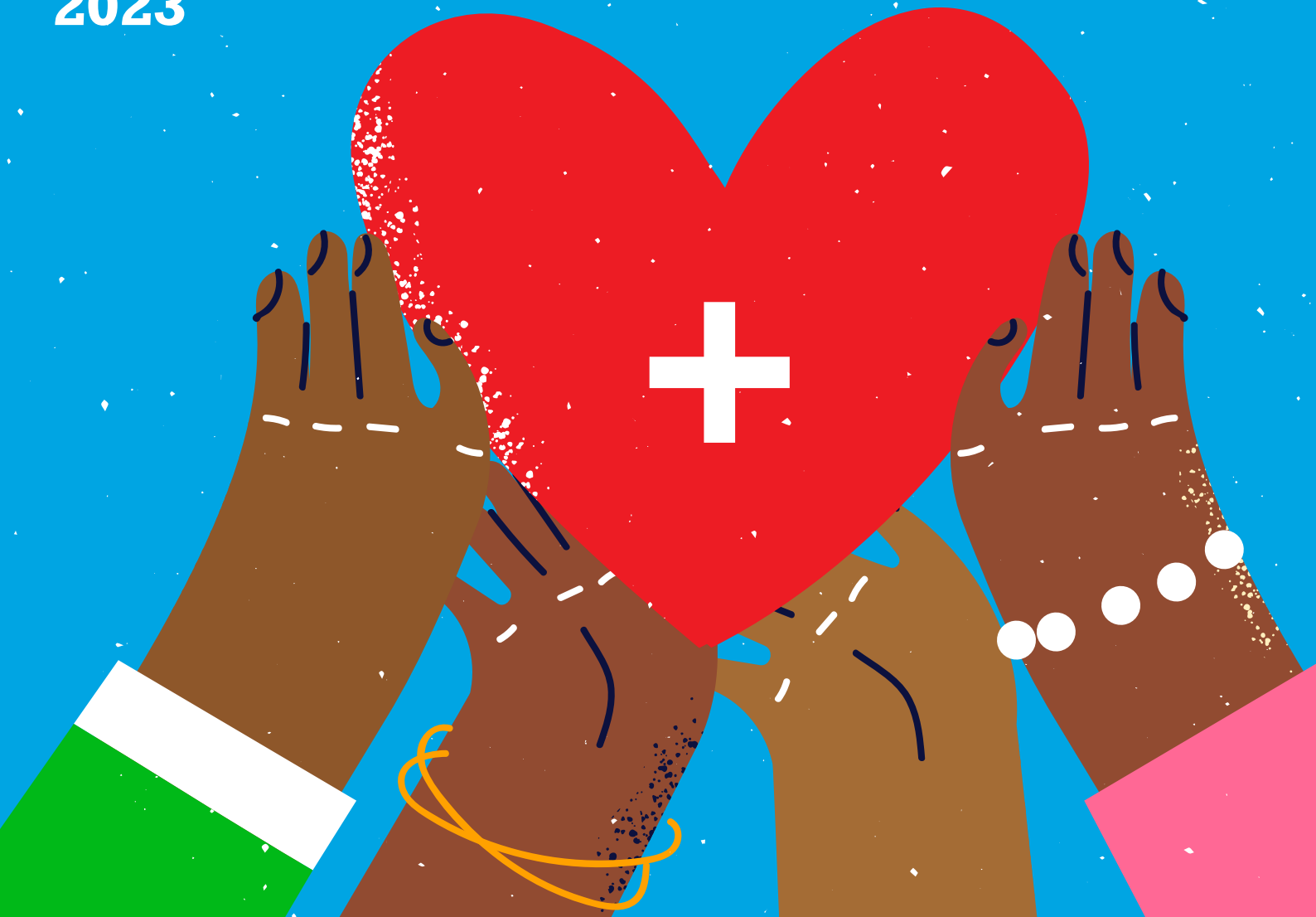
April 2023



Achieving universal health coverage for young people in Tanzania

through realising their sexual and reproductive health and rights, and scaling up selfcare for health

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Developed by African Alliance

Universal health coverage and self-care: Tanzania

April 2023

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Introduction

In September 2023, governments will meet in New York during the second United Nations High-Level Meeting (HLM) on Univer-sal Health Coverage (UHC) to agree on new commitments to realise UHC by 2030. In 2019, during the first-ever HLM on UHC, an ambitious Political Declaration was adopted to guide countries in their efforts to reform health systems, increase funding for health, and address barriers that prevent people from receiving the health services they need.

The world has fundamentally changed since 2019, with the COVID-19 pandemic demonstrating the devastating impact of weak health systems, underinvestment, and harmful policies and laws that prevent vulnerable, marginalised and stigmatised popula-tions from taking care of their health.

This new HLM is critical to get world leaders back on track and agree on the need to invest in long-term, sustainable responses to ensure life-saving health services are guaranteed for everyone, particularly in the face of the ongoing effects of the COVID-19 pandemic – and the potential impacts of future pandemics. In addition, there needs to be a continued push for socio-cultural and economic change; intersectional, human-rights based and gender-inclusive approaches to health; inclusive engagement of civil society in the development, implementation and monitoring of health policies and funding; and empowering and equipping people to meet their own health needs, including through scaling up self-care interventions for realising sexual and reproductive health and rights (SRHR).

Self-care has never been more relevant than during the COVID-19 pandemic, where, globally, public health systems failed to meet the demands and needs of citizens. Governments increasingly stepped up self-care and digital health interventions to reduce the burden on public health systems and give people choices to access the services they need despite COVID-19-related service restrictions related to the emergency response measures, including movement restrictions, total lockdowns and social distanc-ing – affecting people's ability to reach clinics, but also – with the demand on emergency health services – resulting in increasing shortages of healthcare workers.

Solutions such as HIV self-testing, self-sampling for sexually transmitted diseases (STIs) and digital health information of-fer new options for people unable or willing to access clinic-based services. The barriers to health services are not just due to COVID-19-related limitations but also poverty, gender-based violence (GBV), (dis)ability and other vulnerabilities, as well as a lack of privacy and the related fear of stigma and discrimination that prevent adolescents and young people (AYP) from accessing sexual and reproductive health (SRH) services in public clinics.

