

Lessons from a sexual reproductive health initiative for Tanzanian adolescents

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How should young people be involved in sexual RH programmes?

World Health Organisation assessments in 2000 of adolescent sexual and reproductive health (ASRH) activities in refugee camps in western Tanzania discovered major shortcomings. Young people complained that services did not meet their needs, service providers were judgemental, waiting times were long and confidentiality was non-existent. Lack of privacy exposed them to the risk of being spotted by parents while visiting health centres. Given the strong cultural taboos against premarital sex and child bearing outside marriage, youth were scared of being seen as challenging traditional norms. Adolescents were not involved in programmes, thought service providers were insensitive and felt their participation was not valued.

In response, UNHCR set out to create accessible, culturally-acceptable and youth-friendly ASRH activities in three refugee camps. Multi-Purpose Youth Friendly Centres are now open throughout the day and occasionally at weekends. Young people are

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trained in ASRH activities, encouraged to talk about substance abuse, teenage pregnancy, early marriage and family planning and receive counselling and treatment for STIs and opportunistic infections. They are given opportunities to watch videos, dance, do drama and play ball games. Nutrition and hygiene advice is offered together with training in

vocational skills such as gardening, tailoring and cooking. Young people are taught how to provide home-based care to those with HIV/AIDS and, along with their parents, have been trained to become peer health educators. The training manual that is being used has been developed with the participation of youth, service providers, parents and religious leaders and is being revised annually. Language courses in English, French, Kiswahili and Kirundi are available. Centres are run by youth-led committees made up of trained peer educators.

Community involvement during pilot stages was limited. Failure to consult parents, religious leaders and influential leaders led to anxieties and grave suspicions about what was going on in youth centres. Parents were concerned that young people should not be encouraged to talk and learn about reproduction and the use of condoms until late adolescence. Parents, peer educators and community leaders had widely different expectations. Activities were targetted at boys while girls, trapped at home with domestic activities and constrained by their parents, were ignored.

Lessons learned by programme organisers include the need to:

- involve religious leaders, parents and youth before commencing any ASRH programmes
- realise that young people are highly adaptable
- establish youth-friendly spaces with trained ASRH specialists able to ensure privacy and confidentiality

- ensure that skills which are taught to youths are marketable: there is little point in teaching tailoring and basket-making when markets are saturated
- provide flexible drop-in counselling and treatment services (not forcing youth to make appointments)
- offer financial incentives to peer counsellors to ensure they do not drop out of programmes, thus demotivating other young people
- realise the importance of data collection and ongoing monitoring and evaluation and feedback in order to improve outcomes.
- listen to young people: they should be involved in all aspects of project design and implementation - there should be a transparent plan of action that clearly stipulates the roles of all stakeholders.

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