WORKING PAPER

Investigating Risky Sexual Behaviours among Youth in the Context of the HIV Epidemic in Mbeya Region, Tanzania

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CONTENTS

TABLES

ABBREVIATIONS

CSO	civil society organization
FGD	focus group discussion
IDI	independent interview
MOHSW	Ministry of Health and Social Welfare
MPEE	Ministry of Planning, Economy, and Empowerment
NBS	National Bureau of Statistics
NGO	nongovernmental organization
ORCM	Office of the Regional Commissioner of Mbeya
SRH	sexual and reproductive health
STI	sexually transmitted infection
SW	sex worker
TACAIDS	Tanzania Commission for AIDS
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
USAID	U.S. Agency for International Development

EXECUTIVE SUMMARY

Background: Mitigating HIV and AIDS among youth has been a major policy agenda both internationally and nationally, within Tanzania. Two concerns associated with mitigation efforts are increasing sexual activity at young ages and a burgeoning population of out-of-school youth whom poverty, lack of supervision, and unemployment seem to push into alternative life patterns that present risks to their health. This situation poses a serious challenge for Tanzania, where half the population is categorised as young. This study had the following goals:

- Understand the sexual behaviours youth engage in that increase their risk of acquiring HIV and influence the HIV epidemic
- Assess youths' knowledge about HIV and AIDS and sexual and reproductive health (SRH)
- Investigate how gatekeepers and health service providers are positioned to address risky sexual behaviours among youth
- Analyse the social, cultural, economic, and legal challenges to addressing these behaviours in youth in the rural and urban areas of Mbeya Region in Tanzania

Method: The study focused on 54 individuals (27 males and 27 females) from three identified categories: youth ages 15–24 years old (30 respondents); gatekeepers (16 respondents); and health service providers (8 respondents). Data collection involved qualitative techniques: in-depth interviews (IDIs), focus group discussions (FGDs), and document review.

Results: The majority of youth studied had heard about HIV and its related effects; however, condom use, and attendance at SRH services is very low among this population. The government, parents, nongovernmental organisations (NGOs), religious institutions, and health service providers play a role in addressing risky sexual behaviours among youth. Parents have some responsibility for engagement by youth in risky sexual practices: poor marital relationships and instability in the home, supervising their children poorly, failing to communicate with their children about HIV and prevention, and putting their children in unsafe and vulnerable situations. However, many other factors contribute to participation by youth in risky sexual practices, such as the following:

- Lack of education about HIV and SRH by schools and other institutions
- Lack of decision-making power
- Drug and alcohol abuse
- Household poverty
- Desire for material goods
- Lack of appropriate income-generating activities for youths
- Poor implementation of policies and laws that have the potential to decrease HIV transmission

Conclusion: Despite increased government and NGO measures against HIV and attempts to minimise youths' vulnerability to the disease, the community still does not fully support these efforts, and youth behaviour change remains a challenge. The study recommends that the Tanzanian government remain engaged and demonstrate leadership by effectively contributing to initiatives that address the HIV epidemic and create an environment supportive of access and use by youth to SRH services.

BACKGROUND

The HIV epidemic is a serious threat to the social and economic development of Tanzanian citizens. In recognition of this, the United Republic of Tanzania implemented different initiatives to fight HIV, by developing, strengthening, and reforming legal and policy frameworks. The goal is to reduce HIV-related vulnerabilities, particularly among youth, who account for more than half of the Tanzanian population (NBS, 2012).

At the national level, the government developed a policy on HIV and AIDS in 2001 as a response to the HIV epidemic that provides a framework for leadership and coordination: the National Multi-Sectoral Strategic Framework (2003–2007). Accordingly, the policy aims to do the following: provide appropriate interventions to effectively prevent HIV and AIDS and other sexually transmitted infections (STIs); protect and support vulnerable groups; and mitigate the social and economic impact of HIV and AIDS (Prime Minister's Office, 2001). The policy identifies people who use drugs, people with multiple partners, sex workers (SWs), and young adults as more vulnerable to the epidemic. The government further developed policies and strategies that explicitly address the HIV epidemic and youth vulnerability, including the National Strategy for Growth and Reduction of Poverty I and II (NSGRP-MKUKUTA I and II); the Tanzania Development Vision 2025; and the National Youth Development Policy (2007), which addresses multiple issues that increase youth vulnerability to HIV. To achieve the government's goals, the Tanzania Commission for AIDS (TACAIDS) was established. It has collaborated with other institutions to address the epidemic and has made HIV a crosscutting issue that is mainstreamed in all its policies and programs. Despite these international, regional, and national legal frameworks and initiatives, HIV is still a health and development concern in Tanzania, particularly for the country's youth.

Mitigating HIV among youth has been one of the major agendas in global and national health policies and programs. Key concerns are the increasing prevalence of sexual activity at increasingly younger ages, a burgeoning youth population that does not attend school, and high unemployment that seems to push youth into alternative life patterns that involve risks to their health. High-risk behaviours include drug abuse, multiple sex partners, anal sex (boy to boy, girl to girl, and boy to girl), and young boys and girls having sex with older men and women for economic reasons.

This situation poses serious challenges. Other population groups are at risk for HIV transmission, but youth—especially girls—are at the highest risk, (MPEE, 2006). This is because of gender imbalances that prevent girls from having agency and decision-making power. The HIV rate among Tanzanians ages 15–49 is 5.1 percent (THMIS, 2013). Among youth, defined as those 15–24 years old, 2 percent are HIV-positive, with higher rates among women (3%) than men (1%) (THMIS 2013). Tanzania's youth population is more vulnerable to HIV and unplanned pregnancy owing to a lack of SRH services and information, sociocultural and gender issues, and poverty (MPEE, 2006). Other factors known to be associated with HIV prevalence among youth are poor knowledge of preventive methods, age, marital status, gender inequality, level of education, rural or urban residence, exposure, culture and traditions, migration status, and socioeconomic activities related to livelihood and religion.

The HIV epidemic shows strong regional variation. Regions with the highest youth HIV prevalence are Mbeya (14%), Iringa (13%), and Dar es Salaam (11%). Across the country, HIV prevalence among youth

varies considerably, from a reported low of 0 percent in Pwani and Manyara Regions to a high of 5.1 percent in Njombe Region (see Table 1).

Table 1. HIV prevalence among youth ages 15–24 in Tanzania

Region	%	Region	%	Region	%	Region	%
Dodoma	1.4%	Iringa	4.1%	Manyara	0.0%	Lindi	2.1%
Arusha	0.8%	Mbeya	2.0%	Njombe	5.1%	Mtwara	2.0%
Kilimanjaro	1.8%	Singida	1.2%	Katavi	2.8%	Kagera	2.5%
Tanga	1.0%	Tabora	0.8%	Simiyu	1.5%	Mwanza	1.3%
Morogoro	1.1%	Rukwa	2.2%	Geita	2.9%	Shinyanga	3.7%
Pwani	0.0%	Kigoma	2.1%	Ruvuma	2.3%	Mara	1.0%
Dar es Salaam	4.0%						

Source: Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) (2013)

One study showed that having partners at higher risk of being HIV-positive in the past 12 months (e.g., SWs) was associated with higher HIV prevalence among women but not men (THMIS, 2003). Women who are sexually active who reported having no partners at higher risk in the past 12 months had an HIV prevalence of 8 percent, but HIV prevalence was 11 percent for those who had one partner and 17 percent for those who had two or more sex partners at higher risk of being HIV-positive in the last 12 months. For men, HIV prevalence seemed to decrease as the number of sexual partners at higher risk increased in the past 12 months. No difference in HIV prevalence was found between men who had had sex with SWs in the 12 months preceding the survey and those who had not. As for condom use, the study showed that HIV prevalence tended to be higher among those who used a condom the last time they had sex, especially among women. It is therefore difficult to determine the direction of the relationship between condom use and HIV transmission, because condoms can be used to protect HIV-negative users from acquiring the virus but can also be used by HIV-positive individuals to protect their partners. Low HIV prevalence among those who reported not using a condom the last time they had sex may be associated with the type of relationship; a majority of those who did not use a condom the last time they had sex might have had sex with a husband or wife.