Thus, self-care is crucial to realising UHC, which is defined by the World Health Organization (WHO) as **all people having access to the health services they need, when and where they need them, without falling into financial hardship**. The *"where and when they need them"* is the essence of self-care, where this approach means people are not dependent on the availability of doctors, nurses or the capacity or accessibility of health clinics for all their health needs. It also increases people's autonomy, choice, and power concerning their health.

For this reason, the partner organisations implementing the YouthWise and YouthCare projects in Malawi, Uganda, Kenya, Tan-zania and Zambia are advocating for governments to commit to scaling up self-care in the 2023 UHC Political Declaration as a crucial component of health systems strengthening; self-care services and commodities must be included in national UHC plans and budgets.

Purpose of this Document:

To inform this advocacy, the African Alliance ('the Alliance'), funded by Aidsfonds, conducted a series of policy analyses for the five countries above to understand better why self-care is critical to improve the SRHR needs of AYP and achieve UHC. The anal-yses assessed the policy landscape; lived experiences around UHC, SRHR and self-care; and the current limitations AYP face in accessing the services they need – and used this process to develop a set of country-specific advocacy messages for partners in the five countries to take forward in the run-up to the HLM.

COUNTRY SNAPSHOT: TANZANIA

KILE HLM JUU YA UHC INAHITAJI KUSIKIA -NA KUFANYA!

Mazoea ya kihafidhina ambayo mara nyingi yanahusishwa katika tamaduni na mila mara kwa mara huwazuia vijana kupata maarifa na ujuzi unaohitajika ili kuzunguka ulimwengu wanamoishi. Kwa kuwa sera haijatekelezwa kwa upana, mahitaji ya kiuchumi ya kijamii na SRHR ya vijana mbalimbali na walio katika mazingira magumu hayatimiziwi. Viongozi lazima wafanye kwa vitendo wanachokihubiri kuhusu kuwaweka vijana katikati ya mustakabali wa Tanzania - kwa sababu wao ni Tanzania ijayo!

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Conservative practices, often couched in culture and tradition, consistently prevent young people from accessing the necessary knowledge and skills to navigate the world in which they live. With policy not being widely implemented, the socio-economic and SRHR needs of diverse and vulnerable young people are unmet. Leaders must walk the talk of putting youth at the centre of Tanzania's future – because they are Tan-

Tanzania is regarded as one of the more politically stable countries in the East Africa region and on the continent. The Tanzania mainland is mainly Christian, with Zanzibar being majority Muslim. Its long-term development trajectory is framed by the *Tanzania Development Vision*, which seeks to increase growth, reduce poverty, and transform the country into a middle-income economy by 2025. However, unemployment is far above average, reflecting both a significant youth bulge in the population demographics and elated skills and training gaps (poor qualifications)[1]

HIV landscape:

In terms of the HIV landscape, 1.7 million were people living with HIV in Tanzania as of 2019, while 65,000 new infections are recorded annually. Approximately 32,000 deaths linked to HIV-related illnesses have been reported since the start of the epidemic[2]. While HIV is a generalised epidemic, AYP and sexual and gender minorities are disproportionality affected. Women and girls have higher vulnerabilities compared to men and boys, with young women accounting for 80% of all new HIV infections[3]. A key challenge in the response is the lack of availability of anti-retroviral treatment (ART) at more than 70% of health facilities, which contributes to high rates of HIV[4] and a comparatively lower viral load suppression among those aged 15–24.

Of its total population of 61.7 million (2023), Tanzania's median age on the mainland is 18 and 20 in Zanzibar. Approximately 51.3 % of the total population is identified as women aged 15-49[5].

1 National Bureau of Statistics (2022). p 30.
2 University of Dar es Salaam (2019).
3 UNAIDS (2020).
4 University of Dar es Salaam (2019).
5 National Bureau of Statistics (2022). p 25.

Young people's experiences of SRHR Service Access.

NI NINI HLM (MKUTANO MKUU) JUU YA UHC (AFYA KWA WOTE) UNAHITAJI KUSIKIA -NA KUFANYA!

Licha ya kuridhia mikataba ya kimataifa na kikanda inayoahidi "kusaidia mahitaji ya afya ya uzazi na ujinsia kwa vijana kama sehemu muhimu ya SRH", Tanzania haina sera maalum na za bayana za SRHR au mipango kamili ya ujinsia ambayo inatekelezwa kitaifa. Badala yake, masuala yanayohusiana na afya ya uzazi yanataja tu kuhusu afya na kushuka kwa viwango. Suala la 'afya ya wanawake' lina madhara makubwa kwa afya ya uzazi ya vijana nchini Tanzania. Pamoja na mimba zisizopangwa na utoaji mimba usio salama unaoashiria hali halisi ya wasichana wengi wadogo na karibu theluthi moja ya wavulana wa shule za msingi wanaopata magonjwa ya zinaa, vijana wa kitanzania wanaendelea kuwa katika hali hatarishi sana. Serikali inapaswa kutanua wigo wa huduma na mipango ya SRHR, ikiwemo kutoa mafunzo ya kutosha kwa walimu na kushirikisha wazazi, walezi na na viongozi wa dini kupunguza mimba zisizopangwa, kupunguza viwango vya juu vya vifo vitokanavyo na uzazi na kuzuia kuenea kwa VVU.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Despite ratifying international and regional agreements that commit to "supporting the sexual and reproductive health needs of adolescents and young people as a key SRH component", Tanzania does not have specific and clear SRHR policies or comprehensive sexuality programmes that are implemented nationally. Instead, issues related to reproductive health are mentioned only concerning health and relegation. The issue of 'women's health' is having devastating consequences on the sexual health of adolescents in Tanzania. With unplanned pregnancies and unsafe abortions characterising the realities of many young girls and nearly a third of primary school boys experiencing STIs, young people in Tanzanians continue to be extremely vulnerable. The government needs to commit to a wide upscale of SRHR initiatives, adequately train teachers and engage parents, guardians and religious leaders to mitigate unplanned pregnancies, reduce high maternal mortality rates and prevent the spread of HIV.

Some of the specific realities for AYP that impede their health service access are outlined below.

Age of consent to sex and marriage

The age of consent for sex and marriage is both 18 for boys and girls, however up until 2019, it was 15 for girls and 18 for boys until a High Court ruling against child marriage raised the age to 18 in 2019. However this is yet to be reflected in the *Law of Marriage Act* (1972)[6] and advocacy is ongoing to ensure the ruling is reflected in law as two in five girls are married by the age of 18, and more than 50% of 18-year-old girls are pregnant or already mothers. More than half of young people have initiated sexual activity by age 18 and are thus vulnerable to SRH-related issues. These include teenage pregnancy and early childbearing – affecting 1 in 4 teenage girls[7] – and complications arising from unsafe abortions. Adolescents, in particular, are at higher risk of maternal mortality and morbidity[8].

