.5	Synthesis	• Summary of learning • Post-test, evaluation/activity assessment

Option 4. Growing Up (Orientation on Appreciating Developmental Tasks and Issues During Adolescence)

Participants: Male and female adolescents aged 13-19 years

Number of days: 1 day

Objectives:

- To deepen the awareness and appreciation of participants on the changes and process during adolescence
- To enable adolescents on how to cope with these changes

No. of Hours	Main Topic	Contents
0.5	Preliminaries	• Invocation, national anthem, messages, pre-test
3	Adolescence as a Stage of Human Development	• Who are the adolescents? • Changes during adolescence o Physiological/physical/hormonal/somatic o Psychological o Social • Open Forum
2	Developmental tasks and social expectations during adolescence	• The various developmental tasks during adolescence • Open Forum
1	Tips on Becoming a Personally Effective Adolescent	• What adolescents can do to be successful in their current stage of development?
0.5	Synthesis	• Summary of learning • Post-test, evaluation/activity assessment

B. Building the Capacities of Adolescents on ASRH and Life Skills

Option 1. Training Youth Leaders on ASRH and Life Skills (can also be adopted for Youth Camps)

Participants: Male and female adolescents aged 15-19 years

Number of days: 5 days

Objectives:

- To enhance the knowledge and awareness of participants on ASRH issues and concerns
- To build the life skills of adolescents to enable them to prevent adolescent pregnancy and to effectively cope with the challenges of everyday life

Day	No. of Hours	Main Topic	Contents
1	30 mins	Preliminaries	• Invocation, national anthem, messages, pre-test
	2	Appreciating Adolescence (Discovering the Pains and Gains in Growing Up)	• Who are the adolescents? • Changes during adolescence o Physiological/physical/hormonal/somatic o Psychological o Social • Development tasks during adolescence
	2	What is Adolescent Reproductive Health (RH)?	• Definition of RH o What does RH imply? o What are the elements of RH? • Definition and implications of Adolescent Reproductive Health • Current situationer on ASRH (Facts and Figures)
	2	What is Human Sexuality?	• Definition of Sexuality • Elements of Sexuality o Sex and gender concepts and issues o Sexual identity and orientation o Sexual behaviors
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
2	3	Gender Concepts and Issues	• Definition of gender (versus sex) • Gender issues o Stereotyping o Discrimination o Violence against women o Patriarchy • Improving gender relations
	4	Confronting THREATS and RISKS during Adolescence	• Various threats and issues during adolescence o Too early pregnancy/marriage o STI and HIV/AIDS infections o Sexual violence and exploitation (including rape and trafficking) o Poverty and socio-economic issues (e.g. high drop-out rates and unemployment) o Non-sexual risk behaviors (substance abuse) o Family relations o Passivity o Suicide or low self-esteem o Pornography
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics

Day	No. of Hours	Main Topic	Contents
3	3	Life Skills Development	• Self-Awareness • Life Planning (visioning and objective setting) • Establishing harmonious family relationship
	4		• Effective Communication Skills o Interpersonal communication o Refusal o Negotiating o Self-assertion
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
4	3		• Critical Thinking • Decision-making
	3		• Effective and healthy management and expression of emotions • Empathy • Spirituality
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
5	3		• Leadership skills
	1		• Action Planning
	0.5	Synthesis, Assessment	• Synthesis • Post-Test • Evaluation of the day's topics

Source: Commission on Population (2000).*Sexually Healthy and Personally Effective Adolescents (SHAPE) Modules.*
Department of Health, UNFPA and WHO (2000). *Adolescent Health: A Training Programme for Health and Non-Health Service Providers: Facilitator's Guide.*

C. Building the Capacities of Adolescents on Peer Counseling

Participants: Male and female adolescents aged 15-19 years

Number of days: 5 days

Objectives:

- To enhance the knowledge and awareness of participants on ASRH issues and concerns
- To build the life skills of adolescents to enable them to prevent adolescent pregnancy and to effectively cope with the challenges of everyday life
- To capacitate adolescents on guiding and counseling their peers towards positive and healthy sexual behaviors

Day	No. of Hours	Main Topic	Contents
1	30 mins	Preliminaries	• Invocation, national anthem, messages, pre-test
	2	Appreciating Adolescence (Discovering the Pains and Gains in Growing Up)	• Who are the adolescents? • Changes during adolescence o Physiological/physical/hormonal/somatic o Psychological o Social • Development tasks during adolescence
	2	What is Adolescent Reproductive Health (RH)?	• Definition of RH o What does RH imply? o What are the elements of RH? • Definition and implications of Adolescent Reproductive Health • Current situationer on ASRH (Facts and Figures)
	2	What is Human Sexuality?	• Definition of Sexuality • Elements of Sexuality o Sex and gender concepts and issues o Sexual identity and orientation o Sexual behaviors
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
2	3	Gender Concepts and Issues	• Definition of gender (versus sex) • Gender issues o Stereotyping o Discrimination o Violence against women o Patriarchy • Improving gender relations

Day	No. of Hours	Main Topic	Contents
	4	Confronting THREATS and RISKS during Adolescence	• Various threats and issues during adolescence o Too early pregnancy/marriage o STI and HIV/AIDS infections o Sexual violence and exploitation (including rape and trafficking) o Poverty and socio-economic issues (e.g. high drop-out rates and unemployment) o Non-sexual risk behaviors (substance abuse) o Family relations o Passivity o Suicide or low self-esteem o Pornography
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
3	3	**Peer Counseling** • Basic Concepts	• What is Peer Counseling? • The Purpose of Counseling • Characteristics of Good Counselor
		• The Counseling Process	• Protocols and confidentiality rules in counseling • Establishing support network and sources of support • Limitations of the peer counselor's role • Procedures for referral • Techniques of counseling (The GUIDE approach, Do's and Don'ts of counseling, etc.)
	4	Skills in Counseling (Role Playing/Demonstration)	• Effective Interpersonal Communication Skills • Empathy • Critical Thinking
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
4	8	Practicum on Counseling	• Developing Skills in Peer Counseling
	0.5	Synthesis, Assessment	• Synthesis • Evaluation of the day's topics
5	4	Practicum on Counseling	• Developing Skills in Peer Counseling
	1		• Action Planning
	0.5	Synthesis, Assessment	• Synthesis • Post-Test • Evaluation of the day's topics

Note: *The most effective process for training peer counselors includes both didactic and experiential techniques in a basic four-step sequence: (1) identifying and defining the skill in behavioral terms -- breaking it down into small steps; (2) demonstrating or modeling both effective and ineffective examples of the skill; (3) practicing the skill with supervision and feedback until minimum competence is achieved; and (4) practicing the skill with supervision in real counseling situations.*

Training the trainers can also be accomplished within the peer counseling program, using a pyramid approach in which more advanced peer counselors, under professional supervision, act as trainers. This method has the advantage of providing the more experienced with new skills and new trainees with models of effective peer helping. Other ways of ensuring effective trainers include professional development workshops for counselors, and prepackaged training curricula with accompanying trainers' manuals (Danish and Brock, 1974).

D. Building the Capacities of Parents, Guardians, and Relatives on Forming Responsible and Healthy Sexual Behaviors

Option 1. Training of Parents on Child Development

Participants: Couples (male and female parents)

Number of days: 3 days (may be done in series)

Objectives:
- To enable participants to appreciate themselves as parents and individuals
- To capacitate parents on effectively assisting their children towards healthy development

Day	No. of Hours	Main Topic	Contents
1	30 mins	Preliminaries	• Invocation, national anthem, messages, pre-test
	1	Me as a Parent	• Self-awareness • Value for children • My responsibilities as a parent
	2.5	Child Development Knowledge and Care	• The typical child development processes and behaviors; • Providing developmentally-appropriate physical care and environment (e.g., feeding, diapering, home safety) • Fostering children's positive emotional development (e.g., self-esteem, providing stimulating environment)
	2.5	Positive Interactions with Child	• The importance of positive, non-disciplinary interactions with children • Using skills that promote positive parent-child interactions (e.g., demonstrating enthusiasm, following child's interests, offering appropriate recreational options) • Providing positive attention

Day	No. of Hours	Main Topic	Contents
2	2	Responsiveness, Sensitivity, and Nurturing	• Responding sensitively to child's emotional and psychological needs (e.g., soothing); providing developmentally-appropriate physical contact and affection
	2	Emotional Communication	• Using relationship-building communication skills (e.g., active listening) • Helping children identify and appropriately express emotions
	2	Disciplinary Communication	• Giving clear and developmentally- appropriate directions; setting limits and rules; stating behavioral expectations and consequences
3	1	Discipline and Behavior Management	• Attitudes about discipline strategies • Attributions about child misbehaviors • Monitoring and supervision practices and techniques • Specific reinforcement and punishment techniques • Problem solving about child behaviors • Consistent responding or generalization
		Promoting Children's Social Skills or Prosocial Behavior	• Teaching children to share and cooperate, use good manners, and get along with peers, siblings, or adults
		Promoting Children's Cognitive or Academic Skills	• Using incidental teaching • Fostering children's language or literacy development • Enhancing child's school readiness and performance

Source: US Department of Health and Human Services (2009). *Parent Training Program: Insight for Practitioners*.

