Sexual reproductive health capabilities: girls' voices heard

A study on the influence of economic, social and cultural factors on girl's experiences of sexual reproductive health and education in Magu, Tanzania.

Source: author

Lorraine Catherine Spruijt

Utrecht, November 2014

International Development Studies
Faculty of Geosciences
Utrecht University

Student no: 4002865
Supervisor: Dr. W.H.M. Leung
Host organisation: SNV Tanzania

SNV

Utrecht University

Abstract

Worldwide, sexual reproductive health issues are topic of interest in the field of international development. Sexual reproductive health is an important part of general health and a central aspect of overall human development. Especially during adolescence and adulthood sexual reproductive health issues prevail and are of special importance for women particularly during their reproductive years. Failure to properly cope with sexual reproductive health problems at any stage in life might cause health and developmental problems later in life. The highest attainable level of sexual reproductive health is not only a human right, but also a prerequisite for social and economic development as humans are the driving forces of development. Sexual reproductive health is not solely based on absence of diseases or infirmity, but also deals with reproductive processes at all stages of life and must be understood in the context of relationships too. Involvement and empowerment of young women in the development and implementation of programs and services is needed. Thus far focus has been on the quantity rather than quality i.e. availability of goods rather than capability and opportunity to make well informed decisions. Little account of the social and cultural realities that young women encounter regarding their reproductive lives and decision making is taken.

Different actors from public and private sector and civil society examine on local, district, national and international level whether any interventions in this area are needed to improve the situation for girls and women worldwide. This qualitative study is focused on the sexual reproductive health status and education of adolescent girls in Tanzania and how this is influenced by economic, social and cultural factors. Through questionnaires and in-depth interviews with adolescent girls (whether enrolled in school or dropped out), parents, teachers and health care professionals the situation for adolescent girls in Magu, Tanzania is well identified. The results of this study show that there's much room for improvement. Girls are not capable of managing their sexual reproductive health properly and with dignity. Girls do not have sufficient knowledge on the topic, information is scarcely provided, and issues related to the topic are often not discussed but kept silent. Beliefs and practices are often in line with socio-cultural and religious norms and values that are often based on conventional wisdom and old customs as taught by parents, teachers, religious leaders etc. The topic doesn't receive

much attention within the school curriculum and education is often based on morality and risk reduction. Economic factors like accessibility and affordability of goods and services unable girls to maintain their sexual reproductive health and hygiene and lack of facilities at schools often influence the school performance and attendance of girls.

Key words: Sexual Reproductive Health (SRH), adolescent girls, education, economic, social and cultural influences

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List of abbreviations

HDI	Human Development Index
MHM	Menstrual Hygiene Management
MDG	Millennium Development Goals
ODA	Overseas Development Assistance
SNV	Netherlands Development Organisation
SRE	Sex and Relationship Education
SRH	Sexual Reproductive Health
UNDP	United Nations Development Programme
WHO	World Health Organisation
UN	United Nations

1. Introduction

1.1 Publicity on girls' development in Tanzania

The local newspapers in Tanzania seem to pay much attention to the development of girls within the country. On a weekly base articles are published related to girls' development issues, varying from very positive articles about girls outdoing boys with exam results to very negative articles about high levels of unwanted and unplanned pregnancies among schoolgirls. The negative articles however seem to prevail. Recently an article in The Guardian of Tanzania was published about a girl enrolled in secondary school, who lived with her grandparents and was dating a boy from her school. She didn't got her monthly period and worried if she was pregnant, but after other girls of her age told her it was normal here worries were smothered. But after her second period stayed away, she knew she was pregnant but didn't shared this with anyone as she believed a miracle would happen and she could get rid of her baby. This of course didn't happen and the boy that got her pregnant didn't took his responsibilities. The girl immediately got expelled from school as the school regulations do not tolerate love affairs and within her family the girl was considered to be a shame. The boy however got away with it. A perfect example of sexual reproductive health related challenges for girls in Tanzania. This is only one example, but many more exist unfortunately.

In Tanzania adolescent girls provide large part of the high rates on early pregnancies, sexual diseases and school dropout, which obviously has negative effects on their overall development. Better understanding on the underlying causes of this is needed in order to develop an intervention that meets the needs of these girls in order to improve their future situation.

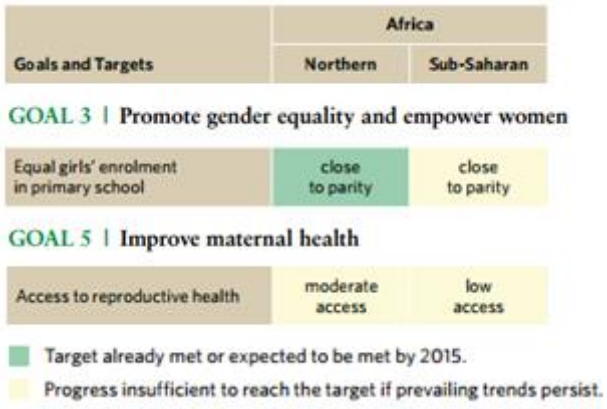
1.2 Girls' development: a global issue

Adolescents comprise nearly half of the world population and in many countries even the largest proportion of society. Adolescents have shown to be particularly vulnerable to ill health and especially girls are vulnerable due to biological factors and gender issues. During adolescence, a critical juncture in life, girls are highly vulnerable and at increased risk. When girls pass through adolescence there are a number of factors that influence whether a girl will develop the knowledge, skills, attitudes and behaviour in life that will set her on a path to healthy sexual reproductive adulthood. Due to

inequalities in opportunity, justice, and dignity a girls' potential is often irrecoverably lost or stolen during adolescence (World Bank, 2014).

Empowerment of women is essential to the health of a whole nation and its social and economic development, inequalities that deprive the rights and opportunities of women have a clear influence on other population dynamics too. Over the last few years there has been an increased recognition of the importance of sexual health of adolescent girls among policymakers, but the implementation of effective interventions shows to be a challenge (Matasha et al, 1998). The importance of this is also recognised on a global scale and different development policies have been developed to improve the situation for women around the world as it is believed that girls need to be safe seen and celebrated. The Millennium Development Goals (MDG's) are gathered and adopted during the United Nations (UN) Millennium Summit in 2000. The MDG's address extreme poverty in its many dimensions- income, disease, hunger, shelter and exclusion- while promoting education, gender equality and environmental sustainability, with quantitative targets set for the year 2015. The MDG's are also basic human rights, the rights of each person on the planet to health, education, shelter and security as pledged in the Universal Declaration of Human Rights and the UN Millennium Declaration (Sachs & McArthur, 2005). The MDG's underscore the importance of women to international development efforts. Millennium Development Goal 3 is developed to promote gender equality and empowerment of women. The target is to eliminate disparities between men and women in education and employment (UN, 2008). According to the latest facts and figures provided by the UN, there's almost equal enrolment of boys and girls in primary education in Sub-Saharan Africa, but the progress is insufficient to reach the target if the prevailing trends persist. For secondary education enrolment the gender disparities are larger (UN, 2014). Development Goal 5 is developed to improve maternal health. One of the main targets is to achieve universal access to reproductive health (UN, 2008). According to the latest facts and figures provided by the UN, there's still low access to reproductive health in Sub-Saharan Africa and again the progress is insufficient to reach the target if the prevailing trends persist (UN, 2014). So despite all the good intentions, the universal attempt is far from reaching its goals and this is especially the case in Sub Saharan countries, see figure 1.1.

Figure 1.1 Progress Millennium Development Goals 3 & 5



Source: UN, 2014

1.3 Silence, stigma and taboo

Among many different ethnicities, culturally based rituals are important for passing down guidance on reproductive health, menstrual management and sexual behaviour (Sommer, 2010). The guidance taught during these rituals however is often based on misconceptions and conventional wisdom and do not positively contribute to the health of adolescent girls. Restrictions imposed by social, cultural or religious beliefs often cause that girls do not have the freedom to live their lives with dignity. Besides these existing rituals, silence, stigma, and taboo related to sexual reproductive health cause challenges for young girls. Due to stigma and taboo, becoming is women is not something to be celebrated as it is often related with reputation, risks, dangers and impurity which cause feelings of fear, shame, disgust and lack of confidence. Because thing cannot openly be discussed girls wonder around with millions of questions and lack of knowledge make them unable to make healthy decisions in life. Recently the government of The Netherlands and Denmark have pulled their strengths together to address this issue. They put sexual taboos on the development agenda. The government in cooperation with the private sector are mobilizing funds to support local development organisations in addressing sensitive sexual topics in an innovative way. The Dutch Minister for Foreign Trade and Development Cooperation Lilianne Ploumen, said that in many countries around the world the ability to make healthy decisions about one's own body and access to good quality sexual reproductive health care cannot be taken for granted, because these topics are often considered a taboo. According to Ploumen, Western states are only in the position to emphasise the importance of these

issues, but that organisations within the developing countries need to try and initiate dialogue as the real change must come from within the countries themselves (Dutch Government, 2014).

1.4 Girls' voices heard

Programs focused on empowerment of young women do not receive as much attention and financial support as needed compared to other development interventions because according to the World Bank, effectiveness of these programs is often lacking. Promotion of the need for programs to improve things like health and education for young women and girls is thus highly needed (World Bank, 2014). Challenges for adolescent girls have been acknowledged and lots of organisations express their concern about the issues related to sexual reproductive health. Too little empirical data exists that captures girls' experiences and challenges. This is however of critical importance to address the challenge to meet the needs of the girls in the best suitable manner. A deeper understanding of girls' daily struggles and rationale behind beliefs and behaviour is essential to develop effective interventions. Therefore we need to start from the bottom and listen to the stories of young local girls.

1.5 Aim of this study

As mentioned before do many girls in developing countries experience challenges when it comes to the development or maintenance of their sexual reproductive health. Multiple economic, social, cultural, and religious factors influence the sexual reproductive health related beliefs and practices of adolescent girls. The aim of this research is to describe how adolescent girls in Tanzania currently deal with their sexual reproductive health. The main research question of this study therefore is:

"How do adolescent girls in Tanzania deal with their sexual reproductive health?"

With the results of this study we aim to gain understanding on the lived experiences of adolescent girls in Magu, Tanzania on their ability to manage their sexual reproductive health and how this is influenced by the economic, social and cultural context according to them and other relevant actors, and how this might be useful for the development of tailor made interventions in this particular area and on a larger scale if relevant.

2. Theoretical framework

2.1 Introduction

This is definitely not the first study that aims to understand and explain the practices and beliefs regarding sexual reproductive health among adolescent (school) girls in developing countries. This study is however not less important as there is still much unknown regarding this issue. The topic relates to many different fields of study, because it touches many different issues like gender, health and education. A wide range of literature on the different topics already exists and this literature was very helpful to get insight on how things have evolved over the years. The different models provided in the literature were very useful to analyse the situation in a suitable manner. Although the different models are somewhat outdated, they are still very useful and they are subject to change within new research. Because things evolve and change over time, experts in the field from varying studies all ask for more research on the topic to obtain more knowledge and get a better understanding of current issues. New insights and developments are needed to get a wider and more in depth understanding on topic. As this study touches different topics, the theoretical framework will be based on the different related theories and associated models. Analysing sexual reproductive health related attitudes and behaviour is very complex. Many different factors have a high influence on the development of these beliefs and practices and it is highly context specific. During this research many models have passed by, within this chapter the most relevant ones that offered useful insights to study this subject will be discussed.

2.2 Sexual Reproductive Health (SRH)

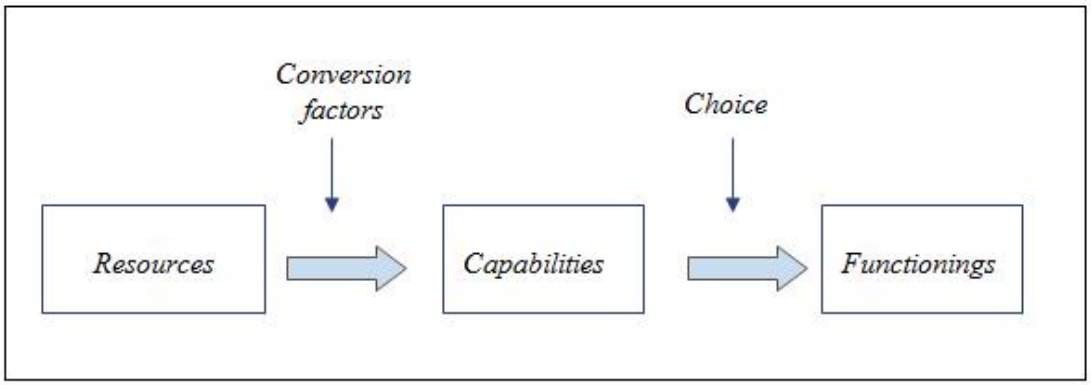
There is no single definition of sexual reproductive health but within the literature, sexual reproductive health is described by the mixture of “sexual health” and “reproductive health”. Sexual health recently has been defined as a state of physical, emotional, mental and social well-being related to sexuality: (1) absence of disease, dysfunction or infirmity; (2) a positive and respectful approach to sexuality and sexual relationships; (3) the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence; and (4) respect for the sexual rights of all persons. Reproductive health therefore implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Men and women have the

rights to be informed, have access to safe, effective, affordable and acceptable methods of family planning and health care services of their choice, as well as other methods of their choice for regulation of fertility which are not against the law. Sexual reproductive health is a construct that thus goes beyond the absence of sexual diseases and also includes psychological and social well-being (WHO, 2002).

2.3 Capabilities and freedom ; a closer look

As mentioned above is sexual reproductive health related to capabilities and freedom. These are also important concepts within the capabilities approach as developed by Amartya Sen. In the mid-eighties, Amartya Sen developed the capabilities approach which became a dominant paradigm in the field of human development. It became even the foundation of development measurements like the Human Development Index (HDI) developed by the United Nations (UN). The capabilities approach included factors that were thus far never included in development approaches. Within this approach development is not measured solely on measurements like consumption, education or health but development is seen as an expansion of capabilities (Alkire, 2002). The capabilities approach roughly consists of four main characterises. First, people should enjoy the same real freedoms regardless of their official formal rights. Social arrangements should thus be evaluated according to the extent an individual or group has the freedom to achieve valuable functionings in life. Second, it looks beyond subjective satisfaction and recognizes that preferences are context specific and are somewhat adaptive. Third, it recognizes that preferences are not general and differ from person to person and the emphasis is on identifying freedoms people value. Last, it is concerned with an individuals' capability to turn resources into actual functionings and thus not only focuses on the availability of or access to resources like other development approaches (Gasper, 2007). The capability refers to a person's ability to do valuable acts or reach valuable states of being. According to Sen does a life without poverty requires more than simply the goods and services a society provides. For him a life without poverty means that an individual can lead a life without shame, is able to visit and entertain one's friends and to keep track of what is going on and what others are talking about (Sen, 1985). The analytical framework of the capability approach is shown in figure 2.1 and is based on three concepts: resources, capabilities and functionings.

Figure 2.1 Analytical framework Capability Approach



Source: Verd & Andreu, 2011

A resource can be defined as a stock or supply of money, materials, staff and other assets that can be drawn on by a person or organisation in order to function effectively. Capabilities represent the alternative combinations of things a person is able to do or be. Functionings are a set of ways of being and doing that an individual puts into practice. The distinction between a capability and a functioning is the same as the difference between what is possible and what is actually carried out (Verd & Andreu, 2011). The conversion of commodities into functionings is influenced by conversion factors and someone's choice. The conversion thus depends on personal, social and environmental factors. The conversion factors are of great importance as they might constrain the capability of an individual to achieve certain functionings. Sen didn't provided an infinite list of capabilities because the approach can be applied very broad, from having the capability to drink clean water to the capability of visiting your best friend (Alkire, 2008). All capabilities together correspond to the overall freedom to lead the life that a person regards valuable or important (Robeyns, 2011). The approach of Nussbaum is in line with the capability approach of Sen, she advocates that an individual should be a free and dignified human being. She concentrates mostly on women within society, therefore her approach is very useful for this study. Nussbaum developed a list of central human capabilities (table 2.1).

Table 2.1 Nussbaum, central human functional capabilities.

1. *Life*. Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so reduced as to be not worth living.

2. *Bodily health*. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.

3. *Bodily integrity*. Being able to move freely from place to place; having one's bodily boundaries treated as sovereign, i.e. being able to be secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.

4. *Senses, imagination, thought*. Being able to use the senses, to imagine, think, and reason—and to do these things in a ''truly human'' way, a way informed and cultivated by an adequate education, including, but by no means limited to, literacy and basic mathematical and scientific training. Being able to use imagination and thought in connection with experiencing and producing self-expressive works and events of one's own choice, religious, literary, musical, and so forth. Being able to use one's mind in ways protected by guarantees of freedom of expression with respect to both political and artistic speech, and freedom of religious exercise. Being able to search for the ultimate meaning of life in one's own way. Being able to have pleasurable experiences, and to avoid non-necessary pain.

5. *Emotions*. Being able to have attachments to things and persons outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love, to grieve, to experience longing, gratitude, and justified anger. Not having one's emotional development blighted by overwhelming fear and anxiety, or by traumatic events of abuse or neglect. (Supporting this capability means supporting forms of human association that can be shown to be crucial in their development.)

6. *Practical reason*. Being able to form a conception of the good and to engage in critical reflection about the planning of one's own life. (This entails protection for the liberty of conscience.)

7. *Affiliation*.

A. Being able to live for and towards others, to recognize and show concern for other human beings, to engage in various forms of social interaction; to be able to imagine the situation of another and to have compassion for that situation; to have the capability for both justice and friendship. (Protecting this capability means protecting institutions that constitute and nourish such forms of affiliation, and also protecting the freedoms of assembly and political speech.)

B. Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails, at a minimum, protections against discrimination on the basis of race, sex, religion, caste, ethnicity, or national origin.

8. *Other Species*. Being able to live with concern for and in relation to animals, plants, and the world of nature.

9. *Play*. Being able to laugh, to play, to enjoy recreational activities.

10. *Control over one's Environment*.

A. *Political*. Being able to participate effectively in political choices that govern one's life; having the right of political participation, protections of free speech and association.

B. *Material*. Being able to hold property (both land and movable goods), not just formally but in terms of real opportunity; and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others; having the freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into mutual relationships of mutual recognition with other workers.

Source: Nussbaum, 2000

Among the list of central human capabilities are different capabilities that are useful for this study. For example, being able to have a good reproductive health, opportunity for sexual satisfaction, choice for matters of reproduction, being able to produce self-expression of one's own choice, religion etc. and to engage in various forms of social interaction. Nussbaum also developed the capabilities threshold, below this level truly human functioning is not possible for an individual. According to Nussbaum are women in developing countries often the ones who suffer from capability failures. In many parts of the world, women lack support for the fundamental functionings of a human life. Women are often less nourished and healthy, more vulnerable to physical violence and abuse, less likely to be literate and in some country they're not even equally treated under law. Even where laws do not discriminate, tradition and culture often do so. In developing countries girls tend to receive less food and health care and are the first to be withdrawn from school when resources are scarce. This hinders them to fully develop themselves (Moller Okin, 2003). Overall do women have fewer opportunities to live the life they want and this negatively influences a woman's overall well-being. All too often women are seen as supporters to the end of others (caregivers, agents of family's general prosperity) instead of being seen as ends in their own right, a person with dignity that deserves respect (Nussbaum, 2000). As this study is about capabilities regarding sexual reproductive health, we take a closer look at the health capability approach. The health capability approach is used to understand the conditions that facilitate heath and the ability to make healthy choices in life. The theory consists of health functioning and health agency. Health functioning is the outcome of an action to maintain or improve health and health agency is seen as a person's ability to achieve health related goals that they value, both physically and mentally (Prah Ruger, 2010). As formerly mentioned, health capability includes more than just provided resources, it includes an expansion of capabilities like knowledge and skills, social and cultural norms and relations and values and the ability to make your own choices. The capability approach distinguishes between what an individual is capable of doing in an optimal environment and capable of doing in its current environment. It acknowledges that internal factors and external factors enhance or inhibit the health capability of an individual. Internal factors are acquiring needed knowledge, skills and beliefs, being able to convert this into reasonable decision making and the motivation to achieve positive health outcomes. External contextual factors are access and affordability of goods and

services, economic circumstances, social norms, cultural values, group influences and the extent to which an environment is created to maintain or improve an individual's health. In short it is a set of conditions that enable optimal health (Prah Ruger, 2010).

2.4 Gender and its different levels of influence on SRH

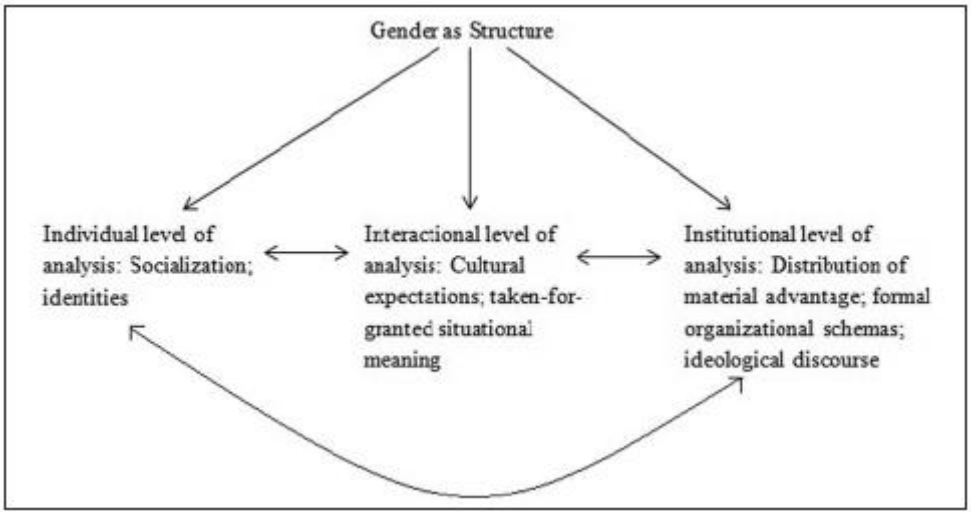
The capabilities approach as developed by Sen and Nussbaum, emphasizes that the capability of an individual can be inhibited or enhanced by internal and external factors. One very important issue that is subject to both internal and external factors, is gender. More in depth theories on how sexual reproductive health is shaped by gender on different levels will be discussed below.

Issues related to human sexuality have received much of attention over the last decades. Different theories which try to explain attitudes and behaviour have passed. The development of these theories however are not in line with the rapid changes of social life that have evolved and that highly influence this development process (Simon & Gagnon, 1986). Sexual behaviour is not just an individual decision making process, this behaviour is influenced by socially constructed relations and institutions. The social network, religious background and political environment that are on their turn influenced by larger socio-economic and political processes, shape an individual's behaviour (Price & Hawkins, 2007). If sexual reproductive health is placed within the broader social context, men often dominate women. Power disparities between men and women are common in many cultures, and are often based on traditional ideologies. Simon and Gagnon developed the social scripting theory which is a metaphor for the understanding of human sexual encounters and social and learned encounters. The theory consists of three levels: the cultural, social and personal level. The script can be seen as an agent that prescribes what is considered standard within a culture or society and so directs the sexual behaviour of people. The script will be passed on by members in society that already adopted the script. The way society is built also determines how the script is designed. On the personal level the sexual script provides a sense of hold on how people should feel and what they can expect (Wiederman, 2005). The theory of sexual scripting evaluates the influence of sociology, culture, anthropology, history and social psychology on human sexuality (Berntson et al, 2014). Within sexual reproductive health men and women are believed to be most different. Sexual scripts are therefore often gender based and the scripts of men and women are meant to be complementary. Sexual scripts set out appropriate behaviour for men and women. Traditional sexual

scripts for girls are however often based on behavioural restraint and control. Girls genitals are taught as dirty aspects that require hygiene and women can get pregnant. This makes that girls often receive more information on sexuality and especially about its risks and dangers. It is highly related to her reputation and therefore women often have different meanings and motives to sexual activity. Women are expected not to engage in sexual activities while not having a relationship, while men can seize every opportunity to have sex. This believe produces gender inequality in the field of sexuality and often causes sexual dilemma's for women (Hamilton & Armstrong, 2009). Sexual behaviour in line with traditional sexual scripts might cause decreased sexual health empowerment and this lower sexual autonomy causes higher risks for pregnancies and sexual transmitted diseases (Grose et al, 2014). While for boys sexuality is dealt with in terms of powerful joy, sexuality for girls is often dealt with in terms of future reproduction and conveyed as negative and disgusting. This distortion damages a girls' sense of oneself (Farrelly, 2007).

Gender is something which is embedded in all social processes and organisations in everyday life. Risman has developed a theory about gender as a social structure. The analytical framework is shown in figure 2.2.

Figure 2.2 Gender as structure



Source: Risman & Davis, 2013

This theory is in line with the sexual scripting theory. According to this theory is gender inequality produced, maintained and reproduced at the individual, interactional and institutional level. At the individual level this happens for women through

internalization of the female identity. At the interactional level this happens through stereotyping women, which includes cultural believe that shape what is expected. At the institutional level different organizational processes, again often with cultural reasoning, cause gender inequality (Risman, 2004). This theory is very useful for this study as we aim to evaluate how on different levels the sexual reproductive health of girls is influenced. This sex role socialisation theory provides the insights that endemic socialisation creates the illusion that gender is naturally occurring. Gender is not something we are but something we morally do. An individuals' sex is based on societally defined biological differences. The sex related behaviour however is enforced and constraint during social interaction, gender appropriate related behaviour is often rewarded and encouraged. Organisational structures as well provide unequal opportunities and are the core problem to gender inequality and not the different gender related behaviour. So if men and women would receive the same opportunities, gender inequalities could be solved (Risman & Davis, 2013). The environment in which young people are making decision related to sexual reproductive health is rapidly evolving, today's adolescents and especially girls grow up in circumstances very different from those of their parents (Hindin & Fatusi, 2009). It is already mentioned that adolescents and especially adolescent girls within the population are particularly vulnerable for sexual reproductive health problems. Their sexual reproductive health is at increased risk due to socio-economic, political and cultural factors. Inequalities in age, gender, socio-economic opportunities and sexuality increases this vulnerability even more (Price & Hawkins, 2007). Sexual reproductive behaviour is socially negotiated, heavily affect laden, motivated by individual arousal and subject to moral and sociocultural standards that vary across religion, age and gender (Schaalma et al, 2004). Although socio-economic, cultural and political factors shape behaviour regarding gender and sexuality, it is not said that these prescribed norms and values create attitudes and behaviour within every individual that are in line with these expectations. On a small scale people hand new ideas, knowledge and practices but cultural traditions create an obstacle for behaviour change. The conventional wisdom that prevails in combination with a lack of knowledge make it hard to change people's mind-set (Price & Hawkins, 2007). In one of her articles Risman argues that young people and especially girls nowadays are more free to believe and act the way they want compared to back in the days when traditional femininity was leading (Risman, 2009). But to what extent this

also counts for girls in developing countries is questionable as traditional beliefs regarding women do still prevail there often. Sexual empowerment is a process that requires intrapersonal and interactional components. Knowledge, skills and attitudes can be seen as a part of the intrapersonal component and social and cultural beliefs can be seen as interactional components. The dynamic between the intrapersonal and interactional component, or in other words between the individuals and community increase the opportunities to control life affecting decisions (Grose et al, 2014).

2.5 Education as a key to development

As mentioned earlier on in this chapter do men and women have the rights to be well informed about sexual reproductive health. Knowledge is seen as a key to development and therefore education is highly important. Given the changes in sexual reproductive health behaviour among adolescent girls, it is important that they receive good quality education and information from reliable sources. As the current generation of adolescents will determine what the social fabric, economic activity, reproductive health and wellbeing around the world will look like in the next coming decades, it is very useful to invest in this generation. The communication needs to be adapted as these issues are highly sensitive especially among cultures in developing countries. Today's parents do not possess the sufficient knowledge regarding sexual reproductive health and are thus unable to pass this crucial knowledge on to their children. Parent child communication about these topics is therefore incredibly difficult (Hindin & Fatusi, 2009). In this study we also aim to evaluate the level of communication between parents and daughters and possible challenges that occur. In many developing countries sexual reproductive health issues are stigmatized and a taboo, this is expected to highly influence the information delivery from health care providers and also how teachers approach the topic during class. Health care policies about the provision of services and goods to adolescents may not be in line with personal cultural beliefs of service providers. Teachers' moral views on about adolescent sexuality make it difficult for them to teach sexual reproductive health related knowledge and skills (Schaalma et al, 2004). In countries where sexual reproductive health issues are stigmatised and a taboo, teachers might see sexual activity as distracting, causing bad school performances and dropout. School programmes that offer education on sexual reproductive health, often do not address social factors like gender roles and sexual scripts that are linked to negative sexual health outcomes, especially for girls (Grose et al, 2014). The school

system in developing countries is also often not set to properly support girls with their special needs related to sexual reproductive health, especially in case of pregnancies. The level of support at schools will also be investigated in this study. Both cause a negative effect on the adolescent girls educational attainment and thus their overall development. The level of support at schools will also be investigated in this study. Content and methods of education o sexual reproductive health vary across time and between cultures depending on sexual taboos, religious beliefs and social and cultural attitudes towards sexuality (Schaalma et al, 2004). In the literature three different perspectives on sexual reproductive health education prevail: the cultural preservative approach, risk minimization approach and the approach that sexual expression should enable individual emancipation (Farrelly et al, 2007). The cultural preservative or traditionalist approach treats sexual health as a moralist issue, abstinence before marriage is the overarching goal. This traditional discourse produces a conservative understanding of sexuality (Farrelly et al, 2007). In many African countries where religion is a very important aspect in life, abstinence is indeed major part of education and is heavily promoted. The traditional approach is often used among parents, teachers who have a significant influence on the development of adolescents. Even some aid organisations and religious institutions highly rely on these beliefs (Schaalma et al, 2004). The functionalist approach focusses on the reproductive mechanisms of sexual health. It focuses on safe sex practices and methods to alleviate the risks of pregnancies and Sexual Transmitted Diseases (STD). Sexual reproductive health education is often seen as a risk reduction strategy. In many African developing countries where high levels of (unwanted) pregnancies and sexual diseases exist, this approach is applied within sexual reproductive health education. Among development organisations too, practical knowledge on condom use and other types of safe sex practices are paramount within interventions (Farrelly et al, 2007). The last approach is very recent and increasingly accepted but not universally so, thus far it mostly prevails in modern developed countries. The Sex and Relationship (SRE) approach is a more holistic approach that starts from the assumption that sex is a positive thing. Information and critical thinking is linked with empowerment, choice and acceptance of sexual diversity. Sexual health is conceptualized as more than solely abstinence of pregnancies and STD's. The approach has developed out of critique against the other two more conservative approaches on sexuality (Ferguson et al, 2008). Each of the discourses assumes that

particular practices, based on appropriate knowledge or absence of knowledge will secure desirable individual and cultural experiences, feelings and behaviour. Each discourse implies a particular view of the process of emergence of an appropriate set of attitudes and behaviours in relation to sexual expression and identity (Farrelly et al, 2007). Within this study we also want to find which educational approach is used at secondary schools in Tanzania. Social, political and historical issues should be integrated in sexual education. Sexual education has the potential to be transformative, because cultural ideologies change over time and can be challenged by youth. This change is needed to empower adolescents in their sexual reproductive health. School is an institution where adolescents face social and cultural norms on a daily base, so they could play an essential role in empowering youth to make well informed decisions about their sexual reproductive health (Grose et al, 2014) .

2.6 Millennium Development Goals

In the introduction the Millennium Development Goals and its relation to human rights were mentioned. Also mentioned was the fact that the universal attempt was far from reaching its goals especially in many parts of Africa. Progress in addressing basic human rights like adequate food, shelter, healthcare, clean water and education has been made, but high levels of suffering and deprivation prevail (UN, 2014). But the conception of the MDG's, dissecting 'development' into a few goals that frame development policies and practices is somewhat problematic. Development includes much more than just these eight goals. The MDG's are only part of the action plan to make basic human rights actionable, they provide consensus and benchmarks for action. The MDG's embody a mix of objectives, approaches, end and means, and ambivalence and compromise unfortunately largely prevail in the goals and targets (Khoo, 2005). The achievement of the quantitative targets, might neglect the broader qualitative concerns. Although on the national level the quantitative targets seem to progress, inequalities on local levels seem to increase. Although equality is a crucial issue in development, it is often overlooked in the MDG conception (Khoo, 2005). Also the top-down nature of the global goal setting doesn't seem to be the best way to address certain problems. A fundamental principle of the human rights is that people are free to express their preferences and how they wish to develop. The poorest people who suffer most from deprivation, declined welfare and increased inequalities should be central and not the Western moral ideology on how development should happen(Khoo, 2005). Within this particular study, we also aim to

approach the topic from the point of view of schoolgirls, they are central. Focus will not just be on quantitative goals like levels of school enrolment, but on the qualitative concerns of girls' development.

2.7 Previous research in Tanzania

As already mentioned before, this is not the first study that aims to understand and explain sexual reproductive health related practices and beliefs among adolescents in developing countries. Much literature already exists and it is useful to take outcomes of earlier research into account. Continuation or changes in certain patterns might be revealed if existing literature is compared with outcomes of this current study.

In the study of Sommer, attention has been paid to the factors that influence the transitional period of a girl moving from girlhood into young womanhood. The experiences of every life among pubescent girls in Tanzania is captured because it is likely that this transition has influence on for example school performances and sexual diseases. The social context of girl's lives in Sub Saharan Africa often introduces challenges for young girls school performances due to changes occurring during puberty (Sommer, 2009). More and more literature exists on the sexual and social dynamics of adolescents in developing countries under the influence of globalisation and modernisation. If traditional practices are fading due information girls receive through school and modern media, it is important to understand how girls perceive and experience these pubertal changes (Sommer, 2009). The results of this study show that girls don't know where to seek for advice on sexual health issues due to the shift from traditional guidance to formal schooling. Also girls report that they keep menstrual issues for example hidden as they fear to be accused for premarital sexual activities. Girls believe that sexuality is inappropriate to talk about at their age and simply adhered to silencing of the issue (Sommer, 2009). Knowledge about important aspects of sexual reproductive health among girls seems to be lacking, according to the number and nature of questions girls had within this study. Also girls report their desire for true explanations on sexual health related issues while adults prefer to silence the discussion on the topic. The only information girls receive regarding the negative outcomes of their sexual maturation make that girls experience their transformation from a girl into a woman mostly as frightening (Sommer, 2009).

