

ADOLESCENT FRIENDLY HEALTH SERVICES IN TANZANIA

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Adolescent Friendly Health Services in Tanzania

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Masters of Public Health

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRH	Adolescent Sexual Reproductive Health
BCC	Behavioural Change Communication
BLM	Banja La Mtsongolo
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DHMT	District Health Management Team
FCI	Family Care International
FGM	Female Genital Mutilation
GDP	Gross Domestic Product
GNI	Gross National Income
HIV	Human Immune Virus
HSR	Health Sector Reforms
ICRW	International Centre for Research on Women
IDC	Infections Disease Centre
IEC	Information Education and Communication
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
LPS	Life Planning Skills
MOE	Ministry of Education
MOH	Ministry of Health
NACP	National AIDS Campaign Programme
NGO	Non-Governmental Organisation
NHIF	National Health Insurance
NHP	National Health Policy
PSI	Population Services International
RH	Reproductive Health
RHMT	Regional Health Management Team
SRH	Sexual & Reproductive Health
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission For AIDS
TASO	The AIDS Support Organisation
TDHS	Tanzania Demographic Health System
TRCHS	Tanzania Reproductive and Child Health Survey
UMATI	The Family Planning Association of Tanzania (Uzazi Na Malezi Bora Tanzania)
UNAIDS	United Nations Program on HIV/AIDS
UNFPA	United Nation Population Fund
UNICEF	United Nation Children Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YFS	Youth Friendly Service

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ABSTRACT

An adolescent in Tanzania face sexual and reproductive health problems leading to disability, diseases and even death. Sexual and Reproductive Health services (SRH) are often adult centred and limited. This paper provides an overview of the country Adolescent Sexual Reproductive Health (ASRH) in Tanzania, factors contributing to these problems, and actions that have been taken in Tanzania and in the neighbouring countries to address ASRH. This paper provides recommendations on how to improve ASRH based on literature review.

Majority of adolescents are at risk of unsafe sex. The social culture and environment are among influencing factors, which contribute to sexual behaviour that leads to health problems. Perceptions of risk, lack of effective sex education, socio-cultural norms, and peer pressure are among some of the contributing factors to SRH problems. Adolescent's utilisation of SRH services is limited.

There is a need to have responsive interventions addressing ASRH. The policy and legal environment need to be supportive of ASRH to facilitate healthy life styles. Policies from the education sector and the health sector need to be harmonised. Making existing health services in all health facilities country wide available, friendly and accessible to all adolescents requires re-organise and re-orient SRH services to ensure privacy, confidentiality and involvement of adolescents themselves. Key opinion leaders such as religious leaders and traditional healers need to be part of programme planning and implementation. Collaboration is needed among different stakeholders working on SRH to avoid duplication of efforts, ineffective and inefficient use of limited resources.

Key words: Adolescent Sexual and reproductive health indicators, sexual behaviour, adolescent development and puberty, factors influencing reproductive health behaviours, peer pressure and peer educators, unwanted pregnancy and unsafe abortions, sexual transmitted infections and HIV/AIDS, adolescent friendly services, including Tanzania health policy.

INTRODUCTION

My interest to work with adolescents started in 2003 when I was working in Huruma Hospital in the department of surgery and the in obstetrics and gynaecology ward. The major causes of admission among adolescents were complications due to unsafe abortion and recurrent sexually transmitted diseases.

I was very surprised to see how these adolescents suffer from infection even when drugs were available. The formal system and infrastructure of health facilities in Tanzania was not adequately addressing the root causes of the problems being presented at the health facilities. In fact, there were no special services or units for adolescents. As a Catholic nun, it has been a challenge to understand that sexuality education is very important and this masters course has challenged many of my original views about the subject.

In this paper, adolescents are defined as the 10 to 19 year age group in accordance to the WHO guidelines (WHO, 2003). Adolescents face Sexual and Reproductive Health (SRH) problems such as unplanned pregnancy, unsafe abortion, sexually transmitted infections including HIV and sexual abuse. There is also limited information, education and communication on sexual matters, from parents, teachers as well as from health providers to the adolescents. As a result, most adolescents are at risk of indulging in sex at a very young age (Mapella, 2005). Consequently, they find themselves having unwanted pregnancies and sexual infections because they do not have knowledge and/or skills on how to protect themselves.

A study, done by the National AIDS Campaign Programme, (NACP) in 2005, which consisted of a review of records over a five year period at Muhimbili Hospital in Dar es Salaam, found that about 54 deaths out of 76 deaths, among adolescents aged 13-19 years in Dar-es Salaam city were due to self medication and suicide associated with unwanted pregnancy among adolescents (TDHS, 2005).

When an adolescent is pregnant, she often finds it difficult to attend antenatal care as she first wants to hide the fact that she is pregnant and she fears that she will be subjected to judgmental attitudes of health service providers (Klepp et al., 2008). In another study, adolescents who had tried self-medication mentioned that the nurses were rude to them, they did not have time to listen to their problems, there was no privacy, and that they were requested to go and come back with parents or the guardians in order to receive the health services from the health facilities (Mapella 2005)

Another challenge is limited information about what services are available and where they are available in order to address their SRH needs. Other barriers for accessing SRH are the availability of health facilities unaffordable consultation fees, services being offered at hours when adolescents are at school or working places, and poor attitudes of health providers towards

adolescents especially for being sexually active. The barriers to service utilisation often lead to self-medications in case of STIs and abortion and others seek care at traditional healers.

Adolescent Sexual Reproductive Health (ASRH) cannot be neglected because adolescents are the base for the future of a nation. If access to family planning services was increased, this unmet need could be met, therefore the provision of sexual education should be promoted. Part of meeting the targets for the Millennium Development Goals for Tanzania requires addressing the ASRH needs which will directly contribute to reducing maternal and child mortality.

Through this document, the following terms will mean,

Adolescents 10 – 19

Youth 10 - 24

Young People 15 – 24

(WHO, UNFPA, UNICEF, 2003)

CHAPTER 1. BACKGROUND INFORMATION

1.1 The Nature and Sequence of Changes during Adolescent

The word adolescent means someone who is growing up, or some one who is neither a child nor an adult, a person who may be biologically an adult but yet socially immature (IPPF, 2005). According to World Health Organization, adolescence is defined as the period of life between the age of 10 and 19 years. It is an age characterized by impatience as well as curiosity, and by a strong desire to leave childhood to adulthood.

This period is characterized by a notable spurt in both the body growth and structure and by the appearance of secondary sexual characteristics. During this period, the body develops in size strength and reproductive capabilities, and mind becomes capable of more thinking that is abstract. (UNICEF, 2003). The speed at which some of the physical changes manifest, themselves, may vary from one adolescent to another, depending on factors like, the genetic background, race, sex, economic and social class, area of a country or previous life experiences (WHO, 2003).

Investing in adolescents' health and development will also reduce the burden of morbidity and mortality in later life because healthy behaviours and practices adopted during adolescence tend to last a lifetime (Mapella, 2005). Investing in adolescent sexual and reproductive health is good for a country's economy, as adolescents will contribute to productivity gains when they enter the workforce. As a human right adolescents have a right to achieve the highest attainable level of health (WHO, 2007).

1.2 Global Information on Adolescents Sexual and Reproductive Health.

There are more than 1.1 billion adolescents worldwide today. One in every five people aged between 10 and 19 years. About 85% live in developing countries (World Population 2007). Majority of them are sexually active, and they face problems to access their needs especially services related sexual health services. Lack of Adolescent Sexual and Reproductive (ASRH) put them to practice sexual risk behaviour such as unsafe sex that leads to unwanted pregnancy, early marriage, contact of sexual transmission infections, including HIV/AIDS as well as unsafe abortions (WHO, 2006).

The estimated growth of urban adolescent population in developing countries was pegged at 600% between 1970 and 2025 (World Urbanisation report, 2005). Globally it is about 73 million adolescents aged between 10 and 14 years who work in informal sectors have risk to their health including their RH (UNICEF and ILO, 2005). Millions of adolescents throughout the world live and work on the street, which presents high risk to sexual abuse, infections and substance use (ILO, 2002 to 2005).

Many adolescents are sexually active, and in some regions are married (ICRW, 2007). Sexual activities put adolescents at risk of different reproductive

health challenges. Each year about 15 million adolescents aged between 15, 19 years give birth, and about 4 million seek abortion while STIs affect about 100 million adolescents (UNFPA, 2006).

Globally, 40% of all new HIV/AIDS infections occur among the 15 to 24 age group and about 7,000 adolescents are infected every day with HIV (UNAIDS report 2006). All these health problems are attributed to factors such as early sexual debut, early marriage, lack of sex education gender inequities and sexual violence (Senderowitz, 2005). Coupled with these challenges, are limited access to sexual reproductive health information and services in rural and urban areas by adolescents needs. Many adolescents need relationships with parents or siblings with whom they can talk about their sexual and reproductive needs and problems. Despite these challenges, programs that meet the information and service needs of adolescents also are not readily accessible (Mapella, 2005).

There is a growing prevalence of sexual abuse of adolescents globally and adolescents are trafficked for commercial sex work further jeopardising adolescents SRH. Another challenge facing adolescent is Female Genital Mutilation (FGM), which presents a very high risk of infection, sterility, and permanent sexual dysfunction. WHO findings stipulate that between 5 and 97 per cent of women experience FGM in regions where it is practiced and that 100 million girls have had their genitals cut with 3 million undergoing it each year. In much of sub-Saharan Africa in countries such as Egypt, Somalia, Sudan, Tanzania, female genital cutting is practiced (CEDAW Report, 2008).