Option 2. Training of Parents and Guardians on ASRH and Effective Parenting of Adolescent Children

Participants: Couples (male and female parents)

Number of days: 5 days (may be done in series)

Objectives:

- To enhance the knowledge and awareness of participants on ASRH issues and concerns
- To enable participants to appreciate themselves as parents and individuals including their sexuality
- To capacitate parents on effectively assisting their children towards adopting healthy and responsible sexual behaviors

Day	No. of Hours	Main Topic	Contents
1	30 mins	Preliminaries	• Invocation, national anthem, messages, pre-test
	1.5	Me as a Parent (Self-Awareness)	• Self-awareness (my values, strengths, and weaknesses) • My responsibilities as parents
	4	Understanding my Sexuality	• What is sexuality? • Elements of sexuality o Sex and gender identity and expected roles o Sexual identity and preferences o Sexual attitudes and behaviors • Having a healthy and responsible sexuality
2	2	Nurturing a Happy and Harmonious Family	• The concept of Filipino family • Challenges and threats to Filipino family • How to build harmonious and happy family?
	3	Understanding Adolescence	• Changes during adolescence and its implications o Physiological changes o Sexual maturation o Social changes ▪ Relationship with peers ▪ Relationship with family o Cognitive and moral development • The developmental tasks during adolescence • The threats facing the Filipino adolescents
	2	Educating and communicating healthy sexuality among adolescent children	• How to communicate sexuality concerns to adolescents? o Effective approaches in communicating sexuality to adolescents o Responding effectively to ASRH issues among adolescents

Day	No. of Hours	Main Topic	Contents
2&3	5	Educating and communicating healthy sexuality among adolescent children	• Nurturing an Enabling Relationship with adolescent children • How to communicate sexuality concerns to adolescents? o Effective approaches in communicating sexuality to adolescents o Responding effectively to ASRH issues among adolescents
4	3	Building and nurturing Life Skills among Adolescents	• Self-Awareness • Life Planning (visioning and objective setting) • Establishing harmonious family relationship
	3		• Effective Communication Skills o Interpersonal communication o Refusal o Negotiating o Self-assertion
5	3		• Critical Thinking • Decision-making
	3		• Effective and healthy management and expression of emotions • Empathy • Spirituality
	1	Synthesis Post-Test	• Synthesis • Action Planning • Post-Test • Closing Program

For Further Readings

Commission on Population (2000). *Sexually Healthy and Personally Effective (SHAPE) Adolescent Training Package.*

Department of Health. *Adolescent Health: A Training Programme for Health and Non-Health Service Providers: Facilitator's Guide.*

Department of Social Welfare and Development. *Manual on Effective Parenting*.

Annex E Things to consider in conducting training and other communication strategies

The information below provides the things that should be considered in conducting training, capacity building activities, public discourses, and other communication similar communication strategies to make such activities more effective. You should consider them in your BCC strategies.

The effectiveness of communication strategies rest on the smooth flow of information from the source to the target audience. The more conducive and facilitative the medium is, the clearer would be the message. As such, in any communication strategies, the challenge is to ensure that information are smoothly conveyed to achieve the desired feedback or response from the audiences. This entails ensuring the conduciveness of the training environment to ensure learning. Consider the following:

On physical facilities (venue, physical arrangement)

- The training room or venue should be spacious enough for undertaking interactive activities and can accommodate everyone comfortably.
- Seating arrangements should allow maximum interaction.
- Provide sufficient space for discussion or workshops. You may secure separate rooms for workshops provided that it does not entail material time for the participants to move to such room.
- External distractions emanating from the environment should be eliminated or minimized.

On supplies, instructional aids, and equipment

- Check that all supplies, audio-visual aids, and equipments are readily available in the room.
- Ensure that equipment are functioning well. Set-up and check all equipment before the training proper.
- Arrange materials orderly. Distribute them after discussion so participants can pay attention to the resource person or facilitator.

On participants

- Always ensure that the appropriate participants are invited and actually attend to the training to ensure its effectiveness and relevance.
- Review the profile, characteristics, interest, and current attitude or knowledge on the subject matter to inform resource persons so that they may consider it in their methodologies.

On assessment and follow-up

- Make an assessment or feedback mechanism be part of the training design to get an idea on the effectiveness of the training and to gather information that may help in improving the succeeding communication strategies.
- Assessment instruments should be simple and understandable.
- The completed evaluation or assessment forms should be analyzed for programming subsequent communication activities.

Annex F Legal mandates for the provision of ASRH information and services to adolesents

This material was adopted from the **"Primer on the Legal Bases for Adolescent Health Services in the Philippines"** developed by the National Technical Committee on Adolescent and Youth Health and Development (NTCAYHD) in 2011. You may use this material for the development of your project concept on BCC strategies as well as in providing legal context for your BCC interventions. This can also be adopted as basis for designing relevant policies as support BCC initiative.

I. Background Information:

1. About the Document

Given the current situation of the Filipino Adolescent and the legal issues faced by the health service providers, the Department of Health, in consultation with multi-sectoral agencies and development partners crafted the Standards for Adolescent-Friendly Health Services in 2009. As there were conflicting beliefs and views among the health care providers as far as the legal bases for providing certain health information and services that were identified in the Standards, particularly on reproductive health, the National Technical Committee on Adolescent and Youth Health and Development (NTCAYHD) saw the need to review and stock existing international and country legal instruments that can guide health care providers in delivering health information and services to adolescents especially in the area of reproductive health. Thus, on March 19, 2010, the National Technical Committee on Adolescent and Youth Health and Development (NTCAYHD) met to make an inventory of all known existing international, national and sub-national laws and issuances that support the provision of health information and services to Filipino adolescent.

2. The Target Audience

This document aims to provide information on the laws and issuances supporting the provision adolescent-friendly health services to the following:

(a) Primary Audience: Health Care Providers in various settings, i.e. community, school, workplace
(b) Secondary Audience: Parents, Adolescents and Youth, Law Enforcers, Social Workers, Educators, Policy and Decision-Makers including Local Chief Executive, Media

3. The Objectives of the document

(a) Take stock and clarify existing international, national and sub-national laws, policies and guidelines in relation to the provision of adolescent health services;
(b) Increase public awareness and understanding on existing laws, policies and guidelines that support adolescent health care provision; and

(c) Identify enabling factors in existing laws, policies and guidelines that affect the accessibility, availability and quality of an adolescent-friendly health care provision.

4. The Methods used in gathering Laws and Issuances

(a) Consultative meetings of the NTCAYHD.
(b) Research and review of existing international instruments and national laws and issuances, including department policies of the Department of Health (DOH) and the Department of Interior and Local Government (DILG).
(c) Review of available documents on the existing situations of Filipino adolescents and practices undertaken by health care providers in assisting adolescents.

5. Scope and Limitation of Laws and Issuances Cited in the Document

This document will tackle the international instruments and local laws and issuances as they apply and support the National Standards for Adolescent Friendly Health Services. It will also try to discuss and address some of the identified legal issues confronting the health service providers, in the context of what is provided by international instruments and national laws and issuances. The issues presented in the document are based on experiences shared by some of the members of the NTCAYHD.

However, not all provisions in the laws presented in this document have legal interpretations that can provide clear response to certain issues that health care providers have encountered or may face in the future. For instance, the concept of parental authority and its relation to the principle of the best interest of children as enunciated in the UN CRC has not yet been clearly construed, and remains a vague area in the law. Under the Family Code, parental authority encompasses the rights of parents to represent their children in *all matters* affecting their interests. Does this mean that children, in particular, adolescents, who are mature enough to exercise their rights, have to secure the consent of their parents in *all* matters affecting their interests? Does this provision of the Family Code contradict the principle of the evolving capacity of children enshrined in Article 5 of the UN CRC as regards the exercise of their rights?

Another limitation is that there may be some local ordinances and school-based policies that have not been acquired during the course of doing the inventory.

II. Definition of Terms:

1. **Health Workers** – refer to all persons who are engaged in health and health-related work, and all persons employed in all hospitals, sanitaria, health infirmaries, health centers, rural health units, barangay health stations, clinics and other health-related establishments owned and operated by the government or its political subdivisions with original charters and shall include medical, allied health professional, administrative and support personnel employed regardless of their employment status (*Section 3, Republic Act 7305*) including volunteer workers (*Section 4 [g], Executive Order No. 51*).

2. **Public Health Service Providers** – refer to persons engaged in health and health related works in any government entity whose primary functions according to its legal mandate is the delivery of health services.

3. **Children** – refers to person below eighteen (18) years of age or those over but are unable to fully take care of themselves or protect themselves from abuse, neglect, cruelty, exploitation or discrimination because of a physical mental disability or condition. (*Section 3 (a), Republic Act No. 7610*)

4. **Adolescents** – refer to persons whose ages range from 10-19 years old. (*WHO*).

5. **Youth** – refer to person whose ages range from 15-30 years old. (*Section 4 (a), Republic Act No. 8044*)

6. **Young People** – refer to persons from 10-24 years old. (*WHO*)

7. **Child Abuse** – refers to the maltreatment, whether habitual or not, of the child which includes any of the following:

   a. Psychological and physical abuse, neglect, cruelty, sexual abuse and emotional maltreatment;
   b. Any act by deeds or words which debases, degrades or demeans the intrinsic worth and dignity of a child as a human being;
   c. Unreasonable deprivation of his basic needs for survival such as food and shelter; or
   d. Failure to immediately give medical treatment to an injured child resulting in serious impairment of his growth and development or in his permanent incapacity of death. (*Section 3 (b), Republic Act No. 7610*)

8. **Best Interest of the Child** – refers to the totality of the circumstances and conditions which are most congenial to the survival, protection and feelings of security of the child and most encouraging to the child's physical, psychological and emotional development. It also means the least detrimental available alternative for safeguarding the growth and development of the child.

9. **Reproductive Health** – a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. (*International Conference on Population and Development Programme of Action, par. 7.2*)

10. **Parental Authority** - the ensemble of right and powers that the law accords to the father and the mother with respect to the person and the goods of their unemancipated minor children, to the end of their accomplishing the duties of protection, education, and support that are incumbent on them (Rubellin-Devichi 1999). It includes among others, the natural rights and duties of parents to: (a) enhance, protect, preserve and maintain their physical and mental health at all times; (b) furnish them with good and wholesome educational materials, supervise their activities, recreation and association with others, protect them from bad company, and prevent them from acquiring habits detrimental to their health, studies and morals; (c) represent them in all matters affecting their interests; and (d) perform such other duties as are imposed by law upon parents and guardians. (*Art. 220, Family Code of the Philippines*)

11. **Substitute Parental Authority** – refers to the following: (a) the surviving grandparent or the one designated by the court when there are several surviving grandparent; (b) the older brother or sister, over 21 years of age, unless unfit or disqualified; and (c) the child's actual custodian, over twenty-one years of age unless unfit or disqualified. (*Art. 216, Family Code of the Philippines*)

12. **Special Parental Authority** – refers to the authority and responsibility over the minor child, of the school, its administrators and teachers or the individual, entity or institutions engaged in child care, while the said minor child is in their supervision, instruction or custody. Authority and responsibility shall apply to all authorized activities whether inside or outside the premises of the school, entity or institutions. (*Art. 218, Family Code of the Philippines*)

13. **Parental Consent** – informed consent given by a parent on behalf of a minor or otherwise incompetent child.

