

**Sexual and Reproductive Health Needs of  
Adolescents' and programmes response  
towards these Needs in Tanzania.**

**Lemmy Medard Mabuga  
Tanzania**

**44<sup>th</sup> International Course in Health Development  
September 25, 2007- September 14, 2008**

**KIT (ROYAL TROPICAL INSTITUTE)  
Development Policy & Practice/  
Vrije Universiteit Amsterdam**

# **Sexual and Reproductive Health Needs of Adolescents and programmes' response towards these Needs in Tanzania.**

A thesis submitted in partial fulfilment of the requirement for the degree of  
Master of Public Health

By

Lemmy Medard Mabuga

Tanzania

Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.  
The thesis, " Sexual and Reproductive Health Needs of Adolescents' and programmes response towards these Needs in Tanzania." is my own work.

44<sup>th</sup> International Course in Health Development (ICHHD)  
September 25, 2006 – September 14, 2007  
KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam  
Amsterdam, The Netherlands

September 2008

Organised by:

KIT (Royal Tropical Institute), Development Policy & Practice  
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU)  
Amsterdam, The Netherlands



## Table of Contents

List of Figures and Tables .....	V
List of Abbreviations .....	VI
Acknowledgments .....	VIII
Abstract.....	X
Introduction.....	12
Chapter One: Tanzania Country profile.....	16
1.1. Socio - Demographic characteristics.....	16
1.2. Education .....	17
1.3 Economic profile .....	17
1.4 Adolescents Sexual and Reproductive health issues.....	18
1.4.1 Family planning services .....	18
1.4.2 HIV/AIDS among adolescents and its impact on adolescents lives	19
1.4.3 STIs among adolescents.....	20
1.4.4 Female Genital Mutilation (FGM).....	21
1.5 Health policy.....	21
1.6 Health Care System .....	22
Chapter Two .....	23
2.2. PURPOSE AND STRUCTURE OF THE THESIS .....	24
2.3. General Objectives .....	25
2.4. Specific objectives.....	25
2.5. Methodology of the study.....	26
Chapter Three.....	27
3.1. Adolescent’s sexual and reproductive health practices and problems... 27	
3.2. Premarital sexual activity .....	27
3.3. Age of marriage.....	28
3.4 Contraceptives among adolescents and a need for contraceptives services .....	29
3.5 Other adolescent’s sexual and reproductive health worries .....	30
3.6 Female Genital Mutilation (FGM).....	30
3.7 Source of Sexual and reproductive health information.....	31
Chapter Four .....	33
4.1. Factors contributing to premarital sex and early age of marriage..... 33	
4.1.1 Changes in social context .....	33
4.1.2 Rising age at marriage coupled with decline age at menarche .....	33
4.1.3 Poverty and greed for material things .....	33
4.1.4 Sexual abuse and coercion.....	34
4.1.5 Tradition and cultural practice .....	35
4.1.6 Gender roles.....	36
4.1.7 Value for virginity.....	36
4.2 Consequences of unprotected sex and early marriages.....	37
4.2.1 Early pregnancy and child bearing .....	37
4.2.2 Sexually transmitted infection (STIs) and HIV.....	37
4.2.3 Unwanted pregnancies and unsafe abortion .....	38

4.3 Adolescent's sexual and reproductive health needs.....	39
4.3.1 <i>Accurate information</i> .....	40
4.3.2 <i>Life skills</i> .....	41
4.3.3 <i>Acceptable and affordable health services including counseling</i> .....	41
4.3.4 <i>Safe and supportive environment</i> .....	41
Chapter Five.....	43
Policy and programme Response towards adolescents sexual and reproductive needs.....	43
5.1. Policies and laws affecting ASRH in Tanzania.....	43
5.1.1 <i>HIV policy</i> .....	43
5.1.2 <i>Reproductive and Child Health Policy</i> .....	44
5.1.3 <i>User fee policy</i> .....	44
5.1.4 <i>Education Policy</i> .....	45
5.1.5 <i>Age of consent for sexual activity</i> .....	45
5.1.6 <i>Age of consent for Marriage</i> .....	45
5.2 Response from the Africa Youth Alliance (AFHS) .....	45
5.2.1 <i>Targeted population</i> .....	46
5.3 AYA approach for implementing AFHS.....	46
5.3.1 <i>Needs assessment</i> .....	46
5.3.2 <i>Health provider's characteristics</i> .....	47
5.3.3 <i>Health facility characteristics</i> .....	47
5.3.4 <i>Programme design characteristics</i> .....	48
5.3.6 <i>Achievements of AYA programme</i> .....	48
5.3.7 <i>Challenges faced by AYA programme</i> .....	48
5.3.8 <i>Lesson learned in provision of AFHS</i> .....	49
5.4 MEMA kwa Vijana Programme – multiple component.....	49
5.4.1 <i>MEMA Kwa Vijana phase 2 Approach</i> .....	49
5.4.2 <i>Sexual health</i> .....	49
5.4.3 <i>Youth friendly services</i> .....	50
5.4.4 <i>Community intervention</i> .....	50
5.4.5 <i>Success of MkV2 Programme</i> .....	50
5.5 ISHI campaign – mass media .....	50
5.5.1 <i>ISHI approach</i> .....	51
5.5.2 <i>Success of ISHI campaign</i> .....	51
5.5.3 <i>Factors contributing to ISHI success</i> .....	52
5.5.4 <i>Challenges faced</i> .....	52
5.5.5 <i>Lesson learnt by ISHI campaign</i> .....	52
5.6 Discussion of the policies and programme approaches to meet adolescents' SRH needs.....	53
5.6.1 <i>Adolescent's policies</i> .....	53
5.6.2 <i>Use of existing structures, and expands on what is already done</i> .	54
5.6.3 <i>Use of Multi sector response</i> .....	55
5.6.4 <i>Community and parent's involvement</i> .....	56
5.6.5 <i>Diverse groups of adolescents</i> .....	56

5.6.6 programme evaluation .....	57
Chapter six: Conclusions and Recommendations.....	58
6.1. Conclusions .....	58
6.2 Recommendations.....	59
References .....	60
Annex 1: Map of Tanzania.....	66
Annex 2: Standards of adolescent friendly reproductive health services. ....	67

### **List of Figures and Tables**

Table 1: Prevalence of FGM by ethnic groups and region.....	21
Figure 3: Percentage of adolescents (aged 15-19) enagaging in sexual activity before age 15.....	27
Figure 3: Percent reporting use of condom at first sex by age at first sex and gender. ....	30
Map of Tanzania.....	66

## List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AFHS	Adolescents Friendly Health Services
AMREF	African Medical Research Foundation
ARV	Anti Retro Viral
ASRH	Adolescents Sexual and Reproductive Health
AYA	Africa Youth Alliance
CBOs	Community Based Organisations
CHMT	Council Health Management Team
FBOs	Faith Based Organisation
FGM	Female Genital Mutilation
GNP	Gross National Product
HIV	Human Immune Virus
IEC	Information Education and Communication
ILO	International Labour Organization
MIS	Management of Information System
MoE&VT	Ministry of Education and Vocational Training
MoH&SW	Ministry of Health and Social Welfare
MoLY&SD	Ministry of Labour Youth and Sports Development
NBS	National Bureau of Statistics
NGOs	Non Governmental Organisation
NIMR	National Institute for Medical Research
PATH	Program for Appropriate Technology in Health
PMTCT	Prevention from Mother to Child Transmission
RCHS	Reproductive Child Health Services
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic Health Surveys
UNDP	United Nation Development Programme
UPE	Universal Primary Education
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services





## **Acknowledgments**

I thank GOD for the good health, strength and this opportunity to attend this course.

I would like to express my deep and heartfelt appreciation to my thesis advisor and my thesis back stopper who have tirelessly worked with me throughout this undertaking.

Special thanks to the ICHD course coordinators, Prisca, Yme and Sanjoy, I greatly appreciate your guidance and support provided throughout this course.

I would also like to thank the course secretary Rinia for the guidance and logistic support during the course

Many thanks to NUFFIC. This course would not have been possible without your financial support.

I would also like to thank the 44<sup>th</sup> ICHD colleagues. You have been as a family to me. I have learn a lot from this diverse background of participants

My sincere appreciation is also extended to my mother in law who took a good care of my children during my absence. May God bless you!

I also thank my children, Nadine and Jeremy for their flexibility and patients during the year. I felt your support and motivation every time when I talked to you through phone, and through posting me lovely letters.

Lastly, I would like thank my family, especially my mother who kept on encouraging me throughout this course.



## **Abstract**

### **Introduction**

Adolescence in Tanzania like in many other Sub-Saharan Countries face a number of Sexual and Reproductive Health (SRH) problems. Different initiatives respond to the SRH needs of adolescents. There is a need to relate the programme approaches and the SRH needs of adolescents.

### **Method**

Literature from Tanzania, Sub-Saharan and other developing countries was reviewed

### **Results**

Adolescents in Tanzania practice unprotected sex through premarital sex and early marriage. Factors influencing adolescents unsafe sex practices include poverty, globalisation, increased age at marriage coupled with decreased age at menarche, sexual abuse, coercion and socio-cultural practices. Consequently, adolescents SRH problems include STIs, HIV, and unwanted pregnancies. Adolescents in Tanzania lack accurate SRH information and life skills to make informed choices. National policies and strategies are conducive and allow adolescents' access to SRH information and services. However these policies are not fully implemented due to inadequate mechanisms for policy dissemination. Initiatives such as African Youth Alliance (AYA), MEMA kwa Vijana (MkV) and ISHI campaign have responded to ASRH needs, but their impact has been mainly on improved SRH knowledge and attitudes, with no impact on behaviour change. These programmes have minimal community and parental involvement in their design and implementation. ASRH programmes also lack collaboration with other programmes which address gender, social and economic issues of adolescents.

### **Conclusion**

Adolescents SRH needs are multifaceted and can be addressed in a holistic way using a multi sectoral approach. Community involvement is very crucial to allow smooth implementation of the ASRH activities.

### **Recommendation**

Programmes addressing SRH needs should use existing structures and activities such as schools, health units and recreational facilities to reach a big number of adolescents. Life skills building activities should be strengthened and promoted to achieve behaviour change.

**Key Words:** Adolescents sexual practices, adolescent's sexual and reproductive health, adolescents sexual reproductive health programmes and policies addressing adolescents



## **Introduction**

In 2005, there were 1.21 billion adolescents in the world; this is the largest attained number of the population in the history of mankind. The age 10 to 19 is estimated to increase by 1.23 billion by 2040. (World Population Prospects, 2004). This makes it needless to say that young people are simply the raw materials of human development. One of the most important investments a country can make is enabling its young population to grow into healthy citizens. Adolescents are often thought to be healthy since they have survived childhood diseases and health problems of old age are still far away. However this is not necessarily the case because the data shows that nearly 10% of global burden of disease, in terms of Disability Adjusted Life Years (DALYs) lost is borne by young people between 10 and 19 years of age (WHO, 2003).

Adolescence is a particularly an important phase in life where the physical, mental, emotional, social and spiritual developments takes place (WHO, 2001-2004). It is a time when young people naturally explore and take risks in many aspects of their lives, including sexual relationships. Those who have sex may change partners frequently, have more than one partner at the same period or engage in unprotected sex. All of these behaviors increase young people's risk of contracting HIV and other STIs (Bankore A, 2004). Many of the young people have had to navigate their way through sexual maturity without the benefit of appropriate information or services which are known to promote healthy sexual and reproductive life. Thus they are poorly informed about their bodies, sexuality, reproduction and consequences of sex. They also lack the skills to say no to unwanted sex or to negotiate for safer sex (WHO, 2001-2004).

Socially accepted gender roles and position of females in many societies have a strong impact on the needs of adolescent girls. Practices such as early marriage are still common in Africa. These adolescents' girls get married to much older men, who are sexually more experienced and are likely to have had multiple sexual partners before marriage (Bankore A, 2004). These young girls find it difficult to avoid coercion and are forced into sexual relations. Today adolescent's girls, are more vulnerable to HIV infection while a million of girls are facing unwanted pregnancy each year, unsafe abortions and sexual transmission infections have become repeatedly problems affecting adolescents (UNFPA, 2002). WHO estimates that globally up to 4.4 million women aged 15 to 19 undergo abortions annually. Many of these abortions are unsafe and illegal, and they are an important cause of mortality and morbidity for the 10 to 19 age group (UNAIDS, 2006)

Young people now attain biological maturity earlier than in previous generations (Lloyd C, 2005). Most of these changes are attributed to better health and nutrition. Another key factor for adolescent's sexual behavior is the increasing educational investments made by governments. This has resulted in increased number of adolescents years spent in school coupled with a rise in the age at which one marries which potentially increases the length of time that unmarried adolescents are exposed to sexual risk behaviors and pregnancy (Lloyd C, 2005).

Further to this, the existing programmes on young people's health have tended to treat youth as a homogeneous group. Little effort has been made to explore the reproductive health context and needs of young people from various demographic backgrounds (Rani M, 2004). The need to invest in and respond to young people's reproductive health need is emphasized given the fact that reproductive health needs are basic human rights and should be given high priority in all development plans. Healthy adolescents are more likely to safeguard the health of their own children in future and contribute more effectively the process of wealth creation for the nation and themselves

The ASRH issues have been my area of concern throughout my work career; I have been involved in programmes that address SRH needs of adolescents. Currently, I worked with National Institute for Medical Research (NIMR- Tanzania) conducting process evaluation research for an innovative adolescent's sexual and reproductive health programme called MEMA kwa Vijana which is scaling up in four district of Mwanza region. Research activities connected me directly with young people through visits to primary schools and health units to observe the behaviors of services provided to adolescents through mystery clients. I am also involved in other research activities such as conducting focus group discussions, observations, interviews and other participatory activities for the purpose of gathering information. That is why my interests have been in adolescents. Through my thesis, I would therefore like to gain more insight on adolescents sexual and reproductive health needs by exploring their sexual behaviors and its consequences. The overall aim of my thesis is to review the relationship between adolescent's sexual health needs and the programme response to these needs. In order to review this relationship a literature review will be done to;

- Understand sexual behavior of adolescents and its consequences
- Understand sexual and reproductive health needs of adolescents
- Review the extent to which the existing ASRH programmes addresses the needs of adolescents

Following the findings from this review, recommendations will be put forward to address any existing gaps as well as to address any emerging

issues. The recommendations will be shared with programme managers from Ministry of Health and Education for consideration when designing adolescent's programmes. The information will be disseminated through workshops, meeting, and writing abstracts for the local and international conferences. Also a copy of my thesis will be handed to programme managers of the reviewed SRH programmes, Ministry of Labour Youth and Sports Development (MoLY&SD). This will be implemented immediately after the completion of my studies.