Access to contraception

Factors contributing to early sexual debut and high numbers of unplanned pregnancies include a contraception prevalence of just 12% for sexually active adolescents and young women (15-24 years old), customary and religious laws, a historical legislative environment permitting girls to be married as young as 15 years (18 years for boys and now girls, but the High Court ruling described above has not been reflected in law) as well as limited provision of comprehensive sexuality education in schools resulting in little awareness around HIV, AIDS, and SRH[9].

Access to abortion

Abortion is permitted only under limited circumstances but only on the mainland. Examples include a pregnancy that puts the woman's life at risk or results from rape, defilement, incest, or if there are foetal abnormalities.[10] It is important to note, though, that even where abortion is partially decriminalised, women struggle to obtain accurate information about when it is legally available. The social, religious, and legal stigma of abortion, particularly where most of the country (on the mainland) identifies as Christian, cannot be underestimated. This, coupled with the unclear and often confusing abortion laws and policies, means that many people are not aware that abortions can be legally obtained in these circumstances, and, as a result, many women turn to unsafe, clandestine abortions with devastating consequences. These are significant causes of death and health complications.

Age of consent to access health services

It is important to note that in Tanzania, customary and religious laws often take precedence over statutory policies, a barrier to the acceptance and uptake of contraceptives. This is further impacted by the lack of accessible youth-friendly health centres across the country: "Acceptance of adolescent sexual and reproductive health and rights is slowly improving, but cultural beliefs and taboos are still barriers to ensuring young people have adequate access to information and services."[11] In addition, the *National Family Planning Guidelines and Standards* (2013) and the *National Education Act* (1978) are in conflict, where the more recent *Guidelines and Standards* provides for family planning services for everyone, but the *Education Act* restrict student access to family planning commodities, resulting in AYP engaging in SRH service seeking and support in secret which puts them at high risk.

Comprehensive Sexuality Education (CSE)

Tanzania has an extensive education policy framework, including the need for SRH education. However, there are inconsistencies in how these are understood and implemented in practice. This includes challenges of weak coordination systems, inadequate responsiveness to adolescents' needs, conflicting education and health policies and limited understanding and participation among frontline implementers such as education and health officers[12].

6 See: https://www.equalitynow.org/discriminatory_law/the_law_of_marriage_act_1971_as_amended_by_act_23_73_act_15_80_and_act_9_96/

7 Ministry of Health, Community Development, Gender, Elderly and Children (2016).

8 UNICEF Tanzania (2018)

9 HEARD (2015). p 3.

10 The Penal Code (2019). Cap 16 R.E.

11 UNFPA Tanzania (2017).

12 HakiElimu (2021).

Criminalisation

Same-sex, sexual conduct between men remains a criminal offence in Tanzania, with same-sex sexual conduct between women specifically criminalised in Zanzibar (but not the Tanzanian mainland). Sex work is fully criminalised in Tanzania.[13]

What this means in practice

In practice, this means that AYP have limited access to accurate information and youth-friendly services, which contributes to high rates of teenage pregnancy, HIV transmission, and GBV in the country. In addition, harmful customs/traditions such as child marriage and female genital mutilation (FGM) continue to affect young women's health. Related social and cultural norms also make discussing SRHR with young people challenging. Financial limitations compound these issues where there are limited resources to access services and information; linked to this, poor nutrition, especially iron deficiency (anaemia) for adolescent girls, affects their SRH and growth.

While the Government is committed to responding to and mitigating the effects of HIV and AIDS, gaps in human resources, domestic financing, health infrastructure, the supply chain for commodities and stigma and discrimination continue to challenge progress. In addition, despite its young population, AYP's specific healthcare needs tend to be overlooked. Little is known about the extent to which young people access healthcare due to the limited availability of age and sex-disaggregated data. Consequently, policies and programmes targeting HIV and SRH may fail to achieve their full intended impact.

13 The Penal Code (2022) Cap 16 R.E.

Health Policies & Funding

NI NINI HLM (MKUTANO MKUU) J

UU YA UHC (AFYA KWA WOTE) UNAHITAJI KUSIKIA -NA KUFANYA!

Matumizi ya sekta ya afya nchini Tanzania, wakati yakiwezeshwa kwa kiasi kikubwa na bajeti ya serikali na kuchangiwa na wafadhili wa kimataifa, lazima yapangwe kimkakati ili kuhakikisha kuwa huduma, upatikanaji wake, na huduma za afya zinazozingatia haki, zinawafikia vijana kwa wakati zinapohitajika. Sehemu kubwa ya sera na mikakati bado haijafadhiliwa kikamilifu, pamoja na tatizo sugu la uhaba wa wafanyakazi (na kutokuwa na uwezo/utayari wa kubadilisha mifumo ili kuvutia na kubaki kwao kazini) kunasukuma upatikanaji wa haki ya afya mbali zaidi ya uwezo wa vijana. Ufadhili wa upatikanaji wa huduma za afya pia lazima ufanyike sambamba na mageuzi ya mijadala ya kitaifa kuhusu haki za msingi, na uhuru bila kuingiliwa na wadau ambao wanaendelea kutumia dini, utamaduni, na mila kama silaha za kuzuia upatikanaji wa haki za afya ya uzazi na ujinsia(SRHR) kwa vijana.

WHAT THE HLM ON UHC NEEDS TO HEAR

–AND DO!

Tanzanian domestic health spending, while mainly funded by the Government and complemented by international donors,[14] must be strategically targeted to ensure that services, access, and rights-based health care meet the youth at their point of need. The abundance of policies and strategies remain unfunded fully, aggravated by persistent healthcare worker shortages (and the systems' inability/unwillingness to transform to attract and retain them pushes the realisation of health justice further out of the reach of young people. Financing health access also must happen in tandem with a national evolution of discourse around fundamental rights and freedoms and their freedom from interference by stakeholders who continue to weaponise religion, culture, and tradition to hinder the realisation of SRHR for young people.

