

Lessons Learned From SEATS' Experience

Applying Best Practices to Youth Reproductive Health

By Nancy Newton, M.A., M.P.H.

January 2000



The goal of the Family Planning Service Expansion and Technical Support (SEATS II) Project is to expand the development of, access to, and use of high-quality, sustainable family planning and reproductive health services in currently underserved populations. It built and followed on the SEATS I Project (1989-1995).

John Snow, Inc. (JSI), an international public health management consulting firm, headed a group of organizations implementing the SEATS II Project. These included the American College of Nurse-Midwives (ACNM), American Manufacturers' Export Group, AVSC International, Initiatives, Inc., the Program for Appropriate Technology in Health (PATH), World Education, and United States Agency for International Development (USAID) Missions and other partner organizations in each country where SEATS was active.

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List of Acronyms

ABBEF	Association Burkinabé pour le Bien-Etre Familial
AFPA	Albania Family Planning Association
AGI	Alan Guttmacher Institute
AIDS	Acquired immune deficiency syndrome
ASBEF	Association Sénégalaise de Bien-Etre Familial
CA	Cooperating agency
CERPOD	Centre for Applied Research on Population and Development
CQI	Continuous quality improvement
CSO	Central Statistical Office [Zimbabwe]
CSW	Commercial sex worker
EC	Emergency contraception
EHP	Eritrea Health and Population Project
EQUIPE	Expanded Quality to Improve Program Effectiveness
FGD	Focus group discussion
FGM	Female genital mutilation
FLE	Family life education
FOCUS	FOCUS on Young Adults Program
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method

MASO	Midlands AIDS Support Organization [Zimbabwe]
MI	Macro International
MIS	Management information system
MOH	Ministry of Health
NGO	Nongovernmental organization
NHC	Neighborhood Health Committee [Zambia]
NUEYS	National Union of Eritrean Youth and Students
OC	Oral contraceptive
PLA	Participatory learning and action
PNPF	National Family Planning Program [Senegal]
PRB	Population Reference Bureau
PSI	Population Services International
PTA	Parent-teacher association
PVO	Private voluntary organization
RHAC	Reproductive Health Association of Cambodia
SEATS	Family Planning Service Expansion and Technical Support Project
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCR	Video cassette recorder
WHO	World Health Organization
YAC	Youth Advisory Committee
ZNA	Zambia Nurses Association
ZNFPC	Zimbabwe National Family Planning Council

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Foreword

The purpose of the Family Planning Service Expansion and Technical Support (SEATS) Project (1995–2000) was to expand the development of, access to, and use of quality family planning and reproductive health services in currently underserved populations and ensure that unmet demand for these services was addressed through the provision of appropriate financial, technical, and human resources. In order to fulfill this mandate, SEATS combined the strengths of a broad-based, flexible program capable of addressing all aspects of service delivery with five Special Initiatives designed to tap into underutilized resources to meet the needs of important pockets of the underserved. Quality, sustainability, and monitoring and evaluation were cross-cutting technical themes of all activities.

The five Special Initiatives included:

- ✦ **Midwifery Association Partnerships for Sustainability (MAPS):** Empowering midwives, through their professional associations, to develop and sustain community-based reproductive health care services.
- ✦ **Youth:** Meeting people's needs early in their reproductive life cycle.
- ✦ **Urban:** Using a data-driven approach with multisectoral urban partnerships to create more effective and sustainable services in African cities.
- ✦ **Integration of family planning/reproductive health into nongovernmental organization/private voluntary organization (NGO/PVO) programs:** Working with well-established community programs to improve both access to and quality of reproductive health services.
- ✦ **Women's Literacy:** Reaching women already striving to improve their lives with reproductive health information and services.

Special Initiative activities were often implemented in conjunction with or through SEATS' 30 subprojects in Africa, Asia, the Near East, and Eastern Europe. This paper summarizes SEATS' experience with subprojects and activities of the Youth Initiative, many of which combined the resources of the Urban Initiative and MAPS.

Executive Summary

The sexual and reproductive health needs of young people are complex, diverse, and demanding of urgent attention. Young people not only need, but also have the right to, reproductive health information and services, a principle endorsed by the global community at the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth International Conference on Women in Beijing in 1995. Meeting these needs was a focus of SEATS' sub-projects and activities in eight countries: Albania, Burkina Faso, Cambodia, Eritrea, Russia, Senegal, Zambia, and Zimbabwe.

SEATS' youth-oriented subprojects and activities shared several features. Many reflect agreed-upon best practices, and others represent novel approaches to promoting, protecting, and improving young people's sexual and reproductive health. Characteristics of subprojects included:

- ✦ The use of multiple interventions in multiple settings to address young people's reproductive health problems.
- ✦ Clinical services for youth, including contraception, sexually transmitted disease (STD) screening and treatment, antenatal and delivery care.
- ✦ Focus on urban youth.
- ✦ Collaboration among local, national, and international institutions.
- ✦ Youth involvement in program design, implementation, management, and evaluation.
- ✦ Outreach, including peer education.
- ✦ Incorporation of youth reproductive health programming into ongoing program activities.
- ✦ Community mobilization and advocacy.
- ✦ Attention to quality and sustainability.

Among the lessons that SEATS learned as it carried out its broad, flexible mandate to improve health services for youth while simultaneously applying a range of documented best practices and testing new approaches are:

- ✦ Addressing the special needs of young people does not require starting with a separate project or intervention targeting youth.

- ✦ The willingness to pioneer new ventures in reproductive health services for young people is not exclusive to the private sector.
- ✦ Basic human rights—clients’ rights and reproductive rights—are a compelling rationale for offering reproductive health education and services to young people.
- ✦ Young people and service providers demand integrated reproductive health interventions.
- ✦ Integrated reproductive health services that include STD prevention and screening can attract young men.
- ✦ Health centers can be reconfigured to attract youth seeking information and counseling as well as services.
- ✦ A “champion” for youth within a clinical setting can help maintain a youth-friendly environment.
- ✦ The costs associated with referral services are a barrier to access.
- ✦ Young people also prefer contraceptive method choices.
- ✦ Programs require support, advice, and assistance in addressing community resistance and opposition to youth reproductive health interventions.
- ✦ Identifying a sustainable and appropriate package of compensation and incentives for peer educators is complicated.
- ✦ Peer educators can be very resourceful fundraisers.
- ✦ Adult-friendly programming may be as important as youth-friendly services.
- ✦ Standard family planning and reproductive health monitoring indicators do not capture the results of youth projects.
- ✦ Evidence of sexual activity among girls 12 and younger points to the need to develop appropriate interventions targeting this age group.
- ✦ The sensitivity surrounding reproductive health services for young people is not an insurmountable barrier to demonstrating their feasibility.

The staff of SEATS and its many counterparts and collaborators are proud to have contributed to making young people’s right to appropriate information and confidential, private reproductive health services a reality in the eight countries.

Introduction

The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services.

(UNFPA 1994)

Since 1989, the Family Planning Service Expansion and Technical Support Projects (SEATS I and II), managed by John Snow, Inc. (JSI), provided financial and technical support to expand the development of, access to, and use of quality family planning and reproductive health services in currently underserved populations.¹ The problems associated with early, unwanted, and unprotected sexual activity among today's generation of 1.6 billion young people between the ages of 10 and 24 justify the designation of youth as an underserved population.



photo by Marty Lueders

Young people under age 25 account for one half of all HIV infections, and have the highest rates of STDs.

The transition from childhood to adulthood is a period of great possibilities as well as a time of great risk. Although rates of childbearing among women under 20 are declining in many countries, approximately 15 million young women ages 15 to 19 give birth every year. Pregnancy and childbearing among adolescent women frequently lead to school dropout, reducing opportunities for both further education and future income. Maternal mortality is estimated to be twice as high for women ages 15 to 19 than for women ages 20 to 24. Infant and early childhood mortality is also higher when the mother is under age 20. Many pregnancies are unwanted. In some countries, complications from unsafe abortions are a leading cause of death among teenage women. Young people under age 25 account for one half of all human immunodeficiency virus (HIV) infections, and the highest rates of sexually transmitted diseases (STDs) occur among 20 to 24 year olds, followed by youth ages 15 to 19. There is growing evidence that many young women and girls experience rape, incest, and other forms of sexual violence, with severe repercussions including an increased likelihood of drug abuse and prostitution. Millions of girls are subjected to female genital mutilation (FGM) each year (PRB 1996).

How Old Is a Youth?

The World Health Organization (WHO) considers adolescence as the period between 10 and 19 years. The United Nations defines youth as 15 to 24 years. In SEATS I and II, each country used a locally established definition of "youth, young people, or young adults." For example, in Cambodia, the subproject aimed to reach young people 12 to 25; in Eritrea, the target population was youth 14 to 35; and in Zambia, the goal was to provide improved reproductive health information and services for young people 10 to 24.

¹The SEATS I Project operated between 1989 and 1995. The SEATS II Project ran from 1995 to 2000. "SEATS" is used throughout the document to refer to both projects, although only activities in Burkina Faso occurred during the SEATS I project.

These global data mask the enormous differences in young adult sexual and reproductive behaviors from one country to another, and from one setting to another within countries. For example, the proportion of women who have their first child by age 18 ranges from less than 10 percent in Rwanda to more than 50 percent in Zimbabwe, 38 percent of young men and women aged 20 to 24 report they were sexually active by age 18; in Ghana, 43 percent of males and 66 percent of females say they had intercourse before they were 18. Young women who live in urban areas and those who have completed seven or more years of school are more likely than their counterparts in rural areas and with less education to delay childbearing until they are at least 18 (AGI 1998). In addition, the social and cultural context of young people's sexual activity—and the risks and consequences associated with it—differ greatly for males and for females in almost all societies (Weiss et al. 1996).

Focusing on the very real problems resulting from early, unprotected, and unwanted sexual activity also obscures the many valuable assets young people bring to their families, communities, and countries: tremendous energy, new ideas, and society's potential for development and growth. The attention to problems can also mislead one into thinking that most young people are sexually active. In fact, in the developing world the majority of young women aged 15 to 19 are not sexually active, and when they are, most sexual activity takes place within marriage (McCauley and Salter 1995).

Clearly, the sexual and reproductive health needs of young people are complex, diverse, and demanding of urgent attention. Young people not only need, but also have the right to, reproductive health information and services, a principle endorsed by the global community at the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth International Conference on Women in Beijing in 1995. Experts on adolescent health, many health program practitioners, and youth themselves agree that all young people need access to the reproductive health information, counseling, and related skills (both life skills and those specific to reproduction and sexuality) that will help them lead healthy lives. Young people who are sexually active require these interventions as well as access to a broad scope of reproductive health services, including a range of contraceptives, screening and treatment for STDs, pregnancy testing, and other clinical services such as antenatal, postpartum, and postabortion care (Hughes and McCauley 1998; WHO/UNFPA/UNICEF 1997).

Barriers to Information, Counseling, Skills, and Services

Despite global calls for action, the barriers to young people's access to information, counseling, skills, and services are many. Adult discomfort with young people's sexuality is almost universal. Many policymakers, program planners, and parents mistakenly believe that information and education about sexuality and reproduction encourage sexual activity among unmarried teens. Numerous studies show that young people are poorly informed about basic sexual and reproductive health matters; yet, parents, teachers, and health care providers are often unprepared to discuss sexuality with youth. While programs such as family life education (FLE) in schools and mass media campaigns directed at young people can improve knowledge, they rarely include skills development components that help young people learn to protect themselves and form positive relationships. Sometimes youth disregard available information because the content is perceived as irrelevant or the source as unreliable or outdated (Hughes and McCauley 1998; McCauley and Salter 1995).

For sexually active young people, particularly those who are not married, obtaining reproductive health services is even more difficult than gaining accurate, culturally relevant, age-specific information. Although well over half the young women and men in most developing countries report that they have heard of at least one modern contraceptive method, many do not know where to get these methods or how to use them. Few clinics are designed, prepared, or even willing to provide services to young people. Although legal barriers sometimes limit young people's access to services, more often than not, practices such as providers' judgmental attitudes, inconvenient clinic hours, and lack of confidentiality deter young people from seeking services. Costs and geographic distances also limit access. Since family planning services have traditionally served women, young men are even less likely than young women to feel welcomed at many clinics. Consequently, many young people, both married and unmarried, are left with an unmet need for contraception and other reproductive health services (AGI 1998; PRB 1996).

Social norms, especially those for gender roles, and other environmental factors contribute to these barriers as well as to the conditions underlying poor reproductive health among young people. The same conditions that limit countries' abilities to offer adequate health services to the entire population obviously affect their ability to serve young people. In most societies, women, and especially young women, have little power to negotiate sexual activity. Childbearing may be a young woman's only way to avoid social outcast or to gain social status. Poverty leads growing numbers of young people to engage in sex in exchange for money, food, or gifts (Kilbourne-Brook 1998).

The SEATS Project and the Unmet Reproductive Health Needs of Young People

The starting point of all SEATS' efforts is people's reproductive health needs:

- ✦ Access to sustainable, quality reproductive health services that meet the needs of women and men throughout their lives and that emphasize health promotion and prevention, but also include therapeutic care.
- ✦ Knowledge and the skills required to make good use of that knowledge when making decisions that affect reproductive health.
- ✦ An enabling socioeconomic and legislative environment that supports access to family planning and reproductive health services and encourages healthy behavior.

Meeting these three needs was at the center of SEATS' activities to improve young people's reproductive health. The attention that each need received in a subproject varied according to the specific socioeconomic and cultural context. In basing its approach on these three needs, SEATS recognized that health services alone are insufficient—and often, inappropriate—to improve the reproductive health and enhance the personal development of young people. At the same time, SEATS and its many courageous collaborators did not shy away from the controversy and sensitivity that often surround the delivery of reproductive health services for young people; all its youth-oriented subprojects and interventions included a range of clinical services.

This report presents a review of SEATS' experience in programming for young people, including early experiences under the SEATS I project. Overviews of subprojects in Albania, Burkina Faso, Cambodia, Eritrea, Russia, Senegal, Zambia, and Zimbabwe (grouped by geographical region) highlight program approaches and innovations—the new techniques and approaches designed to improve access to and use of quality reproductive health information and services for youth. Subprojects in Zambia and Zimbabwe were fortunate to have access to resources for pre- and post-intervention evaluations; these are reported with more depth. The final section outlines lessons learned.

Innovations in Programming for Young People's Reproductive Health: An Overview of SEATS' Experience

The evidence, particularly from developing countries, upon which to base firm conclusions about the most effective interventions for young adult reproductive health is extremely limited. Numerous expert reviews of program experience to date highlight the dearth of research and call for greatly increased attention to program evaluation. Nevertheless, there is a broad consensus about best practices based largely on experience, expert opinion, process evaluations, and qualitative research (McCauley and Salter 1995; Hughes and McCauley 1998; Senderowitz 1997a; Senderowitz 1997b; PRB 1996; WHO/UNFPA/UNICEF 1997).

