Girls Reproductive Health, Rights and Empowerment Accelerated in Tanzania (GRREAT)

Baseline Study Findings

Introduction

Girls Reproductive Health, Rights and Empowerment Accelerated in Tanzania (GRREAT) is a five-year initiative implemented by UNICEF and UNFPA with financial support from Global Affairs Canada to support the Government of the United Republic of Tanzania and the Revolutionary Government of Zanzibar to improve sexual and reproductive health (SRH), rights and well-being among vulnerable adolescent girls. This five-year partnership from April 2019 to March 2024 focuses on Mbeya and Songwe regions in Tanzania mainland and all districts of Unguja and Pemba islands in Zanzibar. Specifically, the GRREAT initiative envisages to contribute to improvements in three outcomes:

Outcomes envisaged under the GRREAT initiative

Reduced barriers for adolescent girls and boys to rights based, gender sensitive and adolescent-friendly SRHR and nutrition information and services in selected districts	Adolescent girls have better decision making and control over their SRHR and nutrition status in selected districts	Increased utilization of evidence for national and sub national decision making and girls' leadership in adolescent and gender responsive SRHR and nutrition services

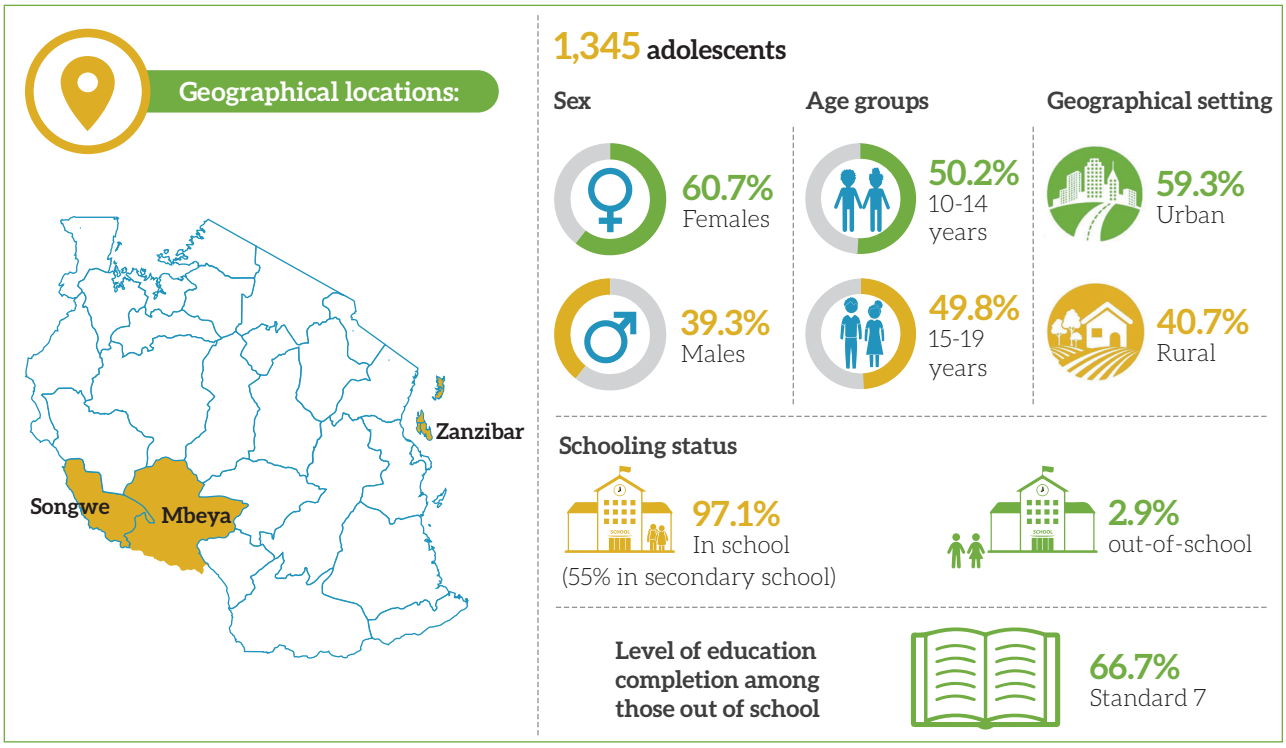
A baseline study was conducted in 2020 to gather and organize relevant information and data to serve as a baseline to inform planning, implementation, monitoring and coordination of the interventions planned under the GRREAT initiative and to facilitate programme performance monitoring and decision-making.