Policy landscape

Health policies have held a central stage in the various phases of Tanzania's post-independence era. In addition to the *Constitution*, there are several health, SRHR and HIV policies, strategies and guidelines adopted by the Government and agencies working in public health (see Annex 2). Key documents that pertain to both SRHR and UHC provisions include the *National Health Policy* (2017), which states that every citizen has the right to access quality health services. This policy has seen significant efforts by the Government - in collaboration with the community and other key stakeholders - to expand, improve and distribute reproductive, maternal, newborn, child, and adolescent health services to target populations. This is also the primary policy document on UHC. However, there are gaps in implementing this policy and barriers such as a lack of resources and infrastructure and limited access to healthcare in rural areas. Services related to family planning, pregnancy, STIs, GBV, violence against children, FGM, harmful traditional practices, breast and cervical cancer screening, and prevention and treatment of infertility are inadequate, and there is a minimal provision of adolescent-specific health services.

The *National Policy on HIV/AIDS* (2001) and the *National Multisectoral Strategic Framework for HIV and AIDS* (2018/19 to 2022/23) are key documents that provide the framework, direction and general principles for the national HIV response interventions in the prevention, care, and support of those infected and affected by the epidemic and mitigation of its impact. The 2001 Policy specifically recognises HIV as a social, cultural, and economic problem and the need to protect women and girls from their increased vulnerability to HIV infection.

In terms of UHC, the *National Health Policy (2017)* briefly mentions 'universal access' at the start of the policy, with a stated mission to: "facilitate the provision of basic health services that are of good quality, equitable, accessible, affordable, sustainable and gender sensitive". There is also some reference to delivering essential services and protecting the poor from the financial burden in recognition of the need to protect people "especially the poor and vulnerable groups... in terms of financial barriers." The main aim of the *Health Sector Strategic Plan V (2021-2026) "Leaving No One Behind"* is to transition to UHC by 2030.

There's no mention of UHC in any of the country's SRHR, HIV and AIDS and youth related policies.

14 PEPFAR contributed almost **three-quarters** of the health budget in financial year 2017/2018

Financing for health

Historically, inadequate funding for full implementation may prevent UHC from being fully achieved, though there are more recent efforts towards resourcing UHC, including increased investment in the health budget and national health insurance plans. Specific programmes and policies, such as the National Accelerated Action and Investment Agenda for Health and Wellbeing (NAIA-HW), also focus on ensuring UHC for health issues such as HIV/AIDS and maternal and child health. In addition, through the Tanzania Commission for AIDS (TACAIDS), the Government has also established the Tanzania AIDS Trust Fund (ATF). The rollout and implementation of these initiatives have, however, been slow.

Despite extensive rural health infrastructure that affords 80% of the population access to a health facility within five kilometres of their home[15], many of these facilities lack essential resources and are understaffed, the impacts of which mirror large inequities in healthcare access with the rural population being the worst affected. Government expenditure on health has steadily declined, with out-of-pocket expenditure increasing. In 2020, health expenditures stood at 6.7% of all Government expenditures, well below the Abuja target of 15%[16]. This is not transparent, and over 90% of SRH and HIV interventions are development agency-driven and financed[17]. The perception of this by civil society is that the Government covers infrastructure and human resources components of SRHR services while foreign development partners cater for commodities. These include specific donors such as PEPFAR, USAID, and the Global Fund and include both commodities (contraception and medications) and activities (programmes and funding for local partners).

Inclusion of SRHR and self-care in policies and funding

Self-care interventions (i.e., self-testing for HIV, accessing contraception, including emergency contraception and PREP, etc.) are primarily managed by the Government and not consistently or easily accessible in certain areas or facilities. Additionally, some services may require payment (such as STI testing and treatment), which is a barrier for those AYP who cannot afford them. Certain products, such as lubricants, are also banned in Tanzania, making it harder for AYP to access them and increasing the risk of STIs. While some AYP have access to health insurance (mainly those in universities and from well-off families), often the available packages don't cover everything, limiting their usefulness to access needed health services:

"...what I have seen is that only very few hospitals accept the use of health insurance cards, and you might find people require urgent care and believe that since they have the insurance, they can access the service, but once they are at the hospital, they get informed that their package doesn't cover their needs; they are not always aware of the [detail of the insurance] packages. I think this is a challenge, and it would have been better if the insurance is for everything or just one thing."

(Male, youth participant)

15 National Bureau of Statistics (2022).
16 UNICEF Tanzania (2020a).
17 HEARD (2015). p 2.

While significant policies are guiding AYP SRH services (see Annex 2), it is important to note that the term 'self-care' is not commonly used; this is still a new concept in the SRHR and UHC space. Instead, language such as 'youth friendly' and 'adolescent friendly services' is prevalent and understood as, for example, the need to "reorient health staff on compassionate care, patient charter and rights of adolescents" by prioritising "school-age and adolescent health, education, child protection, equity, gender, and inclusiveness, WASH, nutrition, HIV and AIDS."[18] Additionally, the term' family planning' is extensively used in the policy documentation, which is problematic in that it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice', and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choice; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' also does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention. The concept is best placed within a broader SRHR framework founded on the understanding of choice.

It is clear that more work must be done to socialise the term and approach of self-care in Tanzania to bring the SRHR landscape in the country in line with contemporary thinking around AYP-focused and led approaches to SRHR service provision. Working with the Minister of Health and the Adolescent Health Technical Working Group (TWG, which brings together practitioners, civil society organisations (CSOs), and Government decision-makers to discuss issues related to adolescent health) may be one avenue to promote self-care as a concept and practice – and ensure that it is adequately funded – as well as working with private service providers to ensure they can provide self-care interventions to young people that meaningfully supplement what Government is doing and focus on agency and choice as much as different options for service provision.

To that end, initial key steps could include developing a set of principles, policies and guidelines for self-care that can be integrated into the current policy framework and practices – and the broader conversation about UHC. This is happening more broadly in the region so there are current examples the Tanzanian Government could leverage from[19]. Creating such spaces for internal (to Tanzania) and external (i.e., across the region) learning around how to develop proper guidelines to ensure safe and effective self-care will ensure that good practices are documented, learned from, and adapted to different contexts. In addition, not many youth-led organisations and networks are part of the UHC conversation in Tanzania. Instead, the bigger NGOs and Government agencies form part of the TWGs for UHC, so there is a need to ensure young people are meaningfully involved and can fully participate in these processes.