## **Chapter One: Tanzania Country profile**

In this section, I will review the demographic characteristics, epidemiological, socio-cultural and economic factors of Tanzania and explain how they impact on adolescent's lives and health in the country.

### ***1.1. Socio - Demographic characteristics***

The current estimate of the population of Tanzania is 39.3 million people (Tanzanian Demographic profile, 2007) with a growth rate of 2.09%. Almost two third of the Tanzania population is under the age of 24 and almost 20% of the population is aged between 15 to 24 years. These young men and women are future the of Tanzania, thus their health and well being must be a priority for the growth and prosperity of the country (TBS, 2004-05).

Tanzania has more than 120 ethnic groups with major groups of more than one million members in each of tribes; the Sukuma, Haya, Nyakyusa, Nyamwezi and Chagga. Other groups which are slightly smaller include the Pare, Sambia or Shambala and Ngoni. Understanding the ethnic groups in Tanzania is very important since different ethnicities have different cultures and practice that affects adolescents such as female genital Mutilation (FGM).

Tanzanians have Bantu origins. The national language is Swahili while, English is the official language. The main religions are Christianity 30%, Islam 35% and traditional faiths 35%. In Zanzibar, by contrast, the population is predominantly Muslim with more than 99% (Tanzanian Demographic profile, 2007). In the predominantly Muslim society in Zanzibar, premarital sex is strictly forbidden and the value for marrying a virgin is still high. Muslim parents marry their girls at early ages for fear that if they delay, girls may start having sex without their awareness and this is the big shame for the family. In this Muslim society, the adolescents sexual and reproductive health (ASRH) services are integrated to the maternal and child heath clinics for antenatal care or family planning which are mainly catered to adults and married adolescents, in fear that leaving the services open to all adolescents may encourage them to start having sex, since they will have access to contraceptives methods (Pathfinder, 2005)

## **1.2. Education**

Tanzania literacy rate in 2005 for males between 15 and 20 of age was 93.8% compared with 89.4% for females. The literacy rate has increased due to the introduction of Universal Primary Education (UPE) policy in 2002 which led to an increase in enrolment rate to 97%. Meanwhile, the expansion of primary school education without concurrent access to secondary education has meant that a low proportion of young people 8% to 10% matriculate to secondary school (Ministry of Education and Culture, 2005). Also at secondary level, school fees still exist which constitutes a barrier for low socio-economic status parents to afford sending children to school. According to the rapid assessments done by ILO in Tanzania it was found that about 61% children had dropped out of school due to lack of money to meet education cost. The lack of an attractive career perspective of adolescent's girls has caused them to opt for marriages or child bearing as there are no other opportunities to be utilized (ILO, 2003).

Furthermore, data shows that the out of school youth are more likely to get involved in high risk behavior and are therefore more vulnerable to HIV/STIs (Bastien S, 2007). However pregnancies among school girls are on the rise in Tanzania. For example, in 2006, there were, 3,479 in primary school and 993 in secondary school drop outs which were due to pregnancy alone (MoE&VT, 2006). More often, pregnant students are expelled by school authorities. Tanzania law allows girls to return back to school after delivery. However, strong stigma associates them with premarital sex. Trauma and hardship prevents mothers with children to take up such opportunities.

## **1.3 Economic profile**

Tanzania is among the least developed countries with per capita GNP of around US \$280 and at the 162 position on UNDP Human Development Index Scale (WHO, 2005). Agriculture is the mainstay of the economy, accounting for about half the national income. TDHS 2004-5 shows that most young people aged between 15 to 24 years of age work in the agriculture sector. However, recently the agriculture sector has not been performing well due to unpredictable weather changes. This has led to young people migrating to urban cities like Dar-es-Salaam and mining areas in search for employment. A study done by Madihi (2000) estimated that 300,000 pupils leave primary school education at age of 13-17 years to become independent without a source of income (Madihi, 2000) Other youths, mostly girls aged 10 to 24 years who are out of school often work as housemaids, barmaids, hairdressers in salons, or sell things in kiosks, shops and in other low status, informal jobs (ILO, 2003). Most of these jobs lack

clear contracts describing the terms and conditions of service. They often are oral contracts. With this kind of job conditions, adolescents are exploited by their employers. In many instances their employers and customers refuse to pay them, if at all they are paid; their payment is very low and irregular. Some adolescents are forced into sexual relationships with their employers or the relatives of their employers (ILO, 2003)

#### ***1.4 Adolescents Sexual and Reproductive health issues***

Tanzanian National Policy Guidelines for Reproductive Health and Child Health Services (2003) support young people's access to sexual and reproductive health (SRH) and services. However there are many gaps in its implementation since there has been no effort to change attitudes of service providers towards the provision of SRH services to adolescents. Because of the staff attitudes, Tanzanian adolescents have found it difficult to access reproductive health and HIV/AIDS services (Pathfinder, 2005).

For years, the government of Tanzania had been willing to let NGOs take the lead in providing SRH information and services to adolescents, but 80% of Tanzanians live in rural areas, where there are few NGOs that have the capacity to run district wide interventions, thus most of the NGOs that have youth SRH programmes are urban based and their over reliance on donor funding limits their sustainability (Pathfinder, 2005).

##### **1.4.1 Family planning services**

Family planning services have been provided as part of maternal and child health services since their introduction in 1974. This has led young people to perceive family planning services as an adult service, thereby creating a barrier for both male and female adolescents. Africa Youth Alliance (AYA) – Tanzania conducted a needs assessment and one of the reasons for low utilization of sexual and reproductive health services including contraceptive use by young people, was that service outlets were specifically designed to serve adults. Adolescents felt uncomfortable to use such facilities. According to this assessment, other factors were lack of access to youth friendly services, lack of information on available services, poor skills of health providers and stigma associated with seeking SRH services (AYA, Pathfinder, 2003).

Currently, a number of initiatives have been developed and are being implemented to promote and provide adolescents youth friendly reproductive health services. For instance the Africa Youth Alliance (AYA) programme aims to strengthen ASRH initiatives from selected health facilities that will be used as best practice and will be scaled up. Other

initiatives include chama cha uzazi na malezi bora Tanzania (UMATI) which have been providing family planning, STI screening and treatment plus counseling to adolescents. The challenge with the existing best practices from NGOs is that they do not have proper coordination and operates at a smaller scale. Lack of documentation of what the initiatives cost makes it difficult for scaling up of the initiatives

#### **1.4.2 HIV/AIDS among adolescents and its impact on adolescents lives**

The unprotected sex among adolescents places them at serious risk of HIV/STI infection. This is because the high levels of sexual activities among adolescents have not been accompanied by the consistence use of condoms (World Youth Report, 2003). Youth in Tanzania account for over 60% of the new HIV infection, while the sexually active women and men aged between 15 to 24 years who reported condom use in their most recent sexual encounter ranged from 44 to 47 (TACAIDS, 2003-04).

There are many reasons why adolescents engage in unprotected sex. Most of adolescents have incorrect information about sex and HIV/AIDS, this is further compounded by the fact that a majority of adults believe that sex education encourages sexual experimentation, consequently programs and campaigns have been limited to promotion abstinence (Leshabari M, et al 2008). Despite the devastation caused by AIDS, adolescents may not change their risk behavior because of the consequences of their actions are not immediately affecting their health, owing to the long incubation period between infection and disease onset (World Youth Report, 2003). The limited condom use can be as a result of peer pressure, incase peers think unprotected sex is not risky, lack of negotiation skills especially for adolescent's girls and limited availability of condoms attributed to the costs and poor distribution system for condoms (World Youth Report, 2003)

One of the most serious consequences of AIDS epidemic has been the illness and the death of parents. Information collected from several parts of the country indicates that people who have developed AIDS and are not in Anti Retro Virus (ARVs) die in about four to 12 months, on average, after falling ill, a member of the family often has to stay with the patient at home or in the hospital to provide care, especially during the terminal stages of the disease. Often it is an adolescent girl child who assumes the role of a care provider. During this period children including adolescents may be irregularly attending school in order to care for their sick parents (ILO, 2003).

Further more the medical, emotional and social costs to patients and families are very high. More socio-economic difficulties arise when the patient is the

primary breadwinner in the family; this has also led to some children to give up education in order to work so that they can support their family and their sick parents. When death finally comes, the economic repercussions can be serious and can result in young people being withdrawn from school and forced to seek work to help support their siblings. (ILO, 2003).

Studies have also shown that orphaned youth tend to be in poorer health than youth living with their families, this is attributed to poverty, inadequate access to needed health services and repeated exposure to infections commonly associated with HIV such as tuberculosis, pneumonia, diarrhea diseases and respiratory infection from having resided in a household with an AIDS patient (World Youth Report, 2003).

#### **1.4.3 STIs among adolescents**

The burden of STIs among adolescents is large. A study conducted to adolescents who were attending an STI clinic in Dar-es- Salaam revealed that genital discharge was the most common complain. Other STIs such as gonorrhoea, Chlamydia and syphilis were also reported. This large burden of STIs in adolescents indicates that, adolescents are at high risk of being infected with HIV (Chalamilla G, 2006) Furthermore, given the limited access of adolescents to STIs and youth friendly services one can assume that more is a hidden problem.

#### **1.4.4 Female Genital Mutilation (FGM)**

Female Genital Mutilation (FGM) in Tanzania is most common in the Northern and central region where prevalence ranges from 20 to 18% (See table 1).

**Table 1: Prevalence of FGM by ethnic groups and region**

Tribes	n	Had FGM	%
Chagga	166	8	4.8
Pare	81	29	35.8
Sambaa	38	5	13.2
Zigua	15	1	6.7
Gogo/rangi	19	9	47.4
Nyaturu/Nyiramba	19	6	31.6
Kuria	6	1	16.7
Sanadawe/Mangati	6	4	66.7
Nyakyusa/Makonde/Ngoni/Zaramo	29	0	0

**Source:** Findings from Msuya S, (2002).

The age at which girls undergo Female Genital Mutilation (FGM) varies among ethnic groups, but according to the Tanzania Bureau of statistics (1997), nearly 70% undergo FGM by age of 15 (Msuya S, 2002). Immediate and long term complications have been reported in women who have undergone FGM, there is likelihood of experiencing long term obstetric, gynaecological and perinatal death than deliveries to women who have not had FGM (WHO, 2006). Therefore in Tanzania, interventions to eliminate the practice should be tailored to the ethnic groups concerned.

#### ***1.5 Health policy***

The aim of the 1990 National Health policy was to improve the health and wellbeing of all Tanzanians, with the focus on those most at risk and to encourage the health system to be more responsive to the needs of people. The general goal was to improve survival, health and well being of all children and women and especially the vulnerable groups (Arvidson et al, 2006).

The new 2003 National Health Policy expands on the scope of health sector policy to include new aspects of human health. One of the visions spelled out in the 2003 policy is access to quality reproductive health services for all individuals of appropriate ages (Arvidson et al, 2006).

This policy directly addresses young people within the age range of 15 to 24 in the strategic goal and targets of the policy. These are;

- To reduce the spread of HIV among young people between the ages 15 to 24 by 30%.
- To increase knowledge of HIV transmission in the population by 95% among young people aged 15 to 24
- To reduce the adverse effect of HIV/AIDS on orphans by increasing the ratio of current school attendance among orphans (TACAIDS, 2003).

### **1.6 Health Care System**

Geographical coverage of health care facilities is fairly distributed to more than 80% of the population. However other factors affect accessibility to these facilities. The quality of care is also generally poor. Staff is unequally distributed, especially in rural health facilities, due to the lack of incentive to attract and re-tain health professionals in underserved remote areas. Furthermore, AIDS is placing incredible pressure on the health sector which has already a low per capita expenditure. A study by Palangyo (2000) indicate that as many as 50% of all hospital beds in the country are occupied by patients with HIV/AIDS related illness. Furthermore, in Tanzania, the nursing care for HIV/AIDS victim is estimated to be US\$ 290 for adult and US\$ 195 for children (Palangyo, 2000). Consequently, health budgets are seriously strained as facilities try to provide STI treatment programmes and voluntary counseling and testing (VCT), mother to child transmission (PMTCT) services, and HIV treatment and care. The increase in hospitalizations related to HIV/AIDS has resulted in shortage of beds for people with other illness as well as decline in quality of care in some hospitals operating above capacity. Young people who generally suffer less morbidity than other age groups are likely to miss out the needed preventive services as the sector focuses its limited resources on curative and palliative services (World Youth Report, 2003).

### **1.7 DEFINITION OF THE KEY WORDS**

Who are adolescents, youth and young people: "Adolescence" is the age between 10 to19 years and "Youth" are those aged between 15 to24 years, while the term "young people" is used to cover adolescents and youths, thus it encompasses the 10 to 24 age group (WHO, UNFPA, UNICEF, 2003)

## **Chapter Two**

### **2.1 Statement of the problem**

The government of Tanzania has long recognized that its adolescents' is the nation's most valuable resource. National developmental goals have invariably been geared towards the improvement of the quality of life of the population in general and adolescents in particular. However, the welfare of the adolescents' continue to be threatened by a number of factors such as the high rate of teenage pregnancies, high rates of STIs and the increasing rates of new HIV infection.

