Because of temptations: children, sex and HIV/AIDS in Tanzania
van Reeuwijk, M.A.J.

Citation for published version (APA):
Childhood sex: Vulnerability to poor sexual health and HIV

From the view of public health, the early onset of sexual activity, the short duration of relationships (and associated likeliness of multiple partners) and low use of condoms that characterize the sexual behavior of primary school children in Tanzania is concerning. Especially regarding their future vulnerability to STI and HIV infection. We found that the sexual debut of boys and girls generally occurs with a partner of approximately the same age. Because HIV and STI rates are low among children up to the age of 15 in Tanzania, the most pressing public health concern is unsafe abortion following unwanted pregnancies which result in high maternal mortality rates. Since sex costs boys money and access to money is limited for most boys, I suspect sexual activity for most boys and girls is infrequent. Lack of funds also limits schoolboys’ access to older, more experienced girls or women. However, it is imaginable that as girls grow older, have sexual experiences and hopes for marriage they would establish sexual relationships with more interesting partners. Such partners might be young men who have finished school, are earning some money and are potentially marriageable. This is the category of men that Nnko and Pool are referring to in their article about sexual discourse among primary school pupils in Mwanza: not the stereotypical middle-aged sugar daddy, but out-of-school youth in the 18-25 age group (1995).

In the previous chapters the relative ‘protective’ value of school was described. Children’s decisions to wait with sex are often related to ideas and perceptions of schooling. Informants of this research used school as the most frequently used reason or excuse to say no to sex. Perhaps the steep rise in HIV prevalence in girls between 15 and 20 (Obasi et al. 2001) can be explained by girls’ increasing interest in young men with jobs, an increasing frequency of sexual intercourse and multiple partners, but also because the protective value of school falls away when girls finish Standard 7 around age 16. Unfortunately the group of informants who did not go to school was too small to make a good comparison or strengthen the argument of the relative protective value of schooling. However, my impression was that schooling also positively contributed to girls’ assertiveness and ability to openly reject boys and men when
approached. One must bear in mind that this assertiveness could also be related to the girls’ home location, family background or personal characteristics. Yet we felt that girls, who were not going to school, were younger or who were from rural areas were more submissive and passive. These girls might have been prone to stay silent when approached by an older boy or men or to avoid negation. Thereby weakening their negotiation power and making them more vulnerable to experience continuous pressure or situations of harassment and force.

As the children indicated, poverty appears to directly increase a girl’s vulnerability to ‘give in to temptations’ in particular to the monetary incentive that comes with sexual activity. More generally, gender inequality and the power differences between adult men and girls decrease girls’ negotiation power and increase their vulnerability to poor sexual and reproductive health (SRH) as well as unwanted sex. The power differentials and the sexual taboo in Tanzania make it difficult for girls to ask for help or report harassment as illustrated by the stories about abuse by teachers. The indication that sexual relationships between teachers and schoolgirls are common signals the extent of power differences. The ‘commonness’ of this situation and remarks such as from the guardian teacher “He chooses big girls, who are from a poor family background and are not very smart, who don’t have a lot of confidence” indicate that pedophilia is an insufficient explanation for this phenomenon. This remark highlights the increased vulnerability to harassment of girls who are poor and less assertive. I expect we might learn more about perceptions of childhood and sex and about gender and power inequalities if we had been able to hear how teachers and ‘older men from the village’ who approach girls justify their behavior.

Despite a reasonable knowledge of HIV/AIDS, individual risk reduction strategies and societal attempts to regulate and control children’s sexuality, children of primary school age in northwest Tanzania are at considerable risk to become infected with HIV or other STIs, to have unwanted pregnancies and to experience unwanted sex. This is true for girls more so than for boys. In general, the unsafe temporary relationships that characterize children’s sexual behavior result from social-economic structures that cause children to value sex as important and beneficial and the mixed messages and social expectations that lead to ambiguity and secrecy. Sexual taboo resulting in incorrect and incomplete information, temporal orientations of risk perceptions, ideas about responsibility and gender inequality are a few of the reasons why condoms are hardly used by children in Tanzania. Boys are placed at risk by prevailing Tanzanian norms for masculinity. Contrary to girls there is an expectation
that boys will become knowledgeable and experienced about sex. The children indicated that their relationships with their parents or caretakers as well as their economic and educational backgrounds were prominent influences on the onset of their sexual activity. Poverty interacts with many of these structures and increases the children’s vulnerability to HIV by many different routes.