The study did not report on HIV prevalence in relation to sexual behaviour among youth. In fact, no study in Tanzania has compared sexual behaviour among youth in regions with high versus low HIV prevalence. The study also did not compare and contrast rural and urban areas in the same or different regions. Nevertheless, because there are differences in HIV prevalence among regions, populations, and between the sexes, it is important to compare and contrast the factors associated with young people's risky sexual behaviours in both urban and rural Tanzania. Only with this information can policymakers effectively design, plan, and allocate HIV-prevention resources according to youths' needs. Identifying factors that motivate youth to engage in risky sexual behaviours is critical to HIV mitigation.

Ultimately, HIV prevalence data provide important information to plan the national response, evaluate program impact, and measure progress on the National Multi-Sectoral Strategic Framework on HIV/AIDS (2003–2007). We hope that the findings from this study will give national decision makers and other development partners in the HIV and AIDS sector a better understanding of the motivators of current risky sexual behaviours practiced by youth in urban and rural areas of Mbeya and other regions.

Research Questions

The following research questions guided this study:

1. What are the risky sexual behaviors that youth engage in that affect the prevalence of HIV among youth in rural and urban Mbeya Region?
2. What factors influence the level of HIV prevalence among youth in rural and urban Mbeya Region?
3. What knowledge do youth have about HIV and AIDS and SRH?
4. How are gatekeepers and health service providers positioned to address sexual risk behaviours that influence HIV prevalence among youth?
5. What are the social, cultural, economic, and legal challenges to addressing sexual risk behaviours among youth in rural and urban Mbeya Region?

STUDY METHOD

Study Design

This study adopted an exploratory research design using qualitative data collection to investigate risk behaviour among youth within their natural context. This methodological approach allowed the researcher to explore participants' attitudes, behaviours, experiences, and opinions (Bryman, 2004), yielding important insights for health programs and policies.

Study Setting

This study was conducted in the two councils of Mbeya Region, which is located in southwest Tanzania and borders Zambia and Malawi, to the south. The region has a population of 2,707,410 and a population growth rate of 2.7 percent (NBS, 2012; ORCM, 2016). The two study areas were Mbeya City Council and Mbeya District Council. Mbeya Region is culturally diverse, with a number of ethnic groups from different regions and countries. The region was selected because of the high HIV prevalence among all age groups (9.0%) and the presence of a broad array of sociocultural and economic activities (THMIS, 2013). Neighbouring Njombe Region has a higher HIV prevalence (9.4%) among its overall population, but the area is over-researched. In addition, Njombe is a newly formed region.

After consulting with local leaders, two wards were selected for data collection: Nsalala from the Mbeya District Council and Luanda from Mbeya City Council. Nsalala was selected because of its proximity to the Mbalizi center, which attracts business people from a variety of industries. In addition, it is transitioning from being a rural to an urban area, a shift that is attracting more youth; and it is located near the highway to Tunduma, so it is a potentially risky area for HIV transmission. Luanda was identified as a very risky place for youth, because it contains a number of locations, such as bars, guesthouses, and brothels, which are unsafe for youth. It also has large populations of people who use drugs and people from diverse ethnic backgrounds. Respondents in the IDIs reported that the area attracts many business people and businesses. Indigenous people and those from areas outside Mbeya interact, sometimes in ways that involve greater health risk (according to the IDI respondents).

Data Collection

Qualitative data collection techniques were employed—IDIs, FGDs, and document review. IDIs were conducted with 30 respondents from the two study areas (15 from Mbeya City Council and 15 from Mbeya District Council). Thirteen females and 17 males were interviewed. The interview protocol was designed in English and later translated into Kiswahili. Interviews were conducted in Kiswahili and tape-recorded with the respondents' consent.

We conducted four FGDs, each with six participants from the first two groups in Table 2, for a total of 24 FGD participants. The FGDs involved a heterogeneous composition of participants, a mix designed to allow community members from various positions to engage and share their opinions and recommendations. There were 10 male and 14 female FGD participants. The FGDs were conducted in Kiswahili and tape-recorded with the assistance of a research assistant.

Published and unpublished documents from government institutions, private organisations, and academic institutions were identified and reviewed. The documents were mainly accessed through internet browsing and from the institutions' archives. The majority of documents reviewed were from the year 2000, but other important documents, particularly policies and laws, were more than 50 years old.

Population Sampling

Respondents were categorised into three groups (see Table 2). The first group was recruited using purposive and random sampling. The second and third groups were recruited by using random sampling, though the location was identified with the assistance of the local leaders. Interview and FGD guides were developed to assist the interviews and discussions.

Table 2. Respondents recruited for the study according to respective group

#	Group	Reason for assessment	Settings	Total involved
1.	Men, women, and children, ages 15–30, including street youth, petty traders, students, homosexuals, SWs, injecting drug users, and other youth from the community	Key informants on youth behaviour	Streets, households, secondary schools, vocational training centers, universities, nightclubs/ bars, and guesthouses	30 (17 males, 13 females)
2.	Gatekeepers (stakeholders), including parents/guardians, religious leaders, community leaders, teachers, NGOs, and government department staff	Act as role models; trainers; and, at the same time, gatekeepers	Respective offices, including the district council, village and ward offices, and schools	16 (7 males, 9 females)
3.	Health service providers, including health workers in public and private clinics, the public hospital, NGOs and community-based organizations whose focus is on health services, and pharmacists and traditional healers	Providers work closely with beneficiaries and are guided by government guidelines on the provisions of voluntary counseling and testing. They act as a source of information regarding SRH and frequently interact with youth	Health center, home, pharmacy, bar, ward and village offices, and streets	8 (3 males, 5 females)
	Total			**54**

Source: Field data (2016)

Data Analysis

Before starting the data analysis, the recorded data (which was recorded in Kiswahili) was transcribed verbatim, typed, translated into English, and then edited. The data obtained from IDIs, FGDs, and documents were analysed thematically, with issues emerging from the data organised by themes related to the research questions.

Ethics Review

Research clearance was first granted by the Office of the Vice Chancellor, University of Dar es Salaam, and then by the regional and district authorities of the respective study areas. The researcher was given a letter to take to the respective wards, neighbourhoods, and villages selected for the study. During the IDIs and FGDs, respondents were informed of their right either to agree to participate or to withdraw from the study at any point; verbal consent was sought from each respondent. Respondents were also assured confidentiality, and for purposes of anonymity, no names were used. The results of the interviews and FGDs were stored in a manner that ensured confidentiality.

Limitations of the Study

First, the study was not conducted when planned, owing to the Tanzanian general elections, and it was difficult to reschedule data collection amid competing priorities. Second, although all groups we intended to interview were reached, the limited population sample may not adequately represent all youth and stakeholders. Third, low awareness by some of the respondents about research required the researchers to do extra explaining and education to introduce the study purposes. This lengthened the amount of time it took to conduct the IDIs and FGDs. The time it took to introduce the study resulted in some respondents becoming bored and also increased the time spent on data collection.

RESULTS AND DISCUSSION

This study helped to increase the knowledge base about the risky sexual behaviours that Tanzanian youth in Mbeya City Council and Mbeya District Council are involved in and how such behaviours affect the HIV epidemic. The study investigated the factors that contribute to youth involvement in these behaviours and how the gatekeepers (parents, the government, health institutions, CSOs, and NGOs) are positioned to address them. The findings identified the challenges facing youth in addressing risky sexual behaviours, and suggested that youth involvement in these behaviours is caused by a number of factors. These include parents' irresponsibility and poor supervision, household poverty, youth desire for material things, drug and alcohol abuse, forced early marriage for daughters, poor quality and accessibility of health facilities, and lack of support and opportunities for youth self-employment.

