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Research Report 08.5

Negotiating Safe Sex among Young Women:

The Fight against HIV/AIDS in Tanzania

John R.M. Philemon
Severine S.A. Kessy

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Table of Contents

List of Tables

Abbreviations

AI	Amnesty International
AIDS	Acquired Immune-Deficiency Syndrome
ART	Antiretroviral Therapy
BC	Before Christ
CBO	Community Based Organisations
FBO	Faith-Based Organizations
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
NGOs	Non Governmental Organisations
PMTCT	Prevention of Mother-to-Child Transmission
SPSS	Statistical Package for Social Sciences
SRSE	Sexual Risks Scale - Expectations to Resist Unsafe Sex
SSA	Sub Saharan Africa
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TGNP	Tanzania Gender Networking Programme
TV	Television
UK	United Kingdom
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USA	United States of America
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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Abstract

The study intended to assess how female youth negotiate safe sex in order to fight against the scourge of the HIV/AIDS pandemic. It focused on the empowerment of women and sought to explain how empowered young women are able to freely engage in their reproductive and productive affairs. The study looked into factors that influence the vulnerability and strength of women in sexual affairs.

Focus group discussions, questionnaires and interviews were used to collect data from the field using young researchers. The rationale behind the use of young researchers was to enhance the quality of research, generate an objective wealth of knowledge and empower the youth to be able to identify and delineate their own problems and find appropriate and relevant solutions.

Findings of this study revealed that female youths do not have strong negotiating powers. They are not empowered in all spheres of life, that is economically and socially and their limited knowledge, skills and formal education do not make it easy for them to have a say over their bodies and sexual relationships.

The study makes various recommendations to empower female youths to make better decisions and choices on safer sex. This could be achieved through campaigns and sensitization on sexually transmitted diseases in order to educate female youths on the existing risk of early sexual practices. Parents need to be encouraged to provide counselling to their daughters instead of leaving this vital responsibility to their peers, the media and teachers.

Suggested keywords:
Tanzania, HIV/AIDS, sexual behaviour, sexually transmitted diseases, STDs, sexually transmitted infections, STIs, sexual risk, negotiating safe sex, condom use, sexual risk scale, youth, adolescent, women

1 Introduction and Background Information

Acquired Immune Deficiency Syndrome (AIDS) is a major public health issue in most regions of the world. It is a disease defined by symptoms that are caused by Human Immunodeficiency Virus (HIV). HIV produces a defect in the body's immune system by nvading and then multiplying within white blood cells. Stevenson (1993) argues that the lack of an effective treatment for AIDS and the fact that HIV is a retrovirus, that is, once in the body it is there for life, have played a large part in the construction of AIDS as an impending pandemic. However, it is important to note that HIV/AIDS can only be transmitted from one person to another if infected blood, semen or vaginal secretions enter the bloodstream of another person. Practically, HIV is spread by sexual contact, needle sharing, blood, blood products, or organ donation.

According to the United Nations Program on HIV/AIDS[1], 39.4 million people currently live with the HIV/AIDS. Statistics have shown that the numbers of people living with HIV have continued to rise[2]. This could be triggered by population growth and, more recently, by the life prolonging effects of antiretroviral therapy. Quoting UNICEF, Sithole (2000) noted that:

> *"every minute six people under the age of 24 are infected with the AIDS virus and many young people in the worst hit countries do not know they are at risk".*

This was also divulged in the UNAIDS (2006) report on the global AIDS epidemic that this group is highly vulnerable and exposed to HIV/AIDS. In Sub-Saharan Africa (SSA), a region with the largest burden of the AIDS epidemic, research findings also indicate that the HIV incidence rate has peaked in most countries.

Quite disheartening findings reveal that more than half of the HIV/AIDS infected people worldwide are female. This is evidenced by the new survey data which underscore the disproportionate impact of the AIDS epidemic on women, especially in Sub-Saharan Africa (SSA), where, on average, three women are HIV infected for every two men (ibid). This condition has become even worse in SSA where the number of infected women is higher than the number of infected women in developed countries. This was mainly attributed to their economic status as Keene (2001) argues that women's lower status in many African societies is one of the main factors in the spread of HIV. Stereotypical gender roles place young women, and to an extent young men, at heightened risk of HIV infections[3]. Young women in many parts of the developing world have little control over how, when and where sex takes place[4].

1.1 Research Problem

Gender inequality and disempowerment of women and girls have contributed significantly to the rampant spread of HIV. While a lot of effort, time and money have been spent on researching for an HIV/AIDS vaccination, cure and preventive interventions, Ramdas (2004) argues that most policy makers have still failed to address one of the most significant causes for the continued devastation wreaked by this disease, and to discern the deep patterns of systemic and intense discrimination against women. Women's lack of voice and the lack of real choices in their lives because of entrenched gender inequality and inequity have escalated the

1 UNAIDS, 2004
2 UNAIDS, 2006
3 Kim and Aggleton, 1999
4 Gupta et al, 1996

epidemic. Statistics show that among young people (15 to 24 years old), the ratio widens considerably to three young women for every young man[5]. This corroborates Annan's (2004) statement that empowering women and girls must be a top priority if the fight against HIV and AIDS is to be won. The fight is of particular concern in countries where women are still legally and economically subservient to men. The lack of women's equality - from poverty and stunted education to rape and denial of women's inheritance and property rights - are major obstacles to victory over the virus[6].

It is the thesis of this study that women's status, and their ability to protect themselves from infection, is largely determined by their access to education, employment, and political representation. Because women have less control than men over their sexual behaviours, the power dynamics between men and women represent an important but neglected aspect of HIV/AIDS prevention[7].

1.2 Significance of the Study

This study is important because of the alarming prevalence of HIV/AIDS in most districts in Tanzania. Three districts were chosen for this study because of their characteristic features regarding HIV/AIDS. These districts are Rungwe, Temeke and Njombe. Rungwe District in the Mbeya region was chosen because the region, according to WHO (2004), has a high prevalence of HIV. Additionally, Rungwe can be categorised as semi-urban district and therefore attracts many activities that can increase the risk of HIV infections. In a strongly patriarchal society such as Rungwe's, the understanding of the effect that a power imbalance may contribute to the HIV prevalence, necessitated this study.

Given its nature and location, Temeke District was considered to be one of the districts in the Dar es Salaam region with a high proportion of its population with a low literacy level. Given this level of literacy, it was thought that the respondents in this district would provide information on the vulnerability and strength of women in sexual relationships and affairs. Njombe district in the Iringa region was also selected because it lies at the junction of the Mbeya and Ruvuma regions. Njombe is an active and strategic district for many business activities. Its level of commercialization and networking expose the district residents to HIV/AIDS infections. Information from this district provides a clue to other active, but less researched districts in Tanzania.

The findings of the study are expected to help policy makers, medical workers and other stakeholders take a complementary approach to the HIV/AIDS prevention drive by focusing on, and trying to bring equity to, the female-male power relations. The young women, aged between 15-24, should also benefit from the study findings. The findings will be communicated to the young women in the language they understand (Kiswahili) through village based seminars and by identifying coping strategies and it should empower them to respond appropriately to the social and economic pressures encountered.

[5] UNAIDS, 2006
[6] UNAIDS, 2004
[7] Mays & Cochran, 1988 and O'Leary & Jemmott, 1995

1.3 Research Objectives

The main objective of the study was to assess the gender power relations in negotiating safe sex in HIV /AIDS prevention. Specific objectives:

i. Examine power relations among the female youths in the three districts;

ii. Examine factors leading to a higher prevalence of HIV/AIDS among the female youth in the three districts;

iii. Examine educational opportunities for females in the districts;

iv. Examine female youths' powers and decision making regarding condom use, and

v. Examine the female youths' powers and decision making regarding abstinence.

1.4 Research Questions

i. What are the power relations among the female youth in the three districts?

ii. What factors are driving the higher prevalence of AIDS among the female youth in the districts?

iii. To what extent are educational opportunities used to empower young women in their fight against HIV/AIDS?

iv. In which way is the power of female youth used to make decisions in condom use?

v. In which way is the power of female youth used to make decisions in abstinence?

