Self-Help Groups and Access to Sexual and Reproductive Health Services and Rights among Youth in Mtwara and Lindi Districts, Tanzania

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Abstract

In Tanzania, as elsewhere in the world, adolescent pregnancy and sexually transmitted infections are serious public health issues among youth. This study was conducted to assess the impact of self-help groups on access to sexual and reproductive health services and rights among youth in Mtwara and Lindi districts. Specifically, the study envisaged to (i) examine the availability and access to sexual and health reproductive services and rights among youth and (ii) examine the capacity of self-help groups in promoting access to sexual and health reproductive services and rights among youth in the study area.A cross sectional design incorporating a longitudinal perspective was used. Mixed methods of data collection were used, including organisational capacity assessment, focus group discussions, key informant interviews and documentary review. The findings show that most youth groups were conducting networking meetings and reaching over 7000 youth with sexual and reproductive health messages, and were members of the youth networks in their respective districts. These networks had helped to connect the youth with other youth in their villages, wards and districts, and had created forums for information sharing and articulation of different issues affecting their lives. The self-help groups have been very instrumental change agents in sexual and reproductive health issues in their communities through peer education, life skills, public meetings, festivals, sports and games. This has contributed to reducing the

number of early and unwanted pregnancies, abortions and early marriages. Overall, the study has shown that youth self-group groups' approach is a very effective and powerful methodology for empowering youth socially, economically and politically.
Key words: self-help groups, sexual and reproductive health services and rights, youth

1.0 Introduction

Adolescent pregnancy and Sexually Transmitted Infections (STIs) are worldwide problems representing serious public health issues. Globally, every year, 2.6 million young people die due to accidents, pregnancy related complications and violence (Deogan *et al*., 2012; WHO, 2012). In Tanzania, it is estimated that by the age of 17 approximately 25% of the females are either pregnant or already mothers (Engelbert, 2009; Mbeba *et al*., 2012). In 2010, the Tanzania Demographic and Health Survey revealed high fertility rate among girls: 116 pregnancies per 1000 girls aged 15-19 years (URT, 2010). About one in 20 girls in Tanzania have begun childbearing when they are only 15 years old, and this rises sharply to one in four among 17 year olds and more than one in three among 18 year olds. Girls in rural areas are almost twice as likely as girls in urban areas to start childbearing before they reach 19 years (Mbeba *et al*., 2012; UNICEF, 2013).

In fact, these figures are likely to be higher due to spontaneous and hidden induced abortions during early months. UNICEF (2013) estimates that nine percent of females and 10% of males aged 15-24 years report having had sexual intercourse for the first time before age 15. Fifty percent of women and 43% of men aged 18-24 years report having had sex before age 18. Related female school drop-outs strongly affect the education sector and have a long term impact on the girls' educational and socio-economic development. Further, unprotected sex in adolescence can not only lead into unwanted pregnancies, but also to STIs, which may lead into infertility and HIV/AIDS (Engelbert, 2009).

In Mtwara and Lindi regions in Southern Tanzania, unwanted teenage pregnancies are common among primary and secondary school students. Girls and women are particularly marginalized partly because they live in a society where socio-cultural factors underpin negative gender inequities in the home and in the wider community. These factors lead to disparities in access to, and quality of health, educational, financial and other services. Traditional practices such as early and forced marriages and sexual initiation ceremonies put girls at high vulnerability to early pregnancies, STIs and HIV infections. Furthermore, existing sexual and reproductive health (SRH) services in most health facilities are adult-centered, depriving adolescents of their SRH rights (Bangser, 2010; Mbeba *et al*., 2012). Poverty and lack of reliable sources of income are also common among youth. A study by Bangser (2010) in Mtwara region found extremely limited work opportunities for women and young people, in agriculture, government employment, formal sector, business and other avenues of economic opportunity.