Many parts of the world continue to experience relative poverty despite many development gains made in the past century. Poverty and poor health systems make adolescents vulnerable to sickness and premature death (WHO, 2007). It has been estimated that about 20% of adolescents in developed countries have access to RH health services compared with 5% of adolescents in developing countries (WHO, 2007).

1.3 Information on adolescent's sexuality and reproductive health in Tanzania

According to the 2002 National Census, 33% of the population of Tanzanians is aged between 10 to 24 years. One out of every three Tanzanian is a young person.

Adolescents in Tanzania are at risk from a broad range of health problems. Sexual and reproductive health behaviours are among the main causes of death, disability and other diseases among young people including adolescents. They face a high risk of unwanted pregnancy and pregnancy related complications (UNICEF, 2006) including sexual infections like HIV/AIDS.

Unwanted pregnancy is a big problem for adolescents and a challenge for adolescents to manage the transition from adolescents to parenthood, isolation, unstable relationships and social family opposition to their involvement as young fathers and young mothers (UNAIDS,2006).

About 3 000 to 5 000 adolescent girls dropped out of school due to pregnancy (MOE, 2005). School drop out in Tanzania in the southern part of the country is increasing every year due to culture that a girl should get married at the age of 13-14 years. At this age, the sexual reproductive organs are not matured, in addition no information about sex has been provided to them. The myth here is, to avoid ovary decay. Furthermore, adolescent mothers in Tanzania face many health problems due to becoming young mothers (UMATI, 2006).

Pregnant adolescents face problems during delivery due to immature reproductive organs, which put them at high risk of complications such as fistulas due to obstructed labour. The risk of mortality and morbidity is higher in infants born to adolescent mothers than among older women (Safe mother hood, 2006). Hospital data shows that the adolescent's pregnancies account for the 40% of maternal mortality rate (Pathfinder, 2005). In a country where 80% of pregnant women receive Antenatal Care and 60% end up delivering in health facilities assisted by a skilled health provider, and 40% attended by unskilled birth attendant and in adolescents hospital record shows that 30% of adolescents deliver at home (MOH 2007).

Unsafe abortion is a major problem among Tanzanian adolescents with 30% of maternal deaths occurring among adolescents aged between 2 to 16 years of age (TDHS, 2005). Muhimbili hospital, which is a university hospital, admits 50% of abortion related complications admissions are among young people aged between 15 to 24 and as many as 24% die from abortion-related causes (Hussein et al., 2005). Due to poor attitudes of health care providers, 10% of adolescents when they are pregnant prefer to seek advice on termination of pregnancy from unqualified persons, including traditional healers (Klepp et al., 2008). Such services put them at risk of morbidity and even death.

With an overall 7% HIV prevalence rate, in Tanzania the 15 to 19 age group has a prevalence rate of 2.1% for both females and males. In this same age group, comprehensive knowledge of HIV was at 44% among females compared to 49% among males. Sexual intercourse among youth was 66% while contraceptive use was at 7%. Condom use among adolescents in Tanzania is very low. Less than 37% of adolescents aged between 15 and 19 knew the 3 primary ways of avoiding infections that is abstinence, being faithful and consistent condom use (Pathfinder, 2003). Low rates of comprehensive knowledge of HIV, high incidents of sexual intercourse among teenagers, low contraceptive use and a HIV infection risk among adolescents makes it important for the comprehension of sex education among adolescents (NACP, 2007/Berer,2003).

Records at the Infection Diseases Control (IDC) in Dar es Salam shows that 55% of all STI clients seen for the period of one year were adolescents from 15 to 24 years of age (NACP, 2006).

The practice of FGM varies across Tanzania. In some regions it is as low as 18 of girls subjected to the practice while in other areas, almost every girl undergoes FGM. According to the Tanzania Demographic a Healthy Survey, in Kilimanjaro region the prevalence of FGM in 2005 to 2006 dropped to 25 per cent from the recorded 37% in 1996. Nationally, FGM prevalence is at 15 per cent (CEDAW Report, 2005).

Adolescents also face physical and psychological trauma resulting from FGM, sexual abuse and other forms of gender based violence. This particular age group is also vulnerable to problems because they often engage in sex unprepared and may have many sexual partners. Their vulnerability is further aggravated by limited awareness of protection against infections, lack of skills to negotiate safer sex and poor health seeking behaviour (Mapella, 2001-2004).

Gender roles are masculine or feminine behaviour expressed according to culture or social customs and norms as boys and girls globally are treated differently from birth onwards it is during adolescence when gender roles intensify (WHO, 2002). Boys achieve more power to authority while girls get fewer opportunities to acquire authority. Adolescents develop a close relationship with peers conforming to language, dress and customs (CRC 2005). It helps them to feel protected and gives them a sense of belonging to a large group.

Peer pressure, together with gender inequities within a sexual relationship could mean that a man have undue power to dictate sexual decision to females (CEDAW, 2006). The relationship of parents and adolescents can prevent adolescents from acquiring unhealthy risk behavioural.

CHAPTER 2. TANZANIA COUNTRY PROFILE

In this chapter, the author will provide an overview of Tanzania that will include the country's geographical location, the demographic statistics, the socio-economic situation, the health care system, and the adolescent reproductive health issues.

2.1 Country location

Tanzania is in Eastern Africa and lies between longitude 29⁰ and 41⁰ East, latitude 1⁰ and 12⁰ South. The country is bordered by Kenya and Uganda to the north, Rwanda, Burundi and Democratic Republic of Congo in the west; Zambia, Malawi and Mozambique in the south; and the Indian Ocean in the east (United Republic of Tanzania 2006).

Tanzania is the largest of the Eastern African countries and has a spectacular landscape of mainly three physiographic regions namely the Islands of Mafia, Pemba and Zanzibar; the coastal plains to the east, and the highlands. The Great Rift Valley that runs from north east of Africa through central Tanzania is another landmark that adds to the scenic view of the country. The country has an area of 935,087sq km of which 59,050sq km is taken up by water while land makes up the remaining 886,037sq km. It has a mixed culture, which is partly from Africa, Arab, European and Indian influence (United Republic of Tanzania, 2006).

The highest mountain in Africa which is Mt Kilimanjaro is found in Tanzania which is bordered by the three largest lakes on the African continent which are Lake Victoria (the world's largest fresh water lake in the north; Lake Tanganyika (the world's deepest lake) lies in the west; and Lake Nyasa is found in the southwest (Tanzania Country Profile 2006).

2.2 Demographic situation

The 2002 census estimated the population of Tanzania to be 34 million people with a growth rate of about 2.9% and it has been projected that by 2010, the population will be 43 million people (URT 2002). In the 2002 Population and Housing Census in Tanzania, found that the country's population was 34,569,232 (33,584,607 Mainland; 984,625 Zanzibar (TACAIDS, 2005). Tanzania's population is largely young with 65% of the population aged below 25 years. The 10-24 age group make up 31% of the total population (TACAIDS, 2005). There is a variation of population density by region attributed to a number of factors such as fertility and mortality difference and internal migration in search of arable land. The highest population density is found in Dar es Salaam Region with about 1793 people per sq. km while the lowest population density is found in Lindi Region with a population density of about 12 per sq. km.

2.3 Socio-Economic Situation

More than 80% of the population is rural. In terms of religion, 40% are Muslims, another 40% are Christian while 20% of the population practice indigenous beliefs. Kiswahili is the main official language seconded by English. Tanzania has a higher literacy rates among males, 79.9% for the mainland and 86% for Zanzibar. In contrast, female literacy rate is 67% in the mainland and 76.8% in Zanzibar. There are about 120 ethnic groups with the largest ethnic groups are the Nyamwezi, Nyakyusa, Chaga, Sukuma, and Haya, with a population of more than 1 million each (Country Statistics, 2006). The majority of the work force is in the agricultural sector (80%) while the industry, commerce and government share the remaining 20%. The GDP in 2006 was \$11.98 billion and Tanzania has an average economic growth rate of 6.2% and a per capita income of \$319. Agriculture accounts for the 44.7% of GDP while the industry contributes about 9.2% of the GDP. In terms of trade, in 2006, exports were worth \$1.723 billion (Country Statistics, 2006). The country's national parks occupy 4.5% of the country's total land, play a major role in biodiversity preservation, and are major tourism attraction that contributes to the country's foreign currency (Country Profile, 2006).

2.4 National Health Policy

The Tanzanian government soon after independence in 1961 identified three enemies to fight with namely poverty, ignorance and disease. The government implemented a health policy aimed at providing free health services for all through the establishment of referral systems starting from village to the national level, by following the Arusha Declaration in 1967. Although this was an ideal policy for insuring availability of basic health services to the poor community, it was not achievable and was not sustainable. The government then embarked on Health Sector Reforms (HSR) in 1984 aimed at redefining health policies and restructuring its health system focusing on policies, structures and institutional functions, efficiency and performance monitoring. This resulted in decentralization of health services from the central to the community level through District Health Management Teams. This led to changes in resource allocation, priority setting and management of health service delivery within the local community (National Health Policy, 2002-2007). The government spent 9.4% of its total budget on health for the year 2007. It intends to make sure that 93% of the population are within a distance of 10 kilometres of health facilities (National Healthy Policy, 2004)

There are laws and policies affecting the rights of adolescents such as protecting adolescents below the age of 18 from early marriage (Marriage Act, 1971). and the policies aim to improve the overall quality of life of adolescents. The health policy has been based on gender equality and equity, participatory decision-making, respect for adolescent's human rights, efficiency and effectiveness. Specifically, the policy aims to create a conducive environment and legal framework for advancing adolescent's health; increasing

participation and utilisation of innovative, integrated and high quality services and among parents and adolescents, positive attitudes and behaviour change (MOH, 2003).