In the study of Wamoyi & Wight, attention has been paid to the role of the environment of young people's upbringing on their sexual reproductive health. Thus far attention was

mostly paid to individual behaviours but in this study among adolescents in rural areas of Tanzania, research is done on the underlying patterns of social systems which are beyond the control of an individual. The focus in this article was on the mutual influence of parents and their children. Related to economic circumstances, provision of material resources and the amount of time parents spend with their children is highly influential on the sexual reproductive health status of children (Wamoyi & Wight, 2014). Gender is also mentioned as an important structural factor, differential treatment of boys and girls often prevails with boys receiving more affection, attention and educational support than daughters. Fathers also seem to be unable to communicate with their daughters about secretive issues like sexual health as this is gender determined (Wamoyi & Wight, 2014). According to parents social respectability is very important, a moral system of respectability is salient for community members among the different Tanzanian tribes. Respectful behaviour is demonstrated through unquestioning obedience, deference to parents and a correct dress code (i.e. total body covering). Lack of this appropriate behaviour, is seen as a shame for the family (Wamoyi & Wight, 2014). In case children do not obey to the expectations of their parents, like premarital sexual behaviour or unwanted pregnancies this is believed to be a shame for the family. A bit contradictory is the acknowledgement of educational importance. On the one hand parents stimulate their children to go to school and focus on their future but on the other hand parents resent school for undermining cultural traditions. Nowadays children feel more knowledgeable and seem to be more disobedient. Also modern means of communication and state education as a result of globalisation, make that children see their parents as living behind the times and having little to teach them which causes traditional processes of socialization to fade (Wamoyi & Wight, 2014).

Despite numerous efforts to improve the sexual reproductive health, mortality and disease rates remain high. Possible reason behind this is the imperative way in which life skills are taught through moral based education. The results of the study of Oluga et al. show that cultural practices are a key reason for teachers' difficulties in teaching sexual reproductive health. First, the pervasive taboo regarding discussing sexual health between adults and children and second the different cultural beliefs regarding certain menstrual and sexual practices (Oluga et al. 2010). Teachers personal values seem to collide with the school curriculum. Education on sexual reproductive health can only be key to development if it is based on factual knowledge and not influences by personal

ideas from teachers about beliefs and behaviour that are fed by cultural beliefs and traditions (Oluga et al. 2010).

Addressing the sexual reproductive health (SRH) needs of young people remains a challenge for most developing countries (Godia et al. 2013) The study of Godia et al. is focused on youth friendly health services and the experiences of health service providers. Youth friendly SRH services can be defined as accessible, acceptable, equitable and appropriate services that meet the needs of young people. Such services should be provided in a youth friendly environment that motivate young people to return and refer for the use of these services. Adolescent friendly policies, friendly and supportive health care providers and privacy are for example essential (Godia et al. 2014). The results of this study show that sufficient knowledge and skills to provide qualitative services matching with needs of young people is often lacking. Health care providers often use their working experience of parental skills to help adolescents (Godia et al. 2014). Besides this, health care providers report that they face a dilemma between being true to their cultural and religious values and being sensitive to the needs of adolescents. Tension between adolescent sexual reproductive health rights and cultural and traditional values exists. Many health care providers are not willing to provide adolescents with condoms or other contraceptives. Although they are aware of the fact that they should not deny these goods and services to adolescents, their personal values and beliefs often take precedence (Godia et al. 2014).

2.8 Knowledge gap

Thus far most of the attempts from development organisations, policymakers and researchers to investigate and improve the situation for girls were based on practical issues like access and affordability of resources and services that address the physical well-being of people. This is of course of a great importance, but only this is not the solution that covers the whole problem. Much of the research on sexual reproductive health in Tanzania is also solely based on physical well-being of people. This is understandable as adolescent girls in Tanzania account for a large part for the cases of pregnancies and STD's. Lack of social and material resources to support well-informed, empowered choices about sexual reproductive health causes a huge problem and therefore this problem is well addressed. The psychological and social well-being is however less addressed. Relevant literature as provided in the previous sector is scarce, therefore various suggestions for further research exist. Researchers advocate for more

in depth qualitative studies from the perspective of the most vulnerable people to understand the influence of the socio-economic and cultural context on their sexual reproductive health. We need to have eye for societal, religious and cultural factors that highly influence the situation as well. The individual concerned with the problem should be put central within research, as they know best what challenges they experience and what they need to overcome these. For this study the girls are central, but to get a more complete picture we also take the point of view of people in their near surrounding into consideration. In much of the literature focus is on biological factors that influence or determine the (sexual) development of girls. Socio-economic and cultural factors are also believed to be influential but how is often still unknown. This study aims to explain extensively on how sexual reproductive development of girls is influenced by its socio-economic and cultural context. There is some literature on this, but these studies are often focused on women in modern, developed countries. This context is not comparable with these of girls in developing countries, especially when we focus on socio-economic and cultural factors as these differ far more than the biological factors of women.

3. Contextual framework

3.1 Country profile – United Republic of Tanzania

Geographical information - The United Republic of Tanzania, is the largest country of East Africa covering 945.000 square kilometres. Tanzania is situated south of the equator and has frontiers with eight other African countries (NBS, 2012) (Figure 3.1).

Figure 3.1 Map of The United Republic of Tanzania and its eight bordering countries.

Source: Maps of the World, 2014

Among Tanzania's inland waters are Lake Victoria, the world's second largest lake and Rufiji River, Tanzania's largest river. One of Tanzania's most distinctive geological feature is the Great Rift Valle, caused by geological faulting throughout Eastern Africa and is associated with volcanic activities in the north-eastern areas of the country. Most of Tanzania lies 200 metres above sea level and the highest point is mount Kilimanjaro at almost 6000 metres above sea level. Tanzania has a tropical climate and is partly desert. Around Lake Victoria the rainfall is well distributed throughout the year.

Tanzania hosts a large number of National Parks and Game Reserves, with Serengeti being the most famous one (NBS, 2012).

History - Tanzania (before Tanganyika) became independent from England's colonial rulers in 1961 and the year after it became a republic. The offshore island Zanzibar became independent in 1963 and in the following year Tanganyika and Zanzibar joined together as what is today's United Republic of Tanzania (NBS, 2012). Since 1976 Dodoma is the main capital of Tanzania, before it was Dar Es Salaam which is de biggest city of Tanzania. Ever since its independence Tanzania has enjoyed political stability. For administrative purposes, Tanzania mainland is divided into 21 regions. The regions are subdivided into several districts.

Socio-economic information - The Human Development Index (HDI) is a composite index measuring average achievement in three basic dimensions of human development; a long and healthy life, knowledge and standard of living (UNDP, 2014). Tanzania is one of world's poorest countries; in 2013 it ranked 160 out of 185 countries in terms of human development and is classified as a low human development country (UNDP, 2014). Tanzania has a mixed economy of agriculture (60%) and service industry (40%) . Agriculture plays a key role in the Tanzanian economy, with crop growing, fishery and forestry as main activities. Droughts and the global financial crisis however caused a decrease in production and economic activity. The official currency is the Tanzanian Shilling (TZS) and the national language is the Bantu language Kiswahili whilst English is also used (NBS, 2012). Tanzania has more than 120 different ethnic groups, with the Sukuma being the largest ethnic group that represents around 16% of the total population. Although the official language of Tanzania is Kiswahili, all these different ethnicities have their own dialect too.

Population - The population of Tanzania has tripled in the past four decades to around 45 million people in 2012, but the country is still sparsely populated. Population density is very uneven, in some parts of the country the density is very high (Dar Es Salaam and Mwanza are the two biggest cities of the country) and has been increasing over time. Roughly 70% of the Tanzanian population lives in rural areas (NBS, 2013). High fertility rates (especially in rural areas) and decreased mortality rates have caused this massive

population growth rate. Life expectancy has increased over time, but is still significantly low. Distribution of population by sex is almost equal, 51% is female and 49% male. Children and youth comprise largest part of the population, with around 44% of the population being under the age of 15, 20% between 15 and 24 and only 36% over the age of 24 (NBS, 2013).

Health - The health status of the Tanzanian population is worrisome. Roughly estimated does 7% of the Tanzanian people currently live with HIV. Women are slightly more vulnerable than men. This may result in lower life expectancy, higher infant mortality rate, higher death rate, changes in age and sex distribution and lower population growth. In Tanzania especially the health of women and children is threatened by poor nutrition, gender inequalities and illiteracy levels. Access to social services is doesn't reaches everyone as accessibility of services like medicines, for the majority of the population is unaffordable. Lacking financial capacity on a national level causes inadequate resource allocation. Tanzania relies for a large part on external cooperation and almost half of the budget for health services is financed through bilateral or multilateral agencies. This will become a future challenge as this budget will fall in the next couple of years (UN Tanzania, 2010).

Education - School enrolment is improving but cohort completion, passing rates and education quality are still challenging. In general, schools tend to be neither healthy nor safe environments, especially for adolescent girls. School enrolment in primary school seems to be sufficient but a huge drop in secondary school enrolment is visible, especially for girls. Key constraints in the education sector are inadequate and inequitable access to quality education due to inadequate funding, resource allocation disparities across districts and poor management of resources. On a national level financial shortcomings, lack of policy implementation and service provision and poor accountability and result monitoring contribute to stagnation of improvement (UN Tanzania, 2010).

WASH - Poor water, sanitation and hygiene (WASH) that influences both health and education, leads to high levels of disease and loss of life especially among women and children. Besides this it leads to loss of rights and dignity and it hinders development.

Especially in schools and health facilities within communities access to clean water and poor hygiene management prevail (UN Tanzania, 2010).

Governance - Tanzania has a multiparty democratic government system. Since the introduction, good governance is practiced and social stability and assurance of peace are pursued (UN Tanzania, 2010). In 1992 the Tanzanian government implemented the National Population Policy. National and international developments that have taken place since then have direct bearing on the population and development. The policy is revised in 2006 to accommodate these developments. The objectives of the policy are to provide a framework and guidelines for the integration of population variables in the development process. Specific issues are determining priorities in population and development programmes; strengthening preparation and implementation of socioeconomic development planning and coordinating and influencing policies and programmes that ensure sustainable development. Guidelines for gender equality and empowerment of women were also included. The overriding concern of the policy has been to improve the standard quality of life of the population. Main goal of the policy is to direct development policies, strategies and programmes to ensure sustainable development of the people. Specific goals are gender equity, equality, women's empowerment and development for all individuals; eradication of poverty; harmonious relationship between population and environment and increased and improved availability and accessibility of good quality social services (Ministry of planning, economy and empowerment, United Republic of Tanzania, 2006). Tanzania is one of the largest aid recipients, on an annual basis it receives billions of dollars of Overseas Development Assistance (ODA) from development partners, with significant funding from new developing country donors. One third of the national budget is financed by foreign aid (UN Tanzania, 2010).

3.2 Regional / district profile – Mwanza /Magu

Mwanza - Mwanza is one of the 21 regions in the mainland of Tanzania. It is situated in the North near Lake Victoria (figure 3.2). Regional capital Mwanza is the second largest city of the country. The region is covering around 25.000 square kilometres, less than 3% of the total country, and is roughly divided in half water (13.000 km2) and half land (12.000km2) area.

Figure 3.2 Location of Mwanza region / Magu district

Source: Maps of the World, 2014

The population in Mwanza region was around 2.8 million in 2012, roughly 6% of the total population. Roughly 90% of the population here belongs to the Sukuma tribe. Within Mwanza region the economy relies heavily on food and cash crop growing like cassava, sweet potatoes, rice and cotton. Other activities that contribute to the regional economy are mining, transportation, ICT, financial services and constructions. Fishing industry is also highly important with roughly one million people being employed as

fisherman (W. Karumuna, regional economic officer Mwanza, personal communication, May 2014) .

In Mwanza region the HIV infection rate is 7,6 % which is slightly higher than the national rate. Malaria is a bigger threat in this region, roughly 35% of the people suffer from malaria each year. A lot of children in Tanzania grow up in unfavourable conditions, within Mwanza region the number of children of vulnerable children is around 52.000 (D. Fidelius, regional health officer Mwanza, personal communication, May 2014).

Over the years the number of primary and secondary schools in Mwanza region are highly increased. Secondary schools are still scarce however compared to the number of primary schools. The increase in number of schools had negative influence on the quality of education however, due to lack of qualified teachers and lack of facilities (J. Baseki Sheja, regional education officer Mwanza, e-mail correspondence, May 2014).

Magu - Magu was the research area of this study and is one of the districts within Mwanza region. Magu again is also divided in different divisions that comprise multiple villages. Within the villages is a traditional structure, which each village ruled by a chief that cooperates with some elder people. The estimated population in Magu is around 300.000 people, mainly living in the rural areas of the district. The inhabited people belong mainly to the Sukuma tribe (W. Karumuna, regional economic officer Mwanza, personal communication, May 2014). Observation and informal talks with the local people gave a clear picture of the local situation. Self-build small houses provide shelter to large families. The dwellings are widely spread over a great distances. Most families are self-sufficient and economy is mainly based in farming and keeping livestock. Some people try to sell some of their crops like tomatoes and bananas. Electricity and clean running water are often lacking. In town some small shops sell a collection of products varying from bottled water to soap, depending on what is supplied from the big depot in larger cities. Hardly no transport is available within the district, only along the main road to Mwanza there are local busses passing by. People have to walk to cover long distances between home, school, health services etc.

Adolescents aged 15-24 comprise 60% of the population in Magu. According to local statistics is the number of vulnerable children that grow up in unfavourable conditions 5.802. The actual number however might be much higher as a good registration system

is lacking. The HIV infection rate within Magu is dreadfully high in comparison with the national rate, around 9% of the people are infected. Within Magu there's only one hospital, there are four health centres and about 46 dispensaries and most of these are provided by the government. Large part of the population however relays on treatment of traditional healers (D. Fidelius, regional health officer Mwanza, personal communication, May 2014). Magu has around 111 primary schools and only 23 secondary schools, for college and university children in Magu have to move to a larger city like Mwanza. The quality of the education is not desirable, there's a large deficit in number of teachers and also the available facilities are below the needed standard. In Magu around 69.000 children go to primary school in 2014, more than half of them are girls. In comparison with the primary level, only 12.000 children go to secondary school witch is a far less amount. Also there's a shift in the distribution of sex, the number of girls at secondary level is much lower than the number of boys. Besides the dropdown in number of children attending secondary school, there's also a dreadful number of children dropping out from school at secondary level. Around 55% of the children dropped out from school in 2013 (J. Baseki Sheja, regional education officer Mwanza, e-mail correspondence, May 2014).

3.3 SNV (Netherlands Development Organisation)

Netherlands Development Organisation (SNV) is an international non-profit development organisation that aims to improve the livelihoods and prospects of the poor in 39 countries in Africa, Asia and Latin America. With expertise in agriculture, renewable energy and water, sanitation and hygiene (WASH), they try to contribute to solving some of the leading problems that the world faces today. They help to find local solutions to global challenges and sow the seeds for lasting change and sustainability. Advisors have different cultural and technical backgrounds and the majority of them are nationals of the countries in which they operate. They are experts in their field and have in-depth understanding of the local context in which they work. SNV is dedicated to a society in which all people, irrespective or race, class or gender, enjoy the freedom to pursue their own sustainable development (SNV, 2014). SNV Tanzania is the host-organisation through which this research was conducted.

In Tanzania different organisations are active and cooperate to improve the situation for girls. Besides SNV are PLAN International, WaterAid and UNICEF actively involved in Mwanza region. Few years ago these organisations set up some guidelines and a

strategic plan to improve the level of water, sanitation and hygiene at primary and secondary schools in Mwanza. Since 2008 SNV and UNICEF actively cooperate. The results of their joint research so far on sanitation facilities at schools, show that the situation at most of the schools is worrying. There's often no water and no privacy which undermines the dignity of girls and has effect on their attendance and performance. High numbers of girls drop out from school, especially at secondary schools due to this. Girls often stay away from school when having their period due to a lack of facilities, this results in lacking behind and in the end often drop-out because of bad performance. Currently SNV is developing a Menstrual Hygiene Management (MHM) programme that is connected to the WASH programme but is more focussing on menstrual hygiene practices among young girls in Mwanza region. This research also aimed to get a better understanding of the MHM situation among girls living in Magu.

4. Methodology

4.1 Introduction

When doing research it is important to have a well thought plan on what to investigate and how. Without this plan it will be highly difficult to find answers on the research questions when being in the field and the researcher might end up with a whole bunch of data without knowing what it exactly answers and then the whole purpose of the research could be lost. When being in the field doing research however, it might appear that things are encountered that force the researcher to be flexible in his approach. Also, when doing research in a foreign country, ethical considerations and practical barriers that might be encountered have to be taken into account. After setting out the theoretical framework and the contextual framework of this study, the methodology used in this study and the issues that were encountered when doing the actual research in the field will be discussed.

4.2 Operationalization

In this section different indicators will be specified to measure the outcomes of the research questions. These indicators will derive from the different models and theories mentioned in the theoretical framework.

Main research question

"How do adolescent girls in Tanzania deal with their sexual reproductive health?"

The beliefs and practices will be evaluated based on the concepts of the capabilities approach. In line with Sen's capabilities approach the expansion of capabilities and the influence of internal and external factors will be measured. Knowledge, skills, social and cultural values and capability to make healthy choices. It will be evaluated what resources are available for girls to manage their sexual reproductive health, to what extent girls have the possibility to deal with their sexual reproductive health and how they actually deal with sexual reproductive health. Some of the central human capabilities offered by Nussbaum will be used to measure this. It will be evaluated of the girls are able to have a good sexual reproductive health, if they have opportunities and choice related to sexual satisfaction and reproduction and if they have the freedom to make their own choices about social, cultural and religious issues related to sexual reproductive health.

To make the research manageable, we break the somewhat abstract main research question mentioned in the introduction, up in several sub-questions so we can address the related aspects of this study more specifically.

Sub-question 1

"What is the level of knowledge and what are beliefs and practices regarding menstruation and sexuality among adolescent girls in Tanzania?"