2 Literature Review

2.1 Gender Dimension and HIV/AIDS Prevalence

Several researchers have concluded that gender-based factors such as a woman's interpersonal connections, traditional social norms, sexual roles, race and socioeconomic vulnerability affect her ability to engage in HIV-related self-protective behaviours[8]. In most, if not all societies, the socioeconomic relations between women and men are largely unequal and hierarchical. Our focus on women reflects the need to "*strengthen women and to redress imbalances in the power relations between women and men"* (Richters, 1994). Gender refers to the rules, norms, customs and practices through which biological differences between the males and females are transformed into social differences reinforced by relations of power. As a result, women/girls and men/boys are valued differently and have unequal opportunities and life chances[9]. It also includes the power relations that define how and why these activities are performed. Gender does not mean 'sex'. Genes and biology determine sex, but a gender perspective recognizes the socially defined, sexually differentiated roles and power relationships between women and men in a society[10].

Although gender roles vary widely across cultures, the power relations that tend to place males in positions of power and privilege over women seem to be similar. Expectations of gender behaviour come from the idea that certain qualities, and therefore certain roles, are 'natural' for men while others are 'natural' for women. It is crucial at this point to understand some important observations on gender as reported during the seminar on Gender Issues in Development Policies held in Vienna from 9th -11th March 2003. In this seminar, the following gender descriptions were observed:

- The concept of gender does not focus on women or men but on the relations between both of them;
- Gender is a social product not a biological fact;
- Gender is an important element of human identity and refers to many aspects of life;
- Differences about gender must be considered;
- Gender is something very dynamic;
- Gender relations are power relations, and
- Gender is an important element of development.

There are many reasons why HIV/AIDS intervention programs need to be gender based. First, there is a need to address the unequal gender relations that drive the epidemic. Second, it is the vulnerability of women to become infected. Third is the fact that women suffer more discrimination than men do, and fourth is the fact that women bear the burden of AIDS care (Mpuntsha, 2003). Wilson (1993) and Durana (1994) also assert that women bear the heaviest burden of AIDS care and it is therefore pertinent among the stakeholders to take into account gender dimensions in their interventions.

[8] Amaro, 1995; Amaro, Raj and Reed, 2001; Felmlee, 1994; Gomez & Marín, 1996; Heise and Elias, 1995
[9] UNAIDS, 2005
[10] Crawford and Maracek, 1989; Balmer 1994; Cook, 1994

While both men and women are affected by HIV/AIDS, women are at higher risk, given that gender relations configure with sexual behaviour and economic security[11]. The authors argue that if interventions around HIV/AIDS are to be effective, they must address the factors that drive the epidemic. These factors are deep seated and intransigent/inflexible, embedded in the very power relations that define male and female roles, both in intimate relations and the wider society.

The biggest factor leading to vulnerability to HIV is adverse socio-economic circumstances[12]. In addition, there are more profound biological and social-cultural factors that have been presumed to exacerbate the HIV/AIDS spread among women in general and female youth in particular. These biological and social-cultural facts are detailed in the following sections.

2.2 Biological Vulnerability of Female Youth

Biologically, the risk of infection during unprotected sex is two to four times higher for women than men[13]. Female youth are even more vulnerable because their reproductive tracts are still maturing; tears in the tissue allow easy access to infection[14]. Two thirds of newly infected youths aged 15-19 in sub-Saharan Africa are female. Among women, the peak age for HIV prevalence tends to be around age 25, 10 to 15 years younger than the peak age for men[15].

2.3 Economical Vulnerability of Female Youth

Women in many regions do not own property or have access to financial resources and are dependent on men - husbands, fathers, brothers and sons - for support[16]. This situation causes women in susceptible environments to be abused of power. For example, power differentials and differences in social norms regarding girls and women affect young women's ability to control sexual situations, thus making them vulnerable to gender-based violence and coerced sex. Financial or material dependence on men means that women cannot control when, with whom and in what circumstances they have sexual intercourse with men. Many women have to exchange sex for material favours for daily survival. Women who are economically marginalised are often only able to support themselves and their children by exchanging money for sex[17].

[11] Baylies and Bujra, 2000
[12] Keene, 2001
[13] Royce et al, 1997
[14] Best, 2000
[15] de Silva, 2003 UNAIDS, 2004
[16] UNAIDS, 2004
[17] AL-USA, 2000

Women have few or no marketable skills and viable employment opportunities, which forces them into exploitative situations that increase their risk of infection. The associated dependency on a man may also make it more difficult for women to leave an abusive relationship where they have little or no say in sexual matters. The high price of condoms both in real terms and in relative terms is considered to be a barrier to safe sex in Africa. With a very small per capita income, as is the case in most sub-Saharan countries, money spent on condoms is money not spent on food or other necessities[18] .

2.4 Social and Cultural Vulnerability of Young Women

Women in Sub-Saharan Africa face many socio-economic constraints that compromise their health. These constraints have two major causes: lack of quality education (which leads to socio-economic vulnerability), and a culture that places excessive social expectations on the shoulders of women[19]. Culturally, femininity promotes innocence and virginity, which promotes ignorance on reproductive and sexual matters. This prevents women from seeking and accessing information and services about their reproductive health[20].

Another social dimension, which explains the vulnerability of female youth to the HIV/AIDS pandemic in most African countries, is that while boys and young men are expected to discuss their sexuality, women are not. Furthermore, men are not only allowed, but even encouraged, to seek multiple sex partners[21]. Caldwell (2006) claims that most Africans believe that men are programmed for sex, making it acceptable for men to be involved in polygamous relationships.

Extra challenges for HIV prevention arise from traditional expectations that men should take risks, have frequent sexual intercourse (often with more than one partner) and exercise authority over women. Among other things, these expectations encourage men to force sex on unwilling partners, to reject condom use and the search for safety as 'unmanly', and to view, for instance, drug-injecting as a risk worth taking[22].

2.5 Limited Education

Importance of education is central in this study and thus deserves a separate section of discussion. Limited education heightens the risks for women, undermining their self-confidence, status, and ability to find employment and other opportunities. Keeping children in school makes them less vulnerable to exploitation and abuse. Women who do not receive any formal education find themselves in a *"situation of land scarcity and with few opportunities for employment outside of the agricultural sector"*[23]. The illiteracy of the majority of women limits their chances of having access to information and quality health services. According to the Tanzania Gender Network Programme (TGNP) website, women and girls access to education and training is constrained by existing socio-cultural norms and values, while their right to property is limited by patriarchal ideologies[24].

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[18] Philipson & Posner, 1995
[19] Keene, 2001
[20] Mpuntsha, 2003
[21] AI-USA, 2000
[22] UNIFEM, 2001
[23] Klepp et al,1994
[24] http://www.tgnp.org/0gbi_intro.htm, retrieved on 2003, November 10th

Reduced access to education, information, and knowledge mean that women are often poorly informed about health issues, about how their bodies function, and how to protect themselves from diseases. They are therefore also disadvantaged in their ability to recognize and act on signs and symptoms of illness[25]. Poverty of education creates a vicious circle of myth and misinformation that perpetuates health damaging behaviours and harmful practices[26]. There are multiple benefits derived from girls' education; increased family incomes, reduced risk of HIV infection, reduced infant and maternal mortality rates, healthier children and families and greater opportunities and life choices for women[27].

2.6 Safe Sex and the ABC of Sex

Social and economic factors compound the biological factors and increase young women's vulnerability to infection. These factors force young women to engage in sex with older men, who, for a variety of reasons, may insist on unprotected sex[28]. What then is safe sex and what is not, are questions that have been disturbing many people for a long time. In fact, the definition of safe sex depends on who is asking the question and who is providing the answers. The American Heritage Dictionary of the English Language (2000) defines safe sex as a sexual activity in which safeguards, such as the use of a condom and the avoidance of high-risk acts, are employed to reduce the chance of acquiring or spreading a sexually transmitted disease. However, this brings the problem of how safe is the condom use? To emphasise that the probability of acquiring or spreading a sexually transmitted disease is merely reduced and not eliminated when following recommended safeguards, some advocate the use of the term safer sex instead of safe sex. In order of effectiveness, not withstanding the wrongly alleged impracticality of some of the methods, the following methods have been used to promote and enhance safe sex: premarital abstinence, mutual faithfulness, condom use.

2.7 Pre-marital Abstinence

There have been varied definitions of what abstinence is and is not, however, for the purpose of this study, abstinence is defined as: the act of not having sexual intercourse until marriage, regardless of whether or not one currently has a partner[29]. Abstinence means refraining from sexual contact of any sort, including genital intercourse, oral sex, anal sex, dry sex, mutual masturbation, or any other physically intimate activity done for the purpose of sexual gratification.