Although many of the “recommended approaches” or “key elements” arising from the expert reviews evolved after SEATS subprojects were designed, interventions were remarkably consistent with the state of the art and with the approaches recommended by the WHO/UNFPA/UNICEF Study Group on Adolescent Health and Development in particular (see box). The affinity of subprojects with the WHO/UNFPA/UNICEF framework can be attributed to both SEATS' approach to meeting reproductive health needs and a key innovation that all subprojects shared: the use of **multiple interventions in multiple settings to address young people's reproductive health problems.**

Rather than relying on a single predominant strategy, e.g., peer counseling, mass media outreach, school-based education, or facility-based services (McCauley and Salter 1995; Senderowitz 1997a; Senderowitz 1997b; Israel and Nagano 1997; Birdthistle and Vince-Whitman 1997),

FRAMEWORK FOR PROGRAMMING FOR ADOLESCENT HEALTH		
Keys to Success	Major Interventions	Settings
✦ Put youth at the center ✦ Address multiple health problems ✦ Build on and link existing interventions in various settings ✦ Combine interventions ✦ Respect cultural diversity ✦ Strengthen programme management ✦ Encourage positive adult attitudes and behaviors	✦ Create safe and supportive environments ✦ Provide information ✦ Build skills ✦ Provide counseling ✦ Improve health services	✦ Home ✦ School ✦ Health center ✦ Work place ✦ Street ✦ Community organization ✦ Residential center ✦ Media/entertainment ✦ Political and legislative systems
SOURCE: Adapted from “Framework for country programming for adolescent health” in WHO/UNFPA/UNICEF. 1997. Action for adolescent health: Towards a common agenda: Recommendations from a joint WHO/UNFPA/UNICEF study group. Geneva: WHO		

each subproject drew upon many approaches and many existing institutions to overcome barriers and increase access to youth-friendly information, counseling, skills building, and services. The lessons learned from a study of the youth programs of 10 family planning associations in sub-Saharan Africa also guided the design of subprojects (IPPF/AR and JSI/SEATS 1997).

SEATS subprojects shared other features. Many reflect agreed-upon best practices, and others represent novel approaches to promoting, protecting, and improving young people's sexual and reproductive health.

- ✦ **Clinical services for youth.** SEATS' mandate to focus on quality family planning and reproductive health services meant that SEATS did not ask if services for youth were politically or culturally possible; rather, it asked what was needed to improve young people's access to and use of services. Several subprojects specified the creation of "youth-friendly" (see box, page 7) clinical settings as objectives. Others took steps to modify services to ensure they were acceptable to young people, although they did not use the term "youth-friendly." These efforts to expand access to clinical services were a first for each of SEATS' counterpart institutions.
- ✦ **Focus on urban youth.** Most subprojects and activities took place in cities and towns, usually national and provincial capitals. Young people ages 10 to 24 make up a growing proportion of the population in urban areas—sometimes as much as 35 percent (Sambisa et al. 1999). A number of trends put the reproductive health of urban youth at great risk. Secondary school enrollment is higher for urban youth than rural youth. Although the advantages of higher education are indisputable, the interaction with schoolmates, greater freedom from parental supervision, and the declining influence of traditional cultural values and institutions that discourage nonmarital sexual activity may all contribute to a greater likelihood of sexual relationships before marriage among urban youth. Urban youth also marry later than rural youth. These patterns, combined with the universal tendency for earlier onset of puberty, lengthen the period when young people in cities and towns are at risk for unprotected sexual activity and unwanted pregnancy (AGI 1998; Singh 1998).

✦ **Collaboration among existing institutions.** Subprojects turned to health care service delivery systems, youth organizations and recreation centers, schools, local governments, neighborhood advisory bodies, and other on-the-ground institutions to build and strengthen capacities to meet young adult reproductive health needs. In addition to support from the United States Agency for International Development (USAID), many subprojects benefitted from the inputs of other international donors such as the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) as well as USAID cooperating agencies (CAs) such as MotherCare, FOCUS on Young Adults (FOCUS), and Johns Hopkins University/Center for Communication Programs (JHU/CCP).

✦ **Base in public- and private-sector institutions.** The sensitivities involved in delivering reproductive health care to young people often mean that nongovernmental organizations (NGOs) are more willing than public-sector institutions to offer services (Senderowitz 1997a; McCauley and Salter 1995). Contrary to this trend, public-sector institutions were the base for many SEATS subprojects; collaboration between the public and private sectors marked all of them.

✦ **Integration of reproductive health interventions.** The specific nature of the reproductive health issues facing youth in the subproject communities, coupled with a growing “post-Cairo” consciousness and the expressed needs of youth, led all subprojects to address pregnancy and STD prevention as well as other reproductive health issues such as FGM and pregnancy care and delivery.

WHAT ARE YOUTH-FRIENDLY SERVICES?	
Provider Characteristics	Health Facility Characteristics
✦ Specially trained staff ✦ Respect for young people ✦ Privacy and confidentiality honored ✦ Adequate time for client and provider interaction ✦ Peer counselors available	✦ Separate space and special times set aside ✦ Convenient hours ✦ Convenient location ✦ Adequate space and sufficient privacy ✦ Comfortable surroundings
Program Design Characteristics	Other Possible Characteristics
✦ Youth involvement in design and continuing feedback ✦ Drop-in clients welcomed and appointments arranged rapidly ✦ No overcrowding; short waiting times ✦ Affordable fees ✦ Publicity and recruitment that inform and reassure youth ✦ Boys and men welcome and served ✦ Wide range of services available ✦ Necessary referrals available	✦ Education material available on site and to take away ✦ Group discussions available ✦ Delay of pelvic examination and blood tests possible ✦ Alternative ways to access information, counseling, and services
SOURCE: Senderowitz, J. 1999. Making reproductive health services youth-friendly. Washington, DC: FOCUS on Young Adults program.	

- ✦ **Youth involvement.** Many international organizations attribute the success of their youth programs to the meaningful involvement of youth in all aspects of programming (Senderowitz 1998). Creating and maintaining mechanisms for youth participation in program design, implementation, management, and evaluation was one of the ways that SEATS subprojects demonstrated their faith in young people's capabilities and talents.
- ✦ **Outreach.** Many SEATS youth subprojects were the first in their countries to introduce trained peer educators or counselors to reach young people in their communities with more than HIV and acquired immune deficiency syndrome (AIDS) prevention information. In other subprojects, health providers went beyond the clinic walls to reach parents, teachers, school students, and others.
- ✦ **Incorporation of youth reproductive health programming into ongoing reproductive health programming.** Initially, SEATS II envisioned programming for youth sexual and reproductive health as a separate special initiative. As SEATS began its discussions with USAID missions and counterpart agencies, the need for models that take into account and address the specific needs of youth as an integral component of a comprehensive approach to reproductive health became apparent. Rather than addressing youth separately, SEATS' programming evolved into full integration of youth-oriented reproductive health programming into existing institutions—either through youth-targeted subprojects or general quality improvement interventions.
- ✦ **Community mobilization.** All SEATS subprojects faced the challenge of gaining the acceptance, involvement, and support of parents and community leaders for youth reproductive health initiatives, particularly for clinical services. Subprojects employed a range of strategies—from including community members in advisory committees, to sharing research results and engaging parents, leaders, and youth in defining subproject objectives—aimed at creating a supportive environment for sustaining and advancing subproject achievements.
- ✦ **Attention to quality and sustainability.** Quality of care and sustainability were cross-cutting technical themes of all SEATS II subprojects, not only those focused on young people. In addition to attention to “youth-friendly” information, education, and services, SEATS II's Quality Initiative introduced innovative quality assurance approaches such as continuous quality improvement

(CQI) to bring together multiple sites and multiple stakeholders in defining, assessing, and ensuring quality of care. Sustainability was addressed through attention to management capacity, leveraging of existing resources, and the use of nonclinical, community-based interventions, which have a lower cost than clinic-based interventions and are often easier for youth to access.

- ✦ **Flexible, multisectoral approaches.** SEATS' broad mandate, multidisciplinary capability, and wide range of skills allowed youth-oriented subprojects to creatively combine the application of known best practices with the involvement of new, sometimes unconventional, resources.
- ✦ **Consistency with USAID strategies and national public health priorities.** Because all subprojects included integrated reproductive health interventions, they contributed to achievement of several of the strategic objectives of USAID's Global Population, Health, and Nutrition Center as well as the strategic objectives of the USAID missions in the countries where they took place. All subprojects reflected their host governments' reproductive health policies and programs, many of which had been recently reformulated to designate young people as a specific audience.



photo by Willow Gerber

In most societies, women, and especially young women, have little power to negotiate sexual activity.

Country Programs, Subprojects, and Activities

Summary of Achievements

SEATS' youth-oriented subprojects and activities reflected the specific situation and needs in each country. Some subprojects addressed youth needs through general improvements in the quality of care and did not track clients by age. Hence, overall results cannot be quantified. Principal achievements in each country are listed below.²

Burkina Faso: 125 peer educators trained; 77,304 youth reached; reproductive health services offered in two youth clinics; clinical services to 7,459 youth; program model replicated in Burkina Faso and other Sahelian countries

Eritrea: 72 peer educators trained; 85,945 youth reached; 313,000 condoms distributed; reproductive health services offered in three youth centers

Senegal: 22 peer educators trained; reproductive health services offered at multipurpose youth center; youth-oriented education and services incorporated into public- and private-sector programs

Zambia: 20 peer educators trained; 18,217 youth reached; 18 service providers trained in youth-friendly services; reproductive health services offered in seven city clinics; 4,400 new contraceptive users; 7,494 visits for other reproductive health services; services rated highly by young people; provider and community attitudes changed from negative to positive; youth-friendly services incorporated into other service sites nationwide

Zimbabwe: 40 peer educators trained; 8,141 youth reached; 43 providers trained in youth-friendly services; reproductive health services offered in seven city clinics and multipurpose youth center; services rated highly by youth; 500 adults reached through advocacy and community mobilization; improvements in young people's attitudes toward condom use and increases in reported use of condoms; city government committed to sustaining services

²Unless otherwise cited, data reported in this document come from unpublished SEATS subproject reports, memoranda, interviews with staff, and SEATS Database Management System.

Albania: Trained providers offered youth-friendly services and counseling; range of contraceptive options for young people expanded; information, education, and communication (IEC) materials developed

Russia: Trained providers offered youth-friendly services and counseling; outreach and education for youth established; range of contraceptive options for young people expanded; providers committed to youth reproductive rights

Cambodia: 47 peer educators trained; 2,000 youth reached; additional donor funding obtained to expand to three other cities

Burkina Faso: “Youth for Youth” Replicated by Ministry of Health

SEATS began to incorporate services for young people into its program portfolio under SEATS I (1989 to 1995). The subproject “Youth for Youth: Family Planning Services and Family Life Education for Youth,” implemented by the Association Burkinabé pour le Bien-Etre Familial (ABBEF), set the pace for subsequent SEATS’ programming for youth: it used multiple approaches to reach youth including clinical service delivery.

A First for Francophone Africa

In the early 1990s in sub-Saharan Africa, the idea of young people providing health information to other youth—peer education and counseling—was just beginning to gain adherents, and few countries were willing to get involved in the delivery of reproductive health services to adolescents. Burkina Faso was. The data on adolescent sexual activity and reproductive health pointed to the need for better information and services for young people. The overwhelming majority (92 percent) of women 20 to 24 years were sexually active by age 20. Although most sexual activity took place within marriage, only 2 percent of the sexually active women aged 15 to 19 who did not want a child soon were using a modern contraceptive. Ever-use of modern contraception was higher among unmarried women aged 15 to 19 (31 percent) than among married women of the same age (14 percent). Only half of the ever-married young women in urban areas knew where to obtain a modern method (AGI 1998).

Although the evidence of need was compelling, it was not the only factor contributing to the uncommon willingness to embark upon an innovative approach to delivering reproductive health information and services to youth.

Equally important was the policy environment, marked by a public commitment to improving reproductive health, an openness to innovation, and substantial attention to building support from community, religious, and government leaders. Consequently, the pioneering pilot project “Youth for Youth” took no one by surprise, nor was it subject to overt opposition.

Begun in 1992 in the two major urban centers of Burkina Faso, Ouagadougou and Bobo Dioulasso, the four-year subproject aimed to develop a model for the provision of IEC, FLE, and clinical services in family planning to in-school and unemployed youth aged 14 to 20. Input and advice from community leaders, parent-teacher associations (PTAs), government institutions (particularly the Ministry of Health [MOH], the Ministry of Education, and the Ministry of Social Affairs), and youth shaped the subproject design and secured enthusiastic endorsement of the activities. A specially established Youth Center in each city, staffed by a trained midwife and two social workers, along with a visiting physician, offered reproductive health services and counseling. Centers also had libraries stocked with information on reproductive health and showed films on family life and sexuality-related topics daily. The 125 trained male and female peer counselors came from every district in the two cities. They visited homes, community settings, and schools to hold group education sessions, show films, perform dramas, and provide one-on-one counseling. ABBEF staff and the peer counselors produced and broadcast almost 50 radio shows. Initially, the peer counselors did not distribute condoms; midway through the subproject, they began to sell them at a modest price, keeping a small portion of the profit as an incentive.

Burkina Faso: Subproject Overview

Dates: January 1992 to September 1995

Target population: Youth 14 to 20 in two cities

SEATS’ counterpart: Association Burkinabé pour le Bien-Etre Familial (ABBEF)

- ✓ Advocacy and community mobilization: meetings with parents and leaders
- ✓ 125 peer counselors (high school students and unemployed youth) trained
- ✓ IEC materials developed: leaflets, posters, t-shirts, radio talk shows
- ✓ 77,304 youth reached
- ✓ Clinical services to 7,459 youth: contraception, STD screening, gynecology in two Youth Centers
- ✓ Management information system (MIS) to track client visits, referrals, outreach
- ✓ Program model replicated in other cities
- ✓ Youth Unit established within MOH
- ✓ Subproject cited as model for other Sahelian countries
- ✓ Collaboration with MOH

The peer counselors' performance far exceeded expectations: they reached 77,304 youth, compared with a target of 20,500. Most (about 80 percent) of the youth reached were not in school. The counselors, particularly those from the informal sector (the unemployed), gained status and recognition in their communities. The peer counselor component also faced the challenges common to many peer outreach programs that rely on volunteers: a high turnover rate, the need for frequent refresher training, unsystematic data collection, and limited geographic coverage due to lack of transportation (Senderowitz 1997b).

The Youth Centers were popular sources of information. After 18 months of operation, 12,000 young people had visited the centers, and many students residing in the surrounding neighborhoods came to learn about and discuss reproductive health topics with Center staff. Many also came for reproductive health care: 1,329 clients (mainly young men) sought diagnosis and treatment for STDs, 1,771 young women consulted for gynecological problems, and 4,359 (mainly young women) came for contraceptive services. Subproject staff believed that the inconvenient locations of the Centers for many youth, the failure to open on weekends, and the shyness of young women were barriers to greater use of clinical services. They proposed exploring the incorporation of recreational and vocational activities and the expansion of the operating schedule beyond regular business hours to make the Youth Centers more attractive to young people. The lack of laboratory services for STD diagnosis at the Youth Centers further inhibited appropriate service delivery. The young people referred to other facilities could not pay the associated costs of transportation and services; they also feared ridicule, scolding, or violation of confidentiality by service providers at these other facilities.

