Reproductive Health Education for Young People

A Case-Study in Magu district, Tanzania

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Supervised by:
Dr. Henk Huisman & Dr. Annelies Zoomers

Frida van der Graaf
3026868

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Executive Summary

The purpose of this study is to look into the factors that influence utilization of reproductive health education services by young people. To be precise, factors that influence utilization of reproductive health education by young people are the accessibility of the service as well as the quality, the awareness-level young people have, the youth-friendliness of the facilities provided and lastly there are socio-cultural factors that play a role. The study attempts to provide an answer to the question to what extent these factors play a role in utilizing reproductive health education services. The findings are extended into recommendations that can be used by every actor or stakeholder that strives to improve young people's reproductive health through education. In order to do this, the research was carried out in the District of Magu, in the Lake Zone in north-west Tanzania.

Reproductive health is important since it is a crucial part of general health and a central feature of human development. It has a strong influence on general health during childhood, adolescence and adulthood, but it also sets the stage for health after the end of the reproductive age for women is passed and it affects the health of the next generation. Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems. Reproductive health education is therefore particularly important for young people, because they are in a stage of their lives wherein they need to define their own norms and values for the rest of their lives. It is the stage where young people need to receive sufficient education in order to enable them to make well-informed decisions.

While development thinking has changed profoundly in the last decades, the notion of reproductive health has changed as well. It is not solely about physical well-being or family planning; it is about being capable to reproduce and having the freedom to decide if, when and how often to do so. Therefore it is important to recognize the right of men and women to be informed and to have access to safe, effective, affordable and acceptable family planning of their choice. The changes in the notion of reproductive health manifested itself in the International Conference on Population and Development (Cairo, 1994), which pledged to achieve universal access to reproductive health services for all people in all countries by the year 2015. Still much has to be done in order to achieve this goal, but also to achieve the Millennium Development Goals for which improving reproductive health is important, if not essential.

The research was carried out during a period of four months using qualitative and quantitative methods. Secondary data were collected from the Magu District Council, various health facilities and relevant NGOs and other organizations working in the area. Self-administered surveys were used to gather information from and gain insight into the perception of primary and secondary school pupils. Staff members at health facilities and NGOs were interviewed to gather practical information and gain insight into their opinions regarding young people's reproductive health. Lastly, focus group discussions were carried out with different groups of young people, including out-of-school youth. The findings present a case-study, explaining issues around young people's reproductive health education and how these issues relate to broader, national policies.

The findings show that the quality of the reproductive health (education) services need to be improved, as a primary concern, since many young people do not go to the facilities, because they know staff members will not be able to help them adequately. It is also shown that reproductive health education provided within the formal education system, by health facilities

and by NGOs raise the awareness of young people to a certain extent. However, their awareness-level should be higher, for them to make informed decisions and know where to go when they have questions or need help. Further, costs that come with using and the distance to the facilities are both barriers to access reproductive health services, although costs are found to be a bigger barrier to young people than distance. Thus, in order for people to raise their awareness, the accessibility of the services should be improved. Young people often feel too ashamed to go to a health facility to ask for reproductive health information; they fear being judged by community-members, or being treated badly by staff at the facility. Therefore, reproductive health should become a topic open for discussion in which young people can participate, so that they will feel free to go and ask their questions or ask for help and so that the relation between staff at health facilities and young people can be improved.

Much has already been done to improve service delivery in developing countries. The government of Tanzania also implemented many policies to reduce poverty and to enhance service delivery. One of the most important changes in policy was the shifting away of political and administrative authority from the national to the local government – decentralization, which increased ownership on the local level and the cooperation between civil society, the private sector and the government. In Magu District, some cooperation indeed exists between these stakeholders, but what becomes apparent in this study is that much more cooperation is needed concerning reproductive health. This support can be gained by emphasising the integral character of reproductive health. Only with the support from the various actors and stakeholders can reproductive health among young people be improved.

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Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
AMREF	African Medical and Research Foundation
GNP	Gross National Product
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
LGA	Local Government Authority
MDC	Magu District Council
MDGs	Millennium Development Goals
MKUKUTA	National Strategy for Growth and Reduction of Poverty
NGO	Non-Governmental Organization
NIMR	National Institute for Medical Research
PHC	Primary Health Care
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RHE	Reproductive Health Education
SAP	Structural Adjustment Programme
SNV	The Netherlands Development Organization
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAPs	Sector-Wide Approaches
TANESA	Tanzanian Essential Strategies against AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

The International Conference on Population and Development states that " reproductive health... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable family planning of their choice..." (UN, 2009). Today, reproductive health does not only include family planning, it entails much more, including the right to have access to information in order to make informed decisions about how to lead lives that result in good reproductive health.

Reproductive health is important since it is a crucial part of general health and a central feature of human development. It has a strong influence on general health during childhood, adolescence and adulthood, but it also sets the stage for health after the end of the reproductive age for women is passed and it affects the health of the next generation. Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems (UN, 2009). Therefore, reproductive health is particularly important for young people, since they need to be able to secure their reproductive health for their own future and that of their country. There is a certain stage in a person's life where parents do not look after their children as much as they did and young people need to define their own norms and values for the rest of their lives. This is the stage where young people need to receive sufficient reproductive health education in order to enable them to make the right decisions.

However, many problems exist for people in accessing and using the services that are, sometimes scarcely, available to them. Socio-cultural aspects and economic aspects play a role in these difficulties. Without a doubt, accessing these services is especially difficult for young people, because the services are often adult-centred and focus often solely on married women. This results in a situation wherein young people have a low awareness-level on reproductive health issues, leading to uninformed decisions and unsafe behaviour and all kinds of serious health problems, including HIV/AIDS.

This study investigates young people's reproductive health education and presents a case-study of Magu District in the north of Tanzania. The objective of the research is *to assess the awareness-level, accessibility and other factors influencing young people's utilization of reproductive health education services*. The aim is to give an example of the status of reproductive health education for young people.

Development of the Study

The research presented here was done in cooperation with SNV (The Netherlands Development Organization). In Tanzania, SNV works within the framework of the National Strategy for Growth and Reduction of Poverty (MKUKUTA). This strategy is aligned to the Millennium Development Goals and recognizes as the key implementers Local Government Authorities, Civil Society Organizations and Private Sector Organizations.

SNV Lake Zone Portfolio aims at improving the capabilities of local organizations in the areas of education, tourism, water & sanitation and livestock. Because they are interested in involving themselves in the education sector in Magu District, the researchers were asked to do a baseline survey in Primary Education and visit four primary schools in the District, in order to see what the status of primary education is and what SNV could mean to improve the situation. One of the aspects of education the organization is interested in is the issue of school girl's pregnancies, especially in primary schools, since this seems to be a problem in the Lake Zone. The host-organization wanted to know what the reasons are that this problem exists and what can be done to improve the situation. Because an important reason for the existence of this

problem and many other problems related to reproductive health, may be lack of education on reproductive health education this interest provided the researcher with an excellent entry point to research young people's reproductive health education.

Yet, the study presented here is much broader: the issue of school girl's pregnancies is merely the entry-point for the research. Besides the perception of primary school pupils, secondary school pupils are also an important part of the research. The rationale for doing extensive research into the formal education system is that most young people in the district attend at least a few years of education, meaning that reproductive health education within the schools has the potential to reach the majority of the relevant population. In addition, health facilities, non-governmental organizations and other organizations working in reproductive health were visited in order to see what role these organizations have in educating young people on reproductive health issues. For the study, the perception of out-of-school youth is also important.

Structure of the Study

The central research objective of the study is *to assess the awareness-level, accessibility and other factors influencing young people's utilization of reproductive health education services.*

In order to assess this objective the thesis is divided into four parts.

First, the study is dedicated to provide the several trends and themes important for the issue at hand (chapter 1). In addition, the contextual framework for Tanzania is provided in chapter 2, divided into the national level, the regional level and the local level. This chapter gives information about the historical background of Tanzania and opens up on the several trends in policies related to health and education. Chapter 3 provides an overview of the status of young people's reproductive health in Tanzania, offering a link between the first and the other parts of the study.

The second part outlines the research questions and explains about the methodologies used during the fieldwork in order to gather interesting data and answer the research questions, for the area in which the research was carried out (chapter 4).

The third part deals with the analysis of the data gathered using the methodologies in chapter 4. This part is divided into four chapters. First, a chapter is dedicated to providing an overview of all reproductive health education services that are available in the research area (chapter 5). Second, a chapter focuses on the awareness-level of the respondents in the research area (chapter 6). Third, a chapter explains how accessible reproductive health services are for young people in Magu District, while an overview of their utilization of these services is provided (chapter 7). The last chapter in this part explains what the several factors are that influence utilization of the reproductive health services (chapter 8).

The fourth and last part runs through the main findings again and provides recommendations for the host organization and potential other policy makers improving reproductive health in the district.

Chapter 1
Thematic Framework Reproductive Health

Through time the concept of reproductive health (further referred to as RH) has changed profoundly, especially from the 1980s onwards. It has changed together with changes in discourse in development thinking. This chapter provides the thematic framework in which this thesis is structured in. The first part of this chapter provides an overview of the changes in discourse, or the evolution of development thinking, in order to clarify how several important concepts, relevant for this thesis, have changed with the changes in discourse. The second part will give an overview of health sector reforms in developing countries from the 1980s onwards. Then, the third part will explain what kind of implications these reforms have had on RH and what kind of leading concepts came about through these reforms. The fourth part focuses on why RH is important, touching upon Amartya Sen's capabilities approach and the Millennium Development Goals (MDGs). Lastly, the focus will be on RH for young people and the leading concepts that are relevant for this issue.

1.1 The Last Fifty Years of Development Thinking

The economic and social development of the Third World was evidently not a policy objective of the colonial rulers before the Second World War. In the late forties and fifties, scholars started being seriously interested in studying and better understanding the development process as a basis for designing appropriate development policies and strategies. This part will provide a short overview of the changes in development discourse from the 1950s onward.

1.1.1 The 1950s-1960s: Modernization

In the 1950s, economic growth was absolutely the main policy objective in the newly independent countries. The common belief was that these countries would follow the same path to development as western countries did, with no attention given to the historical differences in starting positions between non-western and western countries. Economic growth and modernization would eliminate dualism and income inequalities. Growth of the Gross National Product (GNP) was believed to be the solution to all other social and economic objectives.

Industrialization was conceived as the engine of growth which would pull the rest of the economy along. Developing the industrial sector included the implementation of import-substitution and developing countries had an in-ward looking approach to industrial growth. This led to the fostering of highly inefficient industries. The agricultural sector was looked at as a passive sector that could be stressed and discriminated against in order to extract the necessary capital resources to fuel industrial growth. A minimal amount of public resources were going to rural areas and there was a lack of encouragement given to the promotion of rural institutions. This resulted in rural areas that lagged far behind the industrial sector.

During the 1960s the complementary and essential role of the agricultural sector became appreciated again. At an early stage of development a gross flow of resources from industry to agriculture was necessary to generate an increase in agricultural output which would facilitate the growth of the industrial sector; inter-sectoral linkages were needed.

In addition, policy makers for the first time realized that creating an attractive environment would encourage the build-up of productive activities (Thorbecke, 2006).

1.1.2 The 1970s: Dependency Theory and the Basic Needs Approach

By the seventies it was clear that many serious problems were not solved and could not be overlooked. The most important problems included; the increasing level of unemployment, the unequal income distribution, the many and rising number of people living in poverty, rising rural-urban migration and the worsening external position of development countries.

The late sixties were the start of a new approach towards development thinking; radical dependency theory. Followers of this theory claimed a neo-colonial system of exploitation had replaced the previous colonial system, in which the backward position of developing countries was built-in in a world power and trade system. This theory called for a massive redistribution of assets to the state and the elimination of most forms of private property in order to become self-reliant.

One of the ideas which surfaced in the seventies includes the clear interdependence between economic and demographic variables. A number of empirical studies appeared that tried to shed some light on the relationship between sets of variables as education, nutrition, health and fertility, infant mortality and birth rate. These studies highlighted the complex nature of the relationship between population growth and economic development.

By the mid-seventies it was clear in many circles that aggregate growth is not synonymous with economic and social development. From a belief that growth was a necessary and especially sufficient condition for the achievement of economic and social development, it became increasingly recognized that, though necessary, growth was not enough. One of the first steps that had to be taken was to move away from aggregate growth by itself towards poverty reduction. The *basic needs* approach was developed in a response to this change. This approach includes two elements; certain minimal requirements of a family for private consumption, such as adequate food, shelter and clothing and essential services provided by and for the community at large, such as safe drinking water, sanitation, and health and educational facilities (Thorbecke, 2006).

1.1.3 The 1980s: The Lost Development Decade

The eighties are often characterized as *the lost development decade*. Because of the extremely heavy foreign debt burden, higher interest rates and a recession in the western countries the international institutions such as the International Monetary Fund (IMF), World Bank and USAID put the development and poverty alleviation process on hold until developing countries agreed to implement Structural Adjustment Programmes (SAPs). These were the conditions of loans given for so called ‘economic restructuring’. The programmes entailed among others the reduction of public spending, price reforms, the liberalization of trade, privatization of public enterprises and institutional reforms (Potter, Robert B, 2004). Under the influence of ideological changes in the Western World, strongly influenced by the Reagan and Thatcher administrations, developing countries were strongly encouraged to rely on the operation of market forces.

Even though development and poverty alleviation were put on hold some important contributions to development thinking were formed during this decade. One of the contributions, particularly relevant to this thesis is that it became clear how important human capital is as the prime mover of development and also how important the government’s role is in improving human capital. Even though the IMF and the World Bank had decreed that the government’s role should be as small as possible, it became clear that investing in e.g. health is not beneficiary to the private sector, but it is in the long run for a country and its government. Thus, the government was needed in improving service delivery.

Many international NGOs had serious complaints about SAPs. According to them neither the IMF nor the World Bank has been able to show any connection between SAPs and economic growth. UNICEF published a paper that highlighted the reversals in human development that were currently occurring after a period of previous advancements. However,

these international organizations did not question the need for adjustment; they simply wished there was more attention to the needs of vulnerable groups (Thorbecke, 2006).

1.1.4 The 1990s-Now: Poverty Reduction and Good Governance

SAPs which were believed to stabilize developing countries were still thought of as necessary and crucial up till the mid nineties. However, critical scrutiny followed and 'adjustment with a human face' became the preferable development strategy. More attention was given to vulnerable groups in society, such as women and children under 5. The eighties showed an abandonment of poverty alleviation as the prime goal of development, but the nineties again took poverty alleviation as the prime goal (Thorbecke, 2006).

In the early nineties, concepts like good governance and social capital came to be prominent on the international development agenda's. More attention was given to the social networks, or social capital, poor people often already have to cope with their poverty. Social capital was proven to be complementary to human capital. Now attention was given less to 'the government', and more to 'governance'; the sound management of a country's economic and social resources for development. Governance entails the processes of networking and establishing partnerships and the framing of collective action, which means that it includes topics such as democracy, human rights, accountability and the fight against corruption (Nuijten, 2004). However, the outward orientation and the reliance on markets remains the trend.

The evolution of development thinking was described in chronological order, even though many of the above theories and ideas changed through time and influenced each other. This order was chosen, because it gives an impression of the changes in development thinking that eventually resulted in changes in service delivery. In the next section it will be explained how these changes in development thinking influenced the health sector in developing countries.

1.2 Changes in Development Thinking and its Influence on the Health Sector

Over the last two decades health sector reforms (HSR) have been taking place in most developing countries. In low-income countries public health services have deteriorated as a result of rising costs and investments falling short of need. Health services are overburdened due to diseases as HIV/AIDS and are facing increasing problems because of ageing populations. Therefore, health reform was and is needed. Box 1.1 describes the goals of health sector reforms. This section will clarify what influence the changes in development thinking from the 1980s onwards have had in reforming the health sector.

1.2.1 The Eighties up until the Mid-Nineties

Because of the economic crisis and the SAPs in the eighties, public expenditures were cut back from the health sector which resulted in public-sector health facilities falling in chronic disrepair at all levels. The quality of the health sector deteriorated, often with missing or broken essential equipment and a lack of supplies. Many facilities lacked skilled health staff and wages fell which resulted in staff members asking informal payments from their patients. The costs of health care for the poor rose and more and more people were forced to use private services or treat themselves with traditional methods. Health sector reforms in this period were an attempt to deal with serious challenges caused by the collapsing health services delivery in many poor countries.

The reforms in this period mainly focused on improving the functioning of the national Health Ministries through more efficient financial and human resource management. Financial management was dealt with by implementing user-charges, pre-payment schemes and insurances, while human resource management was improved by the introduction of other means of performance monitoring.

Improving the quality of the services was attempted by encouraging the government to develop a more selective approach to primary health care by introducing minimum packages or 'basic packages' of services (Dmytraczenko, 2003).

Arguably the most important organizational change that had its influence on health sector reforms is decentralization. According to the World Bank, improving service delivery is an implicit motivation behind most decentralization efforts in developing countries (Ahmad, 2005). It is believed that decentralization would especially improve service delivery to the poor. There are different forms of decentralization, which is shown in box 1.2.

Box 1.1: Five Goals of Health Sector Reform

Health sector reforms try to correct system wide problems in health care that hinder the delivery of priority services. Five goals underlie the reforms:

Efficiency: Health improvements should be achieved at the lowest possible cost.
Quality: Appropriate and safe clinical services, adequate amenities, skilled staff, and essential drugs, supplies, and equipment should be available.
Equity: Health resources should be distributed fairly so that nobody is denied access to essential care.
*Client responsiveness***:** The system should meet people's expectations and protect their rights, including their rights to individual dignity, privacy, autonomy in decision-making, and choice of health provider.
*Sustainability***:** The health system can continue to achieve its goals using available resources.
Source: WHO, 2000

Basic services such as health are the responsibility of the state. However, these services are systematically failing, especially the poor. Public spending seems to have only a weak relationship with outcomes. According to the World Bank, public spending on health does not have a significant association with reductions in child or infant mortality. The failure of services is the most important reason to decentralize (Ahmad, 2005).

It is often said that the eighties hold the essential start for decentralization, but that decentralization efforts increased during the nineties. In respect of health, the concept emerged in the wake of the Primary Health Care (PHC) Conference at Alma Ata in 1978. Decentralization was increasingly recommended during the nineties as an essential strategy of health sector reforms, because of its perceived potential to improve the quality and efficiency of government health services.

Placing decision makers closer to the users and given the users a voice in the process will equal better decision-making. Similarly, matching health services closely with local needs and preferences, which can be achieved with decentralization, was argued to increase (technical) efficiency and thereby improve the quality of public services. Thus, serious efforts were made from the early nineties onwards to decentralize in order to improve public health services (Kawonga, 2003).

Box 1.2: Different Forms of Decentralization for the Health Sector

Deconcentration: Administrative responsibilities are transferred to locally-based offices of a national government ministry. The office remains accountable to higher levels of government.
Delegation: Management responsibility is transferred to a semi-autonomous entity such as a health board. The entity remains accountable to the national government.
Devolution: Political and administrative authority for health is transferred to an independent local-level statutory agency, e.g. a local council. This agency is typically allowed to generate revenue and is therefore accountable to the electorate.
Privatization: Health functions are transferred to a private entity. Goal of the state is to improve the quality of the services by encouraging consumer participation and competition. The government still holds some regulatory and overall co-ordination responsibility. The entity is accountable to the government and the consumer of services.

Source: Mills, 1990

Apart from these policy reforms, governments were pushed to develop stronger relations with the private sector, since they were believed to be more efficient and able to reach a larger part of the population. Of course, the eighties and its neo-liberalism believed that the competitiveness between private health facilities would improve the quality of the service.

The health sector reforms of the eighties and the early nineties led to some concerns, including the fact that the health sector reforms overall had a 'one size fits all' approach which did not take into account contextual factors, such as the nature of the political regime, which have their influence on the reform's outcome. In addition, the reforms did not take into account important stakeholders at the local level, such as civil society organizations which could have a huge impact on the improvement of health service delivery (Dmytraczenko, 2003).

1.2.2 The Late Nineties

In the late nineties the bilateral aid budgets continued to decline, but there was an increase in the loans from multilateral agencies, particularly for expenditures in the health and education sector. This was partly because of an increasing concern of the negative effects of SAPs on the social sectors in developing countries.

There was a move away from donor-specific project funding to what became known as sector investment programmes and sector-wide approaches (SWAPs). Project based funding was seen as distorting national planning and creating islands of better resourced programmes and services. Thus, more long-term planning and financing of health and other sectors was needed, negotiated between governments and the group of aid donors and multi-lateral organizations. At this time, more attention was given to the needs and concerns of users and to the role a broader group of stakeholders could play in providing health services.

Because the previous decade had not shown many improvements in health service delivery, especially in Sub-Saharan Africa, there was the concern what should be done to actually improve the services. However, the failure of the health sector reforms of the eighties and early nineties had many reasons, including the HIV/AIDS pandemic which has produced an economic and social crisis in some countries which goes beyond issues of health service delivery and has seriously affected health and social indicators, but also wider systematic problems, like armed conflict.

The late nineties were characterized by an increased awareness that the development of basic packages and selective interventions were the way to improve health service delivery. In this manner a maximum health gain per unit of expenditure would be created in order to use the scarce resources as efficiently as possible. There was also more attention for the ways to regulate the private sector in health service delivery. Also, social marketing of packageable health goods and services such as condoms, contraceptives and mosquito-nets became a common way to reach as many people as possible (Dmytraczenko, 2003).

1.2.3 Late Nineties up until Now:

The period from the late nineties up till now has seen that the triumph surrounding neo-liberal ideas and policies should be re-assessed. The IMF's 'one size fits all' approach was attacked by many scholars and poverty has re-emerged as a global concern in key macro-economic groups such as the G7 and international financial institutions. The link between poverty and poor health was proven en became clear to these organizations and other influential groups.

The Heavily Indebted Poor Countries Initiative which focuses on the 40 poorest countries, links debt-relief to increased national spending on the social sector. The World Bank required these poor countries to create Poverty Reduction Strategy Papers (PRSPs) in order to receive loans with low interest rates. Countries are expected to undertake poverty assessments involving discussions with poor people regarding their needs and concerns. In these discussions health concerns were prominent. Poor people especially stressed the devastating effect of illnesses on their ability to work and the high costs of treatment which causes them to fall deeper into poverty.

As clarified earlier, the idea that ill health is both a cause and consequence of poverty was clear for a few decades, but it fell off the international poverty alleviation program in the eighties. The PRSPs helped put this issue back on the agenda. International institution's commitments to poverty reduction have become enshrined in the Millennium Development Targets (see box 1.4).

In the late nineties the consensus developed that health is a 'global public good' which means that health is a good where one person's use does not prevent another person from using it, the use of health should be available to everyone and the benefits of health extend across national boundaries. This consensus came about in a time of an increasing awareness of the threats of the international nature of communicable diseases (Standing, 2002)

The health reform agenda in the last decade or so up till now was and is being influenced heavily by governance and accountability issues. Since the late nineties these issues are part of a larger international debate about what the underlying conditions should be for economic and social development and what kind of role the government should play in creating these conditions, but also about how to improve the performance of the delivery systems in the health sector.

The concept of accountability describes the rights and responsibilities that exist between people and the institutions that affect their lives, including governments, civil society and market actors. Two issues are important regarding accountability; *answerability* – the right to get a response and the obligation to provide one – and *enforceability* – the capacity to ensure an action is taken, and access to mechanisms for redress when accountability fails. When accountability works, citizens are able to make demands on powerful institutions and ensure that those demands are met. When institutions such as health facilities are more responsive, users will know better what their rights are and gain access to the facilities (Newell, 2006),

It is interesting that the debate nowadays is more about how health services are provided and less about who delivers the services, which was the debate up till the early nineties. Attention is given more and more on ways to keep governments and service providers accountable to their clients.

1.3 Health Sector Reforms and Their Influence on Reproductive Health

The health sector reforms from the 1980s onwards have been outlined earlier. Here it is explained what kind of influence these HSRs had and have on reproductive health service delivery and reproductive health in general. This influence will be explained in the context of the macro-economic changes from the 1980s onwards.

In the period from 1980 up to the mid-nineties, RH was not given much attention. It was not until the 1994 Programme of Action of the International Conference on Population and Development (ICPD) that RH was given more attention. This was a conference held in Cairo which pledged to achieve the goal of universal access to reproductive health services for everyone in all countries in 2015. An impressive number of 179 countries declared and pledged to make changes in their legislation and RH related policies according to the Program of Action (Abrejo, 2008). This conference defined reproductive health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or sickness, in all matters relating to the reproductive system and to its functions and processes'. A summary of the ICPD goals is provided in box 1.3.

Box 1.3: Goals of the ICPD

During the ICPD a few goals were formulated directly related to RH. Here, a short summary of these goals is provided:

- *Access to Reproductive and Sexual Health Services*

By the year 2015, all countries should have made sure that reproductive health services are accessible through the primary health care to all individuals of appropriate ages. The most important reproductive health services include:
Family planning information and services; safe pregnancy and delivery services, prevention and treatment of sexually transmitted infections; prevention of abortion and dealing with the consequences of abortion; attention to other factors, such as violence against women.

- *Reduction of Infant and Child Mortality*

By the year 2000, countries should have reduced their infant and under-five mortality rates by one third, or to 50 and 70 per 1000 live births. By 2015, all countries should aim to achieve an infant mortality rate below 35 and an under-five mortality rate below 45 per 1000.

- *Reduction of Maternal Mortality*

Since all countries have different 1990 levels of maternal mortality, different countries have different goals. However, all countries should reduce maternal mortality levels and disparities in maternal mortality within countries and between regions, socio-economic and ethnic groups should be narrowed.

Source: United Nations ICPD, Programme of Action: Chapter 7 and 8, 1994

The little attention given to this important topic before the ICPD can be largely explained by two reasons. First, health sector reforms in this period were more concerned with the supply side of the services, meaning they were more concerned with issues regarding the financing mechanisms and human resource management, while RH advocacy was more concerned with the services itself and how these are delivered to the clients. Second, this period can be characterized by the concern of the providers to at least be able to provide basic packages to the

client. Reproductive health services were seen as 'special interest' services, which resulted in health sector reformers neglecting this sector (Standing, 2002).

The late nineties dealt with implementing the Programme of Action of the ICPD, but it proved to be quite difficult to translate the Program of Action into practice. One of the biggest issues was the fact that most public, but also many private, services were not able to integrate reproductive health services into their 'normal' set of services. When they were able to integrate these services, they were often not able to broaden service provision beyond family planning and maternal and child health services. Donors continued to fund reproductive health services vertically, despite the move towards SWAPs. There was little advocacy for implementing SWAPs in the health sector, proven by the fact that USAID, the largest donor in the field of RH, still does not participate in sector-wide approaches and by the fact that international bureaucratic interventions like Safe Motherhood programmes, do their work via parallel tracks, with separate management structures and budgets (Standing 2002).

According to a report of the UN Development Programme 2006, advances in this area have also been hindered because of the complexity of the concept. Matters related to sex and reproductions are sensitive, enmeshed in issues of culture and ideologies of social institutions and personal identities. This means that various groups in society have different understandings and positions on RH. Public discussion and attentions may be limited so that political division can be avoided or because there is stigma attached. (Crichton 2006).

The period from the year 2000 up until now has shown some challenges. The Bush administration followed a powerful anti-progressive path and has undone some of the progress in advocacy for RH of the last decade. Health sector reforms have marginalised the Program of Action and internationally driven initiatives have continued to work via parallel tracks, not working with SWAPs. A further important issue is the fact that RH is not directly implemented in the Millennium Development Goals (MDGs), much to the surprise of many scholars (Standing 2002).

Much effort is still needed to build advocacy for RH on national and international level and to build bridges between the various stakeholders in order to find a way into good policy. One of the issues that need to be dealt with is the operationalization of the expanded concept of RH, e.g. gender inequality and accessibility. Although RH is not directly included in the MDGs, not all is lost, since some of the goals can obviously be linked to RH. Maternal mortality remained a target in the MDGs, and HIV/AIDS is there as well. Gender equality and empowerment, issues that obviously have much to do with RH, are there as well, especially in the education targets (Standing 2002).

1.4 Importance Reproductive Health

The previous section explained why so little attention was and, to a certain extent, still is given to RH. This section will attempt to explain why improving RH should not be neglected. For this purpose an overview is provided of the RH problems people in developing countries face, after which it is explained why especially improving reproductive health education (further referred to as RHE) is important for the development of a country and specifically for the achievement of the MDGs.

1.4.1 Reproductive Health Problems

A lack of access to reproductive health services is a major public health concern, especially in developing countries. Globally, death and disability due to bad RH accounts for 18 percent of the total disease burden. Bad RH accounts for 32 percent of the disease burden among women of reproductive age (15-44). Of course, there is much regional variation; due in large part to the HIV/AIDS crisis, the reproductive health disease burden accounts for about one third of Africa's total disease burden.

Even though there have been significant declines in fertility in most regions of the world, these declines have recently slowed down. Especially in Sub-Saharan regions fertility rates remain high, and within countries people in rural areas often do not have access to family planning information and services which leads them to have the highest fertility rates.

The level of contraceptive use accounts for a substantial portion of the variation in fertility rates. Unfortunately, although there have been dramatic increases in the use of family planning services the unmet need for family planning remains very high in various regions. What is worrying is that a large proportion of married men aged 25-39 in Sub-Saharan Africa say that they have not discussed family planning with their partners. Also, condom use within marriage is associated with unfaithfulness and mistrust, which leads contraceptive use among married people to be very low (Bernstein 2006). Unsafe sex is the second most important risk factor leading to disability or death in the poorest communities and the ninth most important in developing countries (Glasier, 2006). The availability of contraceptive methods is thus very important for the lives of people living in developing countries.

Hundreds of millions of women every year suffer disability as a result of pregnancy complications and more than half a million die in pregnancy and childbirth, or following unsafe abortion (Glasier, 2006). The large majority of these deaths occur in developing countries. While women in industrialized countries face a 1 in 2,800 chance of dying in pregnancy or delivery, women in Sub-Saharan Africa (SSA) face a risk of 1 in 16 (Bernstein, 2006). Almost all these deaths are preventable, especially by increasing the proportion of births attended by skilled health workers, which is now only 41 percent in SSA, and by giving more attention to the problems around abortion, which accounts for 13 percent of maternal deaths.

The HIV/AIDS pandemic constitutes a major threat to the development of especially countries in SSA. In this region the epidemic is established in the general population and is largely spread through heterosexual contact. It is the second most important cause of loss of health in women, especially young women, and it almost always are the poor and the marginalized that are at greatest risk of exposure. More than half of men and women in most countries lack comprehensive and correct knowledge on how to prevent HIV transmission (Bernstein, 2006)

All these problems that exist because of bad RH show that improving RH is important for the lives of many people.

1.4.2. Improving People's Capabilities through Reproductive Health Education

The human development approach, Amartya Sen's work and his book Development as Freedom (1999) are particularly relevant for the issue at hand. The human development approach arose partly because of the growing criticism to the dominant development approach of the 1980s and beliefs in a strong link between economic growth and the expansion of individual human choice. Amartya Sen and others provided an alternative and broader human development approach, defined as a process of enlarging people's choices and enhancing human capabilities and freedoms, enabling them to live a long and healthy life, have access to knowledge and to have a decent standard of living and lastly participate in the life of their community which enables them to make decisions affecting their lives.

> "Human development, as an approach, is concerned with what I take to be the basic development idea: namely, advancing the richness of human life, rather than the richness of the economy in which human beings live, which is only a part of it." *Amartya Sen - UNDP*

Amartya Sen with the capabilities approach believes that policies should be evaluated not on the basis of their ability to satisfy utility or increase income, but on whether or not they enhance the

capabilities of individuals and their ability to perform socially accepted functionings. Capability can be explained as a set of various functionings that a person can achieve that reflects a person's freedom to lead one type of life or another (DeJong, 2006, Fukado-Parr, Sakiko, 2003).

When discussing RH, capabilities embrace concepts such as the ability to live through pregnancy and to a mature age without suffering premature mortality. It is important to note that two people could be equally deprived of functioning, e.g. having unsafe sex, but not have the same capability. One person could not use a condom, with all risks involved, out of free will, while the other might be deprived of any contraceptive methods or is not educated on how important condom use is.

Choice in RH is essential; people should be capable of deciding for themselves when and where they want to have a baby and whether or not to use contraceptive methods. However, to make the right decisions, people should be educated so that they can make informed decisions.

Therefore, education is one of the most important components of development as freedom. Education is a basic capability that promotes freedom and agency to participate further in education and to enlarge wider freedoms. This is interesting; because it contradicts the basic needs approach that believes people only need a basic minimum of education. Now, it seems policy makers realise that practical skills are not enough in order to enable people to improve their lives; people also need to understand the consequences of their behaviour, feel responsible and have the ability to make decisions that do not compromise the choices of future generations (Radja, 2003). This is the essence of RHE, where people learn these important skills.