2.5 Health care system

At national level, the consultant hospitals are for referrals, teaching and research services. At Regional and District level, the Regional Health Management Team (RHMT) and District Health Management Team (DHMT) manage the system. The teams are responsible for planning, organising, implementing, supervising and evaluating health services. There are village health services at village posts and dispensaries that provide health care. In addition to that, there are health services provided by Non-Governmental Organisations (NGOs) and the private sectors (MOH, 2004). The Reproductive and Child Health Unit of the Ministry of Health coordinates all RH services including The National Family Planning Programme. Family planning services have evolved from being a small component of maternal and child health and by 1986, a separate unit was established dedicated to FP services. The infant mortality rate is 68 per 1,000 live births (MOH, 2000).

In relation to HIV/AIDS programmes, there is the National AIDS Control Programme, which is responsible for coordinating all HIV and AIDS related activities in the country. At regional level, the RHMT is responsible for coordination and supportive supervision of District HIV/AIDS activities including awareness rising to general population. An AIDS coordinator is responsible for condom distribution to the health facilities and peer educators, and these should reach adolescents (NACP, 2005).

2.6 Health Financing

Tanzania has over the last two decades, undergone several reforms in health care financing ranging from user fees, introduction of a national health insurance fund for the public employees and a community health fund for the rural and for the informal sector. Other developments include the introduction of the Micro Insurance Schemes covering the informal sector and a National Social Security Fund for the private formal sector. Despite these attempts to make health care accessible to all, a vast majority of people have limited access to health care with catastrophic out of pocket payments (MOH, 2004). From 1986 the country adopted a policy of subsidizing health services by funding operational and personnel emolument costs to public health institutions.

Since subsidy remitted to health institutions were only covering 40% of the actual annual budget, while priority was directed to children and pregnant women also for the life threatening conditions such as malaria, malnutrition diarrhoea and others (MOH, 2000).

During the past one decade, the government adopted a cost-sharing scheme in which the government remitted at least 70% and the remaining is covered through individual patient's contribution (user fee.) to all public and private health care facilities (MOH, 2000). The policy on health services user charges did not exempt adolescents from charges, whilst another called for services for adolescents to be free. Sexual health education was proposed in one, but out of school youth were not mentioned (National Health Policy, 2004).

2.7 Adolescent sexual and reproductive Health

Sexually transmitted infections are a widespread problem among adolescents in Tanzania. Every year 20% of adolescents suffered from a curable sexual transmitted infection and every 3 minutes one adolescent is infected with STIs and HIV/ AIDS. The National AIDS Campaign Program has documented this in the year 2006. HIV prevalence is currently at 7.3% and the epidemic is associated with nearly 50% of deaths among adults aged between 15 and 44 years (Masatu et al., 2008). About 80% of HIV transmission in Tanzania is through heterosexual activity. The remaining portion is through blood transfusion and contaminated surgical instruments with blood and blood products and mother to child transmission including drug injection users. Study done by the team from NACP from 2000-2007 shows that only 2 to 5% of HIV infection is through peri-natal transmission and intravenous drug users (NACP, 2005).

As the major mode of transmission of STIs and HIV/AIDS is sexual intercourse, condom use one of the major method for protection against STI and sexually transmitted HIV infection (NACP, 2005). Condoms are usually available throughout the country. However, the access to condoms among adolescents is a challenge. Adolescents feel uncomfortable to go to the public health units to be seen by their relatives and parents, taking condoms. There are also laws in the county that states that sexual debut should not start before the age of 18 (Marriage Act, 1971). Adolescents should delay sex until marriage, which is emphasised for both the Islamic and Catholic religious groups (Eklesia, 2007). As a result, adolescents get them from private pharmacies and in private health care units if they can afford them, which is often not the case (Pathfinder, 2001).

CHAPTER 3. PROBLEM STATEMENT AND OBJECTIVES

3.1 Problem Statement

According to background information, Tanzania is one of the developing countries facing the major public health problems in sexual and reproductive health for their adolescents. The majority of adolescents in Tanzania are at risk from a broad range of health problems. Sexual and reproductive health behaviours are among the main cause of death and disability. Adolescents are at risk of unwanted pregnancy, unsafe abortions, pregnancy related complications, STIs, and HIV/AIDS (WHO, 2005).

The Tanzania Reproductive and Child Health Survey conducted in 2003 shows that the median age at first sexual intercourse for girls is less than 17 years and about 18 years among boys (MOH, 2003). By the age 18, 40% of girls were sexually active and by age 20, about 60% of boys were already sexually active. To address the needs of ASRH is important because:

- Most adolescents live in a world where sex meets different needs for survival, pleasure, peer pressure, and having multiple partners and can lead to consequences such as unwanted pregnancy, unsafe abortions and STIs;
- Exiting potential of adolescents to contribute to the development of the country;
- Adult centred SRH services not attractive to adolescents;
- The underlying socio-cultural practices leading to unsafe behaviours;
- There are some gaps, which have been identified in the implementation of adolescent's sexual reproductive health interventions requiring redress.

3.2 Overall Objective

The overall objective of this thesis is to assess the sexual and reproductive health needs of adolescents in Tanzania, and to analyse factors contributing to risky sexual behaviour, in order to recommend appropriate interventions to comprehensively address the needs of adolescents and promote quality services in Adolescents and Sexual Reproductive Health (ASRH).

Specific Objectives

- To describe sexual reproductive health issues and its influencing factors.
- To identify existing programmes addressing SRH in Sub-Sahara including Tanzania.
- To identify current barriers affecting SRH in Tanzania.
- To make recommendations to policy makers, programmers, and other stakeholders on how to improve make adolescent SRH more user friendly.

3.3 Study Questions

1. What is the sexual and reproductive health status of adolescents in Tanzania?
2. What are the contributing factors to adolescent sexual reproductive health needs not being met?
3. What kind of barriers do adolescents in Tanzania face when accessing SRH information and services?
4. What kind of action has been taken in Tanzania to try to address the sexual and reproductive needs of adolescents and what are the gaps?
5. What kind of action has been taken in other countries to try to address the sexual and reproductive needs of adolescents?
6. What lessons can we draw from the experiences of other countries in addressing the sexual and reproductive needs of adolescents?
7. What recommendations can be made after analysing the issues affecting adolescents, and interventions addressing adolescent's sexual and reproductive needs?

3.4 Study Methodology

This thesis is based on a literature review on sexual and reproductive health needs, sexual behaviour and interventions aimed at adolescents in Sub-Saharan Africa and in Tanzania. It also uses personal experience in working with adolescents on sexual reproductive health issues. The criterion used to select information is based on similarity to of the situation in Tanzania with regard to social, cultural, and economic situation of countries in Sub-Saharan Africa where most of the references, relate.

3.5 Key words and Search Strategy

Sexual and reproductive health indicators, sexual behaviour, risk behaviour, teenage pregnancy, early marriage, sexual abuse, gender norms influencing reproductive health, adolescent development, puberty, sex education, HIV and youth, family planning, unsafe abortion, youth friendly health services, peer education, and Tanzania health policy.

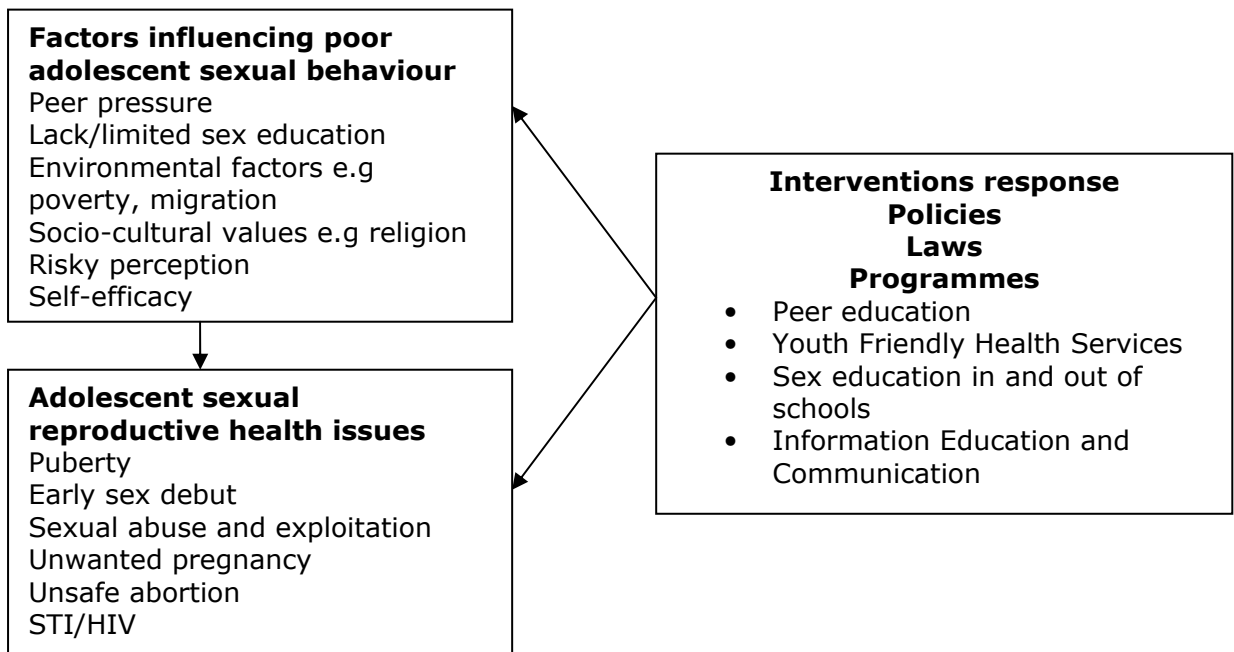
Search engines such as go ogle Pub med, and others were used. The search was conducted on websites of organisations such as WHO, UNICEF, UNFPA, NAPC, UMATI, AYA, IPPF and Pathfinder. Literature reviews were made from websites of ministries of health, education and ministry of culture in Tanzania, Malawi, Uganda and Kenya. The KIT Library was used as a source of published literature.