Sexual reproductive health is a very broad subject and it includes many different aspects. For this study we focus on the aspects of menstruation and sexuality. The first thing we want to know is what girls know and how they think and behave with regard to these two aspects.

The level of knowledge will be measured by using several statements based on factual knowledge related to menstrual issues and sexual issues as provided by the UNICEF WASH section. Different topics like menstrual pains, contraceptives use, pregnancies and STD's. Beliefs and practices will be measured in a similar way. Several examples of sexual beliefs and practices will be provided to evoke their opinion.

Sub-question 2

"How do socioeconomic and cultural issues influence knowledge, practices and beliefs regarding menstruation and sexuality among adolescent girls in Tanzania?"

It is highly expected that economic, social and cultural factors influence what adolescent girls in Tanzania know, believe and do with regard to menstrual and sexual issues. This question too will be studied with both, the capabilities approach and gender as a social structure theory in mind. Socio-economic and cultural issues are seen as the conversion factors as mentioned in the capabilities approach, constraining of enhancing the ability to convert resources into capabilities. It will be evaluated to what extent cultural and social values at the interactional level shape expectations and to what extent organizational processes based on cultural reasoning influence provision of services. According to the scripting theory, this study will investigate what is socially and culturally expected among communities in Tanzania.

Sub-question 3

"How is sexual education taught and how does this influence knowledge, practices and beliefs among adolescent girls in Tanzania"?

Education is seen as one of the most important factors in order to create knowledge and well informed decision making and behaviour about menstrual and sexual issues. The way in which sexual health education in taught and by whom are also likely to influence how adolescent girls think and act related to these issues. This question will be studied based on the different educational approaches mentioned in the theoretical framework. It will be investigated what type of education in these schools prevails. Personal beliefs of teachers regarding sexual reproductive health will be evaluated to see how they influence their way of teaching adolescent girls. We will also evaluate to what extent personal beliefs of health care providers influence the provision of information. It will also be investigated how sexual reproductive health knowledge is provided through traditional guidance.

Sub-question 4

"How do availability of sexual reproductive related facilities at schools and hospitals influence practices and beliefs among adolescent girls and how does this influence school performance and attendance?"

The last sub-question is thus two folded. It is highly expected that sexual health related knowledge, beliefs and practices could influence school attendance and performance among adolescent girls in Tanzania. It is expected that access to health services and facilities also contributes to this. The school system will be evaluated on its practices of addressing the special needs of adolescent girls and availability of facilities will be observed. This will be evaluated both from the point of view from adolescent girls and teachers. The health services will be evaluated in terms of youth friendly facilities. Youth friendly services include concepts like availability accessibility, affordability, and acceptability as mentioned by Godia et al. in the theoretical framework. This will be evaluated both from the point of view from adolescent girls and health care providers.

4.3 Methods

To get an answer on the main research question and related sub questions a suitable method was chosen that would also be well applicable in the local context. In this study different methods were used to collect data. First, observation to get to know the local situation, cultural practices and local standards and values. Secondly, questionnaires to get a broad overview of the situation within Magu district among school-girls. Lastly, semi-structured interviews to get in-depth information on the situation within Magu district from different point of views. All methods will be discussed more in detail below.

Observation - In the first weeks of this research the situation in Magu district was observed. The relevance of observation is to get a first impression of the research area through watching people and situations, taking notice of casual conversations and divergent opinions of individuals (Van Donge, 2006) . First there were a few visits to the district offices of education and health. They provided us with information on how the district was set up and how the health care system and school system worked. They also provided us with geographical information, socio-economic information and data related to health and education. In the first weeks a few secondary schools in the rural and urban areas of Magu were visited to see what daily life was like at school for adolescent schoolgirls. This observation was also good to already make contact with the headmaster of the school to explain what the aim of the visits was and to ask for their cooperation. It was also good to let the schoolchildren get used to the presence of a researcher. The first couple of times the research team arrived at the school it drew all the attention which would not have been good for the research, but by the time the questionnaires and interviews started everyone was used to their presence and continued doing their own things.

Semi-structured questionnaires - For this study we started with semi-structured questionnaires after extensive observation of the local situation. A semi-structured questionnaire combines structured questions to obtain basic information with others that permit more flexible answers to convey ideas or perceptions in an open-ended matter (Simon, 2006). The questionnaire was only designed for schoolgirls as they were the main target group of this study. The questionnaire consisted of three main topics. 1) Menstrual Hygiene, 2) Sexual Reproductive Health, 3) School attendance. Within each

domain there were structured and open questions to get a clear basic idea on the situation (Appendix I). At the end of this questionnaire there was a recap question that reverted to the rest of the questionnaire, girls had to indicate to what extent they agreed on different statements . The questionnaire was carried out among 70 schoolgirls.

Semi-structured interviews - After the questionnaires were completed, we started with semi-structured interviews. As questionnaires are limited in the degree to which they can provide explanations for patterns or consider attitudes and opinions, interviews are a good addition to examine processes, motivations and reasons for successes or failures (Willis, 2006). For the schoolgirls the interview model was also based on the three main topics 1) Menstrual Health, 2) Sexual Reproductive Health, 3) School attendance. Each topic was further divided into smaller topics, to get more in depth information (Appendix II).

For the girls that have dropped out of school, the semi-structured interview was almost the same as the one for the schoolgirls. 1) Menstrual Health, 2) Sexual Reproductive Health, 3) Drop-out. Of course within this interview the emphasis was more on obtaining information about their dropping out of school (Appendix III).

For the parents and teachers the semi-structured interview was also based on three main topics 1) Menstrual Health, 2) Sexual Reproductive Health, 3) School attendance/Drop-out. Within this interview the emphasis was more on the view of teachers and parents on the different topics and the situation of young girls within their community.

For the hospital staff the interview was only based on two main topics 1) Menstrual Health, 2) Sexual Reproductive Health. Within this interview the emphasis was on what facilities and services health care professionals provided in the district hospital and what their personal view was on menstrual and sexual related issues among adolescent girls.

Kick off meeting - During a kick off meeting at the end of the internship, preliminary results of the study were presented to relevant actors like SNV, district officials and business people from the supply side of sexual reproductive health facilities. The aim of this meeting was to create awareness among the different actors that are influential in this sector and to find out how they can address these issues.

4.4 Participant selection

School-girls - The research sample was quit small but in order to select a representative sample from the girls though, random sampling was used for this study. In general, each person from the selected target group (adolescent school girls) had the same equal chance of being chosen as a participant in this study. Selection of schoolgirls wasn't a difficult job. From all the schools there were in Magu district, we randomly picked two schools in the rural area and two schools in the urban area. We choose to ask only girls from secondary schools to participate in this study as it was more likely that with their age, they already experienced menstruation and sexual activities. Within each of the four schools, first there was a random selection of 17 or 18 girls from different classes and all ages to carry out the questionnaires. They were taken separately outside of the classrooms, far from the other schoolchildren so they wouldn't be disturbed. The research assistant gave an introduction and went through the questionnaire together with the girls before they started. Also, they signed an informed consent about the confidentiality and anonymity of the study (Appendix IV). The girls were separated from each other so they wouldn't discuss their answers, won't be influenced by each other and to make sure they were able and felt comfortable to answer the questions openly and honestly as possible. Before, during and after completing the questionnaire girls were able to ask questions if they wanted to. Afterwards there was room for some informal talking with the girls, which also yielded some useful additional information.

Within every school there were also seven or eight girls randomly selected from all different classes, to have more in depth interviews with. We however made sure that none of the girls had already participated with the questionnaire. The girls were taken separately outside the school to make sure they felt comfortable to speak openly and honestly as possible about their situation. We ensured them that the information they gave us would be processed anonymously and only for this research. The girls had to sign a paper for agreement on the recording of the interviews. On average, each interview lasted about 30 to 40 minutes. Afterwards all girls got the opportunity to ask questions or tell us anything they wanted. All the girls that participated in this study received a soda as an expression of appreciation for their cooperation. In total 70 girls carried out the questionnaire and 30 girls participated with the interview. Although the group of participants was easily found, it took a lot of time to get all the questionnaires and interviews done, as we couldn't simply took the girls out of the classrooms during

their lessons. Also, few schools were already in their final examination period, so girls had to study and prepare their exams.

Drop-out girls - Dropout girls were mostly selected through snowballing technique. At the school we asked the schoolgirls if they had any female friends who dropped out of school for any reason and if they knew where the girls lived. After the first drop-out girl was interviewed she suggested other possible interviewees. This was the best way to find these respondents as there was no clear record of drop-out girls available. It was definitely time consuming, especially in the rural areas where girls lived in very remote areas sometimes. It was definitely worth the effort however, because interviewing them in their daily life environment also gave a good picture of their situation. We managed to interview six girls, five in the rural area and only one in the urban area. The latter because it turned out that most girls from the urban areas had run away from home, so they couldn't be traced anymore. The interviews lasted around 30 to 40 minutes but a lot of girls felt the need to tell us more about the challenges they face in daily life.

Parents - Parents were selected both within the rural and urban areas. At first we only wanted to interview mothers as we expected the young girls to discuss this subject mostly with their mother. In the end however we decided to also include fathers out of curiosity to hear their stories and opinions as well. Interviews were held at these parents' homes. Before we started the interview we asked the parents if they had adolescent daughters that were in secondary school, or dropped-out. If so, we explained the purpose of our study and asked for their cooperation. In total eight parents were interviewed. Each interview lasted about half an hour, but most parents took time to discuss things in further detail even more after the interview. All parents didn't wanted to be recorded, so we only took notes.

Teachers - Within each of the four schools we selected two or three teachers for an interview. First, we wanted only to ask biology teachers to participate, but then it appeared that basically all teachers could teach all different subjects as no special training was required so we could ask any of them. Interviewing teachers asked for some planning ahead. We couldn't interview them during the lessons but schooldays lasted from early in the morning till early in the evening and the research team had to

leave the research area early to get home before dark because of safety considerations. In the end we interviewed ten teachers, each interview lasted about 30 to 40 minutes. All teachers didn't wanted to be recorded, so we only took notes

Medical staff - Within the district hospital of Magu, we asked five health care providers to contribute to our research. We selected people from the family planning department and obstetrics department. Both male and female nurses and doctors. It was somewhat difficult to make an appointment with these people as they were always incredibly busy as this was the only hospital for whole Magu district. We managed to talk with five health care providers however, but because of busy time schedules as mentioned, interviews only lasted about 15 minutes. Although all interviews contain some useful information, not all have been incorporated in this study as they were less specific in line with the research questions. None of the medical staff wanted to be recorded, so we only took notes during the interview.

4.5 Ethical considerations

When collecting research data in the field, it is very important to treat the people that help you with this process in a respectful way. In a developing country like Tanzania and especially in the rural Magu district some ethical considerations really have to be taken into account. First trust has to be gained from the people that participate and cooperate in the study. Being a white, female and western researcher within an area where there's hardly no interaction with foreign people this really takes time. The language barrier makes it even more difficult as the researcher always needs to have someone with him to make the aim of his presence clear. We had to clarify that our presence there was to investigate the local situation through information from the local people in order to find out if an intervention was needed and what local people thought this intervention should look like. All participants in this research were told that there contribution would be anonymously and that no one but the researcher would use the information and also that the information would only be used for the purpose of this study. All participants signed an informed consent and were told that whenever they wanted they were free to stop the questionnaires or interviews at any time. A separate list was signed for the recording of the interviews, if people didn't wanted this we just took notes.

4.6 Strengths and limitations

Although research is always carried out with the best intentions, the best suitable methods in the local context of the study and best possible treatment of all the participants, research always comes with some strengths and limitations.

Local people as a starting point - The main strength of this study but at the same time also the weakness of this study is the qualitative method used. With this method the local people (young girls, parents, teachers and medical staff) have been put central and they have determined the results of this study. Their stories about their lives and experiences altogether gave an answer on the main questions of this study. Instead of large shallow data, this qualitative method gives more in depth information on the situation, although on a small scale. With the involvement of different participant groups, this study reflects the issue from multiple points of view.

Research duration - The duration of the actual research in the field has been thirteen weeks. Within this time it was possible to gain trust from the people we had to work with. Also there was some time to be flexible when things took more time than actually planned. This made it possible that besides the on forehand designed interview outlines that were used, some people came with stories related to the subject which enriched the quality of the study even more. The duration of the research also made it possible to really deliver some useful input to the host-organisation.

Language barrier - The main limitation of this study was the language barrier. In Tanzania the majority of people speak Kiswahili, a local Bantu language. Besides some basic greetings the researcher wasn't able to properly communicate with the local people, especially in the rural area where this research was conducted. Luckily a very motivated research assistant was available however. She spoke rather good English, so before the research started the topics were discussed to make sure that when interviewing she asked the right questions that were in line with the research objectives. For the researcher it was more difficult to participate so sometimes little redundancy was experienced and the researcher sometimes didn't had control on the situation and had to hand over the work and trust the research assistant. For example, the researcher couldn't check if the participants understood the questions, or could not check if the

research assistant asked questions in the right way and if she tried enough to ask further questions.

Participant selection - Maybe rather a challenge than a real limitation was the selection of participants sometimes. This was the case for the drop-out girls. As these girls are nowhere really registered after dropping out of school, so we had to ask schoolgirls who were friends with these girls to show us where they lived. When reaching their home place it often turned out that most of these girls had run away from home and even parents didn't knew where the girls went. On the one hand this caused only a small number of drop-out participants available for this study, but the story that they run away from home was actually a result in itself. Conversations with parents and other family members gave a clear picture of the lives of these drop-out girls.

Generalisation - As said before a qualitative study is both a strength and a weakness. The weakness of a qualitative study is that it makes it impossible to generalise the results of this research. The number of participants and the local rural research area are not representative for the situation of the whole population and country level. This study can however be a good start for a further larger scale research on the topic within Tanzania. As this study was a contribution for the intervention of my host-organisation no generalisation was needed as they only wanted to start the intervention in this particular research area and comparable areas.

4.7 Conclusion

The above mentioned strengths and weaknesses show that conducting research in a developing country in general but also in this specific context is rather a challenge sometimes and that some limitations unfortunately not always led to the most favourable outcomes. Already taking these limitations into account on forehand would probably have benefited the research but some strengths and weaknesses however simply only become visible when being in the field. Doing research is a learning experience and encountering the necessary ups and downs is just part of the process. This study, before, during and after the actual research has gone through many stages to come to its final framework that captured the aim of the study best. Including the local people and context has increased the quality of the study even more.

Results

5.1 Introduction

The following chapters will set out the obtained results from this study. As many girls participated in this study it is not possible to discuss all their stories in detail, but as their stories somewhat overlap the results below will reflect largely all their knowledge, believes and behaviour in general. The same applies for the stories of parents, teachers and medical staff, although not that many participated in this study they delivered very much insights. In special boxes one particular story from each group of participants is highlighted.

5.2 Background information participants

Schoolgirls – In this study 70 school girls from four different secondary schools in Magu filled in a semi-structured questionnaire. Another 30 girls were interviewed. Exactly half of the girls were from schools in rural areas and the other half were from school in the urban areas of Magu. On selected school was a boarding school where girls also stay after school. Girls only go home during holidays. The girls were randomly selected from classes from grade one to five. The age of the girls varied between 14 and 20, the mean age was 17. The girls in this study had a vary varied cultural and religious background, which was highly expected as Tanzania has a rich diversity of tribes and religious. The Sukuma tribe, the biggest one in Tanzania, was mostly represented among the girls in this study. Furthermore the Christian and Catholic religions prevailed.

Dropout girls – In this study six girls that dropped out of school were reached and interviewed. Most of the girls were found in the rural areas of Magu, only one girl lived in the urban area. The age of the girls varied between 16 and 20 years old. All the girls belonged to the Sukuma tribe and all of them were Christian or Catholic. The girls were between the age of seven to 19 when they dropped out of school, one of the girls was still in primary school by that time and most of the others didn't get any further than the first grade of secondary school. During our search for drop out girls in the urban areas it appeared that most of the girls run away from home and didn't leave any information behind about where they would be or if they would return. Parents were often not even aware that the girls were planning to leave and they seemed really worried. Parents reported that the girls probably went to the bigger cities. This reason behind this was two folded, first of all it is a shame for the family if a girl drops out of school (especially

in case of pregnancy), secondly there are no job opportunities in the urban areas of small towns like Magu. Although for girls in the rural areas the first reason also applies it was dealt with differently. Girls assist with household chores, field cropping or care for cattle and together with their mother they take care of their baby and the rest of the family.

Parents – In this study eight parents were interviewed. The age of the parents varied between the 35 and 54. We spoke mostly with mothers and only two fathers participated in this study. Apart from one parent all were part of the Sukuma tribe and were Christian or Catholic. The number of daughters varied between one to five. The educational level varied between not having any education up to university degree, but the large majority at least finished primary education. Although it was considerably challenging to talk about sensitive topics like menstruation and sexuality with parents, the interviews were very helpful to get insight in the situation.

Teachers – In this study ten teachers were interviewed. Their age varied between 25 and 38. The teachers all belonged to different tribes and they were Christian, Catholic or Muslim. At first we only wanted to include biology teachers as we expected that only they would provide classes about sexual reproductive health, but when it appeared that basically all teachers were involved in this we decided to include teachers with different educational backgrounds. Teachers however differed in their years of experience with teaching children about sexual reproductive health. Although all teachers are involved in this education, a special training on this is not required. So they aren't specialized but simply teach based on experiences and personal beliefs. As girls are at school most of the time, the teachers were perhaps the second most important participants in this study as they see the girls develop every day and because they have high influence in educating the girls.