Thus, with qualitative RHE, people will learn the skills to make the right and informed decisions that will improve their lives and the lives of others.

1.4.3 Achieving the Millennium Development Goals

This link between demography and poverty reduction has been contested through time. However, with the coming of the Millennium Development Goals (MDGs) arguments for the importance of good RH are easy to find. Many reports have been written on this issue. According to these reports RH is an important aspect in achieving the MDGs by the year 2015. The MDGs are outlined in box 1.4.

Primarily, declining fertility rates, but a healthier population provides a unique chance to spur economic development as the work force increases, but the dependency burden of society decreases. When the MDGs were formulated and accepted by the largest gathering of world leaders in history in 2000, many scholars were surprised that achieving universal access to reproductive health services was not included in the Goals. Especially because the large majority of all countries had agreed to achieve access to primary reproductive health services for all individuals in 1994 and by the year 2015.

In 2005, the United Nations came with a report after the World Summit of that year that ratified the belief that progress towards the MDGs depends on attaining the ICPD's reproductive health goals (United Nations, 2005). In the next section, it is explained how improving RH and access to these services will help substantially in achieving the MDGs.

According to Bernstein (2006), the achievement of the MDGs is influenced by population dynamics such as population growth, fertility and mortality levels, age structure and rural-urban distribution. Each developing country has its own combination of demographic factors that affect the prospects for progress towards the MDGs and the course of and prospects for poverty reduction.

Three of the eight MDGs are directly linked to RH. The first one, reducing child mortality (Goal 4), is influenced by maternal behaviour and fertility. Children born to very young mothers and children born to close together are at an increased risk. Actually, children born to teenage mothers are twice as likely to die during their first year of life as those born to women in their 20s and 30s. The mother's RH and her knowledge on RH issues are important to achieve this MDG. Improving maternal health (Goal 5), is very much connected to the fourth

goal. There are about 205 million women in the world with an unmet need for contraceptive methods, which means that even when they want to delay their first birth or when they want to have more space between children, this is very difficult to achieve. On top of that, only about 70 percent of births in developing countries are preceded by at least one antenatal care visit. Improving access to reproductive health services is thus important for achieving goal 4 and 5. The third goal that is directly related to RH is goal 6; combating HIV/AIDS, malaria and other diseases. This is related to the availability of contraceptive methods and improving access and use of preventive services. Education on this issue is important in order to prevent more infections from occurring (Bernstein, 2006).

Box 1.4: The Millennium Development Goals

During the Millennium Summit in September 2000 the Millennium Development Goals (MDGs) were adopted by the largest gathering of world leaders in history. By doing this, these world leaders committed their nations to a new global partnership to reduce extreme hunger and poverty and setting out a series of quantified and time-bound targets, with a deadline of 2015. These goals also entail basic human rights; the rights of each person on the planet to health, education, shelter and security. The MDGs consist of eight goals, shown in figure 1.1.

Figure 1.1: The Eight Millennium Development Goals

1	Eradicate extreme hunger and poverty
2	Achieve universal primary education
3	Promote gender equality and empower women
4	Reduce child mortality
5	Improve maternal health
6	Combat HIV/AIDS, malaria and other diseases
7	Ensure environmental sustainability
8	Develop a global partnership for development

Source: United Nations, 2006

According to the United Nations there has been significant process in achieving most of the goals. Between 1990 and 2002 the average overall incomes increased by 21 percent, the number of people in extreme poverty declined by an estimated 130 million, child mortality rates fell from 103 deaths per 1000 live births a year to 88, life expectancy rose from 63 years to nearly 65 years, an additional 8 percent of the developing world's people received access to water and an additional 15 percent acquired access to improved sanitation services.

However, this process has not been uniform across the world or even across the MDGs. Huge disparities exist between and within countries. Within countries, poverty is greatest for rural areas, though urban poverty is also extensive, growing and underreported by traditional indicators. Sub-Saharan Africa was and still is the epicentre of crisis, with continuing food security, a rise of extreme poverty, stunningly high child and maternal mortality and large numbers of people living in slums. Here, there is a widespread shortfall for most of the MDGs. Asia, on the other hand, is developing fast, while Latin-America and the Middle East and North Africa, have mixed results, often with slow or no process on some of the Goals.

There is much criticism in the world regarding the MDGs, mostly because they are over-ambitious and too narrow by not including civil and political rights. However, there is also much praise, since achieving the MDGs is one of the first real efforts of world leaders together to eradicate poverty and many people see the MDGs as a success, even when there is only little progress.

Source: United Nations, 2006

However, ensuring good RH also contributes to achieving the other five MDGs. Eradicating extreme hunger and poverty (Goal 1) may be achieved partly by offering information about the benefits of smaller families. A high level of fertility contributes directly to poverty, reduction of women's capabilities, decreasing expenditure on every child's school education, precluding savings and increasing vulnerability and insecurity. Following, studies have shown that a child's school attendance rate is negatively associated with the number of siblings in the child's family. Achieving universal access to primary education (Goal 2) is therefore also associated with RH and family planning. Larger families often keep their children, especially the girls, at home (Bernstein 2006). Promoting gender equality and empowering women (goal 3) cannot be accomplished without better RH. Reproductive health services promote voluntary, safe and healthy sexual and reproductive choices. Besides supplying contraceptive methods and providing information, combating gender-violence, sexual coercion and female genital cutting must be included in the efforts to improve RH and with that empower women and promote gender equality.

Population growth, among others, has led to expansion of cropland, intensified farming and overuse of water and forest sources. Ensuring that people are more aware of the importance of family planning and make informed decisions about their family is essential in order to achieve goal 7; ensuring environmental sustainability.

Goal 8, creating global partnerships, is an important instrument in achieving universal access to reproductive health services. When countries work together, chances are better that the goals will be achieved.

It is now clear that all these issues are interrelated. As a last point here it is important to stress that ensuring universal access to RH services will also help attain sexual and reproductive rights (see box 1.5).

Box 1.5: Definition of Sexual Rights

Sexual rights embrace human rights that are already recognised in national laws, international human rights, documents and other consensus statements. They include the rights of all individuals, free of coercion, discrimination and violence, to:

The highest attainable standard of sexual health, including access to sexual and reproductive health care services;

- Seek, receive, and impart information related to sexuality;
- Education on reproductive health;
- Respect for bodily integrity;
- Choose their partner;
- Decide whether or not to be sexually active;
- Consensual sexual relations and marriage
- Decide whether or not, and when to have children;
- Pursue a satisfying and safe and sexual life.

Source: Glasier, 2006

1.5 Young People's Well-Being

Currently, the largest generation of adolescents in history, counting 1.2 billion people, is living in a rapidly changing world. Nearly half of all people are under the age of 25, which is the largest youth generation in history. Their status of education and health, the way they grow up so that they can take on adult roles and responsibilities and the support they receive from their families, communities and governments will determine not only their own future but the future of their countries (Blum, 2007).

The World Health Organization uses the term young people when referring to adolescents (10-19 years old) and youth (15-24 years old) together. Young people are thus people in the age 10-24. Other institutions define young people as a group of people who are not yet entered into adulthood, but because this is too open for debate the definition of the World Health Organization is used in this thesis.

This part will first explain why RH is important for young people in particular. Second, it will provide insight in the problems young people face in accessing and using reproductive health services.

1.5.1 The Importance of Reproductive Health for Young People

Today, young people in developing countries are facing many problems because of a complex and rapidly changing world. Many of these problems are related to RH, such as early marriage and childbearing, incomplete education and the severe treat of HIV/AIDS. Half of all new HIV infections occur in people aged 15-24. Young people in developing countries are likely to be sexually active at a relatively young age, while the marriage age is being delayed; meaning this group of people is at a higher risk of contracting HIV, unwanted pregnancies and other undesirable outcomes. Female young people are likely to be sexually active at a younger age than their male counterparts, which means they are at a particular risk for these problems. Contraceptive use is very low in most developing countries, which has all sorts of bad outcomes (Biddlecom, 2007)

The diversity of the social group 'young people' requires special attention, because some subgroups are extra vulnerable and cannot be forgotten in programme planning. An example of such a group is the group of young mothers, because they are at a particular risk of marginalization and require special consideration. Married young girls are at an even higher risk, because they are often subject to large age gaps between their husband and themselves, have high levels of unprotected sexual relations, are under intense pressure to become pregnant, often did not go and are not going to school, do not have a large social network and have little access to media, such as radio and television. Programs must take these differences between subgroups in account and give much attention to the context (Bernstein 2006).

Young men and young women are often underserved in development planning. This is noticeable for example in the MDGs; the goals do refer to young people (meaning 15-24 years old) but institutional frameworks for addressing their needs are not organized around age categories or prepared to give the youth special attention (Bernstein, 2006). Young people in developing countries face difficulties in accessing and using reproductive health services. Reproductive health services are often adult-centred. Society does not expect young people to need these services yet, but practice shows otherwise. Young people are very much in need of reproductive health services and even have specific needs. Adolescence is a period in a person's life that is very important; it is a transition phase in which children become adults and in which they learn what their norms and values will be for the remainder of their lives (Bruce 2006).

According to the United Nations Population Fund (UNFPA) and the State of World Population 2003 Report, increasing the knowledge, opportunities, choices and participation of young people will enable them to lead healthy and productive lives so that they can contribute fully to their communities and to a more stable and prosperous world. Thus, more education on RH is needed in order to make sure young people know what choices they can make, so that they will make the right decisions and can build up their future and that of their family and country. It is found through several studies that comprehensive RHE is effective in improving knowledge and reducing risk behaviour. Nevertheless, RHE is not wide-spread in all countries, which means that many young people lack information on RH issues (UNFPA, 2003). When it is the case the RHE is available to young people, issues such as accessibility and utilization arise.

1.5.2 Accessibility and Utilization

The accessibility of a service depends primarily on spatial factors; how many services there are for the population and the proximity of the service, and on economic factors; what the costs are for using the services (Mamdani, 2004).

It is found that it is often harder for young people to access a facility than it is for older people. Facilities are often too far away from young people's homes, because young people in general find it more difficult to find transport to the service, unless public transport is available. They generally have less money to pay for using or going to a health facility than older people (Moya, 2002).

While a growing number of countries are paying more attention to the health information and service needs of young people, surveys in several countries show that young people feel reluctant to go to clinics. Both young women and men report feeling shy and uneasy about RH issues and express concern about negative reactions from service providers or the community (Bernstein, 2006). Because of this, young people often even find that the clinics are too nearby their homes; they are afraid they will run into a family or community member when they are entering, using or leaving a health facility.

The clinics should be youth-friendly in order to make young people feel comfortable going to a clinic. Besides the facility itself and the design of the services the attitude of staff members is also important for young people when they visit a clinic. Actually, research indicates that staff member's attitude is the single most important barrier for young people to receive care. Box 1.6 shows how health facilities can make their services youth-friendlier.

When young people have access to reproductive health services, but also feel free to actually use these services, they have a bigger opportunity to learn about RH issues and learn how to prevent bad reproductive health.

Box 1.6: Health Service's Youth-Friendliness

Barriers young people face at health facilities are: legal and policy constraints related to age and marital status; lack of privacy and confidentiality; fear that they will be treated badly at the facilities; inconvenient hours and locations of facilities; and high costs. However, health services can be made youth-friendly and should focus on:

Service providers

- Specially trained staff
- Respect for young people
- Privacy and confidentiality honoured
- Peer counsellors available

Health facilities

- Separate space or special times set aside
- Convenient hours and location
- Adequate space and sufficient privacy

Program design

- Drop-in clients welcomed or appointments arranged rapidly
- No overcrowding and short waiting times
- Affordable fees
- Wide range of services available.

Other possible characteristics

- Educational material available on site to take away
- Group discussions available
- Alternative ways to access information

Source: UNFPA, 2003

1.6 Conclusion

This chapter has shown that development thinking has changed profoundly through time. In the beginning economic growth was seen as the means to and goal of development, but later it became clear to many policy makers that developing human capital was actually important if not essential in ensuring economic growth and the development of their country.

The health sector became important and health sector reforms were pushed through. These health sector reforms showed that it is now more important how services are provided and less about who delivers the services. Mainly through decentralization, attention is given more and more to ways to keep governments and service providers accountable to their clients.

Of course, these health sector reforms had their influence on the provision of reproductive health services. It proved to be difficult to implement reproductive health services in the health sector reforms, but improvements have been shown. The International Conference

on Population and Development in 1994 created a significant impulse to put RH on the international agenda, after years of neglecting this issue.

The ICPD placed people at the centre of development efforts, which ensured that policy makers see individuals increasingly as having a leading role in their own lives and less as objects of external interventions. However, to be capable to have a leading role, people need to have access to reproductive health services. Then people can be educated and make informed decisions about for example family planning. This means that improving reproductive health (services) is important for people's rights and freedom. In addition, universal access to reproductive health services is important, if not essential, in achieving the MDGs.

To many policy makers it has become clear that developing young people's lives is essential for the development of a country, since they are in a transition face to adulthood and are starting to take on responsibilities for their family and country. Now, more attention is given to how important good RH is for young people. Nevertheless, young people especially face many RH health problems and significant problems still exist related to young people's accessibility and utilization. A long way is still ahead before young people have full access to reproductive health services and feel free to use the services in order to improve their reproductive health.

Chapter 2
Contextual Framework

This chapter provides the regional context in which the research took place. This context will help to understand the situation in the research area and it provides some additional information in order to better understand the role of RH in Tanzania.

The first part of this chapter provides the context of the national level, Tanzania, which includes a geo-political profile, an overview of the changes in the system of governance and a socio-economic profile. The second part focuses on Mwanza Region, which is part of the Lake Zone Region. Here, a geo-political profile and a socio-economic profile will be given. Also some characteristics concerning RH will be provided. The last part provides the context of the research area in Magu district, where the fieldwork took place.

2.1 National Level: Tanzania

Here, the context on the national level will be provided. A general profile will be given which deals with the characteristics of Tanzania and poverty in the country. Then an overview of the system of governance will be provided, that deals with decentralization and prominent national policies. Lastly, the status of service delivery in Tanzania, focusing on health and education, will be clarified.

2.1.1 General Profile

The United Republic of Tanzania is situated in East-Africa. Neighbouring countries are Kenya and Uganda in the North, Rwanda, Burundi and the Democratic Republic of the Congo in the West, Zambia, Malawi and Mozambique in the South. The country is bordered by the Indian Ocean in the East (cf. map 2.1). Dodoma is the official capital city, but Dar es Salaam remains the commercial capital and is also the biggest city of the country.

Map 2.1: Tanzania

Tanzania's surface is covered by bush and savannah for almost 50 percent, while the remaining land is semi-desert. Around 5.5 percent of the entire country is covered by inland water, such as Lake Victoria and Lake Tanganyika. The climate varies from tropical along the coast to temperate in the highlands.

The country assumed its present form in 1964 by unifying mainland Tanganyika and the island Zanzibar, including Pemba, after decolonization. The two parts attained independence from Britain separately; Tanganyika in 1961 and Zanzibar in 1963. Decolonization was relatively peaceful, in large part because of the positive influence the first president had in the process, Julius Nyerere (BBC, 2009).

Official languages in Tanzania are English and Swahili, of which Swahili is by far the more widely spoken one. There are about 120 ethnic groups in the country, but none of them exceeds 10 percent of the population. Larger ethnic groups include Sukuma, Nyamwezi, Ha, Chagga, Masaï, Haya and Gogo. In addition, there are Asian and expatriate minorities. Around 35 percent of the population is Christian and 35 percent is Muslim. The remaining 30 percent of the population practices traditional beliefs (Foreign and Commonwealth Office, 2009).

Since 2005, Tanzania is governed by Jakaya Mrisho Kikwete. The ruling political party is called CCM which means Party of the Revolution. The CCM has dominated political life in Tanzania from its independence, largely because it was the only permitted political party in Tanzania up till the year 1992. Now, the party is slightly contested by the Civic United Front (CUF). Kikwete's policies have made him popular in the international community because of his achievements in fighting corruption, investing in people through education and push for new investments (BBC, 2009).

Tanzania's population of 40.4 million is pre-dominantly rural with three quarters of the population living in rural areas. The country has one of the lowest population densities in Sub-Saharan Africa. Yet, Tanzania has an urbanisation rate that is one of the fastest in the world and the share of the urban population is rising fast, from 6 percent in 1967 to 24 percent in 1996. The United Nations have warned that they expect Tanzania to reach an urbanization ratio of 46 percent by the year 2015. This places and will place even more pressure on Tanzania's urban services and employment rates. Interesting to note is that 31 percent of the population is adolescent (World Bank, 2002).

Poverty in Tanzania is deep and pervasive with 36 percent of the population living under the basic needs poverty line and about one in five living in abject poverty. The United Nations placed Tanzania at the 159th place on the Human Development Index of 2005. Table 2.1 shows at what position Tanzania can be placed globally.

Table 2.1: Tanzania's Human Development Index 2005

HDI value	Life expectancy at birth (years)	Adult literacy rate (> age 15)	Primary, secondary and tertiary GER	GDP per capita (PPP US$)
1. Iceland (0.968)	1. Japan (82.3)	1. Georgia (100.0)	1.Australia (113.0)	1.Luxembourg (60,228)
157. Eritrea (0.483)	154. Namibia (51.6)	101.Madagascar (70.7)	146. Ghana (50.7)	169. Sierra Leone (806)
158. Nigeria (0.470)	155. Burkina Faso (51.4)	102. Algeria (69.9)	147. Benin (50.7)	170. Niger (781)
159. Tanzania (0.467)	156. Tanzania (51.0)	103. Tanzania (69.4)	148. Tanzania (50.4)	171. Tanzania (744)
160. Guinea (0.456)	157. South Africa (50.8)	104. Nigeria (69.1)	149. Gambia (50.1)	172. The Congo (714)
161. Rwanda	158. Chad	105. Guatemala	150. Myanmar	173. Burundi

(0.452)	(50.4)	(69.1)	(49.5)	(699)
177. Sierra Leone (0.336)	177. Zambia (40.5)	139. Burkina Faso (23.6)	172. Niger (22.7)	174. Malawi (667)

Source: UNDP, 2007

As is clear, Tanzania does not hold a very good position on these rank lists. Interesting to note is that the literacy rate in Tanzania is relatively good, compared to many other countries, but that their GDP per capita is one of the lowest. Table 2.2 below provides a quick overview of important basic indicators that allows the reader to see in a glance what the situation is in Tanzania compared to Sub-Saharan Africa (SSA) as a whole.

Table 2.2: Tanzania Data Profile

Indicator	**Tanzania**			**SSA**
	2000	**2005**	**2007**	**2007**
Population, total	33.9 million	38.9 million	40.4 million	800 million
Population growth, annual	2.4	2.6	2.4	2.4
Life expectancy at birth	49	51	52	51
Under-5 mortality rate per 1000	143	124	116	146
Fertility rate (births per woman)	5.7	5.4	5.2	5.1
Infant mortality rate (under 1)	..	..	73	..
HIV prevalence among age 15-49	7.1	6.4	6.2	5.0
Primary completion rate %	..	56	85	60 (2006)
GNI (US$)	8.9 billion	13.4 billion	16.3 billion	761.0 billion
GNI per capita (US$)	260	350	410	951
GDP (US$)	9.1 billion	14.1 billion	16.3 billion	847 billion
GDP annual growth (%)	5.1	7.4	7.1	6.2

Source*:* World Bank 2008b, World Bank 2008c

In the above table one of the important aspects to be noted is the fact that HIV prevalence is substantially higher in Tanzania than in the rest of Sub-Saharan Africa. On the other hand, under-5 mortality and primary completion rate are relatively better. The Gross National Income per capita is less than half of the average GNI per capita in Sub-Saharan Africa.

2.1.2 System of Governance

Historical Overview

After decolonization Tanzania had few exportable minerals and a relatively primitive agricultural system. To solve this problem, Julius Nyerere, the first president of Tanzania, issued the 1967 Arusha Declaration. This declaration called for self-reliance through the creation of cooperative farm villages and the state taking control of the economy through nationalization of crucial sectors like industry, plantations, banks and private companies. The idea behind the cooperative farm villages was that mutual help, as practiced within the African family, would be repeated at the village, district and national level (IOB evaluations 2004). Farmers lived in a community where everyone together provided social facilities like education, health centres and water pumps for all villagers. This program was strongly influenced by Mao Zedong in China and Nyerere accepted large numbers of Chinese military instructors and technicians which led the United Stated to cut off aid (BBC News, 1999). This program came to be regarded as one of the most important political documents to have emerged in the developing world.

A decade later, this program called 'Ujama' had completely fallen apart due to inefficiency, corruption, resistance from farmers and the rise in the price of imported petroleum. This was despite considerable financial and technical aid from the World Bank and helping countries, like the Netherlands. On top of this Tanzania had to undertake a military intervention to overthrow President Idi Amin of Uganda (BBC, 2009).

Between 1980 and 1985 Tanzania's economy deteriorated rapidly; growth in GDP fell to an average of 1.1 percent per year and the foreign debt took uncontrolled proportions. Consequences became especially clear in rural areas, where agricultural production underwent a deep crisis. Import restrictions led to scarce inputs, stagnation of export crops and the lagging behind of food production in comparison to population growth (IOB 2004, 26). In the 1980s the Tanzanian government, under President Ali Hassan Mwinyi, accepted conditional loans from the International Monetary Fund and underwent "Structural Adjustment", although this was a deeply unpopular decision.

Structural Adjustment amounted in concrete terms to a large-scale liquidation of the public sector, deregulation of financial and agricultural markets. Educational as well as health services, however modest they may have been under the previous model of development, were not spared from cuts required by the IMF's conditionalities. Initially, economic growth increased after introduction of the economic reform policy. After the mid 1980s, food production improved at a fast rate as a result of the free market, higher market prices and favourable weather conditions. However, in the early 1990s, food production again decreased not only due to lower input caused by the abolition of subsidies and the decreasing market prices but also because of the absence of any major technological breakthrough to keep up with the population growth (IOB, 2004).

Despite this disappointment, implementation of more reforms was given serious consideration from 1995 onwards, when Benjamin Mkapa was elected President. Due to these reforms, inflation rates went down from 25 percent to 5 percent per year and the private sector participated more because of cutbacks in the public sector. This had a positive effect on economic growth which surpassed 5 percent in 2001. Foreign investment increased, with positive effects on exports and on tourism, although it stayed below 20 percent of the Gross Domestic Product. Agricultural growth remained below the target of 5 percent per year, output growth in agriculture proved insufficient to make an impact on rural poverty reduction. The overall per capita income rose modestly (IOB, 2004). President Kikwete has pledged to continue Mkapa's reforms as well as halt endemic corruption in the country. The parliament and the media are playing an increasingly prominent role in ensuring government accountability.

Today, Tanzania's prospects for development look increasingly promising, as its natural resources provide an excellent foundation for future investment and economic growth. Tanzania's economy still heavily relies on agriculture, which accounts for nearly half of GDP with 45.3 percent and employs 80 percent of the workforce. Tourism is growing in importance and it actually ranks as the second highest foreign exchange earner after agriculture. The services sector (including tourism) had a growth rate of 7.2 percent in 2006. Mineral production (gold, diamonds, and tanzanite) has grown significantly in the last decade. It constitutes Tanzania's most important source of economic growth, provides over 3 percent of GDP and accounts for half of all Tanzania's exports (Foreign Commonwealth Office, 2008).

A last point to be mentioned here is the role Tanzania has in the international community. Tanzania is member of several international groupings and organizations. Among them are the East-African Community (EAC), the Southern African Development Community (SADC), World Trade Organization, African Union (AU) and the United Nations (UN). Since the EAC is probably one of the most important organizations Tanzania is a member of, some explanation is needed. The new East African Community (EAC) was formally launched in January 2001 and is meant to create a Customs Union and a Common Market. Further the community would like to establish a monetary union and ultimately a political federation. The

EAC now consists of Tanzania, Uganda, Kenya, Burundi and Rwanda. The community aims at strengthening the economic integration of these countries on a selective and pragmatic basis, including facilitation of trade through harmonization of tariffs, payments, transport, and movement of people and harmonization of other areas of common interest (United Republic of Tanzania, 2009)

Decentralization

One of the most important changes in the system of governance for all developing countries was decentralization. The Tanzanian government started decentralization effectively in the 1980s, under the SAPs. A local government system was present in the country since the sixties but in the early seventies these local governments were abolished, because they were unable to deliver adequate services to the people. Central government and ministries were put in charge of the administration of basic government services at the local level, including education and health care. However, service delivery actually deteriorated even more under this system and local governments were introduced again by the Local Government Act in 1982 (Mmari D.M.S., 2005).

While Local Government Authorities (LGAs) were officially introduced in Tanzania, they were still tightly constrained by the central government. During the nineties, it became clear that this system did not work, leading to the publication of the Policy Paper on Local Government Reform in 1998 and the redefinition of the Local Government Act in 1999. The new legislation involved the devolution of powers to elected bodies, including powers to levy local taxed and the obligation of the central government to provide local governments with adequate grants. This gave the local governments more independence from the central government regarding the use of financial resources made available by the central government. In addition, the Act promotes the openness of council decisions which makes it accountable to the population (IOB 2004 & Mmari D.M.S., 2005).

Lastly, a program started in 2000 which has as a main objective to improve the quality of public services with the final goal of contributing to poverty reduction. This includes shifting responsibility for providing services to LGAs at the district council level and allowing councils greater freedom in organizing and managing their personnel (IOB, 2004).

The present system of local governance is organized down to the sub-village level, which means that even the sub-villages have an elected representative for the village council that meets monthly. The District Council constitutes the highest political authority, consisting of elected members (one for each ward), Members of Parliament in the district and other appointed members. The Council can delegate responsibilities to ward committees and village councils (IOB 2004 & Mmari D.M.S., 2005)

The LGRP makes decentralization a comprehensive process encompassing political, financial and administrative dimensions, which allows for participatory development planning. Nevertheless, the process is still closely monitored by the CCM, which maintains its powers in almost all districts. This is noticeable, because in many districts, council members of the CCM have been elected unopposed (IOB 2004 & Mmari D.M.S., 2005).

Overview National Policies

While development thinking changed over the course of time and the governance system changed with it, many national policies were formulated that had as an objective to be a guide in developing the country and eradicate poverty. Here, an overview is provided of the most prominent national policies.

- **Development Vision 2025:** This is an attempt to update Tanzania's national vision, first expressed in the Arusha Declaration. The document was published in 1999 and projects a future free of poverty and with high level of human development, with Tanzania graduating to a middle income country by the year 2025. The vision talks about integrating Tanzania into the new global economy – competitive, diversified and economically stable and characterized by good governance and the rule of law. The document on this vision does not provide any specific strategies to achieve these goals, nor does it discuss the policies required in detail (World Bank & IMF 2004).
- **The National Poverty Eradication Strategy (NPES***):* This strategy was formulated in 1997 and was more specific in its goals and strategies. Within the context of Vision 2025, policy makers actually saw the NPES as the means to coordinate policies and programs. The strategy has an implementation time up to 2010. The NPES defined goals in the areas of economic growth, income levels, primary education, literacy, access to water and sanitation, disease burden, mortality and health, employment, housing and infrastructure. However, it failed to prioritize among its many planned interventions, making it inappropriate as an action plan. (World Bank & IMF 2004).
- **Poverty Reduction Strategy Paper:** Tanzania developed its PRSP in 2000 after it had qualified for the HIPC Initiative debt relief programme. The PRSP acts as the national action plan for the implementation of the Vision 2025 and the NPES. It is also the main reference point for anti-poverty initiatives and an instrument to build consensus on national priorities for poverty reduction and its development agenda. The PRSP identifies major priority areas which are key to achieving the MDGs. These include agriculture, primary education, rural roads, water and sanitation, and health. The PRSP was implemented during 2000-2004. (United Republic of Tanzania, 2006b).
- **National Strategy for Growth and Poverty Reduction (MKUKUTA):** The NSGRP builds upon the PRSP and the strategy's goals coincide with the targets of the NPES and has an implementation time of 5 years up to 2010 which is two thirds of the way towards the MDG's (2015) and 15 years towards the targets of Vision 2025. The 5 year perspective allows for a more sustained effort of resource mobilization, implementation and evaluation of the poverty reduction impact. Besides being committed to the Tanzania's Development Vision 2025 and the MDGs the paper makes it clear that the government of Tanzania strives to widen the space for country ownership and effective participation in development and commitment to regional and other international initiatives for social and economic development. The strategy requires increased commitment and resources from domestic stakeholders and development partners in the medium term. To increase the effectiveness of aid, Tanzania will pursue the principles laid down by the Tanzania Assistance Strategy (TAS) and Joint Assistance Strategy (JAS) for the harmonized alignment of aid modalities (United Republic of Tanzania, 2005).
- **Tanzania Assistance Strategy:** This is a coherent national development framework for managing external resources to achieve the development strategies as stated in the development vision 2025, the NPES and the PRSP. The strategy came about in the late 1990's. It is a government initiative aimed at restoring local ownership and leadership by promoting partnership in the design and execution of development programs. It seeks to promote good governance, accountability, transparency, capacity building and effectiveness in aid delivery. (United Republic of Tanzania, 1997).

- **Joint Assistance Strategy:** A strategy developed jointly with all 35 members of the Tanzania Development Partners Group (DPG), finalized in 2007. It has the goal to improve collaboration with all 35 members. The last section of the document clarifies which agency will focus on which area/sector in Tanzania, in order to prevent duplication and to make sure every sector in Tanzania is covered. (World Bank 2007).

Reproductive Health Specific Policies

Family planning and reproductive health services have been provided as part of maternal and child health services in Tanzanian public health facilities since their introduction in 1974. The problem was and is that communities in Tanzania were lead to believe that these services are especially there for adult married women, which created a barrier for both men and young people to access the facilities (African Youth Alliance, 2005). There are numerous national policies that were developed from the 1990's onwards to improve the Tanzanian population's health, of which some are directly focused on young people. Promoting reproductive health rights is an important objective of these policies. This section presents the several national policies related to health that are important in improving young people's RH.

- **The National Population Policy**: This policy was formulated in 1992 and revised in draft form in 2001. The revised draft policy calls for a more explicit role for government, civil society and the private sector. Goals of the policy were poverty reduction, elimination of discriminatory and harmful practices and promotion of reproductive health and rights, all within a multi-sectored approach. The 2001 draft does not give much attention to young people specifically but it does call for the development of youth friendly reproductive health services (Price 2003). In the final version of the revised National Population Policy, published in 2006, young people are given greater prominence, particularly in relation to unsafe abortion, HIV/AIDS and school education (United Republic of Tanzania, 2006).
- **The National Health Policy:** This policy was formulated in 1992 and does not address young people directly except when it is clearly stated that family planning services are denied to adolescent girls who have no children. This is in direct contradiction with the Family Planning Guidelines and Services Standard formulated in 1994, in which it is stated that "all males and females of reproductive age including adolescents irrespective of their parity and marital status shall have the right of access to family planning information, education and services. In the revised draft of the national health policy this phrase has been removed and now there is only one reference to young people, as one of several vulnerable groups (Price, 2003).
- **National Adolescent Health and Development Strategy**: This is the strategy that came about through one of the eleven objectives of the National Reproductive and Child Health Strategy. It was drafted in 2000-2001 and it remained in draft form for over two years. The strategy has five objectives which relate to: enabling the policy environment, improving access through youth friendly services, provision of behaviour change communication, development of livelihood skills and increased capacity for youth programs (Price 2003).
- **HIV/AIDS Policy and Strategy:** The Tanzanian Government actually has been slow in putting in place effective HIV/AIDS programs. The in 2003 Health Sector HIV/AIDS Strategy has shifted HIV/AIDS from being a vertical program to an integral component of the health services. This strategy identifies young people as a priority vulnerable group. One of the strategy's goals is to reduce vulnerability to HIV/AIDS and STDs among in-school and out-of-school young people. Strategies include the creation of youth-friendly services and youth-focused health promotion, including the mass media, incorporating HIV/AIDS/STD education into the school curriculum, involving parents in prevention actions, incorporating HIV/AIDS education into extra-curricular activities, and using peer-educators to promote behaviour change at post-secondary level and among out-of-school youths (Price 2003).

