STAKEHOLDER ENGAGEMENT IN SEXUAL AND REPRODUCTIVE HEALTH PROGRAM IN KIGOMA, TANZANIA

BY

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MAY, 2018

DECLARATION

I declare that this thesis is my original work and has not been submitted for any other award of a degree and published at any institution of higher learning.

…… ……/……/……

Tchakubuta Remy Nicolas **Date**

APPROVAL

I declare that this thesis has been done by the student under my supervision and is ready for fur cross examination by other examiners.

…… ……/……/……

Dr. Mwesigye Edga Kateshumbwa **Date**

DEDICATION

I dedicate this thesis to my Dad Mr. Remy Tchakubuta, my Mum Ms Victorine Thomas, and to my Siblings: Powe Tchakubuta, Roda Remy, Gloria Remy, Aly Mshenibwa, Happy Remy, Irene Remy and Remy wa Remy.

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LISTS OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
CDA	Canadian Development Agency
CDCP	Centers for Disease Control and Prevention
CHANGE	Center for Health and Gender Equity
CRS	Congressional Research Service
CSR	Corporate Social Responsibility
FP	Family Planning
HIV/AIDS	Acquired immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDS	Institute of Development Studies
IFC	International Finance Corporation
IUDs	Intrauterine Devices
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NGO	Nongovernmental Organization
PMTCT	Prevention Of Mother To Child Transmission
SPSS	Statistical Package for Social Sciences
STIs	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
WHO	World Health Organization

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ABSTRACT

The study investigated the effect of stakeholder engagement on sexual and reproductive health program in Kigoma, Tanzania. The following objectives guided the study: i) to establish the effect of stakeholder identification and analysis on sexual and reproductive health program in Kigoma, Tanzania; ii) to determine the effect of information disclosure on sexual and reproductive health program in Kigoma, Tanzania; and iii) to establish the effect of stakeholder consultation on sexual and reproductive health program in Kigoma, Tanzania. This study adopted a cross-sectional study. The target population was 662 and the sample size was 249, however, 195 respondents successfully participated in the study. The research instruments included questionnaires and interview. Data was analyzed using frequency and percentage tables, descriptive statistics (mean and standard deviations) and inferential statistics (regression analysis). The study revealed that stakeholder identification and analysis significantly affected the variance in sexual and reproductive health by 41.7% (R^2=0.417, p=0.000); information disclosure significantly affected the variance in sexual and reproductive health by 46.7% (R^2=0.467, p=0.000), while stakeholder consultation significantly affected the variance in sexual and reproductive health by 54% (R^2=0.540, p=0.000). The study concluded that stakeholder engagement is a great tool in promoting sexual and reproductive health program in Kigoma District. The study made the following recommendations: the need for the program team leaders to emphasize identification of stakeholders who would be directly and indirectly affected by the program at an early stage; the need for program leaders to perform an interest-based analysis and do some mapping that can help to clarify the motivations of different actors and the ways in which they might be able to influence the program; the need for program leaders to make sure that information about sexual and reproductive health is accessible to the public in a format that is readable and easily understandable by even the most lay person; the need for program leaders to act transparent to the government, sponsors, the district leaders as well as the beneficiaries of the project; and the need for program leaders emphasize consultation at all stages of the program.

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

1.1.1 Historical Perspective

Globally, it is estimated that more than 220millionwomen in low and middle income countries have an unmet need for family planning (Morris & Rushwan, 2015). Overall, little progress has been made in increasing uptake of contraception. While increases in use have been slightly higher with adolescents than older women, this group are more affected by contraceptive failure and discontinuation rates, and use of traditional methods of contraception are still notable (Morris & Rushwan, 2015). Adolescent girls who have ever had sex or are currently sexually active are more likely to be or have been married than boys in the same categories. Married adolescents often do not want a pregnancy, but have low contraceptive rates; in fact, recent data have shown that current use of contraceptives is often lower among sexually active, married adolescents. For example, in Bangladesh contraceptive use among women aged 10–49 years rose from 49% − 61% from 1996–2011, while for married adolescents aged 15–19 years it rose from33%−47% in the same time period (Morris & Rushwan, 2015). Similarly, in Malawi, contraceptive use among married women aged 15–49 years increased from 13%−46% from1992–2010,whereas among married adolescents aged 15–19 years it rose from 7% − 29%. Unmet need for both married and unmarried adolescents is therefore still extremely high. Research suggests that current contraceptive use prevents approximately 272,000 maternal mortalities per year, and if current family planning needs were met, another 104,000 lives would not be lost, many of which would be adolescents' lives saved (Morris & Rushwan, 2015).

In Sub-Saharan Africa, a report by United Nations Population Fund ((UNFPA), 2014) revealed that though progress has been made, the region lags far behind other world regions on measures of sexual and reproductive health. It is home to only 15% of women aged 15–49 in developing regions but accounts for 63% of maternal deaths and 89% of HIV infections transmitted from mothers to infants in those regions. Furthermore, UNFPA (2014) revealed that each year, 183,000 women die in Sub-Saharan Africa from pregnancy related causes, and 1.2 million newborns die in the first month of life and yet most of these deaths could be prevented with adequate medical care. In addition, unmet need for sexual and reproductive health services is heavily concentrated among the poor. In Sub-Saharan Africa, only 26% of women from the

poorest households deliver their babies in a health facility, compared with 81% of women from the wealthiest households (UNFPA, 2014).

In order to address the disparities in sexual and reproductive health in the country, Uganda established a comprehensive policy for sexual and reproductive health. This has several components involving sexual and reproductive health such as adolescent sexuality, fertility concerns, contraception, unsafe abortion, care of the pregnant adolescent, and sexually transmitted infections and HIV/AIDS. The strategies by which the goals and objectives are met in this policy include: advocacy; information, education, and communication; training; service provision; resource mobilization; research; and coordination (Klepp, Flisher, & Kaaya, 2015).

Tanzania has over the years also drafted National policies, laws, plans and guidelines to address issues of sexual and reproductive health in the country but with minimal success. For example, in 2007 it drafted a Comprehensive Family Planning Procedure Manual (2007): advocating the provision of as many services as possible in one facility, calling on family planning providers to respond to HIV and emphasizing particular HIV services, such as HIV counseling and testing. In addition, National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths (2008– 2015), emphasized the integration of HIV, particularly prevention of mother to child transmission (prevention of mother to child transmission, (PMTCT), maternal health, and reproductive health (Ministry of Health and Social Welfare, 2010).

