

# YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS IN TANZANIA

## Results from selected civil society organizations

*From the African Community of Practice on Management for Development Results at the African Capacity Building Foundation*



Case Study  
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### SYNOPSIS

Tanzania is a signatory to regional and international agreements on human rights that include adolescents' sexual and reproductive health (ASRH) - a program that spans the reproductive health lifecycle - with special attention to the needs of very young adolescents (ages 10 to 14), preventing early pregnancy, and addressing the needs of young mothers taking into account the gender and social norms that create barriers to SRH information and services provided to adolescents, leading to poor SRH outcomes. This case study shares experiences on how civil society organizations (CSOs) have contributed to ASRH in Tanzania.<sup>1</sup> It shows that CSOs have indeed aided in government ASRH efforts and have responded to young people's needs for ASRH knowledge.

**Key findings.** The CSOs working in the sector show that adolescents respond to education and services that address their ASRH needs when delivered in a friendly and non-judgmental manner. In some settings, mass media programs, when combined with other community activities (such as educational materials and linkages to health services) have contributed to changing HIV behavior and social norms among young people.

**Key lessons.** Coordination with local authorities, including health centers is a valid strategy that links initiatives from the start to local duty bearers, highlighting the fact that these are the actors responsible for SRH services. Also, a multisectoral approach to addressing ASRH issues, which includes strong participation of young people and parents presents a unique opportunity to facilitating an enabling environment for the provision and acceptance of ASRH education, information, and services.

**Key recommendations.** There is a need for institutional and human resource capacity building and it is necessary to invest in the long term by changing social norms, providing community support, and sustaining behaviour change among adolescents and their families. A multifaceted approach should encompass all stakeholders, including CSOs, government, the private sector, and parents in ensuring sustainability of ASRH interventions. It's also important for Tanzania and other countries to amend policies and laws that prohibit comprehensive sexuality education.

### Introduction

In Tanzania, the young population (age 0–14) constitutes about 44 percent of the population, and the youth population (15–35) about 35 percent, based on the 2012 census (NBS 2013). This is a young age structure. The future of the country depends on the health and well-being of its young people, who

have their own needs for information and support, particularly during the years of adolescence (10–19), which are the years of physiological and social transition to adulthood. It can be a time of experimentation and initiation of sexual behavior, and is associated with vulnerability to adverse sexual and reproductive health (SRH) outcomes. While

<sup>1</sup> And adolescents'/young people's sexual and reproductive health rights.

many Tanzanian adolescents grow to adulthood healthy, some do not, and more are at risk for a range of health problems, including those related to SRH (Chandra-Mouli et al. 2013). The policy and legal environment for adolescent reproductive health is generally supportive to the health and development of adolescents.

The objective of this case study is to review the results of adolescents' sexual and reproductive health (ASRH) programs that received core funding from the Embassy of Sweden/Swedish International Development Cooperation Agency (Sida) implemented by Restless Development, Amref Health Africa, and the Femina Health Information Project in Tanzania. The study was qualitative and predominantly focused on a desk review of existing literature and secondary sources of mainly external evaluation reports of civil society organizations (CSOs) involved in ASRH programs.

### **Young people's sexual and reproductive health rights interventions in Tanzania: Results from selected civil society organizations**

Government bodies and non-governmental organizations (NGOs) in many low- and middle-income countries have implemented ASRH programs and projects, often with support from international NGOs, bi- and multilateral agencies, and private foundations (Chandra-Mouli et al. 2015). Youth participation in ASRH policies and programs has flourished worldwide, operating at different levels from international advocacy to local levels (Villa-Torres and Svanemyr 2015). After the International Conference on Population and Development (ICPD) +5, there was a proliferation of ASRH programs, in part because of the flow of resources from international donors after the commitment to investing 20 percent of total funding in youth-related programs (Cook 2008). In Tanzania, young people start sexual activity at an early age. Due to the stigma attached to adolescent sexuality there has been

opposition to youth access to reproductive health information and services for fear of promoting immorality among the age group.<sup>2</sup>

For that reason, there have been few efforts by policy makers, government leaders, and SRH providers to promote provision of youth-friendly services. Most SRH stakeholders believe that such services can only be provided by NGOs rather than the public health delivery system.<sup>3</sup>

The following cases come from a growing body of evidence in Tanzania on promising interventions to improve ASRH and youth-friendly reproductive health services. The government of Sweden, through Sida and its embassy in Tanzania, have been at the forefront in supporting CSOs promoting ASRH.

