Hospitals, Witch Doctors and Churches
Urban young people’s perspectives on health education and services in Mwanza, Tanzania
“Youth need to be seen as part of the solution; in doing so, we increase the likelihood that not only will our interventions be accepted, but that they will be more effective because they will be more consistent with the health priorities of young people.”
(Blum & Nelson-Mmari, 2004)
Abstract

Despite an increased focus on youth health in Sub-Saharan Africa over the past two decades, few academic inquiries (and resulting policy changes), include the voices of young people. Consequently, access to and uptake of health services and education continue to inhibit the health and wellbeing of young people in the region. This qualitative interpretive case study aims to include the voice of urban young people, both in-school and out-of-school in this discourse. More specifically, it addresses how young people perceive their access to, the quality and relevance of, and future vision for health services and education in Mwanza, Tanzania through insights from eleven focus groups and four interviews. Results revealed that the three most valuable health service facilities were hospitals, Witch doctors and churches. In-school participants valued spiritual and emotional health more than their out-of-school counterparts who prioritized physical health services. Overall, participants were not satisfied with the current health system except for privatized facilities, which they viewed as high quality, despite few young people having access to these services. Participants perceived the low quality of other health services to be a result of lack of education and awareness and corrupt health practices. The suggestions for improvement included more holistic and inclusive education models and call for their peers to not participate in corrupt practices.

Keywords: health education, health services, in-school and out-of school, gender, youth perspectives, Tanzania, Sub-Saharan Africa.
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# Table of Contents

Abstract ........................................................................................................................................... 3  
Acknowledgements ............................................................................................................................ 4  
List of Acronyms and abbreviations .................................................................................................. 10  
**Chapter 1:** Introduction ............................................................................................................... 11  
  1.1 Problem statement ......................................................................................................................... 12  
  1.2 Social and academic relevance ...................................................................................................... 13  
  1.3 Research questions ....................................................................................................................... 14  
  1.4 Thesis outline ............................................................................................................................... 15  
**Chapter 2:** Theoretical framework ............................................................................................... 16  
  2.1 Definitions .................................................................................................................................. 16  
    2.1.1 Young people ............................................................................................................................ 16  
    2.1.2 Health services ....................................................................................................................... 17  
    2.1.3 Access .................................................................................................................................... 17  
    2.1.4 Challenges ............................................................................................................................... 17  
    2.1.5 Relevance and quality .............................................................................................................. 18  
  2.2 Health education ........................................................................................................................... 19  
  2.3 Youth agency ............................................................................................................................... 20  
  2.4 Strength-based approach ............................................................................................................. 23  
  2.5 Conceptual scheme ...................................................................................................................... 24  
**Chapter 3:** Contextual background .............................................................................................. 26  
  3.1 History of health services ............................................................................................................. 26  
  3.2 Previous health research in Mwanza ............................................................................................ 27  
  3.3 Research location ........................................................................................................................... 29  
    3.3.1 Mwanza Youth and Children Network (MYCN) ................................................................. 29  
    3.3.2 Oxfam ...................................................................................................................................... 29  
**Chapter 4:** Methods ....................................................................................................................... 31  
  4.1 Grounded-theory ........................................................................................................................... 31  
  4.2 Case Study .................................................................................................................................... 33  
  4.3 Participants .................................................................................................................................... 34
4.4 Procedure .................................................................................................................. 36
  4.4.1 Focus group discussions ..................................................................................... 36
  4.4.2 Interviews ............................................................................................................ 39
  4.4.3 Document review ............................................................................................... 39
  4.4.4 Field log .............................................................................................................. 39
4.5 Data analysis ............................................................................................................ 40
4.6 Limitations ................................................................................................................ 40
4.7 Ethical considerations ............................................................................................... 42

Chapter 5: Results ............................................................................................................ 44

5.1 Defining health services .......................................................................................... 44
5.2 Access to health services ........................................................................................ 47
  5.2.1 Prioritization and utilization .............................................................................. 47
    5.2.1a Hospital ........................................................................................................... 51
    5.2.1b Witch doctors ............................................................................................... 51
    5.2.1c Churches ....................................................................................................... 55
  5.2.2 Factors that contribute to access ...................................................................... 56
    5.2.2a Confidentiality .............................................................................................. 56
    5.2.2b Cost ............................................................................................................... 57
    5.2.2c Dependency on elders .................................................................................. 58
    5.2.2d Traditional beliefs ....................................................................................... 58
    5.2.2e Education ...................................................................................................... 59
  5.2.3 School enrollment status .................................................................................. 60
  5.2.4 Gender ............................................................................................................... 61
5.3 Relevance and quality of health services ................................................................. 63
  5.3.1 Relevance .......................................................................................................... 63
  5.3.2 Quality .............................................................................................................. 64
    5.3.2a Public v. private health services ................................................................. 64
    5.3.2b Corrupt health practices ............................................................................. 65
5.4 Vision for health services and education ............................................................... 66
  5.4.1 Education .......................................................................................................... 68
  5.4.2 Corruption ....................................................................................................... 72
Chapter 6: Conclusion

6.1. Defining health services

6.2 Access to health services

6.3 Relevance and quality of health services

6.4 Vision for health services

6.5 Policy recommendations

6.6 Suggestions for future research

References

APPENDIX A: Operationalization Table

APPENDIX B: Organizational Reports

APPENDIX C: Coding Scheme

APPENDIX D: Map of Tanzania

List of Tables and Figures

Tables
Table 4.1: Number of participants in the focus group and interviews
Table 4.2: Number of male and female participants in and out of school
Table 5.2a: Top three group priorities by school enrollment and group (YW or Mix)
Table 5.2b: Treatments young people seek at top three prioritized health services
Table 5.2c: Self-reported use of witch doctors by gender and school enrollment status

Figures
Figure 2.5 Conceptual scheme
Figure 4.1 Focus Group Discussion
Figure 5.0 Photo of a mixed in-school discussion
Figure 5.1 List of health services
Figure 5.2 Number one individual health service by school enrollment status
Figure 5.3 Number one individual health service by gender
“It is the kind of disease that forces us to visit health centers. You go to the witchdoctor, but they cannot treat you, so you end up visiting the hospital. Sometimes, the diseases are complex so you go [directly] to the hospital. Then they tell you to go home and wait [because they cannot provide treatment]. Then you turn to faith; whereby God is there and you will be healed in time” (female, in-school, YW)
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune Deficiency Syndrome</td>
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<tr>
<td>AFHS</td>
<td>Adolescent Friendly Health Services</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussions</td>
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<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>MCMV</td>
<td>My City My Voice</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>MRMV</td>
<td>My Rights My Voice</td>
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<td>MYCN</td>
<td>Mwanza Youth and Children Network</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNCRC</td>
<td>United Nations Convention on the Rights of the Child</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
</tr>
<tr>
<td>YW</td>
<td>Young Women</td>
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## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>MX</td>
<td>Mix of Young Women and Young Men</td>
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Chapter 1: Introduction

The 1.5 billion people alive in the world today between the ages of 12 and 24 - comprise one quarter of the world’s population (World Bank, 2007). This is the largest adolescent and youth group in human history. The transition from childhood to adulthood offers both extraordinary opportunity and risk marked by dramatic biological, cognitive and psychological change. This is as true for individuals as it is for the demographic as a whole. When healthy, educated and engaged, young people can be powerful actors in shaping the economic, social and political futures of their cities and countries.

From a health perspective, the wellbeing of any such sizable segment of the population cannot be understated. The opportunity to educate and empower young people in understanding their rights, establishing health-promoting habits and avoiding preventable accidents, illness and disease, is critical for our existence. We know that nearly 35% of all disease burden is rooted in adolescence (WHO, 2014a). Some young people are at greater risk of rights abuses that have seismic health repercussions. For example, millions of girls are coerced into unwanted sex or marriage to then also face high risks of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs), HIV and childbirth (UNFPA, 2013).

The reality is that most young people’s health problems are preventable. Worldwide, HIV/AIDS and depression are the leading causes of disease burden for young people (those aged 10–24 years) (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). Half the newly-acquired HIV infections occur in young people, with most of those affected living in developing countries (WHO, 2006). The top five causes of death for young people are road injury, HIV, suicide, lower respiratory infections, and interpersonal violence (Bradshaw Bourne & Nannan, 2003).

Rooted in the Millennium Development Goals (MDGs) and the United Nations Convention on the Rights of the Child, international nongovernmental organizations (NGOs) have established mandates for specifically addressing young people’s health. Currently, three of the eight MDG’s for 2015 focus on health: (1) combating HIV/AIDS, Malaria and other diseases, (2) reducing child mortality and (3) improving maternal health. Despite the practically universal agreement on the importance of youth focus on these topics, many countries have not put
sufficient emphasis on adequately addressing their specific needs. Often times, young people are either treated with the same approach as adults or children – especially apparent in issues concerning mental health.

For the past twenty years, much research has emerged on the barriers to health services for young people. Broadly, these can be described as related to availability, accessibility, acceptability and equity (Tylee, Haller, Graham, Churchill & Sanci, 2007). In some contexts, these barriers are compounded. For instance, in a developing country context, primary health services might not exist at all, or might be inaccessible because of inadequate transportation infrastructure. When services are limited, those with the least positional power in society (often based on age, economics, gender, etc.) are last in line to receive services, if offered access at all. Additionally, unsafe abortions are a leading cause of deaths in young women in developing countries (Kleinert, 2007).

In culturally-conservative contexts, sexual activity before marriage might be seen as unacceptable. As such, young people can be reluctant to ask questions about reproduction or uptake STI/HIV services for fear of being seen by the community (Ross et al., 2007). Over the past several decades, in light of international development efforts, there has been an increased focus on health services globally. However, in many countries in Sub-Saharan Africa, young people encounter significant challenges in receiving health services and lack access to preventative health measures such as access to service and health education.

1.1 Problem statement

In Tanzania, specifically, the government has recognized that currently, health services do not meet acceptable quality standards and that services vary drastically amongst health care providers (Evans, Hsu & Boerma, 2013). The government identified that the inconsistency in services results in a lack of adolescents attending health services; increasing risk for infections and disease. Furthermore, out-of-school young people are often not recipients of health education as a majority of health education takes place in school (Masatu, Kvåle & Klepp, 2003; Matasha et al., 1998). Thus far, the main focus on increasing adolescent receipt of health services has been on creating youth-friendly services and providing training for health care professionals. However, an effort to understand why adolescents are not attending health clinics and what
In addressing the challenges to youth health, research has tended to (1) focus on barriers to access of health services more than solutions to overcoming those barriers (2) neglected to include the voices and opinions of young, especially those out-of-school, in gaining insights into what types of information they would like to receive and their vision for future service and (3) often theorizes about the current situation prior to academic inquiry or program implementation.

1.2 Social and academic relevance
The purpose of this research is to fill an existing knowledge gap related to youth experiences in accessing health services in Mwanza, Tanzania by including the voice of young people, highlighting young women and those out-of-school, and by assessing the current perceptions of health services in order to contextualize young people’s vision for future health services and education. Specifically, it lends insight into young people’s perceptions of access, quality and improvement ideas related to health services in this urban environment.

Progress on young people’s health globally depends on not only identifying the barriers, but seeking strategies to overcome those barriers. Recommendations encouraging the removal of these barriers have been complemented by the World Health Organization (WHO)-led call for the development of youth-friendly services worldwide (Kleinert, 2007).

While it is important to understand challenges in order to overcome them, the aim of this research is to empower and encourage young people to be active participants and advocates for the receipt of health services. Therefore, a strong emphasis is placed on youth agency and a strength-based (solution-focused) approach (addressed in the next chapter). In doing so, this research aims to fill the present gap in academic research by including the perspectives of young people.

Many studies to date have focused on adolescent friendly services for health workers (Chandra-Mouli, Mapella, John, Gibbs, Hanna, Kampatibe & Bloem, 2013; Mmari & Magnani, 2003; Tylee, Haller, Graham, Churchill & Sanci, 2007), sexual health and reproductive rights of adolescents (Changalucha, Gavryole, Grosskurth, Hayes, & Mabey, 2002; Hargreaves et al., 2008; Hayes, 2004; Hayes et al., 2005; Hock-Long, Herceg-Baron, Cassidy & Whittaker, 2003; Khanna, 2003; Kusimba, 2003; Plummer et al., 2004; Ross et al., 2007; WHO, 2008) and health
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

education (Fuglesang, 1997; Matasha et al., 1998; Plummer et al., 2007) but very few have included the voice of young people (Amuyunzu-Nyamongo, Biddlecom, Ouedraogo, & Woog, 2005). Including young people’s perspectives and experience in the formation of new policies and practices enhances not only the ‘resource base’ for these health services but can increase the accountability of service providers as well (Mehrotra & Jarrett, 2002).

Furthermore, health education research often begins with an intervention and then assesses the effect on the intervention on behavior change. Hornik (2002) poses a new way of reframing health education research that begins “with trying to understand the extraordinary secular trends in some health behaviors that are already in place” (p.15). Instead of starting with an intervention, Hornik (2002) suggests that research should build from the effects of health education then examine behavior, before interventions take place.

This research is designed to do exactly as Hornik (2002) recommends in contextualizing interventions prior to implementation. It is part of a one-year program called My City My Voice (MCMV), which is part of the larger three-year program, My Rights My Voice, organized and funded by Oxfam, an international NGO. My City My Voice (MCMV) sets out to establish how urban children and youth can better engage in decision making and in enforcing accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban youth, particularly young women and out-of-school young people, think about health services, how they currently engage and how they would like to engage.

1.3 Research Questions

Educating, involving and empowering young people to enable them to play a larger role in the development of health services is integral to the process of ensuring that quality health services are being developed and accessed. The first step in empowering young people to access these services is to understand how they perceive and access current health services, and how they would like to interact with the current health services and providers. The following main research question aims to address their related opinions and experiences:

To what extent, and how, do urban young people access and utilize health services in Mwanza, perceive the relevance and quality of these services, and suggest to improve health services and education?
The following sub-research questions have been devised to aid in the understanding of the main research question:

- **To what extent do young people have access to health services in Mwanza, and how do they benefit from these services?**
- **What are the factors that enhance or constrain their opportunities to access health services?**
- **How do they view the relevance and quality of health services available to them?**
- **From the perspectives of young people, how can the relevance and quality of health services be improved?**

### 1.4 Thesis Overview

Following this introduction, the second chapter is the theoretical approaches used throughout. First definitions of key words are presented then the two key theories, strength-based approach and youth agency, are explained in order to frame and contextualize this research. The third chapter provides a brief historical background on Tanzania and reviews previous health research conducted in the region. The fourth chapter will address the methodological approach, procedures, techniques and methods of analysis used for this qualitative and interpretive case study research. The fifth chapter will first re-define health services according to young people. The chapter will then address the sub-research questions in three main areas of focus: access, relevance and quality, and vision of health services. The Access section is related to what treatments young people receive at health centers and deciphering for which treatments do they attend which health service. The Relevance section is their perception of whether or not their needs are met and what quality are these health services and education. Lastly, the Vision section relates to how they would like to interact with health services and what health educational programs and services would they like to receive. Vision is the focal point of this research. The thesis ends with the conclusion, chapter six, which begins with the local definition of health services, highlights the findings in the results section, indicates the limitations of the study, proposes recommendations for policy and practice, and suggests direction for future research on health services in Tanzania.
Chapter 2: Theoretical Framework

This chapter begins by defining key terms of the theoretical framework as they may differ cross culturally. Then, a brief background of health education is given before introducing the two core theories, youth agency and strength-based approach. Integral to highlighting the voice of young people, the theoretical framework of youth agency is addressed. Core to this theory is that young people are important change agents and actors that should be included in decision-making about health education and services. Young people should not be solely recipients, but rather active participants in their health services. Simultaneously, in order to not replicate previous studies and to integrate the voice of young people into the research, a strength-based approach is taken. A strength-based approach focuses on the positive assets and aspects of young people in order to empower and include young people in the process. The chapter concludes by presenting a visual conceptual scheme, which is the amalgamation of all theories and definitions outlined here.

2.1 Definitions

It is important to define the main topics in the research questions as definitions may vary across research and readers (Kreuter, Lukwago, Bucholtz, Clark & Sanders-Thompson, 2003). Therefore, health services, access, challenges, and relevance and quality are defined prior to introducing the theoretical framework of youth agency and strength-based approach in order to understand the framework from which this research is built. The internationally relevant and accepted terms are defined for the purpose of this section.

2.1.1 Young people. The broad term 'young people' is used throughout this research in order to satisfy conflicting definitions of the target group of participants internationally and locally in Tanzania. The target age group for this research is people between the ages of 15 to 25. Internationally, this age group is often defined as *youth* for both research and statistical purposes by various organizations (United Nations Youth, 2014). While this has been adapted in Tanzania’s Youth Development Strategy of 2007, different national policies have an age range as wide as 10-35 years old (Restless Development, 2007). As such, local program partners defined youth as anyone within this age range, which is too broad for this research. In order to respect
both of these definitions and for the research to be understood universally, especially by local partners, the term young people has been used throughout the research.

2.1.2 Health services. The WHO defines health services as the

“diagnosis and treatment of disease, or the promotion, maintenance and restoration of health…”

Health services are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions.” (WHO, 2014b, p.1)

The WHO recognizes that simply making health services available to young people is not enough. The unexpressed health needs of young people need to be anticipated and services need to be sensitive, empathetic and confidential. The ability to ensure the latter is difficult as definitions of what constitutes a health service vary among researchers, professionals and organization specifically with regard to formal and informal health services. Here, the broad WHO definition is taken as the background definition of health services. In section 5.1 a more specific and customized definition of health services will be elaborated on in relation to young people in Mwanza, Tanzania.

2.1.3 Access. There are three main dimensions to access: Physical accessibility, financial affordability and acceptability (Evans, Hsu & Boerma, 2013). Physical accessibility focuses on the location of services and assumes that health services should be within reasonable reach from those in need. Affordability means that people should not be placed in financial hardship for accessing these services. The costs of services are not limited to treatment, but also include indirect costs such as transportation. Acceptability is the willingness of people to seek health services. This is largely effected by sociocultural factors such as age, sex, or status, which can influence the health care providers treatment (Lalloo, Smith, Myburgh & Solanki, 2004; Stierle, Kaddar, Tchicaya, & Schmidt-Ehry, 1999). This research aims to add another dimension to acceptability of not only sociocultural factors, but also the interpersonal decision-making process of young people when deciding when and how to access health services.

2.1.4 Challenges. In many countries in Sub-Saharan Africa, young people encounter significant obstacles in accessing and receiving essential health services. Physical constraints such as inconvenient location of health service facilities, inadequate amount and distribution of supplies, and unequal distribution of skilled health workers are challenges still faced by many young people globally (Hock-Long, Herceg-Baron, Cassidy & Whittaker, 2003; Schneider,
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

Blaauw, Gilson, Chabikuli & Goudge, 2006). Currently, studies show that socio-cultural challenges have a larger impact, over physical challenges, on young people’s health-seeking behaviors (Mmari & Magnani, 2003; Muela, Mushi & Ribera, 2000; Satimia, McBride & Leppard, 1998; Stierle et al., 1999; Sugishita, 2004). An example of a sociocultural factor includes, community acceptance and knowledge of, and social stigma associated with health services and treatments. Additionally, poor management and leadership affect the lack of implementation of seemingly applicable health service policies for young people (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). This research explores young people’s perceptions of challenges in order to give context to the factors that may influence their vision for service improvement.

2.1.5 Relevance and Quality. Despite availability of health services, young people need to view these services as relevant and of high-quality in order to be motivated to uptake them (De Cock, Mbori-Ngacha & Marum, 2002). ‘Relevance’ addresses whether or not the service provided is in the interest of the young people researched. Literally, it refers to whether or not the services described are pertinent and applicable to the lives of those questioned. There is no ‘right answer’ when it comes to whether or not a service is relevant. Rather, this is a subjective measure based on the perception of the young person describing the service, which might not have a bearing on others in the group.

In regard to ‘quality’ of health services, the working definition for this research must be applicable to both perceptions of individuals (a young person) and the demographic group (young people). The WHO identifies six broad dimensions in composing a picture of what it means for a health service to be deemed ‘quality,’ including:

- **effective**, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- **efficient**, delivering health care in a manner which maximizes resource use and avoids waste;
- **accessible**, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- **acceptable/patient-centered**, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

- *equitable*, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
- *safe*, delivering health care which minimizes risks and harm to service users (WHO, 2006, p. 9).

Reports indicate that the adolescent health services in Tanzania are acknowledged by the Ministry of Health and Social Welfare (MOHSW) to be both of poor standards and largely inaccessible to those who are intended to be served (Chandra-Mouli et al, 2013). Similarly to access, this study aims to understand how young people view quality and relevance of current health services in order to better understand their vision for future services.

2.2 Health Education

It has been recognized that key to improving the health of population is health education (Hargreaves et al., 2008; Hou, 2014). However there are two main challenges with current health education and services research: (1) Health education in Sub-Saharan Africa is largely dependent on international funding, that guides priorities. (2) As a result, health programs are often implemented in school not reaching out-of-school populations.

Currently, a majority of health education research in Sub-Saharan Africa is linked with international funding priorities. An example of this, as previously mentioned, is the fact that three of the eight MDG’s are health related (WHO, 2005). Despite this health-heavy focus in funding, a majority of countries are not on-target to meet the MDG’s by 2015 or improve their health education systems (Easterly, 2009). One reason for this is that global goal setting is not addressing contemporary issues but rather focuses on previously defined health issues (Fukuda-Parr, 2012). Traditionally, health research about drugs and disease (ex. HIV/AIDS) have engaged stake holders and funding because it is seen as more prestigious than other forms of research on preventative health measures. Strong international focus and research has been based on HIV/AIDS prevention and safety but there is little knowledge or focus on strengthening current health systems (Travis et al., 2004). Instead, the MDG’s have over-simplified the international development agenda by deducing the ‘meeting’ of health goals by quantifying basic health needs and placing less emphasis around understanding the current health systems that are in place.
While quantifying goals is important as a base line for international research (Fukuda-Parr, 2012; WHO, 2005), it is suggested further that knowledge about which health strategies are effective and which are not, are just as needed (Travis et al., 2004) because several previous studies have not been successful (Brieger, Delano, Lane Oladepo & Ovediran, 2001; Stuckler, Basu & McKee, 2010). The MDG’s should be used as a baseline, but research should expand upon the MDG’s to include the efficacy of current health services and education. In order to address this knowledge gap in health research, this research aims to understand how young people view and interact with current health services in order to more thoroughly understand the health services young people access and utilize instead of relying on previous information.

Another by-product of MDG’s influence on health education is the heavy focus on formal education systems (ex. schools) as they often do not include out-of-school young people. One main reason for targeting school is that they serve as easy access for a large number of participants (Plummer et al., 2007). However, attendance in primary and secondary schools, despite being a main developmental focus of the MDG’, are increasing slowly and large gaps in attendance are still present (Oketch & Rolleston, 2007). This means that in Sub-Saharan Africa over one-third of young people are not included in health education as they do not complete primary education (UNESCO, 2012). Primary education is suggested to be the minimal amount of education required to benefit from health programs (Global Campaign for Education. 2004). However, these programs, especially those regarding sexual and reproductive health (SRH), are employed only in secondary schools (WHO, 2008). This is a huge issue because young people are shown to be sexually active in primary school (Matasha et al., 1998) yet do not have access to a majority of health education. In order to address and assess this gap, this research specifically targets and includes out-of-school young people in order to better understand their interaction with and needs for health services and education. Moreover, this research compares out-of-school and in-school young people in order to see what differences and similarities there are with regard to their access, utilization and vision for health services and education.

2.3 Youth Agency
The United Nations Convention on the Rights of the Child (UNCRC) recognizes and emphasizes that young people have rights as citizens and are capable to enact change in their own lives (UNICEF, 1989). Specifically, stated was that “the best interest of the child shall be a prime
consideration” (Article 3.1) in several areas. Relevant for this research, health (Article 24) and education (Article 28) are addressed. There are three main theme regarding health education: provision, protection and participation. Provision states that children should have equitable access to and good quality health services (Article 24). Protection implied that young people should not be free from ill-treatment (Article 19). Lastly, participation states that young people have the right to participate and make decisions in areas that directly effect and influence their lives (Article 12 & 13). These rights are protected regardless of whether or not adults hold the decision making power. When adults make decisions on behalf of young people, they should not only respect young people’s views but also take them into consideration (Article 12). Similarly, independent from adult decision-making, young people have the right to access (Article 17) and share information (Article 13). In sum, the UNCRC gives young people to independently be agents of change for their health and education.

Many international development practitioners call upon individuals to be “agents of change” in their lives and communities. In essence, this concept is about agency, which can be defined simply as the ability to act in one’s own interest. This concept challenges the notion of individuals (or groups) as passive actors in their life experience, and replaces it with the ability to define goals and act upon them (Kabeer, 1999). It is not limited to using voice and speaking out, but transcends into being active participants in developing one’s future and exercising one’s empowerment. Agency can manifest in a variety of ways, including but not limited to, advocacy, negotiation, bargaining, reflection, analysis, goal setting, action and resistance as well as less positively-associated concepts of deception, manipulation and subversion.

For the purpose of this research, the discourse can be further narrowed to focus on youth agency.

