Iterative intervention development for improvement of adolescent reproductive health services in Tanzania and Niger

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Background

Poor adolescent reproductive health (ARH) continues to be a major cause of morbidity and worsening poverty in sub-Saharan Africa [1]. ARH programmes within the health and education sectors are seriously hampered by adverse prevailing cultural norms and practices within those sectors [2]. Interventions have to date focused on building skills among adolescents or targeted individual actors (e.g. training individual health workers) without addressing the broader cultures, practices and attitudes that systematically undermine intervention effectiveness. We present preliminary results of a large-scale study in 2 regions in Tanzania and Niger using community health psychological (CHP) approaches to work with actors within the health, education and community sectors to identify "*mediating moments*" within daily practice that operate to undermine ARH service provision.

Methodology

The study has been ongoing in 72 wards targeting health facilities, schools and communities in Tanzania and Niger. It employs participatory focus group discussions (FGDs), in-depth interviews (IDIs), and Venn diagramming (VD).

Iteratively, participants discussed strategies to link ARH risks, needs and resources in their communities in designing focused ARH interventions.

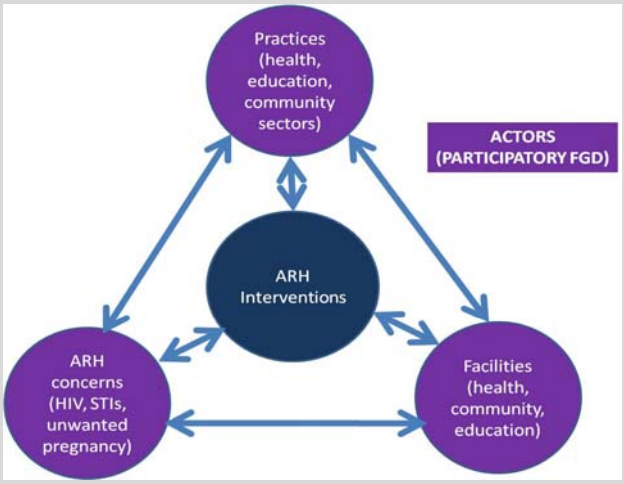

Figure 1 iterative intervention development

Participants used ARH resources as a basis to brainstorm other resources available in their communities, into which ARH can be integrated.

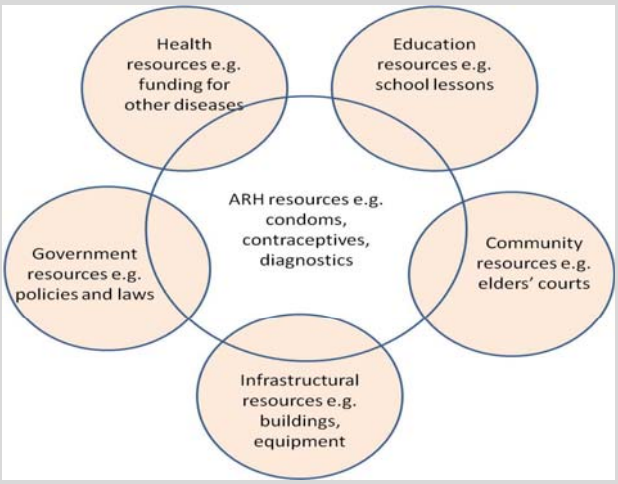

Figure 2 Venn diagramming

From February to March 2011 in Mwanza Tanzania, 3 combined FGDs/VD sessions and 65 IDIs were conducted. The participants included primary school teachers, school committee members, dispensary and health centre staff, as well as close-to-community providers such as drug-shop owners and traditional healers. ARH service provision in general was discussed, with specific topics including relationships between health, education and community sectors in promotion of ARH, scope of ARH education in schools, pupils' and teachers' RH behaviours, and challenges faced by health facilities and close-to-community RH service providers. Participants suggested interventions they felt were appropriate to meet the challenges. Interactions were conducted in Kiswahili language. Notes were handwritten in notebooks and the proceedings were digitally recorded. Field notes and verbatim transcripts of FGDs/VDs and IDI were translated in English. A thematic analysis of the transcripts is on-going using QSR NVivo 9. This methodology will also be used in Niger, where field activities are due to start.

Results

The findings presented here are preliminary, based on notes taken during FGDs/VD and IDIs. Analysis of transcripts is still on-going. The preliminary findings show that ARH interventions are affected by structural factors in education, health and community sectors:

Education sector

The national primary school curriculum does not have a focus on ARH. Pupils get information on ARH mostly from their peers. Schools lack resources such as books and visual aids such as posters on ARH. Teachers reported that ARH in their schools was a major issue. For example, they noted that adolescent pregnancies continue to happen in schools, although their reporting was minimal. There is no education policy on supporting pregnant pupils or young mother former pupils. Teachers expressed willingness to teach ARH. However, promotion or provision of STI/HIV/pregnancy prevention methods such as condoms in schools is prohibited.

Health sector

Health facilities are understaffed. They lack ARH resources including medicines. Providers were unwilling to offer certain RH services to adolescents such as contraceptives, claiming they condone sexual activities. Concerns emerged regarding reservations by adolescents to seek RH services from providers of the opposite sex.

Community sector

There is a general negative attitude towards ARH in communities. Close-to-community providers such as drug shop sellers reported they can not provide condoms to adolescents because that would lead to promiscuity. They lack competence on ARH service provision. Some of them e.g. traditional healers have never been trained on ARH.

Participants suggested capacity building, links with higher service levels such as hospitals and community ARH promotion. These interventions will be piloted, and emerging proposals taken into new designs to complete the intervention iteration.

References

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2. Wight, D., et al., Contradictory sexual norms and expectations for young people in rural Northern Tanzania. Social Science & Medicine, 2006. 62(4): p. 987-997

Acknowledgments

The IntHEC partners from institutions and affiliations in the UK, Belgium, Tanzania and Niger contributed to this study.

Further information

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

Funding

IntHEC project is funded by the European Union 7th Framework Programme