IV. Principles on Child Rights Programming

The Philippines is a signatory to the United Nations Conventions on the Rights of the Child (UN-CRC), which binds all signatory States to recognize the right of the child "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and bound "to ensure that no child is deprived of his or her right to access such health services". Hence, provision of programs and services to children must at all times consider the five (5) core principles on child rights programming. This is to ensure that programs and services are best designed to the needs and concerns of the children.

The following are the 5 core principles on child rights programming:

1. **In the best interest of the child** –

This principle is reflected in Article 3 of the UN CRC and states that "All actions concerning the child shall be in his or her best interests.

The best interest of the child is a major building block in the philosophy of the CRC. It reflects a fundamental aspect of the CRC: the contradiction between the vulnerable and the competent child. On one hand children are competent human beings, with the right to influence matters affecting their lives. On the other hand children are vulnerable and in need of special support and protection. How can children be granted equal value and still be given the protection they need? Considering "the best interest of the child" is part of the answer.

"Best interests" covers all decisions affecting boys and girls. In any action taken by the state, by the authorities and by relevant private institutions involving children, their best interests should be the primary consideration. Procedures must be developed to ensure governments and decision-making bodies consider the interests of the child before taking decisions that affect him or her. Boys and girls should be given primary consideration when resources are mobilized and allotted.

"Best interest" will not normally be the only consideration when decisions are made which affect children but it should be among the first aspects to be considered and should be given considerable weight in all decisions affecting girls and boys.

2. Survival and Development

This principle as reflected in Article 6 of the UN CRC states that "Every child has the right to life. The State has an obligation to ensure the child's survival and development.

A basic concept of the CRC is that children carry within themselves the potential for their own development. This Article states that all children should be allowed and supported to develop their full potential. It recognizes that children, especially young ones, are vulnerable and need special protection and support. They must be kept from harming themselves, but they must also have the options, both physically and socially, to be active in their own physical and social development: to play, explore and interact; to think for themselves and have their views recognized.

The concept of the developing capacities of the child is one of the key features of Article 6. This means that the age and maturity of the child should be taken into consideration when determining the scope of self-determination and freedom of the child. Child development is a holistic concept, demanding consideration of the whole child. As this includes her physical, cognitive, emotional, social, cultural and spiritual development, approaches to development must be multi-disciplinary and cross-sectoral.

3. Non- Discrimination

This principle is enshrined in Article 2 of the UN CRC and states that "All rights apply to all children without exception. It is the State's obligation to protect children from any form of discrimination and to take positive action to promote their rights."

Discrimination can be practiced by governments themselves, by adults against children, by one community against another, by one group of children against another. It can result from active direct and deliberate actions, or it can happen unconsciously through insensitivity, ignorance or indifference. Discrimination can take place through legislation, institutionalized attitudes, media and government's action or inaction.

4. Participation

Article 12 of the UN CRC specifically provides for this principle. It states that "Girls' and boys' have the right to be involved in decisions affecting them."

Article 12 places an obligation on governments to ensure that girls' and boys' views are sought and considered in all matters that affect their lives. Children of any age should be allowed to express their views and in ways with which they are comfortable. Decision-making bodies, other institutions and families must listen to children and take their views into account in accordance with the child's age and maturity. In order to be able to make decision, children have the right to relevant information provided in a form they can understand.

5. Accountability

This principle promotes that "when States ratify human rights instruments, they become accountable to all citizens, including children, and to the international community." It also

provides that children are recognized as "holders of rights", and that they should not be objects of charity. On the other hand, the State is the "primary duty bearer", hence, the State must ensure that the CRC is implemented for all children living within the country (including those who are not its citizens).

III. Roles and Responsibilities of Health Care Service Providers

A. Duties and Obligations:

Health service providers are persons mandated by law to engage in the direct provision of preventive, curative, and rehabilitative health services. Pursuant to this mandate, a health care service provider has the obligation to ensure the fulfillment of the right to health of a person.

According to the UN-CRC, the following are the right to health concerning particularly the adolescents:

1. Protection from hazardous and exploitative work and labor;
2. Protection from accidental death and injuries;
3. Protection from violence and abuse;
4. Provision of necessary services to prevent and treat mental disorders and psychosocial illness (including depression, eating disorders and self-destructive behaviors);
5. Protection from information and marketing of unhealthy products and lifestyles like tobacco and alcohol;
6. Provision of access to sexual and reproductive information regardless of their marital status, including, family planning and contraceptives, dangers of early pregnancy, prevention of sexually transmitted infections, HIV and AIDS;
7. Provision of health services to pregnant adolescents that are sensitive to their rights and particular needs; and
8. Right to informed consent to treatment that includes provision of confidential advice and respect for privacy and confidentiality.

B. Application of duties and obligations in specific cases:

Case Illustration No. 1

A 14 years old girl is brought by a maternal aunt to the health clinic due abdominal pain. Gynecological examination reveals that she has pelvic inflammatory disease. When asked about the possible cause of the disease, the girl revealed that she was forced into prostitution in Oriental Mindoro. The aunt is suspected to be involved in prostituting the girl. The family is dysfunctional as both parents are separated and has abandoned her to the maternal aunt.

(a) To what extent should the health service provider be involved once the pelvic inflammatory disease has been resolved?
(b) What should the health service provider do next as far as maintaining the confidentiality of the gynecological examination that was done?
(c) Should the health service provider divulge the result of the examination to the maternal aunt without the consent of the girl?

Answers:

(a) Section 4 of the Implementing Rules and Regulations (IRR) of Republic Act 7610 (RA 7610) mandates the head of any public or private hospital, medical clinic and similar institution, *as well as the attending physician and nurse*, to report, either orally or in writing to the Department of Social Welfare and Development (DSWD) the examination and/or treatment of a child who appears to have suffered abuse within forty-eight (48) hours from knowledge of the same. Since health service providers are obliged to protect children from abuse and violence, they are mandated by law to report to the DSWD the case of the 14-year old girl.

(b) The health service provider has the obligation to maintain confidential the result of the gynecological examination pursuant to Section 23 of the IRR of Republic Act 7610, which provides that *all records pertaining to cases of sexual abuse shall be strictly confidential and no information relating thereto shall be disclosed* except in connection with any court or official proceeding thereon. This is in response to the right of children to privacy and confidentiality.

(c) The health service provider should respect the right to privacy of the patient. They should guard as a sacred trust anything that is confidential or private in nature that they may discover or that may be communicated to them in their professional relations with their patients. (*Section 6, Article II, Code of Ethics of the Medical Profession in the Philippines [Republic Act No. 4224]*). Information shared by the patient to the health service provider is covered by the principle of "privileged communication". (*Rule 130, Section 24, Revised Rules of Court*) As the law does not make any distinction as to age, the health service provider cannot disclose the result of the examination to the maternal aunt without the consent of the patient.

Case Illustration No. 2

A 16 year-old girl went to the hospital due to profuse bleeding. The girl refused to give the contact details of her parents as they do not know that she had an abortion.

(a) As a health service provider, will you give her medical treatment despite lack of parental consent and despite the fact that she had an abortion?
(b) After the treatment, would you insist that the parents be informed? Or can the child just be referred to DSWD?

Answer:

(a) The health service provider should immediately provide medical treatment to the child despite lack of parental consent as it would serve the best interest of the child. Preventing the death or the permanent incapacity of the child should be the primordial concern of the health service provider. Failure to provide immediate medical treatment will make the health service provider liable for child abuse under *Section 3, paragraph (b) of Republic Act 7610*. In addition, refusal on the part of the health service provider to provide immediate medical treatment to a child in need on the ground that the latter had an abortion is in violation of *Section 13 of Republic Act 7305*, which provides that health service providers shall discharge their duties humanely with conscience and dignity, and should perform their duties with utmost respect for life.

(b) Once the minor is declared out of danger, the health service provider should exert effort to encourage the child to divulge information on the whereabouts of her parents. If the child still refuses despite diligent efforts, the health service provider should refer the minor to the DSWD for appropriate psycho-social interventions.

Case Illustration No. 3

A 17 year-old old went to the clinic to request treatment of his STI. You learned that he is engaged in high risk sexual activity. He does not want his parents to know. To what extent can confidentiality be upheld in his case? If he needs to be worked up for HIV/AIDS, can the health service provider pursue without parental consent? What about treatment?

Answer:

Article 259 of the Revised Penal Code penalizes any physician or midwife, who taking advantage of their scientific knowledge and skills shall cause an abortion or assist in causing the same. It also penalizes any pharmacist who, without the proper prescription from a physician, shall dispense any abortive.

Taking into account the provision of the law, the health service provider could validly refuse to perform the abortion. He should also inform the parent of the child that they could likewise be penalized under the law. The health service provider could likewise refer the parent and the child to a counselor or a social worker from DSWD.

Case Illustration No. 4:

A 16 year old girl is brought to the clinic by the mother. The mother is requesting an abortion of the unborn fetus. How should the health provider handle the situation?

Answer:

(a) It is submitted that confidentiality must always be upheld. **Article II, Section 6 of the Code of Ethics of the Medical Profession in the Philippines** states that, "the medical practitioner should guard as a sacred trust anything confidential or private in nature that he may discover or that may be communicated to him in his professional relation with his patients, even after their death. He should never divulge this confidential information, or anything that may reflect upon the moral character or a person involved, except when it is required in the interest of justice, public health, or public safety". The law does not make any distinction as to age with regard to the exercise of confidentiality.

(b) Section 15 of RA 8504 (Philippine Aids and Control Act of 1998) provides that written informed consent must be first obtained from (a) the person concerned id he/she is of legal age; or (b) from the parents or legal guardian in the case of a minor or a mentally incapacitated individual if the minor needs to be tested for HIV/AIDS.

Under RA 7610, a child is defined as those below 18 years of age. Hence, the health service provider needs to secure the consent of the parent of the minor prior to the latter's testing for HIV/AIDS.

(c) As regards treatment other than referral for HIV testing/screening, applying Article 16 of the UN CRC, it is submitted that if the minor is mature enough to understand the effect and consequences of the treatment to be given to him, and he gave consent to the same, the health service provider could provide the needed treatment. It must be remembered that the "best interest of children" shall be the paramount consideration in all actions concerning them. Denial of treatment on the ground that the child refuses to secure parental consent might worsen his condition and lead to his permanent disability or even his death.