“Youth agency [exists] within a politicized context of power relations and issues of difference. Specifically, we use the terms actor, agency and change-making to refer to the multiple ways youth act to minimize, challenge, subvert and/or transform unjust and disenfranchising material and discursive conditions in their lives….We refer to basic amenities (such as food, shelter, clothing, transportation, safety) as well as the structures and practices which comprise our societal and education systems.” (Gardner, McCann & Crockwell, 2009, p. 8).

In this study, the focus is on youth agency related to health services – in young people not simply participating in discussions and actions related to their physical, mental and emotional well-being, but rather leading the ideation and implementation of change-forging actions.
Youth agency, and validating youth perspectives, in health specifically, is a concept that is contested in research and practice. One argument is that adolescents’ self-reports of sexual health are inconsistent and unreliable (Plummer et al., 2004). Education about health, like socialization, is ironically assumed to be something that happens to children, in which they had little awareness of, and little part in (Montgomery, 2005).

Child sociologists have challenged this notion that young people were simply raw material and that their wavering opinions are invalid, through the conceptualization and documenting accounts of children actively participating, negotiating and renegotiating their life worlds. Research includes describing and explaining young people’s actions, motivations and meanings, where young people are perceived as human ‘beings’ rather than as human ‘becomings’ (Montgomery, 2005).

There has been a shift in themes of young people’s participation within international development from “working for [young people] to work with or even by [young people]” (White & Choudhury, 2007, p. 533). As mentioned in section 2.2, traditional research has focused on meeting basic needs of health and education, but has left out research on the systems in which they function. Similarly, international development methods have focused on working for young people, thus excluding their voices and working with them. This switch in working with or by young people widens the scope of young people’s participation.

Taking young people as participants and social actors in their lives is not exempt from challenges. While young people being included in decisions that affect their lives appears to be a generally positive, traditional methods of youth-agency and participation within international development masque or stifle their voices.

Often young people are ‘paraded’ around by NGO’s in order to showcase their inclusion of young people’s voice to donors. Additionally, young people are asked to recount traumatic events in story telling as a part of their young people’s participation in their programs (White & Choudhury, 2007). While aimed at including young people, and providing them agency, these methods instead have an adverse effect. In order to advocate for more holistic inclusion of young people’s participation in this research, young people will not be asked to recount any negative personal experiences, but rather the focus will shift to the positive influences in their lives through a strength-based approach.
2.4 Strength-based approach
Traditionally, research within education, mental health and social services has had a deficit-based approach. Recently, there has been a shift to strength-based approaches, which focus on what individuals and groups have, rather than what they are lacking (Laursen, 2000). This supports and encourages the positive assets of individuals. Such approaches allow participants to partner with researchers and professionals to find solutions. Core to strength-based approaches is the belief that participants should be actively included and make decisions about their current situation and future. As the aim of this research is to place young people’s perspectives about health services at the forefront, in order to optimize adolescent health and educational programs, this approach will stand as one of two primary theoretical frameworks from which the research is developed.

Mainly, these approaches have been used in clinical research, as both formal (ex. survey) and informal (ex. discussion group) measures. In international development, strength-based approaches are often used for community-development projects (Mathie & Cunningham, 2003). Below are some methodological suggestions for community-based development that can be adapted for this research:

- Collecting stories of community successes and analyzing the reasons for success;
- Mapping community assets;
- Forming a core steering group;
- Building relationships among local assets for mutually beneficial problem solving within the community;
- Convening a representative planning group;
- Leveraging activities, resources, and investments from outside the community.

(Mathie & Cunningham, 2003, p.477)

Elaborating upon these methodologies, four main values of strength based approaches are highlighted (adapted from Lee, 1994, as stated in Laursen, 2000, p. 74) (1) participants empower themselves, practitioners aid in the process of actualizing potential (2) communities with a shared vision “need one another to attain empowerment” (3) change is more likely to occur when participants tell their own story (4) participants are victors not victims (5) making resources available to help participants empowerment yields social change. Taking this strength-based approach form a platform in which adolescents have a safe space, the confidence and feel
empowered the discussion in order to create and have ownership of their idea and vision for health services.

2.5 Conceptual Scheme

Figure 2.1 shows a visual representation of this research. It is compartmentalized into the three main constructs of interest (1) access (2) quality and relevance, and (3) vision for future services. The main outcome variable, from the strength-based approach, is highlighted in white, enhancement of access and vision for improvement. Coming from a strength-based approach, it is important to stress the areas of health care that enhance their current experience and understand what their vision is for improving services in the future. In order to gain a holistic view of their vision, it is important to understand the constraints; however this will not be a focal point of the research, hence the blue arrow distinction.

Highlighted in the blue boxes are the three main concepts of interest in this research. Terms such as quality, relevance, access, and treatments are self-explanatory. For example, quality refers to the young people’s perceptions about the quality of health services and education. Treatments refer to young people’s knowledge of services received at these health services. The remaining terms require some clarification and contextual definitions.

Current health services are defined as services that young people are using. Available health services expands this definition and refer to health services and education programs that they know are available but may or may not currently be using. Vision for health services is asking young people how they would like to engage in future health services, and what health education programs would they like to receive. Within vision there are two main topics, improve and enhance. While both are derived from a strength-based approach of focusing on success, improve in this context is used to describe what services and education programs can be added to improve the current system. Enhance is used to describe how current services can be revamped to meet the needs and wants of young people.
Figure 2.5 *Conceptual research scheme*

A diagram illustrating the relationship between socio-cultural context, national government policies, health services (HS), current HS, available HS, vision for HS, access, quality, relevance, treatment, improve, and enhance. The diagram shows how these elements interact and influence each other.
Chapter 3: Contextual Background

In order to understand the social and societal norms that influence this research, it is important to consider background information on the country as well as previous studies conducted in the region (Mwanza, Tanzania, in this case), as social and community-level factors can be influential in the decision making process (Mmari & Magnani, 2003). Tanzania is a country in East Africa bordered by Kenya and Uganda to the North, Rwanda, Burundi and the Democratic Republic of Congo to the West and Zambia, Malawi and Mozambique to the South. The country, then called Tanganyika, was a part of German East Africa from the late 1800’s until early 1900’s. Post-World War II, the territory was under British rule. Tanganyika and Zanzibar gained independence in 1961 and later formed Tanzania.

Tanzania is divided into 169 local districts of which 34 are urban. These 34 districts are classified into three city councils: Arusha, Mbeye and Mwanza. The research city, Mwanza is located in the North of Tanzania along the southern bank of Lake Victoria. Mwanza region has a population of over 2.7 million people in 2012. Mwanza city is the second largest city, next to Dar es Salaam the capital, with a population of over 700,000 people (Dar es Salaam, 2012). Mwanza region is further divided into seven districts. The Nyamagana and Ilamela districts are located in the North and boarded by Lake Victoria to the North and West.

Tanzania ranks at the bottom of the Human Development Index (152 out of 187 countries and territories) (UNDP, 2013). Life expectancy at birth, in Mwanza specifically, is 46 years for women and 50 years for men. The age and sex composition of the population is typical of those with high growth rates, with almost 50% of the population under 15 years of age (Changalucha, Gavyole, Grosskurth, Hayes & Mabey, 2002).

3.1 History of health services

Various health service initiatives have been implemented beginning in from the early 1900’s in Tanzania. Under British rule, there were several health and education initiatives implemented in the 1920’s, such as the building of hospitals and mission-led schools. These health practices have been heavily researched from the early 1970’s (Chagula & Tarimo, 1975). The majority of research has focused on the rural areas of the country and Mwanza region. As urban regions are
seen to have lower poverty rates compared to rural regions (Muzzini & Lindeboom, 2008), there is less local research interest in urban regions with regards to health and education. Conversely, it is thought that young people living in urban areas have greater access to health services. While this may be the case, there is still variance in socioeconomic standing, which can affect contact with health services. Those who live in the poorer city regions often have less access to services (Kida, 2012) and/or are not brought to health clinics when they are ill (UNICEF, 2012).

Additionally, with rapid urbanization, there are an increased number of people living in wards just outside of the cities, which are just as poor as the surrounding rural regions (Muzzini & Lindeboom, 2008). This results in a diverse population with a large inter-regional gap in poverty levels and resources. While several studies have examined health practices in the Mwanza district (Murphy 2007), none have included the voice of the young people and their perception of, engagement in and vision for receipt of education and health services.

3.2 Previous health research in Mwanza
There are three pieces of previous research that are most relevant to this study of young people’s perceptions of health services in Mwanza – two conducted in Mwanza and one conducted in Arusha, Tanzania.

The first study was done by the Tanzanian Ministry of Health and Social Welfare in collaboration with the WHO. The research focused on addressing the inclusion of adolescents in health services by training adolescent-friendly health services (AFHS) in ten districts of Tanzania (Chandra-Moul et al., 2013). It consisted of three main parts: 1.) all organizations working on adolescent-friendly health services were identified through mapping exercise. 2.) A week-long workshop was held with various stakeholders in adolescent health services in order to define national standards of AFHS. 3.) Lastly, in order to ensure the implementation AFHS, health facilitators, managers and community were engaged in AFHS through educational workshops. Training also included monitoring and evaluation services in order to report on the progress and effectiveness of AFHS.

The Tanzanian Ministry of Health and Social Welfare did a follow-up in 2008 to evaluate the AFHS training, which yielded mixed results. Districts varied in the level of SRH training of health providers, use of standardized operating procedures, and effectiveness of services. Specific to the Mwanza region, it was concluded that “contextual factors, such as high turnover
rates of local government officials, staff shortages, and inadequately equipped facilities inhibited the scale up of services’’ (Chandra-Mouli et al., 2013, p.6). Furthermore, they suggest that future research includes large-scale interventions, support to local health councils and the utilization of local expertise to identify and overcome obstacles in providing AFHS.

The second study relevant to this research was exactly what was recommended-- a large scale longitudinal intervention study (N=9,654) that was conducted in twenty rural communities in Mwanza (Ross et al., 2007). This community-randomized trial aimed to educate adolescents, health care workers, teachers, peers and the community about AFHS and adolescent sexual health. Results showed a significant positive change in self-reported attitudes and behaviors between males and females. Males reported lower instances of sexual activity and more positive behavioral changes. Contrary to these findings, there was no significant change in biological outcomes (HIV, STI or pregnancy). Meaning, AFHS changed personal behavior choices but not the rates of infection.

Some possible explanations for these inconsistencies are the absence of risk-taking behavior measures, societal gender differences and lack of including out-of-school participants (Ross et al., 2007). There is a general lack of societal acceptance in talking about health issues, especially SRH issues, with young people. As the social and community level factors can be influential in the decision-making process, understanding community dynamic is important (Mmari & Magnani, 2003). In Mwanza, traditional power relations based on gender and age put decision making and knowledge share in the hands of men, specifically older men. Adherence and deviance from these norms illustrate the conflicting views between individuals, communities and generations. Young people cope with these differences by hiding their sexual relationships. In doing so, they close off the communication about the need for essential health services. This research was conducted exclusively on participants in-school. It reinforces the notion that knowledge about out-of-school participants continues to be extremely limited (Ross et al., 2007).

The third study related to this topic aimed to find which sources adolescents perceived to be the most reliable sources of health information, and how frequently they received information about health from these sources (Masatu, Kvåle, & Klepp, 2003). Conducted in the urban district of Arusha, Tanzania, results revealed that the adolescents’ reported the media, as the most frequent source of information along with teachers. Health workers and parents were considered to be infrequent sources of information. The former could be due to lack of adolescent
attendance to health services or receipt of unfriendly adolescent services. The latter could be attributed to cultural taboo of adolescents talking about health with their parents (Fuglesang, 1997). However, for credibility of health information, the inverse was true. Parents and health workers were rated as the most credible sources of information (Masatu, Kvåle, & Klepp, 2003). While the sources of information were considered how they would prefer to receive health information was not included in the study. Moreover, young peoples’ perspectives of what types of information they would like to receive, their vision, continued to be left out of research.

While studies have tried to find various ways of supporting young people to receive health services, two issues are consistently ignored: Firstly, the inclusion of out-of-school young people and secondly, giving voice to young people through hearing what health services they want. Using a two-pronged theoretical framework based on strength-based approach and youth agency, and employing a grounded-theory methodology (explained in the following section 4.1), this study aims to fill the gaps in research previously mentioned regarding youth health services in Mwanza.

3.3 Research location
This research is conducted in collaboration with Oxfam Novib, a Dutch non-governmental organization (NGO), their national affiliate, Oxfam Tanzania and the Mwanza Youth and Children Network (MYCN).

3.3.1 The Mwanza Youth and Children Network (MYCN). The MYCN is a youth-led NGO aimed at inspiring and educating youth to actualize their rights and actively participate in the development of equitable essential services. They seek funding to implement supportive programs to help young people actualize their intellectual, physical, moral and financial potential. MYCN actively implements programs for children and young people mainly in the Nyamagana and Illamela municipal district of Tanzania. They were selected as the local host organization due to their previous relationship with Oxfam. Oxfam Tanzania oversees the MCMV project, while MYCN staffs, recruits for and implements the project.

3.3.2 Oxfam. The research is a part of a one-year program My City My Voice (MCMV), which is a sub-program of the larger three year program My Rights My Voice by Oxfam international. The project is funded by Oxfam Novib of the Netherlands, and re-granted to Oxfam Tanzania in the capital city of Dar es Salaam. Oxfam Tanzania then partners with local
organizations, in this case, Oxfam Tanzania. Oxfam Tanzania then contracts local organizations, such as the Mwanza Youth and Children Network (MYCN) in order to implement local programs. My City My Voice (MCMV) sets out to establish how urban young people can better engage in decision making and enforce accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban young people, particularly girls and those out-of-school, think about education and health services. It addresses how they currently engage and how they would like to engage. The health sector is solely focused on this research so as to enable more young people, especially those out-of-school to meaningfully participate.
Chapter 4: Methods

Taking a grounded-theory approach, this qualitative interpretative case study consisted of eleven focus group discussions with youth aged 15-25 years old and four interviews with health workers. The aim of the focus group discussions was to find out how urban youth, especially young women and out-of-school youth, currently utilize health services and how they would like to interact with health services in Mwanza City. Four interviews with NGOs and medical professionals were held to expand upon the broader scope of how young people interact with health services. Additionally, document review, field notes were used to contextualize the focus groups and interviews. All of these methods are explained in this chapter. This chapter then goes on to discuss how the data was open-coded and analyzed and concludes with the ethical considerations of the study. It begins with the methodology, grounded-theory, from which the research stems.

4.1 Grounded-theory

Grounded-theory is a systematic methodology, which derives a theory from the data (Glaser and Strauss 1967 as in Heath & Cowley, 2004). The goal is to “get through and beyond conjecture and preconception to...the underlying processes of what is going on, so that professionals can intervene with confidence to help resolve the participant's main concerns” (Glaser 1998, p.5).

Historically, grounded-theory was strongly influenced by symbolic interactionism, which is a positivist approach rooted in the belief that there is a reality and that contains three main pillars physical objective reality, social reality and unique reality (Blumer, 1969). Physical objective reality states that individuals act towards their environment in accordance and on the basis on the meanings these things have for them. Social reality is the interaction that the individual has with their environment from which their meaning is derived. Language plays a large role within these social interactions. The way in which meaning is communicated aids in the construction or destruction of an individual’s social reality. Lastly, unique reality refers to the interpretative process of modification by which the individual creates throughout and during interactions within their environment (Blumer, 1969).
Goulding (1998) challenges this interpretation of traditional grounded theory by stating that it is an interpretivist approach, grounded in symbolic interactionism. This interactionism includes, but is not limited to human actions (ex. body language, gestures and actions), which should be considered in research. These human actions, which shape the reality of social actors (ex. young people), are socially constructed. Therefore, objective reality cannot be discovered by the researchers (Walsham, 1993). Rather the researcher aims to understand reality as perceived experiences by the actors. From this, the researcher shapes their understanding and knowledge of the research throughout the research process (Bradley, 1993).

In understanding the reality through the actor’s perceptions, two methodologies are used in this research: (1) knowledge sharing and (2) coding scheme. Firstly, the cross-sharing of materials and notes from the researcher to the participant. This allows for the participants to further explain, define and get closer to their reality (Bradley, 1993). For this research, all notes, observations, papers and information gathered was shared with the participants, translator and local organizations in order to strengthen the research process. Additionally, all final reports, presentations and this paper were reviewed by MYCN and Oxfam staff members in order to make sure all reports and conclusions were interpreted appropriately and culturally accurate. Secondly, grounded-theory methodology also involves breaking down the data, most commonly interviews, observations and focus groups, into distinct codes, which are then labeled to generate concepts. Data is then re-evaluated as it is collected (Goulding, 1998) (For more information on coding see section 4.5). This is aligned with the epistemological position of this research, interpretivism, as the coding scheme allows the researcher to understand phenomena through the words participants assign meaning to.

This unique use of position is chosen as the voice and opinion of young people and how they construct their reality is core to the research. The research should be thought of as a form of objectivity in order to validate young people’s opinions, which are often not valued in traditional society (Bordonaro & Payne, 2012; Fuglesang, 1997). Moreover, their voice is seen as a representation of the accumulation of their experiences. Is it through these voices of young people that the construction of their vision for improving the current health education and systems are built.
4.2 Case Study

The research is based in the urban regions, Nyamagana and Illemela, of Mwanza, Tanzania. The regional focus was derived from the ongoing project, MCMV, as these regions consist of a majority of the urban space in Mwanza. The Mwanza Youth and Children Network was chosen as the lead organization as they have worked with several youth programs from Oxfam Tanzania in Mwanza for the past five years.

Stemming from MYCN, four other local organizations were contacted to participate in the focus groups. The organizations are listed in alphabetical order: Haki Zetu, Kuleana, Wadada and Wote Sawa. Haki Zetu meaning “our rights” in Kiswahili is an organization that teaches vocational training skills to young women out-of-school. They work to equip young women with the skills necessary to start and run their own business. Kuleana is a center that aims at helping street children transition from living on the street to being active members of society. The center provides a residence for members while they receive social services, therapy and education to prepare them to (re)integrate into society. Wadada meaning “daughter” in Kiswahili is a youth-led young women’s organization that empowers young girls and women to access their rights in order to live free from sexual abuse and exploitation. Wadada uses a solutions-focused approach to helping strengthen, advocate and raise community awareness in order to ease young women and girls’ access to their rights. Lastly, Wote Sawa is another youth-led organization that works to provide legal and psychosocial support to child domestic workers to help them access their rights. The organization was inspired and led by female former domestic workers.

All of these organizations are relevant to the project for four main reasons. Firstly, they all focus on aiding young people in accessing their rights. This is closely aligned with the main goal of the MCMV project, which aims to explore how young people would like to engage and access their rights. As the participants within these organizations are working on accessing their rights, it is assumed that they will be more open and familiar with discussing engagement and how they would like to participate in society. Secondly, all of the organizations work on an aspect of health whether it is mental (ex. therapy and counseling) or physical (ex. sexual and reproductive health and rights). Therefore, participants will be generally familiar and have experience with some aspect of health services. Thirdly, all of the organizations work with urban young people. Lastly, since there is a focus on gender, specifically young women, and school enrollment status, specifically those out-of-school, it was important for the selected organizations
to work with one or both of these target groups. Organizations focusing on rights and health of urban young people, especially young women and out-of-school, is pivotal to this project because the focus group discussions (FGDs) are one-time discussions, participants familiarity will help maximize the amount of information exchanged.

4.3 Participants

Participants were predominantly associated with one of the five aforementioned organizations. They come from different organizations in order to expand the target population and control for organizational bias. Each organization was asked to select participants, between the ages of 15 and 25, for four focus groups with six participants each, totaling twenty-four participants. The four focus groups were split by gender participation and school enrollment status. The groups formed were as follows: young women (YW) in school (female=6), young women out of school, mixed young women and men (MX) in-school (male=3, female=3), and mixed young women and men out-of-school. If the organization worked with only one target group, for example, out-of-school young people, then the organization was asked for four groups (two YW and two MX) of their target group. Organizations that worked almost exclusively with women, were asked for two groups of YW in-school and two groups out-of-school. Table 4.1 lists the number focus groups and participants by organization. As can be seen from Table 4.1 only one organization, MYCN, was able to select participants for all four focus groups.

Due to organizational capacity, ability to recruit participants, time constraints, researcher decision to cancel two groups and communication between the organization and researcher, not all groups were able to be collected. This will be elaborated on in the limitations section of Chapter 6. Two of the focus groups were run together (Wadada in school YW and MX) as participants arrived at the same time. In order to retain the participants, it was suggested by both the group organizer and translator to run them together.

A total of eleven focus groups were collected: seven in-school and four out-of-school. Of these groups five were young women only and six were mixed groups. As the project focused on young women and out-of-school young people, and not all groups were collected, there was a lower representation of males as seen in Table 4.2. Particularly, young men out-of-school were extremely underrepresented.
Table 4.1

*Number of participants in the focus groups and interviews*

<table>
<thead>
<tr>
<th>Organization</th>
<th>In/out of school</th>
<th>YW(^a)</th>
<th>Mix(^b)</th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus Group Discussion</strong></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>Haki Zetu</td>
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<td>6</td>
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<td></td>
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<td>Kuleana</td>
<td>In</td>
<td>X</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>In</td>
<td>X</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td></td>
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<tr>
<td>MYCN</td>
<td>In</td>
<td>X</td>
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<tr>
<td>Out</td>
<td>X</td>
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<td>5</td>
<td></td>
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<tr>
<td>In</td>
<td>X</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out</td>
<td>X</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wadada(^c)</td>
<td>In</td>
<td>X(^c)</td>
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<td>6</td>
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<td></td>
</tr>
<tr>
<td>In</td>
<td>X(^c)</td>
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<td>3</td>
<td>6</td>
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<td>Wote Sawa</td>
<td>Out</td>
<td>X</td>
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<td>16</td>
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<td></td>
</tr>
<tr>
<td>In</td>
<td>X</td>
<td>2</td>
<td>4</td>
<td>6</td>
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<tr>
<td><strong>Total:</strong></td>
<td>7 In, 4 Out</td>
<td>5</td>
<td>6</td>
<td>55</td>
<td>19</td>
<td>74</td>
</tr>
</tbody>
</table>

*Interviews*

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<tr>
<td>Health workers</td>
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<td></td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Grand Total:</strong></td>
<td></td>
<td></td>
<td></td>
<td>57</td>
<td>21</td>
</tr>
</tbody>
</table>

*Note:* \(^a\) YW = young women \(^b\) Mix = young men and women \(^c\) Groups held simultaneously

Table 4.2

*Number of male and female participants in and out of school*

<table>
<thead>
<tr>
<th></th>
<th>Females</th>
<th>Males</th>
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<tbody>
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<td>In-school</td>
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<tr>
<td>Out-of-school</td>
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</tbody>
</table>

In addition to the focus groups, four interviews were held with health, medical and NGO workers. Two interviews were with NGO workers specializing in health, one was with a medical student, and another was with a previous NGO worker who worked with street children.
All participants across this research were between the ages of 11 and 30 years old. The health workers interviewed were between 22 and 35 years old. Organizations were asked for participants to be between the ages of 15-25 in order to focus the research and for ethical consent reasons. There was only one focus group with 2 participants below the age of 14 years old, Kuleana in-school group 1. It was for this reason the researcher cancelled the subsequent focus group, Kuleana out-of-school YW, as the researcher was informed that all participants were below the requested age.

4.4 Procedure

Focus group discussions were approximately two and a half hours long each and were semi-structured in nature. The interviews were also semi-structured in order to allow for both flexibility and structure to provide depth into the topic while maintaining the theme of young people and health services. FGDs and interviews began with an explanation of the project both visual and written and a review of the confidentiality provision, as well as oral consent to participant in the research project. For the interviews, the researcher presented a broad list of the topics. As each interviewee came from different fields, this open approach allowed for them to expand on questions that resonated with them, as opposed to being pigeon-holed into answering more specific questions.

4.4.1 Focus Group Discussions. A young post-secondary Mwanza native, born-again Christian female directly translated all FGDs. She was suggested by MYCN as a previous candidate for work at the organization, but did not spend time working there. The translator does not have formal translating experience or certifications but has completed coursework in translations and attended private schooling in English throughout her life, except for one year of public school. The translator and the researcher met the week prior to discuss the project outline, expectations of the FGDs and to clarify translating content literally within the cultural context. The structure of the FGDs can be broken down into eight steps.

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1 This was essential as the research previously was receiving translation through Oxfam Tanzania and MYCN for a separate research project for MCMV in which translations were inconsistent, inaccurate and overall missing (exact translations, generally topics were summarized). During this time the researcher worked with four different translators. It was for this reason the researcher decided to pay the translator for translations services in order to ensure translations were accurate, and understood. The researcher paid the translator comparable to a government teacher salary in order to ensure questions were asked in a culturally acceptable manner and properly understood.
Step 1. The discussion opens by having the participants explain what the term *health services* means to them. After the opening discussion on health services, participants were given a list of health services created by the first two groups and asked if there are any health services they would like to remove from the list because they do not view them as health services. An example of this is shown in Figure 4.1.

![Figure 4.1](image)

*Figure 4.1 Focus Group Discussion: Photo taken post discussion about health services (listed to the left) participants write down individually which health services they use while the translator translates the written questions. Group: Wote Sawa in-school, mixed.*

Step 2. Next, each participant was handed a booklet and asked to fill out some background information, including: age, sex, residence, and number of adults/children at home. Participants were then asked to individually list the health services that they currently use and how often they visit these services in a year\(^2\). Each participant was then asked to prioritize the top three services that they used by placing the numbers 1, 2 and 3 next to the service. The booklets were then handed in in order to keep information confidential.