A Model for Replication

"Youth for Youth" convinced the MOH of the political and cultural feasibility of this model of delivering reproductive health information and services to young people. Immediately following the end of the subproject, the MOH, with support from UNFPA and the Dutch government, began to train additional peer counselors in Ouagadougou, Bobo Dioulasso, and other urban areas; it is now starting to open more Youth Centers. The MOH also established a Youth Unit within the Family Health Division.

The subproject also had an impact beyond the borders of Burkina Faso. In a 1995 seminar in Bamako, Mali, to review and disseminate the findings of quantitative and qualitative research on adolescent reproductive health in the Sahel, representatives from public- and private-

sector organizations in Burkina Faso, the Gambia, Mali, Niger, and Senegal learned of the ABBEF subproject. Together, they recommended that countries “draw on the Burkinabe experience as a model of accessibility of contraceptive methods” for young people (CERPOD 1997). ABBEF is now well-positioned to explore and refine new models to reach young people.

Eritrea: Youth Leadership Takes the Lead in Promoting Reproductive Health

During Eritrea’s lengthy struggle for independence, the National Union of Eritrean Youth and Students (NUEYS) was one of the main and most effective grassroots organizations supporting the quest for freedom. Following independence in 1991, NUEYS defined new priorities, programs, and policies to engage the country's youth in action-oriented contributions to the task of national reconstruction. Encouraging healthy lifestyles among young people, with a special focus on the dangers of unwanted and early pregnancies, HIV/AIDS, STDs, and other social problems such as early marriage and FGM, became one of the NGO’s principal objectives.

Developing the Capacities of a Youth Organization

In 1996, SEATS II and NUEYS decided to work together to strengthen NUEYS’ capacity to promote, develop, and implement young adult reproductive health programs. NUEYS was—and continues to be—well-positioned to take a lead in addressing young people’s reproductive health. Its role in the war for independence earned it visibility and respect from the Government of Eritrea and community members. Its nationwide presence—a membership of 100,000 of both genders (80 percent are in the age range 18 to 24) and offices in all 10 zones of the country—and its multisectoral programs in sports, recreation, environment, health, and job training—allow it to reach a large portion of Eritrean youth. The values guiding NUEYS’ actions, including youth involvement in program design and

Eritrea: Subproject Overview

Dates: November 1996 to July 1998

Target population: Youth 14 to 35 in three cities and in the National Service Camp

SEATS’ counterpart: National Union of Eritrean Youth and Students (NUEYS)

- ✓ 72 peer counselors trained in three urban sites
- ✓ IEC materials developed: leaflets, posters, story writing, video
- ✓ 85,945 youth reached; 313,000 condoms distributed
- ✓ Clinical services in Youth Center in Asmara and clinic in Sawa Camp with referrals to MOH facilities
- ✓ MIS to track client visits, referrals, outreach
- ✓ Organizational capacity strengthened: training of trainers; training in management, quality, sustainability
- ✓ Other donor funding obtained for national expansion and purchase of printing press
- ✓ Advocacy and outreach for eradication of FGM
- ✓ Collaboration with MOH, Ministry of Defense, UNFPA, MotherCare, BASICS, Population Services International

management and a commitment to gender equity, are particularly important for young people's reproductive health. The designation of young people as a specific target group for increased access to and use of reproductive health information and services complemented the ongoing MOH/USAID Eritrea Health and Population Project (EHP), which focused on strengthening the delivery of integrated primary health care. Activities took place in three of NUEYS' urban youth centers in Asmara, the capital, Mendefera, and Agordat—sites corresponding to the EHP emphasis zones—and the National Service Camp at Sawa, where twice a year, more than 20,000 young men and women come together for mandatory national service. During subproject development, discussions among SEATS II, NUEYS, UNFPA, and the MOH resulted in substantial additional support from UNFPA to NUEYS, allowing the youth reproductive health program to take on a national scope.

Capacity-building actions took many forms. NUEYS gained trainers that can continue to train peer educators and advocates for change of harmful traditional practices, and its management has skills in NGO sustainability. SEATS also helped NUEYS obtain grant funds from two other donors to purchase a printing press. At the time the subproject began, the only other operating printing press in the nation was owned by a religious institution, which refused to allow the production of materials promoting condom use. Owning the printing press allowed NUEYS to provide at-cost printing services for its own programs and for other NGOs.

In each of the three urban sites, about 20 trained peer counselors, all NUEYS members, conducted IEC outreach activities in the schools and communities, and made referrals for services and counseling. The NUEYS recreational facility in Asmara was refurbished, and a trained nurse provided counseling, nonclinical family planning services (oral contraceptives [OCs] and condoms), and referrals to MOH health facilities.

Reaching a Captive Audience

Program planners often suggest that a “captive audience” is the easiest one to reach; activities at the Sawa Camp gave NUEYS the opportunity to test this saying. Twice a year, more than 20,000 young men and women gather at the camp for mandatory national service. Two health providers at the camp health center received training in family planning and offered nonclinical services to trainees and referrals to the MOH hospital in the nearby town of Agordat (also a subproject site). Every six months, camp staff conducted reproductive health education sessions during a two-week period. In the mornings, the health providers and other NUEYS staff made presentations in the three Eritrean languages.

In the evenings, after the sand storms and rains had subsided, they showed films and videos such as the MOH/SEATS coproduction on the consequences of unwanted pregnancy, *Could They Have Been Saved?* Debates and question-and-answer sessions followed the films. Sometimes, trainees presented their own poems on AIDS and other reproductive health themes. Trainees received copies of the subproject leaflets on contraception and STDs in national languages along with condoms. Over time, IEC activities extended into surrounding villages, where many trained youth remain to perform their national service.

NUEYS also took on a challenge that other Eritrean organizations were unwilling to address: the almost universal practice of FGM. It formed an FGM technical advisory group, and members received training in “communication for change,” vowing to engage in individual and collective actions to combat the practice.

By the end of the subproject in mid-1998, NUEYS had reached almost 86,000 young people with information on reproductive health and distributed more than 300,000 condoms. Although the massive size of the groups at Sawa camp ruled out one-on-one counseling, the IEC sessions did serve as an open forum for bringing up reproductive health concerns. Trainees asked about issues such as masturbation, the “safe period,” contraception and promiscuity, and legalization of abortion, and the printed materials reflecting the Eritrean cultural context were very popular. NUEYS also succeeded in institutionalizing reproductive health IEC into Sawa camp: the camp military commanders and NUEYS agreed to a regular schedule for IEC activities.



photo by Susan Rae Ross, USAID/Entrea



photo by Marty Lueders

By the end of the subproject in mid-1998, NUEYS had reached almost 86,000 young people with information on reproductive health and distributed more than 300,000 condoms.

NUEYS' combined recreation and health center at Asmara, with its associated peer counselors, reached only a fraction (less than 5 percent) of the total 86,000 youth benefitting from the subproject.³ Nevertheless, the number of young people seeking services at the Asmara Center increased steadily over the subproject—from fewer than 100 per quarter to more than 550 per quarter by subproject's end. NUEYS staff believe that offering reproductive health services alongside a recreational program made the reproductive health component more attractive. The majority of the Center's clients were young men seeking STD prevention or treatment, but requests for contraception by young women also increased. Although the demand for services offered by MOH facilities was low (as evidenced by the low number of referrals), the establishment of the links between NUEYS and the MOH was an important achievement. The lack of overt opposition to the Center's activities was another indicator of its potential. Before this subproject, open discussion of sexual and reproductive health matters was discouraged. Nevertheless, the conservative nature of Eritrean society made it difficult for NUEYS to carry out its plans to develop community advisory committees.

Off to the Front

When armed conflict between Eritrea and Ethiopia broke out in 1998, many of NUEYS' members and constituents were called to the front, affecting all of NUEYS' activities, including its reproductive health program. Even under these difficult circumstances, NUEYS members in Agordat (in the war zone) requested peer counselor training, and NUEYS responded. The opportunity to further improve the status of women, an important result of Eritrea's war for independence, was one possible ray of hope in the renewed conflict.

NUEYS' commitment to promoting young people's reproductive health as a means to personal and national development remains, and it is determined to continue with peer counselor programs linked to MOH health services along with actions to eradicate FGM. In fact, NUEYS renewed its reproductive health services in mid-1999, and the numbers of young people served were similar to those reached before the war. NUEYS also produced a feature-length video on HIV/AIDS.

Equally important, NUEYS, an organization managed by young people serving young people, now has the experience and capacities to carry out such programs, the confidence and support of donor agencies, the established working relationship with the MOH, and the implicit endorsement of the public to move forward.

³Peer counselors in Mendefera and Agordat did not receive training until the last quarter of the subproject, so data on their performance are not available.

Senegal: Multiple Strategies to Improve Youth Reproductive Health

SEATS II's large, multifaceted program portfolio in Senegal focused on groups and sectors not previously targeted by the National Family Planning Program (PNPF)—youth, factory employees, municipal governments, and private midwives. Although only one subproject specified youth as its target population, SEATS II's Urban Initiative and quality improvement activities, introduced in 1997 and 1998 respectively, identified youth as a priority audience for improved reproductive health services.

Dakar, the nation's capital and the largest metropolis in the Sahel region, has lower rates of adolescent marriages (71 percent of women are single by age 20), of adolescent premarital sex (22 percent of women report sexual relations by age 20), and of adolescent childbearing (12 percent give birth before age 20) than other cities in the region. But married adolescents begin childbearing soon after marriage, and less than 20 percent aged 15 to 24 say they have discussed with their spouses the number of children they want. Many fewer use a modern contraceptive—7 percent of married women 20 to 24 report ever use (CERPOD 1997). Fifty-five percent of all urban women 15 to 19 do not know where to obtain a modern method of contraception, and only 5 percent of all women in this same age group can name the fertile days in the menstrual cycle (AGI 1998).

Inspiration From Burkina Faso

Inspired by ABBEF's experience with "Youth to Youth" in Burkina Faso, the Association Sénégalaise pour le Bien-Etre Familial (ASBEF) asked SEATS II to assist in strengthening and expanding its youth IEC and counseling activities to include an effective strategy for making quality family planning services more widely available to young adults.

Senegal: Subproject Overview

Dates: November 1995 to September 1997

Target population: Young adults in a peri-urban community

SEATS' counterpart: Association Sénégalaise pour le Bien-Etre Familial (ASBEF)

- ✓ Community input through Advisory Committee
- ✓ 22 peer educators (young men and women) trained
- ✓ IEC materials developed
- ✓ Young Adult Community Center with capacity to provide reproductive health services and recreational activities
- ✓ Clinical services: contraception, STD screening, gynecology, psychological counseling in Youth Center
- ✓ Reproductive health education in classrooms
- ✓ MIS to track client visits, referrals, outreach
- ✓ End-of-project qualitative evaluation
- ✓ Collaboration with MOH

The center of the subproject was the Pikine/Guédiawaye Juvenile Protection Center, which provides primary, secondary, and vocational education to 300 young people in its custody (for a variety of legal infractions, including infanticide and having had an induced abortion) and some 1,000 other unemployed youth who are completing their education. Building on ASBEF's experience in integrating reproductive health instruction into the Center's classes, the subproject aimed to transform the Center into a comprehensive resource for young adult reproductive health, serving students at the Center and the 150,000 young people residing in Pikine and adjacent Guédiawaye, peri-urban communities of Dakar.

An Advisory Committee, composed of young people, teachers at the Center, parents, and ASBEF and MOH representatives, played a critical role in gaining and maintaining parent and teacher commitment to activities. At first, its large size made decision making cumbersome, but over time the involvement of many stakeholders yielded beneficial results.

A reproductive health center, staffed by a midwife, with regular visits from a physician and a psychologist, was created within the Center. Following training, 22 peer educators, recruited from among Center students, offered information to their counterparts in the Center programs and in the surrounding communities, distributed condoms and vaginal foaming tablets, and made referrals to clinical services in the Center. Seven trained teachers served as peer educator supervisors, and two were coordinators. Reproductive health education in the classrooms improved, after 13 additional teachers received training in the use of participatory, interactive teaching methodologies. Parents on the Advisory Committee facilitated conferences and meetings with other parents from the community.

Challenges to Community Outreach and Quality Services

Although activities enjoyed parental support and the Government of Senegal increased its financial support to the Center, end-of-project focus group discussions (FGDs) with peer educators revealed that they faced challenges in carrying out their community-based work. Young people were reluctant to seek individual information or counseling publicly, although youth participated in group activities such as drama and sports events organized around reproductive health themes. Many claimed they did not need “family planning,” as they were “chaste.” Although a few youth secretly requested condoms, knocking on a peer educator's window at night, the educators believed that young people preferred sources of information and services outside the neighborhood,

such as pharmacies, where privacy and confidentiality were more likely. In contrast, the married women students at the Center and in the surrounding areas appreciated the peer educators' services. In fact, about one half of the clients reached by the subproject were married/adult⁴ women and men (Thiam 1999).

Local residents doubted the chastity of peer educators engaged in distributing contraceptives. "The fact that you are explaining these things to us means you must use contraceptives yourself. Hence, you cannot swear that you have not had sexual relations." Although a few young women peer educators were willing to reveal that they used contraceptives in order to gain their audiences' confidence, many, especially in the beginning of the subproject, feared the label "unchaste." Home visits were particularly difficult for the young women educators. Male heads of household often accused them of being "perverts" seeking to seduce their children and occasionally reported them to the young women's parents, who in turn questioned their daughters' virginity. This type of censure made many peer educators prefer to work outside their own neighborhoods. Some peer educators became known as "Mr. Condom," causing them shame and leading them to suggest that they be allowed to distribute a wide range of essential drugs to "avoid all suspicion" (Thiam 1999).

The peer educators responded to these criticisms by taking a cautious, step-by-step approach to introducing issues in reproductive health. They began by talking about AIDS, a universally acceptable theme. The key message was "chastity." Once they gained confidence, they would introduce contraceptive methods as a means to prevent STDs and HIV/AIDS (Thiam 1999). Holding separate sessions for young men and young women resulted in greater parental support, as this approach was consistent with traditional religious and sociocultural norms.

Other barriers reduced the effectiveness of the peer educators and the subproject activities. Despite ASBEF's interest in young adult reproductive health, it failed to take into account the fact that programmatic approaches that work well for married adults may not adequately meet the special needs of young people. Its lack of staff with expertise in youth programming impeded its ability to provide appropriate monitoring and support to the Center and the peer educators. By the time the MIS was in place, peer educators had been trained; introducing new data collection procedures into their ongoing activities was difficult. A stock-out of contraceptive commodities early in the subproject left Center staff and the peer educators demoralized when they could not offer the services wanted by clients. The peer educators' other commitments limited the time they could give to the subproject, and the lack of transportation and compensation reduced their motivation. When

⁴Married women, even if under the age of 20, were considered adults, not "youth."

trained peer educators graduated from the Center, they abandoned their peer education responsibilities. New educators were not trained to replace them.