Sample and methodology

The National Institute for Medical Research (NIMR)-Muhimbili Centre was contracted by UNICEF with support from Global Affairs Canada to conduct a cross sectional population-based study employing mixed methods involving both quantitative and qualitative data collection methods. The team also reviewed the literature and obtained information from the District Health Information Software (DHIS2) data base, the Demographic and Health Survey, and the Malaria Indicator Survey 2015-16. The study was conducted in sampled healthcare facilities and communities in Mbeya, Songwe and Zanzibar.

This study recruited a number of people including randomly selected adolescents aged 10 to 19 years, parents/caregivers, community leaders, teachers, healthcare workers and community health workers, representatives from persons with disabilities and community influencers. Data collection in Mbeya and Songwe took place between February - March 2020. Due to COVID-19 pandemic, data collection in Zanzibar was delayed until July / August 2020. Data collection included interviews, observations and record review. Interviews were conducted to ascertain the level of adolescent girls' confidence and self-esteem, knowledge on SRHR, nutrition, HIV and contraceptives as well as their leadership and participation in economic activities.

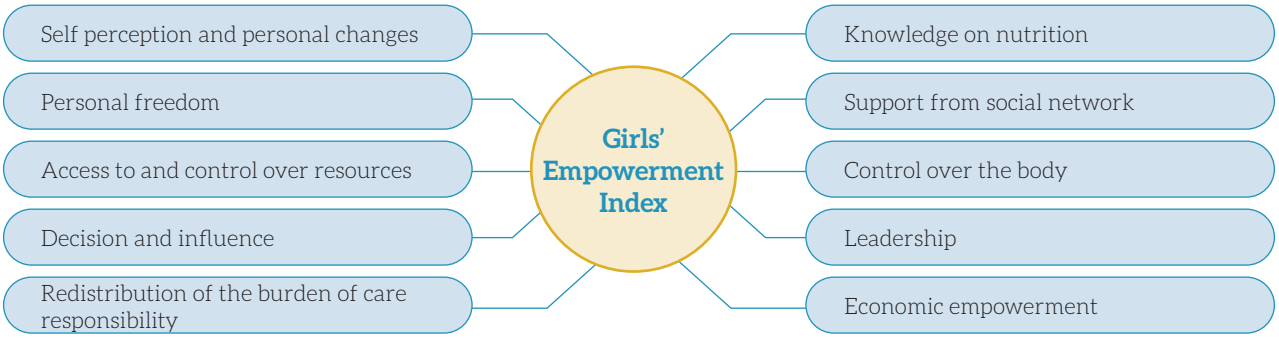
Characteristics of adolescents who participated in quantitative interview



Girls' Empowerment Index

In order to assess the level of empowerment among adolescent girls in the study areas, a Girls' Empowerment Index was constructed based on the tested and well-utilized Oxfam model[1]. This model was adapted to include ten domains of empowerment for adolescent girls. Girls' Empowerment Index allows the combination of a variety of indicators describing characteristics of empowerment into one unique composite index.

Conceptual framework of who is an empowered girl



[1] Lombardini, S., Bowman, K. and Garwood, R. (2017) 'A "How To" Guide to Measuring Women ' s Empowerment: Sharing experience from Oxfam's impact evaluations', Oxfam GB. doi: DOI: 10.21201/2017.9750.

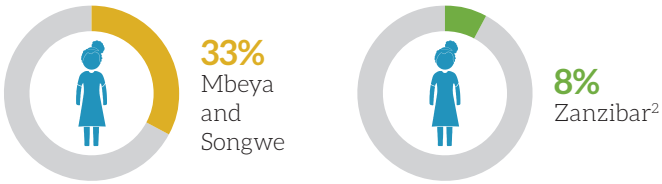
The measurement tool was adapted and developed to measure girls' empowerment at the lowest possible level of analysis – the individual level. However, some questions were developed to measure changes taking place at higher levels (household, community and environment) by asking individual girls about changes occurring in these spaces. A set of questions was prepared to measure each individual domain. Average percentage score of each girl on all 10 domains was calculated where the girl scored positively and was termed as "individual girl empowerment index". To get overall **Adolescents Girls' Empowerment Index (GEI),** average score of individual girl empowerment index was calculated from all 816 girls. This was done by summing up all individual girl empowerment index and dividing by 816 girls. The GEI has been calculated on a scale of 0 to 1, with 0 indicating no empowerment and 1 indicating full empowerment.