Medical staff – In this study we interviewed four nurses and one counsellor at the district hospital of Magu. Their age varied between 37 and 57. All the nurses were female, only the counsellor was a man. They all belonged to different tribes and were Christian or Catholic. The years of working experience varied between two and 30 years. Although the interviews with the medical staff were short because of busy schedules,

they provided us with very useful information about the facilities and services available at the district hospital.

5.3 Menstruation - Knowledge, beliefs and behaviour among schoolgirls.

Knowledge – Among all the girls that participated in this study, the majority knew at least something about menstruation before they got their menarche. Still a large number however had never heard anything about it before onset of their menstruation. Even more striking is that some girls have even never received any information about it until today. Most of the girls got the information the information from teachers at school, or from their mother or sister(s). Girls from urban areas report that through advertisements in magazines or on the radio and television they receive information about products available for menstruation issues. Most of the girls felt able to discuss their menstrual issues, but still one fourth didn't. The girls prefer to discuss these issues with their mother, sister(s) or female friends. Girls from the boarding school report to discuss menstrual issues rather with their friends than for example with their mother, this because they spent less time with their mother as they only go home during holidays. During the research it became clear that the younger girls felt more shy to talk about menstruation than the older girls. Basically all girls report that they didn't received any special classes on menstruation and they all wish for more classes.

To check the current knowledge about menstrual issues of the girls, we provided them with five statements they had to answer. An overview of these statements can be found in table 1. On the first statement about disease, 83% of the girls responded that the statement was incorrect and 16% responded that the statement was correct. On the second statement about sickness, 51% of the girls responded that the statement was right, 42% responded that the statement was wrong and 7% didn't knew the answer. On the third statement about physical activities, 62% responded that this was true, 25% responded that is was false and 13% responded that they didn't knew the answer. On the fourth statement about menstruation and pregnancy 87% responded that the statement was incorrect, 4% responded that this was correct and 9% didn't knew the answer. On the fifth and last statement about age and menstruation, 84% responded that this was right, 10% answered that this was wrong and 6% of the girls didn't knew the answer. The number and content of questions girls had during and after the questionnaires and interviews also revealed their lack of knowledge on the topic.

Table 5.1 Statements to test knowledge - menstrual issues		
S 1	Menstruation is a disease	FALSE
S 2	If you feel pain during menstruation, it means you're sick	FALSE
S 3	It is harmful if a women does physical activities during her period	FALSE
S 4	Pregnant women can menstruate	TRUE
S 5	When women grow old they stop menstruating	TRUE

Beliefs – The girls who never received any information about menstruation were often shocked, felt uncomfortable bad and confused, because they believed something bad happened to them. The girls who did received some information on the other hand felt very happy, proud and mature when they got their first period as they believed they were a grown up women now. As an introduction to discuss cultural traditions related to menstruation, a few examples of traditions from other cultures around the world were provided, see table 5.2.

Table 5.2 Overview cultural traditions around the world	
CT 1	The blood on exposed cloths will attract evil spirits so must be buried.
CT 2	Women are not allowed to touch cows because they are holy and may be contaminated
CT 3	Isolation in women's huts where rituals are conducted and wisdom and experiences exchanged, because menstruation is believed to cause pollution at home.

These traditions and taboos are documented all over the world and are often the same across different cultures around the globe too. It is however only in some parts of the world where these rituals are still followed, for example in several countries in Asia and Africa. Some rituals were perceived as good, for example the one about burning cloths, because the girls believed these traditions teach women about how to maintain hygiene. Some girls even believed that wrong disposal of menstrual products could lead to witchcraft, disease and even infertility. Other rituals were perceived as very bad, for example the one about isolation of women, because girls believed this was

discrimination. The girls believed that these rituals denied girls' freedom and rights and caused gender-inequality. Some girls even mentioned that women play an important role in the community and that they have a lot of responsibilities and that these traditions hinder the development not only of women but of the whole community. Especially girls with more knowledge about menstruation disapprove the cultural rituals. Almost two third of the girls reported that they knew about similar cultural traditions within their own tribe. Other girls reported that their own tribe didn't had these cultural traditions but that they knew other tribes or religions who did. Different religions for example impose restrictions for women when having their monthly period. The Muslims do not allow women to touch the Koran or visit the mosque to pray and the Christians restrict women to receive communion. Furthermore girls report restrictions like not being allowed to cook, to touch the cattle and to sleep with or have sex with men as women are considered dirty and impure during their period. Some girls said that these restrictions are based on outdated knowledge, misconceptions and ignorance. The vast majority of girls is convinced that these traditions need to be prohibited or changed if they cause bad influences on the health or rights of women. The girls report that in order to abolish these traditions and beliefs, educating the community is of major importance. Education will help to ease out all the currently prevailing conventional wisdom. The results of this study however reveal that girls with an Islamic background, act less against cultural related practices and do not disapprove religious precepts like the Christian and Catholic girls in this study reported.

Behaviour – One fourth of the girls reports to have incredible pains, one fourth reports to have normal pains and half of the girls report that they have little to no pain at all. This was measured on a scale from 0-10 (0 = experiencing no pain at all, 10 = experiencing incredible pains). Almost all the girls report some physical discomfort when having their period, varying from stomach-ache, to headache, back pain or feeling nauseous. Less girls experience emotional discomfort. The girls who experience emotional discomfort report to feel tired, ashamed, less confident or having mood swings. Despite the physical and emotional discomforts, most of the girls feel able to carry out their daily activities, like going to school and assisting in the household. A significant number of girls however does not feel able to do this, they report that they are not able to carry out heavy household chores like fetching water and working in the field because this causes heavy

bleeding. The majority of the girls report that they use old cloths or cotton when having their period, only few girls can afford to buy pads. Pads are preferred among all the girls however as they protect from leaking and thus make them feel more comfortable. Most of the girls report that they wash themselves once a day and change their cloths, cotton or pads twice a day on average. They wash it out and dry it, throw it away or sometimes even burn it. Compared to the rural areas are goods and services related to menstruation easier accessible in urban areas. The district hospital is located in the urban area and shops provide products like pads while this is not the case in small shops in rural areas.

5.4 Sexuality - Knowledge, beliefs and behaviour among schoolgirls.

Knowledge – The girls that participated in this study report that they have received some information about sexual matters at school or through informal talks with friends and fellow students. Girls from urban areas report that through girls magazines or girls programs on the television they receive information about relationships, love and sexuality. The majority reports that they have received classes at school about pregnancy, STD's and bodily changes during puberty but a significant number of girls reported that they have never received any education. The girls that have received education about the topic, report that the information was sufficient and that further classes aren't needed but the girls who didn't received any education would love to be educated about the topic. The girls in general feel able to discuss sexual issues but only with their boyfriend, friends or fellow students. The issues are absolutely not discussed with family members. During the research it became clear that the older girls felt less shy to talk about sexuality than the younger girls. Young girls in the beginning were even shy to admit they were sexually active if this was the case, while the older girls even seemed to be happy to be able to openly talk about it.

To check the current knowledge about menstrual issues of the girls, we provided them with five statements they had to answer. An overview of these statements can be found in table 3. The first two statements were about pregnant possibilities, on the first one 64% answered the statement was correct, 23% answered the statement was incorrect and 13% didn't knew the answer. On the second statement 59% answered the statement was correct, 28% answered the statement was incorrect and again 13% didn't knew the answer. On the third statement about protection, 35% answered this was right, 62% answered this was wrong and only a small amount of girls didn't knew the

answer. On the fourth statement about the need of treatment, 6% answered that this was true, 91% answered this was false and only a small amount of girls didn't knew the answer. On the fifth and last statement about the pill, 54% didn't knew the answer, 35% answered this statement was incorrect and only 11% answered this statement was correct. Again, the number and content of questions revealed the lack of knowledge among the girls on this particular topic.

Table 5.3 Statements to test knowledge - sexual issues

S 1	A women can get pregnant on the very first time that she has sexual intercourse	TRUE
S 2	A women is most likely to get pregnant if she has sexual intercourse halfway between her periods	TRUE
S 3	Condoms only protect against pregnancy, they do not protect you against Sexual Transmitted Diseases (STD's)	FALSE
S 4	Contraception pill might decrease menstrual pains	TRUE
S 5	If you have a STD you are able to recover without any treatment	FALSE

Beliefs – Related to sexual issues girls report that they know some cultural and religious related restrictions. One expectation, reported by almost all the girls was that girls are expected not to have sex before marriage, before they reach adulthood or while they're still enrolled in school. Girls are taught that sex before marriage is a shame for the family, that it is dangerous as it can cause pregnancy or diseases or it can have a negative influence on school performances. Sexual issues are hardly never discussed within the community as sexual issues are perceived as a taboo. The topic is stigmatized and kept silent. To gather the opinion of girls about sexual issues we provided them with eight statements they had to answer. An overview of these statements can be found in table 4. On the first statement about pre-marital activities the large majority responded that they agreed with this, only a small majority didn't agreed or had no opinion about it. On the second statement about regret however the large majority also responded approvingly and again a small number didn't agreed or had no opinion about it. On the third statement about virginity the large majority agrees and only a few do not agree or

don't have an opinion about it. On the fourth statement about forced sex, the large majority of girls responds dismissive but surprisingly some girls agree with this statement. The last three statements were about usage of protection. Most of girls the refuse to have sex without using any protection, less girls report to insist on condom use and the large majority of girls agrees that it's a girls' responsibility to care about protection. Quite a significant number of girls doesn't have a clear opinion about it.

Table 5.4 Statements to obtain opinions regarding sexual issues

S 1	Boys and girls can have sex before marriage if they love each other
S 2	Boys are allowed to force a girl to have sex if they love the girl
S 3	Most girls who have sex before marriage regret it afterwards
S 4	A girl has to remain virgin until she is married
S 5	I feel confident enough to insist on condom use when having sex
S 6	I would refuse to have sex with someone who is not prepared to use a condom
S 7	It is the responsibility of a girl to ensure that contraception is used
S 8	A boy will not respect a girl who agrees to have sex with him

Behaviour - One third of the girls in this study reports to be sexually active yet, so the majority of girls is not sexually active yet. Most of the girls who are sexually active, had their sexual onset at the age of 15 or 16. Some of the girls were however much younger, between the age of 12 and 14. The majority of girls report that it was their own choice to have sex, but sad enough some girls report to be forced. Most of the girls report that they have used protection when they had sex. Some girls didn't because their boyfriend didn't wanted to use condoms and they didn't know about contraceptives like the pill. None of the girls report any pregnancies or STD's, although the girls report not to be sure about the latter as they never got tested. Compared to the rural areas are goods and services related to sexuality easier accessible in urban areas. The district hospital is located in the urban area and shops provide products like condoms while this is not the case in small shops in rural areas. The girls who weren't sexually active yet had different reasons for this, some thought it was inappropriate to have sex before marriage, some

were afraid of getting pregnant or having STD's and few simply didn't felt ready for it yet.

Box 5.1 Highlighted Story of an 18 year old school girl

Among all the school girls in this study, this girl was the most inspiring one when it comes to making a change in current thinking to improve the current situation for girls. The girl was very aware of the differences in coping with menstruation and sexuality and peoples mind-set between the modern world and the developing world. This girl told us she read about things like menstruation and sexuality in magazines and books, and heard things on the radio and television that were different from what she heard from her grandmother, aunts, mother and sisters. Girls are, as she said, caught between a world of conventional wisdom and a world of modernization. She wants to be a pioneer in creating awareness and educating people about menstruation and sexuality, because she believes these things are normal and biological and should not be restricted by societal and cultural values or misconceptions. Most important she said, is making the topic discussable, because young people get involved in dangerous behaviour and non-hygienic menstrual management because they deal with the issues secretly and alone. If the young people don't feel ashamed to talk about it and feel able to ask questions about this, they will be better informed and will make decisions that positively contribute to their sexual health. This girl mentioned that the consequences of misbehaviour are often worse for girls and not only influence their sexual health but also hinders their overall development.

Overall abilities - At the end of all the questionnaires and interviews we provided the girls with six statements about different topics related to sexual reproductive health in order to understand how girls in general think about their capabilities related to this. An overview of the statements is presented in table 5. on the first statement about knowledge, half of the girls report that they have sufficient or very good knowledge about sexual reproductive health. The other girls report that they doubt about it or definitely not have enough knowledge. On the second statement about skills, less girls report that they have sufficient skills to manage their reproductive health. Far more girls report that they do not have the sufficient skills to manage their sexual reproductive

health. On the third statement about economic resources, two third of the girls doubt or disagree that they have enough economic recourses to manage their sexual reproductive health, and only one third agrees. On the fourth statement about social support, half of the girls report that they do not receive enough social support to manage their sexual reproductive health, the other half reports that they do so. On the fifth statement about cultural restrictions, one fifth of the girls report that they neither agree or disagree about this, almost half of the girls report that cultural traditions impose restrictions and the rest report that they don't. On the last statement about the ability to make choices, exactly half of the girls report that they feel able to make their own choices but the other half reports that they doubt it or don't.

Table 5.5 Statements to measure capabilities
S 1 I have sufficient knowledge about menstrual and sexual reproductive health issues
S 2 I have sufficient skills to cope with menstrual issues and sexual reproductive health issues
S 3 I have enough economic resources (money etc.) to cope with menstrual and sexual reproductive health issues
S 4 I have enough social resources (support from family etc.) to cope with menstrual and sexual reproductive health issues
S 5 Cultural values do not restrict me in my decision making about menstruation and sexual reproductive health issues
S 6 I feel able to make my own choices regarding menstruation and sexual reproductive issues

5.5 Knowledge, beliefs and behaviour among drop-out girls

Knowledge – All the girls that dropped out of school report that they have received information about menstruation from family members like their mother and sister(s) or from a teacher at school. Not all of them however received this information before they had their first period. The girls all felt comfortable to discuss menstrual issues and prefer to do this with their mother, sister(s) or friends.

All of the girls also report that they received information about sexual issues. They received this information through informal talks with their friends, but they didn't felt

comfortable or able to discuss everything. These issues were not discussed with teachers or family members.

Beliefs – The same examples of cultural traditions in other countries that were used for the schoolgirls were also presented to the dropout girls. The girls all believed that none of these were good and that they were perceived as discriminative against women. Surprisingly enough, none of the girls reported that they knew examples of cultural traditions within their own tribe or religion.

Behaviour – Most of the girls report that they particularly experienced physical discomfort like stomach ache when they had their menarche. Some of the girls report emotional discomforts like mood swings and feeling tired. They all felt able to carry out their daily activities, but the bleeding period some had after their delivery made them unable to do this. The girls all prefer to use pads when having their period as these are more comfortable, hygienic and prevent from leaking. They often use cloths or cotton however because they can't afford to buy pads.

All of the girls were sexually active yet, ever since she was 12 years old. Five out of six girls report that they didn't used any protection during sexual activities. One girl reported that her boyfriend refused to have sex with a condom, the other girls reported that they weren't aware of the consequences of unsafe sex and that they lacked the knowledge about contraceptives.

Box 5.2	**Highlighted story from a dropout girl**

Among the few girls interviewed in this study, the story of this girl was most touching. This 17 year old girl lived together with her two sisters, her parents both died. Her older sister was also dropped out of school but her younger sister was still enrolled in primary education. She and her older sister both had a child, she had her delivery about three weeks before our interview, at home with some assistance of her older sister. Both of their boyfriends left them after the child was born, although they promised to support them and be a father for their child. This girl was one of the ten best performing girls in her class, she got excellent grades and went through the different levels easily. When the girl found out she was pregnant she was both happy and

frightened. She felt honoured but knew that this meant she had to leave school and her future wasn't very prosperous anymore. When she left school the teachers told her she had to try to return to school after her delivery because she was such an excellent student. Without having parents however this will be a challenge for her, she has no financial support and now she has to take care of her child besides the household, cattle and field cropping. She can't let her older sister do all the work and she doesn't want her younger sister to drop out of school either. Despite this she was positive and hopeful that maybe a miracle would happen and she would be able to finish her studies later in life.

5.6 Menstruation - Socio-economic and cultural influences

The socio-economic and cultural influences on menstruation reported by the girls are already extensively discussed above. Therefore in this part of the results the answers provided by parents, teachers and health care providers will be presented. Only half of the parents report that they discuss menstrual issues with their daughters. Results of this study reveal that especially higher educated parents teach their daughters about menstrual issues and discuss the issues more openly. The parents who discuss these issues do so in order to prevent their daughters from pregnancies. The parents that discuss these issues say they feel proud to teach their daughters about the transition from a girl to a grown up women and educate her on hygiene matters. Parents that do not discuss these issues say that the girls are too young for it or that these issues should be kept secret and be dealt with privately. Parents prefer to discuss the issues in a private place where no one else is and to wait with this until their daughter reaches puberty. The higher educated parents report that they teach girls not to believe in all cultural traditions related to menstruation as they believe that some of these traditions could be very bad for a girl's health. The majority of parents however teach their daughter(s) about cultural and religious related traditions related to menstruation about good behaviour and how to take good care of themselves. None of the parents perceive cultural or religious traditions as an obstacle to discuss menstrual issues with their daughter(s). Neither do they report any challenges when discussing menstrual issues with their daughter(s), they only note that girls feel very shy to talk about it. Parents do however report that they issues are not discussed in public and not with men because of community customs and traditions.