In Kigoma, there is limited knowledge of sexual and reproductive health among the men and women. A survey by Centers for Disease Control and Prevention (CDCP), 2015) revealed that although most women had heard of short-term family planning methods such as injectables and the pill, fewer had heard of the long-acting reversible methods such as the Intrauterine device (IUD) and implants. Furthermore, the study by CDCP (2015) found that although almost all women received antenatal care (ANC) during their pregnancies, very few (17%) begin receiving this care during the first trimester, the time when health problems can be detected early. Furthermore, during ANC care visits, fewer than half of women reportedly received instruction on pregnancy complications or had their blood pressure checked. In addition, CDCP (2015) found that in Kigoma, 74% of women received family planning counseling during pregnancy, but very few (2%) receive it at the time of delivery, and only 28% receive postpartum

counseling. All in all, the CDCP survey in Kigoma signifies that there is a lot to be done in promoting sexual and reproductive health in the area.

However, it is not yet well established whether sexual and reproductive health projects promote stakeholder engagement. Over the past 20 years, stakeholder engagement has come to be viewed as essential to fostering more responsible and sustainable business practices International Finance Corporation (IFC), 2012). In the 1990s, it emerged as a new method for understanding and addressing a broader set of social and environmental, as well as economic interests when planning and implementing corporate activities in France, German and the United Kingdom. Eventually, corporations developed tools and guidance to support them in designing systematic and effective engagement processes (IFC, 2012). The practice of stakeholder engagement is still a new concept in Africa, Tanzania inclusive. This study was intended to assess the extent of stakeholder engagement in sexual and reproductive health projects run by EngenderHealth in Kigoma district.

1.1.2 Theoretical Perspective

This study was guided by Health Belief Model by Becker (1974) and Stakeholder Theory by Freeman (1984). However, the study was anchored on Health Belief Model. The Health Belief Models assumes that human behaviour depends mainly upon the value placed by an individual on a particular goal, and upon his or her estimate of the likelihood that a given action will achieve that goal. With respect to health behaviour, the two main factors are: the desire to avoid illness or to get well, and the belief that a specific behaviour will prevent or reduce illness.

According to the Health Belief model (Becker, 1974), the likelihood that an individual engages in a given health enhancing behaviour is seen as a function of the following factors: a) perceived susceptibility: One's subjective perception of the risk of contracting a particular disease, for instance the perceived risk of being infected with HIV; b) perceived severity: feelings concerning the seriousness of the consequences of getting the disease (medical, clinical and social consequences). Most people probably believe that being infected with HIV would mean reducing life expectancy substantially. Some people may believe that being HIV infected leads to social rejection and discrimination; c) perceived benefits: The extent to which the individual believes that the various available actions are effective in reducing the threat. If use of condoms

is regarded to be effective in reducing the risk of contracting HIV or birth control like family planning, the likelihood of taking such action is higher than if this is believed not to be the case; d) perceived barriers: the potential negative aspects of a particular health action may function as impediments to undertaking the recommended behaviour. If a person believes that using a condom is going to reduce pleasure during sexual intercourse, this is expected to reduce the likelihood that this person actually will use a condom; e) cues to action: These may sometimes trigger appropriate health behaviour. This could be internal cues like bodily symptoms, or external cues such as the death of a friend, social influences, or exposure to a mass media campaign.

1.1.3 Conceptual Perspective

Stakeholder engagement is defined by Neil (2009) as the process by which an organization involves people who may be affected by the decisions it makes or can influence the implementation of its decisions. According to International Organization for Standardization (ISO) (2010), stakeholder engagement are all those activities which are undertaken to create opportunities for dialogue between an organization and one or more of its stakeholders with the aim of providing an informed basis for the organization's decisions. On the other hand, stakeholder engagement is defined by Greenwood (2007) as the process of ensuring that the appropriate people are identified and involved throughout the research process so that they are in a position to inform study design and then make use of the results when a study is completed. Furthermore, Heismann (2014) believes that stakeholder engagement is when an organization initiates open, two-way dialogue, seeking understanding and solutions to issues of mutual concern. Stakeholder engagement is the systematic and strategic process of identifying and including individuals, groups, and institutions in the planning, development, and execution of the sexual reproductive health. This study operationalized stakeholder engagement using stakeholder identification and analysis, information disclosure, and stakeholder consultation.

Sexual and reproductive health is when women and couples have the number of children they want, when they want them; deliver their babies safely and have healthy newborns; and have healthy sexual lives, free from HIV and other sexually transmitted infections (STIs) (WHO,

2008). This study operationalized sexual and reproductive health as family planning, reproductive health, and maternal health.

1.1.4 Contextual Perspective

EngenderHealth, in partnership with the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), works in Tanzania nationwide on family planning (FP), gender issues, FP-HIV integration, and other health initiatives. The expansion of EngenderHealth's FP program to all 26 regions of the country has contributed to women's having a wider choice of methods, including the highly effective but harder to deliver hormonal implants, intrauterine devices (IUDs), and permanent methods, such as female sterilization. Increased access and choice has led to rising use of contraception, through interventions like the RESPOND Tanzania Project (RTP), which expanded services to lower-level facilities and promoted task shifting to nurse practitioners for implants and IUDs. The use of hormonal implants in Tanzania has increased steadily since 2004 (EngenderHealth Report, 2016).

From 2013 to 2015, the Expand Family Planning Project (ExpandFP) complemented the national FP program and RTP's efforts by training providers at 21 facilities across the Arusha and Iringa health zones (inclusive of six regions); these providers could not have been trained with existing resources. EngenderHealth and the MOHCDGEC worked to increase access to and use of FP at the facility level during routine services and special FP day events, as well as using mobile outreach services to improve access within hard-to-reach communities. The holistic program design also worked to improve the quality of these services, supervision, and the use of data for decision making, particularly for contraceptive security (EngenderHealth Report, 2016).

EngenderHealth further works to ensure the reproductive rights of Tanzanian women and their families by integrating FP with HIV and comprehensive postabortion care services. EngenderHealth over the years facilitated outreach to marginalized groups, including sex workers, key and vulnerable populations, and youth. EngenderHealth's work in Tanzania is changing the health care landscape. Today, long-acting and permanent contraceptive methods are in high demand throughout the country. At EngenderHealth-supported sites, the rate of HIV transmission from mothers to newborns is at an all-time low, and most postabortion clients leave the clinic with a contraceptive method of their choice. Though more needs to be done to achieve

national reproductive health goals, EngenderHealth is committed to continuing its work to improve the access of Tanzanian women, men, and families to quality reproductive health (EngenderHealth Report, 2016).