Analysis involved descriptive analysis of frequency distribution and percentages for key study variables. Bivariate analysis was used to establish the statistical association between dependent variables such as Girls Empowerment Index. Empowered girls were those who scored between (80-100%), moderate disempowered (40-79.9%) and most disempowered (<40%). Independent variables included age, sex (male/female), site (Mbeya, Songwe and Zanzibar), setting (rural/urban) and level of education (Non/primary and secondary/college). Cross-tabulations was done to determine significance of associations between the independent variables taking one at a time and the dependent variable, where the chi square test and their respective p-values were calculated.

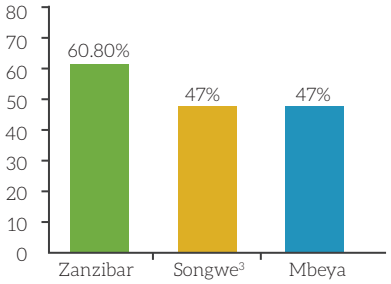
Findings

ULTIMATE OUTCOME: Adolescent girls in Mbeya and Songwe regions of Tanzania Mainland and in Zanzibar are able to realize their sexual and reproductive health rights (SRHR) and nutrition rights.

Adolescent girls aged 15–19 years who had begun childbearing



Prevalence of anaemia among adolescent girls aged 15–19 years



Girls' Empowerment Index (GEI)

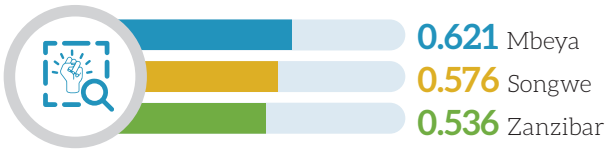
In order to assess the level of empowerment among adolescent girls in the study areas, a Girls' Empowerment Index was constructed and included ten domains of empowerment for adolescent girls. Some key findings are shared below:

- Adolescent girls' empowerment index in all the studied areas was **0.582**. Adolescent girls residing in Mbeya (0.621; p<0.001) and those aged 15-19 years (0.625; p=<0.001) were more empowered than their comparison groups.

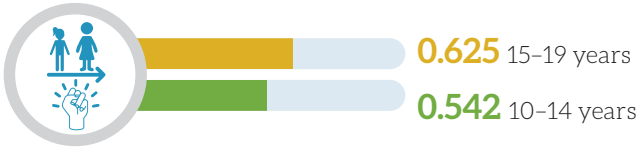
[2] TDHS (2016) 'Tanzania 2015-16 Demographic Health Survey and Malaria Indicator Survey', Tanzania 2015-16 Demographic and Health Survey and Malaria Indicator Survey.

[3] TDHS (2016) 'Tanzania 2015-16 Demographic Health Survey and Malaria Indicator Survey', Tanzania 2015-16 Demographic and Health Survey and Malaria Indicator Survey.

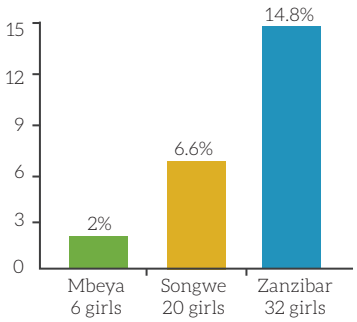
Girls' empowerment index according to region



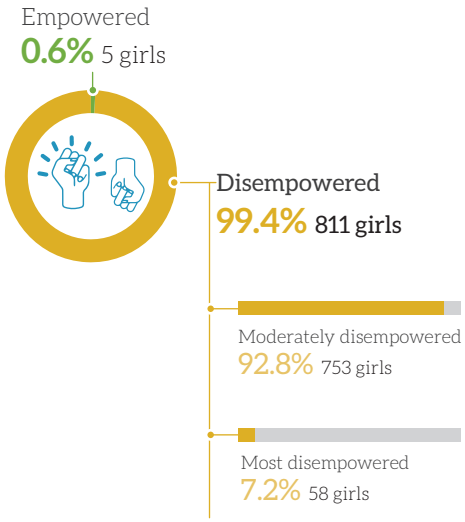
Girls' empowerment index according to age