CHAPTER 4. ADOLESCENTS AND SEXUAL REPRODUCTIVE HEALTH

This chapter describes a framework that has been selected for the analysis of adolescent sexual behaviour and interventions aimed at addressing them. This chapter also the adolescent sexual reproductive issues.

The framework below, has been developed specifically for this thesis to illustrate factors influencing poor adolescents sexual and reproductive behaviors such as peer pressure, lack of or limited sex education, environmental factors (poverty, migration), socio-cultural values (such as religion), risky perception and self efficacy. These factors contribute to adolescent sexual reproductive health issues being faced by adolescents. The column on the right illustrates the strategies used to address both the factors influencing adolescent sexual behaviour and the adolescent health issues. This framework takes into account the fact that addressing SRH of adolescents is not only about behaviour change, but also treating the consequences when a desired behaviour change, fails to take place. This framework has been useful in establishing parameters of work and interpretation of an analysis of approaches used to address ASRH policies, strategies and program experience in Tanzania.

Frame work to analyse adolescent sexual behaviour, influencing factors and interventions.



4.1 Sexual Reproductive Health and Puberty

Sexual health is the absence of illness and injury associated with sexual behaviour, and a sense of sexual well being (WHO, 2003). Reproductive health in adolescents is a state of complete physical mental and social well

being without disease in all matters relating to the reproductive system and to its functions. The transition from childhood into adult hood is marked by physical and psychological changes. In many traditional cultures, elaborate rituals are carried out to commemorate the onset of puberty to announce sexual readiness and to celebrate the arrival of an adult into the community. There are cultural traditions to mark puberty in boys for some ethnic groups. Boys are circumcised and they are told to have first sex with a virgin in order to empower him to gain authority over a woman (Graziell et al., 2008). For example the among the Massai ethnic group in Tanzania, men after undergoing puberty rites are given the authority from elders to have sex with any woman. According to the Maasai tradition, every woman is for a Massai man and children born are regarded to belong to the community. The prevalence of pregnancy among adolescents is very high in these tribes (Kaaya et al., 2008).

A study in Gabon shows that the percentages of boys after puberty at the age of 15 years were 48% due to the culture that a boy should show his masculinity by impregnating a girl (Cynthia et al., 2005). In Sub-Sahara Africa, about 7% of adolescent boys and girls are young fathers and mothers, this is caused by the power from parents and traditions that soon after circumcision, the boy should marry to prove the reproduction of bearing children.

4.2 Early initiation of sexual

Historically, sexual initiation was part of initiation ritual performed in most sub Sahara countries (Mair, 1969, La Fontaine, 1985). Such an ritual are necessary because is the entry into adulthood and to the inception of sexual relations. Among boys and girls is often a result of influence from peers. Lack of parental guidance as well as lack of correct early sex education from parents, teachers and other members of the society, makes adolescents to rely on information from peers which often is wrong (FCI, 2007). In a study, which was carried in the U.S.A, one of the middle schools showed that sexual initiation among adolescents was heavily influenced by television and 43% of the students became pregnant (Rebecca et al., 2004).

Vulnerable children and orphans are at a high risk of early sexual debut as one study in South Africa in Kabuli-Natal shows that 23% of orphans had sex by the age of 12 when compared with the 15% of children of the same age group who were not orphaned (IWHC, 2007).

There is suggestion that the primary motivation for first sex among boys is to enhance one's masculine status in response to peer pressure. Boys ridicule others who are inexperienced as 'impotent', 'cowardly' or feminine. A boy's reputation with his peers can be of more importance than sexual pleasure (Wight D et al., 2004).

In Tanzania, adolescents can start having sex as early as the age of 14 for boys and the age of 13 for girls as described by a study done in Kigoma district (UNFPA, 2005). Another study in Mwanza, Tanzania found that 80% of boys and 68% of girls aged 12, had experienced some form of sex. Half of the boys and girls reported having experienced vaginal sex while 40% reported to have had oral sex (IWHC Report, 2007).

The percentages are so high because in Mwanza district, the Sukuma tribes taught their children to practice sex at the age of 7 years by using candle as a model of male genital and a small pawpaw as a model of girls, organs so in that case adolescent practice such a behaviour with their peers (MOC and MOE Report, 2005).

In Sub-Saharan Africa the system of early marriage and early intercourse, including childbearing among adolescents is very common. The percentage of adolescent girls who have sex before the age of 15 years is 30% in Zimbabwe and Niger, while in Rwanda and Guinea it is 27% (Klepp et al., 2008).

4.3 Sexual abuse and commercial sex exploitation

There are different power dynamics that contribute to adolescents having sex that may lead to poor health and injury. These include rape, sexual abuse, forced sex through ritual practices and coerced sex from older men wanting to have sex with girls. Sexual abuse is facilitated by a number of factors including socio-cultural vulnerability of children living in the street and orphans, lack of social services in the community, gender inequality, and poor political system to protect children and adolescents from sexual abuse (UNICEF Report, 2001/ (Nancy et al., 2005). Generally, in Sub-Saharan Africa, especially in East Africa there are two types of sexual exploitation and commercial and non-commercial sexual abuse.

Non-commercial sex exploitation of children and adolescents does take place in Tanzania. Older men who have sex with young girls are referred to as 'sugar daddies' while women who also force young boys including male children, are referred to as 'sugar mummies'. Intergenerational sex is on the increase and one of the reasons is due to the myth that having sex with virgins cures HIV/AIDS. In addition, it is often relatives of the child who are involved in sexually abusing young persons. When this happens, such cases are rarely reported (Ngoma et al., 2003; Human Rights Watch 2003). In Tanzania an increase in the number of cases of sexual abuse has put the government under pressure to set up a special health clinic in all police stations for cases of gender based violence including sexual abuse of adolescents (MOH Report, 2007; and Social Welfare Report, 2007). Under these issues, if the culprit is found guilty he is jailed for 30 years.

In Kenya, adolescents who are working as house cleaners say that they had first sex with wealthy women because they were forced (Kenya DHS 2004,

Zambia DHS, 2004). Due to poverty, and lack of source of income adolescents are also often forced to have sex with sugar daddies and sugar mummies (Erulkar, 2004).

In a study done in Mwanza and Arusha regions in Tanzania, 28% of adolescents reported having sex against their will and 48% said that they were forced to have sex with sugar daddies (TDHS, 2006). In Uganda, a study found that 12% of virgin adolescents were forced to have sex with men having HIV with the belief that they will be cured from the HIV/AIDS (Uganda AIDS Commission, 2007). The consequences of sex exploitation are psychological trauma and social trauma even increasing high risk of sexual infections and unwanted pregnancy (UNICEF Report, 2005).

Sex exploitation leads to health risk to adolescent mothers due to early pregnancy and its complication in delivery, unsafe abortion, and health risk to the baby if not aborted. On the other hand of consequences of sexual exploitation are cervical cancers for adolescent's girls, as research shows that a women risk of this disease is doubled if her first sexual activity was in early adolescence (Hussein et al., 2007).

Commercial sexual exploitation includes adolescents and children being trafficked to be used in sex industry as well as in the emerging sex tourism industry, including. In Tanzania, it such exploitation is common in the coastal region, and parents sell their children and adolescents to tourists as well as traders from Dubai and other Arabic countries in exchange for money (Kivulini Women Rights Organisation, 2007).

In many traditional cultures in Tanzania, sex abuse in adolescents girls is serious due to fact that, grand mothers take girls to the bush and teach them the way to perform sex with different young men. A Massai man can have sex with an adolescent girl whom he has met from his clan (Women Rights Organisation, 2007). Sexual abuse leads to unwanted pregnancy and sexual infections. Research done by the Kivulini women in 2006 in the southern part of Tanzania and central part of the country, found that sexual exploitation in adolescents aged between 12 to 15 years were often by men who had recently undergone circumcision (Kivulini, 2006).

In countries like Tanzania, Kenya, and Zambia, children and adolescents have been found working in major cities of Dar-es-Salaam, Nairobi, Lusaka and (UNICEF Report, 2002) where they end up being trafficked to Italy, Germany, and United Kingdom via South Africa and Dubai (International Centre for Research on Women, 2007).

In Sub Sahara Africa, there are some traditional practices from parents to their adolescents such, In Mauritania, Ethiopia, and Chad, sexual intercourse is linked with arranged marriage from parents as the source of income through the dowry system (Pranitha et al., 2007). In Tanzania, girls are

married off early as a source of income in poor communities. In Pogoro and Massai tribes, the parents arrange early marriages as soon as the baby girl has been born and at the age of 7, a child girl will go to live with her parent's in-law and practise sex with the father in-law (FCI, 2007).

