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‘Falling Through the Cracks’

Adolescent Girls in Tanzania:
Insights from Mtwara

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Adolescent Girls in Tanzania: Insights from Mtwara

Maggie Bangser
Independent Consultant
On behalf of Juárez and Associates, Inc.
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Summary

This report presents findings and recommendations of an overview study on adolescent girls in Mtwara Region commissioned by USAID/Africa Bureau in cooperation with USAID/Tanzania in late 2009. Interviews were conducted with over 150 individuals in Mtwara and Dar es Salaam, and relevant studies and other materials were reviewed from Tanzania and the international literature. Six themes emerged from the analysis: the economic vulnerability of girls; family structures; adolescent girls' sexuality; the situation of health and education services; current projects in Mtwara; and, girls' view of their future. Options for future work are proposed focusing on seven strategic approaches to strengthen rights, equity and accountability on behalf of adolescent girls.

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"There is a near-perfect convergence between protecting the rights of adolescent girls and making the right public policy choices to establish a sound foundation for development"

Start with a Girl. Center for Global Development, 2009

I. Introduction

Background

In late 2009, at the request of USAID/Tanzania, the USAID/ Africa Bureau through its contractor, Juárez and Associates, Inc., commissioned an overview study of adolescent pregnancy in Mtwara region in cooperation with USAID/Tanzania. USAID's decision was based on the view that gender equality cannot be achieved without addressing issues affecting women's and girls' empowerment, and a key issue among these is adolescent pregnancy (AP). When girls become pregnant, they face a myriad of challenges to their capacity to perform in and complete school, to achieve positive health outcomes, and to avoid social and economic threats. Yet despite these challenges, girls continue to 'fall through the cracks'[1] of most development policies and programs worldwide.

Mtwara is among the regions with the highest prevalence of AP in Tanzania, and as such, the overview study focused there. However given that health, educational and other policies and interventions typically require national level decisions and are not specific to particular regions, USAID sought relevant information on issues affecting AP in Tanzania nationally, as well as considerations of lessons from global knowledge on this issue.

This overview should be considered a "snapshot" of AP, and not an exhaustive analysis of either the challenges or potential solutions. It is a desktop review of the issue informed by a 12 day visit to Mtwara, and selected interviews with a range of relevant actors. The strategic recommendations identify several options for investment and action, principally for donors to consider, and urge a focus on the systemic issues that could most influence the 'drivers' of adolescent girls' well-being. Nonetheless, other strategies which are suitable to different actors surely exist, and combinations of options may be most appropriate for different actors. The ultimate objective is to create meaningful change for adolescent girls in Tanzania who continue to fall through the cracks

Scope of Work

The scope of work for this overview study included the following tasks:

- To compile available information on policy, services, schools, communities and advocacy issues related to AP in Tanzania, with a special focus on Mtwara Region.
- To study the extent of the problem of AP in Tanzania and more specifically for Mtwara Region.
- To assess the underlying causes of adolescent early pregnancies in Mtwara Region.

[1] Term used in "Start with a Girl". Center for Global Development, 2009

- To collect and assess opinions from a wide range of stakeholders on underlying causes and suggestions on how to solve the problem.
- To identify relevant initiatives and best practices already undertaken by different development players in the region in addressing the problem.
- To suggest strategies and approaches to address AP in Tanzania and more specifically for Mtwara Region.
- To suggest sector-specific and/or integrated programmatic options for current and/or future USAID activities in Tanzania and more specifically for Mtwara Region.

Methodology

The methodology used in this overview study entailed:

- Document review of approximately 65 reports, studies, policies, guidelines, project materials (Annex 1)
- A field visit of two weeks to Mtwara, including Mtwara town, peri-urban Mtwara, and Mtwara Rural district
- Interviews with approximately 150 people including
  - 73 students, parents, teachers, school officials
  - 26 day-laborers/*Vibarua/Mama Ntilie*
  - 26 NGO/INGO, activists, researchers, media
  - 8 health workers
  - 7 government officials
  - 5 donors
  - 5 business people and 'others'

Caveats and limitations

The period of this work including presentations to several audiences covered 35 days in late 2009 and early 2010. In a limited period of time, the number of people interviewed, sites visited, and types and number of documents reviewed is necessarily constrained. As such, this is not an exhaustive review of the issue of AP in Mtwara, in Tanzania, nor certainly internationally. Some nuance in interviews may have been lost in translation. Lastly, this overview study is not an independent evaluation of any particular program or intervention.

II. Key Themes

Six key themes emerged from the discussions in Mtwara that shape the analysis and the recommendations. Each theme is addressed, in turn, in this report and photographs capturing the core images related to each theme are presented in the Powerpoint presentation accompanying this report (Annex 2).

