Martha Peter Mwolo

Girls as Minorities: Norms, Social Processes and Practices and their impact on Girls' Sexual Health in Tanzania

Universidade Fernando Pessoa
Porto 2015

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"TODOS OS DIREITOS RESERVADOS"

Martha Peter Mwolo

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Tese apresentada à Universidade Fernando Pessoa como parte dos requisitos para obtenção do grau de Doutor em Ciências Sociais (Especialização em Estudos de Minorias), sob a orientação do Professor Doutor João Casqueira Cardoso.

RESUMO

MARTHA PETER MWOLO:
As raparigas como minorias: normas, processos e práticas sociais e o seu impacto na saúde sexual das raparigas na Tanzânia
(Sob orientação do Professor Doutor João Casqueira Cardoso)

A vulnerabilidade dos raparigas às ameaças à sua saúde sexual é um assunto que não tem recebido a devida atenção até à data. O presente estudo foi estabelecido para investigar os processos sociais e práticas influenciando os comportamentos sexuais de risco, gravidezes indesejadas e transmissão de VIH junto das raparigas na Tanzânia. O estudo começou com extensa revisão da literatura científica para mapear a sexualidade adolescente e a saúde. O objetivo foi analisar os factores subjacentes aos comportamentos sexuais de risco, gravidezes indesejadas e transmissão de VIH junto das raparigas, e especificamente para identificar os significados sociais sobre género e sexualidade adolescente relevantes na sociedade mais ampla e avaliar as implicações na saúde das raparigas. A segunda parte é constituída por um estudo empírico, que foi realizado, principalmente em Dar-es-Salaam, com quatro organizações não governamentais.

Clara tendências surgiram a partir do presente estudo para indicar que os comportamentos sexuais de risco, gravidezes indesejadas e transmissão de VIH junto das raparigas são intimamente relacionados com formas involuntárias ou parcialmente involuntárias de reprodução das relações de poder, significados sociais, códigos morais, com o estigma e o silêncio associados à sexualidade das raparigas e à sua saúde sexual no seio de instituições-chave, neste caso normas jurídicas (incluindo políticas) e as organizações não governamentais. Consequentemente, os comportamentos sexuais de meninas são ocultados, à medida em que se envolvem em relações sexuais discretas. Elas não podem usar os instrumentos disponíveis, as informações sobre a saúde sexual e os serviços oferecidos, por medo de deixar conhecer o facto de serem sexualmente activas. Embora possam ter já uma experiência da vida, ter na sua posse e/ou negociar o uso do preservativo é susceptível de prejudicar a sua respeitabilidade perante parceiros sexuais masculinos. Elas podem igualmente ser punidas pelos pais, tutores e professores, algo que não é necessariamente aplicável aos rapazes. O preservativo e uso do preservativo estão intimamente associados, para as raparigas, com a falta de confiança, com a infidelidade e com a promiscuidade.

O estudo conclui que as normas jurídicas (incluindo políticas) e as organizações não governamentais não devem reforçar os significados sociais associados com a identidade de género e a sexualidade adolescente, ou outros elementos que colocam em risco a saúde das raparigas. Todos os esforços para proteger os direitos das raparigas relacionados com a saúde através de normas jurídicas e de políticas, incluindo a prevenção de comportamentos de risco sexual, gravidezes indesejadas e transmissão de VIH, tem que ter simultaneamente uma dimensão individual e uma dimensão coletiva.

Palavras-chave: Minorias; Rapariga; Tanzânia; Saúde; Sexualidade; Processos sociais.

ABSTRACT

MARTHA PETER MWOLO:
Girls as Minorities: Norms, Social Processes and Practices and their impact on Girls' Sexual Health in Tanzania
(Under the supervision of Professor João Casqueira Cardoso)

Adolescent girls' vulnerability to sexual health threats is a subject that has not received adequate attention to date. The present study was set out to investigate the social processes and practices influencing sexual risk behaviors, unintended pregnancies, and HIV transmission among adolescent girls in Tanzania. The study began with an extensive revision of scientific literature in order to map adolescent sexuality and health. The aim was to examine the underlying factors of sexual risk behaviors, unintended pregnancies, and HIV transmission among adolescent girls, and specifically, to identify the social meanings about gender and adolescent sexuality relevant in the wider society, and assess implications on girls' health. The second part constituted an empirical study which was conducted, mainly in Dar es Salaam, with four non-governmental organizations.

Clear trends emerged from the present study to indicate that sexual risk behaviors, u nintended pregnancies, and HIV transmission among adolescent girls are closely related to unintended and partially intended reproduction of the power relations, social meanings, moral codes, stigma and silence attached to adolescent girls' sexuality and sexual health within key institutions, in this case laws (including policies), and non-governmental organizations. Consequently, girls' sexual behaviors go underground as they engage in discreet sexual relations. They may not use available tools and sexual health information and services offered, for fear of being known to be sexually active. Although they may have life skills, carrying and/or negotiating condom use is likely to damage their respectability before male sexual partners. They can also be punished by parents, guardians and teachers, and the same does not necessarily apply to adolescent boys. Condom and condom use are closely associated, for girls, with lack of trust, with infidelity and with promiscuity.

The study concludes that, laws (including policies) and non-governmental organizations should not reinforce the identified social meanings about gender identity and adolescent sexuality, and any other elements which jeopardize girls' health. All efforts for protecting girls' rights related to health in laws and policies, including, prevention of sexual risk behaviors, unintended pregnancies, and HIV transmission, have to have both an individual dimension and a collective dimension.

Keywords: Minorities; Girl; Tanzania; Health; Sexuality; Social processes.

RÉSUMÉ

MARTHA PETER MWOLO:
Les filles en tant que minorités: normes, processus et pratiques sociales et leur impact sur la santé sexuelle des filles en Tanzanie
(sous la direction de M. le Professeur João Casqueira Cardoso)

La vulnérabilité des filles aux menaces pour la santé sexuelle est un sujet qui n'a pas reçu une attention suffisante à ce jour. La présente étude a été conçue pour approfondir les processus sociaux et pratiques influençant les comportements sexuels de risque, les grossesses non désirées et la transmission du VIH chez les filles en Tanzanie. L'étude commence par un examen le plus ample possible de la littérature scientifique pour situer la sexualité des adolescents et la santé. L'objectif y est d'analyser les facteurs qui sous-tendent les comportements sexuels de risque, les grossesses non désirées et la transmission du VIH chez les filles, et plus précisément d'identifier les significations sociales quant au genre et à la sexualité des adolescents dans la société en général, et d'évaluer leurs répercussions sur la santé des filles. La deuxième partie se compose d'une étude empirique, effectuée principalement à Dar-es-Salaam, avec quatre organisations non gouvernementales.

Des tendances claires se dégagent de cette étude, qui indiquent que les comportements sexuels à risque, les grossesses non désirées et la transmission du VIH chez les filles sont étroitement liés à des formes involontaires ou partiellement involontaires de reproduction des relations de pouvoir, à des significations sociales, à des codes moraux, à la stigmatisation et au silence associés à la sexualité et à la santé sexuelle des filles au sein des institutions-clé socialement, dans ce cas les normes juridiques (y compris les politiques) et les organisations non gouvernementales. En conséquence, le comportement sexuel des filles est occulté, tandis que ces dernières continuent à entretenir des relations sexuelles discrètes. Elles ne peuvent nullement utiliser les instruments disponibles, les informations sur la santé sexuelle et les services offerts, par crainte de faire connaitre qu'elles sont sexuellement actives. Bien qu'elles puissent avoir une certaine expérience de la vie, le fait de détenir et/ou de négocier l'utilisation du préservatif est susceptible de nuire à leur respectabilité face à des partenaires sexuels masculins. Elles peuvent également être punies par leurs parents, leurs tuteurs et leurs enseignants, chose qui n'est pas nécessairement applicable aux garçons. Le préservatif et l'utilisation du préservatif sont étroitement associés, pour les filles, avec le manque de confiance, l'infidélité et la promiscuité.

L'étude conclut que les normes juridiques (y compris les politiques) et les organisations non gouvernementales ne devraient pas renforcer les significations sociales associées à l'identité de genre et à la sexualité des adolescentes, ou d'autres éléments qui mettent en danger la santé des filles. Tous les efforts pour protéger les droits des filles par le biais de normes juridiques relatives à la santé et de politiques, y compris la prévention des comportements sexuels de risque, les grossesses non désirées et la transmission du VIH, doivent avoir simultanément une dimension individuelle et une dimension collective.

Mots-clé: minorités; fille; Tanzanie; santé; sexualité; processus sociaux.

DEDICATION

For mama **ALPHONCIA DAMIAN MANGO**, words cannot express my gratitude. Thank you for being a dedicated and loving mother, provider, mentor, and my number one fan.

To my **LATE BROTHER GEORGE PETER MWOLO**, you have always been a caring, inspiring and supportive brother. Although you are not with me physically, you are always in my heart and I miss you. Thank you for encouraging me to dream big. Rest in Peace.

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And to all **adolescent girls** who need to be empowered and protected.

With the support of:

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LIST OF ABBREVIATIONS

ABC	Abstain, Be Faithful, use Condoms
AD	*Ano Domino*
AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
AIS	AIDS Indicator Survey
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
CBOs	Community Based Organizations
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CIA	Central Intelligence System
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DIIS	Danish Institute of International Studies
EAC	East African Community
ECHR	European Convention on Human Rights
ECOSOC	Economic and Social Council
FBOs	Faith Based Organizations
FCNM	Framework Convention for the Protection of National Minorities

FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FP	Family Planning
GDP	Gross Domestic Product
GTZ	*Deutsche Gesellschaft f*ür *Technische Zusammenarbeit*
HIV	Human Immunodeficiency Virus
HMIS	HIV and Malaria Indicator Survey
HRC	Human Rights Committee
ICASO	International Council of AIDS Service Organizations
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICT	Information, Communication and Technology
ICTR	International Criminal Tribunal for Rwanda
IEC	Information, Education and Communication
IWRAW	International Women’s Right Action Watch
KBOS	Kenya Bureau of Statistics
KDHS	Kenya Demographic and Health Survey
KNBS	Kenya National Bureau of Statistics
LHRC	Legal and Human Rights Centre
M&E	Monitoring and Evaluation
MHIS	Malaria and HIV/AIDS Indicator Survey

MkV	*Mema kwa Vijana*
MSM	Men who have Sex with Men
NCAPD	National Coordinating Agency for Population and Development
NFPGS	National Family Planning Guidelines and Strategies
NGOs	Non-Governmental Organizations
NISR	National Institute of Statistics Rwanda
OAS	Organization of American States
OPCESCR	Optional Protocol to the International Covenant on Economic, Social and Cultural Rights
PLHAs	Persons Living with HIV/AIDS
PPP	Purchasing Power Parity
PRB	Population Reference Bureau
PWD	Persons with Disability
RDHS	Rwanda Demographic and Health Survey
SOSPA	Sexual Offences Special Provision Act
SRH&R	Sexual and Reproductive Health and Rights
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for HIV/AIDS
TBS	Tanzania Bureau of Standards
TDHS	Tanzania Demographic Health Survey

TMHIS	Tanzania Malaria and HIV/AIDS Indicator Survey
UAIS	Uganda AIDS Indicator Survey
UBOS	Uganda Bureau of Statistics
UDHR	Universal Declaration of Human Rights
UDHS	Uganda Demographic and Health Survey
UDMR	United Nations Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities
UN	United Nations
UNBS	Uganda National Bureau of Statistics
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children Emergency Fund
URT	United Republic of Tanzania
USA	United States of America
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization
YMEP	Young Male as Equal Partners

INTRODUCTION

This thesis describes a research study about the underlying influences of sexual risk behaviors, unintended pregnancies, and HIV/AIDS transmission among adolescent girls.

Adolescent health continues to be an important agenda in national, regional and international forums, also in academic research in the 21st Century (Blum et al , 2012; Sawyer et al, 2012, Patton et al, 2012). While health is increasingly recognized as a fundamental human right, health constitutes much more than a mere absence of diseases, and sexual health is understood an integral aspect of it.

Consequently, the right of all adolescents to health is enshrined within international human rights provisions such as Article 12 (1) and Article 2 (2) of the International Covenant on Economic, Social and Cultural Rights; read together with the General Comment No. 14 of ICESCR[1]; and Article 2 (1) of the Convention of the Rights of the Child; read together with the General Comment number 4, also in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). On top of that, these provisions prohibit all forms of differential treatment based on gender, sex, ethnicity, religion, disability, age, marital status or any other status, which impede recognition, respect, and protection of human rights of adolescents. The right of all adolescents to health is also enshrined within national laws and policies.

When the work for the present study began there was well documented evidence in scientific studies to illustrate that, so much has been done to contain pertinent health issues among adolescents, and the gains were evident. However, there was also substantial evidence to demonstrate that worldwide, particularly in developing countries; adolescents have poor sexual health outcomes. Sub Saharan Africa, of which Tanzania is a part has the worst profile (Bearing et al, 2007; Okofua, 2007; UNICEF,

[1] See also General Comment No. 20 (United Nations, 2009).

2011a). Further still, while overall substantial gains in adolescent health have been achieved (UNICEF, 2011a), evidence from information documented in most recent national health surveys such as demographic and health survey, Aids indicator survey, HIV and malaria indicator survey, small scale surveys, and qualitative studies conducted in East Africa, including Tanzania, indicated that, sexual health of adolescent girls necessitates special attention.

A significant number of adolescent girls become sexually active at least by age 15, and before they turn 18 years old. Of the great importance, however, is that, adolescent girls bear the largest share of sexual risk behaviors, unintended pregnancies and HIV/AIDS (Mwakagile et al, 2001; Dilger, 2003; Haram, 2005b; Haram, 2005b; Mabala, 2006; Masatu et al, 2007; Mabala, 2008; Mabala & Cookey, 2008; Klepp et al, 2008; Chinsembu, 2009; Kirchengast 2009; Masatu et al, 2009; Kazaura & Masatu, 2009; Bangster, 2010; TDHS, 2011; Madeni et al, 2011; TMHIS, 2013; Mbeba et al, 2012; Mbelwa & Isangula, 2012; UNICEF, 2011a; McCleary et al, 2013; UNESCO; 2013b).

Previous works in this area in Tanzania, but also in several other African countries have shown that, multiple complex factors influence health threats among adolescents (Eaton et al, 2003; Marston & King, 2006; UNICEF, 2011a); individual level factors such as physiological characteristics, psychological, social cognitive factors (Lugoe et al, 1996; Maswanya et al 1999; Obasi et al, 2006; Klepp et al, 2008; Masatu et al, 2009); and factors beyond an individual such as peer pressure, poverty and economic importance of sex, (Nnko & Pool, 1997; Van Haren, 1999; Nnko et al, 2001; Rasch et al, 2000; Wight et al, 2006; Mabala, 2006; Klepp et al, 2008; Mabala & Cooksey, 2008; Wamoyi et al., 2010; Wamoyi et al, 2011; Bangster, 2010; Zakayo & Lwelamira, 2011), coercive or forced sex (Mabala, 2006; Mabala, 2008), initiation rites of passage, early or child marriages (Bangster, 2010; McClealry-Sills et al, 2013), and collective views of gender and sexuality, particularly what is considered sexual and the meanings attached to it among individuals and groups in a particular society — including adolescents, are also important and need to be understood and addressed (Rivers & Aggleton, 1999; Weiss et al, 2000; Kathide, 2003; Wellington et al, 2006; WHO, 2006).

Most importantly, there was evidence in extant literature to demonstrate that institutions play a critical role in influencing behaviors related with health among different

individuals and groups (Courtenay, 2000; Gachoin, 2010). Different actors within institutions (Kathide, 2003; Dilger, 2003; Airhibenbuwa & Webster, 2004; Haram, 2005b) construct social meanings about who is permitted to have sex, for what outcomes, how and when to become sexually active (Airhibenbuwa & Webster, 2004; Haram, 2005b; WHO, 2006; Wight et al, 2006; Parker, 2009). In turn, these social meanings are internalized by individuals and groups, including adolescents, and may influence how they perceive their sexuality, engage in actual sexual behaviors, access and use available health information and services, and above all, their vulnerability to health threats (Eaton et al, 2003; Varga, 2003; Airhibenbuwa & Webster, 2004; Roberts et al, 2005; Haram, 2005b; WHO, 2006; Wellington et al, 2006; Wight et al, 2006; Parker, 2009). However, it was observed that, much is still unknown with regard to why adolescent girls in Tanzania are disproportionate vulnerable to sexual risk behaviors, unintended pregnancies and HIV/AIDS transmission, and the need for more social inquiry to be carried out to fill that important lacuna became evident.

Using functionalist perspectives advanced by Talcott Parsons and Giddens' Structuration theory as an overarching framework for conducting social analysis, it was argued in the present study that, a social phenomenon cannot be understood and addressed by focusing only on micro (individual, internal) factors associated with it, but also macro (beyond an individual, external) factors (Giddens, 1984; Gauntlett, 2002). However, macro explanations are also not sufficient. Further, there is recursive relationship between structure and agency and micro and macro (Giddens, 1984: Gauntlett, 2002)[2].

In that line of thinking, this critical inquiry in qualitative methods was set out to assess the social meanings of gender and adolescent sexuality relevant in Tanzanian society and institutions, in order to investigate the social processes and practices influencing sexual health among adolescent girls as minorities.

Evidence contributes in the body of knowledge in social science research, unfolds social dialogue about adolescent girls' sexuality, and demonstrates the need for continuous action to protecting sexual health of adolescent girls as minorities.

[2] Giddens refers to institutions as 'structures' (Giddens, 1984: 24).

— *An overview of the Research Problem*

In 2010, newspaper articles and reports in Tanzania unveiled increase in the number of secondary school girls getting pregnant. Data released by the Ministry of Vocational Training and Education in Tanzania showed that pregnancy incidence rate among school girls was on its toll, within the past five years. Between 2004 and 2008 28,600 girls dropped out of school because of pregnancy[3]. Data on increase in pregnancy rate among school girls became a public concern[4]. While girls were blamed and considered 'badly behaved' (Mabala, 2006; 2008; Mabala & Cooksey, 2008) by many, practice shows that in Tanzania, probably in East Africa, pregnant school-going girls have been expelled from schooling[5].

While increase in adolescence pregnancies makes headline, some skeptics questioned the validity and reliability of pregnancy prevalence data, majority blamed pregnant adolescent girls for trespassing social and/or moral boundaries; some activists lobbied politicians and policy makers, soliciting adoption of policies that would allow adolescent mothers to continue with schooling. Generally, there was less concern on the state of adolescent girls' health.

Public outcry on prevalence of pregnancies in schools and its consequences on girls' education triggered the researcher's concern over health and well being of adolescent girls.

The researcher was concerned by the fact that the increase in pregnancy rates gives two signals; first, school girls, whom most of them are in their adolescence, are sexually active, and they engage in sexual risk behavior; second, although no data did indicate that pregnant girls were also found to have contracted HIV/AIDS, data showing rise in pregnancy rate indicate that girls are increasing vulnerable to sexually transmitted diseases including HIV/AIDS. Initially, the researcher was motivated to embark on an

[3] Daily News, May 11, 2010; Guardian May 26, 2010.

[4] Public concern about early pregnancies and sexually transmitted diseases including HIV is a new phenomenon. According to Fuglesang (1997), in 1990s, several articles on pregnancies and HIV in young people were published in local newspapers in Tanzania.

[5] In 2002 Tanzania passed a law to sanction expulsion of pregnant girls from school. Of recent, there is no data to indicate that this practice is addressed to the fullest (Global Campaign for Education, 2012). See for more at: http://campaignforeducation.org/docs/reports/GCE_INTERIM_Gender_Report.pdf

inquiry with the aim of acquiring an in-depth understanding of the meanings school girls attach with their involvement in sexual risk behavior despite risk of getting unintended pregnancies and contracting HIV/AIDS. However, during preliminary review of literature, it was evident that sexual risk behavior, unintended pregnancies and HIV/AIDS are not only major health issues among school-going and unmarried adolescent girls, but also among out of school and married adolescent girls (Mabala, 2008; Masatu et al, 2009; Kazaura & Masatu, 2009; Mkumbo & Ingham, 2010).

Further, reports confirm that despite social restrictions on adolescent sexuality, adolescents, especially girls, becomes sexually active early (Dilger, 2003; Haram, 2005a; Haram, 2005b; Mabala, 2008; Mabala & Cookey, 2008; Klepp et al, 2008; Kazaura & Masatu, 2009; Bangster, 2010).

According to empirical research many adolescents become sexually active between 15 and 18 years old (Lugoe et al, 1996; Matasha et al, 1998; Maswanya et al, 1999; Masatu et al, 2007; Kazaura & Masatu, 2009). Similar to adolescents in other African societies, they do so in a very sporadic and unplanned way (Varga, 2001; Eaton et al, 2003; Undie & Benaya, 2006: Wanjiru, 2006; Muparamoto & Chingwenya, 2009). It is important to mention that according to data from official health surveys, a majority of adolescents are not sexually active (TDHS, 2011; UNICEF, 2011a). However, of the greatest concern is that, adolescent girls engage in early and unprotected sexual activity (TDHS, 2011, TMHIS, 2013). Statistical data adds further cause of concern: adolescent girls are at greater risk of sexual health threats probably than adolescent boys of similar age (Mwakagile, 2001; Mabala, 2006; Mabala, 2008) and adult women (Mabala, 2006; TDHS, 2011, UNICEF, 2011a; TMHIS, 2013).

Previous work in this area has shown that multiple complex factors influence health threats among adolescents (UNICEF, 2011a); individual level factors such as physiological characteristics, psychological, cognitive factors (Lugoe et al, 1996; Maswanya et al 1999; Obasi et al, 2006; Klepp et al, 2008; Masatu et al, 2009); and factors beyond an individual such as peer pressure, poverty and economic importance of sex (Mmari et al, 2009), coercive or forced sex (Mabala, 2006; Mabala, 2008), initiation rites of passage, early or child marriages (Bangster, 2010; Mbeba et al, 2011; McClealry-Sills, 2013), and collective views about gender and sexuality (Dilger, 2003;

Haram, 2005a; 2005b; Wight et al, 2006; 2012), particularly what is considered sexual and the meanings attached to it among individuals and groups in a particular society — in this case adolescents are also important and need to be understood and addressed (Wellington et al, 2006; WHO, 2006). However, despite decades of implementing policies and programs that aim to prevent sexual health threats among adolescents in Tanzania (Obassi et al, 2006; Bangster, 2010; Mbeba et al, 2011; UNICEF, 2011a; Wight et al, 2012), empirical evidence demonstrates that adolescent girls between 15 and 18 are disproportionate vulnerable to sexual risk behavior, unintended pregnancies and HIV/AIDS transmission (Mabala, 2006; Masatu et al, 2009; TDHS, 2011, UNICEF, 2011a; TMHIS, 2013) and little is done to address this important lacuna. Therefore, the present study attempts to investigate social processes and practices, and also the norms — social and legal — which may influence health among adolescent girls as minorities.

— *Research Objectives*

The overarching aim of the present study is to find out why adolescent girls in Tanzania are disproportionate vulnerable to health threats.

The following objectives represent the specific issues to be addressed:

- To examine the international Human rights provisions protecting adolescent health;
- To examine the underlying factors influencing sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescent girls;
- To assess how gender and sexuality influence health among adolescents;
- To examine how sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescent girls are perceived by actors within selected institutions;
- To examine how institutions empower adolescent girls to avoid sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission.

— *Research Questions*

With regard to the aforementioned research objectives, the following research questions are posed:

— First, what international human right provisions protect health in adolescents?

— Second, what are the underlying factors that influence sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls?

— Third, how do social meanings related to acceptable or unacceptable gender and adolescent sexuality influence sexual risk behaviors, unintended pregnancies and HIV/AIDS? Does this work differently for adolescent boys and girls?

— Fourth, how do actors perceive sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls? Do they produce or reproduce differently the social meanings about gender and adolescent sexuality and other elements, different ones, relating to health among adolescent girls?

— Fifth, what measures are implemented in order to empower adolescent girls to avoid sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission?

— Contribution of the study

The choice of this study was motivated by researcher's personal interest to understand the determinants of sexual health threats among individuals and social groups which are commonly described as 'vulnerable groups' such as persons with disabilities, women, children, youth, adolescents, the elderly, ethnic and racial minorities, sexual minorities, refugees, asylum seekers, immigrants, stateless people, indigenous people and so on. Literature sources worldwide demonstrate that these social groups experience a myriad of social vices such as poverty, discrimination, health threats a few to mention.
While empirical evidence in Tanzania illustrates that adolescent girls are disproportionately vulnerable to sexual risk behaviors, unintended pregnancy, HIV/AIDS, it is very unfortunate, to note that, albeit being interrelated, sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescents are addressed

separately in research and practice (Rutenberg et al, 2003). On the one hand, sexual risk behaviors and HIV/AIDS are addressed as public health issues, and on the other hand, unintended pregnancy is categorized as a reproductive health issue. We overlook the fact that, these crucial health concerns have a common pathway, which is sexuality. And that sexuality is not only an individualized phenomenon, but also the produce of societies and institutions, (Foucault, 1990; Varga, 2003; WHO, 2006; Wellington et al, 2006; Tamale, 2011). This approach limits our understanding of the underlying factors of sexual risk behaviors and sexual health outcomes among adolescents a diverse social group.

It is therefore argued in the present study that influences of adolescent girls' health cannot be fully understood and addressed by focusing solely on individual factors or micro factors, but also macro factors, and especially on the social processes and practices which may contribute to adolescent girls' vulnerability to sexual health threats.

Evidence demonstrates that adolescent girls' vulnerability to sexual risk behaviors, unintended pregnancies and HIV/AIDS transmission is not only related to certain individual level deficiencies, and macro explanations, but also stigmatization and silencing of adolescent girls' sexuality and sexual health, and above all, lack of protection of the economic, social, and cultural rights of girls within law (including policies) and in adolescent sexual health practice in non-governmental organizations.

Therefore, evidence contributes to question a body of knowledge in social science, especially within the area of adolescent health and minority studies. Simultaneously, evidence unfolds social dialogue about adolescent girls' sexuality and sexual health, and the need for continuous action to empower and protect girls as minorities

— Structure of the thesis

The thesis begins with an introduction which provides for an overview of the study and relevant research problem. Further, each of the five chapters of this thesis shall include a brief introduction, with a focus on the specific issue looked at, the research objectives, and the contribution of the study.

Chapter one *situates the study*. The chapter commences with general background information about Tanzania within East African context. Drawing from the 1994 Rwanda genocide, a brief account on the economic, social and cultural rights of women and girls follows. By and large, the chapter aims to provide survey data and information to highlight current trends and pattern in sexual risk behaviors, unintended pregnancies, and HIV transmission among adolescents in East Africa, but with a specific focus in Tanzania.

Chapter two describes relevant *concepts and theories* and how they relate to the present study . In this chapter the international Human rights instruments stipulating the rights of adolescents and governing protection of adolescent health are also examined.

Chapter three presents findings from existing empirical literature for *mapping adolescent sexuality and health*. The chapter begins with an examination of the factors associated with sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescents. An analysis of laws and policies influencing health among adolescents follows. Most importantly, the chapter looks at the social meanings of gender and adolescent sexuality in Tanzanian society, especially within key institution—law. Accordingly, specific legislation and norms (including policies) are identified. In the same vein, an assessment of their implication on health among adolescents is provided. Finally, an overview of other key stakeholders in adolescent sexual health practice, particularly civil society organizations is presented, as a transition to chapter four.

Chapter four presents *research methods and fieldwork process*. Specifically, methodological considerations, research paradigms, research strategies, methods of data collection, and procedure used in data analysis are detailed. The rationale for their use in the present study is described. The chapter also reports the fieldwork process, including procedure applied in selecting the sample population and institutions. Furthermore, the chapter demarcates limitations encountered during data collection process.

Chapter five provides for the *findings and discussion* of the research done. In this chapter, Giddens' Structuration theory and functionalism are used to look through findings from reviewed literature and empirical findings from selected NGOs in order to address the research problem. The chapter also provides for summary and conclusion.

Each chapter of the thesis also include a final division where a brief summary of the main findings, allowing for a transition between parts and helping the reader to follow the reasoning. In doing this research, the author was guided by the intent to produce a clear, useful work, and the objective to achieve a social utility for a specific vulnerable population. This, reminding the words of Victor Hugo in his work *Les Misérables*: "show me the woman and the child : it is by the amount of protection with which these two feeble creatures are surrounded that the degree of civilization is to be measured"(Hugo, 1862).

CHAPTER ONE.
SITUATING THE STUDY

1. Introduction

The idea that led the researcher to embark on the present study is to acquire an in depth and realistic understanding of the social processes and practices within the society which may privilege some individuals and social groups at the expense of others in terms of health outcomes—in this case adolescent girls. Health is understood as a fundamental human right because its violation may hinder enjoyment of other human rights such as right to life, education and right to work (LHRC, 2012).

This chapter situates the study. Since the social phenomenon relevant in this study may have local and regional relevance, Tanzania is situated within regional space, East Africa. According to sources, recently, countries forming the East African Community including Tanzania are experiencing economic growth and have achieved significant gains in education and poverty reduction.

However, the chapter uses the 1994 Rwandan genocide to demarcate the status of the social, economic, and cultural right of women and girls in East African Context, especially those related with health. To be more specific the chapter explores the nature and magnitude of sexual violence committed during the genocide. The chapter describes the ramifications of sexual violence committed during the genocide on women's health.

Most importantly, the main agenda of the chapter is to use evidence from extant scientific literature and statistical data to document trends in sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescents in East Africa with a special focus on Tanzania. It is observed that, some scholars have used survey and statistics as an authentic measure of adolescent sexual behavior. Other scholars in social sciences view these as unreliable. Few conventional health research examine the veracity of such statistics. Therefore, the chapter simultaneously, make use of qualitative studies to achieve the same.

1.1. East Africa Context

If we consider geographical location and boundaries as a factor in our contextual analysis, it is evident that the East Africa region is considerable vast. For the purpose of the present study East Africa includes countries forming the East African Community (EAC); Tanzania, Kenya, Uganda, Rwanda and Burundi. However, the focus will mainly be on Tanzania, Kenya, Rwanda and Uganda

Originally East Africa constituted of Kenya, Tanzania and Uganda. The integration between the three countries was officiated in 1977 through the formation of the East African Community (EAC)[6], which collapsed in 1984 and re-established in 1999. In 2007 other members Rwanda and Burundi joined EAC.

1.2. Socio-economic Situation

East Africa region envisions to securing socio-economic progress and improve the quality of life of people in the region. This includes strengthening the economy, education and attaining a healthy population.

Table 1: Real GDP Growth Rates 2005 to 2010[7]

	2005	2006	2007	2008	2009	2010
Tanzania	7,4	6,7	7,1	7,4	6,0	7.0
Kenya	5,7	6,1	7,0	1,7	2,6	5,6
Uganda	10,0	7,0	8,1	10,4	3,9	5,6
Rwanda	7,2	6,5	7,9	11,2	6,1	7,5
Burundi	7,2	6,5	7,9	11,2	6,1	7,5
East Africa	6,2	6,4	6,7	7,0	4,4	5,9

Source: Partner States and East African Statistic Database.[8]

[6] Throughout this study, East Africa region stands for countries forming the East African Community (EAC), mainly Tanzania, Kenya, Uganda and Rwanda.

[7] In addition to data on real GDP growth, most recent data indicate that economic growth in Rwanda is 7.7%, Tanzania 6.8%, Uganda 7.2% and Kenya accelerates at 3.8%. According to projections, if the current trend in economic growth persists, East African region will attain middle income status in 2022. As the data on development initiatives updated in September 2012 shows. See (http://devinit.org/social-protection-and-poverty-reduction-in-east-africa#!/).

[8] Note: Rates for Uganda were computed using GDP in local currency.

Table 2: Poverty

% of Population below $ 1 a day sub Saharan Africa in 2005 PPP									
1981	1984	1987	1990	1993	1996	1999	2002	2005	2008
40.4	44.2	43.6	45.6	48.7	47.2	47.0	44.7	41.1	37.3

Source: World Bank, (2012).[9]

Table 3: Education

% of literate women age 15-24 as % of literate men age 15-24				
Tanzania	Kenya	Uganda	Rwanda	Burundi
97	100	96	100	98

Source: Population Reference Bureau, (2012).[10]

Data above indicate that, while East Africa is experiencing economic growth and improvement in literacy rates and enrolment of girls in primary and secondary schools, extreme poverty abounds. On the whole, according to sources, while 'minorities' are illustrated the most affected, as they languish in extreme poverty, increase in extreme poverty is commonly associated with health threats among girls.

1.3. Religion

East Africa is diverse in terms of religious and ethnic composition (Ringheim & Gribble, 2010). There is Christianity, Islam and traditional African religions. Others are Hinduism, Buddhism and Sikhism (DIIS, 2006).

Table 4: Religion and Demographic data

Tanzania Mainland	Christians 30%, Muslims 35%, Indigenous Religion 35%
Tanzania Zanzibar	99% Muslims, 1% Christians and others
Uganda	Roman Catholics 41.9, Protestants 42%(Anglican 35%, Pentecostal 4.6%, Seventh Day Adventist 1.5%), Muslims 12.1%, Others 3.1%, non-religious 0.9%
Kenya	Protestants 45%, Roman Catholic 33%, Muslims 10%, Indigenous Religion 10%, Other 2%
Rwanda	Roman Catholic 56.5%, Protestant 26%, Adventist 11.1%, Muslims 4.6%, Indigenous religion 0.1%, none 0.7%(2001)
Burundi	Christians 67% (Roman Catholic 62%, Protestant 5%), Indigenous religion 23%, Muslims 10

[9] See http://data.worldbank.org/topic/poverty (consulted 15 November 2012).

[10] See http://www.prb.org/pdf12/2012-population-data-sheet_eng.pdf (consulted 15 November 2012).

Source: CIA World Book Facts, 2012. https://www.cia.gov/library/publications/the-world-factbook/geos/xx.html (consulted 15 November, 2012).[11]

Historically, religion is found to have enormous influence on peoples' conducts and societies (DIIS, 2006). In many societies, religious institutions have influenced sexuality and sexual behaviours among different segments of the population including young people (Mantell et al, 2011). However, contrary to the conventional thinking that globalisation and diversity will push religion into the background, and according to literature sources, religion continues to be important in the lives of many people in many societies in East Africa, inTanzania (Lange et al, 2000; DIIS, 2006), as well as across the globe.

2. Status of the Economic, Social and Cultural Rights at a Glance

Economic, social and cultural rights are important for the survival and achievement of full human potential (IWRAW, 2004; Kaufman, 2012). Contrary to that contention, since their adoption in 1966, and despite several attempts to revitalize the commitments and obligations stated under ICESCR (Coomans, 1995), worldwide, the current position of the economic, social and cultural rights is marginal (Chirwa, 2002; Asher, 2004; IWRAW, 2004).

Several factors are described to have contributed to the marginal status and weak implementation of the economic, social and cultural rights; nature of the normative content and states' obligation. According to sources, economic, social and cultural rights are stated in 'vague' wording. In addition, there is the concept of 'progressive realization', which means, states can comply with their obligations by implementing the economic, social and cultural rights gradually, and depending on the availability of resources[12].

[11] In many countries in East Africa, there is no reliable source of demographic data on religion.Concsequently, many sources depend on self- reported data. In Tanzania for example, religion is omitted as a variable in national census since several decades ago. Hence, Table 4 should be interpreted with caution.

[12] See International Covenant on Economic, social and cultural rights (ICESCR). Also see: http://www.unesco.org/new/en/social-and-human-sciences/themes/advancement/networks/larno/economic-social-and-cultural-rights/

However, despite setbacks, advocates for the economic, social and cultural rights have persisted for wider recognition and implementation of economic, social and cultural rights. The efforts have culminated into the adoption of the Optional Protocol to ICESCR.

The Optional Protocol to ICESCR was adopted by UN General Assembly resolution A/RES/63/117 on 10 December, 2008. It opened for signature in 2009 and entered into force on 5 May, 2013. According to sources, fourty (40) states have already signed and other ten (10) have ratified it[13]. Although ratification is still minimal, the Optional Protocol opens doors for submission of communication to the Committee on economic, social and cultural rights by individuals and groups of individuals claiming violation or denial involving their rights,[14] including right to health.

2.1. The Rwanda Past

It is impossible to enter the discussion about the social processes and practices that may relate to health threats among adolescent girls in an East African country— without acknowledging the recent past major human rights crisis that happened in 1994 — the Rwanda genocide. This session discusses nature and magnitude of sexual violence committed against women during the genocide, its consequences on women's health. Further, an overview of the situation of women human rights in the post-genocide context is provided.

— *Sexual Violence during the Genocide*

Sexual violence in the context of warfare and conflict is not a recent phenomenon[15]. It is neither an African issue (Cohen et al, 2013). According to reports, women and girls are

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[13]See:http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3-a&chapter=4&lang=en [consulted 20/5/2013]

[14] See Article 2 of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights: http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCESCR.aspx (consulted on 12/06/2014).

[15] Sexual violence is described as recurrent human right abuses in warfare and conflict situation worldwide (Onyejekwe, 2004; Alison, 2007). In Europe it is reported to happen during World War II whereby Russian, German and Japanese soldiers sexually abused women, in Yugoslavia— Bosnia and Kosovo and American soldiers sexually abused Vietnamese women (Chinkin, 1994; Gardam, 1998; Loyth, 2001). In African context sexual violence is reported to abound during conflicts in Liberia,

at greater and increasing risk of sexual violence during wars and conflicts (UNESCO, 2013).

For the case of Rwanda, extermination of Tutsi men; young and old, could not be deemed satisfactory (Sharlach, 1999). As additional, torture and rape was used to humiliate not only the individual woman but also the entire Tutsi ethnic group or community (Human Rights Watch, 1996; Sharlack, 1999; Jones, 2002).

According to the Human rights watch report a significant number of women and girls were individually raped or ganged raped. In some instances, women were brutally raped with objects such as sticks or branches of trees and weapons. It is estimated that in twelve weeks 250, 000 to 500,000 women were the victims of rape and other forms of sexual violence (Jones, 2002: 81). It is evident that women and girls suffered inconceivable brutality. They were raped, sexually mutilated and then killed. Some were raped, mutilated but not killed.
It is important to state here that, reasons for resorting to sexual violence against women and girls in warfare and conflict situation may relate. But can also be complex and may vary according to socio-cultural context and time (1996). As described by Annette Lyth:

> The reasons why individual women are singled out for violent treatment can vary. It may be because of their sex and gender, because of her relationship to a man or because of the religious or ethnic group she belongs (Lyth, 2001:3).

According to sources, in Rwanda, women belonging to Tutsi ethnic group were targeted mainly, for sexual violence compared to Hutu women due to reasons beyond gender[16] (Human Rights Watch, 1996; Sharlach, 1999). As Alison explained, sexual violence deliberately targeted women and girls of ‘other’ ethnic groups. She espouses that not all women and girls were targeted indiscriminately. And that, “ethnic and social positioning contributes enormously to differences of experience (...)” (Alison, 2007: 91). Apparently, during the genocide, sexual violence, particularly rape, was used to torment the enemy and inflict long term physical and psychological torture, to humiliate

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Ethiopia, Democratic Republic of Congo, Sierra Leone, Eritrea to mention but a few (Onyejekwe, 2005; Bosmans, 2007).

[16] Scholars who espouse that gender power relation influences the phenomenon of sexual violence during warfare use term ‘Gender- based violence’ and ‘sexual violence’ as equivalents (Onyejekwe, 2005).

and to destabilize social cohesion and cultural identity of the targeted communities or ethnic groups (Clifford, 2008; Colombini 2002; Jones, 2002; Sigsworth, 2008).

Moreover, sexual violence against Tutsi women committed during the genocide is associated with unequal socio-economic relations between Hutus and Tutsi.

Throughout history, Tutsi women were perceived to belong to the noble class, superior to Hutu women and inaccessible to Hutu men (Sellstrom & Wohlgemut 1996; Sharlach, 1999). Tutsi were pastoralists who owned cattle and Hutu were farmers. During pre-colonial era in Rwanda, a cow was considered as the symbol of wealth and prestige. The social status of a Hutu man could be elevated to equal that of a Tutsi man when he acquires many cattle through two possible ways; providing service to the Tutsi in exchange for cattle, or marrying a Tutsi woman from a rich family. However, not all Tutsi men were wealthy (Sellstrom & Wohlgemut, 1996). It is evident that just like a cow, a Tutsi woman was a symbol of wealth and prestige. The social construction of gender and ethnic status of Tutsi women was therefore used to incite sexual violence against Tutsi women (Gallimore, 2008: 13).

— ***Effects of Sexual Violence on Health of Women***

Sexual violence or rape can lead to adverse effects on sexual and reproductive health. For instance physical complications to women (Chinkin, 1994). The impact of rape on girls can be more devastating. According to a WHO report as cited in Columbini, rape became forced sexual initiation to the majority of girls' victims and survivors (Columbini, 2002:168). Consequently, girls sustained damage to their reproductive organs and their sexuality as a whole. Unfortunately, it is difficult to obtain data showing the extent which genocide rape in Rwanda became forced sexual initiation to girls. All in all, there is evidence to show that a substantial number of women and girls who were raped, became pregnant and contracted STI, including HIV/AIDS (Columbini, 2002).
According to data established in a study carried by Avega Agahozo in 1999, as cited in (Mutamba & Izabiliza, 2005: 10); 66% of 250,000 of women who were raped during the genocide tested HIV positive. This data is correlated with estimates of the rate of HIV infection in military and armies in the East African region, in Rwanda 35%

soldiers, who were among the perpetrators of sexual and gender based violence were HIV positive (Jones, 2002:82).

As pointed out earlier, sexual violence did not affect individual female survivors alone but society as a whole. In the post genocide context, rape was subjected to social stigma and shame. Survivors, who disclosed, that they are the victims of genocide rape, were isolated, rejected and discriminated by their communities and families. On top of that, they lost the chance of getting married or remarry and start a family (Chinkin, 1994; Human Rights Watch, 1996). Therefore, stigma and discrimination against victims of rape hindered an understanding of the magnitude of sexual violence committed during conflicts (Human Rights Watch, 1996).

Moreover, rape committed during Rwanda genocide unleashed other long-term consequences. Statistics released by the national population office illustrated that approximately 2000 and 5000 children were born out of rape (Human Rights Watch, 1996). The birth of the children born as a result of rape reminds families and community of the atrocities of the genocide (Clifford, 2008). Further to that, raising and taking care of ‘rape babies’ has long term emotional and psychological impacts on families and children themselves. These children face stigma and identity crisis (Clifford, 2008). Mothers of these children were also at risk of being socially isolated (Chinkin, 1994).

– ***Women in the Post-Genocide Context***

The overall economic, social, cultural, and political situation of women in the aftermath of the genocide was overwhelming (Newsbury & Baldwin, 2000). Despite of the fact that sexual violence is recognized as crime against humanity[17], some of the survivors continued to bear the physical, emotional and psychological pain inflicted by sexual violence committed during the genocide, exacerbated by the persistent social stigma and

[17] The International Court of Justice for Rwanda (ICTR) could not prosecute Jean-Paul Akayesu for committing rape as a war crime because the court could not establish that he was the member of armed forces or was in charge of military duties during the genocide. However, because rape is classified as crime against humanity Akayesu was pronounced guilty. Rape is also recognized as a form of genocide (Lyth, 2001).

limited health facilities in the aftermaths of the genocide (Human Rights Watch, 1996; Newsbury & Balwin, 2000).

By and large, evidence from 1994 Rwanda genocide indicates that women and girls were vulnerable to sexual violence and the related health effects, especially, unintended pregnancies, and HIV/AIDS but not indiscriminately. Tutsi women and girls were disproportionate vulnerable to sexual violence due to both, the behaviors of individual perpetrators of sexual violence (micro factors), also dominant gender and ethnic ideologies (macro factors) that existed in Rwanda society before the outbreak of the genocide. Yet, despite this reality, legal and institutional mechanisms for protecting women and girls in warfare situation — their human rights and for addressing their unique situation— in this case vulnerability to sexual violence and related health effects, remain inadequate[18]. To be more specific, efforts to protect women and girls during warfare and conflict situation, against sexual violence, by targeting to transform the social and cultural factors in a particular society inciting sexual violence seem to lag behind.

3. Trends in Adolescent Sexual Health in East Africa

Paying attention to adolescent sexuality and how it relates with health, especially sexual risk behaviors, unintended pregnancies and HIV/AIDS is paramount due to a number of factors. First and foremost, overall, in East Africa and sub Saharan Africa children and adolescents take the largest share of total population. Most countries in East Africa are reported to experience what is known in demography discourse as 'youth bulge' (UNESCO, 2013b: 12). And just like any other segment of the population, specifically adult population, and according to the international human rights treaties, children and adolescents have right to attain standard health. Second, East Africa is reported to have lower sexual health status among adolescents (Chacko, 2007; Klepp et al, 2008; UNICEF, 2011b). It is probably second to Southern African region (Okonofua, 2007). Above all, findings from an array of scientific studies and other reports reveal that adolescent girls in East Africa, and Tanzania in particular are increasing sexually active early, mostly between 15 and 18 years old, and are disproportionate burdened by sexual

[18] See also, for more information: Chinkin (1994), Gadham (1998), Gardam & Charlesworth (2000), Lyth (2001), Bosmans (2007).

health threats (Rasch et al, 2000; Silberschmidt & Rasch, 2001; Ringheim & Gribble, 2010; UNICEF, 2011a; Doyle et al, 2012; UNESCO 2013b; Presler-Marshall & Jones, 2012).

While, in several literature sources, protecting sexual health of adolescents is described as a significant health priority in sub Saharan Africa (Biddlecom et al, 2007a; Klepp et al, 2008; Bankole et al, 2007; Bankole et al, 2009), there is dearth of scientific studies addressing, specifically sexual risk behavior, unintended pregnancies and HIV/AIDS among adolescents in East Africa and Tanzania, and more importantly, among adolescent girls. Extant scientific literature is replete with investigations of adolescents sexual risk behaviors and health in South Africa. Further, considerable amount of research have documented level of sexual activity, number of sexual partners, type of sexual activity, age at which sexual activity, frequency of condom use, and type of sexual relationship especially among those between the ages of 10-19, 10-24, and 15-24 years[19] (Undie & Benaya, 2006). Furthermore, in almost all demographic and health surveys, 15 year old adolescents and above are categorized as adults (15-49), and information on sexuality and health of 15-18 adolescent girls is patchy.

So, throughout this chapter, our analysis of adolescent sexual risk behaviors and health draws mainly from data and information documented in recent national health surveys such as DHS, AIS and HMIS in East Africa. These national health surveys contain important and updated scientific representative quantitative data revealing trends in health among population in different countries. These trends and patterns are documented and disaggregated based on age, sex and other socio-economic variables. Our focus is on data on adolescent childbearing and fertility, sexual behaviors', condom use, HIV knowledge, and comprehensive knowledge about HIV/AIDS, though not exclusively.

Evidence from small-scale surveys and qualitative studies in Tanzania and East Africa is also useful. However, evidence from international literature provides important data and information. In addition, qualitative studies on adolescent sexual behaviors are also important and considered to provide more and in-depth information.

[19] In most of literature sources, a person which age is between 10-19 years old is addressed as “adolescents”; from 10-24 years old as “youth”, and 15-24 years old as “youth” or “young people”.

3.1. Demographic Characteristics of Adolescent Population

Worldwide adolescent population is illustrated to growing very rapidly. Presler-Marshall and Jones describe the current generation of adolescents as the largest the world has ever seen (2012). This trend is also acknowledged in a UNFPA report (2012a). In 2009, worldwide, adolescent population (10-19) stood at 1.2 billion, reaching 18% of world population. While 88% of the world adolescent population resides in developing countries, mainly, in South Asia or East Asia and Pacific region changes are projected. Experts suggest that considering current fertility trends, Sub Saharan Africa (SSA) will have more adolescents than any other region by 2050; surpassing Asian region by small margin (UNICEF, 2011b: 20). In 2010, according to a population research bureau report, half of the population in SSA ages 18 years and below (Ringheim & Gribble, 2010).

In addition, according to recent statistics in East African countries are most populous and considerable diverse compared to other countries in SSA (Ringheim & Gribble, 2010). In Kenya adolescents comprises 24% of the total population (NCAPD, 2010). In Tanzania, adolescents (10-19) are 9.9 million of the total population which stands at 43,187, 823. Hence, the proportion of adolescent population out of the total population is 23% (UNICEF, 2011a)[20]. Rwanda has 22% of 10-19 adolescent population[21]. Uganda is reported to have the world largest youthful population. At least 60% of Ugandan population comprises of individuals under age 20 (Presler-Marshall & Jones, 2012). Out of the current population of 34.2 million, 78% are below 30, 15% are 15 and below, and 21.3% are between 18 and 30 years (UNFPA, 2012a). It is evident from the statistics that, there are no wide variations in adolescent population in East African countries. And that, East Africa has the youngest population.

3.2. Sexual Risk Behaviors

It is widely acknowledged in literature sources that “adolescence marks the start of sexual activity for many individuals” (Biddlecom et al, 2007a), and in many countries

[20] See: http://www.unicef.org/infobycountry/tanzania_statistics.html#104

[21] See http://www.unicef.org/infobycountry/rwanda_statistics.html#109

first sexual activity may take place between 16 years and 18 years, even below (Nzioka, 2001; Biddlecom et al, 2007a; Ringheim & Gribble, 2010) or before 20 (Madkour et al, 2010). All in all, data on adolescent sexual behavior in Sub Saharan Africa resonate with international statistics on adolescent sexual behaviors to indicate that:

> The age at which teens in Sub Saharan Africa typically initiate sex is surprisingly similar to that of teens in the United States and other developed countries. Although only a small proportion of teens have sex by age 15, sexual experience is common, by the late teen years. By their 20th birthday, roughly three in four young women and six in 10 young men in Sub Saharan Africa have had intercourse (Boonstra, 2007: 4).

It is more than a decade since a World Youth Report suggested that, it is not having sex that jeopardizes health among adolescents. It is rather having unprotected sex. The report refers to adolescents as a 'high risk population' because, high levels of sexual activity in this group has not been accompanied by consistent use of condom (United Nations, 2004:341). In African context, unprotected sex is described to be an important determinant factor of unintended pregnancies and HIV/AIDS among adolescent girls, regardless of marital status (Gueilla & Madise, 2002: Presler-Marshall & Jones, 2012).

There is well documented research indicating that, consistent and effective use of condoms prevents simultaneously, unintended pregnancies and HIV/AIDS, among sexually active people, including adolescents (Bankole et al, 2009; Maticka-Tyndale, 2012). Condoms are also considered to be more accessible to adolescents compared to other methods which may demand frequent medical visits or prescription (Bankole et al, 2007: 36). Yet, despite decades of implementing condom promotion and distribution policies and programs for HIV prevention, research documents that, condom use is generally rare among sexually active adolescents, especially girls in East Africa and Tanzania in particular. Further, data indicate that adolescent boys are more likely to use condoms when engaging in sexual activity, before marriage, compared to girls (Ringheim & Gribble, 2010; Doyle et al, 2012; UNFPA, 2012a). Furthermore, married adolescent girls are more likely to engage in unprotected sexual activity compared to their unmarried counterparts (Presler-Marshall & Jones, 2012).

Although according to studies, there is improvement in terms of delay in sexual debut among Kenyan adolescents, sexual activity, especially before marriage, is high among Kenyan adolescents (Kabiru & Orpinas, 2009). Kenya population data sheet reveals

that, 22% of adolescent boys and 11% of adolescent girls in Kenya become sexually active before 15 years (PRB, 2011) and they are not likely to use condom during sex compared to adolescent boys (Tenkorang et al, 2010). In other words, they engage in unprotected sexual activity (Nzioka, 2004). The 2008-2009 Kenyan Demographic and Health Survey data (KDHS, 2010) indicate that nearly 60% of 15-19 adolescent girls who had sexual intercourse in the last 12 months and 100% of 15-19 adolescent boys engaged in higher-risk sex[22].Among these, only 40% of girls and 85% of boys used a condom at last sexual intercourse. Recent data reveal that, only 1 out of 4 adolescent girls used a condom at their last sexual encounter (NCAPD, 2010).

In Rwanda a study conducted by Babalola documented that, many Rwandan adolescents engage in sexual behaviors related with health. Early sexual experimentation and non use of condoms are common among adolescent boys and girls (Babalola et al, 2002: 11). Many adolescent boys become sexually active at 15.8 years of age (26.4%) and adolescent girls at 16. 6 years of age (13.4%). Condom use was also found to be rare among adolescents studied. Only 26% of sexually active boys and 15% of sexually active girls reported to use condom during last sexual intercourse. However, 80% of girls and two third of boys involved in the study reported to never had sex (Babalola et al, 2002).

The 2010 Rwanda Demographic and Health Survey (RDHS) results demonstrate relative better trends in adolescent sexual behavior and health. Rwanda is reported to have, probably, the lowest percentage of ever-had sex adolescents population in Sub Saharan Africa. Other sources indicate that adolescent girls in Rwanda are less vulnerable to sexual risk behaviors, unintended pregnancies and HIV/AIDS compared to adolescent girls in Tanzania, Kenya and Uganda. Most of adolescent girls in Rwanda are more likely to become sexually active at the age of 20 (Boonstra, 2007). Similar finding is established in a more recent study to suggest that, an adolescent girl in Rwanda is less likely to be sexually active early, have pregnancy during adolescence, even when she has a boyfriend (Ringheim & Gribble, 2010).

[22] Higher-risk sex which is described as having sexual intercourse with a partner who was neither their spouse nor living with them.

In RDHS report 4.6% adolescent girls and 5.2% adolescent boys reported to have had sex in the past 12 months. Moreover, approximately, 4% of adolescent girls and 11% of boys had sex before 15 years, whereas 17% of adolescent girls and 27% of boys had sex before 18 years. Data on condom use are also shown to be favorable. 41.9% of sexually active female adolescents and 57.5% male adolescents reported to use condom during last sexual intercourse. 87.8% female and 88.2 % male adolescents believe that condom use every time they have sexual intercourse reduces the risk of contracting HIV infection (RDHS, 2010).

Comparatively, the proportion of adolescents with knowledge on where they can obtain condom is relatively higher in Rwanda than in Uganda, Kenya and Tanzania. More than 80% of female adolescents and male respectively, know where to get a condom. Yet, this may not imply that early and unprotected sexual activity is uncommon in Rwanda.