III. International and Philippine Laws and Issuances as Applied in the National Standards for Adolescent Health Care Provision

Standard No. 1: Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and to obtain services from it.

Legal Bases:

A. International Laws

1. *Article 12.2 par. (c) and (d), General Comment No. 14, ICESCR* provides for the right of all persons to health facilities, good and services for the prevention, treatment and control of diseases.

2. *Article 24, par. 1 of the UN CRC* provides for the right of every child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. It likewise provides that no child should be deprived of his or her right of access to health care services.

3. *General Comment No. 4 of the Committee on the Rights of the Child* provides for the right of adolescents to access adequate information essential for their health and development and for their ability to participate meaningfully in society.

4. *Article 16, par. 1 of CEDAW* provides that the state should guarantee the right of women to access information, education and the means to exercise the right to freely and responsibly decide on the number and spacing of children.

5. *Recommendation No. 15 of the CEDAW Committee* provides that the State should intensify efforts in disseminating information to increase public awareness of the risk and effects of HIV infection and AIDS, especially among women and children. The reproductive and subordinate role that women and children occupy in the society must be given special attention.

6. *Beijing Platform for Action* provides for the affirmative action that the State has to perform in order to address the inadequacies and unequal access to health care and related services of women, children and adolescents.

7. *ICDP Benchmarks* provides for access to: (a) voluntary reproductive health services, including family planning to reduce unwanted pregnancy, unsafe abortion and maternal death; and (b) reproductive health care to fight HIV/AIDS by teaching young people abstinence outside of marriage, safe sex (use of condom) and responsible sexuality.

B. National Laws and Issuances

1. *Section 22 of Republic Act 8504* or the *Philippine AIDS and Control Act of 1998* provides that persons with HIV/AIDS should be afforded basic health services in all government hospitals, without prejudice to optimum medical care which may be provided by Special Aids wards and hospitals.

2. *Section 19 and 22 of Republic Act 7610* provides that delivery of basic social services in health and nutrition to children of indigenous cultural communities and children in situations of armed conflict should be given priority and should be kept unhampered.

3. *Section 9, par. 6 of Republic Act 9231* mandates the State to provide working children access to immediate free medical and psycho-social services.

4. *Section 3 of Republic Act 9710* or the *Magna Carta of Women* provides that all people have the right to participate and access information relating to decision making processes that affect their lives and well-being.

C. Department Issuances applicable to all Standards:

1. Department of Health –

   (a) Administrative Order No. 34-A, series of 2000, re: Adolescent and Youth Health Policy which ensures that all adolescents and youth have access to quality comprehensive care and services in an adolescent and youth friendly environment.
   (b) Administrative Order No. 43, series of 2000, re: Reproductive Health Policy, which provides for the Reproductive Health Framework and ensures that RH services are available in all DOH retained hospitals and LGU health facilities.
   (c) Administrative Order No. 0010, series of 2007, re: National Policy on Violence and Injury Prevention, which establishes the national policy and strategic framework for injury prevention activities for DOH and other government agencies, LGUS and NGOs

Application/Explanation

Standard 1 ensures that access to information and services are provided in the health facilities.

As a state signatory to international instruments and conventions, the Philippines have the obligation to ensure that adolescents are given appropriate information, counseling and treatment in health facilities. Every child has the right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of their illness. No child should be deprived of the right to access health care services solely on the basis of their age. Adolescents have the right to access

adequate information essential for their health. This is anchored on the principle that the right to health is a fundamental right of every human being. The law does not make any distinction as to the age of the child. Hence, no distinction should likewise be made by state parties when applying the provisions of the international conventions. This standard finds more application in cases of child abuse wherein medical services and procedures for assisting victims-survivors must be clearly spelled out in the health facilities.

In addition, adolescents, regardless of their circumstances, e.g. differently abled, employed, in emergency, members of indigenous communities, should have access to a facility that can be reached safely and within reasonable time. The cost for availing health information and services should also be affordable and have preferential consideration for adolescents from economically poor families. Activities to popularize and effectively inform young people about the services, including proper referral, should be implemented.

Standard No. 2: The services provided by health facilities to adolescents are effective and in line with the accepted package of services, and are provided on site or through referral linkages by well-trained staff effectively.

Legal Bases:

A. International Law

1. *General Comment No. 14 of the ICESCR* provides that the right to health in all its forms and at all levels must adhere to the essential elements of availability, acceptability and quality.

2. *Article 12 of the ICESCR* provides that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.

3. *Article 12. 2 (a) of the ICESCR* provides that women (including adolescents) has the right to maternal, child and reproductive health services.

4. *Article 21.1 of the General Comment of the ICESCR* provides that the realization of the highest standard of health is the enjoyment of a variety of facilities, goods, services and conditions provided in a timely manner, and includes access to health related education and information, including sexual and reproductive health.

5. *Article 3, par. 3 of the UN CRC* provides that institutions, services and facilities should conform to the standards established by competent authorities, particularly in the areas of safety and health.

6. *Article 25, par. 1 of the UDHR* provides that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care.

B. National Laws

1. *Republic Act No. 7624* provides for the integration of the ill effects of drug abuse, addiction, or drug dependency in the intermediate and secondary curricula as well as in the non-formal, informal and indigenous learning programs.

2. *Republic Act No. 8044* or the *Youth in Nation-Building Act* recognizes the need to institutionalize delivery of comprehensive services in areas without or with inadequate services in order to promote and protect the physical, moral, spiritual, intellectual and social well-being of the youth for the improvement of their quality of life.

3. *Republic Act No. 8172* or the *Act for Salt Iodization Nationwide (ASIN)* provides for the protection and promotion of the health of the people through effective food regulatory system. It also ensures that women and children are given proper nutrition.

4. *Republic Act No. 8972* or the *Solo Parents Welfare Act* mandates the DOH to develop a comprehensive health care program for solo parents and their children, which include among others, expansion of knowledge on health care, behavior management and preventive stress management strategy. The program shall be implemented by the DOH through retained hospitals and medical centers and the local government units (LGUs) through their provincial/district/city/municipal hospitals and rural health units (RHUs).

5. *Republic Act No. 7727* or the *Magna Carta for Disabled Persons* mandates the DOH to establish medical rehabilitation centers in government provincial hospitals and to formulate and implement health services, which include but is not limited to, prevention of disability through immunization, nutrition, and medical treatment and rehabilitation.

6. *Section 5 of Republic Act 8504* or the *Philippine AIDS and Control Act of 1998* provides that HIV/AIDS education and information dissemination shall form part of the delivery of health services by health practitioners, workers and personnel. The knowledge and capabilities of all public health workers shall be enhanced to include skills for proper information dissemination and education on HIV/AIDS.

7. *Section 3 of Republic Act 8505* or the *Rape Victim Assistance and Protection Act of 1998* provides for the establishment of a Rape Crisis Center in every province and city located in a government hospital or health clinic or in any suitable place for the purpose of providing among others, psychological counseling, medical and health services, including medico-legal examination, of rape victims.

8. *Section 17 (a) and (b) of Republic Act 9710* provides that a comprehensive, culture-sensitive, and gender responsive health services and programs covering all stages of a woman's life cycle and which addresses the major causes of women's mortality and morbidity must be provided by the State at all times. Access to the following services must be ensured: (a) Family and State collaboration in youth sexuality education and health services without prejudice to the primary right and duty of parents to educate their children; (b) Prevention and management of reproductive tract infections, including sexually transmitted diseases, HIV, and AIDS; and (c) Prevention of abortion and management of pregnancy-related complications. In addition,

women in all sectors must be provided by the State with appropriate, timely, complete, and accurate information and education on all aspects of women's health in government education and training programs.

Application/Explanation

Standard 2 ensures that the services provided to adolescents are acceptable, efficient and of quality.

International standards mandate that health care facilities, goods and services must be sufficiently available, respectful of medical ethics, scientifically and medically appropriate and sensitive to gender and life-cycle requirements.

Hence, it vital that health services and information provided to adolescents should be delivered by trained and competent health care service provider and are based on established protocol and guidelines, e.g, Adolescent Job Aid Manual - A Practical Guide on Adolescent Health Care, and the Women and Children Protection Units and Health Services Performance Standards and Tools.

In addition, the age and maturity of the adolescents must be taken into account in the provision of appropriate and efficient health care goods and services, which includes among others, the provision of artificial contraceptives.

It is therefore important for the DOH to come-up with a tool to determine the maturity of the adolescent so that appropriate health care goods and services are provided to them.

In other countries such as the United States of America (USA), maturity of the adolescent is being considered by the health care service provider when providing health care services to them.

Standard No. 3: The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable.

Legal Bases:

A. International Law

1. *Article 16 of the UN CRC* provides that in order to promote the health and development of adolescents, State parties are encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counseling on health matters. Health care providers have an obligation to keep confidential information concerning adolescents, bearing in mind the basic principles on the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counseling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.

2. *Article 3 of the UN CRC* provides that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

B. National Laws

1. *Article II, Section 6 of the Code of Ethics of the Medical Profession in the Philippines* provides that the medical practitioner should guard as a sacred trust anything confidential or private in nature that he may discover or that may be communicated to him in his professional relation with his patients, even after their death. He should never divulge this confidential information, or anything that may reflect upon the moral character or a person involved, except when it is required in the interest of justice, public health, or public safety.

2. *Section 18, (d) of the IRR of Republic Act 9208* or the *Trafficking in Persons Act of 2003* provides that the DOH shall make available its resources and facilities in providing health care to victims of trafficking which shall, at all times, be held confidential.

3. *Section 15 (c) of the IRR of Republic Act 8505* provides that medical reporting of rape cases shall be limited to the basic facts of the case and devoid of sensationalism. The name and address of the survivor and other information tending to establish her or his identity shall not be included in the report unless the survivor gives his or her consent in writing.

4. *Section 30, RA 8504* provides that all health professionals, medical instructors, workers, employers, recruitment agencies, insurance companies, date encoders, and other custodians of any medical record, file, data, or test results are directed to strictly observed confidentiality in the handling of all medical information, particularly the identity and status of persons with HIV.

Application/Explanation

Standard 3 guarantees that privacy and confidentiality in the health facilities are maintained to ensure that adolescents are comfortable in availing services in the health facility.