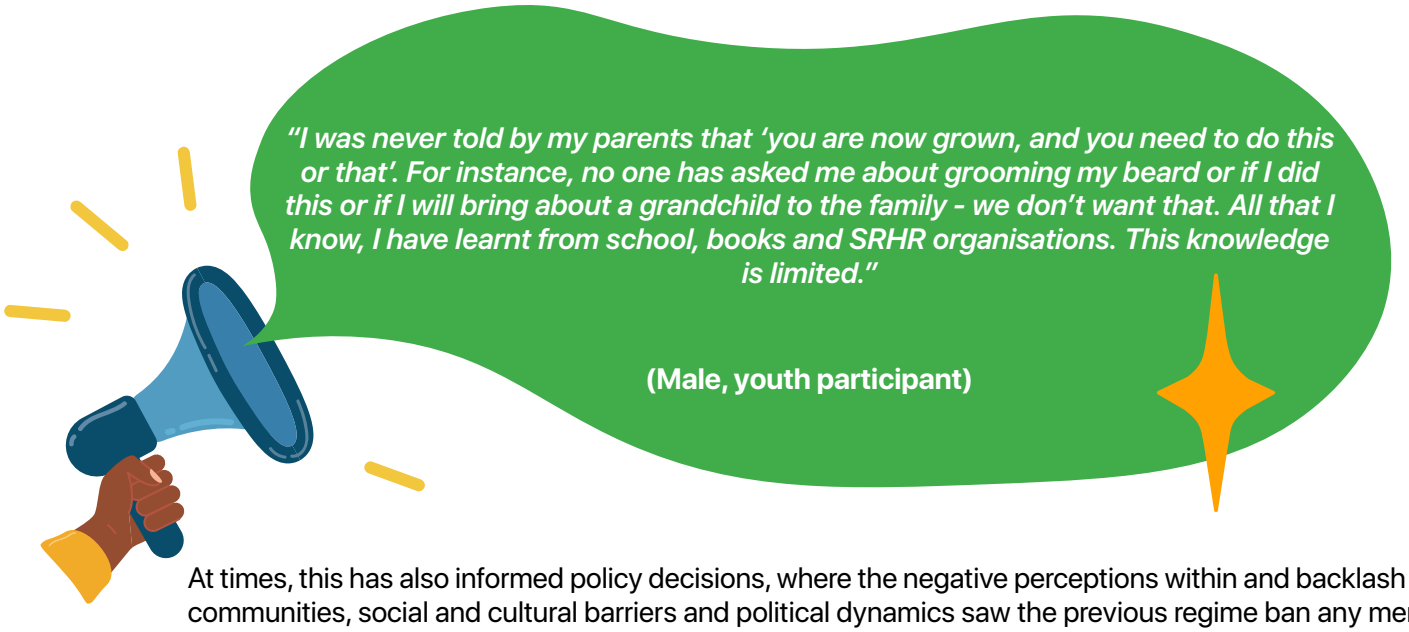
18 Ministry of Health, Community Development, Gender, Elderly and Children Tanzania (2021) P 13.

19 See: https://knowledgesuccess.org/2021/09/28/advancing-self-care-in-uganda/

Voices of young advocates

Key barriers

Some of the key barriers shared by the young people engaged in this process included the difference between the **age of consent laws**, which makes it difficult for young people to access SRH commodities and services, putting them at risk of STIs and teenage pregnancy. This is compounded by a **cultural resistance** to talking about sexuality, a barrier that is selectively used as an excuse to avoid discussing important issues related to SRHR for AYP, limiting their access to the resources and information they need to make informed decisions about their sexual health and wellbeing:



At times, this has also informed policy decisions, where the negative perceptions within and backlash from communities, social and cultural barriers and political dynamics saw the previous regime ban any mention of family planning and discourage the use of contraceptives. Unsurprisingly then, there remain limited public platforms to discuss these issues. Despite official Government websites like the Ministry of Health website, information has focused on prevention against Ebola, COVID-19, and HIV/AIDS; there is very **little publicly available information on SRHR issues**. This is reflected in health centres that are not set up for privacy, so AYP are inhibited from seeking information and counselling on SRH issues - or if there are youth-specific officers and support services, these are not well promoted to AYP, so, even if they could afford to access them (given the high rate of youth unemployment) many are just not aware that these avenues exist. Additionally, there are limitations brought about by **religious beliefs** on contraception and family planning, compounded by the spread of misinformation and peer pressure, which can lead to poor decision-making.

Out there, parents believe that the [SRHR] organisations are degrading social values by keeping things open and transparent. They detail things as they are, while parents don't. It makes them look bad as they encourage young people to practice sex.

(Female, youth journalist)

Socio-economic factors

Socio economic factors such as the lack of quality education and resulting poor self-awareness due to AYP not being adequately prepared for real-world challenges; and the unequal distribution of unpaid care work amongst boys and girls which limits young women's participation in other social and economic activities, also impact on AYP's access to SRH services.

Youth leadership

However, there is hope, where young people reported joining youth groups as a way of mitigating risks by accessing information, especially related to SRHR. By receiving training and championing these campaigns at family and community levels, young people are becoming knowledgeable about new concepts and changing their beliefs and those of their peers. Young people, especially those working in media, have taken up awareness raising to engage in discussions on key SRHR and employment issues.

Young people & self-care

Interestingly, most young people who engaged in this process understood the self-care concept and affirmed using it as the first step to managing their health. They reported the use of painkillers and herbs prior to visiting a health facility. For many, self-care included self-diagnosis of symptoms and consulting family members/friends on health conditions. A young female entrepreneur remarked that she doesn't rely on hospitals to maintain her health. When she feels sick, she regularly takes Panadol and sleeps with the hopes of getting better from rest. She didn't believe that "she cared for herself" by doing this, but it was the only option for her since she must get to work the next day. Self-care and particularly "healthy lifestyles" depend on families' upbringing styles. A young woman in the media recognised that her behaviour and attitude towards visiting health facilities for checkups and treatment is a result of how her parents raised her:

"So, if a person is raised in a family with a different background, it is very hard to transform and adopt this way of life because of that background. Therefore, it is important to work at the family level to push for this transformation so that we don't struggle in the future, and we should start at the family level."

Young people credited access to the internet as one area to explore the self-care approach since many have used Google and Apps to track health information. A young female journalist confirmed the use of Google to check what causes certain illnesses, sharing that the internet is about understanding her symptoms, not treatment:

> "I use Google to find out what things could have caused changes I currently experience if the results show that at least one activity that I had done or something that has happened to me, then it becomes my starting point to visit the hospital".