Pre-marital abstinence is an absolute answer to preventing STDs, although it is not always practical or desirable. Bishops from the United States of America affirmed in their 1987 statement: abstinence outside of marriage and fidelity within marriage as well as the avoidance of intravenous drug abuse are the only morally correct and medically sure ways to prevent the spread of AIDS.

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[25] Manderson, 1994 and Vlassoff, 1994
[26] Hammad, 1994
[27] Walker, 2003
[28] Chinake et. al. 2002
[29] Marindo et. al. 2003

2.8 Mutual Faithfulness

Being mutually faithful refers to having sexual intercourse with only one partner, preferably a spouse. The idea of reserving sexual relations for married couples, or remaining faithful to one partner, has become old-fashioned. Many Faith-Based Organizations (FBO) do not find this in line with their faith teachings. The position taken by most of these organizations is based on the belief that sex is the beauty of lifelong fidelity, the freedom of sexual purity and the delight of sexual discovery with one and only one partner. Long-term mutual monogamy (faithfulness) eliminates risks unless one partner is already infected. This also limits the number in a given group who became infected[30].

2.9 Condom Use

A condom is a prophylactic that is used to prevent pregnancy and to prevent the spread of some sexually transmitted diseases (STDs), from one partner to another. The oldest illustration of a condom was found in Egypt and it has been speculated that around 1,000 BC the ancient Egyptians used a linen sheath for protection against disease. Some time later the Romans were said to have been making condoms from the muscle tissue of warriors they defeated in battle[31]. Condoms have been used to protect against sexually transmitted infection since the sixteenth century and to prevent unwanted pregnancy since the eighteenth century[32].

The use of condoms have featured in ethical discussions, arguments and counter arguments for a long time. The arguments for or against condom use as a safe sex instrument revolve around the morality of its use, effectiveness, alleged association with increased sexual activity among adolescents and its correct and consistent use or lack of both.

The Catholic Bishops of South Africa, Botswana and Swaziland have argued that there are many reasons to believe that the widespread and indiscriminate promotion of condoms is an immoral and misguided weapon in our battle against HIV/AIDS. The use of condoms, they argue, goes against human dignity: It changes the beautiful act of love into a selfish search for pleasure - while rejecting responsibility[33]. Another argument made against condom use is that talking about condoms or giving people condoms will make them sexually promiscuous[34] .

Theoretically, if the condom, especially the male condoms that are more widespread, were used consistently and correctly, it should be effective against pregnancy 97% of the time. Most reports of condom failure are the result of inconsistent or incorrect use, not breakage[35]. Religious arguments aside, it has been found that the use of condoms is less effective because people do not always use them properly. When used correctly and consistently, condoms are about 90% effective in preventing HIV transmission[36]. Hearst and Chen (2004) noted that no goodevidence exists to prove that condoms are the most effective method to curb the spread of AIDS in most societies. Therefore, the actual effectiveness among users is only between 80% and 90%. This difference is due to the occasional rupture of a condom during intercourse, spillage of semen from a condom during withdrawal, delayed placement of a condom on the penis, rupture due to manufacturing defects, and failure to use a condom during each act of intercourse.

[30] McIlhaney, 2004
[31] Hall, 2000
[32] Himes, 1963
[33] A Message of Hope (2001)
[34] Hartigan, 1997
[35] Macaluso et al., 1999
[36] Hearst and Chen, 2004

Empirical Evidence:
2.10 Prevalence of HIV/AIDS

In SSA, the main mode of HIV transmission is heterosexual transmission[37]. In SSA, the conditions are exacerbated by the fact that the frequency of non-marital sex in Africa appears to be very high by international standards[38]. There are on average 13 infected women to every 10 infected men[39]. The trend is on the increase. Among young adults aged 19 to 24, the ratio is five or six to one in the worst affected countries.

A 2002 UNICEF study in Ethiopia, Malawi, Tanzania, Zambia, and Zimbabwe, found that there were five to six 15-19 year-old girls infected with AIDS for every boy in that age group[40]. The researcher argues that the high rate of infection among 15-19 year-old girls also reflects women's powerlessness within and outside of marriage to control the terms of sexual contact. HIV/AIDS infections from male to female are found to be between two and four times the infections from female to male[41]. An early study found that the rate of male to female transmission of HIV is 12 times more likely than female to male transmission[42]. The rates are disturbingly different, but what is common is that they all show high rates of infections from male to female.

Doyal (1994) gives an explanation for the higher rate of infections from male to female as being the higher concentrations of HIV in semen than in vaginal fluid. A second concern is a larger area of exposed female tissue than male genital surface area. Thirdly, there is the greater permeability of the mucous membrane of the vagina compared to those of the penis. The last reason for the higher prevalence of male -female infections is the longer period of exposure of semen within the vaginal tract. To further consolidate the point, do Prado (1994) and Pesce (1994) argue that anatomically, with unprotected intercourse, women are the depositories of seminal fluids, hence making it easy for them to be infected. Moreover, because of their childbearing role (involving pregnancies, abortions, and births), women run a significant risk of receiving blood transfusions and other blood products that, without adequate blood-screening procedures, may be contaminated with HIV[43].

Conclusively, compounding their biological vulnerability, women often have a lower status in society at large and in sexual relations in particular. This gender vulnerability, again, is *"particularly acute for young girls"* (UNAIDS, 2000).

[37] Fitzpatrick etal, 2004
[38] Caldwell et al, 1989; Philipson and Posner, 1995
[39] Ross, 2004
[40] Burkhalter, 2003
[41] Mantell et al., 1988; Rodin and Ickovics, 1990; UNDP, 1992 and Adeokun, 1994
[42] Padian et al, 1990
[43] Pesce, 1994

2.11 HIV/AIDS in Tanzania

A number of related studies have been carried out in the country in an attempt to identify root causes of the high prevalence of HIV/AIDS among the youth. Mhoja (2005) states that marital rape and forced marriages among young female children whose ages range between 10 and 17 years is rampant in Arusha, Mara, Morogoro and the Shinyanga regions. The practices, the researcher noted, are a precursor to the rampant HIV/AIDS prevalence among young women in the four regions studied.

Klepp, et al (1994) carried out a study targeting public primary schools in the Arusha and Kilimanjaro regions. The study used an evaluation method in which a quasi-experimental, nested cross-sectional design including baseline and six month follow up surveys was adopted. The schools were stratified according to locations which were randomly assigned to intervention. The results were that the intervention pupils scored significantly higher on AIDS information, AIDS communication, and AIDS knowledge, attitudes towards people with AIDS, subjective norms and intention. The study revealed no attitude change towards sexual intercourse.

Jacqueline (1999) takes debate on sexual rights as a starting point, questioning whether adolescents and adolescent girls in particular, are able to control and express their sexuality upon self-chosen terms. The study was conducted in Dar es Salaam in 1997 to investigate how adolescent sexuality is constructed and organized. The researcher concluded in his study, by applying a gender-power analysis, how control over sexuality is gendered in such a way that it gives girls less control than boys over their sexuality.

Kessy (1995) undertook a population-based study in the Moshi rural district, Kilimanjaro region, during March through June 1995, to determine the prevalence and risk factors for infection with HIV/AIDS and other Sexually Transmitted Diseases (STDs), among youth aged 15-24 years. Among other findings, the study revealed that knowledge on preventive measures of female youth was generally low. Findings show that high risk behaviours among youth in a rural setting were associated with HIV/STDs, females being more at risk than males. There is, therefore, an urgent need to target interventions towards behavioural change among the female youth to reduce the rate of transmission of these diseases.

3 Research Methodology

This chapter focuses on the methods and instruments used to collect and analyse data collected from the field. It starts by describing the population of our study, sampling plan and frame. Sample units, size and data collection instruments are also discussed. The chapter concludes by discussing the approaches to data collection and analysis of data.

3.1 Population

This study focused on the female youths from various villages and wards in three districts of Temeke in Dar es Salaam, Rungwe in Mbeya and Njombe in Iringa. The term female youth is used to refer to the young women aged between 15 and 24 years old. The choice of the age group was informed by the research findings that sexually transmitted infections (STI's) including HIV are most common among young people aged 15-24. In some countries, up to 60% of all new HIV infections occur among 15-24 year olds[44] .

Rungwe is one of the 8 districts of Mbeya region, the district covers a land area of 2,211 sq. km. According to the 2002 Tanzania National Census, the population of the Rungwe District was 307,270. Ninety percent (90%) of the district's population are engaged in livestock keeping and smallholder farming. Cash and food crops grown in the districts are coffee, tea, pyrethrum, cocoa, maize, paddy, banana, beans etc.