To address these challenges and contribute to improved access to SRH services and rights among youth in Mtwara district, in 2010, Amref Health Africa introduced the '*Sauti ya Vijana'* project (meaning the *voice of youth*). In 2012, USAID funded '*Tujumuike'* (Let Us Come Together) project that worked directly with local youth self-help groups (SHGs) as primary beneficiaries and expanded project coverage to reach Lindi Municipal Council as well. The present study was, therefore, conducted to assess the impact of youth SHGson access to SRH services and rights among youth in Mtwara and Lindi districts. The specific objectives of this study were to (i) examine the availability and access to SRH services and rights among youth and (ii) examine the capacity of SHGs in promoting access to SRH services and rights among youth in the study area. The study builds on an earlier study by Mbeba *et al*., (2012), which investigated the barriers to SRH services and rights among young people in Mtwara district. Although we adopted similar methodologies as those

used by Mbeba *et al*., (2012), the current study also departs from theirwork in that it isan evaluative study conducted after the implementation of the project and focuses on two districts: Mtwara district and Lindiurban district.

2.0 Study Area and Methodology

The present study was conducted in Mtwara district and Lindi urban district. Mtwara district is located in Mtwara region in the southern part of Tanzania mainland. The district is divided into 6 administrative divisions, 28 wardsand 157 villages. According to the 2012 National Population and Housing Census, the population of Mtwara district is 228,003 people, including 107, 922 males and 120,081 females (URT, 2013). In 2010, young people (aged 10 – 24 years) were estimated to be 28% of the total population. In this district, the study was conducted in nine wards, which were the intervention areas for the '*Tujumuike'* project. These included Msanga Mkuu, Nanyamba, Dihimba, Kitaya, Mayanga, Naumbu, Ndumbwe, Njengwa and Nanguruwe. Lindi urban district is divided into 18 wards and has 18 health facilities. According to the 2012 National Population and Housing Census, Lindi urban district has a population of 78,841 people of whom 37,525 are males and 41,316 are females with an average household size of 3.5(URT, 2013). In 2010, young people aged 10-24 years were estimated to be 34% of the total population. In this district, the study was carried out in six wards, namely: Makonde, Mingoyo, Mitandi, Raha Leo, Mwenge and Msinjahili.

This study adopted a cross sectional design using mixed methods of data collection and incorporating a longitudinal perspective. Data were collected at a single point in time, which is one the characteristic features of a cross sectional design (Kumar, 2005). In addition, the study incorporated a longitudinal perspective by using more or less similar data collection tools that were used in the baseline study (Mbeba *et al*., 2013), by asking retrospective questions to project beneficiaries and key informants, and by documenting case studies.

Mixed methods of data collection

involving quantitative and qualitative approaches were used to get deeper insights into the research phenomenon, and subsequently contribute to validity and reliability of the findings. The use of mixed methods and tools of data collection strategies entails combining elements of quantitative elements such as surveys and elements of qualitative methods such as focus group discussions, key informant interviews and case studies, either simultaneously or sequentially (Axinn and Pearce, 2006). This study employed five data collection methods namely; Organisational Capacity Assessment (OCA), Focus Group Discussions (FGDs), Key Informant Interviews (KIIs) and document review.

The OCA tool was used to assess the capacity of youth SHGs in promoting access to SRH services and rights among youth. The tool contained 4-point Likert scale questions that aimed at generating quantitative information and open-ended questions aimed to solicit in-depth qualitative information to complement the quantitative data. This tool was administered to 15 youth SHG leaders (13 males and 2 females).Four FGDs were held with youth SHG members involving 26 participants (13 males and 13 females). This was crucial because FGDs explicitly call for participants to interact with one another in formulating responses (Axinn and Pearce, 2006), and are useful in exploring perceptions, experiences, and understandings of a group of people with some common experience on the issue being investigated (Kumar, 2005). In addition, the study carried out 13 KIIs with 6 community leaders, 5 council officials and 2 youth network leaders. An interview guide was used as the main tool for these interviews. Secondary data were collected through review and analysis of the relevant available data from district officials, community leaders at ward level, and the youth SHGs, and project documents.

This study employed purposive sampling techniques to select the respondents. The actual sample size was determined by each of the data collection method employed, which required focusing on specific categories of respondents. For example, the OCA focused on group leaders and the FGDs

on between 6-8 group members. Table 1 shows the distribution of the sample respondents and the corresponding data collection methods used.