It was recommended that further research should be conducted on the feasibility and effectiveness of implementing self-care strategies in the context of SRHR in Tanzania.

Key Advocacy Messages

A clear set of recommendations emerged through this process:

YOUNG LEADERS ARE LEADERS!

Young people must be involved in making these linkages between SRHR, HIV and UHC – and how self-care can effectively strengthen health systems. This resounded in the youth discussions where they ad-vanced the clarion call of "nothing about us without us". And there are good practice examples of this in Zanzibar already:

"Although Zanzibar has a youth council, Tanzania mainland doesn't have one. We are advocating for this platform but not so many people are moved with this agenda. If we get this as young people we can take part in decision making as we will be represented and decide for ourselves. We are tired of people who are not youths making decisions on our behalf – [it] is not fair"

(Female, Young Person)

LEADERS MUST LEAD!

Despite significant overarching health policies, and specific SRHR policies and strategies in Tanzania, there is a clear gap in terms of implementation, with a strong need for:

- Regularly updated standards and guidelines to reflect current realities, linked to regular review and update cy-cles for SRHR-related policies.
- Accessible standards and guidelines (at key levels of the health system) that translate the policy into tangible practice for service providers and users;
- Processes to ensure that CSOs and community-based organisations (CBOs) are adequately involved at the design and implementation stages, with special emphasis on engaging youth-led and young women-led or-ganisations.
- Greater inclusion of AYP, their communities and service providers through human rights literacy training (with a specific focus on health rights and how these can be realised within the context of the SRHR and HIV response in the country), tailored to how AYP best receive information (online, via Apps, via peers, and so on).

LEADERS MUST ACCOUNT!

There are many opportunities for communities to hold leaders accountable practically. However, the mechanisms to do this can be very opaque. Some examples of how to hold leaders to account at different levels include:

Leveraging the regional and international instruments Tanzania has signed onto and their inbuilt accountability mechanisms. CSOs can check the status of these various treaties online[20] to identify important advocacy opportunities, for example, submitting Shadow Reports to supplement periodic Government reporting on women's rights.

Similarly, understanding the national policy frameworks – and the gaps – provides a foundation for influencing through national bodies, such as national HIV and AIDS councils' review cycles for their National Strategic Plans or Technical Working Groups' reviews of key strategies and guidelines for AYP SRHR services.

Influencing through targeted information campaigns catering to key audiences' information preferences, e.g., hardcopy posters, dialogues, and activations in communities, or online (via Apps and social media) or via peers for AYP.

Ensuring all SRHR-related policies and any associated strategies, plans and guidelines have regular review cycles and a schedule that can be accessed by civil society to influence policy updates by ensuring they reflect current realities on the ground.

Leveraging off the significant work already being done by CSOs in Tanzania, for example, CSOs successfully advocated for the Government to improve the quality and branding of Government-provided condoms. As a result, quality was improved, and the branding changed to 'ZANA ya Ukweli' (meaning tool of reality), which was felt to be more acceptable to young people[21]. These CSOs also act as information centres for AYP, sharing tailoured and relevant SRHR information and services, for instance, the distribution of condoms. Other activities include managing specific helplines that provide support on SRH and HIV/AIDs concerns; collaborating with the Ministry of Health to answer frequently asked questions; using innovative approaches such as pleasure-based CSE to engage and inform young people about SRHR issues and self-care approaches and shift the focus away from negative connotations of SRHR, and towards more positive, healthy, and pleasurable aspects; offering capacity building training on SRH advocacy; and developing a guideline for youth organisations to customise and address their specific organisational SRH policy needs.

LEADERS MUST INVOLVE!

There is a strong need to more effectively and meaningfully engage young people for evidenced-based projects, interventions and services, i.e. gathering the voices and experiences of young people to understand their needs and realties better and use those to develop user-friendly services that are inclusive and accessible to all young people without leaving anyone behind.

Young people noted that the current lack of evidence that documents and shares the lived experiences of Tanzanian youth contributes to the misconceptions and misinformation in the interventions aimed at addressing youth SRHR. This work needs to consider increasing access and affordability of SRHR services, particularly for adolescent girls and young women. Achieving this involves including AYP in decision-making processes, whether through the creation of a specific young people's decision-making body or by including them in existing platforms. This is a big gap.

20 See: https://www.ohchr.org/en/countries/tanzania

21 Mathew, M. (2016).

Although Zanzibar has a youth council, Tanzania's mainland doesn't have one. We are advocating for this platform, but not so many people are moved by this agenda. If we get this as young people, we can participate in decision-making as we will be represented and decide for ourselves. We are tired of other people who are not youths making decisions on our behalf, which is unfair."

(Female youth activist)

"The Government has developed good policies like the NAIA-HW, I don't recall its long form, but it highlights youth-specific issues on SRHR and AIDS. If I am based in the city, I can access a smartphone and participate in SRHR organisations. I only found out about this last year (2022); what about those based in rural areas? The Temeke districts register about 80 non-governmental organisations monthly, but how many of the youth-led organisations registered are made aware of this policy that gives them the mandate to work with young people SRHR and HIV/AIDS...."

(Young woman)

This includes leveraging off the significant work already being done by CSOs in Tanzania, for example most of the organisations who engaged in this research embed movement building and working in partnership with politicians and other organisations in their advocacy for reproductive health and rights as a key strategy. This brings together youth-led organisations that focus on various issues, not just SRHR and HIV, and helps them connect with decision makers and regional leaders to achieve their goals.

LEADERS MUST UNITE!

Tanzania has a strong network of stakeholders engaged in different ways in the public health sector generally and the SRHR and HIV landscape specifically. There is, however, a clearly articulated need *to better resource local CSO networks – particularly youth-focused and youth-led - to build a critical mass of stakeholders to drive the rights agenda.*
This can include:

- catalysing around a shared issue to leverage different expertise and resources
- seeking joint funding for shared action (campaigns, movement strengthening)
- seeking unrestricted funding for non-traditional forms of advocacy that local groups can implement without 'sign off' from a donor.

LEADERS MUST EVOLVE!