- **The National Education Act and Policy**: Providing education on RH is not compulsory, but the Education Act allows Family Life Education (FLE) and HIV/AIDS education in schools. Government regulations under the Education Act encourage schools to interpret pregnancy by schoolgirls as misbehaviour, for which they should be expelled (Price 2003).
- **Children Development Policy:** This policy, formulated in 1996, asks for the removal of legislative and policy barriers that deny access of RH information and services to young people. It further emphasizes the need to educate and mobilize parents, guardians, communities and institutions for a better understanding and upholding of children's rights (Price 2003).
- **National Reproductive and Child Health Strategy**: This strategy was formulated by the Reproductive and Child Health Section of the Ministry of Health in 1997 and it ran from 1997 to 2001. The strategy had eleven objectives of which one related specifically to advocacy for a national youth reproductive health strategy. After 2001 The RCHS developed a National Package of Essential Child Health Interventions. The thirteen categories of these interventions do not specifically address adolescent's RH, although mention is made of provision of Information, Education and Communication (IEC) to young people on the dangers of unsafe abortion, safer sexual practices, birth spacing and delaying child bearing, and risk behaviour regarding HIV transmission. Recently, a new Reproductive and Child Health Strategy for 2003 – 2006 has been developed. Young people in this strategy are identified as a priority for RH services, but there is no clear vision on the provision of youth-friendly services. (Price, 2003)

Clearly, there are several national policies at least partly dedicated to improving (young) people's reproductive health and rights. However, there is much room for improving the implementation of the policies and much more effort is needed to increase advocacy for young people's RH. Chapter 3 will deal with the status of young people's RH in Tanzania, since this is important to understand the issue at hand.

2.1.3 Service Delivery

Tanzania has been famous for its achievements in the social sector, in particular in health and education, since the 1970s. In late 1970s claims were made that three-quarters of the population lived within five km of the nearest health facility and that life expectancy had been improved and child mortality had dropped significantly. Enrolment rates amounted to 90 percent and literacy rates were claimed to be as high as 93 percent among men and 88 percent among women.

Sadly, the earlier mentioned economic crisis of the 1980s had a serious, negative effect on the health and education sector. Financial constraints lead to a lack of basic supplies and equipment for health facilities, while the country suffered from a rapid increase in HIV/AIDS victims. Enrolment rate and literacy rates declined and government expenditure on education fell dramatically. The health sector also had to deal with a downturn, but less dramatically than in education. In addition, expenditures were unevenly distributed throughout the country in which especially rural areas were left behind. The status of service delivery did not show much improvement throughout the 1990s; the literacy rate showed minor improvement, just as the access and functioning of health facilities (IOB, 2004).

Table 2.3 provides some of the health indicators for Tanzania. It provides a general overview of the health status in the country.

Table 2.3 Health Indicators for Tanzania

Indicator	
Crude birth rate, 1990	44
Crude birth rate, 2007	40
Adolescent fertility rate (births per 1,000 women ages 15-19), 2006	123
Contraceptive prevalence (% of women ages 15-49), 2005	26
Births attended by skilled health staff (% of total), 2005	43
Maternal mortality ratio (deaths per 100,000)	950
Crude death rate, 1990	15
Crude death rate, 2007	13
Immunization, measles (% of children ages 12-23 months), 2006	93
% who have comprehensive knowledge of HIV, 2002–2007, male	40
% who have comprehensive knowledge of HIV, 2002–2007, female	45

Source: World Bank, 2008c and World Bank, 2009.

Most of the disease burden in Tanzania is the result of preventable diseases, such as HIV/AIDS, malaria and tuberculosis and reproductive disorders. Child mortality and morbidity are major problems in the country; one out of 8 children dies before age five (cf. table 2.2). It is found that Mother-to-Child transmission of HIV/AIDS is an important contributor to deaths in children.

Despite major efforts made, access to quality reproductive health services remains a significant problem. This is reflected in the high maternal mortality rate of 950 per 100.000 life births and a fertility rate of 5.2 women age 15-49 and 123 births per 1000 women ages 15-19. Contraceptive prevalence among women is only 26 percent. Interesting to note is that the percentage of deliveries attended by skilled staff has barely changed and even decreased from 44 percent in 1999 to 43 percent in 2005.

Women are significantly more affected by HIV/AIDS than men, since 60 percent of new infections among young people aged 15-24 years are in women. Many children are infected and there are about one million AIDS orphans on a population of 40 million. People living with AIDS occupy more than half of scarcely available hospital beds and it is estimated that each AIDS infected person treated in the health care system absorbs about 290 USD per year in nursing and drug costs (WHO, 2005).

The structure of the Formal Education and Training System in Tanzania constitutes two years of pre-primary education, 7 years of primary education, 4 years of Junior Secondary, 2 years of Senior Secondary and up to 3 or more years of Tertiary Education. Specifically, the education system has three levels, namely: Basic, Secondary and Tertiary.

Besides the fact that education is important to the development of individual lives and the development of a country, education is specifically important in preventing bad RH. Therefore, attention should be given to the status of education in Tanzania. Table 2.4 provides an overview of education indicators for Tanzania.

Table 2.4: Education Indicators for Tanzania

Indicator	**Tanzania**			
	1999	**2002**	**2004**	**2006**
Primary education net enrolment rate, total	49.6	74.0	88.0	97.8
Primary education net enrolment rate, male	48.8	74.6	88.8	98.5
Primary education net enrolment rate, female	50.5	73.5	87.1	97.2
Primary education completion rate, total	56.8	59.3	59.1	74.3
Primary education completion rate, male	55.5	58.3	59.3	75.5
Primary education completion rate, female	58.0	60.2	58.8	73.2
	2000-07			
Primary school attendance ratio, male	71			
Primary school attendance ratio, female	75			
Survival rate to last primary grade (%)	83			
Secondary school enrolment ratio, male	22			
Secondary school enrolment ratio, female	20			
Secondary school attendance ratio, male	8			
Secondary school attendance ratio, female	8			
Youth (15-24) literacy rate, male	79			
Youth (15-24) literacy rate, female	76			

Source*:* UNICEF Statistics, 2004

The enrolment rate in primary education has improved significantly from 1999 up to 2006; from 49.6 to 97.8. The net enrolment rate to secondary education is very low, compared to primary education, despite the growth of private secondary schools. Though small there are still gender disparities concerning all indicators in table 2.4. Illiteracy remains high, about 28.6 percent of Tanzanians cannot read and write in any language. There is more illiteracy among women (36 percent) than men (20.4 percent). Among youth the illiteracy rate is lower with 21 percent for male and 24 percent for female.

Much still has to be improved in the education sector in Tanzania, especially because so few people enrol in secondary school and the attendance ratio is low in both primary and secondary school.

2.2 Regional Level: Mwanza in the Lake Zone

The fieldwork took place in the Lake Zone in Tanzania in which Mwanza Region is situated. This is the region where the research took place. This section explains the situation in Mwanza, in which special attention is given to the health and education sector, since these two sectors are important for the issue at hand. Lastly, some of the young people's RH characteristics for Mwanza will be explained.

Map 2.2 shows the Lake Zone, which consists of the regions Kagera, Mara, Mwanza and Shinyanga. Tanzania is divided into 26 regions. Mwanza is a region in the north-west, bordering Lake Victoria. The regions are divided into 127 districts. Mwanza itself is divided into 8 districts which are: Ukerewe, Sengerema, Geita, Msungwi, Kwimba, Nyamagana, Ilemela and Magu. The capital of Mwanza is Mwanza city.

Map 2.2: Lake Zone

Source*:* UN, 2009

Map 2.3: Mwanza Region

Source: Wikipedia, 2009

Mwanza is administratively led by the Regional Commissioner (RC) as a chief representative of the government in the region. In Mwanza this role is taken by Daniel Ole Njoolay. He is coordinator of all development and administrative services to the local government authorities and other organizations within the region. He is supposed to promote an enabling environment through law and order to ensure peace in the region to function effectively. The RC is advised by the Regional Administrative Secretary (RAS). The RAS is the head of all public services and the accounting officer in the regional secretariat. The RAS in Mwanza region is Clemence Rutaihwa.

2.2.1 Socio-Economic Situation

The population in Mwanza region was almost 3 million in 2002 and it is believed that there will be approximately 4.2 million people in the region in 2012. The dominant ethnic group in the region is Wasukuma, with 90 percent of the population belonging to this group.

About 85 percent of the population in Mwanza lives in rural areas and relies upon agriculture, livestock keeping and fishing activities for subsistence and income. Agriculture is the backbone of Mwanza's regional economy, contributing to at least 65 percent of all regional GDP earnings. The most important food crops in the region are: Maize, rice, sorghum/millet cassava, sweet potatoes, bananas, beans and cowpeas. Besides food crops, cotton stands out among other cash crops grown in the region, but production is declining because of low profitability and inefficient marketing arrangements. Fisheries activities are increasingly contributing to the regions income. Mwanza's rural population is relatively poor and conditions are worsening due to high population density and consequent land shortage, exacerbated by erratic rainfall patterns in many parts of the region. Food is often imported from other regions, since food shortages are common.

Worth to mention is also the position Tanzania and especially the Lake Zone had and has in the prolonged crisis in the Great Lakes Region. For decades Tanzania has hosted one of the largest refugee populations in Africa. This is also one of the reasons why Tanzania has been a 'donor darling' since many years. UNHCR announced on 30 January 2007 that, for the first time in more than a decade, the population of refugee camps in Tanzania had dropped below 300,000. More than 250,000 refugees have returned to their homes from Tanzania since 2002. Of those that remain, as of September 2008, 130,000 are Burundian and 103,000 Congolese in September 2008. Another 220,000 Burundian refugees who have lived in self-supporting settlements in central Tanzania since 1972 have been given the option to either return voluntarily to Burundi or become naturalised Tanzanian citizens (FCO 2008). This situation has

put a tremendous stress on Tanzania's scarce resources. Many of the refugees, without the opportunity to go home, settled in Mwanza city.

Health

Primary health care is the basic strategy of a policy which aims at making available the services of this system to every citizen who is in need. This way, the government strives to provide an infrastructure which at village level is represented by village health workers and trained traditional birth attendants. The dispensary as a frontline facility is equipped and staffed to take care of some 90 percent of all cases in need of curative medicine. The dispensary is backed by a referral hierarchy of health centres and hospitals to take care of the remaining 10 percent which normally need more skilled health care, more sophisticated equipment and medical supplies. Thus, the dispensary type of health care is the most prominent in the region.

HIV/AIDS is not only a major threat to the health of the region's population, but also to the economic and social well being of the people. Regionally, 6.9 percent of the population was infected by HIV/AIDS in the year 2001.

Education

In 1974 there were 476 primary schools in the region. These had increased to 902 primary schools in the year 2002. The district with the smallest increase was Ukerewe at 29 percent, followed by Magu at 37 percent. All the other districts in Mwanza, lead by Mwanza City, made impressive increases in the number of school. Although enrolment rates have increasingly increased during the last decade, the quality of education services has been declining.

2.2.2 Reproductive Health in Mwanza

Factual information about young people's RH is not widely available. However, this section provides the characteristics that could be found.

HIV/AIDS accounts for 53 percent of all deaths among 20-29 year olds and young women are herein at a particular risk. Almost 5 percent of 19 year olds in rural areas are HIV positive and over 30 percent of girls will have contracted HSV-2 (Herpes) by the end of their teenage years, which could have serious complications. Also it seems that pregnancy is still an important reason for failure to complete primary school among girls (Obasi, A.I. 2006)

The percentage of young men in Mwanza that know about HIV prevention methods is lower than the national average with 65 percent compared to 68 percent, while the percentage of young women in Mwanza that know about prevention is 93 percent, compared to a national average of 73 percent.

Even though the knowledge of young women on how to prevent HIV is quite high in the region, contraceptive use is very low in this group of people. The percentage of young women in Mwanza using a modern method of family planning is only 4 percent compared to a national average of 12 percent. The percentage found in Mwanza is actually the lowest percentage of all the country's regions except one (Shinyanga).

This might be the reason why young women's HIV prevalence in the region is 6 percent compared to the national average of 4 percent. Also young men's HIV prevalence is higher than the national average, with 3.8 percent compared to 3 percent. (National Bureau of Statistics, 2006).

Clearly, more effort is needed to prevent problems regarding reproductive and to improve RH of the young population in Mwanza Region.

2.3 The Fieldwork Area: Magu

Magu is one of the eight districts in Mwanza region. In this district, a number of villages were visited to undertake the research. These visits did not cover the entire district (cf. map 4.1). Nevertheless, the context of Magu District is provided here, in order to create a better understanding of the situation in the research area.

Magu is, just as the other districts, divided into smaller administration areas called divisions. The district has an area of Km^2 4,800, with water covering km^2 1725. Dry land area is km^2 3075. Administratively the district has six divisions, 27 wards, 124 registered villages, 765 hamlets and 70065 households with an estimated population of 450.000 people and an annual population growth rate of 2 percent. More than 90 percent of the population is engaged in agriculture and livestock keeping which contributes 85 percent to the DGDP. Per capita income is 48450 Tsh, which amounts to about 36 USD.

The annually cultivated area is on average 160,000 hectares, which is 68 percent of the arable land. Food crops grown are sorghum, rice, cassava, sweet potatoes, maize and legumes. Cash crops are rice and cotton. The bigger part of the district is in the lee-ward side and therefore suffers drought occasionally. Livestock in the district consists of cattle, sheep, goat, chicken and donkey. Fishing is done in the lake on small scale level. Annual catch is about 5,760 tons worth about Tsh 710, 570. The district's industrial sector is on the medium and small scale, with 4 cotton ginneries and one fish processing factory. Small-scale industries include carpentry, wielding and auto garages. Mining is almost non-existing in the district, except for stone mining in Kisesa ward.

The economic infrastructure consists of roads, marine transport and railway transport. Roads are the major means of transport inside and outside the district. Most economic activity is situated alongside the road leading from Mwanza to Musoma and further to Nairobi. Marine transport is mostly for merchandise and short distance ferrying of people, mostly people living on the islands. (Magu District Profile 2006).

Education

Magu District has 196 primary schools, 35 secondary schools and one private university in the region. The district has to deal with many problems concerning education, just as all the other districts in the country. However, according to a review of the strategic plan 2003-2007 there has been some improvement in the education sector. In these five years, many extra classrooms have been built, just as there are many more desks, books and other material present in the district. Nevertheless, these achievements are still under the national target, which means there is still much room for improvement. Important to note is that there has been much improvement concerning pit latrines for boys and girls in schools. In 2003 the latrine-pupil was 1:78, but in 2007 it improved to 1:40. The enrolment rate is about the same in Magu district as in the whole of Tanzania.

In 2005 the number of people out of school was 3437, while it dropped to 1856 in 2007. Reasons for this improvement could be the effort the local government puts in educating these people even when they are not in school. This is done by the programme called COBET (Complementary Basic Education in Tanzania), which focuses on educating out of school children, especially girls.

Health

The district has two hospitals of which one is government owned and one is privately owned. There are six health centres and 46 government dispensaries. These facilities do not meet the district requirement of four hospitals, eight health centres and 80 dispensaries.

The infant mortality rate in the district is 140:1000 and the under-five mortality rate is 168:1000. Under-five mortality rate on national level is 118:1000. Maternal mortality rate is 529:100.000. Immunization of children stands at a percentage of 94 percent. Just as in education, there have been many improvements in the health sector in Magu District. One of the

reasons why these improvements came about could be the increase in village health meetings in the district. In 2000, 80 percent of the villages held these meetings, while in 2005 95.2 percent of the villages did.

The top ten diseases affecting the district are malaria, diarrhoea, pneumonia, worms, eye infection, anaemia, skin infections, STD/HIV/AIDS and ear infections. Severe malnutrition is about 2.3 percent.

HIV/AIDS stands at a relatively high rate in Magu District, namely 8.2 percent. Every year 2000 more people become infected with HIV and one in every three deaths is because of AIDS. According to the district council, factors contributing to this high HIV/AIDS prevalence rate are socio-cultural factors. The belief in witchcraft, traditional dances and the weekly markets are all factors that contribute to this. Risk areas include lake shore areas, main road areas, fishing islands, guesthouses and bars. There are some control-measures taken which include awareness creation at all levels and school and out-of-school programmes on HIV/AIDS control.

The District Medical Office has a number of actors to help improve the health status in the district. Prominent among them are:

1. The Health Basket Fund Programme, which deals mainly with the rehabilitation of health facilities, procurement of medical supplies and equipment and capacity building. The latter includes awareness creation and training of health staff.
2. UNDP/UNCDF, which is charged with the rehabilitation/construction of health facilities.
3. Child Survival Protection and Development is a UNICEF programme that deals with health education, maternal health and the supply of equipment.
4. AMREF deals with reproductive health, the rehabilitation of health facilities and capacity building.
5. TANESA deals with reproductive health education.
6. UMATI deals with reproductive health and capacity building (Magu District Profile 2006).

Chapter 3
Young People's Reproductive Health in Tanzania

The contextual framework provided an overview of the situation in Tanzania. Besides providing a general profile and a historical overview of processes in the country, national policies focusing on RH and the health and education status were provided. Before continuing this study it is important to lay out what the RH status is for young people in Tanzania, since this will shed more light on why improving RH is important, providing an extra rationale for this study.

The first part of this chapter will give an overview of the status of RH by using statistics. The second part will clarify some of the reasons why the status of RH is as it is in Tanzania.

3.1 Young People's Reproductive Health Status

Young people constitute a large proportion of the Tanzanian population; 65 percent of the population is under age 25 and almost 20 percent falls within the age range of 15-24. These young men and women are the future of Tanzania, which should make their health and wellbeing a priority for the growth and prosperity of the county. The social group faces many challenges in the area of RH and is at risk for a broad range of health problems (National Bureau of Statistics, 2006). Among these problems are early sexual debut, unwanted pregnancies, pregnancy related complications, unsafe abortion, sexually transmitted infections (STI) and HIV/AIDS.

Young people are especially at risk because they are more likely to engage in unplanned and unprotected sex, they do not have the skills to negotiate for safer sex with their partner, they have sex with more than one partner and they have only little awareness of STI prevention. What is also important to note is that most young people in Tanzania find it difficult to access and use reproductive health and HIV/AIDS services, just as many young people in developing countries face these problems (cf. section 1.5.1 and 1.5.2).

The National Bureau of Statistics in Tanzania conducted a survey assessing the RH status of young people in Tanzania, with assistance from USAID and Family Health International. Data was taken from the 2004-05 Demographic and Health Survey and the 2003 Tanzania AIDS Indicator Survey. Here a short summary of the status of young people's RH in Tanzania will be given.

3.1.1 Health Services and Education

Very few young women age 15-19 talked to a health professional about family planning, although they do see family planning messages in the media. Only 8 percent of women age 15-19 discussed family planning with a field worker or health professional in a health facility in the year before the survey. This means that more than 90 percent of young women have never spoken with a health professional about family planning, which represents a huge missed opportunity for educating and counselling this group. Older women are more likely to talk to health professionals about family planning, although only one quarter of this group discussed family planning. Just as young women, young men are also unlikely to discuss family planning; they are most likely to hear about family planning on the radio, in the newspaper, magazines and posters.

About half of younger mothers are assisted by a medical professional at delivery, which means that still a large group is not helped adequately at delivery which increases the risk of serious complications. Among young mothers who delivered at home, only 15 percent received the recommended check-up after delivery. What is also found by the National Bureau of Statistics is that young mothers are slightly less informed of the signs of pregnancy

complications than older mothers. However, the majority (94 percent) of young mothers under age 20 received at least one antenatal care visit from a medical professional.

3.1.2 Awareness

Knowledge of family planning methods has increased since 1999. Young men know more about family planning methods than young women. About 90 percent of young people know about at least one family planning method, of which the pill, condoms (male and female) and injectables are the most commonly known methods. Important to note is that respondents were presented with a list of family planning methods. Other surveys require spontaneous naming of methods and these show a much lower awareness level. Nevertheless, even young people who have never been married and have never had sex could mention at least one family planning method.

Only half of women age 15-24 and almost one quarter of men of the same age group know where to get a condom. This knowledge is especially low among young people who never went to school or only attended some years in primary school. Almost 80 percent of young people know that using a condom reduces the risk of contracting HIV and more than 90 percent knows that it is an effective family planning method. Among all women age 20-49, 65 percent believes that children should be taught about using a condom to avoid AIDS. These adults support teaching about condom use in schools.

Almost all young men and women have heard about AIDS. Nevertheless, fewer know how to prevent HIV transmission; 73 Percent of young women and 68 percent of young men could name two ways of preventing HIV: using condoms and limiting sexual intercourse to one uninfected partner. Knowledge on HIV prevention is slightly higher in urban areas than in rural areas and also greater among young people with higher levels of education, those living in wealthier households and those who have ever been married or ever had sex. Naturally, knowledge is also higher among people in the age range 20-24 than in the age range of 15-19. More than two thirds of young people know that HIV can be transmitted through breastfeeding, but only few know that maternal to child transmission can be prevented if the mother takes special drugs while she is pregnant.

According to this survey, the awareness on these important RH issues is quite high among young people in Tanzania, even though the knowledge is quite basic.

3.1.3 Behaviour, Attitude and Practice

Many Tanzanian young people are sexually active; on average young men begin to have sex between ages 18 and 19, while women start to have sex around the age of 17. Among women age 20-24, 14 percent had had sex by the age of 15 and 63 percent had had sex by age 18. Men start sex later; only 5 percent had had sex by age 15 and 43 percent had had sex by age 18.

Women get married at about age 18 or 19, which is more than 5 years earlier than men. Almost one quarter of young women age 15-19 are already married. In addition, only a quarter of young men age 20-24 are married while the majority of women are married at this age. More than half of 19 year old women are already mothers or are pregnant with their first child. Teenage pregnancies are more often unwanted and can result in all sorts of problems, such as abortion and complications while giving birth. Teenage pregnancy and motherhood are more common in rural areas (29 percent) than in urban areas (20 percent). It is important to note that people in Tanzania are getting married at a later age then say 20 years ago, but that the age they start having sex has not changed noticeably. Also, the rapid growth in school attendance and attainment rates in Tanzania means that a rising proportion of young people are becoming sexually mature when they are still in school, often even in primary school. This means that RHE in primary school is becoming increasingly important and education solely in secondary schools is not enough.

Certain sexual behaviour can be placed under high-risk behaviour. One of them is having multiple sexual partners. Among sexually active young people, eight percent of women and 33

percent of men reported to have had more than one sexual partner in the past year. Actually, young men report having an average of four sexual partners over their lifetime and young women report two lifetime sexual partners. Premarital sex is also placed under high-risk behaviour. About half of never married young people have ever had sex and one third of never married women and one fifth of never married men had sex in the year before the survey.

Important to note is that among women age 15-19 who had non-marital sex in the year before the survey nine percent had sex with a man who was ten or more years older. This could put tremendous pressure on the decision making power of the woman, which could result in a higher risk of contracting a diseases like HIV.

Young women are less likely than older women to discuss family planning with their husbands: 50 percent of married women age 15-19 never discuss family planning; while only one third of women aged 20-24 never discuss family planning with their husband. 85 percent of young women approve of the use of family planning, but only 40 percent of young women believe that their husbands approve of family planning. In addition, about one third of young men believe that family planning is women's business and appear not to take responsibility for family planning.

Among young people who have ever had sex, 17 percent of women and 26 percent of men say that they used a condom the first time they had sex. Unmarried young people are less likely to be sexually active, but they are more likely to use a condom; 37 percent of women and 43 percent of men say they used a condom the last time they had sex.

Among users of family planning, young married women mostly use injectables, the pill or a traditional method such as periodic abstinence, withdrawal or a folk method, while unmarried women mostly use condoms. Use of family planning by young women is higher in urban areas than rural areas with 19 percent and 9 percent respectively. Only 12 percent of all young women use a modern method of family planning. Family planning increases with age among young women. Use of a modern methods of family planning is much higher among sexually active women aged 20-24 than those younger than 20.

Voluntary testing for HIV/AIDS is not a common use among young people in Tanzania. Only eleven percent of young people have ever been tested for HIV/AIDS. It is more common in urban areas than in rural areas and is most common among young people with higher levels of education and among those living in wealthier households (National Bureau of Statistics, 2006).

3.1.4 HIV Prevalence

HIV prevalence is still lower among young people than among older adults, but young people are being infected at a faster rate than adults; 60 percent of all new HIV infections in Tanzania occur in young people aged 15-24. The total HIV prevalence among young women age 15-49 is 7.7 percent, for young women aged 15-24 this percentage is 4 percent. Important to note is that young married men and women are more at risk of HIV infection than unmarried young people. Actually, HIV prevalence is double among married young people compared to unmarried young people. In the entire population age 15-49, HIV prevalence increases with education and wealth; people with higher levels of education and people living in wealthier households have a higher risk of getting HIV. However, for young people there are weaker or no associations between education, wealth and HIV. This means that prevention messages should be aimed at young people of all educational and economic levels (National Bureau of Statistics (2006).

3.2 Explaining the Status

Chapter 2 showed that there are many national policies in place that have as an objective to improve the status of young people's RH. These policies and strategies support among others young people's access to reproductive health services, but there are many gaps in its implementation. Since many years the Tanzanian government has been supportive to let NGO's take the lead in providing reproductive health information and services to young people. The problem here is that 80 percent of the Tanzanian population lives in rural areas, where there are only few NGO's that are able to undertake district-wide interventions. Most of the reproductive health services for young people, run by NGOs are urban-based and dependent on donors. This makes them less sustainable than public health facilities. (African Youth Alliance, 2005)

This reliance on NGOs to deliver reproductive health services to young people led to a situation where public health facilities did not have an adolescent health and development strategy. There was no standardized training for youth-friendly services, just as there were no youth-friendly service delivery standards or guidelines. At the district and council levels, delivering reproductive health services to young people in a youth-friendly way was not a priority and therefore not part of the comprehensive health or development plan (African Youth Alliance, 2005).

In 2005, the Tanzanian Ministry of Health formulated the Standard for Adolescent Friendly Reproductive Health Services. The Chief Medical Officer, Dr. Gabriel L. Upenda writes in the foreword:

> "Access to high quality reproductive health services in the country is generally poor and young people; especially adolescents, find it more difficult to access these services. A number of factors contribute to this situation including among others, the negative attitudes of services providers and community at large to adolescent sexuality, unfriendly environment in the health care facilities and lack of privacy and confidentiality. There are some initiatives mostly by non-governmental organizations that provide youth-friendly reproductive health services, but most of them are small-scale and with limited impact. In addition, there is no proper coordination and standardization of the individual initiatives."

In the Standard for Adolescent Friendly Reproductive Health Services it is said that National Policies and Strategies are conducive but not widely disseminated and implemented. Services managers continue to ignore the need of providing reproductive health services to adolescents. Existing socio-cultural and religious norms are a constraint to the promotion of provision of adolescent friendly services. Moreover, the services that are available are of poor quality and not user-friendly. Because of these reasons and the trouble NGOs have in implementing their initiatives, the Ministry of Health has taken a lead role in developing service standards for young people's reproductive health care (Ministry of Health, 2005)

Given the fact that RH needs are a basic human right, the Tanzanian government has taken upon itself to invest and give high priority to young people's RH needs. A very important reason to give young people's RH high priority is that healthy young people are more likely to safeguard the health of their own children and contribute more effectively to wealth creation for the nation and themselves (Ministry of Health, 2005).

3.3 Conclusion

To conclude, this part will be linked with the problems people face in developing countries regarding RH. As is said in chapter 1 (1.4.1) fertility rates are still very high in many developing countries. In Tanzania, it is found that many 19 year old women already are mothers or are pregnant with their first child. This is partly because there is still an unmet need for contraceptive methods. Young people in Tanzania overall do know how important using contraceptive methods is, but do not know where to get one, which is one of the reasons why only a small part of the country's young population uses contraceptive methods. This is a serious problem, because unsafe sex is the second most important risk factor leading to disability or death in the poorest communities. One further problem is that younger people are less likely to discuss family planning with their partner or husband. These problems are somewhat equal to the RH problems young people in developing countries face.

Overall it is found Tanzanian young people are less likely to use contraceptive methods, are at a higher risk of getting HIV/AIDS and know slightly less about RH issues than older people. Because they are the future of Tanzania, much attention should be given to the RH of young people, making it as important as women's RH.

Even though there have been and are many policies in place to improve young people's RH, it seems that these policies have not been effective enough. Nevertheless, there have been many improvements and the Tanzanian government has now taken a lead role in developing service standards. Hopefully, the government can play a big part in improving young people's RH.

Now, the theories, themes and problems around RH have been examined and clarified. The next four chapters will provide a case-study of Magu District, Tanzania, concerning young people's RHE services, focusing on the awareness-level, accessibility and utilization of these services.

Chapter 4
Methodology

This chapter provides the details of the research methodology used in the study. Here, the research objective and research questions are presented, as well as the conceptual model. Further, the main methods of data collection used in the study, the data analysis process and ethical considerations are explained.

Focus Group Discussion with young women in Magu Town

4.1 Research Objective and Questions

During the fieldwork in Magu District, the host organization was SNV – Lake Zone Portfolio. Because they are interested in involving themselves in the education sector in Magu District, the researchers were asked to do a baseline survey for Primary Education in the district. In addition, the organization is interested in the issue of school girl's pregnancies. Since an important reason for the existence of this problem is arguably lack of education on RH issues, this interest provided the researcher with an excellent entry-point to research young people's RHE. With this issue as a starting point a research objective was formulated together with four research questions:

Research objective:

To assess the awareness level, accessibility and other factors that influence young peoples' utilization of reproductive health education services

Research questions:

Question 1:

What are the different sources of reproductive health education for young people in Magu District?

RHE can be provided to young people through the formal education system, but also by health facilities and non-governmental organizations (NGOs). In addition, there usually are other sources where young people can receive health education, such as their church, by listening to the radio or watch television and even by talking to their parents, family members or friends. Assessing this question serves to provide a clear overview of all RHE services.

Question 2:

What is the awareness level of young people on reproductive health issues?

The awareness-level of young people on RH issues depends on what they know about a range of issues, such as HIV/AIDS, pregnancy and family planning. It is expected that young people who receive RHE to a certain extent will have a higher awareness-level than people who receive no or less RHE. Thus, it is expected that RHE raises the awareness-level on RH issues.

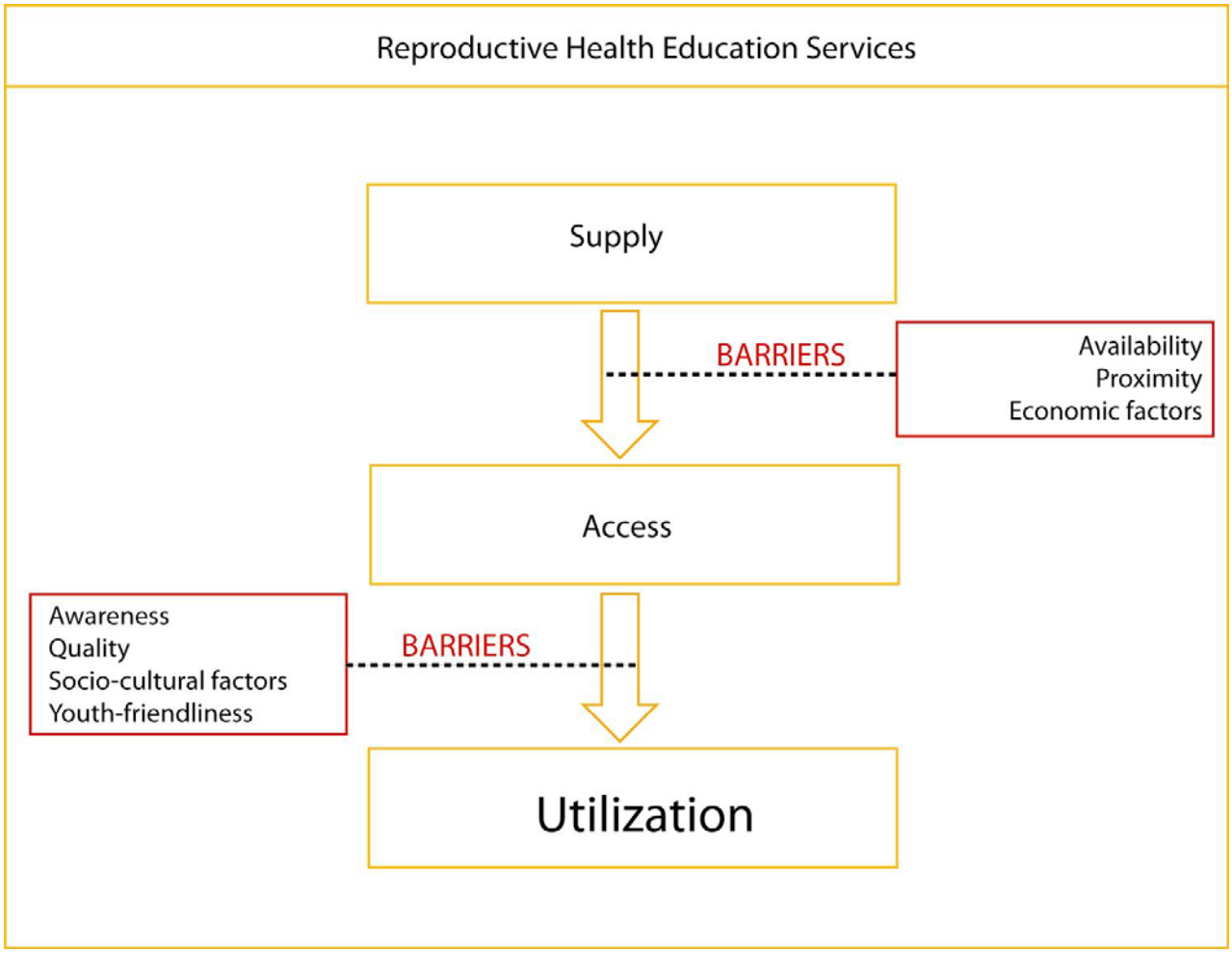
Question 3:
What is the accessibility of reproductive health services for young people?