Sometimes there are wide age differences between sexual partners and this affects the ability to negotiate sexual activities and condom or contraceptive use. Some studies from Ghana and Zambia and Uganda show that adolescents aged between 12 and 14 years have been forced to have unprotected sex before their 15th birth day (Uganda AIDS Commission, 2007). Moreover, some had their first sex in exchange for money and gifts.

4.4 Unwanted pregnancy and unsafe abortions

Globally about 80 million women each year have unwanted pregnancies. Unwanted pregnancy is often seen only as a problem for adolescent girls, but recent research shows that adolescent's fathers face some of the same issues that young mothers face. In Tanzania about 20% of adolescents, aged 15-19 have unwanted pregnancies. Unwanted pregnancy often leads to safe abortion or unsafe abortion (Hussein et al., 2004). The unwanted pregnancy rate among adolescents age wise increases from 3% at 15 years to 54% by age 19. Adolescents between ages 15 and 19 account for 12% of the total fertility rate and youth in the age group 20-24 account for 24%. It means that 25% of female adolescents in Tanzania have already started bearing children.

Unwanted pregnancies may occur due to failure of contraceptives, lack of access to condoms, curiosity on sexual desires rape, force, sexual abuse, sex for money or the one way of living for the as well as lack of information on sexual and reproductive health, among adolescents. A recent report from Tanzania shows that in Mbeya region the total number of unwanted pregnancies among primary school girls from 2006-2007 was 409 in one region, and in the same region 294 girls in secondary school were impregnated (The guardian News Tanzania, 2008). This has occurred due to lack of ASRH in the schools and from parents and condoms and contraceptives are not allowed in the schools (Guardian news Tanzania, 2008). Abortion in Tanzania is illegal, is legal in case of life saving to women. Because of restricted laws in abortion, adolescents opt to seek for traditional healers or to take self-medications to induce abortion. In Kenya 20% of adolescents had unwanted pregnancies in school due money exchange for relieving and poverty, and material goods (Health Youth in Kenya, 2007). In Uganda 12% of unwanted pregnancy in adolescents is due to rape from the gorillas fighters in north of Uganda.

As remarked before Globally 80 million women each year have unwanted pregnancies, 45 million of which are terminated (Guttmacher, 2002). Of these 45 million abortions, 19 million are unsafe, 40% of them are done on women

aged under 25, and about 68000 women die every year from complications of unsafe abortion (WHO, 2004).

Unsafe abortion is a procedure of terminating an unintended pregnancy done by unskilled person or individually under unsterile conditions and it occurs in the regions where abortion is illegal.

Every year, approximately 50 million unwanted pregnancies end in abortion. 55,000 abortions a day, over 20 million a year, are unsafe and 95% of unsafe abortion occurs mainly in developing countries in Africa about 70% of abortions are among adolescents under 20 years of age. Of all death related to sexual and reproductive health, those from abortion are most likely to be underestimated and most can be prevented (WHO, 2007). Legal obstacles to provision of safe abortion services force women to resort to unsafe abortion when faced an unwanted pregnancy.

Pregnancy among adolescents contributes to morbidity and mortality (Klepp et al., 2008). Every year, an estimated 19-20 million unsafe abortion take place every year, 68,000 women die from unsafe abortion, and 40% of them are done on women aged less than 24 years (Guttmacher, 2006). In Tanzania, 32.9% of unsafe abortions occur in girls aged 19 years and below and 20% are primary adolescents and secondary school adolescents. According to the report from a gynaecologist in one of the hospital, 50% of admission in female ward is due to complications of unsafe abortion (Hussein et al., 2005).

In Sub-Sahara countries like Kenya 60% of unsafe abortion among adolescent aged 12-14 (WHO, 2000) Ethiopia also has cases of unsafe abortion among the 12 to 19 of age in primary school girls was 54% (Safe mother hood ,2003). Every day 55,000 unsafe abortion take place in developing countries which are 95% which is performed under unsafe conditions (WHO, 1998a).The estimated of 68, 000 death from unsafe abortion occurred in developed countries while half of death arise from Africa (WHO, 2006).

4.5 Sexual transmission infections and HIV/AIDS

A Sexually transmitted infection is a disease that occurs after having unprotected sex with someone who is already having the infection.

Globally an estimation of 340 million of curable and preventable sexual transmitted infections occurs to young people below 24 years of age (TACAIDS, 2006). In Tanzania, more than one out of 20 adolescents will contract a curable and preventable sexually transmitted infection, not including HIV/AIDS (TACAIDS, 2006). Tanzania is facing major problems of STIs among adolescents that may cause acute illness, infertility and long-term disabilities even death. Among patients seen at Infectious Disease Control (IDC) in Muhimbili Hospital in Tanzania aged below 25 years, 55% had sexual transmitted infections. Ministry of health had introduced syndromic

management approach of sexual transmission infection countrywide and the drugs are affordable (MOH, 2005). Available reports of researchers to find out the prevalence of STIs in pregnant mothers in Sub-Sahara alone, the result show that an estimated of 164,000 pregnant women have undiagnosed syphilis which causes stillbirth and peri natal mortality (UNAIDS, 2006

The recent prevalence rate of HIV in Tanzania is 8.8% (NACP, 2008). The mode of transmission of HIV/AIDS is through heterosexual activities in 80% and other transmission is through blood transfusion and transplantations of organs like kidneys, or bones, contamination of instruments through surgical operations and circumcisions to both boys and girls including transmission of mother to child as well as intravenous drug users.

The behavioural changes that related to sex issues such as reducing number of sexual partners, or use protective measures like consistently condom use, screening of blood before transfusion, sterilization of surgical instruments and prevention of circumcision which is done using sterile techniques (TACAIDS, 2008).

The majority of adolescents have heard about the spread of the infection, but they do not protect themselves, because they lack adequate decision-making skills, social support, or the ability to adopt safer sexual behaviours. Tanzania faces a mature, generalized HIV epidemic. Among the 1.6 million people living with HIV/AIDS, 70.5% are 25 to 49 years old, and 15% are 15-24 years.

Populations at high risk for HIV infection include people in prostitution, mines, police officers, prisoners, people in the transportation sector, and the military (UNAIDS, 2006) 140,000 adults and children died of AIDS in 2005 and AIDS orphans were 1.1 million in 2005. Children who were born with HIV some ten years ago, are now becoming adolescents with HIV, and they need to be prevented for further infection (TACAIDS, 2008). Adolescents are vulnerable to HIV due to the risky sexual behaviour substance abuse, and their lack of access to HIV information and prevention services (Pathfinder 2005).

CHAPTER 5. Factors INFLUENCING POOR ADOLESCENTS SEXUAL AND REPRODUCTIVE HEALTH

5.1 Ineffective laws, regulatory frameworks and policies

Laws exist in Tanzania that encourages child marriages by the age of 15 as long as parents give consent (Marriage Act, 1971). Even in countries where laws prohibit child marriages like in Zimbabwe, but enforcement of existing laws is inconsistent (Pathfinder, 2001). Furthermore, legislation, standards of practice, or both, affect the provision of services to unmarried adolescents or those who are below a certain age because it is assumed they are too young for to be having sex. Laws prohibiting abortion or permitting prosecution of girls and women who have undergone abortion do not necessarily prevent abortion, but facilitates clandestine abortion in unhygienic and unsafe ways (Safe motherhood, 2007). Limited protection from legislation against sexual violence, rape, incest, and trafficking of adolescents increases vulnerability to SRH problems (ICRW, 2007).

5.2 Peer Pressure

Peer groups are group of people of about the same age, same ideas even the same feeling to do something similar (UNFPA, 2007). Peers frequently focus on the attitudes in relationships concerning sexual behaviour and social behaviour even cultures in the same community (FHI, 2005/ Youth Net, 2005). Given the significance of peer influence, this power can put adolescents towards greater or lesser risk taking. Peer pressure, combine with gender inequities within a sexual relationship can mean that males have undue power to dictate sexual decision to females. Adolescents girls fear losing their boys friends if they refuse having sex, due to pressure from boys (Mapella, 2005).

Peer grouping can have positive attributes as well as negative ones. Positive things may include self-confidence and the feeling of being respected, being involved in planning or being responsible. The negative consequence of peer pressure can lead to involvement in risk behaviours like practicing unsafe sex, drinking alcohol, being involved in rape and other behaviours simply because one wants to conform to the norms of a group (MOH/RCH Services 2003-2007).

5.3 Sex Education

Sex education has a big role to prevent the risky sexual behaviour of adolescents and young people. The education Act in Tanzania provides for Family Life Education and HIV/AIDS in school. The challenge is that sex education is not compulsory so the teachers do not teach sex education as they said that, "Sex education in not examinable as a result teachers opt to value is low and teach the subject which will be examinable." In secondary school in Tanzania, the curriculum is allocated for 45 minutes and the teacher

will biology and physiology and not sex education in primary schools no sex education is conducted (Ndeki et al., 2007).

Education level of the in adolescents of great importance as it contributes to the prevention of risks associated with sex behaviour. Educators in schools or in the community and health workers can provide information on ASRH adolescents to make decision on sexual activities whether to delay sex or to use the precaution measures. Adolescents who had school education had better chance to know about sexual behaviour and reproductive information (TDHS, 2006) and they have broader idea on sexual risks behaviours.