In Uganda there are concerns on early sexual activity and condom use among adolescents (Konde-Lule et al, 1997; Neema & Musisi, 2004; Neema et al, 2006; Kibombo et al, 2007; UDHS, 2011). Neema & Musisi, and Kibombo *et al.* found out that, many Ugandan adolescents delay sexual activity and condom use has increased among those who are sexually active (2004; 2007). However, Kibombo *et al.* contend that, sexual initiation remains early sexual activity and condom use is low among Ugandan adolescents. 27% of female and 47% of males reported to have used condoms at last sex (2007:2). These trends resonate with findings in Bankole *et al.* Sexual activity in adolescents is reported to increase steadily, between 15 and 19. Approximately, by age 20, about three quarter of females and close to two-thirds of males are already sexually active (2007a:30).

The 2011 Uganda Demographic and Health Survey (UDHS) show the percentage of adolescents who had sexual intercourse before reaching age 15 and 18. According to statistics, 12.2% of adolescent girls age (15-19) and 17.9% of adolescent boys (15-19) had sexual intercourse before 15. Also, 58% of 18-19 adolescent girls had sexual intercourse before the age of 18 and 53% of adolescent boys. Further, according to findings from an influencial study on adolescent sexual behavior in Africa, the proportion of sexually active among very young female adolescents is found to be higher in Uganda compared to Burkina Faso, Malawi and Ghana. Furthermore, at least

1 in 10 very young adolescent reported to be aware that, close friends are sexually active (Bankole et al, 2007b: 34).

Turning to Tanzania, the 2003-2004 Demographic and Health Survey (DHS) results showed that many adolescents were sexually active. Similar findings are established in recent national health surveys and reports. It is also acknowledged within the Adolescent Health and Development Strategy that, a substantial number of adolescents are sexually active and practice unprotected sexual activity (URT, 2004-2008). Further still, TDHS 2011 and THMIS 2013 surveys document that, adolescent girls are more likely to become sexually active earlier, and engage in unprotected sexual activity than adolescent boys of similar age.

Results from TDHS 2011 reveal that only 75% of adolescent girls (15-19) know a condom source and 83.3 % of adolescent boys (15-19) respectively TDHS, 2011: 235)[23]. Data on age at first sexual initiation show that 11.3% of adolescent girls and 7.8% of adolescent boys (15-19) have had sex before 15 years (TDHS, 2011:136)[24]. Data on recent sexual activity among never-married adolescents indicate that 26.9 % of girls have had sexual intercourse in the past 12 months, and out of these 38% know a condom source; 15.6% do not know a condom source and 50.2% reported to have used condom at last sexual intercourse (TDHS, 2011: 238). On the other hand, 25.1% of never married adolescent boys reported to have had sexual intercourse in the past 12 months, and out of these 54% know a condom source; there is no data on those who do not know a condom source; and 46.1% reported to have used condom during last sexual intercourse (TDHS, 2011).

In 2013 THMIS report, data on recent sexual activity indicated that 22.4% of adolescent girl (15-19) had sex within the past four weeks prior to the survey; 19.8% within a year and 5.0% within one or more years. Similarly, data on recent sexual activity among adolescent boys (15-19) revealed that 13.6% had sexual activity within four months before the survey; 17.2% within a year; and 8.2% within one year or more.

[23] In several literatures, this trend is reported almost all over East Africa, majority of older adolescents (15-19) know where to get condoms, and perhaps they are more likely to use condoms than younger ones.

[24] Data showing the proportion of adolescent boys and girls who initiate sexual activity before 18 is missing.

Findings in TDHS and THMIS reports, small-scale surveys and qualitative studies demonstrate that, a significant percentage of adolescents in Tanzania become sexually active early and engage in sexual risk behaviors such as unprotected sexual activity. However, in small scale surveys adolescent boys are shown to be more sexually active, and ealier compared to female counterparts. Lugoe conducted a study in Arusha, examined the psychosocial determinants of sexual behaviors among adolescents in secondary schools. Findings revealed that, out of 501 adolescent boys 411 were sexually active, which is 82.0% and out of 378 adolescent girls 115, which 33.2% were sexually active respectively (Lugoe et al, 1996: 447). It is reported in another study of sexual and reproductive knowledge and problems among in school adolescents, conducted in Mwanza that, 80% of boys and 68% of girls in primary schools were already sexually active. On the other hand, 89% of boys and 48% of girls in secondary schools were sexually active (Matasha et al, 1998). All in all, findings from other studies illustrate that sexual intercourse among girls and boys starts pretty early (Nnko & Pool, 1997; Van Den Berg, 2008b; Kazaura & Masatu, 2009; Zakayo & Lwelamira, 2011; Madeni et al, 2011; Njau et al, 2013).

Unprotected sexual activity among adolescent is a concern in Tanzania. Several empirical studies on adolescent sexual behavior documented low levels in condom use among adolescent boys and girls, but mainly among girls (Lugoe et al, 1996; Silberschmidt & Rasch, 2001; Nnko et al, 2001; Plummer et al, 2006; Masatu et al, 2007; Klepp et al, 2008; Kazaura & Masatu, 2009; Zakayo & Lweramila, 2011; Exavery et al, 2011; Madeni et al, 2011; Katikiro & Njau, 2012). Exavery *et al.* reported that 61% of adolescents did not use condom during last sexual intercourse. Njau *et al.*, who studied condom use among sexually active adolescent found that almost half of the respondents did not use condom during sexual intercourse within last three months. Further, the study revealed that adolescent girls were less likely to use condoms compared to boys (Njau et al, 2013). Except in a study done by Masatu *et al.*, condom use was shown to be higher among adolescent boys and girls (2009).

Strikingly, in extant empirical literature, high proportion of sexual activity among adolescents is reported in small scale studies compared to DHS results (Mmbaga et al, 2012) and probably other national health surveys. In two important national health surveys, data on recent sexual activity among youth revealed that 65.7% (TDHS, 2011),

and 60.2% (THMIS, 2013) of adolescent boys (15-19) never have had sexual intercourse. On the other hand 67.7% (TDHS, 2011) and 52.7% (THMIS, 2013) of adolescent girls (15-19) are reported to never have had sexual intercourse. It is also observed in several studies that, adolescent boys are more sexually active compared to their female counterparts. Moreover, out-of-school girls are shown to be more sexually active compared to in-school adolescent girls. In other instances, in-school adolescents are reported to be more sexually active compared to their out-of-school counterparts. But, all in all, findings in existing scientific studies confirm that a significant number of adolescents, including girls become sexually active by the age of 15 and 18.

3.3. Unintended Pregnancies[25]

Unintended pregnancy among adolescents is a worldwide concern. But, levels in adolescent pregnancy rate vary from country to country (Singh & Darroch, 1999). Statistics reveal that despite declines in average fertility rates, about 14 to 16 million 15-19 adolescent girls give birth annually, which forms 11% of all births. Out of these, 95% occurred in developing countries. In low and middle income countries adolescent pregnancy and birth related complications is mentioned as the leading cause of death among adolescents. Additional evidence reveals that Sub Saharan Africa has the largest share of adolescent pregnancies. According to reports, more than 50% of the world's proportion of births occurring during adolescence takes place in SSA (Boonstra, 2007; UNESCO; 2013b).

Therefore,data on level and trend in adolescent pregnancy reveal that adolescent pregnancy is not a phenomenon restricted to the developing world or in fact, to East African countries. Adolescent pregnancies are common in developed countries as well, including in Europe and USA. However, while USA is leading in terms of having the highest adolescent pregnancy rate in developed world, many countries in Europe have recorded decline in adolescent pregnancy since several decades ago (Singh & Darroch, 1999). For example in 80s and 90s Portugal had the highest level in adolescent pregnancy rate compared to other countries in Western Europe (WHO, 2004). Todate,while adolescent pregnancy remains a concern in Portugal, Portugal has

[25] In other reports these are alternatively known as unplanned and unwanted pregnancies.

recorded an impressive reduction in adolescent pregnancy rate, and it is doing better compared to countries such as the United Kingdom. Portugal has 23 out of 1000 level in adolescent pregnancy (Singh & Darroch, 1999; Pedrosa et al, 2011).

By and large, adolescent pregnancy is described as 'dangerous'in most literature sources (Presler-Marshall & Jones, 2012). Adolescent pregnancy is associated with high morbidity and mortality for mother and child (TDHS, 2011). There is considerable evidence to suggest that adolescent pregnancy has health consequences regardless marital status (Bledson & Cohen, 1993; Zabin & Kiragu, 1998; Presler-Marshall & Jones, 2012). Further, adolescent pregnancies is documented to have socio-economic repercussions on the child, the adolescent mother, and society as a whole (Bledson & Cohen, 1993; Mensch et al, 1998; UNICEF, 2011a; UNICEF; 2011b; NCAPD, 2010; UNICEF, 2011b; Madeni et al, 2011; Mbelwa & Isangula, 2012; Presler-Marshall & Jones, 2012). Adolescent pregnancy is also described as a crucial contributing factor to school girls' dropout in Tanzania and probably, in other East African countries (Matasha et al, 1998; Kibombo et al, 2007; Madeni et al, 2011; McClearly-Sills et al, 2013).

According to other reports, East Africa including Tanzania has seen some improvements in terms of reduction in adolescent pregnancy and births. However, adolescent pregnancy remains a major health issue of concern (Bledsoe & Cohen, 1993; Tumbo-Masabo, 1994; Rasch et al, 2000; Silberschmidt & Rasch, 2001; Furstenberg, 2003; Kirchengast, 2009).However, Tanzania and Uganda are earmarked to be among countries with highest adolescent childbearing in SSA (Chacko et al, 2007; UNFPA, 2012a; Mbelwa & Isangula, 2012). In Tanzania, 28% of girls give birth before 18, and 56.4% of women give birth before they turn 20 (TDHS, 2011). Moreover, TDHS report reveals fertility trends tend to be slightly higher among adolescents aged 15-19. Although young women are not the focus of our study, it is important to document that fertility trend in Tanzania escalates among 20-24 (TDHS, 2011). Furthermore, according to the Ministry of Education and Vocational Training data between 2004-2008 28,600 girls left or were expelled from school due to pregnancy[26].

[26] There is probability that, these estimates did not include the number of girls who dropped out of schoo before their pregnancies were noticed by school authorities, and/or those who had induced abortion. Consequently, these estimates may not give the complete picture of levels and magnitude of adolescent

It is documented that in Tanzania half of all births occur before women reach 20 years old (McCleary-Sill et al, 2013). The center for reproductive rights illustrated that, 44% of adolescent girls in mainland Tanzania have either given birth or are pregnant exact at 19 (2013). Studies also indicate that most adolescent girls do not plan to become pregnant early (Ringheim & Gribble, 2010; NACPD, 2010; Center for reproductive rights, 2013). The prevalence of unsafe abortion among sexually active unmarried adolescent girls manifests that pregnancies are unintended or wanted later (Biddlecom et al, 2007a; Ringheim & Gribble, 2010; Ikamari et al, 2013). This does not suggest however that, all pregnancies among unmarried adolescent girls are unintended (Ikamari et al, 2013). In East African context, high levels of adolescent pregnancy happen, mainly, because many adolescent girls become sexually active early, are married early, but they are also less likely to use contraceptives, particularly, condoms (Ringheim & Gribble, 2010; UNFPA, 2012b).

Table 5: Adolescent Childbearing in East Africa (births per 1,000 15-19 women)

Year	2008	2009	2010	2011
Kenya	100	99	99	99
Uganda	145	141	136	131
Rwanda	38	37	37	36
Tanzania	130	130	129	129

Source: World Bank Data, 2013.[27]

In Kenya, a review of DHS reports of 2003 and 2008-09 revealed a rise and fall pattern in fertility among adolescents, and in different age groups. Overall, the proportion of adolescents who have begun childbearing is reported to increase dramatically from 2 at age 15 to 36 at age 19. Findings from several DHS reports in Uganda resonate with World Bank data on adolescent fertility rate. The proportion of adolescents who have begun childbearing is abating; from 43 % in 1994 to 31% in 2000-01, to 24% in 2006 and 24 in 2011. The proportion of adolescents who have began childbearing increases from 2 at age 15 to 58 at age 19.

In Rwanda the proportion of adolescents who have begun childbearing decreases steadily from 11% in 1992 to 7% in 2000, and 4% in 2004, finally increased slightly to

pregnancy. Apart from that, there is dearth on pregnancy data among out-of-school adolescents (Leshabari & Kaaya, 1997) and married adolescents.

[27] See http://data.worldbank.org/indicator/SP.ADO.TFRT

6%. Similar trends in increase on the proportion of adolescents who have begun childbearing between age 15 and 19 was documented in the past DHS reports in Rwanda and Tanzania. Currently, Rwanda has the lowest adolescent childbearing in East Africa which is nearly similar to some developed countries (Ringheim & Gribble, 2010:18).

Table 6: Trends in Adolescent Childbearing in Kenya

Percentage of who				
	have had live Birth	are pregnant with first child	have begun childbearing	Number of women
Background Characteristics				
Age				
15	1.0	1.1	2.1	317
16	8.2	1.3	9.4	437
17	13.0	3.4	16.5	332
18	21.6	4.6	26.5	353
19	30.0	6.2	36.2	321

Source: 2008-09 DHS.

Table 6a: Trends in Adolescent Childbearing in Uganda

Percentage of who				
	have had live Birth	are pregnant with first child	have begun childbearing	Number of women
Background Characteristics				
Age				
15	0.7	0.9	1.6	480
16	5.0	3.5	8.5	414
17	13.1	7.7	20.8	367
18	28.3	9.1	37.4	417
19	48.7	8.8	57.6	370

Source: 2011 DHS.

Table 6b: Trends in Adolescent Childbearing in Rwanda

Percentage of who				
	have had live Birth	are pregnant with first child	have begun childbearing	Number of women
Background Characterisitics				
Age				
15	0.0	0.0	0.0	677
16	0.5	0.3	0.8	655
17	2.3	1.0	3.3	530

18	7.6	2.1	9.7	605
19	16.3	4.0	20.3	478

Source: 2010 DHS.

Table 6c: Trends in Adolescent Childbearing in Tanzania

Percentage of who				
	have had live Birth	are pregnant with first child	have begun childbearing	Number of women
Background Characterisitics				
Age				
15	2.0	3.3	5.2	467
16	8.2	3.3	11.5	483
17	15.0	5.6	20.7	446
18	28.0	10.6	39.0	391
19	37.8	6.5	44.5	385

Source: 2011 DHS.

3.4. HIV/AIDS

HIV/AIDS is a global crisis (Aseka, 2009). Social researchers especially scholars in HIV/AIDS, describe HIV/AIDS epidemic as a devastating epidemic in contemporary history (Parkhurst & Whiteside, 2002: 313; Barnett & Whiteside, 2006). Parkhurst and Whiteside further describe HIV/AIDS as a lethal epidemic compared to Ebola fever because it spreads, mostly, among the people who are at the margin of the society (Parkhurst & Whiteside, 2002: 314), both in developing, and developed nations (Guiella & Madise, 2007; Whiteside, 2002).

First AIDS cases were reported in Tanzania in 1983 in Northern western in the region of Kagera. Since its outbreak and by 1986 HIV/AIDS had already spread in at least 20 regions. And among different segments of the population, especially young females are described to be highly vulnerable to HIV infection (Leshabari et al, 2008). Generally in African context, HIV/AIDS is mainly transmitted horizontally (through unprotected sex which involves contamination with body fluids like semen, blood and vaginal fluids). HIV can also spread vertically (through mother to child during pregnancy, labor or breast milk), and injecting drug users (UNAIDS, 2012). In other parts of the world, especially in developed countries, HIV/AIDS spread, mostly, among certain groups of the population. For example men who have sex with men and injecting drug users (UNAIDS, 2012). Apart from the above mentioned paths of HIV transmission, HIV can

be transmitted through contaminated instruments such as needles, syringes and other injections and blood transfusion. However, HIV/AIDS is widely acknowledged to have its roots in the broader social and cultural structures of a particular society (WHO, 2006; UNAIDS, 2010).

Recent reports show that many countries around the world have begun to halt and reverse the spread of HIV/AIDS (UNAIDS, 2010; UNAIDS, 2012). Data indicate that new infection has declined by 50% or more in 25 countries around the world, of these, 13 are in SSA (UNAIDS 2012). Globally, Africa has the worst levels of HIV/AIDS epidemic (Whiteside, 2002). Despite gains in decline of HIV prevalence rate in many countries around the world, and since the release of WHO report in 2004, young people continue to be at the centre of HIV/AIDS. In 2001 research has approximated that, in 8 countries in Africa, with at least 15% of HIV/AIDS prevalence rate, one-third of 15year old population were expected to die of AIDS (Mane & Aggleton, 2001:23). In 2006 nearly half or more than a half of new HIV infection occurs in young people (Marston & King, 2006).

According to several sources, in SSA, including Tanzania, adolescent girls are described to be at three or four times more likely than adolescent boys to be HIV positive (Mabala, 2006; Biddlecom et al., 2007a; Mabala & Cooksey, 2008; Underwood et al, 2011; UNAIDS, 2012). Eastern and Southern Africa regions are described to be the hardest hit by the epidemic (Ringheim & Gribble, 2010:13) and named by a recent report as “the epicenter of the global HIV/AIDS” (UNESCO, 2013b:18), in other reports. Further, adolescent girls in Eastern and Southern Africa are reported to be at far greater risk and vulnerable to sexually transmitted disease, including HIV (UNICEF, 2011b; Doyle et al, 2012; UNESCO, 2013b). The above mentioned gender differences in vulnerability to HIV have persisted and social sciences research is sought to provide an understanding about why and how this happens (Harrison, 2008).

Reliable statistics showing trend in HIV infection among adolescents is scarce in most East African countries. According to current estimates, in Tanzania, more than 60% of new HIV infections occur mainly among individuals aged 15-24 (Obassi et al, 2006; Katikiro & Njau, 2012). On the other hand, studies show that adolescent girls aged 15-19 are four times more likely to contract HIV/AIDS than their male counterparts (URT,

2004-2008). While finding reported in the above mentioned reports gives a clear picture of level and trend in HIV/AIDS infection among adolescents, we have also relied on DHS data about comprehensive knowledge about HIV and HIV prevention, and condom use, to demarcate trends in HIV/AIDS among adolescents.

Uganda is among very few countries in the world that are hailed to have succeeded to dramatically reverse the spread of HIV/AIDS from 15% in 1991, to 6% (Neema & Musisi, 2004; Kibombo et al, 2007; UAIS, 2011). Rapid decline in national HIV prevalence rate is associated with behavior change; abstinence and delay of first sex, reduction of the number of sexual partners and condom use (Neema & Musisi, 2004; Kibombo et al, 2007). Unlike previous reports, according to 2011 UAIS preliminary report, the current the national HIV prevalence is 7.3%, which signal a gradual increasing trend in HIV prevalence in Uganda.

In 2000, a study conducted by Sekatawa indicates that despite decline in national HIV prevalence rate, adolescents in Uganda remain at risk of HIV infection. Female adolescents are reported to be highly at risk of HIV/AIDS. According to the study, girls aged 15-19 are two to six times likely to contract HIV than boys of similar age (Sekatawa, 2000). Data provided by Sekatawa is substantiated by data documented in a study conducted by Kibombo *et al*. Reporting data released by a study conducted by the Ministry of Health in Uganda and ORC Macro in 2006, it is shown in Kibombo *et al.* that, HIV prevalence was 2.6% among 15-19 females and only 0.3% among males (Kibombo et al., 2007:1). Further, the 2011 Demographic and Health Survey in Uganda contains information concerning HIV knowledge and sexual behaviors among youth. Findings show that, while majority of Ugandans especially adult population have comprehensive knowledge about HIV, 15-19 adolescents are reported to have lower comprehensive knowledge about HIV; 36% (15-19), 34.1% (15-17) and 38.1% (18-19) among females, and; 34.8% (15-19), 35.8% (15-17) and 32.8% (15-18) among males.

What is striking in UDHS data on HIV among youth is that, while both adolescent boys and girls aged 15-19 score more or less the same on possessing comprehensive knowledge about HIV/AIDS, majority of adolescent girls have relatively low information about where to get a condom or having knowledge about a condom source

compared to adolescent boys with similar socio-economic status[28]. 69.4% (15-19), 67.4% (15-17) and 77.0% of females know where to get a condom, while 86.5% (15-19), 84.0% (15-17) and 91.7% (18-19) of males are aware of a condom source.

Overall, many people in Kenya have information about HIV prevention methods; 75 % of women and 81% of men are aware that condom use reduces the chances of contracting HIV,93 % of women and 92% of men are aware that sticking to one faithful partner can make them avoid getting HIV and 90% of women and men are aware that abstinence can as well enable them to avoid contracting HIV virus. Findings from DHS also indicate that in Kenya adolescents aged 15-19 have lowest knowledge of HIV prevention methods in all of the identified behavioral aspects.
On the aspect of possessing comprehensive knowledge about HIV[29] At least 49% of women (15-49) and 56% of men (15-49) are documented to have comprehensive knowledge about HIV. On the other hand, data show that at least half of Kenyan youth aged 15-24 have comprehensive, 48% among young women and 55% of young women. Moreover, majority of young people aged 15-24 know where to obtain condom or condom source. Yet, level in comprehensive knowledge about HIV and knowledge about condom source is illustrated to be lower among 15-19 adolescents.

KDHS data (KDHS, 2010) also reveal percentage of adults who agree on provision of condom education for HIV prevention among children (12-14 year old). 61% of women and 72% of men agree that children should be taught how to use condom for the sake of HIV prevention. Kenya AIDS Indicator Survey is another source of data on HIV/AIDS prevalence rate among women and men aged 15 to 64. According to 2012 KAIS preliminary report[30] the current nationwide HIV/AIDS prevalence rate stands at 5.6 percent in adult population (15-64). Moreover, KAIS reports indicate risk of HIV infection to increase with age (KAIS, 2012).

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[28] See figure: 13.16.

[29] Having comprehensive means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common of misconceptions about HIV transmission or prevention.

[30] See:http://nascop.or.ke/library/3d/Preliminary%20Report%20for%20Kenya%20AIDS%20indicator%20survey%202012.pdf

Rwanda is also hit by HIV epidemic. According to reports, more than a decade ago Rwanda had a national HIV prevalence rate of 13%. HIV prevalence among sexually active adolescents was 10% (Babalola et al, 2002). Currently HIV prevalence rate in Rwanda according to DHS report is 2.8%. It is the lowest in East Africa (Ringheim & Gribble, 2010).

2010 RDHS results reveal that almost 99.9% of adolescent boys and girls aged 15-19 have knowledge about HIV or in other words have heard about HIV. On the aspect of having knowledge about at least two HIV prevention methods, results reveal that adolescents aged 15-19 lack sufficient knowledge on how to protect themselves against HIV. However 87.8% of girls (15-19) and 88.2% of boys (15-19) are aware that condom use is a means for protecting themselves from being infected with HIV. Findings also reveal that in Rwanda there is favorable adult support for condom education as a means of helping young people (12-14) from contracting HIV. At least 1 in 10 adult men and women agree regarding provision of condom education for HIV prevention among 12-14 adolescents.

RDHS data on trends in comprehensive knowledge about AIDS and knowledge of a formal condom source among young people reveal that, adolescent boys have less comprehensive knowledge about AIDS compared to adolescent girls, but also they have more knowledge on where to get a condom than adolescent girls[31]. Further 2010 DHS result reveal HIV prevalence rate across different segments of the population in Rwanda. Among youth who were tested (15-24), HIV prevalence is higher among young women (2 percent) and among young men (less than one percent). It is established in the report that, HIV prevalence increases by age among young women and men.

In 1990s Tanzania was reported to have high proportion of AIDS cases (Maswanya et al 1999). Of recent, Tanzania is among countries which are documented to have achieved a decline in HIV prevalence rate (Ringheim & Gribble, 2010). Generally, the recorded national HIV/AIDS prevalence is lower than Kenya and Uganda and higher compared to Rwanda (Ringheim & Gribble, 2010). Comparatively, in 2003-2004, 2007-

[31] See figure: 13.14.

08 and 2013 THMIS results for national HIV prevalence among adult population (15-49) was estimated at 7.1%, 5.8% and 5.3% respectively[32]. HIV and Malaria Indicator Surveys in Tanzania include data on HIV prevalence. Estimation of the national HIV prevalence is derived from women attending antenatal clinics and blood donors. Currently the national HIV prevalence rate is estimated at 5% among adult population aged 15-49.

Data from different sources reveal that young people are vulnerable to HIV/AIDS in Tanzania (Maswanya et al, 1999; UNICEF, 2011a), and indicate that 60% of all new infections in Tanzania occur among young people (15-24) (Leshabari et al, 2008). In 2011-12 HIV prevalence among adolescent girls (15-19) was 1.3% and 4.4% among young women (20-24). On the other hand, HIV prevalence rate among adolescent boys (15-19) was 1.0, and 1.3% among young men respectively (TMHIS, 2013). Although according to estimates 69% of women (15-49) and 77% of men know the chance of getting HIV is reduced by using condoms[33]. Differences on the level of knowledge of HIV prevention methods are documented. Adolescents aged 15-19 have lower knowledge of how to prevent HIV compared to adults. It is also observed that, among adolescents (15-19), knowledge of condom use for HIV prevention is higher among boys than girls. 59.4% of adolescent girls know that condom is a means for preventing HIV infection and 71.5% of boys are aware that condom use prevents HIV. It is worth mentioning that Tanzanians in the mainland are shown to have high level of comprehensive knowledge about HIV compared to those in the island; Zanzibar. Further, according to HIV and Malaria Indicator survey, Tanzanian adolescents, females and males aged 15-19, have lower comprehensive knowledge about HIV.

Despite of the fact that adolescents in Tanzania have low level of comprehensive knowledge about HIV, most of them are reported to be knowledgeable on where to obtain a condom. While only 36% of adolescent girls (15-19) have comprehensive knowledge of HIV, at least 57.9% know a condom source. On the other hand, 41.9% of adolescent boys have comprehensive knowledge about HIV and 78.7% know where to

[32] See 9.1.These estimates are drawn from mainland Tanzania. Zanzibar is excluded.

[33] Knowledge of key HIV prevention methods; using condoms, limiting number of sexual partners or remaining faithful to one partner, and delaying sexual debut or abstinence for the young and the never married is widespread in Tanzania.

get a condom[34]. A significant observation is drawn from data to show that adolescent sexual behavior in East Africa is substantial diverse. The fact that adolescent sexual behavior in Africa is diverse, is espoused by Djamba and Kimamu who argue that, "African adolescents do not follow the same path and in fact, sexual behavior among adolescents is quite peculiar to each country" (Djamba & Kimamu, 2008: 14)[35]. The diverse nature of sexual behaviors of African adolescent is also demonstrated in Doyle *et al.* in their compilation of data on adolescent sexual behavior from DHS/AIS reports in 24 African countries since 2005 (2012).

In East Africa context, empirical data on current trends and pattern in adolescent sexual behavior and health indicate that adolescent boys are more likely to become sexually active early, use condoms less, and are at risk of HIV infection. Overall, data on sexual behavior and health among adolescents aged 15-18 is patchy. As observed in these major national health surveys, this age group is mixed with other age groups, described either as 'young people' (15-19 and 15-24) or adults (15-49). In DHS reports, those who are below 15 years (0-14) are categorized as children[36].

However, adolescent girls in East Africa are reported to become sexually active later compared to adolescent boys[37]. This trend seems to be similar among adolescents in South Africa, and contrary to adolescents in West Africa whereby a substantial proportion of girls become sexual active within the context of marriages (Presler-Marshall & Jones, 2012). According to statistics and information on adolescent sexual

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[34] For more, see Table 8.1.

[35] Adolescent girls in Rwanda are described to become sexually active at least at 20 years, and are least like to get unintended pregnancies even when they have boyfriends and are sexually active compared to adolescents in other African countries (Ringheim & Gribble, 2010; RDHS, 2011).

[36] In our analysis of adolescent sexual behaviour in East Africa, especially in major national health surveys we have relied on data provided for adolescents aged 15-19.

[37] This type of data should be interpreted with caution because it may hide intriguing patterns that have important implications for protecting adolescent girls due to bias. Validity of survey data on self reported sexual behaviour is questioned in scientific research worldwide. Many people, including adolescents are reluctant to report about their actual sexual behaviours (Wellingtons et al, 2006; Giddens, 2006; TDHS, 2011; Erickson et al, 2010).In Tanzania several researchers are concerned with validity of data on sexual behaviours of adolescents due to high likelihood of underreporting on the part of girls as their sexual behaviours are socially sanctioned, and over reporting on the part of boys because of permissiveness of their sexual behaviours in the society (Lugoe et al, 1996; Matasha et al, 1998; Wamoyi et al, 2010). As Plummer et al emphasized there is a need for survey data on sexual behaviours to be complemented by other qualitative methods such as in-depth interviews for the sake of reducing bias (2004). It therefore suffices to say that, a sizeable proportion of adolescent girls in Tanzania may be sexually experienced early, probably more than survey data on adolescent sexual behaviours in national health surveys reveal.

behavior, many adolescents in East and South Africa become sexually active before marriage (Doyle et al, 2012). But of the greater importance however, is that, with the exception of Rwanda, and especially in Tanzania, adolescent girls are revealed to become sexually active earlier compared to male counterparts; most of them between age of 15 and 18, are found to be disproportionate vulnerable to unprotected sexual activity, unintended pregnancies and HIV transmission and there is dearth of empirical evidence to explain why this trend occurs (Weiss et al, 2000: 234).

3.5. Summary

This chapter situated the study. Tanzania is situated within regional spaces as the phenomenon addressed in the present study may have local and regional relevance. In recent years countries forming the East African community are documented to achieve significant growth in terms of economic development. And some important gain is documented in poverty reduction and in education sector in each country. It is described in this chapter that most of these countries specifically Tanzania are culturally diverse. Religion is not only important, but traditional African religion; Christianity and Islam coexist side by side. Others are Hinduism, Buddhism and Sikhism.

However, with the exception of Tanzania East African countries have experienced prolonged conflicts and violence. Among these, the 1994 Rwanda genocide in particular led to massive violation of the economic, social and cultural rights of women and girls. Massive sexual violence was committed against women, and had short term and long term ramifications on health of the survivors. The key dynamic in regard with sexual violence committed during Rwanda genocide and related health effect is that all women and girls were vulnerable to sexual violence and the related health effects, especially, unintended pregnancies, and HIV/AIDS. Yet, this was not indiscriminately. Tutsi women and girls were reported to be more vulnerable to sexual violence due to both, the behaviors of individual perpetrators of sexual violence, also dominant gender and ethnic ideologies that existed in Rwandan society before the outbreak of the genocide.

In order to advance further the agenda of the present study, the chapter examines statistics, survey data and other empirical evidence to demarcate trends and pattern on adolescent sexual behavior and health in Tanzania which is situated within the context

of the East African Community, together with countries such as Kenya, Uganda, and Rwanda.

In East Africa context, including Tanzania, empirical data and statistics on trends and pattern in adolescent sexual behavior and health indicate that adolescent boys are more likely to become sexually active early, use condoms less, and are at risk of HIV infection. Overall, data on sexual behavior and health among adolescents aged 15-18 is patchy. As observed in these major national health surveys, this age group is mixed with other age groups, described either as ‘young people’ (15-19 and 15-24) or adults (15-49). In DHS reports, those who are below 15 years (0-14) are categorized as children. However, on the whole, many adolescents in East Africa are documented to be sexually active before marriage. But of the greater importance however, is that, with the exception of Rwanda, and especially in Tanzania, adolescent girls are revealed to become sexually active earlier compared to male counterparts; most of them between age of 15 and 18, are found to be disproportionate vulnerable to unprotected sexual activity, unintended pregnancies and HIV/AIDS, and there is dearth of empirical evidence to explain why this trend occurs.

CHAPTER TWO.
CONCEPTUAL AND THEORETICAL FRAMEWORK

1. Introduction

Chapter 1 situated the study. Hence Tanzania is situated within regional space. It is observed in chapter 1 that it is impossible to enter the discussion about the social processes and practices that may related to health threats among adolescent girls in an East African country— in this case Tanzania, without acknowledging the recent past major human rights crisis that happened in 1994 — the Rwanda genocide. Massive sexual violence was committed against women and girls, and had short term and long term ramifications on health of the survivors. Some of them got unintended pregnancies and/or contracted sexually transmitted diseases particularly HIV/AIDS. However, the key observation emerging from an analysis of scientific studies demarcating recent trends in adolescents health is that, with the exception of Rwanda, and especially in Tanzania, adolescent girls become sexually active earlier compared to male counterparts; most of them between ages of 15 and 18, and they are disproportionate vulnerable to sexual risk behaviors, unintended pregnancies, and HIV transmission.

This chapter comprises of the key concepts and theories framework, justifications for their adoption and their applicability in the present study is also described. In social sciences concepts and theoretical frameworks have played a significant role in generating ideas, and advancing arguments and assumptions. In so doing, they have contribute in the building or development of new theories and concepts. Minority, gender, sexuality, health, and adolescence are the key concepts in the present study. Some scholars define these concepts as if they were universal and static. Others scholars do not agree with this perspective because these concepts are understood differently across cultures and societies. They are also dynamic. However, many scholars do not negate existence of some commonalities. Therefore, in order to achieve the goal of the study, this chapter provides for broad and dynamic definitions of the key concepts.

Giddens' theory of Structuration is used as an overarching framework for social analysis in the present study. In addition, the study also draws from functionalist perspectives according to Talcott Parson. Talcott Parson espouses that institutions have functions to play in relation to contributing in maintaining order and stability in a particular society. However, the view positions societies and institutions as if they were totalities. Giddens's structuration theory is described to have enormous contribution in contemporary social thinking, especially in relation to providing an understanding about relationship between agency and institutions. The theory upholds the view that, a social phenomenon cannot be adequately understood by focusing on the micro dimensions while negating the macro dimensions associated with it. But on the other hand, you can't study it by only looking at 'macro' level explanations (Gauntlett, 2002). Hence, its main tenet is that structure and agency are inseparable, and that structure is both enabling and constraining. This is the opposite of functionalist perspectives which view structures as constraining only.

The chapter also describes key international instruments and/or standards for protecting adolescent health particularly the United Nations Convention on the Rights of the Child and its General Comments. And the Covenant on Economic, Social and Cultural Rights and its General Comments.

1.1. Concept of Minority

The concept of minority is highly debatable. Its origin can be traced back to the League of Nations which created a legal framework for addressing minority issues in the aftermath of World War 1 (Vijapur, 2006; Grote, 2008). After World War 1 borders were readjusted and new states in Central and Eastern Europe were formed. Consequently, groups of individuals who resided in disintegrated nation states found themselves within the territory of new states which had different culture, religion and language. This led to the co-existence of majority who share dominant culture and small groups of individuals who had their own cultural identity different from the dominant one. Consequently, individuals and groups which were in non-dominant position within newly established states started to demand their rights to preserve their cultural autonomy and identity (Pentassuglia, 2002;Vijapur, 2006;).

Following the demise of the League on Nations minority protection system was weakened. By and large, minority issues were accorded scant attention within the newly established United Nations system, which was created in 1945, and the Universal Declaration of Human Rights (UDHR) in 1948. The attempt to exterminate minorities by Nazi regime necessitated a move that aimed at protecting individual rights of all 'human beings' (Vijapur, 2006), based on the principles of equality and non-discrimination. The assumption is that, protection of individual rights guarantees non-discrimination and protection of minorities. However, later on, it was realized that paying attention to minority rights was an unavoidable agenda because protection of individual human rights did not suffice to wither tensions between states and national or ethnic minorities. Hence, minority clause was retained in UDHR. As stated in the UN General Assembly Resolution 217 C (III) ("Fate of Minorities"), that, "UN cannot remain indifferent to the fate of minorities". In addition to that, the Economic and Social Council (ECOSOC) was tasked to conduct a thorough study about the situation of minorities. Years later, minority rights were incorporated in a key human rights document, namely Article 27 of the International Covenant on Civil and Political Rights (ICCPR).

1.2. Relevant International Instruments on Minorities

Two instruments of the UN are significant here. First, the Article 27 of the Covenant for Civil and Political Rights (CCPR)[38], which is the essence in minority rights protection. ICCPR was ratified by Tanzania on 11 June, 1976. The United Nations Declaration of Minority Rights was adopted in 1992. Article 27 is the only international legally binding provision on minorities and minority rights protection (Vijapur, 2006: 374). It recognizes rights of persons belonging to ethnic, religious and linguistic minority. It stipulates that:

> In those States in which ethnic, religious, or linguistic minorities exist, persons belonging to such minorities cannot be denied the right, in the community, with other members of their group, to enjoy their own culture, to profess and practice their own religion, or to use their own language.

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[38] ICCPR was adopted by the United Nation General Assembly Resolution 2200 A (XX1) of 16 December 1966. It entered into force on 23 March 1976 according to article 49, for all provisions except those of article 41; 28 March 1979 for the provisions of article 41 (Human Rights Committee) according paragraph 2 of the same. For more see UN General Assembly, International Covenant on Civil & Political Rights, 16 December 1966, United Nations, Treaty Series, Vol. 999, p 171 available at: http://www.refworld.org/docid/3ae6b3aa0.html [Consulted 15/3/ 2012]

Despite being a key legally binding instrument in minority protection, and internationally, Article 27 of ICCPR is described to have some weaknesses (Henrard, 2010). First, it confers protection to the "persons belonging to ethnic, religious and linguistic minorities" (Kulegmann, 2007:232). Second, being a minority is associated with essentialist views about ethnic, religious, linguistic and cultural identity. Minorities are perceived as homogenous (Grote, 2008). Third, it gives primacy to the protection of the rights of individual minorities over collective or group rights of minorities (Vijapur, 2006; Casals, 2008; De Vito, 2008; Grote; 2008).

As Spiliopoulou Akermark affirms:

> The fact that Article 27 is placed in the context of a document on individual civil and political rights (with the exception of Article 1 on self-determination of people), the *travaux preparatoires* to the Covenant emphasize that minorities do not have a legal personality in international law and the fact that the Optional Protocol to the Covenant recognizes *locus standi* only to individuals, all arguments supporting position that Article 27 guarantees only individual rights (Akermark, 1997:46).

It is important to note however that, despite its deficiencies, Article 27 of ICCPR as a key provision on minority rights and protection may be relevant for addressing the situation of minorities in contemporary societies. As stated in the General Comment No. 23 (1994),[39] article 5.2:

> Article 27 confers rights on persons belonging to minorities which "exist" in a State party. Given the nature and scope of the rights envisaged under that article, it is not relevant to determine the degree of permanence that the term "exist" connotes. Those rights simply are that individuals belong to those minorities should not be denied the right in community with the members of their group, to enjoy their own culture, to practice their own religion and to speak their language. Just as they, they need not be permanent residents. Thus migrant workers or even visitors in the State party constituting such minorities are entitled not to be denied the exercise of such rights.

Moreover, Human Rights Committee in the same General Comment No. 23 (1994), article 6.1, recognizes states which have ratified the covenant as primary custodians of the rights of minorities:

> Although article 27 is stated in negative terms, that article, nevertheless, does recognize existence of a "right" and require that it cannot be denied. Consequently, a state party is under an obligation to ensure that the existence and the exercise of this right are protected against their denial or violation. Positive measures of protection are, therefore, required not only against the act of the

[39]. See http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/fb7fb12c2fb8bb21c12563ed004df111?Opendocument [Consulted 11/3/2012]

State party itself, whether through its legislative, judicial or administrative authorities, but also against the acts of other persons within the State party.

Second, the United Nations Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (or UDMR)[40], of 18 December 1992 (resolution 47/135 of the United Nations General Assembly), is another key international instrument that devotes solely to minority rights. Its adoption was an important development in international minority protection. It was perceived by many scholars in minorities and minority rights as a move that would consolidate protection of group rights of minorities at the international level. Its adoption indicated that, protection of individual rights in international, regional, and national legal instruments does not suffice to accommodate the needs and rights of minorities (Grote, 2008).

Both the ICCPR (Article 27) and the UDMR (Article 3.1) are enshrined with rights for individual belonging to minorities (De Vito, 2008; Vijapur, 2006). As Vijapur describes that, the collective or group rights for minorities were left without being accorded desirable attention in these norms, except for the phrase about enjoyment 'in community with other members' of the group (Vijapur, 2006: 381). It is important to recall that, while UDMR guarantees protection of collective rights of minorities, it is not a legally binding instrument in minority protection (Akerberg, 2001). However, it remains one of the key and influential developments in international legal discourse on minority protection in the Post World War II period.

— Other Relevant Human Rights Provisions

The African Charter on Human and People's Rights for instance, alternatively known as Banjul Charter is the groundwork of human right protection system in Africa. It was adopted on 27 June 1981 and entered into force on 21 October 1986. When compared to other regional human rights instruments, namely, European Convention on Human Rights (ECHR) and The Charter of the Organization of American States (OAS), Banjul Charter is known for embracing a holistic concept of 'human rights'. The Charter integrates protection of human rights of individuals and groups, and civil and political rights and economic, social and cultural rights (Udogu, 2001; Dersso, 2007). The

[40]. See http://www.ohchr.org/Documents/Publications/GuideMinoritiesDeclarationen.pdf [Consulted 10/3/2012]

Charter embraces the principle of non-discrimination, which is important for minority protection.

Further, the Charter establishes the African Commission on Human and People's rights and gives it the mandate to enforce the rights. Despite of its strengths in relation to confer protection of both individual and people's rights, the African Charter may not assure effective protection of minorities. First and foremost, the Charter does not, refer to the term "minorities", and neither establishes a legal definition of "minority" (Dersso, 2007)[41]. On the other hand, as used within the Charter, the concept 'people' has not been clarified either and its use may not necessarily connote "minorities". It may rather refers to collective rights of people (Dersso, 2007)[42].

1.3. Debates over the term Minority

Over the years, social scientists in different fields such as sociology, social work, political science and anthropology have been concerned with minority issues. There have been attempts to define a "minority". By and large, in social sciences, a "minority" does not constitute a numeric superior or inferior social entity (Turyatunga, 2010; 58; Nassali, 2011: 7).

Louis Wirth proposed in the first half of the Twentieth century a definition of minority which has been influential and widely used in minority studies in social sciences. According to Wirth (*cited in* Anye, 2008: 14):

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[41] The Framework Convention for the Protection of National Minorities in Europe (FCNM) is another legal instrument on minorities and minority protection. It was adopted by the Committee of Ministers of the Council of Europe in 1994 and entered into force in 1998. FCNM is a multilateral legal binding instrument devoted in the protection of minorities and considered to contain most comprehensive standards in minority rights so far. The reasons why FCNM is regarded as a commendable legal document in minority protection because minority protection is regarded as an integral part of human rights protection based on the principles of equality and non-discrimination. Further, the definition who is a minority has some general understandings but also flexibility on who is a minority and what rights should be protected. The aspect of flexibility is very important because the framework convention stipulate principles and states' obligations in the protection of the rights of minority. In order to enable states to fulfill their obligations the framework convention does not define who is a 'national minority' because it is acknowledged in the framework convention that minority situation differs across countries. See http://www.ohchr.org/documents/publications/guideminorities8en.pdf consulted on 20/3/2012) and http://www.coe.int/t/dghl/monitoring/minorities/1_atglance/pdf_h(1995)010_fcnm_explanreport_en.pdf

[42] In international law words 'minority' and 'people' may not be necessarily synonymous.

> A minority group is any group of people who because of their physical or cultural characteristics are singled out from the others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination.

Wirth's description of minorities is based on the physical and cultural traits that minorities possess, which are distinct from the larger group or groups in a society in which they are a part. These traits have been used to justify stereotypes, prejudice and differential treatment of minorities (Turyatunga, 2010). This pioneer vision has been widely used after World War II by the UN.

At that stage, it appeared clearly that the concept of minority itself is contested. What constitutes a minority has multiple connotations (Casals, 2006).

There have been attempts to define the concept minority in international law, in order to provide a general understanding of who minorities are and guide protection of their rights worldwide. The conceptualization of the term "minority" in international law is a result of the work done by Special Rapporteurs of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities, namely, Francesco Capotorti and Jules Deschênes (Slimane, 2003; Akerberg, 2001). Capotorti definition has been cited by a number of scholars in international minority studies.

Drawing from article 27 of ICCPR, Capotorti defines a minority group as:

> A group which is numerically inferior to the rest of the population of a state and in a non-dominant position whose members possess ethnic, religious or linguistic characteristics that differ from the rest of the population, and show implicitly a sense of solidarity directed towards preserving their culture (Akerberg, 2001: 7; United Nations, 2010: 2).

There were disagreements on Capotorti description of minorities. In order to try to redress the inadequacies of Capotorti definition, another definition was proposed by Jules Deschênes. According to Deschênes:

> A group of citizens of a state constituting a numerical minority and in a non-dominant position in that state, endowed with, ethnic, religious or ethnic characteristics which differ from those of the majority of the population, having a sense of solidarity with one another, motivated, if only implicitly, by the a collective will to survive and those who aims to achieve equality with the majority in fact and in law (Deschênes, 1981 *cited in* Akerberg, 2001:7).

The definitions proposed by Capotorti and Deschênes proscribe objective and subjective criteria for defining a "minority". It is still debatable whether the above premises suffice for recognition and protection of minorities across countries (Henrard, 2010: 209). For example Khan and Rahman describe some of the criteria as "vague, misguiding and inadequate for the diversified minority situations" (Khan & Rahman, 2009: 2).

Two criteria have been used so far: An objective and a subjective one.

The objective criteria comprise three aspects; the numerical inferiority, non-dominance, and nationality or citizenship divides with the rest of the population.

Numerical inferiority has been regarded as a prerequisite in defining minorities. According to Capotorti in order to qualify as minority, a group has to be numerically smaller than the "rest of the population" or the majority, approximately less than fifty percent. Quantification of minority has been questioned by scholars in international law. John *Ballantyne et al v Canada,* Human Rights Committee Communication No. 359/1989/385/1989[43] is as an example to illustrate the complexities associated with the numerical threshold criterion in describing minorities. HRC ruled out that the Quebec state violated article 19 of ICCPR by restricting commercial advertising in English as it denied the English speaking community freedom of expression. The Committee opined that the law could allow use of both French and English in public advertisements instead of completely forbidding use of English. However, the Committee ruled out that the authors could not claim rights established under article 27 as linguistic minorities because the English speakers are not numerically a minority in Canada. Instead, they are the majority of the population at the state level. The Human Rights Committee ruling has been widely criticized for its reasoning (Henrard, 2010; Khan & Rahman, 2009).

Quantification does not describe the situation of marginalized groups (Casals, 2006). There is also evidence to show that, in some countries, particularly in African context, it is hard to find a single numerically dominant group, and a single numerically minority group, which need to be protected against the actions of the dominant majority group

[43] http://www.minorityrights.org/2914/minority-rights-jurisprudence/john-ballantyne-et-al-v-canada.html

(Dersso, 2010). Historically, in Africa, the minority phenomenon is closely associated with access, control and ownership of power and resources (Dersso, 2010: 68).

Non-dominance has been cited as another important objective criterion in defining a "minority" (Slimane, 2003, Akerberg, 2001; Turyatunga, 2010). It has been related with numeric inferiority of a group. The assumption being, a numeric minority is likely to be excluded from participating in decision making and control of the political machinery (Khan & Rahman, 2009) compared to the dominant group. However, some scholars have argued that there is no direct relationship between numerical inferiority or numerical superiority and non-dominance (Casals, 2006). For example, blacks in South Africa during apartheid were numerically superior compared to white, but were subjected to marginalization. The Tutsi in Rwanda and Burundi is another example of powerful numeric inferior minority (Slimane, 2003; Dersso, 2010)[44].

While non-dominant position of minorities has been a central aspect in protection of minorities since the League's era, literature has revealed existence of pessimism among states that have signed different international and regional legal framework for protection and rights of minorities. Referring to minorities as members of a group in a non-dominant position is perceived as problematic, since many groups may fall under the category of a "minority" (Casals, 2006; Grote, 2008). For example non-dominance is not mentioned within the Framework Convention for the Protection of National Minorities in Europe (FCNM) (Akerberg, 2001).

According to Capotorti and Deschênes, *citizenship or nationality* is another objective criterion for a minority status. Many scholars disagree on the relevance of citizenship or nationality in defining "minority". The argument is that, minorities need not be permanent citizens or to have established long ties with the particular country. And that framing a "minority" within citizenship or nationality excludes so many other groups which may be in a situation that require special protection of their rights (Henrard, 2010). As noted earlier, although the issue of nationality is clarified by the Human Rights Committee in General Comment No. 23 for ICCPR, evidence in literature illustrates that, practically, nationality is used as a criterion of minority status. And the

[44] Also black majority and white minority in the United States of America

practice is meant to limit influx of individual or groups of individuals claiming a minority status (Grote, 2008).

The subjective criterion refers to group's sense of solidarity. According to this dimension a group has to possess distinguishing physical or cultural traits different from the rest of the mainstream society and has to manifest its determination to maintain or retain its distinct cultural or social identity. Scholars have also taken different positions on this. Most of them agree that a subjective criterion is necessary (Akerberg, 2001, Henrard 2001; Mbanaso & Korieh, 2010). Nevertheless, scholars like Henrard have some reservations about the subjective criterion. The author is of the view that, subjective criterion should not be given utmost importance in defining a "minority" because some groups may not be claiming right to preserve culture and identity according to article 27 of ICCPR (Henrard, 2010). There are *different forms* in exclusion or marginalization in economic, social, and cultural life. This scenario is more relevant in Africa (Henrard, 2010). Hence, a mere continued existence of a vulnerable population group should be sufficient in itself (Henrard, 2001).

— Main Conceptual Issues in Minority studies and Minority Rights

First question related to the concept: does it provide *individual* or *group* rights — or both? So far, one may note that, the concept of "minority" is still associated with primordial characteristics — ethnicity, race, religion, culture and language differences — which are aligned with individualistic "identity" notions. In that vein, the debate on justification of minority rights is based on the "assertion that some groups possess an identity that allows them to be identified as a "minority" (Casals, 2006: 23).

Advocates of minority rights argue in favor of recognition and protection of certain group differentiated rights for some groups (Kymlicka, 1995). Their arguments center on the premise that international Human rights discourse — looking at the traditional identity aspects — does not suffice to protect individual citizens who are also members of 'cultures', 'nations' or simply 'people' (Kymlicka, 1995) different from the mainstream society or majority. Thus, the rights of members of certain groups should be protected on the basis of *being different*. While the protection of the rights of individual belonging to minority group (national, ethnical, cultural or linguistic) is at the center of

minority protection regime today, the notion of 'minority' as a culture which is autonomous is currently an arena of intense debate. To put this differently, it is increasingly acknowledged that a "minority" may emerge as a result of socio-historic conditions, from a *group* condition, from observed social contrasts, rather than from a phenomenon inherent to an individual member of that group (Chantler & Smaile, 2004 *cited in* De Finney et al, 2011: 364). This has two essential consequences: first, you can have minorities within minority groups; second, and most importantly, the concept of minority can include the fact of sharing an *objective social group vulnerability* which is not only a *subjective identity element*.

Second question to ask: whether minority rights are part and parcel of the *existing Human rights framework* or do they form a *separate framework*?

Some authors do not question the relevance of minority rights since it is previously established in international human right discourse. But they question the relevance of collective notion of minority rights as human rights. The disagreements emanate from two contending philosophical and human rights theories, namely, individualism and communitarianism.

> Thus individual liberalism claims that communitarianism advocates for collective values and consensus, even if it means trampling on the rights of individual members of these (as well as other) communities. In other words, in this debate, the communitarian position seems to equate liberal, individualistic promotion of universal values with cultural assimilation that results in the fragmentation and demise of various traditional cultures. Liberal individualistic on the other hand, blames communitarian relativism for its oppressive tendencies and conservative towards those minorities who do not agree with the commonly adopted values and social norms (Sirkku, 2010: 38).

Jack Donnelly is one of the influential human rights theorists and a critic of minority rights as group rights. Based on his book *Universal Human Rights Theory and Action* Donnelly developed a theory of human rights which Valen-Sendstad called 'minimalist universalism' (Valen-Sendstad, 2010). According to Donnelly, human rights are for protecting human dignity. He stresses that human rights are the rights that one has simply as a human being (Donnelly, 1999a). As Casals describes:

> As far as the notion of group rights is concerned, collectivists and individualist disagree upon whether or not a minority or any other social group can be said to possess moral interests, as this is commonly regarded as necessary to justify the attribution of human rights (Casals, 2006: 19-20).

Currently, group rights are present in some of the international human rights instruments, but they are stated in a 'declaratory nature' (Jovanovic, 2010:33) and do not cover a wide variety of groups and minorities in contemporary diverse and dynamic societies (Grote, 2000; Yacoub, 2010). In current literature, scholars in minority studies argue in favor of collective minority human rights because both individual rights and group rights are important and linked. While it is plausible that both liberal individualism and communitarianism may hamper rights of minorities, for example women (Sirkku, 2010), the critical question is on how to accommodate minority rights as both group and individual rights. Some scholars prefer adaptation of the current human rights system to reflect the diverse nature of cultures and minorities worldwide (Yacoub, 2010).

Others scholars suggest earmarking appropriate instruments for protecting minorities and establishing how best to protect minority rights and at which level — at international, regional or national levels (Vijapur, 2006; Henrard, 2010). The consequence of this position is that minority rights are human rights — this is Vijapur view, for instance (Vijapur, 2006). Vijapur's view is echoed by Asher who stresses that:

> Human rights, as part of international law, are rights that every human being possesses, irrespective of race, religion, political or *traditional* beliefs, legal status, economic status, language, color, national origin, gender, ethnicity, etc. In other words, human rights are accorded to every individual human being. They apply to all individuals and groups on the basis of equality and non-discrimination. Even if they are not always honored in fact (defacto), everyone is entitled (dejure) to enjoy benefits of human rights. A fundamental aspect of human rights is that they protect human dignity and integrity. They are based on generally accepted principles of equality and justice and, in this way, protect individuals and groups from elementary forms of injustice. Human rights belong to all and must never be regarded as a favor, gift, or privilege conferred by the state or by any organization or individual. Human rights place a particular emphasis on the protection of *minorities* as they are most likely to suffer from discrimination and deprivation. Examples include most women, and in particularly adolescent girls in developing countries; indigenous people; refugees; asylum seekers; minorities *(ethnic, religious and linguistic)*; migrant workers; and children [Emphasis added] (Asher, 2004:7).