The accessibility of a service can be determined by looking at spatial factors and by looking at economic factors. It is expected that distance and costs are both barriers for young people to access reproductive health services.

Question 4:
What are the several factors that influence young peoples' utilization of reproductive health services?

Factors that can influence young people's utilization are the awareness they have on what is available to them, the accessibility of the service, the quality of the service, the youth friendliness of the service and finally socio-cultural characteristics.

4.2 Conceptual Framework



The supply of the RHE services is characterized by the actors and the type of the service. Actors can be the formal education system, services given by health facilities, NGO's, civil society organizations (CSOs) and the media. In this study the focus will be on RHE services as a type of service. The supply of these services may lead to access, when barriers such as the proximity to the clinic and the costs that come with using the service are possible to overcome. However, having access to facilities does not necessarily mean young people will use the facilities. There are many factors that influence utilization of the provided facilities. When they are unaware of what kind of services are available to them or when they think the quality of the services is not good enough, they are unlikely to make use of the services. Other factors can be socio-cultural, e.g. that they feel ashamed to make use of reproductive health services. When the services are not youth-friendly young people may feel very reluctant to go to a health facility.

4.3 Definitions and Operationalization

Most terms are already explained in the study, but some terms need a clear explanation. Here, the most important terms will be explained and operationalized.

Accessibility: A service is accessible when the distance to the facilities is not too big and the costs that come with using the service are not too high in the opinion of the respondents (Mamdani, 2004). In this study, distance is assessed by looking at the travelling time that is needed to arrive at the facility.

Awareness: The amount of knowledge someone has concerning a certain subject, here RH issues. It is believed that people who have much awareness are able to make informed decisions, and can improve their RH, partly because they are aware of where to go for help. The awareness-level is operationalized in appendix 1.2.

Peer education: Is often used to generate healthier behaviours among young people. Young people's influence over one another is used to make positive interventions in young people's lives. Peer education operates on the principle that young people are more likely to be influenced by members of their own group of friends than by outsiders, particularly adult authorities. Peer educators receive special training and information which they pass on to their friends (UNFPA, 2004)

Reproductive health: Addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services (WHO, 2004).

Reproductive health services: The services provided which have as a goal improving RH. The following services are considered to be reproductive health services: Family planning education, counselling and services; education and services for antenatal, safe delivery and postnatal care and health care for infants and women; prevention of management of abortion complications; treatment of RH conditions; prevention and treatment of reproductive tract infections and HIV/AIDS; information, education and counselling on human sexuality and responsible parenthood (UNFPA, 2004).

Reproductive health education: All forms of education provided that tries to generate knowledge on reproductive health issues. In this study, reproductive health education is divided up in three groups. (1) RHE provided within the formal education system, (2) RHE provided through health facilities and NGOs, (3) RHE provided through remaining sources, such as the media, church etc. RHE is operationalized in appendix 1.1.

Utilization: Young people will use reproductive health services, including education, when they have a need (demand) to use these services and when they can overcome the various barriers shown in the conceptual model.

4.4 The Methods

This part provides an overview of all the methods used to collect the data needed for this study. To create an understanding of all sides of the issue at hand the research was organised according to three levels, which were:

1. District level: Magu District Council, Magu District Education Department, Magu District Medical Department.
2. Facilitators level: Health facilities, Primary and Secondary schools, Non-Governmental Organizations, other institutions
3. Bottom level: Young people living in Magu District

Previous to the research, relevant literature and past research were studied thoroughly. Undertaking fieldwork began by gathering and analysing all the relevant documents and literature to be found from sources in the district. Most documents were received from the District Council, but others were provided by other institutions and NGO's offices that were visited. The larger part of the fieldwork consisted of gathering empirical information by undertaking interviews, discussions, surveys and observations.

Interview

The semi-structured interviews were addressed to key informants, which were purposefully selected by the virtue of the positions they held in the Magu District Council, schools, health facilities, NGOs and other relevant institutions. The interviews were undertaken with the help of a list of topics that had to be covered during the interview. The list covered the development of RHE services in the district, the structure of these services and the perception the interviewees have on young people's RH in general and particularly in the district. During the interviews, it was kept in mind not to use leading questions, so to let the interviewees answer the questions to their personal knowledge and opinion.

In addition to semi-structured interviews several conversational interviews took place, which were open and informal discussions with various parties. These interviews were used to filter and cross-check the information obtained during the semi-structured interviews.

The interviews were particularly useful in researching the characteristics of the several RHE services in Magu District. However, they were also useful in forming a general picture of the issues surrounding the accessibility and utilization of the services.

Map 4.1: Distribution of the fieldwork in Magu District, Tanzania

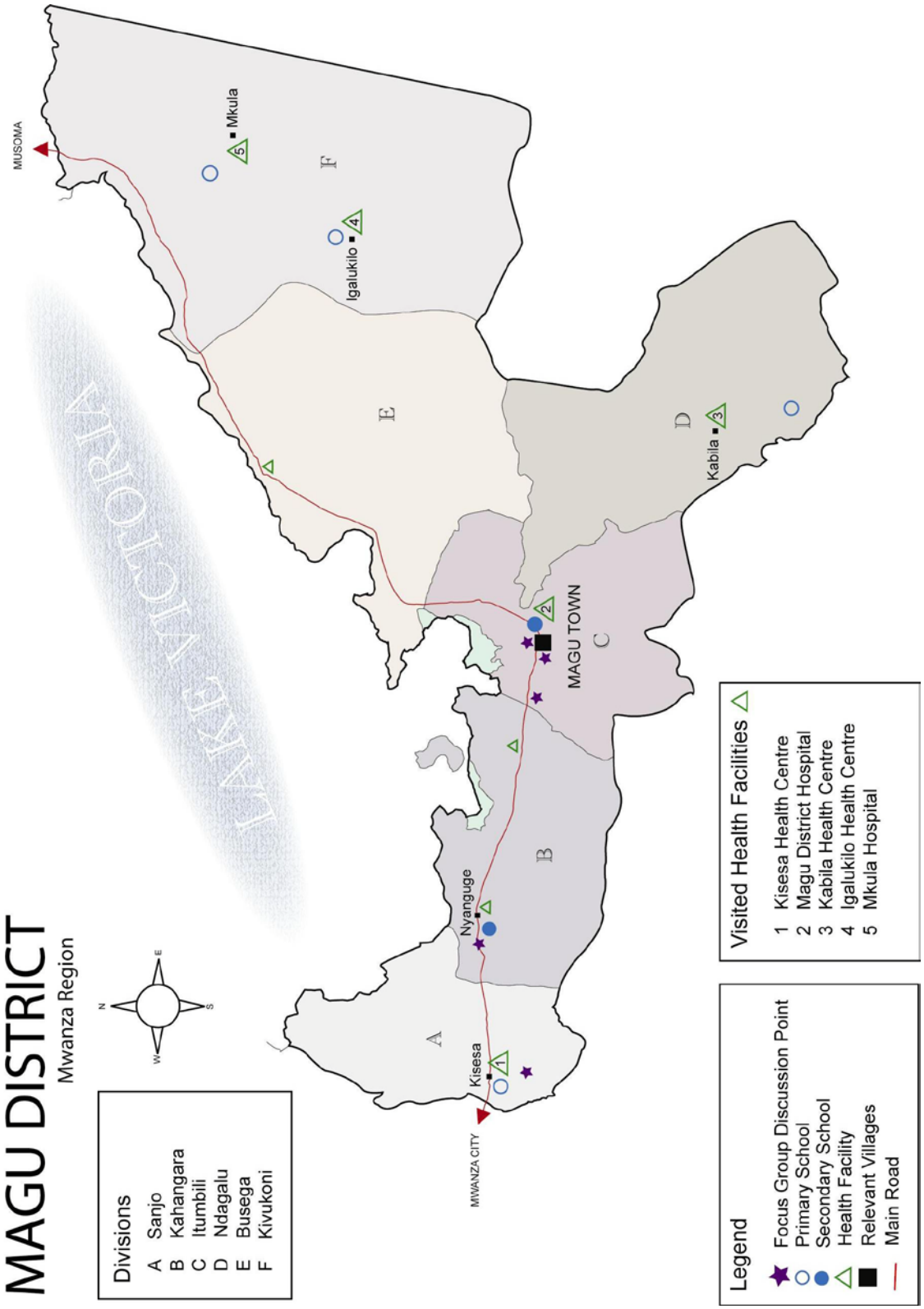


Table 4.1: Interviewees

Level	Interviewee	Purpose
Magu District Council	Community Development Officers, District Education Officers	To look into the issues present in the communities and in the schools
Magu District Medical Department	District Medical Officer, Reproductive Health Coordinator, School Health Coordinator	To look into the RH issues surrounding young people in the district and to see what the perception of young people's RH is among officers in the District council.
Health facilities	Head clinical officers and head nurses	To look into the ability of the facilities to provide RH services, to look into their perception of RH issues.
NGOs	AMREF, TANESA, Aide-et-Action, CARE	To see how they address RH issues in Magu, what their perceptions are on RH issues
Other institutions	NIMR, PSI	To see how they address RH issues in Magu, what their perceptions are on RH issues

Self-Administered Survey

The surveys were addressed to pupils in primary and secondary schools. The primary schools were purposely selected by three criteria: Their geographical position, their performance level and their proximity to a health centre. Two schools were positioned in a relatively central area of which one performed well and one performed poorly and two schools were positioned in a more remote area of which one performed well and one performed poorly. All four primary schools were positioned in proximity to a health centre. In primary schools ten boys and ten girls were randomly selected out of the last three standards; standard five, six and seven. The reason for choosing these standards was because according to the national standards, RHE should be given in these three standards. The selection amounted in a total of about sixty pupils in each primary school and 233 primary school respondents.

The secondary schools were purposefully selected by their position nearby the main road. Most secondary schools are positioned nearby the main road and due to logistical reasons and time constraints the researchers could only visit secondary schools easy to reach by public transport. In secondary schools thirty boys and thirty girls were randomly selected out of all possible forms; forms 1-5. In total 128 pupils filled out the survey divided over two secondary schools.

The survey for primary and secondary schools were slightly different from each other, because of age range and difference in experiences. While the pupils were answering the survey questions boys and girls were separated to make sure girls and boys felt confident answering the questions. In addition, a translator was present to explain the questions when they had trouble answering it. Here, it was made sure that the translator stayed objective towards the questions and only explained the purpose of the question.

Purpose of these surveys was primarily to look into the awareness level young people have on RH issues. In addition, issues concerning availability, accessibility and utilization of reproductive health services were addressed in the surveys.

Focus Group Discussions

Participants were purposively selected with the assistance of staff at health facilities, a ward counsellor and other use of the network build up during the fieldwork. For the focus group

discussions (FGDs) open questionnaires were developed covering topics concerning the overall health situation of the respondents, their reproductive health seeking behaviour, their perception of RH issues in the community, their awareness level on RH issues and their experience with contraceptive methods

Table 4.2 Focus Group Discussions

Location	**Participant**	**Number**
Kitomba Secondary School	Boys attending the school	10
Kitomba Secondary School	Girls attending the school	10
Magu Town	Young men who attend the Training for the Youth program	5
Magu Town	Young women who attend the Training for the Youth Program	9
African Inland Church	Young male and female members of the church	12
Llungu	Out of school youth, mixed	12
Nyanguge	Out of school young men	6
Nyanguge	Out of school young women	8
		72 individuals

It is important to note that the purpose was to always separate female and male respondents during FGDs, however, due to a lack of translators it was difficult to always carry this out. During mixed FGDs it was made sure that, when possible, male and female respondents spoke an equal amount of time.

Observation

While visiting health facilities and schools, observation of the facilities and its surroundings were carried out to understand more of the situation besides what the respondents were telling. A check list was used to undertake these observations.

Data Management and Analysis

During the fieldwork period the notes made during the interviews were processed with the help of Microsoft Word. The semi-structured interviews were already laid out in a thematic manner, so that it was not difficult to work them out thematically. Further, the FGDs were recorded and transcribed when necessary after which they were worked out thematically using Word. The self-administered surveys were inserted in excel using a thematically ordered data sheet. Later on, the data was analysed using SPSS.

Assistance

Since most respondents during the fieldwork spoke Swahili and no English a translator was needed to assist. The first translator was chosen out of five young women, who were interviewed by the researchers. A woman was preferred because of the sensitivity of the theme. This translator's role was primarily to translate the developed surveys for the primary and secondary schools and to translate the given answers on the questions of the survey. In addition the translator assisted while the pupils were filling out the questions in the survey. For some of the FGDs another young woman was used since she lived nearby the research area which was more convenient. She was chosen after interviewing two young women living in Magu Town. For the last few FGDs a young man assisted, he was introduced to the researchers by a trustworthy female ward counsellor. For the interviews little assistance was needed since most respondents spoke English. The little assistance that was needed was given by SNV staff members.

Box 4.1: Problems Regarding the Surveys and Analysis

Even though the researchers put much effort into making the survey questions and answers easy to understand for the respondents, it seemed that some questions were only answered by a few respondents. This is probably because pupils in primary schools feel ashamed to answer these questions. While designing the survey for primary schools, some questions were not asked altogether, because it was expected that pupils would not feel comfortable while answering these questions.

The secondary school survey was slightly different than the primary school survey, in that the questions were more elaborate and most relevant sensible issues were included. It was expected that these older respondents would know more about and feel less shame concerning these questions. However, some questions, especially concerning abortion and family planning, were not answered, especially when these questions were quite personal.

Taking into account these problems, some issues cannot be discussed thoroughly in this study. On top of the problem of a low response-rate it should not be forgotten that the issues raised in the study and in the survey are sensitive to the respondents and when they did answer the sensitive questions, it is possible they gave an answer that they feel less ashamed about or that they thought the researchers would like to hear. Nevertheless, during focus group discussions, some very sensitive issues were raised and overall, participants were very open about these issues. These discussions were therefore very useful in cross-checking the answers

4.5 Ethical considerations

Since the topic of RH is a sensitive one, especially with regard to young people, the research had to be undertaken carefully with much attention for the various ethical considerations. Anonymity while undertaking interviews and through the self-administered surveys was made clear to the respondents. During FGDs it was made clear nobody had to answer if they did not want to. The issue of HIV/AIDS is still highly sensitive in the research area and this is something the researchers had to be aware of. While developing the questions for interviews, FGDs and the surveys, much attention was given to the phrasing of the questions.

SNV and the researcher highly value the importance of local ownership while carrying out a project. Therefore, before visiting the primary or secondary schools a meeting with the District Education Officer was arranged in order to explain to him what the research entailed and in order to receive his consent. Throughout the research the DEO and other officials were kept up to date on the progress of the research. Just before finishing fieldwork in Magu a presentation was prepared for several Magu District Council Officials in order to explain the initial conclusions and recommendations and after finishing the baseline survey and the fieldwork a presentation was prepared by the researchers for all stakeholders in Magu District.

Chapter 5
Reproductive Health Education in Magu District

This chapter serves to provide an overview of the research population and its characteristics, where it is examined what kind of reproductive health problems young people face in the district. Further, the chapter provides an overview of the several sources of reproductive health education (RHE) in the District, focusing on the formal education system. Here, it is also explained what is actually being taught to young people in the district.

5.1 Reproductive Health Issues

In order to assess the several factors that influence utilization of RHE services by young people it is important to assess what the RH problems are among young people in Magu District. This part provides an overview of what kind of problems were found by the researcher in the district, but also what kind of problems there are according to various officials and staff members at NGOs and health facilities. The sensitivity of the issue at hand should be taken into account, giving an explanation for why some issues could not be examined thoroughly.

Box 5.1: The Research Population

Here a short overview of the research population's characteristics is given in order to provide a clear overview of the people who participated in the research

Out of the primary school respondents 52 percent is male and 48 percent is female. They have an age range of 10 to 20 years old and 83.2 percent is between ages 12 to 16 years old. Interestingly 30 percent falls within the reproductive age (15-45). The most common work respondent's caretakers do is farming with 71.4 percent. The majority of the respondents have a radio, while only few have a television. Almost all respondents work at home for their family as an activity outside of school.

The secondary school respondents also had a slightly bigger male group than female with 58 percent. Age runs from 14 to 20 years, with 95 percent falling within the reproductive age. Out of interest the respondents were asked to which tribe they believe they belong and 60.2 percent of all respondents said to belong to the Sukuma tribe which is the biggest tribe in Mwanza Region. The majority is Christian with 93.8 percent. Secondary school student's parents also mostly work as a farmer with 74.6 percent. Only a small group of the respondents (17.5 percent) says to earn money for his or her family and the large majority would say that their household is poor (46.6 percent) or very poor (30.2 percent).

Source: Primary and Secondary School Survey

First, the spread of HIV/AIDS and other sexually transmitted diseases (STDs) is a problem in the district; in 2004 the HIV/AIDS prevalence was 8.2 percent. The focus group discussions clarified that all young people are aware of the fact that HIV/AIDS is a threat to the communities they live in and they expressed their concern about it, while many of the participants hold misconceptions about the way HIV/AIDS is transmitted and how to protect themselves against it. Some of the participants think sharing clothes or sharing food holds the risk of HIV/AIDS transmission and the majority thinks that correctly using a condom does not protect against the disease, while some even think that using a condom will actually increase the risk of infection.

The various officials and staff members at health facilities and NGOs were asked what they think are the most severe problems in the community. HIV/AIDS was always mentioned, since the disease has such a grave influence on the lives of people. These interviewees without exception would say that ignorance and no education on this issue are the most important reasons for the spread of the disease.

Second, school girl's pregnancy was mentioned by some young people in the survey, most people during focus group discussions and by some interviewees as a huge problem in the district. It proved to be difficult to find exact numbers on how big the problem of school girl's pregnancies actually is, probably because of the sensitivity of the issue. What was difficult as well is that the various officials and other interviewees all had different opinions regarding the issue. The officials in the Magu District Council were divided the most; some said it was a huge problem, while others said that it was not a problem at all in Magu. Overall, it seemed that nobody in the District Council could provide documents that could proof it is either a problem or not. Teachers in the primary schools on the one hand said that this problem did not exist in their schools, while on the other hand staff members at the health facilities situated near these particular schools said that they occasionally are visited by young girls who are pregnant and in school. These staff members all agreed that schools girl's pregnancy is a problem in the district. Many of the young participants said that an unwanted pregnancy for a girl has severe consequences; she has to drop out of school, she will probably be in severe conflict with her family and might even have to leave the community.

Third, abortion is a problem in the communities. Women often self-induce an abortion with local herbs, since they do not want to be pregnant and abortion is illegal in the country. Self-inducing an abortion often results in complications, infections and often even death. Staff members at the health facilities say that many women and sometimes young women come to the facility asking for help after self-inducing an abortion, because the facilities are allowed to provide a service called Manual Vacuum Abortion (MVA). They are only allowed to offer this service, when the women already underwent an abortion and nothing else can be done about the situation.

During the focus group discussion in Llungu, a village nearby Magu Town, the female participants were asked what they would do when they would become pregnant unwanted. Interestingly, all of the participants said they would try to get an abortion, either by using local herbs or by going to a private doctor who would be willing to do the abortion for a large amount of money.

Fourth, contraceptive methods use is low among young people in the District. From the younger age group only 4.5 percent has ever used a condom during sexual intercourse, while out of the older respondents 29.7 percent has used a condom during sexual intercourse. Therefore, the older respondents were asked more elaborate questions on this issue. Out of the older respondents 38.1 percent answered that they are sexually active and 18.2 percent says to have had more than one sexual partner in their lives. It was asked whether or not they carry around condoms which resulted in only 12.7 percent of the respondents answering they did carry around condoms, of which only 8 percent carried around condoms the day they filled out the survey and 15 percent carried around condoms in the week before filling out the survey. It was also asked whether they used a condom last week; 8.5 percent answered positively to this question. Only 8.2 percent used a condom the last time they had sex. Thus even though about 30 percent of the respondents ever used a condom during sexual intercourse, contraceptive method use is very low compared to the proportion of sexually active people. The FGDs provided many interesting statements and perceptions concerning this issue. The young women in Magu Town mentioned that one of the problems in the community is that men are the decision makers in society.

> 'There are men who use a condom out of free will, but we do not have a choice when our husband or partner does not want to use one. Men are careless like this, because they believe there is no pleasure with a condom.' *Young woman - Magu Town*

Interesting to note is that the majority of the participants and interviewees said that the problems in their community related to RH are mainly caused by ignorance, which means that education could be one of the solutions to these problems. One of the problems here is that young people do not use the available reproductive health (education) services, even though they do express in the surveys and during the focus group discussions that they do want and need more RHE. Actually, 98 percent of the respondents in primary schools said they want more RHE. There are several factors that young people give as a reason for not going to the health facilities, even when they do want and need more information or treatment.

In brief, possible reasons for young people not to go to a health facility or other services are (1) the accessibility of the services for young people, (2) a low awareness-level on why RH is important and on what kind of services are available, (3) the quality of the service, (4) socio-cultural reasons, e.g. young people are afraid to be judged for going to a health facility and (5) the youth-friendliness of the service. These reasons are examined thoroughly further along in this study (chapter 8).

5.2 Reproductive Health Education Sources

Young people in Magu District receive their RHE from several sources. The formal education system provides RHE in some way in primary and secondary school. Health facilities in the district offer health education which also includes RHE. In addition, Non-Governmental Organizations provide RHE in certain parts of the district. The remaining sources of education are: churches which in their own manner offer important information to their young members, the media that provides health education through several programmes on radio and television and lastly friends and family members who can be an important source of RHE.

In order to assess the quality, accessibility and utilization of these sources it is important to clarify the characteristics of these sources of RHE. The focus will be on who the several actors are in providing RHE and on what young people are being taught through these sources. This part also provides an insight into what kind of problems services face when trying to educate young people.

5.2.1 Formal Education System

Overview:

In Magu District RHE for young people is predominantly provided through the formal education system. The majority of the respondents answered in the survey and during focus group discussions that they receive education in primary and secondary schools. RHE within schools is very important for the awareness-level of young people, because most young people in the district attend at least a few years of primary school, which means that RHE in school has the potential to reach a large group of people.

In primary school there is a slight difference between boys and girls regarding RHE; 63.7 percent of the boys and 70.5 percent of the girls say to receive RHE in school. This still leaves about one third of the respondents without any RHE provided by the school. The majority of the respondents say that RHE is given once a week (53 percent). In primary schools, RHE is given from standard five up to standard seven. Standard six and seven receive slightly more RHE than standard five. According to the majority of primary school respondents, boys and girls are taught the same material and are taught in the same classroom at the same time, which could create a situation wherein e.g. girls do not feel comfortable to talk about RH issues in class. Teachers however, say that commonly boys and girls are not taught at the same time and have partly different material to learn from. Important to note is that 90.2 percent of primary school pupils enjoys learning about RH issues and that 65.8 percent feels most comfortable talking with their teacher about RH when compared to staff at health facilities, caretakers, friends etc.

In secondary schools RH education is supposed to be provided in every form, although during the survey only 53.2 percent of the respondents said that they are provided with education on safe sex, 65.1 percent said this about education on STDs and only 50.8 percent said they are being taught on issues around pregnancy. Depending on the subject and the policy in the school boys and girls are not taught the same material and are not taught at the same time. For example; RHE on HIV/AIDS and STDs, is according to the majority of the respondents taught to boys and girls together (56.6 percent), but issues around safe sex are taught to boys and girls separately. The majority answered in the survey that health workers do come to their school to teach them about safe sex, STDs and pregnancy. The most common subject during these visits is HIV/AIDS and other STDs

Answers to the question who the respondents feel the most comfortable with talking about RH education gives the interesting result of only 3.2 percent of the respondents choosing teachers to talk to. This is a surprising answer because this percentage was much higher in primary school (65.8 percent) and because 42.7 percent of the secondary school respondents answered they prefer to learn about RH issues in school.

Overall, the issue of STDs, including HIV/AIDS is discussed the most in both primary and secondary schools. Interesting to assess is whether or not pupils are being taught what kind of reproductive health (education) services are available for them at other institutions than the school. When young people know what kind of services are available they are more likely to make use of it. The majority of respondents (71 percent) are being taught where they can find more information on RH issues and 55 percent is told what kind of reproductive health services there are available to them at health facilities.

Issues:

This part will focus on issues that exist in the schooling system and have their effect on the provision of RHE. The focus will be on primary schools, for two reasons: First, only few young people (5.7 percent) enrol in secondary school after primary school in Magu District, which means that primary school might be the only place for many young people to learn about RH issues on a regular basis. Second, the enrolment rate for primary schools has increased significantly in the last few years, which means that more and more people are now attending school, but also that an increasing amount of young people in primary school have reached their reproductive age. In this particular study, 30 percent of the respondents in primary school already reached their reproductive age, when it is particularly important to be educated on RH issues, in order to make the right decisions later in life. Of course, attention will be given to secondary schools, but this part serves primarily to clarify why RHE within schools does not reach many young people in the district.

In primary school RHE is normally given during subjects like biology, science or life skills and not offered as a separate subject, which in this case means that teachers are not trained specifically to teach about RH issues, but implement these issues in e.g. biology classes, often leading to a situation wherein little attention is given to RH specifically. In addition, the national curriculum which every school should follow is not provided to every school and talks primarily about life skills, e.g. how to life together, and barely about RH specifically. These two issues together are indicators that RHE in the formal education system is not of a very high quality.

In order to improve this situation, TANESA, a Non-Governmental Organization active in the district, started a project in the late nineties. The organization taught a guardian and a few peer-educators in each primary school in Magu District about RH issues in order to enable them to pass this information on to students in their school. According to the director of TANESA they started this initiative because RHE was pretty much non-existent for young people in the district. In the period from 1994-1998, for example, the national curriculum did not speak about HIV/AIDS at all.

Nevertheless, through surveys and focus group discussions it became clear that few schools offer these services now. Only 38.8 percent of the respondents answered to have ever talked to a peer educator about RH issues. Examples of what they talked about are; how to avoid sex below the age of 18, HIV/AIDS and how to protect oneself against infection, unsafe sex, why there are problems with RH, unwanted pregnancies leading to abortions and about female students who are being deceived by older men and then engage in high-risk behaviour.

Peer educators and trained teachers could have been a valuable addition in teaching young people about important RH issues, especially since it is believed that young people are more comfortable talking to someone of their own age and background about these sensitive issues. This is confirmed by the teachers in Itumbili Primary school who do claim to have peer educators and a guardian and who say that pupils feel comfortable talking to these peer educators. Possibly, the project worked up to the time the peer-educators left school.

A further issue in the schools is that teachers, but often health workers who come to the school as well, are not allowed to give demonstrations, e.g. on how to use a condom. Teachers are held back in this manner to effectively teach their students about RH issues.

On top of these issues many children drop out of primary school or do not continue to secondary school, because of several reasons. Many children need to work at home, especially during the harvest season, but also during the dry season, when they need to find food somewhere else for themselves and for their family. It is found that especially girls have difficulties with staying in school. One of the factors contributing to that is that girls stay home when they are menstruating, because there are not enough latrines for girls in the schools. Many of the students said that girls stay home from school when they are menstruating because they do not have privacy in the school and because there is no water in the school. This means that girls often miss as many as six school days a month. In addition, it is found that girls have more chores to do at home than boys, which often leave them unable to finish their homework.

Lastly, there is the issue of school girl pregnancies which also contributes to drop-outs. Because the enrolment rate is so high in Tanzania and in Magu District many more young people are still in primary school when they arrive at an age where they become sexually active. Even though the different interviewees hold different opinions on this issue it is clear that school girl's pregnancies is a problem in the district. One of the documents that were retrieved stated how many schoolgirls were 'caught' being pregnant and dropped out of school. The large majority of these girls were already in secondary school, only few were still in primary school. According to the students in primary schools it is a problem and 4.5 percent of the respondents knows about a school girl who was pregnant and had to leave school. This percentage is much higher in secondary schools (55.1 percent), which is logical, since pupils there are older than in primary schools.

It is found that the majority of the respondents in primary and secondary school receive education on safe sex, pregnancy and STDs, which implies that they will have some knowledge on these issues. However, still a large group within the school claims to receive no RHE at all. This, combined with the facts that teachers are not specifically trained to teach about RH issues, RHE primarily focuses on life skills, peer educators are not present in many schools and that teachers and health workers are restricted by certain rules gives the impression that schools are unable to and do not provided adequate RHE. In addition, the several drop-out factors existing in primary and secondary schools and the fact that a group of young people do not attend school at all, leads to a situation wherein part of the young population and especially girls, in Magu does not receive the RHE offered by the schools. Other sources are needed to reach this part of the population.

5.2.2 Health Facilities

RHE in Magu District outside the formal education system is mainly provided through health facilities. These facilities offer health education several times a week. However, this education does not target young people specifically; it is for everyone who comes to the facility asking for information. Some staff members mentioned that young people hardly ever attend health education sessions, but that they try to educate young people individually when they come for treatment. The visited health facilities all had posters hanging on the wall which explained about RH issues, e.g. how to prevent HIV/AIDS. Pamphlets covering RH issues were present in each visited health facility. Staff members of these facilities said to occasionally visit schools to teach students about health and especially RH issues. Because of lack of funding mostly secondary schools are visited; staff members barely go to primary schools.

One of the programs that do exist specifically for young people is the Adolescent Friendly Reproductive Health Services program. This is a national programme that started in Magu District in November 2008. By interviewing the health staff at the visited four health centres it was found that only Kisesa health centre actually implements this program. Staff from this health facility goes to several primary schools, one every month, where they have a short workshop to explain various important RH issues, only to the students in Standard VII. These staff members are allowed, contrary to teachers, to give demonstrations on condom use. It is important to note that this programme is one of the first programs coming from health facilities that actually aim at young people. It is supposed to entail more than just going to the schools and offer education; it is also meant to raise the awareness on the importance of youth-friendly services. There is an Adolescent Friendly Reproductive Health Services Standard which explains to the facilities how to make the facilities more youth-friendly. This project is not evaluated yet, which makes it difficult to assess the project here. However, considering this is the only programme present in the district that is focusing solely on young people and that this programme up till now has only been implemented in one of the four health centres that were visited it is clear that for now, only a small part of all young people in the district will reap the benefits of this standard.

Poster on a wall in Kisesa health centre, explaining that respect in a relationship is important in granting each other human rights.

Besides providing education, health facilities provide free condoms, often in a box outside the building so that people can come and get a few condoms without feeling embarrassed. This box is often empty, because there are many delays in delivering supplies to the facilities. The same applies to birth control pills which are also free, but are almost never available at the facilities. It is found that mostly boys from the age of 15 onwards come to the health centres for condoms, girls are rarely seen. Depo-Provera, a contraceptive injectable, is also provided free by health centres when it is available.

The health centres are allowed to help women who come to the health centre with incomplete abortions. Women often use local herbs to induce a miscarriage when they find out they are pregnant, since abortion is illegal. However, this practice often results in an incomplete abortion which has to be dealt with at the health centre or hospital. Igalukilo health centre is visited once every two months or so by young women who need help with an incomplete abortion.

The fact that condoms and other contraceptive methods are often unavailable at the health facility is only one example of the problems health centres face in the district. The health facilities have to deal with many problems, such as lack of skilled staff members, medicines that run out of stock due to delays in orders, leading to life-threatening situations, and lack of funding which results in staff members not getting paid for extra hours. In addition, accessing clean water is difficult, since the groundwater is of low quality.

Although 41 percent of the respondents in primary schools say they learn the most about RH from health facilities (excluding education in school), only four percent of primary school students ever went to a health facility to ask for more information on RH issues.

The majority of secondary school pupils too say they learn the most from education given by health facilities. However, only 48.4 percent of the respondents say they ever went to a health facility to attend a health education session and only 33.9 percent say they ever went to ask for more information regarding safe sex, pregnancy and/or STDs. About half of the respondents have asked a doctor or nurse for information about RH issues.

It is found that health facilities could be a useful instrument to teach students about RH issues, primarily because so many people say they learn the most from health facilities and most of them are also quite comfortable talking to staff at the facilities. However, health facilities face many difficulties in providing enough RH education and other RH services. In addition, education given by health facilities only reaches a small part of the young population in Magu District, meaning that many people miss out on RH education, unless they are being taught in some other way.