The key themes are:

1. Economic and social marginalization of Mtwara
2. Families in flux and on the move
3. Sexuality is alive
4. Education and health - achieving minimal change
5. "Patchy patchy projects"
6. "I want to be a doctor"

1. Economic and social marginalization of Mtwara

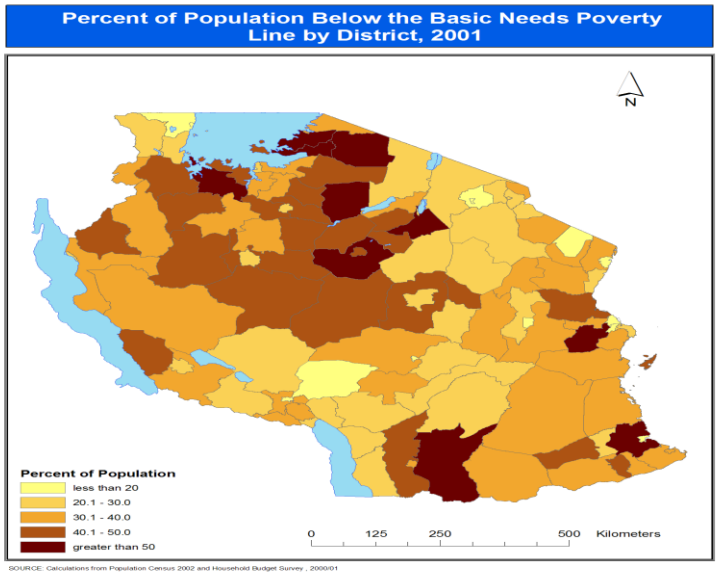
> **"These people have nothing.**
> ***Nothing*."**

Perceptions of economic status and livelihoods
Virtually everyone interviewed spoke about the extremely limited work opportunities for women and young people, in agriculture, government employment, formal sector, business and other avenues of economic opportunity. Many young people living in Mtwara seek work in large cities of Tanzania, and those interviewed spoke about having to bribe in order to secure employment.

Across the board, respondents stated that economic investment and development in Mtwara have lagged behind the rest of Tanzania and that the situation has not improved in the last decades. While some positive change has come with the construction of the Mkapa Bridge and the recent introduction of electricity in the region, the underlying economic fabric reportedly does not provide an economic foundation for the people of Mtwara. In particular, respondents noted the failure of the cashew-nut industry to provide sufficient livelihoods to farmers, and that agricultural initiatives such as *Kilimo Kwanza* have not improved people's welfare.

Mtwara and other regions
Other regions of Tanzania score lower than Mtwara in terms of population living below the basic needs poverty line. Lindi, Singida, Pwani, Shinyanga and to a lesser extent Mara, have the highest income poverty and highest food share as a proportion of household expenditure.

Figure 1



Data on school enrollment for girls, and illiteracy among females, is highest in Rukwa and Tabora, with each region showing alarming results.

Table 1: Percentage of females unable to read a sentence in selected regions

Region	15-19 years	20-24 years
Rukwa	65.9	45.4
Tabora	58.7	53.5
Mtwara	36.0	47.0
Kagera	25.1	39.0
Dar es Salaam	10.1	17.2
Zanzibar South	9.5	14.4

Source: Population Council analysis of TDHS 2004/5

In addition to education, respondents observed that health services are inadequate, despite national level policy to construct more facilities. Finally, concern was also expressed about the widening gap between the rich and poor.

Livelihoods and girls' vulnerability

The limited economic, work and livelihoods opportunities have particular repercussions for girls' schooling, and girls' sexual lives. For example, numerous respondents spoke about girls being told to deliberately fail their Standard 7 (primary school leaving) examinations because families could not afford to pay fees for secondary schools or because the girls could then be married off and bride-price paid to the girls' families for the marriage. Some respondents, including parents and girls themselves, spoke about families pushing girls into having sex for money in order to buy basic items for the family.

1. Families in flux and on the move

Family structure and its affect on adolescents

Family structure in Mtwara is reportedly highly 'fluid" and "chaotic". Monogamy is not commonly aspired to, nor practiced. Reportedly many marriages end in divorce, and re-marriage to different partners, multiple forms of partnering, and multiple family configurations are common. While certain communities in Mtwara are matrilineal, this does not seem to translate into stronger women's or girls' decision-making power. Women may feel a positive sense of camaraderie amongst themselves, but in relation to men, their social role is still clearly subservient.

The 2004-05 Tanzania Demographic and Health Survey (TDHS) shows just over half of 10-14 year olds in Tanzania live with both parents. During this field visit to Mtwara, only about one-quarter of the children interviewed reported living with both parents. While not a representative sample of children in Mtwara Region, this indication was troubling.

Trafficking of girls

"Even if you want ten girls now, you'll get them."

Another concerning observation – though not specifically examined in this study – was girls being sent to, sold into, or otherwise trafficked to Dar es Salaam (and elsewhere) for 'domestic work' and other forms of hardship and exploitation. One observer remarked that, "even if you want ten girls now, you'll get them", indicating the ease with which girls are bought and sold.

2. Sexuality is alive

Sex and adolescent pregnancy

People spoke very openly about their perceptions of the causes of AP. Most notable was grinding poverty and the actions taken by girls and families to make ends meet. Many people also spoke about the 'temptation' that girls succumb to in the pursuit of material items that sex for money, or sexual liaisons, can provide. Other causes of AP reported were the pervasiveness of videos – including sexualized (potentially pornographic) – that are shown at night in villages and attended by young people.