Sexual health interventions: Understanding meanings and realities

There is increasing evidence that sexual health interventions that aim to prevent poor sexual and reproductive health, including HIV, in young people through sexuality education, increased access to SRH services or life skills building, are of limited success. Large scale randomized controlled trials in Africa, like the MEMA Kwa Vijana67 trial among primary school students in Mwanza region, and other evaluated interventions showed an increase in knowledge, but very little impact on biological outcomes such as HIV, pregnancy and STD rates (MKV policy brief 2008, Yankah and Aggleton 2008). Explanations that are given include that there is insufficient addressing of wider societal norms, that life skills programs are too simplistic to offer any valuable solution to the complex needs of African young people and that a comprehensive approach to HIV prevention is needed, including a variety of measures (Yankah and Aggleton 2008). These explanations are supported by the outcomes of this research. However, I want to try to give more concrete explanations for the lack of behavior change of primary school children in northwest Tanzania and reflect on points that I believe are critical for the design, implementation, monitoring and evaluation of SRHR interventions.

a) Many interventions insufficiently fit with children’s realities and do not take into consideration what is at stake for children.

I argue that one of the reasons why interventions that aim to promote the sexual health of youth are of limited success is that they focus exclusively on the dangers of sex and do not take into account the children’s perceived and experienced benefits of sex, how vulnerability is experienced and how risks are managed and become personalized. The narratives of Tanzanian children not only demonstrate that children benefit from sexual relationships, but

67 www.memakwavijana.org
also what they have to lose if they do not engage in sex. Social aspects of risk predominated the children’s narratives. What is at stake for them is negative feedback from peers, parents, caretakers and partners with consequences that impact their feelings about the self, social support and relationships. The children considered these a greater risk than the more abstract health risks such as HIV. This perception is rarely considered by intervention efforts, especially those that promote abstinence and faithfulness. Unless there is a strong religious conviction, which I found in only a few boys and girls, abstinence and faithfulness are not relevant options for the majority of the boys and girls. Furthermore, interventions that exclusively focus on the dangers of sex and try to increase knowledge about HIV transmission and prevention do not take into account the fact that HIV is not perceived by the children as a significant risk because of their individual risk management strategies. If we want boys and girls to use condoms, we need to realize that pregnancy is perceived as a much higher risk of sexual activity than HIV and the emphasis should be placed there. I think it is crucial to change boys’ existing ideas about responsibility for pregnancy and provide children with clear information about the ‘cycle method’ and condoms by targeting misconceptions. The script-like courtship dialogue and the setting of place and time for sexual activity actually provide entry points to introduce condom negotiations that fit with children’s realities. It should be considered that in Tanzania girls are not supposed to provide the condom. Yet the debate between boys and girls in Nyahali showed that boys might be willing to consider agreeing upon the use of condoms and of female controlled prevention methods like the female condom and possibly microbicide gels. Because sexual encounters are highly planned, gels could be an acceptable and relevant option. The acceptability of using these preventive methods among children and young adolescents should be explored. Negotiating prevention methods need to be practiced, perhaps through debate and role-play, so that condom use will become part of the sexual scripts of children and youth. Group debates seem to offer an acceptable and encouraging setting for girls to voice their concerns and opinions to boys and for boys and girls to seek solutions together. This seems to be a good starting point for empowerment trainings in which negotiation skills can be build. Asking boys and girls to switch gender perspectives during such debates could teach them to consider wishes and boundaries of future sexual partners. Through role-play practice, children could learn to accept that girls can initiate talks about prevention and bring condoms. It is important to include a focus on contraceptive negotiation at an early stage of developing sexual scripts rather than trying to change or insert it in already existing scripts. In general sexual health interventions should target children in Tanzania at least from the age of 10 and onwards. Young children
are confronted with situations in which they have to make sexual decisions. There is a need to teach them how to deal with these situations. At the same time interventions should make condoms available and affordable for children and youth and continue to increase knowledge on sexual and reproductive health.