#### **Project on Sexual Reproductive Health Rights for the Young Peoples (*Tuitetee – Let's Fight For It*), 2010–2015**

This project was implemented by Amref Health Africa, with support from the Embassy of Sweden and Sida in three districts (Kinondoni, Ilala, and Iringa). This end-of-project evaluation of Swedish support was commissioned by the embassy, through Sida's framework agreement for reviews and evaluations (Andersson et al. 2015).

The overall objective of the project was to promote ASRH among 100,000 young people in the Iringa and Dar es Salaam regions. The project had four main components: advocacy and policy; strengthening youth-friendly SRH services by enabling the realization of two youth-friendly model service centers in Iringa and Dar es Salaam; capacity building (for supporting and setting up youth-friendly services, directed to peer educators in and out of school, district planners, health providers, school teachers, and community-based CSOs); and health systems strengthening (supporting the health system on service provision, human resources, information systems, leadership, and governance).

The evaluation reported that the strategic components of the project design were logical and

<sup>2</sup> <http://allafrica.com/stories/201504211475.html>.

<sup>3</sup> <http://allafrica.com/stories/201504211475.html>

well conceived, and corresponded to Tanzanian policies for youth-friendly services and reproductive health services. It also stated that the results framework had served the project well in monitoring project activities and documenting annual progress reports. It also made the following points:

1. The project applied a human rights perspective as it was non-discriminatory in considering the need of vulnerable groups (young people living with HIV, deaf young people) and key populations (men having sex with men, commercial sex workers, and lesbians), both boys and girls. The project was highly relevant for the rights holders and addressed the identified problems related to ASRH and specific needs of the vulnerable groups, through youth-led organizations composed of or representing these groups. The project had a sustainable impact in changing awareness, behavior, and care seeking of a considerable number of young people in the three municipalities.
2. Project interventions were participatory as the rights holders and the wider community, such as parents, teachers, community leaders, and health service providers had been involved in project activities. The capacity of duty bearers was built to be accountable to the rights holders in providing youth-friendly services, albeit with some resource constraints. Via technical assistance, capacity building, and models of youth-friendly services, the project was also highly relevant to the duty bearers. The number of visits to youth-friendly ASRH services increased—an indicator of demand for services.
3. The Municipal Councils in Iringa, Kinondoni, and Ilala increased their own resources for youth-friendly ASRH services for young people. The target of providing such services in at least 30 percent of existing health facilities was reached in Iringa Municipality. Through the efforts of the project and working with the municipal council, 31 health facilities in the three municipalities provided youth-friendly ASRH services. Capacity building through advocacy and planning meetings created awareness among municipality officers of the need to provide such services.
4. Capacity was built for providing services as well as raising awareness of ASRH. The target for an increased number of service providers, peer educators, and school teachers trained was achieved. Training packages were developed and used. Organizational capacity building of youth-led CSOs was conducted with good results.
5. Project design was highly relevant to Tanzanian ASRH policies, largely as it was built on national strategies, guidelines, and the national curriculum (for training). Project interventions ensured equal gender representation in activities and access to youth-friendly ASRH services. Gender disaggregated data for beneficiaries were provided, albeit inconsistently.
6. On gaps and challenges, despite the project having a sustainable impact in changing awareness, behavior, and care seeking, structures to continue activities in the municipalities or to scale them across to other municipalities were not sufficient. Service provision at the end-of-project level, quantitatively and qualitatively, may continue for some time, but may not be sustainable without further support. Limited national government funding will prevent the expansion of services to other health facilities.
7. Although there was a plan for scaling up youth-friendly services in the National Adolescent Health Strategy 2011–2015, progress had been slow. The training created a sustainable impact on the persons trained as well as in developing training packages, but financial conditions for continued training were lacking at municipal level. A decreasing health budget was unlikely to promote progress for national scale-up of youth-friendly SRH services.