\(^2\) It was initially requested to do the number of health services per month. However, the first group mentioned that it would be very difficult, so a year was adapted or all groups instead. Group: Wadada: in-school, mixed.
Step 3. Then, participants were told to imagine that they themselves were the head of health services. Participants were asked to name, as ‘head of health services’ what their top three priorities would be for urban young people. They were given three sheets of square paper progressively increasing in size. Their number one priority went on the largest sheet and the second on the middle and the third priority on the smallest. In Figure 4.1 an example of the priorities are given by the green squares on the middle sheet. All squares were glued to the flip chart in descending size. Participants were then asked to share their number one priority with the group. Due to time constraints all priorities were written but not explained.

Step 4. As a group, participants discussed and prioritized the top three health services that they thought were most important for all young people in Mwanza City.

Step 5. Given their top 3 health services, participants were asked to list what kind of treatments young people would seek at these facilities and locations. They were told examples did not have to be their own personal experience, but could be things that they saw from their friends or family as well in order to depersonalize sensitive topics.

Step 6. Participants were asked if their needs were likely to be met by these services and to discuss what inhibits or enhances their access to health services.

Step 7. Participants were asked open-endedly what their vision for future health services are. This was further explained to include what kind of programs and policies do they think should remain, be changed, or created in order to actualize their vision.

Step 8. Participants were asked to draw a map of where these services are in relation to home and school (if applicable). Participants could draw a daladala (public transport car) or human stick figure whether or not they walk or take public transport to these services.

Closing. All focus groups concluded with an opportunity for the participants to add anything to the discussion, and ask questions to the researcher and translator regarding the project.

All focus groups were held in Kiswahili in order to allow participants to express themselves equally. Some participants were not highly literate, or did not attend secondary school, of which English is the language of instruction. Not all participants or groups understood the questions being asked, or how to answer them. In these instances, the translator would state their answer and follow-up by saying she did not think that they understood the question. Another way of phrasing the question was suggested, until all participants understood. Because
the FGDs were held in Kiswahili, no recordings were taken, as the researcher would not be able to understand nor financially be able to translate the discussions. All notes were taken directly by the researcher during the discussions and further elaborated on post discussion in collaboration with the translator. Therefore, quotations are only derived from the translation of what participants said. As this was an explorative study, the main focus is on the themes of what was said and not the direct translation. It is noted that all quotations throughout this paper are adapted indirectly through a translator’s translation and the researchers ability to note take. Quotes are as close to direct for translation with added worlds denoted by brackets. For the analysis, the notes taken were used, as there were no transcriptions. As the main purpose of this research is to include the voice of young people, FGDs were prioritized.

**4.4.2 Interviews.** For interviews, the initial research proposal set out to include twenty interviews, however only four are included here. This is mainly attributed to personal illness shortened the research period by several days. Therefore, if during the FGDs an opportunity for an interview arose, one was conducted. However, health care professionals and key stake holders were not interviewed. Interviews ranged from 1-4 hours long and took place on site of the organization, or were set up in a neutral area (ex. soda shop) if requested. Interviews took place in English. All interviews were coded along with FGD.

**4.4.3 Document review.** As grounded-theory calls for the researcher to continually incorporate and analyze data, document reviews were read and integrated when presented. For example, the MYCN has a resource shelf in which there are documents about previous research and programs run by local organizations. These documents were read and are a part of the researchers positioning, understanding and interpretation of the data, even if not directly mentioned or references in this report.

**4.4.4 Field log.** Alongside FGD, interview, and document notes, a field log was taken. Daily and weekly observations were notes in a hand-written journal. The field log included daily activities, conversations, interactions and observations.

**4.5 Data Analysis**
As the methodology is grounded-theory, the data was analyzed simultaneously as it was collected. Data was then meta-coded openly by hand at the end of each day in order to uncover the main themes as they are emerging. As new themes emerge, changes could be made to both
the focus group and interview schemes to mirror the new information. For example, the main change in the FGDs was the activity assigned to understand perceptions of relevance and quality. After the first two FGDs did not supply adequate timing to complete it nor was it easily understood, the activity was removed from further FGDs. Additionally, as the theme of the use of Witch doctors emerged, it was explored and integrated into the coding process. Especially important for exploratory analysis, grounded-theory allows for the inclusion of all new and old themes. Similarly, new information or themes from document analysis was also be utilized in the same manner, integrating new themes and knowledge into the focus groups and/or interviews. Upon completion data was further categorize by creating sub-codes (APPENDIX C).

Codes were classified into the three main themes: access, quality and relevance, and vision. As notes were typed immediately in translation, the sub-codes are a reflection of the direct translation of themes. For example, ‘relevance’ was translated to mean are your ‘needs met’ and were coded as such. Access was coded as ‘access’, ‘easy’, ‘difficult’, ‘frequency’, ‘treatments’ and the individual health services names listed in Figure 5.1. Quality and relevance were coded as ‘quality’ and ‘meet needs’. Lastly vision was coded as ‘individual priorities’, ‘vision’, ‘young people change’, and ‘how’. These codes were used in order to give a general structure. The data was then examined more closely to place quotes and ideas in the appropriate sub-section. For example, the term ‘church’ was a code used for access. However participants might have used it in reference to their vision. Codes were then reassigned to the appropriate sub-section and labeled as a group or individual idea specifically. In the case of individuals, quotes were taken using participants numbers and later classified by their gender, school enrollment status and FGD group.

4.6 Limitations.

There are several limitations to the scope of this research. First off, there is a language barrier, as the researcher did not speak Kiswahili. While notes were taken through translation, it would have influenced the data collection and transcription. Additionally, the translator identified as born-again Christian could have also influences the group’s ability to share information as well as filtered the translation. Second, the researcher was associated with local and national NGO’s. While it was clear that the researcher was independent, it is possible this research is inherently subject to organizational bias. Third, grounded theory usually commences once data saturation
has been reached. However, with the limit of 10-week research, it is possible that this saturation level was not reached to its fullest, thus limiting the scope of the research. Fourth, the researcher themselves must “be critically conscious through personal accounting of how the researcher’s self-location (across for example, gender, race, class, sexuality, ethnicity, nationality), position, and interests influence all stages of the research process” (Pillow, 2003, p 178). As characteristics are influential in a researcher’s research decisions, methodology and methods as well as interpretation and experiences in the field, it is critical to take them into consideration (Wellington, Bathmaker, Hunt, McCulloch & Sikes, 2005). Therefore, as this was the researcher’s first qualitative international development study, it is imperative to consider their personal background and philosophical positioning, in relation to their research interests. As this shapes their personal ontological and epistemological positioning as well as the organizational association with MYCN and Oxfam Novib and Oxfam Tanzania. Lastly, personal ability to prioritize, organize data, and field notes and to continually synthesize them was a challenge due to personal illness and lack of Internet. Moreover, due to personal illness and time constraints, health workers and policy makers could not be interviewed.

In addition to personal illness, there are several other limitations of the research. (1) There was a strong gender difference in the FGDs. Often the voice of young women in mixed-groups was less present than their male counterparts. This was especially the case for young women in the out-of-school mixed groups. Despite the researcher’s efforts to have everyone respond to the questions, the young women in these groups did not want to participate. Additionally there was a strong voice of males out-of-school, despite there only being a total of three. This could be due to the fact it was the second-to-last FGD to be held therefore the researcher and translator were more refined in their questions. Also because of grounded theory, new themes had emerged so the later groups were more applicable. (2) Despite the research strength-based approach, there was a strong emphasis on deficits. It was difficult for participants to voice dissatisfaction than it was to give examples of satisfaction. Similarly, when the researcher asked how young people could be involved or change situations, it was difficult for participants to think critically or ‘outside-the-box’ about their vision. As such, those who were able to do so are voice disproportionately, especially with regard to vision. (3) The concept of relevance was not understood due to difficulty in translation and delivery. This lack of understanding was consistent throughout the majority of FGDs. (4) Participants were
inconsistent in answering questions. This was especially present in the difference between individual answers, at the beginning of the FGD, and the group discussions, in the middle of the FGD. This could be due to the fact the research was associated with a local and international NGO’s or the researcher’s background characteristics (ex. female, Caucasian). This difference was especially present for the in-school groups. From the researcher’s perspective this was attributed to the formal education system in which participants expected there to be a ‘right’ and ‘wrong’ answer.

4.7 Ethical Considerations

Research ethics are defined as “building mutual beneficial relationships with people in the field and… acting in a sensitive and respectful manner” (Scheyvens, Nowak & Scheyvens, 2003). Hopkins (2007) states further that the researcher should reflect continually throughout the process of development in order for the researcher to apply their experiences in the field into their research. New issues will emerge and the researcher should be open to change and adapt their research ethics. This is integral in the research approach and ideology. Each FGD was unique and has different points of emphasis. In order to allow for the participants to feel that they were in a confidential and safe space, the research questions were rearranged in each group to suit the setting. Integrating this, it was the researchers ability to be (1) personally reflexive, (2) address concerns of confidentiality, (3) obtain informed consent and (4) provide compensation or organizational and individual participation.

Firstly, it is important to highlight the need for reflexivity in social research. The ability to be aware of the implications of personal actions, methods, values, biases, decisions and presence. Recognition that the researcher is not neutral and that gender, socio-economic, national and political affiliations will be inherently integrated into the research experiences and impact data (Sayer, 2000). While organizational bias was attempted to be controlled by selecting participants from different groups, half of the focus groups were held on the organizations property and in four of the groups, organizational leaders were in the vicinity while the discussion was taking place. A majority of participants, since they were suggested by an organization, are most likely highly valued by the organization. Additionally, all participants had the time and resources to attend the discussions; therefore, they are more privileged than those who do not have the time to participate due to chores, obligations, or previous engagements.
Secondly, it was indicated that all discussions and interviews will be completely confidential and informants will remain anonymous. No names were requested or used in any reports or papers resulting from the research. Each participant was assigned a number that will be used throughout the research. Participants in the first FGD were given numbers but their statements were not correlated to notes. Therefore, quotations from these participants are reported as (unknown, in-school). Others are reported given their gender and school enrollment status. Group type (YW or MX) is listed for female participants only as all males are in mixed groups. Additionally, no numbers were used in reports to the local organizations where leaders were present.

Third, it was critical to ensure that all participants were aware of what the research is about, and that they were willing to contribute towards the research. This was particularly true in some cases where participants may have shared personal information about their circumstances and experiences. The researcher was given oral consent by the organization for participation. The research was told was standard procedure for research FGDs by each organization. Additionally, participants were asked to give their oral consent at the beginning of each discussion, after the explanation of the project. All participants are able to choose to not participate in the research, answer specific questions or discontinue at any time. Participants were also told that they were able to leave at any time if they needed to, and did not have to give explanation. Only one participant chose to leave in order to attend church services.

Lastly, participants were financially reimbursed for their exact transportation costs to and from focus groups and snacks will be provided to all groups. An exception for this is made for participants who would have been on site regardless of whether or not the focus groups were held. For example, participants in the Wote Sawa group were already on site for their weekly vocational training, as such, they did not receive transportation money. As for organizational participation, their participation in the My Right My Voice project will result in an educational gain about how young people engage with health services, and which types of programs they would like to receive. Additionally a short summary report of the results for the focus groups will be created for each organization (See APPENDIX B).
Chapter 5: Results

Throughout this chapter, the results of this study are presented. Specifically addressed are the three main areas of focus, and sub-research questions, regarding access, relevance and quality and vision. Urban young people presented their ideas and opinion about current services and vision for future health services and education. Each section compares and contrasts opinions and responses between young women and mixed groups (gender) as well as (2) in-school and out-of-school participants (school enrollment status) where relevant.

5.1 Defining health services

Compared to section 2.1, where international definitions were given for health services, here urban young people in Mwanza give their own definition of health services. These interpretations are crucial for understanding the meaning behind their interaction and vision for health services and education.

To open discussion, participants were given a sheet of health services, previously defined by young people and asked to add or remove health services from the list (see Figure 5.1). In order for a service to be removed from the list, the whole group had to agree. For time purposes, there was not an elaborate discussion about exact definitions of health services. Rather these services were generally understood to be facilities in where these services take place. There were two main themes that emerged when discussing health services: (1) defining hospitals (2) differentiating between Witch doctors and traditional healers and (3) regarding mental and spiritual services as health related. Lastly, participants’ use of religion as almost exclusively church-based religions is addressed.

First, there was discussion about what constitutes a hospital treatment. Participants had difficulty defining ‘hospitals’ with respect to other health services (ex. laboratory and pharmacy) where treatments overlap with those in hospitals (ex. pregnancy test, blood work). Hospitals often had their own laboratories and pharmacies within. In order to decipher these services, laboratories and pharmacies on the list are those independent of hospitals. As such, hospitals are referred to as any building complex deemed a ‘hospital’ government or private and is inclusive of all the services that they offer, independent of any treatment overlap.
Second, related to definitions, “We should understand that there are two kinds of Witch doctors, those who deal with issues on faith and those who are herbal specialist” (male, in-school). Some Witch doctors provided herbal remedies but all focused on faith-based issues. The difference between a herbal witchdoctor and a traditional healer is that traditional healers “cannot provide the technique behind a person be witching you and see what is happening, what is causing your illness” (male, in-school). Traditional headers were defined solely as herbal specialists. As shown in Figure 5.1, witch doctor was split into two separate sections, herbal witch doctor and herbal-faith-based witch doctor. This discussion took place mainly in the first FGD and was referred to in other FGDs as well. Therefore, this distinction clarified the use of Witch doctors and was the definition used throughout this research.

Third, some participants did not consider religion (ex. churches and mosques) as health services, while others stated them as a critical aspect to their health. Those who did not define religion as a health service said it was because health services are solely physical. They considered spirituality as ‘not important’ or that religious services were ‘ineffective.’ Both of these reasons imply that religion is a health service. An unimportant service refers to the ranking or prioritization of health service, which is addressed further in the next section, 5.2. Similarly, an ineffective health service means that there are treatments and that young people attend in
order for them to be deemed ineffective. This misunderstanding of defining health services could be due to the gap in translation from the researcher to participants. Moreover, it could be that the participants were given the list, created from the previous groups, and did not understand why they would need to (re)define health services if they were already on the list.

Defining further, participants stated that the ‘spirit is independent from the body,’ meaning that their physical self requires health services, but spiritual or non-physical health did not constitute as a health service. Lastly, there was discussion specifically around the use of ‘prayers’ or praying as a health services. Some participants saw churches and mosques as places where people pray and did not understand exactly why either faith or the physical church buildings were related to health services. These participants often placed a stronger emphasis on physical health.

In every group when this was brought up, there were participants who countered their argument with examples of health services offered by religions institutions. For example, ‘priests provide guidance and counseling’, and ‘churches offer low-cost services’. A large contributing factor to defining religion as a health service was faith. “If you believe in God, that he is our healer and if you have faith [you can be healed]” (male, in-school). Participants believed that having faith can heal, which similar to medicine that can heal, constituted as a health service. Participants who did not define religion as a health service were not aware that some religious institutions offered these services, which are similar to a laboratory or pharmacy. Once a participant stated this, those who did not define it as a health service did not further refute it as one. As no group came to the consensus on the removal of religion as a health service, it remained on the list for all groups to be considered throughout the FGD.

It is important to note that participants almost exclusively mentioned ‘churches’ when referring to religious services. While religion was not asked as a background variable, of the participants that listed religion as a health service that they attended, 8% of them listed mosque compared to the 92% that listed church. This suggests that the majority of participants identified with a church-based religion. As such, minorities in a FGD are less apt to join the discourse unless their minority status is specifically addressed (Smithson, 2000). In order to shed light on all health services, a FGD might not be the ideal environment. Moreover, the aim of the research was to highlight the voice of young people, questions were asked for clarity, however no suggestions or deeply probing questions were asked. As the research was conducted by student
and not FGD professional, the researcher was unaware of this dynamic during the FGDs. As such, participants were not explicitly asked to share experiences of attending a mosque for health services. Therefore, the research is mainly focused around church services. Throughout the results, religion from Figure 5.1 is considered to mean church-based religions.

5.2 Access to health services

This section addresses the first research sub-question: to what extent urban children and young people have access to health services in Mwanza, and how do they benefit from these services? The sub-question is two-fold, it inquires about (1) which health services young people use and (2) the reasons why they use those services. Results showed that the most prominent discourse regarding access was that urban young people attempt to access any health services only when they are extremely ill. Preventative health measures taken by young people are limited and often filtered through societal and traditional means such as financial means (ex. economic independence) and parental interactions (elaborated on in the next chapter). When they do access these services, they are often faced with several challenges that inhibit their access. Education, money and quality being the main driving forces that that enhance their access to health services. As such, the most highly accessed health service amongst young people was self-reported to be hospitals, however in the FGD it suggested to be Witch doctors.

This section opens with how young people access health services and goes further including what health service young people use and for what purpose. Comparisons between gender and school enrollment status are made and then final conclusions are drawn. Generally, it was very difficult for participants to think of way to increase or enhance young people’s access to health services. It was much easier to list limitations to their health services. Despite coming from a strength-based approach and having a main aim to focus on ways to enhance access, it was suggested multiple times by the translator to start with constraints in order to make it easier for the participants to understand the content of the question.

5.2.1 Prioritization and utilization. Groups were asked which three health services they thought, on behalf of all urban young people, were the most important. Then they were asked to rank them from one to three with one being the most important. Table 5.1 shows the priorities of each group segregated by school enrollment and group and Figure 5.0 shows a group discussion taking place. The top three overall priority services in no particular order were:
• Hospital
• Church
• Witch doctors

These were derived not only from Table 5.1 but also from focus group notes and discussions. The group placed their chairs in a circle and had a discussion amongst them, while the researcher and translator sat outside the circle. Some groups decided really quickly while others discussed for long periods of time unable to rank their top three.

In order to understand why young people made the decision to access and prioritize these certain health service, it is important to explore why they made specific choices. In order to do so, they were asked for examples of treatments they would receive at their top three group priorities. In this section, participants are asked when they go to health services, why do they decide to attend and for what treatments do they receive at these services. Thus, a majority of what is explained throughout this section will refer to illnesses instead of specific treatments. Table 5.2b lists the treatments for the top three overall prioritized health services, hospitals, Witch doctors and churches. For a full list of treatments for each group see APPENDIX B.

Figure 5.0 Photo of a mixed in-school group discussion
Table 5.2a

*Top three group priorities segregated by school enrollment and group (YW or Mix)*

<table>
<thead>
<tr>
<th>In-School</th>
<th>YW</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Hospital&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1. Hospital&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2. Church</td>
<td>2. Church</td>
</tr>
<tr>
<td></td>
<td>3. Witch doctors</td>
<td>3. Witch doctors</td>
</tr>
<tr>
<td>1. Hospital&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1. Pharmacy</td>
<td></td>
</tr>
<tr>
<td>1. Counseling</td>
<td>2. Laboratory</td>
<td></td>
</tr>
<tr>
<td>1. Faith Centers&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3. Dispensary</td>
<td></td>
</tr>
<tr>
<td>1. Hospital</td>
<td>1. Hospital</td>
<td></td>
</tr>
<tr>
<td>2. Church</td>
<td>2. Counseling</td>
<td></td>
</tr>
<tr>
<td>3. Counseling</td>
<td>3. Church</td>
<td></td>
</tr>
<tr>
<td>1. First aid (home)</td>
<td>2. Dispensary</td>
<td></td>
</tr>
<tr>
<td>2. Pharmacy</td>
<td>3. Hospital</td>
<td></td>
</tr>
<tr>
<td>1. Dispensary</td>
<td>1. Hospital</td>
<td></td>
</tr>
<tr>
<td>2. Pharmacy</td>
<td>2. Witch doctor</td>
<td></td>
</tr>
<tr>
<td>3. Hospital</td>
<td>3. Church</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-school</th>
<th>YW</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Laboratory</td>
<td>1. Hospital</td>
<td></td>
</tr>
<tr>
<td>2. Pharmacy</td>
<td>2. Witch doctor</td>
<td></td>
</tr>
<tr>
<td>3. Hospital</td>
<td>3. Church</td>
<td></td>
</tr>
<tr>
<td>1. Dispensary</td>
<td>1. Hospital&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>2. Pharmacy</td>
<td>2. Laboratory</td>
<td></td>
</tr>
<tr>
<td>3. Hospital</td>
<td>2. Hospital&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> both groups had the same priorities as the YW did not understand the question completely and listed the same

<sup>b</sup> the group could not prioritize which was the most important, but all participants agreed that all three were the most important. Therefore, the number one is assigned to all in order to not give priority.

<sup>c</sup> faith centers were defined as a service that one has faith in, for example a church or Witch doctor

<sup>d</sup> due to the large size of the group, participants were split into two groups. Listed here are the two priorities that the group had in common.
Table 5.2b

*Treatments young people seek at the top three health services hospitals, churches and Witch doctors*

<table>
<thead>
<tr>
<th>Young women</th>
<th>Mixed group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-school</strong></td>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>STD</td>
<td>Demons</td>
</tr>
<tr>
<td>UTI</td>
<td>Financial aid during death of family member</td>
</tr>
<tr>
<td>Malaria</td>
<td>Incurable disease*</td>
</tr>
<tr>
<td>Cancer</td>
<td>Drug use/addiction*</td>
</tr>
<tr>
<td>Counseling</td>
<td>Loss of family member*</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-school</strong></td>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>STD</td>
<td>Incurable disease</td>
</tr>
<tr>
<td>Malaria</td>
<td>UTI</td>
</tr>
<tr>
<td>High fever</td>
<td>Typhoid</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Mental disturbances</td>
</tr>
<tr>
<td>Serious physical injury</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Swollen legs or stomach</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Over bleeding</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td></td>
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<td></td>
<td></td>
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<td></td>
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<td></td>
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</tbody>
</table>

*Note: Blank sections indicate the selected groups did not prioritize said services. Participants listed ‘faith centers’ as a priority which included churches and Witch doctors.*

Overall, when asked how many times they accessed a health service, a majority of participants responded with ‘I only go when I am really sick’ or ‘when my condition is persistent.’ Consistently, throughout all groups, participants waited until they were in critical condition before attempting to access health services. “Most of the time [young people] start with the hospital and if it completely fails, you go to the witch doctor. If that fails then you go to the church” (female, out-of-school, mixed). Similar to the opening quote of this paper, young people often spoke of ‘failing’ services as a reason why they use one service over another. Some
would attend the hospitals first, and attend Witch doctors as a last resort. For others the inverse was true. They would attend Witch doctors first then go to the hospitals as a last resort. This is because while hospitals offer a variety of services, they are not able to treat all diseases, especially ‘the spiritual kind’. Regardless of the order in which participants chose to attend these service, the top three prioritized services were always referred to: hospital, Witch doctor and churches. Young people’s access to and use of these three services are discussed below.

5.2.1a Hospital. The ranking and placement of hospital services varied in every group. Some would go to the Witch doctors first stating, ‘they do not always help’ or sometimes you have ‘several treatments, but you do not get better,’ then you go to the hospital. Whereas others would go to the hospital first then seek alternative options if their treatment was not successful.

The main reason young people attended hospitals was for STD’s, STI’s, malaria, typhoid, and HIV/AIDS tests and treatments. Almost all participants strongly associated hospitals with surgery, ‘x-ray’, ‘ultrasound’, ‘appendix removal’ and ‘operations’. “For early pregnancy delivery one has to visit a hospital. Maybe the organs are not developed enough, so in the hospital is where the operation can be done” (female, out-of school, YW). However, it is usually only in ‘extreme cases’ that they go to the hospital for these services or when they are referred to the hospital through another service. “[You go to the hospital instead of the dispensary or pharmacy] because the nature of the diseases are complex. Sometimes the dispensary will even refer you back to the hospital” (female, out-of-school, YW).

With regard to hospital access, participants often mentioned ‘fear’ of health services. Fear was mostly exclusively associated with surgical hospital procedures. Young people said they were fearful of hospitals because they ‘took organs’. “For instance, if you have a broken leg, you might be scared of services [in the hospital] which take an organ off and might be in a lot of pain. It might take shorter and a low price [less expensive] to go to a witch doctor” (in-school, mixed, unknown). Fear of known procedures happening in hospitals inhibited young people from attending.

Other participants never or infrequently accessed hospitals. For example, in a discussion with one out-of-school YW group, a participant suggested hospitals as one of the three top priorities. The group responded by laughing and one person said, ‘when have you ever been to a hospital?’ Often when defining hospital services as related to the group priorities, access and frequency influenced their ranking. Overall, out-of-school participants ranked priorities based on
the importance of the services available, whereas in-school participants ranked what they thought were the most valued services offered by society.

While all participants prioritized hospitals, both individually and in the FGDs, it was revealed that a majority of young people attend Witch doctors and church services. There are a few possible explanations for the high ranking of hospitals. First, as hospitals, doctors and western medicine is becoming more known through globalization, media and education; young people in Mwanza think it is important for them to have access to hospitals and their services, even if that is not currently the case. Secondly, as the research was associated with several NGOs, participants answered thinking that this was the targeted, or ‘correct’ response. Third, as the researcher is a Caucasian female from a Western context, participants thought western traditional practices were ideal. Fourth, there is a difference between what young people value as important health services and where they attend – in other words, young people think hospitals are important health services despite not attending them frequently or using them.