Senegal: Urban Initiative and Youth

Intervention dates: September 1997 to March 1999

SEATS' counterparts: Mayoral districts in Dakar and Louga

- ✓ Baseline data collection and dissemination
- ✓ Coalition building among municipalities, donors, NGOs
- ✓ Development of data-based action plans, including interventions for youth reproductive health
- ✓ Community mobilization
- ✓ Peer educators
- ✓ Clinical services

Senegal: Quality Initiative and Youth

Intervention dates: May 1998 to June 1999

SEATS' counterparts: PNPF, ASBEF, Santé Familiale

- ✓ Site-based quality teams of managers, providers, community members
- ✓ Baseline data collection on client perspectives and site-specific problems
- ✓ Action planning to address priority problems, including youth reproductive health
- ✓ Community outreach and mobilization
- ✓ Ongoing assessment and changes
- ✓ Collaboration with Management Sciences for Health, AVSC International

Costs were another obstacle the peer educators and their clients faced. The Center service providers often referred clients to other clinics for specialized services. Clients demanded that the educator accompany them, or they asked the educator or Center to pay their bus fare. This placed the educators in a difficult position, as they wished to help, but did not have the means to do so.

Despite the shortcomings, the work in Pikine/Guédiawaye did establish Senegal's first comprehensive youth reproductive health education and services project. The Advisory Committee continues to work with the Center staff and teachers, exploring new activities such as income generation to strengthen the program.

Urban and Quality Initiatives Generate Local Solutions

In contrast to the ASBEF subproject, which began with youth as a specific target audience, the process-oriented interventions of SEATS II's Urban Initiative and quality improvement actions created awareness of the need to expand and improve reproductive health services for youth.⁵

Empowering municipal governments, which had recently gained control over social service and health budgets, to advocate for, design, develop, and take responsibility for appropriate reproductive health care services for their constituents, was the essence of the Urban Initiative in Senegal. Meetings, workshops, and roundtable discussions brought together municipal officials, urban leaders, NGO and donor agency representatives, and young people in new coalitions in the municipalities of Dakar and Louga. Analysis of local data on reproductive health led many of the 11 participating mayoral districts to identify access to information and services by young adults as a priority action. More than 250 youth peer educators received training in basic reproductive health messages, and

⁵The experiences of the Urban Initiative and those of quality improvement activities are further analyzed in *Meeting the growing demand for quality reproductive health services in urban Africa: Partnerships with municipal governments. Lessons learned from SEATS' Urban Initiative* (Rossi 1999) and *Mainstreaming quality improvement in family planning and reproductive health services delivery: Context and case studies* (JSI/SEATS in press), available on the SEATS website www.seats.jsi.com

supervisors supported them while they provided information and referrals. Each municipality funded at least 20 percent of these actions, and several successfully obtained additional outside funding. At least 100,000 youth received information and referrals; some clinics reported up to 50 percent increases in visits for STD symptoms and family planning.

The Urban Initiative showed that powerful advocates for young adult reproductive health can be created by building new and stronger relationships among elected officials and health-sector authorities, local NGOs, and communities.

SEATS II's quality improvement activities adapted and combined the components of the USAID Maximizing Access and Quality initiative and techniques from CQI into an approach called EQUIPE (Expanded Quality to Improve Program Effectiveness). EQUIPE's clinic-based quality teams emphasized collaboration among service delivery sites, referral sites, and the communities they serve. Service providers and communities worked together to identify and make quality improvements and to measure the outcomes of the changes. Eight public and private-sector sites in Dakar formed a network to learn from each other and reinforce the testing of innovations and application of best practices.

At least three sites undertook actions addressing youth reproductive health. For example, providers from one site collaborated with the local high school's family life education program, offering classroom presentations and discussions. Another clinic initiated regularly scheduled "youth teas," where young people from the community gathered to view films and videos and hold group discussions. Offering education on reproductive health did not trouble providers at this site, but they were unwilling to make condoms available at the teas, despite requests from young people. At a third site, providers and managers engaged in in-house dialogue designed to increase awareness of the need for special approaches to youth and to foster willingness to provide services to this population.



photo by Marty Leuders

Zambia: Subproject Overview

Dates: October 1997 to April 1999

Target population: Youth 10 to 24 in the catchment areas of seven urban clinics

SEATS' counterpart: Lusaka District Health Management Team (LDHMT)

- ✓ Participatory appraisal of adolescent reproductive health
- ✓ Community mobilization: Neighborhood Health Committee actions, school Anti-AIDS clubs, PTAs, businesses
- ✓ End-of-project qualitative evaluation and client exit interviews
- ✓ 20 trained peer educators (male and female) and "Youth Corners" in two model clinics
- ✓ IEC: films, videos, theater, print
- ✓ Resource generation for sustainability
- ✓ Youth-friendly services in seven clinics; 18 service providers trained
- ✓ 18,000 youth reached; 42,000 condoms and 14,500 foam distributed
- ✓ 4,400 new contraceptive users; 7,494 visits for other reproductive health services
- ✓ Provider and community attitudes changed from negative to positive
- ✓ Collaboration with CARE, UNICEF, FOCUS, USAID bilateral Family Planning Services and Zambia Integrated Health Package, Family Life Movement of Zambia, Planned Parenthood of Zambia, JHU/CCP, PSI, MotherCare

EQUIPE's consultative feedback mechanisms and focus on quality, rather than specifically on youth, allowed service delivery sites to design and implement improvements that reflect community concerns, resource availability, and provider comfort with youth sexuality.

The Urban Initiative and the quality improvement approaches led to locally generated solutions to youth reproductive health issues. Although perhaps not far-reaching, these approaches allowed communities to take ownership of the problems—an important contribution toward creating a supportive environment in the context of the social conservatism surrounding youth sexuality and Islam's teachings on family planning.

Zambia: "A Window of Hope" in the World of HIV/AIDS

The devastating impact of the AIDS epidemic and high rates of unsafe abortion among young women were among the reasons the City Council of Lusaka developed a 1996 action plan to provide improved reproductive health information and services to youth in all its health facilities. Ongoing health reforms, focused on reorienting health services to decentralized, integrated programs, shaped the management context. A USAID Mission that placed priority on integrated health actions for adolescents facilitated immediate support for follow-up to the plan.

The Lusaka District Health Management Team (LDHMT) initiated youth-oriented reproductive health actions in 1996, with support from CARE International and UNICEF. In 1997, SEATS II, together with the FOCUS project, was asked to assist seven more city clinics to integrate outreach and services that addressed youth needs, building on the trust and confidence generated through experience with the existing SEATS subproject "Expanding Family Planning Services in Lusaka Urban District." Two of the seven clinics—Bauleni and Matero Reference—served as model demonstration sites for documenting and evaluating a comprehensive approach to improved reproductive health services for youth in peri-urban communities.

A participatory appraisal of adolescent reproductive health, Participatory Learning and Action (PLA), in the communities surrounding the two model clinics, launched the subproject. The appraisal was adapted from the experiences of CARE and its counterparts. Unlike more conventional formative research methods, in which information is collected from the community and analyzed by outside experts, PLA engages the community in gathering and assessing data. Derived from participatory rural appraisal methodologies, the PLA in these two communities generated an understanding of stakeholder perspectives on youth reproductive health and simultaneously created a forum for community mobilization in support of the subproject. Neighborhood Health Committees (NHCs), composed of local residents and designed to provide a link between health providers and the community, helped organize and recruit participants for the PLA. Through FGDs, other qualitative methodologies (ranking and scoring, mapping, and transect walks), and meetings to disseminate and discuss the findings, service providers, youth, and community members helped define the scope of activities and built a foundation for ongoing collaboration (Shah 1999; Sambisa and Chibbamulilo 1998).

Risky Behaviors and Barriers to Services

The PLA findings confirmed that young people in these two communities, like their peers throughout Zambia, engage in numerous behaviors that put their reproductive health at risk (Sambisa and Chibbamulilo 1998; Koster-Oyekan 1998; Pillai et al. 1999). Parents and youth stated that girls initiated sexual activity at age 10 to 12, and boys somewhat later at 12 to 14. Parents attributed early sexual activity to sex videos and films; observing immoral behavior among adults; lack of parental role models and guidance; peer pressure; alcohol and drug abuse; and condom promotion. “When youths are given condoms, they go on [a] rampage, thinking that there is nothing wrong with sex.” Young women reported that sex in exchange for money or other forms of payment was common. Parents and young people agreed that the appropriate age for initiating sexual activity was much older—around 20. The potential adverse consequences of sexual activity were well-known: STDs, AIDS, unwanted pregnancy and the stigma of illegitimate children, and unsafe abortion. Knowledge of condoms and pills was high, but reported use was low. Youth perceived condoms as inappropriate for steady relationships. “When you have been in love with your girl friend for a long time, she becomes like your wife; so you stop using a condom,” said one youth. The PLA participants tended to believe that pills caused infertility or birth defects (Sambisa and Chibbamulilo 1998).

Lusaka Youth Speak about Condoms

“Boys accuse us of being promiscuous when we want to use condoms.”

“Girls think we are promiscuous when they see us with condoms.”

“Skin-to-skin is better.”

“Boys are clever. They may wear condoms, and then secretly prick the tip, so that they can then refuse to take responsibility after pregnancy. Hence, it is better not to use them.”

SOURCE: Sambisa and
Chibbamulilo 1998.

Young people said that friends were their most prominent source of reproductive health information, followed by radio and television, and schools, through science lessons and print materials. The youth viewed aunties, grandparents, and parents—the people who gave their parents information in the past—as outdated, inaccurate, and unreliable sources of information (Sambisa and Chibbamulilo 1998).

Youth and parents reported that young people used local clinics only as a last resort in cases of suspected STDs. According to the young people, clinics did not offer privacy, the lines were long, the fees were unaffordable, providers were rude and “too inquisitive,” and discussing sexual matters with providers of the opposite gender was embarrassing. Parents and youth believed that clients could only receive STD treatment when accompanied by their partner, although providers stated this was not the case. Young people preferred traditional healers and private health practitioners, where services were faster and more private, and did not involve “scolding sessions” by nurses (Sambisa and Chibbamulilo 1998).

The PLA identified additional barriers to reproductive health information and services for youth. NHC members echoed parents’ sentiments when they said that contraceptive use by young people was immoral and should be targeted to married people only. Both clinics already had youth-friendly clubs with peer educators, although youth did not mention them as sources of information and support, and the NHCs were unaware of the clubs. The members of the youth-friendly clubs reported that they faced numerous obstacles to engaging neighborhood youth in their endeavors: limited knowledge and skills in STD/HIV/AIDS education and counseling; community disapproval of reproductive health education and services for young people; and lack of financial and material resources to support recreational, skills building, and educational activities (Sambisa and Chibbamulilo 1998).

Planning and Acting Together

On the last day of the PLA exercise, participants from the two communities came together to discuss the findings and the subproject plans to initiate youth-friendly services. These dialogues between providers, NHC members, parents, and youth were an opportunity to clarify misconceptions about contraception and generated many suggestions for activities, including more publicity about the youth-friendly clubs; the introduction of entertainment, games, and vocational skill building to attract youth; and sensitization and increased involvement of parents and the NHCs. These frank discussions were a turning point in the subproject, initiating a process of creating a supportive environment

*“We did not know how you
felt . . . if we have been serving
[youth] as badly as you have just
described, we vow to change our
attitudes so as to serve you better.”*

Lusaka Health Provider

for the provision of youth reproductive health information and services, one of the subproject's key objectives. "Thank you very much for this exercise. Our minds are now opened up," said one NHC chairperson.

The community input reinforced the decision to strengthen and expand the youth-friendly clubs through training and support for peer educators and the creation of Youth Corners in the clinics—private spaces located away from the busy outpatient departments. Ten peer educators (five male and five female) from each of the two model sites, selected with input from the community, participated in an initial one-week training. Over the next year and a half they attended two refresher training workshops. These follow-up courses allowed the peer educators to exchange experiences, review data collection tools, and gain additional information and skills on topics such as self-image and decision making. The peer educators received an allowance to support their transportation and related costs. High-energy exchange visits between the peer educators from the two sites offered further opportunities for brainstorming about novel approaches to reaching out into their communities.

The Youth Corners offered both a gathering place and private room for counseling. Billboards throughout the city and signs at the clinic gates informed the community that "youth-friendly services are provided here," and on the clinic doors a poster directed youth to the Youth Corners. Each clinic designated a trained nurse midwife to act as the peer educator supervisor.

Although only two clinics had Youth Corners and peer educators, all seven clinics took steps to make services more youth-friendly and mobilize the community in support of the improved services. Two or three providers from each of the seven clinics, along with their respective supervisors, received training in comprehensive youth-friendly reproductive health services, including antenatal, delivery, and postpartum care; family planning; STD services; and counseling. They in turn oriented the other providers at their clinics about youth-friendly services. Some clinics established lunch-time and weekend hours, and services were free. Clinics offered a full range of contraceptive methods, including emergency contraception.

Clinic staff did not always welcome the changes required to make clinics youth-friendly. For example, the peer educator supervisor at one clinic reported that some clinic staff resented shifting their lunch hour and "giving up their kitchen," where the Youth Corner was set up.

These staff also claimed that the supervisor was neglecting her duties when she joined the peer educators in the communities, and they did not agree with the provision of free services to youth who did not have “medical schemes” [insurance].

Selection Criteria for Peer Educators

Subproject staff, community members, and youth defined the selection criteria for the peer educators:

- ✓ Serve as credible role model for the social competencies they will advocate (e.g., safe sex)
- ✓ Are accepted by peers and able to establish good relations within a group
- ✓ Are admired and respected for their social skills
- ✓ Are committed to family planning and reproductive health issues
- ✓ Can communicate clearly and persuasively with peers
- ✓ Can read and write English
- ✓ Have completed at least nine years of education
- ✓ Have good interpersonal skills including listening skills
- ✓ Are interested in self-enhancement, have self-confidence, and have potential for leadership
- ✓ Have time and energy to devote to work without a salary
- ✓ Can work irregular hours
- ✓ Have been selected by community
- ✓ Are capable of being nonjudgmental and confidential
- ✓ Are between 17 and 26 years old

Subproject staff also shared the results of the earlier PLA exercise with the NHC of the other five clinics. NHC members were encouraged to view the staff of the youth-friendly clinics as modern-day “grandparents” and “aunties,” with responsibility for providing education on sexuality and reproduction (Chirwa 1998). The NHCs formulated action plans for further engaging community and parental support for the youth-friendly services and the peer educators. NHC members reached out to churches, PTAs, and businesses, informing them of the subproject and encouraging them to share information about it. Church elders made announcements in their Sunday services, taverns and markets placed posters about the clinics, and community clubs invited NHC members and clinic staff to talk about the initiative. Midway through the subproject, each clinic formed a quality team, which took on responsibility for monitoring and supporting the community mobilization actions in the overall context of improving the quality of care.

