Community choices on appropriate adolescent reproductive health referral interventions in rural communities in Mwanza Tanzania

J. Dusabe[1], N. Ribesse[2], Z. Shabani[3], A. Jonas[3] E. Mapella[4], L. Sayi[5], J. Kaphipa[6], A. Obasi[1], IntHEC - Health, Education and Community Integration

[1]Clinical Group, Liverpool School of Tropical Medicine, Liverpool, UK, [2]Institut de Recherche Santé et Société, Universite Catholique de Louvain, Brussels, Belgium, [3]National Institute of Medical Research, Mwanza, [4]Ministry of Health and Social Welfare Dar Es Salaam Tanzania, [5]Ministry of Education and Vocational Training, Dar es Salaam, Tanzania, [6]Family Health International, Dar es Salaam, Tanzania

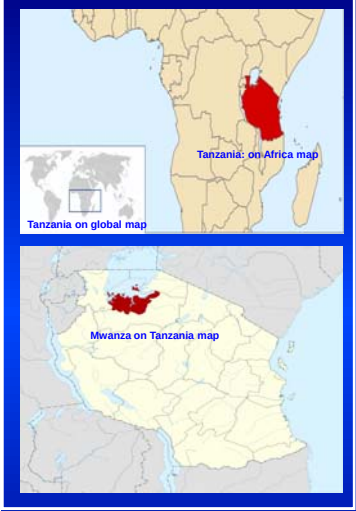
Background

Beside the mainstream health sector, adolescents access reproductive health (RH) services through 'close to community' (CTC) providers. These CTC providers include non-governmental organizations, community-based and religious organizations, voluntary and youth groups and associations, clubs and youth centres, pharmacies and drug shops, community health workers and traditional healers. Little is known about adolescents' views on the services they provide. There is however, evidence that integration with mainstream services could be improved [1]. To enhance such integration, our study is investigating a process of developing community referral interventions. It aims to establish the readiness and capacity of the CTC providers, adolescents, and the health services to undertake community referral interventions.

Methods

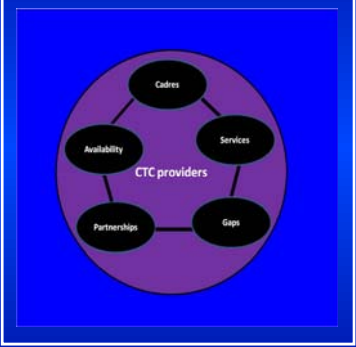
This study started in February 2011 in Mwanza Region Tanzania, covering 18 wards (communities). It employs multiple methods of participatory mapping with adolescents and CTC providers, involving focus group discussions (FGDs) and in-depth interviews (IDIs). CTC mapping using Geographic Information System (GIS) is on-going to locate the CTCs on the global map.

Setting



CTC mapping: services

37 FGDs with CTC providers investigated type of CTC cadres existing in communities, services they provide, services they are not able to provide, challenges they face, their partnerships, and what RH interventions they need for community referral.



Adolescent consultations: risks and resources

19 participatory FGDs and 19 IDIs. FGDs covered risk and resource mapping, temporal and spatial, unmet needs, preferred services but not provided. IDIs followed-up case stories of adolescent experiences when seeking RH services.

Spatial mapping: GIS

This approach defines GPS locations of CTC providers within communities, distances between them with the mainstream health and other public services, locations of popular CTC providers and underserved areas.

Adolescent consultations and CTC mapping took place from February to April 2011. The adolescent consultations were carried out at village level in 3 villages of 3 different wards. CTC mapping took place at ward level in 18 wards. All discussions were conducted in Kiswahili language. Proceedings were handwritten in notebooks and digitally recorded. FGDs and IDIs were transcribed in Kiswahili. Their translation and back-translation to English is on-going. Analysis using QSR NVivo 9 will determine the participants' perceptions on the study themes. GIS mapping is on-going at ward level in 4 wards, starting in May 2011 and will take 2 months. GIS data will be analysed using ESRI ArcView and Tanzania ShapeFile.

Results

The findings discussed here are preliminary, as data analysis is still on-going.

CTC mapping

We established that 9 main cadres of CTC exist in the communities. They include village AIDS committees, village health workers, traditional healers, traditional birth attendants, community-based voluntary organisations, village drug owners and sellers, village social workers, home-based care providers and youth clubs. In addition to these CTCs, dispensaries were included in the CTC mapping. Services provided by CTCs include HIV/STI prevention and treatment, contraceptives, and deliveries. Most of the services which are formal such as routine ante-natal care are provided by dispensaries. CTCs lack resources including medicines, structures and equipment, training, and their partnerships with the mainstream health sector are non-existent. The main intervention they required to support RH referral was training.

Adolescent consultations

Adolescents considered that their communities posed RH risks. Highly risky areas include highways, mining and fishing sites, forests and trading centres. Risks adolescents experience in these areas lead to unprotected sex, rape and other abuse especially verbal and physical. Adolescents preferred government dispensaries as their first point of call for RH problems because they are accessible and their services are free. They were not aware of the services offered by the other CTCs except traditional healers, which the majority did not prefer. Their preferred referral intervention was to bring RH services into the villages.

GIS mapping

This will verify the existence of CTC providers and their precise locations in the communities, to inform referral interventions and integration.

Prototype interventions

The overall prototype referral interventions will include capacity building of CTCs, developing linkages between CTCs and the mainstream health sector, community RH promotion to raise adolescents' awareness, and empowerment of CTCs and mainstream health sector to bring RH services into the communities. After full analysis we will publish the design of proto-type interventions and indicators for evaluation of their effectiveness.

References

1. Mills, A., R. Brugha, et al. (2002). "What can be done about the private health sector in low-income countries." Bulletin of the World Health Organization **80**(4): 325-330

Acknowledgments

The *Int*HEC partners from institutions and affiliations in the UK, Belgium and Tanzania contributed to this study.

Further information

For comments and additional information, please contact the Consortium coordinator, LSTM, Pembroke Place, Liverpool, L3 5QA, England. Email: **intec@liv.ac.uk**, Website: **www.inthec.org**

Funding

This study is part of *Int*HEC project and is funded by the European Union 7th Framework Programme