5.2.1b Witch doctors. “Should we hide the issue of youth going to Witch doctors” (male, out-of-school) one participant whispered, but the translator still heard. “No, we should not hide it. It is true that most of the youth are not attending hospitals, but rather these Witch doctors” (female, out-of-school, mix). While some were shy to address the use of Witch doctors, a majority of participants agreed that young people are accessing Witch doctors. This was reflected both in the group discussions and individual reports of attending.

Four of the eleven groups mentioned it as a priority. For example, a group of out-of-school YW who did not list Witch doctors in the priorities, later unanimously agreed in the FGD that “most of the youth go to Witch doctors” (female, out-of-school, YW). Their reason for not including it in the priorities was that none of them personally visit the Witch doctor, but they know that many young people do. Whereas individual reports of access show a quarter of the participants attend Witch doctors. It appeared as though participants thought there was a right and wrong answer to FGD questions, especially those in-school. This was apparent throughout the discussion about what services young people use. Every group brought it up and almost unanimously agreed that young people use Witch doctors more. However, when asked individually, at the beginning of the session, which services they use, 25% said that they went to traditional healers and/or Witch doctors. In one group, the participants who wrote Witch doctors had their hand over their book and did not want others to see. Despite the study being
‘confidential’ in assigning numbers to each participant there still was a risk of what others in the group thought or knew about each other (Smithson, 2000). Additionally, this could be because of the strong socio-cultural context in which participants report to what they think is accepted verses the reality.

Contradictory to both of these findings, participants who voiced their attendance were always in the minority. There were usually only one or two people in the discussion that actively argued and took a solid stance on why Witch doctors should be included.

“The Witch doctors are very helpful. For instance, if you have a swell in you and you go to the hospital, they remove it [through surgery]. The swell grows again and you have to get surgery again. But with a witch doctor, they will not grow again. Today I am alive because of the witch doctor”

(female, out-of-school, YW)

While Witch doctors addressed some physical diseases, they were mainly used in reference to spiritual ones. Young people who prioritized Witch doctors said it was because “some diseases cannot be treated by the hospital - the spiritual kind… so instead of going to the hospital they rush to the witch doctor” (unknown, in-school).

Spiritual diseases were often referred to as ‘mental disturbances,’ ‘demons’ or ‘evil spirits.’ Mental disturbances were usually caused my demons and were when young people would ‘act different.’ Demon affliction was described as someone who is ‘possessed by the devil’ with demons themselves being defined as “huge and powerful not like evil spirits” which were less invasive (translator). This affected young people’s health because some demons “prohibited people from taking food, caused bouts of fainting” (unknown, in-school).

Young people are affected by these demons through two main mediums: ‘ancestors’ and ‘modernization.’ Ancestors can wish harm on you or protect you. An example of a treatment for this would be changing your name to that of your ancestors in order to gain protection from demons or evil spirits (translator). However, in order to know whether or not this is the case, you need to attend a witch doctor as they have the special ability to address these faith-based spirits. Young people are more susceptible to demon attacks because they like to be “up-to-date which opens the gate [for demon attacks]” (male, out-of-school). In other words, because young people like to be modern and up-to-date of a variety of worldly topics, they are more susceptible for attacks. Specifically, wearing adornments such as perfume and jewelry also made someone more
susceptible to these ‘attacks’. As treatments for these issues, Witch doctors provide potions and will boil roots in exchange for hens or goats.

Those who did not access or use Witch doctors said it was because Witch doctor treatments were a façade. The Witch doctors “tell you to bring two white hens and one egg just to make you think he can treat you. But he ends up adding problems and demons to you” (male, in-school). Those opposed generally stated that Witch doctors are unsuccessful in their treatment and are very resource heavy. Moreover, while supporters went to Witch doctors to cast demons away, those opposed said that Witch doctors were the source of these demons. As such, when someone was possessed or bewitched they would attend religious institutions, specifically churches, to have them cast away.

Many of those against the use of Witch doctors also mentioned that the church ‘forbid’ going and that the ‘law was against it’. The Traditional and Alterative Medicines Act of 2003 promotes the supervision, control and regulation of traditional medicines and protects citizens against mal-practice. It was fairly recently in 2009 that the use of traditional medicines were banned in order to save the lives of albino Tanzanians who were targeted and killed by Witch doctors for traditional heading practices. While the government said that all licenses would be revoked (New York Times, 2009), this never took place. The ban was lifted in fall 2010 claiming the practice could not be outlawed due to the fact a majority of Tanzanians depended on Witch doctors for health services. A law was then set in place to require all practitioners to register with the government in an attempt to control practices. While some young people are under the impression that law bans the practice, it currently is not. However, banned or not, it did not seem to affect whether or not young people attended Witch doctors.

Interestingly enough, both in-school and out-of-school participants reported attending Witch doctors, however, only the in-school groups prioritized these services. This conflicts with generally accepted knowledge that urban young people in-school would be less apt to attend traditional health practices due to education in schools about modern health service, stronger infrastructure (access) and more available resources than those out-of-school (Sugishita, 2009). Additionally, while those out-of-school participants said that they attend these services and are more prone to because they have contact with Witch doctors more often than medical doctors, they did not prioritize their services (Table 5.1). All of the young women groups prioritized laboratories and pharmacies, while the mixed group prioritized Witch doctors. This is aligned
with individual reports on gender where males show a higher attendance to Witch doctors compared to their in-school and out-of-school counterparts (Table 5.2c). However, it is in direct contrast with individual reports of use by school enrollment. While out-of school females did not prioritize witch doctor services, they attended more frequently than their in-school female counterparts. These inconsistent results show make it difficult to draw conclusions about the use of Witch doctors. This is consistent with reports of FGD dynamics. It is possible that this discrepancy could be due to the fact that male participants dominated the discourse on Witch doctors throughout discussions (Smithson, 2000). As for out-of-school participants, their high attendance reporting could be due to the fact that they are highly stigmatized by society and thus are not prone to shielding their attendance due to cultural taboos. Despite these conflicts, one thing remains very clear - a higher than expected proportion of young people are attending Witch doctors for health services.

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<th>Witch doctor</th>
<th>In-school</th>
<th>Out-of-school</th>
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</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>Yes</td>
<td>2</td>
<td>6</td>
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<td></td>
<td>No</td>
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<td>10</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>Yes</td>
<td>2</td>
<td>8</td>
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<td></td>
<td>No</td>
<td>22</td>
<td>20</td>
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5.2.1c Churches. Generally, those who attended religious institutions for health services did so because there were ‘illnesses’ that could not be cured elsewhere. Demon attacks and prayers and the protection of God, through attending church, could also cast evil spirits away. “I had demons disturbing me, I would do crazy then [the parish] administered prayers and I was cured” (unknown, in-school). Demons were not always caused by mental disturbances. “For example, you have a problem where you are not sleeping, or eating it can be caused by demons, so you need a priest to send them away” (female, in-school, YW). Moreover, prayers can cure ‘minor diseases’ and ‘life hardships’, for example: unemployment, family problems or life stress. Priests also play a pivotal role in counseling services. While young people attended churches for
different health services, physical treatment or prayers, one thing was clear, they played an important role in their health services and were attended to very often.

5.2 Factors that contribute to access. When asked what inhibited or enhances their access to hospitals, Witch doctors and churches, it was almost always easier for participants to come up with constraints. Constraints to health services included: ‘ignorance,’ ‘lack of education,’ ‘infrastructure,’ ‘cultural taboos,’ ‘religion,’ ‘fear,’ ‘poor management’ and ‘cost.’

Ignorance and lack of knowledge were described in relation to the community and governmental awareness. “Sometimes government officials are supposed to provide education but instead of helping people they sit in their office quietly so the masses do not know about health services” (male, out-of-school). Whereas ignorance, on the community level, addressed why young people did not access certain health services, for example hospitals. “For instance, one has malaria, and it is clearly just malaria, but they rush to the Witch doctor thinking they are bewitched” (in-school, female). Often governmental ignorance was associated with lack of action or dissemination of health service education or knowledge, whereas community level ignorance was associated with traditional beliefs.

Participants referenced infrastructure with regard to physical infrastructure and reported that health services were still not easily accessed. Despite living in a city, because many wards and home were located in places without paved roads or off the public transport line, leaving health services difficult to reach. If participants were able to access the service, they were subject to poor management and unfriendly services.

Within the FGDs, the factors that contributed to inhibiting access were often areas, which enhanced access. Taking ‘cost’ for example, lack of money means that participants were not able to access certain health services, however, low-cost health services increased their chance to attend, increasing their access. Therefore, the main themes of confidentiality, costs, dependency on elders, traditional beliefs and education are discussed with regard to both increasing and decreasing access where notable.

5.2.2a Confidentiality. Not only was it taboo to attend Witch doctors (as mentioned in 5.2.1a), so was actually being a Witch doctor – it was ‘nothing to brag about.’ Witch doctors often hid by setting up their practice in bushes. They placed signs throughout the city, village or ward, with their phone number in order to be reached. This increased access as it made it easy for young people to reach Witch doctors by contacting them in a private manner. They could place a
phone call instead of walking into a facility that was more visible. Moreover, since it was a shameful practice, they felt as though their appointment would be confidential. Several public services were also said to lack confidentiality, namely, hospitals and churches. Young people “do not want to attend [health services]. If I tell a doctor something, it will get back to the street. I will not expose my issues there” (male, in-school). Meaning, when they have a counseling session with a priest or a discussion with a nurse about HIV (for example), it will not be confidential, everyone in the community will know about it. Young people often considered confidentiality before accessing a health service.

5.2.2b Cost. Cost played a large role when considering health services. Those who accessed Witch doctors said are much less expensive costing around 2,000 THS (€2) compared to hospitals, which cost 15-20,000THS (€8-10) per visit. Not all participants agreed that these factors influence access to health services. Conversely, participants did not agree with those who attended Witch doctors said it was because their services were considered ineffective and costly. Those against often reported that Witch doctors would ask for gifts in exchange for services. “They instruct you to get the nails of a lion, [for your treatment] which is hard to do. So they are just liars and only after money” (unknown, in-school). While those who access Witch doctors believe that they possess special powers that allow them to cure diseases that are incurable by western medicine, those in opposition say that their power is a mask for their financial greed. Moreover, several participants speaking out against the use of Witch doctors, recounted instances where they went to a witch doctor, and received several treatments but were not healed. Witch doctors “are liars, they are after the hens that you bring them and nothing more” (female, out-of-school, YW). They felt that the cost of services was not worth the treatment. Moreover, those in opposition said, “the money they use [for Witch doctors] could be used for the hospital to get treatment” (female, in-school, mixed).

On the topic of cost for service, churches often give reduced or even free health services. “Medicine for people outside is 5,000THS (€2.5) but in the church it is 1,000THS (€0.5)” (male, out-of-school). This was also challenged by some participants who thought that while “most churches advertise free health services, their main aim is for you to become a member” (male, out-of-school). Treatments from churches were not only physical; faith was often an integral aspect of treatment. If you “take medicine you have to believe [and pray it will work]. [Faith and treatments] are related” (female, out-of-school, YW).
5.2.2c Dependency on elders. Young people are usually not financially independent. Therefore, they are subject to consulting their parents or elders when asking for money for health services. This, coupled with the cultural tradition of respecting elders, young people are consequently and at times implicitly, urged to follow the practices of their parents and/or elders. For example, participants said young people do not go to the hospital because their parents do not go. Instead they go to the dispensary or pharmacy first which their elders frequent more.

Young people also receive treatment by their elders at home. “Most parents in the [local] tribe boil leaves….then you are cured of malaria. Most people do not go to hospitals” (translator). This suggests that young people are dependent on their elders for access to hospitals and that they do not make their own decision on attending. On the other hand, it was suggested that “most youth do not attend the hospital easily, they have to be forced by their parents, most of them visit Witch doctors….but are not getting cured” (male, out-of-school).

5.5.2d Traditional beliefs. Traditional beliefs were considered to be taboo and as such limit young people’s access to services.

“Youth come from different environments so they have different beliefs. Some think they are bewitched and most of the time it is not so, it is just a normal disease. But because of these poor traditional beliefs we are losing the workforce of the country. People die and a lot of money is spent on less important medicine. But a huge percent believe in Witch doctors, so instead of hospital getting treated, they go to the witch doctor” (female, in-school, mix) Traditional beliefs limit access to health services because some “young people do not believe in hospitals, but in the healing power of Witch doctors, therefore they do not attend hospitals” (male, in-school). Others suggested that traditional beliefs sometimes prohibit attending some health services. “For example, we have a tribe where pregnant women cannot visit the hospital because they practice female genital mutilation (FGM) and so they do not like to be exposed, so they have midwives” (in-school, male). Similarly, some religions, specifically church-based religions, ban young people from visiting Witch doctors. While participants agreed this was the case, it was often refuted. Several participants said those who went to church also visited Witch doctors and vice versa, it is just not talked about. It was further suggested that having increased access to Witch doctors reinforces these traditional beliefs.

“Most of the health seminars on the street are ones on traditional beliefs or Witch doctors, but not professional classes from doctors. Doctors have their own status so they will not come on the
street and talk to nobody’s. So the youth come into contact more with Witch doctors which is why they visit them” (male, out-of-school).

When talking about access to health services it was apparent that while attending Witch doctors was taboo, many young people did so because they had easier access to their services. The fact that young people interact with Witch doctors more often relates back to education and access. Witch doctors are more accessible to young people not only because they come into contact with them more, but also because they are educated on the services that they provide and how to locate them.

5.2.2e Education. Education was often a reason why young people accessed a health service. “If one is educated, it is easy to support an illness by rushing to the hospital. If you are not educated you stay sick for a long time or turn to wrong solutions like Witch doctors” (female, out-of-school, YW). Despite coming from an out-of-school participant, it was generally assumed throughout all FGDs that education was negatively correlated with attending Witch doctors. Meaning those who are in-school and have health education are less likely to attend Witch doctors. This divide in education of health services is related to previous research on health education, which has almost exclusively been held in schools (Masatu, Kvåle, & Klepp, 2003; Matasha et al., 1998; UNESCO, 2012). However, the group priorities do not reflect this.

One out of four out-of-school groups prioritized Witch doctors, compared to 3 out of 7 of the in-school groups, which listed Witch doctors as a top three priority. Meaning in-school groups gave priority to Witch doctors more often than those who were not in school. This could mean a few things (1) participants that were out-of-school had attended school for a period of time and have some level of education, but are not currently in-school, (2) in-school participants attend Witch doctors more than those out-of-school, (3) in-school participants understood the questions more thoroughly and reflected what they thought young people as a whole rather than drawing from their own personal experience. The latter was affirmed in two of the out-of-school young women groups, both stating that Witch doctors were important to young people, but because they did not go, they did not list it as a priority. This shows that the question was misinterpreted or translated and the participants did not generalize their group priorities to young people as a whole.

Consistent throughout all groups, participants often waited until they were in critical condition before attempting to access health services. Miseducation about signs and symptoms is
a huge contributing factor to how they employ services. “Most young people get sick because of ignorance, so if they were advised, they would not be sick” (male, ou-of-school). Another participant recounted a recent event:

“A few days ago I told my boyfriend that my urine was so yellow and smelled really bad. I thought it was not normal…but he told me that I was okay. He said it was because I [ate many different] foods. So I stayed for three says and then [my vagina] was itching to the maximum so I had to be hospitalized. If only I was well informed before, there was no reason to be hospitalized” (female, out-of-school, YW)

Other participants were not self-aware of their miseducation. For example, one participant said: “You need to go to the hospital for urinary tract infections (UTI) because they cause STDs.” (female, in-school, YW). In not understanding the signs and symptoms, prevention or nature of certain illnesses, young people are not able to seek or use available services optimally. (see section 5.4 for elaboration on this).

5.2.3 School enrollment status. In comparing the health service access and use of in-school and out-of-school young people there was a clear difference in the type of health service reported and the prioritization of services. As shown in Table 5.1, young people in school frequently prioritized mental health services such as counseling (emotional) and churches (spiritual), whereas out-of-school young people tended to focus mainly on physical health services. In addition to the FGDs, participants were asked to prioritize the health services that they used individually which yielded different results. As shown in figure 5.2 below, both in-school and out-of-school participants individually prioritized hospitals as the most important. They also both had a tie for second place: in-school participants tied between first aid and religion, out-of-school participants between laboratories and religion. Both second individual priorities included religion, the main difference in the choice of first aid and laboratories. Out-of-school participant thought laboratories were more important where was in-school participants values first aid. Participants were asked to individually prioritize health services prior to a group discussion of priorities, in order to not influence individual results. However, this difference shows that (1) young people thought that they had to prioritize hospital, because it is highly-valued socially as a health service (2) group discussion made participants feel more comfortable talking about traditional practices (3) FGDs can be swayed by strong participants (Smithson, 2000) or (4) individually young people value hospitals and churches, however it is not a reflection of the services they currently access and utilize. These conclusions can be assumed for
all future differences between individuals and group throughout this chapter and will be elaborated on in the next chapter.

Figure 5.2 *Top 4 individually prioritized health services by school enrollment status, represented as a percentage*

As such, in-school participants were able to give more examples of treatments of church services compared to their out-of-school counterparts. One treatment that was specific to those in-school was regarding counselling services. Young people were often counselled by priests, or told ‘to stop certain deeds which are not deemed by God’ (male, in-school). However, it was mentioned that these priests have their own agenda. “Young people are against priests because you pay your offering but they have their own needs” (male, in-school). Meaning priests ask for money in exchange for inadequate services. Confidentiality often came up as to why these services were inadequate. “It is not fair if one believes in you [to tell you their problems] and then you just expose it in church’ (female, in-school, YW). Despite this, not every one was opposed us using priests as counsellors “even if the person between you and God is looking out for their own good you still go because what matters is what is in your heart” (female, in-school, mixed). Whether young people attended or not, there was no opposition to the notion that often priests have their ‘own agenda’ and do not keep counselling sessions confidential.

5.2.4 Gender. Both young women and men listed hospitals as their number one priority. Just over 60% of both groups list hospitals as their most important priority as shown in Figure 5.3. The main difference was in the second most popular priority. More young men listed first aid as a priority (16%) compared to their young women counterparts (6%). For young women, religion was the second highest priority with 14% compared to 11% for young men.
Additionally, females were twice as likely to prioritize Witch doctors as a second or third priority compared to their male peers. Combining this with previous difference, which said females prioritized religion, it is suggested that females prioritize more spiritual health services compared to males. Also important to note, is that the only health service not prioritized in the top two by either genders were clinics. No females reported clinics compared to 5.5% of males who prioritized them third. This conflicts with a majority of the FGDs, where a clinic was understood to be mainly meant for pregnant women and children. However, three males from an in-school focus group said that clinics and dispensaries were important health service as they catered to the needs to young people if hospitals were full or too busy. Contrasting the young women and mixed groups there were no notable differences (Table 5.1). Both groups prioritized hospitals and churches more often than any other services. One hundred percent of young women groups listed hospitals compared to 80% of the mixed groups.

With regard to treatments, young women were more likely to report having gone to the hospital for ‘stomach aches’ compared to men. These stomach aches were mainly a result of their monthly period. When asked why many said it was due to their period and others said ‘it was a bit private’ and did not share why. Another reason women attended the hospital, related to their menstrual cycle, was for overbleeding and if they skipped a period. Overbleeding was explained to be when a young women bled for more than the supposed set amount of days for her period. As a treatment, they go to the hospital and get ‘tablets’ which solve the issue. When asked how often this occurs, the response was ‘some people go each and every month it happens.’ For those who skipped a period, they would attend not only hospitals but laboratories, dispensaries and pharmacies for pregnancy tests and consultation.
Young women also mentioned attending the hospital “when someone is raped” (female, out-of-school, YW). In order to report a rape, the victim needs to file a police report and then is required to have a medical examination at the hospital. “Mostly they place a pipe up you and clean you up and clean for an infection or any STDs” (female, out-of-school, YW). Once the examination is complete the hospital report must then be brought back to the police in order to verify the rape and place charges, a process which can take over a week. Due to societal and family shame and cost of reporting, many cases so not go reported (Interview). This is consistent with research which shows low reports of rape (Muganyizi, Kilewo & Moshiro, 2004).

5.3 Relevance and quality of health services

In this subsection, results for the third research question on quality health services is addressed: how do urban young people view the relevance and quality of health services available to them? Overall, participants were not currently satisfied with health services. The few who stated that they were satisfied, gave a specific example of a time they were satisfied, with services, but did not comment on health services in general.

5.3.1 Relevance. Relevance was translated to mean do health services currently ‘meet your needs’ as a young person. For some groups, participants were asked to scale their level of satisfaction with health services from one to five, with five being ‘fully satisfied’ and one meaning ‘completely dissatisfied.’ Other groups were not able to complete this activity due to time. For those that did, it usually it took a while for participants to understand the activity. Moreover, some FGD environments made it difficult to carry out the activity. As such, a majority of the FGDs did not complete this activity but were asked the question instead. This lead to a more binary ‘yes’ and ‘no’ response from participants and showed that participants were generally dissatisfied. The groups that used the scale seemed to be more diverse range of responses and a higher percentage of people who were satisfied. Some possible explanations for this could be that (1) scaling allowed for independent decision making, slightly more independent than sitting in a circle group, (2) it was easier for participants to recall moments of dissatisfaction or (3) the question regarding relevance was not clear. Moreover, participants would give specific reasons or instances in which their needs were met or not. This could mean that they interpreted the question more narrowly, or that in order to explain their positioning on the topic they felt the need to give an example. Despite this challenge in methodological execution,
participants’ views of relevant health services are presented, albeit briefly, due to the aforementioned challenges.

An overwhelming majority of participants said that their needs were not met by current health services and gave an example. Those who said their needs were met were more broad in their response, ‘I get everything I need’ or ‘my needs are met’. Participants who did not have their needs met usually addressed a specific health service. “My needs are not met because if someone gets raped, you do not need prayers for you, you need a hospital” (unknown, in-school).

Those in support of churches said that churches provide counselling, prayers, and financial support, so they were satisfied with health services

One participant recounted how his needs were not met by hospitals:

“I would like to share my own experience with my retina. The [hospital] doctor said this disease had never been seen or heard in the world. My treatment was so poor it made me stop school for a year and a half. Then this specialist from Germany came to Tanzania - to my hospital. It was confirmed I had a chronic disease with my retina and was told [by the German doctor] that I should be treated urgently otherwise I would go blind. I was home for a very long time without any treatment. If [the Tanzanian doctors caught this] I could have gotten better, [so my needs were not met, I did not get the treatment I deserved]” (male, in-school).

The participant went on to state that the doctors knew about a specialty hospital that could have treated this type of condition, but did not inform him that this place existed. This highlights youth dissatisfaction with the knowledge gap between doctors and patients and lack of proper treatment. As is shown by the above two examples, participants’ examples of relevance often blended with issues of quality. They attributed a ‘long cue,’ ‘doctor qualifications’ and overall ‘quality’ as contributing factors to their needs being met or not. As relevance was a precursor to the discussion about quality health services, the discussion about young people’s needs being met is tied into the next section on quality.

5.3.2 Quality. Quality health services was a theme throughout the FGDs. Participants mentioned ‘confidentiality,’ ‘unqualified doctors,’ ‘lack of education’ and ‘supplies’ as reasons for their dissatisfaction. This revealed two main themes effecting quality health services: (1) discrepancy between public versus private sector health practices and (2) corruption.

5.3.2a Public v. private health services. Throughout the FGDs, participants would discuss frequently whether or not services were ‘high quality’ or not. Once a participant mentioned ‘public services,’ separating the dialogue into public and private health services.
Overall, participants were not satisfied with public health services, but were satisfied with private health services. Cost was almost always mentioned as a reason why young people did not obtain private health services. “The services are there, but it matters how much money you have” (female, out-of-school, MX). Private facilities were more expensive than public ones. However, they had the “best, quick and easy[est] services” (unknown, in-school). Young people rarely had access to these private services, but attended them in emergencies. “My child got sick and I went to the [government] hospital where we were being skipped in line. In the evening I had to go to the private hospital” (female, out-of-school, YW). Private services, specifically hospitals and dispensaries, were viewed as having high quality services and young people were satisfied with their experiences there, but they were costly and infrequently attended.

Public facilities were said to be ‘overcrowded’, have ‘long cues’, unfriendly and unknowledgeable staff, ‘lack of confidentiality’ and were overall associated with low quality. “Most of the girls they get pregnant at very tender age. It is your time to go for delivery and the nurses throw harsh words to you: ‘[getting pregnant] was out of your own pleasure and ‘do not disturb us’, so that is low quality’ (female, out-of-school, YW). This lack of confidentiality and unfriendly health services are consistent with several previous accounts of unfriendly health services for young people (Hayes et al., 2005). Lastly, lack of adequate medicines attributed to perceptions of low quality. Certain medicines, which were supposed to be free to young people, were consistently out of stock. If medicines were there, they were sometimes ‘out of date’, or the prescription directions were not clear. This lack of medicine was often not due to the high volume of patients, but attributed to corrupt staff practices.