Table 1: Distribution of respondents by data collection methods

Category of respondent	*Number of respondents*	*Data collection method*
SHG leaders	15	OCA tool
SHG members	26	Focus group discussions
SHG members	3	Case studies
Council officials	5	Key informant interviews
Community leaders	6	Key informant interviews
Youth network leaders	2	Key informant interviews

The collected data were analyzed using both quantitative and qualitative techniques. The quantitative data collected using the OCA tool were processed, coded and entered in the Statistical Package for Social Sciences (SPSS) to make them amenable for analysis. These data were analyzed for descriptive statistics such as frequencies and mean scores for the Likert-scale questions. Index scores for the different SHG capacity themes were computed to enable comparison between the different groups across the two districts. A 4-point rating scale was used in the OCA (1=lack of capacity, 2=limited capacity, 3=moderate capacity, 4=significant capacity). The mean score for each capacity area was obtained by computing the sum of all scores divided by the number of questions or elements in that capacity area. The qualitative data obtained from FGDs, key informant interviews, case studies and the open-ended questions in the OCA tool were transcribed and analyzed using qualitative content analysis. This involved transcribing the field notes from interviews and FGDs, and reading through the field notes and transcripts to identify key themes and patterns relevant to the study objectives. Because quantitative and qualitative data are mutually dependent and tend to complement each other, the presentation and discussion of the findings weave together the quantitative and qualitative data.

3.0 Results and Discussion

3.1 Characteristics of Youth Self-Help Groups

Table 2 presents an overview of the key characteristics of the SHGs involved in this study. As already stated, 15 SHGs participated in this study. Two-thirds of

the SHGs (67%) were established in 2013 and one-fifth (20%) in 2012. Comparatively, a large majority of SHGs in Lindi were relatively new, established mostly in 2013 (83%) and a good number of them in Mtwara were old, some dating back to 2006. Most of the groups (40%) were established by Amref Health Africa through the *'Tujumuike'* project: 67% in Lindi and 22% in Mtwara. In Mtwara, 44% of the surveyed youth SHGs were established by UNICEF and another 22% by the youth themselves. Thus, most youth SHGs in Mtwara are relatively older than their counterparts in Lindi, partly because of previous interventions by UNICEF and Amref Health Africa in the former district.

These groups were mostly registered by their respective district councils as commercial organisations (53%) in the Department of Agriculture, Irrigation and Cooperatives and the rest (47%) as community based organisations (CBOs) in the Department of Community Development. Only one SHG (in Lindi) reported having no operational base, one group used a rented private office and the rest (87%) were operating from their respective village, ward offices or primary schools. This means that almost all groups had space for their members to regularly meet and carry out their group activities. The most preferred means of communication among group members, and with other stakeholders was through mobile phones (67%), letters and mobile phones (20%) and letters (13%). Most of the group members had mobile phones and, thus, could easily communicate among themselves and with other stakeholders.

Table 2: Characteristics of youth self-help groups by council (n=15)

Characteristics	Responses	Mtwara	Lindi	Both
Year group was established	2006	1(11.1)	0(0.0)	1(6.7)
	2011	1(11.1)	0(0.0)	1(6.7)
	2012	2(22.2)	1(16.7)	3(20.0)
	2013	5(55.6)	5(83.3)	10(66.7)
Group was established by	Amref	2(22.2)	4(66.7)	6(40.0)
	UNICEF	4(44.4)	0(0.0)	4(26.7)
	District council and Amref	1(11.1)	0(0.0)	1(6.7)
	Youth	2(22.2)	1(16.7)	3(20.0)
	TASAF	0(0.0)	1(16.7)	1(6.7)
Year group was registered	2012	1(11.1)	0(0.0)	1(6.7)
	2013	6(66.7)	2(33.3)	8(53.3)
	2014	2(22.2)	4(66.7)	6(40.0)
Group registered as	Registered as a commercial organisation	4(44.4)	4(66.7)	8(53.3)
	Registered as a CBO	5(55.6)	2(33.3)	7(46.7)
Preferred way of communication	Mobile phones	5(55.6)	5(83.3)	10(66.7)
	Letters	2(22.2)	0(0.0)	2(13.3)
	Mobile phones and letters	2(22.2)	1(16.7)	3(20.0)
Location of operation base	Building owned by a government partner	9(100.0)	4(66.7)	13(86.7)
	Private rented venue	0(0.0)	1(16.7)	1(6.7)
	Do not have office	0(0.0)	1(16.7)	1(6.7)

Figures in brackets are percentages.