Demographic Characteristics of the Respondents

As shown in Table 2, among the 54 respondents, there was an equal representation of males and females, although men and women were not equally represented within the three categories; there was a higher percentage of male respondents in the youth category. Table 3 shows the age distribution of the respondents, with the highest percentage of respondents being ages 15–25 years old.

Table 3. Respondents' distribution by age (N=54)

Age	Youth		Gatekeepers		Health providers		Total
	Male	Female	Male	Female	Male	Female	
15–25	14	11	0	0	0	0	**25**
26–35	3	2	1	1	1	2	**10**
36–45	0	0	3	3	1	1	**8**
46–55	0	0	2	4	1	1	**8**
56+	0	0	1	1	0	1	**3**
Total	**17**	**13**	**7**	**9**	**3**	**5**	**54**

Source: Field data (2016)

As shown in Table 4, the majority of respondents (20) were single, followed by those who were married (17), divorced (10), and widowed (7). This variable was considered important, because it has been observed that married couples are at greater risk of acquiring HIV. Yet, this study showed that both married men and women are at risk of acquiring HIV because they engage in risky behaviours with unmarried male and female youth (IDIs and FGDs).

Table 4. Respondents' distribution by marital status and sex

Marital status	Youth		Gatekeepers		Health providers		Total
	Female	Male	Female	Male	Female	Male	
Single	4	8	2	2	2	2	**20**
Married	2	6	3	3	2	1	**17**
Divorced	6	1	3	0	0	0	**10**
Widow	1	2	1	2	1	0	**7**
Total	**13**	**17**	**9**	**7**	**5**	**3**	**54**

Source: Field data (2016)

Sex between married adults and unmarried young people was mentioned specifically by the following respondent:

What I find very risky and that embarrasses in this community and contributes to the increase of HIV incidences, is the involvement of married women in commercial sex. This was not there before. The only experience we were used to is to see married men involving themselves in having affairs with never-married sex workers. This causes the youth to do the same, because their role models are their parents. If these women get female children, they are more likely to convince them to involve themselves in that business. [Laughs.] *The money they receive is very small that cannot satisfy all their needs. . . . Commercial sex workers receive between 2000 and 5000 shillings at maximum and sometimes get nothing* (IDIs).

Focus group discussions with married women identified household poverty, irresponsible husbands, and the need to support families as the reasons that the majority of married women were involved in sex work. It was also asserted that many women were living as single parents, despite having husbands. This was articulated by one respondent:

You know, traditionally, both married men and women had a role to play in their respective families, however, nowadays majority of men (husbands) have become very dependent, hence the burden has increased to the wives. In that regard, women who find sex working pays join that club (FGDs).

Also, unethical behaviours of parents has led to family relationship disintegration and led to many youth practicing sexual risk behaviours (FGDs).

All except six respondents had at least a primary-level education. More than a quarter of the respondents (28%) had college or university-level education. Men seemed to be better educated than women (16 versus 13), holding a secondary level of education or higher (Table 5).

Table 5. Respondents' education level by sex (N=54)

Education level	Youth		Gatekeepers		Health providers		Total
	Male	Female	Male	Female	Male	Female	
None	2	1	1	2	0	0	**6**
Primary	8	8	0	2	0	1	**19**
Secondary	4	3	2	2	1	2	**14**
College/university	3	1	4	3	2	2	**15**
Total	**17**	**13**	**7**	**9**	**3**	**5**	**54**

Source: Field data (2016)

Table 6 shows that the study respondents were engaged in a total of 15 occupations. Interestingly, respondents who were victims of sexual exploitation and those who identified themselves as sex workers identified other occupational activities they engaged in, such as grocery attendant (a term used to mean a kiosk selling only drinks—both nonalcoholic and alcoholic), bar attendant, and petty trader (food vending, selling vegetables, and other small businesses). As the FGDs revealed, the majority of SWs engaged in sex work in areas where they did other work, for example in guesthouses, bars, hotels, and groceries. For this reason, respondents in FGDs said, these places were identified as places where the SRH of youth is at risk, particularly for those brought from different regions to work.

Table 6. Respondents' occupation by sex and study categories

Occupation	Youth		Gatekeepers		Health providers		Total
	Male	Female	Male	Female	Male	Female	
Student	1	2	0	0	0	0	**3**
Petty trader	2	1	0	0	0	0	**3**
Local brewer	0	0	0	3	0	0	**3**
Local leader	0	0	2	0	0	0	**2**

Program officer	0	0	1	1	0	0	**2**
Pharmacist	0	0	0	0	1	2	**3**
Home-based care provider	0	0	0	0	1	2	**3**
Nurse	0	0	0	0	1	1	**2**
Farmer	2	3	1	3	0	0	**9**
Teacher	0	0	1	1	0	0	**2**
Public servant	0	0	1	0	0	0	**1**
Bar attendant	0	4	0	0	0	0	**4**
Grocer	0	1	0	1	0	0	**2**
Motorcycle drivers	7	0	1	0	0	0	**8**
No job	5	2	0	0	0	0	**7**
Total	**17**	**13**	**7**	**9**	**3**	**5**	**54**

Source: Field data (2016)

Risky Behaviours that Influence HIV Prevalence among Youth

In the two study areas, respondents were asked what they understood by the term "risk behaviours." The responses fell into three broad categories: (1) risky behaviour leads to disease transmission, (2) unplanned pregnancy, and/or (3) moral decline. The following three responses provide additional insight:

> *Risk behaviours are those behaviours that might cause a person, particularly young people, to be in a situation of being infected with HIV and other diseases* (IDIs; FGDs).

> *Risk behaviours are identified as practicing unsafe sex, using drugs, and alcohol abuse whereas such practices might influence a person to be involved in unplanned sex* (IDIs; FGD).

> *Risk behaviours are any behaviours or actions practiced by youth that might lead them to unethical behaviours, which affects their security and the community's security, as well* (IDIs; FGDs).

The majority of respondents were familiar with the term risk behaviour, so the researchers were able to use the term to pose questions in relation to the study's aim.

Analysis of the IDI and FGD data revealed that youth engage in many risky sexual behaviours. The major ones are alcohol abuse; unsafe sex; drug use (e.g., smoking marijuana and injecting or taking cocaine); sex work and sexual exploitation; dressing in a manner that entices men; truancy; sharing of sharp objects such as needles; multiple sex partners; sexual relationships with adults; and male-to-male sexual contact (IDIs).

During an IDI, one respondent said:

> *Following the majority of youth having no job and involved in informal business, most of their time is spent in risky behaviours. The motivation factor is most of the time alcohol abuse. If you are a drunkard, your capacity to make good decisions decreases; hence you find yourself making decisions that lead you to become infected with HIV and other sexual transmitted disease.*

It was also reported by some students that during maize season, many students spend their time in maize plantations instead of going to school, using them as hiding places to smoke marijuana and practice unsafe sex (IDIs). According to respondents, these behaviours risk acquisition of HIV and activities such as banditry (FGDs).

In addition, respondents said, some youth are involved in social networks that influence them to engage in unsafe sexual behaviours. As they wait for the harvesting period, many youth are idle and spend their time at bus stands searching for part-time work (IDIs). In doing so, they connect to social networks that push them into risky behaviour, particularly alcohol abuse (IDIs). When those youth go back to their villages, they go with learned behaviours that their peers imitate (IDIs).

The findings revealed that sexual relationships between older men and women with younger men and women might be common. Intergenerational sexual partnerships were identified as one of the causes of HIV transmission among the youth population (FGDs). One respondent reported the following:

> *Madam, the stories in town is about sugar daddies and sugar mummies, and you won't believe your eyes when you visit barbeque places or in Kiswahili well known as "nyama choma" places. You can find women aged between 45 and 60s having fun with young boys. You might think they are mothers and their children, but no, it is boyfriend and woman friend. I can tell you, the situation is real bad. Majority of these women are widows or divorced and might have already being infected* (IDIs).