Peer Educators as Entrepreneurs

The peer educators at Bauleni took on the issue of sustainability whole-heartedly, demonstrating their entrepreneurial abilities. Together they obtained a vacant building and converted it into a reproductive health performing arts center, where they showed films and videos, and gave theater performances for a small fee. They also rented out the vacant rooms and sold soft drinks at the clinic. Their net income after one year was approximately K300,000 (US\$150).

The peer educators, NHCs, and the community also played an active role in generating resources to support the youth-friendly services. With support from the NHCs, peer educators earned money doing community chores such as weeding fields and cutting hedges. Each clinic sold the youth-published newspaper *Trend Setters* at a locally determined price to earn funds to

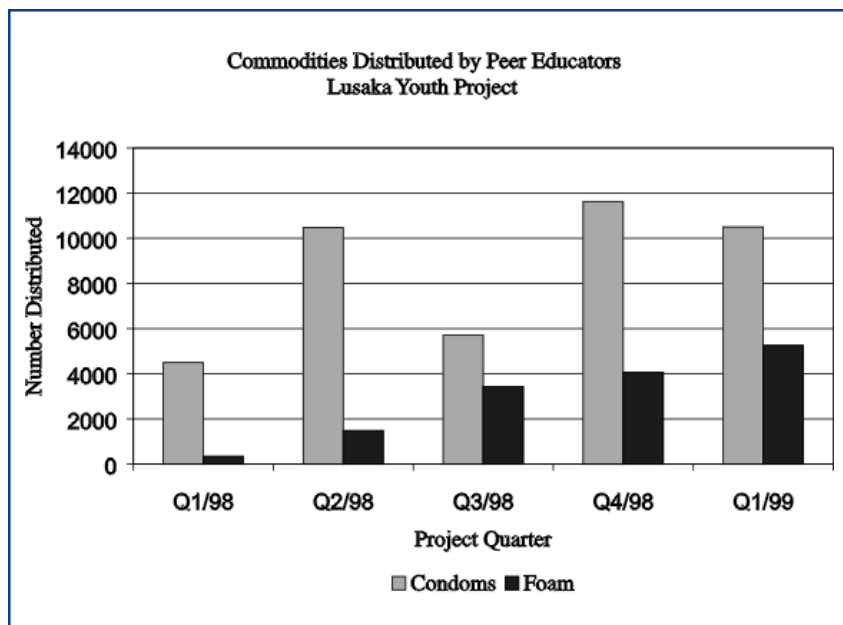
purchase more papers, develop IEC materials, and/or pay for transportation to meetings with other peer educators. Several NHCs held fundraising events such as “braais” (bar-b-ques) and requested donations from businesses to generate financial support for the peer educators and clinics.

Alliances with local schools were formed through collaboration with the Anti-AIDS Clubs of 10 primary and secondary schools in the catchment area of the seven clinics. Each Club sent two members to a two-day workshop that introduced the youth-friendly health services and reviewed facts and feelings about unprotected sexual activity. Clubs regularly invited the peer educators and clinic staff to give talks in the schools, and schools received updated information on reproductive health to share with staff and students.

The Coordinating Committee for the existing subproject, which included clinic and SEATS staff along with representatives of the LDHMT, CARE, and the Family Life Movement, expanded to include youth leaders. At first, some Committee members were uncomfortable sharing authority with young people. Over time, they recognized that many of the issues affecting the delivery of services were common to adults and youth, and welcomed the younger members.

Reaching Youth in the Community

The peer educators were responsible for collecting data on clinic services provided to youth as well as on their own activities. They compiled and submitted monthly reports, based on daily activity reporting formats developed specifically for the subproject. The MIS included data on clinic-based cases for antenatal care, STD screening and treatment, family planning, and referrals for abortion complications as well as on peer educator activities: commodities distributed, individuals counseled, group sessions conducted, and referrals made.



Lusaka Youth Speak on Peer Educators

“When I suspect that I have an STI, I go to the peer educator who also refers me to the clinic where nurses give proper medication.”

“In the past we were so nervous to go to the clinic after contracting STIs. We feared being shouted at by the health worker and we were denied proper treatment. . But nowadays, we go to the peer educators in confidence, who discuss problems and fears and give us the information we need about sex. In cases of STIs, they write referral letters to the clinic.”

SOURCE: LDHMT 1999.



The peer educators were extremely active, reaching 18,217 young people with individual counseling and group educational activities. Of these, they referred 4,100 for services at “our” youth-friendly clinics. Although only 19 percent of the contacts represented individual counseling sessions, the group activities were for the most part appropriately small—with about 12 participants. The peer educators made efforts to reach all young people in their communities. Prison authorities in Matero welcomed the peer educators when they came to give education to young inmates there.

The peer educators reached many more young women than young men—12,372 young women versus 5,845 young men. They distributed 42,814 condoms and 14,587 foaming tablets (see box). The data on foaming tablet distribution give further evidence of the peer educators’ effective outreach to young women. Spermicides represented 25 percent of the contraceptive commodities distributed by peer educators, and most (58 percent) of these were distributed in individual counseling sessions, suggesting that recipients requested this method (rather than obtaining it as “sample” in a group session).

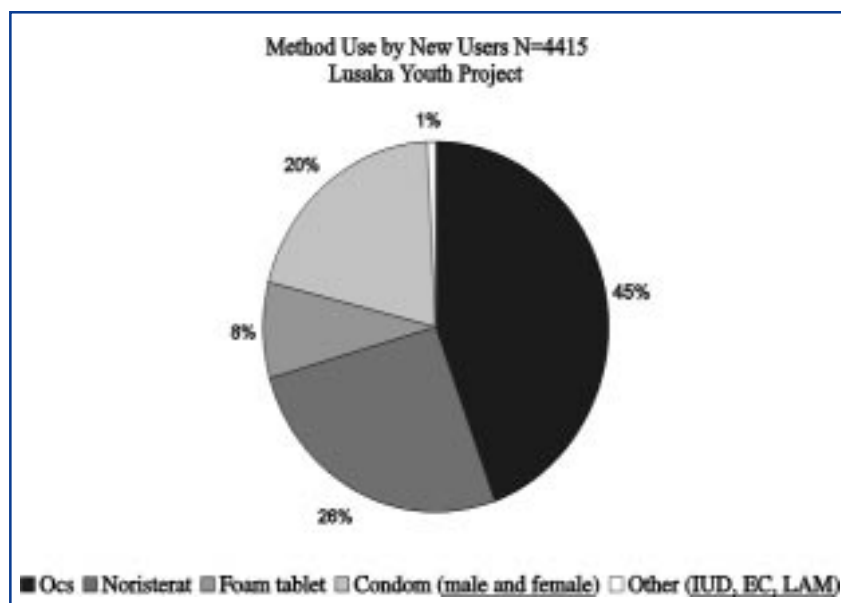
The end-of-project evaluation also provided evidence of the peer educators’ effectiveness. Peer educators’ ranking as a source of information on reproductive health rose from no mention at the baseline PLA to a major source, along with mass media. Youth also cited peer educators and the youth-friendly clinics as among the most reliable sources of information (LDHMT 1999). After observing the progress made by the two model clinics, a third clinic included a funding request for a peer education program into its annual work plan submitted to the LDHMT. The request was approved, and the peer educators were trained and on the job by June 1999.

In addition to the peer educators’ remarkable performance, there was very little turnover among them. Of the original 20 trained, four dropped out, but they were replaced. Subproject staff attributed the peer educators’ success to many factors: having their own space in their “own” clinics; their responsibility for data collection; their participation in project management; refresher training; community support; and their active role in fund raising.

By the end of the subproject, allowances and other forms of incentives for peer educators had become a point of contention. Although the subproject paid a modest transportation allowance to the peer educators, the LDHMT recommended it be discontinued because other youth projects did not provide monetary payments to their peer educators. On the other hand, the peer educators and often their families, their supervisors, and the NHCs, believed that larger allowances were essential. “If the issue of transport and lunch allowance is not looked into, the peer education program is dead,” said one peer educator. These conflicting viewpoints raised key questions about the role of incentives and the meaning of volunteer service in peer education programs (LDHMT 1999).

Increased Access to and Use of Youth-Friendly Information and Services

Youth did use the youth-friendly clinics for a variety of reproductive health concerns. During the subproject’s 18 months, 3,268 young people aged 10 to 19 (1,631 males and 1,637 females) came for sexually transmitted infection (STI) screening and treatment; 4,126 young women (12 to 19 years) came for antenatal care, and 100 (12 to 24 years) for treatment of abortion complications. The seven clinics had 4,415 new youth acceptors in the age range 12 to 24 years. The method mix (excluding those who received commodities from the peer educators) was diverse and included injectables, OCs, condoms, emergency contraception (EC), and lactational amenorrhea method (LAM) (see figure). A few young people selected dual methods.



Exit interviews with youth clients found that they were generally satisfied with services they received. Three out of four considered the nurses friendly or very friendly, and even more said they were polite and resolved the clients’ problems. Although pleased with the services offered and the treatment they received, young people were slightly less satisfied with opening hours and privacy. Lack of medications was clients’ greatest complaint. In almost all respects, youth rated the peer educators in the Youth Corners higher than the nurses in the main clinic. For example, all who saw a peer educator, compared to 77

Neighborhood Health Committees Support Peer Educators and Youth-friendly Services

“... youth-friendly services should be supported because they educate and motivate youth to talk and discuss freely on matters related to sexuality among themselves.”

“This is where our children seek help on sexual and reproductive health issues and problems affecting them. They find it easy to express themselves fully as they are attended to by their fellow youths called peer educators.”

SOURCE: LDHMT 1999.

percent of those who saw a nurse, reported that the provider took time to listen to their concerns. Similarly, only 3 percent stated they did not feel comfortable talking to the peer educator, while 13 percent said they felt uneasy with the nurse (JSI/SEATS 1999).

Interviews with providers trained in youth-friendly services, conducted at the end of the subproject, found a generally positive attitude toward youth sexual and reproductive health needs and services, compared with the discomfort and reluctance to provide services revealed in the baseline PLA. Providers said they would support the use of contraception among youth of either sex as early as there is a need. They stated there were no age restrictions in providing any contraceptive method, with the exception of voluntary surgical contraception. Contrary to prevailing sociocultural norms, which do not support communication about sexuality between parents and children, the nurses believed that parents should feel free to share information on reproductive health with their children. Unfortunately, many trained providers had been transferred to other sites, and the untrained providers were much less supportive of youth-friendly services and the peer educators (LDHMT 1999; JSI/SEATS 1999).

In addition to the need for a “critical mass” of providers trained in youth-friendly services, another important factor in the success of youth-friendly services was the ongoing presence of a “youth champion” within a clinic. At one model site, where the enthusiastic and supportive peer educator supervisor remained the same throughout the subproject, progress in establishing youth-friendly services was much faster than at the other site. This “youth champion” even advocated for an increased allowance for the peer educators, reflecting her acknowledgment of their hard work. At the other site, personnel changes resulted in much slower start-up, inconsistent support, higher absenteeism among the peer educators, and poorer record keeping. By the end of the subproject, peer educators at both sites reported adequate satisfaction with their supervision (LDHMT 1999).

A Supportive Community

Community enthusiasm for this new program was high. NHC members were aware and supportive of the peer educators and youth-friendly services (see box). The commitment to meaningful community involvement, dedicated staff, and active outreach transformed an environment of staunch opposition to reproductive health services for young people into one of support.

Nevertheless, all involved—peer educators, service providers, NHC members, and SEATS staff—believed much, much more needed to be done. They agreed that it was unrealistic to expect 20 peer educators to reach a substantial portion of the young people in their catchment areas. Indeed, the end-of-project evaluation found many youth still lacked specific knowledge about health-promoting behaviors, such as how to use and dispose of condoms. Misconceptions about the safety and effectiveness of condoms and contraceptive methods continued. Some parents opposed youth-friendly services (LDHMT 1999).

Zambia Nurses Association Expands Youth-friendly Services Nationwide

Nurses and midwives are usually the primary providers in many health services in Zambia and are often the only clinicians with whom adolescents have contact. With support from the SEATS Special Initiative, Midwifery Association Partnerships for Sustainability (MAPS), the Zambia Nurses Association (ZNA) carried out a subproject to strengthen the ability of the association and its members to provide quality sustainable reproductive health services to youth throughout Zambia. One of the first activities was training the providers from the seven SEATS-supported clinics in Lusaka in youth-friendly services. ZNA also adapted the national reproductive health training curriculum to produce its own modules on youth reproductive health. Trained ZNA facilitators used the modules in conducting continuing education updates for more than 500 members attending ZNA branch meetings.

In early 1999, the ZNA held a series of “youth meetings,” where peer educators and the producers of *Trend Setters* exchanged views with ZNA members in order to encourage the nurses and midwives to become more involved in offering youth-friendly information and services at their places of employment throughout Zambia. Follow-up visits in mid-1999 found that 85 percent of the facilities visited had begun actions such as establishing Youth Corners to make the services more youth-friendly. For example, ZNA members working at the University of Zambia health clinic helped recruit 10 peer educators from among various student clubs and were about to start delivery of youth-friendly services in a university residence. At the Kapiri Mposhi District Hospital, 161 youth had already made use of the new youth-friendly services, and hospital management contributed funding for furniture for the youth corner. Visits by young people to all service sites staffed by trained ZNA members rose to 4,540 in April 1999.

With its ability to reach nurses and midwives in both the public and private sectors, the ZNA has the potential to make youth-friendly health services a nationwide reality.

City Youth Committee Identifies Reproductive Health Concerns

The intersectoral Youth Committee of Gweru City identified a range of reproductive health concerns facing young people:

Lack of knowledge of human sexuality and reproductive health due to:

- ✓ Poor communication between parents and children
- ✓ Parents' lack of knowledge and discomfort in discussing sexuality
- ✓ Decline in traditional modes of sexuality education, previously provided by aunts and uncles
- ✓ Limited availability of appropriate literature and counseling on human sexuality and reproductive health
- ✓ Shortage of trained teachers or other community educators

Reproductive health services inaccessible to youth due to:

- ✓ Negative staff attitudes
- ✓ Lack of training
- ✓ Inappropriate policies
- ✓ Lack of meaningful entertainment, recreational, and vocational training facilities
- ✓ Unprotected sexual activity resulting in unwanted pregnancy, STD, school drop-out, illegal abortion, and other social problems
- ✓ Unemployment and poverty among youth contributing to the problems associated with youth

Subproject staff suggested measures to advance community ownership and management of the program: sustainability measures and peer educator incentives could be defined by the community; training workshops could include community members as presenters; and education of parents could be strengthened to better prepare them to cope with their children's sexuality and issues such as early initiation of sexual activity and coercive sex. NHC members recommended training more peer educators; establishing Youth Corners and services outside the clinics; expanding community awareness activities; strengthening linkages with other community organizations; and improving educational and recreational activities for all young people. Together these actions could expand the "window of hope" in the world of HIV/AIDS that this subproject represented.