### ***Restless Development Tanzania Programs, 2007–2015***

Restless Development Tanzania is a youth-led organization targeting rights holders in urban and rural settings in 18 regions of Tanzania, focusing on three strategic areas: ASRH, civic participation, and livelihoods and employment. Restless Development works with young national and community volunteers and youth networks, highlighting the importance of focusing on young people given that more than half the population is under 25 (NBS 2012). Sida was the main donor and provided core support to the organization during two Restless Development strategy periods (2007–2010 and 2011–2015). In 2015, the Embassy of Sweden, through Sida's framework agreement for reviews and evaluations, commissioned an external evaluation of programs covering the two periods (Holmberg et al. 2015).

The 2007–2010 strategy focused on HIV/AIDS and SRH. The aim during this period was to increase leadership roles among the youth to address urgent issues facing their lives and communities. Its core strategic objectives were to reduce vulnerability to HIV/AIDS among young people in the project areas; and to put young people at the forefront of development efforts in Tanzania, particularly in addressing HIV/AIDS.

The strategy was also guided by four objectives: enabling young people to take up significant roles in policy making processes that affect their lives; ensuring government is contributing to a supportive environment where young people take responsibility for their SRH choices; enabling young people to make responsible decisions on their SRH; and improving life skills and livelihood opportunities among young people.

The 2011–2015 strategy focused on three areas: civic participation—ensuring that young people are significant contributors to the development process; livelihoods and employment—helping young people to take up productive livelihoods and employment

opportunities; and ASRH—promoting safe SRH practices among young people.

On ASRH, the external evaluation reported that promotion was coordinated with local duty bearers and was cautiously contextualized to local realities. The program had been able to reach large numbers of in- and out-of-school young persons, teachers, health workers, and community members, and had contributed to increased awareness and knowledge of SRH. It also reported that entrepreneurship training and employment-promotion services to young people had improved knowledge on how to start and run a business. Young people viewed Restless Development's approach of working with youth-led groups engaged in income-generating activities as suitable.

The external evaluation also highlighted other points:

1. Comprehensive sexuality education and youth-friendly ASRH services are highly contested in Tanzania. Social and cultural norms influence the extent to which ASRH can be discussed. Education in school is governed by the curricula and national education policies. In the school setting, Restless Development is dependent on what space and methods the authorities allow. Policy is restrictive on allowing the open sharing of information on SRH and HIV/AIDS.
2. In-school respondents revealed that information from SRH teachers does not include discussions on rights, and as such is not addressed from a human rights-based approach or child rights perspective. Abstinence and what was labeled "good behavior" are promoted by teachers rather than coming from young rights holders' knowledge on sexuality issues and what sexual and reproductive rights they have.
3. Interventions during both strategy periods contributed to increased awareness on HIV and STI, and how to prevent early pregnancies among young people attending schools or who were in the different groups of adolescents and young adults. Duty bearers and volunteers interviewed confirmed that pregnancy rates in