Factors that Influence HIV Prevalence among Youth

In understanding what influences youth to be involved in risky sexual behaviours, three types of factors emerged: sociocultural, economic, and legal. Sociocultural factors cause parents and religious leaders to hesitate to talk in public about HIV prevention, particularly condom use and safer sex. They feel that informing youth about condom use and safer sex is immoral. Hence, youth are not receiving clear information on HIV prevention and SRH from close, trusted people but rather from health providers, peers, or no one at all. However, the status quo is slowly being challenged, in spite of parents' and religious leaders' reluctance to talk about HIV transmission among youth. This was noted as an issue particularly among fathers, who tend to be more silent on the subjects of sex and HIV than mothers (FGDs). One respondent commented:

> *The issue of using condom and safe sex cannot be spoken openly by majority of parents and religious leaders while they know their children are involved in relationships. They believe that talking about those things is like telling them to commit sin before marriage* (IDIs).

As in most places, youth learn from a variety of sources, including friends, television, and social media. They have constant exposure to information, and if the topic of HIV is mentioned, they are not attentive and may even tune out. Many do not want to hear more about HIV and AIDS issues (IDIs). One of the religious leaders explained:

> *We cannot preach on condom usage but we tell people to observe ethical standards. Unethical behaviours influence HIV prevalence so we just preach for ethical standards to married couples and advise those in the age of getting married to test for HIV before marriage and be honest and respect each other after marriage* (IDIs).

Upbringing can create or influence children's poor behaviour, which carries through into adolescence. Respondents argued that many parents do not know what their children do. They observed that the majority of parents are not sufficiently engaged to understand with whom the children are associating, where they are, and what they are doing. Many never question how their child paid for something or how the child obtained money—although in many cases, the parent knows the child does not have a legitimate job. Respondents said they thought that the majority of fathers, compared to mothers, do not question

the types of networks in which their children are involved. Fathers (more than mothers) were blamed for failing to monitor their children's behaviour (IDIs).

Our study also found that conflicts between parents are a major contributing factor for youth engaging in risky sexual behaviour. When parents divorce, money is tighter, and the childrearing burden often increases for the mother and/or grandparents. That can lead to poor supervision of children, and girls may feel the need to search for money by whatever means possible (FGDs). An IDI respondent corroborated this:

> *Parents' conflicts are the main cause as these leads to majority of children and youth living in difficult conditions. When you interview those involved in risky sexual behaviours, you find that almost all of them live with either grandparents* [or] *single parents in streets. When you ask them the reasons, many refer to conflicts between their parents and divorces as reasons* [for their difficulties] (IDIs).

Nonetheless, the respondents suggested that the majority of single mothers provide too much freedom to their children—by choice or by necessity—and this makes it difficult to control and monitor the children's behaviour. They noted that some single parents who want to support their children find that single-parenting responsibilities do not allow them to:

> *Parents and children do not see each other. For example, if parents are not around, a student can arrive from school and just put the bag down and leave. Even if parents come back at home and find that someone is not around, they don't make follow-up. Even when a student come back late at night, most of parents do not ask them* (IDIs).

> *Sometimes parents use their children as bread earners; that is why they keep silent on children's bad behaviours* (IDIs).

There are some parents who still perceive having a female child as capital, a phenomenon recognised in Kiswahili as *mtaji*. When parents need money, they might force their daughter into early marriage without her consent, without examining the history of the future husband—a situation that has caused many young girls to acquire HIV (FGDs). Another situation respondents commented on was traditional singing, during which people often drink alcohol. Some respondents reported that men buy drinks for adolescent girls and later ask for sexual affairs. The girls were thought to feel pressured because of the favor. FGD participants suggested that it is difficult for girls to assert themselves in sexual communication or negotiations, which could involve refusing sexual advances or insisting on condom use:

> *When I once conducted research with girls, what they said was that, "I just receive gifts—any gift from different men/boys, and when I am asked for sex I don't say no to all. At the same time, I do not remember to ask men to use condoms, and in reality I have never thought of that. Maybe if it happened the man himself desires to use condom."* (IDIs).

> *Despite that also men were at high risk of being infected with HIV. But the risk is higher to girls because of their ignorance, powerless, and being envious of material things"* (FGDs).

Respondents said that the inability of some women to sustain their families following divorce or widowhood forces them and their children to be involved in risky sexual behaviours. As other studies have shown, youth whose parents have an intact marriage are at lower risk of being involved in risky sexual activity than youth living with a single parent or only with grandparents (Negeri, 2014; Stephenson,

2009). Household poverty influences many women—married, widowed, and single—to be involved in transactional sex with multiple partners to support themselves and their children (FGDs).

Children can be forced into risky situations (IDIs). For instance, in poor communities, parents may use their children to support family businesses, such as selling smoked bananas, maize, groundnuts, boiled eggs, and other snacks. Business usually starts in the late evening and is conducted on the street, in bars, and in other areas that are regarded as risk zones (IDIs). These businesses conducted by children have been a gateway to sexual exploitation for some girls in the form of sex work (IDIs). Poverty can also result in children having to drop out of school. We found that out-of-school girls, particularly those younger than 18, are more at risk than their male peers.

According to our study findings, many youth involved in sex work, people who use drugs, and men who engage in transactional sex with men (identified as populations key to controlling the HIV epidemic) were involved in risk activities because of economic challenges in the home. For instance, the majority of SWs engage in transactional sex to get money to support their families, even at the expense of their health. It was thought that the majority do not use a condom, according to their customers' demands:

> *Payments always differ, for example, for condom usage and noncondom usage, meaning that when commercial sex workers asked for condom usage were paid less and paid more for not using condom. So, many sex workers prefer the latter and in the process injure their health* (IDIs).

> *Yet, according to the CSWs* [sex workers] *identified, the majority said that, after knowing your status you just don't use condom, maybe if you meet men who strictly demand the usage of condom* (IDIs).

Boys are involved in sexual exploitation and sexual abuse, either with adult men or women (IDIs). Respondents reported that older women paying for sex with boys or younger men are given names like "aunt so and so" to make it seem acceptable and legitimate. Some men who have sex with men do so for money. These men are from indigenous communities but work in well-known bars and lodges, are familiar to many, and operate publicly (IDIs). They do this even though homosexual activity is illegal in Tanzania and subject to severe penalties, according to section 154 (1) of the Penal Code regarding unnatural offences Ord. No. 47 of 1954 s.3, Act No. 4 of 1998 s. 16:

> *"Any person who- a) has carnal knowledge of any person against order of nature; or c) Permits a male person to have carnal knowledge of him or her against the order of nature, commits an offence, and is liable to imprisonment for life and in any case to imprisonment for a term of not less than thirty years (URT 1981:61).*

Selling illegal traditional alcoholic drinks in the household is another contributing factor leading youth to engage in risky sexual behaviours. Respondents said that many women depend on the income from selling such alcohol. Because the government prohibits the sale of such drinks, the business is always conducted from the home to evade police scrutiny. Respondents thought that having strangers and drunk men at the house exposes children in the home to great risk, particularly girls:

> *Business is operated at home; because many of the sellers are poor, customers sit at the seller's bed. If such a family has girls, when the customers get drunk, sometimes they rape the seller's daughters and for those daughters who consume alcohol, they end up having affairs with customers. This can be by agreement or by force, but such girls agree to attract customers for their mothers' business* (IDIs).

For some young people, a desire to support themselves led to drug abuse. Some respondents revealed that, though they have since stopped, they started taking drugs after first selling them. They said that after hearing that the drugs might be counterfeit, they started trying them to test their authenticity, and this led to drug addiction (FGDs).

Youth involved in motorbike transport, or the *bodaboda* business, revealed that such a business has led to their involvement in risky sexual behaviour. One respondent said the following:

> *Many girls and women see them as people in the mining sector, where money is not an issue. You find that you have a woman customer, the way she touches your waist and chest when driving them, the way she talks and sometimes their reluctance to pay you, you exactly know what she wants* (IDIs; FGDs).