1.2 Problem Statement

There is limited knowledge of sexual and reproductive health among the men and women of Kigoma. A survey by Centers for Disease Control and Prevention (CDCP), 2015) revealed that although most women had heard of short-term family planning methods such as injectables and the pill, fewer had heard of the long-acting reversible methods such as the Intrauterine device (IUD) and implants. Furthermore, the study by CDCP (2015) found that although almost all women received antenatal care (ANC) during their pregnancies, very few (17%) begin receiving this care during the first trimester, the time when health problems can be detected early. Furthermore, during ANC care visits, fewer than half of women reportedly received instruction on pregnancy complications or had their blood pressure checked. In addition, CDCP (2015) found that in Kigoma, 74% of women received family planning counseling during pregnancy, but very few (2%) receive it at the time of delivery, and only 28% receive postpartum counseling. All in all, the CDCP survey in Kigoma signifies that there is a lot to be done in promoting sexual and reproductive health in the area.

The government of the Republic of Tanzania has over the years drafted National policies, laws, plans and guidelines to address issues of sexual and reproductive health in the country but with minimal success. For example, in 2007 it drafted a Comprehensive Family Planning Procedure Manual (2007): advocating the provision of as many services as possible in one facility, calling on family planning providers to respond to HIV and emphasizing particular HIV services, such as HIV counseling and testing. In addition, National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths (2008– 2015), emphasized the integration of HIV, particularly prevention of mother to child transmission (prevention of mother to child transmission, (PMTCT), maternal health, and reproductive health (Ministry of Health and Social Welfare, 2010). All these efforts have received varied but limited success in the different regions of Tanzania, and Kigoma in particular.

In order to further act as a solution provider to the sexual and reproductive health challenges in Kigoma and other regions within Tanzania, EngenderHealth has since 2013 been providing sexual and reproductive health services in the areas of family planning, counseling, reproductive health, maternal health among others. However, these numerous projects have not been assessed to substantiate the extent to which stakeholders are engaged in them. The rationale for this study was therefore to substantiate the extent to which stakeholders are engaged in sexual and reproductive health projects run by EngenderHealth in Kigoma region.

1.3 Purpose of the Study

To assess the effect of stakeholder engagement on sexual and reproductive health program in Kigoma, Tanzania.

1.4 Objectives of the Study

i. To examine the effect of stakeholder identification and analysis on sexual and reproductive health program in Kigoma, Tanzania.
ii. To assess the effect of information disclosure on sexual and reproductive health program in Kigoma, Tanzania.
iii. To examine the effect of stakeholder consultation on sexual and reproductive health program in Kigoma, Tanzania.

1.5 Research Questions

i. What is the effect of stakeholder identification and analysis on sexual and reproductive health program in Kigoma, Tanzania?
ii. What is the effect of information disclosure on sexual and reproductive health program in Kigoma, Tanzania?
iii. What is the effect of stakeholder consultation on sexual and reproductive health program in Kigoma, Tanzania?

1.6 Hypotheses

i. Ho_1: There is no significant effect of stakeholder identification and analysis on sexual and reproductive health program in Kigoma, Tanzania.
ii. Ho_2: There is no significant effect of information disclosure on sexual and reproductive health program in Kigoma, Tanzania.
iii. Ho_3: There is no significant effect of stakeholder consultation on sexual and reproductive health program in Kigoma, Tanzania.

1.7 Scope of the Study

1.7.1 Geographical Scope

This study was conducted in Kigoma City. Kigoma resides in the northwestern corner of Tanzania. The region lies at about 5^0 south and 30^0 east Greenwich. The region is bordered to the north by both Burundi and Kagera region. To the east, it is bordered by Shinyanga and Tabora regions, and to the west by Lake Tanganyika. Specifically the study will be conducted under the engender health program.

1.7.2 Theoretical Scope

This study was guided by Health Belief Model by Becker (1974) and Stakeholder Theory by Freeman (1984). However, the study was anchored on Health Belief Model. The Health Belief Models assumes that human behaviour depends mainly upon the value placed by an individual on a particular goal, and upon his or her estimate of the likelihood that a given action will achieve that goal.

1.7.3 Content Scope

This study was confined to stakeholder engagement (independent variable) measured using stakeholder identification and analysis, information disclosure, and stakeholder consultation; while sexual and reproductive health (dependent variable) was measured using family planning, reproductive health and maternal health.

1.7.4 Time Scope

This study reviewed a period of 3 years, that is, from 2014 to 2017. This is because, there have been several sexual and reproductive health projects within this period of time.

1.8 Significance of the Study

The findings of this study will be helpful to the Ministry of health by providing evidence of the strength and weaknesses of the ongoing sexual and reproductive health projects in Kigoma. This will help them to address the weaknesses accordingly and strengthen areas where there is strength.

Furthermore, policy makers will also find the materials of this study helpful in coming up with policies that are helpful in promoting sexual and reproductive health projects through consultative venture.

In addition, Nongovernmental organizational and donors will use the findings of this study to improve service delivery in sexual and reproductive health projects through timely delivery of finances and capacity building of both the healthcare workers and beneficiaries of such projects.

Similarly, scholars and academicians shall use the findings of this study in the future to carry out similar studies.

1.9 Operational Definition of Terms

Stakeholders: refers to persons or groups who are directly or indirectly affected by a project, as well as those who may have interests in a project and/or the ability to influence its outcome, either positively or negatively and they include locally affected communities or individuals and their formal and informal representatives, national or local government authorities, politicians, religious leaders, civil society organizations and groups with special interests, the academic community, or other businesses.

Engagement: refers to a form of stakeholder relations along a spectrum of possible interactions that also include activities like message delivery, media outreach, deal negotiations, lobbying, coalition development, advocacy, damage control, research surveys, focus groups, issue management and benchmarking.

Stakeholder engagements: refer to practices which an organization undertakes to involve stakeholders in a positive manner in organizational activities

Stakeholder Identification and Analysis: refers to the process used to identify all people or organizations that may be impacted by or have an impact on the project.

Information Disclosure: refers to communicating information in a manner that is understandable to the stakeholders in the process of stakeholder engagement

Stakeholder Consultation: refers to a two-way process of dialogue between the project company and its stakeholders.

Maternal health: refers to the health of women during pregnancy, childbirth and the postpartum period.

Family planning: refers to when both the husband and wife together discuss and mutually decide how many children they would like to have and when, so that they can give sufficient love, care, attention and good education to each of their children.

Reproductive health: refers to the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter reviewed publications from scholars and authors so as to better understand the main constructs of the study, that is, stakeholder engagement and sexual reproductive health. The chapter is subdivided into; theoretical review, conceptual framework and Related studies.

2.1 Theoretical Review

This study was guided by Health Belief Model by Becker (1974) and Stakeholder Theory by Freeman (1984). However, the study was anchored on Health Belief Model.

2.1.1 Health Belief Model

This study was anchored on Health Belief Model (Becker, 1974). The Health Belief Models assumes that human behaviour depends mainly upon the value placed by an individual on a particular goal, and upon his or her estimate of the likelihood that a given action will achieve that goal. With respect to health behaviour, the two main factors are: the desire to avoid illness or to get well, and the belief that a specific behaviour will prevent or reduce illness.