Just like parents, teachers report that girls feel shy and uncomfortable to discuss menstrual issues with them. Girls fail to express themselves and feel ashamed to talk about it. Teachers experience this as a problem however, during classes on menstruation girls do not feel free to ask questions and teachers really have push them to actively participate in class. They receive relatively little feedback, so they don't know to what extent the girls understand everything. Teachers report that according to cultural and religious traditions this topic is kept secret and not discussed with men at all. Cultural traditions and customs make the topic a taboo. Teachers report different cultural traditions that impose restrictions related to menstruation. They mention that the Islamic religion forbids girls to touch the Koran and to preach in the mosque as a woman is perceived to be impure. On the other hand, if a women has her menstruation during Ramadan a girl is temporarily preserved from this. Among different tribes in the country, rituals that are accompanied with music and dances teach a girl what her responsibilities and rights are and how she should behave now she is matured. This ritual is very valuable to the older generations, but teachers report that customs are outdated. The health care providers report that due to community related customs, parents often do not allow girls to visit the hospital for menstrual related issues because these things are dealt with within the family. Because this is kept private girls do not dare to talk about it with friends or other people within the community. The medical staff reports that menstrual issues can be freely discussed at the hospital and that girls are free to ask questions, but because menstruation is dealt with privately the girls are shy to do so. The counsellor of the hospital was aware of religious restrictions related to menstruation. Not being allowed to pray at the church or mosque again was mentioned. A social restriction within communities is that girls aren't allowed to sleep with men or have sex during their period. Just like parents, teachers mentioned cultural traditions carried out among different tribes accompanied by dances and music to teach girls about the transition from a girl into a women. These traditions are highly valued and create a tight relationship within families and communities. The rituals however make girls shy or afraid.

Box 5.3 Highlighted story of a husband and father

Among all the parents in this study, this was the most dedicated husband and father in supporting his wife and daughters to fully develop themselves. When we started our interview and talked about menstruation, he looked at us somewhat surprised. He had never heard about this phenomenon and was convinced that in his 30 years of marriage his wife never had a period and so did his daughters. A menstrual pad also was so something completely new for him, he touched it and smelled it and looked wondrous at us. When we explained everything to him, he wondered why his wife and daughters had never talked about this with him, because if he would have known this, he would have supported them in order to maintain their hygiene and health. After our interview he went home with the intention to talk about this with his wife and daughters, and to let them know that he would be there to support them if needed. After being taught about the issues, he was also very determined to change the situation. He said that education about the topic was needed for parents, teachers and other community members that could be supportive to the girls. He said, if no one knows no one can do something, so let's make a start and begin with educating the older generations so they can in turn teach the younger generations.

5.7 Sexuality – Socio-economic and cultural influences

The socio-economic and cultural influences on sexuality reported by the girls are already extensively discussed above. Therefore in this part of the results the answers provided by parents, teachers and health care providers will be presented.

Half of the parents report that they do not discuss sexual issues with their daughter(s). On the one hand they think they are too young for this and on the other hand they believe it is a license to sexual activity. The parents who do discuss these issues, believe it is important to teach their daughter(s) about consequences of early sexual activity and related challenges girls might face. Results of this study reveal that especially higher educated parents teach their daughter(s) about sexual issues and discuss the issues more openly. Fathers are more involved when discussing sexual issues compared to menstrual issues. According to cultural and religious values, girls are taught about abstinence before marriage when they're young and enrolled in school, consequences of early and unsafe sex and to live according to community rules. Parents do not perceive

cultural or religious traditions as obstructive when they want to discuss sexual issues. They see the traditions more as habits that simply exist for a long time already and will be passed on to next generations as well. The issues are discussed privately and preferably when a girl reaches puberty. Parents do not report challenges when they want to discuss sexual issues, they note however that girls feel very shy to talk about it. They feel uncomfortable to talk about their problems or ask about things.

Teachers do report it as a challenge that girls feel shy and uncomfortable to talk about the issues, because teachers don't know how to cope with this behaviour. Boys and girls are kept separated during classes on sexual issues because boys and girls feel ashamed to talk about this in front of the other sex. So in order to make them feel comfortable to express themselves they receive separate education. According to the teachers do customs and traditions treat sexual issues as an adult related matter. Teachers really would like to discuss sexual issues to create awareness and prevent sexual misbehaviour. Again during classes about sexual reproductive health, girls do not ask many questions and seem not to actively participate in class. Teachers see cultural traditions and customs as the underlying cause. Different taboos related to sexual health are reported by teachers. Gender is mentioned as a very important issue. Men are awarded a dominant role in relationships and girls adopt a more passive recipient role, therefore girls are not in the position to make their own choices about their sexual health. Teachers report that within relationships girls feel shy to discuss sexual issues like condom use with her boyfriend, so she often simply does whatever he wants. 'Unyago' and 'Chagulaga' are culturally related ceremonies among different tribes in Tanzania. Unyago is a ritual when a girl is coming of age, she is taught by the older women about sexual and relationship related behaviour that is expected from a women. Chagulaga is a ritual for men to find a suitable partner, girls need to present themselves at their best to be favoured, but this is at a very young age and the position of the girl is inferior relative to the man as she has no rights in decision making and participating. The teachers however report that religious values like abstinence do prevail, and that traditions and religious values are often old fashioned.

The medical staff from the hospital reports that girls not very often visit the hospital for sexual related issues if not pregnancy, because they feel ashamed and only discuss these issues with friends. Health care providers report that sexual issues can openly be discussed in the hospital and that girls are open to ask questions too. They believe it is

even very important that girls do so, because if they keep questions or problems to themselves and make no well-considered decisions this could negatively influence their health. The medical staff believes that it is needed to create awareness and to clear up prevailing misconceptions among many people within communities. No social or cultural rituals are reported by the nurses and counsellor. They do believe however that girls should abstain from sex when they're young, enrolled in school and not married, but they experience this more like a habit than a social or cultural tradition. They also admit that sexuality is stigmatized and seen as a taboo. One nurse however reported that certain tribes perform circumcision at girls in order to reduce the pleasures of sex to make sure that girls are less seduced. If girls do however get involved in sexual activities in these cases, they please that girls use protection like condoms or contraceptives in order to prevent pregnancies and STD's.

5.8 Education on sexual reproductive health

Menstruation – Parents report that they believe education is very important for their daughter(s). They see it as a parents' responsibility to educate girls about menstrual health related issues. In case of menstruation, the mother is seen as main responsible as they have experience with this, are with their daughters most of the time, and have the closest relationship as well. Parents report that they teach girls about hygiene, how to keep themselves clean, how to use and dispose cloths or pads and about related issues like stomach aches. Some parents also teach them about sexual reproduction that starts when a girl is menstruating, to avoid pregnancies. Parents see school also as a very important actor in educating girls about these issues, because girls spent most of their time at school and teachers know best how to educate children. According to the parents other member of the community and health care providers should also be involved in the education of girls. In case of education about sexual health related issues, less parents report to believe that they should play a role in the educating their daughters. The majority of parents report that they would like to receive support when discussing menstrual issues and supporting their daughter(s). They would like to receive education about menstrual hygiene and management and they would like to know the best way to discuss these sensitive issues. They want their daughters to be well informed so they know how to keep themselves clean and healthy. Parents also would like to receive financial support so they can buy good products like pads for their girls.

The majority of parents report that they would like to receive support when discussing sexual issues with their daughter(s), because they want to know how to deal with their shy behaviour.

All the teachers report that education about sexual reproductive health is provided in the third grade of primary school. One teacher reports however that this topic is not discussed extensively, because it is believed that this issue should be taught by parents in general. The teachers report that girls are taught about personal hygiene, bodily changes during puberty, differences in menstruation patterns among girls and external factors that can influence this and the usage of the menstrual cycle in order to prevent pregnancies. Male teachers report that they don't give education about this topic at all because they don't know much about it and they believe it is not of their concern as it is something only women get and women have experience with. Teacher report that parents, health care providers and other people within communities like peer groups should be involved in the education of girls about this topic. They believe that parents are seen as main responsible for the education of their children, health care providers are believed to possess the right knowledge and teachers could be helpful as they are familiar with educating children. Cooperation is believed to be very helpful, because in this way people can learn from each other, which is highly important in a country like Tanzania where many different religions and tribes live together. The teachers report that they do not have sufficient knowledge to educate girls about menstrual issues, female teachers solely rely on their personal knowledge and experience. Boys are kept separated from the girls when they are taught about menstrual issues as it is none of their concern. Some teachers however report that they think it's important to teach boys about this as well to make them aware of what happens to the female body so he can be supportive if needed.

Box 5.4	**Highlighted story of a female teacher**
Among all the teachers, this was the most open minded one when we discussed the challenges women face regarding sexual reproductive issues. The teacher said that girls spend most of their time at school, so teachers can follow their development during puberty closely. Therefore teachers are the assigned people to educate young girls about the changes in body and mind that occur during puberty. Teachers however face	

challenges in doing so, as cultural stigma and taboos cause girls to be shy and ashamed to talk about it. The environment girls grow up in is not conducive as silence around these topics cause feelings of insecurity and ignorant behaviour. The curriculum at school doesn't positively contributes to the development of girls. Although teachers give children the opportunity to talk about the issues and ask questions, education is mainly focused on abstinence and frightening the children with negative consequences. Also, men and boys are often excluded in discussing issues about menstruation and sexuality because it is not seen as their concern. Teachers should receive a special training on educating these topics and the mind-set of people who should provide young people with information has to be changed in order to make sure they provide information based on actual knowledge instead of conventional wisdom.

Sexuality – Education about sexual health is not necessarily seen as important, but rather as a license to sexual involvement if you make youth aware of it. Some parents , especially the higher educated ones however see it as important to teach girls about how to maintain good health and prevent themselves from pregnancies and STD's. Again school is seen as an important actor in the education of girls, because girls spent most of their time there and teachers are educated to do this. Other actors like the government, religious leaders and other community members are perceived to be important in educating girls about sexual health.

The teachers report that during classes on sexual reproductive health, girls are taught about consequences of irresponsible sexual behaviour like pregnancies and STD's. Secondly they are taught to abstain from sexual activities before adulthood, as long as they are enrolled in school and before they are married. Last, girls are taught about safe sex practices if they fail to control their feelings. One teacher also mentioned that she educated the girls about different social and cultural factors that influence sexual beliefs and practices. Sexual reproductive health is taught both by male and female teachers. Both boys and girls are taught about the topics, but they are often kept separated during these classes although it concerns both sexes. Male teachers discuss the male related issues with the boys and female teachers discuss the female related issues with the girls. For both education on menstrual and sexual issues teachers report that schools lack finances, tools and equipment to provide practical classes, while they believe this is the best way to educate girls.

Health care providers from the hospital report that they believe only well-educated girls are able to manage their sexuality. The girls who lack education often engage in early risky sexual behaviour and are vulnerable to pregnancies and STD's.

5.9 Sexual reproductive health related facilities

Hospital – Health care providers from the Magu district hospital report that a lack of water for many girls in the district is a huge problem, because girls are unable to wash themselves and their used cloths. Besides this the availability of pads is often lacking especially in the rural areas of the district, moreover the pads are often unaffordable for the girls. The medical staff reports that girls hardly never visit the hospital for menstrual issues, only some girls visit the hospital with complaints about heavy pains during their menstruation. The hospital provides the girls with information about menstrual hygiene and reproductive health. They are tested on sexual reproductive health related infections and given treatment if needed, in worse cases they are send to the region hospital which is more equipped. There is no youth friendly environment or special programme within the hospital, but the medical staff believes that this would be very useful. The threshold for girls will be lower and girls will receive applied knowledge and skills. The medical staff advocate for a special department in the hospital especially for youth. Cooperation between different actors like parents, school, community, religious leaders and the government could be helpful for several reasons according health care providers. A wider audience can be reached, girls have more ways to obtain knowledge and knowledge and skills can be exchanged. To improve the level of knowledge and skills among young girls, the medical staff also advocates for more and better education and practical classes. In case of sexual health lots of girls visit the hospital in case of rape or pregnancy. If girls visit the hospital for sexual related issues they are provided with information about family planning, pregnancies and STD's, they are provided with free condoms, STD tests, treatment and counselling. The same as with menstrual health there's no special youth friendly department or program with regard to sexual health issues, the same solution to this problem is mentioned by the medical staff. Parents are held responsible however for the health of their daughter(s) and peers are seen as a major influence. The barriers girls face when they want to visit a health centre is lack of permission, time and money according to the health care providers. Support from family and teachers could be helpful in this case. Parents report that they would support their daughter(s) if they need to seek help for menstrual issues in a health clinic. No matter if

it is for counselling, education or treatment. One parent however said that things like menstrual pains are not a disease and that there's no need to seek for medical help. In case of sexual issues parents also report that they would support their daughter(s), but only in case of education. Parents do not allow their daughters to perceive contraceptives or condoms.

Among the schoolgirls who participated in this study, the majority has never visited any health clinic for menstrual or sexual issues, only a small group of girls did. The older girls report usage of health care more than young girls do. The girls who report that they have never visited a health clinic give different reasons for this. Some report that they do not get permission from parents to visit a health clinic, others report that they can't afford it or that facilities are too far away, others feel afraid or ashamed to go there or they simply never needed any health care. Among the girls who did visit a health clinic for menstrual or sexual issues, the number of visits varied between one and five. Only one quarter of the girls who visited a health clinic felt comfortable to talk with the nurse or doctor about their issues, but despite this the majority was however satisfied with the information or treatment they received during their visit.

Except for one girl, all the girls that dropped out of school visited a health centre at least once in the last three months. Most of them went for general health issues, some to get information about their pregnancy, delivery or how to take care of their baby and others to get information about avoidance of sexual diseases. Financial issues often withheld these girls to get treatment at the hospital, they only went there to get information. Only one of the girls that have been pregnant had her delivery in the hospital, the others didn't receive any support and had their delivery at home.

Box 5.5 Highlighted story of a male counsellor

Among the medical staff, the counsellor was the one who admitted the challenges regarding sexual reproductive health women face within communities. The counsellor admitted that health services in the district, are not equipped to provide youth friendly services which are easily accessible for adolescent girls. On top of that often parents do not give approval for seeking help as these things are handled privately within the family. Rituals among different tribes and religious believes cause young people to be ignorant and focus is only on prohibiting and restricting certain behaviour instead of

providing them with knowledge and skills that enables them to make healthy choices in life. Stigma and taboo cause silence around the topic, so if girls experience any problems they won't share it and try to manage themselves with the knowledge they have. As this knowledge is often lacking problems will only get worse. If the problem is caught at an early stage the situation can be prevented instead of cured. Different actors should cooperate in order to reach a wider audience and increase accessibility to information about sexual reproductive health issues, girls should have multiple options in life to obtain knowledge and skills. Besides knowledge and skills should access to health services an provision of pads, condoms, medication etc. be more affordable for people with limited financial possibilities.

School - The observation at different schools made it quite clear that the facilities at school are subpar or sometimes even completely lacking. The conditions in which girls need to deal with their menstrual health are subpar. First of all, especially in the rural areas, water supply is lacking which means no flushing toilets. Secondly, there are no doors in the toilets. No toilet paper or clean water is available to clean oneself after doing one's needs. There are also no facilities to properly wash hands after a toilet visit. Facilities to dispose used pads are lacking and lastly, there is no provision of pads or other products to manage periods at school. Above all this, the toilets are really dirty and smelly and a lots of mosquito's fly around the toilet area.

Teachers report that girls face challenges with managing their menstrual period at school. The teachers try to provide them with counselling and practical support like provision of pads if possible. The girls are often allowed to go home to change, because especially female teachers admit that the facilities at school are very bad. Besides the fact that there are no pads available, the toilets are very dirty, there is no place to dispose pads and there's no water so girls can't keep themselves clean. It should definitely be improved according to the teachers.

5.10 School performance and attendance

Among all the schoolgirls that participated in this study, more than half report that they've missed a day of school in the last three months. Only one third of the girls say that they haven't missed a day at school over the last three months. Among the girls that have missed some schooldays, around half of the girls have missed one or two days of school and the remaining half of the schoolgirls have missed three or more days at

school in the past three months. The reason for missing school varies among the girls. Most of the girls report not going to school because of their menstruation or illness. Other important reasons are family issues or financial issues. The results reveal that girls from the boarding school report less school absence. As these girls not only get education at boarding schools but also actually live there, they are better to cope with their sexual reproductive health as facilities are always near. Girls that reported menstruation as a reason not to go to school were asked what the exact reason behind this was. The large majority reported pain or illness as their main reason not to go to school, others mentioned that the facilities to manage their menstruation at school were not sufficient and that there was a lack of goods. Among the girls that didn't stay home when menstruating, almost all of them reported that the facilities at school were not sufficient and that the school/teachers didn't provided them with any goods or support either. Almost all the girls report that they go home during a school day to change themselves, but most of them come back afterwards. Girls report that they have difficulties with concentrating during classes when having their period because they feel tired and are distracted because they are afraid of leaking.

Five out of the six girls that dropped out from school, did so because of pregnancy. Only one girl dropped out because of family issues. The girls report that when they find out that they were pregnant they went to the headmaster to discuss it. The headmaster contacted the parents (if possible) and after joint conversation the girl was expelled from school. Right now their daily activities consist of field cropping, taking care of the cattle or taking care of their baby and the household. All of the girls would love to return to school and finish their studies to become more knowledgeable. Most of them feel supported by friends and family to return to school if possible but for some it will be quite a struggle to achieve this. Besides the permission they need to get from parents, girls need financial support to pay school fees and buy a school uniform and school related materials like books.

Half of the parents that participated in this study report that their daughter(s) have missed some days of school during the last three months. Two parents report that their daughter even dropped out of school because of pregnancy. One parent reported that here daughter stays home during her monthly period, because she experiences heavy blood flows and the school doesn't offer the needed facilities. The parents report that they will support their girl to return to school as soon as the situation allows this.

Education is seen as a key to success and parents believe it is good for the future of their daughters to finish school. Their future will be promising and comfortable and she can take care of the family and deliver a contribution to society.