Health care service providers should be able to effectively attract young people and succeed in retaining them for continuing care because of their respectful, accommodating, non-judgmental and non-discriminatory attitude towards young people. They should provide enough time for discussion, reasonable waiting time, sufficient privacy, relaxing space and reassuring attitude for follow-up visits or continuing care.

Health service providers are encouraged to observe the right of adolescents to privacy and confidentiality, including with respect to advice and counseling on health matters. Information shared by the adolescent to the health service providers should be treated confidential by virtue of their professional relationship with them. Only in cases allowed by law, or as required by the court, or if the same would redound to the best interest of the child should the health service provider divulge the said confidential information.

Standard No. 4: An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services.

Legal Bases:

A. International Law

1. *Article 21. 1 of the General Comment on the ICESCR* in particular that which provides for the participation of the population in all health-related decision-making processes at the community, national and international levels.

2. *Article 2 of the UN CRC* that prohibits discrimination of children on the basis of the status, activities, expressed opinions, or beliefs.

3. *Article 3, par. 2 of the UN CRC* provides that children should be afforded protection and care as is necessary for his or her well-being.

4. *Article 12 of the UN CRC* which provides for the right of the child who is capable of forming his or her own views to express those views freely in all matters affecting him/her, and his/her views being given due weight in accordance with his/her age and maturity.

5. *Article 24, par. 3 of the UN CRC* provides that traditional practices prejudicial to the health of children should be abolished.

6. *Article 5 of CEDAW* provides that State Parties must take appropriate measures to: (a) modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women; (b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

B. National Laws

1. *Article 1, Section 2, RA 7610* which provides that the best interest of children shall be the paramount consideration in all actions concerning them.

2. *Section 32 of Republic Act 9710* which provides that measures to eliminate all forms of discrimination against girl-children in education, health and nutrition, and skills development must be pursued by the State.

Application/Explanation

Adolescents are generally healthy and do not see health as an issue that needs a service response. In reality, however, adolescents face fears and concerns on the dramatic physical and emotional changes that they experience at this stage and do not know where to find answers. Public education campaigns and ordinances to support the acceptability and utilization of the adolescent health services must be done. Young people must be educated about their needs and rights and about the availability of service providers who are respectful and responsive to their needs and concerns. They must also be provided with the opportunity to participate in designing health service program that will respond to their concerns. Community support to adolescent health needs must be ensured through continuous issuances and revisions of policies on the provision of information and services to adolescents, including reproductive health.

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Annex G Sample script for theater presentation dealing with ASRH issues

These materials were gathered from LGUs and institutions that implemented theater arts and presentation as a communication strategy. You may refer to this in developing your own script in similar strategy.

A. Script for Theater Presentation dealing with ASRH Issues

Maagang Pag-Aasawa
(by Ifugao Youth Theater Group)
Courtesy of Ifugao Provincial Population and Sustainable Development Office)

Characters\cast:

- Agripina
- Sarah
- Ana
- Goryo
- Mangghihilot
- Mga chismosa:
  - Jerson Orig
  - Emannuel
  - Denver Pinkihan
- Ayod Men:
  - Rester
  - Romeo
- Chidren

Entrance Song:

Dakamin tatagud Ifugao
An mahlu an muntamu
Dakol di anataton mi
An mangipaphod hi boble [2x]

Scene I
(to be sung simultaneously)

Uyawe kan Bugan, uyawe kan damayon
Te imbuggan mud boble, indamayon mud boble

Uyawe kan guinid, uyawe kan bulintao
An inguinid mud boble, inbulintao mid boble

Boys:
An man upe't Bugan ka, man upet damayon ka
Mu inbuggan mud boble, indamayon mud boble

Girls:
An maupet guinid ka, man upet bulintao ka
Mu inguinid mu dalan, inwedwed mu hi dalan

Boys:
Man dintong mi nan payom, dintong mi bananu na
Munkabding di page na, munkabding di bako na

Girls:
Man dintong mi nan balem, dintong mi halaung yu
Ya mun kag ay atop na munkag ay dagede na
Rester:
Tutut yu mayutmut yu
Aga ket tobalon yu ta mun an anla taku
Boys:
Immaliya hi bale yu
Ot ibaga di naminhod u
Te nun naud an hean abu di wahtu hi nomnom ku

Scene II
(Mga chismosa enters)
Greek koro:
Early marriage
Ang maagang pag-aasawa
Iwasan yon..
(*conversation of the chismosas talking about the young ladies who are married at an early age*)

Scene III
(Three pregnant women enters with matching *rampa* and dance)

Sarah:	*Ako si Sarah, Sa dami ng nakilala, Ito ang napala, Bongga diba?*
Ana:	*Ako naman si Ana. Ang sabi nila, masaya ang buhay may-asawa. Sa akin naman, wag na..*
Pina:	*Ako si Agripina. Dahil sa maagang pag-aasawa, Eto dumami sila, Kaya girls,,,*
Jova:	*Uno!*
Rica:	*Dos?*
Geraldine:	*Tres!*
All:	GUSUTAN NA!

Scene IV

(Mga chismosa enter with their conversation)

Pina:	*Hoy!mga murat na malalaki ang bunganga, ako ba ang pinaparinggan niyo?*
Jerson and Eman:	*Ay may narinig ka?*
Eman:	*Gusto mo ng take two?*
Pina:	***Magsilayas nga kayo!***
Mga chismosa:	*I don't care..e.e..er* (exit)
Jova and Rica:	*Haay! Mga chismosa talaga. Wala ng ginawa kundi ang siraan si Agpina.*
Sarah:	*Uy kumusta pala? Di ba tatlong buwan na yang dinadala mu?*
Ana:	*Ah oo..tatlong buwan daw itong dinadala ko sabi ni doctor. E ikaw?*
Sarah:	*Ako? Pumunta ako sa clinic kahapon para magpapre-natal. Buti na lang lalaki ang magiging anak ko kasi kung babae na naman, siguradong madadagdagan pa.*
Ana:	*uhmmm sabagay…*
Sarah:	*Eh ikaw Pina, malaki na yang tiyan mo ah. Kelan ka ba manganganak?*
Pina:	*Ewan ko ba!*
Ana:	*'Di mo alam? Yan kasi hindi ka nagpapacheck-up para malaman mo ang eksaktong araw ng panganganak mo.*
Sarah:	*At para malaman mo rin ang kalagayan ng beybi mo.*
Pina:	*Tumigil nga kayo! Alam niyo, papunta palang kayo, pabalik na ako. Ibig sabihin,' di hamak na mas marunong ako sa inyo. Sa dami ba naman ng mga anak ko*...(kapitan and Madame nurse are seen entering)
Sarah:	*Pero mali yan..*

Scene V

Kapitan:	*Ay 'yon pala sila…Naglalaba..*
Nurse:	*Hello mga misis, labadami a.*
Sarah and Ana:	*Ay si madame nurse!*
Sarah:	*Napasyal kayo?*
Nurse:	*Ah oo..kumusta na kayo? Balita ko konti lang ang dumalo sa naganap na free check up at prenatal noong isang lingo ah.*
Sarah:	*Oo nga po eh. Kami lang ang nakadalo.*
Nurse:	*Bakit?*
Kapitan:	*Ah mukhang marami pa kayong pagkukwentuhan ah. Maiwan ko muna kayo.*
Sarah, Ana and Nurse:	*Sige po kapitan.*
Ana:	*Eh kasi madame nurse, anihan ditto sa amin at iyon ang pinagkakaabalahan ng karamihan dito.*
Nurse:	*Aah.. o sige kayo na lang ang tutulong sa akin na hikayatin ang ga kagaya niyo para dumalo sa nalalapit na seminar tungkol sa mabuting pagpapamilya.*
Sarah and Ana:	*Oo ba madame nurse.*

Nurse:	*Aasahan ko yan ha. Te'ka diba si Agripina yon?*
Sarah and Ana:	*Ah oo siya nga..*(proceed to laundry)
Nurse:	*O Agripina, malaki na ang tiyan mo ah pero bakit hinda kita ata nakita ni minsan na pumasyal sa klinika natin?*
Pina:	*Hindi na kailangan madame nurse. Sa dami ng anak ko e naipanganak ko naman sila ng maayos dito sa bahay. Sayang lang ang pera at panahon.*
Nurse:	(papangaralan si Pina at aanyayahin na dumalo sa nabanggit na seminar)
Pina:	*Sige na madame nurse. Susubukan ko.*
Nurse:	*Hindi lang subukan. Punta ka na. o ano maglaba na kayo para matapos nang makauwi na rin kayo ha.*
Sarah and Ana:	*Sige po madame nurse.* (exits nurse)
Ana:	*Sarah may ikukwento ako sa iyo.*
Sarah:	*O ano yon?*
Ana:	*Alam mo ba nung naglilihi ako? Kawawa ang asawa ko.*
Sarah:	*Bakit naman?*
Ana:	*Hatinggabi pinaghahanap ko siya ng palakang may nunal.*
Sarah:	*Palakang may nunal? Aanhin mo naman 'yon?*
Ana:	*Iyon ang gusto kong kainin sa ganoong oras. E ikaw, naglihi ka ba?*
Sarah:	*Aba oo. At alam mo ang pinaglihian ko?...Ang kili-kili nga asawa ko. Gustun-gusto kong amuyin ang kilkili ng asawa ko.*
Ana:	*Ganun? Eeeeew. Hindi kaya mabaho yon?*
Sarah:	*Hindi. Kaya nga yon ang gusting-gusto kong amuyin eh.* (Titingin kay Pina at sabay na Sabihin na)
Sarah and Ana:	*Eh ikaw Pina?*
Sarah and Ana:	*Pina?*
Pina:	*Pumutok…*
Sarah:	*Ha?*
Pina:	*Pumutok…*(Lalapitan nina Sarah at Ana)
Ana:	*Ano ang pumutok?*
Pina:	*Pumutok…*
Sarah:	*Ano nga ang pumutok?*
Pina:	*Ang patubigan ko.* ***Manganganak na yata akooooo…***
Sarah:	*Si Goryo, ang asawa 'nya tawagin mo…*
Ana:	***Goryoooo..Goryo maanganganak na ang asawa mo!*** (Goryo enters running)
Goryo:	*Pina,asawa ko manganganak ka na!* (tingin kay Ana) *Tawagin mo si Amboy para dalhin ang ayod.* (Ana runs to the center then runs back to Goryo)
Ana:	*Hindi ako ang tatawag. Dapat ikaw.* (Goryo runs to the exit and calls Amboy with the Ayod, prepares to carry Pina and freeze)
Greek koro:	**Ayod Saves Life. Bearing the Ayod Requires a Team.** (exit)