Parents talked at length about a lack of communication between themselves and adolescents regarding social behavior, and about their distinct loss of 'control' over their adolescents.

This situation exists against a backdrop of scarce availability of contraception for young people, and a decaying educational system that provides little if any support for children and adolescents to manage their sexual health.

Sexual health

> **"*'Sexual health'* is having enough sex and being sexually satisfied."**

Sex and sexuality were typically presented in a 'positive' way. A number of respondents, particularly those working in public or reproductive health, talked about a relative openness around sexual behavior and multiple partnering in Mtwara. People move across sexual relationships, and relationships of different kinds, with regularity. Some of this, but not all, was also related to the 'fluid' family structure discussed above.

Interestingly, some respondents expressed concern about outsiders – largely expatriates – who come to Mtwara to research local sexual practices. The interest of international organizations to examine sexual practices in Mtwara, despite potentially positive intentions to address early pregnancy and school dropouts due to pregnancy, was perceived to be judgmental. This concern could well create apprehension about the purpose and value of efforts by outsiders on sexual and reproductive health issues.

Unyago

"*Unyago*" is a local rite of passage, or initiation period, into social roles and sexuality in Mtwara. Forms of *unyago* are also practiced in other ethnic groups of Tanzania, but *unyago* in Mtwara is often singled-out as a key cause of early pregnancy. It is perceived to be a highly sexualized social event, which often takes place at a young age (girls are sometimes as young as eight years old), thus raising concern among reproductive health and HIV/AIDS professionals. In contrast to these professionals, however, ordinary citizens interviewed in Mtwara reported being very proud of *unyago*, given that it is a principal method to relay important social messages of self respect, respect for parents and elders, community building, and the strength of women in the community.

While *unyago* is a time of social 'permission-giving' for adolescents to have sex – and this could present serious threats to their health - *unyago* should not be seen or treated as a singularly sexualized event that alone drives early pregnancy. Forces larger than *unyago* determine sexuality among adolescents in Mtwara, principally social and gender expectations, and the economic

situation which leaves few opportunities for security and well-being. As one researcher in Mtwara described, "rituals (such as *unyago*) contribute to sexuality in as much as they are the 'teaching tool' within a larger model of sexuality and gender roles".

3. Education and health - achieving limited change

The state of schools visited

Visits to five schools and five health facilities provided a quick sense of the state of educational and health services in Mtwara. The observations were troubling.

Typically, only half the teachers on the official teachers' roster were present on the day visited, and those present were often in the staff room rather than in the classrooms. While the number of teachers officially recruited in Tanzania has risen dramatically in recent years, this does not necessarily translate into increased classroom teaching time.[2] For example, at one of the schools visited in Mtwara, five out of the 16 teachers were absent from school because of an exercise to verify voter rolls.

The quality of education provided in Mtwara appears to be severely low. For example, in a visit to a Standard 5 classroom in Mtwara (children approximately 10-12 years old) I observed approximately 70 children in the room, about 20 of them sitting on the floor because there were no desks. There was no teacher in the room. The subject being 'taught' was English, and on the blackboard were conjugations of "Who", "Whose", "Whom" and the like. When I asked in English "How are you?", the answer, declared in unison, was "YES". When the children were asked "How is school?", again, the answer was "YES".

Corporal punishment continues to be widely practiced across schools in Tanzania, and in Mtwara it was often cited by children as a reason for not attending school. The issue arose in a number of schools visited. For example, during a visit to one primary school I observed a class of children squatting on their knees in the sun, arms thrust upwards. Following this, each child was systematically caned on the palm of the hand by the teacher. When I asked the teacher why the students were being hit, the teacher said because "They don't know how to read". During a follow-on discussion about how children learn, the teacher was of the firm opinion that corporal punishment would lead a child to know how to read.

The lack of toilets was a serious problem in schools, particularly for girls who are menstruating. One school visited with 900 students did not have a single toilet for the children. One teachers' toilet has been allocated to students and the school administration was struggling to raise funds from parents to build new toilets (only about one-sixth of the cost of the new toilets was reportedly provided by the local government).

Mandatory pregnancy testing and re-admission of pregnant schoolgirls

As in other parts of Tanzania, mandatory pregnancy testing is conducted on schoolgirls in Mtwara, typically in Standards 5 to 7. Numerous respondents supported this policy, including teachers, at least two managers of a sexual health program, and several students. It was not possible to determine the extent to which mandatory pregnancy testing and induced abortion by adolescent girls is linked, but both phenomena reportedly exist side-by-side in Mtwara, as in other regions.

[2] See notes of other recent field visits by partners, including Twaweza, 2009.