- primary schools had dropped sharply and attributed this to collaboration with Restless Development. This was an important outcome.
4. In primary and secondary schools with SRH clubs, students met as an extra-curricular activity to discuss SRH issues. In community action groups, respondents mentioned that discussions on ASRH had been part of the capacity building they had received and that awareness on the need of youth-friendly services had increased among young people and at health clinics.
  5. The interventions reached young people and community members not directly involved in SRH activities. For example, an unexpected result reported a reduced number of dropouts in schools and with the assistance of counselor teachers, improved academic results in two program areas of Iringa and Ruvuma. School officials and teachers believed it was because the relationship between students and teachers had improved.
  6. Coordination with local authorities, including health centers, is a valid strategy that links initiatives from the start to local duty bearers, highlighting the fact that these are the actors responsible for SRH services. Restless Development supports counselor teachers with alternative education, enabling them to address ASRH differently and use other teaching methods that create dialogue between the students and teachers. This strategy can sustain some of the shorter-term initiatives both in the targeted communities and in society at large, because teachers can be transferred to other regions. These strategies are mainly founded on collaboration and less on empowerment of young people to claim their rights to comprehensive sexuality education, youth-friendly SRH services, and non-discrimination of young girls who become pregnant.
  7. The Tanzania Commission for AIDS commented that Restless Development's work complements its own work, particularly in terms of capacity to link to young people.
  8. On gaps and challenges, any focus on gender equality and discussion on rights was weak, with a negative impact on the effectiveness and sustainability of results. Given the restricted ASRH policies, the low awareness among duty bearers of the importance of comprehensive sexuality education and youth-friendly services, and legislation such as the Law of Marriage Act 1971 that allows girls to be married at 14 (with parental consent), ASRH advocacy by Restless Development and other CSOs is sorely needed.
  9. The work focused on abstinence, sexual health, and family planning did not cohere with a comprehensive approach to ASRH. Information to young people should ideally be comprehensive and rights based, grounded in gender equality commitment, and include education on sex and relationships. A human rights-based approach requires special attention to young people exposed to stigma and discrimination.

***Femina Health Information Project Strategic Plan, 2006–2012***

Femina is a civil society multimedia initiative working with youth, communities, and strategic partners across Tanzania to promote the “Femina Lifestyle”—a range of values, attitudes, and behaviors related to sexuality, reproductive health, HIV/AIDS, gender equality, economic empowerment, and civic engagement.

“Edutainment”—entertaining while educating—is the cornerstone of Femina’s approach to inform, create awareness, and stimulate young people to sustain healthy behaviors.

As the Embassy of Sweden in Tanzania was the lead donor in a basket-funding mechanism, through Sida’s framework agreement for reviews and evaluations, it commissioned an external evaluation of the strategic plan in 2013 (Chipeta et al. 2013). The evaluation focused on four output areas: engage youth in conversations on SRH and on civic engagement; create a supportive environment for youth; develop partnerships and create a public

debate to promote the “Femina lifestyle” brand and the edutainment methodology; ensure Femina management, and organizational and structural arrangements and capacity.

The evaluation reported that Femina had been consistent in delivering planned outputs, highlighting the following achievements of its strategic plan:

1. Femina is very popular and a trusted source of information, especially on sexuality and reproductive health. There is still some resistance in Tanzanian society. For example, Fema magazines are not allowed to be distributed in the schools of Zanzibar. But apart from this, Femina has been able to strike a balance between being culturally sensitive and confronting important issues. Femina has contributed to a more open public debate on sexuality, and a large part of the youth population embrace the “Femina lifestyle.”
2. One important success has been wide outreach via its magazines, which are distributed more widely than any other printed communication. Fema has a readership of 2.8 million, and 9.8 million people know about it. Si Mchezo has 1.2 million readers, and 5.4 million people know about it.
3. Femina has a unique angle on youth and sexuality, in a space not assumed by any other body. Femina has reached youth and generated dialogue on their issues, abetted by its “edutainment” approach. According to surveys conducted by the Tanzania All Media and Product Survey, the approach is popular among readers of Fema, and most of the youth find the magazines easy to read and the content easy to understand.
4. Femina is a well-managed organization with a strong learning culture. It has a youthful and very motivated staff and has strong skills in media and communication.
5. On gaps and challenges, the evaluation highlighted a need for Femina to work on strengthening school and community

partnerships by coordinating activities closely with parents and the teachers who are guardians of Fema clubs. There was also a need for stronger targeting of young girls. While the aim of Femina’s products is to target issues relevant to women and girls, this group is a minority of readers, club members, and youth communicating with Femina. This major challenge demands strong targeting, and the evaluation recommended that Femina should design a new strategy with emphasis on gender equality, adopting indicators for girls and young women’s participation, as supported by research.