Zimbabwe: Gweru, A City that Supports Its Youth

The achievements of Zimbabwe's national family planning program are notable and contribute—along with universal education—to the somewhat more positive reproductive health data on young people, when compared to data on their peers in other sub-Saharan African countries. For example, Zimbabwean young women aged 15 to 19 are more knowledgeable about modern contraception (90 percent know of modern methods) and more likely to use modern contraception (33 percent of unmarried, sexually active women in this age group use a modern method) than their counterparts in most other countries in the region. Rates of premarital sex by age 18 have remained steady between generations, whereas they have risen in other countries (AGI 1998). Childbearing among teens in Zimbabwe has declined over the last 25 years, reflecting efforts to keep girls and women in school through more advanced levels to improve their socioeconomic status (CSO and MI 1994).

But much of the data substantiate Gweru City Council's concern for the reproductive health of the city's 45,000 young people aged 10 to 24. Forty-seven percent of Zimbabwean women aged 20 to 24 have had a child by age 20, and 50 percent of adolescent births are unplanned (AGI 1998). An estimated 26 percent of the adult population 15 to 49 is living with HIV/AIDS. Rates of HIV infection among antenatal clinic attendees are even higher: in 1995, 28 percent of women 15 to 17 years of age in the capital city, and 49 percent of women 20 to 24 in a southern province, tested positive for HIV (UNAIDS and WHO 1998).

The Gweru City Youth Committee, composed of representatives from central ministries, local government, and NGOs, advises on citywide youth programming. In 1997, the Committee identified numerous reproductive health concerns facing youth (see box) and recommended that action be taken to improve the reproductive health of youth 12 to 24 through increased access to quality information and services in the context of the existing SEATS II subproject "Gweru Family Planning Service Delivery: Support for Quality Improvement and Training" with the Gweru City Health Department. The subproject design called for community mobilization, peer education, and youth-friendly reproductive health services in seven City clinics and in the renovated multipurpose Ndhlovu Youth Center. The FOCUS project joined SEATS II in providing financial support and technical assistance.

Zimbabwe: Subproject Overview

Dates: November 1997 to June 30, 1999

Target population: Youth 10 to 24 in Gweru City

SEATS' counterpart: Gweru City Department of Health

- ✓ Baseline and postproject surveys data
- ✓ Community mobilization: City Youth Committee, community leader and parent sensitization and advocacy workshops, multisectoral involvement
- ✓ Youth advisory committee (YAC); YAC members on Gweru Youth Committee
- ✓ Multipurpose youth center with health, recreational, and vocational services
- ✓ 40 trained peer educators; peer educator contact monitoring system
- ✓ 43 providers trained and provided youth-friendly services in seven City clinics
- ✓ 8,141 youth reached; 4,845 condoms and spermicides distributed
- ✓ Peer educators reached more at-risk youth over time
- ✓ Youth Corners in seven clinics and in Youth Center
- ✓ IEC at all sites and in peer education
- ✓ Youth rated services and peer educators as friendly in exit interviews
- ✓ Improvements in attitudes toward condoms
- ✓ Collaboration with FOCUS, Zimbabwe National Family Planning Council (ZNFPC), Midlands AIDS Support Organization (MASO), Zimbabwe Republic Police, Ministry of Education, Ministry of Sport, Recreation, and Culture, UNICEF

Beliefs, Behaviors, and Risk

A baseline survey gathered information from a systematic cluster sample of 250 unmarried youth aged 12 to 24. In addition to the usual questions on reproductive health knowledge, attitudes, and behaviors, the survey also explored young people's use of time, their social interactions in the community, the value they attributed to male-female relationships, and the context of sexual activity (Sambisa et al. 1999).

Thirty-nine percent of the respondents were currently in school, and 61 percent were out of school, although 85 percent of these indicated they had completed secondary education. Respondents reported that they spent an average of six hours the previous day engaged in social and recreational activities including playing, gossiping, watching TV, listening to the radio, and family gatherings. Sixty percent did not participate in organized sports, religious, or service activities. Thirty-four percent of the sample had had sexual intercourse in the past (24 percent of young women and 44 percent of young men). The mean age of the first sexual experience was 17.

Knowledge of the “facts” was quite high: almost all respondents, regardless of age, gender, or sexual experience, could cite modern contraceptives, name STDs, and state basic physiological changes that occur at puberty. Practical knowledge information—that could be applied to actions to protect one’s sexual health—was much lower. For example, only 10 percent of young women knew when in the menstrual cycle a woman was likely to conceive, and 37 percent of males and 14 percent of females could describe the steps involved in the correct use of condoms (Sambisa et al. 1999).

Attitudes toward the condom and its use were somewhat positive, although often contradictory. Although 71 percent agreed that a girl who carries a condom is responsible, 36 percent thought that a woman would lose a man's respect if she requested him to use a condom. Less than half (29 percent) agreed with the statement “Condom use is not necessary when a relationship moves from casual to serious”; yet when asked if condoms *should* be used in steady boy-girl relationships, 82 percent said they should not. About three-fourths believed that condom use prevented HIV/AIDS (Sambisa et al. 1999).

Knowledge of the facts about contraception, STDs, and HIV/AIDS and relatively positive attitudes toward condoms appeared to have little impact on these youth’s perception of their risk of HIV/AIDS. Eighty-one percent assessed their risk to be low to nonexistent. Young women were much more likely than young men to see themselves as

at risk. Among those who had had sexual intercourse, the difference was sevenfold; 43 percent of young women perceived themselves to have moderate to high risk, while only 6 percent of the young men did (Sambisa et al. 1999).

Although many young people indicated they did not see themselves at risk of HIV/AIDS, those who were sexually active nevertheless did take steps to protect themselves from STDs and pregnancy. Among the 24 percent of respondents who indicated that they had been sexually active in the last 30 days, 83 percent reported that they and their partners used a method to protect themselves against STD or pregnancy at every sexual encounter. Two-thirds of the respondents thought it was easy for unmarried young men and women to obtain contraceptives, and 27 percent thought it was difficult. The reasons for difficulty in obtaining contraceptives include disapproval of the elders, difficulty in finding contraceptives, and shyness (Sambisa et al. 1999). Young people in Gweru discussed reproductive health and other matters related to their well-being with their friends and their teachers, but only rarely with family members, health professionals, counselors, or religious figures (Sambisa et al. 1999).

Together, the findings revealed a somewhat puzzling portrait of young people's risk of unprotected and unwanted sexual activity, while reconfirming the appropriateness of peer education, increased access to services, and outreach to youth through a multipurpose youth center.

Multipurpose Services for Youth

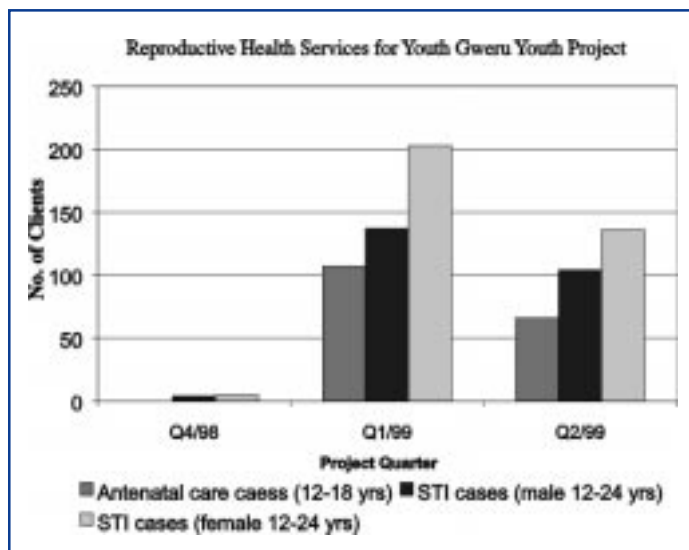
The Ndhlovu Youth Center was transformed into a multipurpose center offering health, recreational, and vocational services to attract both male and female youth of a range of ages and with differing interests. New clinical equipment was added, along with a trampoline, ping-pong tables, a marimba, chess sets, handball goal posts, and a TV and video cassette recorder (VCR). The City Department of Health seconded a full-time nurse to provide health and counseling services, with referrals to other clinics. The City Department of Social Work provided a full-time counselor to offer additional counseling support for issues such as education and employment. The counselor and nurse organized workshops, seminars, and informal talks on communication, decision making, goal setting, risk reduction, and other reproductive health-related topics. By the subproject's end, the City of Gweru had extended the Center's opening hours to include Saturdays.



photo by Lisa Mueller

The Youth Center nurse, instructors from other City youth centers, and 43 providers from the City's seven clinics received training in youth-friendly reproductive health services. Each clinic established a Youth Corner, similar to those in Lusaka, Zambia. Peer educators staffed these private areas, which were stocked with IEC materials. The subproject coordinator and the City nursing officer supervised the clinical services, monitored the use of the Youth Corners, and supported the youth-friendly trained nurses. The 797 youth who used the clinics came mainly for STI services and antenatal care (see figure). Many youth also came to get condoms. The majority of the youth visiting the Youth Corners sought information; about two-thirds were not in school, indicating the appeal of these services to this group of young people.

Several months after the subproject ended, trained youth interviewers conducted exit interviews with all youth between 12 and 24 who sought services for themselves at four City Health clinics over a two-day period. Most (75 percent) clients were female; half were aged 21 to 24 years; and one in three had a child. The majority (76 percent) were out of school. About half came for reproductive-health related-reasons (antenatal care, STD treatment, family planning, and/or counseling and information). Young men used the Youth Corners much more than young women: 23 percent of males, and 9 percent of female respondents consulted with a peer educator in a Youth Corner (Moyo 1999).



Overall, respondents expressed satisfaction with the quality of the services they received. Almost all (98 percent) who saw a nurse reported that the provider was polite and took time to listen to their concerns. More than 90 percent agreed that services had adequate privacy, convenient opening hours, skilled providers, and confidentiality of information. Among the most-liked factors about the clinic, respondents cited the friendliness of the nurses, the availability of informational materials, and the peer educators. Eight-seven percent said the nurse was friendly or very friendly, although the proportion rating the nurse as very friendly varied greatly among the four clinics. "Nurses take time and understand our problems. They have good manners; they are patient, welcoming, and show respect." The most frequently mentioned problems were dissatisfaction with a medication dispensed and cost of drugs (Moyo 1999).

In almost all respects, those who visited a Youth Corner rated its services more favorably than the services of the main clinic. Those who saw the peer educator rated the peer educators as friendly or very friendly. However, most respondents were not aware of the Youth Corners nor had they met the peer educators. Ten percent of respondents had met a peer educator in the community to discuss a reproductive health issue. Within the clinics, nurses made few referrals to the Youth Corners, believing that only clients with reproductive health concerns should be sent to this service (Moyo 1999).

Expanding Into the Community

Before activities began, and throughout the course of the subproject, small workshops and seminars sensitized political, civic, and religious leaders and parents to youth reproductive health concerns and the subproject. Almost 500 adults participated in 41 meetings and workshops. Their initial skepticism gave way to eagerness to see the subproject succeed and promises of support. Curious and concerned parents began to visit the youth consultation rooms. They often came away positively impressed, saying reproductive health information was vital for their children's well-being, especially in this age of AIDS.

The training workshop for the peer educators propelled the subproject into high gear and generated much enthusiasm. Forty peer educators, provided with specific terms of reference and recruited from church and church-related organizations such as the Young Women's Christian Association; drama, art, and music groups; and the Ndhlovu and other youth centers, received training in a one-week workshop. The workshop used role play, games, and video to introduce reproductive anatomy and physiology, contraception, STDs/HIV/AIDS, hygiene, alcohol and drug abuse, communication skills, counseling skills, self-esteem, assertiveness and decision making, and record keeping and report writing to the participants. Staff from many community agencies, including the Midlands AIDS Support Organization (MASO), Zimbabwe National Family Planning Council (ZNFPC), Zimbabwe Republic Police, and City Health Department, provided technical assistance and trainers for the workshop.

Equipped with a t-shirt, tote bag, condoms, and IEC materials, the highly motivated peer educators focused on reaching out-of-school youth. Supervised by instructors from city youth centers, they attended monthly meetings, where they reviewed activities, clarified doubts, and received an allowance to offset transportation expenses. Peer educators used an innovative, low-cost methodology to monitor their activities (Mueller et al. 1999). Over a nine-month period, the peer educators reached 8,141 young people, distributed 4,845 condoms

Table 1. Percent of Peer Educator Contacts Reporting Reproductive Health Behaviors

and spermicides, and held 2,430 individual counseling and 833 group education sessions in the community and at major events such as the Musicians Against AIDS concert. The main topics discussed by peer educators were STDs and HIV/AIDS, sexuality, drugs and alcohol, and pregnancy. Slightly more of their contacts were young women (54 percent) than young men (46 percent). Out-of-school youth represented 54.5 percent of the contacts. Most contacts were between 17 and 20 years old (Mueller et al. 1999).

The monitoring system also showed that the peer educators' contact networks expanded as they reached more young people outside their circle of friends and family over time. For example, in the first quarter of 1999, the peer educators were not well-acquainted with 34 percent of their contacts; in the second quarter, this percentage increased to 50 percent. Their networks also grew to include greater numbers of youth more likely to be at risk of unprotected and unwanted sexual activity. Contacts who lived with their parents and who participated in some kind of organization decreased from the first to second quarter of 1999 (Mueller et al. 1999).

The behaviors reported by peer educator contacts also changed over time (see Table 1). Contacts reporting sexual intercourse decreased, while those who visited a clinic in the previous six months increased as did those reporting use of a family planning method at last sexual intercourse (Mueller et al. 1999).

Visits from outsiders bolstered the morale of peer educators and subproject staff. A delegation from the provincial medical directorate of a neighboring province was very impressed with the work of the peer educators. Members of the City Councils of Harare and Chitungwiza, Zimbabwe's capital and third city, respectively, also came to learn from the subproject. The mayor and others from Birmingham, Alabama, Gweru's sister city, had the opportunity to discuss with the peer educators the problems facing Zimbabwean youth.

Outcomes: A Preliminary Picture

An endline survey gathered information from a sample of 606 never-married youth aged 12 to 24.⁶ Compared to the baseline survey sample, the endline survey sample had: more males (58 percent versus 50 percent); more in-school youth (52 percent versus 38 percent); and more recently employed youth (22 percent versus 16 percent) (Moyo et al. 1999).

⁶At the time of publication, analysis of endline survey results was very preliminary. A full report is forthcoming and will be available on the SEATS' website: www.seats.jsi.com

No more than one in five respondents had made use of any of the services developed and offered by the subproject: 20 percent had been to a clinic for a reproductive health matter, although not all had made their visit within the last six months; 9 percent had been to a Youth Corner at a clinic, and 12 percent reported they had met with a peer educator in the community and discussed an issue of concern (Moyo et al. 1999).

Young people's knowledge of the facts remained high at endline, although knowledge of specific contraceptives decreased slightly for all methods except safe period (period abstinence) and withdrawal. There were some increases in practical knowledge, although the changes varied by gender, topic, and age (see Table 2) (Moyo et al. 1999).