Opinions regarding the re-admission of pregnant girls to school after childbirth were nearly all positive, and most respondents noted that they would support this move. Among the few detractors, school administrators expressed reluctance, although this may have been a reflection of their understanding that expulsion of pregnant schoolgirls is formal policy (it is technically not policy, nor is it law). Some female students expressed concern about girls returning after delivery, particularly in light of their responsibility to care for the baby (including breastfeeding) and their concern that pregnant school girls would be stigmatized. Some girls talked about girls with babies being 'adults' themselves, so they could not be in school in the standard subordinate role of a student.

A few respondents felt that only "serious" female students – good students who by implication don't have sex and get pregnant - should be allowed to return. One interviewee remarked that girls should not be allowed to return, because "we already gave her a chance (at education)" and she clearly failed with the opportunity. It is noteworthy that this person is herself the manager of the sexual health program in Mtwara

Sexual health and life skills in the schools

There is still no national sexual and reproductive health (SRH) curriculum in schools in Tanzania, despite reports of at least a decade of materials development and advocacy for curricular attention to SRH. Numerous people working with young people, SRH and HIV/AIDS reported that the Ministry of Education and Vocational Training (MOEVT) is the most significant obstacle to moving forward with a curriculum, or other programming, on SRH.

Evidently some information on anatomy, reproductive functions, etc., is included in the biology curriculum starting in Standard 5. However people remarked that the information is limited, teachers are not trained adequately to teach the subjects, and they lack teaching resources. In addition, there are reportedly few science teachers in schools. Some schools have none at all.

There are a few notable extra-curricular SRH programs now in place; particularly PASHA (a GTZ funded project) that numerous people said is bringing much needed information and a positive influence to schools through its materials and peer-education approach. In contrast, no respondent spoke about the role of the *Stadi za Maisha* (Tanzania Institute of Education/Centers for Disease Control) project in the schools. There was also no evidence to show that the out-of-school population was reached with SRH programming, a critical gap.

Fees and contributions

Overall, as in other parts of Tanzania, young people in Mtwara expressed a strong desire to attend school and to get an education. However, the cost of education was reported to be a major constraint. At the secondary level in Tanzania, official fees are Tshs 20,000 per year (non-residential) and Tshs 40,000 per year (residential). When parents were asked about the *real* costs, however, the total amounted to Tshs 250,000 per year or more, inclusive of fees and '*michango'* (contributions). At one school visited during the second week of the new term, of the 600 students on the register only 40 were present, reportedly because families of the missing students were unable to pay the costs.

Abortions

As in other areas of Tanzania, anecdotal reports of abortions are high in Mtwara. This includes among schoolgirls, especially at secondary school level. The methods of abortion most commonly reported were inserting sticks of the cassava plant into the uterus; and boiling cassava or neem ('*marobaini*') leaves, or three coins, in water and drinking the water. At the hospitals visited (four), abortion complications ranked high among in-patient gynecology cases.

Access to and quality of health services

> ***"'The poor don't get health services."***

Many people stated that health services are inaccessible to those living in poverty. Whether due to official fees, 'unofficial fees' (bribes), or the costs of treatment and medicines, people living in poverty are often locked out of medical care. Numerous people reported that for those who do access care at the regional hospital, care is well below the established standards. People try to gather the necessary money to attend mission hospitals, despite their higher formal charges, because they are reported to give better services.

A key problem for health care in Mtwara is the serious shortage of qualified health workers. "No health worker wants to come down here", a doctor in Mtwara explained. This is true throughout under-served and remote regions of the country.

The health centers and dispensaries visited had health workers in place, although few. For example, at one health centre in Mtwara Rural, there appeared to be over 200 people attending on the day of the visit. The facility had 10 staff including two Clinical Officers; and no Assistant Medical Officers were assigned there. Some patients waited seven hours to see 'the doctor'.

A Community Health Fund (CHF) is available in Mtwara Rural, with a cost of Tshs 5,000 per year for a family of eight. Still, many people reported they cannot afford the fees; some health workers stated that people do not understand the CHF so do not join. Others commented that "only government workers can afford health insurance".

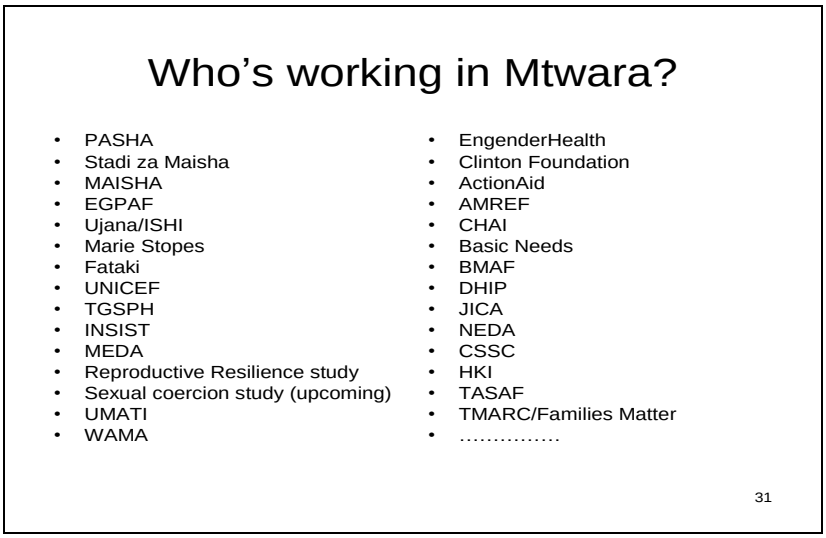
"Adolescent friendly health services" (AFHS)

No AFHS were observed during the field visit in Mtwara. A government official reported that AHFS do not exist virtually anywhere in Tanzania, and that there has been no budget line in the MTEF (Medium Term Expenditure Framework) for adolescent health in the past two years. There are guidelines and standards for AFHS (adapted from WHO), but reportedly no implementation of the services.