**5.3.2b Corrupt health practices** The top two most corrupt practices in health services, according to participants, were the absence of medicine and accepting bribes. Medicines were reportedly not provided because doctors and nurses would take them from the hospital and resell them in their private pharmaceutical practice, making medicines unavailable for the public. “I took my child to the hospital. They listened to the health problem but told me they did not have the medicine that was supposed to be free. The doctors have pharmacies outside the hospital so that is why. They [take the medicines and then they] are sold here” (female, out-of-school, YW). It was common for participants to be directed to certain pharmacies or dispensaries owned by the staff to get the medicine from.
Additionally, prioritization was given to those who either knew the doctor or bribed them, typically with money. “If the doctor sensed someone is rich, then he gets treated first, others are left” (male, in-school). Participants mentioned that people were often segregated within the waiting room based on financial status and age. Those especially at risk for not receiving services due to this segregation were young people living on the street. “Nurses don’t give them much attention because they are from the street. They get into trouble, it is just their normal behavior” (female, out-of-school, YW). One participant recounts their experience with a doctor asking for a ‘bribe’:

“[At the local government hospital] I paid 5,000 THS for the file at reception. After, I was directed into a room where the doctor asked for money for a checkup. I had 5,000 THS left over but it was not enough. So, they wrote off what I should take… but I was never checked. So I used the other money at the pharmacy [to buy my medicine]” (female, out-of-school, YW).

Generally, young people taking medicine without being ‘examined’ was a common theme. In this instance the participant was seen by the doctor, however in others instances young people are not even seen by the doctor or were asked for bribes from nurses before they even went to the doctor. Often young people wanted a checkup before receiving treatment.

A doctoral student said that many Tanzanians and young people in general expect to receive medicine when they visit the doctor, however, it is not always necessary. This shows that there is a gap between young people’s perceptions and medical professionals. The doctoral student says that sometimes corruption can be mistaken for a lack of education. Young people need to be educated on the process and expectations of health services in order to differentiate between services that are denied due to lack of adequate payment, and those that are unjustifiably denied. Understanding how young people view quality health services was important in order to understand the meaning and motivation behind their vision for future health services.

5.4 Vision for health services
Finding out how young people accessed certain health services and how they viewed the quality of these services was the foundation from which participants built their vision for future health services. This section includes these visions in addressing the fourth and last sub-research question, which is: how can the relevance and quality of health service be improved?
The main focus for the FGDs was on youth agency. Specifically, how can young people change or actively participate in order to bring their vision to fruition? Participants’ vision included ‘increasing the number of health service facilities,’ ‘lowering costs,’ ‘adequate medicine supply,’ ‘increased work ethic of doctors and nurses’ and decreasing ‘segregation’.

Overall young people’s visions can be placed into two categories: (1) education and (2) corruption. Two sub-themes present in both of these are accountability and reassurance. These visions are discussed as well as how to actualize their vision and from whom they would like to receive these services.

Generally, it was very difficult for participants to respond to the question regarding vision. The question was usually repeated, or the translator had to explain it in two to three different ways in order to participants to respond. Participants continually hesitated or struggled to answer strength-based questions about vision and positive access. In the first FGD, participants were asked what three things they would do as head of health services in the middle of the FGD. It was then found that all the responses were aligned or addressed their three main priorities. This led to a switch in schedule, which asked participants to discuss vision at the beginning of the session. Many young people envisioned quality health services to mean simply creating more services. They called for hospitals to be ‘on every street’ and for there to be a continual supply of ‘free medicines.’

In conjunction with talking about their vision, whenever participants mentioned a disadvantage or challenge (section 5.2.2), they were asked how young people could solve it. Generally, participants did not easily understand these questions either. They either were silent or did not understand the question. Often it was repeated, especially for the out-of-school FGDs. Despite this, there were no specific differences with regard to how to actualize their vision. All groups made similar suggestions for how to access youth for educational programming and for how young people can resolve corruption. The mediums through which they wanted to be heard were ‘media,’ ‘TV,’ and ‘radio.’ One unique suggestion from an out-of-school participant was ‘concerts’ and ‘games.’ These can be combined to emphasize the importance of high-quality health services in a fun an interactive way. “The different concerts should be prepared [in such a way] to give education on the importance [of health] and where the services are located” (male, out-of-school). Generally, young people want to be educated through a medium that is relevant and of interest to them. For the in-school participants, that was mainly ‘in school’ and for the
out-of-school participants it was ‘open dialogues’ and ‘street-based’ education. All of which is ‘where young people are.’ Concerts and games were suggested, as they can be educational without having people know directly that they are being educated. Further discussed are the main responses of actualized vision focusing on the aforementioned themes education and corruption.

5.4.1 Education. All FGDs stated that they wanted more education about health services. Specifically, they wanted education on (1) the signs and symptoms of diseases and where and (2) how to locate health services. The gap in previous health education is two-fold: there has been a strong emphasis on HIV/AIDS, not all health and education has focused on the consequences, but has not addressed how to identify certain diseases. Participants would attended health services for HIV testing and also seek counseling on ‘how to deal with the disease’ emotionally if contracted. However, “most of the youth focus on HIV/AIDS. So, sometimes someone has contracted another disease but keeps on [engaging in sexual practices] because his main focus is on HIV/AIDS” (female, out-of-school, YW). Therefore, young people called on the need for more education on other diseases, specifically STD’s and STIs. Moreover, they wanted education on the signs and symptoms, so that they can prevent transmission of various diseases.

Aligned with this, currently education about health has been about the impact or consequences of disease, but has not focused on the signs and symptoms of health issues. Many young people are not aware of what they have (if anything) prior to attending health services. For example, many of the young women recounted times that they went to the hospital for stomach cramps or ‘over bleeding’, which turned out to be due to their ‘monthly period.’ Similarly, the previous quote shows that young people are not aware of the signs and symptoms for STDs, which contribute to the spreading of the diseases. Therefore, they also called for health education to be more holistic in order to help young people identify and prevent the transmission of diseases. Specifically, they are interested in this type of education for STDs and STIs.

While there is education on HIV/AIDS, there is limited education on the practical implications of it. While those affected can seek counseling, the community at large remains uninformed. “Today the community believes that if they shakes hands [with someone infected by HIV] they will get HIV, so they need to be educated” (male, out-of-school). Health education should also address the community. As the community level factors can be influential in young people decision-making process (Mmari & Magnani, 2003), they should be included in educational efforts.
Participants mentioned that young people should not be the sole recipients of education. In addition to the community, medical professionals should be educated as well. Medical professionals should have education on how to be ‘youth friendly,’ ‘hard working’ and programs that hold them accountable for maintaining ‘confidentiality.’ “Most pregnant girls are considered immoral and mannerless so the nurses attend to you as if you are from the street and that you are not raised well which is why you are there” (female, out-of-school, YW). As stated before, young people were generally disappointed with the way in which medical professionals treated them. Therefore, their future vision included training for the doctors and nurses on how to not use ‘harsh words’ when talking to young people. However, medical professionals are not solely responsible for unfriendly services. Participants recognize that young people themselves also need to learn how to communicate appropriately in such interactions by ‘being polite and not shouting,’ when they are faced with inappropriate or unfriendly language of medical professionals. They need to know how to respond appropriately and not return the ‘harsh words.’ While some agreed with this notion, others challenged it. “[Young people] have to fight for their right…they do not have to keep quiet [or comply]” (female, in-school, YW). Despite this debate, participants agreed that future services should be friendlier towards young people.

Addressing work ethic of medical professional, young people call for there to be salary increases and education for medical professionals in order to motivate professional to work hard. “For example, you go to the hospital and [medical professionals] are all there but they are not working the way they are supposed to work. I was at [the government hospital] and there was a woman who was in the car in the parking lot about to give birth. The nurse was there. But she did not help the person in the car because she said she did not have gloves. If she could have known her work she would have grabbed the gloved and done it perfect” (female, in-school, YW).

Lack of supplies was not the only instance where work ethic was addressed. “In government hospitals, you find the nurses making stories all day” (male, in-school). A few participants recounted times when they would go to a hospital and there would be staff present, but no one would attend to or help them. In order to ensure that medical professionals are working, participants call organizations to hold staff accountable for their actions. They should be held accountable for having medicines properly in stock, providing treatment equally and not accepting bribes.

Additionally, young people called for collaboration between medical professionals and young people. They envision a peer education group and health center to help them access
information on location of services. First and foremost, almost all participants in-school and out-of-school called for a collaborative health education efforts between medical professionals and young people. “[We young people] have seen the impact of these low-quality services and should be able to make our voices heard” (male, out-of-school). They wanted their voices to be heard to the government in addition to collaborating with medical professionals. Their solutions took three main forms: (1) seminars and meetings, (2) youth peer educators and (3) health education center.

Seminars and meetings could be used to address current challenges within health services and be able to provide education to young people. Young people expressed that they should not only be the recipients of educational information, but should be the driving-force and experts of young people’s health service needs. Several participants said that they would like to have meetings with government officials in order to ‘make them aware’ of challenges young people currently face and provide solutions to these challenges. “We should be able to sit [with stakeholders], give out opinions: for instance, we are in the need of education on health issues. Then our views should be allocated to those who are concerned” (male, out-of-school).

Seminars with doctors and nurses would be used to provide health education to young people. The seminars should be ‘in-school,’ ‘on each and every street’ and other places where young people are located.

Participants wanted information from doctors and nurses; however, they said that young people rarely interact with them in an educational setting. This was especially the case for young people living on the street.

“Most of the seminars on the street are on traditional beliefs of on the issue of Witch doctors, not professional classes from doctors. Doctors have [high] status [in society] so they will not come into the street and talk to nobody’s. Most youth have contact with Witch doctors which is why they visit them” (male, out-of-school).

In order to address this gap between medical professionals and young people, participants suggested the creation of a peer-education health program ‘under the supervision of doctors’ and medical professionals. This peer education program in essence would be a “team of doctors, nurses and young people to visit [young people] wherever they are” (female, out-of-school, YW). Current seminars and education programs are mainly in schools (Ross et al., 2007) and address the impact of adverse health problems, but do not educate about the signs and symptoms.
These peer education programs could address this gap by providing education on the signs, symptoms and preventative measures, decreasing the spread of STDs and STIs.

In addition to young people suggesting a variety of topics that they would like to be educated about, they were also asked from whom they would like to receive education. A majority said that they want to work with doctors and nurses specifically on certain projects (see 5.4.3). However, when it came to general health education, they had a different response – ‘anyone who is trained.’ The discussion boiled down to the issue of ‘trust’. Young people ‘trusted’ information from ‘doctors’ and ‘nurses’ but said when it comes to health education, anyone who is ‘trained’, ‘certified’ or ‘well informed’ they would like to receive health information from. They did however want information about STD and STI’s to come from ‘specialists’ on the various infections and diseases.

In terms of education, another point of dissatisfaction amongst participants was the practical application of healthy behaviors and follow up related to education taught previously. For example, young people were told how an ‘unsanitary environment’ could lead to health complications, but they were not told how to clean. There was no portion of the seminar that ‘motivated’ them to do so. Additionally, they did not feel empowered, or given the tools to successfully share information that they learned at seminars with others. Taking this into consideration, educational sessions would be run by peer-educators as they can identify with young people and know ‘where they come from’ and how they think. The educators would also be trained in health services so they would be able to share their knowledge with others.

“Education can spread by gathering youth. You educated them, and then they can educate others” (female, in-school, MX). This team would be a mobile team that visits various places where young people congregate in order to disseminate and share information. This should not be strictly informational, they should leave opportunity to host an ‘open dialogue’ as well. This informal setting will allow for young people’s voices to be heard through discussion and reach a larger group, compared to the current seminars, which usually target a specific – already informed group. “[We should] have open dialogues. We know [this NGO] and have talked to them at some point before, but out there are a lot of youth who have a lot to say - even [more informational] than what we have said here” (female, out-of-school, MX).

Even if young people are equipped with health education on the signs and symptoms of certain diseases, they need to know where the services are located in order to be able to access
them. Currently information is decentralized in various schools, health services, and NGOs. Young people feel this information is not readily available. For example, there are some organizations that offer free health services to young people, but participants were not aware such services existed. To resolve this, participants suggested the building a youth-led education center that would be able to aggregate all information regarding available health services (ex. location, available treatments, price of services) in order to help young people know where to go for what treatment. This youth-led center would also contain doctors and experts in the health field that would be able to provide free treatment for all young people. In order to do this, the center would have to collaborate with various organizations currently working within health services in order to ‘enable the provision of high quality services.’

In several instances, young people recounted their experiences at the hospital and stated that the hospital staff was not performing their work duties. Young people mentioned improper or inadequate use of equipment several times throughout the focus groups. Despite being a recurrent theme, they did not link the lack of supplies with hospital staff’s inability to help all patients.

Young people were ‘not aware of their rights’ to health care generally stating that medicine was not ‘free’ when they went, when they ‘should be’. They were also generally unaware of the process of the health care system, where should you pay for services, how much and for what service? As one participant previously stated (in section 5.2.3b), they were disappointed in the services because the doctor asked for money for a check-up, a ‘bribe’, but they did not have enough money. It is possible that payment for these services are received by the doctor, and that she did not have enough money for a full check-up. Therefore, young people need to be educated on the process and expectations of health services in order to differentiate between services that are denied due to lack of adequate payment, and those that are unjustifiably denied.

5.4.2 Corruption. Beyond taking supplies and being accountable, young people also raised corrupt practices, more generally, as an area that should be addressed. Mentioned throughout the FGDs, corruption was attributed to the dissatisfaction of young people with health services. They envision future improvement to services as relating to the reduction or elimination of corrupt practices, specifically, ‘bribing,’ ‘segregation’ and stealing supplies.

In order to access health services, participants mentioned the frequent use of bribes. “If you have money you are okay, but if you do not, you are sick in your bed until you die” (male,
Generally young people do not have their own income. As such they lack financial resources to pay for health services – let alone paying for bribes.

“In several hospitals they do not have proper services for their patients because of corruption. Young people have no money and they cannot get proper service until the doctors are given money. So, maybe the youth are seriously sick and without money you cannot get services and might die” (female, in-school, MX).

Participants also voiced concern for other groups that are affected by this mainly, pregnant women, children, the elderly and disabled. This is why young people vision future health services to be free of bribing doctors and nurses in exchange for health services.

“Health services should be provided equally to those who are rich and who are poor” (male, out-of-school). In addition to bribes, people who ‘looked wealthy’ or were highly valued in society were treated first. Participants referred to this as ‘segregated’ health services. Patients wait in line to receive service, and believe that those who come first should be treated first. However, in reality, patients are ‘segregated by financial status.’ Young people call for health services to not discriminate patients and to treat them all equally. If patients are discriminated against they should be done so based on the severity of their condition. Patients who are extremely ill, or who need immediate medical attention (ex. women in labor) should be given priority.

Young people were often told that the medicine is not available in the hospital. Therefore, their vision was to have ‘free medicine’ for young people. As discussed previously, this has been attributed to medical professionals who take medical supplies and re-sell them in their private pharmaceutical businesses. As such, young people call for medical professionals to be held accountable for their actions. They also envision health services that record medical distribution and hold those who steal accountable by ‘ceasing their license,’ or revoking the right of a medical professional who breached the law from future practice.

Regarding national policy on what constitutes these ‘free medicine’ is conflicting. Some studies state that HIV/Aids information should be free. In contrast, there are several facilities that give out free medicine or require a flat rate payment for services (The United Republic of Tanzania, 2004). While there is no legal right to access health services guarantees by the Tanzanian Constitution (Mulumba, Kabanda & Nassuna, 2008) or regulations around payment for these services, there are provisions around the right to education (Article 11). Specifically
addressed are confidentiality of their personal conversations (Constitution Article 16) and
information about HIV/AIDS (National Aids Policy), which many young people are not aware
of. They would just refer to education on the ‘law’. This gap of education on rights around health
services feeds young people’s dissatisfaction with the services while perpetuating the knowledge
gap between professionals and young people.

The participants had several suggestions for how young people can tackle corruption in
the future. Participants suggested (1) meetings (2) prioritizing work and (3) increasing the
number of doctors as possible solutions. “Providers of the health services should be enlightened
on the negative impacts of corruption. If they are aware of their impacts, they will stop taking
bribes. Then, the youth can get good health services” (male, out-of-school). Many participants
thought that:

“The best way would be to call a meeting head of hospital should attend and these head of hospital
would be informed what is going on in the hospital. Maybe they are not aware of what is going on in
the hospital. Maybe they do not know the medicine is [re-]sold [by staff], they think the medicine is
there and that it should be given out for free. With this meeting they are informed they will be in
charges of checking and making sure the rules (female, in-school, YW)

As such, participants suggested meetings with government officials and medical
professionals in order to educate them about the negative impact of corruption on young people.
An example of this was when a participant stated “youth should use a national assembly to have
the government help [young people access health services]” (female, in-school, MX). The
following exchange took place.

Researcher: “Did you know that there already is a national assembly for
youth?”
Participant: “Then nothing needs to change”
Researcher: “So young people’s voices are being heard by the government?”
Participant: “To some extent”
Researcher: “Can you elaborate?”
Participant: “Not all things are being done but some of them are”

This comment, illustrative of participants’ tendency to give brief and broad responses, displays
the lack of knowledge young people have of services (and advocacy opportunities) available to
them. Young people envisioned seminars to ‘motivate’ them to know more, but did not actively
seek out more information themselves. They often took information at face value, a very literal
interpretation, but had limited understanding how to motivate themselves internally. They wanted health service seminars to not only be informational but to teach them how to motivate.

Participants had differing views on the subject. On one hand, some thought government officials were not aware of the corrupt practices within health services. Others thought officials were well aware, but chose not to mobilize or impact change. “The central government allocates a certain percentage of money to the local government special to help hospitals. Many leaders are eating this money. They are embezzling public funds. It is not going straight to the specific needs” (male, in-school). Government officials were often referred to as ‘putting it in their stomach’ or ‘pocketing’ the money. Due to this, others thought that handling corrupt practices should not solely rely on meeting with the corrupt parties; instead young people should take action themselves.

Some suggestions as to how young people can address corrupt practices themselves were by (1) joining together to reject corrupt practices, (2) increasing the number of medical students and (3) educating the public about corrupt practices.

“The youth should say no to corruption. [Some of us] have economic status [and can afford health services], but there are some people who have nothing. The youth should join hands in saying no to corruption….Even if you refuse to bribe [medical staff member], and someone else comes and they are ready to bribe [then it will not work]. This is why we should join hands. In the end [medical staff] will be forced to treat all people equally because no one is ready to bride so you will have to be treated equally. (female, in-school, YW)

‘Saying no’ to corrupt practices would help reduce the additional cost of health services, however, young people still need money in order to access these services. Therefore, young people should ‘work hard to have money to get their health medication.’ Young people should have entrepreneurial education and experience in order to enable them to be financially capable of making independent decisions around health services. Moreover, young people should be able to access resources if they are denied services. “The law [ex. right to health services] should be educated as well so if [young people] do not get their medicine for free, they know where to go” (female, out-of-school, YW). Young people should be able to locate no only where various health services are located, but be educated on their rights and be able to locate services that aid young people obtaining health services.

Corruption was suggested to exist because there is no competition for doctors. This lack of competition allows doctors to feel secure in their positions, as there is no risk of losing their
job for malpractices. There is ‘no one watching’ to hold them accountable. In order to address this issue, “young people should give priority to [pre-medical] subjects. Currently we have few doctors because of [people failing, told not to take them by their parents, or not interested in pre-medical studies]. More young people should study because then we would have competition. That way if you mess up, then you will be out [fired]” (female, out-of-school, YW). Creating a highly-competitive market for medical positions, coupled with a generation of medical professionals educated about and against corrupt medical practices, will help ensure high-quality services for future generations.
Chapter 6: Conclusion

This research is designed to lend insight into how young people in Mwanza currently use health services, factors that inhibit and increase their access to services, and to extrapolate their vision for future quality health services and health education. Especially through the inclusion of the latter vision, this qualitative, interpretive case study adds to a growing body of knowledge on how young people interact within health services. This research focused on understanding the similarities and differences of youth’s perspective in the aforementioned domain, specifically related to gender and school attendance. While research has examined how young people interact with health services, all too often, the opinions of young people are absent from these inquiries. It is a main premise of this research that “[young people] need to be seen as part of the solution; in doing so, we increase the likelihood that not only will our interventions be accepted, but that they will be more effective because they will be more consistent with the health priorities of young people.’ (Blum & Nelson-Mmari, 2004).

Throughout the research, there were two consistent discussions that were the most striking, (1) the juxtaposition between modern and traditional medicine and (2) conflicting views on the future of health education. In terms of modernization, one might imagine that through urbanization, young people in Mwanza would be more likely to access health services and less likely to rely on Witch doctors and non-medical remedies to illness. Furthermore, as there are several health education programs in schools, young people attending school could be assumed to be more ‘educated’ and motivated to uptake modern health services. On the contrary, this research shows that a majority of urban young people, regardless of education status or gender, attend Witch doctors for medicinal treatments. However, education about health and the services provided are conflicting.

While participants were aware of various health services (ex. hospitals, clinics and churches) they were often unable to link their current experiences with their vision for health services and health education. Meaning, participants would advocate for more ‘hospitals on every street’ and ‘free medicine’ but did not link this to the current available services and low uptake of those services. Participants thought that ‘more’ of something would improve the quality of services and education about services. They were not particular critical about the practical implications of these additions. This is presumably related to a cultural lack of youth
agency and the historical undervaluing of young people’s perspectives. Young people struggled to form and convey their own views and opinions. Participants were however, aware of this gap of agency and once given the space in the focus group, were able to address this.

When asked their opinions, young people called for health education to not only include their voices, but for the formation of collaborative efforts between young people and health professionals. Young people were very aware of the focus on specific health initiatives (ex. HIV/AIDS) and wanted more education about how they could monitor their health independently. This was present by the majority of focus groups calling for education on (1) signs and symptoms of health issues, (2) centralization or resource center of available health centers and the services they offer, and (3) participation in educating their peer groups. This is extremely important to note that young people are knowledgeable about the gaps in their health care systems and have practical ways to address these gaps, but are lacking the agency, support and follow through of stakeholders and organizations to bring them to fruition. These perspectives of young people lend critical insight and strengthen understanding of the complexity of health systems for urban young people.

This chapter continues with conclusions on the four main areas of focus, (1) defining health services, (2) access, (3) relevance and quality and (4) vision for health services and education. From these conclusions, recommendations are made for both policy and practice. Finally, the chapter, and this research, conclude with suggestions for future research.

6.1 Defining health services
Definitions of what constitutes a health service varied amongst groups and individuals. According to the participants’ definitions, there are several overlapping treatments and services at different health facilities. Participants were not aware of which facility provided which treatments and how/if they overlapped. A distinction was also made between modern and traditional health services, which were each further categorized into physical, mental and spiritual health. This distinction between modern and traditional medicine is not new to literature (Hausmann Muela, Muela Ribera, Mushi & Tanner, 2002; Kusimba et al., 2003; Satimia, McBride & Leppard, 1998). However, the polarized description of traditional medicine is. Participants made a distinction between Witch doctors and traditional healers, however, other studies suggested that there are over five different types of traditional healers with specific
treatments and procedures (Hausmann Muela, Muela Ribera, Mushi & Tanner, 2002). Using these definitions as a critical contribution to the research, it is important to note that defining health services is complex and layered. Specifically regarding health, it is important to take into consideration not only the surface definition, but also the cultural interpretations and understanding to contextualize urban young people’s perceptions of success, quality and vision for health services.

The greatest difference between defining health services as physical, mental and spiritual was that out-of-school participants associated health services as more physical than their in-school counterparts. This was particularly the case with out-of-school young women groups who defined health services to be only physical. It is through this definition the gaps in access were revealed.

6.2 Access to health services

Overall, in-school participants accessed and put greater value on emotional and spiritual services, while out-of-school participants mainly focused on services aimed at remedying physical ailments. While participants attended health services for a variety of reasons, confidentiality, cost, dependency on elders, traditional beliefs and education were influential factors when deciding where to go and what services to access. Participants only accessed health services when they were extremely ill (ex. morbidity was a threat), a finding which is consistent with previous research (Gedif & Hahn, 2003). Fear, shame and uncertainty were factors that inhibited young people from acquiring the services that they wanted. Several participants said that they would attend services more often if they were ‘assured’ that they would be attended to and receive quality services. Moreover, two of their top three prioritized health services of hospitals, Witch doctors and churches are consistent with previous research, which polarizes modern, and traditional medicine use (Kusimba et al., 2003; Sugishita, K, 2009).

Discrepancies in access were very present between individual and group reports of access. Individually, all participants prioritized hospitals as their number one services. Meaning of the services they personally attended, hospitals were the most important for them to have access to. However, once group discussion took place, hospitals were often not ranked as a number one priority if at all. While hospitals were seen as important to young people, they did not access them as frequently as Witch doctors.
In making decisions about which services to access, participants’ definition of services had an impact on responses. Defining health services as physical or mental/spiritual meant in-school participants prioritized spiritual, churches and Witch doctors, more than their out-of-school peers. This conflicts with literature, which suggests that non-educated people are more likely to access traditional medicines (Satimia, McBride & Leppard, 1998).

Prioritization of physical health services was especially the case with out-of-school young women who only prioritized physical health services. This conflicts with previous research that found young women more likely to access and prioritize physical health services (Gedif & Hahn, 2003). This could be due to the national and international focus on SRH education. These conflicting research findings are interesting especially because the least-likely group to prioritize traditional medicine, young women out-of-school, does not.