If we want to encourage children and youth to communicate about safer sex options, we need to include a focus on the positive sides of sex. Including space to talk about desire and pleasure, which are highly valued by the children involved in this research, and empower them to make positive decisions. If boys and girls learn to communicate about their sexual wishes and boundaries this can enhance mutual respect, strengthen relationships and decrease experiences of unwanted sex. A positive approach in sexuality education could include efforts to change collective meanings of for instance condom use. If boys learn that being a good lover means to ensure a girl is relaxed and not worrying about negative consequences like pregnancy and therefore better able to enjoy the sex, they might be more willing to use condoms. An approach to sexual education that includes a focus on non-sexual aspects of relationships and intimacy might contribute to changing gender inequality and make children aware of their rights and responsibilities as well as those of others.

b) Insufficient training and monitoring of people responsible for ‘educating’ children and youth

Intervention efforts should carefully design, monitor, evaluate and follow up on the training of teachers, volunteers, health educators, peer educators etc. The teachers and educators we encountered during this research were not fully supportive of the contents of the programs they were part of, despite being trained by reputable NGO’s. Many of them felt their task was to prevent children from having sex, not to teach them how to have safe sex. This meant they offered the children incomplete information and an emphasis on the dangers and reproductive aspects of sex. The incomplete information led to misconceptions and reinforced contradictory messages that children already receive. Ideas and perceptions about sex and children and social norms regarding respectful inter-gender and inter-generational interactions are deeply rooted in Tanzania. It is unfair and unfeasible to expect people to ‘accept’ children’s sexuality over night and to provide ‘correct and positive’ information on sex in an interactive, open and honest way after only a few days or weeks of training. I therefore think attempts to improve teacher, parental or caretaker communications about sex might be problematic, consuming and inefficient in Tanzania. This does not mean teachers, parents and
caretakers should not be involved in interventions. On the contrary, their support for early and comprehensive sexuality education is essential. I believe that the effort should go into diminishing adults’ principal reason for resistance, the fear that information about sex and access to condoms encourages their children to engage in sex. A way to decrease fear is to ensure parents receive regular feedback about the monitoring and evaluation of SRHR projects and can provide input on project adaptations that is taken seriously by the implementers. Many of the parents and caretakers interviewed were aware and concerned about their children’s sexual lives. They recognized the high prevalence of teenage pregnancies and frequent sexual abuse of children by teachers. They acknowledged that not talking about sex led to secrecy rather than to abstinence and that their children hid their sexual relationships. These parents and caretakers actually wished for their children to receive sexual education but by someone other than themselves. Providing such programs in schools appears to be the most efficient and sustainable option. But the educational system in Tanzania is overburdened and teachers are accustomed to a one-way didactic teaching approach. Their own norms and perceptions do not fit with contents of the sexuality education they have to teach. Unless the quality and intensity of teacher trainings improve it would be more appropriate to have an independent professional ‘guardian’ teacher selected on his/her ability to communicate about sex who visits schools or groups of youth and who is independent from the schools. It would be easier for such an outsider to establish trust and confidentiality with the children and teaching staff and make it less challenging to report on sexual abuse by teachers. There is a compelling need for structural intervention of sexual harassment and abuse by teachers in Tanzanian schools.