While significant policies are guiding AYP SRH services in Tanzania, the term 'self-care' is rarely used. Instead, language such as 'youth friendly' and 'adolescent friendly services' was prevalent and written from a top-down perspective. Similarly, the term' family planning' is extensively used in policy documentation. This is problematic where it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice' and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choose and to be safe; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention. The concept is best placed within a broader SRHR framework founded on the understanding of choice.

Advocacy opportunities to change policy language

These language issues present significant opportunities for advocacy, where partners and communities can influence at different levels (policy influencing and community-based activism) around more inclusive, rights-based language that, in the You(th) Care project context, prioritises AYP's agency in accessing services and making decisions about their SRHR – and that also reflects that we do not live in a heteronormative paradigm of identities, orientations or choices.

There is a need to better socialise the concept of self-care amongst AYP and their families, community members, traditional and religious leaders, CSOs (both those working for young people and those led by young people), and Government officials at all levels.

»due to socially constructed norms, sometimes when you go for raising awareness on SRHR (about providing information or services to adolescents), it looks like you are certifying the adolescent to go for sex. So, it's a bigger challenge that we are tackling right now"

(male representative of youth organisation)

»It is difficult for PWD to access and enjoy health services. For instance, with blind pregnant women, we assume they have been raped (even health care workers); hence these services are not friendly for them. It is very rare to find many PWD attending prenatal care clinics, counselling services just like that"

(a young woman working in SRHR)

"Kwahiyo hata mimi kuna vitu vingi nimefanya kwa kutokujua, kwani ningekuwa nimepewa taarifa hiyo kwa muda ule, ingekuwa msaada sana na ingenikinga nisifanye vitu vingine"...Ni muhimu sana kwa mzazi kukaa na mtoto wake kuzunguza kuhusu masuala ya ukuaji wake"

«So, there are a lot of things I've done unknowingly. If I had been given that information by then, it would have been very helpful, and it would have protected me from doing other things"... It's very important for a parent to sit down with their child totalk about issues of growth."

(Young woman – translated)

TAKE SRHR INFORMATION ONLINE!

There is a need to use technology in innovative ways given the many examples of the use and access of the internet through mobile phones (or other online channels) by young people in the country to access health information/self-care as a potential mechanism to enact different advocacy and influencing initiatives, alongside the provision of comprehensive, accessible SRHR information and referral information for key health services.

ANNEX 1:
Research Methodology

In August 2022, following reflections from You(th)Care consortium partners about gaps in knowledge of the policy landscape for SRHR and HIV in each programme country, Aidsfonds commissioned the African Alliance ('the Alliance') to undertake an initial country-specific (Kenya, Tanzania and Zambia) policy analysis to provide the consortium with insights into each country's policy environment to support partners to better promote and realise AYP's SRHR and HIV self-care needs, including AYP access to self-care services and commodities.

This first phase of work had a specific focus on mapping policies, strategies and guidelines related to AYP aged 10–25, as well as identifying key stakeholders and the specific barriers or enablers to progress in improving SRHR and the practice of self-care. To that end, the Alliance engaged stakeholders from the You(th) Care consortium cohort (partners and young people) alongside a small sample of thought leaders working regionally, continentally, and globally on SRHR and self-care to better understand the policy landscape and what opportunities may exist for You(th) Care to inform its adaptation and future implementation. The policy analysis process sought to understand the state of the national adolescent and young people's SRHR and HIV response in each country and the possibilities to practice self-care; key policies and guidelines that influence adolescent and young people's SRHR and HIV vulnerability and access to self-care; barriers and opportunities for improving adolescent and young people's SRHR, the practice of self-care; the main stakeholders; recommendations to impact on adolescent and young people's SRHR, the practice of self-care and HIV/AIDS in the country.

The process was phased, consisting of an initial briefing with You(th) Care colleagues from Aidsfonds, a desk review, and country-based semi-structured discussions with consortium partners and the young people (aged 18-25) they work with. A second phase was commissioned in September 2022 to add an analysis of Malawi and Uganda and build on the initial process with an adjusted focus to consider what commitments or policies on UHC each country has in place and how they are being implemented.

In Tanzania, the following stakeholders were engaged in this process:

- Children's Dignity Forum **(CDF, staff and young people)**
- Network of Young People Living with HIV and AIDS in Tanzania **(NYP+, staff and young people)**
- Eastern Africa National Networks of AIDS and Health Service Organisations **(EANNASO, staff)**
- Tanzania Youth Alliance **(TAYOA, staff)**
- Young and Alive Initiative **(YAI, young people)**
- African Youth and Adolescents Network **(AFRIYAN, young people)**
- Chama cha Uzazi na Malezi Bora Tanzania **(UMATI, young people who form part of the** Youth Action Movement **(YAM) in Dar es Salaam)**

Through this approach, the Alliance sought to draw from the base set of findings from the desk review and build on these through the in-country processes, ensuring that the data collected is meaningful and nuanced rather than repetitive to draw a clearer picture of what is happening in each country from multiple perspectives. The Alliance used thematic analysis to the group and compare the findings in each country and draw out country-specific advocacy recommendations. Where possible, useful examples of good practice are identified in the narrative. Findings are presented as individual country snapshots, with a summary' global brief' that also considers the profile of self-care in regional and global debates. Illustrative quotes are used throughout this document, extracted from the in-country conversations with partners and AYP.

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Kiswahili in Tanzania with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.
- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Dar es Salaam in Tanzania) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

ANNEX 2:
Key Policies and Guidelines

National policy landscape

While Tanzania has good policies and plans to improve healthcare, partners who engaged in this review felt that implementation was lacking:

> *"We have documents which are very good on paper because most of these documents are donor-funded, but then where's the government's accountability when it comes to implementing the policies, the strategies that we have*

A sample of the most current or available national policies, strategies and guidelines is below, noting that this is not an exhaustive list:

Policies:

- Law of Marriage Act (1971)
- National Education Act (1978)
- Sexual Offences Special Provisions Act (1998)
- National Policy on HIV/AIDs (2001)
- National Youth Development Policy (2007)
- National Health Policy (2017)

Strategies and guidelines:

Gender Operational Plan for the HIV and AIDS Response (2010-2012)

- National Adolescent Health and Development Strategy (2010-2015)
- National Family Planning Guidelines and Standards (2013)
- Standard Treatment Guidelines (STG) and National Essential Medicines List (NEMLIT) (2013)
- National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in Tanzania – One Plan II (2016-2020)
- National Plan of Action on Ending Violence Against Women and Children (2017/18-2021/22)
- Health Sector HIV AND AIDS Strategic Plan IV (2017–2022)
- Health Sector Strategic Plan V "Leaving No One Behind" (2021-2026)
- National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (2021/22-2024-25)
- National Multi-Sectoral Strategic Framework on HIV and AIDS (2018/19-2022/23)