Njombe is one of the 7 districts of Iringa region, the district covers an area of 10,200 sq. km. According to the 2002 Tanzania National Census, the population of Njombe District was 420,348, making it one of the most populous districts in the region. The main economic activity of people of Njombe is farming of both cash and food crops.

Temeke District is the southern-most of the three districts in Dar es Salaam, the district covers an area of 786.5 sq. km. The 2002 Tanzania National Census reports that the population of Temeke District is 768,451. The main economic activities include manufacturing industries, services, wholesale and retail trade and smallholder farming.

[44] Kim and Aggleton, 1999

3.2 Sampling Plan and Frame

The sample frame for this study was generated from the ward/village executive officers (WEO and VEO) and from the secondary and primary schools in the districts. To enhance the representativeness of the sample selected, the respondents for the study were randomly selected from the sampling frame. The sample units in this study were the female youth of the indicated age range. To avoid limitations, this study involved 250 individual respondents for the survey questionnaires and 101 discussants were involved in 12 focus group discussions. The number of discussants involved in each focus group discussion (FGD) ranged from between 6 and 12. The distribution of individual respondents for the survey was Temeke (102), Rungwe (76) and Njombe (72). The sample size of Temeke is higher than the other two districts because of its population size[45]. The level of interactions and economic activities in Temeke district is also higher compared to the other two districts.

3.3 Data Collection Instrument

For the quantitative part of the study, questionnaires were self-administered to sampled young women to collect data. The qualitative methodology and the data collection technique used were focus group discussions[46] with a previously drafted and pre-tested guide. The focus group technique included group meetings in which a moderator led the discussion. One male researcher and a female assistant researcher were involved in each FGD, one was a moderator and the other acted as a recorder. The discussions were recorded in writing and on audio cassettes with the participants' consent. The questionnaire mainly focused on the sexual risks scale (the expectations to resist unsafe sex), self-efficacy for negotiating condom use, attitudes towards abstinence, and general information that related to safe sex practices and education. The other FGDs focused on general knowledge on sex and safe sex, behavioural risks, and dating and going out with new people experiences. Nature and patterns of sexual negotiation, sex in coercive situations, use of 'protection', worries when having sex with a new person and refusing to have sex were also issues that were explored by the FGDs checklist.

3.4 Data Sources

Both primary and secondary data were used for our study. The purpose of this study, primary data was collected through survey and FGDs with the young women. Secondary data, on the other hand, was obtained through reviewing various documents from government departments, university libraries, public and private institutions. In addition to the above data sources, shorter follow-up sessions were conducted wherever necessary to clear up confusion about the facts and to verify perceptions and interpretations. Notes were taken during and after the interviews and focus group discussions. The main objective of the unstructured part of the interviews and FGDs[47] was to let the informants talk about themselves, in their own words, which is consistent with the principles of grounded theory[48].

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[45] According to the population census of 2002, Temeke had 768,451 people, Njombe had 419,115 and Rungwe had 306,380 people (National Bureau of Statistics Tanzania: http://www.nbs.go.tz/indicators.htm)

[46] Denzin and Lincoln, 1994; Ulin et al, 2002

[47] Mc Cracken, 1998

[48] Glaser and Strauss, 1967

3.5 Approaches to Data Collection

Given the nature of this study, the main focus was the involvement of young researchers in various stages of executing the research. Two young research assistants were recruited to carry out various activities in this study. We proposed two young research assistants because they were more comfortable in collecting data from their peers who were respondents of this study. Research assistants were trained on the following:

- The relevance and importance of the research on youth;
- Confidence building in various stages of executing research;
- Data collection, interviewing skills, how to conduct focus group discussion, and
- Report writing skills.

Apart from facilitating the execution of research, the training helped to build capacity among the young researchers to carry out researches related to their daily challenges and problems. It is the researchers' belief, therefore, that the use of young researchers helped to improve the quality of this research and enhanced young people's participation in the study.

3.6 Data Analysis

Data collected from FGD was analysed through deduction, organising and finally condensing them in order to draw a conclusion. This was achieved through writing a joint report from individual FGD reports. The results were then placed in an appropriate category of survey results for more emphasis on findings collected by questionnaires. The conclusion drawing and verification helped in determining the meaning of data collected. The data collected through the questionnaires was edited, coded and entered into the SPSS computer package for further data analysis. In this particular study, frequency tables and cross tabulations were used to summarise the information collected.

4 Research Findings and Observations

4.1 Introduction

This section presents the findings obtained from the field. The first part of the section provides demographic profiles of the respondents. The second part focuses on power relations regarding female and male's sexual relationships, and factors driving the higher prevalence of HIV/AIDS among female youth. The third part focuses on the relationship between power and decision making regarding condom use, abstinence, sexual experience and coercion encountered in sex. The fourth dwells on number of sexual partners, behavioural expectations to resist unsafe sex among young females. The last part of the section detailed the conclusion and recommendations for this study.

4.2 Demographic Profiles of the Respondents

The age group of the respondents ranged between 15 years and 24 years. Out of these female youths, 74% were aged between 15-19 years whereas the rest (26%) were aged between 20-24 years. Over 92% of the respondents had attained ordinary level education or less during the survey. Only 3% were form six leavers and 1.4% had gone beyond post-secondary school education. It should, however, be noted that most respondents (85.3%) who had not gone beyond O-levels in education explained that given another chance they would like to continue with studies. They stated reasons for their failure to advance their studies as being death of parents and parents' inability to pay for further studies. Eleven percent of respondents explained that they would not like to further their education due to advanced age, family and business responsibilities and the expectation of getting married.

Almost all respondents except 7.6% were not married. It was further revealed that 1.3 % were separated, while 0.4% were divorced. This was an interesting finding as previous researches in Tanzania have shown that most girls drop out from schools and get married early. The findings are, however, indicating that even those who were not in school were not married. Eighty five percent of the respondents had no child, whereas 11% had one child, 3.2% had two and 0.5% had three children. In terms of respondents' occupations, the findings revealed that the majority (68.3%) of the respondents were students whereas the rest were either business women (13%), employed (6.9%), peasant (5.7%), or engaged in other non-business activities such as tailoring, embroidery etc. Findings through observations revealed that most of respondents engaged in these petty activities earned a very small amount of money. Additionally, through FGDs, the respondents affirmed that the income obtained from these activities is not enough to cover daily expenses. In this regard, some admitted that when given Tshs. 500 they would accept unsafe sex.

4.3 Factors Leading to High Prevalence of HIV/AIDS among Female Youth

Despite the acknowledged consequences of engaging in unsafe sex or just sex for that matter, most respondents noted that pressures of life force them to be involved in sex. The pressure then makes seemingly innocent female youth engage in the acts which stoke the spread of HIV/AIDS, sexually transmitted diseases and pregnancies.

Household poverty and generally harsh living conditions make it easy for the young girls to be easily tempted. *"With just 500/= a girl can be enticed to have sex with a man much older than her own father,"* a discussant retorted. Some discussants, however, noted that poverty should not be the excuse for someone to engage in sex at very young age as there are girls from rich families who engage in sex but not for money needs. Conversely, there are female youth from very poor families who exercise great self control. Peer pressure was also mentioned as being the reason for the early initiation into sex for girls. As parents find it is hard to discuss sexual matters with their daughters, relatively older friends feed the youth false information that pushes them into early sex.

There are girls who attain puberty at a very young age and with wrong messages and information received, they end up responding to the hormonal drives with no self control. Equally noted during discussion was the diverse range of magazines, radio and TV programmes and pornographic video tapes which are used as vehicles to transmit incorrect information and messages to the uninitiated young girls. Video shows in makeshift buildings attract uninformed minds to pornographic images that portray nudity and all sorts of immoral behaviour.

4.4 Female Youths' Knowledge on HIV/AIDS

Presented here is the evaluation of the female youths' knowledge regarding various issues surrounding HIV/AIDS and other STDs, identification of HIV/AIDS victims, VCT (Voluntary Counselling and Testing), factors forcing female youth not to go for HIV/AIDS testing, protection against HIV/AIDS and female youth understanding of safe sex.