Adolescents in Tanzania initiate sexual intercourse at an early age and are engaged in multiple sexual partners. Studies conducted in Tanzania shows that the median age of first sex for girls and boys was 15 (Matasha et al 1999). Furthermore, early marriage and early childbearing continue to be common in Tanzania. Over 50% of women are married by age 19. Twenty-five percent of women between the ages of 15 to 19 are pregnant or already have children (TDHS 2004 – 05). Adolescents' who become pregnant face serious health risks as they may not be physically mature to handle the stress of pregnancy and child birth. Early marriage and child bearing increase the risk of pregnancy complications and contributes to higher rates of maternal and infant mortality. More to that, early marriage also limits women's access to higher education, better incomes, and more control over their lives (Save the children, 2004).

The contraceptive use among adolescents in Tanzania is very low the reasons being that they don't know about it, can't afford it, or don't have access to it (TGNP, 2007). One of the reason to explain the low utilization of family planning among adolescents is the fact that the services are integrated as part of maternal and child health. Thus adolescents perceived that only adults are allowed to access contraceptives (Rasch V and Silberschmidt M, 2008).

In Tanzania, it is estimated that 60% of all new HIV infection occur in young people between the age group (TACAIDS, 2005). This implies that sexual and related risk behaviour that expose young people to transmission of HIV are still fairly common despite efforts to raise the level of awareness about AIDS using various initiatives (Leshabari et al, 2008)

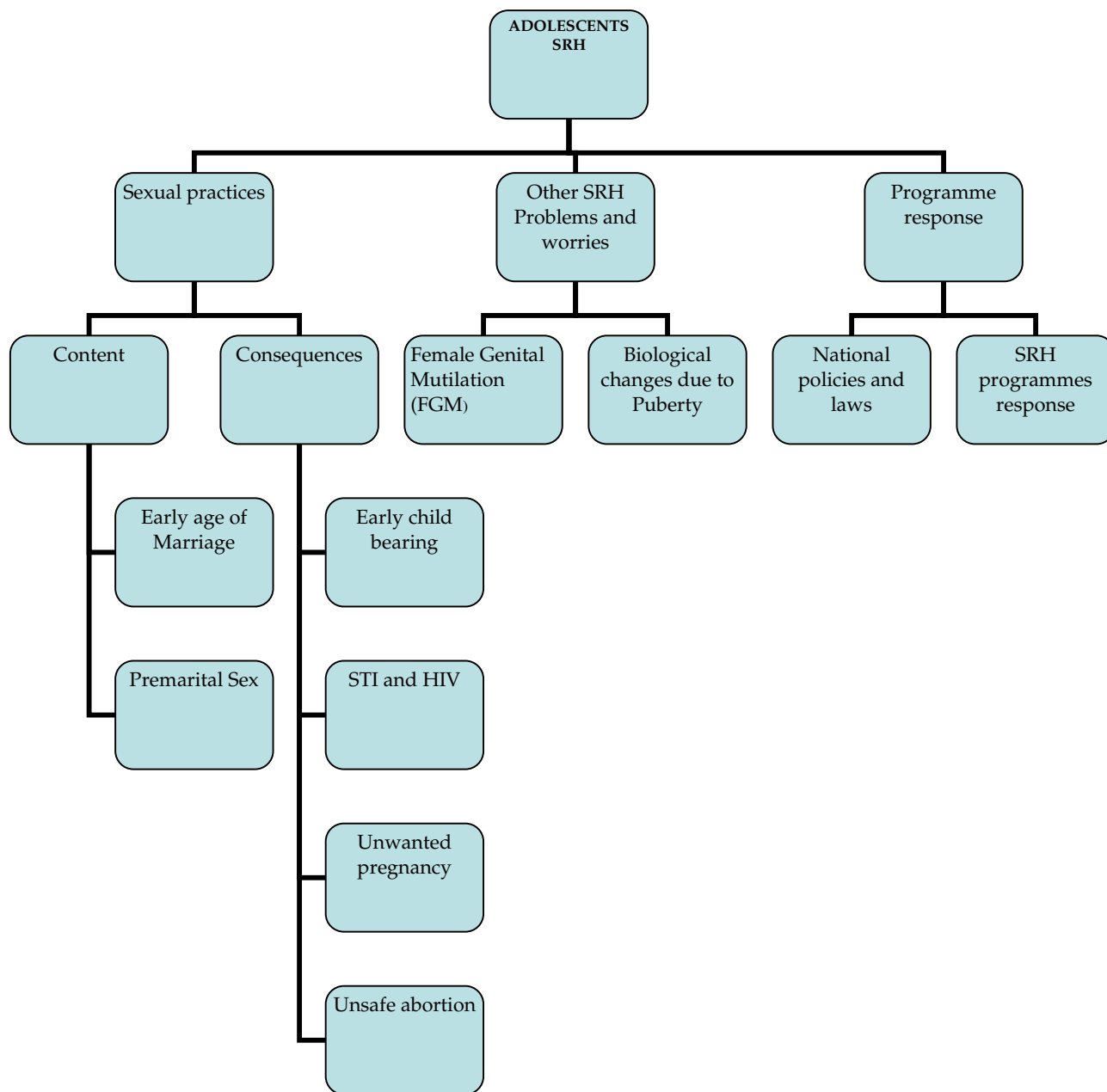
Therefore, there is an urgent need to explore adolescent's sexual and reproductive health needs and relate them to programme responses in order to identify the opportunities and the gaps in addressing adolescents needs.



The recommendations will help future programming to exactly fit the needs of adolescents in Tanzania.

## ***2.2. PURPOSE AND STRUCTURE OF THE THESIS***

First, I shall explore the sexual and reproductive health practices and problems of adolescents and its consequences. Then the consequences will identify adolescents SRH needs. Subsequently, I shall then review the existing programme responses in terms of the policies, and programmes and discuss how they address adolescent's SRH needs. Based on the findings, recommendations will be put forward to programme managers and government of Tanzania for consideration in future programming aimed at addressing ASRH needs.



### **2.3. General Objectives**

- To explore sexual and reproductive health needs of adolescents in Tanzania and to develop recommendations for programmes to address sexual and reproductive needs of adolescents.

### **2.4. Specific objectives**

- To explore sexual and reproductive health practices and problems of adolescents and influencing factors in Tanzania

- To explore the consequences of unsafe sexual practices of adolescents in Tanzania.
- To describe policies and programme response to the emerging sexual and reproductive health needs of adolescents
- To identify opportunities and constraints in the existing policies and programmes that affects the delivery of sexual and reproductive health needs of adolescents.
- To give recommendations for future programming of adolescents sexual and reproductive health interventions.

### ***2.5. Methodology of the study***

This thesis is based on the literature review from Tanzania and other Sub Saharan African countries. Materials were searched using different websites such WHO, UNAIDS, UNFPA, FHI-Youth InfoNet, Guttmacher, PUBMED, Science direct, VU data base were used. KIT library references such as books and previous thesis were also used.

The key words used in the search were adolescents and sexual practices, adolescents and reproductive health needs, sexual and reproductive health programme, Tanzania Policies and youth.

## Chapter Three

### **3.1. Adolescent's sexual and reproductive health practices and problems**

Adolescents are more likely than adult to engage in risky sexual behavior which put them at risk of HIV/AIDS, STIs, unwanted pregnancy, unsafe abortion and early childbearing. In this section, I will review the existing evidence of sexual practices among adolescents in Tanzania and in other Sub-Saharan countries. Different sexual behaviour will be discussed in detail by exploring the contributing factors and the consequences of the behaviour to adolescent's health and wellbeing. Other SRH issues like contraceptive use, source of SRH information and SRH worries of adolescents due to biological body changes will be discussed.

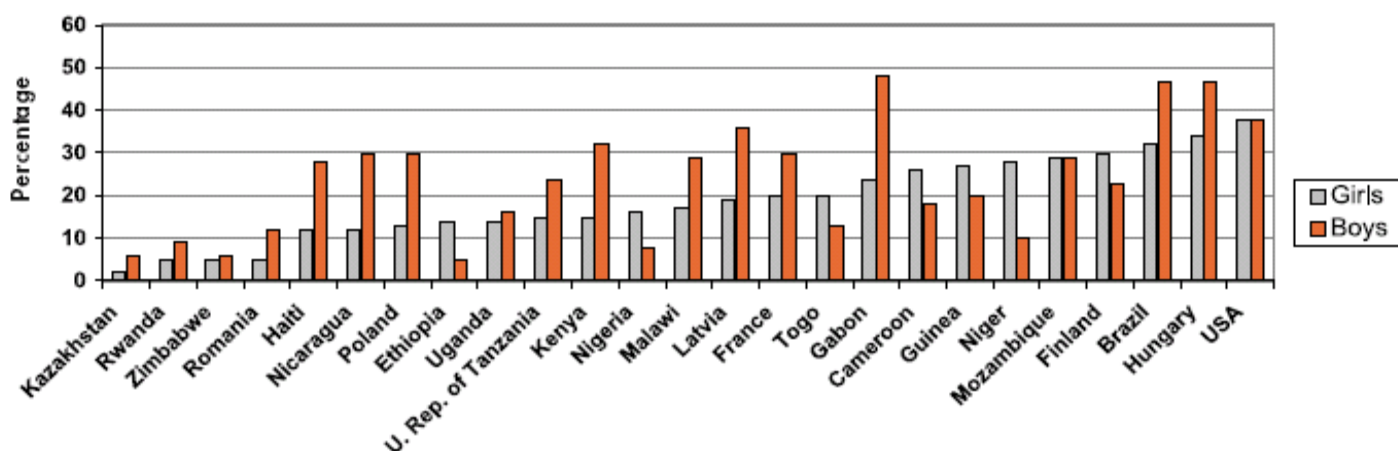
### **3.2. Premarital sexual activity**

Pre marital sex is not a new concept. Historically in pre – independence societies, premarital sex was permitted given the defined circumstances and sometimes it was organized by elders or parents. In East Africa societies, for instance among the Kikuyu of Kenya and Masai pastoral ethnic groups of Kenya and Tanzania, sex is allowed with uninitiated girls as young as 11 years, as long it does not lead to pregnancy. This practice still exists today (Talle, 1994).

Some tribes in Tanzania, a hut is built when adolescents enter a menarche period. A small hut is the sign of being independent and starting engaging in sexual activities. For instance, tribes like Kipsigis of Kenya, the hut was built for only male children, while Sukuma tribe in Tanzania the hut is build for both girls and boys. However, in this situation still pregnancy is considered shocking, since it was outside the marriage (Talle, 1994).

Overall many young people in Tanzania start sexual activity at an early age. Trend data from TDHS shows that on average, young women begin to have sex at age of 17, while young men start having sex between ages 18 and 19 (DHS, 2004-05). However other studies have revealed that young people become sexually active at before the age of 15 (See figure 3)

### **Figure 3: Percentage of adolescents (aged 15-19) enagaging in sexual activity before age 15**



**Source:** UNICEF/MICS, Measure Demographic and Health Surveys, 1998-2001

The sexual practices of adolescents are unplanned and unprotected and their engage in sexual activities with multiple partners. This places them at greater risk of contracting STIs and HIV (World Youth Report, 2003)

### 3.3. Age of marriage

In many parts of the world including Tanzania, the issue of sexuality is of importance. Girls are considered eligible for marriage both legally and informally. In Tanzania for instance, the marriage Act no 5/71 set the minimum age of marriage at 15 years with parental consent. While in Uganda the minimum age of marriage is 18 years.

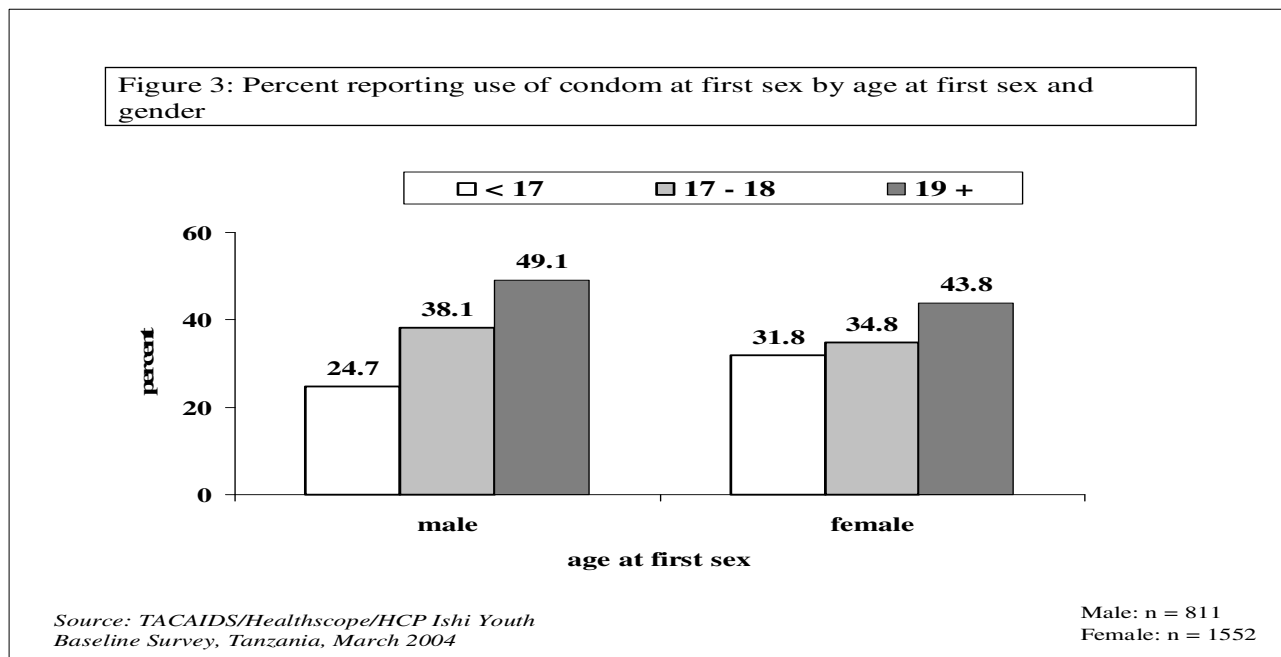
In Tanzania fourteen percent of women aged 20 to 24 and 5% of men of the same age group have had sexual intercourse by age 15. By age 18, 63% of young women and 43% of young men have become sexually experienced. Almost one quarter of young women aged 15 to 19 are already married, compared to only 1 percent of young men aged between 15 to 19. The majority of women aged between 20 to 24 are married, while only 1 in 4 men aged between 20 to 24 are married (TDHS 2004-05). This data shows persistent variation by sex of married youth in all age groups, with the larger proportion of married females than males. This suggests that young females do not always draw partners from their age category but are married to men older than themselves. This wide difference between the ages of married male and female adolescents is one of the possible explanations for higher infection rates of HIV/AIDS cases observed amongst young females, who are likely to be exposed to older and more sexually experienced partners (Mwakagile et al, 2001).