Teacher differ in their experience with girls leaving school for menstrual issues. Some report that girls do not go home, while other report that girls ask permission to go home to get changed as facilities at schools are lacking. Other reasons for absence are sickness, financial issues or family matters. Teachers report that parents do not acknowledge the importance of education for girls and that they keep their daughters home often. On an annual basis teachers report that three to eight girls drop out of school. Although this is roughly equal to the number of boys dropping out of the school, the underlying reason for it differs. Girls drop out because of pregnancy or early marriage and boys drop out because of bad performance or truancy. When a girl is suspected to have a STD, she is taken to the hospital for a test and treatment. After recovery she can come back to school. If a girl is suspected to be pregnant, she is taken to the hospital for a test, the parents are informed and the girls is expelled from school until after her delivery. According to the teachers extra attention should be paid to the needs of girls. Also they advocate for education of parents and teachers.

5. Discussion

The previous chapter gave an extensive overview of all the results obtained in this study. In this chapter the results will be discussed in line with the theoretical framework and research questions mentioned in the methodology.

6.1 Knowledge, beliefs and practices

On the personal level, girls lack the capability to manage their sexual reproductive health properly. The results show that the level of knowledge and skills among adolescent girls in Magu is not sufficient, many girls are ignorant about the topic. Absence of knowledge cause unpleasant surprises during menarche, lack of ability on menstrual hygiene management, lack of ability to make well informed choices regarding sexuality and cause risky sexual behaviour among sexually active girls. On a large scale, girls ask for more education on sexual reproductive health (figure 6.1). Not only among school girls and girls that dropped out of school knowledge is lacking, the same applies for parents and teachers. Parents and teachers support girls based on their own beliefs and experiences with menstrual and sexual issues.

Figure 6.1 Adolescent schoolgirls during class in Magu, Tanzania

Source: author

The beliefs that girls pursue are rather conventional and often based on social and cultural influences from older people and are not based on actual knowledge. The beliefs are rather incongruent with the current information provided through modern media. Girls seem to be caught between conventional wisdom and current knowledge. Especially girls in urban areas experience a shift from traditional guidance to modern ways of acquiring knowledge trough modern media. Some girls are highly motivated to ease out the ignorance and misconceptions related to the prevailing conventional wisdom, but the majority of girls struggle with this as they consider respect for the beliefs and practices of their ancestors as important too.

Practices of girls depend on their sufficient level of knowledge, but also on the resources available and the examples and expectations provided by society. Girls that lack the knowledge on menstrual hygiene often fail to keep themselves clean and to use and change menstrual products in a proper way. Lack of knowledge on safe sexual practices, causes girls to have unprotected sex and being vulnerable to sexual diseases and pregnancies. Although some girls do have the right knowledge, the lack of availability and affordability of resources makes them unable them to manage their sexual reproductive health issues properly. Girls cannot buy menstrual pads or condoms due to lack of financial resources or because these products are not available to them within their neighbourhood.

6.2 Socio-economic and cultural influences

External factors highly influence the capability of girls to manage their sexual reproductive health like they reason valuable. Socio-economic and cultural factors highly influence the knowledge, beliefs and practices among adolescent girls as well as parents, teachers and health care providers. As already mentioned above, are lack of availability and affordability of resources a problem for the girls. Due to a lack of resources the girls are not capable to manage their sexual reproductive health the way they want to and need to in order to maintain good health. Sexual reproductive health is a topic that is preferably not discussed among communities in Magu and dealt with privately. People don't talk about these issues in public and within the family girls only discuss these issues with their mother and sister. This causes that girls feel unable to discuss issues, they feel uncomfortable and ashamed when the topic is addressed. There is a clear social script on what is socially expected from girls and this is passed on by older generations. The social and cultural related restrictions that are related to sexual

reproductive health negatively influence the sexual reproductive health of girls. Menstruation and sexual activity is highly stigmatized and a taboo. Being considered dirty and impure is not very good for a girls view about the self. Not being capable to carry out daily activities or having the freedom to visit a church or being together with other people are also things which restricts girls in their functionings. According to Sen's view do these girls grow up in impoverished circumstances, as they can't lead their life without shame, are unable to visit a church and being with friends and unable to keep track of what is going on and what others are talking about (Sen, 1985). Girls show feelings of shame when talking about issues regarding their sexual reproductive health, restrictions are imposed to them in line with social and cultural determined scripts on how girls should behave and as the topic is treated as a taboo they are unable to obtain the information needed to make well informed decisions. Although not all participants in this study perceived the cultural traditions as problematic, they admit that these old habits that have been passed on for generations are based on old customs and knowledge. Some traditions might be outdated and according to current knowledge some might even negatively influence the sexual reproductive health and rights of women. Due to social and cultural restraints, girls might develop a negative view of one self. The traditions are overlooked and this has to change. For ages, traditions have been the main source of informal education. Instruction are taught through rituals, songs, dances and narratives. This way of informal teaching provides the trust and understanding that people seek in dealing with various issues in life. For generations people rely on the wisdom of their traditions above other forms of learning. We need to acknowledge these traditions and specific forms of communication as we cannot simply impose our modern beliefs and practices to these cultures. But we can transfer our knowledge that might induce changes in cultural traditions. People can keep their traditions but just slightly adapted to up to date knowledge and skills, in this way we create scientifically explained but cultural sensitive education. Encouragement of respectful communication about sensitive topics like sexual reproductive health is needed to create mutual respect among boys and girls, men and women. Adapting new behaviours and giving up old habits however needs to involves common decision making, planning, motivational control and goal prioritisation processes in order to be successful (Schaalma et al, 2004).

6.3 Education on sexual reproductive health

It can be concluded that there's lack of sufficient education on sexual reproductive health. Cultural and moral influences on the acceptability of sexual desire and sexual behaviours mean that facilitating the development of social skills prerequisite to safer sexual practice is challenging. Existence of stigma and taboo disrupt communication and exercises crucial to the development of social skills (Schaalma et al, 2014) . Teachers' sexual experiences or moral views about teenage sexuality may make it difficult for them to facilitate the development of skills relevant to safer sex negotiation. They may also need to be sensitive to different (1) levels of experience; (2) values; and (3) sexualities amongst their students if they are to avoid alienating members of the class. Consequently, those who deliver education on sexual reproductive health may require special training (Schaalma et al, 2004). Sexual reproductive health education is basically given based on the traditionalist and functionalist approach of sexuality. Sexual health is treated as a moral issue and the emphasis is on abstinence before marriage. Also, focus is on the reproductive mechanisms of sexuality and practical knowledge on safe sex practices are taught in order to alleviate risks of pregnancies and sexual diseases. These two approaches are very useful, but rather conventional. As the education provided by teachers is often based on their own beliefs and behaviour, they often lose sight of the aim of education. No attention is been paid to the sexual rights girls have and the ability to have a responsible, satisfying and safe sex life (WHO, 2002). Education designed to shape behaviour must target psychological change beyond increase in knowledge. Education should include rules about confidentiality and exercise on feelings and values. Health promotion also depends on the establishment of a classroom atmosphere where young people feel free to discuss sensitive and intimate issues as this might also break taboos concerning the public discussion of sexual reproductive health related issues (Schaalma et al, 2014).

6.4 Sexual reproductive health related facilities

Based on observations and stories from girls, teachers and medical staff we can conclude that necessary facilities for adolescent girls lack regarding their sexual reproductive health. Because girls lack the resources, they are not capable to be or do what they consider valuable regarding their sexual reproductive health. Sexual reproductive health related services are, although on a small scale, available in Magu. Provision of information, treatment and contraceptives like condoms are available, but adolescent

girls simply not use these goods and services. Hospitals do not deliver a youth friendly environment for adolescent girls that lowers the threshold to seek for information or health related to sexual reproductive health issues and they are rather treated like adults when they come and seek for help. The hospital has no special program to teach adolescents about these issues and information provided is besides its safe sex practices character highly influenced by social views on sexual activity.

At schools water and sanitation facilities lack which causes girls not being able to maintain their hygiene. Lack of water causes girls not being able to clean themselves during and after a toilet visit, the little bucket of water available is often polluted and is a source of bacteria. The special needs of girls when having their period are not met as there are no disposal facilities. Toilets lack doors which causes girls not being able to manage their menstrual issues with privacy and dignity. As the toilets in school are extremely dirty and smelly, the facilities constitute a danger to the girls' health and makes them more vulnerable for sexual reproductive related diseases (figure 6.2)

Figure 6.2 Girls' toilet at secondary school Magu, Tanzania

Source: author

6.5 School attendance / drop out

Although girls and teachers report different reasons for absence or drop out of school, main reasons seem to be menstrual issues and sexual related issues like pregnancy. Schools are not equipped to address the special needs of girls which increases the chance on drop-out. During their period girls often leave school, if only for a few hours or the complete duration of their menstruation. As this is on a monthly basis, girls lag behind on the curriculum which might cause decreased performances, which in turn might lead to failure in passing a school year. As parents lack the financial resources and often not recognize the importance of education for girls, they tend to keep girls home as soon as this happens so a relatively small problem has tremendous effects on the life's of girls if it is not being solved. In case of disease or pregnancy girls are easily expelled from school instead of being taken extra care of. A is it a frequent occurring problem, it should be considered to develop a special program in order to keep these girls at school. Girls are now denied their ability to develop themselves and working towards a prosperous future. Instead they are designated to motherhood and the related responsibilities, often at a very young age (figure 6.3)

Figure 6.3 Dropout girl with her child in Magu, Tanzania

Source: author

6.6 The main research question answered

Based on the overall findings of this study, we can say that there's room for improvement for the sexual reproductive health situation of adolescent girls in Magu district. This chapter so far answered the sub-questions of this study, right now we turn to the main question and reflect on the theoretical framework.

The results of this study show the vulnerability of adolescent girls and the challenges they face regarding their sexual reproductive health. The majority reports that they lack sufficient knowledge, skills, economic resources and social support. They report that they are often not able to make their own choices regarding their menstrual and sexual health and feel influenced by social and cultural prevailing norms and values. Despite this they try to manage their sexual reproductive health the best way possible with the resources available to them. According to the capabilities approach of Sen and the complementing ideas of Nussbaum, the girls lack resources and capabilities in order to achieve certain functionings. Conversion factors like social, cultural and religious expectations and restrictions unable girls to make their own choices. The lack of ability to make their own choices influences their ability to translate capabilities into functionings. The conversion factors mentioned in the analytical framework highly influence the ability of girls to convert the resources into capabilities. The central human functionings related to bodily health and integrity are not beneath the capability threshold developed by Nussbaum, but they are far from desirable. The social scripting theory was highly applicable within this study, the appropriate behaviour as prescribed by social and cultural norms and values advocate for sexual restraint and control a for girls. According to Risman's theory on gender as a social construct, is the interpersonal level highly influenced by especially the interactional social level and also somewhat by the institutional level. Girls on the interpersonal level develop a negative view on menstruation and sexuality due to its dirty, impure displayed image and the possibility of dangers and risks as prescribed by the interactional level. On the institutional level the difference in how girls at school are supported and how their special needs are unmet, influences the interpersonal level of girls regarding sexual reproductive health issues. A tailor-made adolescent sexual reproductive health programme should be implemented at schools and hospitals and the community at large should also be included to improve the situation for adolescent girls in Magu.

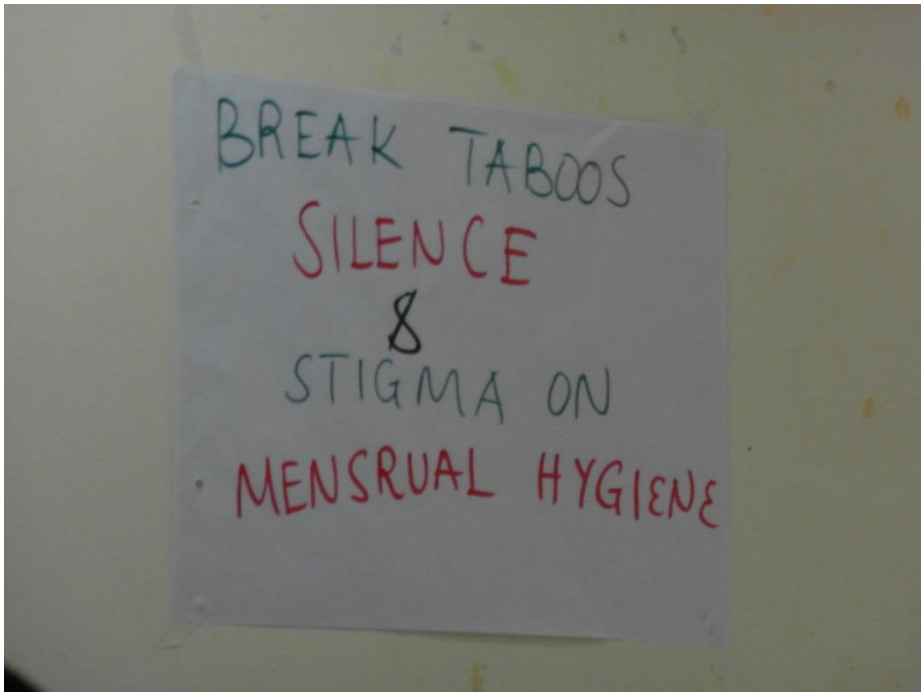
6.7 Recommendations

Countries should protect and promote the rights of adolescents to reproductive health education, information and care. Governments should establish appropriate mechanisms to respond to the special needs of adolescents, in collaboration with NGOs and the private sector. At the end of this internship, a kick-off meeting was arranged to present the results of this pilot study. In this meeting different actors could share their experiences and ideas on issues related to the sexual reproductive development of young girls. Present were SNV professionals in the WASH sector, employees from the different district offices that were concerned with education and health and several business man operating on the supply side of sexual health related goods. Based on the results of this study, although on a small scale, some recommendations were given that could be used to develop ways forward for policy implications and further research.

Policy implications – During the kick-off meeting everyone agreed that the sexual reproductive health situation among girls is subpar and has to be improved. Challenges experienced by these young girls should be eliminated as much as possible. We agreed that sexual reproductive health issues should be discussed openly and more transparent; the silence has to be broken and stigmas and taboos need to be eased out (figure 6.4). The facilities at school and in health centres have to be improved and need to be more adjusted to the needs of young girls. Everyone agreed that girls deserve a better future. Their sexual reproductive health has to be improved through better and more education, provision of goods and services should increase their confidence and dignity. A better sexual reproductive health would result in better school performances and higher levels of school attendance. The different actors believe that the current generation is able to make a change and create a sustainable sexual reproductive health status for themselves and future generations. If they receive good education and are better informed, they are able to pass this on to their children.

Teachers need to receive vocational training on sexual reproductive health and their full commitment and cooperation is needed. Teachers have to receive instructions on how to deal with the special needs of girls and on how to discuss these sensitive issues. Teachers play an important role as girls spent most of their time at school. Within the community awareness about sexual reproductive health has to be created, among parents, religious leaders etc.

Figure 6.4 SNV Kick off meeting on sexual reproductive health



Source: author

Attitudes of health-care providers should not restrict adolescents' access to the services and information they need. These services must safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values and religious beliefs as well as the rights, duties and responsibilities of parents.

Knowledge has to passed on in order to change cultural traditions that are harmful to the sexual reproductive health of girls. According to the people from the district offices funds need to be made available to meet the needs of girls in the community regarding their sexual reproductive health. Accessibility and affordability of pads has to be improved. The price for pads should be reduced and pads have to be sold in more shops especially in the rural areas of Mwanza. If the demand for pads increases the price can be lowered, but to achieve this a subsidy from the government is needed to create awareness among adolescent girls on usage of pads. Accessibility of water is point of attention for a long time already, the government is working on this as this is also part of the MDG's they would like to achieve. SNV is committed to deliver their contribution through provision of knowledge and facilities. District employees ask for help from organisations to improve facilities at schools, like clean and proper toilets. They advocate for a tool that monitors menstrual hygiene related management at schools on a monthly basis. Provision of services, goods and education should create a sustainable environment for girls to manage their sexual reproductive health (figure 6.5).

Figure 6.5 National sustainability day; sexual reproductive health for girls

Source: author

Different actors reported that concentration thus far was mostly on construction of facilities but that there was too little focus on capacity development. As a result, goods and facilities are not (properly) used and maintenance and sustainability is not established in this way. Focus on influence of social and cultural beliefs on practices in this study, was a valuable additive according to the different actors. With this in mind, future efforts can be more adjusted to this. Also, efforts so far by different NGO's or stakeholders from the private sector were experienced as uncoordinated which resulted in different actors bumping in to each other instead of collaborating and complementing each other. A kick-off meeting like this was positively received as the different actors were able to discuss the issues together and coordinate their efforts. Some actors reported that engagement of different actors is time consuming however, as it takes time to negotiate about establishment of development efforts in order to ensure everyone's full commitment. The different actors agreed on a three stage process involving first the assessment of the current situation, secondly the analysis of roles and responsibilities of different actors, and thirdly the mobilization of potential resources to create a sustainable sexual reproductive environment for young girls.

Further research - It might be useful to do more detailed research on existing cultural traditions related to the sexual reproductive health of girls. This study only focused on the cultural traditions related to menstrual and sexual issues, but sexual reproductive health includes much more than this so further research could be interesting. Although this study included many relevant actors, especially the ones so important for bottom up development. It is however also very important to do more extensive research on the role of NGO's, government and private sector as these actors have a huge influence within top down development. This research revealed that media is gaining more ground in developing countries, therefore more attention should be paid to the role of these new information resources in further research. This research focused on the story of girls, but boys might as well face challenges with their sexual reproductive health. Further research therefore could maybe include boys as well, to investigate their level of knowledge and their beliefs and practices related to sexual reproductive health. Thus far mentioned recommendations were based on the substantive part for future research. Recommendations on the implementation of research are also present however. This study only covered a small area of Tanzania, further research should cover a wider area as it is believed that these issues occur on a larger scale. Last, this research was carried out by a student, further research should be done by experts who have experience in investigating these sensitive issues.