Asked about their knowledge of sexually transmitted diseases (STDs), 88.4% responded in the affirmative that they understood what sexually transmitted diseases are. On further probing, those who did not mention HIV/AIDS as one of the sexually transmitted diseases, 89% claimed to know what HIV/AIDS is. Regarding their knowledge of HIV/AIDS, respondents seemed to inadequately explain what HIV/AIDS is all about. Notably, 12% stated that they did not know what HIV/AIDS is all about.

Table 4.1 Knowledge of Sexually Transmitted Diseases (STDs)

Responses	Frequency	Percent
Yes	221	88.4
No	25	10.0
No response	4	1.6
Total	**250**	**100.0**

Source: Field research findings (2006)

Over 56.9% of the respondents claimed they could identify someone infected with HIV. The results show that 43.1%, however, claimed they cannot identify someone who is an HIV victim, because someone could be looking healthy and seemingly strong, whereas he/she is infected. Of all the respondents, only 3.5% stated that they had contracted STD's and among them, 82% received treatment from hospital, whereas 18% received treatment from a pharmacy. None of these had ever received treatment from traditional healers.

4.5 Factors Forcing Female Youth Not to Go for HIV Testing

Out of 250 respondents, 26.5% had gone for HIV/testing whereas the rest (73.5%) have never tested their HIV status. The reasons given for not having tested for HIV were varied. Most respondents claimed that they were confident that they were not infected because they had had no sex before and they did not have sexual partners as yet. They also admitted that the fear and anxiety of the whole HIV testing experience was a limiting factor for testing. Other reasons mentioned were the claims that VCT centres do not allow girls below 16 years to go for testing, lack of pre-testing and the post-testing counselling and fear of receiving positive HIV test results. This was also noted by one respondent that, *"When diagnosed positive I may commit suicide or die of blood pressure."* Others noted proper and consistent use of condoms, lack of time, non-readiness, lack of parental permission and trust on the partner or spouse as reasons for not going for HIV/AIDS testing.

On whether they are able to convince their sexual partners to go for HIV/AIDS testing, most girls noted that it is hard, especially when they are already in love. Most times, girls tend to believe that their friends are safe. One discussant noted that normally a potential sex partner would secretly go for HIV/AIDS testing and when found negative would come back and tell the partner to go for the test. There were few males who did this and they are those whose partners would not budge and agree to have sex until they established their partners' HIV status.

4.6 Protection against STDs and HIV/AIDS

Results on whether the respondents use any protection against sexually transmitted diseases revealed that 62% of respondents use protection against STDs and HIV/AIDS and the rest (38%) did not use any form of protection. 38% may seem an alarming percentage, but through information garnered using focus group discussion, it was revealed that some respondents did not seem to consider abstinence as one of the methods of HIV/AIDS prevention. Deducing from their responses as to how they protect themselves against HIV/AIDS, 62% mentioned abstinence, 22% condom use and only 16% said that mutual faithfulness was the method they mostly use.

4.7 Relationship of Power and Decision Making Regarding Condom Use

The self-efficacy for negotiating condom use scale[49] was used to assess female youth negotiation for condom use. The results show that 43.1% of respondents could ask new partners to use a condom. Respondents of the same percentage pointed out that they would refuse to have sex when a condom is not available. Only 37.6% indicated that they strongly agreed with the statement that they can ask partners who had not been using condoms before, to start using them during sex. 29.8% reported that they would get their partners to have sex using condoms even when they are drunk.

"Being faithful is the best protection, condom use is mere business". This sentiment was shared by the majority of the discussants during focus group discussions. Almost all discussants claimed that they don't believe that condoms fully prevent HIV/AIDS infection. Their reasoning was that if they do, then only for a small percentage. The discussant noted that whereas the campaign for condom use has been on for quite a while, there is no corresponding decline in the new HIV/AIDS infections. Table 4.2 details the results on self-efficacy for negotiating condom use

[49] Barkley and Burns (2000)

Table 4.2: Self-efficacy for Negotiating Condom Use

Statements	Disagree %	Neutral %	Agree %
I can ask a new partner to use condoms.	17.0	4.0	79.0
I can ask a partner I have not been using condoms with to start using them.	22.4	4.9	72.7
I can refuse sex when I do not have a condom available.	28.0	4.9	67.1
I can get a partner to use condoms; even if I am drunk or high	23.6	11.6	64.8
I can get every partner to use male condoms, even if they do not want to.	21.2	10.6	68.2

One discussant from Makandana Village (Rungwe) claimed that she believed that condoms prevent HIV/AIDS infections by 10% only. Some discussants noted that a girl could not force a partner with money to use a condom if he does not want to use it. The majority of the discussants noted that it is hard to start using a condom with a partner with whom you have been having sex all along without using a condom. To the contrary, it was revealed that most sex partners start their love affairs using condoms and eventually abandon using them even before going for HIV/AIDS testing. In most case it is the male partner who would suggest abandoning the use of condoms.

On the question of girls carrying a condom in their handbags, discussants stated that it would be difficult for them to carry condoms as their boy friends would wrongly perceive them as being prostitutes. Girls also fear being found by their parents having condoms in their possession. Relatively mature discussants, who were living independently, explained that it is possible to carry a condom just in case of an unplanned sexual encounter with a boyfriend.

4.8 Relationship of Power and Decision Making Regarding Abstinence

Most of the information on abstinence was garnered during focus group discussions. The majority of the discussants, especially those in schools, noted that it is possible to abstain from sex till marriage. Discussants noted that one can succeed in abstaining by resisting temptations, resisting peer pressure, having a very tight timetable with no idle time to think about men and sex, and by avoiding intimate friendship with males. Others noted that it is important for girls to have self-respect and value their precious lives. The majority of the school going girls were strong advocates of abstinence. The out-of-school girls were of the opinion that it is impossible to abstain, but one needed to be faithful and always use a condom.

Findings generated by using questionnaires regarding abstinence are shown in table 4.3. The majority stated that they believe that abstaining is the best option or method in the fight against the spread of HIV/AIDS. As demonstrated elsewhere, however, they cite so many explanations that are considered (at least according to them) beyond what they can do.

Table 4.3: Attitudes towards Abstinence

Statements	Disagree %	Neutral %	Agree %
It is important for me not to have sexual intercourse before I get married.	14.4	4.2	81.4
Having sexual intercourse should be viewed as just a normal and expected part of teenage dating relationships.	74.3	5.2	20.5
It is against my values for me to have sexual intercourse while I am an unmarried teenager.	14.7	2.3	83.0
A teen who has had sexual intercourse outside of marriage would be better off to stop having sexual intercourse and wait until marriage.	8.5	2.0	89.5
Teens who have been dating the same person for a long time should be willing to go along and have sexual intercourse if their partner wants to.	71.3	7.5	21.2
The risk of AIDS and other sexually transmitted diseases is reason enough for teenagers to avoid sexual intercourse before they are married.	21.5	2.0	76.5
It is all right for teenagers to have sexual intercourse before they are married if they are in love.	81.7	4.9	13.4
Having sexual intercourse is something only married couples should do.	17.1	4.5	78.4
Even if I am physically mature, that does not mean I am ready to have sex.	23.6	2	74.4
I think it is OK for females my age to have sex.	81	3.7	15.3
People who do not want to have sexual intercourse should have the right to say "NO."	12.3	2.4	85.3
My sexual values and beliefs agree with those of my parent(s).	32.6	5.3	62.1

4.9 Sexual Experience and Coercion into Sex Encounters

Regarding sexual practices, the majority of the respondents (68.5%) stated that they had had no sexual intercourse in their lives. The remaining 31.5% had had sexual experience. Out of the 250 respondents, those who have been forced into having sex (some not successful) were 26%. Forty eight percent of these said that they did not report the incidents anywhere, citing the following reasons:

(a) The perpetrator of the crime promised not to do it again.

(b) The victims were threatened with beating if they reported it.

(c) The one who forced the young women into sex was a friend.

(d) The one who forced the young women into sex was a relative.

(e) Society doesn't give enough opportunity for a victim to complain.

(f) The victims successfully fought back and hurt the perpetrator, and found no reason to Report the incident.

(g) The victim explained the adverse effects of what he was about to do and he under stood.

(h) The victim feared her parents would beat her up.

(i) The victim did not understand anything that was happening, because of her age and misinformation.

(j) The victim felt ashamed to report it.

(k) The victim did not like many people to know her secrets. She thanked God that she neither conceived nor did she get infected with any Sexually Transmitted Diseases.