The surveyed groups had 337 members: 179 males and 158 females (Table 2). The youth SHGs in Mtwara were relatively larger than their counterparts in Lindi. In Mtwara, the number of members ranged from 12 to 70 with an average of 31 members, whereas the groups in Lindi had a range of 6-15 members with an average of 10 members. This could be attributed to the geographical location of the two districts and their experience of working with youth. Because of the rural context of Mtwara district, it seemed relatively easier to mobilize and organize youth into SHGs than in the urban setting in Lindi. Similarly, given the relatively longer time most of the groups in Mtwara had been operating, they had gained sufficient experience to recruit and retain members, although some groups reported that their membership had declined over the years. These findings support those of Gavin *et al.,* (2010) who found that stable and long-lasting youth development interventions are likely to be effective in empowering youth, building their skills and engaging them in real roles and activities.

Most of the groups in Mtwara had a higher proportion of male members (56%) than female members (44%). On contrast, SHGs in Lindi had a significantly higher proportion of female members (62%) than male members (38%). This could mean that

female youth in rural settings are more likely to have limited associational life than their counterparts in urban and peri-urban areas, partly because of the socio-cultural barriers that are more predominant in rural than in urban areas. URT (2010) arrived at a more or less similar conclusion that rural youth are less likely to have comprehensive HIV/AIDS and family planning knowledge.

Table 3: Distribution of youth self-help groups by council, ward and membership

District	Ward	Name of SHG	Members			
			Male	Female	Total	% female
Mtwara District Council	Nanguruwe	Changamka Group	25	20	45	44.4
	Dihimba	MTAZAMO	22	14	36	38.9
	Kitaya	Mtandao wa Vijana Kata ya Kitaya	8	12	20	60.0
	Mayanga	MVIWA	32	38	70	54.3
	Ndumbwe	TVG	6	6	12	50.0
	Njengwa	Jitegemee	8	7	15	46.7
	Nanyamba	TUVINA	12	6	18	33.3
	Naumbu	Never Loose Afya na Maendeleo	35	10	45	22.2
	Msanga Mkuu	Vijana Nguvu Kazi	8	8	16	50.0
Lindi Municipal Council	Makonde	SHEVIGRO	3	9	12	75.0
	Msinjahili	Muungano	3	12	15	80.0
	Mtanda	Sauti ya Jamii	6	-	6	0.0
	Mwenge	Umoja	4	3	7	42.9
	Rahaleo	Tujumuike	3	6	9	66.7
	Mingoyo	Mkombozi	4	7	11	63.6
Total			179	158	337	46.9

3.2 Availability and Access to SRH Services and Rights

Most of the respondents, youth and key informants, alike, acknowledged that most youth in the study area had acquired relevant knowledge and skills

on SRH services and rights. In the past, SRH services were perceived by service providers and youth themselves as solely for adults, and especially married women. Currently, the majority of youth are generally aware about SRH services and rights. *"We did not know our rights, could not talk in public meetings and were afraid of facing the doctors or nurses to ask condoms, things that we are now capable of doing*" said one male FGD participant in Mayanga. Female FGD participants in Msanga Mkuu told us that: *"Child pregnancies have greatly declined in this village. In the past, some girls could get pregnant even at the age of 12 years. Nowadays, getting pregnant is no longer a serious problem but an individual's decision."*

The community leaders and district council officials who were interviewed, shared the latter view. In one KII, a community leader affirmed that: *"There are big changes. In the past, many cases of school pregnancies were frequently reported to my office. But since 2013, I have not received any case or complaint of school pregnancy from either teachers or parents."* Youth SHG members also attested that they now have space to express themselves and discuss SRH issues that they may be facing at home and in the community. In cases where the youth feel that the situation is beyond their ability, they are free and confident to interact with service providers in order to get youth friendly SRH services and other support. In the literature, lack of appropriate sexual and reproductive health education, and lack of the means or knowledge to prevent unwanted pregnancy; have been cited as major causes of teen pregnancies and other SRH problems (Mbeba *et al*., 2012; UNICEF, 2013). Thus, interventions by the SHGs in both districts could be seen as important steps to provide the required knowledge and skills through peer education and other youth-friendly means, and contribute to improving youth SRH outcomes.