Despite this aspect of the *bodaboda* business, it has been identified by parents and the government as an activity that has allowed youth some financial independence. But *bodaboda* work has also been seen as pushing both men and women, and particularly girls, into risky sexual behaviour. Respondents said some girls aspire to a certain life standard that cannot be provided by their parents. These aspirations, along with unmet transportation needs, were seen as making girls targets for *bodaboda* operators, who exploit the opportunity to provide free service in exchange for sexual relationships that might lead to early pregnancies and HIV transmission (FGDs; IDIs).

Our findings revealed that a lack of effective implementation of laws has also contributed to youth engaging in high-risk behaviour. Although there is a law that prohibits a person from transmitting HIV to others knowingly, implementation remains impracticable. The law contradicts the legal guarantee to the right to privacy for people living with HIV. This continues to be a challenging situation with HIV prevention, particularly for youth, who still perceive an HIV-positive person as one who is thin, with rashes on his or her skin. In FGDs, the majority of youth interviewed claimed that they can identify people living with HIV, and they always think of testing after having sex multiple times (IDIs). Respondents said the following:

> *There are people who are well-known by the community that are HIV-positive and they are on antiretroviral but continue publicly having sexual relationship with other people, particularly youth* (IDIs).

> *It was identified that majority of such people are those who are financially well-off, as they use their money to bribe youth, particularly young girls; the public knows that but keep silent* (IDIs; FGDs).

> *Shockingly, is when you find such people to have been widowed twice or more but you find he or she continue engaging to new husbands and wives, whom he or she infects; the public knows and the law is silent despite its existence* (IDIs).

The qualitative findings revealed that, though there are government policies regarding HIV prevention that recognise youth as vulnerable, enforcement and implementation of these policies is poor. Because enforcement and implementation are lacking, so are effective mechanisms for monitoring the accessibility and availability of such policies to the majority of citizens, particularly youth. This lack of implementation is driven, in part, by a lack of financial and human resource capacity to inform citizens of the policies and enforce the laws (FGDs). One respondent said this about the laws:

> *Yet, many people are ignorant on the existing laws, even if he or she find that she was infected purposely, she or he do not know where to report. I can just say the legal challenges exist and limits many people* (IDIs).

Youth Knowledge of HIV and AIDS and SRH

Among the 30 respondents categorised as youth in this study, all of them indicated they were aware of the HIV epidemic. When asked about their source of HIV information, 16 respondents indicated that they got information through different ongoing HIV campaigns on radio, television, and outdoor advertisements. Four respondents identified friends, brothers, and sisters as their main source of information; six respondents received information from a seminar conducted at their church; and the remaining four respondents indicated health centers as their primary source of information when they went for counseling and testing sessions. Three female respondents who were pregnant had to undergo an HIV informational session under the Tanzanian government initiative for prevention of mother-to-child transmission. Respondents characterised HIV awareness as follows:

> *I would not say that people are not aware that HIV is there, and no one would say there is no HIV. Majority of the people in our community knows that there is HIV, but people are not eager to go for testing. Those who go for testing are those who are more aware of the incidence; some test after becoming very sick and forced by the doctors to do so, while women test during pregnancy* (IDIs).

Thirty percent (9) of the youth respondents indicated they did not have sufficient SRH knowledge. When the remaining 70 percent (21) with sufficient SRH knowledge were asked about their source of information, six indicated that they got the information from KIHUMBE, an NGO that operates in rural and urban areas of Mbeya; six were informed through television, radio, and fliers; six from peers or friends; and the remaining three respondents obtained information from clinics they attended during their pregnancy follow-up. When asked to identify what family planning methods they knew of, almost all respondents could identify one, with condoms being the most common, followed by the pill (identified by 12 respondents), injections (10 respondents), withdrawal (8 respondents), traditional methods (6 respondents), and abstinence (4 respondents).

When asked about condom use, only five youth respondents indicated that they always use a condom when engaging in sexual activity. The reasons identified were that they were not married and had no permanent partner (IDIs). The results indicated that most of the sexually active male and female respondents do not use a condom. Female youth respondents mostly relied on pills or injections for birth control. When they were asked why they do not prioritise using a condom, they indicated a lack of concern, due, in part, to other health and financial concerns. One respondent explained:

> *Being infected with HIV is not a problem, because even if you would be infected you would not die, because there is medication. Considering the current economic situation, having a child is difficult to raise and if you are infected with malaria, you might die as well* (IDIs).

Male youth respondents reported that they sometimes thought of using a condom and often carried one in their pockets, but later forgot to use it (IDIs; FGDs). Some of their responses follow:

> *I always have a condom with me, and I know where I can get one; but after having a woman with me, and already drunk, I forget using it* (IDIs).

> *Sometimes, you know, you meet a girl unexpectedly and agree at that particular time. With that sexual desire you find yourself engaged in unsafe sexual activity without searching and use a condom. Regrets always come later* (IDIs).

It takes confidence to decide whether to use condom or not when I am with my partner. You may ask yourself if your partner is infected or not, but instead of thinking of going for testing, you just think of how long you have been with him or her; and after looking at his or her skin, if it has rashes or not, and say oh.. aha… but his/her skin is ok, no rashes, it is smooth, and he or she is not thin. You continue having sexual intercourse, and this is what is practical to majority of us youth. We are not yet educated and with limited information. We still test HIV by our eyes and ignore about going for testing in hospitals (IDIs).

Although many guesthouses provide condoms at no cost, a myth is in circulation that the condoms supplied transmit HIV. This idea arises from youths' suspicion of the condoms, because they are distributed free of charge. Consequently, many youth prefer buying them from shops or from the guesthouse attendants after discovering that they do not provide condoms in the rooms. Late at night, when the shops are closed, or when the guesthouse attendants have run out of condoms, sexual activity still happens, but without a condom (IDIs).

We found, however, that the majority of drug users, youth who are exploited sexually, and men who have sex with men were not concerned with condom use and contraception, despite their high-risk sexual behaviours. When asked why, they had different reasons. The youth involved in sex work and sexual exploitation indicated that they prefer condom use, but sometimes their customers do not (IDIs). People who use drugs were using neither condoms nor contraceptives, because they said that they were not engaging in sexual activities. When they do, they said that they had sex with people whom they know are not HIV-positive. When asked how they know this, they said it was by looking at the person's appearance (IDIs).

The men who have sex with men for money who were interviewed indicated that most of their customers do not prefer condoms. Also they receive less money when using a condom but try to use a certain gel to avoid "itchiness" that is perceived to increase the risk of HIV (IDIs). The majority of respondents from this category (men who have sex with men, SWs, and people who use drugs) observed that HIV is currently not a threatening disease, because antiretroviral drugs are provided for free for people living with HIV, and "life goes on" (FGDs). One respondent said, "We are not afraid of HIV epidemic, but malaria and other diseases, because there were medications provided for free when infected with HIV" (IDIs with SWs).

Yet, as was revealed by 21 respondents from the youth category, SRH information and services are very important to them and other youth in the community for prevention of HIV and other STIs, particularly hepatitis B (IDIs). Some respondents said that when they learned about hepatitis B, they came to believe that it is more threatening than HIV. Hence, they argued that awareness creation for the whole community about all STIs is important, because it is not only HIV that is a threat (FGDs).

The majority of youth interviewed were aware of HIV, STIs, and SRH issues; however, there is still a gap between having the right information and knowledge of HIV prevention and taking care of one's SRH. This increases the danger for youth of contracting HIV and STIs and unintended pregnancy. However, we found that youth, particularly those still in school, experience different challenges with accessing SRH information. These include lack of confidentiality from health service providers, parents' reluctance to provide SRH information to youth, and community misconceptions about SRH issues among youth (IDIs).

Another challenge identified was that health centers do not necessarily have the SRH services one would expect. In addition, traditional beliefs that there is a certain age and time for youth to be informed about SRH prevail, even among trained health providers. These biases and stereotypes regarding youth sexual activity, and their right to have complete and accurate SRH information and services, prevents some providers from offering SRH information and services to younger clients, particularly those who are not married. Not only is this a missed opportunity but also it discourages youth from positive health-seeking behaviours.