In Sub-Sahara Africa, from the study shows those adolescents' girls who are educated have more access to ASRH and health services and they also have less risk of unwanted pregnancy, and sexual transmission infections (G.Tenderbiego et al., 2003).

5.4 Religion

Religion had a big role in the community. Religious leaders are respected in the community also, people are influenced to them, and therefore, they have opportunity to influence any age group within the community. Such an influence they can mobilise the adolescents in the community to adopt the positive sexual behavioural (Eklessia,2007).A case study in Uganda shows that prevention and promotion of sexual behavioural changes targeted to adolescents in primary schools through religious leaders, it was successful because the incidence of sexual infections declined (G.Tiendrbeogo,2004).

Religious leaders and its councils in Tanzania have strategies on sexual and reproductive health where emphasis is on abstinence for unmarried people (Eklesia 2007). The Roman Catholic is against condom use and family planning, for both married adolescents and unmarried. They recommend Abstinence and Being Faithful (the A, Bs of HIV prevention). However, adolescents continue to have unsafe sex and the majority of them suffer from sexual infection and unwanted pregnancy (MOH, 2005). The Anglican Church recommends Abstinence, Be faithful and Condom use (ABC) while Muslims recommend condom use only within marriage. One of the Catholic church's Archbishop of Nairobi, Raphael Ndingi Nzeki told the program: "AIDS has grown so fast because of the availability of condoms" (Kenya Times, 2007/Eklesia, 2007).

It is only a recent development in Tanzania that the National AIDS Control Program with the collaboration of religious leaders, made progress to promote sex education and reproductive health in secondary schools and for out-of-school adolescents (NACP Report, 2007).

5.5 Socio-cultural factors

Gender has important consequences for the outcome of SRH. An estimated 94 million girls and women are affected because of discriminatory treatment

ultimately increases mortality (Klasen and Wink, 2002). When female adolescents reach puberty, some are subjected to female genital mutilation and suffer its adverse health consequences. Gender roles especially in Sub-Saharan Africa give men authority over sex and reproductive decisions that eventually affect health such as negotiation about condom use. Gender disparities in health care increases vulnerability to SRH infections, injuries and mortality. Cultural definitions of manhood and masculinity contribute to gender-based violence such as sexual abuse. The World Bank estimates that, "among women of reproductive age, domestic violence and rape account for 5 to 16 percent of healthy years of life lost to death and disability (DALYs), depending on the region" (Pathfinder, 2001).

Socio-economic, social culture, financial issues, politics and environmental condition like religion, level of adolescents education are the crucial environmental factors that influenced to adolescent's sexual behaviour (WHO Report, 2007).

Demographic and Health Surveys in Tanzania indicate that ages of sexual debut for girls is increasing due to social-economic situations, even early marriage is increasing because of the myth that early marriage will prevent sexual infections (NACP 2005). In the central region of Tanzania, adolescents girls get married soon after primary school to economically well off men to get out of poverty (Gupta et al., 2003).

5.6 Risk Perception

Risk perception is the judgement that adolescents make about their own risk to infection or pregnancy when they indulge in sex. The majority of adolescents believe that they are not vulnerable to the sexual diseases (Nancy, 2005). Such a perception is facilitated by the poor information about ASRH from parents, schools, the community and other people who provide information on sexual and reproductive health.

A study conducted by the Pathfinder in 2007 in high schools in Arusha region in Tanzania, shows that adolescents have the perception that sexual risk behaviour is a serious issue in general but not for them individually as they don't understand the consequences of the diseases. Their perception is that HIV/AIDS or sexual infections affect drug users, commercial sex workers, lesbians and men having sex with men (Pathfinder 2007; Youth Net, 2007).

Another perception is found among the ethnic groups of Haya in the Bukoba district of Tanzania where young men perceive that having sex with a condom affects ones manhood and that having sex with a virgin reduces sexual infections (Kivulini,2007)

In a study done in Zimbabwe 2007 to identify the risk perception from adolescents on condom use, it shows that individual risk was facilitated with

availability of condoms in the cities among adolescents. Students in Kenya and Zimbabwe who were using condoms had a better perception on risk sexual behaviour (FCI, 2007).

5.7 Self Efficacy and skills

Self-efficacy refer to a situation when a human being is able and confidence to protect himself or herself to adopt positive sexual behavioural. For example an adolescent girl, to negotiate to tell her boy friend to use condom. To increase the confidence and skills on condom use, the condoms should be available and negotiating the use of it correctly (Masatu, 2005). Some research and studies show that, the skills on safe sex is lacking to behaviours that related to actual sexual behaviour including decision-making. Such skill can be introduced in the health reproductive programs. In Tanzania the life skills to teach the use of condom is not fully implemented in schools, and adolescents who vulnerable like HIV adolescents. On the other hand, condoms are available everywhere but the skills is lacking (NACP, 2007).

5.8 Shortcoming of existing interventions

Surveys in many countries suggest that when young people are looking for urgent treatment for what they consider sensitive conditions, health services are often their last resort. Health services providers lack knowledge on how to approach the adolescents needs (FCI, 2007). There are barriers that can exclude adolescents to use the existing health facilities such as lack of knowledge to access for services on the part of adolescents, legal or culture restrictions, physical or logistical restrictions, poor quality of clinical services and negative attitudes from the health services providers (WHO 2003/ Mapella, 2005).

Operational barriers can be one of the factors , long waiting hours, appointment for the result or for the referral, in fact adolescents are not patient they want to " drop in "and deliver services and go home they don't want to wait too long for the fear that they will be seen by parents or nearest neighbour (Mapella, 2004).

CHAPTER 6. IMPROVING ADOLESCENTS SEXUAL REPRODUCTIVE HEALTH

The focus on Adolescents Sexual and Reproductive Health Services and adolescents Friendly Services (AFHS) started having much focus after the International Conference on Population and Development in Cairo in 1994 (WHO,2002). Interventions aimed at addressing AFHS and ASRH in Africa Sub Sahara, including Tanzania, will be discussed to illustrate what is being done to address the needs of adolescents in the region. Examples from Sub Sahara have been selected based on proximity and similarity to the Tanzanian context.

6.1 Interventions in Sub-Sahara Africa

The government of Zambia introduced a program on ASRH to adolescents aged 10 to 24 years. The program focuses on youth needs such as information on sexual issues. Peer educators are used to promote the messages on behaviour change through distributing of condoms, conducting role-plays and drama as a means to address high rates of teenage pregnancy in Zambia where 22.5% of girls are pregnant by the age of 19 (ZSBS, 2005). The Zambian government also supports the school health program. Topics covered in this programme include issues about love, sex and abstinence; reproductive health; sexually transmitted infections; understanding HIV and AIDS, working together safely; children's rights, growing up; understanding gender, and sexual feeling and behaviour; pregnancy; sexually transmitted infections; understanding HIV and AIDS; and coping well with life (Siziya, S. et al., 2008).

In Malawi, the Education Sector Support Programme (ESSP) with support from UNICEF provides knowledge and life skills to girls in schools (UNICEF, 2006). In addition, a curriculum on life skills was developed and is used in all primary schools with simple messages and knowledge about the human body, sexual behaviour, violence or exploitation as well as HIV and AIDS. Teachers have been trained on how to deliver the information and how to interact with the children in a participatory manner. In secondary schools, the World Bank (UNICEF, 2006) has supported the life skills curriculum.

A number of NGOs are involved in ASRH initiatives, just to mention a few, USAID in Malawi supports an international NGO known as Population Services International (PSI) a youth programme known as Youth Alert!. This programme encourages adolescents to make good health and life choices that would reduce their vulnerability to consequences brought by unprotected sex. It also provides skills building to enable adolescents deal with the challenges of growing up. The Youth Alert! Programme uses the peer education (MOH, 2007).

There is also a radio programme aired three times a week for young people who call in live during the show all write to the program producers asking questions about sex, HIV and other reproductive issues. Another approach used in Malawi is from an NGO known as Banja La Mtsogolo,(BLM) which established Youth Drop-in Centres in five of the 29 SRH clinics it runs in the country run by youths (UNFPA, 2007). The BLM trained youth Community-Based Distribution Agents for contraceptives to youths such as pills and condoms. This has improved access to information and services about SRH beyond the health facility (UNFPA, 2007). As are trained by Banja La Mtsogolo to counsel and refer young people for clinical care or advice on STIS and other SRH issues they cannot handle. Also sensitizes youth, parents, traditional healers, religious leaders and counsellors, politicians and other opinion leaders to advance SRH in their areas (BLM,). Youth Friendly Health Services initiative has been adopted by the health sector and has been scaled up in all the districts in Malawi. It is supported by both the Ministry of Sports and Youth in collaboration with the Ministry of Health (MOH, 2007).

Uganda ASRH programs focused on achieving and measuring adolescents behaviour change among youths aged 10 to 24 years. Schools have programs on sexual education and religious leaders are involved in teaching sexual and behaviour change intervention within the religious structures (Asiimwe et al., 2005). According to studies done in Uganda, the rate of sexual infections had dropped from 30% to 5% between 2001-2005 (Uganda AIDS commission, 2007)

NGOs like Uganda Women Council (UWC) target adolescent is SRH with Information, Education and Communication (IEC) activities through the radio and the television. Health services available for adolescents include general curative and prevention of sexual infections and reducing number of adolescents pregnancy in the western of Uganda (John et al., 2007). Popular programmers through the media complementing existing ASRH activities include the "Straight Talk" programme where youth share information about issues affecting their lives and that include issues on SRH (John et al., 2007).