According to the Health Belief model Becker (1974), the likelihood that an individual engages in a given health enhancing behaviour is seen as a function of the following factors: a) perceived susceptibility: One's subjective perception of the risk of contracting a particular disease, for instance the perceived risk of being infected with HIV; b) perceived severity: feelings concerning the seriousness of the consequences of getting the disease (medical, clinical and social consequences). Most people probably believe that being infected with HIV would mean reducing life expectancy substantially. Some people may believe that being HIV infected leads to social rejection and discrimination; c) perceived benefits: The extent to which the individual believes that the various available actions are effective in reducing the threat. If use of condoms is regarded to be effective in reducing the risk of contracting HIV or birth control like family planning, the likelihood of taking such action is higher than if this is believed not to be the case; d) perceived barriers: the potential negative aspects of a particular health action may function as impediments to undertaking the recommended behaviour. If a person believes that using a condom is going to reduce pleasure during sexual intercourse, this is expected to reduce the likelihood that this person actually will use a condom; e) cues to action: These may sometimes

trigger appropriate health behaviour. This could be internal cues like bodily symptoms, or external cues such as the death of a friend, social influences, or exposure to a mass media campaign.

Susceptibility and severity jointly determine the perceived threat of the disease, sometimes referred to as vulnerability. Perceived benefits of a specific action and perceived barriers to taking that action can be referred to as out-come expectations (Rosenstock, 1990). A number of adjustments and additional predictors of the Health Belief Model have been proposed. In some versions of the model, an individual's general health motivation, defined as "readiness to be concerned about health matters" has been included (Becker et al., 1977). Lau et al. (1986) have proposed that the value that the individual places on health should be included. Wallston & Wallston (1982) have argued that health locus of control beliefs (whether individuals consider their health to be under the control of internal factors, powerful others, or chance) would add to the predictive power of the model. Rosenstock et al. (1988) proposed self-efficacy (conviction about one's ability to carry out the recommended action) as another candidate predictor. It was argued that this would improve the explanatory power of the model. Becker et al. (1977) suggested that behavioural intentions should be placed as a mediator between the predictors and behaviour.

According to Stroebe (2000), the formal relationships between the factors of the Health Belief Model have not been sufficiently spelled out. In most studies based on this model, the six constructs described above have been treated as separate groups of predictors. This has led some critics to maintain that the Health Belief Model should not be regarded as a systematic theory, but rather as a collection of variables (Conner, 1993). Some researchers have, however, proposed more specific models.

Benefits and barriers are sometimes combined into one single index and this has also been the case with susceptibility and severity. Strecher et al. (1997) have argued that the model should not be regarded as a list of promising predictors which can be thrown into a multiple regression analysis in order to identify which variables are "the best swimmers". They have provided advice regarding measurement of variables and guidelines for statistical analysis including a number of interaction effect hypotheses.

Rosenstock (1990) claimed that the Health Belief Model has received considerable empirical support. In their review of studies based on the model, however, Harrison and associates (1992) concluded that the four predictors that have most frequently been studied (susceptibility, severity, benefits, and barriers) on average have shown only modest associations with health behaviours. “Cues to action” and “general health motivation” have more or less been neglected in empirical tests of the Health Belief Model (Sheeran & Abraham, 2010).

In two reviews it is concluded that “perceived barriers” was the single most powerful predictor of health behaviours across all studies reviewed (Harrison et al., 1992). This may seem surprising since perceived barriers is the only factor among those originally included in the Health Belief Model which clearly goes beyond the sphere of health concerns. This may actually point to one of the weaknesses of the model.

The Health Belief Model seems to be based on an assumption that health concerns are the most important kind of predictors of health behaviours. This is not necessarily the case. Other concerns, such as the social consequences of a specific behaviour or the immediate pleasure associated with some health compromising behaviours, may be at least as important predictors of health behaviour as worries about health consequences. The Health Belief Model focuses mainly on health-related cognitive factors. The social and contextual factors which may influence behaviour, and emotions and effect are not sufficiently explicated and taken into account.

The health Belief Model is related to this study in the following ways: i) because of the factor of *perceived benefits*, people believe that the various available actions are effective in reducing the threat. For example, people will choose to use family planning methods such as use of condoms because of the benefits it has in reducing unwanted pregnancies; ii) perceived severity: feelings concerning the seriousness of the consequences of getting the disease. In this case, people will practice proper reproductive health such as abstaining or sticking to one partner so as to avoid catching AIDs/STIs whose consequences are severe when one catches such diseases as a result of multiple partners; iii) cues to action: These may sometimes trigger appropriate health behaviour. Because of one’s cue of their bodies and some health complications, one may choose to engage in proper maternal health such as frequent visit to health facility for antenatal care services, so as to avoid morbidity or unsafe abortion.

2.1.2 Stakeholder Theory

Stakeholder theory promotes a practical, efficient, effective, and ethical way to manage organizations in a highly complex and turbulent environment (Freeman, 1984; Freeman, Harrison and Wicks, 2007). It is a practical theory because all firms have to manage stakeholders. It is efficient because stakeholders that are treated well tend to reciprocate with positive attitudes and behaviors towards the organization, such as sharing valuable information (all stakeholders), buying more products or services (customers), providing tax breaks or other incentives (communities), providing better financial terms (financiers), buying more stock (shareholders), or working hard and remaining loyal to the organization, even during difficult times (employees). It is effective because it harnesses the energy of stakeholders towards the fulfillment of the organization's goals.

According to Freeman, Harrison, Wicks, Parmar and deColle (2010), stakeholder theory is useful in a complex and turbulent environment because firms that manage for stakeholders have better information upon which to base their decisions and, because they are attractive to other market participants, they have a degree of strategic flexibility that is not available to competitors that do not manage for stakeholders All management decisions contain an ethical component, and the ethical arguments in defense of managing for stakeholders are as important to the theory as are the practical considerations. Scholars have defended stakeholder theory using a wide variety of theoretical perspectives, including integrated social contacts theory (Donaldson & Dunfee 1999), Kantianism (Evan & Freeman, 1993), the doctrine of fair contracts (Freeman, 1994), the principle of fairness (Phillips, 2003), the principle of the common good (Argandoña, 1998), feminist ethics (Wicks, Gilbert & Freeman, 1994), and pragmatism (Wicks & Freeman, 1998).

