COVID-19 AND IMPACTS ON MENTAL HEALTH, VIOLENCE AND ADOLESCENT VULNERABILITY IN RURAL TANZANIA

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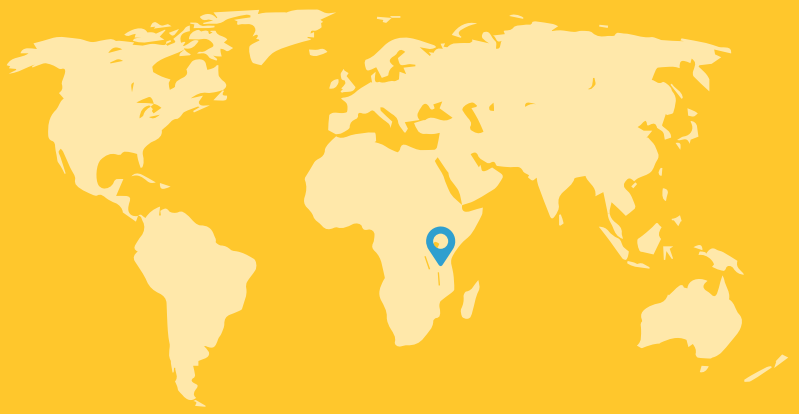

I. COVID-19 PANDEMIC AND MENTAL HEALTH

As of late 2020, the COVID-19 pandemic continues around the world, with negative impacts on livelihoods, economic security, and access to health services. These consequences of the pandemic may affect individuals differentially across the lifecycle. Adolescence is a key period of development when adolescents acquire assets and capabilities, and investments in adolescence are often thought to have a "triple dividend" (Patton et al. 2014), with benefits today, tomorrow and in the next generation. Conversely, adverse events such as the pandemic and related consequences during this development window may have long-lasting consequences. The world is currently experiencing its largest adolescent population, and Sub-Saharan Africa has the worst regional adolescent health profile (Patton et al. 2012). As such, adolescents in the region are particularly vulnerable to negative shocks such as the economic and health effects of COVID-19. These poor health indicators, potentially exacerbated by the pandemic, are problematic for

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countries' ability to harness the so-called "Demographic Dividend," a one-time opportunity for poverty reduction and accelerated economic growth due to changes in a country's population structure. Tanzania in particular has approximately 13.6 million adolescents (out of a total population of 56.3 million). Policymakers interested in strengthening adolescents' multidimensional capacities to ensure future growth for their country need more information about how the pandemic is affecting youth well-being. In this brief, we summarize the effects of the pandemic on mental health, violence, exploitation, and general vulnerability among a sample of youth[i] participating in the Government of the Republic of Tanzania's Productive Social Safety Net (PSSN) programme in rural Tanzania.

Executive Summary

We find that fear and anxiety were common among youth interviewed, and community leaders underscored that fear was common in the communities studied. This anxiety stemmed from worry about COVID-19 infection but also economic pressures exacerbated by the pandemic. Relatedly, youth reported being isolated and those who were still enrolled in school were frustrated about the interruption to their schooling. Despite global evidence that COVID-19 has increased violence against women and children, risk of violence does not appear to have increased according to adolescents surveyed. Moreover, engagement in transactional sex appears to have decreased as compared to before the pandemic. Some adolescents and community members did report occurrences of pregnancies among schoolgirls during the closures, and reduced capacity among health care facilities to provide regular services during the pandemic may have exacerbated barriers to access to sexual and reproductive health services to prevent pregnancy. To mitigate some of the increased vulnerability among adolescents, we recommend expanding social protection; ensuring that adolescent-friendly health services are available; increasing community-based mental health programming; and other economic strengthening initiatives.

Findings

Sample Characteristics

Youth in this sample were on average 20 years old (range 17-24), and 22% were married (26 percent of females and 19 percent of males) at the time of interview. Just under 14% were attending school prior to COVID-19-related closures (16% of females and 12% of males).