6. Conclusion

7.1 A healthy sexual reproductive life; not so self-evident

This study made it very clear that leading a healthy sexual reproductive life, having the ability to make your own well informed decisions, not being restricted by social norms or cultural values, and being able to live your life in freedom and dignity is not something to be taken for granted. Unfortunately many young women around the world day after day, face challenges related to their sexual reproductive health. Lots of young women lack the knowledge to make healthy decisions regarding their sexual reproductive health, are hindered in their development and unable to live their life in freedom and with dignity due to imposed restrictions regarding their sexual reproductive health due to silence, stigma and taboo resulting from social, cultural and religious values and ideas. The results show that girls are not fully able to cope with their sexual reproductive health in a proper and sustainable manner. The fact that these girls are not provided with sufficient information, lack the ability to discuss sexual health related issues, face cultural and religious related restrictions and lack access to youth friendly sexual reproductive goods and services at school and in health centres undermines the rights of these girls. Violation of these rights is one of the underlying factors that perpetuates poverty. Unwanted pregnancies, pregnancies at young age and sexual diseases contribute to high mortality rates and low educational levels for example. If girls receive sufficient information and access to affordable sexual health related goods and services these problems can maybe overcome.

7.2 Concluding remarks

I would like to conclude this thesis with the words of a very inspiring women, Eleanor Roosevelt. She said: “Where, after all do universal human rights begin? In small places, close to home, so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person: the neighbourhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity and equal dignity without discrimination”. The same applies for the girls that participated in this study. All adolescent girls, regardless of having their period, being sexually active or being pregnant should be able to live life wherever they are, at home at school at the hospital or church, with dignity and without shame and discrimination. The highlighted

stories provided in the results section are examples of how different people, on a small scale seek for equal justice, opportunity and dignity for every girl. If these people are able to pull their strengths together, the initially small change might expand and trickle down on a larger scale. When I started my masters we got an assignment to make a picture that covered the international character of the study. Together with three other girls we decided to draw three different developing continents of the world in the air with a flashlight and photograph it with a slow shutter. This resulted in a picture that can be compared with the silver linings around a cloud. We titled the picture 'Silver Linings' because despite all the negative things going on in the world and the many people living in appalling conditions, we believe that hope dawns at the horizon. The same applies for this study. Although the results were somewhat negative I believe that the situation for these girls will improve bit by bit over time.

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8. Appendices

Appendix I

Questionnaire

Dear participant,

This questionnaire is to obtain information about menstrual and sexual reproductive health issues among girls. The questionnaire is to get more insight on how girls cope with sexual reproductive and menstrual health, to obtain information about attitudes and experiences regarding these issues and how these issues influence education opportunities.

Participation with this questionnaire is not compulsory. You are free to decide not to participate, or to quit filling in the questionnaire at any point.
The information from this questionnaire will be kept strictly confidential. All information will be processed anonymously. Information you provide will not be shared with anyone outside the scope of this research and will only be used for the purpose of this master thesis and goals of the host-organisation.

If there's anything unclear to you, please say so. If you have any questions before, during or after the questionnaire, feel free to ask them.

Thank you very much for your cooperation.

Lorraine Spruijt

- **I have read this information (or had the information read to me) I have had my questions answered and know that I can ask questions later if I have them.**
- **I agree to take part in the research.**

Date: _____-_____-_____ **Place:_____**

Name:_____ **Signature:_____**

Respondent number:

Research area:

Background information

Q 1.1 What is your age? _____
Q 1.2 In what grade are you currently enrolled? _____
Q 1.3 What tribe do you belong to? _____
Q 1.4 What religion do you practice? _____

Menstrual Health
The following questions will be related to menstrual health.

Q 2.1 Did you know anything about menstruation before onset of your menarche*?
(*menarche is your first time of menstruation)

- YES
- NO

Q 2.2 How did you experienced your menarche?

_____
_____
_____

Q 2.3 Have you ever received any information about menstruation? (If no, go to Q 2.4)

- YES
- NO

Q 2.3.1 From whom and/or where did you received this information?

_____
_____
_____

Q 2.4 Do you feel able to discuss menstrual issues? (If NO, go to Q 2.6)

- YES
- NO

Q 2.5 With whom do you discuss menstrual issues? _____
Q 2.6 With whom would you prefer to discuss menstrual issues? _____
Q 2.7 Have you ever attended classes about menstruation at school?

- YES
- NO

Q 2.8 Do you think the school should provide (more) classes on menstruation, less classes or were the number of classes sufficient?

- More
- Less
- Sufficient

Q 2.9 Please indicate whether you think the statements below are true or false, or you don't know.

Q 2.9.1 Menstruation is a disease
□ True □ False □ Don't know
Q 2.9.2 If you feel pain during menstruation, it means you're sick
□ True □ False □ Don't know
Q 2.9.3 It is harmful if a women does physical activities during her period
□ True □ False □ Don't know

Q 2.9.4 Pregnant women can menstruate

□ True □ False □ Don't know

Q 2.9.5 When women grow old they stop menstruating

□ True □ False □ Don't know

Q 2.10 On a scale of 0 to 10, indicate the average level of pain you experience during your period. (0= no pain at all and 10=worst pain you've ever had)

0 1 2 3 4 5 6 7 8 9 10

Q 2.11 Do you experience physical discomfort when menstruating? (If NO, go to Q 2.12)

- YES
- NO

Q 2.11.1 What physical discomforts do you experience when menstruating?
(You can pick more than one answer)

- Stomach ache
- Backache
- Headache
- Nauseous
- Other.. _____

Q 2.12 Do you experience emotional discomfort when menstruating? (If NO, go to Q 2.13)

- YES
- NO

Q 2.12.1 What emotional discomforts do you experience when menstruating?
(You can pick more than one answer)

- Feeling tired
- Feeling ashamed
- Feeling less confident
- Having mood swings
- Other.. _____

Q 2.13 Do you feel able to cope with your menstruation properly? (If YES, go to Q 2.14)

- YES
- NO

Q 2.13.1 What challenges do you experience when menstruating?

_____

_____

_____

Q 2.14 What products do you normally use when you are having your period?
(You can pick more than one answer)

- Tampon
- Sanitary pads
- Menstrual cup
- Cloths
- Cotton
- Natural materials
- Other.. _____

Q 2.15 Why do you use these product(s) and no other ones?

_____
_____
_____

Q 2.16 Does your menstruation make you unable to carry out daily activities? (If NO, go to Q 2.18)

- YES
- NO

Q 2.17 What activities are you not able to carry out when menstruating and why?

_____
_____
_____

Q 2.18 Below you see a list of cultural and societal traditions regarding menstruation from different communities around the world.

- The blood on exposed cloths will attract evil spirits so must be buried.
- Women are not allowed to touch cows because they are holy and may be contaminated.
- Isolation in women's huts where rituals are conducted and wisdom and experiences exchanged, because menstruation is believed to cause pollution at home.

Do you think these traditions are good or bad?

- Good
- Bad

Why?

_____
_____
_____

Q 2.19 Do cultural or societal traditions regarding menstruation exist within your community? (If NO, go to Q 3.1)

- YES
- NO

Q 2.120 What are these traditions and/or values?

_____
_____
_____
_____
_____
_____

Q 2.21 How do you think about these traditions and/or values?

_____
_____
_____

Q 2.22 Do you think these traditions and/or values need to change? (If NO, go to Q 3.1)

- o YES
- o NO

Why?

_____
_____
_____

Q 2.23 How do you think these traditions and/or values can be changed?

_____
_____
_____

THE QUESTIONNAIRE CONTINUES ON THE NEXT PAGE

Sexual Reproductive Health
The following questions will be related to sexual reproductive health.

Q 3.1 Have you ever received any information about puberty and sexuality? (If NO, go to Q 3.2)
- YES
- NO

Q 3.1.1 From whom and/or where did you received this information?

_____
_____
_____

Q 3.2 Do you feel able to discuss sexual issues? (If NO, go to Q 3.4)
- YES
- NO

Q 3.3 With whom do you discuss sexual issues?_____
Q 3.4 With whom would you prefer to discuss sexual issues? _____
Q 3.5 Have you ever attended classes about puberty and sexuality at school?
- YES
- NO

Q 3.6 Do you think the school should provide (more) classes on these issues, less classes or were the number of classes sufficient?
- More
- Less
- Sufficient

Q 3.7 Please indicate whether you think the statements below are true or false, or you don't know.

Q 3.7.1 A women can get pregnant on the very first time that she has sexual intercourse
□ True □ False □ Don't know

Q 3.7.2 A women is most likely to get pregnant if she has sexual intercourse halfway between her periods
□ True □ False □ Don't know

Q 3.7.3 Contraceptives (condoms etc.) only protect against pregnancy, they do not protect you against Sexual Transmitted Diseases (STD's)
□ True □ False □ Don't know

Q 3.7.4 Contraception pill might decrease menstrual pains
□ True □ False □ Don't know

Q 3.7.5 If you have a STD you are able to recover without any treatment
□ True □ False □ Don't know

Q 3.8 Have you been sexually active yet?
- YES (If YES, answer Q 3.9 till Q 3.16 and move to Q 3.18)
- NO (If NO, go to Q 3.17)

Q 3.9 What was your age when you had sexual intercourse for the first time? _____
Q 3.10 The times you have sex, is it your own choice?
- YES
- NO

Q 3.11 Do you use any form of protection against pregnancy and STD's when you're having sex?

- YES (If YES, go to Q 3.11)
- NO (If NO, answer Q 3.12 and then go to Q 3.14)

Q 3.12 If your answer on Q 3.11 was NO, can you explain why you didn't used protection?

_____

_____

_____

Q 3.13 If your answer on Q 3.11 was YES, what form of contraception did you used?

- Condom
- Contraception pill
- Withdrawal
- Other.. _____

Q 3.14 Have you ever got pregnant? (If NO, go to Q 3.16)

- YES
- NO

Q 3.15 What happened to the pregnancy?

_____

_____

_____

Q 3.16 Have you ever got any STD's? (If NO, go to Q 3.18)

- YES
- NO

Q 3.17 What did you do to cure the STD's?

_____

_____

_____

Q 3.18 If your answer on Q 3.8 was NO, what is your reason for not being sexually active yet?

- Not ready yet to have sex
- Not had the opportunity to have sex yet
- Sex before marriage is wrong
- Afraid of getting pregnant
- Afraid of getting any STD's
- Other.. _____

Q 3.19 Please indicate for the following statements if you agree, disagree or don't know.

3.19.1 Boys and girls can have sex before marriage if they love each other

□ Agree □ Don't know □ Disagree

3.19.2 Boys are allowed to force a girl to have sex if they love the girl

□ Agree □ Don't know □ Disagree

3.19.3 Most girls who have sex before marriage regret it afterwards

□ Agree □ Don't know □ Disagree

3.19.4 A girl has to remain virgin until she is married

□ Agree □ Don't know □ Disagree

3.19.5 I feel confident enough to insist on condom use when having sex

□ Agree □ Don't know □ Disagree

3.19.6 I would refuse to have sex with someone who is not prepared to use a condom

□ Agree □ Don't know □ Disagree

3.19.7 It is the responsibility of a girl to ensure that contraception is used

□ Agree □ Don't know □ Disagree

3.19.8 A boy will not respect a girl who agrees to have sex with him

□ Agree □ Don't know □ Disagree

Q 3.20 Have you ever visited a health facility to receive information or services related to menstruation or sexuality? (Contraception, pregnancy, STD's, etc.)

- YES (If YES, answer Q 3.21 till 3.24 and move to Q 4.1)
- NO (If NO, go to Q 3.25)

Q 3.21 How many times did you seek for information or services in the last three months? _____

Q 3.22 The last time you used health facilities, what was your reason for going?

_____

_____

_____

Q 3.23 Did you feel comfortable to talk with the health care provider about your issues or ask questions?

- YES
- NO

Why?

_____

_____

_____

Q 3.24 Do you think the information/services you received were sufficient?

- YES
- NO

Why?

_____

_____

_____

Q 3.25 Why have you never visited a healthy facility?

_____

_____

_____

THE QUESTIONNAIRE CONTINUES ON THE NEXT PAGE

School attendance
The following questions will be related to school attendance

Q 4.1 Have you missed any school days in the last four weeks? (If NO, you're finished.)

- YES
- NO

Q 4.2 How many days of school have you missed in the last four weeks?

0 1 2 3 4 5 6 7 8 9 10 10+

Q 4.3 Why weren't you able to come to school?
(You can pick more than one answer) (If you do not pick menstruation, you can skip Q 4.4)

- Menstruation Illness
- Pregnancy
- Family issues
- Financial issues
- Other.. _____

Q 4.4 If your reason for absence from school was menstruation, what aspect(s) of menstruation made you decide not to go to school? (You can pick more than one answer)

- Illness/Pain
- Lack of facilitations
- Lack of goods to manage menstruation
- Feelings of discomfort/shame
- Other.. _____

Q 4.5 If you picked any other reason for not attending school at Q4.3, can you elaborate a little more and explain more detailed what kept you from going to school?

_____
_____
_____

Q 4.6 What do you think needs to change to prevent you from missing school?

_____
_____
_____

THE QUESTIONNAIRE CONTINUES ON THE NEXT PAGE

Q 5.1 Please indicate on a scale from 1 to 5 how you evaluate the following statements:

1 = Strongly disagree
2 = Disagree
3 = Neither agree nor disagree
4 = Agree
5 = Strongly agree

Q 5.1.1 I have sufficient knowledge about menstrual and sexual reproductive health issues

1 2 3 4 5

Q 5.1.2 I have sufficient skills to cope with menstrual issues and sexual reproductive health issues

1 2 3 4 5

Q 5.1.3 I have enough economic resources (money etc.) to cope with menstrual and sexual reproductive health issues

1 2 3 4 5

Q 5.1.4 I have enough social resources (support from family etc.) to cope with menstrual and sexual reproductive health issues

1 2 3 4 5

Q 5.1.5 Cultural values do not restrict me in my decision making about menstruation and sexual reproductive health issues

1 2 3 4 5

Q 5.1.6 I feel able to make my own choices regarding menstruation and sexual reproductive issues

1 2 3 4 5

THE END

Thank you for your cooperation!

☺

Appendix II

Interview outline schoolgirls

*** Background information**
- age
- grade
- tribe
- religion

*** Menstrual Health**
- menarche
- information
- discuss menstrual health
- education
- knowledge
- experience (physical/emotional)
- coping/challenges
- cultural traditions/taboos

*** Sexual Reproductive Health**
- information
- discuss menstrual health
- education
- knowledge
- sexually active
- sexual behaviour
- cultural traditions/taboos
- usage health care services

*** School attendance**
- missed schooldays
- reasons
- prevention
- facilities

*** General**
- sufficient knowledge
- sufficient skills
- economic resources
- social resources
- decision making
- own choices

Appendix III

Interview outline dropout girls

*** Background information**
- age
- tribe
- religion

*** Menstrual Health**
- menarche
- information
- discuss menstrual health
- education
- knowledge
- experience (physical/emotional)
- coping/challenges
- cultural traditions/taboos

*** Sexual Reproductive Health**
- information
- discuss menstrual health
- education
- knowledge
- sexually active
- sexual behaviour
- cultural traditions/taboos
- usage health care services

*** School dropout**
- dropout age/grade
- reason
- family situation
- everyday life
- returning
- support (economic/social)

*** General**
- sufficient knowledge
- sufficient skills
- economic resources
- social resources
- decision making
- own choices

Appendix IV

Informed consent

Dear participant,

My name is Lorraine Spruijt, I am a student from Utrecht University in The Netherlands. For my master thesis I am doing research on sexual reproductive health among young girls in Tanzania. I cooperate with SNV (Netherlands Development Organisation) Tanzania, a non-governmental organisation (NGO) working on Water, Sanitation and Hygiene (WASH) issues in Tanzania.

Tanzania has high ratios girls being temporary absent from school or even completely dropout from school. In order to get more insight in the causes of this high ratios, SNV Tanzania is trying to analyse and improve the situation for school girls. As part of my master thesis, the aim of this research is to investigate how girls cope with sexual reproductive health issues and how it influences their education opportunities. This research is to get more insight in different factors that play a role in coping with sexual reproductive health. This research is to obtain information about attitudes and experiences regarding sexual reproductive health and menstruation among young girls.

For this research I will conduct interviews with girls who are in secondary school or dropped out of school. Also interviews with parents, teachers, nurses and people from the district office will be carried out. The interview will take about one hour.

Participation with the interview is not compulsory. You are free to decide not to participate, even during the interview you are able to quit at any point.
The information from this interview will be kept strictly confidential. All information will be processed anonymously. Information you provide will not be shared with anyone outside the scope of this research and will only be used for the purpose of this master thesis and goals of the host-organisation.

If there's anything unclear to you, please say so. If you have any questions before, during or after the interview, feel free to ask them.

Thank you very much for your cooperation.

Lorraine Spruijt

- **I have read this information (or had the information read to me) I have had my questions answered and know that I can ask questions later if I have them.**

- **I agree to take part in the research.**

Date: _____-_____-_____ **Place:_____**

Name:_____ **Signature:_____**

Contact: L.C.Spruijt E-mail: lorrainespruijt@gmail.com / Phone: 0768 300 829