For interventions to have a chance to address structural and individual determinants of sexual behavior in children and young people they first have to reach this target group. This means that the messages and information that are given to this group should be complete, fit with the perceptions and experiences of children and youth and is communicated by persons who are accepted by the target group and listened to. Children in our research said they preferred to get information from older brother/sister figures rather than from peer educators or teachers. Teachers were not trusted and sometimes not respected. The problem with peer educators is that they were frequently considered arrogant, judgmental or as catering only to pupils who did not want to get involved in sex. Like teachers, peer educators’ ways of communicating the

68 See Plummer et al. (2007) for a discussion on the suitability of Tanzanian schools as a setting for adolescent sexual health promotion and the requirements schools need to fulfil to become adequate settings.
messages and information were found pedantic. We heard complaints that peer educators often did not have the answer to questions that were raised by boys and girls and that peer educators could not look for answers because they shared the same limitations to sexual information as the other children. Just as some adult educators, many peer educators seemed to fear losing face if they admitted that they lacked knowledge and therefore provided incorrect information instead. I found that the young women and men in their 20’s that I worked with during this research, like my interpreters and persons like Hope, had the ability to relate to and talk with children about sex on fairly equal terms and in an open and honest way. Children seemed to be better able to identify with these persons and interested to hear their personal experiences, opinions and advice. Trust and confidence are quicker established if information is personalized. Boys in this research were actively inquiring the advice of my interpreter Godfrey, who could be considered a role model to the boys, about how they should treat a girlfriend. Godfrey’s personal stories about respect and condom use seemed to be listened to intently.

The potential of child participation in interventions

For SRHR interventions to be able to reach children and youth and fit with their realities there is a role for child and youth participation on different levels and in different stages of such interventions. The first step is to base such interventions on in-depth research of determinants of sexual behavior and meanings of sex and relationships whereby children are actively involved both as informants as well as advisors and co-researchers. Data provided and collected in cooperation with children will provide necessary insights into children’s preferred ways of communicating and will lead to a better representation of children’s experiences, needs and interests. Insight into how children understand, define and label key concepts should inform quantitative research. Furthermore, children can be consulted during the design of projects, participate in the implementation of interventions, assist in the production of materials and instruments and be involved in the monitoring and evaluation of projects. Children can advise us how to best reach other children and what methods are most favorable for optimal expression for children. In the context of northwest Tanzania it is important for children not to expose themselves as being sexually interested or active. However, using role-
play, songs and debates children have group protection and can express their sexual concerns, needs and questions. Children’s advice on methods is important in the design of assertiveness or communication trainings that I have mentioned above. Their advice can ensure that condom promotion and negotiation skills training can be fitted within their courtship structures. Children can actively collaborate in the design, production and evaluation of intervention materials and in awareness raising or educational activities. Such materials could for instance be games or films. These materials would help facilitate discussions among children particularly about sensitive or difficult topics. Materials could be shown to parents and caretakers to inform them of proposed actions. In this manner, the researchers could determine if there is adult resistance and if so, why. There is a possibility to have a dialogue with parents and caretakers in an attempt to diminish their resistance towards SRHR promotion, if parent and caretakers see there is a demand coming from the children themselves. The video camera is a useful tool for ‘child friendly reporting’ as a device to monitor and evaluate projects. The camera also provides the researcher with the ability to include illiterate children in the data collection. If children are asked to do the filming and interviewing there is a potential advantage of more honest opinions. Furthermore, meaningful participation by children in research has empowering qualities (Laws & Mann 2004). Children develop useful skills, are educated in the process, improve self-confidence and help to create an environment where more children can exert their rights. Empowerment through meaningful participation can induce ideas of citizenship, lead to active citizenship and contribute to processes of social change and transformation (IAWGCP 2008).

But child participation in research and interventions is not without challenges. One of the main challenges of child participation in both research and interventions is to convince gatekeepers, communities, intervention staff and policy makers of the usefulness and validity of children’s opinions, experiences and needs and their participatory and sexual rights (see Chapter 2). Other challenges in regard to child participation are related to methodology, demands of donors (time, efficiency and resources), training of child participants (e.g. to equip them with research skills) and the necessity to adjust work methods and procedures in order to give children and youth the power to truly influence decisions. But if active

---

69 See, for example, the R.A.P.-song project of Youth Incentives, international programme on youth and sexuality of the Rutgers Nisso Groep. R.A.P. stands for Rights, Acceptance and Participation, Youth Incentives principle approach in its’ SRHR interventions. http://www.youthincentives.org
participation of children in research and interventions can be achieved, children can become important agents for change (Van Reeuwijk 2008).