Table 2. Percent of Respondents With Basic Reproductive Health Knowledge by Selected Background Characteristics

Percent who knew:	Baseline	Endline
When during cycle a woman becomes pregnant		
Total	10	28
Males	n/a	33
Females	10	21
12-14 years	0	14
15-17 years	18	25
18-20 years	11	37
21-24 years	4	35
Can girl get pregnant if she has sex standing up		
Total	59	55
Males	59	65
Females	58	43
12-14 years	30	26
15-17 years	61	53
18-20 years	69	68
21-24 years	65	67
Girl can get pregnant if boy withdraws before ejaculation		
Total	22	20
Males	38	24
Females	6	14
12-14 years	13	10
15-17 years	29	19
18-20 years	16	25
21-24 years	31	22



Visits from outsiders bolstered the morale of peer educators and subproject staff.

Table 3. Percent of Respondents Agreeing With Condom Use Statements by Selected Background Characteristics

Percent who agreed with statement	Baseline	Endline
A girl who carries condoms in her purse is responsible		
Total	71	45
Males	60	46
Females	82	43
12-14 years	58	50
15-17 years	76	44
18-20 years	73	40
21-24 years	75	50
Using condoms is difficult because it looks like I planned to have sex		
Total	44	42
Males	38	41
Females	50	43
12-14 years	45	32
15-17 years	53	42
18-20 years	36	45
21-24 years	42	41
Using condoms reduces sexual pleasure		
Total	30	17
Males	27	30
Females	34	6
12-14 years	32	11
15-17 years	31	12
18-20 years	31	23
21-24 years	27	27
When a relationship moves from casual to serious, it is no longer necessary to use a condom		
Total	29	17
Males	31	20
Females	27	13
12-14 years	38	17
15-17 years	30	16
18-20 years	26	15
21-24 years	35	27
A woman would lose a man's respect if she requested him to use a condom		
Total	36	37
Males	38	44
Females	34	26
12-14 years	21	27
15-17 years	50	31
18-20 years	36	45
21-24 years	35	47

Attitudes toward the condom and condom use tended to be more favorable at endline, although young women's attitudes showed more consistent positive changes over baseline. In addition, younger adolescents seemed to be more approving of condom use than older youth (see Table 3) (Moyo et al. 1999).

Friends and teachers continued to be the people with whom young people most frequently discussed matters related to reproductive health. A few youth mentioned peer educators as the most frequent discussant for topics related to sexuality—sexual urges, whether it is possible to have fun in a relationship without having sex, and body changes during puberty. Compared to the baseline, youth reported discussing certain topics more often: body changes during puberty, relationships with the opposite sex, how to use condoms, and where to get condoms. Unwanted pregnancies or abortion was a topic much less frequently discussed (Moyo et al. 1999).

Parents were also asked about their awareness and opinions of the Gweru youth program. Only 6 percent said they knew of the city program. Of these, 37 percent had participated in a meeting, and all had positive views of the program (Moyo et al. 1999).

Although the activities of the subproject did not directly reach large portions of the population of Gweru, together they helped create a climate of support for young people and their reproductive health. The Gweru City Council committed to sustaining youth-friendly services in its clinics. After several months on the job, two peer educators described their experiences at a meeting of the staff of several SEATS II subprojects in Zimbabwe. As they confidently told about young people's hunger for information on sexuality, the popularity of the youth consultation rooms, and their own need for more knowledge, skills, and resources in order to address the many concerns their peers bring to them, the Mayor of Gweru's wide smile revealed his pride in these youth and their work.

Albania: Ensuring Young People's Reproductive Rights

When SEATS II began working in Albania in 1996, family planning had been legal for less than four years. Sexually active women of all ages relied heavily on abortion as a family planning method. FGDs, conducted by the MOH and the Albania Family Planning Association (AFPA) with support from SEATS II, revealed that most women were unfamiliar with the concept of family planning and had little knowledge of modern contraceptive methods. This was not the case with university students. These young, unmarried women aged 18 to 24 had very



photo by Enilda Gorishti

Albania: Subproject Overview

Dates: January 1996 to
December 1999

SEATS' counterparts: MOH and Albania Family
Planning Association (AFPA)

- ✓ Qualitative research revealed youth concerns
- ✓ Trained providers offer youth-friendly reproductive health counseling and services
- ✓ Increased range of contraceptive options for young people
- ✓ IEC materials developed
- ✓ Collaboration with Aksion Plus (PSI), Marie Stopes International, Albanian Youth Forum, Student Organization for Sex Education, National AIDS Control Program

positive perceptions of family planning—"a basic human right"—and were aware of OCs, injections, and condoms, although they shared with the older and married women concerns about contraceptive safety (Gorishti and Haffey 1997).

These young women also reported that many of their peers were not as knowledgeable as they were. They said that all youth, especially girls, needed more sexuality information, because they often initiated sexual activity without an understanding of the possible negative consequences. Their peers were said to have little concern about STDs and HIV/AIDS, as the youth they knew felt less vulnerable to these health threats. "Pregnancy is the primary thing, even when they speak of the condom. AIDS for them is not dangerous because they think it is difficult to get [infected]" (Gorishti and Haffey 1997).

Despite young people's need for information and services, and the availability of services in the local maternity hospital, the young women said the intimidating nature of the facility and the negative staff attitudes created formidable barriers to access. "Even if we have a disease, we don't go there" (Gorishti and Haffey 1997).

As part of its overall response to the needs of all Albanian women of reproductive age, SEATS II worked with the MOH and AFPA to improve the availability of and access to quality reproductive health services in the public and private sectors. The establishment of youth-friendly reproductive health services outside the maternity hospital setting was particularly important. Service providers working in MOH and AFPA facilities received training in interpersonal communication and counseling, which included issues specific to young people. A variety of print materials—the medium preferred by both young and old in this literate society because it permits the reader to refer to it in private and when needed—on family planning, contraception, and other reproductive health topics was produced. Many of these materials were distributed in collaboration with PSI and reached young people through condom social marketing outlets. SEATS II did not track individuals reached and clients served by age, so determining to what extent young people benefitted from these improvements was impossible. Nevertheless, staff reported that young people were voracious readers of the print materials and increasingly made use of reproductive health services.

Recognizing the need to reach even greater numbers of youth, a consortium of youth-serving agencies approached SEATS II in late 1997 and requested technical assistance and support to improve outreach efforts. Consortium members, including the Student Organization for Sex Education, the AFPA Youth Group, the Albanian Youth Forum, and Aksion Plus, agreed to work together to train and supervise peer educators, produce and distribute youth-oriented materials, and coordinate referrals to services. The National AIDS Control Program was asked to join the effort. Unfortunately, the current security situation in Albania limited SEATS' ability to provide technical assistance to this youth initiative that could further contribute to making Albanian young people's conviction of their reproductive rights a reality.

Russia: The Client-Centered Approach Addresses Young People's Needs

The first time health administrators and service providers in Primorsky Krai, in Russia's Far East with Vladivostok as its capital, and Novosibirsk Oblast, in Western Siberia in the geographical center of Russia, heard about the client-centered approach to reproductive health services, they were skeptical about its relevance and value. They expressed doubt about clients' desire for information, their concern for privacy and physical comfort, and their ability to play an active role in reproductive health decision making. Nevertheless, data from other countries raised interest in finding out more about client perspectives, and the health officials and providers endorsed a small qualitative study to explore clients' preferences, expectations, and levels of satisfaction with existing reproductive health services. In each site, findings from FGDs with specific client groups—women, postpartum women, husbands of postpartum women, and sexually active young women between the ages of 15 and 20—were used to inform policy decisions, design or modify training curricula, and reconfigure service delivery.

Russia: Subproject Overview

Dates: January 1996 to December 1997

SEATS' counterparts: Department of Health Services, Primorsky Krai Administration, and Novosibirsk Oblast Department of Public Health

- ✓ Qualitative research revealed youth concerns
- ✓ Facility-specific action plans to apply client-centered approach to information and services for youth. Interventions included:
 - Outreach to schools and parents
 - Clinic and center renovations/design modifications to increase youth comfort
 - Private counseling rooms and IEC/meeting rooms
 - Condom promotion/STD prevention
 - Clinical services for youth
 - Exit interviews with youth clients
- ✓ Increased range of contraceptive options for young people
- ✓ Provider commitment to youth reproductive rights
- ✓ Decrease in abortions among women under 18
- ✓ Collaboration with MotherCare, AVSC International, JHPIEGO Corporation, JHU/CCP, Centers for Disease

Service providers attitudes and qualifications had the greatest influence on young women's opinions about the quality of services at the women's consultations—outpatient clinics providing gynecological, infertility, and limited contraceptive services. Young women generally viewed physicians as attentive, thorough, and sincere, in contrast to their negative perceptions of nurses, midwives, and administrative staff. "They [the latter] consider all the girls they see as potentially hopeless." "...She shouted at me: 'So young, and already almost a whore'. . . . I refused to go there again." Adult participants in the other FGDs often reflected similar sentiments about young people, calling them irresponsible and accusing them of becoming sexually active without the maturity to make decisions about contraception. Ironically, the young women were the only FGD participants to report making preventive visits to the consultations to seek protection from unwanted pregnancy. They also held the most positive attitudes toward hormonal contraception and condoms, and no other group brought up the importance of protection from both unwanted pregnancy and STDs (JSI/SEATS et al. 1998).

The young women also expressed the strongest desire for more knowledge about reproductive health. "There will never be enough. I know almost nothing about myself. You learn and learn." They requested more and better sex education in schools. "They told us that you will find out all about [pregnancy] from your parents and from the newspapers but we cannot teach that in school." All FGD participants highlighted the need to begin sex education at an early age and the special role of the family in this process. At the same time, most admitted that open communication and mutual understanding between parents and their children about sex-related issues were more the exception than the rule (JSI/SEATS et al. 1998).



photo by Joan Haffey

Acting to Promote Youth Reproductive Rights

Findings such as these, coupled with training in clinical and counseling skills for reproductive health, were fundamental to creating awareness of the special concerns of youth and shaped the action plans of each of the 12 pilot clinics and health facilities participating in the joint SEATS/MotherCare subproject to expand access to, availability, and use of high-quality, sustainable modern contraception and reproductive health services in Primorsky Krai and Novosibirsk Oblast. The subproject was part of the USAID/Russia Women's Reproductive Health Project, which aimed to decrease Russia's high rates of maternal mortality and morbidity by increasing use of modern contraception as an alternative to repeat abortion. The emphasis placed on youth varied from facility to facility, although Novosibirsk Oblast included a youth-specific objective in its oblastwide family planning program. Most sites focused on outreach and support for parents and school teachers, and several also paid special attention to improving services for youth. The cases below exemplify the variety of changes health services made to address youth needs.

The women's consultation in Kuybyshev, a city in Novosibirsk Oblast, began to attract women, men, and youth from the town, the region, and even neighboring oblasts. The renovated cellar of the building with its pharmacy, an IEC/meeting area, and a private counseling corner were evidence of the attention given to client comfort and convenience. The new outreach program to secondary school teachers and parents was very popular. School classes visited the IEC room to learn about sexuality and contraception, and staff reported that often one class waited on the clinic lawn while a second class received education inside. Mothers brought their daughters to the center for a range of services. Officials from the neighboring city of Barabinsk asked the center to assist in serving youth from that city.

In Berdsk, also in Novosibirsk, the adolescent health center *Unona* ("you know") undertook a range of efforts in cooperation with the Department of Education and with the strong support of municipal authorities. The "School for Family Life Training" for grades 7 through 10 operated in all 13 city schools. Classes from kindergarten onward received health education, including sex education, with age-appropriate materials and content. A "School for Young Mothers" offered counseling on breastfeeding and LAM. The center's youth program actively promoted condom use and STD prevention, purchasing condoms locally and supplying them free of charge to young people. A survey of 338 adolescent users of the center identified clients' knowledge and attitudes about contraception, STDs, and center services (Chernyakina 1997).

The Client-Centered Approach

The client-centered approach refers to the organization and delivery of reproductive health services that take into account (a) knowing and meeting the needs and expectations of clients and ensuring client satisfaction and (b) ensuring the high performance of programs and service providers according to up-to-date clinical standards.

SOURCE: JSI/SEATS et al. 1998.



Russian Providers Speak About Youth Rights

“The attitudes of health personnel have changed. . . [the] client-friendly approach means interesting discussions with young people about their problems, and doing this professionally, candidly, tactfully, and truthfully.”

“The client can enjoy her RIGHTS at last! . . . to improve the quality of services, to create a comfortable environment, and to ensure confidentiality are particularly important for counseling adolescents. . . that is, to provide for the clients’ rights.”

SOURCES: Chernyakina 1997; Makiyan 1997.

The center’s branch counseling room, managed by the deputy mayor in charge of health care and next to the city’s marriage registration office, became a mandatory stopping point for all couples about to be married. In this city, the number of abortions among women under 18 decreased almost 25 percent during the first year of the subproject (see box).

Centers in Primorsky Krai also took steps to make services more youth-friendly. In the new Ussuriysk Family Planning Center, house plants, large and colorful posters on the walls, and a donated TV and VCR made the center more comfortable to young people. A gynecologist specializing in adolescents worked part-time there. The local Youth Affairs Committee in Lesozavodsk supported the renovation of its Youth Center, including a music room, a computer room, and a family planning clinic, staffed by trained providers from the Women’s Consultation. In addition to youth-friendly service improvements, reproductive health education was introduced into 20 high schools in the krai.

Providers at all sites endorsed the value of the client-centered approach in their all work, and work with youth in particular (see box). The participatory techniques used in their training sessions were successfully applied to IEC efforts. “We changed to your methods. . . We divided them into small groups and had discussion, video, participation. . . we had a completely different result. . . some young couples came forward for more information or to have counseling or to receive a contraceptive method.”

Although the subproject FLE, counseling, and services for young people generally enjoyed a great deal of support from local political authorities, religious opposition—fueled by the “right to life movement” originating in the United States—to family planning in general and youth services in particular was on the increase. For example, a conservative member of the Novosibirsk Municipal Council denounced a youth reproductive health center, claiming it was “seducing children.” In this case, he publicly retracted his opposition after he visited the center. For the most part, providers and managers were perplexed and unprepared to address constructively the criticisms and negative messages surrounding youth reproductive health. Without support and assistance in dealing with the growing opposition, the ability of these and other centers to continue to serve this vulnerable population will be greatly diminished.

Cambodia: Expanding the Reach of Peer Educators

The Reproductive Health Association of Cambodia (RHAC) was established as a national NGO in 1996 just two years after the Government of Cambodia initiated the National Birth Spacing Program. A year later, RHAC staff, volunteers, and other stakeholders in reproductive health held a strategic planning workshop in which they identified youth as a priority for future RHAC programs. Data from RHAC projects reinforced the staff's observations about the need to reach this population with appropriate information and services. Traditional social norms condemn sexual activity before marriage; yet young, unmarried women were known to seek abortion from unqualified providers. Unmet need for contraception among married women was high and likely to be much higher among the unmarried. The commercial sex industry was growing, particularly in towns and cities, as national reconstruction efforts attracted many migrant workers and day laborers. Many commercial sex workers (CSWs) were young women. It is estimated that 90 percent of the approximately 120,000 HIV-positive individuals in Cambodia are between the ages of 15 and 35.