It was established from the OCA and FGDs that most SHGs used different approaches to communicate and disseminate SRH messages such as community meetings, peer education, sports and games, and Information, Educationand Communication (IEC)

materials. In Dihimba, we observed a variety of IEC materials in the youth's office including posters, leaflets and booklets with different SRH related messages. However, many peer educators in other groups lacked sufficient IEC materials to use for information dissemination. In some villages and wards, youth SHGs were given opportunities to share SRH messages during national and ward festivals, thus, creating forums for the youth and the community in general to receive SRH messages.

Our discussions with the District Reproductive and Child Health Coordinators (DRCHCos) and a review of district data revealed an increasing trend in the proportion of new family planning users over the past three years (Table 4). The DRCHCos attributed these changes to the youth-friendly services that were offered in a number of health facilities, which have greatly encouraged many youth to use family planning services. Presently, Mtwara district has 51 health facilities (47 dispensaries and 4 health centres), and all of them offer SRH services. In Lindi Urban District, 15 of the 18 health facilities (16 dispensaries, 1 health centre and 1 hospital) currently offer SRH services. Additionally, in 2012, the World AIDS Day was nationally commemorated in Lindi Region. This event brought in many stakeholders and interventions on SRH, thus, raising the proportion of new family planning users to in the district to almost 44% in 2012 (Table 4).

Table 4: Proportion of family planning services' users 2011-2013 by council

Year	Mtwara	Lindi
2011	11.3	12.0
2012	27.0	43.6
2013	32.7	21.0

Source: Compiled by authors from data obtained from DRCHCo in Mtwara and Lindi, 2014

Despite these successes, a number of concerns regarding the availability and access of youth-friendly SRH services were also raised, including the limited number of service providers trained on youth-friendly services. For example, Mtwara district had 31 trained service providers on youth-friendly SRH services and Lindi urban district had 6 trained staff. In fact, between 2013 and 2014, the number of trained providers has declined from 35 and 7 in Mtwara

and Lindi, respectively, to the current numbers. The DRCHCo in Lindi reported that although capacity-building interventions for health service providers were always included in the Comprehensive Council Health Plans, funding priorities for health interventions over the past few years have been mainly on medical supplies and equipment, but less on capacity building.

Another challenge is the limited availability of family planning supplies needed by the users. Although family planning services are freely offered in public health facilities, in many cases, councils do not receive exactly what they request from the Medical Stores Department (MSD). In Mtwara, the DRCHCo reported that in the past quarter preceding the study, the council had received only pills while they had requested for a variety of family planning methods as per users' demand. A similar situation was reported in Lindi. This limits the choice of users because the supply does not meet the demand, necessitating some of the users to buy from private drug stores or drop out completely. This was also confirmed by female FGD participants in Msanga Mkuu who reported that: *"Yes, we prefer using family planning methods, but such services are rarely available in our dispensary."*Deogan *et al*., (2012) point out that much emphasis needs to be put on quality of care (technical and user friendliness) for the provision of effective SRH interventions. This will in turn contribute to achieving the objectives of the National SRH Policy of 2003, which views adolescence as an optimal critical time for ensuring access to reproductive health information and services so as to enhance healthy life styles (Mbeba *et al*., 2012).

3.2 Capacity of Youth Self-Help Groupsin Promoting Access to SRH Services and Rights

The capacity of SHGs in terms networking, coalition building and fund raising skills were examined using the OCA tool. Networking and coalition building was measured by looking at the number of networking meetings and SRH information sharing sessions including youth talk shows and debates, and the number of youth reached with SRH messages. It was revealed that

60% of the SHGs (9 out of 15) have 'moderate capacity' and three groups (20%) have 'significant capacity' on networking and coalition building. The overall mean score for this capacity area is 2.8, and can be interpreted as 'moderate capacity' (Figure 1). Close to three-quarters of the SHGs (73%) reported having conducted at least one networking meeting and information sharing sessions on SRH. Only four SHGs (27%), two in Mtwara and two in Lindi, had not carried out any networking meetings. Overall, the surveyed groups reported to have had conducted 98 networking and/or information sharing meetings with an average of 9 meetings per group and had reached an estimated number 7245 youth with an average of 117 youth per group.