In many situations, young married girls enter marriage without adequate information about sexual and reproductive health issues, such as sexual intercourse, contraception, sexually transmitted diseases, pregnancy and childbirth. This is compounded by the pressure to demonstrate fertility soon after the marriage. Consequently they are exposed to risks of early pregnancy that might result in complications such as prolonged labour, stillbirth, postpartum hemorrhage and maternal distress (Mathur S, 2003).

### **3.4 Contraceptives among adolescents and a need for contraceptives services**

In Tanzania, until 1994, family planning was to be used solely for child spacing purposes. Hence family planning advice was given primarily to clients with at least one child. The National policy guidelines and standard for family planning were revised in 1994; it now includes all male and females of reproductive age, including adolescents (Tanzania National Policy Guidelines and Standards for Family Planning Service Delivery and Training, 1994). However there is still discrepancy between the guidelines and practical implementation since there has been no change in attitudes of service providers towards provision of such services to youth, especially adolescents (Silberschmidt and Rasch, 2001).

Condom is an effective method of preventing both unintended pregnancy and HIV. In Tanzania, almost 80% of young people know that using condoms reduces the risk of contracting HIV and unwanted pregnancy (Tanzania National AIDS Control Program, 2002). The awareness and knowledge about condom is not transferred into practice, because high levels of sexual activities among adolescents have not been accompanied by the consistent use of condoms, for instance among unmarried young people who are sexually active, 44% of women and 47% of young men reported that they used a condom, the last time they had sex (TACAIDS 2003-04). Studies have also found that even among adolescents who report recent condom use, less than half used condoms for each episode of sexual activity. Factors that hinder condom use among adolescents include lack of perceived risk, peer norms, condom availability, adult attitudes to condoms and sex, gender power relationship and the economic context of adolescent's sexuality (World Youth Report, 2003).



**Figure 4: Percent reporting use of condom at first sex by age at first sex and gender.**

**Source:** TACAIDS, 2004

### 3.5 Other adolescent's sexual and reproductive health worries

Adolescence is the time of physical, mental and social changes. This period of rapid growth and sexual development is called puberty (WHO, 2001-2004). During this period, majority of adolescents get concerned about the changes that take place in their bodies, even though they are normal (UNAIDS 2006). It is true that these changes may not correspond neatly with precise ages. For instance the speed of physical changes which takes place varies in different individuals and settings. These differences may create fear and stressful environment for adolescent if early or late maturation makes them different from same age peers. Thus adolescents need support in answering the questions about the concern they have about the changes (WHO 2002).

### 3.6 Female Genital Mutilation (FGM)

Female Genital Mutilation is still fairly common in some tribes in Tanzania for instance it is common in Dodoma, Manyara and Arusha. Overall 15 percent of Tanzanian women age 45-49 are more than twice as likely to have undergone female Genital Mutilation as those age 15-19 (TDHS, 2004-05). However, there is evidence of change of attitude towards the practice, especially among young women. FGM is usually practiced on young girls

from the age of 4 years; but is also carried out on adolescents' girls. FGM may be done with or without formal consent of a girl, and in either way, a girl has no power to challenge cultural customs (Msuya et al, 2003). FGM causes severe pain, may result in excessive bleeding and increase the risk of infection including HIV. Other consequences are painful intercourse, difficulties during child birth and low sexual desire (Duncan S, 2003).

### **3.7 Source of Sexual and reproductive health information**

In Tanzania, the traditional rites of passing sexual and reproductive health information from adults to young people are currently reported to lack relevance and are declining. This has led to lack of adult to child communication on matters of sexual health and the little information provided is inform of list of prohibitions and reprimands(Mzinga J, 2002). This is missed opportunity because studies show that young people prefer parents, health workers and teachers to be the main source of information on sexual and reproductive health (Masatu et al, 2003).

The basic sexual and reproductive health information is reported by adolescents to be primarily acquired from peers, information on STDs including HIV and pregnancy prevention is acquired from the mass media, also it appears that mass media and peers give more exposure to information on sexual intercourse than to basic information related to human growth and development such as the onset of menstruating and wet dreams and their implications on reproductive health (Masatu et al, 2003). Peers who are the main source of information are reported to have low levels of reproductive health knowledge, it appears these young people are forced into a situation where "blind lead the blind" (Leshabari and Kaaya, 1997).





## **Chapter Four**

### ***4.1. Factors contributing to premarital sex and early age of marriage***

#### **4.1.1 Changes in social context**

Changing social context play a role in shaping the sexual behavior of adolescents. This has been pointed out by studies from Tanzania as well as in other Sub - Saharan countries. Leshabari and Kaaya (1997) have noted that the society's transition from traditional to modern is occurring throughout the world and is generating a radically different culture for sexual and reproductive decision making among today's adolescents. With increasing urbanization, puberty rituals in many societies seem to be going away. Further more, social economic changes with massive urbanization and migration have lessened the influence of social control mechanism which formerly discouraged adolescents from having sex prior to marriage. As increasing number of rural families migrate to urban areas, parental control and supervision are weakened, and adolescents are exposed to modern influences that encourage sexual activity in relationships before marriage.

#### **4.1.2 Rising age at marriage coupled with decline age at menarche**

An important consequence of rising age at marriage combined with a decline in the age at menarche is that the number of years between menarche and marriage increases substantially over time; this has been due to increase in demand and value for education. However, Data shows that first sex is increasing likely to occur before marriage as a result of the increase age at which marriage takes place. This is supported by the findings that overall marriage delays have not led to delay in age of sexual initiation. In the most traditional and poorest population, girls typically marry shortly after menarche. In contrast, some of the more advanced developing countries, the period between menarche and first marriage approaches a decade. This trend result in a large increase in the number of sexually mature but unmarried adolescent girls thus potentially leading to a higher prevalence of pre marital sexual activity (Lloyed, 2003).

#### **4.1.3 Poverty and greed for material things**

The wide spread poverty experienced by adolescents in Tanzania makes it difficult for them to afford basic needs, thus making sex as an exchangeable commodity for materials goods or money. For instance a study conducted in Kigoma region with primary school children aged 4 to14, revealed that many young pupils engage in sexual intercourse because they need financial resources to support their basic school needs, such as school fees, and

uniforms. The most wide spread form of gift was money, which amount to as little as 10 shillings, and the highest was 5,000 to 10,000 shillings (Grazilla, 2002). Also another study on adolescents girls involved in illegal abortion in Dar –es Salaam city, showed that girls who had just had illegal abortions, engaged in high risk behaviors with older men “sugar daddies” in order to get material benefits (Silberschmidt and Rasch, 2001). Further more, parental pressure emerges as an important cause for pushing their adolescent girls into transactional sex. Girls are told to obtain money to finance their education expenses, and necessities for the household (Nyanzi, 2001; Silberschmidt and Rasch, 2001).

Studies also indicate that adolescent’s wish to obtain luxury items, such as expensive clothing, cell phones, jewellery, fashionable hairstyles, accessories and make up, motivates them to engage in transactional sex. According to adolescent’s girls, materials give them prestige among their peers since girl’s status within this group is often dependent on having nice material things. In this situation, the fear of AIDS, let alone other STIs is far less a concern than the more immediate material things (World youth report, 2003).

Poverty is one of the responsible factors for early marriages in Tanzania. In families that are very poor, a daughter may be seen as an economic burden that must be shed through marriage as early as possible. Similarly, economic gains incurred through the marriage of a daughter may also be an important motivation factor for poor families. This is the same in other settings such as India and Ethiopia where families cite economic reasons for marrying girls early. For instance in Ethiopia, parents state that they married their daughters when they did for the purpose of economic (Berhane S, 1993).

At a societal level, countries, states and regions that are less developed and poorer tend to have fewer resources and a lower level of motivation for investing in alternative options for young girls, it happen that a girl find herself trapped within marriage because she sees no other means of survival. Early marriages are therefore an alternative than in richer and developed settings (Lloyd, 2005).

#### **4.1.4 Sexual abuse and coercion**

Concern about exploitative sexual practices involving children and adolescents is receiving attention in Tanzania. The evidence suggests that the prevalence of child and adolescents sexual abuse has increased. Perhaps, this could be as a result of increasing reporting rate, along with a wider concern for the rights of children and women and with advent of a free

press in Tanzania (Lalor K, 2003). A retrospective of 102 alleged rape cases, carried out by doctors from Muhimbili Medical Center in Dar-es-Salaam, found that 21% of the alleged rape cases were children below 4 years of age and over half the cases were children aged between 2 and 14 years. In 61% of the cases the rapist was either a relative or a person well known to the child, such as a co-tenant or neighbors (Lalor, 2003). Also the presence of coercive sex among adolescents is supported by the findings showing that 23% of primary school girls were raped (Todd et al, 2004). The majority of forced sex was by fellow students, and in some instances was by teachers (Lalor, 2003, Matasha, 1998). The reasons for the increase in cases of rape and coercive sex in Tanzania include;

- Belief that having sexual intercourse with a virgin or young girl can cleanse oneself of AIDS and other STIs. Others are advised by witchdoctors to have sexual intercourse with young children for gaining material wealth.
- Breakdown of the traditional communal childcare system, in which all the adults were entitled to discipline all children in the community and advise parents on their child rearing efforts
- Poverty was also cited as primary motive for young adolescents to be coerced into having sex
- Powerless position of girls is seen as a vulnerability factor for sexual abuse (Lalor, 2003).

The effects of sexual abuse in adolescents has been explored by number of researchers as depression, suicide and death, experiencing lower self esteem, isolation, experiencing communication difficulties with parents, running away from home, having multiple sexual partners, engaging in sexual activities at an earlier age, not using contraceptives, increasing risk of getting pregnancy, getting STIs including HIV/AIDS (WHO, 2001-2004).

#### **4.1.5 Tradition and cultural practice**

Traditionally, in Tanzania, men married relatively young brides in monogamous or polygamous relationships, and there were socially accepted procedures and various roles and obligations which had to be observed. It is possible that the culture norms governing the acceptable age gap between sexual partners have persisted in recent times because majority young girls still marry to much older men, It is unusual and not advisable – from parents points of views, for a girl to marry a same age male or a male partner who is younger than a girl (Leshabari and Kaaya, 1997).

Another study on early marriage was conducted in Ethiopia, and found 80% of the respondents could cite no reason for early marriage other than it being tradition they had adhered to. According to the interviewees, the

perceived reason for early marriage was the desire or need to retain the family's good name and social standing. For men the success of their children is a measure of manhood while for the daughters success rests in her making a good marriage and linking her family to another family (Alemu B, 2006).

#### **4.1.6 Gender roles**

In many societies, boys are regarded as an asset and an investment for parents when they become old. Thus, boys face social and cultural pressures during adolescence to succeed in school. They also have to prove their sexuality, engage in sports and physical activities, develop a social group of peer, and demonstrate their ability to shoulder household economic and financial responsibilities. Rarely do these responsibilities translate to early marriages in boys. In contrast adolescents girls roles entirely prepares them in entry into marital state, emphasis is placed in domestic work and obedience, traits seen as essential to being good wives and mothers(Mathur S, 2003).

The wider range of developmental activities, including schooling, skills building, sports and friendship are often not part of adolescent girl's routine because marriage is on their immediate horizon. Research on age at married in different states which ethnic groups suggests that getting married and bearing children are often the only means for young girls to secure identity and status in families and as adults in society. The more central the role of a wife and mother is to women identities and a fewer alternatives social and economic activities that are available the earlier girls will tend to marry (Mathur S, 2003).

#### **4.1.7 Value for virginity**

Value for virginity and fear about premarital sexual activity is another factors contributing to girls being married in an early age. This was common among the Waha, Chaga and Sukuma of Tanzania. To confirm this, physical examination could be performed before marriage. Furthermore in many cultures around Sub Saharan Africa, a woman's sexuality is not her own to control, but the property of her father, husband, family or ethnic group. Because of this the decision to marry and to initiate sexual activity is often not a young woman's but that of family members, whose honor and shame are defined by whether or not she is a virgin before she is married (Mathur S, 2003). Once a girl has menstruated, fears of potential pre marital sexual activity and pregnancy become the major concern among family members who are accountable for protecting her sexuality. Thus, the timing of girl's

first menstruation is associated with the first steps towards marriage in many settings (save the children, 2004).