Scene VI

(In the house of Goryo with the manghihilot, Pina is seen with the manghihilot on process)

Manghihilot:	*Hay! Talagang hindi ko na kaya 'to. Mas mabuting dalhin nyo na lang sa pinakamalapit na ospital.* (All prepare Pina with the ayod to carry in the hospital then freeze)
Greek koro:	**Para Sigurado ang Panganganak, Dalhin Agad sa Pinakamalapit na Health Center**
Manghihilot:	(*monologue*)

Scene VII

(enters children singing)

Children: Agkuchung pele pele
Matun tunud cha goheng
Nalaoh hi Futala
Finalofog nay oha
Nipohet ad Amfulu
Pangammahan cha fanga
Fangan punhorchan
Fangan punhagaangan
Futi-futi ti
Gahna Fugan
Rica, Jova and Denver:
Komkomsi(3x) bada bada
Owi pan imbabada
Di hongog ni mapulut
Honglut honglut [2x]
(*father Goryo whistles and children assemble to line singing*)

Children:
Father Goryo has many children
Many children has father Goryo
I am one of them and you are too
So let us sing again

Goryo:	*Magbilang!*
Child 1:	*Isa!*
Child 2:	*Dalawa!*
Child 6:	*Anim, huling bilang na po!*
Goryo:	*Bakit kulang! Nasa'n yung isa!*
Jerson:	*'Tay dito po ako.*

Goryo:	*Bilisan mo. Ang kupadkupad mong kumilos! Ngayong araw, tayo ay magtatrabaho. Kayong dalawa, maghugas kayo ng pinggan; ikaw mag-igib ka ng tubig; ikaw maglinis ka ng bahay kasi maraming alikabok; ikaw magsibak ka ng kahoy; ikaw magluto ka at ikaw magbunot k ng sahig. Maliwanag ba?!*
Children:	*Opo 'tay*
Child 2, 3 and 4:	*Pero 'tay…*
Child 2:	*May klase po kami.*
Goryo:	*Walang papasok ngayon. Wala kayong makukuha sa aral-aral na yan!*
Child 4:	*Wala po tayong bigas 'tay*
Goryo:	*Ano? Naubos agad yung binili ko nung isang lingo?*
Child 4:	*Opo 'tay*
Goryo:	*Hala sige at mangungutang ako sa tindahan. Magtrabaho na kayo!*
Jerson:	*Kuya…*
Child 6:	*O bakit?*
Jerson:	*Ate..*
Child 2:	*Ano?!*
Jerson:	*Nahihilo ako…* (matutumba) (*goryo enters*)
All:	*Tadonaaaa..*(all freeze)

Last song:

Ngayon na ang panahom
Ihakbang mo ang yong mga paa
Wag mong hintaying
May buhay na mawawala
Magkaisa't magsama-sama
Tayo'y magsikilos na
Kapakanan ng pamilya
Ito ang mahalaga
Kalusugan, ating pangalagaan.

"PANGANGARAP"

(by Ifugao Youth Theater Group)

Courtesy of Ifugao Provincial Population and Sustainable Development Office)

Cast of characters:

Blessing- *narrator*
Noel- *ama*
Genesis- *ina*
Mica- *rebellious child*
Rhey- *lasenggong anak*
Shawn lee- *nag- aaral na anak*
Mafie- *masunuring anak*
Shikara- *bunsong anak*
Renato- *boss ng isang company*
Emmanuel- *tauhan ng boss*
Richard- *kasintahan ni Mafie*
Rester- *common teenager*

Director- *John Lawton Balacuit*
Stage manager- *Lalie Vic Cawilan*
Scriptwriter- *Blessing Cardenas*
Musicians- *Jefferson Dulnuan, Rodolfo Lim Jr., Jefferson Aniwasal*

Introduction:

Dito sa aming bayan
Sari saring mga kwentuhan
Tungkol sa buhay ng bawat isa
Ano nga bang kapalaran
Nitong aming munting bayan
Sa pag usad ng kamay ng orasan

Dala ba ng kahirapan kaya nagkakantahan
O di kaya'y dahil sa kasiyahan

Monologue: Situationer

Ang isyu ng populasyon ay matagal nang pinagdedebatehan sa ating bansa. Subali't may mga sitwasyon sa ating bayan na kailangang mapagtuunan ng pansin. Hindi sa pamamagitan ng debate, kundi sa pamamagitan ng gaw. Ayon sa mga nakalap na datos, patuloy na dumarami ang mga kabataang nag-aasawa sa murang edad. (The population issue has long been debated heatedly in our country. However, we have situations in our province which is needed to be addressed not through debate but through strong actions. Such data, like young people who got married at the age of 20 and below is rampantly increasing.)

Gusto niyo pong malaman ang aming kalagayan. Kami po'y iyong pakinggan.

GEEK KORO: ANG KABATAAN! MAPUSOK! BASAGULERO! MAHILIG GUMIMIK! SUNOD SA USO! NAGHAHANAP NG BAGONG KARANASAN!

Song:

Boys: *Manang Biday ilukat mu man*
'Ta bintanam ikalumbabam
'Ta kitaem tuy inayawam ay
'Matayakun nu dinak asyan

Girls: *Asinuh ka aglabas labas*
'Tuy hardin ku pagay ayamak
Amum ngarud nga balasangak
Sabung ni lirio di pay nag ukrad

Boys: *Nu nangatu di mu sukdalin*
Nu nababa di mu gaw aten
Nu narig rig di mu piduten
Ay labas labsan kantu pay laeng

MUSIC: DANCE (portraying Courtship) – "Careless Whisper"

BLESS: (Monologue)
Siguro nagtataka kayo kung anong klaseng bayan meron tayo
Bakit lagi silang nakangiti
Kahit sila'y punung-puno ng problema
Sila ba'y tinamaan ng droga

'Wag na kayong magtaka at sigurado
'Pag nakakita kayo ng isang babaeng katulad ko
Ang inaasahan nyo'y isang malumanay magsalita
Laging nakadaop palad at nanggigitla kung nakakita ng malaswa
Naku, dito sa atin
Andami na nating nababalitaang kalaswaan sa ating bayan
Ito ang ating totoong sitwasyon

SONG…..

MICA: *Kung ang pangangarap ay sapat*
At ang buhay ay hindi mahirap
'Di sanay nakapag-aral ako

Kailan makamtan ang kaginhawaan
Hanggang kalian kaya tayo makakahon sa hirap
Mga katanungan ng isang kabataang tulad ko
Bakit may mahirap at mayaman
Bakit ganito ang kalagayan

SHIKAY: (anak) *Ayoko nga!... Ayoko ngang maligo eh…nay…nay….ayoko pong maligo…*
MAFIE: (anak) *Halika na…kailangan mong maligo. Ang dungis dungis mo na nga oh*

SHIKAY: *Ah basta ayoko…ang lamig lamig ng tubig!*

MAFIE: *Ah basta…maliligo ka …sa ayaw at sa gusto mo!*

SHAWN: (anak) *'Nay problema! Exam naming nextweek eh hindi pa ako nakabayad ng matrikula…Sabi nila, di na ako pwedeng mag-exam kung di pa ako nakabayad.*

GEN: (mama) *Hintayin na lang natin ang tatay mo…baka sakaling makapagremedyo.*

REY: (anak) (Kagigising…)
Ang sakit ng tiyan ko…
Oh! Kayong dalawa, anong tinitingin tingin niyo diyan..? (Sabay turo sa mga kapatid)
'Nay may niluto ka na poh ba?

GEN: *Abah.. at gising na ang napakagaling kong anak… S'an ka na naman nanggaling kagabi? Umuwi kang lasing na lasing ah.. Wala ka na talagang ibang ginawa kung di bigyan ng kahihiyan ang pamilyang ito.*

REY: *Kahihiyan????? Matagal na ngang nakakahiya ang pamilyang ito eh… Chupi..chupi… alis ka nga diyan!*

SHAWN: *Abah.. ang yabang yabang moh ah… Kala mo kung sino…*

REY: *Ang talas ng dila moh ah.. Alam moh ba kung sinong mas matanda dito? AKO! Kaya dapat igalang mo ako.*

SHAWN: *Oo..mas matanda ka nga pero wala kang silbi.. ang sabihin mo, ikaw n lang ang mag-aral at ako ang maghanap ng trabaho… bobo!!!*

REY: *Ano? Ano'ng sabi mo?*

SHAWN: *Utak pulburon!*

REY *Anong sabi moh?*

Entrance si Tatay (NOEL) kumakanta..