Third, and lastly, there is a question of the *universality of minority rights*. There is growing consensus that the minority phenomenon is subject to change through continuing cultural, demographic, political and institutional influences (Dersso, 2010, Yacoub, 2010; Mbanaso & Korieh, 2010).

Minority rights are 'domestic' or 'local' because forces that led, are leading, and/or will lead to the formation of a 'minority' may vary from country to country, culture to

culture and group to group. They are also 'international' or 'global' because minorities are not only about individuals belonging to culturally defined groups, numerically inferior to the dominant group and/or groups (Udogu, 2001; 88). While they are different, they share something in common. By and large, minorities can be described as individuals or groups which are in marginal position (Marshall, 1997). Hence, similar to other individuals and groups, they deserve wider protection of their needs and rights (Udogu, 2001). Around the world, minorities experience violation of their basic human rights, prejudice, discrimination, marginalization and stigmatization (Udogu, 2001)[45]. This is true for the ethnic minorities as well as for sexual minorities (Donnelly, 1999b), and, I argue, for other social minorities.

— *Social Minorities*

It is goes without say that "minorities" are not inborn (Dersso, 2010; Mbanaso & Korieh 2010). They are a social construction (Grote, 2008; Turnsek et al, 2009). And thus they are deemed to transform (Yacoub, 2010). Therefore, identifying minorities solely and on the basis of some essentialist cultural, linguistic and ethnic criteria may exclude 'social minorities', particularly those who may be denied their basic human rights depending on certain social and cultural arrangements in the societies they live in. In addition, this kind of understanding is also more likely to exclude other vulnerable groups which may emerge in the future (Grote, 2008: 230), and who may be in need of special protection of their rights (Henrard, 2010).

Sandra Lovelace v Canada could be applied to elucidate the situation of a cultural or ethnic minority on one hand, and a social minority on the other hand[46]. Although gender and sex are used as grounds for differential treatment and may determine minority status, they are not mentioned in many reports on minorities. The case concerns Sandra Lovelace a Maliseet Indian woman who was born and raised in Tobique reserve in Canada. Later, Lovelace married to a non-Indian man and she automatically lost her

[45] See Joseph Yacoub commentaries on minorities in Iraq. Available at: http://www.chaldean.org/NewsInformation/OpinionEditorials/tabid/68/articleType/ArticleView/articleId/432/Iraqi-Chaldean-and-Professor-Joseph-Yacoub-Opines.aspx (Consulted 20/7/2012).

[46] UN Human Rights Committee, Communication No. 24/1977 *Sandra Lovelace v. Canada*. Available at:http://sim.law.uu.nl/SIM/CaseLaw/CCPRcase.nsf/f24e71b48a2b7174c1256835003ceaa3/ef725e6fa1021f30c125664b002c6e14?OpenDocument

Indian status and other rights that accompany it, such as rights to borrow funds from the band for housing, traditional hunting or fishing and other cultural benefits.

The Canadian *Indian Act*, Section 12 (1) stipulated clearly, that a woman who is married to a spouse who is not Indian is not entitled to be registered as Indian. This law is based on "patriarchal assumption that men are the heads of the family and the household and the legal status of women in the family is determined by the male spouse" (Smagadi, 2008: 338). This law did not equally apply to men who married a non-Indian spouse.

Lovelace submitted her application to the Human Right Committee claiming breach of Articles 2(1), 3, 23(1) and (4), 26 and 27 of ICCPR. In its decision, the Committee did not take into account the claim concerning differential treatment of the ground of sex because the marriage took place before ICCPR entered into force in Canada (Smagadi, 2008). The Committee also stated that, the Covenant does not guarantee rights to stay in the reserve[47], it rather establishes violation of article 27[48]. The Committee concluded that to prevent her recognition as belonging to the band is an unjustifiable denial of her rights under article 27 of the Covenant, read in the context of the other provisions referred to[49]. Although the Committee did not take into account how the Indian Act discriminate women based on gender and sex, Lovelace case manifests that gender and sex may be important aspects of a minority status.

Lovelace case and other related cases substantiate that, worldwide, cultural (national, ethnic, linguistic, religious) minorities, indigenous, sexual (Lesbians, gays and transgender), and 'other' minorities experience discrimination and violation of their fundamental human rights within social and institutional structures in the societies in which they live. Minorities have been historically expected or compelled to abide with the majority culture, values, lifestyle, norms and identity. Many societies around the world have been, and are still organized-based on dominant categories or on what Kymlicka and Norman called difference-blind rules and institutions (2005:4).

[47] *Sandra Lovelace v. Canada*, 14.

[48] *Sandra Lovelace v. Canada*, 13.2.

[49] *Sandra Lovelace v. Canada.,* 17.

It is acknowledged in the present study that a minority may constitutes certain inherent characteristics — different ones, but minorities may also emerge in a particular society due to certain social processes and practices that may impinge on access to their basic human rights.

As a result minorities are demonstrated to be disproportionate vulnerable to poverty, violence, extermination, death, health threats[50] and other social vulnerabilities. In the present study we espouse the position that, among other things, being a minority is characterized by *continuous social vulnerability*. However, this perspective does not suggest that any vulnerable group is a minority. As Henrard suggested, the mere continued existence of a vulnerable group in a particular society may also suffice to demarcating a "minority" (Henrard, 2010). There must be observable violation of fundamental human right, such as the right to health.

2. Instruments on Minorities and Health

While health is recognized as a basic human right, research indicate that minorities around the world face health risks, including HIV/AIDS due to stigma, taboo and power relations (Turyatunga, 2010), and have special health needs (ICASO, 2007) that are often lacking appropriated attention. In turn, the concept of health is itself contested as it is understood to have different meanings according to places and times.

2.1. The concept of Health

Balog (1978 *cited in* Boruchovitch & Mednick, 2002: 176) identified three major views on health; (a) traditional medical concept, (b) world health organization concept, and (c) ecological concept. In this study we will assess the traditional medical concept and World Health Organization concept and other recent developments on the concepts of health.

— Traditional medical concept

[50] Although sexual health is considered as a separate domain of health, and has been defined separate in literature, throughout this study terms 'health' and 'sexual health' are used interchangeably. Sexual health is viewed as an integral aspect of health.

The concept of health has been historically confined in the field of medicine and biology. Nordedfelt provided an in depth analysis of the biostatistical theory of health, that was proposed by a prominent American scholar in philosophy of health, named Christopher Boorse (Nordenfelt, 1993; Nordenfelt, 2004). Generally, Boorse subscribes to the conventional view of medical or biological view of health as *absence of diseases and illness*. The major assumption of Boorse's theory, which may also be a pitfall, is that health is associated with the normal functioning of the body. For instance, "A is completely healthy, if and only if A lacks all diseases, i.e. if and only if all his or her bodily or mental functions fall within normal interval" (Nordenfelt, 1993:278). Hence, health can be a subject of vigorous observation, measurement and control (Nordenfelt, 1993).

The aforementioned premise is criticized. Many scholars agree that health does not only entail absence of diseases (Callahan, 1973; Larson, 1996; Nordenfelt, 2004). Nordenfelt proposed his own theory of health. According to Nordenfelt health is a person's ability to realize his or her vital goals (1993:281; 2004: 210). Therefore, Nordenfelt is skeptical of the medical view of health. He believes that health is beyond biology and statistics. (Nordenfelt, 2004: 211). However, he does admit that diseases may affect health.

— World Health Organization Concept

According to the World Health Organization the term health is defined as "a state of complete, mental and social well-being and not merely the absence of disease or infirmary". It is important to note that development of WHO concept of health was associated with maintenance of peace and wellbeing of individuals and communities in the aftermath of World War II (Callahan, 1973). It was also meant to extend the western traditional medical view which emphasized the dichotomy between health and diseases. However, it transcends therefore, absence of diseases or infirmary, (Callahan, 1973; Nordenfelt, 2004) to include mental and social well-being.

Nevertheless, WHO definition of health has been criticized. First and foremost criticisms are directed towards word 'complete'. The argument being, it is virtually difficult for an individual to attain a complete state of health (Callahan, 1973). Second, the concept of 'well-being'; while the inclusion of the concept 'well-being' in the

definition of health has broadened the traditional disease oriented perspective, some scholars have demanded clarifications on the concept of 'social well-being' (Larson, 1996). It is not clear whether social well-being is about the societal context or status of an individual (Larson, 1996). Third, it places health in the hands of medical professionals (Larson, 1996). Last but not least, it has not taken into consideration the spiritual and emotional aspects of health (Larson, 1996), and presents health as an ideal state rather than a dynamic situation or process (Jimmy-Gama, 2009).

It is however evident that, despite criticisms, WHO's definition remains a conventional definition in health related literature. One of its strengths is the recognition that physical functioning of the body has social implications (Callahan, 1973). To put the same thing differently, health issues are broad based societal issues (Myers, 2006:24). This broad view of health is advanced by anthropologists and sociologists who study health. It is emphasized in social research that understandings of health should also be based on a particular social and cultural context in which health is defined (Nordenfelt, 1993: 276). As societies become diverse and multicultural (Yacoub, 2010), the one-dimensional medical perspective of health does not suffice to understand and address health needs and risks among different individuals, groups and communities (Quynh, 2006). Health problems are contextual (Myers, 2006:24). Hence, broad definition of health[51] is becoming more acceptable and desirable especially when health of minorities is concerned (Myers, 2006). Furthermore, a broad view of health takes into account social issues that relate with it such as violence, poverty and ethnic diversity (Myers, 2006:24). In the present study, health connotes overall 'wellbeing of people' (Quynh, 2006).

— Legal Tools

Various international human rights provisions stipulate and protect right to health. ICESCR[52] is an influential instrument that covers a wide range of health related

[51] According to the General Comment No. 4 of CRC the broad definition of health is relevant for embracing right to health, life, survival and development among children and adolescents.

[52] ICESCR was adopted and opened for signature and ratification by the General Assembly resolution 2200 A (XXI) of 16 December 1966 and entered into force 3 January 1976 as per article 27. See UN General Assembly, International Economic, social and Cultural Rights, Treaty series, Vol 993, available at www.refworld.org/docid/3ae6b36c0.html [consulted 12/3/2012].

provisions for different groups, such as women and girls, person with disabilities and 'minorities'. ICESCR was ratified in Tanzania on 11 Jun, 1976. However, to date, Tanzania has not signed the Optional Protocol to ICESCR which establishes individual complaint mechanisms for children.

2.2. International Covenant on Economic, Social and Cultural Rights and the Right to Health

Protection of both civil and political rights, and economic, social, and cultural rights of minorities is not only justifiable, but an overriding issue in contemporary international human rights discourse. While, the International Covenant on Economic, Social and Cultural Rights provides everyone the right to the enjoyment of the highest attainable standard of physical and mental health[53], and healthy development in adolescents.[54] General Comment No. 14 of ICESCR (United Nations, 2000) acts as a groundwork as it clarifies some of the crucial health issues relevant for children and adolescents[55]:

First, there are other rights that form an integral part of the Article 12 of ICESCR on right to health. In other words; realization of the right to health is dependent upon realization of other rights stipulated in the international Bill of rights such as right to education, life, access to information, and non-discrimination and equality.

Second, right to health comprises an array of socio-economic and cultural factors that "promote conditions in which people can lead a health life" and the "underlying determinants of health"[56].

Third, the right to health includes freedoms and entitlements. While "freedom include the right to control one's health and body, including sexual and reproductive freedom",

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[53] ICESCR, Article 12.

[54] ICESCR, Article 12 (2).

[55] See articles 22 and 24 of ICESCR General Comment No. 14 (United Nations, 2000).

[56] See articles 3 and 11 of ICESCR General Comment No. 14 (United Nations, 2000).

"entitlements include right to a system of health protection which provides equality of opportunity for people to enjoy the highest standard of health"[57].

Fourth, the right to health should be based on following characteristics, *availability, accessibility, acceptability and quality.* Accessibility, among other things, but very important, includes non-discrimination and access to information. Thus, minority health is equally important as that of majority.

As stated in article 12(b) of General Comment No. 14 (United Nations, 2000):

> Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, **in law and in fact**, without discrimination on any of the prohibited grounds and others...The right to seek, receive and impart information and ideas concerning health issues without impairing the right to have personal health data treated with confidentiality [Emphasis added].

Fifth, ICESCR gives state parties primary obligation in protecting right to health, including not to impose restrictions that contravene international human rights norm on right to health among certain individuals or groups[58], and to create an environment for other entities to refrain from the same.

Last but not least, and in addition to the above, General Comment No. 14 underlines that the international community, civil society or third sector, private business sector also individuals such as health professionals have responsibility and obligation in regard with respecting and realizing the right to health. For example, third sector institutions can work jointly with state parties in realizing obligations stipulated in article 43[59]. However, the primary responsibility rests on the state parties.

3. Gender, Sexuality and Minorities

Defining gender, sexuality and sexual behaviors in social sciences is a challenging task. There are diverse theoretical frameworks, which to some extent overlap, converge or

[57] See article 8 of ICESCR General Comment No. 14 (United Nations, 2000).

[58] See articles 28 and 29 of ICESCR General Comment No. 14 (United Nations, 2000).

[59] Article 43(a) urges state parties to "ensure the right of access to health facilities, goods and services on a non-discriminatory basis especially for vulnerable or marginalized groups".

oppose each other. According to Vance, the concepts of gender and sexuality interweave at many points, yet, they are distinct (1991). Gender may influence sexuality and sexual behaviors because gender encompasses social meanings of sex (Richardson, 2007). At the same time, not all differences in sexuality and sexual behaviors are determined by gender (Varga, 2003; Muhanguzi, 2011). Sex can act as a separate category (Trigueiros et al., 2001). Therefore, in order to acquire a holistic understanding of the theoretical issues pertaining to gender, sexuality and sexual behaviors, these concepts are analyzed separately.

3.1. The Concept of Gender

The concept of gender is amorphous. There is no common stance of its meaning even among feminists scholars (Wharton, 2005).

The naturalistic notions of gender have historically dominated gender studies. Women are understood as human female and men are human male (Mikolla, 2008). Biological determinism is the origin of the essentialist notions of gender. It employs anatomical, hormonal, physiological and other natural traits to describe all differences between male and female sex. It reiterates that differences between men and women are natural. According to this perspective, sex determines gender and sexual behaviors are natural (Mikolla, 2008). This view is questioned in contemporary social science scholarship.

The social constructionist notions of gender emerged as a criticism against biological determinism. There are various versions of social construction of gender. Although they all agree that, gender is not natural, it rather denotes men's and women's social identity, roles, position, and expected behaviors, based on culture and society, there is no shared definition of the concept gender among them (Jimmy-Gama, 2009; Mlangwa, 2009). It is widely agreed in contemporary social science scholarship that women are not a homogenous social category (Casqueira Cardoso, 2000: 230). Gender is interactional, but also institutional (West &Zimmerman, 1987; Wharton, 2005).

The interactional perspectives of gender was advanced by many scholars, but it was succinctly elucidated by Candace West and Don. H. Zimmerman in their concept of '*doing Gender'.* West and Zimmerman (1987) dispute theories that relegate gender to

biology differences and internal characteristics of individuals. They describe gender as an ongoing activity entrenched in daily social interaction:

> In social interaction throughout their lives, individuals learn what is expected, see what is expected, act and react in expected ways and thus simultaneously construct and maintain the gender order (Lorber, 1994; 102).

Similar to Judith Butler's notion of '*gender as a performance'* (Butler, 1999), West and Zimmerman describe gender as the product of social doing rather than a set of traits, a variable, or a role. According to this school of thought, gender is patterned in social relations and controlled in institutions (West & Zimmerman, 1987: 129). Acker (1992) espouses similar viewpoint.

Gender interactional enhances our understanding of the role of human agency in the construction, reproduction and maintenance of norms governing differences between women and men, boys and girls (West & Zimmerman, 1987; Yancey & Martin, 2004). However, the theory described gender influence in social interactions as if it is a "once and for all" phenomenon, and it separates social interactions and institutions. When discussing the relation between sexual behaviors and doing gender, and based on the work of West and Zimmerman, Christianson emphasizes that. while social relations are situated in the light of doing normative gender ideology, one needs also to understand how this relates to "being" a gendered person in society (2006:17)[60]. Similar, but also different viewpoint is followed by Risman and Yancey & Martin. According to these authors gender is not unidirectional. It's creation and maintenance is the outcome of cyclical relationship between agency and institutions (Yancey & Martin, 2004:1260) or structures (Risman, 2004:433). Risman makes a significant contribution in our understanding of gender as a dynamic category, which also operates within the context of society and institutions.

Many literature sources mention gender identity as a factor impacting on sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescents, particularly girls. However, there is evidence to substantiate that gendered meanings are neither inherent, universal, nor time-bound (Sanday & Goodenough, 1990; Vince, 1991; Parker

[60] See also Kimmel (2012).

& Aggleton, 1999; Undie & Benaya, 2006; Tamale, 2011). Furthermore, other social categories such as ethnicity, religion, race, age, class, economic status, and social status (Georgoudaki, 1991; Casqueira Cardoso, 2000; Trigueiros et al., 2001; Barrow, 2007) influence sexual behaviors related with health. In addition to that, gender is not only embedded in individuals and social relations, but also within institutions (Risman, 2004).

Therefore, gender as a concept is fluid and diverse (Kimmel, 2012)[61]. Worldwide, studies have documented individuals or groups of individuals who do not fit or have not been confined by meanings based on conventional gender ideology. As a result, these individuals or social groups are described to be disproportionate vulnerable to health threats such as HIV/AIDS (Brestrom, 2006). Therefore, in line with the fore mentioned arguments, gender should not be understood as a universal social category. Gender meanings and expectations vary, even in homogenous societies (Sanday & Goodenough, 1990; Casqueira Cardoso, 2000).

4. Sexuality and Sexual Behaviors

Sexuality is a broader concept. The theoretical debate has, and is, always centered on whether individual sexual behaviors are explained by natural or nurture.

Historically, similar to gender, sexuality and sexual behaviors are mainly anchored on determinist and essentialist notions (Bredstrom, 2006). Conceptualization of sexuality and sexual behaviors are derived from the body. Sexual risk behaviors are conceived to be uncontrollable and to have innate hormonal and physical roots (Stanford Journal of Encyclopedia, 2008). Biological determinism is an example of naturalistic models. Sexuality and sexual behaviors are described as natural, universal, inevitable and biologically determined. Sexual risk behaviors in adolescents are mainly considered to be hormonal driven (Stanford Journal of Encyclopedia, 2008). Arguably, one cannot totally refute essentialist view of adolescent sexual behavior. However, it is not

[61] For more details see: http://eprints.lse.ac.uk/41697/1/blogs.lse.ac.uk-Feminist_scholarship_has_shown_us_that_not_only_does_gender_matter_it_is_diverse_and_interacts_with_o.pdf

panacea. Therefore, just like masculine and feminine identities sexuality cannot be devoted from the wider social and cultural context (Silberschmidt & Rasch, 2001).

Carole Vance, in her article *Anthropology Rediscovers Sexuality* (1991), uses cultural influence model to challenge biological and universal notions of sexuality by documenting variations in sexuality. She acknowledges existence of variations in sexuality[62]. According to Vance, “Sexuality as a concept is not natural and universal. It has a wide history and its definition and meanings change overtime and within populations” [Emphasis added] (1991; 47). Decosas on the other hand, argued that, sexuality is already forming before one engages in sexual behaviors (2009). Culture assigns sexuality with meanings which impact women and girls’ ability to protect their health. Although cultural influence model is among theories that have detached understandings about sexuality from biology or nature, it did not escape criticisms. Cultural sexual meanings are neither universal nor immutable (Kambarami, 2006; Tamale, 2011).

Sexuality is a phenomenon beyond biology. It is a social and cultural construct. Sexuality encompasses social meanings of sexual behaviors and/or practices (Parker & Aggleton, 1999)[63]. In many societies especially in Africa, gender is recognized an important aspect of culture by various scholars (Vance, 1991; Haram; 2005a; Dilger, 2003; Undie & Benaya, 2006; Muparamoto & Chingwenya, 2009). However, there is intense debate among scholars on whether gender defines sexuality or vice versa, or whether they are two different things. Most of feminists believe that our sexuality is influenced by gender.

> Feminists view gender as a social identity and a set of norms that are supposed to guide behavior. We are not born men and women; we acquire these gender identities through a social process of learning and sometimes coercion. Feminists believe that our sexual behaviors are deeply imprinted by our gender status (Seidman, 2003).

While radical feminists are renowned to have enormous contribution on the inclusion of gender and sexuality in HIV/AIDS research, by challenging contentions that link sexual risk behaviors and lack of knowledge and information on how the HIV virus is

[62] Also See Tamale, 2011

[63]Social science has enormous contribution in understanding the concept of sexuality. Berger and Luckmann (1967) and Vance (1991) are some of prominent scholars in sexuality research. Accordingly, sexuality is understood as a social and cultural construction.

transmitted, and how individuals can protect themselves against HIV infection to the body and individual behaviors (Brestrom, 2006), their theoretical stance is also challenged by other feminist scholars. Gayle Rubin objects the view that sexuality is derived from gender (Rubin *cited in* Parker & Aggleton, 1999:146). She describes the role of societies and institutions in conceptualizing sexuality. In Rubin's views, societies define what is "normal and abnormal", "moral and immoral", "good and bad", "sinful and holy". While "normal", "acceptable" and "moral" sexual practices or behaviors are supported or promoted, "abnormal", "unacceptable", "immoral" and "bad" are stigmatized (Rubin *cited in* Parker & Aggleton, 1999). Other prominent scholars like Michel Foucault described construction of sexuality without payin g attention to gender differences. Foucault has an indispensable contribution on our understanding of sexuality as the produce of society and institutions apart from 'nature'. According to Foucault:

> Sexuality must not be described as a stubborn drive.....It appears rather as an especially dense transfer point for relations of power: between men and women, young people and old people, parents and offspring, teachers and students, priests and laity, an administration and a population (1998:103 *cited in* Van Den Berg, 2008a:101).

Furthermore, Rubin named examples of sexualities which may not fall under mainstream discourse of sexuality such as sexual minorities; gays, lesbians, and transgender. Other feminists such as Jane Holland argue that sexuality is influenced by ethnicity (Holland, 1993). Thus, there are always variations in terms of sexual behaviors and/or practices. Furthermore, different sources describe the relationship between sexuality and disability. There is evidence to indicate that sexuality of people with disability is not, solely, determined by gender but also physical status. In many societies there is a perception that people with disabilities are asexual. The misconception and stigma attached to sexuality of people with disability hinders their access to relevant health information and services, increase chances to engage in unprotected sexual practices and acts as an impediment to protecting themselves against health threats[64]. The trend may also apply to adolescent girls in some societies.

Therefore, sexuality has natural aspects, can be an outcome of individual behaviors or characteristics, but also the product of culture, institutions and society (Irvine, 1994). In,

[64] See for example http://www.who.int/disabilities/jc1632_policy_brief_disability_en.pdf.

that vein, it includes social meanings, taboos, moral codes, norms and expectations of sexual behaviors of individuals and groups in a particular society (WHO, 2006). However, neither one suggests a static and universal perspective of sexuality (Undie & Benaya, 2006). Even viewing sexuality as a social construct may not be a panacea as the situation of marginalized social groups is likely to be overlooked (Creswell, 2009). Arguably, sexuality is a very complex phenomenon (Ahlberg, 1994; Arnfred, 2004; Helle-Vale, 2004; Undie & Benaya, 2006; Doyle et al, 2012; Lie, 2008; Tamale, 2011). While it is different from gender, it is closely related to it (Silberschmidt, 2001). As argued in an International Council of AIDS Service Organizations report:

An individual's sexuality is defined by whom one has sex with, in what ways, why and under what circumstances and with what consequences. It is more than sexual behaviors; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors influence an individual's sexuality. In each society there is multitude of sexualities (ICASO, 2007).

4.1. Perspectives in Adolescence and Adolescents

Adolescence is generally understood as the period of life between childhood and adulthood. It is mainly associated with puberty and sexual maturation (Adegoke, 2012). However, today scholars interested in adolescence and adolescents agree that the transition from childhood to adulthood does not involve a single factor such as sexual maturity and puberty or menarche. It also involves cognitive, social, emotional, interpersonal and other physical changes (Adegoke, 2012). Furthermore, it is socially defined (Jimmy-Gama, 2009).

According to World Health Organization the period between 10 and 19 years is defined as adolescence. WHO conceptualization of adolescence is further regrouped into early adolescence which ranges between 10 and 14 years and 15 and 19 years as late adolescence (Dehne & Riedner, 2005; Muparamoto & Chingwenya, 2009). In literature there is overlap in describing adolescence. Terms such as 'adolescents' 'teenagers', 'youth', 'young people', 'young adults', 'children' and 'minor' are used interchangeably (Decosas, 2009). Other United Nations organizations describe youth as those between the ages of 15-24 for statistical purposes (Adegoke, 2012).

In many literature sources, the concept of adolescence is attached with age and puberty. During this period an individual is described to undergo through hormonal and biological changes that are associated with development of secondary sexual characteristics, which are presumed to be universal (Dehne & Riedner, 2001). These changes are often associated with sexual risk behaviors in adolescents. However, direct relationship between puberty hormones and sexual risk behaviors in adolescents is not clearly established in research. Wide variation in onset of puberty are documented worldwide (Gentry & Campbell, 2002; Dehne & Riedner, 2005; Adegoke, 2012). Hence, empirical evidence has challenged universality of the biology of adolescence. Adolescence, especially in African context, is a social construction (Dehne & Riedner, 2005). It is also a dynamic concept. As Jimmy-Gama elucidates:

> Therefore, in various ways and for various reasons, the concept of adolescence is fluid. Adolescence as a biological concept may be misleading due to the variations in the social responsibility and cultural construction in various contexts. Therefore, defining adolescence simply in terms of biological and chronological age is a theoretical and limits the potentials for understanding underlying processes associated with adolescence for the production of sexual risk-taking behaviors (Jimmy-Gama, 2009: 28).

Jimmy-Gama’s argument is substantial. It challenges conventional notions of adolescence as advanced by G. Stanley Hall and other scholars who perceive adolescence as the period characterized by “storm and stress”. Judith Bruce and Erica Chong presented a more elaborated concept of adolescence. Adolescents are understood as heterogeneous in terms of ethnicity or race, disability, socio-economic status, gender, marital status, age, sexual orientation, sexuality, disability and so on (Bruce & Chong, 2006; Decosas, 2009). Today, adolescents live in diverse and multicultural societies. While all adolescents may be vulnerable to health threats, factors leading to their vulnerability may be different among adolescents as sub groups (Bruce & Chong, 2006) and their health needs peculiar. The concept adolescence is therefore fluid and pliable (Jimmy-Gama, 2009). Its definition is influenced by biological, legal, institutional, social, and cultural factors (Dehne & Riedner, 2005; Jimmy-Gama, 2009).

Therefore, although WHO and other United Nations organizations define adolescents as those aged 10-19, for the purpose of this study, adolescents are defined as individuals between 15 and 18 years of age. This definition is adopted because of three reasons. First, individuals between the ages of 0 and 18 are recognized and protected as children

and are right bearers under the United Nation Convention on the Rights of the Child (CRC). CRC is enshrined with universally agreed standards and core principles on children protection. Therefore, adolescents are children in their second decade of life (UNICEF, 2005). Second, existing empricial evidence confirms that, a substantial number of adolescents, in developing countries and Africa including girls is more likely to become sexually active at least between 15 and 18 years old. Third, and most importantly, in Tanzania, probably in other East African countries as well, individuals between the ages of 0 and 18 are legally defined as children.

— Legal Tools

Several international human rights instruments and agreements which have been signed and ratified by the United Republic of Tanzania such as International Conference on Population and Development (ICPD) of 1994, The Fourth World Conference on Women UN 1995 Platform for Action and Beijing Declaration, Convention on the Elimination of all forms of Discrimination against Women (CEDAW), and The Convention on the Rights of the Child (CRC) which addresses
the rights related to health among children and adolescence. The Convention on the Rights of the Child is a primary instrument.

4.2. Convention on the Rights of the Child

The CRC is an important legal instrument that denounces all forms of discrimination against children[65]. CRC was ratified in Tanzania in 1991. The convention obligates State parties to protect and safeguard children economic, social, and cultural rights such as the right to health, access to health care services, including abolishing traditional practices prejudicial to the health of children[66] by taking appropriate measures, to the maximum extent of the available resources[67]. It is emphasized that, under all circumstances, the 'best interests of the child' shall prevail.

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[65] Article 2 (1) and (2), CRC.

[66] Article 24 CRC and article 39 of CRC General Comment No. 4 (United Nations, 2003).

[67] Article 4, CRC.

More clarifications about the rights of children and adolescents particularly to health are explained within the General Comments for CRC. Articles 28, 30 and 31 of CRC General Comment No. 4 (on Adolescent health and development in the context of the Convention on the Rights of the Child), recognize that adolescents are vulnerable to unintended pregnancies and STIs, including HIVAIDS. The General Comment acknowledges the relevance of traditions and taboos in influencing adolescents' vulnerability to aforementioned health concerns.Therefore, State parties are obliged to ensure provision of information essential for protecting adolescent health. As stated under Article 26 of the General Comment No. 4:

> Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of State parties to ensure that all adolescent boys and girls, both in school and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviours (United Nations, 2003).

Furthermore, it is emphasized in the CRC General Comment No. 4 that, provision of health information should be regardless of their marital status and whether their parents or guardians consent"[68].

On the other hand, State parties are required to develop measures aiming at: (a) "changing cultural views about adolescents' need for contraception and STD prevention and addressing cultural and other taboo surrounding adolescent sexuality"; (b) adopting "legislation to combat practices that either increase adolescents' risk of infection or contribute to the marginalisation of adolescents who are already infected with HIV"; and (c) taking "measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care" (United Nations, 2003[69]).

Furthermore, although CRC protects the rights of all adolescents, and it does not refer explicitly to girls as minorities, the convention acknowledges that some individual adolescents and sub-groups, including adolescent girls[70] are more vulnerable and their health is at greater risk.

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[68] Article 28, CRC General Comment no. 4 (United Nations, 2003)

[69] See Article 30, CRC General Comment no. 4 (United Nations, 2003).

[70] See Article 31, CRC General Comment no. 4 (United Nations, 2003).

Apart from the above, CRC establishes the Committee on the rights of the child which requires state parties to submit regular reports on the implementation of the stated rights. Records show that a total of 190 states have signed and ratified CRC. Although according to CRC children and adolescents are right bearers, efforts to enforce children's rights as stipulated in CRC were hampered by the fact that before 2014 CRC had no established mechanism of individual claims.

Currently, CRC has three optional protocols; the one that criminalises involvement of children in armed conflicts, and the other on sale of children, all forms of sexual exploitation of children and child pornography, and the third option protocol which allows individual children to submit complaints regarding specific violation of the rights stipulated under the Convention. The Optional Protocol to the CRC on a Communication procedure was approved by UN General Assembly on 19 December 2011 and opened for signature in 2012[71] and entered into force on 14 April 2014. As of late, there are a total of forty five (45) signatories and ten (10) State Parties to the Optional Protocol to the CRC on a Communication procedure[72].

5. Theoretical Considerations

Arguably, just like a methodology a theory cannot be false, but useful or less useful (De Vaus, 1996; Silverman, 2001). As Silverman posited:

> A theory is an interrelated set of constructs (or variables) formed into proposition, or hypotheses, that specify the relationship between variables (typically in terms of magnitude or direction). A theory might appear in a research study as an argument, a discussion, or a rationale, and helps to explain phenomena that occur in the world [Emphasis added] (Silverman, 2001:51).

5.1. Functionalism

There are two basic tenets of functionalism. One, functionalists believe that any society is formed by interconnected parts. Two, each part of the society performs important functions which contribute in maintaining order and stability, and ensure the survival of

[71] See for more http://www2.ohchr.org/english/bodies/crc/ [consulted 15/6/2013]

[72] See for more https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11-d&chapter=4&lang=en [Consulted on 05/5/2014]

that particular society as a whole or part of it (Kingsbury & Scanzoni, 1993; Andersen & Taylor, 2008). According to functionalist perspectives as advanced by Talcott Parson, institutions are very important (Procter, 1980) as they perform functions that are meant to meet the needs of the society. For example, the key function of family is to regulate sexual activity (Anderson & Taylor, 2008).

As Kingbury and Scanzori explained; "the essence, then of functionalism is "*actor's conformity*" to a set of pre-existing standards that promotes the greater good of the larger whole to which actor belongs" (1993:196). Therefore, in any society, social meanings, norms, moral codes and expectations have functions (Prideaux, 2002). And social actors strive to conform to norms and expectations notwithstanding consequences (Goulder, 1970 *cited in* Kingsbury & Scanzori, 2001). Any act of non-conformity to socially acceptable norms, roles and expectations is described as 'dysfunction' and 'deviant behavior' (Kingsbury & Scanzori, 2001). Deviance is perceived as a threat to order, stability, survival of institutions and society as a whole (Kingdbury & Scanzori, 2001).

Functionalism has been used in health related social research. The theory enables researchers to explain the relationship between wider social and cultural context of health related behaviors or outcomes among individuals and groups (Williams, 2003; Nyoni, 2008). In functionalist perspectives, health is defined as "the ability to function in one's normal social roles" (Bowling, 2002:21). In his study of HIV/AIDS among women in Zimbabwe, Chamunogwa Nyoni used functionalism as an overarching perspective, to investigate the socio-cultural factors and practices that obstruct women's quest to achieve behavior change and avoid HIV/AIDS. He found out that, in Zimbabwe, women's vulnerability and susceptibility to HIV/AIDS and inability to engage in safe sexual behaviors is influenced by power dynamics particularly gender roles and cultural practices such as patriarchy (Nyoni, 2008).

Functionalism is however criticized. First and foremost, for according primacy to the constraining nature of structure (institutions, social norms, meanings and moral codes) while overlooking agency, particularly the role of human agents in producing, reproducing and transforming the above mentioned structures. Second, for viewing social structures as static, and for describing societies as if they were totalities (Datta,

2009). Yet, functionalist perspective remain useful in enhancing our understanding of the social meanings about gender and adolescent sexuality relevant in Tanzanian society and institutions, and how they relate with health among adolescents, especially girls. However, the outlined limitations point out the need to adopt another social theory. The present study also espouses the view that, societies and institutions are dynamic, and there is reciprocal relationship between structure and agency (Giddens, 1984). Following that line of thinking, structuration theory is adopted.

5.2. Structuration Theory

Antony Giddens, in his book *Constitution of the Society* (1984) developed structuration theory as an attempt to provide a general framework for social analysis (Rose & Scheepers, 2001; Rose, 2003). In order to address epistemological and ontological discrepancies in social sciences, Giddens developed structuration theory as a framework which constitutes objective and subjective interpretation of social phenomena, and micro and macro perspectives (Gauntlett, 2002; Lamsal, 2012). Unlike functionalism, Giddens suggests an alternative view of human agency and structures as interdependent and recursive related, than divergent (Gidden, 1984, Gauntlett, 2002; Rose, 2003; Lamsal, 2012). Stucturation theory has been influential in fields related to study of organizations and systems. For example, the theory has been widely used in information and health system researches (Rose & Scheepers, 2001; Kouroubali, 2002; Rose, 2003).

Giddens's structuration theory is described to have enormous contribution in contemporary social thinking especially in relation to understandings about agency and institutions (Scott, 2008). There have been disagreements between two camps of theorists in social sciences. On one hand, there are those who espouse that, individuals and institutions may be constrained by the external environment, especially, the social and cultural forces and other higher level institutions such as state and world society (Meyer, 2008). On the other extreme, there are those who emphasize that, individuals and institutions can exercise a certain level of agency no matter how small it is (Rose, 1998) to transforming world around them. The existence of two ways of social thinking and in a continuum compelled researchers to take side until Giddens proposed structuration theory.

According to Giddens the domain of social science scholarship is neither about the experiences and conducts of an individual actor as advanced by interpretative sociology, nor existence of any form of societal totality as propounded by functionalists, but rather social practice ordered across time and space [Emphasis added](Giddens, 1984: 3).This view is clearly illustrated by Gauntlet; "Giddens's theory of structuration notes that social life is more than random individual acts, but it is not merely determined by social forces. To put it other way, it's not merely a mass of 'micro' level activity − but on the other hand you can't study it by only looking at 'macro' level explanations" (Gauntlett, 2002).[73]

Giddens posits that agency connotes power and purpose (Kourobari, 2002: 4). Putting it differently, Giddens believes in agency. Agency "refers not only to the intentions people have in doing things but also their capability of doing those things in the first place" [Emphasis added] (Giddens, 1984:9). Hence, agency is power. Power is therefore not a resource itself (Giddens, 1984; Turner, 1986), rather it is the "capability to make a difference or to influence pre-existing state of affairs or course of events" (Giddens, 1984:14). Put it other way, power includes using the resources available with an intention to act or intervene (Christianson, 2006:17). On the contrary, lack of capability to intervene and make a difference is powerlessness (Rose, 2003). By and large, agency is purpose. On the other hand, Giddens believes that human beings are purposeful or knowledgeable agents (Giddens, 1984). They act or do certain things and can explain, discuss, elaborate on these reasons, even lie about them. However, action has intentional and unintentional outcome. In this case, both decisions to intervene or not to intervene will influence a situation (Giddens, 1984; Christianson, 2006).

The central theoretical underpinning of Giddens's structuration theory is that there is recursive relationship between structure and agency (Giddens, 1984). Put it other way, Giddens does not perceive structure and agency as conflicting. Structure is defined as rules and resources which constitute structural properties of the system. These structures stipulate the rules, techniques, norms or procedures for guiding actions, and the resources, either authoritative or allocative (Giddens, 1984:25). Consequently, people use rules, norms and resources to mediate or guide institutionalized pattern of

[73] See: http://www.theory.org.uk/giddens2.htm

interaction (Turner, 1986), and in their continuous application, the rules and resources can be reaffirmed or changed by human agents (Kourobari, 2002; 3). Hence, structure is both, constraining as well as enabling, and that duality of structure is manifested when "rules and resources are drawn upon in the reproduction of social actions and are at the same time the means of system reproduction" (Giddens, 1984: 19). However, according to Giddens, these structural properties are not real. They can only be real when they are used to guide action or activity, or are retained mentally as remembered codes of conducts or rights to resources (Whittington, 2001). Therefore, structural properties are both medium and outcome of the practices they recursively organize. To put is differently, structures are created by human action and activities hence, they "do not have necessary dominion over human actors" (Whittington, 2001; 696).

It is also argued by Giddens that while human activities depend on power, purpose and 'knowledge ability' of an individual actor, to ensure action achieves intended and satisfactory outcome, agents engage in a continuous process involving sort of reflexive monitoring of own action or other people's action (Christianson, 2006). However, Giddens also suggests that purposive action is not independent from the context in terms of time and space (1984; 3). In other words, human action is not static or just one act, it is rather a process which results from routinized pattern of action (Giddens, 1984; 4).

It is not our intention to expound all concepts of the theory of structuration but to adopt the logic and reasoning behind it. Just like any other theory, Giddens's structuration theory has been criticized: for not clearly, stipulating, on how to employ the theory empirically; for mixing diverse theoretical perspectives and for ignoring micro-macro divide, which can also be its strength; and for being anti-positivist (Turner, 1986). However, in the present study, structuration theory remains a useful analytical framework or way of thinking in social analysis (Rose, 2003), and about the research problem. First, the theory enables researchers to approach a micro and macro phenomenon in institutions and organizations[74].

Notably, Giddens' way of thinking about approaching a social phenomenon does not feature in most of extant studies on influences of adolescent sexual risk behavior and health in Tanzania and East Africa at large. It is widely used in developed countries. In

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[74] See for more information: http://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Organizational%20Communication/Structurational_Theory/.

Africa, studies have— in most cases, used behavioral, psycho-social, and cognitive theories to interrogate factors related to the above mentioned phenomenon. In other studies scholars have used gender theory, symbolic interactionism, and sexual script theories to interrogate about perceptions and meanings related of adolescent sexual risk behaviors and health at interpersonal or interactional level (Maticka-Tyndale, 2012).

Second, it is argued that, institutions play an important role in social reproduction. On the whole, institutions are social actions. Put it other way, since there is dependency between action and institutions; action affect institutions and institutions affect action (Giddens, 1984; Kouroubali, 2002). Third, Structuration is a practice theory (Rose, 2003). It is assumed that, practice constitutes "activities that make and transform the world we live in" (Flohlich et al 2001: 776). In this aspect, through human activities and actions, social meanings related to gender and adolescent sexuality, and other established way of doing things, which relate to health among adolescent girls, can be produced, reproduced, ignored, or reproduced differently (Gauntlett, 2002). Hence, structuration theory facilitates an analysis of social practice and activities, and in so doing, informs critical thinking and reflection (Barley &Tolbert, 1997; Rose, 2001) which are important for social change.
Furthermore, the theory of structuration is a process-oriented theory. Thus, it allows interrogation of processes and practicess which may relate with health outcomes in certain individuals and groups. As Gareth William puts it, "there has been a lack of attention to the development of concepts which will help explain why individuals and groups, for instance adolescent girls, behave the way they do in the context of wider social structures ─ to link agency and structure [Emphasis added] (2003: 140).

Clark presented a well elaborated and comprehensive summary of key arguments of structuration theory (Clark, 1990 *cited in* Macome, 2002:57-58):

- The main substantive focus of social theory is not individual action and the experience of the individual actor (methodological individualism), nor the existence and requirements of some kind of societal totality (structural-functionalism and, to a certain extent, Marxism, but *social practice*. It is practice which lie at the root of the constitution of both individual and society;

- Social practices are accomplished by knowledgeable human agents with "causal powers" i.e. powers to make a difference. Human agents are neither cultural dopes nor simply the product of class forces. They have the capacity for self reflection in day-to-day interaction, a practical, often 'tacit' consciousness of what they are doing and an ability under certain circumstances to do it;

- However, the social practices are not random and purely voluntaristic, but ordered and stable across space and time, in short they are *routinized and recursive.* In producing social practices which make up the visible patterns which constitute society, actors draw upon 'structural properties' (rules and resources) which are themselves institutionalized features of the society.

- Structure is therefore activity-dependent. It is both the medium and outcome of structuration – the production and reproduction of practice across time and space. This process is what Giddens calls 'double hermeneutic' the double involvement of individual and institutions. Put perhaps more truistically, "we create society and at the same time we are created by it" (Giddens, 1984: 14).

6. Summary

This chapter dealt in reasonable details with the main concepts and theories underpinning the present study. While "minority" is a debatable concept and minorities are diverse individuals and/or groups, most minorities are in a vulnerable position compared to other individuals or groups in a particular society. Hence, being a minority is understood as continuous social vulnerability. The broad definition of health is adopted. Arguably, health is not mere absence of diseases. Health is also defined in a particular social and cultural context, and it relates to societal issues such as violence, poverty, ethnicity, gender, sexuality, and so on. While gender entails meanings associated with being male or female in a particular society which are embedded in individuals, interactions and institutions, sexuality entails what is sexual and meanings attached with it among individual or groups in a particular society. Similar to gender, sexuality is the produce of individuals, society and institutions. To fit the purpose of this study we adopt the legal definition of adolescents. Adolescents are understood as children in their first decade of life, and the focus is particularly on those between the age of 15 and 18.

The chapter also examines the international legal norms protecting rights of all adolescents, including girls— and in this case health. According to CRS, the primary international legal instrument for children rights, adolescents are right bearers and their best interest as children should be safeguarded. CRC and General Comment No. 4 obligate States and its institutions to protect adolescents' right to health, and to ensure that other actors do not violate them. These rights include removal **all barriers** hindering access of adolescents to information and preventive measures such as condoms and care.

Finally, the chapter presents relevant theories. Functionalism purports that societies are made of institutions and each institution perform certain functions for maintenance of

social order. Societies also have social meanings, norms, moral codes and expectations which function to constrain sexual behavior of its members for the sake of the same. Functionalism has been used to study social and cultural practices influencing behavior related with health outcomes among individuals and groups, for example women. While it remains a relevant theory in the present study, the theory is criticized for positioning society and institutions as static, constraining than enabling, and as if they were totalities. It hence ignores agency. Giddens's stucturation theory, on the other hand asserts that there is interdependence between structures and agency. Structuration theory is found to be useful in the present study as it provides analytical framework or way of thinking in social analysis (Rose, 2003), and about the research problem. It enables researchers to approach a micro and macro phenomenon in institutions and organizations. Further, it facilitates an analysis of social practice and activities, and in so doing, informs critical thinking and reflection (Barley &Tolbert, 1997; Rose, 2001) which are important for social change. Furthermore, it allows interrogation of social processes and practices which may relate with health outcomes in certain individuals and groups in a particular society— in this case adolescent girls.

CHAPTER THREE.
MAPPING ADOLESCENT SEXUALITY AND HEALTH IN TANZANIA

1. Introduction

According to statistics, information and scientific evidence on adolescent sexual behavior and health, many adolescents in East Africa, become sexually active before marriage (Doyle et al, 2012) and within marriages (Human Rights Watch, 2014). This trend is likely to be similar among adolescents in South Africa, and contrary to adolescents in West Africa, whereby a substantial proportion of them become sexual active within the context of marriage (Presler-Marshall & Jones, 2012). However, as documented in chapter 1 which situates the present study, a small proportion of adolescents are sexually active. Most importantly, as observed in chapter 1, adolescent girls become sexually active earlier compared to male counterparts, mostly between ages of 15 and 18, and are disproportionate vulnerable to unprotected sexual activity, unintended pregnancies, and HIV/AIDS transmission, and there is dearth of empirical evidence to explain why these trends occur (Weiss et al, 2000: 234).

Following that backdrop, this chapter reviews extant literature in Tanzania but not exclusive, to map adolescent sexuality and health. The chapter examines the underlying factors related to sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescents, especially girls. The chapter also assesses the social meanings denoting what is considered acceptable and/or unacceptable gender identity and sexuality among adolescents, specifically girls in Tanzanian society, and within the context of key institution law (including policies), and describe their impact on health. Last but not least, the chapter provides an overview of other key stakeholders in adolescent health, especially civil society organizations, in terms of what they do to address pertinent health threats among adolescents, and the related perspectives. This overview provides the basis for the empirical study.

1.1. Factors Influencing Health among Adolescents

Multiple complex factors are documented to influence sexual behaviors associated with health threats such as unintended pregnancies and HIV/AIDS among adolescents, particularly girls.

i. Individual Factors

In this body of literature, many scholars are of the view that sexual risk behaviors and health threats among adolescents are influenced, primarily, by factors at the level of individual adolescents rather than factors outside them (Mmari & Blum, 2009). This perspective draws from biological make up of the body, and is advanced mainly by psychologists and behavourists. Accordingly, a wide range of behavioral, psychosocial and cognitive explanations (Lugoe, et al, 1996; Matasha et al, 1998;; Maswanya et al, 1999; Campbell, 2003; Obasi et al, 2006; Masatu et al, 2009; Exavery et al, 2011; Katikiro & Njau, 2012) are put forward to explain why adolescents engage in sexual behaviors which predispose them to unintended pregnancies and HIV/AIDS. Few of them are expounded as will be demonstrated in the following sessions.

— *Physiological Characteristics*

Adolescent are considered to be more likely to engage in types of sexual risk behavior (WHO, 2006) due to physical characteristics related with puberty (Kotchick et al, 2001). Puberty is described to mark the beginning of sexual activity, and may be accompanied by risk of becoming pregnant and contracting sexually transmitted diseases including HIV/AIDS (Zabin & Kiragu, 1998). Many adolescents may not use protective mechanisms such as condoms (Neema & Musisi, 2004).

In Tanzania studies have documented that adolescents engage in sexual risk behavior due to curiosity, sexual experimentation, also, fun and pleasure (Nnko et al, 2001; Plummer et al, 2006; Wight et al, 2006; Van Den Berg, 2008a; Zakayo & Lwelemira, 2011). An adolescent boy in the study conducted by Zakayo & Lwelemira describes,

"we do sex for fun and to fulfill our body desire of doing sex" (2011: 378). In another study girls reported to engage in sex for the sake of love (Nnko & Pool, 1997).
Apart from puberty, having immature physical development is associated with health threats among girls. During adolescence, girls are described to have immature reproductive organs which cannot resist sexually transmitted diseases including HIV/AIDS, nurture the fetus, and/or give birth to a baby (Bedsoe & Cohen, 1993; Zabin & Kiragu, 1998; Bearinger et al, 2007; Leshabari et al, 2008; Dixon-Mueller, 2008). It is observed that, physiological maturation is not described to be such detrimental among adult women (Bearinger et al, 2007; Dixon-Mueller, 2008). While, there is sufficient evidence to associate physical characteristics and health threats among adolescents (WHO, 2006), arguably, physiological characteristics *per se* may not suffice to explain girls' disproportionate vulnerability sexual health threats.

— Perception of risks or perceived vulnerability

Perception of risk or perceived vulnerability is described to influence health among adolescents. It is assumed that, the higher the perceived risk to getting pregnancy and contracting HIV/AIDS, the higher the individual's willingness to adopt health protecting sexual behaviors, and *vice versa* is also true (Kotchick et al, 2001; Akwara et al, 2003; Eaton et al, 2003). A recent study found that, adolescents who perceive HIV as a serious and deadly disease are more likely to use condoms compared to those who do not consider themselves to be at risk (Katikiro & Njau 2012:6). Similar results were documented in previous studies (Lugoe, 1996; Maswanya et al, 1999). In general, there is consensus that, majority of adolescents do not perceive themselves to be at risk of pregnancies and HIV/AIDS (Silberschmidt & Rasch, 2001; Van den Berg, 2008a). While perception of risks or perceived vulnerability remain important, there is evidence to reveal that high perception of risk may not necessary translated into avoidance of sexual risk behavior and practice of health protective behaviors such as condom use, among adolescents, especially girls. Perception of risk or perceived vulnerability is also dependent of the broader social context (Awara et al, 2003; Eaton et al, 2003; Dilger, 2003; Haram, 2005b; Harrison, 2008; Leshabari et al, 2008). Thus it may not suffice to account for girls' disproportionate vulnerability to sexual health threats.

— Knowledge and Information

According to biomedical approaches lack of knowledge and information about sexual risk behaviors, unintended pregnancies, and HIV/AIDS, and how they can be prevented is described to impact on health among adolescents (Lugoe et al, 1996; Leshabari & Kaaya, 1997; Matasha et al, 1998, Maswanya et al, 1999; Rasch et al, 2000; Kapiga & Lugalla, 2002; Wight et al, 2006; Wight et al, 2012; Njau et al, 2013). Since several decades ago, research demonstrate lack of information about consequences of unprotected sex as an important factor contributing to health threats among adolescents and youth (10-24) (Leshabari & Kaaya, 1997). On the contrary, access to knowledge and information about pregnancies and HIV/AIDS is associated with adoption of health protection measures and behavior change at the level of an individual adolescent (Chikovore et al, 2009; 2010).

Accordingly, several initiatives and interventions targeting to impart knowledge and information about sexual risk behaviors, unintended pregnancies, HIV/AIDS, and how to avoid them among various segments of the population, including adolescents, especially those beyond 14 years old, have been implemented (TDHS, 2011; THMIS, 2013; Njau et al, 2013). Research affirm that while decrease in HIV prevalence rate, increase in uptake of contraceptives, and high level in knowledge and information among different segments of the population have been achieved. Yet, explicit change in behavior, especially among adolescents, is hardly documented (Obassi et al, 2006). Apparently, low and/or non condom use, fragmented knowledge and information, and misconceptions about unintended pregnancies and HIV/AIDS remain widespread among adolescents, especially girls (Nnko & Pool, 1997; Silberschmidt & Rasch, 2001; Wight et al, 2006; Wight et al, 2012).

In a recent study sexually active adolescents reported not to believe that condom offer 100% protection against HIV (Katikiro & Njau, 2012). Furthermore, both adolescent boys and girls admitted that they feel shy and afraid to buy or ask for condoms in public places (Exavery et al, 2011; Katikiro & Njau, 2012). In Wight *et al*. condom use is reported to be perceived by adolescents as “eating a sweet in the wrapper” (2012:6)[75].

[75] Similar perceptions are documented in a study among adult population in rural areas. Condom use is perceived as ‘farming with a hoe in a sack’ (Plummer et al, 2004).

Some girls reported to be told by their male sexual partners that sperm entering the vagina is good for health and should not be wasted (Siberschmidt & Rasch, 2001: 124). In addition, girls are reported to perceive themselves to be too young to conceive (Siberschmidt & Rasch, 2001: 124).

Apart from the above, other findings suggest that girls are aware that unprotected sexual activity is likely to lead to pregnancy. However, they exhibited hopelessness and powerlessness. As one secondary school girl in Dar es Salaam said "you know very well that you can become pregnant. What we are doing is praying to god so that he helps us. But every girl knows that she may become pregnant — every time she is doing this act" (Dilger, 2003:35). By and large, in this area of research, some questions remain unanswered. First, why is it that level in knowledge and information about how to avoid sexual risk behaviors, unintended pregnancies, and HIV/AIDS remain fragmented among adolescents, especially girls? Second, even when girls have appropriate knowledge and information, why is it that it may not necessarily translate into avoidance of sexual risk behaviors and practice of health protective sexual behaviors? (Chikovore et al, 2013). Arguably, while having comprehensive knowledge and information about prevention of sexual risk behaviors, unintended pregnancies, and HIV/AIDS is necessary (Monarch & Mahy, 2006), it may not provide sufficient explanation for girls' disproportionate vulnerability to sexual health threats. Access to health related knowledge and information at the level of an individual girl may also be determined by the broader social context (MacPhail 1998; Roberts et al, 2005; Chikovore et al, 2009; Chikovore et al, 2010).

— Life Skills

Adolescents are considered to be vulnerable to sexual risk behaviors and related health threats due to lack of life skills (Magnani et al, 2005; Chikovore et al, 2013). By contrast, having life skills such as, such as assertiveness, negotiation, decision making and communication skills is considered important for enabling adolescents, including girls, to resist peer pressure to engage in early sexual activity and to insist on condom use for protecting their health when sexually active (Monarch & Mahy, 2006; Neema et al, 2006; Biddlecom et al, 2007a).