## **4.2 Consequences of unprotected sex and early marriages**

### **4.2.1 Early pregnancy and child bearing**

In Tanzania and other Sub Saharan countries, many young people begin childbearing in their teenage years. According to TDHS 2004-05 data, overall, 26 percent of young women (age 15-19) are pregnant or already have children. Teenage pregnancy and motherhood are more common in rural areas (29%) than in urban areas where it is 20 percent (TDHS 2004-05). Early pregnancy impact on a girl's education, economic well being and health. Adolescent's girls get pregnant and have children before they are physically, emotionally and socially mature enough to be mothers (WHO, 2004). Adolescent girls become pregnant for different reasons, for instance a pregnancy can be accidental and result from experimenting with unplanned sexual intercourse and lacking knowledge on preventing conception, while others result from abusive, forced and coerced sex. Married adolescents are pressured to have a child to achieve adult status (UNFPA, 2007). Early parenthood is likely to affect educational achievement with significant implication for employment and socio-economic opportunities, while health complications for both teen and unborn child are higher. Pregnancy before the age of 18 carries greater medical risk for the mother. The risk of dying from complications related to pregnancy or childbirth is 25 times higher for girls under 15, and two times higher for those aged 15-19, than for women their twenties (Save the children, 2004).

### **4.2.2 Sexually transmitted infection (STIs) and HIV**

Adolescents bear an increasing risk of exposure to infection with STIs. Sexually Transmitted Infections are more prevalent among the young rather than adults. In Tanzania, nearly half of all HIV infection occurs among women and men under the age of 25, and in many developing countries, including Tanzania, data indicate that up to 60% of all new HIV infections are among youth aged 15 to 24 years. Infection among females outnumber that of males by the ratio 2 to 1 (World Youth Report, 2003). A study done in Tanzania found that young women were more than four times more likely than young men to be infected with HIV, even though females were less sexually experienced and reported fewer partners than their male counterparts (Mwakakile, 2001). The reasons which explains the susceptibility of young girls compared to their male counterparts include the

biological reason since the vagina and cervix of adolescents are less mature, thus less resistant to HIV and other STIs (Chalamilla G, 2006).

Another factor driving the HIV/AIDS and other STI among adolescents is the behavior of multiple sexual partners which is compounded by unprotected sexual intercourse. For instance in a questionnaire survey carried out among 1041 students in secondary school and colleges students in Dar-es-Salaam, Tanzania, self reportedly, 39% had a regular sexual partner and 13% had multiple partners in the previous year (Maswanya, 1999).

Young people are at high risk of STIs and HIV for a variety of reasons, such as lack of information about STIs, including HIV, not perceiving themselves to be at risk, lack of access and inconsistent use of condoms, lacking of power and skills to negotiate condom use, or cultural religion norms regarding sexuality and fertility (BEST 2000). Adolescents may be reluctant or unable to seek treatment for STIs or HIV because they fear the disapproval of their family or community, or because they are afraid to get tested, or that they do not know the symptoms. In addition, since HIV may be asymptomatic, they may not know they are infected (World Youth Report, 2003).

#### **4.2.3 Unwanted pregnancies and unsafe abortion**

In Tanzania, abortion is highly restricted by law and permitted only if the pregnancy is threatening the women's life. Illegal abortions are punishable by imprisonment up to 14 years for the abortionist; this means seven years for the woman and three years for any person who is caught inducing that abortion. Although the law is very strict, prosecutions for abortions are rare (Silberschmidt and Rasch, 2001). Despite existing anti-abortion law and cultural restriction around abortion, adolescent girls in Tanzania do seek abortions for unwanted pregnancies, for instance a recent hospital based study from Dar-es-Salaam indicates that of the 362 women who had allegedly miscarried the majority had in fact had an illegal abortion. Half of these women were aged 20 years and below (Rasch, Silberschmidt and Mchumvu, 2000).

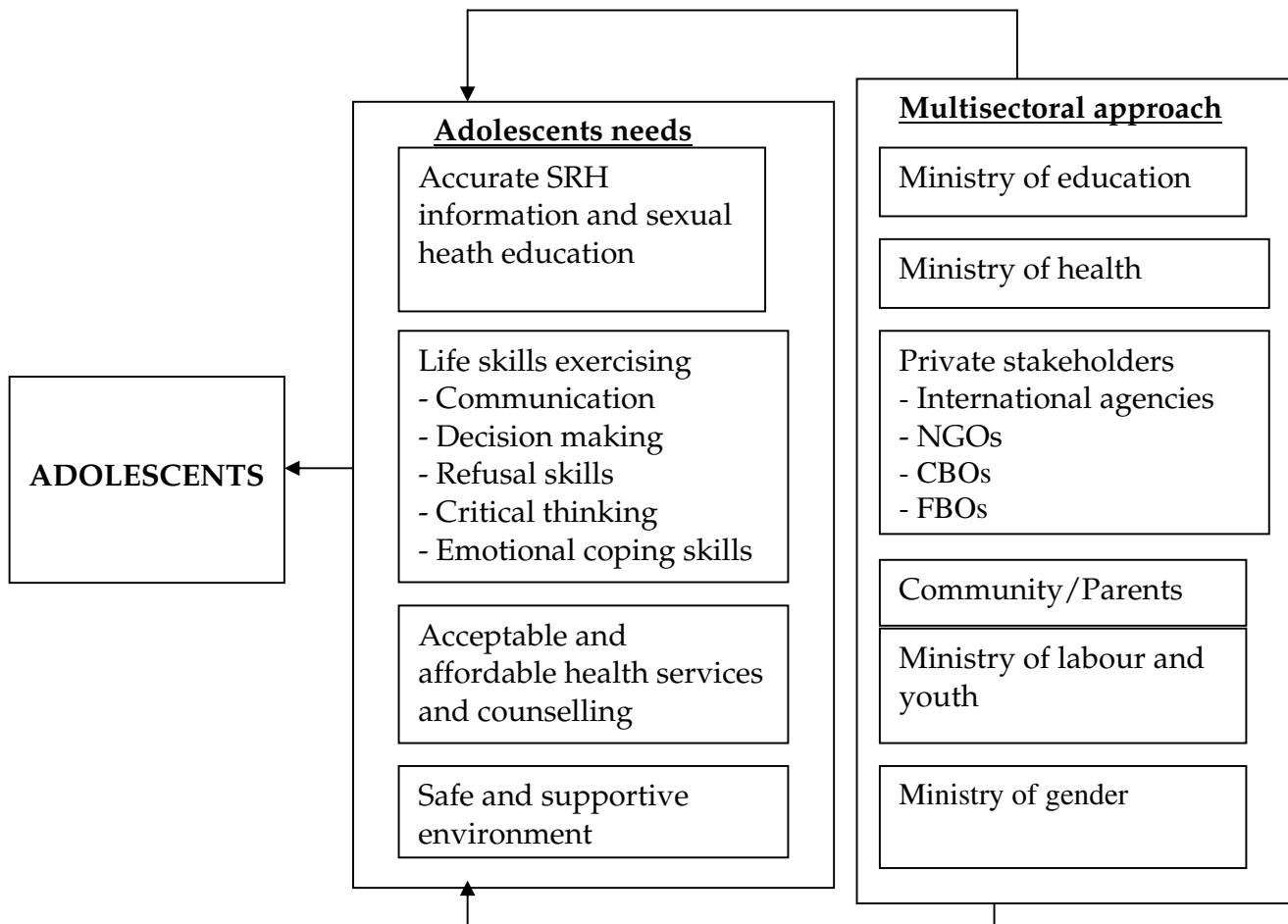
Abortions are often done late during pregnancy and in dangerous circumstances, thereby putting girls and women at high risk of serious complications such as sepsis, hemorrhage, genital and abdominal trauma, perforated uterus or poisoning (WHO, 2001-2004). In addition, the hospital admitted girls due to abortion complications were found to be sexually active at an early age, they had regular sex with different sexual partners and sometimes they dated more than one partner at same period and they did not attend family planning clinics (Rasch V and Silberschmidt M, 2000).

### **4.3 Adolescent's sexual and reproductive health needs**

This section explains the SRH needs of adolescents given their SRH problems discussed in the previous section. The following conceptual framework is used to visualize the needs of adolescents and the response of multisectoral approach on meeting adolescents SRH needs.



**Conceptual framework for Sexual and Reproductive health needs of adolescents and multisectoral response**



**4.3.1 Accurate information**

Different studies have revealed that, Adolescents need accurate and age appropriate information about their physical and emotional development, potential risks of unprotected sex, and information on how to access health services. Adolescents are eager to learn about reproductive health and are open to advice on how to handle their personal problems. The current sources of SRH information such as mass media and peers seem to lack accurate and comprehensive information. There is a need to expand on other credible sources of SRH information such as parents and other community adults. In addition, Different stakeholders and institutions such as schools, health units, vocational training and existing young people activities such as football clubs, drama and scout can be the best sites to target and disseminate SRH messages. Information provided should be designed to motivate adolescents to adopt and maintain healthy behaviors (PATH, 2005).

### **4.3.2 Life skills**

Life skills such as communication, refusal skills, decision making, critical thinking and self evaluation are very important for empowering adolescents to resist pressure on negative behaviors such as unprotected sex, use of subsistence drugs and smoking. Others are emotional coping skills which includes stress management and an internal locus of control. Training in life skills enables adolescents to develop positive and adaptive behaviour that help them make decisions and manage the challenges of their lives. This should go along with information and access to services; life skills help adolescents translate knowledge, attitude and values into healthy behaviours (WHO, 2001-2004).

### **4.3.3 Acceptable and affordable health services including counselling**

Adolescents need comprehensive preventive and curative health services, including sexual and reproductive health services which are adolescent friendly, accessible and affordable. Furthermore, adolescents need counselling from the adults or their peers when they have concern about themselves or events surrounding them, or even when they need help to deal effectively with problems. By understanding their situation better, they will be better equipped to make informed and sound decision (WHO, 2002). Adolescents have in many surveys expressed their views about what they want from health services. These are,

- Welcoming facility, where they can drop in and be attended to quickly
- Privacy and confidentiality and do not want to have to seek parental permission to attend
- Service in a convenient place at a convenient time
- Services to be free of charge
- Staff to treat them with respect and not judge them
- The provision of range of services such as contraceptives, STIs/HIV/AIDS (WHO, 2002).

### **4.3.4 Safe and supportive environment**

The term safe and supportive environment is employed to include the social, economic, cultural, and political context of an adolescent's life, and the types of safety and support that are present. These protective factors include positive relationships with adults at home and in the broader community (WHO, 2007), a positive school environment and peers who have positive attitudes and protective behaviour (World Youth Report, 2003). Whereas at a societal level, it is mainly defined by social and cultural norms, government laws and policies, mass media and some times religion.

Evidence shows that adolescents who live in such environment are less likely to initiate sex too early, use substances or experience depression (WHO, 2001-2004). In addition, adolescents need protection at work, since they are often exposed to abuse, sexual harassment and exploitation (ILO, 2003).

## **Chapter Five**

### ***5. Policy and programme Response towards adolescents sexual and reproductive needs***

Presented here are the existing policies, laws and programmes addressing the SRH needs of adolescents. Programmes is meant here to encompass any organized primary prevention, care or support activity designed to make sexual and reproductive health information and services available to adolescents. Programmes such as Africa Youth Alliance (AYA), MEMA kwa Vijana (MkV) and ISHI campaign will be discussed. The mentioned programmes are selected given their wider coverage of their activities and due to the fact that their activities have been evaluated. A critical analysis identifying gaps and constraints is provided in the discussion chapter

#### ***5.1. Policies and laws affecting ASRH in Tanzania***

##### ***5.1.1 HIV policy***

Youth activities on HIV/AIDS are guided and directed by national policy which itself is based on the National Multisectoral Strategic Framework (NMSF) 2003-2007. National Multisectoral Strategic Framework provides the strategic guidance to the planning of programmes, projects and interventions by various stakeholders in the fight against HIV/AIDS. By following the NMSF, stakeholders have the opportunity to focus on specific thematic areas, objectives, strategies in relation to their area of focus (TACAIDS, 2003).

For instance the NMSF thematic area two (2), calls for stakeholders to participate in HIV prevention activities. According to NMSF, segments of individuals in the society are not the same. Evidence shows that, women, men, young people, and disabled differ in their health needs, based on their economic, social and cultural situation (TACAIDS 2003). Thus, NMSF call programmes to address specific groups using specific approaches. Furthermore, NMSF emphasizes the need to focus on children and young people who are not yet infected with HIV in order to support them to remain HIV free (TACAIDS 2003). The NMSF strategy to achieve prevention of HIV among young people is based on;

- Increasing sources and quality SRH information to adolescents

- Provision of life skills and HIV information in primary and secondary schools through integrating SRH sessions in curricula. The sessions will be teacher led by using participatory methods.
- Intensifying and expanding competent youth centers providing friendly health services and VCT services and other interventions in the community for out of school youth
- Empowering girls to negotiate safer sex through strengthening their knowledge on HIV/AIDS
- Increase the proportion of sexually active young people who use condoms by expanding the distribution of quality condoms to all corners of the country through private and public channels (TACAIDS 2003).

### **5.1.2 Reproductive and Child Health Policy**

The national policy for reproductive health and child health Services (2003) supports young people access to SRH information and services, including family planning services. This policy targets to HIV prevention, unwanted pregnancy, mortality and morbidity during pregnancy and child birth in an integrated manner through Maternal and Child Health department (MCH) and STI department. One of the strategies in improving sexual and reproductive health is through increasing contraceptives use and levels of delivery attended by trained health personnel (Arvidson A and Nordstorm M, 2006).

Furthermore, Ministry of Health under Reproductive and Child Health department have developed a national standard for adolescents' friendly health services. Seven standard statements specify the requirement performance at points of delivery, health worker performance as well as health system performance (See appendix 2). Each standard statement is accompanied by a clear list of what needs to be done to achieve the standards and how to verify that work is proceeding as planned (MoH, 2004).

### **5.1.3 User fee policy**

According to the government policy, the adolescents are not exempted from payment of user fee charges. Exemptions are targeted to vulnerable groups. These have been defined to include pregnant mothers and children under the age of five years who are in greater chance of being affected by diseases, especially the communicable ones. These are directed to get free of charge medical services on essential reproductive and child health related problems. Also, the policy identifies people who are suffering from diseases, such as diabetes, HIV/AIDS, leprosy, TB, polio and cancer, as eligible for exemptions (MoH, 1994).