Disempowerment status of girls according to region

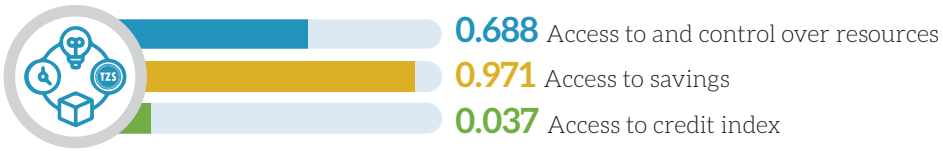


Empowerment status of the girls surveyed



- **Self-perception and personal changes:** This included freedom of movement, economic role, self-confidence and self-esteem. Overall, self-perception and personal changes score was 0.606. However, self-confidence domain scored low at 0.226, with young girls and those residing in Songwe demonstrating a much lower score than their counterparts.
- **Personal freedom and attitude towards violence:**
  - Overall, score for girls' acceptance of gender-based violence was 0.665 with girls aged 15-19 years and those living in Mbeya showing more acceptability than their comparison groups. In particular, neglecting children appeared to be the most common reason girls consider it to be acceptable for a man/boyfriend to hit his wife/girlfriend.
  - Knowledge on the right place to report in case of violence was very low with the mean score of 0.230. Girls aged 15-19 years and those residing in Mbeya demonstrated a statistically significant higher score than the rest.
- **Access to and control over resources:** Overall, adolescent girls had a mean score of 0.688 on access to and control over resources. Overall mean score on access to savings was higher at 0.971 with almost equal distribution across age groups and sites. However, adolescent girls' access to credit index was very low at 0.037, with adolescent girls from Zanzibar demonstrating a slightly higher mean score as compared to the rest of the groups.

Mean scores of adolescent girls on various aspects of access to and control over resources

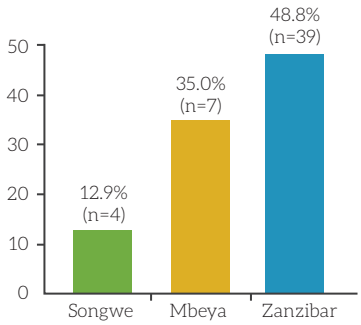


- Generally, adolescent girls' mean score on participation in social networks such as clubs in schools and communities was low at 0.459. Adolescent girls aged 15-19 years and those residing in Songwe demonstrated slightly higher participation score.

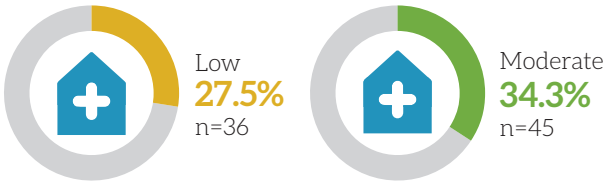
INTERMEDIATE OUTCOME 1: Reduced barriers for adolescent girls and boys to rights based, gender sensitive and adolescent-friendly SRHR and nutrition information and services in selected districts.

- Out of 14 facilities, 14.3% (n=2) met all seven national adolescent sexual and reproductive health standards, and all were from Zanzibar. One fifth (21.4%) met six and over a quarter (28.6%) of the facilities met five standards. A total of 57.1% (n=8) facilities had a special room to provide adolescents friendly services and 57.1% (n=8) of the facilities conduct outreach services for SRH and nutrition.
- 38.2% (n=50) adolescent girls and boys reported to receive quality sexual and reproductive health and nutrition services.

Adolescent girls and boys receiving quality sexual and reproductive health and nutrition services by region



Ranking of quality SRHR and nutrition services at health facilities



The specific barriers for adolescent girls and boys to rights based, gender sensitive and adolescent-friendly SRHR and nutrition information and services emerging in qualitative interviews were fourfold. First, the insufficient implementation of tangible strategies to support adolescents' understanding of their SRH rights. Second, there was a broad consensus on the inadequate efforts to support adolescents to demand their rights. This included community leaders having limited awareness of rights of adolescents with disability. Thirdly, unfriendly healthcare infrastructure as well as inadequate human resources emerged as limiting access of many adolescents to health services. Where SRH services are available, many healthcare workers were of the opinion that adolescents do not prefer going to the health facilities for SRH services. Fear of encountering parents, being recognized by someone who knows them, negativity after expressing their problems, absence of adolescent friendly services in many facilities, and service fee emerged as challenges impacting SRH service use. Finally, adolescents faced problems with nutrition services because information on nutrition is not available outside health facilities, poverty at family level, budgetary limitations at schools and limited understanding of nutrition among parents. However, adolescents are informed about existing SRH services mainly through health education sessions in schools, communities and clinic, one on one conversations with peers, books and brochures. The challenge is that nutrition topics appear to be lacking in these materials.