Studies reveal that adolescent girls, who perceived that they cannot convince their partners to use condoms, are more likely to engage in unprotected sexual activity (Katikiro & Njau, 2012:6). By contrast, adolescent girls who were able to discuss condom use before sex are less likely to engage in unprotected sexual activity (Katikiro & Njau, 2012:5). In addition, girls reported to engage in unprotected sex because their partners demanded (Katikiro & Njau, 2012:4) Furthermore, those who reported to feeling shy to buy condoms were less likely to use condoms than those who did not feel shy (Katikiro & Njau, 2012:5). Arguably, life skills development can enable adolescents to protect themselves against sexual risk behaviors and related health threats. However, findings from a South African study show that the impact of life skills on knowledge and behavior was generally modest. But larger and somewhat consistent among males than females, especially in relation to condom use during first and last sex (Magnani et al, 2005:297). Furthermore, results from a Zimbabwean study entitled *How can I Gain Skills if I don't practice?* suggest that, having life skills is one thing, and practicing or using life skills is another thing, especially among girls (Chikovore et al, 2013). Many adolescent girls may not be capable of initiating discussion about sex with their partners, negotiate condom use, and make decisions about sex due to the influence of the broader social context than lack of life skills (Chikovore et al, 2004; Haram, 2005a; 2005b; Wellings et al, 2006; Chikovore et al, 2013) *per se*. Hence, lack of life skills does not offer a sufficient explaination for girls' vulnerability to sexual health threats.

— Sexual Behaviors

Sexual behavior of adolescents is a significant concern in research. It is regarded as an important determinant of health threats such as unintended pregnancies and HIV/AIDS (Kotchick et al, 2001; Eaton et al, 2003; Neema & Musisi, 2004). Consequently, sizeable amount of studies have attempted to document types of sexual behaviors related with health threats. Being sexual activity early, engaging in unprotected sex, and having multiple sexual partners are identified as some of the sexual behaviors which impede on health among adolescents (Kazaura & Masatu, 2009; Masatu et al, 2009; Exavery et al, 2011; Mmbaga et al, 2012; Katikiro & Njau, 2012).

Among girls, early sexual activity is an issue of significant concern (NCAPD, 2010; Golbasi & Kelleci, 2010). The understanding behind that concern is that girls who

initiate sex early are more likely to have multiple sexual partners during lifetime. Related to that, prolonged exposure to sexual activity is closely associated with unprotected sex and exposure to unintended pregnancy and HIV/AIDS (Rasch et al, 2000; Silberschmidt & Rasch, 2001; Neema & Musisi, 2004; Ringheim & Gribble, 2010; TMHIS, 2013).

Accordingly, unprotected sex or non-use of condom is another issue of concern (Leshabari & Kaaya, 1997; Leshabari et al, 2008). It is directly related to both unintended pregnancy and HIV/AIDS (Schaalma & Kaaya, 2008; Leshabari et al, 2008). Despite of the fact that sexual behavior is cited as a key determinant of one's vulnerability to health threats, evidence is mounting to show that even among adolescents, sexual behavior *per se,* may not be a significant problem (WHO, 2006; Barrow, 2007). This is due to the fact that, individual's sexual behaviors cannot be divorced from the broader social context within which they occur (MacPhail & Campbell, 2001; Campbell & Macphail, 2002; Eaton et al, 2003; Campbell, 2003; Roberts et al, 2005; Marston & Eleanor, 2006; Schoveller et al, 2005; Golbasi & Kelleci, 2011; Erickson et al, 2010). It is possible to argue here that, while documenting types sexual behaviors related with health threats is important, it may not suffice to explain adolescent girls' vulnerability to sexual health threats because sexual behaviors of an individual girl do not happen in a vacuum (MacPhail, 1998). The broader social context of sexual behavior is also important (MacPhail, 1998; Barrow, 2007).

ii. Factors beyond Individuals

Consensus has emerged in extant literature to indicate that, factors beyond an individual (Courtenay, 2000; Sa & Larsen, 2008; Gupta et al, 2008), in this case beyond an individual adolescent, influence sexual risk behaviors and health (Toroitich-Ruto, 1997; Wood & Jewkes, 1997; Wood et al, 1998; Rivers & Aggleton, 1999; Gupta, 2000; Weiss et al, 2000; Ahlberg et al, 2001; Lerclerc-Madlala, 2002; Dilger, 2003; Eaton et al, 2003; Dowsett, 2003; Haram, 2005a; 2005b; WHO, 2006; Wight et al, 2006; Wellings et al, 2006; Mabala, 2006; Klepp et al, 2008; Van den Bergh, 2008a; 2008b; Leshabari et al, 2008; Bangser, 2010; Underwood et al, 2011; Wight et al, 2012).

— Peer Pressure

Worldwide and in Tanzania, peers pressure and peer norms are proved to have strong influence on sexual risk behaviors among adolescents (Lugoe et al, 1996; Nnko & Pool, 1997; Marston & King, 2006; Mabala & Cooksey, 2008; Zakayo & Lwelamira 2011). Peer pressure friends to engage in sex. Adolescents who are not sexually active are likely to be ridiculed by sexually active peers (Zakayo & Lwelamira, 2011: 378), and called names such as *'mshamba'* (hick) (Mabala & Cooksey, 2008: 30). However, while peer norms are shown to have strong influence on sexual behavior among adolescents, a study in USA documented that the influence is not necessarily similar among adolescents as a diverse group. Peer influence was found to be stronger among younger adolescents than older adolescents[76], and among non-white adolescents than white adolescents (Gargner & Steinberg, 2005: 634). In South Africa peer pressure is shown to have stronger impact on sexual behavior of adolescent boys than girls (MacPhail & Campbell, 2000). Similar findings are observed in Tanzania (Van Den Berg, 2008b). On the contrary, studies have also indicated that peers have positive influence on sexual behavior among adolescents (Eaton et al, 2003). Thus, peer pressure *per se* does not suffice to explain adolescent girls' vulnerability to sexual health threats.

— Poverty and Economic Importance of Sex

In this body of literature, poverty is closely associated with sexual risk behaviors and health threats among adolescents, especially girls. According to findings from national health survey, poor girls are less likely to use condoms compared to girls from wealth household (TDHS, 2011; THMIS, 2013). Above findings resonate with results in other various studies in Tanzania whereby girls mentioned financial gain for engaging in sexual intercourse, especially with older men, due to lack of basic needs in their families (Nnko & Pool, 1997; Van Haren, 1999; Rasch et al, 2000; Wight et al, 2006; Mabala, 2006; Klepp et al, 2008; Mabala & Cooksey, 2008; Wamoyi et al., 2010; Wamoyi et al, 2011; Bangster, 2010; Zakayo & Lwelamira, 2011; McClearly-Sills et al, 2013). It is observed that girls who engage in sexual activity for pecuniary reasons become in a disempowered position which limit their ability to protect their health as sexual

[76] See Dixon-Mueller (2008) for more information on cognitive maturation among older adolescents.

decisions including condom use are dictated by male sexual partners (McClearly-Sills et al, 2013: 99)[77].

On the other hand, there are studies which have challenged the poverty-sexual risk behavior thesis. Accordingly, these findings make the relationship between poverty and sexual risk behavior complex (Whiteside, 2002; Djamba & Kimamu, 2008), and inconclusive (Gillepsie et al, 2007). Studies in South Africa and Tanzania demonstrated that some girls may have basic livelihood, yet, they receive money or gifts from sexual partners (Leclerc-Madlala, 2002; Silberschmidt & Rasch, 2001; Wight et al, 2012). In most cultures in Africa exchange of money in sexual relation may be a symbolic practice and a normal aspect of romantic relations (Nnko et al, 2001; Leclerc-Madlala, 2002; Wight et al, 2006; Moore et al, 2007a; Van den Berg, 2008a; Wamoyi et al, 2010; 2011). In addition there is evidence to suggest that, exchange of money and gift in sexual relations is not necessarily disempowering among girls. Its association with non-condom use during last sex is not clearly established (Moore et al, 2007a).

Arguably, while poverty and economic importance has significant influence on sexual risk behaviors related with health among adolescents, especially girls (Ragnarsson et al, 2008:740), it is not necessarily a panacea. As Djamba and Kimuna asserted, “the thesis that poor is more *sexual risky* cannot be generalized to all societies” [Emphasis added] (Djamba & Kimuna, 2008: 15). The authors argued that, in social science, poverty is described to determine sexual behaviors when such behaviors seem to deviate from the mainstream culture (Djamba & Kimuna, 2008: 3). Further, poverty alone does not suffice to describe sexual risk behaviors and health threats among adolescents. Other social and cultural factors such as ethnicity and religion are found to have strong influence on sexual risk behaviors and health among adolescents (Madise et al, 2007: Harrison, 2008; Ericksson et al, 2010). Further still, considerable proportion of adolescents especially girls, may be subjected to sexual exploitation and abuse (Silberschmidt & Rasch, 2001; NCAPD, 2010), and power relations associated with age and gender (Mabala, 2006). As Mabala pointed out, “poverty needs to be unpacked and linked with other factors” (Mabala, 2006: 410).

[77] See also Mabala & Cooksey (2008); Van den Berg (2008b) and Bangster (2010).

— Coerced or Forced Sex

The touchstone in literature on coerced or forced sex is that, sexual behavior among adolescent girls is not necessarily volition (Wood & Jewkes, 1997; Wood et al, 1998; MacPhail & Campbell, 2001; Mabala & Cooksey, 2008). According to several reports, coerced or forced sex is likely to be the driving force of unintended pregnancies and HIV/AIDS among adolescent girls because there is limited chance to negotiate condom use (Biddlecom et al, 2007a; Moore et al, 2007b; Katikiro & Njau, 2012).

In Tanzania, girls who were interviewed in a study conducted by Silberschmidt and Rasch (2001) admitted that their first sexual experienced was coerced or forced. Kazaura and Masatu documented also that, out of 885 sexually active adolescents, 141 (15%) engaged in sexual intercourse unwillingly (2009). In Madeni *et al.*, 52.2% of girls reported that sexual experience was by force (2011: 7). Coerced or forced sex is described to be experienced by girls through various ways, but mainly, verbal insistence, unwanted sexual comments or advances and pestering (Mabala, 2008; Mabala & Cooksey, 2008; Madeni et al, 2011; McClearly-Sills et al 2013)[78]. Further, girls reported to experience a series of propositions and unwanted sexual advances from men they meet in streets, shops, at school and in every day life (Mabala & Cooksey, 2008; McClealry et al, 2013). What is striking from findings established in scientific studies is that, proposing a girl may be considered normal, and any outright rejection by girls may lead to a more serious form of coerced sex, and even to rape (Mabala, 2008)[79]. As a 15-17 year old girl who took part in participatory learning and action study conducted by McClealry-Sills *et al.* describes, “If a boy wants you for sex, he will get you no matter how many times you say no to him and try to avoid him every time you

[78] A recent nationwide report on violence against children in Tanzania reveals shocking statistics. Sexual violence is revealed to be a serious problem among children in Tanzania which needs immediate attention. Nearly 3 out of 10 female aged (13 and 24) has experiences sexual violence before turning 18. 13.4% of males of the same age group experienced sexual violence before 18 years. According to report the common form of sexual violence include sexual touching, followed by attempted sexual intercourse. Among those who had their first sexual experience before 18, nearly one-third (29.1%) of females reported that their first sexual experience was forced and 17.5% of boys reported that their first sexual experience was unwilling, meaning use of force or coercion was involved. What is striking about child abuse in Tanzania, the acts are committed by close relatives for example parent, uncles, cousins, to mention a few (URT, 2011).

[79] Similar findings relating to series of unwanted sexual advances were reported by girls themselves in an EU-Funded Adolescent Reproductive Health Network (ARHNe) study implemented in Arusha Tanzania in 1997 (Lie, 2008: 90).

see him coming near. It doesn't matter if you don't want him, it matters that he wants you" (2013: 102). It is acknowledged in research that, despite of the fact that early sexual activity is not necessarily volition, sexually active girls are blamed for 'misbehaving', while male perpetrators of coerced or forced sex walk free and blameless (Mabala, 2008; Mabala & Cooksey, 2008; Exavery et al, 2011; McClearly et al, 2013).

It should also be noted that, while, findings reveal that a significant number of girls are subjected to coerced or forced sex caution must be exercised when interpreting empirical data on coerced or forced sex. According to Neema *et al.* data showing high prevalence of coerced or forced sex may be influenced by the wider social context. Girls may describe their first sexual experience involuntary to avoid a sense of agency (Neema et al, 2006). On the other hand, research has documented that, in societies where adolescent girls' sexuality is not acknowledged, coerced or forced sex is likely to be unreported due to girls' fear of punishment and shame (Mensch et al, 1998; Neema et al, 2006)[80]. Therefore, coerced or forced sex *per se* may not explain girls' disproportionate vulnerability to sexual health threats.

— Gender

Societies have established and attached different meanings to feminine and masculine identity. In many societies while masculine identity is associated with dominance, aggressiveness and control over women and girls, feminine identity is expected to be subservient and passive (Rivers & Aggleton, 1999; Weiss, 2000; Gupta, 2000; Turmen, 2003; Mlangwa, 2009). Apparently, research suggest that these collective ideologies may have far reaching repercussions on health among adolescents. They tend to create unequal power relations which impact on a range of issues among adolescents, especially girls, including when to become sexually active, with whom, for what outcome and condom use (Ahlberg, 1994; MacPhail, 1998; Van Haren, 1999; Parker,

[80] These scholars as well as others suggest that accuracy in data on sexual abuse among adolescent girls may be hampered by girls' inability to differentiate between consensual and forced sexual activity. It should be noted that in some societies delaying tactic in conceding to sexual advances from boys or men may be considered as 'appropriate' feminine sexual behaviour. This makes demarcation difficult especially by researchers who may ask questions related to forced or coerced sex without being adequately aware of normative aspects and expectations of sexual relations in the societies they study (Nnko & Pool, 1997; Neema et al, 2006).

1999; Rivers & Aggleton, 1999; Gupta, 2000; MacPhail & Campbell, 2001; Dilger, 2003; Varga, 2003; Turmen, 2003; Allen, 2003; Airhibenbuwa & Webster, 2004; Haram, 2005a; Haram, 2005b; Harrison, 2008; Decosas, 2009).

In Tanzania there is small but emerging body of research documenting collective views of gender and their implications on health among adolescents (Van Haren, 1999; Silberschmidt & Rasch, 2001; Dilger, 2003; Haram, 2005a; Haram, 2005b; Wight et al, 2006; Van Den Berg, 2008a; McClealry et al, 2013). In most cases, extant literature highlights gender differences in knowledge, attitude and reported sexual behaviors between adolescent girls and boys (Lugoe et al, 1996; Masatu et al, 2009; Kazaura & Masatu, 2009; Njau et al, 2013) or in sexual relations involving adolescents (Nnko & Pool, 1997; Mziray, *cited in* Rwebangira & Liljestrom, 1998).

According to Liv Haram, who studied how adolescents in Meru society manage premarital sexual affairs, ideas about what is considered ‘proper’ female and male sexual behaviors have strong influence on sexual behavior of adolescents (Haram, 2005a). However, in many societies in Tanzania, sexuality of girls is much more restricted than that of boys. By and large, sexual activity among girls is perceived as unacceptable, illicit (Van Haren, 1999; Silberschmidt & Rasch, 2001; Van Den Berg, 2008b; Wight et al, 2012), and is interpreted as behaving immorally (Wight et al, 2006) or misbehaving (Mabala, 2006; Mabala, 2008; Mabala & Cooksey, 2008; Van Den Berg, 2008b; Wight et al, 2012). Sexually active adolescent girls, especially unmarried ones can be labeled ‘loose’ or ‘prostitute’ (Lugoe et al, 1996; Van Haren, 1999; Mabala & Cooksey, 2008). Accordingly, adolescent girls are generally expected to observe chastity and abstain from sex until they are adults, finish school, preferably, until they are married (Tumbo-Masabo, 1994; McClealry-Sills et al, 2013).

While being sexually inexperienced, ignorant about sex, and submissive in sexual relationships are considered salient features of ‘proper’ feminine identity, sexual experience among adolescent boys is condoned, and being knowledgeable about sex is perceived to constitutes a normal masculine identity (Van Haren, 1999; Haram, 2005a; Haram, 2005b; Leshabari et al, 2008; Wight et al, 2012). Consequently, boys have more sexual freedom than girls to indulge in sexual activity. Being sexually experienced is reported to enhance boys’ respect and reputation, and overall sense of manhood (Nnko

& Pool, 1997; Mziray, *cited in* Rwebangira & Liljestrom, 1998; Van Haren, 1999; Dilger, 2003; Haram, 2005b; 2005b; Mabala, 2006; Wight et al, 2006; Mabala, 2008; Mabala & Cooksey, 2008)[81].

In most societies it is boys who initiate sexual encounters (Van Haren, 1999; Mane & Aggleton, 2001; Ahlberg et al, 2001; MacPhail & Campbell, 2001; MacPhail, 2003a; Dilger, 2003, Chikovore et al, 2004; Haram, 2005a; 2005b; Roberts et al, 2005; Marston & King, 2006; Chikovore et al, 2009; Chikovore et al, 2010; Rassjo et al, 2010; McClearly-Sills et al, 2013). It is illustrated in extant literature in East Africa particularly in Tanzania, that, in some instances, in order to make girls consent to sexual advances, some boys resort to use force, pressure and intimidation (Bujra, 2000; Maticka-Tyndale et al, 2005; Izugbara & Undie, 2008). This can also involve extreme form of sexual violence, rape, especially if a girl refuses to agree to have sex (Nnko & Pool, 1997; Mabala & Cooksey, 2008; McClearly-Sills et al, 2013).

While there is well documented scientific evidence to indicate that gender ideologies influence sexual risk behaviors, and health particularly among girls, there is no evidence to substantiate that, gender is inherent, universal, or time-bound (Sanday & Goodenough, 1990; Vince, 1991; Van Haren, 1999; Parker & Aggleton, 1999; Undie & Benaya, 2006; Parker 2009; Tamale, 2011). Gender may not be the only factor influencing health threats among adolescents, especially girls. Other factors such as age (Van Haren, 1999; Mabala, 2006), most importantly sexuality (Vance, 1991; Rivers & Aggleton, 1999; Allen, 2003; Wellings et al, 2006; WHO, 2006; ICASO, 2007; Decosas, 2009) are also relevant. Similarly, the relationship between collective ideas about ‘proper’ masculine and feminine identity and sexual risk behaviors related with health among adolescents, particularly girls, may not be a panacea.

— Adolescent Sexuality

[81] Similar findings were documented among adolescents in many other societies in East Africa and Southern Africa as well (Wood et al, 1998; Ahlberg et al, 2001; Awara et al, 2003; Eaton et al, 2003; Varga, 2003; Reddy & Dunne, 2007; Harrison, 2008; Jimmy-Gama, 2009; Izugbara et al, 2011; Chikovore et al, 2013).

Just like gender, social meanings attached to what is considered ‘appropriate’ sexual behaviors among adolescents in a particular society influence health (Rivers & Aggleton, 1999; WHO, 2006; Wellings et al, 2006). According to research, in ‘traditional’ societies in Tanzania sexuality was understood to have positive and negative effects (Fuglesang, 1997). For example through fertility clans and kinships were formed and become unified (Fuglesang, 1997). At the same time, sex was understood as a source of tension and diseases (Tumbo-Masabo, 1994; Fuglesang, 1997). Therefore, in order to avoid negative aspects of sex control mechanisms were developed, and each group in the society had its elaborated taboo and code about what is acceptable and/or unacceptable sexual behaviors (Tumbo-Masabo, 1994; Fuglesang, 1997).

In many societies, sexual activity among children is understood as wrong and socially unacceptable (Van Den Berg, 2008a; Doyle, et al, 2012). Sex is for adults (Leshabari & Kaaya, 1997; Van Den Berg, 2008a). Besides, sexual behavior among children is surrounded by silence as they are not likely to be acknowledged as sexual beings (Leshabari & Kaaya, 1997; Haram, 2005a; Haram, 2005b; Wight et al, 2006; Van Den Berg, 2008b). Consequently, adolescents are expected to refrain from any sexual activity until they are deemed ready to assume adult roles and responsibilities, especially marriage and reproduction (Tumbo-Masabo, 1994; Wight et al, 2006; Ragnarsson et al, 2008: Harrison, 2008; Chikovore et al, 2009; 2010; Izugbara et al, 2011; McClealry-Sills et al, 2013).

According to findings in a study conducted in Meru (Arusha), adolescent sexuality is regulated based on notions of good and bad, respect, avoidance, discipline, dignity and shame (Van Haren, 1999; Silberschmidt, 2001; Dilger, 2003; Haram, 2005a; Haram, 2005b; Wight et al, 2006). Overall, while adolescent sexuality is silenced and not approved by adults and communities (Fuglesang, 1997; Van Haren, 1999; Wight et al, 2006; Van Den Berg, 2008b;), sexual double standards for adolescents are documented. As Van Haren elucidated:

> Although according to the society, ideally both teenage boys and girls should not be sexually active, it does not judge the sexual lives of girls and boys the same. It is less acceptable for girls to be sexually active. Protective and moral considerations support the idea that teenage girls should not be sexually active (Van Haren, 1999: 62).

Although collective views about acceptable and/or unacceptable adolescent sexual behaviors influence health, it is observed that, just like masculine and feminine identities (Silberschmidt, 2001), adolescent sexuality cannot be devoted from the social and cultural context. However, a key question remain unanswered in literature sources; how do collective views about acceptable and/or unacceptable sexuality or sexual behavior for particular individuals or group—in this case adolescent girls operate to impinge on sexual health? Arguably, existence of restrictions and control based on gender and adolescent sexuality in a particular society may not *per se* explain girls' disproportionate vulnerability to sexual health threats.

— Initiation Rites of Passage

In Tanzanian societies the practices of '*unyago*' for adolescent girls and '*jando*' for boys were popular forms of initiation rites (Ntukula, 1994; Fuglesang, 1997; Van Den Berg, 2008a). Female genital cutting (FGC)[82] is also cited as an example of initiation rite of passage common in many African societies. Circumcision was an overriding marker of initiation rites for boys (Fuglesang, 1997:1248).

In Tanzania female genital mutilation or female genital cutting is not practiced in all regions (Katapa, 1994; LHRC, 2012). While the practice of female genital cutting has been used as a means to control girls' sexuality (Blum & Mmari, 2004; Human Rights Watch, 2014), there are no studies to establish a clear causal link between female genital cutting and sexual risk behavior (Klouman et al, 2005), unintended pregnancies, as well as HIV infection. In societies where it is practiced, female genital cutting has been used to prepare girls ready for marriage (Mbeba et al, 2012). It is a marker of a new identity for girls (Human Rights Watch, 2014). While girls who are not circumcised may be socially ostracized and referred to as 'rubbish' or 'useless', those who undergo FGC are respected, regarded as matured and ready to be wives (Human Rights Watch, 2014).

Some scholars have associated *'jando'* and *'unyago'* with sexual risk behaviors and health threats. On the one hand, during *unyago* girls are taught and prepared on how to satisfy men sexually, on the other hand, during *jando* boys were encouraged to

[82] Terms female genital mutilation (FGM), and female genital cutting (FGC) are used interchangeably.

experiment sex to reinforce views about ideal masculine identity (Van Den Berg, 2008a; Mbeba et al, 2012). According to these scholars, initiation rites of passage are more likely to be detrimental to girls' health as they were highly sexualized (Mbeba et al, 2012)[83], and were mainly preparing girls for marriage (Van Den Berg, 2008a). Currently, in many societies in Africa, time between puberty and marriage is prolonged (Van Den Berg, 2008a). Hence, initiation rites of passages and related practices can be detrimental to health. The above perspective is contested by other scholars. For them, sexual risk behaviors and health threats among adolescents occur due to disintegration of traditional institutions which imparted information about gender roles and regulated adolescent sexuality. In contemporary societies adolescents are left to navigate the transition from childhood to adulthood alone, particularly in relation to sexuality matter (Ahlberg, 1994; Leshabari & Kaaya, 1997; Fuglesang, 1997; Silberschmidt, 2001; Adegoke, 2012).

Some of these scholars suggest revival of traditional institutions responsible for initiating children to adulthood as a strategy to contain health threats among adolescent (Adegoke, 2012). While the debate about the relation between initiation rites of passage and health threats among adolescents remain unresolved in scholarly work, the practice of initiation rites of passage *per se*, especially '*unyago*', but also FGM, may not suffice to explain girls' disproportionate vulnerability to sexual risk behavior, unintended pregnancies, and HIV/AIDS[84].

— Early Marriages

Early marriage is recognized as a harmful cultural practice impacting on adolescent girls' health (Clark, 2005; UNICEF, 2005; UNFPA, 2012b)[85]. Despite this recognition, early marriages remain common in East African societies (Presler-Marshall & Jones, 2012; Doyle et al, 2012). Although in general, available data signal a decrease in early

[83] See also Jimmy-Gama (2009).

[84] In some societies in Tanzania especially in the Coast region *'unyago'* is still practiced (Bangster, 2012; Mbeba et al, 2012).

[85] In the present study early marriage is equivalent to child marriages because they happen before 18th birthday (Human Rights Watch, 2014).

marriage, 37% of adolescent girls continue to be married at 18 (UNFPA, 2012b)[86]. These findings resonate with recent research in Tanzania to illustrate that, rate of early marriages is decreasing (Van Den Berg, 2008b). However, research also reveal that the practice of early marriage remains prevalent as four (4) in ten (10) girls are married before 18 years of age (UNICEF, 2005; Mabala, 2006; Mabala, 2008; TDHS, 2011; Mbelwa & Isangula, 2012; LHRC, 2012; Human Rights Watch, 2014).

In African societies including in Tanzania girls' social status is elevated through marriage and childbearing (Van Haren, 1999; Jimmy-Gama, 2009). Further, early marriage is assumed to protect girls from unintended pregnancies, HIV/AIDS, sexual violence, sexual harassment and rape (UNICEF, 2005; Jimmy-Gama, 2009; UNFPA, 2012b). This view is challenged, vehemently, in extant literature (UNICEF, 2005; Nour, 2006; Wellings et al, 2006; Biddlecom et al, 2007a; Mabala, 2008; Mabala & Cooksey, 2008; Nour, 2009). Early marriage is demonstrated to be particularly detrimental to girls' health (Clark, 2004; UNICEF, 2005; Nour, 2006; Biddlecom, et al, 2007b; Nour, 2009; Presler-Marshall & Jones, 2012; Mbelwa & Isangula, 2012; UNFPA, 2012b). In most African countries pregnancies among adolescent girls are driven by early marriage (Presler-Marshal & Jones, 2012: 41)[87]. 90% of all pregnancies among adolescents occur within the context of marriage (Presler-Marshall & Jones, 2012).

There is evidence to indicate that, married adolescent girls are more vulnerable to sexual health threats compared to sexually active unmarried adolescent girls (UNICEF, 2005; Nour, 2006; Biddlecom et al, 2007a; Mabala, 2008; Mabala & Cooksey, 2008; Nour, 2009). Most girls are married to older partners and are exposed to frequent and unprotected sexual activity and HIV/AIDS (Clark, 2004). Most importantly, these older partners may have other sexual relations and are more likely to be infected with HIV/AIDS (Biddlecom et al, 2007a; Mabala & Cooksey, 2008; Presler-Marshall & Jones, 2012)[88]. Moreover, soon after marriage girls are pressured to prove fertility by bearing children (UNICEF, 2005; UNFPA, 2012b). The unequal power relations

[86] This data was reported by women aged 20-24.

[87] Other studies have found early marriage to be more prevalent in West Africa than in East Africa (Doyle et al, 2012).

[88] It is important to mention that sexual relationship between older men and girls is detrimental to their health, whether inside or outside marriage (Monarchy & Mahy, 2006:24).

between married adolescent girls and older husbands, and social expectations related to early pregnancy and childbearing among married adolescent girls reduce the chances of negotiating contraceptive use, especially condoms (Biddlecom et al, 2007b; UNFPA, 2012b; Presler-Marshall & Jones, 2012). Above all that, marriage is an important institution within which ideologies of gender and sexuality are produced and reproduced (Silberschmidt, 2001; Mlangwa, 2009). It is within marriage where husbands are granted unquestionable control over wives' sexuality (Bujra, 2000).

By and large, what remains a paradox in literature showing the relationship between early marriages and health threats among adolescents is, why is it that early marriage continues to be prevalent despite of the fact that it is shown to impact on girls' health? Hence, the practice of early marriages *per se* may not suffice to explain adolescent girls' disproportionate vulnerability to health threats.

2. Public Policies

Recognizing the severity of health problems among adolescents particularly sexual risk behaviors, pregnancies and HIV/AIDS, and as a response to its commitment to improve and protect health of different segments of the population including adolescents, the government of URT has put in place policies. Public policy includes sets of vision, principles, values, objectives and strategies (Pillay & Flicher, 2008). Policies are important for addressing different challenges that face a society in different sectors, at a particular time, and among different segments of the population— in this case adolescents. To put the same thing differently, public policy is a tool for promoting health among adolescents (Pillay & Flicher, 2008). Policies identify health issues of concern among adolescents; spell out the target population; outlines what changes in health status of the targeted group to be achieved; sets priorities and goals to guide action (Pillay & Flicher, 2008).

2.1. National Policies influencing Adolescent Health

In this section, some of the key national policies and strategies influencing health among adolescents are expounded.

i. Child Development Policy

Children are understood as important segment of the population whose protection, survival, and development is an important priority. Therefore, policy spells out challenges facing children, and what is needed to be done to ensure survival, protection and development of children.

Lack of proper protection and health threats are identified as key challenges, especially among girls. Girls are described to have low social status compared to boys. According to this policy, a girl child faces additional challenges which threaten her protection, survival and development such as FGM, early marriage, pregnancy, sexually transmitted infections, HIV/AIDS, rape defilement, harassment and molestation. In that vein, the policy directs all stakeholders to protect children's rights.

First, the policy — dating back 1996 — pronounces provision of basic information and services related to health as a priority and a right. Second, the policy directs that protection of children should be according to their age and needs. For example the 14 to 18 year olds need to be protected from early pregnancy, sexually transmitted infections, HIV/AIDS,[89] child abuse, rape and molestation[90].

Further, the policy identifies stakeholders who have the responsibility to ensure protection, survival and development of children. These include families, ministries, NGOs, religious institutions and other voluntary organization, communities and society as a whole. Girls' empowerment, combustion of health problems, prevention of gender discrimination, and changing traditional norms and practices that have negative impact are identified as priority areas that need to be addressed.

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[89] Paragraph 18 of Child Development Policy. Available at: http://www.tzonline.org/pdf/childdevelopmentpolicy.pdf [consulted on 15/05/2014].

[90] See Paragraph 19 of Child Development Policy for information about the needs and problems of 0-5 year old children and 5-13 year olds.

ii. National Youth Development Policy

Youth are described to be an important segment of the population as they play an important role in socioeconomic development of the country, both in present and in the future. Therefore, the policy identifies challenges faced by youth and directs interventions on various youth issues. Health is outlined as a key youth issue. Youth face a number of health problems such as pregnancies, and HIV/AIDS due to harmful cultural practices, early marriage and lack of youth friendly services and information. The policy acknowledges that sexually active youth especially young female aged 15 and 19 are increasing vulnerable to HIV. The policy calls for action to address key youth issues such as health, especially to design and implement programs which target to empower youth by taking on board a gender dimension. It is stated within the policy that, community, values and culture tend to favor men and boys, and leave women and girls vulnerable.

iii. National Population Policy

The development of the current national population policy of 2006 is meant to address pertinent challenges in the society such as increase in adolescent pregnancies and early child bearing especially among girls; prevalence of HIV/AIDS; increase in gender based violence particularly FGM and sexual abuse[91]. However, the main goal of this policy is to direct development of other policies, strategies and programs for addressing overriding population related issues such as promotion of quality of life and development of all individuals, achieving gender equality, equity, women empowerment and social justice. Apart from acknowledging that adolescents are mostly affected by HIV/AIDS due to lack of access to correct health information and services and socio-cultural and gender issues, the policy emphasizes protection of the rights of children and youth[92]. Further, the policy directs eradication of harmful practices such as FGM, elimination of all forms of discrimination, gender violence and transformation of

[91] The existing population policy is a revised version of the 1992 National Population Policy.

[92] The policy defines children as those individual below 15 years, adolescents 10-19 years, and youth are those between 15 and 24 years of age.

cultural values that hinders gender equality. Advocacy and IEC are identified as other important mechanisms for addressing identified population issues of concern.

iv. National Health Policy

The national health policy of 2003 recognizes that good health of all people is a prerequisite for national development. Therefore, the policy provides direction for improving and sustaining health status of all; by reducing mortality, raising life expectancy, promoting gender equality, and empowering women in all health related parameters. Although adolescent girls are not mentioned, the policy calls upon the health system to ensure all people have access to health services, and respond according to their needs. In a more specific way, the policy directs stakeholders to reorient their services to ensure that health needs of vulnerable groups and the most at risk are prioritized. The target groups for this policy are NGOs, FBOs and the private sector.

v. National Policy on HIV/AIDS

The overall goal of the 2001 HIV policy is to lead and to coordinate the national multi-sectoral response to the HIV/AIDS epidemic. This includes spearheading formulation of interventions to prevent transmission of HIV/AIDS and other sexually transmitted infections, to protect and support vulnerable groups effectively. The policy describes adolescent girls as more vulnerable to HIV infection as they do not have control over their sexuality. The policy points out that people have the duty to protect themselves and others against contracting HIV through unsafe sex and contaminated needles or syringes. Further, the society has the right to get information on how to protect against contracting HIV and prevent its spread. The document specifically recognizes protection of the right of PLHAs. Although protection of human rights of PLHAs is emphasized, it is also extended to all other members of the society. In addition, the policy stresses that adolescents have similar rights as PLHAs. The intended stakeholders of the policy are government institutions, communities, and civil society organizations such as NGOs, faith based organizations, CBOs and media.

vi. National Adolescent Health and Development Strategy

The main goal of the strategy is to improve health and wellbeing of adolescents which is important for national development[93]. Therefore, the 2004-2008 National Adolescent Health and Development Strategy pinpoints pertinent issues concerning adolescent health and development such as adolescent pregnancy and childbearing, HIV/AIDS, unsafe abortion and contraceptive use and provide framework for how to contain them.

Provision of adolescent friendly services; development of life skills for income generation; prevention of STIs including HIV/AIDS; protection of adolescent rights; and promotion of positive behavior change of adolescent towards health and development are outlined as important policy outcomes. Adolescents are also acknowledged as a heterogeneous and vulnerable group. However, the strategy gives a particular focus on street children, rural adolescents, younger adolescents, and in and out of school adolescents. The intended stakeholders of the policy are government institutions, communities, and civil society organizations such as NGOs, faith based organizations, CBOs and media.

vii. National Family Planning Guidelines and Standards

National Family Planning Guidelines and Standards (2013), or NFPGS, pronounces access to accurate and complete Family Planning (FP) information and services as a basic human right of all individuals and groups. In addition, some social groups are acknowledged to be in need of special consideration due to social, cultural and economic limitations which limit their right to access complete FP education, information and services, including contraceptives[94], and are at high risk of unintended pregnancies.

Overall, family planning providers are called to avoid restrictions on grounds of gender, disability, marital status, age, ethnicity, religion or other characteristics. It is also

[93] The vision of the strategy is to have healthy adolescents living in an environment that enables access to services and skills for the achievement of their full potential for development. There is a new strategy for year 2011-2015. Unfortunately we could not access it from the relevant authorities and stakeholders.

[94] Male and female condoms are among approved contraceptive methods.

highlighted in the document that different stakeholders are responsible to create supportive environment to make FP services accessible and equitable to all individuals. This includes changing the socio-cultural norms that may prevent access and use of FP services. It is emphasized within NFPGS that rights of adolescents to FP services should be respected as outlined under CRC. The targeted institutions of the policy are health care, NGOs, faith-based organizations, and private sector.

viii. National Standard for Adolescent Friendly Reproductive Health Services

The National Standard for Adolescent Friendly Reproductive Health Services of 2006 acknowledges pregnancies and HIVAIDS as critical health challenges facing adolescents. The document therefore provides standards and principles that can invigorate provision of adolescent friendly reproductive health services (AFHS). Also help to abate sexual health challenges and remove barriers preventing adolescents from assessing basic health services and information.

Provision of “Essential Reproductive Health Package” which comprises of prevention, promotion, curative and rehabilitation services such as information and counseling on reproductive health, sexuality and safe sex, testing services (STIs and pregnancy), condom promotion and provision as a human right and essential for addressing sexual health problem among adolescents. In addition, some specific groups within adolescent population segment such as adolescent living with HIV/AIDS and adolescent girls are describe to be in need of special focus and intervention. The intended audience or stakeholders are health care institutions, NGOs, faith-based organizations, private sector, including program managers, service providers and supervisors of standards for adolescent friendly reproductive services at all levels of the health system and development partners.

3. Laws Influencing Adolescent Health

This session analyses some of the key national laws related to adolescent sexuality and health. According to international human rights treaties governments, particularly State parties to the respective treaties have the primary responsibility to protect human rights related to health among all individuals and groups within its territory. Apparently, the

current Constitution of the United Republic of Tanzania of 1977, which is the principal national legal instrument does not make direct reference to protection of right to health[95]. Nevertheless, Article 1 obliges state and its institutions to use national resources to eradicate diseases. In addition, Article 14 confers to every person right to life and to protection of his life by the society in accordance with the law.

3.1. The *Law of Marriage Act*

In Tanzania, the *Law of Marriage Act* of 1971 is the main law controlling marriage. According to the Act a boy can get marriage if he has reached the apparent age of eighteen (18), and a girl can get marriage if she has reached the apparent age of fifteen (15)[96], but if parental or guardian consent is given. It is further stipulated under the same section that, under special circumstances the court can give consent to allow a marriage to take place if both parties have reached fourteen (14) years old. Furthermore, consent of parents, guardians or court is required for marriage to take place where a girl has not reached apparent age of eighteen (18) years[97].

Although there is ample scholarly evidence to indicate that early marriage is detrimental to girls' health and that, in most developing countries pregnancy-related complications may be the leading cause of mortality among 15 and 19 year old girls (Presler-Marshall & Jones, 2012; UNFPA, 2012b), the Act mainly—protect girls against forced marriages. But, the minimum age of marriage is not equal between adolescent boys and girls[98].

3.2. The *Sexual Offences Special Provisions Act*

The *Sexual Offences Special Provisions Act* of 1998 (also known as SOSPA) amends several written laws making special provisions, and all those laws related to sexual offences and other offences particularly *Penal Code*, 1981, the *Criminal Procedure Act*, 1985, *The Evidence Act*, 1967, the *Children and Young Persons Act*, 1962 (amended in

[95] See also the 2014 Tanzanian Draft Constitution.

[96] Section 13.

[97] Section 17.

[98] Section 13 (1).

1964), and the *Minimum Sentences Act*, 1972. The Act makes special provisions on sexual and other related offences against women and children. The aim is to safeguarding personal integrity, dignity, liberty and security of women and children. According to this Act, it is an offence of rape for any male person to have sexual intercourse with a girl below eighteen (18) years, with or without her consent. In other words, the law prohibits sexual intercourse with a girl who is below eighteens (18) years[99]. However, it is stated under the same section that if the woman who is fifteen (15) year old or more is married and not separated from a man the rape offence does not apply[100].

Further, the act provides children below eighteen (18) years with special protection against sexual assault[101]. It is emphasized that when a boy or a girl who is below eighteen (18) years is involved in sexual assault, stating that the sexual assault took place because it was consented will not be part of the defense.

In addition, all offences stated under section 130 that do not amount to rape, involve an offence of sexual harassment which is also prohibited[102]. Moreover, the Act prohibits any form of sexual exploitation of children[103]. Last but not least, the act makes it an offence for any person who, having the custody, charge or care of any person under eighteen years of age, ill treats, neglects, abandons that person or causes female genital mutilation or procedures that are likely to cause him suffering or injury to health.

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[99] On the other hand Section 15 (3) states that a male person under the age of 12 years is incapable of having sexual intercourse.

[100] Section 130 (3) (a) through (e).

[101] According to Section 135(1) sexual offence occurs when any person who, with intent to cause sexual annoyance to any person utters any word or sound, makes any gestures or exhibits any word or object intending that such word or sound shall be heard, or the gestures or object shall be seen, by that other person commits an offense of sexual assault.

[102] Section 138 (d) (1).

[103] Section 138 (b).

3.3. The *HIV and AIDS (Prevention and Control) Act*

The *HIV and AIDS (Prevention and Control) Act*, of 2008, provides for prevention, treatment, care, support and control of HIV/AIDS for promotion of public health in relation to HIV and AIDS. Section 4 calls upon different stakeholders to promotes public awareness on the causes, mode of transmission, prevention and control of HIV and AIDS; discourage negative traditions and usage which may enhance HIV and AIDS in the community; and promote all traditions and usage which may reduce transmission, and prevalence of the infection in the community. It is also the duty of various stakeholders to protect rights of orphans, PWD, and PLHAs, design and implement gender and disability responsive HIV and AIDS plans[104].

3.4. The *Law of the Child Act*

In Tanzania, the Law of the Child Act, 2009 is the key document that provides for protection of the rights of children including those related to health. Section 4 stipulates that all persons below 18 years of age are legally recognized as children. In addition to that, the Act under the same section, obliges all institutions, public and private to give primacy to the protection of best interests of the child in all actions concerning children. Children are therefore conferred a right to non discrimination by the Act. Section 5 provides that " a person shall not discriminate against a child on the grounds of gender, race, age, religion, language, political opinion, disability, health status, custom, ethnic origin, rural or urban background, birth, socio-economic, being a refugee or by other status".

Rights related to health are spelt under article 8(2) whereby child rights to access to health services or any other thing required for **his/her** development is protected. It is emphasized under paragraph 3 of the same article that, a child should not be denied access to medical care by reasons of religion or beliefs. Further, article 9 outlines other rights of the child. Accordingly, children have right to life, dignity, respect, health, to mention but a few. While article 83 confers children with protection from sexual exploitation, articles 13(1) and 13(3) protect children from torture and degrading

[104] See Section 6(3) for more details.

treatment. Degrading treatment is defined as an act done to a child with the intention of humiliating or lowering his dignity. In addition, the law confers special protection of the rights of children who are orphans, street children, children with disabilities, a few to mention.

It appears clearly, from this session, that laws and policies influencing health among adolescents do not explicitly disapprove adolescent sexuality, especially girls' sexuality. However, this is not to say that, the laws and policies are without flaws, conflicts and contradictions.

4. Identifying Social Meanings of Gender and Adolescent Sexuality or Sexual Behavior

Understanding adolescents' sexuality, particularly the social meanings of their sexual behaviors present in the society and institutions, implications on their health is an important step towards responding to their health needs, protecting, and realizing their right to health (Wellings et al, 2006). In this vein, this session reviews literature to identify what is considered sexual among adolescents, especially girls in Tanzanian society and within the institution of law as well as policies.

— Adolescent sexuality is a taboo

Literature reveals that in many societies in East Africa, including Tanzania, adolescent sexuality is a taboo (Toroitich-Ruto, 1997; Van Haren, 1999; Wanjiru, 2006; Van Den Berg, 2008a). Adolescent sexuality was only talked about in certain context (Wight et al, 2012), especially just before or during puberty and within the context of initiation rites of passage (Fuglesang, 1997). It is during this time when adolescents were recognized as sexual beings (Ntukula, 1994; Pija & Kassimoto, 1994; Tumbo-Masabo, 1994; Fuglesang, 1997; Mabala, 2008; Van Den Berg, 2008b; Wight et al, 2012). Generally, discussion of sexual matters in public is likely to be regarded as immoral (Bujra, 2000)[105]. It is also a taboo for parents to discuss issues related to sexuality with their children (Fuglesang, 1997; Van Haren, 1999; Wight et al, 2006; Van Den Berg, 2008a; Nnamisi et al, 2009; Wamoyi et al, 2010). This may equally apply to many other

[105] In African context taboo related to sex and sexuality have slightly changed after the outbreak of HIV/AIDS. Sexuality and sex have entered, to some extent, the public arena.

societies worldwide. However, taboo associated with boys' and girls' sexuality are not necessarily similar. Existing research reveal that talking about sex is gendered. While adolescent boys can discuss their sexual behaviors and sexual matters, girls are not expected to talk about their sexual behaviors or sexuality freely (Mziray, 1998; Van Haren, 1999; Bujra, 2000; Wight et al, 2006; Wight et al, 2012). Demonstrating lack of knowledge of sexual matter is associated with respectability among girls (Mlangwa, 2009) than among boys. In most cases, girls hide or underreport their sexual experiences (Tumbo-Masabo, 1994; Lugoe, 1996; Van Haren, 1999; Wamoyi et al, 2010; Kakoko et al, 2013; McClealry-Sills et al, 2013).

While in the wider society adolescent sexuality is a taboo, adolescents, including girls are acknowledged to be sexually active in some of the policies we reviewed.[106] However, the key child related policy and law such as Child Development Policy and *Law of the Child Act* remain silent about adolescent girls' sexuality.

— Adolescent sexuality as socially unacceptable

Sexuality among adolescents is a sensitive issue because it is associated with people understandings about morality (Rivers & Aggleton, 1999; Lie, 2008; Ericksson et al, 2011). Being sexually active during adolescence is considered inappropriate (Rivers & Aggleton, 1999).
The dominant norm for adolescents in many African societies, including Tanzania, is, adolescents should not be sexually active (Van Haren, 1999; Tumbo-Masabo, 1994; Mziray, 1998; Babalola, 2001; Wight et al, 2006; Were, 2007; Harrison, 2008; Van Den Berg, 2008a; Wight et al, 2012). These taboo and prohibitions associated with sexuality were produced by the society and passed on to adolescents during initiation rites of passage (Fuglesang, 1997; Van Haren, 1999; Haram, 2005b). However, the messages were not similar for adolescent boys and girls (Van Haren, 1999). Girls were particularly instructed to observe chastity and keep their virginity (Tumbo-Masabo, 1994; Mbonile & Kayombo, 2008; Wamoyi et al, 2010). Generally, the ideal that adolescent girls should not be sexually active was predominant, and remain

[106] See National Standard for Adolescent Friendly Reproductive Health Services and National Youth Development Policy

predominant, but tacit (Van Haren, 1999; Leshabari, 2008). On the other hand, boys did not receive similar messages about chastity and virginity (Mabala, 2008; Wight et al, 2012). Instead, ideas of potent and sexually active boys were promoted. The common understanding is that, it is natural for adolescent boys to experience their sexuality (Ntukula, 1994; Fuglesang, 1997; Van Haren, 1999). According to SOSPA any person who engages in sexual intercourse with a girl below 18 years of age, with or without her consent is guilty of rape. Accordingly, age of sexual consent for adolescent girls is 18.

— Adolescent sexuality is for marriage

Adolescent sexuality is considered normal within the context of marriage (Dilger, 2003; Haram, 2005b; WHO, 2006). In Tanzania sex outside marriage is associated with immorality, shame and lack of respect among adolescents, especially girls (Lugoe et al, 1996; Fuglesang, 1997; Van Haren, 1999; Dilger, 2003; Haram, 2005a; Haram, 2005b; Wight et al, 2006). While abstinence until marriage is emphasized as a moral order, pregnancy outside wedlock is highly stigmatized (McClearly-Sills et al, 2013) and HIV is regarded as the disease of those who engage in immoral or sinful behaviors (Ntukula, 1994; Fuglesang, 1997; Nnko & Pool, 1997; Leshabari & Kaaya, 1997; Bujra, 2000; Dilger, 2003; Wight et al, 2006; Mabala, 2006; Mbonile & Kayombo, 2008; Van Den Berg, 2008a; Wamoyi et al, 2010; McClealry-Sills et al, 2013) [107].

Overall, it is girls who are considered as the gatekeepers of morality (Van Den Berg, 2008a) [108]. During initiation rites of passage girls received information about sexuality and were also taught sexual skills in order to prepare themselves to please their husbands. Accordingly, being sexually submissive to husband’s sexual desires is emphasized, and girls were expected to keep their sexuality under check and control their lust until marriage (Ntukula, 1994; Fuglesang, 1997; Leshabari & Kaaya, 1997; Matasha et al, 1998; Wight et al, 2006; Mbonile & Kayombo, 2008; Van Den Berg, 2008a). The ideal that adolescent girls’ sexuality is for marriage was reinforced[109]. Even

[107] See also in studies conducted in Kenya (Nzioka, 2001; Izugbara et al, 2011).

[108] See also in a study conducted in Australia (Flood, 2003) and in Sweden (Christianson, 2006).

[109] Similar findings emerge from studies in South Africa, Uganda, Kenya, Zambia, Burkina Faso, Ghana, Senegal, Zimbabwe, to mention but a few (Toroitich-Ruto, 1997; Were, 2007; Warenius et al, 2007;

to-date, it is still legal for adolescent girls to be married earlier than boys. The Tanzanian Law of Marriage Act allows girls to be married at the age of fifteen (15) and boys at the age of eighteen (18). What is striking to note in literature is that, in many societies in Africa and in Tanzania, married adolescent girls are perceived and treated as adult women even though they are below eighteen years (Van Haren, 999; Leshabari & Kaaya, 1997; Doyle et al, 2012; UNFPA, 2012b). Further, although SOSPA pronounce sexual intercourse with a girl below 18 years as rape and rape offence does not apply if sexual intercourse takes place within marriage. In addition to that, the most recent Law of the Child is silent about child marriages.

— *Adolescent Sexuality should be controlled*

Just like in many societies of the world, and in Tanzania adolescents are not viewed as sexual beings. Adolescent sexuality is regarded as something that needs to be controlled in order to reduce its harms (Fuglesang, 1997; Leshabari & Kaaya, 1997; Van Haren, 1999; Bujra, 2000). Sexual activity among adolescents is closely associated with health threats such as pregnancies and sexually transmitted infections especially HIV/AIDS (Nnko & Pool, 1997; Dilger, 2003; Wight et al, 2006; Wamoyi et al, 2010). Since it is girls not boys who face the ramifications of pregnancy outside wedlock (Lugoe et al, 1996); and being pregnant is a physical sign to reveal that a girl is sexually active, which does not apply to a boy (Van Haren, 1999; Bujra, 2000; Wamoyi et al, 2010; Izugbara et al, 2011), social restrictions and control mechanisms of adolescent girls' sexuality were stiffer (Tumbo-Masabo & Liljestrom, 1994; Van Haren, 1999). Girls were made to understand that sexual intercourse can result to pregnancy (Fuglesang 1997, Van Haren, 1999; Wamoyi et al, 2010). Adolescent girls are expected to be responsible to rejecting sexual advances and to avoid pregnancy before marriage preferably through abstinence (Tumbo-Masabo, 1994; Ntukula, 1994; Fuglesang, 1997; Mziray, 1998; Van Haren, 1999; Nzioka, 2001; Haram, 2005b; Mabala, 2006; Wight et al, 2006; Mabala, 2008; Van den Berg, 2008a; Mabala & Cooksey, 2008; Wamoyi et al, 2010; Wight et al, 2012; McClearly-Sills et al, 2013). The same may not necessarily be expected from boys. In Tanzania several policies identify pregnancies and HIV/AIDS as

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Kabiru & Orpinas, 2009; Biddlecom et al, 2007b; Jimmy-Gama, 2009; Van Eerdewijk, 2009; Ericksson et al, 2010; Chikovore et al, 2013).

pertinent health issues facing children and adolescents, mainly girls, and illustrate the agency to combat these health problems[110].

4.1. The Influence of the Social Meanings of Gender and Sexuality on Adolescent Health

In Tanzanian society the socially acceptable behavior for adolescents, especially girls, is to abstain from any sexual activity or delay sex until marriage, adulthood or until they finish school (Lugoe et al, 1996; Matasha et al, 1998; Van Haren, 1999; Van Den Berg, 2008b; Wight et al, 2012; McClealry-Sills et al, 2013). Accordingly, adolescents' access to sexual health related information and services is likely to be limited and/or denied by adults. Adolescents are regarded as too young to receive information about sexuality (Leshabari & Kaaya, 1997). Generally, provision of such knowledge and information is associated with promotion of immoral or promiscuous sexual behaviors especially among girls (Lugoe et al, 1996; Fuglesang, 1997; Leshabari & Kaaya, 1997; Rasch et al, 2000; Silberschmidt & Rasch, 2001; Dilger, 2003; Haram, 2005b; Wight et al, 2006; Leshabari et al, 2008; Van Den Berg, 2008b; Wamoyi et al, 2010; Wight et al, 2012). Evidence therefore suggests that, lack of knowledge and information related with sexual health may be a post-factor, meaning, an outcome of stigma, denial and prohibition attached to adolescent sexual behavior, which makes it difficult for them to access information and services needed for them to protect their health. Similar findings were documented in Zimbabwe whereby adolescents are reported to be denied access to health information and services due to moralization of their sexuality (Chikovore et al, 2004; 2009).

Moreover, research suggest that adolescents are aware of the prohibitions and taboo regarding their sexuality and to some extent, their individual sexual behaviors may reflect the same. This was evident in a study conducted by Silberschmidt & Rasch in Dar es Salaam whereby girls reported to be afraid to go to FP clinics because they would be called ‘prostitutes’ (2001). In a recent study adolescents themselves admitted that their engagement in sexual relations is morally wrong (Van Den Berg, 2008b: 164), and girls in particular, emphasized that they have to wait to have sex until they finish school or get married (Van Den Berg, 2008b:173). Similar findings emerged in a study

[110] For more see Child Development Policy.

conducted in Kwazulu Natal in South Africa where adolescent girls admitted to be very young to be sexually active, and that they have to wait until they finish school or they have a serious relationship (Harrison, 2008). In addition to that, several other studies conducted in African context have documented that, while girls mentioned abstinence until marriage as a preferable method for preventing pregnancies and HIV/AIDS (Harrison, 2001; 2008; Kibombo et al, 2007; Reedy & Dunne, 2007), they also perceive abstinence as irrelevant for boys (Mantell et al, 2006; Izugbara, 2008). These findings substantiate what was argued by Schoveller *et al.*, that adolescents look to their social context for clues on what constitute acceptable sexual behavior (2004: 474).