Initiatives to Address Risky Sexual Behaviours among Youth

Government Institutions

Government institutions such as TACAIDS and respective councils have taken different approaches to combat HIV among youth and provide information about HIV transmission, prevention, and risky sexual behaviours (IDIs). TACAIDS has been collaborating with NGOs at the community level and has established centers in almost all regions, to make sure its mission is carried out. In addition, the Government of Tanzania has established an HIV department in each council and each ward and neighbourhood has an HIV committee. The HIV district council coordinator revealed that all HIV-related activities conducted by the government, or by NGOs and other institutions, were under his coordination with the aim of eliminating HIV transmission and supporting and improving HIV services for people living with HIV in the community (IDIs).

A number of activities have been conducted and planned by the HIV department in each council, including youth HIV advocacy and awareness creation; formation of youth HIV and AIDS clubs in schools and out of schools, according to age; an HIV youth league; and buying and distributing condoms to different youth networks (*vijiweni*). In these networks, some well-off youth act as the distributors, because it is easier for other youth to consult them. Some respondents described these efforts:

> *We managed to form youth clubs in secondary schools and for out-of-school youth that focus on HIV and other related themes according to age category. Youth were more vulnerable to the HIV epidemic despite of context or class* (IDIs).

> *In addition, not every youth is a member, for example, in schools you might find among the 500 students, only 80 to 100 are members, yet such youth members have been supporting and helping us in educating and in creating awareness to their colleagues and the whole community when out of school* (IDIs).

> *We have also formed clubs involving out-of-school youth by using special groups such as motorbikes groups* (IDIs).

> *These clubs have been also very instrumental in creating awareness to different youth and other population segment in their respective areas* (IDIs).

The government, through its institutions, has conducted other activities, such as youth gatherings that provide room for different officials to talk about HIV incidence among youth in the community. Through such gatherings, one respondent was able to conduct a youth football league called the UKIMWI (AIDS) Cup that attracted youth from around the district. The competition lasted almost a month, and the finale was held on AIDS Day. Each match was an opportunity to create HIV awareness in relation to transmission, prevention, and support for those who are HIV-positive. Youth were encouraged to share the information with others (IDIs). Although the league had a great impact, and a plan was devised to have this competition annually, due to lack of funds, it has not been organised again (IDIs). The council continues to advocate for proper use of condoms and free distribution to youth networks. Respondents described these efforts as follows:

> *Despite that we advocated for condom usage, we invested our energy more on advocating for abstinence or sticking to single partner. However, for the youth category, we lie to ourselves by telling them about abstinence, because we know that they were involved in sexual relationship that is why we keep on insisting on condom usage. It is hard talking to youth about having single partner, because being faithful is useful if when two partners do so and yet again being faithful is an individual's desire* (IDIs).

As identified by respondents, the majority of youth believe condoms to be the major means for HIV prevention. There have been concerted efforts by the government to make sure youth have access to condoms and know how to use them properly (IDIs). However, some youth ages 15–25 years old lack the maturity, power, and awareness to make the decision to use a condom. For others, it comes down to ignorance. Girls face the double burden of early pregnancy and STIs, including HIV, while boys risk STI/HIV infection (FGDs).

Another respondent thought that the majority of youth pretend they know everything, even when it comes to SRH. This mentality prevents them from seeking information and services from nurses or other knowledgeable people. Youth use condoms because of easy accessibility. However, respondents said consistent or continued use is not sustained:

> *Yet, it was identified that many youth use condom for the first and second intercourse with his/her partner and stop using it after becoming familiar with each other. This happens even if they have not tested for HIV or STDs. You see, this is a problem that exists for most of youth* (IDIs).

The motivation behind these initiatives is to make sure HIV transmission in Mbeya and its respective districts decreases from the current 9 percent to 7.2 percent by 2018. This can be achieved if the youth population is effectively integrated in prevention efforts, as has been the case with other high-risk groups (IDIs). Unfortunately, such initiatives have not managed to reach the majority of youth, because of the diverse nature of the population (e.g., in school, out of school, married, unmarried, on the street, at home, rural, and urban).

Religious Institutions

Religious institutions play a significant role in guiding parents to be positive role models and disciplinarians for their children. They can encourage them to be actively engaged in their children's lives, so the children are less likely to engage in risky sexual behaviours. Faith-based institutions can also be messengers and providers of health information and services. The majority of religious leaders have spent time informing people about HIV. Respondents were familiar with these efforts:

> *In the church I attend, there have been a number of seminars involving youth, and most of the time there is always an agenda regarding HIV incidence and youth. It is through these seminars where youth acquire knowledge and right information; however, such seminars involves few youth compared to the youth population in the area* (IDIs).

> *I once attended a mass, and during that day, the pastor talked about youth misbehaviours and how the parents ignored to talk about such misconducts. That made me to understand that not only parents were supposed to speak with their children, but all community members have the responsibility to do so* (IDIs).

The findings revealed that those parents and guardians that are more religious, compared with those that are less religious, discuss the topics of risky sexual behavior more often with their children. Religious leaders—particularly pastors, sheikhs, and priests—are usually ethically grounded and have a unique ability to inspire the community, particularly youth. Yet when religious leaders abuse their position of authority to commit crimes, such as rape, it creates mistrust in the community; many youth stop believing in them, relying instead on their parents for spiritual guidance (FGDs). The increasing number of churches with different beliefs and focuses has contributed to a chaotic lifestyle for Tanzanians, particularly youth.

Nongovernmental Organisations

Different gatekeepers revealed that all young people are vulnerable to some degree, but young girls (<15 years) have been identified by various NGOs as a priority population (IDIs). In Tanzania, NGOs play an important role in creating HIV awareness among youth. In Mbeya Region, two NGOs were involved in this study: Restless Development and KIHUMBE. KIHUMBE engages in capacity building for HIV prevention among youth and provides home-based care for people living with HIV. The organisation also provides HIV testing and counseling for youth through a mobile clinic and provides other services in various offices. The organisation promotes income-generating activities for youth, in order to get them involved in legitimate work and reduce their prospect of being involved in risky sexual behaviours. The organisation also provides free SRH services to neighbouring youth so that they can escape early pregnancy and HIV.

Restless Development has been providing capacity building for youth since its formation in 1992. The organisation works with in- and out-of-school youth with regard to SRH, with a particular focus on HIV and AIDS, early and unwanted pregnancy, reproductive rights, gender-based violence, STIs, and related issues (IDIs). One of their current projects aims at providing awareness creation for girls ages 10–19, a population identified as vulnerable to gender-based violence, early pregnancy, and HIV. Another project is aimed at building journalistic capacity for young girls so they can report issues like gender-based violence, early pregnancy, HIV, and other related issues facing young girls (IDIs).

Other youth community groups and NGOs have done a good job with HIV awareness creation and care for the community; however, they have not managed to reach all the target groups in the community, despite their attempts to prioritise reaching very risky areas. Almost all the bars, guesthouses, and grocery attendants in Ruanda Ward have been educated by NGOs on how to prevent HIV and proper condom use, though reaching the whole youth population has been very challenging (IDIs).

Parents, Guardians, and Communities at Large

In this study, parents and guardians were reported as being negligent in appropriately monitoring their children's behaviour. For instance, the majority of parents were blamed for not speaking up about what their children wear (IDIs). But the FGD findings showed that close parental monitoring does not always ensure that youth are raised with the most desirable values. Too much monitoring might lead to negative behaviour as youth may rebel against too many rules. Furthermore, despite parental involvement, youth are influenced by peers and technological advancement. For example, television and social media were identified as potentially significant influences on youth decision making.

The findings revealed that the majority of parents try to discuss HIV with their children, but when they are unable to, they turn to religious leaders or relatives to inform the youth on their behalf. Yet, as some gatekeepers revealed, parents may find it difficult to provide HIV or SRH information, because they do not have all the correct information themselves, are unaware of what information to provide, and/or do not understand when is the right time for youth to receive such information (FGDs).