The results further revealed that majority of respondents (40.3%) reported that young girls start having sex between the age ranges of 14 - 16 years. Twenty seven percent claimed that their sexual debut was between 11-13 years and 12.3% said it is before the age of ten. Of all those surveyed, 13.4% stated it was between 17 and 19, and 7.6% noted that most girls start having sex above 20 years of age.

4.10 Behavioural Expectations to Resist Unsafe Sex among Young Females

The DeHart and Birkimer (1997) scale was used to assess behavioural expectations to resist unsafe sex among young females aged between 15-24 years. Research results reveal that girls exhibit strong behavioural expectations of resisting unsafe sex. On average, over 88% of the respondents indicated that they strongly disagreed and disagreed that they would either give in to suggestions for unprotected sex or to other unsafe sex methods.

How much are these expectations matched the actual behaviour is a question that was pursued during focus group discussions. The results for power relations regarding female and male relationships revealed that there is neither necessary nor rational for the female youth to engage in sexual relationship before marriage. Despite this stand, most female youth stated that they find themselves involved in intimate relationships, which arose from many different excuses. Noted, among the various excuses advanced were life hardships, peer pressure, lack of guidance from parents on how to handle relationships and the generally long held perceptions that women are weak and subservient to male domination.

During all FGD's, it was revealed that males have more powers on all matters regarding sexual relationship. The males, it was noted, dictate the time, place and the way sex is to be conducted. Supported by other discussants, one member stated that, *"when a girl and a man are in love, the man becomes even more powerful."* The female youth, therefore, become passive participants in the relationships with threats of beating, and/or withdrawal of financial support or physical protection.

When a female youth visits a casual male friend at his place (home), most times the male friend will have his mind set on making sexual advances. When this occurs, the chances are high that they will end up having unplanned and sometimes unprotected sex. Reasons pointed out for this were that:

(a) Males are physically stronger than females so a girl cannot stop the male from having his way.

(b) A male friend may lock the door, forcing the female youth to acquiesce, fearing that any further delay may lead her parents looking for her, with bad consequences when they find out where she has been.

(c) The female youth cannot scream as the society would not accept excuses that she had visited her friend with no intention of having sex.

Table 4.4: Sexual Risks Scale-Expectations to Resist Unsafe Sex (SRSE)

Statements	Disagree %	Neutral %	Agree %
If my partner wanted me to have unprotected sex, I would probably 'give in'.	94.8	2.0	3.2
If my partner wanted me to participate in 'risky' sex and I suggested a lower-risk alternative, we would have the 'safer' sex instead.	56.5	7.8	35.7
If my partner wanted me to have unprotected sex and I made some excuse to use a condom, we would still end up having unprotected sex.	88.8	7.6	3.6
If my partner wanted me to participate in 'risky' sex and I said that we needed to be safer, we would still probably end up having 'unsafe' sex.	91.0	5.8	3.2
If a sexual partner did not want to use condoms, we would have sex without using condoms.	91.7	2.9	5.4

4.11 Education and Female Youths' Negotiating Powers

Research findings revealed that education has a strong influence on female youth negotiating powers. Out of in-school respondents, 66.3% of them stated that they would not give in to partners' proposal to engage in unsafe sex. This is in contrast with a mere 28.2% of the out-of-school respondents who stated they would not. These results followed the same patterns in all similar statements.

Respondents were asked whether they would ask their partners to use condoms, 53.3% of in-school respondents stated that they would, whereas only 25.8% of the out of schools stated so. Relatively few (11.3%) of schooling respondents had had sex experience before the survey, whilst over 20.2% of the non-schooling had had sex before the survey. 52.3% of the

students had no sex partners at the time of the interview while just 7.9% of those not at school had no sex partners. It can be concluded that education gives respondents more power to negotiate safe sex, such as abstinence and condom use.

4.12 Rural-Urban Influence on Safe Sex Negotiation

Rural female youth were found to have more powers in negotiating for safe sex than their urban counterparts. The findings were consistent over all the statements that were used to measure Self-efficacy for negotiating condom use, abstinence and expectation to resist unsafe sex (SRSE). For instance, respondents were asked *"if my partners wanted me to have unprotected sex, I would probably give in"* 56.9% of the rural respondents (Njombe and Rungwe) said they strongly disagree or disagree while only 37.9% of the urban stated so. 46.7 percent of the rural respondents stated they can ask a new partner to use condoms and only 32.3% of the urban folks replied in the affirmative.

Additionally, 31.5% of all respondents said that they had had sex before the survey. However, 14.5% of these were rural folks, while 17.0% were urban folks. 16.4% of the rural respondents had undergone an HIV/AIDS test while only 10.1% had done so in the urban area. Table 4.5 compares the responses on a rural - urban sexual risks scale - expectations to resist unsafe sex.

Table 4.5: Rural - Urban Sexual Risks Scale-Expectations to Resist Unsafe Sex (SRSE)

Statements	Area	Disagree %	Neutral %	Agree %
If my partner wanted me to have unprotected sex, I would probably 'give in'.	Rural	56.9	0.8	2.0
	Urban	37.9	1.2	1.2
	Total	**94.8**	**2.0**	**3.2**
If my partner wanted me to participate in 'risky' sex and I suggested a lower-risk alternative, we would have the 'safer' sex instead.	Rural	35.6	4.1	20.1
	Urban	20.9	3.7	15.6
	Total	**56.5**	**7.8**	**35.7**
If my partner wanted me to have unprotected sex and I made some excuse to use a condom we would still end up having unprotected sex.	Rural	52.2	4.4	2.8
	Urban	36.6	3.2	0.8
	Total	**88.8**	**7.6**	**3.6**
If my partner wanted me to participate in 'risky; sex and I said that we needed to be safer, we would still probably end up having 'unsafe' sex.	Rural	53.7	2.5	2.4
	Urban	37.3	3.3	0.8
	Total	**91.0**	**5.8**	**3.2**
If a sexual partner did not want to use condoms, we would have sex without using condoms.	Rural	53.5	1.2	3.3
	Urban	38.2	1.7	2.1
	Total	**91.7**	**2.9**	**5.4**

These findings revealed that urban female youth are more vulnerable to unsafe sex practices and hence HIV/AIDS infections than their rural counterparts. The findings were contrary to pre-survey knowledge that the urbanite are more informed and can make sound decisions regarding their reproductive health and sexual behaviour.

4.13 Marital Status and Female Youth Negotiating Powers

The findings revealed that singles expressed a strong conviction that they have more powers over sex matters compared to others who were married, divorced or separated. The differences could, however, be attributed to a very small sample of non-singles or youthful idealism rather than realism. It is worthy noting that out of 26.1% of all the respondents who have undergone HIV/AIDS testing, over 22% were single, 3% were married, and 0.4% was separated. Considering the above results, no significant conclusion can be made on the influence of ones marital status on negotiating powers for safe sex among female youth.

5 Conclusion and Recommendations

5.1 Conclusion

This study sought to examine and report powers of young females in negotiating for safer sex. The study findings have revealed their negotiating powerlessness that emanate from a myriad of sources. The first source noted was a lack of financial resources for basic necessities and simple luxuries. Unemployment for both parents and young female and meager incomes from petty businesses were found to exacerbate the problem. The second source is a lack of education opportunities that limits a female's orientation towards their future, instead they were choosing to 'live for now'. Young females who were in schools were found to have more negotiating powers due to the 'treasure' that they were foreseeing in the future. Limited education has led to inadequate information pertaining to sex, sexuality and general reproductive health. Social and cultural changes have eroded traditional institutions that were capable of formally transmitting and imparting relevant information to the youth on the issues.

An equally challenging situation for the female is the patriarchic culture that implicitly assumes female are esteemed for their passivity while male for their aggressiveness. This makes female vulnerable and powerless as when they act otherwise - fighting for what they consider to be their right of choice or voice, the society as well as family will still ostracize them. Finally, physical powerlessness was equally noted in the sense that female are considered not physically powerful enough to wrestle with a determined male in situation that would in other ways warrant confrontation. The recommendations that are subsequent to this conclusion seek to offer remedy to some of the sources of powerlessness noted in the study.

5.2 Recommendations

The findings have revealed that female youth do not have strong negotiating powers for safer sex. The female youth are not empowered in almost all spheres of life, that is economically, socially and have limited knowledge, skills that would make them have a say over their bodies and sexual relationships. Bearing those facts in mind researchers are making the following recommendations:

i. Failure of parents to acknowledge their daughters opposite sex friends, make female youth fail to adequately handle male - female relationships. The female youth instead try (without much success) to avoid relationships altogether, or get involved in a 'seek and hide' kind of relationships. These relationships only come to light when they turn sour due to unwanted pregnancies, sexually transmitted diseases or when the relationship luckily culminates in betrothal and marriage. Parents need to be encouraged to provide counsel for their daughters without fear, instead of leaving this important responsibility to the peers, media and teachers.