4. "Patchy patchy projects"

While Mtwara is often considered a remote region, there does not seem to be a deficit of organizations and donors working in Mtwara. As one respondent working in reproductive health nationally explained, there are "patchy patchy projects" everywhere in Tanzania but little to show for it.

Figure 2



There are also many policies, standards, guidelines, and training tools, but apparently little coordinated use of these materials. As several people asked, and one can reasonably wonder, what is all this adding up to?

5. Ambition: "I want to be a doctor"

The final theme, and the most promising, that emerged from the field visits is that of girls' ambition. The last visit conducted in Mtwara was to a girls' secondary school. The energy and determination of the girls to advance their education and to aim high in life was palpable. As one girl said, "I want to go to university and become a doctor". Other girls reported wanting to be a lawyer, an engineer, a journalist, a business woman, an accountant.

At the end of the conversation with the girls, one student asked "when you were our age, did you dream of doing what you are doing now?...an unusual question in the best of educational environments. And while the girls at this secondary school are likely to be the 'cream of the crop', they reflect a determination that instills hope.

III. Moving Forward

The themes emerging from this overview present a generally disheartening picture of girls' lives in Mtwara. The social foundations and institutions which should help keep them safe and healthy – schools, health facilities, and most importantly families and community life – appear not to be adequately promoting girls' well-being, and in some cases are working distinctly against it.

If schools lack teachers, toilets, quality teaching and learning; if they are unaffordable and create a climate of fear and intimidation…what precisely *is* the motivation for a girl to stay in school or to not get pregnant? If contraception, comprehensive sexual health, counseling and even basic health services are inaccessible or unavailable, what choices do girls have to stay safe and healthy if they are sexually active?

Two sets of options for moving forward are presented here: specific interventions and strategic approaches. They are not mutually exclusive. For a number of partners, a combination of the options presented may be most appropriate.

Option 1: Support specific interventions aimed at adolescents and/or issues affecting them

Targeted interventions

Many actors currently operate in Mtwara with programs targeting youth or the issues affecting them (see Figure 2). This study did not seek to assess the effectiveness of this work, and no doubt some are likely to be achieving their programmatic objectives. A clear option therefore is to identify the most effective projects, based on transparent criteria and independent (rather than self-reported) assessments of success, and to support their continuation and scaling up. In doing so, consideration may be given to exploring new work or innovations, including on issues or sub-populations that have remained relatively neglected.

In the course of the study the following ideas emerged as possible areas for further exploration. The list is indicative of the type of work that may be worth considering.

1. Support an expanded life skills program for youth rooted in factors driving girls' vulnerability. The PASHA program in particular may be worth reviewing and expanded further to reach larger numbers, including through outreach to out-of-school youth.

2. Carefully and cautiously test 'influencing' *unyago* in order to add information on pregnancy prevention, HIV, etc. Work with elders who are the 'holders' of the tradition.

3. Assess and scale up pilot interventions on 'safe spaces'[3], 'married girls clubs', and girls' empowerment that have been tested in other countries such as Biruh Tesfa; Binti Pamoja; and Girls Power Initiative (see Population Council for further information).

The advantages of this approach are that it allows for specific targeting of adolescent girls, and that limiting the focus and scope of the interventions may make them more manageable and do-able. The potential disadvantages are that projects are unlikely to be able to address larger and structural determinants of AP, be harder to sustain once project funds end, and that the overall effect may be "patchy patchy" as discussed above.

Sector-wide programming

Another potential approach is to intervene one level higher than projects by addressing a sector, and address several key factors together in a coordinated and concerted manner. Several people attending presentations of the findings from Mtwara advocated for sector-wide interventions that reach more people with, for example, important reproductive health services. While also susceptible to some of the challenges of isolated projects, invigorated sector-wide programming could potentially contribute to strengthening girls' health through expanded provision of life-saving services. These include, in particular:

[3] One study in Dar es Salaam which explored the dimensions of vulnerability for adolescent girls and young women found the single most compelling finding was that adolescent girls are not safe anywhere in the city. As soon as a girl reaches puberty, she is considered to be a sexual being. From the age of about 12, girls are subjected to continual propositioning from shopkeepers and market stall holders, teachers and doctors, bus conductors and passers-by. One of the young researchers estimated that she was propositioned between 10 and 30 times a day (Mabala, 2008).