### An overview of African and international policy instruments

Tanzania is a signatory to the following international and African policy instruments on ASRH that take youth to be an important group.

*The Maputo Plan of Action for the Operationalization of the Sexual and Reproductive Health and Rights Continental Policy Framework, 2007–2010* sought universal access to comprehensive SRH services in Africa by 2015. One of its key components was addressing the SRH needs of adolescents and youth; increasing domestic resources for ASRH, also addressing the human resource crisis; including males as an essential partner of ASRH; and adopting a multisectoral approach to ASRH.

*The Sexual and Reproductive Health strategy for the Southern African Development Community Region, 2006–2015* aimed to provide a policy framework and guidelines to accelerate the attainment of SRH for all SADC citizens. The strategy recognized the importance of active discouragement of harmful practices such as female genital cutting and emphasized that indicators on adolescent health in general and reproductive health specifically identify great health risks associated with this age.

*The Africa Health Strategy, 2007–2015, Strengthening the Health Systems for Equity and Development in Africa* called for a specific focus on reducing teenage pregnancies and sexually related

disease as well as ensuring access to post-exposure prophylaxis for victims of rape, and the importance of developing the role of men, both as supporters and recipients of SRH services.

*The African Union Youth Charter* seeks to ensure that young people have the right to high-quality education and are guided to develop life skills to function effectively in society. It covers such issues as HIV/AIDS, reproductive health, substance abuse prevention, and cultural practices that are harmful to the health of young girls and women.

The Youth Charter also aims to ensure that countries institute comprehensive programs to prevent the transmission of sexually transmitted infections and HIV/AIDS by providing education, information, communication, and awareness, and by making protective measures and reproductive health services available.

*The Abuja Call for Accelerated Action toward Universal Access to HIV/AIDS, TB, and Malaria* services urged integrating HIV/AIDS responses into immunization programs and SRH programs—and conversely SRH issues into HIV/AIDS programs—and to reawaken traditional values on abstinence but continually increase condom use.

*The International Conference on Population and Development Program of Action in Cairo in 1994* was forward looking in many areas of SRH and rights and notably in relation to adolescents and young people. In addition to calling attention toward “meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality,” it stressed that reproductive health services should be made accessible through primary health care systems to individual of all appropriate ages, including adolescents, as soon as possible and no later than 2015 (UNFPA 2004).

Yet SRH was omitted from the Millennium Development Goals. Unsafe sex is the second most important risk factor for disability and death in the

world's poorest communities and the ninth most important in developed countries (Glasier 2006). Sexual and reproductive ill-health mostly affects women and adolescents. Women are disempowered in much of the developing world and adolescents, arguably, are disempowered everywhere. SRH services are absent or of poor quality and underused in many countries because discussion of issues such as sexual intercourse and sexuality make people feel uncomfortable.

At the heart of the problem is the increasing influence of conservative political, religious, and cultural forces around the world that threatens to undermine progress made since 1994, and arguably provides the best example of the detrimental intrusion of politics into public health (Glasier 2006).

During the five-year review of the ICPD in 1999, governments recognized that investing in adolescent health was important not only for the well-being of adolescents but also for the current and future well-being of communities and societies. (Chandra-Mouli et al. 2015).

At the 20th anniversary of the ICPD Conference in 2014, the UN General Assembly called upon countries to fulfill the commitments made in Cairo in 1994 and address the widening inequalities and emerging challenges as outlined in the ICPD Beyond 2014 Global Report. The report provided governments with evidence-based guidance on how to realize the unfinished ICPD agenda, including by prioritizing the rights of young people in education, SRH, and decent work.<sup>4</sup>

### Outcomes and overall assessment

A favorable framework for ASRH programming may be slowly taking shape in Tanzania, as part of the trend that saw Tanzania become signatory to international agreements and consensus documents on human rights that include ASRH.