5.2.3 Non-Governmental Organizations

Next to schools and health facilities, several NGOs offer RHE. Most prominent in Magu District are AMREF, CARE and TANESA, which are bigger, international NGOs. The smaller NGOs in general do not have a significant role providing RHE in the district.

TANESA had a project in the period 1996 to 2004 that entailed teaching guardians and peer educators. They were trained to teach the pupils in all primary schools about RH issues. They also used the peer educators when they left school to teach out of school youth in the communities. As was mentioned before, this project failed partly, because not every primary school has either peer educators or a trained guardian.

AMREF is prominent in Magu District in three wards, with a project called Jijenge. They provide health education, especially RHE, to people aged 15-49. In the three wards they have an office where people can come to ask questions besides the health education sessions. When undertaking a focus group discussion in Nyanguge Ward it was found that the Jijenge Project is partly effective. The respondents explained that this project holds sessions at least once a month. During the sessions, family planning is the most discussed issue and the use of condoms is demonstrated. People attending come from different villages. People who have attended Jijenge sessions learned what risk behaviour is, how to avoid getting HIV/AIDS and how to protect themselves from getting pregnant. It is important to note that the boys explained that the sessions teach them important information, but that the girls are less enthusiastic about it. The latter said the project does not reach them and that the project sounds very good but that they do not go there on a regular basis. Some of the girls said that they do not feel free to attend the sessions, because they feel ashamed. All boys on the other hand said they changed their behaviour because of the project. Before, they would often have unsafe sexual intercourse with several people, but after going to the sessions they learned that it is essential to use protection when having sex and that it is better to keep your sexual partners limited.

Poster hanging in AMREF's office in Nyanguge Ward, explaining the dangers of STIs and how these present themselves in women

Smaller NGOs have as mentioned only a small role in providing RH education to young people. There are some organizations who offer vocational trainings to young people and at the same time also have sessions on how to avoid HIV/AIDS. Many NGOs mention that they work in some way with HIV/AIDS, but when giving it a closer look it seems that smaller NGOs completely neglect this issue. An explanation for this is that there are many funds available for HIV/AIDS and all NGOs are trying to find funds, which forces them to include HIV/AIDS in their objectives. MACSONET (Magu Civil Society Network) is an NGO that tries to bring together all Civil Society Organizations (CSOs) in Magu District, and also makes an attempt to create a platform where all institutions and organizations, thus including the MDC, come together to discuss development. However, RH is not an issue being discussed at meetings.

It is found that only 3.6 percent of the respondents in primary schools ever went to NGO to ask for more information on RH issues.

Secondary school pupils visit NGOs for health education more often with a percentage of 33.1. There they mostly talked about HIV/AIDS and how to practice safe sex in order to prevent STDs and getting pregnant.

Young people in the district are not likely to have learnt a great deal from NGOs, since there are only a few bigger NGOs that implemented, often only partly, effective programmes. In addition, these NGOs only have the capacity to focus on a small area. Nevertheless, the smaller NGOs might have much potential in educating young people, when they put more effort in working together.

5.2.4 Other Sources of Education

For many people the church is a very important source of RHE. About two-thirds of the respondents said to have ever had information on RH provided by their church. During focus group discussions participants mentioned that they learn how to protect themselves from getting pregnant during sermons where the preacher tells them to abstain from sexual intercourse until marriage. For them this is also a contraceptive method. The Seventh Day Adventists were mentioned as a church that actually organises sessions to teach their younger church members important RH issues.

Media is another important source of RHE. There are several radio programmes on Radio Free Africa, other radio stations and some on the television that teach young people. Names mentioned were: Ukimwi na maisha, Vijana na ukimwi, afya na jamil, Love Zone, Mambo Mseto. Topics covered by the radio and television include: General life skills, the dangers of drug abuse because it can cause HIV/AIDS, the way HIV is transmitted, the problems of pregnancy below the age of 18, how to practice safe sex and the issue of old men persuading young girls. Out of the respondents who know about radio programmes that talk about RH (62.2 percent), the majority (85.1 percent) listens to the programmes once a week or more than once a week. This means that more than one third of the respondents do not know about any radio programme that talks about RH. Television is a less common medium, since only 35.5 percent of the respondents know about RH programmes on the television and out of

these respondents only 49.1 percent watches these programmes once a week or more than once a week. Radio and, though to a lesser extent, television are potential effective sources for RHE, since it is a source that anyone can use in comparison to education provided by schools and health facilities. It is found that most households have access to a radio or a television. Out of the people who listen to or watch programmes about RH issues 90.2 percent thinks they learn valid information from these programmes.

Finally, in the surveys, pupils in primary and secondary schools were asked whether or not they talk about RH issues with their parents, other family members and friends and the majority of them answered positively (97.8 percent). Some of them even answered that they receive most RHE from their direct family or friends. Secondary school students feel most comfortable talking with their caretakers about RH issues. It seems that personal relations are important for young people for receiving information on RH issues. However, during focus group discussions it was also found that many of the young people feel very reluctant to talk with their parents about these issues. They mention that in general, parents have a shallow relationship with their children.

5.3 Conclusion

Magu District knows severe problems related to RH that have negative effects on especially young people. It is found that the situation regarding HIV/AIDS, abortion, school girl's pregnancies and contraceptive use can be improved extensively by educating young people about these interrelated issues. When they are educated they will be enabled to make the right informed decisions for themselves and live healthier lives.

Young people in the district are provided with RHE through several sources. RHE within the formal education system has the potential to provide many young people in the district with the right education. However, the schools lack skilled teachers, are restricted by rules, many students still say they do not receive RHE in school and there are many drop-out factors. These issues lead to a situation in which part of the young population in Magu district does not receive adequate RH education.

It is found that health facilities could be a useful instrument to teach students about RH issues, primarily because so many people say they learn the most from health facilities and most of them are also quite comfortable talking to staff at the facilities. However, health facilities face many difficulties in providing enough RH education and other RH services. In addition, education given by health facilities only reaches a small part of the young population in Magu District. On top of that there are only a few partly effective projects by NGOs in the district. This makes young people reliable on other sources to receive RH education. Church groups, media and friends and family can all be important sources of RH education, depending on a person's background.

Overall, there are many sources of RHE, but on their own they are not able to provide adequate education to young people due to many reasons. However, when these sources are put together, they comprise a network of RHE that does have the ability to reach the majority of young people in the district. Therefore, more attention should be given to collaboration between the several institutions, so that each institution can use its abilities in an effective manner. That health workers visit the schools is good, but these kinds of efforts should be intensified by building collaboration between the community, schools, health facilities, NGOs and all other actors and stakeholders in educating young people on RH. This network could help raise the awareness-level of young people on important RH issues, so that they can protect themselves from diseases and make the right choices in their lives.

Chapter 6
Young People's Awareness

In Magu District many options exist for young people to learn about reproductive health issues as is shown in the previous chapter. The following chapter deals with the awareness-level of young people on important reproductive health issues. First young people's awareness is assessed per issue. Then an attempt is made to answer the question whether or not the RHE education young people receive influences the awareness-level of young people.

6.1 Awareness-Level per Issue

6.1.1 Safe Sex and Family Planning

Only 58.6 percent of the respondents in primary schools know that correctly using a condom does protect against HIV/AIDS and 66.4 percent knows using a condom does protect girls from getting pregnant. The large majority of this group says that not having sexual intercourse is the way to prevent getting HIV/AIDS or becoming pregnant. Using condoms or birth control pills is second on the list of ways to prevent HIV/AIDS and pregnancy. Primary school children know where to get a condom and where to get a condom for free (at the health facilities) although only 54.2 percent has ever seen a condom, mainly in the streets or in a shop, and a meagre 7.9 percent of the respondents ever used a condom for sexual intercourse. All of the respondents in primary schools know that women get pregnant because they had sexual intercourse with a man. They are also aware of the fact that women need help when they are pregnant, when they are giving birth and just after they had the baby; only a few respondents think that women do not need help during these events. Where to get this help (at a health centre or from a midwife) is more or less clear to all respondents, although some still think that e.g. help from the woman's partner is enough.

Secondary school students logically know more about safe sex and family planning; 62.5 percent of this group knows that using a condom correctly will protect against HIV/AIDS transmission and 97.4 percent knows that using a condom protects a girl from getting pregnant. Their preferred way to prevent HIV/AIDS and pregnancy is the same as in primary schools; not having sexual intercourse, but they are more aware of the possibility of using a condom to prevent HIV/AIDS. Secondary school respondents have more or less the same awareness level on issues regarding pregnancy; they also know how women get pregnant and they know that women need help through all important stages of pregnancy.

During the focus group discussions the participants proved to have somewhat the same awareness on safe sex and family planning issues. In Llungu a young woman said:

> "Most people stay abstinent, because they know the dangers. The problem is that most people cannot abstain though" *Young women - Llungu*

When people cannot abstain, they should have the knowledge that using a condom protects them from these dangers, but still a large part of the respondents did not know using a condom protects against HIV/AIDS. One of the participants used an interesting way to plan his family:

> "I always use the calendar as prevention; I know exactly when my wife can conceive and when she cannot. The reason I want to use this sort of prevention is to avoid a big family, because life is too hard to raise a lot of children." *Young man – Magu Town*

The fact that this young man knows about risk days is worth to mention. However, this method will not protect this couple from getting an STD.

6.1.2 HIV/AIDS and other STDs

The large majority (92.9 percent) of the respondents attending primary school knows HIV is transmitted through having sexual intercourse. Some think that someone can get infected by sharing food or sharing clothes. Almost half, 48.7 percent, believes that it is not possible to get infected with HIV through a healthy looking person and 96.5 said that people living in a town are more likely to get HIV/AIDS than people living in the farming and fishing areas, although in Magu the farming and fishing areas have a higher infection rate than e.g. Magu Town. Most of the respondents did know that there is no cure for HIV/AIDS and thus that no one can cure someone suffering from HIV/AIDS.

Secondary school students seem to know slightly more about HIV/AIDS; the percentage of people knowing that HIV is transmitted through sexual intercourse is almost the same with 89.2 percent, but only 24.1 percent thinks that someone cannot get infected with HIV by a healthy looking person. The majority is aware of the fact that a mother with HIV/AIDS can infect her baby while being pregnant (58.8 percent), during birth (88.0 percent) and through breastfeeding (82.8 percent). This group also knows that there is no cure for HIV/AIDS.

During focus group discussions young people's awareness on HIV became clearer. Many of the participants said that they think the spread of HIV/AIDS is the biggest problem facing the community and that the disease is spreading because people are uneducated which leads them to be unaware of ways to prevent it and because people are poor which forces many of them to engage in high-risk behaviour. The participants were able to mention the various ways HIV can be transmitted, but some of the participants think that HIV is transmitted by sharing clothes or sharing food.

Seemingly, young people in the district do know about the basic issues around HIV/AIDS/STDs, but some misconceptions still exist, e.g. the possibility of getting infected by a healthy looking person. Also it is clear that older people know more about HIV/AIDS than their younger counterparts, arguably because they received more education on these issues.

6.1.3 Issues in the Community

Besides assessing the awareness-level of young people on RH issues such as HIV/AIDS and family planning, it is also interesting to look into young people's awareness on issues that exist in the community concerning RH.

Almost all respondents find unwanted pregnancies in their community a big problem (90.4 percent). However, in primary schools only 4.5 percent of the respondents know about any schoolgirl who became pregnant, while in secondary school this phenomenon is well known; 55.1 percent of the respondents knows about a schoolgirl who became pregnant. The majority of both groups knows what happens to a schoolgirl who becomes pregnant, namely that she has to leave school.

The response rate for questions about abortion was very low, which could either be because it is a very sensitive topic or because these young people are simply not aware of the issues around abortion. In primary schools only 6.4 percent answered that they know about a schoolgirl who had an abortion. There was barely a response (8 people) when asking where these girls would have the abortion and how they would pay for the abortion. Secondary school respondents had a slightly higher response rate; 37 percent answered they know about a schoolgirl who became pregnant and had an abortion. According to the respondents, most girls would have the abortion at home where it is free, meaning they would use local herbs to induce the abortion.

During all FGDs the issue of unwanted pregnancies was discussed. All respondents think this is a huge problem, because women have to drop out of school, it can cause family separation and divorce, and because it can lead to death. The older respondents all know about abortion, that someone can undergo an abortion in a private clinic for an unfixed and large amount of money or self-induce an abortion with local herbs. Although they know unwanted pregnancies can lead to death the participants did not link this to abortion, even though self-inducing an abortion often leads to death.

The survey contained an extra section where questions about 'rights' were asked. What became clear through this section is that 77.6 percent of the respondents knows the word 'rights', but that they can barely give an example of what kind of rights they have, including RH rights. Examples that were given were: the right to have all the treatment I need, the right to be educated on HIV/AIDS, to see the midwife, to be aware of my health and lastly, the provision of good health care.

Interesting to note is the fact that young people find it normal that girls stay home when they are having their period. Out of primary school students 74.1 percent answered that girls always or sometimes stay home from school when they are having their periods. The most common reason for staying home is because there is no privacy in the school, since there are not enough (private) latrines. In secondary schools 85.4 percent answered that girls sometimes or always stay home from school when they are menstruating; reason for this is because there is no privacy and/or no water in the school. Staying home from school when menstruating could be a problem in the community since girls miss four to six days of school a month. This could lead to lower grades and dropping out of school altogether.

It seems that most respondents and especially the older ones know about the biggest issues regarding RH in the community, although they are sometimes not aware of the severity of the issues.

6.2 Reproductive Health Education's Effect on Awareness-level

Now, an overview of young people's awareness on the most important RH issues has been provided. The following part will assess whether or not there is a relation between received RHE and the awareness-level of young people.

6.2.1 Education

In order to assess the influence of education, RHE is divided up into (1) RHE provided within the formal school-system, (2) RHE provided by health facilities and NGOs and (3) RHE provided in other ways, such as through the media, church and drama shows. After dividing RHE up into these three variables, it was decided for each respondent whether he or she belonged to the group that received a low amount of education, a medium amount of education or a high amount of education. In this manner it is possible to see what percentage of respondents belongs to which 'education group'.

Only the secondary school survey was used to look into the influence of education on the awareness-level, since only a small part of the primary school pupils ever received education from any other source than teachers in their school.

While deciding in what class the respondents belong, much attention was given to the justification of the choice (cf. appendix 1.1 and 1.2).

Table 6.1 clarifies what percentage of the respondents received little education to much education from the several sources. Interesting to note is that half of the respondents received only a low amount of RHE from health facilities and NGOs. Also, only 4.7 percent of the respondents received a high amount of RHE from the remaining sources like the church and the media. It seems that the school system provides young people the most with RHE.

Table 6.1: Reproductive Health Education per Source

Group	Education total	Inside School	Facilities and NGOs	Remainder
Low	35.2 percent	22.7 percent	49.2 percent	35.2 percent
Medium	49.2 percent	37.5 percent	26.6 percent	60.2 percent
High	15.6 percent	39.8 percent	24.2 percent	4.7 percent
N. of Respondents	128	128	128	128

Source: Secondary School Survey

No relation is found between the amount of education someone received and this person's gender. This means that male and female respondents receive about the same amount of education. In addition, no relation was found between RHE and age, which is surprising, because it is expected that it is easier for older respondents to go to a health facility or an NGO and receive education and also because there seems to be a difference in awareness between primary school students and secondary school students. Apparently, age within secondary school does not make a significant difference[1].

6.2.2 Awareness-Level

When looking into the awareness-level of young people it is important to note that some knowledge young people have could be regarded as basic knowledge, while other knowledge could be regarded as more than just basic knowledge. An example of basic knowledge is whether or not someone knows how HIV/AIDS is transmitted, while an example of more than basic knowledge is whether or not someone knows that babies can get infected through their HIV/AIDS infected mother's breast milk. To assess the awareness level of young people the questions that cover basic knowledge weighed less than the questions covering more than basic knowledge (cf. Appendix 1.2).

Table 6.2: Awareness-Level on Reproductive Health Issues

Level	Total	Male	Female
Low	18.3 percent	23.3 percent	11.3 percent
Medium	53.2 percent	58.9 percent	45.3 percent
High	28.6 percent	17.8 percent	43.4 percent
N. of Respondents	126	73	53

Source: Secondary School Survey

Table 6.2 shows that more than half of the respondents have a medium awareness-level, while more than a quarter have a high awareness-level. The table also shows that nearly half of all female respondents have a high awareness on RH issues, while only 17.8 percent of male respondents reach this level. Only 11.3 percent of female respondents have a low awareness-level. It is found that there is an average-strong relation between gender and the awareness-level on RH issues[2]. This is interesting, because it is also found that there is no significant relation between education and gender. Thus, the female respondent's awareness-level is higher, even though they receive about the same amount of RHE as male respondents. Possible explanations for this are that women know they often have to ask their partner to use contraceptive methods which gives them more responsibility or that women are overall more responsible and therefore find RHE more important. However, more research is needed in order to understand this issue.

[1] See appendix 2.1 for relevant statistical output.

[2] See appendix 2.1 for statistical output

Another interesting issue is that there seems to be no significant relation between the awareness-level and the age of the respondents. This is surprising, because it would be logical when older respondents know more about RH issues, since they have had more time to receive education on these issues. However, previously it was found that there is no relation between the amount of education someone receives and someone's age, which relates to this issue. A possible reason for this is that all respondents are still in school and are thus at about the same level of RHE.

6.2.3 Relation between Education and Awareness-Level

Here it is assessed whether or not a relation exists between education provided by the several sources and the awareness-level of young people.

It is found that there is no significant relation between RHE as a whole and the awareness-level. Even when dividing the group of respondents according to their age or gender, no relation was found. However, education provided within the school system does have influence on the awareness-level, since a weak relation was found between these two variables. Education provided by health facilities and NGOs also has influence on the awareness level of young people, since between these two variables a weak relation was found as well. Between the education provided by other sources and the awareness-level no relation was found[3].

One of the reasons that there is a relation between education provided by schools and by NGOs and health facilities and the awareness-level could be that this education is provided more regularly. Another reason could be that it might be easier to attend school and receive education there, or go to a health facility or an NGO, than it is to attend e.g. a sermon at a church that talks about RH or visit a drama-show, since schools, health facilities and NGOs are meant to reach as many people as possible, regardless of their background or beliefs.

6.3 Conclusion

It is found that the respondents in general hold basic knowledge on the most important RH issues. However, many misconceptions about these issues still exist among young people, such as the idea that condoms will not protect against HIV/AIDS and that someone cannot get infected with HIV by a healthy looking person. Also, most of them are aware of RH issues that play a role in their community. It is clear that primary school respondents know less about RH than secondary school respondents.

It is found that schools provide the most RHE, meaning schools reach the biggest part of the young population in Magu and is also the source where the biggest group of people receive a high amount of education, compared to health facilities, NGOs and remaining sources.

No relation was found between the amount of education secondary school students receive and gender or age. This is interesting because it does seem that people from primary schools and secondary schools have different awareness levels. This relates to the fact that no relation was found between awareness-level and age. Interestingly, female respondent's awareness-level is higher, even though they receive about the same amount of RHE as male respondents.

Only RHE provided by schools, health facilities and NGOs seem to have effect on raising the awareness-level of young people. Therefore, especially these sources are important for the wellbeing of young people. They should be made accessible to young people, so that they can use them, raise their awareness and make the right choices and prevent bad reproductive health.

[3] see appendix 2.1 for statistical output

Chapter 7
Accessibility Leading to Utilization

The previous chapter dealt with the awareness-level of young people on important RH issues. It was proven that young people's awareness is in some way raised by the education on RH, provided by several sources and especially education provided within schools and provided by the health facilities and NGOs. In chapter 5 it was stated that young people do recognize they need more RHE, so when education services seem to raise young people's awareness on important issues, effort should be made to make these services as accessible as possible for young people. This chapter deals with the accessibility and utilization of reproductive health services in order to see whether or not young people get the opportunity to learn about RH issues and that when they do, they make use of the chance, so that they can make the right decisions and improve their reproductive health.

7.1 Accessibility

Accessibility of services is influenced by socio-spatial aspects and socio-economic aspects. It is possible that the services are not in the proximity of young people's livelihoods which will make it very difficult to access the services, just as it is possible that using the services is too expensive; either because of user fees or because of additional costs, such as transportation costs or even bribes. Young people actually often find it harder to access a facility than older people, because young people in general find it more difficult to find transport to the service, unless public transport is available. In addition, they generally have less money to pay for using or going to a health facility than older people. Young women are found to have even more trouble in accessing these facilities, because of cultural factors. In this chapter, the accessibility for young people of reproductive health services provided by schools, health facilities and NGOs in Magu district is explained.

7.1.1 Socio-Spatial Factors

In order to assess the accessibility of reproductive health services it is important to look into the transport means young people have to travel to the service and how long it takes them to get there.

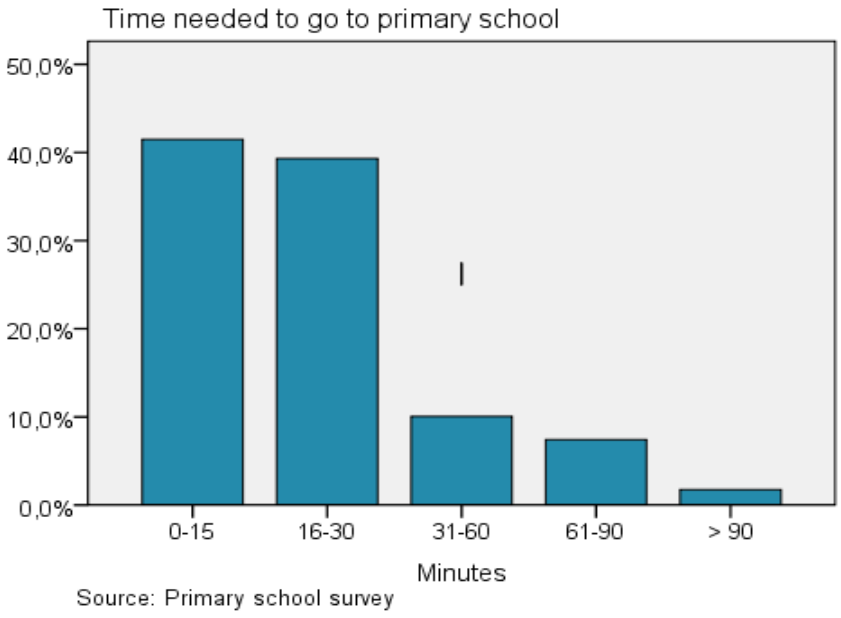


Figure 7.1: Primary school student's travelling time to school Total Number of Respondents (N) is: 229

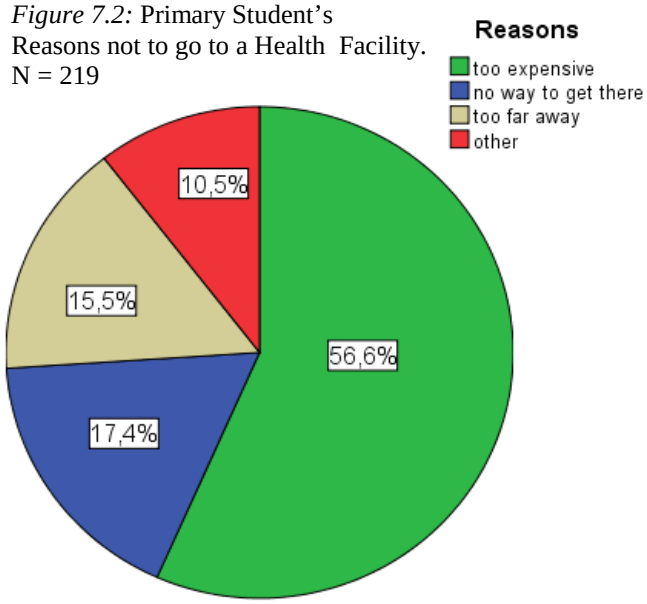
First of all, socio-cultural aspects that influence the accessibility of schools are looked at, since many young people in the district only receive RHE within the school system. In chapter 5 of this thesis the problems around drop-out factors were explained. One of the reasons to drop-out of school or not enrol in school altogether might be the distance to the school. In primary schools 99.2 percent of the respondents answered they usually walk to school. Figure 7.1 shows that 81 percent of the respondents in primary school can arrive at school in half an hour or less. However, this means that still 19 percent needs to walk more than half an hour to go to school and 9 percent even needs to walk an hour or more. Every village should have a primary school, which is probably the reason that the majority of young people live relatively nearby their primary school.

National policy stipulates local governments to have at least one secondary school in each ward. Magu District has 27 wards and has 37 public secondary schools and two private secondary schools. It is found that each ward in the district has indeed at least one secondary school. Nevertheless, wards can cover quite a large area, meaning that many young people still cannot reach the school by foot and find it difficult to have access to the school. There are supposed to be buses to pick them up and bring to school, but these buses are often not in place, which forces the children to walk several hours a day or to ask and ride along with by-passers. Many of the respondents said that they would try to find transport to school for about two hours, if unsuccessful they would turn back home and miss a school day and possibly miss relevant RHE.

A meagre 4.1 percent of primary school respondents says to have ever gone to a health facility to ask for more information on RH issues and only 3.7 percent ever went to an NGO to ask for this kind of information. During Focus Group Discussions with participants under the age of 18, it was also noted that younger people in general do not go to health facilities and/or NGOs. Several reasons were given why they would not want to go to a health facility.

The most important reason for primary school students not to go to a health facility as is shown in figure 7.2 is that they feel the health facilities are too expensive. The second and third most important reason is that they have no way to get to the health facility and that the health facility is too far away. These reasons both imply that distance is a problem for young people to access the health facilities. Magu district counts six health centres, two hospitals and 46 dispensaries on a population of almost half a million. This is a very small number, especially considering the fact that, although there are many dispensaries, the health centres offer qualitatively better RH information for young people than the dispensaries. Thus, young people have to travel far to receive qualitative RHE. According to the national minimal standard the district is required to have four hospitals, eight health centres and 80 dispensaries.

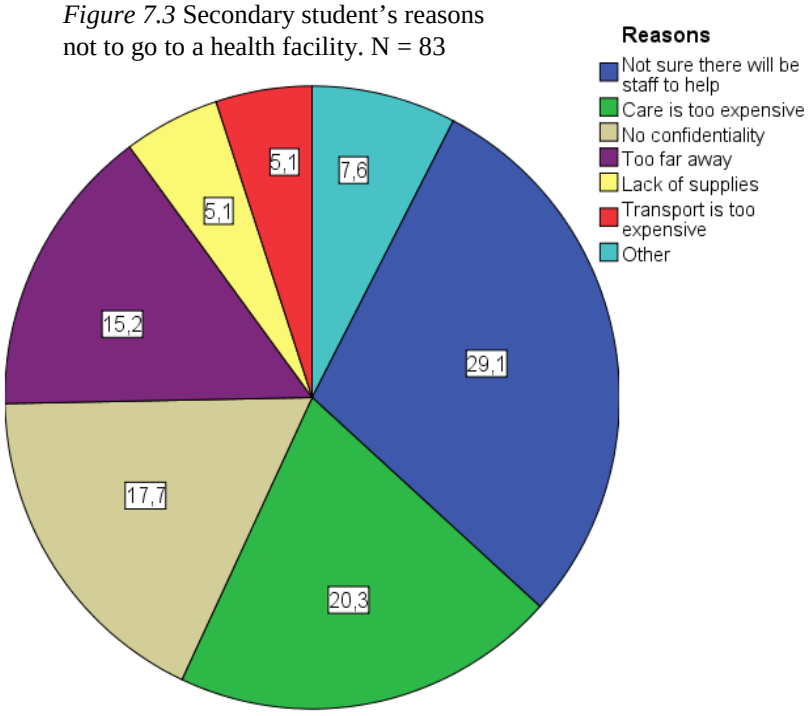
Figure 7.2: Primary Student's Reasons not to go to a Health Facility. N = 219



Source: Primary School Survey

The older youth is more likely to go and visit a health centre or go to an NGO; 33.9 percent of respondents in secondary schools say to have ever gone to a health facility to ask for more information and 33.1 percent ever went to an NGO for this reason. There are still many reasons however why they would not go to a health facility. Interesting to note when looking at figure 7.3 is that reasons concerning distance are far less important among secondary school students as among primary school students. Only 15.2 percent says that the health facilities are too far away and a meagre 5.1 percent says that travelling to the health facilities is too expensive. It is possible that they have more means to go around, because they are older. However, 20.3 of all older respondents still see distance as the most important reason to not go to a health facility.

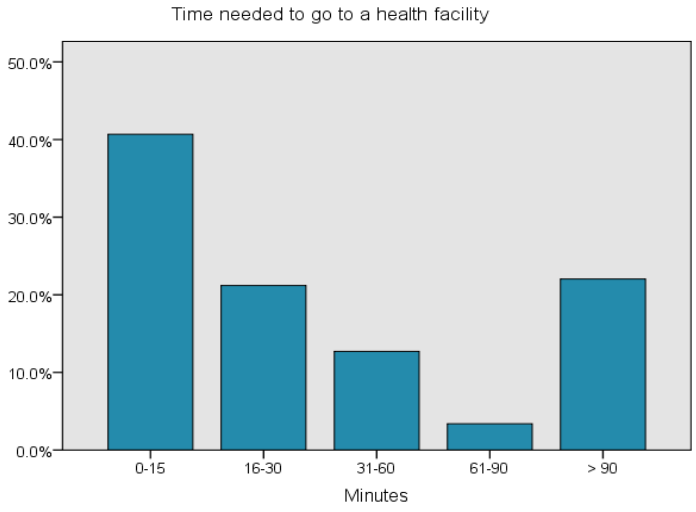
Figure 7.3 Secondary student's reasons not to go to a health facility. N = 83



Source: Secondary School Survey

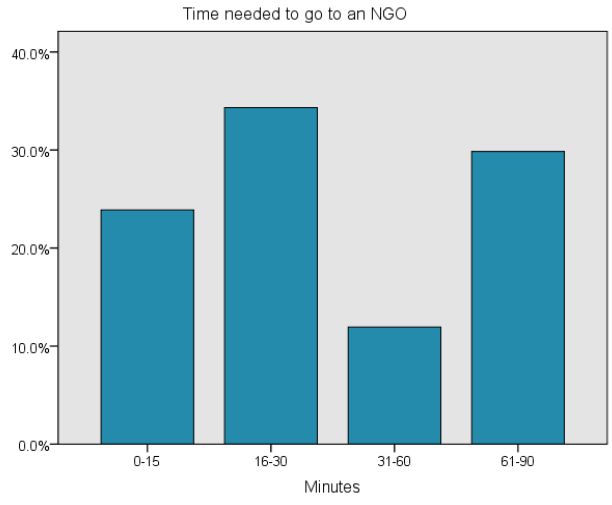
Although 83.9 percent in secondary schools answered that there is a health facility near their community, Figure 7.4 shows that 25.4 percent have to travel at least an hour to arrive at a health facility. NGOs are often even further away as is shown in figure 7.5; 29.9 percent has to travel at least an hour before arriving at an NGO.

Figure 7.4: Secondary schools student's travelling time to a health facility. N = 118



Source: Secondary school survey

Figure 7.5: Secondary school student's travelling time to an NGO. N = 67



Source: Secondary school survey

Concerning distance to NGOs and other organizations that would have RHE services, it is important to note that NGOs usually only work in a particular area; these organizations usually do not have the objective to cover a whole district. This means that access to these NGOs depends more on the availability of these organizations and less on the distance to the NGO. Health facilities, however, should be available to all people in a region, which means that distance is very important in assessing the accessibility of these facilities.

What is found is that distance is usually not a problem for children who want to go to primary school, but it could be a problem for secondary school children; many of them are dependent on public transport which is often unavailable, since they live too far away from the schools to walk. Concerning health facilities, distance is a problem for about a quarter of the research population, keeping in mind that the respondents in this study all live in relative proximity to a health facility. One of the most important reasons not to go to a health facility is the costs that come with using the facility.

7.1.2 Socio-Economic Factors

Economic issues concerning primary school are only a problem for young people whose parents cannot afford the obligatory uniform, pens and other goods a pupil might need for school, since attending primary school in Tanzania is free of charge. Secondary school, however, is not free and although respondents in the survey did not mention this was a problem; participants in focus group discussions did say this was a reason for them not to attend school.

When looking at figure 7.2 and 7.3 it is noticeable that costs for using the health facility are a very important reason for young people not to use the facilities. Transportation costs because of the distance were already mentioned, but there are many other costs that cause people to be reluctant to go to a health facility. A shocking 56.6 percent of primary school respondents say that they find the services at the health facilities too expensive. 20.3 percent of secondary school pupils share this same opinion. Official costs at a health facility are the user fees and transportation costs to the health facility. User fees are normally 2.500 Tsh or 1.5 USD. Nevertheless, many of the services at health facilities are free of charge.