SONG: *Lintik na buhay, walang trabaho, kung saan saan ako napadpad, walang mahanap!*

NOEL: *Letseng buhay 'to oo!!!*

GEN: *Ano na namang problema mo? May trabaho ka na ba?*

NOEL: *'Di nga tayo pinalad eh.. porke't high school lang natapos ko eh din a daw ako tatanggapin.*

GEN: *P'ano na yan?... saan tayo kukuha ng pambili ng pagkain? Paano makapag-aral ang ating mga anak?*

NOEL: *Anong magagawa ko? Ganyan talaga ang buhay.. minsan, nasa taas.. minsan nasa baba… Tanggapin mo na lang…*

GEN: *P'ano ko naman tatanggapin ang ganitong buhay kung may buhay na naman ditto sa sinapupunan ko…?*

NOEL: *ANO??? 'Wag mong sabihing may laman na naman 'yan?*

GEN: *OO.. BUNTIS AKO!!!*

CHORUS: SONG WITH DANCE	*Bumilog na naman ang tiyan ni Nanay* *Higpit ng sinturon ang sabi ni Tatay* *Kapos na nga sa pagkain* *Aksidente na naman daw ulit* *Parang hagdan na kaming magkakapatid* *Ayaw ng manganak pero lagging sumasabit* *Pag nagkamali sa bilang o lasing si ama* *Kawawa na naman si Inay* *Dumarami mga bata sa lansangan* *Parang sardinas itsura ng tahanan* *Kung sino pa ang mahirap* *Sila pa ang sobra-sobra ang anak* *Puro debate ang simbahan at gobyerno* *Sa mga pagamutan, walang gamot serbisyo* *Habang patuloy ang pagdami ng tao* *Lalong naghirap, walang trabaho*
NOEL:	*Eh paano na iyan?*
GEN:	*Ikaw kasi! Kung sinunod natin si Doktor na gumamit tayo ng pills o condom…di sana wala ito!*
NOEL:	*Eh! Ayoko nga sa contraceptive na iyan eh… Lalong lao na ang condom. Para kang kumain ng kendi na may balot.*
GEN:	*Eh lalo naman kung natural ang gamit natin…'Ni hindi ka nga makapagpigil eh! Lagi na lang palpak pag natural family planning!*
NOEL:	*Eh lalo na sa artipisyal na sinasabi mo! 'San naman tayo kukuha ng pambili ng ganyan! Ni wala nga akong trabaho eh!*
SHAWN:	*'Nay, 'Tay, tama na nga yan! Di naman kayo marunong mag family planning eh…Titigil na lang ako sa pag-aaral para tulungan ko si tatay..maghahanap na din ako ng trabaho*
SONG: (SHIKAY)	*Ang batang may muta* *Tinunaw ng kanyang luha* *Panis na laway* *Naghihintay ng kapirasong pandesal* *Ngunit mataas na ang araw sa silangan* *Wala pa rin si Ama*
MUSIC:	"Laklak"

DISCO DANCE: (representing vices of the youth)

MONOLOGUE:

Tulad ng maraming teenager na naging mapangahas
Nag-eksperimento, sumubok na makipaglaro sa tadhana
Sa dinami dami ng mga teenager na naging malikot, di nag iingat, hindi nag isip ng kinabukasan
Siyempre sa huli na lang magsisisi…
At ano naman ang ipinagkaiba ng ating kabataan
Ano ang puno't dulo
Saan kaya sila patungo?

SONG: ENTRANCE NG MAGKASINTAHAN

Sinikap kong magbago ng dahil sa iyo
Minamahal kita
Lumambot ang puso kong dati ay bato
Dahil sa pag-ibig mo

Ako'y binigyan mo ng bagong pananaw
Damdamin ay ginising mo
Pag- ibig kong tigang, iyong dinilgan
Salamat sa pag-ibig mo

Minsan ay nagtatanong ang puso ko
Ba't ako ang mahal mo
Ano ba ang iyong nakita sa akin
Ba't akoy inibig mo
Dahil bulag daw ang pag-ibig
Sigurado nga ay totoo
Dahil ako'y inibig mo

MAFIE: *Mahal na mahal kita pero…*
Natatakot ako sa maaring mangyari
Ang mga magulang ko, maagang nag-asawa tuloy marami kami
So kuya Coco, walang pang tuition dahil walang trabaho si tatay
Si kuya nando naman, araw-araw na lang naglalasing
Kelan kaya matutupad ang pangarap ko? Ang makapag-aral!

RICHIE: *Hwag kang mag-alala! Naiintindihan naman kita!*
Hindi kita pababayaan kailanman
Handa naman akong maghintay ano mang oras, buwan man o taon
Dahil mahal na mahal kita

SONG: *Minsan ay nagtatanong ang puso ko….* (EXIT)

ENTRANCE: with music… tot tot tot…

EMY: *Grabeh.. ang dami na namang aplikante*

MICA: *Tama… alam mo ba may gwapo sa kanila…*

EMY: *Sus.. baka yun naman ung crush ko.. baka gusto mong agawin…*

MICA: *Ikaw talaga.. puro lalaki lang talaga ang alam moh… tumahimik ka na nga baka marinig pa tayo ni Pres.*

NATO: *Magandang umaga… Oh maaga kayo ngayon ah?*

EMY: *Oh, sir..pakitignan na lng poh.. ang daming aplikante!*

NATO: *Hindi natin kasalanan yan…Ah.. pasyensya poh, pero hindi na kami tumatanggap ng mga aplikante!*

SHAWN & RICH: What?

SHAWN: *Sir sige na po, nakikiusap po ako. Kahit janitor lang..sige na po…*

EMY: *Halika kayo.. Ako'ng bahala sa inyo. Doon na lang kayo sa parlor ko magtrabaho…*

SHAWN & RICH: Ngek!!!!

SONG:

Ako'y karaniwang tao
Tatlong kahig isang tuka
Kahit singkong duling ako'y wala
Ako'y karaniwang tao

Nasaan ang trabaho
Nasaan ang gobyerno
Nasaan ang ipinangako
Nasaan ang pagbabago

Exit ang boys… entrance si nanay….

SONG:

Sana'y di magmaliw ang dati kong araw
Nang munti pang bata s apiling ni nanay
Nais kong maulit ang awit ni inang mahal
Awit ng pag ibig habang ako'y nasa duyan

Sa aking pagtulog na labis ang himbing
Ang bantay ko'y tala ang tanod ko'y bituin
Sa piling ni nanay langit ang buhay
Puso kong may dusa sabik sa ugoy ng duyan

MAFIE: *Inay.. may ipagtatapat po sana ako…*

NANAY: *Ano 'yon anak?*

MAFIE: *'Nay…. Buntis po ako…*

NANAY: *ANO? Ano ka ba naman anak.. ang bata bata mo pa para harapin ang buhay ng isang ina.*

MAFIE: *Kaya nga po 'nay.. gusto ko po sanang ipalagalag…*

NANAY: *'Wag na wag mong gagawin yan anak… wag mong solusyunan ang problema ng isa pang problema…. Kasalanan yan anak…. Buhay ang nasa sinapupunan mo.*

MAFIE: *Nakapagdesisyon na po ako inay.*

SONG: Mafie… *Kung ang pangangarap ay sapat*
At ang buhay ay di mahirap
Di sanay nakapag-aral ako

Kailan makamtan ang kaginhawaan
Hanggang kalian kaya tayo makakahon sa hirap
Mga katanungan ng isang kabataang tulad ko
Bakit may mahirap at mayaman
Bakit ganito ang ating bayan

Narrator: *Sa dinami-dami ng teenager na sa huli na lang ang pagsisisi. Nagtangkang takasan ang problema, nagulantang sa takbo ng buhay at pinipilit ibalik sa dati. Ganito nga ba ang gusto nating mangyari sa ating mga kabataan? …Ng dahil sa kakulangan sa edukasyong pangsekswal? O gusto ba nating magkaroon ng anak na nangangalang janjan, feb, mar, april, may, junjun at hulyo?*

Kumusta naman ang ating mga kababaihan na lagi na lang nagagamit. Hindi ba't sila ang kawawa?Hintayin pa ba nating dumating ang oras na hindi na natin mabigyan ng magandang kinabukasan an gating mga anak ng dahil sa kakulangan ng kaalaman sa pagpaplano ng pamilya at maagang pag-aasawa.

(With so many teenagers finding themselves at a dangerous edge. Desperately running blindly, taken aback on how their lives was overturned and tried so hard to bring it back the way it was before. Is this what we want to happen to the hopes of tomorrow, just because, knowledge on sexuality was deprived from them? Or do we want to have children naming January, February, March, April, May, June and July. How about our women? Who have gone thru all the pain and labor, just to give life to the next generation? Can't we spare them their sufferings and give them the right to choose and plan how many children they wanted to have. Should we even have to wait for the moment when we couldn't afford to give our children a bright future. We already held the hopes in our hands to improve and be part of a developing and hopeless life for the next generation.

SONG: *Sana ang buhay ay walang dulo o hangganan*
Sana'y wala ng taong mahirap o mayaman
Sana'y iisa ang kulay
Sana'y laging magmahalan

Sana'y pag ibig na lang ang isipin ng bawat isa sa mundo
Sana'y pag ibig na lang ang isipin
Sana'y magkatotoo
Sana'y wala ng away sanay lagging magmahalan

"UHA SA MAY KUNA"
(Luha ng Isang Ina)

(This is part of the Project of the Commission on Population-CAR entitled *"Strengthening and Mobilizing Youth in Cordillera Administrative Region Using Development Theater and Folk Media"*)

Isang kuna sa bandang, sa gawing kaliwa ng tanghalan. May kadiliman ang tanghalan. Mariringig ang pag-iyak ng isang sanggol sa may kuna. Papasok si ALICIA, naka-bath robe at nakabalot ang buhok ng tuwalya. Agad niyang pupuntahan ang kuna at sisilipin ang umiiyak.

ALICIA: *Uy…nagalit ang baby…nagalit…bakit, ha? Gutom ka na? Gutom? Umihi? Umihi na ang aking baby?...Patingin nga?...Hindi naman ha?...Gutom…sandal at titimpla si mama, ha?...*

Lalabas uli si ALICIA. Patuloy ang pag-iyak ng bata sa kuna. Babalik si ALICIA, may dalang lata ng gatas, isang thermos ng tubig at bote ng gatas ng bata. Magtitimpla ng gatas ng bata habang patuloy ang pag-iyak ng bata.

ALICIA: *Aalis si mommy ngayon mahal…hahanap tayo ng trabaho. Alam mo naman, mahal ang gatas ano?...mahal…Malakas pa man din uminom ang mahal kong baby…ano baby ko? Si tatay kasi ano…wala kasi si tatay ano? Walang pakialam sayo, baby ko no?...*

Mariringig ang wari'y pag-iyak pagtawa ng bata na nasa kuna.

ALICIA: *Uuuy…ngumingiti...ngumiti ang baby ko…Ang cute-cute naman…cute ng baby ko…kahit wala pang ngipin…Cute mo ano? Kahit walang ngipin ano?*

Tatawa ulit ang bata na nasa kuna. Mariringig ang pagtunog ng telepono. Saglit na ibaba ni ALICIA ang ginagawa at sasagutin ang telepono…

ALICIA: *Hello?...Hello?*

Mag-iisip ng malalim si ALICIA. Ibababa ang telepono. Titingin sa may kuna. Mariringig ang pagtawa ng bata.

ALICIA: *Nandito si mama…may nanloloko kay mommy, ano?...Tatawag tapos hindi sasagot…Sino kaya? Sino kaya, baby? Si daddy mo kaya?...Ang sira ulong daddy mo?*

Tatawa ulit ang nasa kuna.