INTERMEDIATE OUTCOME 2: Adolescent girls have better decision making and control over their SRHR and nutrition status in selected districts.

- Overall, none of adolescent girls and boys demonstrated correct knowledge of contraceptives methods, HIV and nutrition. Generally, mean score on contraceptives, HIV and nutrition knowledge was 44%, where mean knowledge score for HIV prevention was 19%, contraceptives 19% and nutrition 67%.
- Out of 104 community influencers interviewed, 79.8% (n=83) demonstrated supportive attitudes towards adolescent boys' SRHR and nutrition needs. Access to sexual reproductive health rights to adolescent boys and knowledge of family planning methods among adolescent boys were the only two domains which were less supported by influencers.
- 84.8% (n=89) community influencers had supportive attitudes towards adolescent girls to receive SRHR and nutrition services. However, only 62.1% (n=64) supported family planning education for adolescent girls aged 10 – 14 even among sexually active girls.

Adolescents utilizing various sexual and reproductive services in Zanzibar

STI/RTI services

10% Females

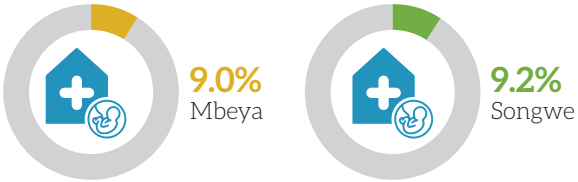
0.21% Males

Contraceptive services

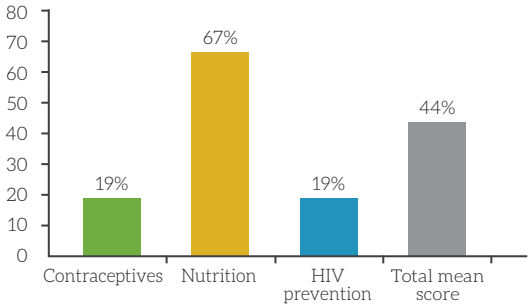
0.22% Females

0.07% Males

Proportion of girls utilizing antenatal clinics



Mean knowledge score for HIV, contraceptives and nutrition

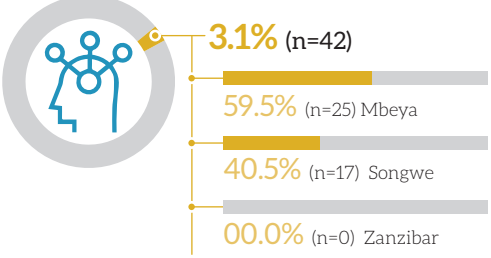


During qualitative interviews, inadequate sexual and reproductive health education was cited as a contributor to low knowledge of SRHR and engagement in unprotected sex after puberty. Participants suggested that weak SRHR knowledge and religiously constructed cultural values contribute to low usage of SRH services among adolescents and called for responsive strategies. Continued SRH and life skills education were commended for reducing teenage pregnancy and incidences of HIV and STIs.

INTERMEDIATE OUTCOME 3: Increased utilization of evidence for national and sub national decision making, and girls leadership in adolescent and gender responsive SRHR and nutrition services

- 36 studies and researches were identified at national and sub-national level which cited girls' rights, adolescent responsive SRHR and nutrition information and services as one of their objectives.

Knowledge of SRHR and nutrition rights in adolescents aged 10–19 years



During qualitative interviews, there appeared to be limited formalized tangible strategies to support girls to gain confidence in contributing to decisions that impact their lives. However, few ad hoc interventions were cited by some including continued encouragement by politicians, conferences and adolescents' forums that offer leadership opportunity for girls in schools and in peer groups. Likewise, a consensus emerged among respondents on the absence of strategies to support girls to gain confidence to challenge patriarchal systems.