The regional and international policy landscape

Significant international and regional law, through treaties, conventions, protocols, covenants and declarations, exists to interpret human rights within the FrameworkFramework of health and specifically to apply those rights to respect, protect and defend human sexuality and human reproduction. These resound with the rights to freedom, equality, non-discrimination, privacy, and human dignity, and confer on states that are party to each treaty, the obligation to provide, domestically, for the highest attainable standard of health. Under several international and regional treaties, Tanzania is obligated to provide healthcare access, including promoting and protecting SRHR. This reflects varying extents in the suite of policies, strategies and guidelines developed to realise these promises. A snapshot of some of these international and regional treaties is provided below.

International treaties and guidance

Universal Declaration of Human Rights (1948)

International Covenant on Civil and Political Rights (1976)

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)

Joint General Recommendation No 31 of the CEDAW

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Convention of the Rights of the Child (1989)

General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003); General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014); and General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)

Fast Track Commitments to End AIDS by 2030

International Conference on Population and Development Programme of Action (1994)

The Framework of actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014

The 2030 Agenda for Sustainable Development

Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030

UNAIDS Agenda for Zero Discrimination in Healthcare Settings

Regional treaties and guidance:

- African Charter on Human and People's Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)
- African Women's Protocol to the African Charter on Human and People's Rights (2003)
- General Comments on Article 14 (1) (d) and (e)of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012); and General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)
- African Youth Charter (2006)
- Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)
- Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006)
- Model Law on HIV in Southern Africa (2008)
- The ESA commitment made by ministers of health and education in 21 ESA countries to scale up comprehensive sexuality education (CSE) and SRH services for AYP (2013)
- Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)
- Southern African Development Community (SADC) Gender Protocol
- AU 2063 Agenda
- SADC Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region
- SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018)
- AU Catalytic Framework to End AIDS, TB and Malaria in Africa by 2030
- The organisation of African Unity, Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases (2001)
- AU Addis Ababa Declaration on Population and Development in Africa Beyond 2014 (2013)
- SADC SRHR Strategy and Scorecard (2019-2030) (2018)

This is not a comprehensive list, but the examples shared give some sense of the extensive international and regional relationships between states and the shared values of the international and regional communities. This provides a basis for engagement of civil society at a national level, as well as within and between states for shared international and regional accountability, recognising that, while it can be difficult to 'enforce' the implementation of the content of these documents, they are important to be aware of as each comes with its own set of review mechanisms that can provide a point of advocacy and influencing for civil society engagement. For example, the African Union (AU) Summits (for the Maputo Protocol) and the CEDAW country reviews, among others.

ANNEX 3:
Key UHC Stakeholders

Key state actors include the Ministries of Health and Social Welfare; Education and Vocational Training; Labour, Employment and Youth Development; Community Development, Gender and Children. The public sector on the mainland is divided into two government levels: central Government and local Government. The central government comprises the ministerial tier as well as the regional administration tier. At the ministerial level, the Ministry of Health and Social Welfare is the lead authority for the health sector, while several other central government agencies provide specific health services, most prominently, the Tanzania Commission on AIDS (TACAIDS). There are 25 administrative regions, which are an extension of the central government, with Regional Medical Officers accountable to the Ministry of Health and Social Welfare for providing regional health services and supervising the delivery of health services. Local government is divided into 158 district-level (urban and rural) LGAs, each of which has, on average, 300,000 residents and is led by an elected local government council. This is the main government level responsible for the delivery of decentralised public services, including the deliv-ery of local health services[22].

- Children's Dignity Forum (participants)
- Network of Young People Living with HIV and AIDS in Tanzania (participants)
- Eastern Africa National Networks of AIDS and Health Service Organisations (participants and CSEM members)
- Tanzania Youth Alliance (participants)
- Young and Alive Initiative (participants)
- African Youth and Adolescents Network (participants)
- Chama cha Uzazi na Malezi Bora Tanzania (UMATI, participants)
- Youth Action Movement (participants)
- Hope Centre for Children, Girls & Women in Tanzania
- Bare Foundation

In addition, Tanzanian members of the Civil Society Engagement Mechanism (CSEM) for UHC 2030 include:

- Care for Dignity and Innovation
- Children's Education Society (CHESO)
- Child Watch
- Community Active in Development Association
- Christian Spiritual Youth Ministry (CSYM)
- Enhance Children and Women of Tanzania
- FUMACO
- The Good Samaritan Social Services Tanzania
- Health Promotion Tanzania
- Kamachumu Environment Care Association
- Kiona Youth Coordinates
- KIVOLEX abroad volunteers
- Initiative for New Generation (I4NG)
- Invest in Women Organisation (IWO)
- New Life Organisation
- People's Health Movement Tanzania
- SHDEPHA+ Kahama
- Tanzania Community Health Information and Support
- Tanzania Medical Student's Association
- Tanzania NCD Alliance
- Tanzania Red Cross Society
- Tunaweza Organization
- Youth and Environment Vision
- Zingatia Tafakari Elimika (ZITAE)

Participants in this process indicated that other community-based organisations and youth structures focus on HIV. These are small structures that they interact with. However, the sense was that they lacked the skills, capacity, and resources to grow.

22 Boex, J., Fuller, L., & Malik, A (2015).

ANNEX 4: Advocacy Roadmap

Timeline - UHC Negotiation Schedule

The UN Language Compendium is a useful tool for high-level United Nations negotiations and can be used for community advocacy to advance human rights commitments — particularly regarding access to healthcare and sexual and reproductive health and rights: https://hivlanguagecompendium.org

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You(th) Care
My health.
My responsibility.

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ARASA
AIDS & Rights
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AYARHEP

CHILDREN'S DIGNITY FORUM
CDF
UTU WA MTOTO

COPPER ROSE
ZAMBIA
Beautiful | Valuable | Empowered

Network for Adolescent and Young Adults of Africa
NAYA

NYP+
Network of Young People
Living With HIV and AIDS

PATA
PATA
PATA

GLOBAL NETWORK OF
YOUNG PEOPLE
LIVING WITH HIV

Developed by
African
Alliance