Stakeholders typically are defined as individuals, groups and organizations that have an interest in the processes and outcomes of the firm and upon whom the firm depends for the achievement of its goals (Freeman, 1984; Freeman, Harrison & Wicks, 2007). Some individuals, groups and organizations are easily defined as stakeholders because of their involvement in the value producing processes of the firm. They include employees and managers, shareholders, financiers, customers and suppliers. These stakeholders may be referred to as primary stakeholders or legitimate stakeholders (Phillips, 2003).

Stakeholder theory suggests that "managing for stakeholders" involves attending to the interests and wellbeing of these stakeholders, at a minimum (Harrison, Bosse & Phillips, 2010). However, frequently other stakeholder groups are included, such as communities, special interest or environmental groups, the media, or even society as a whole. This latter group, society, is a little difficult to comprehend in terms of the core ideas of stakeholder theory because it is, from a practical perspective, impossible to determine what is in the best interests of such a vast and heterogeneous group.

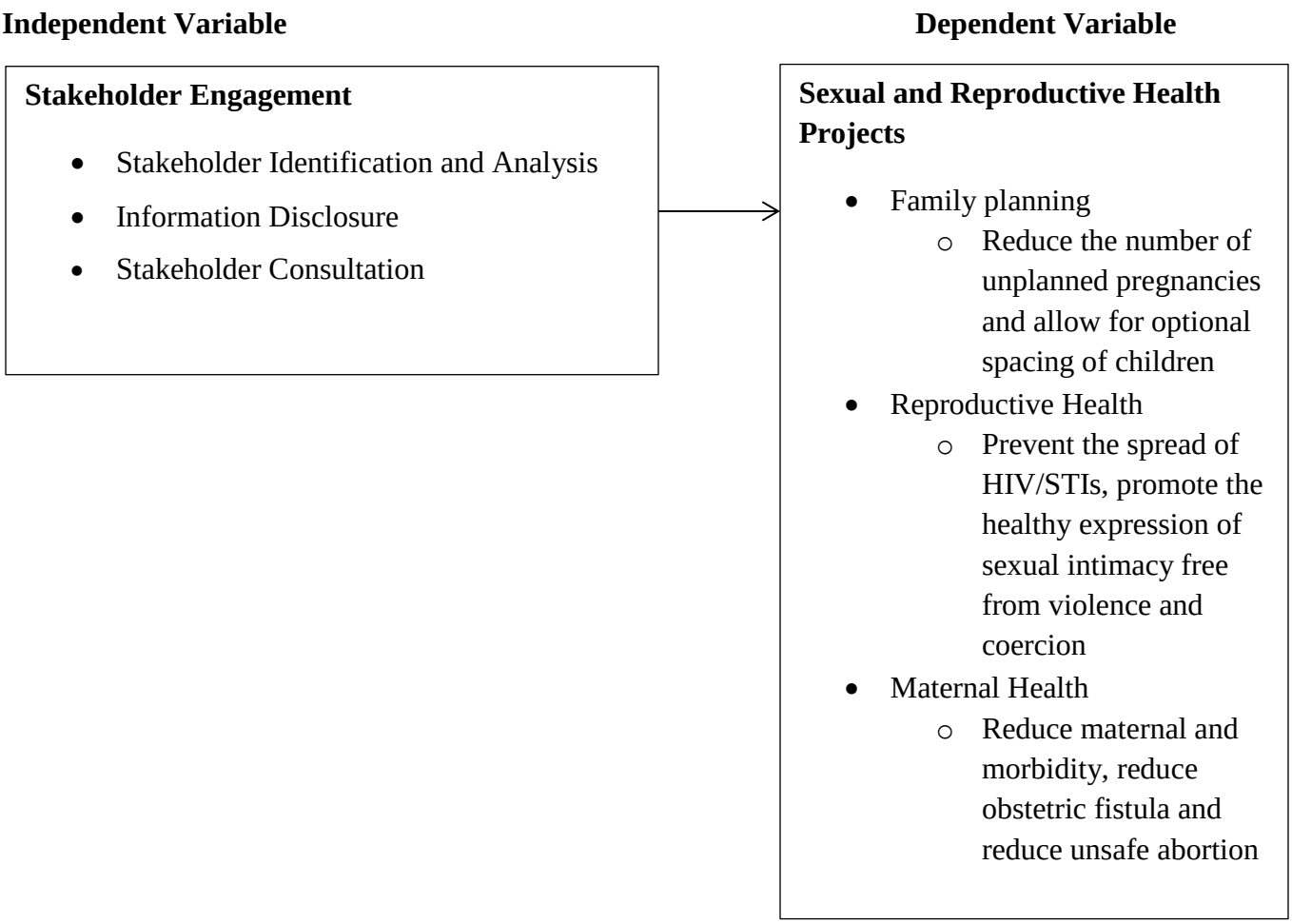
An interesting and important aspect of stakeholder theory is that it is comprehensive in its approach. Stakeholder theory advocates for treating all stakeholders with fairness, honesty, and even generosity. As Harrison, Bosse and Phillips (2010, p. 58) put it, "A firm that manages for stakeholders allocates more resources to satisfying the needs and demands of its legitimate stakeholders than what is necessary to simply retain their willful participation in the productive activities of the firm." Other business disciplines tend to focus on one or a subset of stakeholder groups: human resource theory focuses on employees, marketing theory focuses on customers, financial theory focuses on shareholders and financiers, and so forth.

Stakeholder theory proposes that treating all stakeholders well creates a sort of synergy (Parmar, Freeman, Harrison, Wicks, Purnell & de Colle, 2010; Tantalo and Priem, 2014). In other words, how a firm treats its customers influences the attitudes and behavior of the firm's employees, and how a firm behaves towards the communities in which it operates influences the attitudes and behavior of its suppliers and customers (Cording, Harrison, Hoskisson & Jonsen, 2014; du Luque, Washburn, Waldman & House, 2008). This concept is known as generalized exchange, and it is a core differentiating aspect of the theory (Harrison, Bosse & Phillips, 2010).

This theory therefore relates to this study in a way that it advocates for fair treatment of stakeholders and inclusion in matters that would affect them either indirectly or directly. This implies that when stakeholders are being rightly identified, consulted and information disclosed to them in a proper manner, then it means that they are being engaged in that particular program.

2.2 Conceptual Framework

Figure 1 below shows the relationship between stakeholder engagement and sexual reproductive health projects in Kigoma, Tanzania.



Source: Adopted from: WHO (2008); Greenwood (2007)

Figure 1: Showing Conceptual Framework

The figure above shows that stakeholder engagement is the independent variable measured using stakeholder identification and analysis, information disclosure, and stakeholder consultation; while the dependent variable is sexual and reproductive health which is measured using family planning, reproductive health and maternal health. The relationship between the two variables is that stakeholder engagement ensures implementation of peaceful sexual and reproductive health programs. For instance, identifying and analyzing the stakeholders whom the project would directly and indirectly affect ensures that family planning project is properly adhered to. Furthermore, providing timely and appropriate information to the rightful stakeholders ensures

that both men and women know their reproductive health rights. In addition stakeholder consultation can also promote better maternal health. This is because consulting the husbands, elders, mothers, religious leaders and traditional birth attendants ensures that pregnant women give birth in well facilitated healthcare facilities hence reducing risks and complications related to childbirth.