The main factors that influenced decision making in accessing health services were confidentiality, cost, dependency on elders, traditional beliefs and education are consistent with previous research (Gilson, Alilio & Heggenhounen, 1994; Plummer et al., 2006; Sugishita, K, 2009). For example, participants sought out service that they thought were confidential (ex. Witch doctors) and affordable. Moreover, they were guided to access health services that their elders and family members did. Different from school enrollment status, education in this sense refers to their level of knowledge about available health services and treatments that they offer. Overall, participants were not aware of what services were offered by each facility. Additionally, despite health education has been driven by international priorities (ex. HIV/AIDS) which have focused on prevention of disease, young people were not aware of the signs and symptoms of these diseases. Unable to differentiate or know about the signs and symptoms, participants were not able to decide which service they needed. This was evidenced by the fact that young people generally accessed more than one health service for each treatment. This was especially the case when their treatment did not cure their health issue. This is consistent with previous research (Gilson, Alilio & Heggenhougen, 1994). Meaning, if participants went to the hospital, received medicine, but were not cured, then they would go to the church or witch doctor for alternative treatments.
6.3 Relevance and quality of health services

In order to further understand why young people access certain health services it is important to know how they view the relevance and quality of such services. Overall, relevance was not translated and communicated. As such, a majority of responses addressed issues related to quality of health services instead. Participants listed unqualified professionals, lack of medicine and supplies, and lack of confidentiality as reasons for their dissatisfaction with services. Moreover, participants’ perception of quality was often related to the impact of the treatment. Meaning if they were ‘cured’ from their illness, they viewed the treatment as higher quality, which is consistent with previous research (Gilson, Alilio & Heggenhougen, 1994).

An example of the relationship between quality of service and impact of treatment was shown by participants’ clear distinction of quality between public and private sector health services. Young people viewed private health services to be of high quality and public, or governmental health service to be low quality. Although costly, private health services were said to be high quality because they all had quick and easy services and possesses the proper treatment services. Public services were low quality services because the staff was not friendly to young people, especially those who were pregnant, and lacked adequate medicines for treatment. On the contrary, it was the opinion of health workers that culturally, people expect to receive medicine when they go to a health service, regardless of whether or not it is necessary.

Young people perceived this lack of adequate medicine supply to be due to lack of accountability and corruption of health workers and government officials which is consistent with previous research (Ferrinho & Van Lerberghe, 2002; Gilson, Alilio & Heggenhougen, 1994). Moreover, health workers were viewed as being inefficient, unproductive, unmotivated, and generally not young-people friendly; all of which contributed to low quality services. Unique to this research was that while young people were quick to point the finger at health workers, they also recognized that they themselves contributed to the unfriendly health services. Young people mentioned that while health workers should not use abusive language, nor should they reciprocate with such language. Young people aimed to resolve this issue by calling for more education on how to respond politely to health workers, which is addressed in the next section.

Many young people envisioned quality health services to mean simply creating more services. They called for hospitals to be ‘on every street’ and for there to be a continual supply of ‘free medicines. However, it was also suggested to centralize information into one health center.
As a majority of participants came through youth-focused organizations, they have some access to knowledge on health services. However, they often do not ask about these services either because they do not know they can or because they feel uncomfortable asking health related questions.

Lastly, the gap of education and rights around health services (6.1) feeds young people’s dissatisfaction with the services while perpetuating the knowledge gap between professionals and young people. Lack of national laws and regulations of health services leaves it in the hands of the local private and public sector to control. This commercialization of health services widens the gap of access to quality services. It provides better health services, to those who can afford it, in the private sector. Inversely, it makes the public sector less expensive, but often services are inadequate and of low quality. This places urban young people at an even greater risk of marginalization as there are currently no protective provisions for young people in place to help them access and participate in decisions around their health.

6.4 Vision for health services
Participants continually hesitated or struggled to answer strength-based questions about vision. Vision was not only how young people thought health services and health education could be improved but also how they could participate or take ownership of these improvements. They often mentioned conventional methods of improving services by stating that more services should be provided and health professional should be young-people-friendly. Moreover, participants wanted free medicine and for government to hold health professionals accountable for their actions. This shows that the participants had difficulty in thinking objectively and critically about what they wanted. Once they did form their opinions, young people mainly addressed two areas on concern for future services, education and corruption.

Participants wanted more education on the (1) signs and symptoms of disease, (2) information on how to location health facilities, and (3) what services were offered at each location. They stated that while education is available, mainly in schools, about the prevention of disease little is offered with regard to practical health education such as detecting disease. Participants were interested in information specifically on STDs and STIs. They wanted this education to be a collaborative effort between young people and medical professionals. Young people wanted to be included because they know how to engage young people because they can
better identify with them. So they wanted to for a team of young people to be educated by doctors and be held in a forum that is easily accessed to many young people. For in-school participants this was in school and out-of-school participants suggested community fields and on the street.

Young people called on their peers to address corrupt health practices by refusing to pay bribes and prioritizing math and science subjects. They believed that if all young people unite together and refuse bribes, medical staff would no longer expect young people to pay them. This would increase the reliability of medical staff and increase young people’s attendance to these facilities. Moreover, young people view corruption as a result of a non-competitive job market. By increasing the number to young people in medical school and creating a competitive job market, fewer doctors will engage in corrupt practices for fear of losing their job.

6.5 Policy recommendations

Crucial to understanding young people’s perceptions about health services is the syncretism of modern and traditional local understanding of these services. In order for policies to be effective, young people not only need to be included in the discourse, but also policies should be formed at the junction of modern medicine and local understanding. This, coupled with the findings of this research, comprise the grounding for the following policy recommendations:

• Specific information about the regulations of health services and procedures to access them should be accessible to young people. Moreover, young people should be educated on the procedures in attending health services and included in the discourse of forming these policies.
  o Health education should include the accumulation of all health services offered in the region. Information of location and services offered by each location should be easily distilled and disseminated to and amongst young people.
  o Peer or medical professional education programs on the signs and symptoms of STDs and STIs and ways to prevent the transmissions to disease.
• Reinforce accountability of health workers and transparency of health services.
  o Specific information about the regulations of health services and procedures to access them should be accessible to young people.
Follow-up on all education programs should be included in the formation of health education policies and programs to make sure information is being understood and transmitted appropriately, especially in peer education program.

- Young people should prioritize and be encouraged to study pre-med subjects in secondary school. This would increase the number of doctors, creating a more competitive market for medical professional. Supportive educational programs should be created for those who do study pre-med in order to reduce the percentage of those who fail.
- Map and centralize information about location and services offered by health services in the area. Specific information about the regulations of health services and procedures to access them should be accessible to young people.
- Create educational policies that encourage and build young people’s capacity to think critically and practically about their vision through an open strength-based training program. Create training programs and educate about objective, independent and critical thinking before drawing conclusions about young people’s perspectives.
- Include young people in the discourse, formation and execution of health education policies and programs.
  - Support and create platforms in which young people engage with key stakeholders in health services and education where young people’s voices are not only heard, but also respected and integrated into policies and programs.

6.6 Suggestions for future research

This interpretive case study research has provided insight into urban young people’s perceptions of access to, quality and relevance of, and vision for health services and education. This research has shown that including young people’s perceptions of health services is important to consider as the formation of health services and education are strongly influenced by international donors and do not necessarily meet the wants of young people. Closing this gap by providing more education on relevant health issues will help strengthen health services and programs (Blum & Nelson-Mmari, 2004). However, this research provides an overview, and more in-depth research should be conducted in order to further understand young people’s use and decision-making processes around accessing and using health services.
This is especially the case since young people had conflicting perspectives individually and within the FGDs. Individual interviews or surveys should be used to gain more in-depth knowledge about how urban young people engage in health services. Specifically, research should go further into understanding young people’s decision-making processes to engage in health services. For example, why did many young people say that they go to Witch doctors but they prioritized hospitals instead? Additionally, research should include the motivation for accessing traditional over modern medicine and vice versa. Deeper understanding of young people’s decision-making process around accessing health care would lend insight into this specifically.

Generally urban young people were hesitant or unable to think objectively and formulate their opinion for future health services. This was especially the case for the young women out-of-school FGDs. Research should look into the current education system and assess young people’s ability to think critically prior to addressing youth agency. Moreover, informal education practices and knowledge transmission should be researched in order to better understand how to reach out-of-school young people.

With regard to education specifically, young people felt hindered by society. Even if they were provided health care information, they often were faced with adversity from family and community members. Research should address what are the specific blocks to young people’s motivation to participant and mobilization within society and how can they be overcome. Lastly, in order to gain a more holistic view of how urban young people engage in health services, the perspectives of key stakeholders, health professionals, and decision makers should be included. Both young people and decision makers should cross-share perspectives and ideas on how to include young people in their health service decisions.
“We know [this NGO] and have talked to them at some point before, but there are a lot of youth who have a lot to say – even more [informative] than what we have said here”
(female, out-of-school, MX)
Resources


Mohajer, N., & Earnest, J. (2010). Widening the aim of health promotion to include the most disadvantaged: vulnerable adolescents and the social determinants of health. *Health education research, 25*(3), 387-394. DOI: 10.1093/her/cyq016


http://www.jstor.org/stable/4132875


YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA


YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA


## APPENDIX A

### OPERATIONALIZATION TABLE

<table>
<thead>
<tr>
<th>Concept 1</th>
<th>Concept 2</th>
<th>Dimension</th>
<th>Variable</th>
<th>Indicator</th>
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<tbody>
<tr>
<td>Access</td>
<td></td>
<td>Physical</td>
<td>What resources make access available?</td>
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<td>What factors increase access?</td>
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<td></td>
<td></td>
<td>Non-physical</td>
<td>What illness renders a visit to HS?</td>
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<tr>
<td>Current Health Services</td>
<td>Access</td>
<td>Enhance</td>
<td>What do you think of HS?</td>
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<td></td>
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<td></td>
<td>What does your community think of HS?</td>
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<tr>
<td></td>
<td></td>
<td>Non-physical</td>
<td>How do you think HS providers perceive young people?</td>
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<td></td>
<td></td>
<td>Physical</td>
<td>When have you wanted to visit HS but were not able?</td>
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<td>When have you been unable to access services?</td>
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<td></td>
<td></td>
<td>Non-physical</td>
<td>When have you felt unable to access HS?</td>
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<td>How often would you like to see HS?</td>
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<td>How do you think HS providers perceive young people?</td>
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<td>Active</td>
<td>Where are HS that you use?</td>
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<td>How often do you go to HS?</td>
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<td>Why do you go and for what HS do you receive?</td>
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<td>Passive</td>
<td>Why not use HS?</td>
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<td>Current knowledge of HS</td>
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<td>What informal HS info do you use or see?</td>
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<td>Knowledge</td>
<td>What does access mean to you?</td>
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<td>How do you gain access to health services?</td>
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<td>Availability</td>
<td>Health information</td>
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<tr>
<td>Future Health Services</td>
<td>Vision</td>
<td>Enhance</td>
<td>How good are the HS?</td>
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<td>How knowledgeable are the providers of HS?</td>
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<td>How helpful are HS?</td>
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<td>Do HS apply to your medical needs?</td>
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<td>Improve</td>
<td>What HS do not exist that would be helpful to you?</td>
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<td>If you were to have a youth HS center, what would you do differently?</td>
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<td>Enhance</td>
<td>What would you add to HS to meet your needs?</td>
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<td></td>
<td>What could providers do to ensure access to HS?</td>
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</tr>
</tbody>
</table>
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

APPENDIX B

ORGANIZATION REPORTS
(Double click image to view full .pdf with all 5 organizations)

MY CITY MY VOICE
MWANZA YOUTH AND CHILDREN NETWORK: PROJECT SUMMARY

LET US SPEAK OUT: FOCUS GROUPS
The voice of urban youth on health services in Mwanza
By Signe Hawley
Translations: Violet Sasabo

The Tanzanian government recognizes that currently, health services do not meet acceptable quality standards and that services vary drastically amongst health care providers. The government identified that the inconsistency in health care services results in a lack of adolescents attending health services; increasing risk for infections and disease. The main focus on increasing adolescent receipt of health services has been on creating youth-friendly services and providing training for health care professionals. However, an effort to understand why adolescents are not attending health services and what factors influence their engagement in health services is sparse.

Focus groups were held as a part of an 8 month program My City My Voice (MCMV), which is a sub-program of the larger three year program My Rights My Voice by Oxfam. My City My Voice (MCMV) sets out to establish how urban children and youth can better engage in decision making and in enforcing accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban youth, particularly girls, think about health services. The objective is to give youth voice to young people to deepen understanding about how young people access and utilize health services, how they perceive the relevance and qualities of current services, and provide a platform for adolescents to suggest improvements to current health care systems and providers.

The participants (N=120) are young people, ages 14-25 years, who are currently participating in MWANZA YOUTH AND CHILDREN NETWORK: PROJECT SUMMARY.

MYCN PARTICIPANT PROFILE
Focus Groups:

IN-SCHOOL
1. Young women & men (mixed)
   2 females 3 males
2. Young women
   6 females

OUT-OF-SCHOOL
3. Young women & men
   3 females 3 males
4. Young women
   5 females

Total: 22 participants

Average Age (in years):

IN-SCHOOL
Mixed: Young Women: 17

OUT-OF-SCHOOL
Mixed: Young Women: 19

Top 4 most attended health services

1.0 IN-SCHOOL

2.0 OUT-OF-SCHOOL
or associated with 5 local organizations. Participants are separated into four groups each:
1. Young women in school
2. Men and women in school
3. Young women out of school
4. Men and women out of school.

Focus groups were approximately 2.5 hours long. They begin with an explanation of the project both visual and written. Second, participants will then be asked to define and list the various health services available. Individually, participants will list the health services that they use and how often they visit these services. As a group they will prioritize the top 3 health services and list the treatments that they receive from these services. Third, participants will be asked to draw a map of where these services are in relation to home and school (if applicable). Participants will state whether or not they walk or take public transport to these services. Fourth, on a flip chart, the group will list variables that enhance and constrain their access to these services. Lastly, participants will share their vision for quality health services and programs.

A total of four focus groups for the Mwanza Youth and Children Network (MYCN) were collected. Reported here are the responses.

TREATMENT and UTILISATION:
Each group was asked to prioritize health services separately. The top three priorities per group are listed at the bottom of the grey box on the right side of this page. Participants were asked to state for what purposes young people would attend their prioritized services, below are their responses listed by group.

In order to further understand how participants currently use health services, each participant was asked to give a reason why they attended one of the health services.

Q: For what reason would young people attend the health services you prioritized?

IN-SCHOOL

YOUNG WOMEN

“Most youth, because their parents, do not build the habit of going to the hospital, go to the dispensary or pharmacy. If they are not better then they go to the witch doctor to boil roots for their problem and sometimes they can die” (#40)

All services were given the number one because the group of young women in school was not able to come to a consensus on which health service should be first. However, they all agreed that the following were the top three most important to urban youth.

1. Hospital
   - Sexually transmitted diseases (STD)
   - Urinary Tract Infection (UTI)
     o “Which can turn into an STD if it goes untreated”
   - To see a specialist doctor
   - Cancer
     o “There are many young girls who have breast cancer these days”

1. Counselling
   - Family problems
   - Stress from HIV diagnosis (#39)
   - Stress from love
     o “Stress is very general, but the most serious one is love. When it comes to love, things get very serious. If you get stress from love you cannot go to the hospital because maybe they can help get medicine if you need to commit suicide so maybe these people you need to take the medicine. So counselling is the most important” (#40)

Group prioritization of most important Health Service for urban youth:

<table>
<thead>
<tr>
<th>IN-SCHOOL</th>
<th>OUT-OF-SCHOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YOUNG WOMEN</td>
<td>MIXED</td>
</tr>
<tr>
<td>1. Hospitals</td>
<td>1. Hospital</td>
</tr>
<tr>
<td>1. Counselling</td>
<td>2. Laboratory</td>
</tr>
<tr>
<td>1. Faith Centers</td>
<td>3. Dispensary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUNG WOMEN</th>
<th>MIXED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Laboratory</td>
<td>1. Hospital</td>
</tr>
<tr>
<td>2. Pharmacy</td>
<td>2. Witch Doctor</td>
</tr>
<tr>
<td>3. Hospital</td>
<td>3. Church</td>
</tr>
</tbody>
</table>
1. Faith Centers
   - Drug use or addiction
     - “Most are addicts and in order to change their behavior you need to instill the fear of God in them. If you tell them it’s against God, maybe it will instill fear in them” (#35)
   - Incurable diseases
     - “For example you are having a sleeping problem and you are treated [by the hospital]. But you are sleeping and it can be caused by demons or evil spirits so you need a priest to build them or scare them away” (#36)
   - Called to attend
     - “Most of the youth do not willingly attend faith centers. There are some cases where you are called. Maybe you are a member of a church and you are called because before you behaved good and then your behavior changes and you become a prostitute. If you are a girl they call you and say do this and do that” (#40)
   - Witch Doctors
     - “Faith centers are discovering witch doctors which have a connection with issues of faith….if the hospital fails to treat you they send you back home maybe you have a relative and they tell you to go somewhere with a poster and you get the phone number and call and you attend. Sometimes it is finished [you are cured], and sometimes it persists” (#38)
   - Coping with loss
     - “Youth may attend due to loss of his or her parents or maybe fired from their job so you attend the faith center so they will give you faith and so you don’t feel down because it’s a beautiful afterlife and God will provide you” (#40)

1. Mixed

   1. Pharmacy
      - “If you think it’s malaria you go [to the pharmacy yourself. We give it the first because it’s what most young people do” (#47)
        - Headache
        - Stomach ache
        - Fever (#47)
   2. Laboratory
      - Diarthea
      - Gonorhea (#49)
      - Pregnancy test
      - UTI (#47)
      - Cholera
      - Amoeba
      - Typhoid
      - Malaria (#50)
   3. Dispensary
      - “It’s half the cost of the hospital. In hospital they charge high…[that is why youth go to dispensaries to avoid expenses” (#49)
        - Cuts
        - Accidents

   OUT-OF-SCHOOL

   YOUNG WOMEN

   “In the normal life of the Tanzanian, if you generally don’t feel well you will rush to the lab, then go to the pharmacy and if it still persists then you rush to the hospital” (#43)

   1. Laboratory
      - Stomach aches
      - Diarthea
      - Problems seeing
      - Persistent headache
      - UTI
      - Syphilis (#42)
      - Early pregnancy
        - “Most girls attend to get the pregnancy test which is 1,000 instead of going to the hospital or pharmacy” (#43)
      - HIV/ AIDS
      - Poor sexual
   2. Pharmacy
      - Excessive stomach aches (#43)
      - Malaria
        - “Because the signs of malaria are known you go to the pharmacy” (#45)
      - Minor physical injury (#42)
   3. Hospital
      - Persistent sexually transmitted disease (#43)
      - Only in extreme cases. For example when malaria is so extreme then visit the hospital (#42)
      - Tuberculosis
      - Serious physical injuries

   "Many of the youth do not attend hospitals easily. They have to be forced by their parents, but most
of them visit witch doctors. Nowadays [the hospitals] are some sort of business. The leaders are just after money, but people are not getting cured, so it’s good for the witch doctors” (#54)

1. Hospital
   • STD’s (#56)
   • Heart Disease (#53)
   • UTI
   • Typhoid (#57)
   • Mental disturbance (#55)

2. Witch doctors
   “Most of the seminars on the street are ones on the beliefs or issues of witch doctors but not professional classes from doctors. Doctors have their own status so they don’t come into the street and talk to nobody’s. So the youth come into contact with witch doctors which is why they visit them” (#54)
   • Disease of love
   • Possessed by ancestors
   • Demons(#54)
   • Riches and making money quickly (#57, #56)

3. Church
   • Life hardships (#53)
   • Incurable diseases (#54)

ACCESS:
Understanding what inhibits young people from accessing health services is essential in understanding how they interact with health services. Two mixed groups were asked two questions, what constrains and what accelerates access to health services for young people. The young women focus groups were not asked directly, as there was a strong emphasis on vision for health services and due to time constraints challenges for access were not specifically addressed.

Q1: What constrains access to health services for young people?

IN-SCHOOL

MIXED

• Traditional Beliefs:
  “If you don’t believe in hospitals and believe in traditional medicine then they don’t go to hospital” (#49)
  “There is a difference between treatment and just faith… you go to the witch doctor and they say, ‘Bring two white hens and one egg’ using that to make you think he can treat you but he adds problems and demons to you”  (#49)
  “There are some [witch doctors] who treated for real treated… it depends on what kind of disease and which traditional healer [you go to]” (#51)

• Lack of Education
  “You don’t know the importance of HS and are not aware of the right eating of fruits and drinking water so you don’t want to attend [any health services]” (#47)

• Finances
  “For example it’s hard to get to dispensaries and people who are living are low standard people who lack the money to go to the hospital” (#unknown)

OUT-OF-SCHOOL

MIXED

• Church
  “Most churches advertise, we offer free health services’ but their main aim for treatment is so you will be a member” (#56)

• Absence of specialist
  “Most of the youth that die have a certain disease with no one in Tanzania able to help you, so you end up dying” (#57)

• Poverty
  “Health care providers make it difficult to visit. Maybe in order to get treated you have to bribe him or her” (#55)

• Transport
  “In remote areas maybe you have serious malaria and the vehicles are far and there is poor infrastructure” (#55)

The issue of transportation was brought up in other organization’s focus groups as well. When asked about rural in reference to urban young people, they said that many wards considered to be within Mwanza City are not easily accessed by transport despite being within the city limits.

• Ignorance
  “Sometimes the government allocates the heads of the council to provide education to people but instead they sit in their office quietly so the masses still do not know about health centers” (#56)

• Poor administration
  The administration is not organized in most health centers and often you have to bribe a doctor or administrator in order to receive services. Therefore, this inhibits young people from receiving services.

Q2: What would help increase access of health services to urban youth?

IN-SCHOOL

MIXED

• Education
  “Learn about the importance of health services” (#48)
“Give seminars to [educate] the youth” (#51)

- Money

“Money to build more hospitals and give doctors more money so it would be easier for them to get treatment” (#50)

OUT-OF-SCHOOL

MIXED

- Education

“The presence of advisors, people to conduct different seminars, to visit the hospital and do checkups” (#54)

- Money

“If you have enough money you will rush to the health centers. But if not, you will be forced to stay with your sickness” (#57)

“Presence offer so free health services would make it easy to attend” (#56)

RELEVANCE:

Participants were asked if overall health services meet the needs of young people. Their responses are below.

IN-SCHOOL

MIXED

“If you have money you will be treated well. But if you don’t have money you are sick on your bed until you die” (#unknown)

“Does not fill what I want because they give you first aid and you need to go to [the local government hospital] for more treatment. Dispensaries and other health services you expect to get the medicine and even if you get it maybe it is outdated [expired] so instead of getting cured you get another disease” (#47)

“As for me I get all the needs that I want when I attend” (#51)

“Sometimes some medicines are not there [and sometimes] you cannot find the specialist for a disease” (#48)

OUT-OF-SCHOOL

MIXED

“We have different needs, in the private hospitals it meets by needs but in the government hospitals, no” (#57)

“Same for me” (#53)

“The services are there but what matters is how much [money] you have” (#55)

QUALITY:

Participants were also asked what the current quality of health services is for urban young people.

IN-SCHOOL

MIXED

“Mostly low quality because most of the youth are going to pharmacy or lab [where you] can find the physicians are not well equipped in checking for those diseases. In certain labs they find you with 2-ring malaria, you go to another lab [and they find you with] 7-ring malaria. Also, there is certain doctor who treated two people instead of what they had” (#49)

“Some doctors do not use polite language…. a doctor can become angry because they need the money [meaning they accept bribes]” (#51)

“Some of the health officers are not qualified. Also in the street there are some youth who do not want to attend the dispensary. If you tell a doctor it will get back in the streets. I won’t express my issues there” (#47)

OUT-OF-SCHOOL

MIXED

“Because youth have already seen the impact of these low quality services, their views should be allocated to those who are concerned” (#53)

VISION:

Finally, participants were asked how current health services can be improved for young people and how they would like to engage within health services. Participants brought up several main topics that they would like to be educated about:

IN-SCHOOL

YOUNG WOMEN

1. Increase the number of health facilities.
2. Privacy: if more health services promoted privacy it would be easier for the youth to attend.
   a. “It’s not fair if one believes in you and tells you their problem and then you just expose it in church” (#39)
3. Treatment by nurses: Improve the language used by nurses. They use harsh and not welcoming language (#35)
   a. “It’s different, male nurses are more welcome and comfortable” (#35)
4. Education: Doctors and nurses should pay a visit to the places where youth can be found. In order to make sure they are healthy mentally, give guidance and counselling.