Mental health impacted by COVID-19 and related policy responses

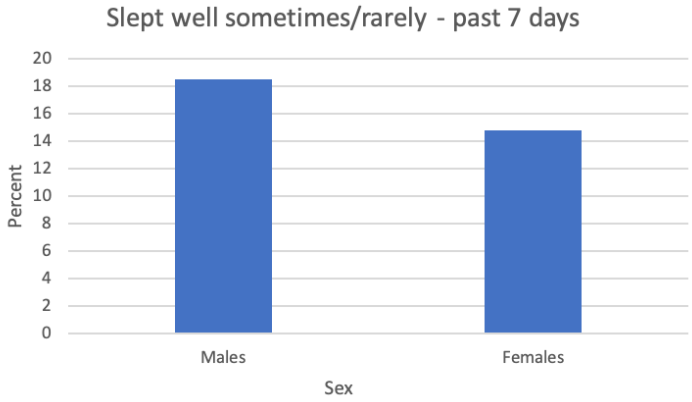
In the qualitative interviews, participants frequently mentioned experiencing fear and anxiety during the COVID-19 pandemic. Fear was expressed by 25 of 46 adolescent participants and 15 of 16 community participants. One adolescent participant said, "When this disease started we were spending the day at home because we were afraid. We would watch the news, and it would be announced so many died here, a hundred there and a thousand in another place." Fear led participants to change their activities to protect themselves. One adolescent reported, "Truly, difficulties were there because you know in the market there are crowds of people, so much that sometimes we miss something you need. You are forced to stay [home] because you are

scared." A community leader said, "there was fear that spread all over the community."

Anxiety among household members was mentioned by 21 of 46 adolescent participants in qualitative interviews. Participants worried primarily about their health and that of their families. "Because you get surprised when you have a cough, you find yourself starting to worry saying 'has this disease has got me or what' you start being anxious since you have suddenly started coughing, you say 'or this disease has caught up with me' Truly, a lot of anxiousness was there." Others reported anxiety about people in the community not following prevention protocols. "For example you would go into a shop; you find there is no water for washing hands... it just caused us anxiety." Economic pressures also caused stress and anxiety during the COVID-19-related closures.

Other responses related to mental health in the qualitative data include feelings of isolation and frustration among students at having to stay home from school. In quantitative surveys with youth, we examined two outcomes associated with depression: having trouble sleeping and being bothered by things that don't usually bother you. In our sample, 17% and 8% reported having trouble sleeping and being bothered by things that don't usually bother them, respectively. In regression analyses controlling for age and other characteristics, youth in this round of mobile surveys were less likely to report having trouble sleeping, as compared to one year prior, and there were no differences in reports of being bothered by things.

Figure 1. Percentages of youth who reported sometimes or rarely sleeping well in the past week, by sex.



Violence and exploitation experiences among youth remain stable

None of the adolescent or community member participants in the qualitative interviews discussed incidents of violence in homes or communities during the COVID-19 pandemic. In quantitative surveys, 9 and 12 percent of the sample reported physical and emotional violence, respectively. When comparing to a year prior (pre-COVID) in multivariate regressions controlling for age and other characteristics, youth were not more likely to report either form of violence.

In qualitative interviews, three participants, all 20-year-old females, reported transactional sexual relationships. Only 4% of females (n=15) in the quantitative surveys reported having started a sexual relationship with someone in the past 12 months in order to get things that they needed, such as money or gifts. In multivariate regressions, females were found to be at decreased risk of transactional sex as compared to one year prior.

Reproductive health services, pregnancy, and marriage
While re-enrollment in school was nearly universal among children and youth who were enrolled before the pandemic, participants noted that there were some children and youth in the community who did not return to school. Three respondents—two community members and one adolescent—discussed pregnancies among schoolgirls during school closures. There were no reported marriages of children and youth under 18 in the qualitative sample households.

In interviews with health service providers in the study areas, 30 percent of facilities reported attending fewer patients for regular services (including family planning) in the period since March 2020, for reasons related to having fewer staff, funding or supplies, or due to an increased caseload of COVID-19 patients. This may have created additional barriers for adolescents to access family planning services to prevent unintended pregnancy.