2.3 Review of Related Literature

2.3.1 Stakeholder Engagement

Stakeholder engagements are practices which an organization undertakes to involve stakeholders in a positive manner in organizational activities (Greenwood, 2007). It can comprise the process of establishing, developing and maintaining stakeholder relations. This can include stakeholder identification, consultation, communication, dialogue and exchange (Burchell & Cook 2006; Greenwood, 2007). Stakeholder engagement activities may accordingly exist within a broad range of business activities. In short, the impetus behind the use of the term 'engagement' in the stakeholder theory and corporate social responsibility (CSR) literatures is the need to emphasize that, for firms merely to interact with stakeholders is no longer sufficient, if, in fact, it ever was. Interaction with stakeholders is a logically necessary activity of business (Noland & Phillips, 2010). Within this context, engagement can be seen as a mechanism to achieve a number of objectives including consent, control, co-operation, accountability and involvement, as a method for enhancing trust or as a substitute for true trust, as a discourse to enhance fairness or as a mechanism of corporate governance (Greenwood, 2007).

In ideal terms, stakeholder engagement could be interpreted as a mutually beneficial and just scheme of cooperation which takes the form of a 'moral partnership of equals' (Phillips, 1997). In this regard, an assortment of economic and behavioural exchange theories provide various additional insights for examining the independencies in these relationships (Donaldson & O'Toole 2007). However, in reviewing the various possible depictions of stakeholder engagement from various theoretical traditions such as business ethics, social accounting and reporting, as well as human resource management, Greenwood (2007) argues that stakeholder engagement is for the most part morally neutral.

As a result, it can be employed in a moral or an immoral way. In business practice, it is the virtue of the actor which ultimately determines the motive behind the engagement undertaken. As a

result, engagement with stakeholders does not necessarily equate with responsible business behaviour (Greenwood 2007). Accordingly, the argument that stakeholder engagement is linked with responsible treatment of stakeholders is simplistic (Greenwood, 2007). Significantly in this regard, past scholarship reveals competing ideas about the proper motivation, method and manner of engaging stakeholders which has culminated in the emergence of a greater awareness of the need to reconceive the purpose of business and the nature of the firm. The most prominent recent trend in this respect is proposed by those scholars who take an Ethical Strategist view. Their interpretation provides the theoretical basis for including honest, open and respectful engagement of stakeholders as a vital part a firm's strategy. They do this by calling our attention to the stakeholders who constitute the firm as people with 'names and faces' and reminding us of business's role in society's pursuit of the good life (Noland & Phillips, 2010).

Crucially, the cognitive transition inherent in this inclusive approach empowers the very purpose of the firm and the capitalist system within which it operates to most optimally invest its resources to enable the creation of synergic value for all stakeholders as originally suggested by Freeman (Freeman, 1984; Freeman, Martin & Parmar, 2007). More specifically in this regard, this evolution towards a greater focus upon stakeholders has resulted in the development of a broad range of engagement strategies which stretch from increased dissemination of information through detailed reporting practices towards more interactive stakeholder relationships (Burchell & Cook, 2008). Within the construct of stakeholder engagement, while rigid identification of the exact persons who qualify as stakeholders may be displaced, identification of what counts as a stakeholder claim is vital (Mitchell et al. 1997). Once this identification has taken place, increased emphasis is placed upon the concept of stakeholder communication and dialogue and its many formats (Burchell & Cook, 2006; ISO, 2010; O'Riordan, 2010).

A very common way of differentiating the different kinds of stakeholders is to consider groups of people who have classifiable relationships with the organization. Friedman and Miles (2006) mean that there is a clear relationship between definitions of what stakeholders and identification of who are the stakeholders. The main groups of stakeholders are: customers, employees, local communities, suppliers and distributors, and shareholders.

In addition other groups and individuals are considered to be stakeholders in the literature of Friedman and Miles (2006): the media, the public in general, business partners, future

generations, past generations (founders of organizations), academics, competitors, NGOs or activists, stakeholder representatives such as trade unions or trade associations of suppliers or distributors, financiers other than stockholders (debt holders, bondholders, creditors), government, regulators, and policymakers. Of course all categories of stakeholder groups could be defined more finely. For example, media could be split up into radio, television and print media, or employees as blue-collar and white collar workers, or in terms for which department they work. An advantage of finer categories of stakeholders is that by doing so more homogeneous grouping of people is more likely. The negative fact about this would be the greater chance of overlap of interests and actions.

The engagement of stakeholders for creating values can take many forms. Greenwood (2007) argued that engaging stakeholders is actually a morally neutral practice and may or may not be related to corporate responsibility. It means there is not always a moral treatment of stakeholders and both parties may or may not be equal, especially in reality, it is more likely that the organization is the more powerful party which sets the terms of cooperation. Dawkins (2014) proposes to use the principle of good faith in stakeholder engagement, which advocates dialogue, negotiation, transparency, and totality of conduct (consistency in pursuing good faith). Sloan (2009) also proved that engagement based on collaboration with stakeholders can create more opportunities in terms of learning, innovation and fundamental corporate transformation, compared to the traditional and common practice of controlling stakeholders for managing risks.

Proactivity is also important in the way to engage stakeholders. It is rather up to managers to decide how they want to do business and develop relationships with their stakeholders for creating values. According to Freeman et al. (2007), managers must develop relationships, inspire their stakeholders, and create communities where everyone strives to give their best to deliver the value the company promises. Therefore, managers should take the proactive role in developing relationships with stakeholders. Corus and Ozanne (2012) also emphasized the deliberative effort of business to build dialogue and exchange platform in a genuine two-way relationships that can bring unexpected advantages.

In terms of practical capabilities of how to engage, Ayuso, Rodríguez, García, Castro and Ángel (2011) specifically talked about stakeholder dialogue and stakeholder knowledge integration:

"stakeholder dialogue leverages organizational resources that promote two-way communication, transparency and appropriate feedback to stakeholders, stakeholder knowledge integration relies on non-hierarchical structures, flexibility and openness to change." Despite these two specific capabilities, literature is generally lacking in the engagement mechanism and companies can vary in who are the stakeholders and how to engage.