   Parents have a duty to be at the forefront of equipping themselves with correct, relevant and proper reproductive knowledge and life skills to their children before they reach puberty. Parents' cruelty and brutality to their child at the first hint of opposite sex friendship only helps to exacerbate the situation, forcing female youth to live in secrecy.

ii. More needs to be done in as far as sensitisation regarding HIV/AIDS is concerned. Most campaigns against the pandemic focus on urban areas using media that mostly reach the urban people. The rural folk miss some of the basics regarding their

reproductive health and HIV/AIDS prevention. The rural folk do not have direct and uninhibited access to radio, newspapers and TV and magazines. The information glut for the urban folk needs to be cautiously censored. Participants pointed out that absence of proper counselling and information make the female youth use other HIV/AIDS information sources from various media, peers among others, who may not be well informed or provide the information in bad faith.

iii. Campaigns against HIV/AIDS need to be holistic, involving women empowerment through provision of life skills, credit schemes and training. Doing this will empower female youth to become more assertive and knowledgeable about their rights and have wider opportunities to pursue their dreams without depending so much on their male friends for their survival.

iv. Government should continue with its efforts to encourage the education of girl children. As noted earlier, female youth in schools were stronger in their conviction to abstain from sex until marriage than their non-schooling counterparts. The possibilities of a standard seven leaver engaging in sex, or even worse, unsafe sex, are higher than a girl who is pursuing secondary education. One pursuing post primary school education will have something to hope for and treasure.

v. Female youth need to be socialized on how they could start treasuring their lives, having respect for what they are and believing in themselves that believing that they can make it. The excuses given to succumb to temptations will not help in making a difference in the fight for HIV/AIDS.

A combination of these recommendations to parents, government, civil society, Community Based Organisations (CBO's) and Non-Governmental Organisations (NGO's) involved in the fight of HIV/ AIDS, and ultimately the female youth themselves need to be well integrated to really have positive impact.

5.3 Area for Further Research

This study has revealed areas which call for further research. The recommended areas that would strengthen our understanding of the youth negotiation and prevention of the spread of HIV/AIDS are:

- Negotiating Safe Sex for HIV/AIDS prevention among youth: A comparative study between female and male youth, and
- Parent-Child Communication: Promoting Sexually Healthy Youth.

The research areas are recommended against the background that negotiation is a two way process involving both male and female youth. In addition, most respondents and participants of focus group discussions underscored the importance of the parents in providing information that can be used in the negotiation process.

References

A Message of Hope, (2001), "Issued during the Plenary Session of the Southern African Bishops" Conference at St. Peter's Seminary, Pretoria, Jul 30

Adeokun, L.A. (1994):, "Gender differentials and household issues in AIDS", *In* Wijeyaratne, P.; Jones Arsenault, L.; Hatcher Roberts, J.; Kitts, J., ed., Gender, health, and sustainable development: proceedings of a workshop held in Nairobi, Kenya, 5-8 October 1993. International Development Research Centre, Ottawa, ON, Canada. pp. 22-31.

AI-USA (2000): "Stop Violence Against Women HIV/AIDS, Women, and Human Rights", http://www.amnestyusa.org/women/hivaids.html, Accessed on 13th May, 2005

Amaro, H. (1995). "Considering women's realities in HIV prevention". *American Psychologist*, 50, 443-447.

Amaro, H., Raj, A., &Reed, E. (2001). "Women's sexual health: The need for feminist analyses in public health in the decade of Behaviour" *Psychology of Women Quarterly*, 25, 324-334.

American Heritage Dictionary of English Language (2000): http://www.bartleby.com/61/

Annan, K. (2004). Stronger Leadership Needed at Every level in Fight against HIV/AIDS. Bangkok International Aids Conference.

Balmer, D. (1994). "Gender, counselling and STDs/AIDS. *In* Wijeyaratne, P.; Jones Arsenault, L.; Hatcher Roberts, J.; Kitts, J., ed., Gender, health, and sustainable development: proceedings of a workshop held in Nairobi, Kenya, 5-8 October 1993". International Development Research Centre, Ottawa, ON, Canada. pp. 46-58.

Barkley T. W. and Burns J. L. (2000). Factor Analysis of the Condom use Self-Efficacy Scale among multi-cultural college students, *Health Education Research*, Vol 15 No. 4 pp. 485 - 489

Baylies C. and Bujra, J. (2000) "AIDS Sexuality and Gender in Africa - Collective Strategies and Struggles in Tanzania and Zambia"; Leeds University Library

Best, K. (2000): "Many Youths Face Grim STD Risks" *Network*, Vol. 20, No. 3 pp. 4 to 9

Burkhalter, H., (2003) "Sex Trafficking and the HIV/AIDS Pandemic" Testimony before the House International Relations Committee June 25, 2003

Caldwell, J. C. (2006). "Will HIV/AIDS Levels in Asia Reach the Level of Sub-Saharan Africa?" *Asia-Pacific Population Journal*, Vol. 21, No. 1, pp 3 - 9

Caldwell, John C., Caldwell, Pat, Quiggen, Pat, (1989) "The Social Context of AIDS in sub-Saharan Africa", *Population and Development Review,* Vol. 15, Issue 2 (June, 1989), 185-234.

Chinake, H., M. Dunbar, A. van der Straten, S. Esim, and N. Padian. (2002). "Intergenerational sex among adolescents in Zimbabwe. "Paper presented at the Fourteenth International AIDS Conference, Barcelona, 7 12 July.

Cook, R. (1994). "Women's health and human rights". World Health Organization, Geneva, Switzerland. 62 pp.

Crawford, M; Maracek, J. (1989). "Psychology reconstructs the female." *Psychology of Women Quarterly*, 13, 147-165.

de Silva D. (2003) "Girls and women more vulnerable to HIV infection" found at http://www.blink.org.uk/pdescription. asp?key=2576&grp=5&cat=148

DeHart & Birkimer (1997). Trying to practice safer sex: Development of the Sexual Risks Scale. Journal of Sex Research, 34 (1), 11-25.

Denzin, N. K, Lincoln Y. S. (1994) "Handbook of Qualitative Research". Thousand Oaks: Sage Publications

do Prado, E. (1994): "Love does not protect against AIDS: reflections about the HIV/AIDS epidemic from a gender perspective", *In* Wijeyaratne, P.; Hatcher Roberts, J.; Kitts, J.; Jones Arsenault, L., ed., Gender, health, and sustainable development: a Latin American perspective. Proceedings of a workshop held in Montevideo, Uruguay, 26-29 April 1994. International Development Research Centre, Ottawa, ON, Canada. pp. 35-38.

Doyal, Lesley (1994) "HIV and AIDS: Putting Women on the Global Agenda", In Lesley Doyal, Jenny Naidoo, and Tamsin Wilton, (eds) AIDS: Setting a Feminist Agenda. London, Taylor and Francis

Durana, C. (1994). "Socioeconomic impact and gender differentials of cholera. *In* Wijeyaratne, P.; Hatcher Roberts, J.; Kitts, J.; Jones Arsenault, L., ed., Gender, health, and sustainable development: a Latin American perspective. Proceedings from a workshop held in Montevideo, Uruguay, 26-29 April 1994". International Development Research Centre, Ottawa, ON, Canada. pp. 134-140.

Felmlee, D.H. (1994). "Who's on Top? Power in Romantic Relationships". *Sex Roles*, 31, 275-295.

Fitzpatrick, L., McCray, E. and Smith, D. K. (2004); "The Global HIV/AIDS Epidemic and Related Mental Health Issues: The Crisis for Africans and Black Americans" *Centers for Disease Control and Prevention*; Journal of Black Psychology, Feb 2004; 30: 11 - 23.

Glaser, B. G., and Strauss, A. L. (1967): "The Discovery of Grounded Theory: Strategies for Qualitative Research", Aldine, pp. 271

Gomez, G., & Marín, B. (1996). "Gender, culture, and power: Barriers to HIV-prevention strategies for women". *Journal of Sex Roles*, 33, 355-362.