ALICIA: *Siguro, gusto ka niyang makita ano?...ano?...baby ko?...gusto kang makita ng tatay mong magaling…Ano?...Manigas siya!..'di ba?...Uy…tumatawa!*

Tatawa ulit ang nasa kuna.

ALICIA: *Akala siguro ng tatay mong magaling, hindi kita mabubuhay kung wala siya noh?...Andito naman si mommy di ba? Hindi natin siya kailangan di ba?*

Iiyak ang nasa kuna. Maalala ni ALICIA ang gatas.

ALICIA: *Ay oo nga pala…ang gatas mo…(magtitimpla). Sorry…sorry baby ko…ulyanin na yata mommy mo…Siguro akala ng tatay mo, hindi na tayo mabubuhay kapag wala siya…Matapos ibigay lahat ni mommy, iniwan niyang akong buntis ano? Umiyak tuloy si nanay…Hindi na siya naawa sa mommy mo noh? Pwes hindi natin siya kailangan! Di ba baby ko?*

Tutunog mula ang telepono. Matitigilan si ALICIA. Tinitigan ang telepono. Pupuntahan ito at sasagutin.

ALICIA: *Hello?...Hello?..Sino ba 'to talaga?...Pwede ba kung wala kang magawa, huwag mo akong istorbohin!*

Ibababa ni ALICIA ang telepono nang pabagsak. Iiyak ang nasa kuna pero hindi titinag si ALICIA. Matagal. Mapapansin niya ang pag-iyak ng bata. Dahan-dahan niyang lalapitan ang kuna at titingnan ang anak. Patuloy ang pag-iyak ng bata na nasa kuna. Hindi titinag si ALICIA ng ilang sandal.

ALICIA: *Tahan na baby ko, tahan na…(Kukunin ang bote ng gatas. Tatahimik sa pag-iyak ang bata.) O eto baby ko, tahan na…Sino kaya ang nanloloko sa mommy mo? … tumataway tapos hindi naman sasagot…luko-luko, ano?*

Tutunog muli ang telepono. Matitigilan muli si ALICIA. Sasagutin niya ito.

ALICIA: *Hello?...Tatang?...Tatang, kayo po ba 'yan?...Hello?...Tatang, kung kayo po iyan, sumagot naman po kayo!*

Maririnig ang pagbaba ng telepono sa kabilang linya, kasunod ng dial tone. Matitigilan muli si ALICIA. Ibababa niya ang telepono.

ALICIA: *Alam ko na baby…ang lolo mo ang tumatawag! Ang lolo mo na ayaw tayong tanggapin..nakakahiya raw kasi ang ginawa ko…hindi ka raw niya matanggap na apo…bakit kaya? Bakit kaya hindi ka niya matanggap? Ang ganda-ganda mo naman ano?..ang cute-cute pa? 'Di ba? Bad nga si lolo mo kasi gusto niya ipalaglag daw kita…Para daw walang makaalam na disgrasyada ako…Pwede ba iyon ha mahal? Payag ka ba? Magagawa ba ni mommy sa iyo yon? Eh ang ganda-ganda mo, 'di ba?*

Sino ba sila sa akala nila? Ano? Akala nila mananalo sila no? Hindi yata papaya si mommy! (titingin sa relo)…Naku, malalate na si mommy! ..Sandali lang ha, magbibihis lang si mommy!

Dagling lalabas si ALICIA. Kasunod nito ay ang pagkawala ng lahat ng ingay. Matagal na katahimikan.

Tutunog muli ang telepono. Lalabas si ALICIA na nakabihis na ng damit pampasok pero hindi pa nakasapatos at nakasuklay. Sasagutin niya ang telepono. Maririnig ang pag-iyak ng sanggol. Matitigilan siya. Ibababa ang telepono. Bigla ang pagtigil ng iyak ng sanggol. Ibabaling nin ALICIA ang tingin sa may kuna.

ALICIA: *Ikaw ba iyon baby ko? Nilolоko mo si mommy ha…Akala mo mabibiro mo si mommy ano?*

Maririnig ang pagtawa ng nasa kuna.

ALICIA: *Loko ka ha baby ko… tinatakot mo si mommy ha. Uhmmm…ang ganda-ganda talaga ng anak ko, ano? …Ano?..Sabi nila, ipapalaglag daw kita noon…Pinipilit nila ako pero ayaw ko…e di wala sana akong ganito kagandang baby ngayon, ano?*

Bubuhatin ni ALICIA ang laman ng kuna – isang garapon na may lamang aborted fetus – at aarugain, wari ay pinapatulog. Patuloy ang maririnig na pagtawa ng isang bata.

ALICIA: *O sige na, ubusin mo na ang gatas mo, at nang makaalis na si mommy…(ibibigay ang bote sa garapon). Ayaw mo na?...O sige (ilalapag ang bote malapit sa may telepono). Dito ka lang ha. Huwag kang aalis diyan..tatawagan kita…sasagutin mo si mommy mamaya ha?..Mommy loves you, baby ko…Mommy loves you!*

Lalabas si ALICIA. Biglang tatahimik. Magdidilim.

Annex H Sample Brochure on Adolescent Pregnancy

Dapat tandaan!

- Maaring mabuntis sa una at minsang pakikipagtalik.
- Hindi tanda ng pagmamahalan ang pakikipag-sex. Maaring magkaroon ng magandang relasyon kahit walang sex.
- Mapanganib sa kalusugan ng ina at sanggol ang maagang pagbubuntis.
- Makakasagabal sa pagtapos ng pag-aaral at pagkamit ng pangarap ng kabataan ang maagang pagbubuntis.
- Ang pagbubuntis ay isang biyaya, ito ay para sa mga handa nang maging ina at magulang.
- Hindi nasusukat sa karanasang sekswal ang pagkalalake. Ito ay nasusukat sa pagrespeto sa kababaihan.
- Hindi lahat ng kabataan ay may karanasan sa sex. Mas maraming kabataan ang nagpapahalaga sa kanilang pag-aaral at pangarap.

Para sa karagdagang impormasyon, makipag-ugnayan sa

_____

_____

_____

Deparment of Health
San Lazaro Cmpd., Sta. Cruz, Manila

Ano ang maagang pagbubuntis?

Ang pagbubuntis ng mga kabataan sa murang gulang lalo na sa mga mas bata sa edad na 20 ay maitututuring na maagang pagbubuntis.

Ang pagbubuntis sa murang gulang ay maituturing na maaga dahil sa kakulangan ng kahandaan ng mga kabataan sa ganitong kalagayan.

Alam mo ba na...

- Noong 2007, isa (1) sa sampung (10) Pilipino ay kabataang edad 15-19
- Isa (1) sa sampung (10) kabataan ay nabuntis at nagkaanak na sa murang gulang (YAFSS, 2004) at ito ay dumarami pa
- Maraming mga kabataang nabuntis ang sumailalim sa aborsyon; natigil sa pag-aaral; at maagang naging ina
- Kung mas bata ang ina, mas delikado o mapangabib ang kanyang pagbubuntis at panganganak

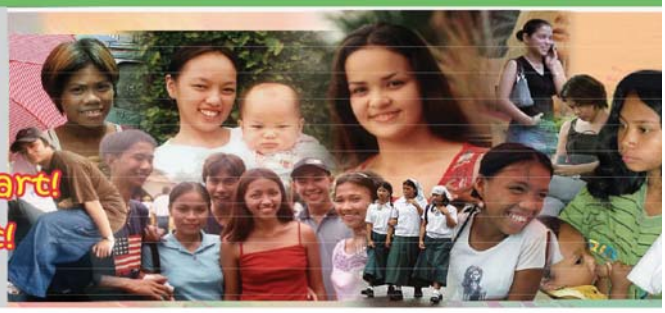
Bakit may mga kabataang maagang nabubuntis?

- Nagpapadala sa bugso ng damdamin
- Hindi alam na pwede na silang mabuntis sa murang gulang
- Madalas nag-eeksperimento at sumusubok sa mga delikadong bagay
- Nalululong sa alak at bawal na gamot
- Kulang sa kaalaman tungkol sa pagbubuntis at sa kanilang sekswalidad
- Mahilig sa pornograpiya at malalaswang impormasyon at imahe

Ano ang mga pwedeng gawin para maiwasan ang maagang pagbubuntis? (UMIWAS)

- **U**-unahin ang pag-aaral para matupad ang pangarap
- **M**-maging matalino at responsable sa pagpasya tungkol sa sex at pagsama sa mga kabarkadang gustong sumubok ng mga delikadong bagay
- **I**-iwasan ang mga gawain, maling impormasyon at kondisyong (tulad ng paginom at paggamit ng bawal na gamot) maaring magtulak sa inyo sa pakikipagtalik o gawaing sekswal
- **W**-'wag magpapadala sa init ng katawan o bugso ng damdamin bagkos gumawa ng ibang mas kapaki-pakinabang na bagay para ang nararamdaman ay lumipas
- **A**-alukin o hikayatin ang partner na gumamit ng kontrasepsyon kung hindi na kayang iwasan ang pakikipagtalik para maiwasan ang pagbubuntis at sakit (HIV/AIDS)
- **S**-sumangguni at makipag-usap sa magulang, sa mga guro, doktor, at iba pang mga nakakatanda na may tamang kaalaman tungkol sa pagbubuntis at sekswalidad

Sex...
Don't start!
Be smart!



Annex I
Sample Posters and Messages on Adolescent Pregnancy

Ang pag-aaral ay
para sa hinaharap
Huwag ipagpalit
sa sandaling sarap!

Maging HANDA at LIGTAS upang
mapangalagaan ang kalusugan.
Ang paggamit ng condom ay proteksyon laban
sa STIs, HIV, at pagbubuntis.

Ako ang KABATAAN NGAYON.
Hindi padalos-dalos,
Nirerespeto ang kababaihan,
Responsable sa aking sekswalidad.

It's OK
to say
"NO!"

SEX?
DON'T START,
BE SMART!

RESPECT.
LOYALTY.
Ang TUNAY NA LALAKI
ay tapat
at marunong maghintay.

AKO ANG
KABATAAN
NGAYON....
...MAY PANGARAP!
...marunong maghintay!