2.3.1.1 Stakeholder Identification and Analysis

The first step in the process of stakeholder engagement is stakeholder identification–determining who your project stakeholders are, and their key groupings and sub-groupings (Ahmad et al. 2015). From this flows stakeholder analysis, a more in-depth look at stakeholder group interests, how they will be affected and to what degree, and what influence they could have on the project. The answers to these questions will provide the basis from which to build the stakeholder engagement strategy. However, it is important to keep in mind that not all stakeholders in a particular group or sub-group will necessarily share the same concerns or have unified opinions or priorities (Ahmad et al. 2015).

Cooperrider and Fry (2010) argues that when identifying affected stakeholders, a systematic approach often works well, starting with delineating the project's geographic sphere of influence. The authors advise that at this stage, one should think of only about the primary project site(s), but also all related facilities, including associated facilities, transport routes, areas potentially affected by cumulative impacts, or unplanned but predictable developments. In other words, this helps in analysis to establish and articulate the project's area of influence and determine who might be affected and in what way (Cooperrider & Fry, 2010). This process will begin to reveal those most directly affected by the project, whether from the use of land at the project site or the effects of air and water emissions, from off-site transportation of hazardous materials, or even the socio-economic effects of job creation throughout the supply chain.

According to Corus and Ozanne (2012), a quick and practical technique for undertaking this type of stakeholder mapping exercise is "impact zoning". By mapping the sphere of influence of different types of environmental and social impacts, the project company can begin to identify distinct groups by impact area, and from this prioritize stakeholders for consultation. For larger-scale projects, with different phases to their development, mapping out both the near term and future facilities may assist the company to identify potential "cumulative impacts" on

stakeholder groups that might not have been evident by just looking at the immediate project (Corus & Ozanne, 2012).

Cottrell et al. (2015) opines that while priority should be given to individuals and groups in the project area who are directly and adversely affected, drawing the line between who is affected and who is not can be challenging. Even with the best of efforts, problems can arise. Communities lying just outside of the designated project impact area can "perceive" impacts or feel they have been arbitrarily excluded from project benefits. For these reasons, defining stakeholders too narrowly should also be avoided (Cottrell et al. 2015).

Curzon (2016) argues that for some projects, the most vocal opposition may come from stakeholders outside the affected area – in other parts of the country, from other countries altogether, or even from overseas. Curzon (2016) explains that underestimating their potential influence on project outcomes may pose risks. He advises that it is important to also include in your stakeholder analysis those groups or organizations that are not adversely affected, but whose interests determine them as stakeholders. Curzon (2016) says "Interest-based" analysis and mapping can help clarify the motivations of different actors and the ways in which they might be able to influence the project. For this set of stakeholders, cost-effective solutions (newsletters, websites, targeted public meetings) can establish and maintain open channels of communication. Dawkins (2014) posits that choosing not to engage with these parties creates the risk that their issues may get discussed through other outlets such as the media or political process. While this may happen anyway, it is usually better to be proactive in trying to manage such risks by offering opportunities for constructive dialogue (Dawkins, 2014).

According to Gao and Zhang (2006), stakeholder identification and analysis can be a challenging exercise. It is at times not sufficient to focus only on the communities and other stakeholders that are actually impacted by the project, but also those who may perceive that they are adversely impacted or who consider themselves the representatives of impacted people.

Gouillart (2014) says identifying stakeholder representatives and consulting with and through them can be an efficient way to disseminate information to large numbers of stakeholders and receive information from them. However, Gouillart (2014) posits that when working to determine representatives, there are a number of factors worth considering. First, try to ensure

that these individuals are indeed true advocates of the views of their constituents, and can be relied upon to faithfully communicate the results of engagement with the project company back to their constituents. Greenwood (2007) asserts that one way to do this is to seek verification that the right representatives have been engaged, by talking directly to a sample of project-affected people. Ground-truthing the views of the designated representatives in this way can help highlight any inconsistencies in how stakeholder views are being represented. According to Romenti (2010), legitimate stakeholder representatives could be, but are not limited to: elected representatives of regional, local, and village councils; traditional representatives, such as village headmen or tribal leaders; leaders (chairmen, directors) of local cooperatives, other community-based organizations, local NGOs, and local women's groups; politicians and local government officials; school teachers; and religious leaders.

2.3.1.2 Information Disclosure

Disclosure is a formal-sounding term for making information accessible to interested and affected parties (Sloan, 2009). Communicating such information in a manner that is understandable to the stakeholders is an important first (and ongoing) step in the process of stakeholder engagement. All other activities, from consultation and informed participation to negotiation and resolution of grievances, will be more constructive if stakeholders, including affected communities, have accurate and timely information about the project, its impacts, and any other aspects that may have an effect on them (Sloan, 2009).

According to Hoffmann and Fieseler (2010), good practice of information disclosure involves taking steps to increase transparency and accountability as a means of promoting understanding about the project and engendering public trust. Hoffmann and Fieseler (2010) argue that adopting a "presumption in favor of disclosure" means being forthcoming with information whenever possible, especially if there is no compelling reason not to share it. Maak (2017) warns that a lack of information can lead to the spread of misinformation about a project that can be both damaging to a company's reputation, and undermine efforts to engage in an informed dialogue with stakeholders. This is an area where perception matters. Sometimes stakeholders care less about the actual content of the information being disclosed than they do about the principle of openness and transparency.

Noland and Phillips (2010) posit that in order to properly disclose information, one must apply the following principles: a) Disclose early – with the aim of providing relevant information to targeted stakeholders in advance of decision-making. At a minimum, explain next steps and be clear about which project elements are fixed and which can be changed or improved upon, based on consultation and participatory inputs; b) Disclose objective information – to the extent possible, and be open about the project. In short, "tell it like it is." Refrain from exaggerating the good news, such as employment opportunities, or playing down the bad, such as anticipated noise levels and traffic disturbances during the construction period. If actual numbers are available, give these out, even if they are only estimates;

c) Design disclosure to support consultation – Where appropriate, treat the disclosure of project and environmental and social information as an integral part of stakeholder consultation. Give people the information they need to participate in an informed manner. Crucially, leave sufficient time between the provision of information about the benefits and disadvantages of the project (or changes to project operations and their implications) and the start of consultations. People need time to think about the issues and weigh the trade-offs. Do not expect that stakeholders hearing or seeing information about a project for the first time will be immediately ready to make decisions about what they want (Noland & Phillips, 2010).

d) Provide meaningful information – in a format and language that is readily understandable and tailored to the target stakeholder group. The aim should be for the information provided to enable people and organizations to make informed judgments about changes that will affect their lives. This may mean that information will be required in different formats in order to meet the needs of various audiences. Points to consider in determining what forms this information should take and how it gets presented include: level of technical detail, local language and dialects, cultural sensitivity, roles of women and men, ethnic composition of communities, literacy levels, community leadership structures, and local methods of disseminating information within stakeholder groups (Noland & Phillips, 2010)

e) Ensure the accessibility of information – by thinking through how the intended recipient will most readily receive and comprehend the information. For example, the regulatory requirement of disclosing information in locations open to the general public (offices of government environmental regulators, local planning authorities, etc.) is a necessary, but not fully sufficient,

means to disseminate information of importance to stakeholders. Especially with affected communities, it may be more constructive to disclose information via public meetings, smaller gatherings of specific stakeholder sub-groups, through the use of individual conduits and intermediaries (such as the head of a local village council, or church or traditional leaders), or through the dissemination of a summary of the key information in the local language, for example via the newsprint and broadcast media, road side displays, or direct mail. In general, it is a good idea to ask for stakeholder input into the consultation process –stakeholders can often readily tell you what type of information they want and need, in what type of format, and how and when they would like to be engaged (Noland & Phillips, 2010).