The majority of the respondents are aware of what is free of charge at the health facilities; they know that free condoms are available and that consulting a doctor is free. There are still some people who are afraid they would have to pay for the service when they visit the health facility because they do not know the services they want are free of charge. However, people who do know services are free of charge are still reluctant to go to a health facility because they are afraid they will be charged for using the service or because there are additional costs involved. Participants in the Focus Group Discussions mentioned that they always expect there to be additional costs when visiting a health facility. These costs can be for medication or bribes staff members ask for. Medication is officially free of charge, but because they are often out of stock and it thus is a scarce resource, staff members often charge money for the drugs people need.

> "The government says it is free, but sometimes I only get the medicines I need when I pay for something that is supposed to be free" *young woman – Magu Town*

When young people need to go to a health facility, they would pay for the costs, whether they are official or unofficial, by asking there parents or friends for money. However, most of the participants said that when they go to a health facility because they need a consult on family planning, a check-up for an STD or anything else related to RH, they would ask e.g. a neighbour

to lend them some money, because they feel ashamed to ask their family. Focus Group Discussion participants said that many people in their age-group are not comfortable telling their parents or other family members what they need the money for, but that it is always possible to get money somewhere.

Concerning costs that could limit access to other sources of RHE services it is important to note that NGOs are only relevant in discussing accessibility when they are available in the young people's area. When they are available, for example in Nyanguge and in villages nearby Magu Town, costs usually only include transportation costs, when the NGO is not situated in walking distance.

7.2 Utilization

The previous provided a clearer view on the accessibility of RHE services. It has been shown that for some people the access to these services is low, especially when they do not have the means to pay for the service provided. Social-economic aspects are a greater barrier than socio-spatial aspects. Chapter 6 already dealt with RHE by dividing into groups depending on the amount of RHE they received or used. This part will explain more about the utilization of these services.

Questions regarding utilization of services were much more elaborate in secondary school surveys, since this latter group of people is more likely to be provided with and use several RHE services. Below, two tables will give an overview of the utilization of these services by primary and secondary school students.

Table 7.1: Primary School Student's Utilization of Reproductive Health Services

The Service	**Percentage**	**N. of respondents**
RH education in school	67.6	222
RH education more than once a week	47.0	166
Ever visited health facility for RH services	4.1	221
Ever visited an NGO for RH services	3.7	218

Source: Primary school survey

Table 7.2: Secondary School Student's Utilization of Reproductive Health Services

The Service	**Percentage**	**N.**
Has RH education in school on the subject 'safe sex'	53.2	126
Has RH education in school on the subject ' pregnancy'	50.8	126
Has RH education in school on the subject ' HIV/AIDS/STDs'	65.1	126
Ever had RH education in school from peer educators	38.8	116
Ever had health worker coming to school to teach him/her about safe sex	70.3	118
Ever had health worker coming to school to teach him/her about pregnancy	61.1	122
Ever had health worker coming to school to teach him/her about HIV/AIDS/STDs	75.4	126
Ever visited health facility for RH services	48.1	122
Ever visited health facility to ask for more information on RH	33.9	121
Ever asked a staff member in health facility questions about safe sex	42.7	124
Ever asked a staff member in health facility questions about pregnancy	42.5	120
Ever asked a staff member in health facility questions about HIV/AIDS/STDs	50.0	122
Ever visited an NGO for RH services	33.1	121

Visits an NGO more than three times a year	51.3	41
Listens to at least one RH radio programme at least once a week	57.8	87
Watches at least one RH television programme at least once a week	21.1	55
Knows about at least one RH campaign	5.6	71
Ever received RH education provided by a church	65.3	116
Ever visited a drama show that taught about RH issues	66.7	93

Source: Secondary school survey

As explained before, RHE within the formal education system is important since most young people attend school at least for a few years. This means that RHE within the formal education system has the potential to reach many people. Tables 7.1 and 7.2 show that the majority of the respondents uses RHE provided by the school, but that still a large part does not use this education. Important to note is that boys and girls in both primary and secondary school receive about the same amount of reproductive health education, but that there are far more boys than girls in the district attending secondary school. This means that girls as a group in the district receive less reproductive health education, presenting a problem in achieving universal access to reproductive health services, including education.

Information provided by the radio is quite well known among the respondents, while information by television is used by about one fifth of the respondents. This is probably because it is relatively easy to have access to a radio.

Especially reproductive health services provided by health facilities should be considered a concern. Only 4.1 percent of the primary school respondents have ever gone to a health facility for RH services, whether or not for treatment or for simple information. Secondary school respondents use services provided by the health facility more, but still more than half has never been to a health facility for reproductive health services. This is surely a missed opportunity to adequately educate young people.

That utilization of services provided by NGOs is only 3.7 percent for primary school respondents and only 33.1 percent for secondary school respondents is slightly less worrying, because reason for these percentages could very well be the simple non-presence of NGOs in the living area of the respondents.

The low utilization of health facilities is worrying because the Tanzanian government has made available many health facilities, but 26.6 percent of all respondents has never received any education from a health facility or an NGO. This is a far higher percentage than the percentage for people who never received RHE within school (5.5 percent) or from other sources such as church-groups, the media and drama-shows (11.7 percent). What is also shown previously is that distance and costs are not unavoidable barriers when wanting to go to a health facility. Therefore, the under-utilization of health facilities has to be explained by other factors.

7.3 Conclusion

It is found that distance is usually not a problem for children who want to go to primary school, since most of them have the option to walk to school. Secondary school students however often have to find other means of transport which is proven to be difficult. Distance thus influences the accessibility of secondary schools. Socio-spatial aspects concerning health facilities seem to be a problem for part of the research population. Overall, it seems that the costs that come with going to and using services provided by the schools and health facilities is the most important barrier to access the services.

Considering the fact that distance to and costs for going to or using the services are a problem for the smaller part of the research population, meaning that the majority would encounter only minor problems while trying to access to service, utilization of the services is very low. Especially considering health facilities, utilization is low. A quarter of the respondents

have never had any education from health facilities, which means an important opportunity to educate and help young people is being missed.

When issues such as costs and distance are not a huge barrier when accessing the services, the question is what the other barriers are that influence utilization.

Chapter 8
Factors Influencing Utilization

In the previous chapters it was found that there are many sources of RHE, but that they are under-utilized by young people in the district, even though they want to know more about RH issues and their awareness-level could and should be higher in order to enable them to prevent bad RH and improve their health. Another issue that was found is that accessibility of the services can be seen as a barrier, but that most people can still find a way to access the service. Looking into the utilization of health facilities is important, because utilization of this RHE source now is very low, even though health facilities are most adequate to teach young people about RH issues. The under-utilization of health facilities is indeed a huge missed opportunity in teaching young people.

Without a doubt, the accessibility of the services is a factor that influences utilization of these services, but there are many other factors that will be explained in this chapter. In order to assess the utilization of RHE services, focusing on health facilities, four issues are essential; (1) the importance of awareness, (2) the overall quality of the services and its influence on utilization, (3) the influence of socio-cultural factors and (4) the youth-friendliness of the services.

8.1 Awareness as a Factor

The awareness-level on important RH issues is already discussed in chapter 6. However, the awareness-level is important as one of the factors influencing utilization. When young people do not know how important reproductive health is or what kind of reproductive health services are available at the facilities, they are less likely to visit the health facility.

8.1.1 Health Service Provider's Perception

Staff members at health facilities are aware of the low awareness young people have on their own biology and of the problem that young people often do not know how important it is to seek help at a facility. One of the nurses in Kisesa Health centre said:

> "Adolescents do not know how to protect themselves. They think condoms will only protect against sexually transmitted infections and diseases, because they do not know anything about their own biology; that condoms are needed to protect against pregnancy or that they can get pregnant." *Nurse Stella – Kisesa Health Centre*

This is why the health centres make a serious effort to reach the communities and teach young people on these important issues and on what is available in the health facilities. All health facilities that were visited said to visit schools and give education on RH education, with a focus on where they can get more information and help when they need it. They also mentioned that after visiting a school, more students come to the health facility for a consult or treatment. It is a shame that only Kisesa health centre made an effort to visit primary schools, all the other health centres solely visited secondary school, because they do not have the time or the funds to visit primary schools as well. Besides visiting schools, they also try to attend village meetings once a month so that they can explain to the community leaders what is available at the facilities, so that these leaders can pass this information on to the villagers.

By educating young people on the importance of good RH, and on what is available at the health facilities, health service providers believe it is possible to influence young people's utilization of these services.

8.1.2 Young People's Perception

Participants in the focus group discussions (FGDs) were overall aware of the importance of RHE, although younger participants seem to be slightly less aware. They know that this education is important because no knowledge can lead to all sorts of problems. During the discussions, many examples were given which made clear why RHE is important. Among others, they mentioned that the biggest problem in their community is the spread of HIV/AIDS, which happens because people are not educated in how to prevent HIV/AIDS from spreading. Next, they expressed their concern about young men and women who are not educated and therefore would often engage in risk-behaviour to earn money. Especially young people in the rural areas are uneducated on these important issues. Ignorance leads to unwanted pregnancies and dangerous sexually transmitted diseases (STDs), therefore, RHE is very important and it should be taught in primary and secondary schools, so that many people can be reached.

It is clear that the participants are aware of the importance of RHE, but it is interesting to note that only a few of them expressed knowledge on the importance to go to a health facility for treatment or the possibility to go there for education.

The large majority of the participants do not know they can get birth control pills for free at the health facility and some did not know condoms are available for free. Also, they think going to the health facility will always cost money, although consultation and STI treatments are free.

When young people are not aware of these issues, they are less likely to go to the health facility.

> "A lack of education is an important reason why people do not go to health facilities. They do not know why they should go". *Young man - Nyanguge*

8.2 Quality of the Service

The overall quality of the service might be the most important factor that influences utilization by young people. When there is a lack of staff, lack of supplies, lack of information pamphlets and posters and when the infrastructure of the facility is in a bad state, young people might be very reluctant to come to the health facility. Going through the trouble of going to the health facility and waiting in line can be too much when this trouble is compared to what the service provides them with.

8.2.1 Health Service Provider's Perception

While interviewing officials in Magu District Council, staff at health facilities, non-governmental organizations (NGOs) and other relevant organizations it was found that they themselves are very much aware of the low quality of the services. One of the problems the majority of staff members at health facilities expressed their concern about is the lack of skilled staff members. Igalukilo health centre as an example has one clinical director, two nurses/midwifes, two auxiliary nurses, one health officer assistant, one ambulance driver and three security guards, while the health centre has a catchment area of 6000 people. The health centre needs at least five more nurses and one lab technician. Lack of staff leads to long waiting hours and de-motivated doctors and nurses, since they have to work harder. All health facilities interviewed expressed their worry that the salaries are too low and that they are not paid for extra hours. This further de-motivates staff members.

What is important to note is that effort is made to train staff members. Kabila health centre says to have five or six trainings per year for a few of their staff members, Igalukilo health centre says to have training at least once every three months. These trainings are paid by the local government and deal with a variety of issues, e.g. new ways to test for HIV or training about Anti-Retro-Viral drugs. Kisesa health centre was the only one who mentioned to have had training to make the health centre youth-friendlier besides other trainings.

The majority of the organizations that provide RH services in the district have to deal with bad infrastructure and lack of resources. Lack of electricity is a logical concern, since it may limit the quality of the service provided. All organizations often have no access to clean water, since the ground water is of bad quality and most villages are not connected to the water supply system. These issues also limit the quality of the services.

The large majority of the interviewed people said that lack of supplies in the facilities is a problem. The problem does not lie in the unavailability of the supplies, but more in the delays after requesting more supplies, like condoms, birth control pills and medication. Each health facility receives a fixed amount that can be spent on supplies. This amount is decided on local government level. For condoms, birth control pills and tools that are needed for treatments related to RH issues, like STI treatment or Manual Vacuum Abortion (MVA), the health facility turns to Mama Muna, who is the Reproductive Health Coordinator for Magu District. Normally they receive a new shipment of supplies every three months. However, when a health facility requests for a new shipment, it often takes a few months more to receive them. This often results in the health facility running out of stock, partly because of bad management.

Staff at health facilities says that the Medical Supply Department (MSD) in Magu is very busy and that that is the reason for the delay. They also mentioned that local governments are slowly changing the system. Drugs are now requested with the help of the Indent system which means that staff at health facilities need to make a request to the District Medical Officer (or any of the staff members at the District Medical Officer), who requests the drugs at the Medical Supply Department. Now and more so in the future the ILS system will be put in place, which means that requests can be made directly to the MSD, which will hopefully help speeding up the deliveries.

A staff member at the National Institute for Medical Research (NIMR) who did research on RHE in Mwanza Region, said that the most important cause for young people's bad RH is absolutely the structural problems health facilities have to deal with. According to him, these problems need to be solved first, otherwise young people can never be provided with adequate reproductive health (education) services.

8.2.2 Young People's Perception

In the survey it was asked what the opinion of the respondents was on the care they received last time they went to a health facility. The majority of the respondents (67.1 percent) felt confident the care they received was good, while 11.8 percent of the respondents said the care they received was ok; they were not sure whether or not they were actually in good health when the doctor or nurse told them they were. Lastly, 21.2 percent thought it was not so good; they did not have the idea that staff members helped them well. Interesting to note is that 29.1 percent of respondents said the most important reason for them not to go to a health facility is the concern that they can go to a health facility; but that they are not always sure there will be a nurse or a doctor to help them. Going to the trouble of finding time and paying for transport could then all be for nothing.

During FGDs, many issues were raised regarding the quality of the service. Some of the participants in Magu Town and in Llungu, nearby Magu Town, said they would much rather travel a little bit further to go to the hospital (in Magu Town) than go to a health centre or dispensary because these facilities do not have enough material, e.g. they do not have

thermometers, and because they feel the check-up is better at the hospital. Of course there are only few people who have the luxury to go to the hospital, since most people live too far away.

Many of the participants mentioned that they always have to wait very long before a doctor or nurse is willing to see them and that they feel frustrated, because prominent people are helped right away. They expressed their concern regarding the lack of staff members in the facilities. One of the participants in Kitumba Secondary School said:

> 'Getting there [the health facility] already takes a lot of time so when I have to wait for hours I feel that it is useless to go to the health facility the next time. I do not have time to spend five hours in the clinic'. *Boy - Kitumba Secondary School*

According to some young people, their parents and friends do not even want them to go to the health facilities, since the quality is too low and the health facility is not clean enough. Some said that they think staff members at health facility are not skilled enough to help them:

> 'Some staff members are not open and willing to answer the questions I have, but that is just because they know just as much about the issues as I do'. *Young woman - African Inland Church*

The supply system at the health facilities is another reason for concern; in five different FGDs it was mentioned that condoms are often out of stock and when they are available at the clinic they are often expired. The same goes for birth control pills, although the problem with these pills is more that young people do not know they can get free birth control pills at the health facility. It is possible that e.g. a young man will not go back to the health centre for condoms, after the first time he went, even though he felt embarrassed, and the condoms were out of stock.

Interesting is that interviewed people at the Magu District Council, health facilities and other organizations, apparently agree with the problems young people express their concern about. There is no disagreement over the fact that the quality of the health facilities should be improved to adequately serve young people who come looking for reproductive health services.

8.3 Socio-Cultural Factors

Young people may be aware of the importance of RH and what is available at facilities, but there are other factors that influence utilization; the socio-cultural characteristics of a group of people can influence utilization. One of the most important characteristics that should be kept in mind is the way people think about RH issues, such as school girl's pregnancies, abortion and family planning. These issues are thought of as very sensitive and that is one of the most important factors that influence utilization by young people.

8.3.1 Health Service Provider's Perception

All health facilities interviewed expressed their worries on young people fearing to come to the health facility because of fear of being judged by either staff members or worse, family and other community members. It is found that students from primary schools are more afraid to come to the health facility than students from secondary schools, the former group is also afraid to take condoms from the health facility. There are still many people who see condom use as promoting promiscuity and as sinful, which is a possible reason why people are ashamed to get condoms at the health facility.

A good example of a very sensitive subject in the district is abortion. According to the head nurse in Igalukilo health centre, abortion among young people is a big problem in Magu

District. When young people experience complications after an abortion they self-induced or had done by a private doctor, they need to go to a health centre, but they are afraid to come, because they fear being judged by their family and other community members. Staff members at Kisesa health centre also mentioned this problem which is shown to them by young people who come to the health centre but lie about being married. They are afraid staff members will not help them when they find out they are unmarried. The staff members said that they suspect there are many young people who induced an abortion with dangerous consequences, but fear coming to the health centre, which may mean that these people get an infection leading to death.

Abortion is an example of a sensitive subject, but RH is actually a sensitive subject as a whole. Especially in rural areas, such as Magu district, RH is a subject that people in general feel ashamed about. This is what the health facilities notice; that especially young people feel ashamed to come to the health service to ask for more information on RH issues or because they need treatment.

This sensitivity is also noticeable in the reaction of the community on new projects that have as a goal to either do research on or improve the RH status of young people in the community. One of the examples is how Magu's Reproductive Health Coordinator, Mama Muna, is trying to sensitize the community about the Adolescent Friendly Reproductive Health Programme talked about before in chapter 5. This fairly new programme focuses on improving RHE, rather than just distributing condoms or other contraceptive methods, namely because education is believed to be essential for improving RH, but also because providing education is accepted by the community, while providing contraceptive methods is often not. It was and is believed that condoms will promote promiscuity. Now with this new approach, Mama Muna thinks the project will be received well by the community.

NIMR undertook a large intervention in the late 90s with the objective to educate primary school students on RH issues to later assess whether or not this education had any influence on the attitude and/or behaviour of these young people. Before starting they had to mobilize the community by having public meetings, sensitizing the project and starting up community committees, to make sure the project would be owned by the community. Despite these efforts, there was still a large group of especially parents who did not want the project to start in their community.

These two examples of interventions show that the subject should be dealt with carefully, because RH is still a very sensitive subject, which makes many people feel uncomfortable.

8.3.2 Young People's Perception

In the survey for secondary school students many questions were asked related to socio-cultural characteristics, but only few were answered by enough people. Luckily, the focus group discussions proved to be useful in getting an insight into young people's perception. Questions that were answered in the survey, relevant for this issue, concerned questions about who they prefer to talk to about RH issues and whether or not they feel comfortable going to a health facility.

The majority of the respondents (55.6 percent) prefers to talk to and learn from a nurse or a doctor and about two/third of the respondents says to learn the most about RH issues from going to a health facility. The large majority of respondents (82.0 percent) also feels comfortable going to a health facility to ask for more information on RH issues. It seems that socio-cultural aspects do not have much effect on utilization for the majority of the respondents of the secondary school survey, since the majority feels comfortable going to a health facility and the majority feel comfortable talking to staff at health facilities. However, to assess this issue, more information is needed.

Interestingly, 75.8 percent and 81.6 percent thinks that having HIV/AIDS and getting pregnant is a punishment for bad behaviour. During the FGD at the African Inland Church all

participants agreed that condom use is sinful for religious people and that it promotes promiscuity among everyone who uses condoms.

The FGDs clarified further how socio-cultural factors influence the utilization of health facilities by young people. By looking into the relationship between caretakers and their children it is possible to see what some of the socio-cultural characteristics are. The discussion in Kitomba secondary school was interesting, because the participants were slightly younger than in the other discussions groups. One of the participants said that some of his friends have an STI or STD but they do not dare to tell their parents. One of the girls expressed how the relationship is between most of the children and their parents:

> "My parents and I have a very good relationship, but I think this is different for most children. They have a bad parent to child relationship; they live together but do not know what is going on in their children's life. So when you cannot talk to a parent, where can you go?" *Young woman - Kitomba Secondary School*

Caretakers in most of the situations know and approve of it when their children go to a health facility, but sometimes they prevent their children from going. One of the reasons mentioned in the FGD why parents do this is because they rather have their children going to a traditional healer; they do not trust public health facility to offer good services. According to one of the participants this is because of ignorance.

> "Our parents are even less educated than we are, they do not know what kind of services we can get there and they never go to the health facilities themselves. Since they do not know anything about the services they do not want me to go there." *Young man – Kitomba Secondary School*

The participants at the African Inland Church said that it depends on the problem for which they need to go to a health facility whether or not their parents or community members want them to go to a health facility and thus whether or not they have to be secretive about it.

> "There are still some people who do not want us to go to a health facility to get advice on RH issues and this is because of ignorance. They do not always know what we need" *Young woman – African Inland Church*

However, as said, most participants think their caretakers would approve when they go to a health facility.

> "My parents would be okay with me taking condoms from the health centre, because they will see it as taking care of myself." *Young man - Llungu*

Many of the participants said that when people know how important their health is, they will feel comfortable going to a health facility, because they want to be sure they are healthy. Some are still shy, but most people feel comfortable asking any kind of question. Besides RH education in health facilities, the only place where many of the young people can get education is within the school. However, the relation between teacher and student is not as good as the relation between health worker and student, so many of the participants said to rather talk to a health worker than to a teacher.

To conclude, RH is still thought of as a very sensitive issue for part of the population in the district. On the other hand young people overall seem quite comfortable going to a health facility and asking for more information on RH issues. However, some of them still fear running

into a community member who might judge them because of their problems and many of them still feel ashamed. It seems to depend largely on a person's background and family whether or not socio-cultural factors play a role in the use of reproductive health services.

Since the majority of the respondents learns the most about RH from going to a health centre the service provided there is very important, especially for young people. Even though RH is a sensitive issue, staff members at health facilities should try their best to ensure the facility is welcoming to young people. This issue will be dealt with in the next part of this chapter.

8.4 Youth-Friendliness of the Service

The theoretical chapter already dealt extensively with the youth friendliness of health services and especially reproductive health services. Here, the youth-friendliness of reproductive health services in Magu district is discussed. The socio-cultural factors influencing utilization already showed that services have to assist young people more careful than adults, because they often feel they are being judged for going to the health facility. To assess this issue, especially the secondary school survey and the FGDs were useful, since only few people attending primary school ever visited a health facility.

8.4.1 Health Service Provider's Perception

Before looking into the youth-friendliness according to young people themselves it is interesting to assess what the perception of service providers on their youth-friendliness is.

Three out of four health centres that were interviewed realize young people are reluctant to walk into a health facility and ask for condoms, which is why they have a box outside the building with free condoms in it, so that young people can come and get some condoms without having to be afraid of being judged by community members.

All health facilities have official opening hours that are not conducive to young people, because they need to go to school or work. Health facilities open at 8am and close before 3am. To improve this, staff members mentioned they would sometimes open in the evening to let young people access the health facility. Dispensaries however, do not have enough staff members to do this, which means that the many young people, who do not live nearby a health centre, do not have access to a facility when they have to go to school or work during opening hours. According to Stella, the head nurse at Kisesa health centre, especially young people experience distance to be a barrier, since they cannot afford to pay for transport. She says that a solution would be to equip dispensaries with more staff and supplies to meet the needs of young people who cannot go to one of the six health centres.

According to the service providers, young people are always able to request to have a consultation in a private room and that they can even choose whether they want to talk to a man or a woman. Some of the staff members said that young people freely come to the health facility, since they know the health workers from their visits to the school. Young people, according to them, are not afraid health workers will tell their parents anything about their visit. Kabila health centre, for example, said that when a school girl comes to a health facility pregnant, she has the option to tell the health workers who the father of the child is, but health workers will not tell the parents of the girl what happened. However, staff at health facilities also said that they are obliged to tell the police about a pregnant school girl, because these girls often became pregnant by an older man, e.g. a teacher. This might make it harder for young girls to come to the facility.

When someone comes in with an STI, he or she is urged to ask the partner to come to the health facility, since he or she has the risk of having the STI too. Nevertheless, some of the interviewed staff members said that young people simply do not know they are not obligated to

tell their partner or their parents and that they do not know health workers will not tell their parents, which means that young people are less likely to use the facilities.

Staff members share the perception that the health facilities are more or less youth-friendly. The problem lies more in the facility itself, e.g. the distance to the health facility and the lack of staff and supplies at health centres and dispensaries. The attitude of staff members is not a problem, according to them, but young people are under the wrong impression that staff members will treat them badly, which makes them reluctant to come to the facility.

8.4.2 Young People's Perception

Table 8.1: Young People's Assessment of Health Facility's Youth-Friendliness

Issue	**Yes**	**No**	**N.**
Comfortable asking staff members RH questions	82.0 %	18.0%	122
Believe staff members will keep your issues private	80.2%	19.8%	116
Possible to talk to a staff member in a private setting	82.5%	17.5%	126
Enough opportunity to ask questions during health education	70.8%	29.2%	116
Enough opportunity to ask questions during examination	60.3%	39.7%	120

Source*:* Secondary School Survey

Table 8.1 shows that young people are quite positive about the youth-friendliness of the health facilities. The majority feels comfortable asking staff members questions on RH issues, believes the staff members will keep their issues private and says they are offered the possibility to talk to a staff member in a private setting. A smaller majority says they are given enough opportunity to ask questions about RH during examination and during health education. It seems that staff members take the time to help young people when they come to the facility. That almost 40 percent of the respondents says they do not get the opportunity to ask questions during examination could also be because the health facilities lack staff members to take their time during examination.

Only 17.7 percent of the respondents said that the most important reason for them not to go to a health facility is that staff members will not keep their questions confidential and only 2.5 percent answered they have too little privacy at the health facility. For the majority of the respondents issues related to accessibility are the most important factors that influence utilization.

Interesting to note is that there is a relation between gender and some of the aspects related to the youth-friendliness of the facilities. It is found that there is a weak relation between gender and feeling comfortable asking staff members questions about RH. Female respondents more often feel comfortable asking these questions than male respondents. There is also a weak relation between gender and being able to talk to a staff member in private. Male respondents more often have the opportunity to talk in private. The purpose of trying to find these relations was to show whether or not the facilities are youth-friendlier for men than for women, or the other way around. Because only two weak relations were found, no clear difference is found between the youth-friendliness for women and for men[4].

FGDs were undertaken to see what these participants with different backgrounds think of the youth-friendliness of the health facilities. It is found that the participants have different opinions regarding this issue. The majority of the participants in the FGD in Llungu said that they think staff members will keep their 'secrets' to themselves; that they will keep the

[4] See appendix 2.2 for statistical output

confidentiality. They say they are welcomed well when they go to a health facility and they feel free to ask any question. One of the male respondents in Llungu explained:

> " I do not have any problem with explaining my personal health problem to a doctor or nurse, because I know I need help, so when I do not go, it is my own responsibility". *Young man – Llungu*

Female participants in Magu Town said that they feel comfortable asking questions about RH issues, especially because it is possible to talk to a nurse or doctor in a private room when they want to. They feel that, when everyone is treated individually, staff members will keep the confidentiality. However, the opening hours are from 8 am up to 2 pm, which makes it virtually impossible for them to go to the health facility, since they need to work or need to go to school. Their solution is to go to a paid service, mostly private, which is the only place they can go to get medical advice outside the health facility's opening hours.

What is interesting is that male participants from the same town and same organization (Tanzania Youth Elderly Employment Development Organization) had very different opinions. Some of them said they rather go to an NGO, since they do not feel comfortable asking sensitive questions at a health facility. When they go there, they feel shame and embarrassment. They also said that the opening hours of the clinic are not as big a problem as the other issues they mentioned. When they really need to go to a health facility, they would always find time to get there. It seems that gender in this case makes a difference.

During a FGD with members of the African Inland Church in Magu Town the participants mentioned that some staff members are open and friendly but that others are not. However they do not feel shame to ask questions on RH. They think that most staff members will keep confidentiality, but that this all depends on their ethics. They would feel more comfortable when staff members had better ethics.

The students in Kitomba Secondary School, nearby Kisesa health centre, said that staff members have a very poor approach towards young people. They use harsh language saying: 'You do not understand anything, why do you not know this?', which makes them feel very uncomfortable. Having such an approach, makes young people feel inferior to the staff members and they fear staff members will tell community members what they asked or told the staff members. Also, all participants said that they would feel most comfortable talking to someone of the same sex, but that this is often not possible, because of lack of staff members. A welcoming environment would make them go to the health centre easier. Opening hours for them is not a problem, since the health centre they go to is often open in the evening.

Concluding, young people's perception of the youth-friendliness of the services is slightly different as the service provider's perception. The difference lies in the opinion on staff member's attitudes; most young people do not feel they are being treated badly by staff members, but there are still many people who do feel reluctant to go to a health facility because of this issue. Health service providers and young people agree on the fact that distance and costs are factors that influence utilization, especially for young people.

8.5 Conclusion

Young people are overall aware of the importance of their RH status and they express concern about the RH situation in their communities. However, they seem to have little knowledge on where to go to improve this status. Only few of the participants expressed knowledge on the importance to go to a health facility to get treated or get tested.

Both service providers and young people themselves agree on the fact that the quality of the health facilities should be improved. Structural changes are needed before young people can be helped adequately when they come looking for reproductive health (education) services.

Service providers are aware of that fact that young people are often reluctant to go to a health facility to ask for help regarding RH. Young people fear running into someone they know, since they feel ashamed. RH is still a very sensitive subject and it should be dealt with accordingly. It is important that this is solved in a sensitive manner, because health facilities are the place where the largest group of young people learns the most about RH. This is why the youth friendliness of the services is so important.

Young people's perception of the youth-friendliness of the services overall is quite good; most young people do not feel they are being treated badly by staff members. However there are still many people who do feel reluctant to go to a health facility because of this issue. Health service providers and young people agree on the fact that distance and costs are factors especially influencing young people's utilization.

Utilization of reproductive health services at health facilities could primarily be improved by providing education to young people, explaining to them how health facilities can improve their RH, but also by providing education to all members of the community, explaining to them how important it is that their children know about RH issues and that both older people and young people should not feel ashamed about the issues regarding RH. This way, young people might not feel so reluctant to go to a health facility. Evidently, staff members at health facilities also need education on how to make their services youth-friendly. Luckily, Magu District knows some initiatives to improve the youth-friendliness of the services. However, without improving the quality of the facilities, young people's utilization will stay low.

Chapter 9
Conclusion and Recommendations

It is clear that young people in Magu District face many problems related to reproductive health. These problems, such as the spread of HIV/AIDS, unsafe abortions, schools girl's pregnancies and low contraceptive use can be improved extensively by educating young people about these interrelated issues, since this will enable them to make informed decisions for themselves and the people in their surroundings and to live healthier lives.

Having said the above, this study aimed to *gain insight into the awareness-level, accessibility and other factors influencing young people's utilization of reproductive health education services*. Through this qualitative and quantitative research it is found that awareness-level, accessibility, the quality of the services, socio-cultural factors and the youth-friendliness of the services are all influencing young people's utilization to a certain extent, partly depending on a person's background and situation in a person's community.

There are many places where young people are provided with reproductive health education in Magu District, most importantly within primary and secondary school and by health facilities. Because schools are the place where most young people can be reached by reproductive health education, schools are important in trying to raise the awareness-level of young people. The problem here is that teachers in schools are not skilled to teach about reproductive health issues and they are restricted by rules, which is shown in the fact that many respondents say they do not receive any reproductive health education in the school, even though schools are urged to provide it. In addition, there are many drop-out factors, some of them related to reproductive health and most of them affecting girls, that add up to a situation where in schools are not able to reach young people and adequately teach them about reproductive health issues.

Even though the majority of the respondents believes they can learn the most from services provided by health facilities, these facilities are under-utilized. In addition, there are only a few bigger NGOs that are implementing partial effective projects to improve young people's reproductive health. On their own, these sources of reproductive health education do not seem to be able to adequately teach young people, but together and combined with sources like the media and church-groups, they comprise a network able of educating the majority of young people in the district.

The majority of the respondents showed in the surveys, but also during discussions that they do have basic knowledge on important reproductive health issues, but many misconceptions concerning HIV/AIDS and family planning still exist. Most of the respondents seem aware of the severe problems related to reproductive health that exist in their community, while only few proved to be aware of the role health services can play in solving these problems. Concerning the awareness-level it is important to say that no relation was found between this and the age of the respondents, however, female respondent's awareness-level is higher, even though they receive about the same amount of reproductive health education. It is found that only education provided by schools, health facilities and NGOs have effect on raising the awareness-level of young people. Reproductive health education provided by these sources is therefore important and should be accessible for young people.