Parents' exposure and awareness of HIV and SRH information was positively linked to discussing HIV and SRH issues with youth. The findings revealed that parents' sociocultural background, where customs and traditions still dominate parental relationships with children, had a negative effect on discussing HIV and SRH issues with youth (IDIs). The majority of youth who were informed of SRH issues by their

parents or guardians had more confidence to talk about HIV and SRH with their peers compared to those who were informed by the media or colleagues (FGDs). Thus, the findings indicate that upbringing and monitoring by parents and guardians are related to shaping youth sexual behaviours, either positively or negatively.

As observed by the majority of youth, information about HIV and SRH from parents reached them too late, at ages where they already risk becoming HIV-positive or pregnant (IDIs). In addition, the majority of youth feel unable to seek assistance or SRH information from parents or guardians. For those who manage to, they have not been provided with in-depth and helpful information (IDIs).

Health Service Providers

Health service providers play a transformative role in providing health information and services, especially to youth who are already HIV-positive and those who are seeking SRH-related assistance. However, health services providers, particularly those at public facilities, are very scattered. There are also not enough providers in each ward to cater to the youth population. Access to care at private health centers is limited, owing to the cost of services. This puts private facilities out of reach for youth who depend on informal employment and/or are from poor families.

Although there are HIV and AIDS committees in each neighbourhood and ward, they are not youth-friendly and do not address youth issues. Such committees have been ineffective at identifying risky sexual behaviours of youth in their area. Even so, with small budgets allocated to HIV and SRH issues, it is difficult to address these behaviours. The health-service provider respondents shared that working with youth is very challenging, because there is no mechanism to ensure that they participate in organised seminars, workshops, or community gatherings that address youth risky behaviours and HIV (IDIs). In addition, many youth view poverty as a more significant threat to their development and career aspirations than HIV (IDIs).

The majority of health providers were still in training and thought they lacked the capacity to inform and support youth with SRH issues. The IDIs revealed that there are NGOs that provide training on testing and counseling services to health service providers working in hospitals. These providers, who are trained to perform youth outreach, were recognised as potential actors in community outreach, encouraging facility-based HIV counseling and testing and SRH services, because many do not provide counseling and testing services outside the health center. Youth from rural areas rely on mobile services run by NGOs, because health centers are too far away. It is difficult to attend HIV/SRH sessions organised by NGOs at their offices, because most NGOs are located in urban areas (IDIs). This argument was supported by FGD findings:

> *If we remember, early last year or the year before last year it was when we received some training from a certain NGO regarding SRH. The training was empowering, and many youth gathered to listen; but since that time we have not received any training* (FGDs).

Most health centers are not youth-friendly. As some respondents revealed, most units in the health centers that provided SRH did not have a separate section for youth to ensure anonymously:

> *It is impossible for a young girl or boy to attend a SRH session with elder women in which there might be a neighbour or parents. With this situation, you find that youth continue to depend on friends and media to get right information*

and thereafter end up in pharmacies. Most pharmacies just sell products and do not take time to involve customers in discussions, particularly youth (IDIs).

I remember one day I went to the public health center where accidentally I met our neighbour, who instead of receiving my greeting first she just asked if I was pregnant and if not why I was there. I was in my uniform while I went there for getting an injection because I was hurt by a nail (IDIs).

Such situation make majority of us afraid of attending the SRH sessions at health centers, because we fear the information to leak, create poor relationship with our parents, neighbours, and school (FGDs; IDIs).

Respondents said many of the health attendants are motivated only by money, and not by helping people. They said that in previous years, health attendants performed their duties willingly, whereas nowadays, they seem to do their jobs because they are forced to (IDIs).

Health institutions have the potential to play a key role in enhancing effective youth participation in preventing HIV and creating SRH awareness, access, and usage. In identifying effective mechanisms to include youth in addressing the HIV epidemic, the IDIs revealed that there was a need for youth themselves to have the courage to speak out about the challenges they face with the HIV epidemic. Parents also play a role, to the extent that they cooperate with provider advice and instructions and support health center initiatives. In addition, health service providers have to change their attitude toward youth SRH. Their services must be youth-friendly if they want to see an AIDS-free generation.

Challenges Facing Youth in Addressing Sexual Risk Behaviours in Mbeya Region

Sociocultural Challenges

First, according to the study results, most parents were unenthusiastic about monitoring their children's behaviour, particularly youth who were seen as able to monitor themselves. Most parents feel they do not provide positive role modeling to their children. They do not take their youth for counseling and testing services before becoming sexually active or encourage birth control or condom use for those already in relationships.

The IDIs revealed that the majority of parents still force their daughters to get married early and without consent. In families where daughters are considered capital, there is little regard for their rights and well-being, which leaves them very vulnerable (IDIs). Powerless over their situation and unable to seek legal protection to block the marriage, some girls were wed to widowed men whose wives had died of AIDS (IDIs). Widow inheritance is still practiced by some tribes in Mbeya. This harmful tradition has been identified as one of the major causes of the spread of HIV. In most of the tribes, you can find a wife who is HIV-positive but is still inherited by a man who is not HIV-positive, or conversely the husband is HIV-positive and inherits a wife who is HIV-negative. During the discussions, no one tells the two to get tested or prevents the marriage (IDIs). This situation is a result of a custom and tradition whereby children are expected to obey their parents unconditionally, and their perspectives are not valued, even if that leads to negative consequences (IDIs).

People in the community lack knowledge about HIV and the type of support available from and provided by NGOs. For instance, when people see NGOs working in their communities, they think they can get money from them. When the NGOs ask the community to gather for a training or seminar without any payment, the turnout is small (IDIs). There is also poor cooperation between local leaders, parents or guardians, youth, and NGOs in addressing HIV. Informal relationships are not conducive to addressing risk reduction. Multiple NGOs that provide the same services work in some areas, while other areas have no services. Such unequal distribution of services is ineffective. This situation allows some youth access to SRH services that are out of reach for others.

Envy or desire for material goods can compel youth to be involved in risky sexual behaviour. The respondents identified that both single and married youth experience this, where both men and women have multiple partners to satisfy their material needs.

Most youth still believe you can determine one's HIV serostatus by appearance alone and do not see the need to go to a health center to be tested. This leads to a false sense of security when engaging in sexual activities with a seemingly healthy-looking partner.

Last, drug and alcohol abuse is still a problem among youth that contributes to risky sexual behaviours. When asked about the relationship between alcohol consumption and HIV transmission, most respondents said that there is no direct relationship, but alcohol consumption impairs judgement and leads a person to do things unknowingly. The youth who had already used alcohol and drugs acknowledged a direct relationship, because alcohol and drug abuse negatively influence a person's behaviour. Substance use encourages risky behaviour even when the individual knows it is bad. The fact

that alcohol is consumed or purchased from unsafe areas imparts additional risk (IDIs). Despite continuing initiatives by the government and NGOs, attempts to address risky sexual behaviours among youth remain challenging.

Economic Challenges

The majority of respondents from Mbalizi suggested that its population and area resemble a town authority or a municipal council, despite their area being located in the village. Even so, Mbalizi lacks both formal and informal employment opportunities, especially for youth, and particularly when they have finished planting and are waiting to harvest (IDIs). Both female and male youth search for activities to support their needs. Male youth migrate to town centers in search of jobs. This may expose them to bribery, drugs, alcohol, and even risky sexual behaviour, such as having sexual intercourse with older women (IDIs). Overall, economic hardship is the leading reason girls take up sex work—usually to get money for their families (IDIs). One respondent recounted the following:

> *I had an opportunity to meet some CSWs* [sex workers] *in an initiative to find girls to inspire other girls in the community and did an interview with them. During the interviews, I remember one lady fall down and started crying. When asked, she said that she became CSW* [a sex worker] *after her parents' death. And she was in a nursing college and no relatives were involved to help her. So the only solution was to enter into CSW* [sex work] *to get money to pay for her fees. Now she's a nurse. When she remembers that moment, she always feels very bad, so it is about financial problems and poor support from the relatives and the community, in particular* (IDIs).