Conversely, in other studies, adolescents have reported that having sex is an important aspect when in romantic relationship (Nnko & Pool, 1997). But, they perceive that it has to be done in a morally correct and respectable way. Accordingly, most adolescents, especially girls, engage in hidden sexual relations (Haram, 2005b). This behavior probably reflects the moral prohibitions of their sexuality in the wider society. More often than not, if proved to be sexually active, especially outside marriage, and while in school, a girl can be punished or chased from home accused for engaging in '*uhuni*' (illicit sexual behaviors) (Nnko & Pool, 1997; Bujra, 2000; Silberschmidt & Rasch, 2001; Dilger, 2003; Haram, 2005a; Haram, 2005b; Wight et al, 2006; Mabala, 2006; Mabala & Cooksey, 2008; Van Den Berg, 2008b; Wamoyi et al, 2010; McClearly-Sills et al, 2013). Arguably, hiding being sexually experienced is likely to be detrimental to girls' health. First, it makes it difficult for girls to seek and access health services, information and care they need the most (WHO, 2006) even in case they are available. As espoused by Harrison, it is difficult for a girl who engages in secretive sexual relationship to seek for condoms publicly (Harrison, 2008).

In many African societies, including Tanzania, a girl is not expected to carry a condom. A girl who is found with a condom or other contraceptives may be labeled as a prostitute or punished by adults (Nnko & Pool, 1997; Mabala & Cooksey, 2008). Carrying a condom is not necessarily stigmatized among boys. A boy may be encouraged to use protective mechanisms such as condoms by parents when is found to be in sexual relations, and this may be accredited as being a 'real man' (Mabala & Cooksey, 2008). Second, it makes it difficult for a girl to negotiate condom and/or initiate condom use while in sexual relations (Silberschmidt & Rasch, 2001).

The difficulty to negotiate condom use among girls is well illustrated in a study conducted in South Africa. Both adolescent boys and girls who were involved in the study acknowledged that condoms should be used, especially by unmarried people to protect themselves from health threats. Yet, in the same study, girls reported that they would use condom if it is initiated by a boy. According to girls' perspectives, it is easy for them to refrain from engaging in sexual activity than to negotiate condom use (Harrison, 2001: 67). Girls who are prepared for sex by carrying or negotiating condom are more likely to be perceived by male sexual partners as too sexually experienced, promiscuous, or unfaithful (MacPhail, 1998; Haram, 2005a)[111]. Similar findings are documented in a study conducted among migrant youth in Nigeria whereby girls who carry or initiate condom use in sexual relations are shown to risk to be stigmatized by male sexual partners (Smith, 2004). As one young man reported, "if a girl keeps a condom in her room you will feel somehow, you know, like she is a professional" (Smith, 2004: 432). Arguably, empirical evidence in the present study, supports the contention that, conforming to what is considered 'proper' or acceptable sexual behavior for girl takes precedence, and health protection is compromised (Bujra, 2000; Dilger, 2003; Haram, 2005a; 2005b; Izugbara et al, 2011). And on the contrary, there is evidence to indicate that adult women can exercise agency by challenging dominant gender and sexual ideologies which predispose them to health risks, for example, by talking to their husbands about the danger of HIV/AIDS, and develop alternative gender and sexuality ideas which have less impact on health (Anfred, 2004; Mlangwa, 2009; Browning, 2011) such as 'mindful lifestyle' (Mlangwa, 2009). Apparently, there is paucity of research to substantiate that adolescent girls, as a social group, are challenging collective views about gender and sexuality by redefining their own sexuality, in a way which is less detrimental to health. By contrast, adolescent girls are shown to be more likely to maintain collective views of 'proper' feminine sexual behaviors which eventually impinge on health. It is these social meanings about gender and adolescent sexuality which pose a significant limitation on girls' ability to protect their health, specifically by adopting healthy sexual behaviors (Barrow, 2007; Gupta et al, 2008; Jimmy-Gama, 2009). Yet, this does not mean to say that girls are entirely

[111] In Tanzanian society even a wife may not dare to propose condom use for the fear of being accused of having other sexual relations and lack of respect (Silberschmidt & Rasch, 2001:1821). See also Bujra (2000) and Marstone & King (2006).

victims (Van Eerdewijk, 2009). Some individual girls are shown to exercise agency. There are studies which have documented that, some adolescent girls do negotiate condom use and refuse unprotected sex (; Kibombo et al, 2007; Njau et al, 2013).

Apart from the above, the influence of the social meanings of gender and adolescent sexuality is manifested through prevalence in early or child marriage. In many societies in Africa and in Tanzania, the practice of early marriage is a socially acceptable path to adulthood, and it has been used to enforce cultural prohibitions surrounding adolescent girls' sexuality, and pregnancies outside wedlock (Bledson & Cohen, 1993; Leshabari & Kaaya, 1997; UNFPA, 2012; Chikovore et al, 2013; Human Rights Watch, 2014). It is not surprising to observe in literature sources that, adolescent girls, especially unmarried ones, are keen to do whatever it takes to prevent pregnancies than HIV infection (Silberschmidt & Rasch, 2001; Izugbara et al, 2011; Plummer et al, 2010; McClealry-Sills et al, 2013). Occurrence of pregnancy signifies that girls are using their sexuality in a way which is not congruent with collective ideas about 'proper' procreation and female sexuality (Smith, 2004; Izugbara et al, 2011), and may lose their respectability (Haram, 2005a; Wight et al, 2006). Moreover, while in sexual relations adolescent girls are expected to be responsible in preventing pregnancy and sexually transmitted infections especially HIV/AIDS than male counterparts (Wight et al, 2006; McClearly-Sills et al, 2013). Similar findings emerged in international studies (Ahlberg et al, 2001; Varga, 2003; Martone & King, 2006). By contrast, in many societies in Africa, including Tanzania HIV is likely to be perceived as the diseases of fornicators (Bujra, 2000), and a punishment from God for sexual promiscuity (Yamba,1997 *cited in* Tenkoranga et al, 2010), and for lack of adhering to religious teachings (Smith, 2004; Wanjiru, 2007; Browning, 2011)[112].

Last but not least, social meanings of gender and adolescent sexuality may contribute to prevalence of coerced or forced sex. While girls are expected to be submissive in sexual matters, being in control of all issues related to sexuality and sexual relations is perceived as male domain (Leshabari & Kaaya, 1997; Izugbara & Undie, 2008). Boys and men are described to have natural and uncontrollable need for sex, and that it is the responsibility of girls to reject unwanted sexual advances (McClearly-Sills et al, 2013).

[112] Similar finding are documented in Nigeria whereby sexuality is closely related to morality (Smith, 2004)

As pointed out earlier, most girls would prefer to abstain from sex until marriage. However, practically they may not be able to do so because refusing sexual advances may provoke use of force from boys to make girls submit (Nnko & Pool, 1997; Mabala & Cooksey, 2008; McClearly-Sills et al, 2013) as rejection is likely to contradict ideal masculine sexual identity.

Illustrative findings from the research conducted in Tanzania, therefore, reveal that, what is considered sexual for adolescents in the society has strong influence on health among adolescents, especially among girls. However, while the influence of collective views of masculine and feminine identity, and adolescent sexuality on health cannot be overstated, the identified social meanings about gender and adolescent sexuality and/or sexual behaviors, relevant in a particular society, may not *per se* influence health threats among adolescent girls. Arguably, to influence health, these social meanings should not only be internal to an individual adolescent, but also they have to be produced, reproduced within society, institutions and social practice. However, they can as well be ignored, reproduced differently and/or ignored [Emphasis added] (Giddens, 1984; Gauntlett, 2002).

5. Stakeholders in Adolescent Health Protection

According to perspectives in social sciences, societies have three kinds of institutions; government or public institutions, corporate or private sector institutions and civil society or third sector institutions. These are different, but they complement each other (Haki Kazi, 2002; Salamon, 2010).

In many countries of the world including in Tanzania, health services to the general population including adolescents, are provided by the governments. Differently put, governments, through institutions such as hospitals, clinics and ministries have the primary duty and obligation to protect and improve health of all people. Despite of the fact that governments are major players in health, it is acknowledged that governments alone cannot address myriad of health issues and especially among vulnerable individuals and groups. Therefore, private institutions and civil society organizations have also stepped in as key players in health. The latter is the concern here.

Research shows that within the last twenty five years, particularly during 1980s, there has been a significant upsurge of civil society organizations globally (Salamon & Anheier, 1997; Salamon, 2010) including Tanzania (Lange et al, 2000; Haki Kazi, 2002; Ndumbaro & Mvungi, 2007; Makaramba, 2007). Civil society organizations constitute institutions which occupy the social space between state and the market in different societies, meaning they are neither part of the government nor business (Cox, 1999; Salamon & Anheier, 1997; Lewis & Kanji, 2009; Salamon, 2010). Institutions such as professional organizations, faith-based organisations, community groups, organizations of socially excluded groups such as women and youth, and non-governmental organizations are described to occupy this space (Salamon & Anheier, 1997; Haki Kazi, 2002; Ndumbaro & Mvungi, 2007; Makaramba, 2007; Salamon, 2010).

At the Global level, the role of civil society organizations in health cannot be overstated (Doyle et al, 2008).

At the national level, in Tanzania for example, the role played by CSOs in providing and delivering health services particularly those aiming at addressing health concerns affecting vulnerable individuals and groups, including adolescents, cannot also be overstated (Mbeba et al, 2012; Chandra-Mouli, 2013)[113]. The strength of most of CSOs in relation to health lies on their capacity to bring institutional, technical and financial resources to health. But also for being unconventional in their approach, especially in bringing unaddressed problems to public attention [Emphasis added] (Salamon, 2010: 168). Further, CSOs are acknowledged in most policies, as influential stakeholders in addressing health challenges among children and adolescents. For example the current National Health policy, National Population Policy and Child Development Policy are oriented to ensure full participation of civil society[114] in protecting the rights of children and adolescents[115], and transform social and cultural values that hinder gender equality

[113] See: file:///C:/Users/L50-A-1F2/Downloads/contribution-of-cso-to-health-in-africa.pdf

[114] Section 3.2-3.2.2 Also see the National Adolescent Health and Development Strategy, and National Family Planning Guidelines and Standards.

[115] See Section 4.4.3 in National Population Policy and paragraph 30 in Child Development Policy.

and traditional norms and practices which have negative impact on health[116]. Accordingly, policies specifically directs civil society organizations to eliminate all forms of discrimination and gender violence.

The fact that various studies have been undertaken to understand factors associated with health threats among adolescents, and above all that, the fact that there is ample evidence accounting for the same cannot be overstated. Yet, despite of the fact that civil society organizations in Tanzania are acknowledged to play a fundamental role in addressing pertinent health challenges among vulnerable populations, there is little efforts in research to incorporate them as an attempt to acquire an understanding as to why certain individuals and groups — in this case adolescent girls, are disproportionate vulnerable to sexual risk behavior, unintended pregnancies and HIV/AIDS transmission. Most studies focus on an individual adolescent girls. As argued by Giddens, practice is an important aspect in social inquiry (1984). Further, institutions are social action (Giddens, 1984). Accordingly, institutions and practice may influence health among adolescent girls.

6. Summary

This chapter presents the mapping of adolescent sexuality and health in Tanzania. Therefore, in this chapter we have assessed factors influencing health threats among adolescent in Tanzania. Illustrative findings from extant literature reveal that multiple and complex factors influence health among adolescents. On one hand there are individual level factors such as physiological characteristics, perception of risk or perceived vulnerability, knowledge and information, life skills and sexual behavior. It is observed that while these are important they are also dependent of the broader social context. On the other hand, factors beyond an individual such as peer pressure, poverty and economic importance of sex, coerced or forced sex, gender, adolescent sexuality, initiation rites of passage, and early marriage influence health among adolescents. It was established in this chapter that the social meanings about adolescent sexuality and/or sexual behavior have stronger influence on health threats among adolescents, especially girls.

[116] See Section 4.5.3 in National Population Policy. See also in the National Family Planning Guidelines and Standards whereby changing socio-cultural norms which may prevent access and use of family planning services among adolescent, and respecting rights of adolescent as stipulated within CRC are emphasized.

In that vein, in this chapter we attempted to identify the social meanings about gender and adolescent sexuality and/or sexual behavior in Tanzanian society, and within laws and policies influencing adolescent health, and assess implications on health especially among girls.

Findings illustrated that there are no explicit restrictions attached to adolescent sexuality within laws and policies influencing adolescent health in Tanzania. Details will also be provided in the forthcoming chapters. Overall, it is observed that, in Tanzanian society, adolescent sexuality is a taboo. It is not socially acceptable for adolescent to be sexually active. Adolescent sexuality is also regarded as something to be controlled. Nevertheless consensus emerged to indicate that the taboo and prohibitions associated with adolescent sexuality are not similar for adolescent boys and girls. Adolescent girls' sexuality is more controlled, restricted and stigmatized. Girls are generally expected to be sexually inexperienced and abstain from sex until they are adults; they finish school; and preferable until they get married. But they are also expected to be ignorant about sexual matters and submissive in sexual relations. Being submissive in sexual relations and ignorant about sex and sexuality is closely associated with female respectability. On the contrary, being highly sexually experienced and knowledgeable about sex, dominant and in control of sexual relations and sex related decisions are associated with adolescent boys' sexuality.

In consequence, girls are subjected to forced sexual activity and they are less likely to disclose that they were forced into having sex. They are less likely to seek for health information and services when sexually active even where necessary health services and information are widely available. Doing so is similar to declaring that they are sexually active or they engage in promiscuous behaviors. Simultaneously, adolescent girls are more likely to be denied access to necessary health information and services important for them to protect themselves against health threats by adults because they are not expected to be sexually active. Furthermore, due to the prohibition attached to their sexuality, most girls, as shown in literature review, engage in hidden sexual relations in order to conform to collective understandings of what is acceptable as sexual for them. While in reality sexual intercourse is increasing described as an important aspect of romantic relations among adolescents, adolescent girls find it difficult to negotiate

condom use when in sexual relations as it may contradict their feminine identity as submissive, sexually inexperienced, and respectable. These social meanings of adolescent girls' sexuality are also closely related to prevalence of early marriage and coerced or forced sex in the society.

Therefore, findings from extant literature support argument that the social meanings about gender and adolescent sexuality in Tanzanian society exert stronger influence on health threats among adolescents especially girls. Accordingly, these acceptable and/or unacceptable social meanings about gender and adolescent sexuality are internalized by individual adolescent girls and reinforced by adults and the society at large, as they are perceived to have the function of maintaining order in the society (Fuglesang, 1997; Van Den Berg, 2008a). Nevertheless, using Giddens' Structuration theory we argued that the identified social meanings about gender and adolescent sexuality may not per se influence health threats among adolescents, especially girls. To influence health these social meanings have to be produced and reproduced in society, institutions, and social practice (Giddens, 1984: Gauntlett, 2002).

It is therefore argued in this chapter that, while there is well documented scientific evidence in social science research to document influences of health threats among adolescents, there is no sufficient evidence to account for adolescent girls' disproportionate vulnerable to sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission. Above all that, a key argument advanced in the present study is that, influences of adolescent girls' disproportionate vulnerability to sexual health threats may be understood and addressed, effectively, if both micro and macro dimensions associated with it are taken into account. Further still, macro dimensions per se may not also suffice. Accordingly, the present study is set out to fill that important lacuna, as will be developed in the next chapter on the field work methodological and substantial aspects.

CHAPTER FOUR.
RESEARCH METHODS AND FIELDWORK

1. Introduction

Consensus emerge in the review of scientific literature on adolescent sexuality and health in Tanzania to indicate that complex and multiple factors influence sexual risk behavior, unintended pregnancies, and HIV/AIDS among adolescents. While individual level factors are described to play an important role in influencing health threats among adolescents, there also factors beyond an individual, and in the broader society, especially the social meanings of gender and adolescent sexuality are documented to exert strong influence on adolescent health particularly girls. However, review of scientific literature in chapter 3 demonstrate that an important lacuna exist in adolescent health research in social science. There is paucity of evidence to explain adolescent girls' disproportionate vulnerability to sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission. It was also established in chapter 3 that, while the social meanings of gender and sexuality are shown to exert stronger influence on health among adolescent girls, they do not act so independently, unless they are produced and reproduced differently in institutions and social practice, but they can as well be ignored.

This chapter therefore, presents research methods relevant in the present study. It also describes fieldwork process and procedure used to select institutions and sample population. According to Harvey a research method is understood as the way researchers go about gathering empirical data (Harvey, 1990). Since qualitative researchers tend to view social reality in terms of processes (Ritchie & Lewis, 2003; Bryman, 2008), and is appropriate when researchers want to understand and explain a social phenomenon and its context (Ritchie & Lewis, 2003). The chapter also provides for a brief account of the social position of the researcher and how it was negotiated.

1.1. Research Paradigms

The term paradigm has multiple meanings. In this study, a research paradigm constitutes basic beliefs, assumptions or worldviews that inform and guide scientific investigation (Guba & Lincoln, 1994; Wahyuni, 2012). We discuss key ontological and philosophical viewpoints of positivist, interpretivist and critical theory research paradigms and decide about which one among them will inform and guide the present study.

i. Positivism

Positivism has its origin in natural sciences. Positivists assert that reality is exterior or independent to human influence and can be discovered through valid and reliable measurements (Broom & Willis, 2007). According to positivists social reality is fixed and objective (Guo & Lincoln, 1994). Putting it differently, the world and the universe operate by universal laws of cause and effect (Broom & Willis, 2007). In social sciences, positivist thinking was advocated by Augustine Compte. Social world is understood to be similar to natural world. Thus, society and social phenomena can be understood through science.

Table 7: Summary of Positivist Paradigm

Positivism	Characteristics
Theoretical perspective	Utility (Guo & Sheffield, 2008).
Main concern	To discover universal laws that can be used to predict social phenomenon (Guo & Sheffield, 2008).
Key assumptions	The social world is objective and external and can be understood and measured by science (Broom & Willis, 2007; Wahyuni, 2012).
Position and perspective of the researcher	According to positivist thinking research is neutral and value free. Hence, in order in order to achieve an objective understanding of a social phenomenon, and to produce findings that can be generalized in other contexts (Wahyuni, 2012) the researcher should be detached from the research process (Guo & Lincoln, 1994).

ii. Interpretivism

Interpretivist paradigm originated in social sciences (Bryman, 2008). It emerged as a criticism against positivist philosophical ideologies (Guba & Lincoln, 1994). Interpretivist stances challenge the notion of pre-existing single objective reality that is external to human influence (Byman, 1984; Fossey et al, 2002; Mottier, 2005; Mackenzie & Nippe, 2006). The core paradigmatic stance is that reality is socially constructed and is subjective (Neuman, 2006). Therefore, people and institutions, being the subjects of social sciences, cannot be studied like the subject matter of the natural sciences (Bryman, 2008: 16).

According to interpretivist paradigm, research is by no means value free. As Mason puts it: “what is distinctive about interpretive approaches however is that, they see people and their interpretations, perceptions, meanings and understandings, as the primary data sources” (Mason, 2002:56). The aim is to explore people individual and collective understandings, reasoning processes, social norms, and so on” (Mason, 2002:56). Interpretivist research take place on the natural setting. The researcher in interpretivist research becomes part and parcel of the research processes and the social context under study (Macome, 2002; Guo & Sheffield, 2008). The researcher aims to acquire an understanding of a phenomenon from the perspectives and experiences of participants rather than his/her own perspectives (Fossier et al, 2002; May, 2011), and may not be concerned with social change (Rubin & Rubin, 1995).

Table 8: Summary of Interpretivist Paradigm

Interpretivism	**Characteristics**
Theoretical perspective	Human agency (Guo & Sheffield, 2008).
Main concern	Actors’ understandings of social reality and social action (Guo & Sheffield, 2008; Bryman, 2008).
Key assumptions	The social world is subjective, context specific, and dynamic, and can be understood through people’s meanings and interpretations of social action or phenomenon (Broom & Willis, 2007; Byman, 2008; Wahyuni, 2012).
Position and perspective of the researcher	In interpretive stance, the researcher aims at gaining access to participants’ meanings of a social action or phenomenon. He/she becomes part and parcel of the research process (Guo & Lincoln, 1994).

iii. Critical Theory Paradigm

Critical theory paradigm is also known as critical or transformative paradigm (Mackenzie & Knipe, 2006). Critical theory in social sciences was advocated by Max Horkheimer and other members of the Institute for Social Research in Germany, alternatively known as Frankfurt school (Comstock, 1982; Myers, 2006; May, 2011). There are variants of critical approaches and perspectives such as feminist, critical race theory, critical cultural studies, postmodern, poststructuralist, postcolonial, critical ethnography to mention but a few (Marshall & Rossman, 2006; May, 2011). Despite differences, critical theories are grounded on social critique, empowerment of individuals and groups, and aim at initiating and/or promoting changes (Hayden & Chamsy, 2006; Stahl, et al 2008). Further, critical theories must be “explanatory, practical and normative”, meaning: (1) They must explain what is wrong with current reality; (2) Identify actors to change it, and (3) Provide both clear norms for criticism and achievable practical goals for social transformation (Horkheimer 1993 *cited in* Bohman, 2005).[117]

In that vein, critical theory paradigm is both epistemological and political (Mackenzie & Knipe, 2006). This paradigm questions power relations or status quo (Kincheloe & Mclaren, 2000; Guo & Sheffield, 2008), and the way gender, ethnicity, race, religion and sexuality constrain our understanding of social reality (Guba & Lincoln, 1994; Mackenzie & Knipe, 2006; Creswell, 2009). By and large, critical researchers engage in reflection and re-evaluation of society’s ideologies, to uncover contradictions in existing institutions, social practice and emphasize social change (Myers, 2006; Hayden & Chamsy, 2006).

[117] http://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=critical-theory

Table 9: Summary of Critical Theory Paradigm

Critical Theory Paradigm	**Characteristics**
Theoretical perspective	Social critique and empowerment
Main concern	Social reality is value laden, multiple, and reflective of power imbalance (Guo & Lincoln, 1994; Denzin & Lincoln, 2000; Myers, 2006; Guo & Sheffield, 2008).
Key Assumptions	Knowledge and truth are subjective, created not discovered, historically and contextually situated (Myers, 2006).
Position and perspectives of the researcher	To understand, describe social reality, but also to change it (Marshall & Rossman, 2006; Datta, 2009; May, 2011). To evaluate meanings, norms and values as situated within society and institutions in order to uncover any contradictions between what is known and unknown, and unacknowledged injustices (Harvey, 1990; Hayden & Chamsy, 2006; Stahl et al, 2008). Evaluation and reflection are important aspects of research which draw from critical theory paradigm (Myers, 2006; Heinze, 2008).

— Rationale for Choosing Critical Theory Paradigm

We begin this session by citing an important argument concerning research paradigm advanced by Lincoln and Guba that, “There will be no single "conventional" paradigm to which all social scientists might ascribe in some common terms and with mutual understanding” (Lincoln & Guba 2000:185).

Hence, the foregoing session was meant to discuss and provide fundamental understandings of interpretativist and critical theory paradigms. The current session focuses on describing the philosophical foundation that act as an analytical framework in the present study and the justifications for the choice. Some scholars perceive critical and interpretive paradigms similar (Heinze, 2008). This view is also questionable. On the one hand, similar to interpretive approach, critical theory paradigm questions the view that people, institutions and societies can be understood based on assumptions of natural sciences (Comstock, 1982; Bryman, 2008). On the other hand, unlike studies which adopt interpretivist philosophical stances whereby the main focus is on people or individuals' experiences and perceptions, critical research further, acknowledges existence of objective factors which influence our actions and perceptions (Heinze, 2008). Put it other way, while interpretivists assume focus on the micro-social interactions, they tend to neglect broader power relations constraining people’s meanings and/or actions [Emphasis added] (Heinze, 2008:52). Critical researchers dig beneath the surface and question how and why those meanings are constituted in order

to uncover the "contradictory conditions of action or practice which are hidden by everyday understanding" [Emphasis added] (Comstock, 1982:371), "so that they can be changed for more individual and/or collective benefits" (May, 2011; 41).

This kind of knowledge is important if we want to understand why there are differences in terms of sexual health outcomes, among individuals and groups in a particular society, and how sustainable changes and equality in health outcomes may be achieved. Hence, critical theory paradigm is found to be more useful as an overarching philosophy in the present study.

2. Methodology

According to Silverman (2001), a methodology guides the researcher in planning and executing a study. A methodology is also described as the logic by which researchers go about answering the research questions (Mason, 2002). Scholars have employed various methodologies in studying the social world and generate scientific knowledge. Despite differences between various methodologies, Silverman argues that, methodologies cannot be false, but can only be found to useful or less useful (Silverman, 2001:4).

There three main methodological approaches in research; qualitative, quantitative and mixed method (Creswell, 2009). The mixed research approach is preferred by scholars who want to break the traditional qualitative and qualitative divide. While for some mixed method studies is adopted, others, the quanti-quali approach which involves direct integration of quantitative and qualitative elements in a single study (Grim et al, 2006) is the most preferable.

Against that backdrop, this is a qualitative study. Traditionally, qualitative research is regarded as mainly interpretive. But consensus emerges in social science research to indicate that not all qualitative research is interpretive (Marshall & Rossman, 2006). Differently put, qualitative approaches to research are not homogenous (Guo & Lincoln, 1994; Mottier, 2005), and there are several types of qualitative approaches (Somekh & Lewin, 2005; Marshall & Rossman, 2006; Creswell, 2009).

However, despite variations, the following are some of the fundamental characteristics of qualitative research (Guo & Lincoln, 1994; Marshall & Rossman, 2006; Mason, 2007; Creswell, 2009): focuses on original meanings of participants about a social phenomenon and action; (Creswell, 2009); researchers focus on gaining holistic view of the context under study; provides thick descriptions of social setting, events and individuals (Bryman, 2008; Corbin & Strauss, 2008 Creswell, 2009); is concerned with development of theory, explanation and understanding than precise testing of theory to the fourth decimal point (Morse, 1994; Bryman, 2008).

Related to the above, and most importantly, the fundamental aspect is that, qualitative research tends to view social reality in terms of processes (Ritchie & Lewis, 2003; Bryman, 2008), and is appropriate when researchers want to understand and explain a social phenomenon and its context (Ritchie & Lewis, 2003).

In health related research, qualitative methods are described to be especially useful for obtaining more fruitful data by “reaching the parts other methods cannot reach” (Mays & Pope, 2000). In most instances, extant research in Tanzania on adolescent sexual sexuality and health is dominated by behavioral, psychological, epidemiological models, which seek to establish quantifiable variables associated with the same.

As Marston and King argued:

> Although quantitative data is effective at answering questions such as “what percentage of adolescents report using condoms the first time they had sex?” it is less useful if we want to know the reasons for their behaviors; nor will it give a broad description of what happened during the sexual encounter. Qualitative data helps describe, and find the reasons for the behaviors and its social context (Marston & King, 2006:1581)[118].

However, some qualitative studies, especially those which interrogate the context of adolescent sexual health are also individualistic. This imply that, they have delved on perceptions, experiences, norms and meanings adolescents associate with sex, condom use, pregnancies and HIV/AIDS in sexual relations in everyday lives (Nnko & Pool, 1997; Dilger, 2003; Haram, 2005a; Haram, 2005b; Wight et al, 2006; Mabala, 2006; Mabala & Cooksey, 2008; Schaalma & Kaaya, 2008; Van Den Berg, 2008b; McClealry et al, 2013). But, there is dearth of studies which seek to understand the underlying

[118] See also Campbell (2003).

influences of sexual risk behaviors and health threats among adolescents both at the individual level and beyond an individual, especially at the level of the society and institutions. There is evidence in scientific literature to substantiate that most of studies which paid attention to the factors associated with sexual risk behaviors and health threats among adolescents both at the individual level and within the broader social context, for example those conducted in Canada have mainly used qualitative methodology (Shoveller et al, 2004, Shoveller et al, 2006; Shoveller et al, 2007; Shoveller et al, 2009). Shoveller *et al.* suggest that individual behaviors or agency, structures, and socio-cultural influences of sexual health among adolescents and youth are interrelated (2004; 2006; 2009). Similar view has been advanced by a prominent scholar in contemporary social theory, Anthony Giddens in his Structuration theory (1984) as described in previous chapters.

Given the above, since Giddens's structuration theory enables social researchers to approach a micro-macro phenomenon, mostly in society, institutions and organizations[119], one of the following qualitative methods described below may be more useful.

2.1. Action Research

Action research is described in the methodological literature, as the most appropriate research strategy in studies that adopt critical theory paradigm. In action research, research and action take place simultaneously in order to improve the situation of certain individuals or groups and/or change society and institutions (Somekh & Lewin, 2005; Blichfeldt & Andersen, 2006; Stahl, 2008). The central feature of action research is that research is conducted through collaborative partnership (Lingard et al, 2008) between the researcher and participants who share the common concern about problem or situation and highlight the need to develop practical solutions to improve the situation of concern (Marshall et al, 2010). Action research is carried out through stages or cycle. In the first cycle researcher and practitioners engage in reflection of the

[119] See for more information: http://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Organizational%20Communication/Structurational_Theory/

problem, plan action or intervention, in the second cycle they evaluate action or intervention implemented (Somekh & Lewin, 2005: 89).

The strength of action research lies on its ability to contribute both to body of knowledge or theory, also to improve practice or find a solution to a practical problem (Meyer, 2000; Marshall et al, 2010). Action research is time and resource intensive because researcher and participants collaborate in all stages of the research process; from problem identification, planning, research design, data collection, action and evaluation of implemented action (Marshall & Rossman, 2006).

In that line of thinking, action research is considered to be less useful as a research strategy in the present study due to the reasons elaborated below:

First, in the present study the researcher does not intend to implement an intervention in order to research about the problem at hand nor change the situation concerned. The researcher, rather, engages in critical analysis of meanings, action and practice related to adolescent girls' health in order to interrogate research problem.

Second, action research emphasizes collaboration between researchers and practitioners throughout the research cycles. To achieve this building collaboration and partnership between the researcher and participants is fundamental. However, because the researcher is an outsider to most of these institutions building collaboration and partnership with the research participants is very challenging.

Last but not least, action research is more suitable for practitioners who want to improve practice and solve everyday practical problems. Related to this, the research idea in the present study did not emerge from practical situation, but within the broader social context.

2.2. Case Study

Case study is research strategy which is widely used in social sciences such as economics, sociology and anthropology, but also in practical-oriented field of research such as environmental studies, education, social work, management, business studies

(Yin, 1994; Johansson, 2003). Different scholars approach it differently (Stake, 1995; De Vaus, 1996). However, in qualitative research case study is used when the researcher intends to investigate complex phenomenon in bounded and naturalistic setting (Stake, 1995; Kohn, 1997; Stake, 2000). According to Stake case study can be any “bounded system” such as an institution, a program, a responsibility, and a collection of a population (2000; 23). In addition, case study is mainly employed in studies that address how and why questions (Kohn, 1997; Yin, 1994). Further, case study is mostly used in less explored research areas (Edmondson & McManus, 2007 *cited in* Eisenhardt & Graebner, 2007:27) especially in studies that seek to establish causal argument about a social phenomenon (Gerring, 2004; Mason, 2007). The overall aim of case study is to generate concrete, practical and context dependent knowledge (Stake, 1995; Stake, 2000).

Following preceding analysis of some of the most relevant qualitative research methods, it is evident that no research strategy is self-sufficient. As with case study a fundamental limitation is that, findings cannot be generalized to other contexts because of the uniqueness of cases (Stake, 1995; Stake, 2000). Nevertheless, in social science researchers need to make a decision on whether to case or not to case. And if they decide to case they have to delineate the case (Yin, 1994; De Vaus, 1996; Stake, 2006). It is however important to note that, in social inquiry a case study does not entail a choice of a research strategy but a choice of what is to be studied (Stake, 2000; Myers, 2006). The present study takes place in Tanzanian context. Put it other way, it is the case of Tanzania and institutions are a unit of analysis.

3. Data Collection Considerations

One of remarkable features of qualitative research is that they provide researchers with the possibility to employing an array of data sources such as interviews, focus group, diaries, memoirs, documents, historical documents, autobiographies, observation, video a few to mention (Aldridge & Levine, 2001; Corbin & Strauss, 2008). It is therefore upon the decision of the researcher, and according to the nature of the research problem to use a single data source alone or combine several data sources. However, recently, many scholars have opted to use several data sources in one study.

Accordingly, qualitative researchers have employed quanti-quali method, whereby, data sources which are traditionally recognized to belong to the domain of quantitative methodology, such as small survey questionnaire and experiment like activities are integrated in a qualitative method (Grim et al, 2006). The aim is to allow collection of richer and more multifaceted data in a cost effective manner, but also to make data analysis easier and transparent (Grim et al, 2006). Further, to collect both subjective views of research participants and some empirical measurements related to same subjective views expressed (Grim et al, 2006:518). In most instances, qualitative researchers have opted for triangulation which also entails use of various types of data, but separately, to interrogate the same research problem (Aldridge & Levine, 2001; Grim et al, 2006; Corbin & Strauss, 2008).

By contrast, quanti-quali methods involve direct integration of quantitative technique into a qualitative method (Grim et al, 2006). Arguably, both methods are more likely to lead into similar outcomes as described above. Therefore, triangulation is found to be more useful in the present study since we aim to collect both qualitative data and quantitative data not for the sake of achieving generalizations and/or deriving inferences, but rather because to interrogate the research problem relevant in the present study, we had to be concerned with a number of issues.

3.1. Triangulation

This research relied on primary and secondary type of data to interrogate the research problem. In that vein, triangulation is considered viable to achieving that endeavor.

Triangulation is also known as multi-method approach whereby researchers seek to triangulate data, meaning using a variety of sources of information such as surveys, documentary analysis, interviews, observation and so on in the study of a social phenomenon (Aldrine & Levine, 2001; Silverman, 2003; Bryman, 2008; Guion et al, 2011). Use of triangulation has a lot of potential in research. But the significant one is that, it enables researchers to collect different type of data that would give multiple perspective about the research problem and improve validity of data collected (Stake, 1995; Alvine & Levine, 2001; Guion et al, 2011). In the present study the researcher sought to use of different data sources in order for them to complement each other.

Quality of materials or data to be collected was also a fundamental concern [Emphasis added] (Corbin & Straus, 2008). Triangulation is also used in data analysis when two or more methods of data analysis are employed in a single study (Stake, 1995; Alvine & Levine, 2001; Guion, et al, 2011).

i. Questionnaire Survey

Surveys may also be used to collect information on the peoples' views and perceptions about a certain social phenomenon (De Vaus, 1996; May, 2011). Questionnaire survey is a widely used as an instrument of data collection in social research (De Vaus, 1996; May, 2011).

Questionnaire is a formalised set of questions for obtaining mainly, quantitative information from respondents (Maholtra, 2005). However, survey may not generate data to reveal detailed information relating to human action (May, 2011:126), especially on why actors do what they do, because surveys rule out dialogue between the researcher and participants [Emphasis added] (May; 2011; 127). In the present study questionnaires constituted both closed and open ended questions.

ii. Interviews

Interview is another important data source in social sciences. Also in the present study. Interviews generate rich and in-depth data about a social phenomenon. There are major three types of interviews; structured, semi-structured and unstructured (Fontana & Frey, 2000; May, 2011).

In *structured interviews* the interviewer asks respondents a set of predetermined and standardized questions in same order or sequence. There is limited set of responses and all respondents are treated in the same manner (Fontana & Frey, 2000).

Unlike structured interviews through which researchers seek to obtain standardized information the goal of semi-structured interviews is understanding (Fontana & Frey, 2000:655). As a result *semi-structured interviews* are designed in a way that allows both direction and exploration (Aldridge & Levine, 2001). Researcher constructs specific

questions but allows respondents to provide broad answers and the interviewer can seek clarifications and probe beyond the answers given. A relative strength of semi-structures interview is that the interviewer and respondents enter into a dialogue or conversation (Rubin & Rubin, 1995:122; May, 2011:134).

Unstructured interviews are also known as in-depth. They are explorative and non-directive (Aldridge & Levine, 2006;6). In unstructured interviews researcher attempts to understand a phenomenon based on the point of views of the respondents (May, 2011:137) rather than imposing predetermined categories that limit field inquiry (Fontana & Frey, 2000; 653).

Semi-structured interviews are found to be more useful in the present study because they allow flexibility and provide an opportunity for the researcher to ask open ended questions and/or follow up questions (Rubin & Rubin, 1995). Qualitative research depends on the meanings that participants hold about a particular social problem (Heinze, 2008; Creswell, 2009), also critical reflection of the researcher (Myers, 2006).

Hence, the concern of the researcher was to choose participants based on their ‘informativeness’ (Mabry, 2008). Put it other way, based on their ability to provide in-depth, quality and reliable information. Following that line of argument, the selection of the sampling procedure was based on whether it provides access to interviewees who have the best knowledge of the social phenomenon of concern and rich practical experience in adolescent health. And that, they can bring in the study multiple perspectives about the social phenomenon.

iii. Documentary Review

Documents are regarded as important source of data in social sciences (Marshall & Rossman, 2006; Mogalakwe, 2006; Bryman, 2008) and in the present study. Documentary review involves collection and analysis of various documents relevant to the research at hand (Marshall & Rossman, 2006). Two types of documents are relevant here; internal and external. In order to ensure that review of documents provide valid and reliable data, we make use of documents that have been requested by the researcher and those which were not requested (Bryman, 2008), meaning, they were available and

accessible to the public either in hard copy or through official websites of the institutions (Bryman, 2008) such as posters, flyers and placards related with activities being implemented (Mogalakwe, 2006; Bryman, 2008). Documents such as quarterly, mid-term or annual reports of completed or ongoing activities or projects related with prevention of sexual health threats among adolescents were requested by the researcher to the authority within selected organization.

External reports such as newspaper articles, policy documents, legal documents, and official statistics were also useful. Official statistics acted as important source of information and was especially useful for advancing the research agenda in the present study. One of the strength of official statistics is that their reliability is fairly high as they are drawn from surveys, which is an important source of data in social research. Also they play an important role in sharpening reflexive practice (Kituse & Cicourel, 1993; May, 2011). However, the researcher is aware of the pitfalls of official statistics due to the fact that respondents may provide misleading information, and results may be influenced by construction process, meanings and understandings of the organizations or individuals involved in the production of official statistics (Kituse & Cicourel, 1993; May, 2011). Hence, caution was taken in their use and interpretation.

iv. Observation

Arguably, most research involve observation of one kind or another. Observation was among various research tools in the present study. There are several types of observation; participant observation, structured observation and unstructured observation (Mason, 2002; Bryman, 2008). Unstructured observation has particularly been used in research adopting feminist and critical paradigms because in this kind of researches the idea that participants are co-researchers is deeply entrenched (Mulhall, 2003:309). The following are some of other reasons which led to the selection of observation as one of tools for data collection in the present study. First, it allows researchers to check whether what people say is congruent with what they actually do. In other words, observation allows researchers to use both eyes as well as ears. So in this case observation was used to complement but also to enrich interviews. Second, observation enabled collection of data that has the possibility to provide evidence for process because it is an ongoing activity (Mulhall, 2003:308).

3.2. Ethical Considerations

In social research ethical standards and norms guide the behavior of the researcher in relation to the research participants and the information they give (Bryman, 2008; May, 2011; Resnik, 2011). Put it other way, ethics ensure protection of participants and institutions from harm and the data they have provided to the researcher. In addition to that, they protect the researcher and the integrity of the research (May, 2011). Ethical clearance and permission can be obtained from participants, research sites and relevant authorities (Klopper, 2008).

There is no universal standard procedure for ethical clearance and for requesting permission to conducting scientific research in Tanzania.
Ethical approval for and permission to conduct field research can be requested from relevant authorities depending on which level the study is taking place; national, regional, district, village, community, but most important on the unit of analysis which can be individuals,— and in our case institutions.[120]

Ethical approval the present study was requested from prospective institutions and authorities at the regional level. To ensure voluntary participation and informed consent of organizations (De Vaus, 2000: 60; Bhutta, 2004; Byman, 2008) documents to indicate aims and objectives of the research, data collection methods and those identifying the researcher were submitted to the relevant organizations[121]. Upon being granted permission, and on the part of sampled participants, informed consent was administered orally administered before a questionnaire was provided or an interview

[120] The procedures for conducting scientific research in Tanzania particularly health research are stipulated by the National Institute for Medical Research (NIMRI). If health research is to be carried at the national level, particularly within the public health system or involving a particular segment of the population, the research protocol has to be submitted to NIMRI for ethical clearance and permission. In addition to that, ethical clearance and permission can be obtained from prospective institutions. For more information see: http://www.nimr.or.tz/ethical-guidelines/

[121] While gaining access to organization and research participant is a fundamental ethical process, it can also be a political process (Bryman, 2008). On the whole, in most organisations access was mediated by gatekeepers particularly those in senior managerial position. Some of the key concerns that emerged were to understand the researcher’s motive, what the organization will gain from the study, and potential risks to the organisation (Bryman, 2008). However, to get access and win trust and cooperation, in some organization the researcher had to rely on an insider to the organisation. For example, it is important to mention that, despite fact that the researcher had established prior contact with one of the organisations, permission to use data for research purpose had to be negotiated.

session was scheduled. Signing written consent forms could breach anonymity and confidentiality as described below.

Confidentiality and anonymity (Wiles et al, 2008; Bryman, 2008; May, 2011) are also paramount ethical issues. To achieve that the researcher planned to use pseudonyms, to alter or paraphrase instead of making direct citations extracts from interview and documents and not to disclose names, position or title of the research participants. It should be acknowledged here that, while respecting ethical procedures is paramount in any research, there is a need to demonstrating authenticity and reliability of data and data sources. This two emerged as conflicting in the present study. Therefore, to strike a balance, while pseudonyms have been used to shield the identity of the institutions, the positions or titles of the research participants were disclosed. In addition to that, the researcher opted to do both; make word-to-word quotations and paraphrasing information extracted from interviews and documents. Yet, the name and title of the research participant who provided information extracted from interview has been concealed. Further, all documents which were not meant to be public are kept secured and used only for the purpose of the study. Furthermore, participants who did not feel comfortable to answer certain questions or to be recorded due to professional ethics and sensitivity of the topic were not compelled to do so (Rubin & Rubin, 1995; Wiles et al 2008).

Needless to say, research ethics is not only about rules and codes. It is also a procedure (Resnik, 2011). As emphasized by Lie, "research findings must be translated into actions that may empower adolescent girls to protect their own health and into actions that make social and cultural context more health promoting" [Emphasis added] (2008:89). Arguably, since critical research is known to being dynamic (Harvey, 1990), apart from fulfilling academic requirement dissemination of findings to the institutions involved in the study is considered as an important ethical issue (Chilise & Preece, 2005; Lie, 2008) in the present study.

3.3. Sampling and Study Population

Purposeful or purposive sampling was employed in determining study sample population. Purposive sampling was opted because it allows the researcher to determine

selection of sample based on its relevance to the study undertaken (Mason, 2006; Bryman, 2008). Putting it differently, and especially according to the purpose of the present study, purposeful sampling enabled the researcher to make a deliberate decision about which settings, institutions, and individual actors provided reliable and high quality information related with the research problem (Pope & May, 1995; De Vaus, 2002). Following that line of thinking, fourteen (14) NGO practitioners were selected for interview.

4. Data Analysis Considerations

It is mainly qualitative. Recently, qualitative researchers have increasingly sought to collect both qualitative and quantitative data. Therefore, there has been an upsurge in use of computerized data processing and/or analysis programs in qualitative research.
On the whole, qualitative content analysis is employed as a method for data analysis in the present study. Qualitative content analysis is a procedure applied when analyzing textual data, such as from the documents and interview transcripts, in a qualitative-oriented way (Krippendorf, 1980; Mayring, 2000; Elo & Kyngas, 2008). According to Krippendorf, other meaningful matters such as work of art, imagines, signs, and so on might be included as data and considered as text as long as they provide information about the phenomenon beyond what can be observed (1980: 19).

Content analysis is considered to offer systematic and reliable approach to data analysis because it allows both; inductive development of concepts or categories[122] and deductive application of concepts or categories in data analysis (Mayring, 2000; Elo & Kyngas, 2008). Inductive approach to content analysis can be more useful when there are no previous studies dealing with the phenomenon or knowledge is fragmented (Elo & Kyngas, 2008). On the other hand, deductive approach in content analysis is recommended when the main aim of the study is to test a previous established theory in a different situation or to compare categories at different time periods (Elo & Kyngas, 2008). Further, content analysis is thought to be suitable for analysis of data when the phenomenon under study is multifaceted and sensitive (Elo & Kyngas, 2008). Yet, both approaches; inductive and deductive could be useful because there is no previous

[122] This is a characteristic of grounded theory (*cf.* Corbin & Strauss, 2008).

studies that dealt with the phenomenon, and researcher applies concepts and prior developed theoretical arguments to the texts in order to describe the phenomenon (Mayring, 2000; Elo & Kyngas, 2008). While qualitative content analysis is criticized for not indicating a standard procedure for data analysis (Krippendorf, 1980; Elo & Kyngas, 2008), it is important to reiterate that what was more important in determining which content to analyze is the theoretical framework, aims and research questions (Krippendorf, 1980; Mayring, 2000)[123]. Consequently, in the present study, in regard with how data was approached, the deductive approach was given precedence over inductive approach because relevant theoretical perspectives for the present study directed the researcher about which data are relevant and important, and how to interpret them (De Vaus, 1996: 23). In addition, inductive and deductive approaches provide an opportunity for broad description of the phenomenon under study and the outcome of analysis is concepts describing a social phenomenon (Elo & Kyngas, 2008:113), in other words, findings to be generated may build than test relevant theories.

Last but not least, content analysis enables analysis and development of salient themes from the text. Of the most importance however is that, the researcher is in the position to search for relevant themes based on the text itself, and in relation to other texts, the communicator of the text, and the wider social context of the text (Krippendorf, 1980; Mayring, 2000).

4.1. Data Analysis Procedure

In this section we delineate procedure for approaching data. First and foremost, questionnaire data was processed by SPSS version IBM 22 for windows. The aim was to obtain descriptive statistics relevant for the research questions.

As Stake pointed out qualitative data analysis is an iterative and reflexive process that start as soon as data are being collected rather after collection process is concluded (Stake, 1995). In our case, apart from survey questionnaire data, the rest of the data, including field notes, recorded interview, observation and documents were transcribed

[123] See also: Robinson, 1993 *cit. in* Elo & Kyngas, 2008:109.

and converted into texts. Thereafter, reading and re-reading of the transcripts and texts in order to identify information relevant for answering the research questions followed. Data was categorized according to single word, group of words and phrases which acted as a unit of analysis. But in order to exhaust data and enrich our findings, we developed a total of seven (7) main categories; gender, adolescent girls' sexuality, rights, behavior change and communication, beyond ABC, socio-economic empowerment, and biomedical. Out of these, though they were not exclusive, we identified a number of sub-categories. Accordingly, folders were opened, whereby words, group of words, and phrases containing similar categories were placed. The process of reading and re-reading transcripts and texts was repeated thoroughly, until the researcher was satisfied that all relevant information from the data sources is saturated.

5. Fieldwork

Fieldwork was conducted in Tanzania. Tanzania is the biggest country in East Africa. It covers the total area of 947, 300 square kilometers. According to recent changes the number of administrative regions, approximately, increased from twenty six (26) to thirty (30). Therefore, a specific study cite was sought to be selected. Initially, the focus of the researcher was to conduct fieldwork in regions which are reported to have alarming rates of adolescent pregnancies but specifically HIV/AIDS. The following regions were considered by the researcher; Mbeya, Dar es Salaam, Arusha, and Iringa. However, it was realized later that the decision about which civil society organizations are selected could not solely be determined by the researcher. It was also dependent on the organizations. In most instances, the organizations select and target regions where the intervention programs are implemented. For instance, we observed during pilot study that most intervention targeting sexual health among adolescents were implemented in Dar es Salaam, Mwanza, Shinyanga, Iringa, Simiyu, Mtwara, Mara and Tanga. This indicates that NGOs target those regions which have pressing sexual health issues among adolescents and youth. Apart from that, NGO consideration about which geographical area to implement a particular intervention is dependent of the law. According to the NGO Act of 2002, an NGO can be registered to operate at the international, national, regional or district level. Accordingly, interventions could be implemented at the district, regional or national level. In addition to the above, and on

the part of the researcher, accessibility to the targeted institutions was a key determinant factor in relation to which organizations are incorporated in the study.

Apparently, it was observed that most civil society[124] organizations, principally NGOs, operate in more than one region or in some cases all over Tanzania (Ndumbaro & Kiondo, 2007). Therefore, it was not possible to select the institutions based on region or geographical boundaries. However, we also observed that almost all surveyed institutions had their head offices in Dar es Salaam. Some had zone and field offices in regions where they have been implementing programs and activities according to the targeted population[125]. Dar es Salaam was selected as a study cite due to many reasons. First, the researcher resided in Dar es Salaam. Hence, proximity to the headquarters of these organizations was important because of the nature of the research, where building rapport with research participants was important and demanded regular visits to the selected organizations. Dar es Salaam was also selected because it has a lion's share of civil society organisations, especially NGOs compared to other regions in Tanzania. This uneven concentration of civil society organizations in regions in Tanzania is also reported in previous studies (Mercer, 1999; Lange et al, 2000; Repoa, 2007) [126].

However, other sites, especially Iringa, Mwanza and Shinyanga whereby some selected institutions were implementing activities related with adolescent sexual health were visited.

5.1. Selection of Institutions

Eight (8) civil society organizations were involved in the preliminary survey. Since civil society organizations constitute of multiple and diverse players, we have drawn our

[124] The term civil society and NGO may not be necessarily similar depending on the context and one's perspective. But in the present study they are used interchangeably.

[125] Prior to embarking on the study, the researcher had a brief working experience (as a volunteer consultant on governance issues) in a youth based civil society organisation. Preliminary identification of civil society organisations was also done by consulting an online data base of NGOs operating in Tanzania and their areas of intervention. The data base is developed and maintained by Tanzania National NGO Coordination unit under the Ministry of Community Development, Gender and Children. See http://www.tnnc.go.tz/ngoresults.php

[126] The report by Repoa used the concept NGOs in Tanzania are 'Dar-centric' to explain inequality in regional distribution of CSOs. Other regions which have well established third sector institutions are Arusha, Kilimanjaro and Zanzibar.

sample from NGOs. Needless to say, selection of NGOs does not come as a surprise. It is drawn from existence of sheer optimism in academic scholarship, in Tanzanian context, also on the part of the researcher about the role and influence of NGOs in the 21st Century. NGOs are the most active among civil society or third sector institutions (Bromideh, 2011). NGOs deliver basic services to vulnerable populations, and organize policy advocacy and public campaigns for change (Lewis et al, 2009). As bromideh suggests in most developing countries NGOs have taken on roles which are played by governments in developed countries (Bromideh, 2011).Unlike other civil society organizations, NGOs focus on meeting the needs of disadvantaged groups and not that of their members (Lewis et al, 2009:11)[127].

Acknowledging the fact that in Tanzania, NGOs play an active role in the health sector especially in addressing sexual health issues among different segment of the population, especially adolescents, and appreciating the fact that NGOs are recognized as important partner in policy development and implementation, five (5) NGOs were included in the preliminary selection; Two (2) health concerned NGOs and Three (3) health concerned and youth-based NGOs. It is important to point out that accessibility was the utmost determinant in selecting institutions.

Thus, only four (4) NGOs were studied; one (1) health concerned NGO and three (3) youth-based NGOs whereby health is one of the targeted areas of intervention. It is important to reiterate here that, this is not a study of NGOs; it is rather a study which seeks to establish the social processes and practices which may relate with adolescent girls' disproportionate vulnerability to sexual health threats in Tanzanian society. Consequently, and as pointed out earlier, institutions, especially law including policies, and non-governmental organizations as a part of the wider civil society,are positioned as a unit of analysis.

[127] See for more, National NGO policy 2001 https://www.bot-tz.org/MFI/Library/NGO_Policy_2002_English.pdf and NGO Act No 24, of 2002 http://www.mcdgc.go.tz/index.php/departments/category/ngo_coordination_division/

Table 10: List of Surveyed Civil Society Organizations

ORGANISATIONS	LOCATION/COVERAGE	MAIN ACTIVITY
NGO 1	National	Sexual rights/Health/Youth
NGO 2	National	FP/Reproductive Health
NGO 3	National	FP/Reproductive health/Youth
NGO 4	National/Regional	Health
NGO 5	International	FP/Reproductive Health
NGO 6	International	Health
NGO 7	International	Humanitarian/Health
NGO 8	International	Humanitarian/Health

5.2. Pilot Study

Pretesting or pilot study is an important aspect of research process. Pretesting or pilot study for the present study was undeclared. It was conducted within the field context similar to that of the main study and sample population is similar to that of the main study (Czaja, 1998; Van Teijlingen & Hundrey, 2001).

According to literature the aim of conducting pilot study is to test questionnaire instrument to ensure that they are well structured and can be understood by the respondents (Van Teijlingen & Hundrey, 2001). It is important to mention however that, pilot study also allows researchers to have a prior understanding of the study context and how to approach the unit of analysis.

Further, it helps the researcher to assess whether the research plan and methods are compatible to the actual field environment (Bhattacharjee, 2012). A total of five (5) questionnaires were field tested after approval and permission from institutions involved in the study was granted. Some inconsistencies in the questionnaire design in terms of question wording, sequencing and layout concerns, arrangements of response categories, and sequencing were detected and corrected. Research plan and methods were slightly adjusted, and main field work was implemented.

5.3. Questionnaire Administration

Almost all questionnaires were self-administered. The method was employed to accommodate busy schedule of most of the participants[128]. A total of forty (40) questionnaires were distributed. Questionnaire return rate was good. Out of 40 questionnaires 33 (82.5%) questionnaires were returned to the researcher.
Only 7 (12.5%) questionnaires were not returned. Of which five (5) questionnaires were sent via internet (e-mail).

Table 11: Socio-economic Characteristics of Questionnaire Sample

	Frequency	**Percentage**
Gender:		
Male	15	45.5
Female	18	54.5
Educational Background:		
Higher Education	3	9.5
College	9	27.5
University	21	63.6

5.4. Administration of Interviews

As pointed out earlier, the selection of the interviewee was determined by researcher, through purposive sampling. The researcher therefore managed to have access to aim to participants who brought multiple perspectives pertinent for addressing research questions. Interview sample comprised of participants in senior management position and also with extensive and rich practical experience in the areas of sexual and reproductive health among adolescents in civil society organizations in Tanzania.

Interviewees were contacted and upon giving their consent to participate in the research interview were scheduled. Interviews were conducted into two phases; 2013 and 2014

[128] Initially the researcher planned to use face to face method.

respectively. In qualitative research preliminary analysis of data specifically from field notes and interview transcripts, allows the research to adjust collection process. Hence, we implemented the second phase of interview with similar participants because additional information needed to be collected (Schutt, 2011).