Gupta, G.R., Weiss, E., & Mane, P. (1996). 'Talking About sex: a Prerequisite for AIDS Prevention'. In L.D. Long & E.M. Ankrah (eds.). Women's Experiences: an International Perspective. Columbia University Press: New York.

Hall L. A. (2000). "Condoms in the Oxford Companion to the Body", Oxford University Press. 2000.

Hammad, A.E.B. (1994). "Introduction: opportunities and challenges for improving women's health status. *In* Wijeyaratne, P.; Hatcher Roberts, J.; Kitts, J.; Jones Arsenault, L., ed., Gender, health, and sustainable development: a Latin American perspective". Proceedings of a workshop held in Montevideo, Uruguay, 26-29 April 1994. International Development Research Centre, Ottawa, ON, Canada. pp. 1-5.

Hartigan, J. D. (1997). "The Disastrous Results of Condom Distribution Programs", Retrieved on 2000, January 27 in http://www.frc.org/infocus /if97k1ab.html.

Hearst, N. and Chen, S. (2004): "Condom Promotion for AIDS Prevention in the Developing World: Is It Working?" *Studies in Family Planning*, 35 (1), 39 - 47

Heise, L., and Elias, C. (1995). "Transforming AIDS prevention to meet women's needs: A focus on developing countries" *Social Science and Medicine*, 40(7), 931-945.

Himes, N. E. (1963)."Medical History of Contraception". New York: Gamut Press, Inc.

Jacqueline, H. P. (1999). Girls in search for love, sex and money. A Study on adolescent sexuality in an urban Tanzanian neighborhood, August. pp. 145, ISBN 90-72639-89-8.

Keene, T. P. (2001). "Stopping The Spread of AIDS among Women in Sub-Saharan Africa, What Works and What does not: A Comparative Study of Uganda and Botswana", Thesis Submitted to the Faculty of the Virginia Polytechnic Institute and State University, Blacksburg, Virginia

Kessy, A. T., (1995). "Prevalence and risk factors for HIV-infection and other sexually transmitted diseases among youth in Moshi rural district, Kilimanjaro region, 1995". Mmed Com Health thesis, Univ. of Dar es Salaam, Tanzania; 1996.

Kim R. and Aggleton P., (1999), “Gender and the HIV Epidemic, Adolescent Sexuality, Gender and the HIV Epidemic” Thomas Coram Research Unit, Institute of Education, University of London

Klepp, K. I., Ndeki, S. N., Seha, A. M., Hannan, P., Lyimo, B. A., Msuya, M. H., Irema, M. N., and Schreiner, A. (1994) “AIDS education Among Primary School Children in Tanzania”; An evaluation study; 11, 791-799.

Macaluso, M., Lawson, L. and Akers, R. (1999) “Prostate-specific antigen in vaginal fluid as a biologic marker of condom failure” *Contraception* 1999;59:195-201

Manderson, L. (1994): ”Expanding quality of care beyond reproductive health”, Paper presented at the workshop on the quality of health care for women in developing countries, 15-17 October 1994, Budapest, Hungary. World Health Organization, Geneva, Switzerland. 6 pp

Mantell, J.; Schinke, S.; Akabas, S. (1988): “Women and AIDS prevention”, Journal of Primary Prevention, 9(1/2), 18-40.

Marindo R, Pearson S, and Casterline J. B. (2003): “Condom Use Among Unmarried Young People in Zimbabwe” Which Strategy, Whose Agenda? No. 170 Relationship power, sexual decision-making and condom use among women at risk for HIV/STDS.

Mays, V., and Cochran, S. (1988) “Issues in the Perception of AIDS Risk and Risk Reduction Activities by Black and Hispanic/Latino Women”. *American Psychologist* 43, 949-957

McCracken, M. W. (1998). “Robust Out of Sample Inference,” manuscript, Louisiana State University

McIlhaney, N. (2004). “Evidence that demands action. Comparing risk avoidance and risk reduction strategies for HIV prevention” The medical institute for sexual health

Mhoja, M.E.M. (2005).The Impact of Inheritance Customary Law to the Status of Windows and Daughters in Tanzania: A challenge to Human Rights Activists, in 'Voices of African Women' - Johanna Bond (ed.) (Durham North Carolina: Carolina Academic Press).

Mpuntsha, L. (2003) “Reproductive Health and Gender aspects” A presentation in a Seminar on HIV/AIDS and reproductive health, During the Bi-National Commission (BNC) meeting in Stockholm in September 2003, Available in http://www.sweden.gov.se/content/1/c6/01/71/34/2abb9611.pdf

National Bureau of Statistics (2006). “Population and Housing Census 2002. Analytical Report, Vol. X”. Dar es Salaam. http://www.nbs.go.tz/indicator.htm

O'Leary, Ann & Jemmott, Loretta S. (1995) “Women at Risk: Issues in the Primary Prevention of AIDS”, Plenum Press, New York, 1995.

Padian, N. S., Shiboski, S., & Jewell, N. (1990, June) The relative efficiency of female-to-male HIV transmission. In Proceedings of the VIth International Conference on AIDS, San Francisco

Pesce, L. (1994): “AIDS research from a gender perspective”, In Wijeyaratne, P.; Hatcher Roberts, J.; Kitts, J.; Jones Arsenault, L., ed., Gender, health, and sustainable development: a Latin American perspective. Proceedings of a workshop held in Montevideo, Uruguay, 26-29 April 1994. International Development Research Centre, Ottawa, ON, Canada. pp. 19-25.

Philipson, T. and Posner, R. A., (1995) “The Microeconomics of the AIDS Epidemic in Africa.” *Population and Development Review* 21:4 December 1995: 835-848.

Ramdas, K. N. (2004). “Empowering Women -The Best Vaccine against AIDS May 15, 2004” President & CEO, Global Fund for Women.

Richters, A. (1994) “Women, culture and violence: A development, health and human rights issue”. Leiden: VENA.

Rodin, J.; Ickovics, J. (1990): “Women's health. Review and research agenda as we approach the 21st century”, American Psychologist, 45(9), 1018-1034.

Ross, E. (2004): “HIV Cases Hit New Record High in 2003”, The Associated press in http://www.rense.com

Royce, R. A., Seña A., Cates W., Cohen M. S. (1997): “Sexual Transmission of HIV/AIDS.” *The New England Journal of Medicine*, Vol. 336, No. 15

Sithole, Emelia (2000) “Young People Bear Brunt of AIDS” UNICEF Says Reuters *NewMedia - July* 12, 2000

Stevenson, K. (1993). 'Young people, sexual behaviour and sex advice in the age of AIDS', Chapter of PhD thesis Retrieved on 2005, May 16th in http://www.staffs.ac.uk/personal /humanities_and_soc_sciences/ks3/chapter2.htm

Tanzania Gender Network Programme (TGNP). http://www.tgnp.org/0gbi_intro.htm

Ulin PR, Robinson ET, Tolley EE, McNeill ET (2002). “Qualitative methods: a field guide for applied research in sexual and reproductive health”. Durham: Family Health International;

UNAIDS (2000) “Report on the Global HIV/AIDS Epidemic”, Geneva, June

UNAIDS (2004). “Report on the global HIV/AIDS epidemic 2004”, July UNAIDS/04.16E (English original, June 2004) (UNAIDS) www.unaids.org.

UNAIDS (2005). “Inter-Agency Task Team on Gender and HIV/AIDS”, KIT Publishers, Amsterdam

UNAIDS (2006): “Report on Global AIDS epidemic”, http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

UNDP (1992): “Young women: silence, susceptibility and HIV infection. Age and gender as independent variables in the acquisition of HIV”, UNDP, New York, NY, USA. 8 pp.

UNIFEM, (2001). “Progress of the World's Women: Biennial Report.” UNIFEM

Vlassoff, C. (1994). “Gender inequalities in health in the Third World” *unchartered ground*. *Social Science and Medicine*, 39(9) 1249-1259.

Walker, K. (2003) “Why Girls' Education Makes a Difference” The Arusha Times October 11-17, 2003, No. 00291, retrieved on 2007, May 10 from http://www.globalservicecorps.org/d/Arush_girls ed.html

WHO (2004). “WHO Assessment of the Epidemiological Situation - 2004” Retrieved 8th August 2007 in http://web.worldbank.org /WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREG-TOPHIVAIDS/0,,contentMDK:20450516~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html

Wilson, J. (1993) “Women as carers.” in Berer, M.; Ray, S., ed., Women and HIV/AIDS: an international resource book”. Pandora, London, UK. pp. 287-288.

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