5. Insurance: increase the number of young people who can be insured.
   a. “I took a scan for my head but it was very expensive. I have insurance, but what about people on the street or people without insurance? If expenses were lower more people, including youth, would be able to go for further checkups” (#35)

6. Accountability and medicine supply: Head of hospital should attend meetings and be informed about what is going on in the hospital. Maybe they do not know the medicine is taken and resold in the doctors private pharmacy’s and they think the medicine is there (#36)

7. Work ethic: Promote hard working health care professionals. For example Doctors are there but they are not working the way they are supposed to work.
   a. “I was in the hospital and someone was [bleeding] in the car and the nurse said she didn’t have gloves, so she could not help. But she could have grabbed gloves and done it perfectly” (#39)

   a. “If you are a young person and you see corruption and you do not provide it to them, maybe it will die” (#39)

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OUT-OF-SCHOOL

1. Laboratories on the streets: increasing the number of labs will lower the costs.

2. More seminars on health issues on each street where street youth and children live.
   a. “Most of the girls are not well informed on issues of family planning and prevention of pregnancies….also not informed about STD’s so sometimes one has the infection but he or she does not know if they are infected” (#43)

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MIXED

1. Protest government: Youth should unite and expose the levels of corruption to the public.
   a. “In the hospitals you [should be able to] get medicines but you are directed to the pharmacy [owned by the doctor] instead” (#47)

2. Know your rights: Youth should know their right to go to the hospital and receive good health care.
   a. “If a doctor or servant of the hospital asks for money, then you give it. If you know your right, you can reject and report that [corruption]” (#49)

3. Proper self-expression: The youth should know how to express themselves appropriately in order to receive kind and appropriate medical treatment.
   a. “The doctor would be stressed working from morning, so the youth should know how to express themselves to the doctor using kind words” (#51)

b. “Most of the programs are about disadvantages. They do not focus on the impact. Seminar to educate girls and make them aware of the impact and be told to strictly abstain from sex….If not abstaining focus on the prevention of pregnancy” (#41)

c. “More specifically about STD’s….most of the youth focus on HIV/AIDS so sometimes someone contracts another disease but keeps [having sex] Because his main focus is on HIV” (#46)

d. “More education on how to spot these STD’s. Maybe she is itching and maybe has a certain discharge and instead of going to the hospital she stays with it so long…by the time they admit it to the doctors it’s too late” (#42)

3. Youth Friendly services, specifically street children friendly services.
   a. “When visiting the hospital the nurse considers your age then they throw harsh words at you…sometimes you feel like you have a disease but because you are scared you won’t visit the hospital” (#43)

4. Free health services for street children.
   a. Family planning: “Currently street children are impregnating themselves amongst themselves. [If they are educated and given health services] then they will stop involving in sexual acts and will be able to reduce the number of street children” (#43)

b. “Tablets to prevent pregnancy should be given freely. Sometimes
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

MWANZA YOUTH AND CHILDREN NETWORK: PROJECT SUMMARY

you are given knowledge but the resources are not there: (#43)

5. Team of health service educators
   a. “Create a team of nurses and doctors to visit street children wherever they are” (#42)
   b. “The youth should be responsible for educating each other on these issues and under the supervision of doctors and nurses” (#41)
   i. “They should be under supervision of a specialist on STD’s” (#41)

6. Confidentiality and privacy
   a. “More health centers for only women because they do not show because it wouldn’t be private, but if they have more with women [only] it would make it easier” (#41)

MIXED

1. Open dialogues:
   a. “There are a lot of youth who have a lot to say so maybe have open dialogues. We know MYCN and have talked at some point but out there are a lot [of youth] who have a lot to say and even better than what we have [discussed] here” (#57)

2. Reproductive health education
   a. “For girls, most of them experience the changes during puberty and are not aware. Some are crying and some think they are dying” (#47)

3. Concerts and Sports games
   a. “There are factors which can pull youth. You can call some artist in Tanzania to sing and in those song is education about HIV and AIDS. And several sports games but they aim to educate about HIV” (#49)

4. Impact of corruption: Health care providers should be informed of the negative impact of corruption. That way they will stop taking bribes and youth will get good health services (#53)

5. Seminars: Nurses and youth should meet together to educate about health services available in the area (#57)

6. Youth educate government about the challenges young people face and government should try to prevent some of the problems (#53)

Participants were then asked from whom they would like to receive information about health services. The young women in school specifically addressed counselling saying they would like people in marriage, parents or friends to counsel them. Some were in opposition to friends as counselors because they are no more wise than they are. Young women out of school wanted anyone who was educated or well informed about health services to educate them. In general out of school participants focused on the physical aspects of health. When asked which services were not health services church and witch doctor were the two most common points of discussion.

In conclusion, the purpose of this organizational report aims to inform the Mwanza Youth and Children Network (MYCN) about how their participants’ currently engage in health services and their vision for interacting within them. Providing a deeper understanding as to what young people want from their health services should encourage MYCN to advocate for programs geared towards their organizational specific needs.

Note: In order to keep confidentiality of the participants age and residence of quotations were not used throughout the report. For any further information regarding this study, please contact the author, Signe Hawley at: signe.hawley@student.uva.n
Focus groups were approximately 2.5 hours long. They began with an explanation of the project both visual and written. Second, participants were asked to define and list the various health services available. Individually, participants will list the health services that they use and how often they visit these services. As a group they prioritized the top 3 health services and list the treatments that they receive from these services. Third, participants will be asked to draw a map of where these services are in relation to home and school (if applicable). Participants will state whether or not they walk or take public transport to these services. Fourth, on a flip chart, the group will list variables that enhance and constrain their access to these services. Lastly, participants will share their vision for quality health services and programs.

A total of two focus groups for Wote Sawa, were collected. The young women group was out of school and the mixed group was in school participants. As Wote Sawa works with child domestic workers, all participants were former or current domestic workers. A large number of participants participated in the young women group as they were a part of an afternoon vocational training session implemented by Wote Sawa. In so to retain participant retention; the focus group was run with all participants split into two groups for discussion purposes. Reported here are the responses collectively as the participants were all in one session.

**TREATMENTS and UTILIZATION:**

Each group was asked to prioritize health services separately. The mixed group listed hospital, counseling and church. The young women’s group was large so the discussion was broken down into two groups. Discussed here are the two priorities that the groups had in common, hospital and laboratory. Participants were asked for what purposes young people would attend their top three priority services. Below are their responses are listed by group.

For what reason would young people attend the health services you prioritized? In order to further understand how participants currently use health services, each participant was asked to give an example of a treatment received or reason why they attended one of the health services.

**IN-SCHOOL**

- **MIXED**
  - 1. Hospital:
    - “When someone is very sick and maybe the dispensary is closed”
    - “If you need an operation to remove an appendix”
    - “Most have skin disease [due to the] use of cosmetics that young people use [to whiten their skin],”
  - 2. Counseling
    - If you are found infected with HIV you can go to the counselors in the hospital after you get checked.
    - “Demons sometime disturb you so you need to see a counselor to return to your normal condition.”
    - Life stress: “I know that love is a complicated thing that can affect you mentally, so you end up at the counselor”. Who counsels you?
    - “A doctor’s father from church”
    - “Someone with wisdom who is mentally fit”
    - “Aged elders who are aware of the different issues they should be very polite and know how to interact.”
    - “You know their wisdom by their physical appearance and their behavior, how they handle different situations”
  - 3. Church
    - “Churches offer spiritual knowledge. If you get spiritual knowledge you have wisdom and mentally you are not disturbed, you are civilized”
    - “Problem with youth they have to address the use of alcohol. They need prayers to break free of the chain of alcoholism”
    - “Chronic disease and the hospital fails so you need prayers”

**OUT-OF-SCHOOL**

- **YOUNG WOMEN**
  - 1. Hospital
    - “Back aches”
    - “Most boys suffer from pus from the penis” [gonorhea]
The Tanzanian government recognizes that currently, health services do not meet acceptable quality standards and that services vary drastically amongst health care providers. The government identified that the inconsistency in health care services results in a lack of adolescents attending health services; increasing risk for infections and disease. The main focus on increasing adolescent receipt of health services has been on creating youth-friendly services and providing training for health care professionals. However, an effort to understand why adolescents are not attending health services and what factors influence their engagement in health services is sparse.

Focus groups were held as a part of an 8 month program My City My Voice (MCMV), which is a sub-program of the larger three year program My Rights My Voice by Oxfam. My City My Voice sets out to establish how urban children and youth can better engage in decision making and in enforcing accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban youth, particularly girls, think about health services. The objective is to give voice to young people to deepen understanding about how young people access and utilize health services, how they perceive the relevance and qualities of current services, and provide a platform for adolescents to suggest improvements to current health care systems and providers.

The participants (N=120) are young people, ages 14-25 years, who are currently participating in or associated with 5 local organizations. Participants were separated into four groups each:

1. Young women in school
2. Men and women in school
3. Young women out of school
4. Men and women out of school

Top 4 most attended health services:

- Hospital: 100%
- Dispensary: 81%
- Church: 71%
- Laboratory: 62%
- Pharmacy: 52%
- Witch Doctor: 38%
- First Aid: 24%
- Clinic: 19%
- Physical Exercise: 10%

Group prioritization of most important Health Service for urban youth:

1. Hospital
2. Church
3. Witch doctors
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

WOTE SAWA: INDIVIDUAL PROJECT SUMMARY

- “If a person is injured, they can put a bandage on it and then clean the wound”
- “Checkups can be conducted to identify cause of problem and be given medicine”

For what kind of problems?
- “Stomach is swollen so they can give you a room and check you up then give you an operation”
- “If one had malaria they will be advises and given medicine and how to use the medicine”
- “If you do not have enough blood they will check you and they will give you an addition [more blood]”
- “For sexually transmitted diseases.. gonorrhea and syphilis”
- “If you over bleed during your monthly period they will give advice or medicine for that”
- “Mostly early pregnancy during delivery one has to visit the hospital. Maybe the organs are not developed enough, so an operation can be done”
- “pierced with a nail [at work, you go] in order to get better”
- “Get stomach ache get an ultra sound. Sometimes an operation or medicine”
- “HIV is a problem. So one might get test and maybe find they are positive. So they can be advised and get medicine to help raise child”
- “When someone is raped but she was shy to say it….Mostly they place a probe up you and clean you up and clean for an infection or any STD”

2. Laboratory
- “...a broken bone”
- “Malaria go to the reception they will send you to a doctor to check”
- “Some laboratories are in hospitals and some just a laboratory”
- “As far as I am concerned, labs are only for check-ups”
- “They can confirm you have a disease and maybe it’s complicated and they can send you directly to the hospital to deal with the condition”
- “In case of economic situation [lack of money] you go to the lab for a UTI”
- “If you are generally feeling bad, go to the lab to confirm”
- “Monthly period skip for a month, so to check up and see if there is any problem that caused to skip”
- “If you want a family go to lab to be counseled which way so you can start family planning with wanted pregnancy”
- “The government allows young people to get free counseling to avoid unwanted pregnancy”

RELEVANCE and QUALITY:
Participants were asked if overall health services meet the needs of young people. Numbers 1-5 signs were hung on the wall with 1 = completely dissatisfied; 2 = dissatisfied, 3 = neutral, 4 = satisfied 5 = strongly satisfied. When asked questions about whether or not the following services met their needs participants were asked to choose a side. Those who were unsure or their needs were not met were asked to stand at number 3. Both young women groups were combined to participate in this activity. The relevance of the groups’ priorities are discussed.

IN-SCHOOL

MIXED

Two participants were highly dissatisfied with the hospital services. “I want to give my own experience, my problem with my retina. The doctor said it was a disease that had never been or heard of in the world. The services were so poor it made me stop school for a year and a half. Then there was a time I got a specialist from Germany who came to Tanzania to my hospital. I asked if it was a chronic disease and it was confirmed that the problem was with the retina and I was told to be treated urgently otherwise I would be blind because I was borne for a long time without treatment. If it was early I would have had a chance of getting better so I had a big problem because of not seeing health services earlier. I am fortunate to attend the school for the blind and many people from the school are suffering from this problem. They are completely blind, but because of the German doctor I can see a little from one eye. Most of the time The hospitals say we have never seen a problem like this and there is no treatment, so the condition gets worse…. “

“I am not happy because I went for treatment early in the morning, right when the hospital opened, but treatment was later.”

One participant was disappointed with the services. “Maybe you have malaria and it is confirmed that you do not have malaria. But you are told go to a hospital and it is confirmed that you really have malaria, so I am not happy.”
Another participant was neither satisfied nor dissatisfied with services due to the inconsistency in testing. “I was told I had 2 malarias and bought medicine and drank them. But the condition got worse. I went back again to another hospital and they said I had one malaria. So I couldn’t not understand why 2 then 1 malaria”

The remaining two participants in the group were satisfied with health services.

“One day I went to the hospital. After arriving they checked me in and it was confirmed that my blood was not enough so they referred me to stay in the hospital for further observation. It took a long time to be given blood but after things got better. I was a little bit happy but the services were late”

“I am a little happy because there is a time my mom went for delivery and she nearly dies because after they received her in the hospital she was left there for a long time and nearly gave birth waiting there because they claimed someone was giving birth [since the only birth room was occupied] she had to wait. I am happy that my mom delivered safe but it took a long time”.

OUT-OF-SCHOOL YOUNG WOMEN

Two participants were very satisfied with the services. “I am satisfied with private hospitals because you pay money and they treat you well, it’s a business”. “When I visit they attend [to me] in polite and nice manner”. Five participants were generally satisfied with hospital services. “A pregnant woman who was in the hospital, it did not happen to me, but they received her well and the woman was about to give birth. They told her if you go out and do some exercises. The woman was in her last minute of birth, so she gave birth outside the hospital and instead of treating her they used harsh words. [I am standing at 4 because] they received her well… most of the people prefer witch doctors because they know how to receive you well”

This comment led to a discussion about witch doctors and their relevance to young people. The group was split with a majority of participants against witch doctors as medical professionals who meet their needs.

“I am against witch doctors because they are liars and are after hens that you bring them [for payment of services] and nothing more”

“Most witch doctors are liars after hens and goats. If you have malaria they will confirm but then they will tell you that someone has bewitched you. Maybe your mom and they cause conflicts between people. While if you were at the hospital you would get treatment”

“In my case the witch doctors are helpful. For instance you have a swell in your hospital they go and remove it [surgery]. And they grow and you have to get surgery again. But with a witch doctor they will not grow again. Today I am alive because of the witch doctor.”

“Maybe in cases where you visit the hospital you go and the medicine is still a problem [not there], so you check another option [witch doctors]”

“If you have a primitive mind you think you are bewitched. There is a type of malaria it can come back and you have to be treated [again]”

As the discussion gained intensity. Participants were reminded to respect each other’s opinions and beliefs. The conversation was then directed to continuing with the satisfaction scale.

Four participants said that they were neither happy nor disappointed with hospital services. “The receptionist do not know their role. A person is brought in really sick [they don’t know how to prioritize]. Some people die in the cue because they do not know how to bring to the doctor”. “Maybe you are really sick with a relative [there with you for support], but they chase them away. I am sick and I need someone to keep me company”.

Participants who were dissatisfied with hospital services said it was due to corruption. “For instance… the medicine is given for free but you are sick and you don’t see a doctor. Or you get medicine and then they don’t see you [for a checkup] and tell you to come back the next day”

Lastly, one participant was highly disappointed with hospital services. “I am not happy. In the government hospitals for instance you are sick but you have a long cue and the doctor will tell you to go home. When you say you are really sick, they [the doctor] says, ‘If you were really sick, you would have come in yesterday’.”

Another participant standing at number 4, satisfied with services applauded this statement. When asked why she applauded, but was standing with the satisfied participants she moved places to join the highly dissatisfied group. “My child got sick and I took her to the hospital. She was being passed over. It was in the evening and I had to go to the private hospital.”
Due to time constraints of the mixed group meeting in the late afternoon and large participant numbers in the young women group, the quality of individual health services were not able to be discussed.

**ENGAGEMENT and VISION:**

Finally, participants were asked how current health services can be improved for young people and how they would like to engage. Participants brought up several main topics that they would like to be educated about:

**IN-SCHOOL**

1. **Service location**: Young people should know where treatment can be found and where specialized hospitals are. “There is a huge gap. The doctors know but the masses are not informed.”
2. **Doctor education**: “Education should be given to the doctors themselves. If they...have never seen this problem before and they should be sent to a place [that specialized in said treatment to know more] then they should sent but [doctors] should never tell a person they cannot be treated in all the world”
3. **Be heard**: Through media, radio and television in order to educate young people on the importance of health services.
4. **Concert**: Given to educate on the importance of high quality health services and the location where they can be found so people can be aware and know the importance of health centers.

**OUT-OF-SCHOOL**

1. **Language**: Young people should be greeted by doctors and nurses with kind and sweet language.
2. **More doctors**: “More support as young people they should focus on science subjects. For example if women are kind and sweet and they will be kind to their patients.”
3. **Knowledge of available services**: “The law should be educated well so that if you do not get your medicine or rights for free you should know where to go”
4. **Passion and coursework**: “Change should begin in the heart… even if you take science you get abused by doctors then you get [to become] a doctor and you repeat the same mistakes. [There should be a] class on how to handle patients.”

Participants said that it was not easy to think of ways in which young people are able to change health services because the health professionals are in a position of power. If doctors tell you that you cannot be treated today and should return tomorrow you have to because there is no place for your voice to be heard.

Due to large participant numbers in the young women group, the mapping exercise did not complete the mapping exercise. The mapping exercise for the mixed group will be presented in the final report due to reporter’s time constraints.

In conclusion, the purpose of this organizational report aims to inform Wote Sawa about how their participants’ currently engage in health services and their vision for interacting within them. Providing a deeper understanding as to what young people want from their health services should encourage Wote Sawa to advocate for programs geared towards their organizational specific needs.
MY CITY MY VOICE

KULEANA: INDIVIDUAL PROJECT SUMMARY

LET US SPEAK OUT: FOCUS GROUPS
The voice of urban youth on health services in Mwanza

By Signe Hawley
Translations: Violet Sasabo

The Tanzanian government recognizes that currently, health services do not meet acceptable quality standards and that services vary drastically amongst health care providers. The government identified that the inconsistency in health care services results in a lack of adolescents attending health services; increasing risk for infections and disease. The main focus on increasing adolescent receipt of health services has been on creating youth-friendly services and providing training for health care professionals. However, an effort to understand why adolescents are not attending health services and what factors influence their engagement in health services is sparse.

Focus groups were held as a part of an 8 month program My City My Voice (MCMV), which is a sub-program of the larger three year program My Rights My Voice by Oxfam. My City My Voice (MCMV) sets out to establish how urban children and youth can better engage in decision making and in enforcing accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban youth, particularly girls, think about health services. The objective is to give voice to young people to deepen understanding about how young people access and utilize health services, how they perceive the relevance and qualities of current services, and provide a platform for adolescents to suggest improvements to current health care systems and providers.

The participants (N=120) are young people, ages 14-25 years, who are currently participating in or associated with 5 local organizations. Participants were separated into four groups each:

- Mixed 1
  - Young women & men (Mix 1)
  - 3 females 3 males
  - Total: 12 participants

- Mixed 2
  - Young women (Mix 2)
  - 3 females 3 males
  - Total: 12 participants

Average Age (in years):
- Mixed 1: 18
- Mixed 2: 16

Top 4 most attended health services by group:

<table>
<thead>
<tr>
<th>Health service</th>
<th>Mixed 1</th>
<th>Mixed 2</th>
</tr>
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<tbody>
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<td>Hospital</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
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<td>6</td>
<td>8</td>
</tr>
<tr>
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<td>4</td>
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Group prioritization of most important Health Service for urban youth:

1. Hospital
2. Church
3. Counselling
4. First Aid
5. Guidance
6. Physical Exercise
7. Clinic
8. Witch Doctor

MORE YOUNG PEOPLE
SHOULD STUDY MATH AND
SCIENCE BECAUSE [WITH
MORE DOCTORS] WE WOULD
HAVE COMPETITION FOR
POSITIONS. THEN, IF YOU
MESS UP YOU WILL BE FIRED

-Kuleana Participant

1 Research Master Candidate, University of Amsterdam, Graduate School of Child Development and Education

Health services attended:
- Hospital 100%
- Pharmacy 92%
- Dispensary 33%
- Laboratory 33%
- Traditional Healer 25%
- First Aid 25%
- Guidance 25%
- Religion 17%
- Physical Exercise 17%
- Clinic 8%
- Witch Doctor 8%

Group prioritization of most important Health Service for urban youth:

1. Hospital
2. Church
3. Counselling
4. First Aid
5. Guidance
6. Physical Exercise
7. Clinic
8. Witch Doctor

KULEANA PARTICIPANT PROFILE

Focus Groups In School:

IN SCHOOL

1. Young women & men (Mix 1)
   - 3 females 3 males
   - Total: 12 participants

2. Young women (Mix 2)
   - 3 females 3 males
   - Total: 12 participants

Top 4 most attended health services by group:

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Group prioritization of most important Health Service for urban youth:

1. Hospital
2. Church
3. Counselling
4. First Aid
5. Guidance
6. Physical Exercise
7. Clinic
8. Witch Doctor
1. Young women in school
2. Men and women in school
3. Young women out of school
4. Men and women out of school.

Focus groups were approximately 2.5 hours long. They begin with an explanation of the project both visual and written. Second, participants will then be asked to define and list the various health services available. Individually, participants will list the health services that they use and how often they visit these services. As a group they will prioritize the top 3 health services and list the treatments that they receive from these services. Third, participants will be asked to draw a map where these services are in relation to home and school. Lastly, participants will share their vision for quality health services and programs.

A total of two focus groups for Kuleana were collected. Both mixed groups were in-school.

TREATMENTS and UTILIZATION:

Each group was asked to prioritize health services separately. The first mixed group (mix1) listed hospital, church and counseling. The second mixed group (mix2) listed home, dispensary and hospital. Participants were asked to state for what purposes young people would attend their prioritized services. Below their responses are listed by group.

Q: For what reason would young people attend the health services you prioritized?

IN-SCHOOL

1. Hospital:
   - “Malaria”
   - urinate blood
   - diarrhea blood
   - From bad water you can vomit bad, amoeba” (#64)
   - “Malaria”
   - blood checkup
   - stomach fever” (#65)
   - “Malaria”
   - typhoid and others.
   - Small rash all over body” (#66)
   - Diabetes (#67)
   - Cholera
   - Skin plucking off
   - Legs swell
   - Sexually transmitted diseases” (#68)
   - “Chicken pox
   - HIV/Aids” (#69)

2. Church
   - Demon attacks and evil spirits. For example we have a tendency those who perform well in class or maybe there is a person who wishes you….they go to the witch doctor and they buy those spirits. Or just in class automatically you can’t see the board or you have sand in your eyes” (#64)
   - “Some go to church for salvation because they have some immoral deeds…. Like harsh words to people or abuse” (#65)
   - “Issues of witchcraft” (#64)
   - “Because demons are evil spirits they cannot be taken to hospital, they need issue related to faith to command out” (#65)

3. Counselling
   - “Most people our age are growing up or maturing and you get shocking changes [puberty] so you need someone to explain them to you” (#65)
   - “For loosing memory….made help to the people who surround you, advise relative or friend to help gain back memory. Take to places before or remind them of past things” (#68)
   - “Visit in order to have knowledge of family planning for HIV some of the youth visit for the ones with HIV so they can be advised on how to stay healthy and medicines” (#64)

MIXED?

1. Home
   - “Pain killers. Maybe the signs and symptoms are known then if you tell them [parents] they are known you tell them and they give you medicine” (#74)
   - “Headaches and wounds. Most of the time you have a wound you take a piece of cloth in hot water and you rub gently the place with the wound” (#73)

2. Dispensary
   - “Maybe your case is serious and you will be treated at the dispensary” (#73)
   - “Diabetes, Urinary tract infection (UTI)
   - “Diabetes” (#70)
   - “Malaria
   - Deep wounds which need more care or a
   - Bone break” (#72)

3. Hospital
   - “If there is a strong fever for a long time you must go to the hospital” (#74)
   - “Operation,
   - X-ray or
UTILISE:

In order to further understand how participants currently use health services, each participant was asked to give a reason why they attended one of the health services. The utilization of services was specifically addressed in Mix1 and indirectly stated in Mix2. Therefore, they are stated here for the first group only.

IN-SCHOOL

MIXED1

Hospital

- “Most of the youth now-a-days, they are modern in a modern world so [it is] not easy to run to church or guidance and counselling so hospitals are the first option” (#67)
- “Most of the youth in Tanzania do not know knowledge on guidance and counselling so hospitals are first option” (#68)
- “Most of the youth have a negative attitude towards pastors because they have the fake pastor. They are there and you pay for your offering but they have their own needs [meaning they take money for personal benefit] so much rush to the hospital instead of church” (#64)
- “Because most youth believe in hospital we have deadly HIV/AIDS. First you need to know you have to visit the hospital” (#64)

Counselling

- “Because there are some problems not solved in hospital or church if you get someone to talk to you, you will be fine” (#65)
- “Because most of the people who guide can easily solve your problem. [For example], my mother is the first person I turn to because where I am now, my mom has been” (#68)

Church/Mosque

- “Maybe for those cigarettes your lung got infected, you cannot be taken to the dispensary so you need an x-ray, go to the hospital” (#75)
- “Ultra sound” (#73)

IN-SCHOOL

MIXED1

- “If health services provided education on preventative means and cure of certain diseases” (#64)
- “Enough medicine and treated well and incase of one not understanding they should be directed” (#66)
- “Doctors and nurses should use polite language and stop nepotism because they know a certain person” (#65)
- “On the issue of segregation, people make a long cue from morning but maybe if the doctor senses someone is rich then he gets treated first, others are left. Sometimes the medicine that is supposed to be free, they are sold outside of the hospital” (#64)

Q: Do current health services meet your needs as a young person?