Recommendations and considerations

Key recommendations are outlined below for Government, UNICEF, UNFPA, NGOs and donors and the rationale and considerations that underpin the recommended actions are provided. These should be considered when implementing GRREAT and other initiatives which aim to empower girls and improve their SRHR and nutritional status

a) **Empowering adolescent girls:**

- Pay particular attention that the GRREAT initiative has age specific and locally relevant empowerment strategies in place
- Support the government to strengthen life skills implementation in and out of schools, update teacher training packages, prioritize girls' education in community discourse and educate parents and caregivers on the importance of education for girls
- Sensitize parents/caregivers and communities on the benefits and rights around girls' empowerment
- Support parents/caregivers and men to challenge negative masculine stereotypes and role model positive male support for girls' empowerment
- Support adolescent girls and boys to build their capacity to make healthy decisions over their bodies and for parents/caregivers not to forcefully marry their children
- Facilitate on-the-job training to teachers, especially in primary schools on girls' empowerment, SRHR and nutrition in addition to mobilizing community healthcare workers, adolescent peer groups in both urban and rural areas
- Identify empowered young women and men as peers to be adolescent peer educators to offer girls empowerment, SRHR and nutrition education so that empowered young people can in turn empower fellow adolescents
- Scale up strategies to support girls, particularly those out of school, to participate in income generating and economic strengthening activities
- Advocate with government to prevent teenage pregnancies and strengthen alternative pathways for education and income generating opportunities for girls who are pregnant or adolescents who are young mothers and fathers
- Decentralize adolescents' programmes to the village levels by working with village offices and establishing safe girls' clubs to facilitate dialogue and protective measures for girls and have role models and girls' support networks
- Strengthen parenting and caregiver engagement and build a culture of positive, non-judgmental communication with adolescents from an early age to improve their life skills, self-confidence and positive attitude, including adolescents who have a disability
- Enhance efforts to work with religious leaders and community influencers to encourage them to involve girls in the community decision-making and support them to have access to resources

b) **Reducing barriers for adolescent girls and boys to rights based, gender sensitive and adolescent-friendly SRHR and nutrition information and services:**

- Efforts are needed to increase friendliness of healthcare services and boost human resources for health, especially at community level, as entry points for improving their access.
- Strategies are important to support Government, community leaders and caregivers to increase understanding of the positive benefits of improving SRHR and HIV access among adolescents and supporting adolescents to access services when they need them.
- Improving community-based health services such as using Community Health Workers (CHWs) and Community Health Volunteers (CHVs) may bring services to adolescents much closer to the communities. Similar education needs to be delivered to adolescents showing them the importance of accessing SRHR services from the healthcare facilities as well as building their self-confidence for them to realize their SRH rights and utilize SRH and HIV services without any fear.
- The following need to be strengthened for promoting adolescents' enjoyment of their rights:
  i. Provision of adolescent-friendly services in health care facilities and structured sexual and reproductive health and HIV education by healthcare workers through facility-based education and outreaches
  ii. Provision of adolescent friendly services through community-based entities such as Community Health Workers (CHWs) and Community Health Volunteers (CHVs)
  iii. Provision of SRH and HIV education by teachers in schools and school clubs
  iv. Interventions by government entities including maternal and child health (MCH)
  v. Strengthening policies promoting adolescent rights, gender and children desks at police stations, health insurance and formation of social groups including adolescents' forum and peer education groups

c) **Knowledge and skills to negotiate on SRHR and nutrition among adolescent girls and boys:** Knowledge of SRHR and nutrition including HIV prevention among adolescent girls and boys was extremely low. This finding is critical considering that other studies have related low HIV, SRH and nutrition knowledge to increased risk of HIV transmission and teenage pregnancy, and poor access to SRHR and nutrition services among adolescents as well. Although knowledge might not be sufficiently protective in and of itself, having accurate information on HIV, SRHR and nutrition might benefit SRH by impacting health-promoting attitudes necessary for successful engagement in healthcare-seeking behaviour.

d) **Drivers of sexual behaviour:** Key drivers for sexual risk behaviours needing to be addressed in the GRREAT initiative are improving knowledge and access to services, addressing harmful social norms and peer pressure, parental support and social media influence. The safe use of social media is another important area which needs to be looked at.

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