#### **5.1.4 Education Policy**

The government of Tanzania recognizes the salient of addressing adolescent's sexual and reproductive health by keeping children and adolescents in school through the policy of Universal Primary Education. In addition, Ministry of education recognizes that children are sexually active at an early age. Thus effective policy measures have been taken to control the spread of HIV/AIDS through the introduction of family life education system by providing effective HIV and AIDS life skills education to all primary schools and out of school youth programmes (Arvidson A and Nordstorm M, 2006).

Furthermore, Ministry of education is concerned of retention and improve the performance of girls in primary and secondary school. The Ministry of Education and Vocational Training strategy to achieve this is through hiring of trained and motivated female teachers and improving gender dynamics in classrooms and within school environment. This will also have an impact in reducing early marriages and early child bearing among adolescent's girls (Arvidson A and Nordstorm M, 2006).

#### **5.1.5 Age of consent for sexual activity**

The consent for sexual activity is 18 years and above. It is stated that a male is said to have raped a girl when she is less than 18 years of age, unless the woman is his wife who is 15 or more years of age and is not separated from the man (Tanzania National laws, updated 2006).

#### **5.1.6 Age of consent for Marriage**

The minimum age for marriage is 15 years for girls and 18 years for boys as per the law of marriage act number 5 of 1971. The same act states that a marriage woman aged 15 years and above is no longer a child (Tanzania National Laws, updated 2006). In addition, Islamic law seems to permit the marriage of individual who have reached puberty, and at that stage, an individual is considered an adult.

### ***5.2 Response from the Africa Youth Alliance (AFHS)***

In collaboration with the National Reproductive and Child Health Section of the ministry of Health (RCHS) in the mainland and the safe motherhood programme of Ministry of Health in Zanzibar, Africa Youth Alliance (AYA) worked with 58 facilities across the country, including 44 public facilities (Pathfinder/AYA, 2005). AYA aimed to increase sustainable outlets of quality

Adolescents Friendly Health Services (AFHS) in the districts, obtain government commitment and support in provision of AFHS in the district, demonstrate that public health facilities can equally provide quality AFHS and in a more sustainable manner than NGOs and was to increase collaboration among government , NGO, and private organizations in promoting AFHS. Services offered in a basic package include;

- Counselling on sexual violence and abuse
- Contraceptives and protective methods provision
- Post abortion care (PAC) counselling and contraception with referral when necessary
- HIV counselling and referral for testing and care
- STI diagnosis and management

### **5.2.1 Targeted population**

The immediate beneficiaries of AYA – project were young people aged 10-24, with the emphasis on adolescents' age 10-19 years old. Other secondary targets included teachers, health workers, social workers and parents. The tertiary target groups were religious leaders, media, politicians and policy makers. Policy makers were crucial in creating a supportive environment for the project to carry out its activities (Pathfinder/AYA, 2005).

## ***5.3 AYA approach for implementing AFHS***

### **5.3.1 Needs assessment**

The pre program needs assessment conducted by AYA – Tanzania discovered major shortcomings. Adolescents complained that services did not meet their needs, service providers were judgmental, waiting times were long and confidentiality was non existent. Lack of privacy exposed them to the risk of being spotted by parents while visiting health facilities. Given the strong cultural taboo against premarital sex and child bearing outside marriage, adolescents were scared of being seen as challenging traditional norms. Adolescents were not involved in the programmes, through service providers were insensitive and felt their participation was not valued (AYA/Pathfinder 2003).

On the side of service providers, AYA found that there was no AFHS training provided to them. On top of that, service providers did not have access to any policies, protocols or standards/guidelines related to providing quality AFHS. And did not have appropriate IEC materials concerning adolescents health, and lastly AYA discovered that reproductive health services provided were not comprehensive and the clinics had frequent shortage of condoms (AYA/Pathfinder 2003)

In response, AYA integrated AYFS in the existing health facilities, which were located in urban and rural areas of the country. AYA worked in 10 districts – Tarime, Karangwe, Kasulu and Kibondo others were Arusha, Ilala, Temeke and Kinondoni. Districts in Zanzibar – Urban West region in Pemba.

### **5.3.2 Health provider's characteristics**

In responding to health provider's attitudes and bias towards adolescents health needs, AYA with other stakeholders designed a training manual and then trained Trainers of Trainees (ToT) who then trained health service providers. The topics included in the curriculum are counseling and communication, contraceptives options, STI and HIV prevention and management, sexual abuse, pregnancy, birth and reproductive health situation of Tanzania's youth. Other health staff was trained on Health Management Information System (HMIS). However the challenge was that, the available data had not segregated the AYA targeted age groups, and thus AYA had to develop its own tools for data collection which included the segregated age group targeted by AYA (Pathfinder, 2005).

To ensure efficient and effective implementation of the activities, AYA provided training to supervisors to equip them with the information and skills needed to support their health providers to adopt positive attitudes towards adolescent's needs. Health providers also learnt monitoring and evaluation skills, and orientation of other staff in health facilities was conducted to support adolescents when they come to the health facilities (Pathfinder, 2005).

### **5.3.3 Health facility characteristics**

Africa Youth Alliance responded to the problem of privacy, renovations of the facilities were done to make them more private and attractive to adolescents. In some facilities adolescents had their own waiting and consultation rooms equipped with television, video, newspapers and behaviour change communication materials. One clinic in Kasulu used its own funds to split one room into four to better serve adolescents and guarantee privacy required.

Furthermore, the opening hours for the health facility were extended during the days and during weekends. The adjusted hours were convenient to adolescents as they did not coincided with school hours and work time (Pathfinder, 2005).



#### **5.3.4 Programme design characteristics**

The AYA programme conducted a community and stakeholders mobilization. City and Municipal authorities were sensitized on unmet SRH needs of adolescents and other youth and the rationale for government involvement and support. This helped to create awareness of the services at community levels (Pathfinder 2005).

The programme has involved adolescents in many ways, for instance youth serves as mystery client, assessment team members, and peer service providers, and they have increased providing feedback through suggestion boxes and feedback registers at the facilities, and have served on youth or health boards. During their participation, adolescents discuss their needs and issues with community members and service providers. The report quoted adolescent females who attended a group discussion session "the quality of reproductive health services has changed, It is no longer a matter off being told what to do and what not to do by the service providers. Nowadays clients are given an opportunity to explain themselves and their needs; and there is now a more open dialogue between service providers and clients about issues that traditionally have not been discussed during medical consultation" (Pathfinder, 2005).

#### **5.3.6 Achievements of AYA programme**

There was an observed increase in adolescent's visits to the health facilities throughout the course of the project. For instance during the program evaluation, they found that the number of young people attending SRH services has increased from 113,083 to 243,070 in 2004. It was also easy to access SRH services for adolescence, since AYA strengthened its health management information system (HMIS) by computerizing SRH service information and through segregating the age groups according to the targeted groups (10-14, 15-19 and 20-24). The country's HMIS does not have such age breakdown, the forms indicate under five and adults. There was also reported high enthusiasm among the Council Health Management Teams (CHMT) to scale up integration of YFS in as many public health facilities as possible (Pathfinder, 2005).

#### **5.3.7 Challenges faced by AYA programme**

The concept of AFHS was new to health service providers and they first perceive it as a new stand alone activity, which implied an additional pay. AYA had to conduct staff orientation and training for them to understand that the introduced adolescents friendly services are part of the Reproductive Health Services. Also the geographical locations of some sites

were hard to reach, thus few supervision visits were provided to the remote sites. (Pathfinder, 2005).

### **5.3.8 Lesson learned in provision of AFHS**

- Involvement of community and government leaders is vital, because it gives conducive environment for programme activities to take place
- Trained health services providers are able to ensure privacy and confidentiality
- Provision of flexible drop in counselling and treatment services has increased adolescents access to SRH services
- Importance of data collection and ongoing monitoring, supervision and feedback in order to improve the outcomes
- Involvement of adolescents in all aspects of project design and implementation
- Use of existing government and private structures ensures sustainability of activities and reduce the costs.

### **5.4 MEMA kwa Vijana Programme – multiple component**

MEMA kwa vijana (“good things for young people” in Kiswahili) phase 2 is an innovative adolescents sexual and reproductive health (ASRH) programme which aimed to build local government capacity to implement a large scale programme in 649 primary schools and 168 health units in four districts of Mwanza Region. Later the community intervention was introduced to support the ongoing school and health facility interventions (Hayes et al, 2005).

#### **5.4.1 MEMA Kwa Vijana Approach**

The programme has multiple components and consists of teacher led, peer assisted ASRH session in standard 5, 6 and 7 of primary school. Another component includes training and supervision of health workers in the provision of youth friendly health services. Third component is community intervention condom promotion and distribution. The programme objectives aimed at delaying onset of sexual intercourse, reducing the number of sexual partners and encouraging the correct and consistent condom use among sexually active adolescents (Hayes et al, 2005).

#### **5.4.2 Sexual health**

The science teachers were selected and trained by District Trainers and Supervisors (DTS) from the education sector to teach SRH sessions in class. The lessons were highly participatory and involved use of drama, stories,

role plays, games and class room exercise. The performance of a series of short drama and role plays were assisted by class peer educators (CPE) who were elected by their class mates. The MkV programme designed teacher's guides and picture charts which were visualized during class session. The MkV - SRH sessions aimed to complement science sessions which were not comprehensive in the school curricula. The MkV2 - SRH sessions were taught once every week (Hayes et al, 2005).

#### **5.4.3 Youth friendly services**

Health workers in the intervention sites were trained to provide youth friendly services. The main emphasize was on adoption of a friendly and non judgmental attitude to young people, and ensuring privacy and confidentiality. Further more health workers introduced the services through visiting the local primary schools. In addition, teachers and health workers organised periodic visits from school to the clinic to familiarize students with the facilities (Hayes et al, 2005).

#### **5.4.4 Community intervention**

A special system of condom promotion and distribution was established. Young men and women were elected by young people themselves in each community. The selected young people were trained to promote and supply condoms to adolescents and young people at affordable price of US\$ 0.08 a pack (Hayes et al, 2005).

#### **5.4.5 Success of MkV2 Programme**

The impact evaluation survey was conducted in 2001/02 and involved 9645 adolescents aged 15-19 years in 20 communities in the 4 programme district. The findings were as follows;

- External evaluation of the intervention showed that the intervention component were high quality, well implemented and achieve high coverage.
- There was improved in knowledge and reported attitude in both males and female adolescents
- There was no consistent impact of the biological indicators of HIV/STIs and pregnancy rates

#### **5.5 ISHI campaign – mass media**

Ishi "to live" in Kiswahili, was an HIV/AIDS behaviors change communication campaign targeting adolescents men and women aged 15 to 19. ISHI has worked closely with its key partners such as adolescents and youth,

Population Service International, Family Health International, FEMINA HIP and other NGOs that target adolescents in the fight against HIV/AIDS. The campaign was coordinated by Healthscope Tanzania under the direction of TACAIDS. The major donors included USAID, IRELAND AID and DANIDA (Glass WS et al, 2002).

### **5.5.1 ISHI approach**

The campaign was launched in three region of Tanzania – Dar-es-Salaam in 2001, Dodoma 2001 and Iringa 2002. The campaign was implemented by phases. The key message for the first phase was “you can not tell by looking: wait or use condom every time”. While the second phase message was “Usionee soo! Sema naye” meaning, “Don’t be shy, talk to your partner”. These messages were delivered through a combination of community mobilization, mass media, and interpersonal communication (Glass WS et al, 2002).

To enhance adolescent’s ownership, the team of 15 young people was formed to lead the campaign, common known as Youth Advisory Group who received technical guidance from NGOs, government leaders and religious organizations. The aim of the group was to increase awareness of HIV/AIDS among adolescents, promote use of the Voluntary Counselling and Testing among adolescents, and to recommend abstinence, remaining faithful to one partner who is uninfected and using condoms (Glass WS et al, 2002).

Different methods were used to effectively disseminate information to adolescents. Mass media was a major component, this included advertising HIV/AIDS preventive messages on radios, preparing sessions by inviting adolescents audience for discussion and this was broadcasted live on TV, and billboards which reminded adolescents and youth about the key messages. In addition, a football league, music performance and youth rallies complemented the mass media component (Glass WS et al, 2002).

The methods were targeting adolescents at different locations, for instance out of school youth were reached through performing art groups at community rallies and public gatherings. While in – school adolescents were reached through involving teachers to organize sports, essay competitions and debates on SRH issues (Glass WS et al, 2002).

### **5.5.2 Success of ISHI campaign**

ISHI campaign quickly scaled up to 23 regions and became a nationwide program supported by mass media, community rallies and teachers who supported the in school activities.

### **5.5.3 Factors contributing to ISHI success**

- Political support from TACAIDS
- Donor Financial support
- Use of mass media (radio and television)
- Formation of youth advisory groups who would carry activities at regional level
- Collaboration with other NGOs such as ANGAZA – VCT who are widely distributed throughout the country
- Use of the music concerts – they used Bongo flavor (Swahili hip hop) which is popular among adolescents
- Activities were peer led. This improved communication among peers and adolescents

### **5.5.4 Challenges faced**

The campaign faced resistance in largely dominated Muslim population in Zanzibar, because the campaign promoted the use of condom. ISHI is underway to see how they can reach adolescents in Zanzibar without offending the culture and religion beliefs of the community; the plan is to mobilize parents, local leaders and religion leaders (Glass WS et al, 2002).

#### Why Challenge

- Lack of research to allow direct adjustments of program activities to take place in different social cultural and religious background of the population
- Lack of parents and religious leaders' mobilization. This is the lesson that Political support is not enough to allow program activities to take place in any community

### **5.5.5 Lesson learnt by ISHI campaign**

For National youth behaviour campaign to succeed, five components must be in place

- Adolescents involvement
- Efficient and clear management mechanism
- High level of political support
- Precisely defined target audience
- Multiple media reinforce one consistent message

## ***5.6 Discussion of the policies and programme approaches to meet adolescents' SRH needs***

This section provides a discussion on the policies and programmes approaches in addressing adolescent's sexual and reproductive health needs. The aim of this section is to identify the opportunities and the gaps in the policy and programme implementation.