In practice, however, some of Tanzania's laws and policies are out of line with human rights norms. For

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<sup>4</sup> [www.unfpa.org/ICPD](http://www.unfpa.org/ICPD).

example, the Law of Marriage Act 1971 allows a girl to be married at 14, when the girl is still a child. And even when good laws exist, political commitment, financial resources, skills, institutions, and systems of accountability are required for them to be enforced. CSOs have been working against this variegated backdrop to implement ASRH interventions.

CSOs activities have shown that adolescents respond to education and services addressing their ASRH needs if they are delivered in a friendly and nonjudgmental manner. This point is taken by the government and its partners. In the space granted to them, CSOs have designed interventions with comprehensive approaches that address ASRH rights and also work toward eliminating gender bias and other social, economic, and legal barriers that prevent adolescents from accessing SRH services. One common strand is that they have focused on putting youth at the center of planning and implementation and creating enabling environments so that young people can realize their SRH and human rights, and, possibly, empower them economically.

Mass media campaigns and communication programs have contributed to raising awareness and stimulating dialogue on ASRH issues, though any further impact is questionable. In some settings, mass media programs, when combined with other community activities (such as educational materials and linkages to health services) have contributed to changing HIV behavior and social norms among young people.

Young people require comprehensive ASRH information and services. There are strong public health, human rights, and economic reasons to invest in ASRH. The foundation for the good health of the population, as adolescents become adults, will be solidified by mutually respectful attitudes between adolescent boys and girls.

## Conclusions and policy implications

### Lessons learned

ASRH programs in Tanzania have usually been implemented within school contexts (as extra-curricular education), community youth groups, or directly to young people through mass media and health workers and few involved parents. There is therefore an urgent need to build capacity and support parents to become and stay involved in the lives of their children and to change their perspectives about their children's sexuality. Interventions should support parents and young people to be able to intercommunicate about ASRH-related matters. Sexual health prevention programs that target parents and young people on communicating would be of high value for safe sex behaviors.

While there is a strong relationship between the capacities of institutions, service providers, and communities to provide information and services to adolescents, there is ambiguity on how to address ASRH and rights more comprehensively in the formal school setting.

Finally, a multisectoral approach to addressing ASRH issues that includes strong participation of young people and parents would present a unique approach to fostering an enabling environment for provision and acceptance of ASRH education, information, and services.

### Policy implications and recommendations

1. Despite progress since the 1994 ICPD Conference in Cairo, ASRH coverage is still low in Tanzania. To realize their SRH and rights, young people need and are entitled to comprehensive sexuality education. There is a need to disseminate the evidence that emphasis on gender, power, and rights in the school setting improves health outcomes.
2. More investment is required to enable the participation of young people in ASRH programs and in evaluating its benefits.

- Youth participation is a fundamental principle in itself.
3. Modern technology such as digital media, telephone hotlines, and mobile phones offer opportunities for engaging with adolescents with ASRH information and services. It can help to reduce the barriers that discourage young people from obtaining important and urgent sexual health services and education. However, there is limited understanding of how adolescents are already using the new technologies to learn and communicate with their peers or trusted adults on sexuality and ASRH. Efforts need to be made to understand this gap in knowledge.
  4. Donors need to support not only implementation of evidence-based interventions but also fund evaluations, implementation research, and information dissemination.
  5. Tanzania needs to make more focused efforts in policy, legislation, programming, research, and funding to accelerate adolescent access to ASRH. Action must be taken to amend policies and laws that prohibit comprehensive sexuality education.
  6. Young people are a highly vulnerable group, partly because they are also curious. A long-term aim via participatory programming should be to alter social norms, offering community support and sustaining behavior change among adolescents and their families.
  7. A multifaceted approach should encompass all stakeholders, including CSOs, government, the private sector, and parents in ensuring sustainability of ASRH interventions. All have their roles in realizing ASRH.

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