Because of the newness of reproductive health information and services in general, accompanied by the sensitivities surrounding young adult reproductive health, RHAC decided to test the applicability of peer education in the Cambodian context through a pilot project in Sihanoukville, the largest port in Cambodia. RHAC's HIV/AIDS prevention programs there led to the selection of this city; almost 6 percent of all clients and 52 percent of the CSWs visiting the RHAC clinic were HIV-positive. SEATS II provided financial support for the in-country costs of the pilot phase, but the technical expertise came largely from within RHAC.

Cambodia: Subproject Overview

Dates: January 1997 to September 1998

Target population: Youth 12 to 25 in one city (pilot phase) with expansion to three other cities

SEATS' counterpart: Reproductive Health Association of Cambodia (RHAC)

- ✓ Advisory Committee: local government, schools, and youth
- ✓ 47 peer counselors (high school students), 7 teachers trained
- ✓ 2,000 youth reached
- ✓ Links and referrals to reproductive health services established
- ✓ \$700,000 additional donor funding to expand program
- ✓ Expansion to additional cities includes:
 - IEC materials development
 - Clinical services: Youth Centers in existing clinics
 - MIS to track client visits, referrals, outreach
 - Baseline and postintervention surveys
- ✓ Collaboration with Department of Health, Department of Education, Youth, and Sports, UNFPA, FOCUS



RHAC

“Quiz shows” organized by the peer educators brought together as many as 1,000 youth who participated in games and other activities to raise reproductive health awareness.

Before the subproject began, RHAC formed an informal Advisory Group, composed of RHAC staff, officials from the municipal Department of Health, representatives from the Department of Education, Youth, and Sports, and young people. The Advisory Group worked closely with RHAC throughout the pilot phase, helping to ensure community acceptance and support. For example, the Advisory Group recommended appropriate topics for the peer educator training curriculum and outreach activities. The two government departments subsequently approved the curriculum with only minor changes.

A workshop to train 23 students (12 young women and 11 young men) from Sihanoukville High School as peer educators and eight teachers launched activities in July 1997. An additional 24 peer educators from the high school in Khan Prey Nop, a district of Sihanoukville, received training over the next 15 months, and 12 of the original group received refresher training. RHAC staff and the teachers supported the peer educators as they conducted group education sessions in schools and in communities and reached more than 2,000 youth with verbal and print information on unwanted pregnancy and its prevention, contraceptive methods, STD and HIV transmission and prevention, reproductive rights, and safe motherhood. “Quiz shows” organized by the peer educators brought together as many as 1,000 youth who participated in games and other activities to raise reproductive health awareness. The peer educators referred youth in need of services or contraception to RHAC clinics or community-based distribution agents, as RHAC was reluctant to allow the peer educators to distribute condoms or other contraceptive commodities.

Expansion to Other Cities

The positive response by government, youth, and teachers to the pilot phase and the requests to expand activities satisfied RHAC that peer education was feasible in Cambodian cities. RHAC received recognition as a national leader in adolescent reproductive health. RHAC also recognized that it needed additional technical expertise in young people’s reproductive health programming. With specific technical skills, RHAC believed it could avoid some problems it encountered in the pilot phase. Attrition among the peer educators was high, the peer educators’ communication skills were weak, and their training focused more on content (the facts) than process (effectively delivering the facts). Out-of-school youth proved hard to reach. Although the peer educators were linked to RHAC clinics, the service providers did not receive any orientation in youth-friendly service delivery. The lack of a formal supervisory system and limited monitoring and evaluation hindered RHAC’s ability to describe subproject outcomes.

Building on the experiences and lessons learned from the pilot project, in late 1998 RHAC received a three-year, \$700,000 grant from the European Union through UNFPA to expand peer education to Phnom Penh, the capital, Battambang, and Kampong Cham. SEATS II, in collaboration with other CAs such as FOCUS, provided technical expertise in a range of areas, including the establishment of Youth Centers within RHAC clinics; improvements in peer educator recruitment, training, and supervision; development of IEC materials; implementation of an MIS; and baseline and postimplementation surveys.

By mid-1999, 281 trained peer educators were active, reaching 6,150 young people. Four RHAC clinics were providing clinical services to young people, including 1,145 contraceptive clients and 1,705 STD clients. More than 6,000 youth visited the RHAC libraries to obtain information on reproductive health.

The efforts of RHAC, complemented by those of the Government of Cambodia and six other national NGOs working to improve youth reproductive health, stand to make an important contribution toward RHAC's goal of improved quality of life for all Cambodians.



RHAC

By mid-1999, 281 trained peer educators were active, reaching 6,150 young people.

Lessons Learned

The observations drawn directly from SEATS' experience with youth reproductive health offer some new knowledge and insight on program design and management. Because SEATS' youth-oriented subprojects and activities began with the premise that drawing upon lessons learned from its own and others' efforts is the most likely pathway to success, the discussion below tries not to repeat what has already been established by others (e.g., youth involvement is essential). Instead, it focuses on what worked and what did not work as SEATS carried out its broad, flexible mandate to improve health services for youth while simultaneously applying a range of documented best practices and testing new approaches.

- ✦ **Comprehensive, multiple-intervention approaches can meet the needs of many audiences.** Field realities—from lack of data to political expediency—often did not permit subprojects to pinpoint a specific target group with regard to age, marital status, gender, and sexual activity, a program practice suggested by some experts (Hughes and McCauley 1998). SEATS found that multifaceted subprojects combining primary prevention with primary care and parental and community involvement were able to reach many subgroups of young people with unmet needs as well as adults. For example, other programs in Africa have found that peer educators are more effective in reaching males and in-school youth than females and out-of-school youth (Herdman 1999). SEATS subprojects in Zambia and Zimbabwe were able to reach all four of these groups.
- ✦ **Addressing the special needs of young people does not require starting with a separate project or intervention targeting youth.** SEATS II's Urban Initiative and the application of client-centered approaches to quality improvement demonstrated that a focus on quality of care can lead programs to recognize the benefits of ensuring access to safe, comprehensive, and high-quality services to all individuals at any stage in the life cycle. These approaches did not have a mandate to start with youth. Instead, they encouraged stakeholders to identify priority groups and actions for improving access and quality, based on available data. Almost always, youth emerged as an underserved group with special needs,

and appropriate interventions followed. In Zambia and Zimbabwe, existing subprojects were expanded to integrate interventions that addressed the special needs of young people.

- ✦ **Flexible, multisectoral, process-oriented interventions incorporate many of the documented “best practices” for improving youth reproductive health.** Approaches such as CQI, EQUIPE, the Urban Initiative, and PLA brought together multiple stakeholders (e.g., providers, youth, parents, and local leaders) from multiple sectors (e.g., health, education, recreation) and involved them in defining, assessing, and ensuring quality of care and creating support for youth reproductive health efforts. These flexible and participatory models allowed subprojects to adjust to realities and newly recognized needs as they arose. They were also well-suited to settings where decentralization policies require local entities to take responsibility for the provision of integrated health care.
- ✦ **The willingness to pioneer new ventures in reproductive health services for young people is not exclusive to the private sector.** The predominance of NGOs in the delivery of reproductive health services to young people has led some to conclude that governments are unwilling to offer services to this population. The experiences in Russia, Senegal, Zambia, and Zimbabwe demonstrated that local governments are eager to take on the challenge and test innovative approaches.
- ✦ **Data can be very persuasive in motivating parents and the community to support youth reproductive health initiatives.** Sharing the findings of formative research or existing data with parents, politicians, local leaders, and service providers allowed these “gatekeepers” to appreciate the urgency and magnitude of reproductive health problems among their communities’ youth and was critical to overcoming initial opposition.
- ✦ **Basic human rights—clients’ rights and reproductive rights—are a compelling rationale for offering reproductive health education and services to young people.** Providers, clients, and young people in Albania and Russia often came to share the conviction that access to quality reproductive health services was the right of people of all ages. In these countries, the concept of rights clearly served as the basis for ensuring that efforts to improve and expand services incorpo-

rated the special needs and concerns of youth. In Cambodia, reproductive rights were a specific theme of peer educators' outreach activities.

- ✦ **Young people and service providers demand integrated reproductive health interventions.** Youth and service providers in SEATS subprojects wanted a comprehensive package of interventions to prevent and address the adverse risks associated with early, unwanted, and unprotected sexual activity.
- ✦ **Integrated reproductive health services that include STD prevention and screening can attract young men.** In most countries, the availability of STD prevention and treatment was the magnet that drew young men into the program—not an interest in family planning or other reproductive health issues. Once young men were “in the door” (or in a community educational setting), they had the opportunity to learn more about other reproductive health issues.
- ✦ **Health centers can be reconfigured to attract youth seeking information and counseling as well as services.** Before SEATS' interventions, few youth cited health care providers or clinics as a source of information on reproductive health, and clinics were considered the resource of last resort for curative services. When clinical settings have trained providers, a welcoming environment, educational materials and resources, and reassuring promotion, youth will visit them for information as well as services. In fact, in some countries, such as Burkina Faso and Eritrea, more youth came to facilities to learn about reproductive health than they did to seek services. Despite the willingness to make changes to better accommodate youth, modifying clinic operations to include evening and weekend opening hours proved to be difficult in many countries.
- ✦ **Offering reproductive health information and services in nonclinical settings such as Youth Centers can also attract youth who may have otherwise avoided a health facility.** In Eritrea, Senegal, and Zimbabwe, reproductive health services were linked with recreational and educational activities offered in multipurpose centers, making it easier for young people to unobtrusively or casually seek assistance. In most other countries, youth, their parents, and project staff urged programs to consider adding nonhealth components.

- ✦ **A “champion” for youth within a clinical setting can help maintain a youth-friendly environment.** In Zambia, the presence of an enthusiastic, outspoken advocate for youth helped overcome other providers’ antagonism to some of the changes required to make the service youth-friendly.
- ✦ **The costs associated with referral services are a barrier to access.** Although all SEATS’ counterparts took care to ensure free or affordable commodities and services at the sites directly involved in the subproject, the costs of services at referral sites and/or the costs of transportation to reach the referral site prevented many young people from obtaining complete and adequate care.
- ✦ **Young people also prefer contraceptive method choices.** An axiom of quality of care is the provision of a range of contraceptive methods. Yet, services for young people often focus heavily or exclusively on nonprescriptive methods (barrier methods and sometimes OCs). The subprojects that were able to offer a wide variety of methods on-site demonstrated that young people appreciate choice as much as older women and men.
- ✦ **Programs require support, advice, and assistance in addressing community resistance and opposition to youth reproductive health interventions.** From the inability of NUEYS in Eritrea to create a community advisory board to the peer educators in Senegal who were uncomfortable working in their own neighborhoods to the confusion of service providers in Russia over attacks by “right-to-life” groups, subproject staff were often unprepared to deal with criticism and condemnation of subproject activities.
- ✦ **In most settings, peer education is a culturally and politically feasible approach to reaching young men and women, in-school and out-of-school youth with information, condoms, and spermicides.** Only in Senegal did the peer educators report that they encountered hostilities in the community, and it is possible that this might have been overcome with more intensive community mobilization and greater support for the peer educators. In Cambodia, staff were unwilling to allow the peer educators to distribute commodities. Although peer educators are accepted, data on their effectiveness in changing knowledge, attitudes, and behaviors and in reaching younger youth (10- to 14-year-olds) are lacking.

✦ **Identifying a sustainable and appropriate package of compensation and incentives for peer educators is complicated.**

Unemployment was often a key factor contributing to young people's decisions to become peer educators, and once they found paying jobs, they left the subprojects. Peer educators were often unhappy with the limited allowances they received. On the other hand, offering wages was neither feasible nor acceptable, and in Zambia, local government authorities urged the subproject to discontinue the allowances. Providing refresher trainings, offering visits to other program sites, delegating responsibility for data collection and compilation, and encouraging the peer educators to raise their own funds were some of the solutions that came out of Zambia.

✦ **Peer educators can be very resourceful fundraisers.** The success of the Zambian peer educators in raising money to support their activities is evidence of young people's talents and energy. Need was not the only factor driving these youth. Their supervisor's trust in their abilities and willingness to let them take the lead were important motivators.

✦ **Adult-friendly programming may be as important as youth-friendly services.** The key to parental and community support in many subprojects was a welcoming attitude toward parental input and involvement in the activities. Inviting parents to visit subproject sites helped overcome their suspicion and gain their approval.

✦ **Young people can be effective agents for eradication of harmful "traditional" practices.** In many countries, youth were more at ease than adults in challenging reproductive health practices shaped by cultural traditions and gender norms such as FGM.

✦ **Standard family planning and reproductive health monitoring indicators do not capture the results of youth projects.** SEATS' youth reproductive health subprojects aimed to reach young people who were not sexually active as well as those who were. Measures such as couples years of protection, contraceptive prevalence, and numbers of clients for different clinical services do not provide information on health-protecting attitudes and behaviors such as self-efficacy, abstinence, or the delay of sexual activity. Other indicators such as percentage of youth who feel they could seek reproductive health information and services if they need them and

percentage of families who support their children's access to information and services may provide a better picture of the outcomes of activities aimed at promoting young people's reproductive health.⁷

- ✦ **Evidence of sexual activity among girls 12 and younger points to the need to develop appropriate interventions targeting this age group.** Although Zambia was the only country where subproject data found that very young girls were engaging in sexual intercourse, this age group is largely overlooked by current reproductive health programming.
- ✦ **The sensitivity surrounding reproductive health services for young people is not an insurmountable barrier to demonstrating their feasibility.** In settings where there is great hesitancy to initiate any programming for young adult reproductive health, moving forward with implementation breaks down many barriers and sets the stage for more efficient programming of evaluation and other resources. Changing social norms and the perception of those norms, particularly those surrounding sexual relationships and activity, can take much longer than a subproject life span. Nevertheless, by initiating open dialogue about youth reproductive health among parents, health providers, community members, and youth, subprojects can set in motion a process of lasting change.

In March 1999, delegates from 177 nations at the Hague Forum on ICPD+5 approved a report reviewing progress in implementing the Programme of Action of ICPD. The report reiterated the needs to improve young people's access to appropriate information and services and to increase political commitment to adolescents' right to reproductive health. But it also pointed out that adolescent reproductive health issues are now on the public agenda and praised those countries where young people now have the right to confidentiality and privacy in service delivery (UNFPA 1999). The staff of SEATS II and its many counterparts and collaborators are proud to have contributed to making this right a reality.

⁷The forthcoming FOCUS publication *A guide to monitoring and evaluating adolescent reproductive health programs* (Adamchak et al. in press) provides useful guidance on measuring the results of youth reproductive health programs.

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