### **5.6.1 Adolescent's policies**

Tanzania lack funds and inadequate mechanism to distribute and disseminate the policies throughout the country. For instance Africa Youth Alliance (AYA) – Pathfinder carried out a needs assessment of broader issues for YFS, including policy, programming and service delivery. They found that one of the limiting factors in implementation of YFS is that, health service providers do not have access to any policies, protocols or standard/guidelines related to provision of quality adolescent friendly SRH services (AYA/Pathfinder, 2003).

Furthermore, though the policies support the access of SRH information and services to adolescents, in reality its implementation is not possible without provision of training to health service providers to change their attitudes and the judgmental communication style which currently exists (Brown H, 2007). Also the existing government structures lack privacy, due to shortages of enough rooms, or sometimes the absence of door in health units. Thus, such environment is not attractive to adolescents who do not want the community and parents to know that they are sexually active and needs SRH services (AYA/Pathfinder, 2003).

In Tanzania the existing policies are not harmonized. Some examples include the policy on health service user charges did not exempt adolescents from paying user fees charges, whilst another health policy called for services for adolescents to be free. According to Reproductive and Child Health (RCH) country coordinator, Dr. Mapella the country has limited resources, and thus free services to adolescents can not be provided (Brown H, 2007). Another example is the contradiction between the HIV/AIDS policy that support condom distribution including at school while the education policy states that condoms can be discussed but no demonstration or distribution can be conducted in schools (Pillay Y and Flisher A, 2008).

Tanzanian law that allows marriage at age of 15 is against the convention rights of a child that internationally recognizes that, anyone below the age of 18 is a child. Meaning that the existing law in Tanzania allows child marriage. Girls who get married at 15 and get pregnant are at risk of

complications during delivery. In addition, Some Tanzania laws lack strong enforcement. For example the law of age of sexual consent and age of marriage are not re-enforced. Thus male take the advantage of these loopholes to sexually abuse girls. This is done by men marrying young girls of lower age than the formal accepted age of 15 years. This has also led to primary school girls drop outs due to pregnancy. Little or none is being done to punish men who are involved in sexual behaviour with young girls.

However, initiations from different NGO's working with adolescents are carrying out advocacy and policy dissemination work. By distribution of policy booklets and brochures to the targeted groups like policy makers, civil leaders, religion leaders, schools, health units, youth and parents. It is hoped that this dissemination will improve knowledge and actual implementation of these policies.

#### **5.6.2 Use of existing structures, and expands on what is already done**

Most sites, even in rural areas, have existing structures such as schools and health facilities which can be tapped by programmes to reach a big number of adolescents. However, there are notable challenges to overcome. The system themselves lack capacity in terms of human and economical to support such activities. There is also lack of supervision necessary to ensure the sustainability of the programme. This is due to the fact that the administrative unit of the district are large, some schools and health units are very far from district canters and hardly reachable during rain season.

Non government initiatives have limited resources to allow the SRH programmes scaling up nationally. However this is possible with government willingness. The government can mobilise funds and involve other stakeholders for the design of curricular and strategies to implement SRH in schools. For instance the government of Tanzania has included family life sessions as part of school curriculum. However, these measures have primarily involved the Ministry of Education. There is a strong need for other stakeholders' involvement in the planning and implementation of measures concerning ASRH inorder to make the curricular more comprehensive while incorporating life skills activities (Leshabari and Kaaya, 1997)

There has been assumption that inclusion of reproductive health issues in the school curricula of primary and secondary schools will be sufficient. But in reality, Teachers are not well prepared. They lack special skills like participatory methods of communication to help them teach children better and psychological support for sexually active young people (Mushi et al, 2007).

The introduction of universal primary education (UPE) In Tanzania in 2001 has increased primary school registration to 97%. However there is huge drop outs of children at secondary level due family failure to pay school fees and also because of the unevenly distribution of secondary school in the region. This gives an opportunity for primary schools to be the main venue to reach young people, including girls who start child bearing before the age of 18. The need to include safe motherhood in school health curriculum is crucial. Other SRH information which adolescents need to learn at an early age include topics such as danger of early marriage and early pregnancies, unsafe sex, dangers of un spaced pregnancies, abortion and HIV/AIDS prevention from mother to child (Mushi et al, 2007)

ISHI campaign activities utilized other existing adolescent's activities such as sports, local events and music concerts. Most of these activities attract a larger number of adolescents. For example SRH information and training in skills can be added to people who are involved in adolescent's recreational activities such as sport teams, religion groups, scouting groups. A good example is in Ghana, where Young Women Christian Association (YWCA) added reproductive health education at a center that had been established to provide job skills and other services to girls who live in urban areas (Speizer I et al, 2003).

### **5.6.3 Use of Multi sector response**

Programmes which respond to adolescents SRH needs will have to seek multisectoral solution that link health sector interventions with other types of interventions delivered through other sectors, either at the programme level or at policy level (Lule et al, 2006). For instance AYA - AFHS activities were facility based activities and did not interact with existing activities at schools or in communities that were also aimed at addressing ASRH. When different sectors complement each others efforts there is often a better outcome as the different issues are best tackled by specific sectors. For example one of the reason adolescents indulge in sex is to get money to support themselves or their families and this needs interventions aimed at addressing their economic need (Brown H, 2007).

Furthermore, programmes like MkV2 and ISHI campaign attempted the use of multi sector approach by having programmes that targeted schools, health facilities and the community. However, there was lack of collaboration with other programmes working with adolescents.

Other sectors apart from the health sector such as the education and gender sector plays big role in improving SRH of adolescents. For instance, studies have shown that both female and males students who remain enrolled in



school during their teens are substantially less likely to have sex than their unmarried peers who are not enrolled in school (Lloyed C, 2005). Thus resources spent on expanding opportunities for secondary schooling in Tanzania may have a direct effect on reproductive health of adolescents.

Looking on the programmes so far, very few addresses FGM which requires a community understanding of gender issues that affect ASRH including FGM.

#### **5.6.4 Community and parent's involvement**

One of the constraints expressed by parents and other significant adults is the opposition to provide sex information and condoms for fear that providing information on sexuality and contraception would lead to increased sexual activity (Kaaya et al, 2005). One of the reasons could be that programmes lack parent's and community's involvement right from the beginning of the programme planning and implementation of activities.

The role of adults in the community including parents is very crucial and influences adolescent growth and development. Thus, little can be done to improve SRH of adolescents without the support of adults. Adult attitudes and behaviour concerning adolescent's sexuality is often one of the greatest barriers to creative and effective programmes that reach large numbers of adolescents (WHO, 2007). For example ISHI activities faced resistance in Zanzibar due to sidelining the involvement of parents, and religious leaders at the community level. Having community interventions at the community level involving opinion leaders allows custodians of culture to start debating about existing practices that may not be healthy to adolescents. This further enables communities to come up with alternatives that are safer (Leshabari and Kaaya, 1997).

#### **5.6.5 Diverse groups of adolescents**

There is a problem in defining the most appropriate stage at which reproductive health information should be introduced into life of young people. For instance in Tanzania in any one class, there may be students at a stage where they can assimilate and comprehend information on menarche, as well as those who are too young to benefit from such information. In such a diverse group, there is a need to address issues such as terminology to be used in explaining reproductive health to children and young people.

As is the case in many developing countries, school based programme have potential to reach large numbers of young people. However, it is equally true that not all adolescents go to school. Out of school youth seems to be often

bypassed with respect to formal programmes; the reason could be that they are often less accessible than the school population. Consequently, programmes need to find means of reaching youth who are not at school (Singh et al, 2005).

Though these formal programs have provisions on sexuality education, they seem to be taking a fragmentary appearance failing to take a comprehensive approach. Researchers have indicated that successful sexuality education programmes use variety of teaching methods, focus on personalizing the information, present basic and accurate information about the risks of and avoidance of unprotected sexual intercourse, and provide opportunities to practice communication, negotiation and refusal skills (Speizer et al, 2003). Many of the existing approaches could have some positive effects upon some outcomes such as increase knowledge and change in attitude. While programmes with reasonably strong evidence of delaying sex, increasing condom or contraceptives use, seem to be very rare (Speizer et al, 2003).

While it is understood and appreciated that sex education is more than knowledge about contraception, STI or HIV education, there is need to include more social, psychological and emotional aspect of sexuality in the programmes.

#### **5.6.6 Programme evaluation**

The lack of evaluation studies seems to be distinct too, with few evaluation studies being conducted so far, research findings can not be used to improve and expand programme approaches. Looking at other regions in Africa, evaluation studies are often too inconclusive to yield reliable guidance on programme effectiveness (Speizer et al, 2003). In addition, some of the problems reported in school based programmes like the unpreparedness of teachers to talk about the aspect of sexuality to the students need more attention.

## **Chapter six: Conclusions and Recommendations**

### **6.1. Conclusions**

Despite the efforts taken to address reproductive health issues among adolescents. Trends still shows that adolescents face major sexual and reproductive health (SRH) problems such as STIs/HIV, unwanted pregnancy and unsafe abortion.

There are several factors influence adolescents unsafe practices in Tanzania. These are poverty and greed for material things, globalisation, rising age at marriage due to increased tome of schooling, sexual abuse and coercion, gender roles, tradition and cultural practices.

Adolescent's in Tanzania lack sexual and reproductive health information and life skills to allow them make informed decisions. In addition, practices such as rape and coercion are reported to have increased. However the increased reported rape and coercion cases could be as a result of improved media and wide spread of human rights information among the communities in Tanzania.

A number of national policies that have beneficial implications for adolescent's sexual and reproductive health have been put in place. However, these policies are not widely disseminated and implemented. Given the lack of inadequate mechanism to distribute and disseminate the policies throughout the country.

Within the country, a number of initiatives have been developed and are being implemented to promote and provide SRH information and youth friendly services. These initiatives tend to have an impact on increased knowledge and change in attitudes towards SRH among adolescent. There no reported behaviour changes.

In Tanzania where the primary school enrolment is high due to universal primary education policy. Primary school has been the best area to target adolescents with SRH information and skills. This is because the drop out rate increases as young people advance to secondary schools.

## **6.2 Recommendations**

- Government should widely disseminate the policies through mass media such as radio and television
- Laws affecting adolescents health should be reviewed and re-enforced
- Government should promote interventions which targets adolescents in an existing structures such as schools and health units, this will allow sustainability of ASRH activities because these structures are permanent and funded by the government
- There is a need for Multisectoral approach in tackling adolescents' health needs. Because adolescent's SRH problems are contributed by many factors ranging from social – cultural, economic and globalization
- Government should invest in secondary schools to reduce the high drop out rate of adolescents. Keeping adolescents in school will reduce adolescents engagement in high risk sexual behaviours such as early marriages and early childbearing
- The programmes designed to meet the needs of adolescents should be culturally appropriate to the locality in which it is instituted and to the target population. Cultural sensitivity included using age appropriate materials, as well as being aware of adolescents coming from different areas. For instance adolescents in Tanzania mainland and adolescents in Zanzibar are different because of social cultural and religion belief. Thus program materials can be adjusted according to different situations.
- Adolescents programs should be linked, for example a school based programme must be linked with clinical services for adolescents. Programmes that raise awareness of adolescents health needs requires support services that can in turn respond to their health problems and concerns. Knowledge about health needs diminishes when there are no complementary health sources available. It is equally important that these services are accessible and close to school
- The NGOs and programme targeting to improve SRH of adolescents should pay attention to parents and community adult by either orient them on importance of ASRH or by training them on ASRH issues and the importance of parents to children communication on SRH issues
- Needs assessment and research components are very important for identifying factors contributing to adolescent's behaviour.

This will help ASRH programmes to exactly responds to the adolescents SRH needs

- Programme experiences need to be documented and reviewed in order to scale up best practices.
- Adolescents sexual and Reproductive health approaches must be reviewed to increase the involvement of young people in order to provide capacity building and empowerment
- Communication skills of health providers need to be modified to meet the needs of adolescents, and the existing infrastructures for providing services needs to be considered to allow privacy
- Comprehensive SRH sessions should be incorporated and taught in teachers college. The sessions should insist the use of participatory method.
- Family life school curricula should be reviewed and made comprehensive to allow adolescents at school learn different issues such as motherhood, safe sex, STIs/HIV, unsafe abortion, contraceptives and biological changes due to puberty.
- Programme design need to realistically confront the reproductive health problems of young people to deal appropriately with pertinent issues such as sexually active teenagers, teenagers who already face problems such as STI and unwanted pregnancy and those who are worried about menarche

## Reference

**Alemu B** (2006), Early Marriage in Ethiopia: Causes and health consequences  
[http://www.kit.nl/net/KIT\\_Publicaties\\_output/ShowFile2.aspx?e=1417](http://www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1417)

**Arvidson A**, Nordstrom M (2006) Tanzania, Health Sector Policy Overview, Paper September 2006

Arvidson A, Nordstrom M, (2006) Tanzania Education Sector policy overview paper. Stockholm environment institute

**AYA/Pathfinder** (2003), Youth Friendly Sexual and Reproductive Health Services: An Assessment of Facilities. AYA/Pathfinder 2003

**Bankore A**, Singh S, Woog V and Wulf D (2004) Risk and Protection: youth and HIV/AIDS in Sub-Saharan Africa (New York, Alan Guttmacher Institute)

**Bastien S** (2007) Out of School and "at risk"? Social- demographic characteristics, AIDS knowledge and risk perception among young people in Northern Tanzania. *International Journal of Education Development* 28(2008) 393-404

**Bayley O** (2003) Improvement of sexual and reproductive health requires focusing on adolescents. *The Lancet*.vol 362. September 6, 2003.  
[www.thelancet.com](http://www.thelancet.com)

**Berhane-Selaisse T**(1993): Research on early marriage or child marriage in Ethiopia; summary of interim report. Newsletter of the Inter-African committee on Traditional practices affecting the health of women and children. Issue 15:11

**Brown H** (2007) Profile Elizabeth Mapella: Prioritizing adolescents health in Tanzania. *The Lancet*, volume 369, issue 9567, 31 March 2007- 6 April 2007, Page 1075

**Chalamilla G**, Mbwana J, Mhalu F, Mmari E, Majigo M, Swai A, Urassa W and Sandsrom (2006) Pattern of Sexually Transmitted Infections in adolescents and youth in Dar-es-Salaam, Tanzania.*BMC Infectious Disease* 2006, 6:22

**Clark S**, Glynn J, Buve A and Carael (2004) Early marriage and HIV risks in Sub-Saharan Africa, *Studies in Family Planning*, 2004, 35(3):149–160; M.