There is also an NGO known as The AIDS Support Organization (TASO), which offers HIV counselling in schools and provide advice to teachers on teaching students sexuality reproductive health issues such as menstruation, pregnancy and HIV/AIDS issues (Asiimwe et al., 2005). Another NGO, the Basic Education Child Care and Development (BECCAD) programme also support drama, football and provision of sexual education through peer education (John et al., 2007). A study done in Uganda showed that peer educators conduct counselling among orphans and children who are HIV positive and provide spiritual counselling, material needs including medicine. Sexually active young people were provided with counselling and condoms (TASO, 2007).

6.2 Interventions in Tanzania

In Tanzania, intervention in sexual and reproductive health have been implemented by different Non-government Organisations (NGOs) such as Uzazi Na Malezi Bora Tanzania¹ (UMATI), Africa Youth Alliance (AYA), Chama cha kupambana na ukimwi Arusha (CHAWAKUA) Family Care International (FCI) and many more. Different approaches have been used to address ASRH needs. These include Information Education and Communication (IEC), sex education in and out of school, peer education and health facility based interventions. For example, UMATI has introduced care of adolescents who have been expelled from school because of pregnancy by providing them family planning education, care of newborn baby. They train peer educators, and to train clinical staff to work with adolescents.

While CHAWAKUA in Arusha region introduce program on out of school sex education to adolescents and they provide family planning and communication skills through radio and billboard information on prevention of sexual infections and unwanted pregnancy. Africa Youth Alliance (AYA) provides information about adolescent and reproductive health for adolescents aged 10-24 years. Main activity is to promote education on sexual behaviour through workshop training, small group discussions, including provision of behaviour change communication (BCC) and life planning skills (LPS)

African Youth Alliance had implemented adolescent friendly services countrywide in order to reduce stigma and judgemental from health providers towards adolescents. Health providers has received training on how to handle adolescent when they visit health facilities for health services or care or any kind of problems about sexual and reproductive health (Pathfinder, 2005).

6.2.1 Information Education and Communication

Tanzania uses different media channels for example the radio, television, newsletters, posters, billboards and leaflets to provide information, education and to communicate about a number of issues including ASRH issues. The use of electronic media such as radio is available to about 60% of the Tanzanian population (MOC, 2007). Moreover, print media is often in the local language of Kiswahili widely spoken almost by every Tanzanian. For people who are illiterate, information from the print media is difficult to access (MOE, 2005), therefore the radio, video, information with pictures are the alternatives. The Family Planning Association of Tanzania popularly known as UMATI, supports SRH programmes aired through television and radio. Although Kiswahili is widely spoken, there are still some challenges with using the language to disseminate information among other ethnic groups due to challenges in translating some of the words on sexual reproductive health, which tend to sound like taboo words when translated into the vernacular (MOH, 2005). Furthermore, health issues differ among the different cultures, which need

¹ UMATI is the Family Association of Tanzania.

specific targeting using other languages of the concerned practices in a specific ethnic group. Drama, poems and role-plays are also a common means of delivering information, education and communicating about SRH issues (MOC and Social Welfare, 2007).

6.2.2 Sex education for in and out- of- school

Sex education was introduced into the primary school curriculum in 2006 in Tanzania by the Ministry of Education to redress teen pregnancy and the increase in primary school dropout rates due to pregnancy. The sex education is under the Family Life Education and HIV/AIDS topic in the school curriculum featuring among other things, abstinence, condom use and female genital mutilation. However, the programme has faced strong opposition from religious leaders who have criticised the government that sex education will promote immorality and that it was a disguised form of providing condom education among young people (MOE, 2005).

Some parents and some schoolteachers especially those who teach primary school pupils, do not support the sex education in schools. The Abstinence, Be faithful, Condom use (ABC) approach is recommended but the condom distribution and discussing condom use is not supported by the education policy (MOE Report 2004). Teaching about use of condoms is only allowed by the Ministry of Education at the college or university level. The Roman Catholic Church also does not support the use of condoms. Most parents and religious organisations support sex education that encourages abstinence only among adolescents. Most teachers in Tanzania are not ready to teach sex education in primary schools as they have a perception that the community will be against provision of sex education to young people due to the belief that it will lead to an increase in sexual activity and promiscuity (Gallant, 2004).

The opposition to sex education in schools lead to the withdrawal of the curriculum in 2006 from the schools by the Ministry of Education, pending "further consultations with religious leaders, health specialists and traditional leaders" (MOE,2005).

From 2003 to 2006, the Prevention and Awareness in Schools of HIV/AIDS (PASHA) programme was established with funding from the German Technical Cooperation (GTZ) to support the government of Tanzania in HIV/AIDS programmes in schools and it was limited to one region of Tanga. The current second phase which started in 2007 and will end in 2009, continues to support HIV/AIDS interventions in primary and secondary schools in the regions of Tanga, Lindi and Mtwara in both public and private schools in Tanga Region and with 2 teacher training colleges. The goal of the programme is to enable school going youths to make informed decisions about their SRH in line with the HIV/AIDS strategic plan of the Ministry of Education and Vocational Training. The approach used focuses on developing skills of heads of schools,

teachers and non-teaching in interacting with students, counselling and peer education activities. Schools have School Counselling and AIDS Education Committees (SCAEC) to support guidance and counselling activities in schools (MOE, 2005)

In collaboration with PATH, AYA implemented a project in Arusha region for the adolescents out-of- school to increase access to information about sex and reproductive health. After noting, that many young people were not attending school and could therefore miss out from the benefits of the in-school sex education programs (Path, 2005). Through the Chama cha Wanawake Kupambana na Ukimwi Arusha (CHAWAKUA), activities implemented for adolescents out-of school focused on life planning skills which include information and communication skills, adolescent pregnancy, and planning for the future. Skills training such as tailoring were provided to enable young people develop skills to earn a living. Entertainments through use of drama, songs were employed to disseminate messages about healthy behaviours. The programme was successful because parents, teachers and community leaders were involved in the planning and implementation of the programmes (Path, 2005).

6.2.3 Peer education

Use of peer education initiatives has been documented as early as the 1960s among American high schools (Ward et al., 1997). The advent of HIV/AIDS in the early 1980s again made peer education popular in addressing injecting drug users, sex workers and adolescents. The merits of the approach include increasing knowledge levels about risk behaviours, harm reduction among groups involved in unhealthy practices and increasing peer led initiatives that increase ownership of problems and interventions (Green, P. 2003). Peer education is used to educate those who are hard to reach with information and encourage them to have positive behaviour (FCI,2007). In Tanzania, peer education was launched by AYA in 2005, focusing on youth aged between 10 to 24 who are vulnerable from HIV/AIDS infections. Peer education has increasingly become a popular method of educating young people in Tanzania.

The Tanzania-Netherlands Project to Support AIDS Control (TANESA) established a project using peer education in Mwanza Tanzania focusing on vulnerable adolescents working in the streets. Peer educators helped set up a general education campaign, video shows, exhibition boards, pamphlets, condom distribution, and discussion sessions with their peers (TANESA Report, 2005).

Family Care International (FCI) worked with the national association of Private Nurses and Midwives Association of Tanzania (PRINMAT), a project facilitating collaboration between peer educators and health care providers to improve the youth friendly reproductive health services at private clinics throughout the country. The result of this program shows that adolescents receive friendly

services from private clinics compared with public health facilities (FCI Evaluation Report, 2008). Peer educators are trained to provide counselling on sexual abuse, preventing unwanted pregnancy and safe sex practices. A study done in Mwanza and Arusha districts in Tanzania to evaluate the effectiveness of peer education showed that the approach increased knowledge, self efficacy and negotiation of condom and contraceptive use among the adolescents (Colivin et al., 2004).

6.3 Developing Adolescents Friendly Services

Adolescents constitute about 31% of Tanzania's population and the majority are highly vulnerable to sexual and reproductive health problems. However, few services are available that offers SRH specifically to young people. And the few SRH services available are often adult centred, stigmatises young people due to judgemental attitudes of service providers and they are not user friendly to young people (Nelson et al. 2000; Coplan et al. in press; Bhuiya et al. 2000;). Adolescents opt to use informal health services such as buying medication from shops, traditional healers and clandestine vendors (Adamchak et al. 2000). Accessible, acceptable, affordable, equitable and appropriate services are part of a package for youth friendly services (WHO, 2003). The AYA programme further demonstrates that adolescent youth friendly services are those that are in the right place, offered at the right time, are affordable and get delivered in the right manner that is acceptable to the users (AYA Report, 2005). Friendly services are those that offer a comprehensive package of services to adolescents such as counselling on sexuality issues, family planning package, post abortion care, condom supplies and HIV testing. The UNAIDS describes the gold standard for adolescents friendly health services which is defined as having an effective, safe and affordable service (UNAIDS, 2004). There are a number of characteristics that are required in order to qualify a service, a YFHS facility. These range from provider and facility characteristics.

6.3.1 Provider characteristics

Health providers have to acquire appropriate skills through training in order to be competent in handling adolescents. Health providers need to maintain privacy and keep information provided by adolescents confidential to increase trust in the services and remove fears that the health providers will talk about their health seeking behaviour regarding their sexuality needs and they will inform parents, relatives or the community (WHO, 2002). Adolescents also need to be respected and not treated as children. Adequate time for client and provider interaction is crucial for effective discussions about their sexual problems and to avoid judgemental approach, to be devoted to have enough time for adolescent to listen their problems. Because their peers influence adolescents more, availability of peer counsellors in the health facilities can enhance sharing of ideas on sexual behaviours and adoption of positive sexual

behaviours when young people are encouraged to be open with the health provider on issues affecting them.