II. TAKEAWAYS

This study examined impacts of COVID-19 on youth well-being, including mental health, violence, exploitation, and general vulnerability. The pandemic does not seem to have exacerbated violence and exploitation risks among adolescents surveyed, despite reports and warnings to the contrary in other settings (Peterman et al. 2020). Moreover, transactional sex does not appear to have increased among females, despite increases in economic insecurity, a risk factor. The qualitative findings around pregnancies occurring during school closures are supported by evidence from the Ebola epidemic in West Africa from 2014-2016 (Menéndez et al. 2015; Sochas et al. 2017). The most salient impacts reported in the study overall were those related to increased economic insecurity, which may have future negative implications for health. Exacerbating the negative economic impacts of this pandemic are the fact that adolescents interviewed come from poor households participating in a national anti-poverty program, the Productive Social Safety Net (PSSN), which experienced significant payment delays of cash transfers in 2019 and 2020. These delays contributed to decreases in households' income. Qualitative findings indicate increased stress and anxiety as a result of the decreased economic security created by the pandemic; however, these findings were not confirmed in quantitative analyses, possibly due to more limited measures available.

Some limitations of these analyses of youths' vulnerability are that, due to the mobile nature of the surveys, we asked a limited set of questions, as compared to what is generally asked in face-to-face settings. Thus, we included selected items from various scales and could not implement the full scales. In addition, some adverse outcomes such as violence and transactional sex may be underreported due to the sensitive nature of the topics. Another limitation is that these findings are not generalizable to all youth in Tanzania. The sample is primarily rural and drawn from households participating in a national social protection program. Thus, they are among the poorest and most vulnerable households in Tanzania.

In order to mitigate adverse impacts of the COVID-19 pandemic on vulnerable youth, government, development partners, and civil society can advocate and implement the following measures:

1. Social protection: Within the Productive Social Safety Net II, ensure regular payments are made on time and consider waiving conditions around schooling requirements for an extended period of time to ensure households receive maximum payments to alleviate economic pressures.

2. Health services: Ensure adolescent-friendly access to health services, including sexual and reproductive health services, continue to be available and implement practices which reduce barriers for adolescents.

3. Mental health interventions: Increase community-based mental health programming. In this setting with limited capacity in terms of professionally trained psychologists, psychiatrists, clinical social workers, and other mental health professionals, community-based interventions are a promising strategy.

4. Other economic strengthening: Given that much of the anxiety and stress reported here was driven by economic security, other interventions which can improve economic security and increase household resiliency to future shocks can be protective against adverse outcomes among adolescents.

III. METHODS

This study takes place in Southern Tanzania, in Mbeya located in the South West Highlands and Iringa located in the Southern Highlands zone. Both regions produce cash crops for export, including coffee, tea, and spices. The main sector of employment is agriculture, and the population in these regions face high rates of child stunting, high fertility, and high rates of HIV/AIDS. Data used in this study come from a longitudinal study, which sampled adolescents between the ages of 14 and 19 years (in 2017) living in households participating in the Government's flagship social protection program, the Productive Social Safety Net (PSSN) (UNICEF Office of Research 2020). Study districts and councils include Mufindi and Mafinga in the Iringa region and Rungwe and Busokelo in the Mbeya region. The study areas (130 villages total) are generally remote, rural villages. For this COVID-19 study, four distinct groups were sampled: adolescents, household heads, community leaders, and health facility staff. The eligibility criteria for adolescents/youth were: being a participant of the existing longitudinal study; and a) being aged 18 years or older; or b) being married and aged 18 years or less. A total of 760 structured interviews were completed. Among the eligible sample, we purposively selected 46 youth to additionally interview in depth with semi-structured interviews. In addition to data collection among youth, we interviewed a sub-sample of 542 household heads in households where the adolescents live and staff in 83 government-run, primary health care facilities in the study area via mobile phone and asked them four short questions. We also conducted qualitative interviews with 16 randomly selected community leaders. Data collection occurred via mobile phone in September and October 2020. All interviews were conducted in

Swahili. Topics covered in the interviews ranged from COVID-19 knowledge prevention; illness and health services utilization; food and water insecurity; time use, including economic activities and chores; mental health; violence; and exploitation. Additional data were collected via SMS with households and youth during the following dates: Round 1: 17 - 30 November; Round 2: 1 - 8 December 2020; Round 3: 15 - 22 December 2020; Round 4: 13 - 20 January 2021. More information on coding and analyses of data can be found in the full report cited at the end of this brief.

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FOOTNOTES

[i] The National Policy of Youth Development (2007) in Tanzania defines youth as 15-35 years.

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