All interviews took place within office premises because the researcher did not target practitioners in civil society organizations as individuals only, but as part and parcel of these institutions.

5.5. Social Position of the Researcher

To begin with, it is also fair to give an account of my journey into the NGO world (Mushi, 2011). Needless to say, conducting research with practitioners especially when sensitive institutions such as NGOs are involved, the researcher is an outsider who does not have substantial professional experience, and sensitive issues such as adolescence, gender and sexuality are involved is challenging. Consequently, the social position of the researcher became an influential aspect throughout fieldwork. I entered the fieldwork as a researcher and scholar who is concerned with adolescent girls' sexual health. Apart from having acquired understanding about adolescent sexuality and health in scientific literature, I grew up as adolescent girl in Tanzanian society between late 80's and 90's. At that time HIV/AIDS epidemic was just discovered in Kagera region, and unintended pregnancies among adolescent girls were not a very significant concern. There were no specific efforts directed towards providing information for preventing unintended pregnancies and HIV/AIDS to girls. However, information targeting the general population through radio and roadside bill boards was assumed to reach adolescent girls as well. Internet and television network were still at nascence, if not very limited. When I was an adolescent girls in a secondary school (public) girls were made to go through routine pregnancy tests. If one was discovered pregnant, she was automatically expelled from school. The notion sex is dangerous (Nyanzi et al, 2008) was common.

Consequently, when I entered the NGO world I was neither a health expert nor an NGO professional, but a social scientist, who recognizes and acknowledge the potentials role of civil society organizations, especially NGOs in addressing social, cultural economic,

environmental, and political challenges facing individuals and different segments of the population in Tanzanian society, including sexual health issues of concern among adolescent girls. After I presented my credentials and explained the nature and purpose of the research was given access. But in the course of conducting field research some practitioners especially those in managerial positions, wanted to know why I was interested to conduct a research on girls' sexual health with them and/or their organizations, instead of asking adolescent girls themselves. As a response I simply underpinned the need to incorporate practical knowledge in social inquiry. I hope the logic behind conducting this research with selected institutions was clearly understood. I understand that it could be contrary to the research tradition they are used to. Perhaps, most researchers enter these organizations asking to have access to the targeted groups of the intervention programs in order to evaluate their efficacy or according to their research interests.

While on the one hand, being an outsider and lacking substantial professional experience with NGOs might have put me as a researcher into a disadvantaged position, on the other hand, it allowed me to pay attention to the details, especially to the things that might have been taken for granted. As a result, throughout the entire fieldwork, opinions, perspective, and experiences of the practitioners were accorded preference. More often than not, I would listen carefully, taking notes when the participants spoke without interruptions, but I would intervene to ensure the interview session does not astray from the research objectives and questions. I also asked questions to seek more clarifications or to stimulate reflection about pertinent sexual health issues confronting adolescent girls in Tanzania and how they were addressed.

Access to respective research participants emerged as a significant challenge. In Tanzania, most projects have a life span, meaning projects are implemented within specified time frame. Consequently, most practitioners had very busy working schedules and were highly mobile. For example they had meetings with key stakeholders from the ministries, relevant government authorities, and probably the beneficiaries and other stakeholders. I had to be a very patient, flexible and a careful time manager. In more than one occasions, particularly when interview schedules were being arranged, I was reminded to be mindful of time. Sometimes there were interruptions and the interview session had to be hurried or postponed. Other times, on

the day of the appointment, the interviewee is not around he or she travelled for official responsibilities or has an emergence meeting. Therefore, during incidences such as these, I had to call back, sometimes several times, to book for another appointment and after rescheduling I had to make full use of the participant's availability at office premises, including to wait until he/she accomplishes his/her activities of the day. Otherwise, lack of patience could entail another rescheduling. Fortunately, albeit operational challenges there were no any rejections. Both trust and collaboration from individual participants and institutions were earned.

Table 12: Socio-economic Characteristics of Interview Sample

	Profile	**Gender**	**Education**
1	Country Director	Male	University
2	Country Director	Female	University
3	Executive Director	Female	University
4	Director of Operations	Male	University
5	Program Manager (Lake Zone)	Female	University
6	Program Manager (ASRH)	Female	University
7	BCC Specialist cum Deputy Director	Female	University
8	Program Manager (M & E)	Male	University
9	Program Manager (M & E)	Female	University
10	Project Manager	Female	University
11	Project Manager	Female	University
12	Project Officer (Communication)	Male	University
13	Project Officer (Outreach Services)	Male	University
14	Project Officer (Capacity building)	Female	University[129]

5.6. Limitations Encountered

Given the fact that NGOs are voluntary and independent organizations, there were no hurdles getting access after fulfilling the required procedures which were not universal to all selected organizations. It is important to stating in this session is that, in some of the organizations access to project reports or other related official documents was not easy. According to one senior manager most project reports are not prepared to be made

[129] This includes participants with university level education both undergraduate degree and graduate degrees.

available to the public, rather to donors[130]. On the contrary, the documents which were prepared for the public were widely available on the tables, at the office reception, and/ or visitors lounge[131]. Yet, some NGO managers were willing to use their discretion to provide access to the requested documents, and few reports were available online or through official websites of some of the organizations. Last but not least, my limited experience or exposure to the NGO world might have led to potential bias and subjectivity[132]. While subjectivity is knowledge in social inquiry, use of multiple data sources or triangulation reduced bias and enhanced objectivity (Mlangwa, 2009; Mushi, 2011).

Following above limitations, and also taking into consideration the fact that civil society organizations especially NGOs are diverse, it is evident that findings, especially practical oriented findings may not be generalized to all NGOs. However, since the present study is not a case of NGOs but Tanzania, findings may reflect the localized context of adolescent girls' sexuality and sexual health. But it is important to acknowledge that findings from the present study cannot be extrapolated to other contexts.

5.7. Summary

This chapter presents a detailed account of the research philosophy, methodology according to which we shall conduct this research. The research methods relevant in the pursuit of the research objectives are delineated.

The present study draws from critical theory paradigm as philosophical lenses, utilizing case study rather than action research to advance our research goals. This is a qualitative

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[130] NGOs can be contracted by the government, intergovernmental organizations, private sectors government from Western countries and other individual donor organizations to implement health related interventions. Consequently, the word donor in the context of the present study represents multiplicity of actors who provide financial support to NGOs.

[131] One among the selected NGOs has a resource centre or library.

[132] Researchers who had prior extensive professional experience with NGO have probably less-long-winded entrance into the NGO world, and their professional experience enables them to play easily, both roles; a scholar and reflective practitioner (Mushi, 2011). But having professional experience may not necessarily reduce potential bias and subjectivity. It is upon the researcher to identify and make sure preconceived ideas and bias to not impact, heavily on research findings.

study. According to literature sources action research is described as the most suitable strategy in critical oriented researches because research and action to improve the situation of certain individuals or groups and/or change institutions and society are taking place simultaneously.

Nevertheless, as we do not intend to generate knowledge through action, but knowledge which may emphasize or stimulate action we shall use case study. While case study can generate concrete, practical and context dependent knowledge, in social inquiry a case study does not necessarily entail a choice of a research strategy, but a choice of what is to be studied (Stake, 2000; Myers, 2006). The present study takes place in Tanzanian context. Put it other way, it is the case of Tanzania, and institution is a unit of analysis.

Accordingly, in order to gain an understanding of the social processes and practices that may explain why adolescent girls are disproportionate vulnerable to sexual risk behaviors, unintended pregnancies, and HIV/AIDS transmission we have to look at a number of issues and case study provides for that (Yin, 2013).

Finally, the chapter details about the operational dimensions of the thesis— recounting how we identified suitable organizations— recruited research participants, and detailing procedures for data analysis. In chapter 5, we will present findings and discussion.

CHAPTER FIVE.
FINDINGS AND DISCUSSION

1. Introduction

The previous chapter illustrates the methodological considerations related with data collection and analysis in the present study and fieldwork. Therefore, this chapter presents findings and discussion, as well as the conclusion.

Briefly, the overriding purpose of the present study was to find out why adolescent girls in Tanzania are disproportionate vulnerable to sexual risk behaviors, unintended pregnancies and HIV/AIDS transmission. Specifically, to establish the social processes and practices that may relate with sexual risk behaviors, unintended pregnancies and HIV transmission among adolescent girls in Tanzanian society. In order to accomplish that key goal several other specific questions were posed:

- What international human rights provisions protect health in adolescents?

- What are the underlying factors that influence sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls?

- How do social meanings related to acceptable or unacceptable gender and adolescent sexuality influence sexual risk behaviors, unintended pregnancies and HIV/AIDS? Does this work differently for adolescent boys and girls?

- How do actors perceive sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls? Do they produce or reproduce differently the social meanings related to gender and adolescent sexuality and other elements, different ones, relating to health among adolescent girls?

- What measures are implemented in order to empower adolescent girls to avoid sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission?

In chapter 3 we have reviewed scientific literature to examine the underlying factors influencing sexual risk behaviors, unintended pregnancies, and HIV/AIDS, particularly by identifying the social meanings of gender and adolescent sexuality relevant in the Tanzanian society, and according to the institution of law (including policies) influencing adolescent health, and implications on health.

Consensus emerged in the review of scientific literature for mapping adolescent sexuality and health in Tanzania to indicate that, while individual level factors play an important role in influencing health threats among adolescents, factor beyond an individual especially the social meanings of gender and adolescent sexuality exert significant influence on sexual risk behavior, unintended pregnancies, and HIV/AIDS among adolescents. Further while, these are neither similar, nor do they exert similar influence on health among adolescent boys and girls. The influence is *stronger* among adolescent girls. Adolescent girls' sexuality is more controlled, restricted and stigmatized. Girls are generally expected to be sexually inexperienced and abstain from sex until they are adults, until they finish school, and preferable until they get married. Worse: they are also expected to be ignorant about sexual matters and submissive in sexual relations. On the contrary, being highly sexually experienced, knowledgeable about sex, dominant and in control in sex related decisions, and sexual relations are realities associated with adolescent boys' sexuality. Consequently, girls are less likely to seek for health information and services even if they were available. In addition to that, they can be denied access to health information and services by adults or punished in case they are found with a condom for being promiscuous. Further, girls hide their actual sexual behavior. And while in sexual relations, they are less likely to negotiate condom use to safeguard their female respectability, particularly to demonstrate that they are less knowledgeable about sex, sexually inexperienced and submissive.They are also likely to be subjected to coersed and forced sex and early marriage.

Accordingly, the key argument advanced after intensive review of scientific literature and information in chapter 3 is that, while the social meanings of gender and adolescent sexuality are shown to exert stronger influence on health among adolescent girls, they do not act so independently, unless they are produced and reproduced in institutions and social practice instead of being transformed. But they can as well beignored.

Therefore, in order to interrogate the research problem of concern, the present study sought to examine how sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls are perceived by actors within one of the key institutions in adolescent sexual health practice, in this case NGOs, and examine the *measures implemented by both institutions; law (including policies) and non-governmental organizations* for empowering adolescent girls to avoid sexual risk behaviors, unintended pregnancies, and HIV/AIDS transmission. Information for answering the relevant questions was generated through questionnaires, interviews, documents and unstructured observation.

Findings from reviewed literature and empirical study suggest that, to some extent, apart from silencing and stigmatizing of adolescent girls' sexuality and sexual health, adolescent girls may be disproportionate vulnerable to sexual health threats perhaps due to lack of protection of human rights of girls which is manifested in terms of unintended, and partly intended reproduction of the social meanings about gender and adolescent sexuality (and other elements such as age, school status, marital status, traditions, and religious beliefs) within the society, but most importantly within key institutions: laws (including policies), and non-governmental organizations.

2. Main Findings

2.1. Perceptions on Sexual Risk Behaviors, Unintended Pregnancies, and HIV/AIDS among Adolescent Girls

Arguably, gaining an understanding about how actors within institutions and practice perceive about sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescent girls is important. as it may somehow determine, the way they approach or, intervene in sexual health issues of concern among adolescent girls[133]. Hence, this session provides an account of the perceptions actors within NGOs ascribe to sexual risk behaviors, unintended pregnancies and HIV/AIDS among girls.

[133] This argument is also espoused by Gordon and Kanstrup, 1992 who found personal values around sexuality among health staffs in primary health care to have intense influence on program design and implementation. See also findings from a study conducted by Tiluhun in Ethiopia (2012)

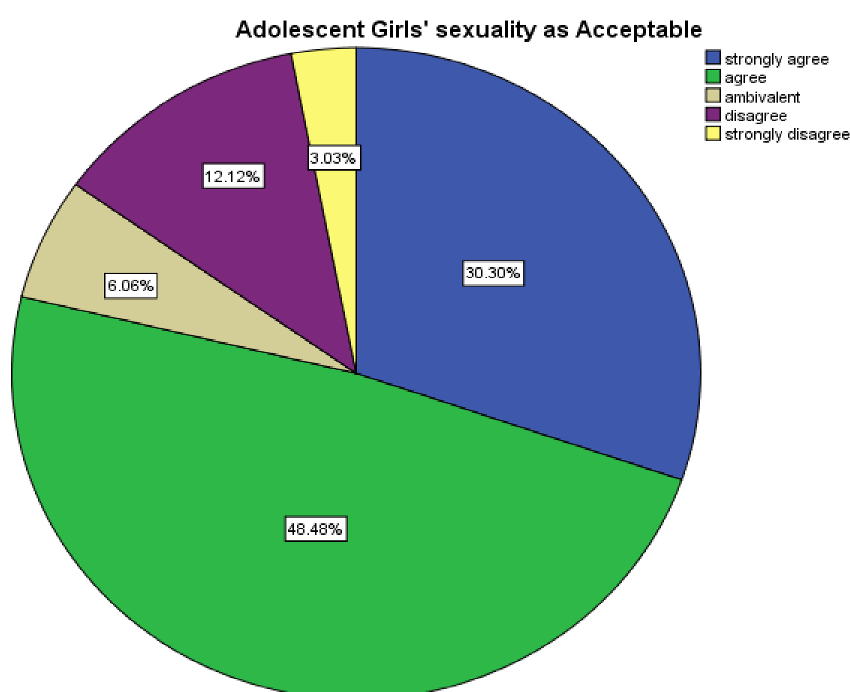
i. Perceptions on Sexual Risk Behaviors

In Chapter 1, research and statistical information reveal that while Tanzania adolescent girls are more likely to be sexually active by 15 years old and before 18 years, probably earlier than their counterparts, adolescent boys. Taking that into account, we aimed to unravel the perceptions and/or meanings actors associated with sexual activity among adolescent girls.

— Adolescent Girls' sexuality as Acceptable

Participants were asked to indicate their views about whether adolescent girls are likely sexually active just as boys counterparts. Data show that out of thirty three (33) participants, 30% (10) strongly agreed that adolescent girls are sexually active just as adolescent boys, 48% (16) agreed respectively. While 6% (2) were ambivalent, 12% (4) disagreed, and 3% (1) strongly disagreed that girls are sexually active just as their male counterparts. Judging by this finding, adolescent girls are perhaps not considered asexual as majority of participants perceive them to be sexually active just as boys counterparts.

Figure 1: Adolescent Girls' sexuality as Acceptable



Again, in order to gain a detailed understanding about actors' perception and meanings associated with sexual activity among adolescent girls, we also included open ended questions. Unlike close ended questions, open ended questions in questionnaires allowed participants to express themselves freely and use their very own words. For that reason, open ended questions provided written comments on the questionnaires.

Participants were asked about how they perceive sexual activity among adolescent girls. Findings show that majority of actors about 30% (10) acknowledged that adolescent girls are sexual beings. While some described sexual activity among girls as “a normal aspect of human nature”; “a sign of maturity; and symbol of love", others affirmed that “girls are sexual beings just as boys”; and that “girls become sexually active early than boys”. As one participant putted it, *“*adolescents have sex; some are very sexually active, as these are new feelings for them, which they want to explore. It is fine, however, they need to learn to protect themselves and take good care of themselves”. Other participants omitted the question or provided information which the researcher sought to be less useful.

Similar findings emerged from documents. Messages to illustrate that sexual attraction is normal among adolescents and youth were communicated through a girls’ power initiative. The aim was to enable girls to protect their lives, including health. Girls were therefore informed about physical and emotional changes taking place within their bodies during to puberty. One of the changes is to have *“hisia za kimapenzi”* (sexual attraction feeling). It is further elucidated that during puberty a girl (also a boy) may feel sexually attracted to the opposite sex, which is described as a joyful and normal aspect of transition to adulthood.

Nevertheless, in addition, girls were warned not to indulge into sexual feelings, and to ensure that sexual attraction feelings do not control them. It is stated that, *“mtu anaweza kukuvutia kimapenzi na unaweza kumfikiria kwa kiasi kikubwa…..ni sawa…..unakua…..kumbuka wavulana na wasichana huwa na hisia za kimapenzi, lakini usiruhusu zikutawale”* (It is possible to be sexually attracted to someone and to have

deep thoughts about him or her. This is normal, remember that boys and girls are growing up, but make sure that the feelings do not control you) (NGO1, 2013: 20)[134].

— Adolescent Girls' sexuality as Immoral

On the other hand, we asked participants to indicate their views about whether sexually active adolescent girls engage in immoral sexual behaviors. According to the data we collected out of 33 participants 3% (1) strongly disagreed to accept that sexually active adolescent girls engage in immoral sexual behaviors, and 36% (12) disagreed. While 21% (7) were ambivalent, 27% (9) agreed, the remaining 12% (4) strongly agreed that sexually active adolescent girls engage in immoral sexual behaviors.

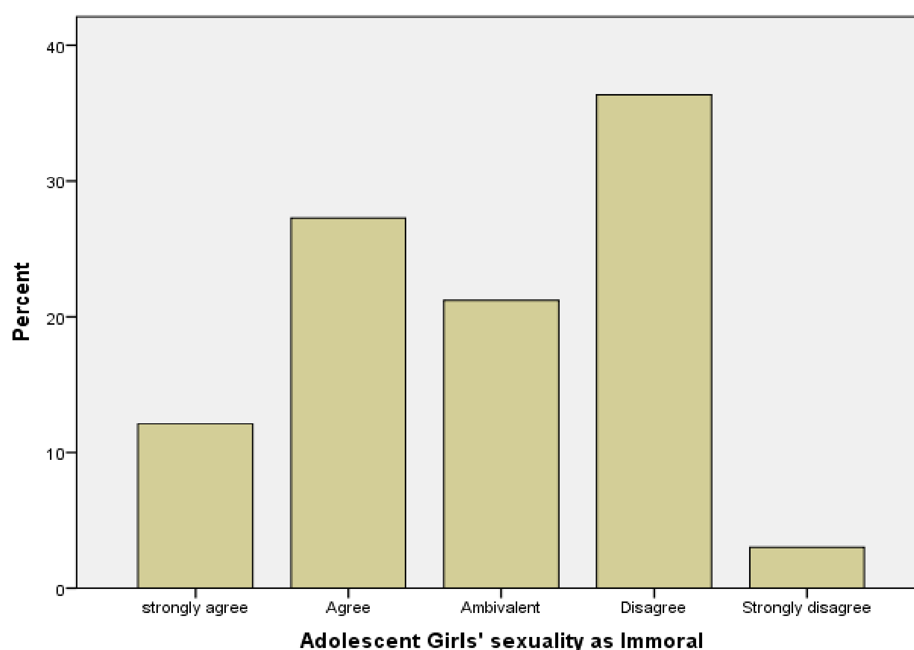
It is evident in data presented in figure 2 below, thata significant percentage of participants (36%) disagreed that sexual behaviors among adolescent girls are immoral. However, this finding is complex and inconclusive. There is a slight margin of difference between percentage of response categories which are in agreement with the statement and that of those which oppose the statement.

However, information obtained from interviews illustrated that imposing a moral code is probably not the domain of NGOs, but that of religious institutions. These two institutions are described to play complementary than conflicting role and they respect each other's role. While religious leaders talk about abstinence and being faithful, NGOs talk about condoms, also abstinence and being faithful (Fieldwork, 2013-2014). There were few participants who associated girls' sexuality with moral frameworks. Yet, as a whole this finding remains complex

On the other hand, message such as, *"kidini nafikiri ngono ni kwa ajili ya waliooana tu"* (I think according to religious instruction sexual intercourse is for married people only) (NGO1, 2013:39) were documented. Although this message was delivered to demonstrate young people own views and perceptions about sex and sexuality, it was included in a booklet which was a part of a health protection project for girls.

[134] It is important to state here that in order to observe ethical standards relevant in the present study, particulary those related with protection of the anonymity of the institutions and individuals that participated in study, all documents obtained from fieldwork, such as magazines, booklets, brochures, leaflets, a few to mention, will not be included in the bibliography.

Figure 2: Adolescent Girls' sexuality as Immoral



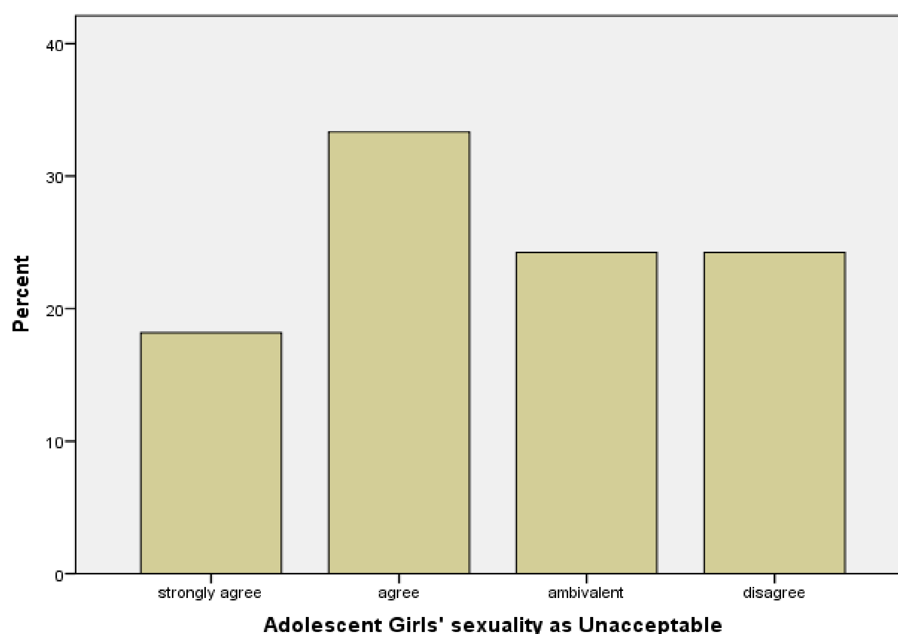
— Adolescent Girls' sexuality as Unacceptable

We asked participants to indicate their views about whether sexually active adolescent girls engage in unacceptable sexual behaviors. Findings reveal that 18% (6) of participants strongly agreed, and 33% (11) agreed respectively. Other 24% (8) were ambivalent, and by contrast, 24% (8) disagreed to accept that sexually active adolescent girls engage in unacceptable sexual behaviors. Although a significant percentage of participants were in agreement with the view that sexually active adolescent girls engage in unacceptable sexual behaviours, this finding demonstrate that participants' views differ sharply. At least 24% of participants could not establish whether they view sexual behaviors among girls as unacceptable or not and 24% disagreed (see figure 3 below).

Apparently, it is difficult to interpret this finding due to high percentage of ambivalence response. While generally, ambivalence about sexuality of an individual or group denotes existence of denial, this finding probably reflects that, actors may have their own individual perceptions of sexual behaviors of girls. But also that of their society. In Tanzanian societies many people, especially adults, do not approve sexual activity

among girls due tradition and religious reasons, (Lugoe, 1996; Van Haren, 1999; Dilger, 2003; Haram, 2005a; Haram, 2005b). On the other hand, ambivalence probably denotes that, some actors in NGOs do not have an adequate understanding of the social meanings attached to sexual behaviors of girls relevant in the wider society as they are tacit (Leshabari et al, 2008).

Figure 3: Adolescent Girls' sexuality as Unacceptable



Following the above findings, and in order to widen our understanding about actors' perception and meanings associated with sexual activity among adolescent girls, we also included open ended questions in the questionnaires. We therefore asked how they perceive sexual activity among adolescent girls. Evidence from open ended questions revealed that about 24% (8) do not acknowledge adolescent girl sexuality. Sexual activity among girls is associated with prostitution, adultery, and sin.

We also reviewed documents obtained from selected institutions in order to obtain rich and detailed data for addressing research questions posed in the present study. Most of documents, especially those which were available to the public were written in Swahili language and some in English language. Most technical reports were in English. As a result, we decided to retain Swahili version of extracts to preserve the originality of the text and authenticity of data. But we have also provided simple and user friendly alternative English transcripts. Language is an important factor in sexuality related

research (Undie & Benaya, 2006). Needless to say, it was difficult to identify actors' own perceptions and meanings attached to girls' sexuality in documentary review. Majority of the messages delivered especially through magazines and booklets were meant to give young people a voice and platform for them to air own views and stories. Therefore, only few messages were identified:

> *"Ngono ni kitu maalumu. Usiache mtu mwingine kukuamulia. Ila la muhimu zaidi ni kusubiri mpaka tutakapokuwa tayari kiumri, kiakili, kifedha, hasa kwenye ndoa"* (sexual intercourse is something special that nobody should decide for you...but it is important to wait until we are ready age wise, mentally, financially, and most important in marriage) (NGO1, 2013:39).

The message above perhaps, represents how most actors perceive appropriate sexual behaviors for adolescent girls. Drawing on our observation of the document and unstructured observation while in the fieldwork context, we found out that: (a), within the booklet or training manual, the message was positioned on the top of the page comprising of other messages delivered by youth as illustrated through the photos, (b), the message is printed in bolded italic letters probably, to emphasize about its importance, and (c) the message was positioned beside the passport photo of one of an identifiable staff and research participant.

Similar messages emerged from interview. At least five (5) participants were of the view that girls need to wait to become sexually active than doing it secretly. This is not because sex is bad, but because they do it 'very early', meaning, before they are matured enough to plan, enjoy, and handle sexual relations. As elucidated by another participant:

> There is a problem on how messages about delaying sex are communicated to adolescent girls (youth). Most of the people in 'the sack of influence' tell them (adolescent girls) sex is a bad, dangerous, and painful thing. As a result, when they engage in sex and find it pleasurable they wonder. They should be told instead, that, sex is nature and it is your right. But every right has a responsibility. Sexual relations have strong emotions and you are not ready to handle that. Also if you enter into sexual relations early, there is a lot of consequences ... it is better for you to wait for the right time or until you are matured enough to handle emotional and other aspects of sexual relations or you get someone you are deeply in love with and enjoy it [Emphasis added] (Fieldwork, 2013-2014)

In addition the above, important findings emerged from documents. While the researcher was waiting for the interviewee in the hallway, the researcher sat facing a mobile placard with information about an HIV/AIDS prevention project which has been implemented by the particular NGO.

Overall, the project intended to sensitize people about the importance of being faithful while in sexual relationship (probably within marriage) as a way of protecting themselves from contracting HIV. The key message was tailored to encouraging people to have 'one love'. What drew researcher's attention to the placard was that in addition to stating the aims of the project, a message was included at the bottom of the placard to indicate that the project was not intended for 18 year olds and below. Therefore, in order to understand the rationale of incorporating such a message from actors' perspectives, the researcher enquired briefly about the project, particularly about the footnoted message in an interview conversation with an experienced actor:

Researcher*; Would you also talk a little bit about the project 'one love'.*

Research participant*; yes of course, the project is being implemented by our organization (mentioning the name of the organization) here in Tanzania. But, it is also implemented in other few countries in Southern and Eastern Africa. The key messages are* "mlinde" *(protect him/her)* "muheshimu", *(respect him or her)* "muhusishe" *(engage him or her).*

Researcher*; At the bottom of the placard there is a statement which reads 'it is not for 18 years and below'. In your opinion what is the importance of that message for adolescents, especially girls and for the project.*

Research participant*; The message is important. In short, it means that the project does not target those who are below 18 years old (emphasizing)....we do not want them (girls) to say our organization (mentioning the name of the organization) says it is okay to have 'one love' (Fieldwork, 2013-2014).*

ii. Perceptions on Unintended Pregnancies

According to statistics in chapter one, Tanzania is among ten (10) countries in Africa with high fertility rate. Adolescent girls are shown to be particularly vulnerable to unintended pregnancies. A substantial number of girls become pregnant and/or have started childbearing before 20 years. Taking that into account, we aimed to unravel the perceptions actors associated with unintended pregnancies among girls through an analysis of the factors they associate with it.

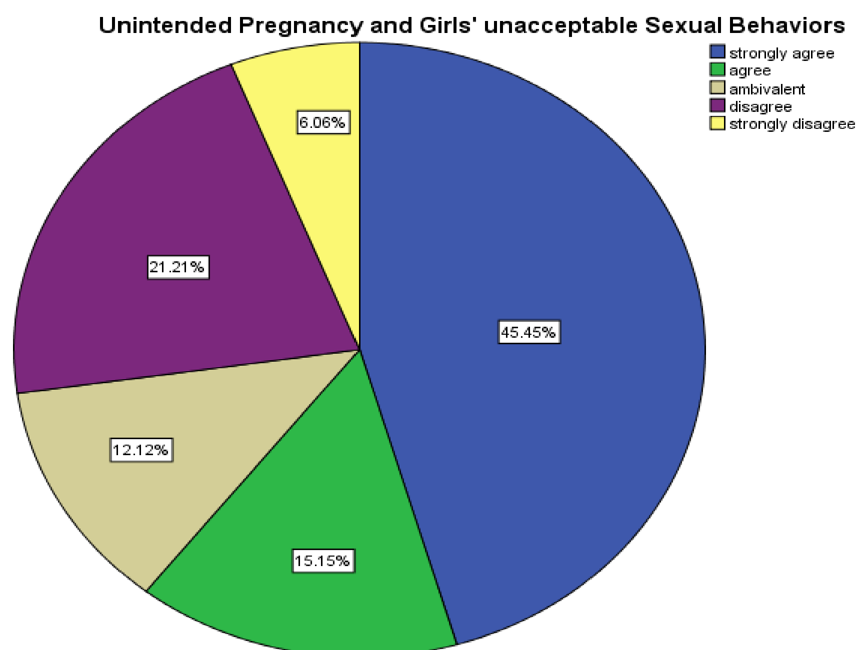
— *Unintended Pregnancy and Girls' Unacceptable Sexual Behavior*

Participants were asked to indicate their views about whether unintended pregnancy among girls is due to girls engagement in unacceptable sexual behaviors What was striking to note in our data is that, 45% (15) of participants strongly agreed, and 15% (5) agreed that unintended pregnancies occur due to girls' engagement in unacceptable

sexual behaviors. Other 12% (4) were ambivalent, 21% (7) disagreed, and 6% (2) strongly disagreed that unintended pregnancies occur because adolescent girls engage in unacceptable sexual behaviors.

According to scientific sources, pregnancy among adolescents is positioned as a public health concern and a development issue due to its ramifications on socio-economic development of an individual girl and the society. Also increase in maternal and newborn mortality rate (Presler-Marshall, 2012), to name a few. Thus, it is a problem which needs drastic measures. This finding perhaps suggest that unintended pregnancy among girls is also perceived as a moral issue as some participants associated it with girls' engagement in unacceptable sexual behaviors. In many societies in Tanzania, and in Africa, fertility and ability to procreate, are used to define girls' social status and femininity (Plummer et al, 2010). However, it has to be according to moral expectations. Especially, within the context of marriage (Izugbara et al. 2011).

Figure 4: Unintended Pregnancy and Girls' unacceptable Sexual Behavior



Data obtained from questionnaires are somehow different but also similar to information obtained from documents. Almost all organizations educate and/or inform adolescents about the dangers and consequences of pregnancy during adolescence.

Accordingly, both adolescent boys and girls are informed about what happens during puberty and the physical changes accompanied with it. But, nature of information

communicated is not similar among girls and boys. While puberty among boys is described to be accompanied by increase in sexual urge and desire, especially when boys see girls, there is silence about the relevance, even irrelevance of increase in sexual urge or desire among pubertal girls. Of course this information was perhaps meant to reflect the biological differences between boys and girls. However, tacitly, the messages may also reinforce the taboo attached to adolescent girls' sexuality.

In addition to the above, within the same document, information about menarche and menstruation for girls is accompanied by messages which, probably are meant to control adolescent girls' sexuality than boys' sexuality. Girls are warned, "*kuvunja ungo si ruhusa ya kuanza kujamiiana*"(to start menstruation is itself not a permission to begin to have sexual intercourse) (See figure 5 below). The message further illustrate that, *"kutoka damu ukeni (hedhi) kwa mara ya kwanza kunaitwa kuvunja ungo. Hii ni dalili ya msichana kuingia utu uzima"(Experiencing first menstruation signifies that a girl has entered adulthood)* (NGO4, n.d). According to this finding, the mainstream view which considers adolescent girls who have already experienced menarche and menstruation[135] as adults is documented in some of health protection and prevention intervention intervention programs in NGOs. On the contrary, In other societies worldwide, especially in developed countries, puberty among girls is viewed just as a developmental stage and may have nothing to do with an adolescent girl becoming an adult (Plummer et al, 2010).

[135] *"kuvunja ungo"* in Swahili.

Figure 5: Girls' Sexuality as a Taboo

Source: Fieldwork, 2013-2014.

— Unintended Pregnancy and Girls' Immoral Sexual Behavior

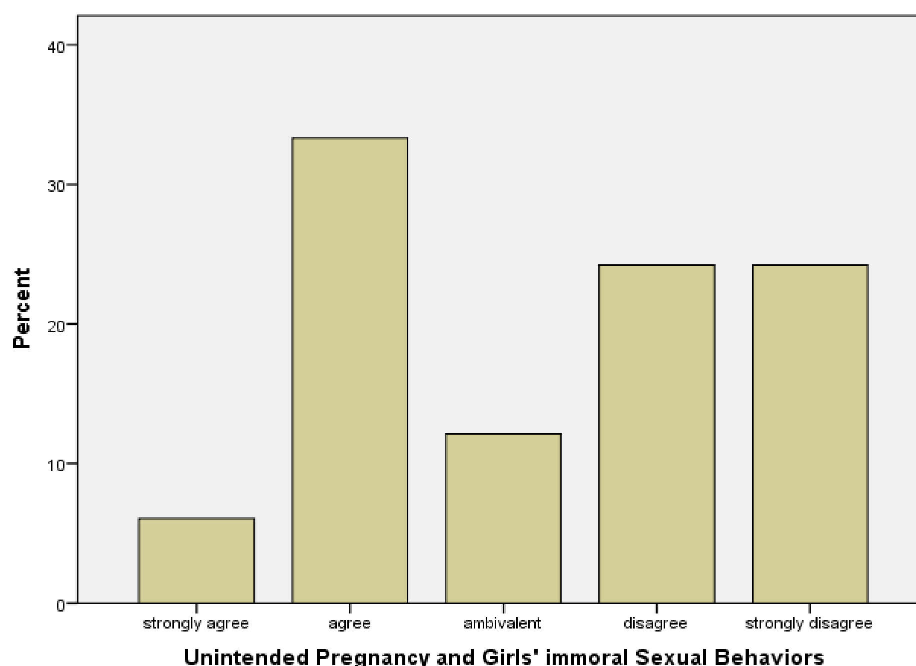
On the other hand, participants were asked to indicate their views about whether unintended pregnancies among girls is likely to occur because sexual activity among adolescent girls is immoral. Findings revealed that 6% (2) strongly agreed, and 33% (11) agreed that unintended pregnancies occur because sexual activity among adolescent girls is immoral. While 12% (4) were ambivalent, 24% (8) disagreed, and 24% (8) strongly disagreed about the same.

Overall, using a bird' eye view, this finding could be difficult to interpret. Although 33% of participants and other 6% related unintended pregnancies among girls and sexual mores, there is equally 24% of participants who disagreed and other 24% who strongly disagreed to associated unintended pregnancies among girls with morality. Perhaps the presence of competing views denote that a substantial number of participants do not associate unintended pregnancies among girls with immoral sexual behaviors.

This finding is the opposite of findings reported earlier (see figure 4), whereby majority of participants associated unintended pregnancies among girls with unacceptable sexual behaviors. Yet, it was observed in documentary review that messages to emphasize health and social effects of pregnancies among girls such as *"kutengwa na jamii"* (to be socially excluded) because *"jamii nyingi haziruhusu msichana kupata mtoto nje ya*

ndoa, achilia mbali msichana ambaye bado ni mwanafunzi" (in many societies bearing children out-of-wedlock among girls, especially school girls, is not acceptable) (NGO1, 2013:63) are communicated. Similar messages such as, *"utoaji mimba ni kinyume na sheria kwenye nchi nyingi"* (abortion is illegal in many countries) NGO3:n.d: 11), and *"dini nyingi haziungi mkono utoaji mimba"* (most religions do not support abortion) (NGO3, n.d: 11) are included as part of pregnancy prevention.

Figure 6: Unintended Pregnancy and Girls' Immoral Sexual Behaviors



We also included an open ended question (which provided for more than one answer) for the sake of documenting further perceptions about unintended pregnancies among girls. According to our data 18% (6) participants associated unintended pregnancies among girls with poverty and pecuniary motives. Other 21% (7) participants associated unintended pregnancy with lack of condom use and unprotected sex. Furthermore, 21%, (7) participants associated unintended pregnancies among girls with cultural views about sexuality and male dominance. One participant noted that "culture makes girls to believe that men are the main decision makers even on issues that affect their lives, and they have to accept men's decisions". Another one added, "culture makes girls to hide their sexual feelings and practices".

iii. Perceptions on HIV/AIDS

In Chapter 1, research and statistics reveal that while in Tanzania half all of new HIV infection occurs among youth, and adolescent girls are particular vulnerable to HIV[136]. Taking this into account, acquiring actors' perspectives on HIV/AIDS among girls, specifically, factors that are considered to expose adolescent girls to HIV infection is important in addressing research problem relevant in the present study.

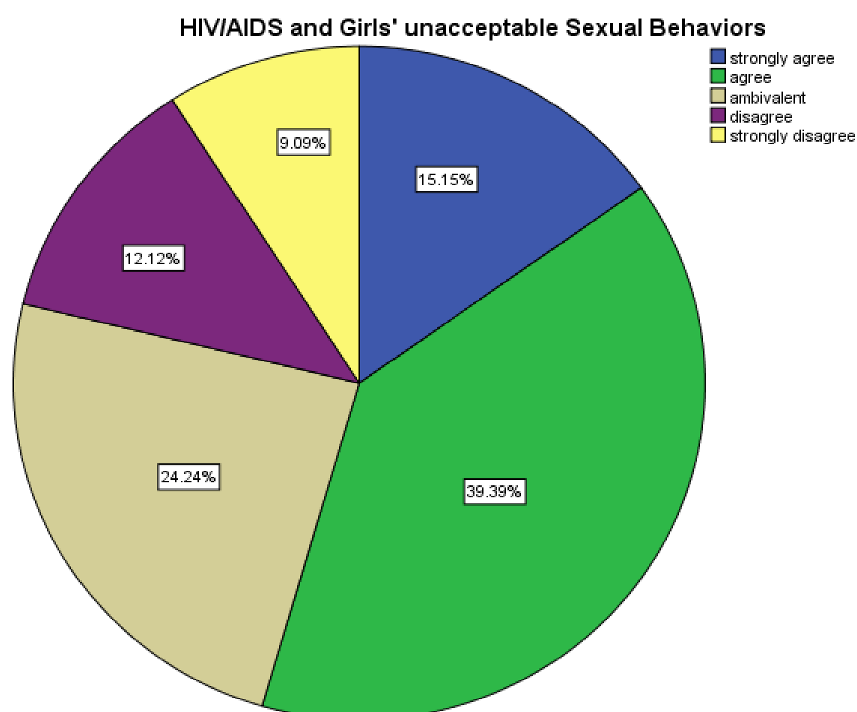
— HIV/AIDS and Girls' Unacceptable Sexual Behaviors

Participants were asked to indicate their views about whether sexually active girls are more likely to HIV because they engage in unacceptable sexual behaviors. According to data we have collected, 15% (5) of the participants strongly agreed, and other 39% (13) agreed that sexually active adolescent girls are more likely to contract HIV/AIDS because they engage in unacceptable sexual behaviors. While 24% (8) were ambivalent, other 12% (4) disagreed, and 9.1% (3) strongly disagreed to accept that sexually active adolescent girls are more likely to contract HIV/AIDS because they engage in unacceptable sexual behaviors.

Noticeably, this findings resonate with findings on unintended pregnancies (see figure 4), while 45(15) of actors strongly agreed, 15% (5) agreed that unintended pregnancies is associated with girls' unacceptable sexual behaviors, 39% (13) strongly agreed, and 15% agreed to that girls' vulnerability to HIV infection is due to engagement in unacceptable sexual behaviors. While the findings may reflect participants own views of HIV/AIDS infection among girls, perhaps findings demonstrate that HIV/AIDS is perceived as a health, also a moral issue among few actors in non-governmental organizations and in the wider society.

[136] According to statistics, in Tanzania, 60% of all new HIV infection occurs among adolescents and youth (10-24).This statistics motivated the design development and implementation of most current interventions targeting youth. For example it was observed during fieldwork that wheel covers of some of the vehicles belonging to an NGO which was implementing the project *"tuitetee"* had message to indicate that youth bears the lion's share of all new HIV infection in Tanzania.

Figure 7: HIV/AIDS and Girls' unacceptable Sexual Behaviors

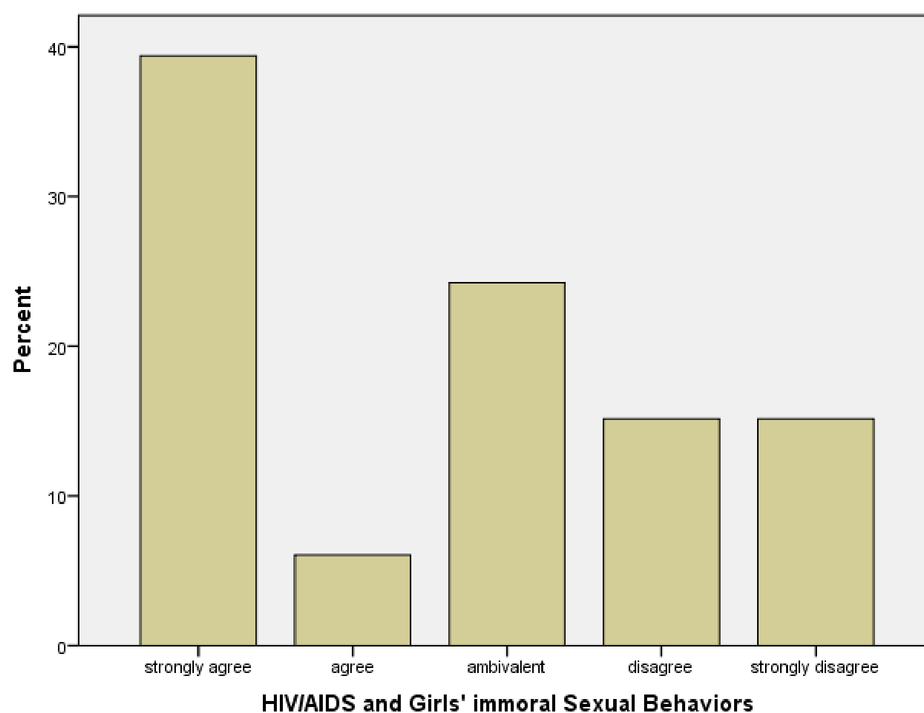


— HIV/AIDS and Girls' Immoral Sexual Behaviors

On the other hand, we asked participants to indicate their views on whether sexually active girls are more likely to contract HIV/AIDS because they engage in immoral sexual behaviors. Results show that 39% (13) strongly agree that sexually active adolescent girls are more likely to contract HIV/AIDS because they engage in immoral sexual behaviors and 6% (2) agreed. While 24% (8) of participants were ambivalent, approximately 15% (5) disagreed and 15% (5) strongly disagreed respectively. Judging by the data we collected from the questionnaires, despite of the fact that civil society organization, in this case non-governmental organizations have stepped in the fore front to implement several intervention for preventing the spread of HIV/AIDS scourge among adolescents and youth, a significant number of actors seem to associate girls' vulnerability to HIV/AIDS with morality. What this data demonstrate is that just like unintended pregnancies, in many societies in Africa, HIV/AIDS is associated with lack of morals or a failure to abide by traditions and religious instructions (Yamba, 1997

cited in Tenkorang et al, 2010; Bujra, 2000; Smith, 2004; Wanjiru, 2007; Izugbara & Undie, 2008; Izugbara et al, 2011).

Figure 8: HIV/AIDS and Girls' immoral Sexual Behaviors



Interestingly, findings drawn from the open ended question which aimed to gather participants' own views on why girls are more likely to contract HIV were not as detailed as those drawn from similar question on unintended pregnancies among girls. Yet, data unveiled perspectives of someactors about factors rendering adolescent girls vulnerable to HIV infection. Approximately, 16 participants (48%) were of the view that sexually active adolescent girls are vulnerable to HIV infection because they lack SRH knowledge and information about sexuality. As one participant putted it, "most girls are uninformed about SRH; therefore they are easily persuaded into having sex".

The issue of cross-generational sex and HIV/AIDS among girls emerged. Almost 4 participants (12%) identified girls' engagement in sex with older men as a factor rendering them vulnerable to HIV/AIDS. This view resonate with findings from research conducted all over Africa whereby, sexual relationships with older men, whether inside or outside marriage is considered to drive HIV, especially in countries with generalized epidemic (Luke, 2003; Monarchy & Mahy, 2006) including Tanzania.

As one participant espoused, "girls are sexually active, and problems like cross-generational sex contributes a lot to HIV infection among girls due to lack of bargaining power in using protection". Again, judging on our data, actors have diverse perspectives about factors which render girls' vulnerability to HIV. For instance, 5 participants (15.2%) cited societal culture together with male dominance in sexual relationship, and unprotected sex as reasons why girls are more likely to contract HIV.

Drawing from the data presented hereinabove; one can argue that a significant number of actors in non-governmental organizations reproduce the social meanings of gender and adolescent sexuality which impact on girls' health as described in chapter 3. While this argument may be valid, it may also be simplistic. Gaining a holistic view of the findings is fundamental. The identified social meanings attached to gender and adolescent sexuality among individual actors in NGOs may just be remembered as code of conduct (Giddens, 1984).

3. Measures for Empowering Adolescent Girls to Avoid Health Threats

While significant number of participants acknowledged adolescent girls as sexual beings by affirming that girls are sexually active just as adolescent boys, finding also illustrated that a substantial number of participants associated unintended pregnancies and HIV/AIDS with girls' engagement in unacceptable sexual behaviors. However, this finding may be incomplete for addressing the research problem relevant in the present study. As Giddens suggests structures are created by human action and activities hence, they “do not have necessary dominion over human actors” (Whittington, 2001; 696). In addition, Giddens argued that, these structural properties are not real. They can only be real when they are used to guide action or activity. Most importantly, Giddens suggests that, there is recursive relationship between structure and agency (Giddens, 1984). In that vein, the study also sought to examine actions related to addressing sexual risk behavior, unintended pregnancies, and HIV/AIDS among girls in law (including policies), and in adolescent sexual health practice in selected NGOs.

Following that line of thinking, this session looked at measures implemented as a way of empowering adolescent girls to avoid sexual risk behaviors, unintended pregnancies

and HIV/AIDS transmission[137]. It is argued that, while empowerment constitutes enabling an individual to protect her own health by addressing individual level factors related with health threats, it also constitutes challenging and/or transforming the factors within the broader society, particularly the social meanings of gender and adolescent sexuality that impinge on girls' ability to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. Information was generated, mainly, from interviews and documents, but also questionnaire and unstructured observation.

3.1. Behavior Change and Communication

In Tanzania behavioral approaches have dominated programs on sexual health among various segments of the population, including adolescent girls. Hence, technical and financial resources have been invested for implementing BCC interventions programs, whereby increase in health related knowledge and attitude, decrease in number of sexual partners, increase in condom use, delay of age in sexual debut and decrease in sharing contaminated injection and equipments are some of the final outcomes (Plummer, 2012). On the whole, BCC intervention programs position an adolescent girl as a rational being who can make independent choices and decisions to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS given access to adequate and correct information and services.

Sexual risk behaviors, unintended pregnancy, and HIV/AIDS are therefore understood to be influenced by choices and decisions made by an individual adolescent girl. Therefore, while the main focus is on A — Abstain, B — Be faithful, and C — use condoms (Mabala, 2006), life skill education or training, voluntary counseling and testing (VCT), condom social marketing, and peer education are other examples of behavior change and communication interventions (Campbell & MacPhail, 2002; Eaton et al, 2003). According to our data, among the four NGOs, it is NGO3 which implements behavioral change and communication strategy as an overarching approach for empowering adolescents and youth to avoid health threats.

[137] Words action, measures, and/ or intervention programs may have different connotations, but are used throughout this thesis.

i. ABC (Abstain, Be faithful, Use condoms)[138]

ABC programs aims to increase age at sexual debut, reduce number of sexual partners, and increase condom use. ABC combines three strategies; abstinence, being faithful, and condom use. Accordingly, Plummer perceives ABC programs to have the potential for reducing sexual risk behavior among individuals and people who have different priorities and desires (Plummer, 2012). Findings show that ABC[139] is an overarching approach in intervention for empowering adolescents, including girls to avoid health threats in almost all non-governmental organization.

Mema kwa vijana (good things for young people) is an example of adolescent sexual health program which was designed based on ABC model. Mema kwa vijana (Mkv) designed, implemented and evaluated in Mwanza Tanzania between 1996 and 2008, phase 1 (1996-2001) — development and evaluation, phase 2 (2001-2007) — scaling up and learning the lesson, Phase 3 (2007-2008) — further survey for long term impact[140]. NGO4 spearheaded design and implementation of MKV together with other national international partners (Plummer, 2012). The overall aim of the project was to improve sexual health of adolescents in Mwanza region and beyond. Mkv was a school based intervention whose primary target group was 12-17 years old in the 3 final years of primary school education (standard 5, 6 and 7) (Obassi et al, 2006). Drawing from the social cognitive theories (Wight et al, 2012), the specific objectives of the project was to delay onset of sexual intercourse, to decrease risk behaviors and to increase uptake of appropriate health services (Obassi et al, 2006; Plummer, 2012).

In NGO1 we had access to a booklet containing health information meant to be used by girls (trainees) and facilitators (trainers)[141]. The booklet was produced as part of a girl power project called *'linda Maisha yako'* (Protect your life). Accordingly, the booklet contained various topics which were covered in approximately eight modules or topics;

[138] During the cause of interacting with practitioners in NGOs the term 'condomize' was coined to denote use condom.

[139] *Acha kujaamiana, kuwa mwaminifu, ukishindwa – tumia* kondom is the Swahili replica for ABC.

[140] See for more at: http://www.memakwavijana.org/about-mkv/summary.html

[141] The booklet was published by the organization in 2013.

"sisi ni wasichana"(we are girls), *"balehe"* (puberty), *"ukatili dhidi ya wanawake"* (violence against women), *tuzungumze kuhusu ngono* (let's talk about sex), *"uhusiano bora"* (good relationship), *"kujiweka salama I* and *II"* (self protection I and II), and *"baada ya yote haya"* (concluding module). There is no specification on what is an overall approach addressed within a particular module. Consequently, abstinence, be faithful and condom use are addressed particularly, within let's talk about sex, self protection I and self protection II modules.

A key finding emerging from the documents is that abstinence plus, whereby adolescents and youth are provided with information about abstinence, and condom use is actively promoted for sexually active adolescents, than comprehensive approach whereby information about ABC is communicated without specifying which among them is better than the other (Plummer, 2012).The latter was relevant in most NGOs. According to the data we have collected abstinence only messages were communicated by NGOs predominantly, in late 1990s and early 2000s. Strikingly, findings also reveal that abstinence or delaying sexual debut seemed to be positioned as a strategy which offers ultimate protection against unintended pregnancies and HIV/AIDS among girls. And is probably suggested as a standard norm or an indicator of good or constructive relationship: *vijana wengi hawajamiiani... lakini hawaonekani kuwa hovyo, wapweke au wenye huzuni...wanapata raha zote* (majority of young people are not sexually active...but they do not look awkward, lonely or miserable...they are rather happy and satisfied) (NGO1, 2013:69)[142]. Information about abstinence is not only delivered to girls, girls are taught to practice sexual refusal skills (according to the instructors manual) for girl power project, *namna ya kusema hapana katika ngono, uzuri wa kusema hapana na jinsi ya kusema hapana* (How to say no to sex and the benefits of saying no to sex) (NGO1, 2013).

In addition, girls themselves are shown to convey different message reinforcing the importance of delaying sexual activity; "saying no to sex is for my life...it is my decision....my choice to wait"[Emphasis added]. This is echoed in other documents whereby the message from a girl (on the photo) reads, *"nataka kusubiri. Sitaki kupata mimba kabla sijamaliza shule"* (I am planning to wait. I don't want to become pregnant

[142] The message was printed in bolded capital letter.

before I finish school) (NGO1, 2013: 39). At the same time, condom use is promoted as an important health protective method. For example adolescent girls were informed that "*kama kondom haijavaliwa basi uume nao huujaingia*" (if the penis does not have a condom on it should not be allowed to penetrate-the vagina) (NGO3, n.d:19). Condom use was emphasized as an HIV prevention method— but in case one fails to abstain or delay sexual activity; *ukimwi unaua vijana wenye uwezo mkubwa kwa nini? Kwa sababu hawakuacha kujamiiana. Kama ukiacha una kinga ukishindwa cheza salama. Tumia kondom* (AIDS kills smart and talented young people because they did not abstain from sex. If you abstain you are protected, but if you cannot abstain play it safe. Use condoms) (NGO1, 2013:41).

Findings also suggest that being faithful is communicated to adolescents and youth, probably without any depth (Plummer, 2012), and/or overtly because doing so may imply that NGOs are promoting sexual activity among adolescents particularly unmarried ones. For example information from mobile placard demonstrated that the target group for 'one love' are married couples. But, information in an ABC up to Z leaflet, which was distributed as apart of a health promotion intervention for youth, revealed that the message one love campaign was also meant for adolescents and youth. Letter **m** stand for *mapenzi salama; mmoja tu anatosha, mlinde, mheshimu, mhusishe* (safe sex; one love is enough, protect him/her, respect him/her, involve him or her).

ii. Voluntary Counseling and Testing

HIV voluntary counseling and service (also known as Voluntary Counseling and Testing, or VCT) is promoted as a sexual health prevention measure for adolescents, including girls, whereby provision of counseling, testing and related support services are understood to lead to change in sexual behavior, particularly reduction of number of sexual partners.