6.3.2 Health facility characteristics

Health facility characteristics of Adolescents Friendly Health Services (AFHS) include separate space and special times for young people. This is encouraged to ensure privacy and increased use of services including periods when young people are not attending classes, or involved in household chores.

In Tanzania, the health facilities are overcrowded and due to number of clients who are suffering from different diseases such as malaria and other non-communicable diseases, therefore the possibility of having separate space for adolescents is not possible, but for those facilities that AYA implement the programs, they have space for adolescents. The managers of private health facilities has improved the out patients rooms for adolescents only. In Mwanza Tanzania, the Mema Kwa Vijana Program (Do good for adolescents) they have renovated 18 health facilities for the purposes of promoting adolescents friendly services in that region (Pathfinder, 2005). In Tanzania, opening hours in health facility is 7.30 a.m. it is not convenient time for adolescents as they are in school or work place. Location of health facilities are in the areas where adolescents cannot reach due to transport problems. Adolescents friendly services are those where they can drop in and receive the services, and the waiting place need to be comfortable with no interaction among adults (Masatu, 2004).

Since not all adolescent can access a health facility even if they were offering AFHS for different reasons including long distance to a health facility, lack of transport to a health facility, alternative ways of offering services include provision of outreach services in rural and urban areas (Mapella, 2005). Tanzania has many adolescents who live in slums of big cities and outreach activities should be within reach of adolescents. For example, in Kibera a big slum in Nairobi city in Kenya, health workers provide SRH services for adolescents twice a week (Health of Youth in Kenya,2007).

CHAPTER 7. DISCUSSION

Providing comprehensive Adolescent Sexual and Reproductive Health through Youth Friendly Health Services poses a big challenge in Tanzania. Interrelated factors are at play such as lack of understanding about the need for sexual education and SRH services from the parents, teachers and religious leaders. Limited resources to support innovative approaches such as (AFHS), add on to the challenges.

The policy and legal environment of Tanzania to some extent contributes to SRH problems. According to an analyse report by the Ministry of Health and AYA on policies and laws that impact on adolescents sexual and reproductive health, revealed that there are some laws and policies that are out dated and they are in conflict with supporting healthy SRH behaviours (Penal code,1972). The current minimum age at marriage is still at the age of 15 with parental consent and the consent for sex is at 18 years (Marriage Act,1971).This means that the existing laws are still encouraging early sexual debut which has consequences for girls should they become pregnant at the age of 15. Even when adolescents may understand the outcome of risk sex behaviours and demand for services to avert these risks, access to such services are limited.

The withdrawal of sex education in schools due to pressure from religious leaders in 2006 was an unfortunate development. It left the education about sexuality limited to biological study of reproduction in secondary school, which does not discuss issues about coping with changes during puberty, emotions, sexual relationships, dealing with sexual feelings, preventing pregnancy and STIs. It is encouraging to note that consultation with religious leaders helped the ministry to have support for sex education in schools by the end of 2007 (Eklesia, 2007).

Though Tanzania has made efforts through many organisations such UMATI, AYA, TANESA, to provide ASRH, not all districts have benefited from such interventions. Scaling up of interventions that proved effective is a problem (own observation).

Parents play a great role in raising their children and communication skills to parents is crucial if they have to discuss with their children who are adolescents. They need to understand the issues surrounding SRH and why it is important for their children to understand such issues (UNICEF, 2006).

Gender as a contributing factor to poor SRH outcomes remains narrowly addressed by interventions tacking adolescent health. Yet FGM affect ASRH and decision making of girls to use condoms remain poor. Even if services were to be accessible, affordable, friendly, that will not address the root causes of the SRH issues that are brought to the attention of the health worker.

Evidence on adolescents friendly health services as an approach to address ASRH needs present a mixed picture (Pathfinder International, 2001). Health facilities are not the first choice for SRH information and services for most adolescents. As a result, increased use of AFHS has not been noted although there is evidence that young people who have been satisfied with the services have often returned to the services being offered. Successful AFHS have been noted where clinical services have been complemented with a supportive environment such as community interventions aimed at changing perceptions of facilities and service providers, parents, and the community (FHI, 2005; UNFPA, 2006). Adolescents friendly health services in non-facility settings are promising. Tanzanian government is the overall of the health provides in the country so it has a potential achievement to the large number of adolescents to receive sexual education through non governmental organization, religious groups, private sectors and individual firms for financial support for the intended programs.

In order to provide a quality and effective adolescents friendly services, there is need to have specialized health staff on sexual and reproductive health matters, respect for adolescents and provision of privacy and assured confidentiality should be maintained. The services should be provided in convenient times and places where adolescents can drop in easily and receive services without waiting for appointment, this will encourage them to come for further information about reproductive health.

Culture and traditions are not bad in themselves, they serve different purposes such as demonstrating acceptance of girls and boys into the society, assigning responsibility during puberty rites. However, it is the elements such as unprotected sex and encouraging early sex that need to be discussed with traditional leaders in order to find a lasting solution to remove such elements of risky practices in a culture.

CHAPTER 8. CONCLUSIONS

There are a number of contributing factors that facilitate sexual and reproductive health problems to adolescents. Such factors are peer pressure; poor knowledge, or no education at all about sexuality and reproduction; religious values that may be supportive of safe sexual behaviours and others that may act as barriers to adoption of safer sexual behaviours. Environmental factors such as poverty and migration; perception of individual risk among young people when they indulge in sex; self-efficacy and skills, shortcomings of existing laws, policies and interventions targeting SRH (IPPF, 2007).

The high numbers of STIs, and unwanted pregnancy, unsafe abortions and the increasing number of HIV/AIDS cases among adolescents between the ages of 10 to 19 in Tanzania requires multiple approaches to address the predisposing factors, and to create supportive environment in which healthy behaviours can be sustained (MOH, 2006).

In Tanzania, there are many interventions with different activities implemented with different organisation, aiming to promote health care services and to provide quality of care countrywide. There is a need to scale up initiatives to ensure sustainability of effective programs (Smith and Colvin, 2000). Once initiatives have been pilot tested and have proved effective, there is need to expand to other areas, interventions can also expand their coverage through complementing their efforts through alliances formed across a network of organizations. In addition, whenever new initiatives come up, they can be integrated into the existing initiatives (FHI, 2001).

There is an evidence of sugar daddies and mummies in the community, which facilitate of increasing unsafe sex, and unwanted pregnancy and school drop out including sex abuse and sex exploitation. This is a public health concern.

Communications skills and provision of training between parents and adolescents need to be understood so that parents are responsible for their adolescents and provide guidance that is informed by correct information on SRH issues.

CHAPTER 9. RECOMMENDATIONS

The policy and legal environment need to be reviewed and policies and laws need to be reinforced to provide a supportive environment where healthy life styles develop and are nurtured. Policies from different sectors that concern adolescent is development have to be aligned with international standards and harmonised in country. Thus the Education policy and the HIV/AIDS policy should both support provision of condoms to sexually active young people whether they are in school or not, and not as it is the current case where the education policy does not support condom use among school going adolescents. The 2003 health policy has to take into account evidence that AFHS are more effective when complemented with other interventions that create a supportive environment for the adoption of new safer behaviours in the community and at school.

Making existing health services in all health facilities country wide available and accessible to all adolescents requires a re-organisation and re-orient of RHS to ensure privacy, confidentiality and respect which are the required characteristics to make the current health services friendly to adolescents. On-going supportive supervision will be needed to assist service providers to deliver quality reproductive health services to adolescents. This means more resources for SRH interventions in the health sector budgets.

Key opinion leaders such as religious leaders and traditional healers need to be involved in programme planning and implementation. There is need for the education sector to negotiate with religious leaders on how best to make the school curriculum that was rejected by religious leaders, to provide culturally sensitive sex education without undermining the delivery of SRH education in schools.

Adolescents as users of SRH services need to be involved in planning, designing, implementing, and evaluating interventions affecting their lives. Thus, skills building should also be provided among adolescents in these areas. Interventions should increase the investment in training young people as peer educators to provide correct information and services such as condoms and contraceptives to their peers in the community.

Sex education in both primary and secondary school should be supported to facilitate safe behaviours. Peer programs in Tanzania need to be promoted and integrated in existing programs and linked with community interventions. The provision of sex education through peer educators, could help to reduce of infections as it had happen in Uganda and Zambia.

The traditional norms towards young man and women need specific interventions involving the community, specifically the custodians of these cultural practices. This will enable the communities to assess risks presented

by infections such as HIV and consider alternatives to the risky elements within the cultural practices.

Interventions targeted at addressing ASRH need to incorporate how the gender issues are going to be addressed so that young people are empowered to negotiate use of condoms, and that boys and girls adopt other ways of demonstrating their masculinity and femininity without causing harm to their health through unprotected sex.

Collaboration is needed among different stakeholders working on SRH with young people to avoid duplication of efforts, ineffective and inefficient use of resources that are already limited. The Tanzanian government in collaboration with NGOs, the private sector, faith based organisations, teachers, religious and traditional leaders, parents and the communities have a major role to play and need to complement each other's efforts and scale-up approaches that have proved to be effective in addressing SRH.

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