1. Family planning/contraception including in particular for youth. A renewed commitment to accessible, affordable and quality family planning services is urgently needed in Tanzania, following a decade of stagnation in this area. Across the world, the unmet need for contraception among young women is double that for older women, and is consistently highest for 15-24 year olds (Start with a Girl, Center for Global Development). Girls who are not in school are particularly at risk of unplanned pregnancy: girls in school are less likely to have had sex, and if they are sexually active, they are more likely to use contraception than non-students of the same age. (C. Lloyd in Bruce and Hallman)

2. Post abortion care (PAC). PAC services could be scaled up across Tanzania to save lives, with potentially significant gains for women and girls' wellbeing. A review of 27 studies in developing countries of hospital based abortion data showed that 60% of admissions for abortion complications were for adolescent girls (Start with a Girl, Center for Global Development). Anecdotal information in Tanzania and selected facility based examination of abortion complications confirm this situation.

3. Adolescent Friendly Health Services (AFHS). Guidelines and standards for AFHS already exist in Tanzania. The problem is implementation. Secured and sustained funding for AFHS, through the MTEF, is needed to support the direct implementation of AFHS; training, supervision and monitoring of providers; and commodities and other supplies.

Each of these interventions are fraught with considerable cultural and political challenges, including approaches from professionals and government officials that prefer to see young people as *asexual* beings until they are married. Work in this area therefore cannot be limited to technical aspects alone. It would need effective and broad public debate accompanying it, as well as support for progressive leadership within government and local communities who take a stand on these issues.

Option 2: Seven strategic approaches to strengthen rights, equity and accountability on behalf of adolescent girls

> **"Hundreds of millions of girls and young women living in the path of HIV have had little or no benefit from schooling, feel unsafe in their communities, face a significant risk of sexual coercion, and - having little or not direct access to economic assets or prospects for making a livelihood – feel compelled to exchange sex (inside or outside of marriage) for money, gifts, food, and shelter"**
>
> Bruce and Hellman, 2008

While the approaches discussed under Option 1 provide concrete ways in which to support adolescent girls' well-being, their main limitation is that they are unlikely to address the deeper underlying determinants that were repeatedly observed during the field visits in Mtwara. Sexual health – including HIV and adolescent pregnancy - is driven by strong socio-economic influences that go beyond the capacity of individual ("patchy patchy") projects to achieve change. In Mtwara and every other region of Tanzania, a community event, a school based peer education session, or a popular song may register in people's minds, but is not likely to change the strong forces that drive girls into early sex, and that deny them the capacity to remain safe and healthy.

Perhaps the most important lesson to draw from this study is that deeper, more systemic and sustained actions that operate *at scale* may be more likely to create the core conditions to support adolescent well-being. Most of these required actions are broad based and do not specifically target AP or AP services, and as such their benefits are also likely to accrue more broadly. For this reason they represent an opportunity to build a broader community of support and resources that go well beyond the more limited SRH constituency in Tanzania.

Seven strategic approaches are proposed below.

1. Support equitable teacher and health worker deployment

Basic services and care for young people, particularly in health and education, cannot be provided without adequate, competent and motivated staff in place. A harmful pattern of human resource deployment continues to exist in Tanzania, with the most under-served regions of the country unable to hire and retain adequate numbers of teachers and health workers. The gap appears to have widened in recent years, despite policies that try to mitigate these effects. Mtwara Region is a vivid example of the impact of these deficits. (Documentation and explanation of this continuing – and, to date, intractable – problem is provided in the Development Partners Group General Budget Support note, 2008.)

The upshot is that many of the needier and poorer Tanzanians are under-served compared to better off Tanzanians. The Budget Support note finds that "lower allocations to poor local

authorities correlate with worse pupil teacher ratios, enrolment rates, and exam pass rates even while controlling for the direct effects of poverty on performance."

The causes of uneven deployment are continually debated, and are attributed principally to poor and un-transparent deployment practices, the difficulties in attracting and retaining workers to under-served areas; continued recruitment and transfers to better served districts; and the lack of an incentive package for remote areas. Addressing these concerns in a way that promotes greater transparency, better incentives and possibly consequences for unwillingness to stay on post (e.g., a bonding system), rather than just instructions that are difficult to enforce, will be essential for improving basic services for adolescents.

2. Support government to get resources to the school and facility level

Money needs to reach and be used efficiently at the local level in order to improve service delivery. For example, the Public Expenditure Tracking Studies (PETS) in Tanzania in 2004 and 2009 have shown that the full Capitation Grant is typically not reaching schools. In several of the schools visited in Mtwara, officials reported that despite level or rising numbers of students, the amount of the Capitation Grant has been decreasing in recent years. School officials have received no explanation for this.

This increases the pressure on school administrators to fill the gap, by requiring families to fund (e.g., toilets) what government is supposed to provide, reportedly under duress in some cases.