NGO3 operates a National Health (afya) AIDS Helpline (177) since 2001, whereby behavior counseling and referrals services including VCT, are provided to an average of 700 to 1,000 callers per day. There is no clear cut gender and age disaggregated data about VCT related calls. Overall, while 34% of callers were female, 66% were males, and 78% of all callers were 14-24 years. Out of this, 17% callers were seeking

information about counseling and testing and 44% called to receive HIV and AIDS preventive counseling. NGO3 also has a mobile unit which offers VCT services in public gathering such as market places, festivals and other social gathering[143]. They also offer what is described as preventive counseling which is much more than VCT services. Consistent use of ARVs and treatment is described as a HIV preventive strategy. Generally, in Tanzania, NGOs have been in the front line offering voluntary counseling and testing services. For example NGO1 is among the first non-governmental institutions to manage and offer professional and reliable HIV counseling and testing services through its *'angaza'* (brighten) and *'angaza zaidi'* (brighten up more) interventions which constitute VCT clinics operating in almost 18 regions in Tanzania.

iii. Life Skills Training

As established earlier (in chapter 3), and echoed in our findings, apart from information and services, adolescent girls needs life skills so that they can be empowered to avoid sexual health threats. According to information from interview and documents the following are some of the skills targeted through role play in outreach programs, and cartoon in magazines such as *'fema'* and *'si mchezo'*(no joke) which are part of a health information project: self esteem and awareness, effective communication (especially how to say no to sex, unprotected sex, and peer pressure), decision making, critical thinking, coping with stress, emotions and assertion to remain healthy. One participant admitted that adolescent girls live in a society which expects them to be submissive. Lack of self awareness among girls was echoed by another participant who said, "*wasichana wengi hawajitambui...wamelelewa kuwa submissive*"(most girls are not empowered...they are socialized to be submissive). Thus, life skills such as self awareness and decision making were described to be very important. It is important to state here that, in most NGOs, life skill was implemented together with other strategies.

iv. Peer Education

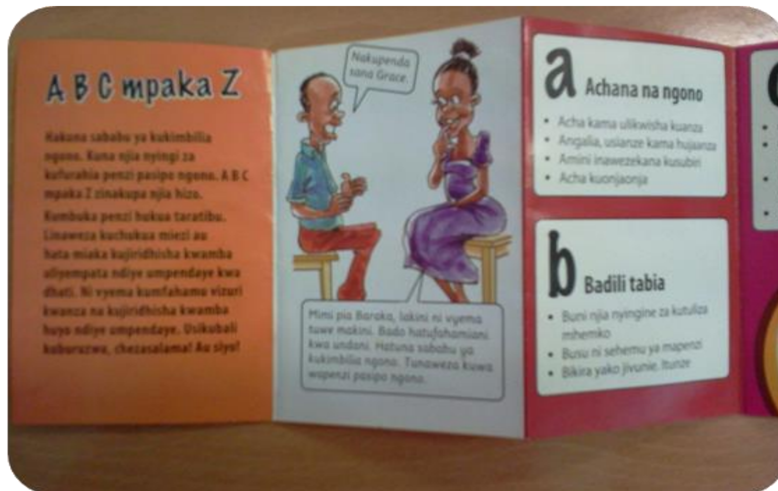
[143] I saw this mobile unit myself at a famous and highly crowded market or business centre known as *Kariakoo* (The market receives retailers and wholesalers from all over Tanzania and probably from most of land locked countries neighbors, particularly Zambia, Uganda, and Congo) but did not have my camera. After a week I returned to the market, it was not there, probably it was moved to service another different location.

Although there is little evidence to confirm effectiveness of peer education in reducing sexual risk behavior, unintended pregnancies, and HIV, peer led education is implemented by most of the NGOs to address sexual health threats for adolescents, including girls. However, peer education was not implemented as a separate intervention, but one of the strategies in an intervention programs. In NGO3, there is data to show that from 2008-2010 a total of 1,035 youth were trained as peer educators under youth *'balozi'* (ambassador) intervention. Under Mkv intervention two hundred and forty eight (248) class peer educators were trained. Peer education was an integral aspect of many intervention programs. One project officer described that they were amazed by peer educators both female and males, especially for their ability to convey sexuality related information to their peers and in a way which is easily understood. As demonstrated during clubs for out of school youth.

3.2. Beyond ABC

Another important finding emerged from practical aspects of adolescent sexual health. In most NGOs, ABC is perceived not exhaustive for adolescents and youth as it does not reflect the contextual and complex reality of social relationships, love and sexuality. Therefore, what is described as 'beyond ABC' strategy is being implemented or adopted by most organizations. Practices such as *'kujichua'* (masturbation), *'kuahirisha kujamiiana'* (delay of sexual debut), *'kutumia condom'* (condom use), *'kubusiana na kukumbatiana'* (kissing and caressing) are communicated as safe sexual behaviors to adolescents and youth (See figure 10 below). *ABC mpaka Z* (ABC up to Z) document which constituted additional alphabets (in Swahili not English language) was a detailed example of beyond ABC initiatives (See figure 9 below).

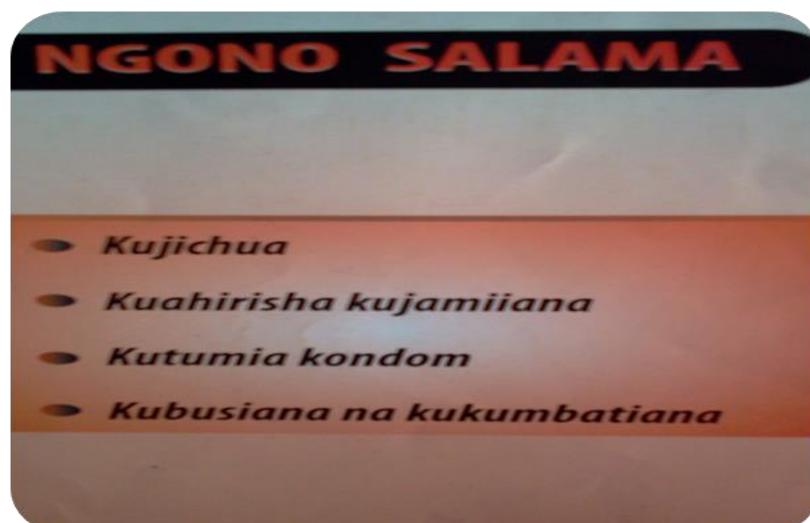
Figure 9: ABC *mpaka* Z (ABC up to Z)



Source: Fieldwork, 2013-2014.

The key message of *'ABC mpaka Z'* (ABC up to Z) is that, adolescents and youth have no reason to rush into having sexual intercourse because they are other various ways of fulfilling sexual desire and many reasons for them not to do so. For example: **D- Denda je**? Stand for (Kissing?); **F- Fanya mambo mbalimbali** (Do other different activities together); I- **Ishi kwa malengo** (Have life goals); **M- Mapenzi salama** (one safe love); **N- Ngono noma mwanangu** (sex is dangerous buddy!); **P- Punyeto je?** (Masturbation?); **T- Tulia** (settle); **S- Soo** (It's not shameful not to have a sexual partner); **W- Wana amani** (They have peace….they have tested….); **Z- Zaa** ukiwa tayari (Give birth when you are ready).

Figure 10: Other Safe Sexual Behaviors for Youth



Source: Fieldwork, 2013-2014.

3.3. Biomedical Interventions

In this session information about recent female controlled sexual health technologies as emerged during fieldwork is reported.

i. Female Condom

According to the data we collected most NGOs communicate messages to adolescents and youth people on how to use both male and female condoms, and where to get condoms (NGO1, 2013:68; NGO3, n.d: 7). However, most participants acknowledged that, there were limitations about condom promotions and distribution. Condom demonstration is allowed to take place out of school and/or within the premises of an NGOs. It is restricted within school setting. There was no clear data to indicate the percentage of adolescents who asked for condoms during various outreach program or in-house. Available data was not categorized in a way that makes it possible to determine achievement in promotion and distribution of female condoms. Female condoms were mentioned as a sexual health prevention mechanism in most documents. There were also pictorial instructions demonstrating how to use both male and female condoms.

ii. Microbicides

Microbicides come in different forms such as spermicidal foams, jellies, creams and films suppositories. These are deposited inside the vagina or rectum for preventing unintended pregnancy, HIV/AIDS, and other STIs. These are meant to empower women and girls to protect their own health without cooperation, consent or knowledge of male sexual partners. This view is echoed by some participants who believe that if microbicides trials were successful, girls would not necessarily need to go through the hurdles of negotiating condom use. According to information we obtained, some NGOs, especially NGO4, initiated microbicides trials but without success (Fieldwork, 2013/2014).

3.4. Rights

As illustrated in chapter one **all** adolescents have a right to enjoy highest attainable standard health, and sexual health is an integral aspect of mental and physical health, This means having sexually healthy adolescents is not only a health obligation but also a basic human right for **all** adolescents.

i. Sexual and Reproductive Health Information and Services

Overall, majority of actors believe that adolescent girls engage in sexual risk behaviors, and/or get unintended pregnancy, and contract HIV/AIDS because they have limited and comprehensive sexual health information. As a result, a number of activities are implemented to provide adolescents and youth with sexual health related information. Edutainment is observed as the most popular strategy. It combines entertainment and education, and include activities such as sports, theatre art, and 'bongoflava' music[144]. Data from NGO3 show that between from 2008-2010 community outreach promotion of HIV/AIDS prevention through abstinence, being faithful and partner reduction reached 280,479 individuals. Information obtained from NGO4 indicated that between 2012 and 2013 four (4) edutainment events were implemented in Iringa and Dar es Salaam. As a result, a total of 11.937, 48.9% male and 51.9% female respectively were reached out. Out of these, 45% aged 10-24, and more than 95% aged 15-24 years.

Although community outreach, edutainment and bonanza are adopted by most NGOs to reach out youth with sexual health information, edutainment is found to be at the heart of sexual rights related interventions in NGO1. NGO1 uses multimedia communication to implement intervention related to sexual rights among adolescents and youth. Different multimedia products magazines, TV talk show, interactive website, radio and social media are used to advance sexual rights agenda for youth, including girls. Some of these are employed as a part of a health information project which aimed to change sexual risk behaviors and attitude by encouraging young people to adopt a 'healthy lifestyle'. A recent report indicate that between 2006 and 2012 a total of two point eight

[144]'Bongoflava' is a local Swahili music genre which is very popular in Tanzania. Local 'bongoflava' musicians were invited to entertain during some of community outreach and awareness campaigns, activities and events.

million people have read *'fema'* magazine[145], and approximately eight point nine million people are familiar with the magazine. Further reports show that *'fema'* is distributed to two thousand and four hundred and thirty six schools, meaning, forty percent of schools have access to *'fema'*, and other five hundred and fifty schools were on the waiting list. On the other hand, a total of one point two million people read *'si mchezo'* (no joke)[146], and five point four million are familiar with the magazine which is distributed to approximately five hundred and seventy four partners.

ii. Sexuality Education

Access to age appropriate, balanced, cultural sensitive and ongoing sexuality education is considered fundamental for adolescents to exercise their rights to highly attainable standard health (Advocates for Youth, 1999: UNICEF, 2013b). Accordingly, reports indicate that many governments in Eastern and Southern Africa are committed to scale up comprehensive sexuality education (UNESCO, 2013). So do civil society organizations — in this case NGOs. For example we had access to a sexuality education curriculum developed by NGO4. The curriculum seems to address pertinent issues related to sexuality education. NGO4 was providing sexuality education course to health care providers and other interested stakeholders. Apart from that, an experienced participant from NGO1 described they are often invited to teach sexuality related education in schools because they are trusted. But, there were limitations about what sexuality issues should be communicated and how which were imposed by some of parents, teachers and government officials. So, even if NGO practitioners wished to be open and non-judgmental about sex and sexuality before adolescents and youth, they could not do so. Instead, they tend to address sex and sexuality related issues indirectly, and cautiously, so that they are not blamed for promoting sexual activity. As one of them put it succinctly, "in our society we do not expect them (especially adolescent girls) to be sexually active ... it is difficult to do away with that" (Fieldwork, 2013-2014).

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145 *'Fema'* magazine targets secondary school youth and *'fema'* clubs which are initiated by students and their teachers.

146 *'Si mchezo'* (no joke) magazine targets out of school youth.

Condom education is understood as an important aspect of sexuality education (UNICEF, 2013). According to the data we collected condom use promotion and distribution is the core aspect of most of the intervention programs. Data from a baseline survey conducted by NGO4 in 2010 illustrate that, few adolescents and youth, at least 5% (out of 87/462) who visited the health facility within the period of three to twelve months asked for condoms. Additional data show that, during the four community outreach or *"bonanza"* conducted between June 2012 and May 2013, condom distribution was only 19% (out of 11,937) youth. Nevertheless, many participants, explained to us that more often than not, during community outreach programs, onsite clinics, and *"bonanza"* (edutainment), they run out of condoms and had go back to their premises to fetch more.

iii. Family Planning Services

Access to family planning or contraceptives is understood as a right for adolescent girls and is important for reducing unintended pregnancies (URT, 2013; Presler-Marshal, 2012). Findings show that almost all NGOs provide adolescents with contraceptive knowledge and information, counseling and services either directly or through referrals. However, many program managers said that implementing activities which aim to provide access to family planning services especially to girls, is an uphill task. Provision of contraceptives and contraceptive information and services to adolescents, especially girls is generally controversial. During implementation of family planning promotion activities, NGO practitioners are often reminded *"wasifundishwe...hawa ni watoto"* (they should not be taught ... they are children) by some teachers and government officials (Fieldwork, 2013-2014).

Data also indicate that, many NGO practitioners are aware that in Tanzanian society girls are not expected to use modern FP methods (Mbeba et al, 2012)[147]. If a girl is found with a condom, pill or any modern contraceptive method within school compound, can be punished or expelled. Simultaneously, girls receive information from some religious institutions to suggest that use of modern FP methods as a sin. Similar to killing. But NGOs do it anyway. As observed from an extract in a booklet:

[147] This article is published as a research and information and dissemination aspect of adolescent sexual and reproductive health intervention programs.

Kuna njia nyingi za kuzuia mimba zinazoshauriwa kwa vijana: kuacha kabisa kujamiiana "kugunga"; vidonge vya kumeza; sindano za kuzuia mimba; kondomu ya kiume na kike; madawa ya kuua manii; kinga ya dharura. Kuacha kijamiiana kabisa ndiyo njia ya pekee na nzuri zaidi ya kuzuia mimba (There are various pregnancy prevention methods that are relevant to youth: abstinence; pills; male and female condoms; spermicidal foams; emergency contraceptives. Among these, abstinence is the best pregnancy prevention method). (NGO3, n.d)

Again, it is interesting to note from the extract above that, while information about using different types of modern contraceptives and FP for preventing unintended pregnancies is communicated to adolescent girls, and despite social restrictions, abstinence is suggested as the only most favorable and effective pregnancy prevention method.

iv. Integrated Abortion and Safe Motherhood Services

Abortion is illegal in Tanzania. However, provision of post-abortion care services is allowed. Therefore, most NGOs use referral system. Other such as NGO2, offers direct post-abortion care services, as well as vocational skills, family planning and counseling services to teenage mothers. The aim is to enable teenage mothers to protect their health and to become economically independent. Integrated abortion and safe motherhood services are offered in clinics operated by NGO2, which are located almost all over the country, especially at Temeke centre in Dar es Salaam.

v. Youth Friendly Health Services

Adolescents need sexual health services that are tailored to meet their needs and rights. Accordingly, WHO advocate for provision of adolescent or youth friendly services to all adolescents (WHO, 2002b; Erukar et al, 2005; Jimmy-Gama, 2009). Adolescent friendly health services are considered important for removing barriers in accessing health services and information and improving health among adolescents (WHO, 2002b). According to WHO adolescent friendly services must be *accessible*, *equitable, acceptable*, *appropriate*, *comprehensive*, *effective* and *efficient* (2002b : 27). In addition and most importantly, they should be delivered in a friendly and non-judgmental manner (Chandra-Mouli et al 2013). Findings show that three strategies are used. First, NGOs provide direct youth friendly services through model youth centers, on site and use normal clinics. NGO2 has clinics which offer reproductive services which are

located in several regions. Second, through referrals. Third, through building the capacity of health care workers to deliver youth friendly services. Related to this, they help to build health centers where they are not available at all. One of these strategies can be opted and implemented according to the situation and health needs a respective NGO find within the targeted area. NGOs aim to ensure that all adolescents or youth have access to health information and services in a friendly environment. As one senior manager emphasized, "when girls come to our clinics we give them all the information and services they need, and answer all their questions" (Fieldwork, 2013-2014). And as another one put it "when we implement our interventions we do not say only married, sexually active adolescents or those who are not sexually active or boys...are eligible to have access to our products" (Fieldwork, 2013-2014).

vi. Advocacy

As far as advocacy for sexual health is concerned, findings reveal that most NGOs promote awareness about sexual health threats facing adolescents and youth. In addition, they promote awareness to adolescent and youth, social gate keepers, and communities that sexual and reproductive health information and services is a right. Simultaneously, they advocate for policy change and budget allocation to ensure that sexual and reproductive health rights of adolescents and youth are respected [148]. At the time the researcher was in the field, two NGOs were supporting review of the national policy guidelines. As elucidated by one senior participant:

Researcher: You have mentioned that your organization advocate for policy change. Would you please clarify what exactly do you intend to achieve.

Participant: Of course, we are supporting specifically the review of national health policy because it does not address adolescent sexual and reproductive health as a right. The policy directs provision of sexual and reproductive health information and services. The policy should address adolescent sexual and reproductive health as a right because there are several groups of adolescents and young people who are marginalized. You know we have youth living with HIV....young people who are married....young people who are at school....I do not know if you are aware that the current education sector policy restricts provision of condoms and contraceptives to young people who are in school. This is the violation of their rights because most of them are sexually active. We also have MSM...there are young men who have sex with men, and young people with disabilities. All these have right to access sexual and reproductive health information and services.

[148] According to reports NGOs in Tanzania have advocated for adoption, or amendment of several adolescent, youth and sexual health related laws and policies. Adoption and enactment of SOSPA is one of the historical achievements as far as NGO role in advocacy for legal and policy change related to sexual health.

Researcher: What about sexually active adolescent girls?

Participant: Of course in many African countries women have got their second position..When you talk about women you also talk about girls. Those girls who are sexually active have right to information and services so that they can protect themselves from pregnancies and HIV/AIDS. Girls also have right to achieve their dreams. You know the Marriage Act...for example...really undermines girls' rights. It allows girls to be married at the age of 15 as long as their parents have consented. Child marriage denies girls opportunity to achieve in education, and subject them to various maternal health problems even death because of early childbearing. [Emphasis Added] (Fieldwork, 2013-2014).

vii. Socio-economic Empowerment

While provision of information and services is fundamental to empower individual girls to protect their own health, having an empowering social and cultural context for girls to be sexually healthy is equally fundamental. The following are some of the measures implemented by most NGOs for achieving the same.

— Economic Empowerment and Civic Engagement

Findings suggest a shift from behavior change and communication towards economic empowerment for preventing sexual health threats among adolescents and youth.

We had access to booklet called *"jenga maisha yako"*(build up your life) which contains information for empowering girls economically (NGO1, 2013). An experienced program manager told the researcher that they perceive entrepreneurial skills to be as important as life skills to empowering girls to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. Various topics such as qualities of an entrepreneur, advantages of being an entrepreneur, financial education, saving, marketing, business management and planning, customer care, a few to mention are covered in eight modules. It was striking to note that, apart from inspiring individual girls to become entrepreneurs and provide them with knowledge, skills, and information for her to succeed in entrepreneurship girls are informed about practices in the wider social context which can jeopardize their venturing in business and entrepreneurship such as gender stereotypes, corruption, sexual harassment, social relations, and family pressure and how to overcome them (NGO1, 2013: 42-45).This approach is good as far as empowering girls to become entrepreneurs. The same may apply to sexual health. Girls need to be made aware about practices in the wider social context which can jeopardize their sexual health.

Apart from that NGO1 also implemented a reality television entrepreneurship competition called *'ruka juu'* (jump up) in 2011. A winner entrepreneur could get a financial capital of about 3000 to 5000 USD.

Vijana ICT (information, communication and technology) also aims to empower youth economically and support behavior change. The project was implemented in between 2010 and 2012 by NGO3. The aims were to enhance employability of youth through provision of computer training, internship for unemployed graduates, and entrepreneurial training. Data show that 300 young people received training during the first year of the intervention and other 600 during the second year. Furthermore, within three years after the project cycle, at least 900 young people were projected to benefit directly, and other 6000 indirectly, through access to online educational radio and job mediation services (NGO3, 2011: 10)[149].

Further, economic empowerment is understood by many participants as an important condition for gender equality, and civic engagement. Hence, various interventions and initiatives have been implemented to promote civic engagement among adolescents and youth, including girls. In 2001-2007 NGO3 implemented a youth parliamentary and good governance leadership intervention program. The aim was to cultivate youth leadership and educate 600,000 youth on the roles, responsibility and daily conduct of the national assembly. The project empowered 2,600 youth during the first phase and other 500 during the second phase[150]. *'Sema na fema'* (talk to fema) is another initiative which aimed to provide space for citizen engagement, whereby youth and adolescents are provided with a platform to express their views and ask questions about multimedia and other health related products provided by NGO1 through social media and automated SMS.

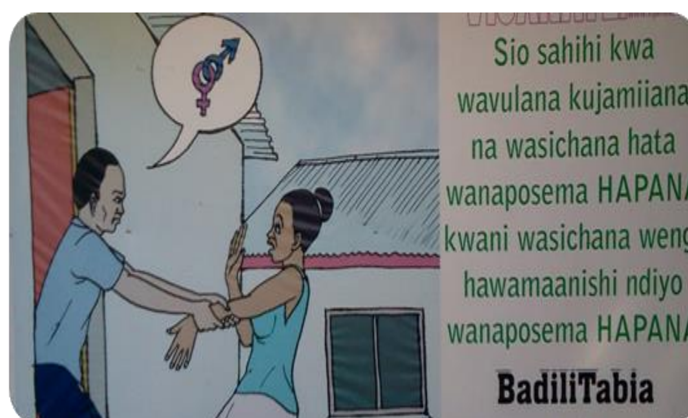
— Gender-based Violence

[149] See: http://www.vijanatz.com/tz

[150] Soon after finishing my master degree I volunteered to work as governance consultant almost at the end of the second phase of this project. For more information about economic empowerment through ICT visit the website of the organization

Prevention of gender-based violence emerged as an issue of concern in adolescent sexual health practice in selected NGOs. Findings reveal that girls were educated about different types of violence, self protection measures, and steps to take in case they have been subjected to rape or forced sexual intercourse, and according to protection guaranteed under SOSPA. Further, girls are counseled to break the silence by reporting to family members, religious leaders, street and ward leaders, and youth based organizations in case they have been subjected to gender based violence. On the other hand, there were efforts to inform boys that, girls have the right to say no to sex, and saying no does not necessarily mean saying yes. This is part and parcel of behavior change (*badili tabia*) strategy (see figure 11 below).

Figure 11: Girls Have Right to Say No to Sex



Source: Fieldwork, 2013-2014.

— Gender and Male Involvement

There is a shared view among many participants that empowering adolescent girls without empowering boys and men is at best a partial solution, and at worst could make efforts to prevent sexual health threats ineffective. As elucidated by a senior program manager:

> You know... our focus is on girls ... but we equally focus on boys because we believe focusing on girls only is wrong. We need to empower boys as well so that they can be responsible. If you see a pregnant girl that girl has not impregnated herself...a boy was involved. If you only target girls it seems as if you consider them to be responsible in avoiding sexual and reproductive health problems. Therefore, we target both boys and girls with sexual and reproductive health information and services. We want boys to ensure that girls do not get unintended pregnancies ... girls do not get HIV infection. Boys also need to be empowered because they will be parents in the future and they will have to be responsible parents (Fieldwork, 2013-2014).

As a result, some intervention programs which focus to increasing male involvement sexual and reproductive health are implemented. Between 2002 and 2009 NGO2 took part in the implementation of a project 'young male as equal partner project' (YMEP). Since then, meaning 2002 the idea of promoting male involvement in sexual and reproductive health is mainstreamed to most of its intervention programs. The main objective of YMEP was to use 'masculinity' to improve sexual and reproductive health and rights (SRHRs) of young people. Key project outcomes were increase in adoption of safer sexual practices, increase in utilization of SRHS services by young men. However, YMEP also targeted to transform gender and sexuality, especially taboo impacting on sexual health of young people. Reports show that YMEP succeeded to make young men and women to discuss sexuality and gender issues openly. There was increased in number of young people seeking STI treatment, increased condom distribution, and increase in use of FP services. But, it was interesting to note that, as described by a senior manager, YMEP in Tanzania, was perhaps framed on the idea that 'men have cultural powers' (Fieldwork, 2013-2014). The rationale behind this idea is that, sexual and reproductive health of women depends much on knowledge, behaviors, and decision of their male counterparts. While increasing male involvement in sexual and reproductive health is logical (Undie & Benaya, 2006), there is no sufficient scientific evidence to substantiate that male involvement in promoting adolescent sexual and reproductive can actually empower girls (Sternberg & Hubley, 2004). Gender inequality remains a central feature of Tanzanian society (Sa & Larsen, 2007).

According to our findings, several multifaceted initiatives ranging from behavior change and communication, biomedical interventions, rights, Socio-economic empowerment, participation, and critical thinking are implemented by selected NGOs as a way of enabling adolescents, youth, and adolescent girls, to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. However, the focal point of many of the intervention programs was to deliver health related information and services to adolescents for behavior change, and/or in other words for them to adopt healthy lifestyle. This finding implies that an individual adolescent girl was the primary target of many interventions. It is further observed that parents, teachers, community leaders, religious leaders and policy makers were secondary target. Furthermore, while some interventions were gender neutral, many other were gender sensitive and some gender transformative.

4. Social Processes and Practices Influencing Adolescent Girls' Sexual Health

In the present study, drawing from Giddens' structuration theory we have argued that while one the one hand, factors at the level of an individual influence girls' sexual health, on the other hand, factors beyond an individual girls, particularly the social meanings of gender and adolescent sexuality present in the society exert *strong* influence on sexual risk behaviors, unintended pregnancies, and HIV/AIDS among girls. It is also argued further that, the social meanings of gender and adolescent sexuality present in the society cannot automatically influence sexual health threats among girls. Most importantly, they may not suffice to exclusively explain why adolescent girls are disproportionate vulnerable to sexual risk behaviors, unintended pregnancies, and HIV/AIDS transmission than adolescent boys of similar age, and probably adult women. Arguably, to influence sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission among girls, the identified social meanings of gender and adolescent sexuality, and other elements have to be produced and reproduced differently, within institutions and practice. But they can as well be ignored.

4.1. Silencing and Stigmatizing

In many societies around the world sexual activity among children and adolescents is socially unacceptable (Doyle et al, 2012). Children and adolescent sexuality is also surrounded by silence (Van Den Berg, 2008). Sex is for adults (Leshabari & Kaaya, 1997; Harrison, 2008). However, the situation is not similar for boys and girls (Van Haren, 1999; MacPhail, 1998). Findings from the reviewed literature (see chapter 3) suggest that, in Tanzanian society, sexual activity among adolescent girls, especially while in school and outside the confine of marriage is perceived as inappropriate (Tumbo-Masabo, 1994; Nnko & Pool, 1997; Van Haren, 1999; Mabala, 2006; Wight et al, 2006; Mabala & Cooksey, 2008; Van Den Berg, 2008a; Leshabari, et al, 2008; Wight et al, 2012). Accordingly, sexually active adolescent girls are stigmatized as 'prostitute' or 'misbehaving' (Lugoe, 1996; Mabala, 2006; Mabala & Cooksey, 2008; McClealrly-Sills, 2013). Simultaneously, there is a general expectation that adolescent girls should not be pregnant while in school and before marriage (Nnko & Pool, 1997; Haram, 2005a; Wight et al, 2006; McClealrly-Sills, 2013).

On the other hand, HIV/AIDS is regarded as the disease of fornicators or those who failed to abide by traditional and religious expectations of their sexuality (Bujra, 2000). Consequently, sexual behaviors of adolescent girls especially unmarried and in school ones go underground for fear of stigma, punishment, or condemnation (Wight et al, 2006; Van Den Berg, 2008; Exavery et al, 2011). There is also evidence to suggest that, probably, for most adolescent girls, maintaining female respectability and integrity takes precedence over health protection (Dilger, 2003: Haram, 2005a).

Yet, it is seldom to find a law or policy which pronounces explicitly, that adolescent girls should not be sexually active until marriage, and/or provision of sexuality related services and information to adolescent girls is inappropriate. Nevertheless, there are few policies which acknowledge the fact that adolescent girls are sexually active, have low status in the society, and are vulnerable to early pregnancy and sexually transmitted infections including, HIV/AIDS. Hence, the need for them to be provided with youth friendly health services and information is acknowledged.[151]Moreover, provision of health related information and services, including condoms and FP is pronounced as a basic right within policies. However, the Law of the Child Act of 2009 is silent about unintended pregnancy and HIV/AIDS among girls. In addition to that, according to SOSPA sexual intercourse among adolescent girls who arebelow 18 years of age is prohibited unless a girl is married.

On the other hand, although data from the empirical research we conducted demonstrated that a significant number of NGO actors acknowledged girls to be sexually active just as boys, girls' sexuality is silenced during implementation of sexual health intervention program and activities. NGO practitioners are not allowed even to say that girls are sexually active. And they are blamed when they address sexuality and sexual health issues openly and positively. For example, as described by a senior participant, some magazines which contain sexuality and sexual health related information are not allowed to be distributed in some schools, particularly in Zanzibar (Fieldwork, 2013-2014).

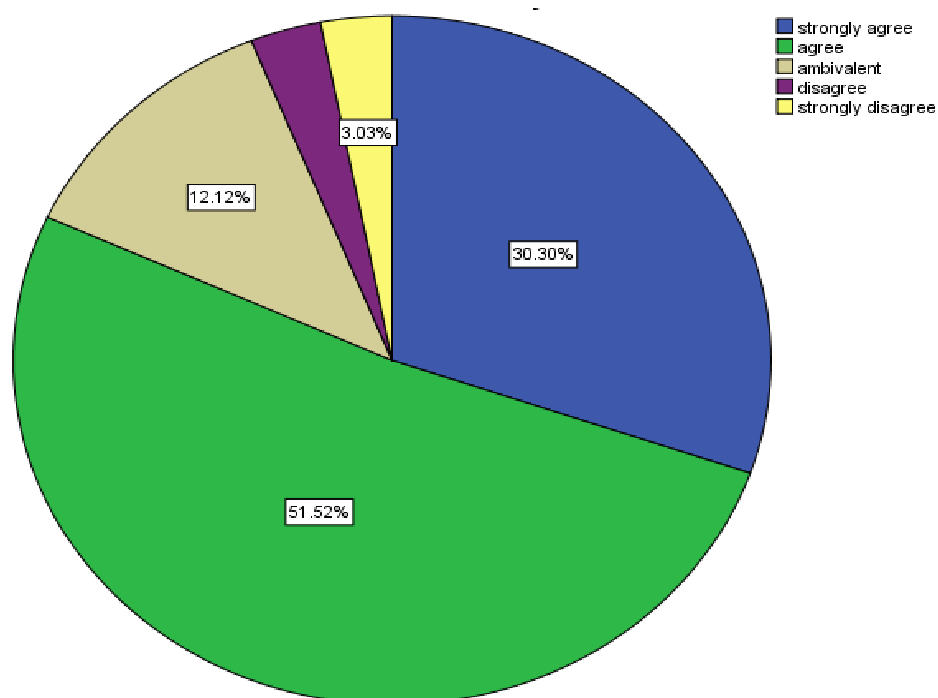
[151] See for example Child Development Policy, 1996, Standards for Adolescent Friendly Health Services (Ministry of Health, 2006), National Population policy, 2007, and National Adolescent Health and Development Strategy, 2004-2008.

Sometimes outreach or *'bonanza'* (edutainment event) could be called off. As one participant described that during an edutainment event in Iringa field officers received a call from an undisclosed public official requiring them to suspended the event. Later on, they were summoned to attend a meeting. During the meeting some government officials wanted to be reassured that condom promotion and/or distribution is not the part of the event.

The event was reported to take place on grounds close to the premises of a certain religious institution. The event which was a part of community outreach program, was allowed after field officers reassured the concerned government officials that they would only provide *"elimu ya afya ya uzazi"* (reproductive health education) (Fieldwork, 2013-2014). Due to these kind of restrictions, some program managers approach sexuality and sexual health related issues in a way that falls within the social boundaries or else they would be closed (Fieldwork, 2013-2014).

Nevertheless, despite of the fact that intervention programs for preventing sexual health issues of concern among adolescents face restrictions, findings also suggest that adolescent girls' sexuality was also approached as risky, dangerous, and thus needs to be restrained. Approximately 30% (10) participants strongly agreed, other 51% (17) agreed with that statement. While 12% (4) of the participants were ambivalent, only 3% (1) disagreed, and 3% (1) strongly disagreed that adolescent girls' sexuality should be controlled due to health consequences (see figure 12 below).

Figure 12: Adolescent Girls' Sexuality Should be Controlled



Related to that, information about *'hatari za ngono katika umri mdogo'* (the dangers of engaging in sex in young age) was communicated in bolded colored letters as observed in a document:

Kujamiiana kunaweza kukupa hisia kali sana.
Wakati mwingine unakuwa hujawa tayari kwa hisia hizi na hujui jinsi ya kukabiliana nazo. Kumbuka ni sawa kabisa kusema hapana. Unaweza kuzuia shughuli za kujaamiiana wakati wowote. Hakuna atakayeugua au kuumia.
(Sexual intercourse can give you intense emotions. Somehow, you are not ready to go through such emotions and you do not know how to manage them. Remember it is quite okay to say no. You can prevent any activity involving sexual intercourse. Nobody will be sick or get hurt) (NGO1: 2013: 69).

Other messages reflecting the danger of engaging in sexual activity in young age were: "*Kupata mimba katika umri mdogo; kujiingiza katika mazingira hatarishi ya kutoa mimba kwa njia zisizo salama; kujishushia heshima mbele ya jamii yako; kujiongezea majukumu katika umri mdogo"* (Getting pregnancy in young age; subjecting yourself to unsafe abortion; to lower your respectability before the society; to burden yourself with big responsibilities while still young) (NGO1, 2013:30).

Above all, other messages were communicated to emphasize that post-pubertal girls are in a dangerous position, as they can become pregnant if they engage in sexual

intercourse. Accordingly, girls were advised to identify relationships which have less likelihood of leading to negative outcomes: "*Kujifunza kuhusu mapenzi na kumzimikia mtu ni sehemu ya furaha ya ukuaji, lakini ni muhimu kubaini kuwa kuna uhusiano wenye madhara ambao unatakiwa uuepuke"* (to learn about sex and to fall in love is a joyful aspect of growing up, but it is important to be able to know or identify relationships which are likely to be detrimental and to avoid them (NGO1, 2013:28).

Consequently, many interventions programs focused on empowering adolescent girls with sexual refusal skills, assertiveness and condom negotiation. Abstinence and delay of sexual debut were the most emphasized. Condom use was suggested for those who fail to abstain or delay sex. Strikingly, kissing, touching, masturbation, a few to mention were communicated as possible alternative ways of fulfilling sexual desire or as "safe behaviors".

In addition, findings suggest that while both positive and negative perspectives of adolescent sexuality coexisted in adolescent sexual adolescent health practice in selected NGOs, alternative 'appropriate sexual behavior' for adolescents and youth, especially for girls was also suggested. Sexual activity is deemed appropriate when girls are matured, are economic independent, and/or are in stable or romantic relationship.

Related to the above, our data also suggest that, some individuals NGO actors imposed restrictions over sexual behaviors of girls perhaps due their own personal attitudes, opinions or values:

Participant: I sometimes tell girls that...yes it is your right, but we do not give you sexual and reproductive information as a ticket for you to find boyfriends. Sexual and reproductive health information will help you later after you finish school or become mature.

Researcher: In your opinion when do you think is the right time for girls to use information you provide to them or to have boyfriends so to speak?

Participant: ... twenty or twenty something ... (Fieldwork, 2013-2014).

On the whole findings suggest that, a minority of actors in non-governmental organizations do not acknowledge girls to be sexually active just like boys of similar age. Unintended pregnancies and HIV/AIDS among adolescent girls are perceived as health and moral issue as some actors associate them with girls' engagement in

unacceptable sexual behaviors. Further, data obtained from the documents and interviews suggests that other elements such as age, school status and marital status which impact on girls' health were included in messages communicated to adolescent girls.

4.2. Lack of Protection of Adolescent Girls' Human Rights

A key finding emerging from this study is that, apart from individual level factors, to some extent, adolescent girls in Tanzania are disproportionate vulnerable to sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission is perhaps due to silencing and stigmatizing of their sexuality and sexual health, but mainly due to lack of protection of adolescent girls'human right which is manifested in terms of unintended, and partly intended reproduction of the social meanings about gender and adolescent girls' sexuality, and other elements such as age, school status, marital status, traditional values, and religious beliefs within the society, but most importantly within key institutions: law and policies, and civil society organizations— in this case non-governmental organizations.

In this session we illustrate the way lack of protection of adolescent girls' human rights related to sexuality and sexual health and reproduction of the power relations are manifested. We have therefore paid particular attention to how sexual violence, female genital mutilation or cutting, and early marriages are addressed in law and in NGOs practice. These are closely related to social meanings about gender and adolescent girls'sexuality, and other elements that may influence girls' health.

— *Criminalization of Consensual Sexual Relations*

Sexual violence (rape, sexual harassment, defilement, molestation, incest etc.) are acknowledged to be serious issues affecting integrity, dignity, liberty, survival and development of girls. Therefore, most laws and policies direct for girls to be protected from sexual exploitation and sexual violence. Findings from the reviewed literature also illustrates that adolescent girls are exposed to sexual harassment in daily lives and majority of them have reported that their first sexual experience was forced. In order to protect adolescent girls from sexual violence and sexual exploitation. Section 130,

subsection (2e)[152] under SOSPA makes it a crime of rape for any male person who has sexual intercourse with a girl who is below 18 years of age unless she is 15 years old and they are married to each other. If convicted under this law and as stipulated in 131 Subsection 1, a person may face not less than 30 years imprisonment with corporal punishment and a fine. In addition, the court may order that person to pay compensation of any amount depending on the injury caused by that person.

Section 130 of the Act does not allow for a defense of consent as girls are considered not to have the capacity to understand the act of sexual intercourse and its repercussions. Hence, the effect of SOSPA is to criminalize even consensual sexual relationship among adolescents. According to scientific evidence a substantial number of adolescent girls aged 15 and 18 are likely to be already sexually active. Accordingly, Subsection 2 offers less penalty if the offence is committed by a boy of 18 years and below which is imprisonment only for first offenders, imprisonment of twelve months with corporal punishment for second offenders, a third offender and recidivist offender shall receive life imprisonment. Yet, Section 15 of the same legislation stipulates that a male under the age of 12 is incapable of having sexual intercourse. In addition to the above, according to Subsection 3 a person who has sexual intercourse with a girl less than ten years shall be sentenced to life imprisonment. This means, according to SOSPA the age of sexual consent for adolescent girls is 18 years. It is not explicitly stated to indicate that the same applies to adolescent boys. Adolescent girls' sexuality is only acknowledged if it is associated with the institution of marriage.

It was interesting to find that, despite strong legal protection against rape, sexual violence and related offences as stated hereinabove, and stiff penalty accompanying with it, many participants pointed out that trans-generational sex, meaning sexual relations between adolescent girls and adult men *"fataki"* in Swahili is prevalent in Tanzanian society, and it contributes to sexual risk behaviors, unintended pregnancies and HIV/AIDS among girls. This indicates that, there is a big gap between what is in the laws and policy documents and in practice. Sexual violence against adolescent girls may be partially tolerated in the wider society and within some government institutions. As a result its perpetrators may be left at large due to prevalence of impunity. An

[152] Section 135 Subsection 2 gives more clarification on prohibited sexual intercourse.

experienced NGO practitioner specializing in psychosocial counseling provided an insight into the above. During interview the participant explained to the researcher about a sexual abuse case brought to their organization by an undisclosed primary school teacher from nearby community. The teacher was concerned about the wellbeing of a standard five girl (undisclosed) and she brought the girl in for counseling. During counseling sessions the girl disclosed that she lived with her father and step mother and she has been sexually abused by her biological father since tender age. The girl was also diagnosed to have contracted STI (not HIV). After treatment and with assistance from the NGO, the teacher reported the case to the street leaders and thereafter to court. The accused father was summoned to the court and the trial began. Eventually, during the court sessions the girl was afraid to testify, and family members including the step mother started to complain to the concerned teacher that the case has led to hardship and instability in the family. While the case was still in court, the family decided to transfer the girl to another school. Without cooperation from the family, it was difficult to proceed with the case and the fact that there was a slim chance for the girl to testify against her father. They also found out later that the girl had sexual relation with another older man in the community. Hence the case was dropped.

— Female Genital Mutilation

On the other hand, and as illustrated in the review of empirical literature in chapter 3, FGM is a practice which among other things aims to control adolescent girls' sexuality. Although there is paucity of evidence in existing scientific studies to establish direct correlation between FGM and HIV infection, during fieldwork, some participants who had fieldwork experience in Lake zone especially in regions such as Mwanza, Mara, Simiyu and Shinyanga told the researcher that adolescent girls who have undergone FGM may be required to have sex with circumcised boys in order to confirm whether healing has taken place or not (Fieldwork, 2013-2014). Therefore to emulate international standards, FGM is illegal in Tanzania. The Child Development Policy directs girls to be protected from harmful traditional practice such as FGM according to CRC. Unfortunately the Law of the Child Act does not explicitly provide for protection against FGM. Rather, Section 13 protect children against torture, inhuman and degrading treatment. According to Subsection 3 degrading treatment constitute any act done to the child with the intention of humiliating or lowering dignity. However,

information we have collected show that in reality, FGM is probably practiced with impunity. As one senior program manager explained, in Mara region for example FGM ceremonies are done publicly with some of the roads closed to allow the parade of girls who have been circumcised to pass, and when everyone is watching, including NGO practitioners themselves, even government officials (Fieldwork, 2013-2014). The participant acknowledged that "traditions are powerful as NGOs we are in trouble, we cannot change them...sometimes we help girls to escape" (Fieldwork, 2013-2014).

Apart from the above, data we have collected illustrate that some intervention programs for preventing FGM constituted mainly, public campaigns to sensitize girls about FGM. Also to organize meetings with parents, teachers, religious leaders, and community gatekeepers urging them to stop the practice of FGM. For example, there was an intervention 'alternative rite of passage' which was implemented by NGO4, the key message of the intervention reads, *"Elimu ni tohara bora kwa mtoto wa kike"* (Education is the best rite of passage or circumcision for a girl child). While this seems logical as staying in school can potentially protect girls from FGM in the short run, interventions such as these may not necessarily change the social meaning associated with FGM. In fact, in societies where FGM is prevalent, the practice is associated with being a matured, marriageable, and respectable woman (Human Rights Watch, 2014). The present study could not generate information about *"unyago"* an initiation rite for pubertal adolescent girls[153].

— Child Marriage

As far as child marriage is concerned, The Marriage Act of 1971 allows girls to be married at 14 and 15 years with court and/or parental consent. Age of marriage for boys is 18 years. There is evidence to suggest that early marriage is socially acceptable especially among conservative members of the society. According to recent media reports, during the proceedings within the constituent assembly tasked to draft new constitution, some members opposed the proposition to have a legal definition of a child

[153] However, according information generated from *si mchezo* (no joke) an NGO which goes by the name of PAYODE give training to *manyakanga* (elderly women who initiate girls during *unyago*) to incorporate reproductive health and how girls can protect themselves from contracting HIV. Approximately 40 *nyakanga* were trained by PAYODE in 2008 (NGO1, 2012:30).

as a person below 18. The main argument was that the definition contradicts religious beliefs and teachings. According to religious norms a girl is allowed to be married soon after puberty:*"....ilielezwa kwamba baadhi ya wajumbe wa bunge maalum wanapinga kutambuliwa umri wa mtoto Tanzania kuwa ni miaka 18. Sababu yao kubwa ni msingi wa kiimani unaotokana na dini ambako msichana akishavunja ungo anaweza kuolewa"* (Mawio, 2014:12)[154]. However, despite objections Section 53(3) of the October 2014 final version of Draft Constitution defines a child as a person below 18 years. It is striking to note that despite of the fact that there is evidence to show that, early marriage accounts for a substantial percentage of maternal health problems and high maternal mortality rate and it violate fundamental rights of a girl child, there is no provision within the Draft Constitution which outlaws the Marriage Act of 1971 nor does it change the current minimum age of marriage. It is almost two decades since it was stipulated within Child Development Policy that, children between 14 and 18 need to be protected from early marriages. However, at the same time, the policy has a clause which states that "in principle all children should be born and brought up in a family based on a legal marriage" (URT, 1996:6).

Furthermore, while, Section 53, provides for child rights, and subsection 1 (e) specifically confers children with the right to health services[155], there is silence about girls' rights. Instead, the draft constitution provides for the rights of youth — Section 54[156], rights of persons with disability — Section 55[157], rights of minorities and indigenous people — Section 56[158], rights of women — Section 57[159], and rights of the elderly — Section 58[160]. But unlike subsection (f) of section 55 which provides

[154] Mawio, 30 July, 2014.

[155] See page 42.

[156] See page 44.

[157] See page 44.

[158] See page 45.

[159] See page 46. Simulteneously Section 13(4) of the current Constitution reads, "No person shall be discriminated against by any person or any authority acting under any law or in the discharge of the functions or business of any state office".

[160] See page 46. Section 13(5) clarifies that, For the purpose of this Article the expression "discriminate" means to satisfy the needs, rights or other requirements of different persons on the basis of their nationality, tribe, place of origin, political opinion, colour, religion, sex, disability or station in life such that certain categories of people are regarded as weak or inferior and are subjected to restrictions or

explicitly, that persons with disability have right to get health services and safe maternal health particularly delivery, the Draft Constitution does not provides, explicitly, for protection of girls' rights, especially right to health.

It is important to however mention that, right to equality and non discrimination are stipulated concisely and comprehensively under Section 34 subsection 1, 2, 5 and 6 of the Draft Constitution. Although the reviewed version of the Draft Constitution was in Swahili, the provision on the right to equality, as stipulated in the 2014 Draft Constitution, seems to be a replica of Section 13 (4) and 13 (5) of the current 1977 Constitution of the United Republic of Tanzania. It is stated under subsection 2 of the Draft Constitution that "*ni marufuku kwa mtu yeyote kubaguliwa na mtu, mamlaka yoyote inayotekeleza madaraka yake nchi au mamlaka yoyote inayotekeleza chini ya sheria yoyote au katika kutekeleza kazi au shughuli yoyote ya mamlaka ya nchi".*[161] It is further clarified under subsection 5 of Section 34 (right to equality before the law) that the word non discrimination entails:

kwa madhumuni ya ibara hii neno "kubagua" maana yake ni kutimiza utashi, haki au mahitaji mengineyo kwa watu mbalimbali kwa kuzingatia utaifa wao, kabila, mahali walipotokea, maadili yao ya kisiasa, rangi, dini, jinsi ya ulemavu au hali yao katika jamii kwa namna ambayo watu wa aina fulani wanatendewa au kuhesabiwa kuwa wadhaifu au duni na kuwekewa vikwazo au masharti ya vipingamizi ambayo watu wa aina nyingine wanatendewa tofauti au wanapewa fursa au faida iliyoko nje ya masharti au sifa za lazima[162].

In addition to the above it is clarified under section 6 that:

Neno "kubagua" kama lilivyotumika katika ibara ndogo ya (2), halitafafanuliwa kwa namna ambayo itazuia mamlaka ya nchi kuchukua hatua za makusudi zenye lengo la kurekebisha matatizo mahsusi katika jamii.[163]

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condtions whereas persons of other categories are treated differently or areaccorded opportunities or advantage outside the specified conditions or the prescribed necessary qualifications (…)". See pages 16 and 17.

[161] See page 26.

[162] See page 27.

[163] It is observed that Section 34 (6) of the Interim Constitution (1965) was partly detached from Section 13 (5) of the current Constitution which reads "For the purpose of this article word "discrimination" shall not be construed in a manner that will prohibit the Government from taking purposeful steps aimed at rectifying disabilities in the society". See also pages 16 and 17.

It is observed that apart from stipulating that children have right to health services under section 53(3), and protecting the right to health services for every individual under section 51(1), the 2014 Draft Constitution is silent about pertinent sexual health issues confronting girls such as sexual risk behaviors, unintended pregnancy and HIV/AIDS. Neither does the document stipulates rights related to girls' sexual health[164].

One the other hand, findings suggest that NGOs talk to parents, religious leaders, and community leaders to stop marrying off girls because it violates their fundamental rights such as right to health, but mainly right to education. It is important to state here that, while right to education is stated under Section 52 of Draft Constitution, there is no provision that clarify and stipulate right to health. NGOs also informed girls about the consequences of early marriage and empower them to say no to early marriage. Sometimes, they helped girls who were running away from being married off by their parents or guardians by providing shelter and sending them to school. Keeping girls in schools is considered as one of the ways to curb early marriages (Fieldwork, 2013-2014). While this seems logical, one needs to understand that, the practice child marriage is deeply embedded in the Tanzanian society (Human Rights Watch, 2014). Unfortunately, in the present study evidence about intervention programs which seek to reach married adolescent girls with sexual health services and information could not be established. This may be due to the fact that in Tanzania marriage is regarded as an important aspect of transition to adulthood. Further, child bearing is the confine of marriage. There is evidence to suggest that in Tanzania girls who become pregnant or married are expelled from schools (Center for Reproductive Health, 2013; Human Rights Watch, 2014). It is important to mention that, the practice of keeping pregnant and married girls out of school is not mandated, explicitly by any policy or law (Human Right Watch, 2014). However, according to the Expulsion and Exclusion of Pupils from Schools Regulation, 2002:

> A student may be excluded or expelled from school for reasons that include: persistent and deliberate misbehavior such as endangering the general discipline or the good name of the school, committing a criminal offence such as theft, malicious injury to property, prostitution, drug abuse or *an offence against morality*, or if a pupil has entered into wedlock (URT, 2002).

[164] See Section 53, subsection 1 (e).

An offence against morality may be interpreted as engaging in premarital sexual activity (Human Rights Watch, 2014:50)[165], probably, engaging in sexual activity while in school, being in possession of condoms and/or using condoms or pills or any other modern contraceptive method. In addition, and related to the above, according to Section 175 of the Penal Code, it is an offence (Traffic in Obscene Publications) to trade or distribute materials that are *obscene* and corrupt *morals.* The words *obscene* or *moral* are not clarified.

Furthermore, while the Child Development Policy directs girls between ages of 14 and 18 to receive counseling so that they can avoid getting pregnant at a tender age, it also directs the community to ensure that children inherit *good traditions and customs*. Apparently, there is no clear clarification on what *good traditions and customs* constitute in relation to girls' health. In addition, according to most recent School Improvement Toolkit, Practical Guide for Head Teachers and Heads of Schools control of adolescent girls' sexuality seems to be suggested is an acceptable way of curbing unintended pregnancies among school girls. Head of schools are instructed to cooperate with parents, and the community in monitoring girls' behavior especially when they reach adolescent age, and to enhance periodic check up (URT, 2013). This kind of regulations reproduce the view that girls should not be sexually active and become pregnant when in school or before marriage to avoid to be expelled from schooling and become stigmatized[166].

— Other Findings

[165] Interview with the National Coordinator Forum for African Educationalist in Tanzania (TAWETZ).

[166] When I was reporting findings for the present study, on 23/1/2015 I was among the people who received a photo that became viral on social media with the caption *"mwanafunzi wa kidato cha pili wa Sekondari ya Keko kajifungua/katoa mimba kwenye daladala eneo la kwa Aziz Ali baada ya kumeza dawa za kutoa mimba"* [Emphasis Added] (A second year student from Keko Secondary School has aborted the baby inside *"daladala"* (commuter bus) near Aziz Ally bus stop after swallowing unidentified abortion pills). We could not publish the photo in this thesis to avoid unintended reproduction of public shaming and stigmatizing of adolescent girls who become pregnant or have been identified to undergo induced abortion. The girl in this case was pictured sitting down probably at the road side, covered by a *"khanga"* (a tradition wrap cloth for women), surrounded by a number of bystanders, among them two women who seemed to have been questioning her. One of them held something which could be a voice recording instrument. Besides the girl, there was the remaining of the aftermath of the alleged induced abortion.

The present study could not establish that NGOs did not address the factors in the broader society that impact on sexual health among adolescents including girls. There were some interventions for addressing the economics and rights related aspects of sexual risk behavior, unintended pregnancies and HIVAIDS. There were also other interventions which were meant to be both gender sensitive and gender transformative. However, issues surrounding gender and adolescent sexuality were addressed at the level of an individual adolescent and in social interactions among adolescents and young people rather than at the level of the society. For example among other things *'tuitetee'* intervention program was advocating right to gender equality and equity for young people. The message was framed as follows:

Since young people (Boys and girls) are affected differently with sexual reproductive related problems they need to be aware that solution to their problems will be provided with a gender sensitive approach and equity in terms of access. This implies that girls and boys have the right to be treated fairly (NGO4, n.d).

Apart from that, YMEP intervention was meant to be gender transformative. The broad aim was to use masculinity to promote sexual and reproductive health and rights. Men were positioned as the source of the problem of unintended pregnancies, HIV/AIDS, sexual violence, to mention but a view. Yet, the goals and output related to transformation of gender inequalities and sexuality, for both Tuitetee and YMEP were either quantified, omitted and/or abstract. The following were some of the expected program's outcomes for *'tuitetee'* intervention:

- Increase education and knowledge of SRHR among young people;
- Increase demand among young people for SRH;
- Increased resource allocation for SRH services for the young people in municipalities;
- Functional Two model centers for offering quality youth friendly SRH services according to national standards;
- Increased number of health care providers skilled in provision of quality and friendly SRH services for young people;
- Institutionalize training program made available along a calendar year to cover various packages addressing friendly services for young people and vulnerable people young people with hearing disabilities (NGO4, n.d).