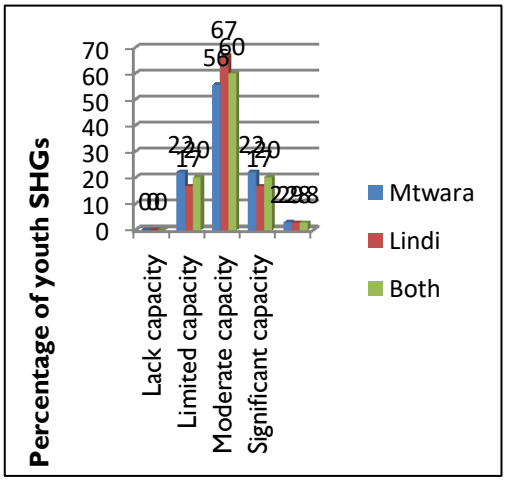

Figure 1: Networking and coalition building capacity ranking

The qualitative information from the FGDs and KIIs revealed that '*Tujumuike*' project has been very instrumental in connecting the youth for common action. This has provided them with opportunities for learning, sharing of information, experiences and challenges in different issues affecting their lives in a youth friendly way. These networks have generally helped to connect the youth with other youth in their villages, wards and districts, and have created forums for information sharing and articulation of different issues affecting their lives. In other words, these groups have increased youth economic, political and advocacy visibility in the community at large. The SHG in Mayanga, for example, reported that it was collaborating with Naliendele Agricultural Research Centre in training the group members on improved farming skills and provision of improved cassava seeds.

Another important finding related to networking and coalition building is the formation of the Mtwara Youth

Development Network (MTWAYODEN) and Lindi Youth Development Network (LIYODEN). The project in collaboration with respective district authorities facilitated the establishment of these networks through consultation meetings with youth leaders and council youth coordinators. In Mtwara, the secretary of MTWAYODEN indicated that the network had 28 groups that were members of the network from all wards across the district. In collaboration with the district community development officers and youth development officers, the network was involved in creating awareness, sensitization, and mobilizing youth to form youth groups or join the existing groups in their wards. LIYODEN was working with 18 groups from all wards in Lindi urban district.

'Connectedness' or social bonding has long been recognized as a central element in youth development programs. A review by Markham *et al*. (2010) concluded that connectedness can be a protective factor for responsible adolescent sexual and reproductive health behavior. Youth programs that provide supportive relationships with pro-social adults, a sense of belonging and appropriate structure may have a positive effect on SRH and other youth outcomes. Indeed, the findings of this evaluation confirm these observations: SHGs are playing a major role in connecting youth with their peers, pro-social adults, family and service providers. This has contributed to improving youth SRH and livelihood outcomes. Previous studies in Tanzania and elsewhere have shown that positive youth development programs help youth strengthen relationships and skills, provide them with the motivation and confidence to use the skills, embed them in positive networks of adults at home, in school and in the community, and help them to develop a more positive view of the future (Gavin *et al.,* 2010; Markham *et al*., 2010; UNICEF, 2013).

The capacity of SHGs with regard to fundraising skills was examined through the number of youth trained and mentored in proposal writing, fund raising and financial management; and percent of youth groups submitting at least one proposal for fundraising to

various donors. The findings show that 12 groups (80%) had at least one member trained on proposal writing with a total of 31 trained members (27 males, 4 females). Ten SHGs (about 67%) reported to have had submitted funding proposals mainly to their respective councils. Further, 93% of SHGs had fundraising strategies, fundraising goals and at least one dedicated fundraiser in the group. Thirteen groups (87%) indicated having at least one group member trained on fundraising skills and diversified funding sources (Table 5).