Considering the accessibility it is found that distance to secondary schools is a problem for many secondary school pupils. The distance to health facilities proved to be a problem for part

of the respondents, while keeping in mind that the respondents all lived in relative proximity to a health facility. Even though distance is a barrier in accessing secondary schools and health facilities for part of the respondents, costs that come with going to and using the services provided by the schools and the health facility seem to be the most important barrier. Still, distance and costs are barriers for only part of the research population, meaning that the majority encounters only minor problems while trying to access the services. Considering this fact, utilization of the services is low; especially the services of the health facilities are barely used by young people. A quarter of the respondents has never had any education from health facilities, meaning that an important opportunity to educate and help young people is being missed, especially because health facilities do have staff members that are skilled enough to teach young people. When the issues distance and costs are only barriers for part of the population there have to be other factors that influence utilization and explain the low utilization of services at health facilities.

Young people are pre-dominantly aware of the importance of reproductive health and know they have to take care of themselves, but many of the respondents are unaware of where to go to be helped. In addition, many do not know the majority of the services are free of charge. Thus unawareness certainly influences utilization. Another factor is the quality of the health facilities. Since the facilities are qualitatively bad, many young people are reluctant to go there, because they know they will not be helped adequately. In addition, many of the respondents are reluctant to go to a health facility, because they feel ashamed. They fear running into someone they know or they simply feel ashamed talking to someone about reproductive health issues. The issue at hand is still very sensitive and should be dealt with accordingly, especially because health facilities are most adequate, and therefore important, in educating young people. The youth-friendliness of the services is thus essential. It is found that pre-dominantly the respondents find the services quite youth-friendly; most respondents do not feel they are being treated badly by staff members. However, a smaller part of the respondents does feel very reluctant to go to a health facility, because of fear of being judged and being treated badly by staff members.

All factors that are described in this study as influencing young people's utilization are important. However, the amount of influence depends on an individual's personal background and beliefs. Coming from a family wherein reproductive health is not considered to be taboo probably makes it easier for a young person to go to a health facility and ask for the information he or she needs. Having the 'luck' to be educated by a teacher who really tries to explain what common reproductive health problems are and how these can be solved or having the luck to live in a place where an international NGO with sufficient funds is active in the area of reproductive health may make a big difference, and of course, living nearby a health centre or being able to spend some money on health care could mean a world of difference in a person's reproductive health status.

This study shows that utilization of reproductive health services at health facilities could primarily be improved by providing education to young people, explaining to them how health facilities can improve their reproductive health and what is available at the health facilities, but also by educating parents and all community members, so that they know how important it is that their children know about reproductive health issues and that both older and young people feel unashamed regarding these issues. This way, young people might not feel so reluctant to go to a health facility. Evidently, staff members at health facilities also need education on how to make their services youth-friendly. Luckily, Magu District knows some initiatives to improve the youth-friendliness of the services. Educating young people, the community and the staff members in health facilities is not enough; structural changes are needed first in order to improve the quality of the services.

The International Conference on Population and Development (ICPD) took place fifteen years ago. The conference has indeed succeeded to place people at the centre of development work. Nevertheless, as the case-study of Magu District shows, much still has to be done to build advocacy for the improvement of reproductive health among young people. The opinions of the young respondents and the low quality of the reproductive health education services provided in Magu demonstrates this. There needs to be more commitment at international but certainly on national level as well to improve this situation. An important incentive to do this is to reach the ICPD goal to achieve universal access to reproductive health services and to achieve the Millennium Development Goals, since improving reproductive health is an essential element to reach these goals.

This study and its findings carry forth some implications out of which recommendations are formulated. One of the main points of this study is that reproductive health education within the formal education system has to be improved, since it is now of a very low quality, due to unskilled teachers and lack of teaching-materials. In order to improve this situation each school should have at least one trained reproductive health teacher and have the materials to teach their pupils adequately. This is actually the outcome of the project TANESA carried out in the late 1990s. The problem with this project was that it was not sustainable; after some years peer educators had left the school, and teachers did not have any follow-up training. Therefore, trainings should be provided regularly by the local government, via the District Medical Office, also explaining to teachers how important it is to teach while following the national curriculum. SNV, planning to work in the education sector in Magu District and an organization that particularly works according to the fact that several sectors, such as education and health, are interrelated, could incorporate improving reproductive health education in the schools in their future plans.

The low quality of the facilities should be dealt with, since this is one of the most important barriers for young people. Because improving the quality of the health centres still has a long way ahead, a solution to this problem could be to equip the many dispensaries in the district with basic material and information on reproductive health, so that most young people will find what they are looking for at the dispensaries and do not need to go to the health centres for information. An additional reason for doing this is that the distance to the dispensaries is not a problem for the majority of the population in Magu.

It is important that all stakeholders and actors realize that improving young people's reproductive health is essential for all development plans existent in the district; it is an integral issue. Much more cooperation is needed between the several stakeholders, in which the local government should have a key role. Decentralization already improved this situation, shown for example in the fact that staff members from public health facilities visit communities and attend village meetings to discuss health issues. However, much more commitment is needed to make sure every source of reproductive health education comes to its full potential, by working together and using each other's information. Therefore, more attention should be given to cooperation between the several institutions, so that each institution can use its abilities in an effective manner. An example of this is that there has been and there is much research in the district regarding reproductive health, but what is found is that the organizations that undertake these researches do not work together and barely share their results. This means a great loss of time and money; resources that are already scarcely available. Another example concerns the cooperation between health facilities and schools. Health workers only occasionally visit the (secondary) schools, to teach pupils about reproductive health issues, but what could be more efficient is to teach the teachers, who already know their pupils, so that they can teach the

pupils. Then teachers can explain to them what is available at the health facilities and what can be expected when going to a health facility, including what kind of costs can be expected and why it is important to go there when they have a health problem, or when they want to have more information. In addition, increasing cooperation between health facilities and the school is very important, because many young people may not be able to access the health services, but they do attend school.

It is important to realize that every actor should have their own focus. Health facilities should have a position wherein they delegate and educate teachers, the community and NGOs who want to work in the district. Teachers in schools should be trained to teach their pupils as much about reproductive health issues as possible, while also telling them what health facilities have to offer. NGOs could try and focus on the communities, especially out-of-school youth so that these people are also reached and know where they can go to with questions and problems. The many smaller NGOs in the district that do have as an objective to improve reproductive health should try and work together in order to have a positive impact.

A possible way to achieve that every organization comes to its full potential is by calling in the help of MACSONET, who already created a platform for all institutions and organizations working in the district. MACSONET could try to open the discussion on reproductive health and enable all the small CSOs that included preventing HIV/AIDS in their plan to work together and come up with a plan to educate young people about reproductive health issues. The MDC, as well as SNV should work out a plan how to work together with MACSONET, because the organization has great potential in bringing all stakeholders together.

It is important to include young people in the discussions around reproductive health, creating an environment wherein they feel free to express their opinions and concerns. Therefore, more commitment is needed in educating the community on what reproductive health actually entails, and try to make it a topic open for discussion. This is especially important because the relation between parents and their children is often not very close, which makes it difficult for young people to talk about reproductive health issues. At present, health facilities and NGOs already visit the communities in their catchment's area, and the head teacher attends village meetings, but more cooperation is needed, so that every actor strives for the same goal, which is improving the lives of people, including young people. When actors and clients meet each other in this discussion, the topic will be open for discussion, making young people more comfortable going to the health facilities and making the health facilities youth-friendlier.

Thus, what becomes apparent in this study is the need of support from the various actors and stakeholders to improve reproductive health among young people. By emphasising the integral character of reproductive health, the need for cooperation will become clear. The involvement and commitment of the range of stakeholders and actors, such as the local government, communities, civil society organizations, the private sector and the national government will improve the quality of health service delivery and reproductive health education. As such, bad reproductive health will be prevented and the health status of young people will improve, because they can make informed decisions for themselves, their future families and their country.

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Appendices

Appendix 1: Justification Variables

1.1 Justification education variable

First, education was divided up into education provided within the formal school system, education provided by health facilities and NGOs and education provided by other sources, such as the church, media and drama shows.

Education provided for each of these three groups was calculated by giving scores to each questions related to this source of education. The scores were given when the question was answered with yes

1. within formal school system:

Table A1: calculation education provided within school system

Question	Score when yes
Provided with education in school on safe sex	2
Provided with education in school on pregnancy	1
Provided with education in school on HIV/AIDS/STDs	2
Ever talked to peer educators on RH issues	2
Health worker came to school to teach you about safe sex	2
Health worker came to school to teach you about pregnancy	1
Health worker came to school to teach you about HIV/AIDS/STDs	2

Lower scores were given to questions about pregnancy, because it is assumed that education on pregnancy is also provided during education on safe sex or HIV/AIDS/STDs.

The highest score to achieve is 12. Three groups were formed:

(1) People who achieved 0-3 points
(2) People who achieved 4-8 points
(3) People who achieved 9-12 point

2. by health facilities and NGOs

Table A2: Calculation education provided by health facilities and NGOs

Question	Score when yes
Ever visited a health facility for health education	1
Ever visited a health facility to ask for more information on RH	2
Ever asked staff at health facility questions about safe sex	2
Ever asked staff at health facility questions about pregnancy	2
Ever asked staff at health facility questions about HIV/AIDS/STDs	2
Ever visited an NGO for RH education	1
Visits an NGO for RH education six or more times a year	2

Visits an NGO for RH education two to five times a year	1

Lower scores were given to the questions: ever visited a health facility or an NGO, because whether or not someone visited does not explain much about the education they received. People who only visit an NGO once or less than once a year received one point, while people who visit more often received two points.

The highest score to be achieved here is 12. Three groups were formed:

(1) People who achieved 0-3 points
(2) People who achieved 4-8 points
(3) People who achieved 9-12 points

3. Remaining reproductive health education sources

Table A3: calculation education provided by remaining sources

Question	**Score**			
Ever received RH education from church	2			
Listens to RH programmes on the radio	Once a month = 0.5	2- 3times a month = 1	Once a week=1.5	> once a week = 2
Watches RH programmes on TV	Once a month = 0.5	2- 3times a month = 1	Once a week=1.5	> once a week = 2
Knows about RH campaigns	1			
Visited a drama show on RH	Once or twice = 0.5	3-4 times = 1	5-6 times = 1.5	> 6 times = 2

Lower scores were given when someone only visited a source for reproductive health education a few times in comparison to many times. Also the question on whether or not someone knows about RH campaigns was only given one for a score, because it does not say much, when someone knows about these campaigns.

The highest score to be achieved here is 9. Three groups were formed:
(1) People who achieved 0-2 points
(2) People who achieved 3-6 points
(3) People who achieved 7-9 points

4. Total education
These three groups of education together form the total reproductive health young people receive, which can also be divided into three levels.

1.2 Justification Awareness Variable

The new variable AwarenessLevel was made by giving scores to each question related to knowledge on RH issues. Questions related to basic knowledge were given lower scores than questions related to more than basic knowledge.

Table B – calculation awareness-level

Question	**Answer + Score**						
HIV/AIDS how transmitted	Sexual interc. = 1	Sharing food = 0	Shaking hands = 0	Using condoms = 0	God = 0	Mosquitoes = 0	Witchcraft = 0
HIV through healthy looking person	Yes = 2	No = 0					
Baby infected with HIV, while unborn	Yes = 2	No = 0					
Baby infected with HIV, during birth	Yes = 2	No = 0					
Baby infected with HIV, through breastfeeding	Yes = 2	No = 0					
Correctly using Condom will protect against HIV	Yes = 2	No = 0					
Is there cure for HIV/AIDS	Yes = 0	No = 1					
How to prevent getting HIV/AIDS	Condom = 1	No Sex =1	Praying = 0	Washing after sex = 0			
Where free condom	Health Fac. = 1	School = 1	Friends = 1	NGO = 2			
How do girls get pregnant	Sex.interc. = 1	Magic = 0	Kissing = 0	Touching = 0.5			
Correctly using a condom prevents pregnancy	Yes = 2	No = 0					
Other ways to prevent pregnancy	No sexual intercourse = 1	Female condom = 2	Pills = 2	Injection = 2	Traditional Method = 0.5	Washing after sex = 0	
Pregnant woman needs medical help	Yes =1	No = 0					
Pregnant woman giving birth needs help	Yes = 1	No = 0					
Woman after giving birth, needs help	Yes = 1	No = 0					
What happens to pregnant schoolgirls	Leave school = 1	Stay in school = 0	Leave and come back = 0	Has an abortion = 0.5			

In total the respondents could achieve a score of 24.
People who have 0-9 points have a low awareness-level
People who have 10-19 point have a medium awareness-level
People who have 20-24 point have a high awareness-level

Appendix 2: Relevant SPSS output

2.1 Education and Awareness-level

Table C1: Cross-tabulation for Level of Education and Gender

		Gender		
		male	female	Total
Level	Low	32.9%	39.6%	35.7%
	Medium	49.3%	47.2%	48.4%
	High	17.8%	13.2%	15.9%
	Total	100.0%	100.0%	100.0% N = 126

Table C2: Chi-square test Level of Education and Gender

	Value	Significance
Pearson Chi-Square	.83	.66
Count	126	

As table C2 shows, significance is 0,66. This means there is no relation between the level of education someone receives and someone's gender.
When splitting education up in education provided by formal education system, outside the formal education system en the remaining sources no relation was found as well between these variables and gender.

Table D1: Cross-tabulation for Level of of
Education and Age Group

		Age Group		
		1	2	Total
Level	Low	36.4%	32.4%	34.1%
	Medium	47.3%	52.1%	50.0%
	High	16.4%	15.5%	15.9%
	Total	100.0%	100.0%	100.0% N = 126

Table D2: Chi-Square test for Level

Education and Age Group

	Value	Significance
Pearson Chi-Square	.30	.86
Count	126	

As Table D2 shows, the significance is 0.86. This means there is no relation between the level of education someone receives and someone's age (in this case <=16 or >16)
Here again, splitting up education into several sources still showed no relation.

E1: Cross-tabulation for Awareness-Level And Age-group

		Gender		
		male	female	Total
Awareness-level	Low	23.3%	11.3%	18.3%
	Medium	58.9%	45.3%	53.2%
	High	17.8%	43.4%	28.6%
	total	100.0%	100.0%	100.0% N = 126

Table E2: Chi-Square test for Awareness-level and Age-group

	Value	Significance
Pearson Chi-Square	10.52	.01
Count	126	

Table E3: Cramer's V for Awareness and Age-group

	Value	Significance
Cramer's V	.29	.01
Count	126	

Table E2 shows that there is a relation between gender and awareness-level, since the value of significance is 0.01, which is less than 0.05. Table E3 shows that the relation between the two variables is average to strong with a value of 0.29.

Table F1: Cross-tabulation for Awareness-level and Age-group
group

		Age group		
		1	2	Total
Awareness-Level	Low	21.8%	15.5%	18.3%
	Medium	54.5%	52.1%	53.2%
	High	23.6%	32.4%	28.6%
	Total	100.0%	100.0%	100.0% N = 126

Table F2: Chi-Square test for Awareness-level and Age-

	Value	Significance
Pearson Chi-Square	1.55	.46
Count	126	

Table F2 shows that the significance value is 0.46, which means there is no relation between someone's age and someone's awareness-level. According to this test, people who are 16 years or young do not have a significantly different awareness-level than people who are older than 16.

Table G1: Cross-tabulation for Awareness and Awareness
Education within the formal education system

		Education-level within formal education system			
		Low	Medium	High	Total
Awareness-level	Low	10.3%	27.1%	13.7%	18.0%
	Medium	75.9%	54.2%	41.2%	53.9%
	High	13.8%	18.8%	45.1%	28.1%
	Total	100.0%	100.0%	100.0%	100.0% N = 128

Table G2: Chi-Square test:

and education formal

	Value	Significance
Pearson Chi-Square	16.64	.00
Count	128	

Table G3: Cramer's V for Awareness and Formal Education

	Value	significance
Cramer's V	.26	.00
Count	128	

Table G2 shows that the significance value is 0.00, which is smaller than 0.05. Therefore, there is a relation between the education provided within the formal education system and the level of awareness. Table G3 shows there is a weak relation between the two variables with a Cramer's V of 0.26.

Table H1: Cross-tabulation: Awareness and Education Health Facilities, NGOs

		Education Health Facilities and NGOs			
		1	2	3	Total
Awareness-Level	Low	9.5%	41.2%	9.7%	18.0%
	Medium	60.3%	35.3%	61.3%	53.9%
	High	30.2%	23.5%	29.0%	28.1%
	Total	100.0%	100.0%	100.0%	100.0% N = 128

Table H2: Cross-tabulation: awareness and education Health Facilities, NGOs

	Value	significance
Pearson Chi-Square	17.21	.00
Count	128	

Table H3: Cramer's V: Awareness and Education Health Facilities, NGOs.

	Value	Significance
Cramer's V	.26	.00
Count	128	

Table H2 shows that the significance value is 0.00, which is smaller than 0.05. Therefore, there is a relation between the education provided by health facilities and NGOs and the level of awareness. Table H3 shows there is a weak relation between the two variables with a Cramer's V of 0.26.

2.2 Youth-Friendliness

Table I1: Cramer's V: Gender and feeling comfortable asking staff members questions

	Value	Significance
Cramer's V	.22	.02
Count	120	

Table: I2: Cramer's V: Gender and being able to talk to staff privately

	Value	Approx. Sig.
Cramer's V	.21	.02
N of Valid Cases	124	

Table I1 shows that the significance value is 0.02, thus there is a relation between the two variables, though only a weak one. The same goes for table I2.

Appendix 3: Interviews and Focus Group Discussions

3.1 Questions for Staff at Health Facilities

Introduction questions
What is your occupation title?
How long have you been working at this health centre?
How many doctors, nurses, staff are there?
How many beds are there? How many buildings/rooms?
What is the average number of patients per day/per month?
What is the age range of reproductive health receiving patients?

Funding Situation
Where do you get your funding from?
How are your funds allocated?
How do you get more funding?
How often do you receive medicinal supplies from the government?
How often do you receive medicine stocks from the government?
How do you solve the situation when you run out of funds or medicines or equipment before the next funding?
Do you accept exemptions or waiver fees?

Magu District
What is the main health issue in the district?
What is the most serious health issue in the district?
What is the main reproductive health issue in the district?
What is the main reproductive health issue for young people in the district?

Community:
What is the most common health issue in the community?
What do you think are the most serious health issues in the community?

Services:
What services do you offer at your facility?
What kind of reproductive health services do you offer?
Are any of these RH Services specifically for young people?
Are the RH services provided to all people, regardless of their age?
What contraceptive methods do you offer?
Are contraceptives provided free of charge? How are they obtained? What is the procedure for getting them?
Is pregnancy among unmarried schoolgirls common in this area?
Have you ever treated pregnant adolescents? How many? How often?
What are some of the reasons this happens?
What happens to pregnant schoolgirls? Are they able to receive care or advice at the health centre?
Have you ever had young girls come in who wanted to have an abortion or had questions about abortion?

Health education:
How often/for how long is health education given to patients?

What topics are covered?
Are there any specific programs aimed at reproductive health?
Do any of these include reproductive health information?
Do you ask patients what topics they would like to hear about?
Do you take questions from them during the sessions?
How extensively do you cover issues on STDs (including HIV/AIDS), pregnancy, and early sexual initiation?
Is there shame or embarrassment related to these issues?
Do you have any information on campaigns related to these issues in the media?
Do you have pamphlets, posters on reproductive health?
Are any of these specifically for young people?

Spatial and Economic barriers
Do you think the distance to facilities can be a barrier for people to come?
What do you think are additional costs for people to use the health facility?
Do you think these additional costs are a barrier for people in general and young people in particular to come to the facility?

Other barriers:
What do you think are other barriers for young people to come to the service?
For example: partner of a girl does not want her to come to the facility, parents of young people do not want their children to come to the facility?
In what extent do you think culture is a barrier to people using the facility?

Youth friendliness:
Do you think young people feel comfortable using this facility?
Are young people welcomed well when they come?
Do adolescents feel comfortable accessing RHS at your centre? Why or why not?
Are clinic hours appropriate to allow adolescents to access them? Are they open outside of school hours?
Are young people able to have privacy when they come with a problem, related to reproductive health?
Are young people able to choose with who they want to talk?
Is staff willing to discuss reproductive health services with adolescents?
Are they given the freedom to describe their problems?
Do staff feel they have an adequate knowledge of issues specifically related to adolescent RH?

Relationship with Community
Do you have any outreach programs for the community? For adolescents specifically?
Do you meet with community leaders to discuss issues in the community? If yes, with which ones? How often do you meet? What kinds of issues do you discuss?
Do you meet with other community based organizations to discuss issues in the community? If yes, which ones? How often do you meet? What kinds of issues do you discuss?
Are there any groups you would like to work with? Which ones and why?
Are you part of a community health committee? If yes, how is this community formed? How many members are on the committee? What activities does the committee undertake?
Do you meet with schools or school board members to discuss health issues related to children or adolescents?
Does the health committee work together with the school committee? If yes, how often do you meet? What kinds of issues do you discuss?

Trends:
What are some of the trends in utilization of reproductive health services in this area?
Did you see a change in demand in the last 5 years?
Did you see a change in utilization in the last 5 years?
Did you see a change in behaviour in the last 5 years?

Delivery Satisfaction
Describe your areas of strength in the service you provide.
Describe your areas of weakness in the service you provide.
How often is your staff given training? Who provides this training?
What kind of training is provided?
Does your health facility give updated trainings to staff?
Have you seen any improvements because of this?
Is your staff motivated?
What kind of incentives do you have in place for your staff?

Current Challenges
What problems does the HC face? What is missing or lacking in this centre?
Why do these problems exist?
What does go well in the facilities?

Suggested Improvements/Solutions
What steps have you taken to address these problems?
Have they proven successful? If not, why?
What are your immediate needs for improvement?
Do you have any further comments or questions?

3.2 Questions for NGOs

1: What are the aims of your organization?
2: Do you focus on reproductive health? i.e. what specific programs do you have that focus on young people's RH issues?
3: What is your target group?
4: What activities do you undertake? Which ones have you undertaken in Magu District?
5: How often do you undertake these activities?
6: Why did your organization choose to work in this area?
7: Do you work together with other non-governmental organizations? Why or why not? And if so: which ones? How do you collaborate? Do you share any data you may have collected?
8: Do you work together with the MDC? Why or why not? How do you collaborate?
9: What are some of the specific reproductive health issues faced by young people?
10: What are some of the barriers young people face in accessing and using reproductive health education services?
11: Do you think young people are underrepresented as a social group when it comes to reproductive health advocacy?
12: Do you offer education or information to young people regarding reproductive health issues and services?
13: Do you think there is an unmet need for young people's access and utilization of reproductive health services as well as education?
14: Do you think existing reproductive health services in Magu District are youth-friendly?

What should and could be done to make the services youth-friendlier?
15: Are there any socio-cultural or religious norms in Magu District which constrain the promotion and provision of youth-friendly services?

3.3 Focus Group Discussion Young People

General Info

1. Average age?
2. Where do they live?
3. What is their occupation? Student or Work? What kind of work?
4. Do you know what reproductive health is? What does it entail?

Issues:

1. What do you think are problems in your area concerning reproductive health? For example:

- STIs, STDs, unwanted pregnancies.
- No access to health facilities
- No money to pay for transport to go to health facilities
- No education in reproductive health, no awareness of the several reproductive health aspects
- Other?

2. Do you know of any young people who have contracted an STI, such as HIV/AIDS?
3. Do you think unwanted pregnancies is a big problem? Among young people?
4. Do you know of any girls who became pregnant unwanted last year? Where they in school? What happened to them? Who was the father?
5. Did they have an abortion? If so, where did they have the abortion? How did they pay for it?

Availability and Utilization

1. Where can you get information about reproductive health (i.e. on STIs, pregnancy, contraceptive methods)?
2. How do health facilities provide you with information on reproductive health? (pamphlets, discussion, individually or in groups, other characteristics?)
3. What other reproductive health services do these facilities offer young people?
4. Is there an NGO, FBO or CBO that provides information on reproductive health?
5. How do these organizations provide information on reproductive health? (pamphlets, discussion, training?) example: TANESA, Jijenge?
6. Do you know of any other actors in your area that offer reproductive health services? (churches?)
7. Where do you prefer to get your reproductive health education from? (school, health facility, family, friends, NGO, other)
8. Did you ever go to a health facility to ask for more information on pregnancy, sexually transmitted diseases or something relating to this?
9. What programs do you know that are on the radio that give information on reproductive health issues?

Barriers:

1. Is there a health facility nearby your home?

2. If you need to pay for reproductive health services, are you able to? Where do you get the money?
3. If you need to travel to a health centre, are you able to pay? Where do you get the money?
4. Are there any additional costs for using the reproductive health facilities?
5. Do you think staff at health centers are friendly and open?
6. Do you feel comfortable asking them questions about sexual/reproductive health?
7. Are you able to talk to a nurse or a doctor in a private room when you want to?
8. Do you feel that staff members are open and willing to answer your questions?
9. Do you think the nurse or doctor will keep everything you tell them confidential?
10. Do you think the opening hours of the health facilities allow you to go there? (what are the opening hours of the facility?) When would you like to visit a health facility?
11. Can you mention some reasons why you would not want to go to a health facility?
12. What would you like to see at a health centre that would make you more likely to go there?
13. Do your parents or caretakers know that you visit health centers for information on reproductive health services? Why or why not?
14. Do you think there is anyone in your direct surroundings, like family-members, friends, teachers, that would not like you to go to a health facility to ask about reproductive health issues? What do you think is the reason for that?
15. Do you know of any reasons why you would not go and look for reproductive health services?
16. If you could change anything in the health facilities, what would you like to change?

Effects, Awareness Level, Behaviour

Knowledge:

1. Where can you learn about reproductive health issues (HCs, NGOs, School)
2. Do you know how HIV/AIDS is transmitted?
3. Do you know how can you protect yourself from infection?
4. Do you know where you can get a condom? How can you pay for it? Is there anywhere you can get a condom for free?
5. Do condoms promote promiscuity?
6. Do you know how girls become pregnant?
7. Does correctly using a condom protect you from pregnancy?
8. Do you know of other methods to protect you from pregnancy?
9. Where can you get these methods?

Behavior:

1. Are you sexually active?
2. Do you use condoms?
3. Do you use any other contraceptive method? Which one?
4. Why do you use contraception methods?
5. Why do you not use contraception methods?

Effect:

1. Can you give examples of something that you did not know and learned due to education on reproductive health?
2. Do you think you act different now you had education on reproductive health?

Appendix 4: Surveys

4.1 Primay School Survey

The purpose of this questionnaire is to find out more about the issues that are in your school. The answers you give will help us to better understand these issues. Please answer each question to the best of your knowledge.
For each question, please circle the correct answer. Where there is a blank space, please write your answer in the space.

We thank you for your time

General information

1. What is your age?
2. Are you male or female?
3. What standard are you currently in?
4. What is the name of the village you live in?
5. What is the name of the ward you live in?
6. What is the name of the division you live in?
7. How do you usually come to school?
1. Walking
2. By bus
3. By bicycle
4. By taxi
5. Other, specify

8. How long does it take you to get from your house to school using the usual method?
1. 0-15 minutes
2. 15-30 minutes
3. 30-60 minutes
4. 60-90 minutes
5. More than 90 minutes

9. How many days of school did you miss in the last 3 months?
1. 1-5 days
2. 6-10 days
3. 11-15 days
4. more than 15 days
5. I did not miss any days of school in the last 3 months

9b. If you missed days of school, why did you miss these days?
1. I was sick
2. I had to work at home
3. I did not want to come to school
4. Other, specify

10a. did you go to another school before this one?
1. Yes , if yes, please complete 10b-10d.
2. No

10b. why did you leave the other school?
1. Me and my family moved
2. I was expelled
3. This school is better If so, why?
4. Other, specify

10c. why did you come to this school?
1. It is near my house
2. My parents sent me here
3. My guardian put me here
4. Other, specify

10d. was the other school you left in this same village?
1. Yes
2. No

11. What type of roof does your house have?
1. Metal
2. Thatched
3. Straw
4. Other, specify

12. What type of walls does your house have?
1. Cement bricks
2. Bricks and mud
3. Bricks and cement
4. Wood and mud
5. Mudd
6. Other, specify

13. What is your parent's or guardian's job?
1. Farmer
2. Laborer
3. Teacher
4. Other, specify
5. They do not have a job

14. Which of the following are in your house?
1. Fan
2. Refrigerator
3. Radio
4. Cell Phone
5. Other, specify

Education:

15. In your math class, after you get your test results or homework marked by your teacher, how often does you teacher explain what you got wrong?
1. Always
2. Sometimes
3. Never

16. In your English class, after you get your test results or homework marked by your teacher, how often does you teacher explain what you got wrong?
1. Always
2. Sometimes
3. Never

17. In your classes, after you get your test results or homework marked by your teacher and you get the answers right, how often does your teacher say "well done" or congratulate you?
1. Always
2. Sometimes
3. Never

18. In the last week, have your teachers missed any of your classes?
1. Yes If yes, please complete 18b.
2. No

19. How many classes did your teachers miss last week?
1. 1 class
2. 2 classes
3. 3 classes
4. More than 3 classes
5. My teachers did not miss any classes in the last week

School environment:

20. How many toilets are there in the school for boys?
1. 0-1
2. 2-3
3. 3 or more

21. How often do boys use the toilets?
1. Always
2. Sometimes
3. Never

22. How many toilets are there in the school for girls?
1. 0-1
2. 2-3
3. 3 or more

23. How often do girls use the toilets?
1. Always
2. Sometimes
3. Never

24. Do you have water in your school?
1. Yes
2. No

25a. Do you drink water during the school day?
1. Yes If yes, please answer 25b – 25e
2. No

25b. How much water do you drink in one school day?
1. none
2. 1-2 cups
3. 2-3 cups
4. more than 3 cups per day

25c. what is the source of the water?
1. Own tap
2. Communal
3. River or rain water
4. Bought
5. Piped or pumped water
6. Open well
7. Taken from home
8. Other, specify

26. What happens if you do not drink water in school?
1. I feel dizzy
2. I find it hard to listen to the teacher
3. I have a headache
4. I feel weak
5. Other, specify

27. If you do not listen in class, what does the teacher usually do to you?

1. sends me out of class
2. hits me
3. makes me stand in the corner
4. yells at me
5. Other, specify

28a. Do you eat while you are at school?
1. Yes If yes, please complete 28b – 28d
2. No

28b. How often do you eat at school?
1. once a day
2. twice a day
3. three times a day
4. more than three times a day

28c. Where do you usually get the food you eat in school?
1. At school
2. I take it from home
3. I buy it at the store
4. Other, specify

28d. What do you usually eat at school?
1. Banana
2. Maize
3. Beans
4. Rice
5. Other, specify

29. How many female teachers are in your school?
1. 1-5
2. 6-10
3. 11-15
4. More than 15
5. There are no female teachers in our school

30. Would you like there to be more female teachers in your school?
1. Yes If yes, please answer 30b
2. No

30b. why would you like to have more female teachers?
1. Female teachers are more patient
2. Female teachers teach better
3. Female teachers are nicer
4. All of these reasons
5. Other, specify

31. How many male teachers are in your school?
1. 1-5
2. 6-10
3. 11-15
4. More than 15
5. There are no female teachers in our school

32a. would you like to have more male teachers in your school?
1. Yes If yes, please answer 32b
2. No

32b. Why would you like to have more male teachers?
1. Male teachers are more patient
2. Male teachers teach better
3. Male teachers are nicer
4. All of these reasons
5. Other, specify

33. Do your teachers teach you about farming?
1. Yes
2. No

34. Do your teachers teach you about fishing?
1. Yes
2. No

35a. Do you have pens, paper, and books that you need for school?
1. Yes If yes, please complete 35b
2. No

35b. Who buys your pens, paper, and book that you use for school?
1. My parent or guardian
2. The government
3. An NGO
4. My school
5. Other, specify

36. Do your parents or guardians talk to your teachers about your school?
1. Yes
2. No

37. What would you like to see changed in your school?

1. I would like to have more desks and chairs
2. I would like to have more toilets
3. I would like to have more water and food
4. I would like to have more teachers
5. Other, specify

38. If you wanted something in your school, who would you ask for it?
1. Parents or guardians
2. Teachers
3. Both parents or guardians and teachers
4. I don't know who I would ask
5. Other, specify

39. If there were going to be changes made in your school, would you want to know about them?
1. Yes
2. No

40. In the last 2 years, have any of the following changes happened in your school?
1. My school got more desks and chairs
2. My school got more toilets
3. My school got more water and food
4. My school got more teachers
5. Other, specify

41. Will you be able to pass this school year?
1. Yes
2. No

42a. Do you want to continue to the next standard?
1. Yes
2. No If no, please answer 42b

42b. why do you not want to continue to the next standard?
1. I want to get a job
2. I want to help more at home
3. I can not afford to go to the next standard
4. Other, specify

43. Will you enroll in secondary school?
1. Yes
2. No If no, please answer 43b

44. Why will you not enroll in secondary school?
1. I can not afford the fees
2. I want to get a job
3. I have to help at home
4. Other, specify

45a. Do you know any students who left school during the year and did not come back?
1. Yes If yes, please answer 45b – 45e
2. No

45b. How many of these students were boys?