The failure of sufficient funds reaching schools has serious implications for the quality and quantity of educational services provided. In turn, this impacts both girls' learning and health. Numerous studies show that completion of primary school is strongly associated with later age at marriage, later age at first birth, and lower lifetime fertility. Secondary school and further education was shown to be the only consistently significant co-variate determining the probability of a first birth during adolescence. However it isn't only the number of years in school that yields benefits in girls' lives. "Literacy appears to drive the relationship between education and health behaviors. This means that school *quality* determines the extent of health benefits girls experience from schooling." (Start with a Girl. Center for Global Development, 2009).

While the Capitation Grant has been accepted as practice in the education sector (although deficient in practice), the concept has not been applied to the health sector. Health facilities have few options for discretionary use of money (typically only using cost-sharing funds, which are extremely limited and present a particular burden for the poor). Assessing the potential merits of a Capitation Grant for health facilities may be worthwhile at this time.

3. Prioritize investments in school water and sanitation

Decent environments are necessary for children to attend school, including water for washing and drinking, and toilets. Water and toilets are particularly important for girls who are menstruating. For example, a recent study conducted by Oxford University scientists found that many schoolgirls from poor families in rural Ghana stay home up to five days each month when they have their period (http://www.wunrn.com).

Visits to the schools in Mtwara revealed that few, if any, have water and toilets despite Primary Education Development Plan (PEDP) funding targeting these infrastructure needs. Toilets were also lacking at the health facilities. Overall, most PEDP funding is reportedly going to classrooms and, to a lesser extent, teachers' housing, and even that is of questionable quality. A greater focus on water and sanitation is needed as part of the infrastructure component of school

funding, with better monitoring. One important aspect of this may be rainwater harvesting, most recently emphasized by Prime Minister Pinda (news reports). Lessons and experiences in this area by UNICEF, Wateraid, SNV and others need to be brought together in a manner that can have a greater strategic effect on mainstream government practice.

4. Support government to institute positive incentives for performance

New initiatives that reward what (and who) works are being considered in Tanzania, and President Kikwete has reportedly supported these plans. They include 'Cash on Delivery' in education (see http://www.cgdev.org/section/initiatives/_active/codaid) and 'Results Based Financing' in health schemes. The main advantages of these approaches are that they create incentives and structure the funding disbursements based on delivery of agreed outputs and outcomes, rather than budget inputs.

The limited experimentation with these approaches appears to show some promise, most notably in relation to health in Rwanda (see www.rbfhealth.org). No doubt, there are huge challenges in pursing these new approaches because it represents a radical departure from current practice, and an assessment of these proposals was well beyond the scope of this study. Nonetheless, piloting new ways to reward positive performance could have positive pay-offs. Rewarding good work could potentially break the current patterns of (under) performance among many teachers and health workers in Tanzania who affect the lives of countless adolescents.

5. Explore savings, microfinance and cash transfers

Economic insecurity can drive girls into high risk sex. This is despite the threats to their health and dignity, and the reality that a sexual transaction may pay as little as Tshs 200 in Mtwara (USD $0.15). Schemes to promote girls' well-being, including importantly their economic security, could ensure a safe foundation for their sexual health as well. Nonetheless, interventions explicitly linking girls' economic vulnerability and reproductive health are limited, and those that exist tend to reach very few girls. New schemes, or scaling up of successful ones, are needed to reach large numbers of girls in safe spaces to provide skills in financial literacy and negotiating sexual relationships, in an environment that creates social connection.

This last point – social connection – is particularly important for reaching the most vulnerable girls including out-of-school girls, married girls, and those living away from their families such as in exploitative work situations. Research from many countries indicates that young women's friendship networks are less robust than those of male peers. A study from South Africa showed that for girls in all income groups, having poor social connectedness increased the likelihood that they had experienced sexual coercion. Married girls are at particular risk even though they are typically considered safe in the 'refuge' of marriage. In reality, they are typically much younger and less educated than their husbands, and have fewer assets; are often under pressure to become pregnant; and have limited opportunities to pursue friendships or move freely outside their homes (Bruce and Hallman, 2008). For girls who are out of school, these safe spaces and innovative approaches might serve as a vehicle for them to return to school or a vocational training program.

Cash transfer programs, along the lines of the well-known Progresa in Mexico, presents another opportunity for potentially strengthening the basic safety net of a vulnerable girl. In the Progresa model, women in the beneficiary families can receive regular cash payments if they take specific steps to improve their families' education, health, and nutritional status. These include, for example: cash for children attending school (with higher payments in higher grades and for girls in those grades); for making a specified number of visits each year to the health clinic; and annual

clinic visits. (As with 'Cash on Delivery' models, an assessment of cash transfer programs was beyond the scope of this study.)

Innovations that work *at scale* to decrease the economic vulnerability of girls, linked to life skills and sexual health, could be a useful area to explore and test in Tanzania.