The findings revealed that some engage in sex work, not out of desperation but because they see others employed or coming from well-off families (FGDs). NGOs have been providing financial assistance and trainings to youth who are abused sexually and those involved in sex work so they can stop, but they do not always abandon the work (IDIs). Others imitate the friends they see who are involved in risky sexual behaviours even if they themselves are from stable families (IDIs). In that regard, rather than poverty, peer influence or desire for material goods motivates the sex work.

Sometimes parents are to blame for their children's involvement in risky sexual behaviours. Parents may not directly convince their children to be involved in risky behaviour, but the businesses they run may create an unsafe environment for youth. A respondent described this phenomenon:

> *Imagine, you find parents sending their children—both girls and boys—to sell boiled eggs, groundnuts, sausages in bars during late hours; this is very dangerous. Such places are full of drunkards who do not perceive such young children as still young, and with alcohol consumption, it is real dangerous* (IDIs).

During IDIs, one respondent argued that the majority of girls hired to work as service attendants in bars, hotels, groceries, and guesthouses were brought purposefully from different regions to be exposed to sex work and exploitation. Contracts involving promises of decent houses and a good salary were used to deceive them (IDIs). Many of the girls do not have relatives, and their lives have become hard. Even when parents know that their children are being exposed to sex work and abuse, they allow it to happen for the sake of money (IDIs).

Most respondents identified economic difficulties as the major contributing challenge facing youth, males and females. Yet, there is no consistent link between economic difficulties and youth involvement in risky behaviours. Not all youth in poor, disadvantaged situations are involved in risky sexual behaviours.

Legal Challenges

The national policy on HIV identifies women and young people, particularly girls, as vulnerable to HIV, owing to "poor control over their sexuality" (Prime Minister's Office, 2001). The policy further recognises poverty as a major factor contributing to HIV vulnerability, because some women engage in risky sexual behaviours for their livelihood (Prime Minister's Office, 2001). However, the policy does not identify risk factors for youth. For example, the policy continues to recognise heterosexual intercourse as a major risk, neglecting the risk for men who have sex with men, especially among young men. Although sex between men is prohibited, it should be addressed by policy, because it is currently practiced openly.

Tanzania's Constitution, which has been amended four times to date, ensures equal rights for women and men, ensures equal respect and recognition for all, and prohibits all forms of discrimination. For instance Article 13(1) states, "All persons are equal before the law and are entitled, without any discrimination to protection and equality before the law" (United Republic of Tanzania, 1977). In addition, clause 13(2) states, "No law enacted by any authority in the United Republic shall make any provision that is discriminatory either of itself or in its effect" (United Republic of Tanzania, 1977). Yet, the Constitution still includes the Marriage Act (1971), which allows girls as young as 14 to be legally married. Despite the local Customary Law (Declaration) Order of 1963 recognising 21 years as the age suitable for a woman to get married, the Law of Marriage Act, which governs civil marriages in Tanzania, discriminates against girls. It states that an exception to the legal age of marriage can be granted "(1) if (a) each party has attained the age of fourteen years; and (b) the court is satisfied that there are special circumstances which make the proposed marriage desirable." The law under Article 17(1) allows an underage female to marry with the consent of her father, mother, or guardian**.** This allows the perpetuation of forced and early marriage, stripping girls of their rights and making them unable to participate equally in safer sex. Given the culture and traditions of Tanzania where women have to respect and obey men, it is difficult for a girl of 14 years to question and challenge the decisions of her father or husband, whether or not such decisions are harmful to her SRH or involve risk of HIV.

The national health policy enacted in 2007 identifies health as "good condition physically, mentally, socially and absence of disease. . . . Good health is a foundation and a valuable resource in contributing to the development of an individual, the family, and the country, particularly in bringing a better life towards poverty reduction" (MOHSW, 2007). In addition, the policy emphasises gender equality and women's empowerment (MOHSW, 2007). However, the policy remains silent on critical issues, such as youth, SRH, and access to SRH services, even when sexual risk behaviours continue to expose youth and adolescents to HIV. In addition, customs and traditions discourage youth from seeking timely SRH knowledge—another issue that is not clearly addressed in the policy.

Despite good laws and policies against alcohol consumption during daylight hours, knowingly transmitting HIV, early marriage, and sex work, the laws are not enforced and have too many loopholes. Such practices continue to be major challenges for youth HIV prevention efforts.

RECOMMENDATIONS

In this study, a number of recommendations are provided at various levels of intervention. Targeting the individual and family level, policies and programs should be designed to empower girls and make them aware of how to identify and address discriminatory practices. They must also provide effective support and strategies to encourage parents to build a strong marriage, so that children are raised in a stable environment, with ethical standards. This would help to minimise disruption in the home and parents' financial dependence on their children.

Policies must include practical, culturally appropriate strategies and empowerment skills to help parents and guardians speak effectively to their children—particularly girls—on issues related to HIV and SRH. There is a need to provide a continuous communication campaign and capacity building on positive parent–child communication so that parents and guardians acquire the skills to speak openly with their children, especially youth and daughters. Practical, culturally appropriate, and evidence-based strategies should be promoted to address this dynamic. This has the potential to instill confidence in parents, make them aware of the impact of HIV and early sexual involvement, and put them in a position to be sources of knowledge and support to their children. The use of media, with its wide reach and popularity, should be taken advantage of for conveying the right information on SRH and HIV.

Youth must be part of the change they wish to see in the future. Respondents suggested that if youth want to see the next generation free from HIV, then they must have influence in creating that reality. At the community level, civil society organisations (CSOs) have to work in partnership with the community, engaging the youth population and the government at large. This is important for the goals of the campaign against HIV laid out in government policies, plans, and programs to be achieved, especially for Tanzania's youth.

Community-based organisations and youth networks should be supported, both financially and through capacity building, to accommodate youth who depend on them for gaining independence. The government and its partners should be innovative in developing educational and training opportunities for youth. Youth should be given opportunities to become creative, entrepreneurial, and proactive through self-employment rather than waiting for employment or being forced into risky income-generating activities. The government should develop policies and incentives for banks to be youth-friendly, for example, by designing low-interest loans that youth could benefit from. The government, in partnership with other CSOs and the community at large, should design sustainable income-generating activities that will help youth transition to independence.

Government officials, from the local level to the national level, should cooperate effectively with all institutions that support the community, particularly on issues related to HIV and AIDS, in a way that can be effectively owned and driven by the community. This is important in part because many community members do not support CSO-led initiatives. The community also has to demonstrate ownership of the support, training, and initiatives provided by institutions if these are to be sustainable.

Policies have to emphasise provision of HIV and SRH outreach strategies for youth and parents residing in rural areas where there are no health centers and scarce NGO presence. The rural population has low

educational attainment. It also lacks an awareness of opportunities, because outreach opportunities are usually provided by CSOs, which are generally urban-based.

There is a need for correct and timely information on HIV counseling and testing and condom use for youth. HIV and SRH services must also be youth-friendly. HIV advocacy strategies should be designed according to the various categories of youth subpopulations and should ensure that HIV and SRH policies, programs, and strategies do not neglect youth.

Finally, since the majority of the population lacks appropriate access to health services, partner institutions should support the government with mobile clinics that can provide HIV and SRH services to youth. To do this, the government has to increase the funding for HIV-related programs, particularly programs for youth.

CONCLUSION

Although country- or region-specific HIV risk factors may exist among youth, the factors that contribute to risky sexual behaviours that influence the epidemic exist, to a large extent, globally. Study respondents in the Mbeya region proposed a number of recommendations for how to address and eliminate risky sexual behaviour among youth. The findings call for government, community, and partner institutions to alter relevant policies to transform people's HIV and SRH knowledge and to support youth in prevention efforts, including safer sexual practices. This study also recommends research to analyse how the community and youth can best be involved in designing HIV and SRH policies that accommodate youths' diverse needs—an important step in comprehensive efforts to eradicate HIV and AIDS.

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