**Glass WS**, Nguma J, Lupogo H, Cunningham E, Gikaru L, Obwaka E, Boulay M, Gilbert S (2002) New HIV/AIDS prevention campaign in Tanzania: Ishi reaches young adults. *International Conference on AIDS*, 2002 Jul 7-12; 14: Abstract no. WePeD343

**Hayes R**, Chagalucha J, Ross D, Gavyole A, Todd J, Obassi A, Plummer M, Wight D, Mabey D and Grosskurth H (2005) The MEMA kwa Vijana Project: Design of a community randomized trial of an innovative adolescents sexual health intervention in rural Tanzania. *Contemporary clinical trial* 26 (2005) 430-442  
<http://www.interpol.int/Public/Children/SexualAbuse/NationalLaws/CsaTanzania.pdf>  
<http://www.measuredhs.com/pubs/pdf/OD45.pdf>

**ILO** (2003) HIV/AIDS and Child labour in the United Republic of Tanzania: A rapid assessment. A case study of Dar-es-Salaam and Arusha. IPEC – International Programme on the elimination of child labour [http://www-ilo-mirror.cornell.edu/public/english/standards/ipec/publ/download/hiv3\\_tanzania\\_en.pdf](http://www-ilo-mirror.cornell.edu/public/english/standards/ipec/publ/download/hiv3_tanzania_en.pdf)

**Kirby D**, Di clemente R.J (1994), School based Intervention to prevent unprotected sex and HIV among adolescents. In preventing AIDS: Theories and Methods of Behavior Intervention. Plenum press, New York pp 117 – 139

**Leshabari M, and Kaaya S** (1997): Bridging the information gap: sexual maturity and reproductive health problems among youth in Tanzania; health transition review, supplement 3 to volume7, 1997, 29-44

**Leshabari M**, Kaaya S and Kessy A (2008) A dolescents Sexuality and the AIDS Epidemic in Tanzania. What has gone wrong.

**Lloyd C** (2005) Growing Up Global: The Changing Transitions to Adulthood in Developing Countries, Washington, DC: National Academies Press. ISBN 0-30909-528-X. National Research Council and Institute of Medicine, panel on Transitions to Adulthood in Developing Countries Sexual relations among young people in developing countries:

**Lule E**, Rosen J, Singh S, Knowles J and Behrman J (2006) Adolescent Health Programs. Chapter59. Disease control Priorities in Developing countries. Medline, [www.sextransinf.com](http://www.sextransinf.com)

**Madihi, M.C.D** (2000): Situational analysis of working children: The case of the mining sector in Tunduru, report submitted to the Ministry of Labour and Youth Development, Child Labour Unit.

**Masatu M** (2003) Frequency and perceived credibility of reported sources of reproduction health Information among primary school adolescents in Arusha, Tanzania. <http://sjp.sagepub.com/cgi/content/abstract/31/3/216>

**Maswaya E**, Moji K, Horiguchi K, Nagata K, Aoyagi S, Honda and Takemoto T (1999), Knowledge, risk perception of AIDS and reported sexual behaviour among students in Secondary school and colleges in Tanzani. Health edu. Res. 14:185 – 196, 1999. Doi:10.1093/her/14.2.184

**Matasha E**, Ntembelea T (1998) Sexual and reproductive health among primary and secondary school pupils in Mwanza, Tanzania. AIDS Care, 09540121, Oct98, Vol. 10, Issue 5. Psychology and behaviour Sciences Collection

**Mathur S**, Greene M and Malhotra A (2003) Too Young to wed. The lives, Rights, and Health of Young Married Girls. International Center for Research in Women (ICRW) [http://www.icrwm.org/docs/tooyoungtowed\\_1003.pdf](http://www.icrwm.org/docs/tooyoungtowed_1003.pdf)  
Ministry of Education and Vocational Training (2006) Basic education statistics in Tanzania (BEST) Dar-es Salaam: The adult Education press

**Ministry of Health, Tanzania – MoH** (1994). Proposals for health sector reform. *Ministry of Health, Dar Es Salaam.*

Mitchell A, Smith A (2000) Safe sex messages for adolescents. Do they work? *Australian Family Physician* 29, 31 – 34

**Mpangile G** (1999), Induced Abortion in Dar es Salaam, Tanzania: The plight of adolescents. *Abortion in the developing World.* Geneva WHO

**Mpangile G.S,** Leshabari M and Kihwele D (1993). Factors associated with induced abortion in Public Hospital in Dar-es-Salaam, Tanzania, Dar-es-Salaam. Family planning association of Tanzania (UMATI).

Msuya S, Mbizvo E, Hussain A, Sundby J, Sam N and Pedersen B (2002) Female Genital Cutting in Kilimanjaro, Tanzania: Changing attitudes? *Tropical Medicine and International Health*, Volume 7 NO 2 PP 159-165

**Mushi L,** Mpembeni R, Jahn A (2007) Knowledge about safe motherhood and HIV/AIDS among school pupils in rural area in Tanzania. *BMC pregnancy and childbirth* 2007, 7:5 doi:10.1186/1471-2393-7-5

**Mwakagile D,** Mmari E, Makwaya C, Mbwana J, Biberfeld G, Mhalu F and Sandstrom E (2001) Sexual behaviour among youths at high risk for HIV-1 infection in Dar es Salaam, Tanzania. *Sexually Transmitted Infections* 77:255-259

**Mwakagile D.,** Mmari E., Makwaya C. (2001) Sexual behaviour among youths at high risk for HIV-1 infection in Dar es Salaam, Tanzania. *Sexually Transmitted Infections* 77:255–59 (August 2001).

**Mzinga J** (2002) Changing gender roles in Tanzania. *Sexual health exchange* 2000-04 [http://www.kit.nl/exchange/html/2002-4\\_changing\\_gender\\_roles\\_i.asp](http://www.kit.nl/exchange/html/2002-4_changing_gender_roles_i.asp)

**National Adolescents Health and Development Strategy:** RCHS – MoH 2004 – 2008

**National AIDS Control Program** (2002), United Republic of Tanzania, HIV/AIDS/STD Surveillance, 2002.

National Bureau of Statistics (2004-05) [Tanzania] and ORC Macro. 2005. *Tanzania Demographic and Health Survey 2004-05.* Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro.

**Demographic and Health Survey** (2004-05) National Bureau of Statistics (NBS) [Tanzania] and ORC Macro. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro



**Nyanzi S.**, Pool R, and Kinsman J (2001). "The Negotiation of Sexual Relationships among School Pupils in South-western Uganda." *AIDS Care* 13(1): 83–98.

**Pathfinder International** (2005) Integrating Youth Friendly sexual and Reproductive Health Services in Public Health Facilities: A success story and Lesson Learned in Tanzania. November 2005

**Population Reference Bureau** (2002) the World Youth 2000

Rasch V and Silberschmidt M (2008) Illegal Abortion among adolescents in Dar-es-Salaam

**Rasch V**, Silberschmidt M, Mchumvu Y, Mmary V (2000) "adolescents Girls with Illegally Induced Abortion in Dar-es-Salaam: The Discrepancy between Sexual Behaviour and Lack of Access to Contraception", *Reproductive Health Matters*, 2000, 8:52-62

**Save the Children** (2004) Children having Children: Where young people mothers are most at risk. USAID, cooperation number HRN-A-00-00-00016-00

**Silberschmidt M** and Rasch V (2001) Adolescents girls, illegal abortions and "sugar daddies" in Dar-es-Salaam: Vulnerable victims and active social agents. *Social science and medicine* 52 (2001) 1815-1826

**Singh S** (2000) Gender differences in the timing of first intercourse: data from 14 countries, *International Family Planning Perspectives*, 2000,26(1):21–28.

**Singh S**, Bankole A, Woog V (2005) Evaluating the need for sex education in developing countries: sexual transmitted infections/HIV and unplanned pregnancy. *Sex education* Vol.5,No.4, November 2005, pp.307 – 331 (New York, Alan Guttmacher Institute)

**Tanzania Commission for AIDS -TACAIDS** (2003), National Multi – Sectoral Strategic Framework on HIV/AIDS 2003 – 2007. The prime ministers office, Dar es Salaam. January, 2003

<http://www.tanzaniahiv aids.info/documents/Strategies/National%20MultiSectoral%20Framework%202003-20007.pdf>

**Tanzania Commission for AIDS –TACAIDS** (2003-04), National Bureau of Statistics (NBS), and ORC Macro. *Tanzania HIV/AIDS Indicator Survey 2003-04*. Calverton, Maryland, USA: TACAIDS, NBS, and ORC Macro.

Tanzania Demographic profile (2007) Tanzania Demographics Profile 2007.htm  
C:\Documents and Settings\Administrator\My Documents\Proposal designing\

**Tanzania Gender Network Programme** (TGNP 2007), Women Health in Tanzania – Key findings from the 2004 -05 TDHS and the 2003 – 04 Tanzania HIV/AIDS indicator survey

Tanzania National Laws (2006) Legislation of Interpol member states on sexual offences against children – Tanzania, Dar-es-Salaam. Updated in spring 2006

**The Future is in Our Hands:** Tanzanian Youth, Reproductive Health and HIV. Data from the 2004-05 Demographic and Health Survey (TDHS) and the 2003 Tanzania AIDS Indicator Survey (THIS)

**UNAIDS** (2006) FACTS FOR ADOLESCENTS: A Contribution to achieving the Global Goals and Universal Access for Young People. A publication from the UNAIDS Interagency Task Team on HIV and Young People, Draft January 2006

**UNAIDS** (2006) Facts for Adolescents: A contribution to achieving the Global Goals and Universal Access for Young People. A publication from the UNAIDS interagency Task Team on HIV and Young people. Draft January 2006

[http://www.afro.who.int/adh/documents/facts\\_for\\_adolescents.pdf](http://www.afro.who.int/adh/documents/facts_for_adolescents.pdf)

**UNFPA** (2003), State of world population 2003, Making 1 billion count; investing in Adolescent health and rights

UNFPA (2007) Giving Girls Today and Tomorrow, breaking the cycle of adolescent's pregnancy. United Nations Population Fund, [www.unfpa.org](http://www.unfpa.org)

**UNICEF** (2001) Early Marriage; Child spouses, Innocents digest no 7  
<http://www.unicef.org/publications/pdf/digest7e.pdf>

**WHO** (2001-2004), adolescents and development: a WHO regional framework 2001-2004. Value adolescents invest in the future. World Health Organization – Geneva.

**WHO** (2002) Adolescent Friendly Health Services. An agenda for change. World Health Organization, Geneva. WHO/FCA/CAH/02.14

**WHO** (2006) Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries: WHO study group on female genital mutilation and obstetric outcome. *The lancet* 2006; 367:1835-1841

**WHO** (2006), Building a better future for youth: Learning from Experience and Evidence, Africa Regional Forum on Youth Reproduction Health and HIV. June 6-9, 2006 Dar-es-Salaam. United Republic of Tanzania. Department of Reproductive health and Research, World Health Organization, Frontiers in Reproductive Health, Population Council, YouthNet, Family Health International

**WHO** (2007) Helping parents in developing countries improve adolescents' health.  
*WHO Library cataloguing in publication data*

**World Population prospects** (2005): The 2004 revision. New York, United Nations.

## **Annex 1: Map of Tanzania**

### **Geographical location**

The United Republic of Tanzania is situated on the East coast of Africa. The country covers an area of 945,234 km<sup>2</sup>, and borders Kenya and Uganda to the North, Democratic Republic of Congo (DRC), Rwanda and Burundi to the West; Mozambique, Malawi and Zambia to the South (see Figure 1).

**Map of Tanzania** (figure 1)



**Source:** National Geographic ( accessed on 10/08/2008)

## **Annex 2: Standards of adolescent friendly reproductive health services.**

- All adolescents will be able to obtain information & advice relevant to their needs, circumstances & stage of development.
- All adolescents are able to obtain sexual & reproductive health services that include preventive, promotive, rehabilitative & curative services that are appropriate to their needs.
- All adolescents are informed of their rights on sexual & reproductive health information & services whereby these rights are observed by all service providers & significant others.
- Service providers in all delivery points have the required knowledge, skills & positive attitudes to provide sexual & reproductive health services to adolescents effectively & in a friendly manner.
- Policies & management systems are in place in all service delivery points in order to support the provision of adolescent friendly sexual & reproductive health services.

- All service delivery points are organized for the provision of adolescent friendly reproductive health services as perceived by adolescents themselves.
- Mechanisms to enhance community & parental support are in place to ensure adolescents have access to sexual & reproductive health services.

However, what this means in practical terms is that all the actions depicted on this slide address both prevention of HIV as well as other aspects of reproductive health (notably prevention of pregnancy, and prevention of mortality during pregnancy and child birth). These include actions to:

- make health workers and support staff adolescent friendly,
- make service delivery points appealing and user-friendly to adolescents,
- draw upon the support of community members,
- Link health service provision to complementary initiatives (such as education programmes) in the community