While the purpose was to increase adoption of safer sexual practices and utilization of SRH services by young men, the following were programs outputs for YMEP intervention:

- Access to information and education on gender and SRH & R among young men and women increased;
- Involvement and participation of young men in SRH increased;
- Utilization of SRH services by young men and young women increased;
- Increased in voluntary counseling and testing by young men and women;
- YMEP activities integrated into respective District plans and those of implementing partners for scaling up and/or sustainability;
- Regional capacity for integrating gender and SRH; monitoring and evaluation; documentation and dissemination of success stories; and operation research enhanced.

On the whole findings from adolescent sexual health practice in NGO reveal that an individual was the main focus and youth especially those aged between 10-24, 15-24, and 10-35 were primary target. However, there was no intervention targeting sexually active adolescent girls. Consequently, abstinence and delay of sexual activity have been emphasized in many interventions. Condom use was somewhat communicated as an option to those youth and adolescents, including girls, who 'fail' to abstain and/or delay sexual activity.

Further, findings illustrate that sexual health is perhaps submerged in reproductive health outcomes for adolescents especially girls. Above all, many intervention programs were implemented in project circle. Although positive aspect of sexuality was identified, messages to indicate sexual activity as risky and dangerous especially among girls were observed.

Several issues accounting for above dynamics in adolescent sexual health practice were raised in selected NGOs: First, limited access to funds and having few donors who were interested to finance such long term interventions was the mostly cited. As one senior manager admitted:

> Gender is one of the issues we address in our programs. But we do not approach it at the level of the society. It is something we do not emphasize...it is a sensitive issue and we approach it according to its sensitivity ...most of our programs target behavior change. There is also lack of funds to address gender at the level of the society because it is deeply rooted and it has been there since time immemorial. Projects to address gender at the level of the society need long term investment. And many donors may not be interested to finance them (Fieldwork, 2013-2014).

Additional findings show that some donors were not only ready to providing funds, but had predetermined agenda on what should be the focus of the intervention and the target group. As one participant explained, a donor was available to provide funds to address sexual health problems among school girls. But the agenda was to reach girls with sexual health intervention information and services before they became sexually active. However, during preliminary survey (there was no explanations on how it was done) they found that, most girls in the targeted schools were sexually active (Fieldwork, 2013-2014). Another senior participant explained that, an unidentified donor was willing to finance an HIV prevention intervention for MSM or people with different sexual orientation. The management declined to accept the funds because they were concerned that targeting MSM would contradict the image of their organization before the society (Fieldwork, 2013-2014). In Tanzania homosexuality is illegal[167]. It is also a taboo. Finding also reveal that many interventions, were implemented between two (2) to four (4) years and were for trial or best practice, in the sense that, they were implemented only within the identified project sites with the view to be scaled up later through government initiatives and funding.

Second, there are policy and legal limitations. Many participants stated that their interventions are developed according to legal and policy directives. And that some of the policies and laws are vague and contradictory. The social context in which they operated is also a concern. As a senior participants earmarked: "we cannot say... in our programs we want to eradicate stigma...we have to balance what we do and what needs to be done, and what we can do in a particular community or society"(Fieldwork, 2013-2014). This was echoed by another experience participant who posited that, "we (NGOs) would want to do more, but we work within policy directives and framework...the government is aware that policies are not implemented but cannot take action...may be the government is afraid of the reaction of parents, religious leaders and the society"(Fieldwork, 2013-2014).

[167] See Section 154 and Section 157 of the Tanzanian Penal Code.

For example apart from directing NGOs as part of voluntary organizations to take part in educating the communities about the rights of the child protecting rights including those related to health among children, and actively defend children rights, it is emphasized in Child Development Policy that "…non-governmental organizations should ensure that all activities involving children do not violate traditions and culture of our nation or are not carried out for individual interests" (URT, 1996:28).

In addition to the above, while the Child Development Policy acknowledges that gender biased customs and traditions affect child development, and instruct NGOs to mobilize communities against harmful traditional practices, the National Population Policy clarifies what constitutes gender equity and gender equality as follows:

> Gender equity is fairness and justices in the distribution of benefits and responsibilities. It is equal opportunity, equal treatment before the law, and equal access to and control over resources and social services. Gender equality is the sharing of power among both females and males not at the personal level but basically at institutional level. It calls for equal rights, responsibilities and duty; **not identity** (URT, 2006).

Last but not least, despite of being aware that a substantial number of adolescent girls are sexually active, and are more vulnerable to sexual risk behaviors, unintended pregnancies and HIV/AIDS, culture was cited by many participants as a barrier in addressing sexual health threats among youth, especially adolescent girls. As observed in documentary review:

> *wasichana [na wanawake] wapo katika hatari zaidi ya VVU ikilinganishwa na wavulana [na wanaume] wa umri sawa na wao. Hata hivyo njia rahisi ya kuwafikia vijana hasa wasichana kwa shughuli za uelimishaji kuhusu ujana na makuzi bado ni changamoto kutokana na mila na desturi ya mtanzania* (girls [and women] are at an increasing risk of contracting HIV compared to boys [and men] of similar age. Nevertheless, reaching young people, especially girls with sexual and reproductive health information remains a challenge due to culture and traditions among Tanzanians (NGO1, 2012:30).

Contrary to the assumption which emerged from questionnaire data to indicate that some participants may not be aware of the social meanings, moral codes, and expectations attached to girls' sexuality, this finding illustrate that actors in NGOs are aware of the social restrictions associated with adolescent girls' sexuality and sexual health. It was observed that interventions to address sexual health threats among men who have sex with men (MSM) were facing almost similar social restrictions. This was echoed in an interview with another senior manager:

> NGOs are a part of the society. We work through gatekeepers… we cannot impose values...or else we will be seen as outcasts. For example while we advocate for the right of homosexuals to have access to health services and information, but we cannot tell the community to accept their right to sexual orientation or homosexuality" [Emphasis added] (Fieldwork, 2013-2014).

However, there is data to show that, despite of the fact that homosexuality is a taboo in Tanzania, especially among female members of the society, some NGOs have stepped up to implement programs that advocate for the rights of people with different sexual orientation to health information and services. But they do not advocate for their right to a different sexual orientation to be respected and protected. This may as well apply to adolescent girls whereby, the main focus of most intervention programs is to ensure that girls have access to health information and services for them to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. NGOs do not to advocate for adolescent girls to be recognized as sexual beings in the broader society. Also for laws and policies to contain provisions which offer continuous protection of sexual health of adolescent girls.

5. Summary

The present study was set out to find out why adolescent girls in Tanzania are disproportionately vulnerable to health threats specifically sexual risk behaviors, unintended pregnancies, and HIV/AIDS than adolescent boys of similar age, and probably adult women. As pointed out earlier to accomplish the goals of the present study and to interrogate the research problem of concern a number of issues needed to be considered. In particular, the following research questions were posed:

- What are the underlying factors that influence sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls?

- How do social meanings related to acceptable or unacceptable gender and adolescent sexuality influence sexual risk behaviors, unintended pregnancies and HIV/AIDS? Does this work differently for adolescent boys and girls?

- How do actors perceive sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls? Do they produce or reproduce differently the social

meanings related to gender and adolescent sexuality and other elements, different ones, relating to health among adolescent girls?

- What measures are implemented in order to empower adolescent girls to avoid sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission?

A key finding emerging from this study is that, apart from individual level factors, to some extent, adolescent girls in Tanzania are disproportionate vulnerable to sexual risk behavior, unintended pregnancies, and HIV/AIDS is perhaps due to silencing and stigmatizing of their sexuality and sexual health, but mainly due to lack of protection of adolescent girls'human rights which is manifested in terms of unintended, and partly intended reproduction of the social meanings about gender and adolescent girls' sexuality, and other elements such as age, school status, marital status, traditional values, and religious beliefs within the society, but mostly important within key institutions: law and policies, and civil society organizations—in this case non-governmental organizations.

To be more precise, findings from the review of literature illustrated that in Tanzanian society the understanding that adolescent girls should not be sexually active remains relevant, but tacit. However, in the present study we asked each research participant to indicate their views about whether adolescent girls are likely to be sexually active as boys' counterparts. Findings demonstrated that majority of participants acknowledged that girls are sexually active just like adolescent boys. A significant number participants positioned sexuality as a normal aspect of development during adolescence. Nevertheless, a minority of participants demonstrated ambivalence and denial about girls' sexuality by relating it to moral frameworks.

When we asked each participants to indicate their views about whether unintended pregnancies among girls was due to girls' engagement in unacceptable sexual behaviors our findings shifted drastically, few of participants related unintended pregnancies among girls with engagement in unacceptable sexual behaviors. This finding perhaps demonstrates that unintended pregnancy among adolescent girls, especially unmarried ones is perceived as a moral issue even among some actors in non-governmental

organizations. Simultaneously, few of participants associated HIV/AIDS among girls with engagement in socially unacceptable and immoral sexual behaviors.

However, in order to acquire an in-depth understanding of the research problem relevant in the present study we also examined measures implemented, and/or action taken as a way of empowering adolescent girls to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. According to our findings several multifaceted initiatives ranging from behavior change and communication, rights, life skills development for economic empowerment, participation, and critical thinking are implemented by selected NGOs as a way of to enabling youth and adolescents, and adolescent girls, to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. However, the focal point of many of the intervention programs was to deliver health related information and services to adolescents and youth for behavior change, and/or in other words for adopting healthy lifestyle. This finding implies that an individual adolescent or young person was the primary target of many interventions. It is further observed that parents, teachers, community leaders, religious leaders and policy makers were secondary target. Furthermore, while some interventions were gender neutral, many other were gender sensitive as well as gender transformative. Our data also illustrated that issues surrounding gender and adolescent sexuality were addressed at the level of an individual girl and in social interactions involving adolescents and youth rather than at the level of the society. This suggests that some actions which were meant to empower and to protect girls could be, to some extent, disempowering. While adolescent sexuality is a taboo and is generally perceived as unacceptable, sexual prohibition, silence, and restraint were more attached to adolescent girls' sexuality than among boys in law and policies, also in adolescent sexual and reproductive health practice in NGOs.

CONCLUSION

The goal of the present study was to investigate why adolescent girls are disproportionate vulnerable to sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission.

This is was a qualitative study which was informed and guided by critical theory paradigm. On the one hand qualitative methods enabled us to describe and find out reasons behind girls' disproportionate vulnerability to sexual health threats and its context. On the other hand, critical theory enabled us to report reality of girls' sexual health, to question the power relations associated with it, to increase awareness of the contradictory conditions of action and practice related to adolescent sexuality and sexual health that might have been hidden by every day understanding, and to inform social change or transformation of the underlying factors that undermine girls health related rights and wellbeing.

In order to achieve research objectives, the definitions of the key concepts and their relevance in the present study were delineated. Minority is one of the key and important concept. It is observed that, in mainstream academic scholarship in international law and in social sciences a minority is commonly associated with certain essentialist notions of ethnicity, religion, culture and language. In this case, minorities are understood as individuals and group of individuals who possess a unique ethnic, religious, cultural identity which is different from the dominant group or groups in a particular society. This understanding compelled national states and other institutions such as NGOs to take actions that ensure the rights of ethnic and religious minorities and indigenous people are protected. However, using examples of white minorities and black majority in South Africa during apartheid regime, white minority and black majority in United States of America and Tutsi minority, Twa minority and Hutu majority in Rwanda, and women (see *Sandra Lovelace v Canada*) it is possible to argue that a minority is not necessarily numerical. Further, not all ethnic, religious and

cultural minorities are in a non-dominant or marginal position. Accordingly, a minority is socially defined. In other words, the present study positioned the concept of minority as universal, dynamic and context specific. Minorities are therefore understood as diverse individuals and groups of individuals whose situation can be a result of certain processes and practices in a particular society impinging on their economic, social, and cultural rights. Therefore, being a minority is continuous group social vulnerability.

In that line of thinking, empirical study was conducted in Tanzania, mainly in Dar es Salaam, with 4 (four) selected NGOs. Both qualitative and quantitative data were collected. Quantitative data was collected for the sake of enriching the study and make data analysis more transparent rather than deriving inferences and generalization about the findings. To sum up data was collected through triangulation of:

- Thirty three (33) *questionnaires*;
- Fourteen (14) *semi-structures interviews with actors*, mainly those in senior management position, and preferably with extensive and rich practical experience in civil society organizations in the area of adolescent sexual and reproductive health;
- The data gathered through questionnaire survey and interview was complemented by *observation and documentary review*.

While SPSS version IBM 22 for windows was used to organize questionnaire data to facilitate descriptive analysis, qualitative content analysis was employed as a method for data analysis. However, it is important to reiterate that what was more important in determining which content to analyze is the theoretical framework, aims and research questions (Krippendorf, 1980; Mayring, 2000). Giddens' structuration theory was adopted as overarching framework for social analysis and complemented by functionalism perspectives as advanced by Talcott Parsons.

A key finding emerging from this study is that, apart from individual level factors, to some extent, adolescent girls in Tanzania are disproportionate vulnerable to sexual risk behavior, unintended pregnancies, and HIV/AIDS transmission perhaps due to silencing and stigmatizing of their sexuality and sexual health, but mainly due to lack of protection of adolescent girls'economic, social and cultural rights, which is manifested

in terms of unintended, and partly intended reproduction of the social meanings about gender and adolescent girls' sexuality, and other elements such as age, school status, marital status, traditional values, and religious beliefs within the society, but mostly important within key institutions: law and policies, and civil society organizations— in this case non-governmental organizations.

Therefore several salient concluding observations and concluding remarks are made. Findings illustrated that a substantial number of adolescent girls are sexually active at 15 years of age, and before their 18 birthday. Of the greater concern however, is that, girls engage in unprotected sexual experience. This finding may also apply to other countries in East Africa. The finding has contradicted statistical data published in conventional public health literature. According to TDHS (2011) and THMIS (2013) reports,a small proportion of adolescent girls are demonstrated not to be sexually active. While these statistics provide useful insights about general trends in sexual behaviors of adolescents, they do not reflect the reality of sexual behavior of adolescents, especially girls. Yet, there was dearth of data to illustrate sexual behaviors of adolescents aged 15-18 years. Available data feature trends in sexual behaviors and health of adolescents aged 15 -19 years. But more often than not, adolescents are categorized together with 15-24 age group, and adult population, 15-49 years.

Findings from reviewed literature also demonstrated that in Tanzanian society girls are not expected to engage in sexual intercourse until they are adults, they finish school, and most importantly in marriage. This ideal is closely related with girls’ integrity and respectability than boys’ respectability. On the contrary, finding showed that idea of potent and sexually active boys remain relevant in Tanzanian society. The common understanding is that, it is natural, and probably unavoidable for adolescent boys to engage in some sort of sexual experimenting and experience before marriage. Similar findings were established in a study on gender and sexuality among young professional couples (Mlangwa, 2009). The norm of pupil or student abstinence is found to prevail in Tanzanian society. According to this norm, children and adolescents who are in schools, including secondary schools, are not expected to be sexually active. This notion is probably relevant in other East Africa societies.

It is observed that, unintended pregnancy and HIV/AIDS among adolescent girls are framed as health as well as moral issues. While pregnancy outside wedlock, or in school is highly stigmatized, HIV is regarded as the disease of those who engage in immoral behaviors and have deviated from the traditions and religious teachings.

As argued in Giddens' structuration theory social life is more than random individual acts, but is not merely determined by social forces. Findings confirmed that, sexual risk behaviour, unintended pregnancies and HIV/AIDS transmission among adolescent girls are not merely influenced by certain individual deficiencies in behaviour, neither are they influenced by what the society considers as acceptable and unacceptable gender identity and adolescent sexual identity. Sexual risk behaviour, unintended pregnancies and HIV/AIDS transmission among adolescent girls are also influence by complex social process and practice within institutions and practice in a particular society. Institutions such as law (including policies) and NGOs play a critical role in influencing sexual health threats among adolescent girls. Nevertheless, as Giddens added, institutions are social actions, and action has intended and unintended outcomes.

Tanzania is a signatory of several international standards and provisions protecting minorities and minority rights. Also CRC and other international provisions which protect adolescent rights related to health. And has made considerable efforts to fulfill its commitment, by domesticating most of the international provisions in several domestic laws and policies.

It is stipulated in Child Development Policy, in Tanzanian society, child survival and development are threatened by FGM, early marriage, adolescence pregnancy and childbearing, HIV/AIDS, rape and child abuse. Consequently, the policy directs protection of the right of the child in order to address the above mentioned problems. Apart from stating that protection should be according to age and children aged between 14 and 18 need to be protected from early pregnancies, abuse and HIV/AIDS, the policy pronounces provision of basic information and health related services as a basic right.

Similar concerns are documented within National Population Policy, National Adolescent Health and Development Policy, National Family Planning Guidelines and Standards, National Standard for Adolescent Friendly Reproductive Health Services and

National Youth Development Policy. Moreover, it is declared in the National Family Planning Guidelines and Standards that, rights of adolescents to FP should be respected according to CRC. National Population Policy admits that sexually active youth, especially female between 15 and 19 are increasing vulnerable to HIV/AIDS. And National Standard for Adolescent Friendly Reproductive Health Services acknowledges that adolescent girls need of special focus and intervention.

Related to the above observation, findings from reviewed literature suggested that, although access to health related information and service such as condoms and other FP methods is pronounced as a basic right within some of the policies described above, there is well documented scientific evidence to suggest that condom use is not widely perceived as an integral aspect of health protection not only among individual adolescents, especially girls, but also in the wider society. Condoms and condom use are stigmatized as they are associated with promiscuity, unfaithfulness, and lack of trust in intimate sexual relations.

In addition to the above, there is silence about adolescent girls' sexuality and vulnerability to unintended pregnancies and HIV/AIDS within the Law of the Child Act, 2009. Consequently, neither do any of the above most influential legislations on child's rights in Tanzania confer, explicitly, protection of girls' rights related to health.

Findings therefore suggested, although traditional institutions responsible for initiating adolescent have withered away and/or are no longer influential in Tanzania, the following collective views about acceptable and unacceptable feminine identity and adolescent girls' sexuality and other elements such as traditions, religious beliefs, age, marital status and school status were also identified within some of key laws and policies influencing adolescent health: adolescent girls are asexual; adolescent sexuality girls' sexuality should be controlled to curtail its health consequences; adolescent girls should not be sexually active when in school, and/or before adulthood and marriage. These views are illustrated to have enormous impact on girls' health. They drive adolescent girls' sexuality and sexual behaviors underground and limit access and uptake of necessary sexual health information and services.

Empirical study demonstrated mixed results in relation to actors' perceptions on sexual risk behaviors, unintended pregnancies and HIV/AIDS among adolescent girls. NGO actors seemed to be aware of the actual sexual behaviors of adolescent girls and they do not perceive girls to be asexual. A significant number of participants perceived adolescent girls to be sexually active just like adolescent boys of similar age. But there was also a minority of participants who demonstrated denial and negative perceptions about girls' sexuality.

Therefore, similar to providers in health care institutions, as documented in extant literature, some NGO actors have negative perceptions and restrictive views about adolescent sexuality. Messages such as: *"Ngono ni kitu maalumu. Usiache mtu mwingine kukuamulia. Ila la muhimu zaidi ni kusubiri mpaka tutakaokuwa tayari kiumri, kiakili, kifedha, hasa kwenye ndoa"* (sexual intercourse is something special that nobody should decide for you...but it is important to wait until we are ready age wise, mentally, financially, and most important in marriage): "*kuvunja ungo si ruhusa ya kuanza kujamiiana*"(to start menstruation is itself not a permission to begin to have sexual intercourse) ; and*"kutoka damu ukeni (hedhi) kwa mara ya kwanza kunaitwa kuvunja ungo. Hii ni dalili ya msichana kuingia utu uzima"(Experiencing first menstruation signifies that a girl has entered adulthood)* were documented and communicated to girls. These messages can be useful as they educate adolescent girls not to rush into sexual relations, and emphasize them to delay in order not to get health related problems. But on the other hand, these messages, especially in societies which have not undergone sexual revolution, such as Tanzania, may reinforce the collective view that girls should not be sexually active until they are adults, they finish school, and mostly important when married.

Further still, findings suggested that most NGO practitioners perceived unintended pregnancies and HIV/AIDS as serious health issues. But there was evidence to demonstrate that unintended pregnancies and HIV infection among girls are associated with engagement in unacceptable sexual behaviors by a minority of actors. Nevertheless, our findings could not establish clearly that these perceptions influenced design and implementation of sexual health related interventions. Most NGO practitioners provided health information and services to adolescents, including girls, without discrimination. Thus, social meanings of gender and adolescent sexuality are probably remembered as code of conduct.

On the contrary, design and implementation of sexual health program was rather influence by a ‘new’ norm of ‘appropriate sexual behaviors’ for girls, which somehow deviates from the mainstream view of adolescent girls’ sexuality in Tanzanian society. While the standard norm for adolescents, especially girls, is to abstain from sex until marriage, in adolescent sexual health practice in NGOs sexual activity is deemed appropriate when girls are matured and/or are in stable or romantic relationship. Consequently, alternative ways of fulfilling sexual desire such as kissing, touching, masturbation were communicated to girls.

Empirical data demonstrated that NGOs in Tanzania, have taken on roles which are performed by governments in developed countries. And this may be the case in East African context. NGOs have initiated and implemented several intervention programs aiming at promoting sexual health of adolescents, including girls. Ranging from ABC, voluntary counseling and testing, life skills development, and peer education; beyond ABC; biomedical intervention; provision of sexuality education; provision of family planning; provision of post-abortion care; youth and adolescent friendly service; advocacy for policy change; economic empowerment and civic engagement; prevention of gender-based violence and male involvement. The present study did not find an intervention program that explicitly, and specifically, targeted to transform the social meanings about acceptable and unacceptable gender and adolescent sexuality and other elements such as traditions, religious beliefs, age, marital status and school status. For example we found that an intervention program, young male as equal partners (YMEP) which in Tanzania was implemented by one of the NGOs we studied for promoting male involvement in adolescent sexual and reproductive health was implemented based on the idea that ‘men have cultural powers’.

According to CRC, which is the primary international human rights instrument for children rights, adolescents are recognized as right bearers and their best interest as children should be safeguarded. Article 1 and Article 24 of CRC, General Comment No. 4 (United Nations, 2003) Articles 28 and 30, acknowledges that adolescents are vulnerable to unintended pregnancies and STIs, including HIVAIDS. CRC, under article 31 also acknowledges that some individual adolescents and sub-groups, including adolescent girls are more vulnerable and their health is at greater risk. The

General Comment also acknowledges the relevance of traditions and taboos in influencing adolescent girls' vulnerability to the aforementioned health threats.

Accordingly, CRC and General Comment No. 4 obligate States and its institutions to protect the right of **all adolescents** to health, and to ensure that other actors do not violate them by taking the following action: to ensure that all adolescent boys and girls, both in school and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practice healthy behaviors; to develop measures for changing cultural views about adolescents need for contraception and STD prevention and addressing cultural and other taboo surrounding adolescent sexuality; to adopt legislation to combat practices that increase adolescents' risk to HIV infection; and to remove all barriers hindering the access of adolescent to information, preventive measures such as condoms, and care.

Apart from CRC, Article 12 of ICESCR and its General Comment No. 14 (United Nations, 2000) have stipulated rights related to health for children and adolescents and have provided clear direction on important issues related with the same. It is provided under article 43 of the General Comment No. 14 that health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, **in law and in fact**, without discrimination on any of the prohibited grounds and others. And that he right to seek, receive and impart information and ideas concerning health issues without impairing the right to have personal health data treated with confidentiality. To put matters into perspective, General Comment No. 14 (United Nations, 2000) of ICESCR delineated what right to health constitutes. Right to health as stipulated within the General Comment is not premised on the conventional definition of health as 'absence of diseases', nor does it entail *to be healthy*. Rather it is comprised of an array of socio-economic and cultural factors that "promote conditions in which people can lead a health life" and the "underlying determinants of health (see articles 3 and 11). It also includes freedoms and entitlements. While "freedom include the right to control one's health and body, including sexual and reproductive freedom", "entitlements include right to a system of health protection which provides equality of opportunity for people to enjoy the highest standard of health (See Article 8). Most important, the right to health should be based on following characteristics, *availability, accessibility, acceptability and quality.* Accessibility, among other things, but very

important, include non-discrimination and access to information. Furthermore, The Committee on Economic, social and cultural right through this General Comment states the international community, civil society or third sector, private business sector also individuals such as health professionals have responsibility and obligation regarding respecting and realization of the right to health.

Related to the above observation, findings from reviewed literature and empirical study demonstrated that law (including policies) and NGOs are influential institutions in ensuring that rights related to health of all people are protected and health related information and services are delivered to the general public. In this case, these institutions can make a difference in health status of Tanzanian population. And they have potentials to address sexual health threats facing adolescent girls. However, despite having good intentions, their capability to make a difference and to influence state of affairs related with sexual risk behaviors, unintended pregnancies and HIV/AIDS transmission among adolescent girls adolescent sexuality can be limited and short lived. Unless deliberate, humane, realistic, and context specific actions are undertaken.

First, there are loopholes in laws, and some laws are outdated. Moreover key laws and policies have controversial provisions. For example the Sexual Offences Special Provisions Act of 1998 (SOSPA) announces that a girls below 18 years is immature and not able to make rational decisions related to sexual matters, and having sexual intercourse with a girl below 18 years of age, with or without her consent, constitutes an offence of rape. SOSPA provide additional clarification that the rape offence is irrelevant if the girls is more that 15year old and is married to that man with whom she has sexual intercourse. SOSPA also contradicts the right of adolescent girls to basic health related services and information as stipulated under CRC and Child development policy as it also condone child marriage.

Further, there is discrepancy between what the law protects in paper; whom the law protects in paper; and what is protected in fact; and whom is protected in fact as far as rights related to health among children are concerned. For example to emulate international standards on child protection, Child Development Policy, Law of the Child Act and the 2014 Draft Constitution provide for the definition of a child. A child is

understood as any person below 18 years. Nevertheless, this definition is probably contradictory to the understandings about who a child in the wider societal context. During the proceedings of preparing the 2014 Draft Constitution, some members of the constituency assembly questioned the idea of recognizing children as persons below 18 years as it contradicts tradition and religious beliefs. They stated that according to their traditional and religious beliefs, girls can be married off soon after they experience their first menses. In Tanzanian society post-pubertal girls are not perceived as children but adult women. There is evidence to show that despite of the fact that early marriage accounts for a substantial percentage of maternal health problems and maternal mortality, and it violates fundamental rights and dignity of a girl child, there is no provision within the Draft Constitution which outlaws the Marriage Act of 1971 by at least proposing an increase in minimum age of marriage for adolescent girls.

Findings from the review of literature also revealed that there is no direct relationship between the practice of female genital cutting or mutilation and sexual risk behavior, unintended pregnancy and HIV/AIDS transmission. The practice of female genital cutting and/or mutilation is illegal in Tanzania. For example Child Development Policy directs girls to be protected from harmful traditional practice such as female genital cutting or mutilation according to CRC, unfortunately does not explicitly provide for protection against female genital cutting or mutilation. Rather, Section 13 of the Law of the Child Act protects children against torture, inhuman and degrading treatment. Yet, female genital cutting or mutilation is still practiced in some regions such as Mara, with impunity. As reported by some participants that in Mara region for example FGM ceremonies are done publicly. Sometimes some roads were closed to allow a parade of circumcised girls to pass while everyone was watching, including street and local government officials.

In 1998 when SOSPA was approved there was jubilation among individuals and organizations that supported its drafting and campaigned for its enactment. SOSPA was perceived a panacea of sexual violence against women and girls. To date, almost seventeen years later, there is evidence to demonstrate that, everyday, girls continue to experience a series of propositions and unwanted sexual advances from men they meet in streets, shops and at school (Mabala & Cooksey, 2008; McClealry et al, 2013). What is striking from findings established in reviewed literature is that, proposing a girl is

perhaps considered normal, and any outright rejection by girls may lead to rape (Mabala, 2008). Another report has shown that violence against children, especially girls is escalating in Tanzania, (URT, 2009). What the present study has revealed is that, although there is stiff legal punishment, there is complacency on the part of some public institutions especially courts to ensure that the perpetrators of sexual violence against a girls are hold into account. Empirical finding suggest that, while sexual violence is positioned as a grave crime within the law, the same may not apply at the level of the society. Sexual violence against girls is still perceived as something to be settled outside court system. And this happens when there are no clearly established community based mechanisms to ensure that perpetrators of sexual violence against children are punished.

It was also observed that, although the 2014 Draft Constitution stipulate that children have right to health services under section 53 (3), and protecting the right to health services for every individual under section 51 (1), it is silent about pertinent sexual health issues confronting girls such as sexual risk behavior, unintended pregnancy and HIV/AIDS. Neither does the document contain provisions that confer special protection of girls' human rights, particularly those related to health. Instead, the Draft Constitution provides for the rights of youth— Section 54, rights of persons with disability— Section 55, rights of minorities and indigenous people— Section 56, rights of women— Section 57, and rights of the elderly— section 58. Some of these rights are not stipulated within the current 1977 Constitution.

Third, some laws and policies have contradictory provisions. It is stated under Section 175 of the Penal Code Cap 16 of the laws revised of 1972 that it is an offence to trade or distribute materials that are *obscene* and corrupt *morals.* What constitutes *obscene and immoral* materials is not clarified. The Expulsion and Exclusion of Pupils from schools Regulation, 2002 on the other hand states that, a student can be expelled from school for engaging in persistent and deliberate misbehavior such as prostitution, *offence against morality* and if a pupil has entered wedlock. Although word offence against morality is not clarified, some sources have suggested this term may constitute engaging in premarital sexual activity, being sexually active while in school, using and/or possessing condoms or any other modern contraceptive method. The most recent School Improvement Toolkit, Practical Guide for Head Teachers and Heads of Schools suggest head of schools to cooperate with parents in monitoring sexual behavior of adolescents.

Head of schools are particularly advised to conduct compulsory and periodical pregnancy check up as a way of curbing unintended pregnancies among school girls.

Empirical findings did not demonstrate that NGOs we studied do not address the factors in the broader society related to health threats among adolescents and youth including girls. There were intervention programs which were meant to empower adolescents, including girls economically. Economic empowerment especially through provision of access to entrepreneurial training, capital and microcredit, was perceived as an important health protection strategy similar to life skills training and development. The rationale behind these intervention programs is that, poverty has significant influence on sexual risk behaviors, unintended pregnancies, and HIV/AIDS. Without negating the influence of poverty on sexual health among adolescent girls, the present study espouses that, the thesis that poor is more sexual risky cannot be generalized to all societies (Djamba & Kimamu, 2008). The authors also argued that, in social science, poverty is described to determine sexual behaviors when such behavior seems to deviate from the mainstream culture (2008:3). Economics and sexual risk behaviours are not necessarily intertwined among adolescent girls. Hence, poverty needs to be unpacked and linked with other factors (Mabala, 2006). Nevertheless, economic empowerment has the potential to enable girls to avoid for example transactional sex. But, most intervention programs were gender sensitive than transformative. However, this does not mean to say that NGOs in Tanzania do not implement gender transformative intervention programs. There are could be gender transformative intervention programs which were being implemented by other NGOs at the time we were conducting fieldwork. Even so were true, the efficiency of those interventions is likely to be limited. Most NGOs were urban based. Most interventions programs on adolescent health, implemented by NGOs, were meant to demonstrate ‘best practice’. Consequently, they were also small scale in terms of geographical coverage and targeted population.

Related to the above observation, youth aged 15-24 or 15-35 were the targeted group in most of the intervention programs we reviewed. Consequently, while health needs and situation of adolescents were not sufficiently addressed, health needs and situation of adolescents as a sub group, in this case sexually active adolescent girls were invisible. Empirical evidence suggest that, even when adolescent girls were targeted separately,

program objective and intended outcomes were almost similar to those intervention programs whereby youth were the targeted group.

Evidence further demonstrated that, NGOs follow policy directives and national laws when making decisions about nature and type of intervention programs to implement in order to empower adolescent girls to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS. For example according to the National Population Policy Gender equity is understood to constitute; fairness and justices in the distribution of benefits and responsibilities; equal opportunity; equal treatment before the law, and equal access to and control over resources and social services. Gender equality on the other hand is understood as the sharing of power among both females and males not at the personal level but basically at institutional level. In addition, gender equality calls for equal rights, responsibilities and duty, not identity. Similar understandings were observed in some intervention programs. *'Tuitetee'* intervention was a good example of intervention which was designed for was defending adolescent sexual and reproductive health rights. The main agenda was to advocate for the right to gender equality and equity for young people upon realizing that young people (boys and girls) were affected differently with sexual reproductive related problems, and they needed to be aware that solution to their problems, perhaps sexual health related information and services would be provided with a gender sensitive approach and equity in terms of access. According to '*tuitetee',* girls and boys have the right to be treated fairly. To achieve the agenda that *'tuitetee'* was advancing, the following were some of the intended outcomes; increased demand among young people for SRH; established functional two model centres for offering quality youth friendly SRH services according to national standards; increased number of health care providers skilled in provision of quality and friendly SRH services for young people. In addition, and as pointed out in earlier chapter, in the present study health is understood not as a mere service or obligation. It is rather a basic human right, which also relate directly and indirectly to other rights such as right to life and right to education. However, according to Article 14 of the current 1977 Constitution a person's right to life has to be protected by the society in accordance with the law.

On the other hand, it is observed that, to a great extent, most NGO depend on external sources of fund for financing various programs and activities. Consequently, decisions

about nature and type of intervention programs implemented to empower adolescent girls to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS were somehow influenced by the agenda and priorities of donors and donor institutions. This suggest lack of interest on the part of donors and donor organization to finance long term programs especially those which would address gender at the level of the society. NGOs have to have a very clear time table of what they are doing. The life span of most of the interventions was between two (2) and four (4) years. Consequently, an individual adolescent girl was the primary target of most of the intervention programs. And programs objectives and outcomes were individualistic and quantitative in nature.

Related to the above observatio most interventions which were financed by donor and donor institutions from the United States of America constituted behavior change and communication, biomedical, and conventional public health approaches in adolescent sexual and reproductive health. On the other hand, those intervention programs which were financed by donors and donor institution from Europe focused on promoting healthy life style through bombarding youth with health related information, and provision of adolescents/youth friendly services. Most of them had right based dimension and an individual is the main focus. In most of developed countries, especially in Europe adolescents, including girls are considered as rational individuals whose sexual health related rights need to be respected and protected through provision of comprehensive sexuality information and services. In turn, adolescents are expected to behave responsibly, particularly to adopt safe sexual behaviors and avoid unintended pregnancies and HIV/AIDS when sexually active and in romantic sexual relations.

Evidence also suggested that, most health concerned NGO adopt a neutral position in issues related to sexuality, unintended pregnancies and HIV/AIDS. Of course, adopting the principle of neutrality in sexual health related intervention programs is meant to make these organizations ‘to do no harm’. Accordingly, most NGOs do not interfere on the culture of the society in which they operate. However, this is achieved perhaps, in theory than in practice. In fact, adhering to the principle of neutrality may reinforce discrimination of certain individual and groups, in this case adolescent girls, and make their sexual health needs and situation go underground. For example messages such as: *"Jamii nyingi haziruhusu msichana kupata mtoto nje ya ndoa, achilia mbali msichana ambaye bado ni mwanafunzi*" (in many societies bearing children out-of-wedlock

among girls, especially school girls, is not acceptable); *"utoaji mimba ni kinyume na sheria kwenye nchi nyingi"* (abortion is illegal in many countries)", and *"dini nyingi haziungi mkono utoaji mimba"* (most religions do not support abortion); and *"kidini nafikiri ngono ni kwa ajili ya waliooana tu"* (I think according to religious instruction sexual intercourse is for married people) are useful. But the impact can be limited and short lived. These kinds of messages do not only instill fear, they also reinforce stigma and taboo attached to adolescent girls' sexuality, unintended pregnancies and HIV/AIDS.

It is also observed that in Tanzania society, most intervention programs on the subject of condoms and other family planning face restrictions. Consequently, the restrictions affected daily implementation of activities and overall efficiency of NGOs in empowering adolescent girls to avoid sexual risk behaviors, unintended pregnancies, and HIV/AIDS among adolescent girls. In Tanzania there is no stand alone sexuality education, yet, sexuality related information and materials provided by NGO were censored. More often than not, NGO actors were not allowed to have open communication about sex and sexuality. They therefore resortd to beat about the bushes when delivering sexuality related information to adolescent girls. Condom promotion activities were also restricted by some teachers and religious leaders. Moreover, most program managers reported that, implementing activities which aims to providing access to family planning service to adolescents was an uphill task. Provision of contraceptive information and services to adolescents, especially school girls is generally controversial. Simultaneously, women and girls receive information from some religious institutions that using modern FP methods as a sin, similar to killing. NGO practitioners are often reminded *"wasifundishwe...hawa ni watoto"* (they should not be taught...they are children) by some teachers and government officials. As Foucault suggested, even in Tanzania, sexuality should not be described as a stubborn drive, more often than not, sexuality appears as an especially dense transfer point for relations of power: between men and women, young people and old people, parents and offspring, teachers and students, priests and laity, an administration and a population [Emphasis added] (Foucault, 1998:103 *cited in* Van Den Berg, 2008a:101).

It can therefore be concluded that in Tanzania, law, policies and non-governmental organizations contribute to some extent, in the social reproduction of adolescent girls'

vulnerability to sexual risk behaviors, unintended pregnancies, and HIV/AIDS transmission. Actions which was intended to protect girls' right related to health in laws and policies, and in non-governmental organization defeats the very core mission these institutions claim to advance; protection of health of marginalized and most vulnerable individuals and groups—in this case adolescent girls. Consequently, adolescent girls 'sexuality is silenced and sexual health of sexually active adolescent girls become invisible.

It is therefore argued that, to influence state of affairs and making a difference in regard with protecting rights related to health among girls, particularly, to adolescent prevent and/or reduce adolescent girls' vulnerability to sexual risk behavior, unintended pregnancy, and HIV transmission in any substantial and sustainable way, these institutions — in this case law (including policies) and NGOs, should not reinforce the identified collective views about acceptable and unacceptable feminine identity and adolescent girls' sexuality and other elements such as traditions, religious beliefs, age, marital status and school status which jeopardizes sexual health of adolescent girls. This requires continuous and critical reflection of action related to adolescent girls 'sexuality and sexual health among girls.

Finding illustrated that most of the interventions drew from several behavioral, socio-psychology, medicine, epidemiology, public health and sexual rights perspectives. In order to achieve long term changes in improvement of adolescent girls' health and well being, more interventions should target to challenge and/or transform the identified social meaning attached to feminine identity and adolescent girls' sexuality and other elements such as traditions, religious beliefs, age, marital status and school status which jeopardizes sexual health of adolescent girls. This would require NGOs and other civil society organizations to put human right principles, particularly principles of equality and non-discrimination at the core of their mission and in the design and implementation of health related intervention programs.

Human rights or right based approach is more promising and potential in empowering adolescent girls to avoid sexual risk behaviors, unintended pregnancies and HIV/AIDS transmission compared to other conventional approaches. Human rights or right based approach provides for the possibility of challenging and/or transforming the power relations responsible for prevalence of sexual risk behaviors, unintended pregnancies

and HIV/AIDS transmission among girls; for reinforcing the social meanings attached to feminine identity and adolescent girls' sexuality and other elements such as traditions, religious beliefs, age, marital status and school status which jeopardizes sexual health of adolescent girls; and for rendering them victims of female genital cutting or mutilation, coerced or forced sexual activity, and early marriage.
Related to the above observation, the government as State party to CRS and ICESCR should enhance protection of rights related to health among adolescent girls including, to ratify and sign the third the Optional Protocol to the CRC on a Communication procedure which was approved by UN General Assembly on 19 December 2011 and opened for signature in 2012 and entered into force on 14 April 2014. The Protocol allows individual children to submit complaints regarding specific violation of the rights stipulated under the Convention.

Further, Tanzania is a diverse society in terms of ethnic and religion composition, and adolescents are diverse individuals and social group.Accordingly, the government and its institutions as well as non-governmental organizations have the obligation to devise not one, or few, but different plans reflecting situation and sexual health needs of different groups, specifically adolescents. And also ensure that other actors and institutions do the same. The present study has demonstrated that, in Tanzania, and probably in East African context, right to health for adolescent girls has to have both an individual dimension and a collective dimension.

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APPENDICES

APPENDIX I
QUESTIONNAIRE GUIDE

My name is Ms. MARTHA PETER MWOLO − I am a PhD student at the University Fernando Pessoa in Portugal carrying out research on girls' sexual health in Tanzania. This study is conducted for academic purpose only. I therefore kindly request you to participate in this research by filling in the questionnaire if you do not mind. The time scale for this activity is one (1) hour.

IDENTIFICATION QUESTIONNAIRE NO: _____

NGO'S PROFILE (TICK only ONE answer that describes your organisation in the box provided after each questions below)

1. At which level is your organisation is registered legally?

International ☐ National ☐

2. In which region do you implement most of your programs and activities?

Dar es Salaam ☐

Mwanza ☐

Iringa ☐

Shinyanga ☐

Any other...

3. Province/District

Urban ☐ Rural ☐

4. Who are the targeted Populations?

Adolescent girls between 15-18 years ☐

Adolescent boys between 15-18 years ☐

Adolescent girls and boys between 15-18 years ☐

In school adolescent girls and boys 15-18 ☐

Out of school adolescent boys and girls 15-18 ☐

Other ____________________________ (please specify)

5. What are the areas that your organization envisions to impact on adolescent health**? (You may TICK more than one option in the boxes provided)**

(a) Provision of information for reduction of sexual risk behaviors ☐

(b) Prevention of unintended pregnancies in adolescents ☐

(c) Provision of sexual health information for adolescents ☐

(d) Provision of HIV/AIDS prevention information and services ☐

(f) Promotion of responsible sexuality in adolescents ☐

Any other (provide your answer in the space below)

----

6. What is your gender?

Female ☐ Male ☐

7. Highest Level of Education attained

Primary ☐

Secondary Education ☐

Higher Education ☐

College ☐

University ☐

Other_________________ (Please Specify)

8. Which among the following statements describe perception of adolescent girls' sexuality? **Please indicate your views (TICK only ONE answer in the boxes provided)**

(a) Adolescent girls are sexually active.

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

(b) Adolescent girls are likely to be sexually active as adolescent boys.

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

(c) Adolescent girls are not likely to be sexually active as adolescent boys.

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(d) Adolescent girls cannot manage their own sexuality as adolescent boys

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(e) Adolescent girls' sexuality should be controlled because it has health consequences.

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

(f) Sexually active adolescent girls engage in unacceptable behaviors or practices.

Strongly agree	agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(g) Sexually active adolescent girls engage in immoral behaviors or practices.

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

9. Briefly, in your views, how do you perceive sexual activity in adolescent girls?

(a)____

(b)____

(c)____

(d)____

10. The following statements describe the reasons why adolescent girls are at increased risk for unintended pregnancies? **Please indicate your views (TICK only ONE answer in the boxes provided)**

(a).Unintended pregnancies occur because adolescent girls engage in unacceptable sexual behaviors or practices.

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

(b) Unintended pregnancies occur because adolescent girls are sexually active.

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

(c) Unintended pregnancies occur because adolescent girls have limited access to comprehensive sexual health information.

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(d) Unintended pregnancies are likely to occur because sexual activity in adolescent girls is immoral.

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(e) Unintended pregnancies are likely to occur because adolescent girls are not prepared to manage their own sexuality

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(f) Unintended pregnancies are likely to occur because adolescent girls have access to comprehensive sexual health information

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

11. Briefly, in your own views, describe why adolescent girls are more likely to get unintended pregnancies?

(a)____

(b)____

(c)____

(d)____

12 The following statements describe circumstances of HIV/AIDS risk among adolescent girls. **Please indicate your views (TICK only ONE answer in the boxes provided)**

(a) Adolescent girls are less vulnerable to HIV/AIDS because they do not engage in sexual risk behaviors

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(b) Adolescent girls are less vulnerable to HIV/AIDS because they are not sexually active

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(c) Sexually active adolescent girls are more likely to contract HIV/AIDS because they engage in unacceptable behaviors

Strongly agree	agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(d) Sexually active adolescent girls are more likely to contract HIV/AIDS because they engage in immoral behaviors

Strongly disagree	Disagree	Ambivalent	Agree	Strongly agree
☐	☐	☐	☐	☐

(e) Sexually active adolescent girls are more likely to contract HIV/AIDS because they have limited access to comprehensive sexual health information.

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

(f) Sexually active adolescent girls are likely to contract HIV/AIDS because they are not prepared to manage their own sexuality

Strongly agree	Agree	Ambivalent	Disagree	Strongly disagree
☐	☐	☐	☐	☐

13. Briefly, in your views, describe why adolescent girls are more likely to contract HIV infection?

(a)____

(b)____

(c)____

(d)____

14. How do you perceive programs that promote safe sex or consistent use of condom during sexual activity among adolescent girls? (**You can tick more than ONE option in the boxes provided below**)

(a) They encourage adolescent girls to be sexually active. ☐

(b)They promote sexual activity in adolescent girls ☐

(c) They empower sexually active adolescent girls to avoid HIV/AIDS and unintended pregnancies ☐

Any other (write your views in space provided below)

____

____

15. How do you perceive programs that promote abstinence or no sex ONLY in adolescent girls? (**You can tick more than ONE option in the boxes provided below)**

(a) They encourage adolescent girls to postpone sexual activity until they are matured or married ☐

(b) They promote sexual activity in adolescent girls as unacceptable behavior ☐

(c) They empower sexually active adolescent girls to avoid unintended pregnancies and HIV infection ☐

Any other (write your views in space provided below)

Asante (Thank you)

APPENDIX II

INTERVIEW GUIDE

My name is Ms. MARTHA PETER MWOLO − I am a PhD student at the University Fernando Pessoa in Portugal carrying out research on girls' sexual health in Tanzania. This study is conducted for academic purpose only. I therefore kindly request you to participate in this research by answering the following questions if you do not mind. The time scale for this activity is one (1) hour.

1. International human rights provisions on rights related to health

(a) Mention any international human rights instrument for protecting health among adolescent that you are familiar with

2. Sexual risk behaviours among adolescents

Research reveals that a substantial number of adolescents in Tanzania become sexually active between ages of 15 and 18, and they engage in unprotected sexual activity.

(a) In your own opinion why do you think adolescents engage in early and unprotected sexual activity among adolescent girls?

(b) Describe briefly what does your organization do to prevent early and unprotected sexual activity among adolescents?

(c) Why have you decided to implement each of the identified activity and/or services offered?

(d) To be more specific what does your organization do to prevent early and unprotected sexual activity among adolescent girls?

2. Unintended pregnancies among adolescents

Studies indicate that substantial number of adolescent girls in Tanzania become pregnant before they reach 18 years and most of these pregnancies are unintended.

(a) In your own opinion why do you think adolescent girls are more likely to get unintended pregnancies?

(b) Describe briefly what does your organization do to prevent unintended pregnancies among adolescents?

(c) Why have you decided to implement each of the identified activity and/or offered services?

3. HIV/AIDS among adolescents

Studies indicate that adolescents in Tanzania are more vulnerable to HIV/AIDS infection

(a) In your own opinion why do you think adolescents are more likely to contract HIV/AIDS?

(b) Describe briefly what is done your organization to prevent HIV/AIDS among adolescent girls?
(c) Why have you decided to implement each of the identified activity and/or services offered?
d) To be more specific what does your organization do to prevent HIV/AIDS among adolescent girls?

4. Social meanings of adolescent sexual behaviours

Studies indicate that social meanings associated with gender and sexuality influence health among adolescents
(a) Describe briefly what is done by your organization to address ideas about gender and sexuality that impact on health among adolescents?
(b) To be more specific what does your organization do to address gender and sexuality and other harmful practices that impact on girls' health at the level of the society?
(c) If yes, what specific social meanings or norms does your organization envisage to transform?
(d) What new social meanings do you envisage to promote?
(e) If not, why don't you have specific activities that target to challenge social meanings of gender and sexuality that impact on girls' health at the level of the society?

5. Mechanisms for protecting adolescent girls' health

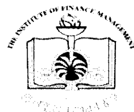
(a) In your opinion what is the role of civil society organizations in enabling adolescent girls to manage their sexuality and to protect their own health
(b) Describe briefly what is done by your organization in order to enable adolescent girls to protect themselves against early and unprotected sexual activity, unintended pregnancies and HIV/AIDS?
(b) Why have you decided to implement each of the identified activity and/or services offered?
(c) What practical challenges does your organization encounter in empowering girls to protect their own health and avoid early and unprotected sexual activity, unintended pregnancies and HIV/AIDS?

Asante (Thank you)

APPENDIX III

COVER LETTERS

CHUO CHA USIMAMIZI WA FEDHA
THE INSTITUTE OF FINANCE MANAGEMENT
(ESTABLISHED UNDER THE ACT No. 3 OF 1972)



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rector@ifm.ac.tz
TANZANIA.

Ref. No.: IFM/PF.815 **Date:** June 1, 2013

To whom it may concern

RE: **RESEARCH CLEARANCE FOR MS. MARTHA P. MWOLO**

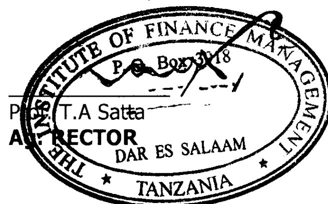
The purpose of this letter is to introduce to you Ms. Martha P. Mwolo who is an academic staff at the Institute of Finance Management, and who at the moment is conducting research for her doctoral dissertation. The research project concerns health issues among adolescent girls. The target of the study is civil society organizations such as non-governmental organizations (NGOs).

I therefore request you to grant the above mentioned access to information according to her research plan and objectives. The Institute declares that the researcher will use this information wholly and exclusively for the purpose of the doctoral research and not otherwise.

The period for which this permission is requested is between June and September 2013. The research will take place, mainly, in **Dar es Salaam region**. In case you may require further information please contact **+255-22-2112931-4.**

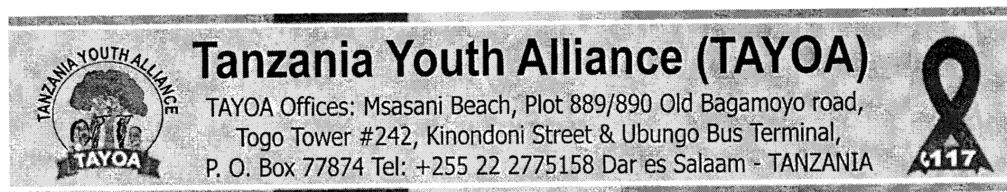
I trust that you will offer her your cooperation for timely completion.

Yours Sincerely,



Prof. T.A Satta
Ag. RECTOR

All correspondence should be addressed to the Rector



30/07/2013

Ref: TYA/2013/hlpln/**2864**

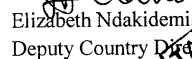
Dear Ms. Mwolo

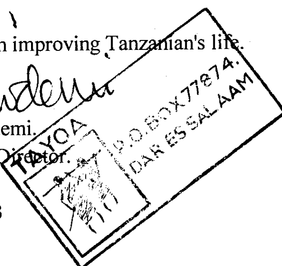
RE: ACCEPTED YOUR REQUEST TO CONDUCT FIELDWORK AT TAYOA'S OFFICE

As the head above states, I am happy to inform you that the team at TAYOA offices have accepted your request to be attached to our programs as part of your studies.

While here, you will be attached to the HIV and Reproductive health projects. It is our understanding that our office will not incur any costs related to your fieldwork or you being attached with us. We are hoping that you will contribute a lot to our team as well as learning the health and economic situation of Tanzania'ns especially young people and women.

Let's join hands in improving Tanzanian's life.





Elizabeth Ndakidemi.
Deputy Country Director.

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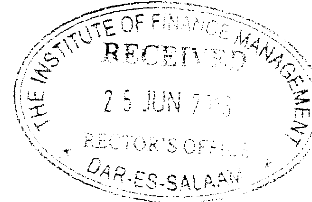
Ref. No. UMT/ADM/02/2013
(Kumb. Na)

Date 14th June 2013
(Tarehe)



Ms Martha P Mwolo,

IFM,

P.O.Box 3918,

Dar-es-Salaam.

Dear Ms Mwolo,

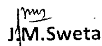
RE: REQUEST TO CONDUCT FIELDWORK

Kindly refer to your letter dated 7th June 2013 on the above caption.

I am pleased to inform you that your request has been accepted. However the Association will not meet any costs during your fieldwork.

We look forward to work with you so as to complete your research project on **An Inquiry on the influences of health threats in Adolescent Girls.**

Sincerely Yours



J.M.Sweta

For Executive Director

CC: Rector,

IFM,

Box 3918,

Dar-es-Salaam

MOVE WITH UMATI INTO 21st CENTURY WITH QUALITY REPRODUCTIVE HEALTH

Chairperson: Mrs. B. Ndunguru; Vice-Chairperson: Prof. S.Y. Maselle; Treasurer: Mr. S. Kilimuhana; ExCo. Member: Prof. G.R.V. Mmari; Executive Director: Mrs. Josephine Mwankusye

Amref Health Africa Tanzania

25th August 2014

TO WHOM IT MAY CONCERN

Re: Permission to conduct field work research for PhD student Martha Peter Mwolo

Refer to the heading above.

The above mentioned student requested to conduct field work research with our organisation for the PhD project on girls' sexual health. Together with the cover letter, curriculum vitae, and identification letter from her employer, the researcher submitted the research protocol.

The Acting Research Manager at Amref Health Africa reviewed submitted documents including clearance from the Institute of Finance Management, upon his satisfaction that there were no major ethical issues that might require additional review by Amref Health Africa Institutional Review Board, he facilitated and provided guidance to her in accessing information needed. The information accessed from the organisation will only be used for the purpose stated herein above. The researcher is expected to provide final report upon completion of the study.

Yours sincerely,

David Ngilangwa
Health Systems Research and Advocacy Manager

P.O. Box 2773 Dar es Salaam, Tanzania, Tel:+255-22-2116610/2131981/2136731, Fax:+255-22-2115823, www:amref.org

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