45c. How many of these students were girls?

45d. Why did they leave school?
1. They had to help at home
2. They had to get a job
3. They did not like school
4. They had a baby
5. Other, specify

45e. Do you know what happened to them after they left?
1. Yes If yes, please answer 45f
2. No

45f. What happened to them?

46. When you are not at school, what do you usually do?
1. Play with my friends
2. Work at home
3. Take care of my brothers and sisters
4. Other, specify

47. When you need money for something, where do you usually get it?
1. From my parents or guardians
2. From working for money
3. I am not able to get money

48. Do you think boys and girls do the same amount of work at home?
1. boys do more work at home than girls
2. girls do more work at home than boys
3. boys and girls do the same amount of work at home

49. How often do you finish all of your

homework?
1. Always
2. Sometimes
3. Never

50. If sometimes or never, why do you not finish all of your homework?
1. I don't have a pen
2. I have to do chores at home instead
3. I don't have paper
4. I have to work
5. Other, specify

51a. Do you have someone to help you with your homework?
1. Yes If yes, please answer 51b
2. No

51b. who helps you with your homework?
1. Parent or guardian
2. A friend
3. Other family members
4. A Teacher

As part of our research we are interested in knowing what you know about "reproductive health". By "reproductive health" we mean pregnancy, sexually transmitted diseases, and sexual intercourse. The questions in the next sections will ask you about these topics.

<u>Reproductive Health Education</u>

52a. Does someone teach you about pregnancy, sexually transmitted diseases, and sexual intercourse in school?
1. Yes If yes, please answer 52b
2. No

52b. Who teaches you about it?
1. A teacher
2. A nurse
3. Other, specify

53. How many times a week do you learn about pregnancy, sexually transmitted diseases, and sexual intercourse?
1. once a week
2. twice a week
3. three times a week
4. four times a week
5. more than four times a week

54. Do you enjoy learning in these classes?
1. Yes
2. No

55. Do boys and girls learn about pregnancy, sexually transmitted diseases, and sexual intercourse in the same classroom at the same time?
1. Yes
2. No

56. Do you talk to your parents about what you have learned in your classes?
1. Yes
2. No

57. Do you talk to other students about what you have learned in your classes?
1. Yes
2. No

58. Who do you feel the most comfortable talking about these issues with?
1. My parents or guardians
2. My brothers and sisters
3. My friends who are girls
4. My friends who are boys
5. My teacher
6. Staff at a health facility
7. Staff at an NGO
8. Other, specify

59. Where do you learn the most about 'reproductive health'?
1. From my parents or guardians
2. From my brothers and sisters
3. From my friends who are girls
4. From my friends who are boys
5. From a health facility
6. From an NGO

<u>Health Services</u>

60. When you are feeling sick, where do you go for help?
1. To my family
2. To a health centre
3. To a traditional healer
4. I do not go to anyone

5. Other, specify

61. Did you ever go to a health facility to ask for more information on pregnancy, sexually transmitted diseases, and sexual intercourse?
1. Yes If yes, please answer 61a – 61j
2. No

61a. which health facility did you go to?

61b. What did you ask for?
1. I asked for pamphlets
2. I asked for condoms
3. I asked for pads
4. I asked for birth control pills
5. Other, specify

61c. Was this health facility in your village?
1. Yes
2. No

61d. How did you get there?
1. Walking
2. By bus
3. By bicycle
4. By taxi
5. Other, specify

61e. How long did it take you to get there?
1. 0-15 minutes
2. 15-30 minutes
3. 30-60 minutes
4. 60-90 minutes
5. more than 90 minutes

61f. At the health facility, did you talk to a nurse or doctor alone in the room?
1. Yes
2. No

61g. Did you believe the nurse or doctor would tell what you told them to anyone else?
1. Yes
2. No

61h. What time of day did you go to the facility?
1. In the morning
2. In the afternoon
3. In the evening

61i. Did you go during the week or on the weekend?
1. I went during the week
2. I went on the weekend

62. What are some of the reasons why you would not go to a health facility?
1. I had no way to get there
2. It was too expensive
3. It was too far away
4. I would rather go to a traditional healer
5. Staff members do not treat me well
6. I do not have any privacy
7. Other, specify

63. From question 61, which one is the most important reason?
1. I had no way to get there
2. It was too expensive
3. It was too far away
4. I would rather go to a traditional healer
5. I have no need to go to a health facility
6. Staff members do not treat me well
7. I do not have any privacy
8. Other, specify

64a. did you ever go to an NGO to ask for more information on pregnancy, sexually transmitted diseases, and sexual intercourse?
1. Yes If yes, please answer 64b – 64f
2. No

64b. What did you ask for? (please circle all that you asked for)
1. I asked for pamphlets
2. I asked for condoms
3. I asked for pads
4. I asked for birth control pills
5. Other, specify

64c. Was this NGO in your village?
1. Yes
2. No

64d. How did you get there?
1. Walking
2. By bus
3. By bicycle
4. By taxi
5. Other, specify

64e. How long did it take you to get there?
1. 0-15 minutes
2. 15-30 minutes
3. 30-60 minutes
4. 60-90 minutes

HIV/AIDS

65. How is HIV/AIDS transmitted?
1. Through sharing food
2. Through sexual intercourse
3. Through shaking hands
4. Through witchcraft
5. By God
6. Through mosquito bites

66. Can someone become infected with HIV/AIDS by a healthy looking person?
1. Yes
2. No

67. Do you think boys or girls are more likely to get HIV/AIDS?
1. Boys
2. Girls

68. Where are you more likely to get HIV/AIDS?
1. In a town
2. In the farming and fishing areas

69. Does correctly using a condom protect people from getting HIV/AIDS?
1. Yes
2. No

70. Who can cure someone who is sick with AIDS?
1. A traditional healer
2. A doctor at the clinic
3. A witchdoctor
4. God
5. No one
6. Other, who?

71. If someone does bad things or behaves wrongly, will they get HIV/AIDS?
1. Yes
2. No

72. How many people do you know who have HIV/AIDS?
1. None
2. 1-5
3. 6-10
4. 11-15
5. 16-20
6. more than 20

73. How can someone stop AIDS from being transmitted? (please circle all that apply)
1. by using a condom
2. by not having sexual intercourse
3. by praying to God
4. Other, specify

74. Where can you get a condom? (please circle all that apply)
1. At a health facility
2. At school
3. From friends
4. At home
5. At a store
6. Other, specify

75. How would you pay for it?
1. My parents give me money
2. I earn money with a job
3. They are free
4. I do not use condoms

76. Where can someone get a condom for free?
1. At a health facility
2. At school
3. From my friends
4. At an NGO
5. Other, specify

77. Have you ever seen a condom?
1. Yes If yes, where?
2. No

78. Have you ever used a condom for sexual intercourse?
1. Yes
2. No

Menstruation

79. When a girl has her first monthly bleeding,

where does she go for help?
1. To her family
2. To her friends
3. To a health facility
4. To a teacher
5. To a health worker in a school
6. Other

80. What kind of protection would she usually use?
1. A piece of cloth
2. A pad
3. Nothing
4. Other, specify

81. Where can a girl get a pad?
1. At a health clinic
2. At a school
3. At a store
4. Other, specify

82. Where can a girl get money to buy a pad?
1. From her parents or guardians
2. From other family members
3. From an NGO or other organization
4. She can get a pad for free If so, where?

83. How often do girls stay home from school when they are having their period?
1. Always
2. Sometimes
3. Never

84. Why do girls stay home when they are menstruating?
1. There is no privacy in the school
2. There are not enough latrines for girls
3. The latrines are not clean
4. Other, specify

<u>Pregnancy</u>

85. How do girls get pregnant?
1. Through sexual intercourse
2. Through magic
3. Through shaking hands
4. Other, specify

86. Does correctly using a condom protect girls from getting pregnant?
1. Yes
2. No

86. What are some other ways to prevent pregnancy? (please circle all that apply)
1. Not having sexual intercourse
2. Using birth control pills
3. Praying to God
4. Washing after sexual intercourse
5. Other, specify

87. Is pregnancy a punishment for bad behavior?
1. Yes
2. No

88. When someone becomes pregnant, do they need medical help?
1. Yes
2. No

89. Where can someone go if they are pregnant and need medical help?
1. To a health facility
2. To their parents or guardian
3. To their friends
4. To a traditional healer
5. Other, specify

90. Does someone who is giving birth need medical help?
1. Yes
2. No

91. Where can someone who is giving birth get medical help? (please circle all that apply)
1. From anyone
2. From a midwife
3. From a traditional healer
4. From her partner
5. Other, specify

92. After someone gives birth, does she need medical help?
1. Yes
2. No

93. Where can someone who has given birth go for medical help?
1. At a health facility
2. To her family
3. To her friends

4. Other, specify

94. Do you know of any schoolgirls who got pregnant last year?
1. Yes
2. No

95a. Do you know who the father was?
1. Yes If yes, please answer 95
2. No

95b. Who was the father?
1. A boy from the school
2. A boy who did not go to school
3. An older man from outside the school
4. Other, specify

96. What happens to pregnant girls? (please circle all that apply)
1. She has to leave school
2. She has to stay in school
3. She has to leave school and come back
4. She has an abortion
5. Other, specify

97a. Do you know of any girl in the school who had an abortion?
1. Yes If yes, please answer 97b – 97d
2. No

97b. Where did she have the abortion?
1. At a health facility
2. At home
3. At a traditional healer
4. Other, specify

97c. How did she pay for it?
1. It was free
2. She borrowed money from a friend or family member
3. Her parents or guardians paid for it
4. Other, specify

98. Would you like to get more information on "reproductive health" issues from other sources?
1. Yes
2. No

4.2 Secondary School Survey

General profile

1. What is your age?
2. Are you male or female?
3. What form are you currently in? Form
4. What is the name of the village you live in?
5. What is the name of the ward you live in?
6. What is the name of the division you live in?
7. Where were you born?
8. What is the name of the tribe you belong to?
9. What is your religion:
   1. Christian
   2. Muslim
   3. Hindu
   4. None
   5. Other, please specify _____

10. What is the main income generating activity within your household?
    1. Farmer
    2. Fisherman
    3. Teacher
    4. Labourer
    5. Other, Please specify:

11. Do you undertake any activity that generates an income for your household?
    1. Yes, please specify what you do:
    2. No

12. When you compare your household to people in your village, would you say your household belongs to:
    1. Wealthy (tajiri)
    2. Comfortable (unajiweza)
    3. Poor (Maskini)
    4. Very poor (Maskini sana)

Mobility:

13. **If** you moved to live here, where did you come from?

14. Have you tried moving away from this village?
    1. Yes
    2. No

15. Do you plan to move away in the next 2-5 years?
    1. Yes
    2. No

16. If you have tried to or planned to go away, what was the main health-specific reason?

17. If you have tried to or planned to go away, where did you want to go?

Finances:

18. Have you ever heard of user-fees (Papo kwa hapo) ?
    1. Yes
    2. No

19. Have you ever heard of the Community Health Fund (Bima ya Jamii)?
    1. Yes
    2. No

20. Are you and your family a CHF member?
    1. Yes
    2. No

Any time you or anyone in your family falls ill, CHF gives you all the free health care at all health facilities in Magu any time during the year of your membership. It costs 10.000 TSH per year for your family and you pay to your health facility.

21. Do you think you would like to join CHF?
    1. Yes
    2. No

Reproductive Health Education

22. When you are feeling sick, where would you go and ask for help? (circle all that apply)
    1. My family
    2. A health facility
    3. A traditional healer
    4. I do not go to anyone
    5. Other, specify:

23. Where can you get more information on safe sex? (circle all that apply)
    1. School
    2. Health facility
    3. Parents
    4. Siblings
    5. Friends
    6. Faith-Based-Organizations
    7. Non-Governmental-Organizations
    8. Community-Based-Organizations
    9. Radio
    10. Television

24. Where can you get more information on pregnancy? (circle all that apply)
    1. School
    2. Health facility
    3. Parents

4. Siblings
5. Friends
6. Faith-Based-Organizations
7. Non-Governmental-Organizations
8. Community-Based-Organizations
9. Radio
10. Television

25. Where can you get more information on sexually transmitted diseases such as HIV/AIDS? (circle all that apply)
1. School
2. Health facility
3. Parents
4. Siblings
5. Friends
6. Faith-Based-Organizations
7. Non-Governmental-Organizations
8. Community-Based-Organizations
9. Radio
10. Television

26. Who do you feel the most comfortable with talking about safe sex, pregnancies and HIV/AIDS?
1. My parents or caretakers
2. My siblings
3. My friends who are girls
4. My friends who are boys
5. My teachers
6. Staff at a health facility
7. Staff at a Non-Governmental-Organization
8. Other, specify:

27. Where do you learn the most about safe sex?
1. From my teachers
2. From my parents or caretakers
3. From my brothers and sisters
4. From my friends who are girls
5. From my friends who are boys
6. From a health facility
7. From a Non-Governmental-Organization
8. Radio
9. Television

28. Where do you learn the most about pregnancies?
1. From my teachers
2. From my parents or caretakers
3. From my brothers and sisters
4. From my friends who are girls
5. From my friends who are boys
6. From a health facility
7. From a Non-Governmental-Organization
8. Radio
9. Television

29. Where do you learn the most about sexually transmitted diseases like HIV/AIDS?
1. From my teachers
2. From my parents or caretakers
3. From my brothers and sisters
4. From my friends who are girls
5. From my friends who are boys
6. From a health facility
7. From a Non-Governmental-Organization
8. Radio
9. Television

30. Who would you prefer to have talk to you about safe sex, pregnancies and sexually transmitted diseases such as HIV/AIDS?
1. Teacher
2. Health centre worker (nurse or doctor)
3. Parent
4. Friends
5. Other, specify

31. Where do you prefer to learn about safe sex, pregnancies and sexually transmitted diseases like HIV/AIDS?
1. Health centre
2. At school
3. Other, specify

Reproductive health education in schools

32a. Does someone in your school teach you about safe sex?
1. Yes
2. No

32b. Do boys and girls learn about safe sex in the same classroom at the same time?
1. Yes
2. No

33a. Does someone in your school teach you about pregnancies?
1. Yes
2. No

33b. Do boys and girls learn about pregnancies in the same classroom at the same time?
1. Yes
2. No

34a. Does someone in your school teach you about sexually transmitted diseases such as HIV/AIDS?
1. Yes
2. No

34 b. Do boys and girls learn about sexually

transmitted diseases such as HIV/AIDS in the same classroom at the same time?
1. Yes
2. No

35a. Do you feel comfortable asking your teachers questions about safe sex, pregnancies and sexually transmitted diseases?
1. Yes
2. No

36. Do you talk to your parents about what you have learned in school about safe sex, pregnancies or HIV/AIDS?
1. Yes
2. No

37. a. Do you talk to other students about what you have learned in your classes about safe sex, pregnancies or HIV/AIDS?
1. Yes
2. No

37. b. Do you have Peer educators in your school?
1. Yes
2. No

37. c. Did you ever talk to these Peer educators about reproductive health issues?
1. Yes
2. No

37. d. What did you talk about with the Peer educators?

38. Has a health worker ever come to your school to talk to you about safe sex?
1. Yes
2. No

39. Has a health worker ever come to your school to talk to you about sexually transmitted infections and sexually transmitted diseases such as HIV/AIDS?
1. Yes
2. No

40a. Has a health worker ever come to your school to talk to you about pregnancy?
1. Yes
2. No

40b. When these health workers come, do they give the pupils demonstrations, for example: condom demonstrations?
1. Yes
2. No

41. When you learn about sexually transmitted diseases, pregnancy, and safe sex in your school do they tell you what kind of reproductive health services are available to you?
1. Yes
2. No

42. In your school, do they teach you where you can find more information on reproductive health?
1. Yes
2. No

Health facilities

43. Do health facilities offer health education?
1. Yes
2. No

44. Does the health facility you go to offer health education every morning?
1. Yes
2. No

45. Did you ever go to a health facility for health education?
1. Yes
2. No

46. Would you feel comfortable going to a health facility to ask for more information on safe sex, pregnancies or sexually transmitted diseases such as HIV/AIDS?
1. Yes
2. No

47. Did you ever go to a health facility to ask for more information on safe sex, pregnancies or sexually transmitted diseases such as HIV/AIDS?
1. Yes, which one:
2. No

48. The last time you went to a health facility what did you think of the care you received?
1. It was good, I felt confident that the care I got was ok.
2. It was ok, but sometimes I was not completely sure if everything was in fact ok
3. It was not so good, I did not have the idea that they helped me in a good way
4. It was not good at all, they said I was ok, but I had big problems

49a. Why would you **not want** to visit a health facility? (please circle all that apply)
1. The staff does not keep my questions confidential
2. The health centre is not open when I need

to go
3. It is too expensive to get to the health centre
4. I can not afford to pay the health centre
5. The health centre is too far away
6. I do not feel comfortable talking to the staff in the health facility
7. I may go to the health facility, but I am not always sure whether or not there is a doctor or nurse present to help me
8. The supplies I need are not there
9. I have no privacy at the health facility

From question 49b, which one is the most important reason?
1. The staff does not keep my questions confidential
2. The health centre is not open when I need to go
3. It is too expensive to get to the health centre
4. I can not afford to pay the health centre
5. The health centre is too far away
6. I do not feel comfortable talking to the staff in the health facility
7. I may go to the health facility, but I am not always sure whether or not there is a doctor or nurse present to help me
8. The supplies I need are not there
9. I have no privacy at the health facility

50. What would you like to get at a health facility?
1. Information/education
2. Supplies
3. Treatment

51. What kind of supplies would you like to get at a health facility? (Circle all that apply)
1. Condoms
2. Birth control pills
3. Pads
4. Medicine

52. Do you feel like you are given enough opportunity to ask questions to doctors or nurses during examination?
1. Yes
2. No

53. Do you feel like you are given enough opportunity to ask questions to doctors or nurses during health education sessions?
1. Yes
2. No

54. What can you do when you want to talk about a certain topic with the doctor, but the doctor does not want to talk about it?
1. Nothing
2. This never happens
3. Talk to other clients so more people can ask for the same question
4. Go ask the community health workers
5. Go ask the village and ward executive officer
6. Go ask the boss of the health facility
7. Other, specify:

55. Have you ever asked a doctor or nurse any questions about safe sex?
1. Yes
2. No

56. Have you ever asked a doctor or nurse any questions about pregnancies?
1. Yes
2. No

57. Have you ever asked a doctor or nurse any questions about sexually transmitted diseases such as HIV/AIDS?
1. Yes
2. No

58. What topics would you like doctors or nurses to talk to you about? (Please circle all that apply)
1. STIs, including HIV/AIDS
2. Prevention of STIs
3. Pregnancy
4. Family planning
5. All of the above

59. What do health facilities offer free of charge for your age group? (circle all that apply)
1. Condoms
2. Counseling
3. Birth control pills
4. Treatment of sexually transmitted diseases and infections

60. Is there a health facility in your area?
1. Yes
2. No

60a. How long does it take you to get there?
1. 0-15 minutes
2. 15-30 minutes
3. 30-60 minutes
4. 60-90 minutes
5. more than 90 minutes

61. At the health facility, can you talk to a nurse or doctor alone in the room?
1. Yes
2. No

62. Do you believe the nurse or doctor will keep your information private?
1. Yes
2. No

63. Can you go to the health facility in the morning?
1. Yes
2. No

64. Can you go to the health facility in the afternoon?
1. Yes
2. No

65. Can you go to the health facility in the evening?
1. Yes
2. No

66. Can you go to the health facility on the weekends?
1. Yes
2. No

67. Is the health facility open in the evening?
1. Yes
2. No

68. Is the health facility open on the weekends?
1. Yes
2. No

69. In the area you live, what has been changed to make reproductive health services:
Better:
Worse:

70. In order to improve the quality of services at the Health facility you go to, can you please think of things/ways that can be done by each of these groups?
1. Client themselves
2. Your community
3. Government
4. Doctors and nurses
5. Young people

Civil Society Organizations:

<u>NGOS</u>

71a Do you know of any Non-Governmental-Organizations where you can go to get more information on safe sex, pregnancies and/or sexually transmitted diseases such as HIV/AIDS?
1. Yes If yes, which ones?
2. No

71b Did you ever go to these NGOs to ask for more information on safe sex?
1. Yes
2. No

72. Have you ever gone to an education session at one of these NGOs?
1. Yes At which NGO?
2. No

73. How often do you go to these NGOs?
1. Less then once a year
2. Once a year
3. Two to three times a year
4. Four to five times a year
5. 6 to 7 times a year
6. Monthly
7. Weekly

74. Was this NGO in your community?
1. Yes
2. No

75. How did you get there?
1. Walking
2. By bus
3. By bicycle
4. By taxi
5. Other, specify

76. How long did it take you to get there?
1- 0-15 minutes
2- 15-30 minutes
3- 30-60 minutes
4- 60-90 minutes

77. What would you like to get at the NGOs (please circle all that you asked for)
1. Information/education
2. Supplies
3. Treatment

78. What kind of supplies would you like to get at the NGOs? (Circle all that applies)
1. Condoms
2. Birth control pills
3. Pads
4. Medicine

79.When NGOs offer health education, what are some of the topics they talk about?

Church:

80a. Do churches offer information on safe sex, pregnancies, or sexually transmitted diseases such as HIV/AIDS?
1. Yes
2. No

81. Have you ever had information on safe sex, pregnancies, or sexually transmitted diseases such as HIV/AIDS from a church group?
1. Yes
2. No

Media:

82a. Do you know of any programs on the radio that talk about issues such as safe sex, pregnancies, and sexually transmitted diseases such as HIV/AIDS?
1. Yes If yes, please answer 82b-82g
2. No

82b. What is the name of the program you listen to the most? Please state full name:

82c. How often do you listen to this program?
1. Never
2. Once a month
3. Two to three times a month
4. Once a week
5. More often then once a week

82d. What are some of the issues they talk about?

82e. What is the name of the second program you listen to most often?

82f. How often do you listen to this program?
1. Never
2. Once a month
3. Two to three times a month
4. Once a week
5. More often then once a week

82g.What are some of the issues they talk about?

83. Do you know of any programs on the television that talk about issues such as safe sex, pregnancies, and sexually transmitted diseases like HIV/AIDS?
1. Yes If yes, please answer 83b-83i
2. No

83b. What is the name of the program you watch most often? Please state full name:

83c. How often do you watch this program?
1. Never
2. Once a month
3. Two to three times a month
4. Once a week
5. More often then once a week

83d. What are some of the issues they talk about?

83e. What is the name of the second program you watch?

83f. How often do you watch this program?
1. Never
2. Once a month
3. Two to three times a month
4. Once a week
5. More often then once a week

83g. What are some of the issues they talk about?

83h. Do you feel like you learn important information from these programs?
1. Yes
2. No

83i. What are some of the issues you learned through listening to/watching these programs?

Other sources of reproductive health education

84a. Do you know of any campaigns present in your area that teach people about issues such as safe sex, pregnancy and/or sexually transmitted diseases?
1. Yes If yes, please answer 84b-84
2. No

84b. What are the names of these campaigns?

85. Did you ever go to a drama show that had as a purpose to teach people about issues such as safe sex, pregnancy and/or sexually transmitted diseases?
1. Yes
2. No

85a. How often in your life did you visit such a show?
1. Never
2. Once
3. Twice

4. Three-four times
5. Five to six times
6. More then six times

85b. Did you learn anything from these shows?
1. Yes
2. No

86. Do you think someone can learn more from such a show than from going to a health facility for health education?
1. Yes, if yes, why?
2. No

87. Have you ever gone to a traditional healer for information on safe sex, pregnancy, or sexually transmitted infections such as HIV/AIDS?
1. Yes
2. No

If so, why?

Behaviour:

88. Are you sexually active?
1. Yes
2. No

88b. How old were you when you first had sex?

88c. How many sexual partners have you had in total?
1. None
2. 1
3. 2
4. 3-4
5. 5-6
6. 7-8
7. 9-10
8. more then 10

88d. How many sexual partners do you have now?
1. one
2. two
3. three
4. four
5. more than four

Awareness-level
HIV/AIDS

89. Do you know your HIV/AIDS status?
1. Yes, Positive
2. Yes, Negative
3. No
4. Yes, but I do not want to say
5. Do not want to say

90. Do people in this community have regular access to Anti-Retroviral-Drugs?
1. Yes
2. No

91. Have you ever had an STD/STI?
1. Yes
2. No

92. Do you know how HIV/AIDS is transmitted? (Please circle all that apply)
1. Sharing food
2. Sexual intercourse
3. Shaking hands
4. Witchcraft
5. God
6. Mosquito bites
7. Using condoms
8. Other, specify:

93. Can someone become infected with HIV/AIDS through a healthy looking person?
1. Yes
2. No

94. Can a baby become infected with HIV while the baby is still unborn?
1. Yes
2. No

95. Can a baby become infected with HIV while the mother is giving birth to the baby?
1. Yes
2. No

96. Can a baby become infected through breastfeeding?
1. Yes
2. No

97. Who do you think are more likely to get HIV/AIDS?
1. Boys living in the towns
2. Boys living in the villages
3. Girls living in the towns
4. Girls living in the villages
5. Boys and girls living in the towns
6. Boys and girls living in the villages
7. All groups are equally likely to get HIV/AIDS

98. Will correctly using a condom stop people from getting HIV/AIDS?
1. Yes
2. No

99. Who can help someone who is sick with AIDS? (Please circle all that apply)
1. A traditional healer
2. A doctor at the clinic
3. A witchdoctor
4. God
5. No one
6. Other, who:

100. Is there a cure for HIV/AIDS?
1. Yes
2. No

101.If someone behaves in a bad way, will they get HIV/AIDS?
1. Yes
2. No

102a. How many people do you know who have HIV/AIDS?
1. None
2. 1-5
3. 6-10
4. 11-15
5. 16-20
6. more than 20

102b. How many of these people are female?
102c. How many of these people are male?
102d. How many of these people are under 25 years old? _____
102e. How many of these people are 25 years or older? _____

103.How can someone prevent themselves from getting AIDS? (circle all that apply)
1. By using a condom
2. By not having sexual intercourse
3. By praying to God
4. By washing after having sex
5. Other, specify

Family planning

104. How many boys do you know who use
1. Condoms _____
2. Pills _____
3. Injection _____
4. Abstinence _____
5. Traditional methods _____

105. How many girls do you know who use
1. Condoms _____
2. Female condoms _____
3. Pills _____
4. Injection _____
5. Abstinence _____
6. Traditional methods _____

106. Have you ever seen a condom?
1. Yes, if yes, where?
2. No

107. Where can someone get a condom? (Please circle all that apply)
1. At a health facility
2. At school
3. From friends
4. At home
5. At a store
6. Other, specify

108. How would someone pay for a condom?
1. My parents give me money
2. I earn money with a job
3. They are free
4. I do not use condoms

109. Where can someone get a condom for free? (Please circle all that apply)
1. At a health facility
2. At school
3. From my friends
4. At an NGO
5. Other, specify

110. Have you ever used a condom during sexual intercourse?
1. Yes
2. No

111. Do you carry around condoms?
1. Yes
2. No

112. Do you have a condom on you today?
1. Yes
2. No

113a. Did you have a condom on you this week?
1. Yes
2. No

113b. Did you use it for sex this week?
1. Yes
2. No

114. The last time you had sex, did you use a condom or any other method to have safe sex?
1. Yes, if yes, which method?
2. No

115. How many years in total have you used family planning?

116. If using Family planning, what choice of family planning do you use now?
1. Condoms
2. Female condom
3. Contraceptive pills
4. Injections
5. Traditional
6. Other, specify:

117. What would be your preferred choice of family planning?
1. Condoms
2. Female condoms
3. Pills
4. Injections
5. Traditional
6. Other, specify ___
7. I do not know

118. Who advised you to start using family planning? (please circle all that apply)
1. My doctor
2. No one
3. My partner
4. My parents
5. My friends
6. My teachers
7. Other, specify:

119. Who discourages you from using family planning? (please circle all that apply)
1. My doctor
2. No one
3. My partner
4. My parents
5. My friends
6. My teachers
7. Other, specify:

120. Who is aware of you using any of the family planning methods?
1. Parents
2. My friends
3. Teachers
4. Doctors
5. Others, who:

121. If you ever tried any type of Family planning but stopped using it, why?
1. Never tried
2. It was bad for my body
3. I was afraid someone would find out
4. I wanted a child
5. The doctor advised me to stop

122. Do you think family planning can have any of these negative effects? (please circle all that apply)
1. Add body weight
2. Cause cancer
3. Will not protect me against HIV/AIDS
4. Other, specify:

Pregnancy:

123. How do girls get pregnant? (Please circle all that apply)
1. Sexual intercourse
2. Magic
3. Kissing
4. Touching
5. Other, specify

124. Does correctly using a condom protect girls from becoming pregnant?
1. Yes
2. No

125.What are some other ways to prevent pregnancy? (Please circle all that apply)
1. Not having sexual intercourse
2. Female condoms
3. Pills
4. Injection
5. Abstinence
6. Traditional methods
7. Praying to God
8. Washing after sexual intercourse
9. Other, specify

126. When someone becomes pregnant, do they need medical help?
1. Yes
2. No

127.Where can someone go if they are pregnant and need medical help? (Please circle all that apply)
1. To a health facility
2. To their parents or caretaker
3. To their friends
4. To a traditional healer
5. Other, specify

128. Does someone who is giving birth to a baby need medical help?
1. Yes
2. No

129. Where can someone who is giving birth to a

baby get medical help? (Please circle all that apply)
1. From anyone
2. From a midwife
3. From a traditional healer
4. From her partner
5. Other, specify

130. After someone has a baby, does she need medical help?
1. Yes
2. No

131. After someone has a baby where can she go for medical help? (please circle all that apply)
1. To a health facility
2. To her family
3. To her friends
4. Other, specify

132. When someone of your age gets pregnant is this a punishment for bad behavior?
1. Yes
2. No

133a. Do you know of any schoolgirls who got pregnant in the last 2 years?
1. Yes
2. No

133b. Do you know who the father was?
1. Yes, if yes answer 133c
2. No

133c. Who was the father?
1. A boy from the school
2. A boy who did not go to school
3. An older man from outside the school
4. A teacher
5. Other, specify

134. What happens to pregnant girls while they are attending school?
1. She has to leave school
2. She has to stay in school
3. She has to leave school and come back when she is not pregnant anymore
4. She has an abortion
5. Other, specify

135. Do you think that unwanted pregnancies are a big problem in your community?
1. Yes
2. No

Abortion:

136a. Do you know of any girl in the school who had an abortion?
1. Yes
2. No

136b. Do you know of any girl of your age-group who had an abortion?
1. Yes
2. No

136c. Where did she have the abortion?
1. At a health facility
2. At home
3. At a traditional healer
4. Other, specify

136d. How did she pay for it?
1. It was free
2. She borrowed money from a friend or family member
3. Her parents or guardians paid for it
4. Other, specify

The next section is for the girls **only.**
Menstruation

137. When a girl experiences her first monthly bleeding, where does she go for help?
1. To her family
2. To her friends
3. To a health facility
4. To a teacher
5. To a health worker in a school
6. Other - Other, specify

138. What would a girl normally use as protection against the bleeding?
1. A piece of cloth
2. A pad
3. Nothing
4. Other, specify

139. Where can a girl get a pad? (please circle all that apply)
1. At a health clinic
2. At a school
3. At a store
4. From her parents
5. From her siblings
6. Other, specify

140. Where can a girl get money to buy a pad? (please circle all that apply)
1. From her parents or guardians
2. From other family members
3. From an NGO or other organization

4. She can get a pad for free If so, where?

141. How often do girls stay home from school when they are having their monthly bleeding?
1. Always
2. Sometimes
3. Never

142. Why do girls stay home when they are menstruating? (please circle all that apply)
1. There is no privacy in the school
2. There are not enough latrines for girls
3. The latrines are not clean
4. There is no water in the school
5. Other, specify

Rights:

143. Have you ever heard of your 'rights'?
1. Yes
2. No

144. Can you please give examples of the rights that you have:
1. At a health facility
2. In your community
3. In your home
4. In schools

145. Can you please give examples of what happened the time you demanded for your right at a health facility?

146. Can you please give me examples of what happened when someone you know or heard of demanded for their right at a health facility?

147. Are your local leaders involved in any activities related to health going on in the community?
1. Yes
2. No

148. Since last year, have you attended any village meetings organized by your local authorities?
1. Yes
2. No

149. Have you participated in any group gathering / activities / events that helps bring your suggestions, ideas or concerns to your local leaders?
1. Yes
2. No

150. Other than during village meetings, do you know how people can organize themselves to bring their suggestions, ideas or worries to your local leaders?
1. Yes
2. No