MIXED2

- “Not in the fullest because there was a time I injured my eye and they could not attend [to my injury properly] and then I had to go to another hospital” (#74)
- “Do not meet my needs because you go to a certain hospital and you stay for a long time and by chance you know the doctor or nurse is when you will be treated first” (#70)
- “Health services do not meet the needs of the
population. More patients very populated. One dispensary you have to stay in a cue for a long time. The Doctor and nurses are not proportionate to the number of people” (#73)

- “Services do not meet my needs because of corruption. If there is a cue and someone is very sick, the one who is less sick will get treated first” (#72)
- “Most government hospitals you find the nurses making stories all day long and patients are segregated on financial status” (#73)
- “I can’t speak because I never get sick that often. The last time I was sick was in 2010” (#75)

VISION:

Finally, participants were asked how current health services can be improved for young people and how they would like to engage. Participants brought up several main topics that they would like to be educated about:

IN-SCHOOL

MIXED²

1. Education: They should aim at increasing the number of counselors and number of doctors and nurses and focus on issues of family matters. And tell youth 15 and above on how to stay away from disease. (#64)
2. Governments should build a hospital on each and every street (#67)
3. Add people who clean the hospital because they are very dirty and if you attend you end up getting sick.
4. Government accountability: Young people should speak to people in authority or in governments [to make sure there is] enough medicine in hospitals (#66)
5. The quality of clinics and dispensaries should be equal to the hospital because if hospitals are far they can provide treatment which will reduce the death rate. (#64)
6. Government established institution to train counsellors and center to receive counselling (#68)

MIXED²

1. Knowledge transmission: provide a platform for young people who attend trainings by organizations to share the knowledge that they learned (#74)
   a. Youth Trainers: Get youth together and educate them, and have them educate others (#70)
   b. Supervision: There needs to be continual education about the trainings and follow up to make sure the information is being communicated properly (#70)
2. STD: Information about the cause, means of transmission and cure for all sexually transmitted diseases (#74)
3. Sustainable knowledge: If seminars are provided they should also have a practical side of education. For example a seminar about cholera said it was a disease due to an unclean environment. However, there was no motivation in the seminar or information about how to clean (#74)
4. More HIV education: Information provided not only to those with HIV but to others on how to live with HIV. Some people still believe if you shake hands with someone with HIV you can get it.
5. Young people should give priority to certain subjects. Currently we have few doctors because [most young people fail their] studies. More should study [math and science] because then we would have competition. If you mess up [as a doctor or nurse] then you will be out [fired].³

Participants were then asked from whom they would like to receive information about health services. For counseling participants said almost anyone can council you but it depends on how close they are to you. Some people said they would like their parents to council while others would prefer professionals. For information relating to disease the group preferred doctors or certified professionals first because the hospitals are the right place to be educated (#64). Then information should be disseminated to the society, parents and grandparents.

In conclusion, the purpose of this organizational report aims to inform Kuleana about how their participants’ currently engage in health services and their vision for interacting within them. Providing a deeper understanding as to what young people want from their health services should encourage Kuleana to advocate for programs geared towards their organizational specific needs.
The Tanzanian government recognizes that currently, health services do not meet acceptable quality standards and that services vary drastically amongst health care providers. The Tanzanian government identified that the inconsistency in health care services results in a lack of adolescents attending health services; increasing risk for infections and disease. The main focus on increasing adolescent receipt of health services has been on creating youth-friendly services and providing training for health care professionals. However, an effort to understand why adolescents are not attending health services and what factors influence their engagement in health services is sparse.

Focus groups were held as a part of an 8 month program My Rights My Voice (MCMV) sets out to establish how urban children and youth can better engage in decision making and enforce accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban youth, particularly girls, think about health services. The objective is to give voice to young people to deepen understanding about how young people access and utilize health services, how they perceive the relevance and qualities of current services, and provide a platform for adolescents to suggest improvements to current health care systems and providers.

The participants (N=75) are young people, ages 14-25 years, who are currently participating in or associated with 5 local organizations. Each organization was asked to split participants into four groups, with 6 participants in each group:

1. Young women in school
2. Men and women in school
3. Young women out of school
4. Young girls in school
5. Young girls out of school
6. Men in school
7. Men out of school

The top 4 most attended health services were:
1. Hospital
2. First Aid
3. Church
4. Counselors

Regardless of religion, all young people go to witch doctors. It's just taboo by society so no one says it. - Wadada Participant, mixed.

Health services attended:
- Hospital: 100%
- First Aid: 67%
- Church: 50%
- Counselors: 42%
- Personal Hygiene: 33%
- Traditional Healer: 17%
- Dr. with Fruits: 9%

Group prioritization of most important Health Service for urban youth:
1. Hospital
2. Church
3. Witch doctors

1 Research Master Candidate, University of Amsterdam, Graduate School of Child Development and Education
2 http://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

4. Men and women out of school.
Focus groups were approximately 2.5 hours long each. They began with an explanation of the project both visual and written. Second, participants were asked to define and list the various health services available. Individually, participants listed the health services that they currently use and how often they visit these services in a year. As a group they prioritized the top 3 health services and listed the treatments that they receive from these services. A summary of these statistics for Wadada are on the right column, first page. Third, participants were asked to draw a map of where these services are in relation to home and school (if applicable). Participants stated whether or not they walk or take public transport to these services. These findings will be presented in the final report. Fourth, on a flip chart, the group listed variables that enhance and constrain their access to these services. Lastly, participants shared their vision for quality health services and programs.

A total of two focus groups, both in school were collect: YW and Mix. Out of school groups were cancelled. Participants arrived at the same time, so to retain participant retention; the focus groups were run simultaneously.

**TREATMENTS:**

Each group was asked to prioritize health services separately, showing the top three health services they deem as most important to young people in Mwanza. The mixed group listed hospital, church and witch doctors as priorities. The young women’s group listed ways to prevent illness such as personal hygiene and hand washing. Due to large group size and time constraints the mixed group priorities were adapted for both groups as all participants in the young women’s group agreed to the priorities. Participants were asked to state for what purposes young people would attend their top three priority services. Below their responses are listed by group.

Q: For what reason would young people attend the health services you prioritized?

<table>
<thead>
<tr>
<th>IN-SCHOOL</th>
<th>MIXED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Sexual transmitted diseases</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>HIV/AIDS</td>
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</tbody>
</table>

**YOUNG WOMEN**

- Malaria
- Counseling
  - Ex. How to prevent malaria, no stagnant water and keep grass short.
- Mental disturbances
  - “Some people who don’t believe fall into the night pub and involve themselves in issues not wanted by society”
  - Get rid of poverty
  - “Poverty hinders one from affording balanced diet or paying for medical needs”

<table>
<thead>
<tr>
<th>IN-SCHOOL</th>
<th>MIXED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possessed by demons go to church for prayers</td>
<td></td>
</tr>
<tr>
<td>Advice on family conflict</td>
<td></td>
</tr>
<tr>
<td>To be free from peer pressure</td>
<td></td>
</tr>
<tr>
<td>“Some people who believe they are so powerful so maybe they give you a charm that protects you against evil attacks or against people that do not wish you well.”</td>
<td></td>
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</tbody>
</table>

**IN-SCHOOL**

<table>
<thead>
<tr>
<th>YOUNG WOMEN</th>
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</thead>
<tbody>
<tr>
<td>Business is not going well go to the church to feel well</td>
</tr>
<tr>
<td>“You won’t have income to afford medical treatment or diet”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MIXED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Untreatable diseases</td>
</tr>
<tr>
<td>“Some people have disease that cannot be treated from the hospital, the spiritual kind”</td>
</tr>
<tr>
<td>Less expensive</td>
</tr>
<tr>
<td>“Instead of going to the hospital [which is expensive], they rush to the witch doctor”</td>
</tr>
</tbody>
</table>

**YOUNG WOMEN**

- Mental disturbances
  - “Issues with mental disturbances to get rid of such problem you ask, ‘who did this to my daughter?’ in order to get revenge”
- Poverty
  - “Some people believe the witch doctor will help them get money through medicines”
The frequency of attending health services was not recorded individually for this focus group.

**UTILISE:**

In order to further understand how participants currently use health services, each participant was asked to give an example of a treatment received or reason why they attended one of the health services. Health services are ordered by the group priorities first, then by the services with the most responses.

1. Hospital:

**IN-SCHOOL: YOUNG WOMEN**

- “I had a stomach ache and diarrhea and went to this hospital and was treated” When asked what it was for the participant responded “It is a bit private”
- “Malaria, I went to the hospital, got medicine and now I am better”

**MIXED**
- “Stomach aches was rushed (to the hospital) and later it was confirmed it was due to my monthly period”

2. Church:

**IN-SCHOOL: YOUNG WOMEN**

- “I had demons disturbing me and would go crazy. They administered prayers and I was cured” When asked how it affected her health she responded, “I would lose consciousness and faint”
- “My dad left the family so I went to church and they helped me with school fees” When asked how this affected her health she replied, “It just brought stress”

**MIXED**
- “Because of family conflict and personal problems that brought stress”

3. Witch Doctors

- “Due to a problem in our family… thief in the family it happened that someone broke the case where they put money. So we went to see who it was…[this affected my health because] when the witch doctor came to the house… my throat hurt and affected me physically. Then after the visit to the witch doctor sickness increased in the family therefore, the problem was not solved. We also went for skin problems help but later problem increased so the witch doctor did not help”

4. Counseling

**MIXED**
- “I was told by a doctor that I had a very big problem [disease] and was told that it cannot be treated in county so I became stressed and decided to get counseling”
- “After the death of my Dad, I was having visions of him appearing and I would find myself talking to him. I went to the man of God [Priest] to be counseled and now I am okay”

5. First Aid

**MIXED**
- “Snake bite so my brother administered first aid to me and later rushed to the hospital.” The first aid was in reference to her brother “tying the cut to prevent blood from flowing”
- “Yesterday because of my ankle in playing football. They administered medicine for the muscles and later boiled water to put on it an elevated it”

**ACCESS:**

Understanding what inhibits young people from accessing health services is essential in understanding how they interact with health services. Collectively, both groups were asked to list factors that inhibit their access to health services.

**IN-SCHOOL: YOUNG WOMEN & MIXED**

Poverty:

Leads to failure for one to afford medical expenses.

Religion:

“If a Muslim has demons but cannot go to the Christian religions. Therefore, he still keeps the demons. [This affects health because] some spirits which prohibit taking kinds of food or making people to faint for a long time which means they are not eating”

Fear:

“For instance on has a broken leg – might be scared of services which take an organ off [in hospital] and in a lot of pain. It might take shorter, and a low price [inexpensive], to go to a witch doctor”

“Scared to share their problem, because of lack of privacy, so
instead of sharing they keep it inside”
Cultural taboos:
“In society which prevent the eating of some things – which can affect diet”
“For example we have a tribe where pregnant women cannot visit the hospital because they practice female genital mutilation (FGM) and they do not like to be exposed, so they have midwives”
Ignorance:
“For instance one has malaria, and it’s just seen that it is malaria, they rush to the witch doctor but in the end death can occur”
“Poor tools and services in the hospital one might think “it’s okay to remain as I am because if I go I will not be treated” ”
Education:
“One is bitten by a snake lack of education on first aid, person can die”
Hatred:
“Between two people there is a misunderstanding, but one person has the answer to help but won’t because they hate me…. [the hatred can also] be among a person and a doctor”
Selfishness:
“If a person is selfish but it’s the only person to solve the problem then the problem will remain”
Additionally, understanding what factors young people think will enable them to access health services were addressed. The following priorities were mentioned:
Cost:
“For instance with the witch doctors services are cheap. If you administered you have to stay over for treatment sleeping there, there is no payment…. If you are administered in a hospital you have to pay 15,000 TSH per day”
“It is very cheap in case of witch doctor cost 2,000 TSH but hospital 15-20,000 TSH”
Infrastructure:
“In towns they have good infrastructure such as roads it is easy but in villages the road are not made and it takes a long time to visit the hospital”
Education:
“If one is educated it is easy to support a certain problem and rush to the hospital. If not educated [you] stay sick for a long time or turn to wrong solutions such as a witch doctor”
High Quality:
“High quality services for example in case of private and government hospitals, the private are the best and quick, easy services”
“Modern equipment makes it easy for one to visit the hospital because one might run to the hospital because they have modern equipment!”
Faith:
“If one believes in hospitals, if he or she falls sick they will go directly to the hospital”
RELEVANCE:
Participants were asked if overall health services meet the needs of young people. Two signs were hung on the wall “Ndlo (Yes)” and “Hapana (No)”. When asked questions regarding the relevance of services, participants were asked to choose a side. Those who were unsure were asked to stand in the middle. Both groups combined to participate in this activity. The relevance of the groups’ priorities are discussed.
1. Hospital
Eight participants said that the hospital met their needs while three participants said that they did not. Hospitals are “expensive and in the government hospitals there is no medicine”. Also mentioned was that there was a “long cue while you are sick” and while “the private hospitals are of high quality they are very expensive”. Participants whose needs were met mentioned that when they attended the hospital they received treatment. No specific examples were given.
2. Church
Seven participants said that their needs were met and four participants stood in the middle. None said that their needs were not met. Participants who said their needs were met mentioned that “the words of God build you up if you need anything God hears you”. “Church is everything for my spiritual health. For prayers or counseling by leaders or to get money if in need”. Lasty, a participant stated that they go “because I need prayers”. Prior to being asked about whether church meets the needs of the participants it was asked if overall health services meet their needs. One participant responded, that health services “did not meet my needs. If someone gets raped, you do not need prayers for you, you need a hospital”. Despite the fact that no participants said that their needs were not met by the church it is relevant to include this response.
Half of the participants who stood in the middle said that they never
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

WADADA: INDIVIDUAL PROJECT SUMMARY

attended church for health services or that they do not use churches, “but I do not say no because some people believe and maybe it can help them”. Another participant brings up the issue of confidentiality. “When I go for advice they [the priest] tells me to bring my parents which is why I went alone [to begin with].”

3. Witch Doctor

Two participants said that their needs were met. “In 2001, I was leaving Ukerewe, and there was an outbreak of disease widely spread and I did not get sick”. The second participant responded that visiting the witch doctors with herbs “meet my needs because [medicine] from the hospital contains toxins which can be harmful to your body. So if you go to the witch doctor you will use medicine that will not harm your body. In the other case of visiting witch doctors based on faith, on the issue of [someone] bewitching you, you cannot go to the counselor because maybe to get back at them you want to have their leg swell so you give back revenge”.

The remaining nine participants said that their needs were not met in attending to witch doctors. Participants said that witch doctors were strictly against their faith which others said that they were after money. “The witch doctors are after money so it’s not the issue that they have the powers, they are also after money”. The “witch doctor standard of bringing a hen or goat so you are broke and not healed instead of [going to the] hospital which is quick, easy and cheap”. “Witch doctors [sometimes] instruct to get the nails of a lion. It is not easy to get so they are completely lies and just after money”. One participant who said their needs were met responded, “regardless of religion all young people go to witch doctors it’s just taboo by society so no one says it.”

VISION:

Finally, participants were asked how current health services can be improved for urban young people. Participants brought up three main topics that they would like to be educated about:

1. The different types of diseases and the preventative measures
2. What food young women should eat during pregnancy to prevent mental illness in their child
3. Address why the government says witchcraft is illegal, but still provided permits to people to practice. “The witch doctors contribute a lot in the increase of death of young people.”

Participants were then asked how they would like to receive this information. They said that they would trust “doctors more because they have a wide scope of understanding on health issues”. Others said that “anyone provided he or she had been trained”. For clarification their response was rephrased, so only people who are certified can conduct health trainings? Participants responded unanimously with “Ndio [Yes]”. “Even if parents have understanding it is okay then I can trust them”. Others stated that “parents or teachers can have knowledge but it won’t go as well as trained professionals”. The group was split between only wanting health professionals for trainings and those who said it did not matter so not [long?] as the person had knowledge about health services.

Overall participants understood the scope of the project and were actively participating throughout the focus group. Generally, it was more difficult for participants to think of ways urban young people can aid in the improvement of health services. It was easier to think of constraints [constraints?] compared to solutions. In conclusion, the purpose of this organizational report aims to inform Wadada about how their participants currently engage in health services and their vision for interacting within them. Providing a deeper understanding as to what young people want from their health services should encourage Wadada to advocate for programs geared towards their organizational specific needs.

Note: In order to keep confidentiality of the participants age and residence of quotations were not used throughout the report. For any further information regarding this study, please contact the author, Signe Hawley at: signe.hawley@student.uva.nl
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

LET US SPEAK OUT: FOCUS GROUPS
The voice of urban youth on health services in Mwanza
By Signe Hawley1
Translations: Violet Sasabo

The Tanzanian government recognizes that currently, health services do not meet acceptable quality standards and that services vary drastically amongst health care providers2. The government identified that the inconsistency in health care services results in a lack of adolescents attending health services; increasing risk for infections and disease. The main focus on increasing adolescent receipt of health services has been on creating youth-friendly services and providing training for health care professionals. However, an effort to understand why adolescents are not attending health services and what factors influence their engagement in health services is sparse.

Focus groups were held as a part of an 8 month program My City My Voice (MCMV), which is a sub-program of the larger three year program My Rights My Voice by Oxfam. My City My Voice (MCMV) sets out to establish how urban children and youth can better engage in decision making and enforce accountability of duty bearers so as to secure their rights. One aim of the program is to build understanding of what urban youth, particularly girls, think about health services. The objective is to give voice to young people to deepen understanding of how young people access and utilize health services, how they perceive the relevance and qualities of current services, and provide a platform for adolescents to suggest improvements.

HAKI ZETU
PARTICIPANT PROFILE

Focus Groups:
OUT-OF-SCHOOL
1. Young women (YW)
   6 females
Total: 6 participants

Average Age (in years):
Young Women: 19

Top 4 most attended health services

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Young Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>100%</td>
</tr>
<tr>
<td>Dispensary</td>
<td>100%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>100%</td>
</tr>
<tr>
<td>First Aid</td>
<td>50%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>17%</td>
</tr>
<tr>
<td>Doctor using fruits</td>
<td>17%</td>
</tr>
</tbody>
</table>

Group prioritisation of most important Health Service for urban youth:
1. Dispensary
2. Pharmacy
3. Hospital

1 Research Master Candidate, University of Amsterdam, Graduate School of Child Development and Education
improvements to current health care systems and providers.

The participants (N=76) are young people, ages 14-25 years, who are currently participating in or associated with 5 local organizations. Each organization was asked to split participants into four groups, with 6 participants in each group:

1. Young women in school
2. Men and women in school
3. Young women out of school
4. Men and women out of school.

Focus groups were approximately 2.5 hours long each. They began with an explanation of the project both visual and written. Second, participants were asked to define and list the various health services available. Individually, participants listed the health services that they currently use and how often they visit these services in a year. As a group they prioritized the top 3 health services and listed the treatments that they receive from these services. A summary of these statistics for Haki Zetu are on the right hand page. Third, participants were asked to draw a map of where these services are in relation to home and school (if applicable). Participants stated whether or not they walk or take public transport to these services. These findings will be presented in the final report. Fourth, on a flip chart, the group listed variables that enhance and constrain their access to these services. Lastly, participants shared their vision for quality health services and programs.

One focus group was selected by Haki Zetu as they work primarily with out of school young women within the Mwanza City region. They have other groups that are out of the scope of this project.

TREATMENTS:

The group was asked to prioritize health services separately, showing the top three health services they deem as most important to young people in Mwanza. The young women group listed dispensary, pharmacy and hospital as their priorities. Participants were asked to state for what purposes young people would attend their top three priority services. Below their responses listed.

Q: For what reason would young people attend the health services you prioritized?

1. Dispensary
   - “STD’s mainly gonorrhea and syphilis… mostly the boys [have both diseases]” (#61)
   - Malaria
   - Diarrhea
   - Amoeba
   - “Most complication for girls is the STD’s” (#61)

   “The dispensary is cheap. For example at [the government hospital] you have to pay money so they give you a file before seeing the doctor. Then at the doctor checkup instead of giving you medicine for free they send you out to the pharmacy to get the medicine. In the hospitals they keep on telling you to wait here [in one room. Then they] make you go around and around [to different rooms] and in the end you are not treated. In a dispensary you don’t have to line up. You explain how you feel and they tell you the medicine you are supposed to have.” (#61)

2. Pharmacy
   - Headache
   - Stomach ache
   - Coughing
   - Fever (#59)
   - Amoeba(#58)
   - Typhoid(#60)
   - “Quick service. You say the medicine and they are available.”

3. Hospital
   - Malaria or very high fever
   - HIV/Aids
     o For guidance and counselling
   - Tuberculosis
   - Swollen legs
   - Cancer
   - Diabetes

   “[You go to a hospital instead of the dispensary or pharmacy] because the nature of these diseases are complex and sometimes the dispensary they refer you back to the hospital” (#59)

ACCESS:

Understanding what inhibits young people from accessing health services is essential in understanding how they interact with health services. The group was asked to list factors that enhance or inhibit their success to health services. It was difficult for the participants to understand the content of the question and what was being asked. There were long bouts of silence and participants were then asked the question about enhances or constrains in four different ways by the translator after which the focus group moved on to the next topic.

1. What makes it challenging to access these health services?

Beliefs:

“Presence of traditional beliefs. Most of the youth go to witch doctors” (#58)

The participant was then asked if most youth go to witch doctors
YOUNG PEOPLE’S PERCEPTIONS ON HEALTH SERVICES AND EDUCATION: MWANZA

HAKI ZETU: INDIVIDUAL PROJECT SUMMARY

why were they not on the list of priorities. Their response was because none of them go to the witch doctor, but they know many young people do.

Money:
“Because if you have enough then you will be treated for services”

What are things that make it difficult to access health services?

Segregation
“Segregation of drivers of motor bike who are known for causing accidents so they are taken to the hospital and being abused by the nurses instead of getting treatment. They get bad words, but not all drivers are bad drivers” (#59)

“The issue of street children. Most are taken to the hospital with certain problem but nurses do not get much attention. They are from the street so they get into trouble. It’s their normal behavior so no one will mind” (#61)

2. What makes it easy to access health services?

“Quick services and if the nurses were nicer” (#61)

“If corruption not there it would be easy for people to get the service,” (#63)

“Availability of enough medicine” (#60)

RELEVANCE:

Participants were asked if overall health services meet the needs of young people. When asked questions regarding the relevance of services, participants were asked to state either ‘yes’ or ‘no’. Each participant was asked to give an explanation. Answers are listed below:

“No, services did not meet my needs. For example my mom was hospitalized and taken in for the night. Until morning nothing happened...[The doctors said] you don’t have what we need so give us the money then we will treat [your mother]. So he [my father] had to give money. If there was no money my mom would have died” (#61)

“...completely do not meet my needs. For example I had to take my child to the hospital...I explained the problem. They listened but in the end they told me they did not have the medicine but the medicine was supposed to be free. The doctors have pharmacies outside the hospital so [the medicine] is sold outside” (#58)

“Do not meet my needs because I went to the dispensary and was checked, I had malaria. They gave me only pain meds and the rest I had to buy outside [at a private pharmacy]” (#60)

“Services do not meet my needs. For instance [at the local government hospital] after reaching there you pay 5,000 TSH for the file at reception. After I was directed into a room where the doctor asked for money for a checkup. I had 5,000 TSH left over but it was not enough. They wrote off what I should take this and this but I was not checked. So I used the other money at the pharmacy [to buy my medicine]” (#63)

“Most government hospitals you visit in the morning and nothing has happened [by the evening] and they send you home” (#62)

QUALITY:

“Most girls get pregnant at a very tender age. You go maybe it’s your time for delivery and the nurses throw harsh words at you for example ‘It was out of your own pleasure and ‘do not disturb us’ so that is very low quality [health services]’” (#61)

“Most of the youth, for example girls, if they are pregnant you are considered immoral and manner less. So the nurse attends to you as if you are from the street you are not raised well which is why you are there.” (#63)

VISION:
Finally, participants were asked how current health services can be improved for urban young people. Participants came up with one answer as to how young people can change health services in the future.

Corruption:
“Fight corruption. If for instance you visit the hospital once you pay him or her you should refuse and we have the institution dealing with corruption, you should go and report. Currently there are people who were responsible to check the pharmacy. They should check where the medicine is coming from and if it comes from the hospital they should be stopped” (#61)

Overall participants had difficulty understanding the scope of the project and there was little active participation throughout the focus group. Momma Cuneuganda, founder of Haki Zetu, said this was due to the fact that one class of young women had graduated the program two weeks before and this was a new class. Generally, it was more difficult for participants to think of ways urban young people can aid in the improvement of health services. It was easier to think of constraints compared to solutions. In conclusion, the purpose of this organizational report aims to
inform Haki Zetu about how their participants’ currently engage in health services and their vision for interacting within them. Providing a deeper understanding as to what young people want from their health services should encourage Haki Zetu to advocate for programs geared towards their organizational specific needs.

Note: In order to keep confidentiality of the participants age and residence of quotations were not used throughout the report. For any further information regarding this study, please contact the author, Signe Hawley at: signe.hawley@student.uva.nl
APPENDIX C

CODING SCHEME

Definition:
HS - Health services (HS)
WD - Witch doctor, traditional healer
H - Hospital (H)
C - Church / prayers

A. Access
   a. Access
   b. Easy
   c. Difficult
   d. Frequency
   e. Treatments

B. Quality and relevance
   a. Relevance
   b. Needs met
   c. Needs not met
   d. Quality
   e. High
      i. Private
   f. Low
      i. Public, government

C. Vision
   a. Priorities
      i. Individual
      ii. Group
   b. Vision
   c. Young people change
   d. How young people change (HYP)
D.1 Photo of Tanzania on the continent of Africa and location of research location.

D.2 Detailed photo of Tanzania.
Photo source:http://img.photobucket.com/albums/v678/rationalpassion/map-africa-tanzania.gif