6. Pilot an information & transparency 'platform' in Mtwara

Public access to information can help drive citizens' demand for accountability and strengthen the citizen-provider-government interface in relation to all of the interventions cited above. Access to information by 'ordinary people' is increasingly understood to be a pivotal component of accountability and personal agency. Development organizations throughout the world are emphasizing transparency and access to information as essential pillars to good governance and effective service delivery. With information on budgets, performance results, infrastructure, staffing patterns, school results, health outcome information, market prices, and more, people can better hold government accountable for service delivery, and improve their own lives (Twaweza, 2009). Print and particularly electronic media (radio, TV), as well as the explosive growth of cell phones, are making information more readily available and people's day-to-day experiences - including their use of public services - more easily reportable.

However, the problem is that, with the exception of mobile phones, information through these other channels is generally supply driven and aggregated, and heavily biased towards national issues. Throughout the field visit I observed that it was generally very difficult for ordinary citizens, especially young people, to access specific and local information about their school or dispensary, about funds coming into their village, or practical options for making change happen. It typically seemed beyond the realm of possibility.

In light of potential for information to build accountability, it may be worthwhile exploring how an 'information platform' focusing on serving ordinary citizens could be established and piloted in Mtwara. The specific design of such a platform is a question for further discussion, but it would likely need to take the following features into consideration: a) it would need to build on the experiences of information platform experiments in other countries; b) it would need to disaggregate information to the facility/school/citizen level so that it is meaningful to ordinary people; c) it would probably have a web-based hub where the information is collected and stored in accessible formats, which then is distributed through existing avenues such as school and health facilities, NGOs/CBOs, mobile phones, religious groups, and trading networks ('spokes'); d) ability to track funds and supplies (such as medical drugs) from national all the way down to facility levels; and e) create practical mechanisms for citizen response, comment and feedback with assurance that they will be taken seriously (Twaweza, 2009). This in turn can be linked to media outlets, so that both positive actions and failures by government can be available for public scrutiny and debate.

7. Agree and rigorously enforce measures of accountability

The performance of government and other stakeholders (e.g., donors, civil society groups) should be regularly and openly measured in relation to the deliverables promised, and the funding allocated for those deliverables. Particular emphasis needs to be placed on measuring change, or the lack thereof, in terms of meaningful *outcomes*, rather than inputs or outputs. Evaluations should be designed carefully to reflect rigorous standards and undertaken by independent entities to avoid conflicts of interest – and conducted by institutions and individuals that have nothing to lose from giving a critical assessment.

Outcomes in relation to both policy and service delivery can be evaluated, for example:

- Are pregnant school girls being re-admitted, are they advancing with their education, and are they leading healthy lives?
- Are life-saving services, e.g., family planning and PAC, being expanded significantly and accessed by the most marginalized girls and women?

Measurement also needs to address who is ***not*** being reached. For example in programs targeting adolescents, are the most vulnerable young people engaged in the intervention? An analysis by the Population Council of youth-serving programs in selected countries found that adolescents at *lower* risk and with greater social assets (stable homes, schooling) are receiving the majority share of youth-serving resources. The 'adolescents' being reached tend to be in-school and older urban based boys who are 20-24 years old (Bruce, 2009). "Indeed, the majority of health, social development, livelihoods and youth programmes are failing to reach the most vulnerable girls living in the path of HIV" (Bruce and Hallman, 2008).

A simple, cost effective tool developed by the Population Council to measure who is being reached in youth-serving interventions may help identify which adolescents are *not* being reached in Tanzania.

IV. Conclusion

This report has painted, based on a limited set of observations and interviews, a generally disheartening picture of adolescent girls' well-being in Mtwara. It has argued that the key drivers of young people's vulnerability are broad and structural, and linked to the economic, social and personal threats through which girls' negotiate (often with limited success) their daily lives.

In addressing these challenges, a number of options have been presented in how to move forward. Programming choices will inevitably be mediated by the perception and reality of existing priorities, organizational mandates and comparative advantages, available resources, and willingness to take risks. One clear caution, however, is to avoid a project-ized way of doing business – to avoid more "patchy patchy" – since the effectiveness of this on adolescent girls' well-being appears to be limited. There are tensions and trade-offs between the options for moving forward which are presented. Concrete interventions addressing specific SRH issues have the advantage of allowing for targeting and manageability; however, they may not address the underlying determinants of vulnerability and therefore fail to make lasting change. Broader level actions may address deeper, strategic issues; however, they may be difficult to achieve due to policy and implementation challenges, and they may have a more tenuous link with concrete outcomes in the lives of adolescents.

Ultimately, there are different ways to intervene which could make a worthwhile difference. Three important considerations affect any approach, however, and could improve the chances to make an enduring impact. The first is to have clear and transparent criteria that inform the choice of those interventions. This will foster greater accountability in measuring impact, and enable greater public scrutiny. The second is to rigorously evaluate outcomes (rather than inputs), using an independent evaluator who has no conflict of interest, and who upholds key standards of good evaluation practice. The third and last is that the people and institutions running those interventions need to engage in critical reflection and learning about what is working and not working and why, and to document and share these lessons among a wide audience. At the end of the day, these sorts of institutional practices may be as influential in promoting the well-being of adolescent girls as the interventions themselves.

Annexes

Annex 1. Documents, reports and materials

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Annex 2. Powerpoint presentation on findings and recommendations (separate file)