The main sources of funds for most SHGs were members' contributions (40%) and a combination of members' contributions and external sources (60%). Most groups were also involved in income generating activities (e.g. cassava farming, brick making, making soap, selling firewood, raising chicken and goats) to raise group incomes. The SHGs that reported having had received funding from external sources were in principle referring to funding obtained from their respective councils. Both councils had mechanisms for supporting youth groups with loans through either the youth or the women development funds. Despite the limited financial capacity of the councils to support all youth groups in their areas, a good number of the surveyed SHGs reported having had benefited from these schemes. For example, the FGDs participants in Mayanga told us that their group had received a loan of TZS 1,000,000 from Mtwara District Council that was required to be paid within 15 months at an interest of 10%. The same was observed in Msanga Mkuu where the district council had issued a loan of TZS 700,000 to the SHG. The interview with Youth Development Officer in Mtwara district indicated that the council had issued a total of TZS 27,000,000/= to support youth SHGs.

Table 5: SHGs individual capacity rakings on fundraising skills by district (n=15)

Capacity area	Capacity ranking	Mtwara	Lindi	Both
Fundraising strategy	Lack capacity	1(11.1)	0(0.0)	1(6.7)
	Limited capacity	2(22.2)	3(50.0)	5(33.3)
	Moderate capacity	3(33.3)	2(33.3)	5(33.3)
	Significant capacity	3(33.3)	1(16.7)	4(26.7)
Fundraising goal or target	Lack capacity	1(11.1)	0(0.0)	1(6.7)
	Limited capacity	1(11.1)	2(33.3)	3(20.0)
	Moderate	6(66.7)	3(50.0)	9(60.0)

	capacity			
	Significant capacity	1(11.1)	1(16.7)	2(13.3)
Presence of a dedicated fundraiser in the group	Lack capacity	0(0.0)	1(16.7)	1(6.7)
	Limited capacity	1(11.1)	2(33.3)	3(20.0)
	Moderate capacity	7(77.8)	2(33.3)	9(60.0)
	Significant capacity	1(11.1)	1(16.7)	2(13.3)
Group members trained on fundraising	Lack capacity	2(22.2)	0(0.0)	2(13.3)
	Limited capacity	2(22.2)	4(66.7)	6(40.0)
	Moderate capacity	4(44.4)	1(16.7)	5(33.3)
	Significant capacity	1(11.1)	1(16.7)	2(13.3)
Diversified funding sources	Lack capacity	0(0.0)	0(0.0)	0(0.0)
	Limited capacity	3(33.3)	4(66.7)	7(46.7)
	Moderate capacity	4(44.4)	1(16.7)	5(33.3)
	Significant capacity	2(22.2)	1(16.7)	3(20.0)

Figures in brackets are percentages.

Despite these achievements, most of the groups indicated that, still had limited funds to carry out their planned entrepreneurship and SRH messages' dissemination activities. For example, group leaders in Msanga Mkuu showed that they had a plan to start tailoring and fishing projects but had not been able to raise the initial capital required for starting these projects. In Mayanga, FGD participants noted that their soccer team rarely travelled to other villages for SRH information dissemination because they did not have the financial resources to hire transport. This suggests that much needs to be done to empowerSHGs with not only the knowledge and skills, but also with the necessary resources for them to be able to run viable income entrepreneurship activities.

4. Conclusions and Recommendations

There is evidence from this study that most youth SHGs are playing an important role in raising awareness among youth and other community members on SRH services and life skills. There is increased awareness among youth on SRH, which has contributed to increasing the demand and utilization of SRH services. Many of the youth attest to a clear increase in self-confidence, pride, a sense respect and authority in their households and communities. SHGs have also been very instrumental change agents in sexual and reproductive health issues in their communities through peer education, life skills, public meetings, festivals, sports and games. Consequently, this has contributed to reducing the number of early and unwanted pregnancies, abortions and

early marriages. Thus, the studyhas demonstrated that youth SHGs approach as used by the *'Tujumuike'* project is a very effective and powerful methodology for empowering youth socially, economically and politically. The district councils should improve access to youth-friendly SRH services throughout the districts by training more service providers on youth friendly services and ensuring availability of family planning supplies in all public health facilities. These facilities should offer a non-judgmental, supportive environment where young people feel comfortable and confident about expressing their concerns and to receive guidance in language that fits their experience and stage of development.

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