2.3.1.3 Stakeholder Consultation

As discussed in the previous section, the disclosure of information should support consultation. Consultation is a two-way process of dialogue between the project company and its stakeholders (Cennamo et al. 2014). Stakeholder consultation is really about initiating and sustaining constructive external relationships over time. Companies that start the process early and take a long-term, strategic view are, in essence, developing their local "social license to operate." Chapman (2014) argues that for projects that have environmental and social impacts, consultation will not be a single conversation but a series of opportunities to create understanding about the project among those it will likely affect or interest, and to learn how these external parties view the project and its attendant risks, impacts, opportunities, and mitigation measures.

According to Chapman (2014), listening to stakeholder concerns and feedback can be a valuable source of information that can improve project design and outcomes and help a company to identify and control external risks. It can also form the basis for future collaboration and partnerships. For stakeholders, a company's consultation process is an opportunity to get information, as well as to educate company staff about the local context in which a project will take place, to raise issues and concerns, ask questions, and potentially help shape the project by making suggestions for the company to consider and respond to.

According to International Finance Corporation (IFC) (2012), there is no one right way of undertaking consultation. Given its nature, the process will always be context-specific. This

means that techniques, methods, approaches and timetables will need to be tailored for the local situation and the various types of stakeholders being consulted. Ideally, a good consultation process will be: targeted at those most likely to be affected by the project; early enough to scope key issues and have an effect on the project decisions to which they relate; informed as a result of relevant information being disseminated in advance; meaningful to those consulted because the content is presented in a readily understandable format and the techniques used are culturally appropriate; two-way so that both sides have the opportunity to exchange views and information, to listen, and to have their issues addressed; gender-inclusive through awareness that men and women often have differing views and needs; localized to reflect appropriate timeframes, context, and local languages; free from manipulation or coercion; documented to keep track of who has been consulted and the key issues raised; reported back in a timely way to those consulted, with clarification of next steps; and ongoing as required during the life of the project (IFC, 2012).

A publication by Canadian Development Agency (CDA) (2014) revealed that informed participation is a more intensive and active form of consultation. This is because participation involves a more in-depth exchange of views and information, leading to joint analysis and decision-making. This increased level of involvement tends to generate a shared sense of ownership in a process and its outcomes. The more a particular stakeholder group is materially affected by a component of the project, the more important it is for them to be properly informed and encouraged to participate in matters that have direct bearing on them, including proposed mitigation measures, the sharing of development benefits and opportunities, and implementation or monitoring issues. Resettlement planning, designing and implementing community development programs, and engagement with indigenous peoples' groups are good examples of where informed participation by affected stakeholders can lead to better outcomes on the ground (CDA, 2014). In certain situations, capacity-building programs may be needed to enable affected stakeholders (particularly local communities and organizations) to be able to participate fully and effectively in the process.

On the other hand, Morris and Baddache (2012) also pointed out that indigenous peoples, as social groups with identities that are distinct from dominant groups in national societies, are often among the most marginalized and vulnerable segments of a population. They can be

subject to different types of risks and severity of impacts including loss of identity, culture, traditional lands, and natural resource-based livelihoods. Morris and Baddache (2012) propose that if a project will directly affect indigenous groups and their traditional or customary lands under use, early engagement is an essential first step in building longer-term processes of consultation, informed participation, and good faith negotiation.

According to World Resources Institute (2013), when consulting with indigenous peoples, the organization in question should try to involve the representative bodies in the prior design of materials for disclosure, and in deciding how people and groups wish to be accessed, where the consultations will take place, the chronology of consultation (there may be expectations of who will be consulted in what particular order) and the language and format to be used during the consultations. furthermore, the organization should allow sufficient time for collective decision-making processes, and review the grievance mechanism established for this phase of the project to make sure it is appropriate and accessible (World Resources Institute, 2013).

Institute of Development Studies (IDS) (2014) asserts that depending on the nature and scale of a project, a company's arrival into a community has the potential to affect many different aspects of people's lives. Therefore it is important to keep in mind that it is likely to affect men and women differently. In most societies, men and women play different roles within the private and public spheres. With these different and complex roles come differential access to resources and finances, to contacts and relationships, to personal skills development, and to opportunity and power. Consulting primarily with men provides only half of the story. Partial information can lead to both risks and missed opportunities. For most companies, failing to consult adequately with women is not deliberate, rather it happens because engaging women in the consultation process usually requires awareness and concerted effort (IDS, 2014).

2.3.2 Sexual and Reproductive Health

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system (Theobold, 2011). It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. To maintain one's sexual and reproductive health, people need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect

themselves from sexually transmitted infections. And when they decide to have children, women must have access to services that can help them have a fit pregnancy, safe delivery and healthy baby (Theobold, 2011).

2.3.2.1 Family Planning

Family planning is the practice of controlling the number of children in a family and the intervals between their births (Mischell, 2015). Family planning is achieved through the use of contraceptive methods and the treatment of infertility (inability to have children). Planning when and how many children to have is the couple's responsibility, not just the man's or woman's. Family planning is just as important for newly married couples as it is for those who already have one or more children. It enables young people to delay their first child till they are prepared to take up the responsibilities of raising a child (Mischell, 2015).

Contemporary notions of family planning, however, tend to place a woman and her childbearing decisions at the center of the discussion, as notions of women's empowerment and reproductive autonomy have gained traction in many parts of the world. According to Tsui et al. (2010), family planning may involve consideration of the number of children a woman wishes to have, including the choice to have no children, as well as the age at which she wishes to have them. These matters are influenced by external factors such as marital situation, career considerations, financial position, any disabilities that may affect their ability to have children and raise them, besides many other considerations. If sexually active, family planning may involve the use of contraception and other techniques to control the timing of reproduction. Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management (Tsui et al. 2010).

Cleland et al. (2015), raising a child requires significant amounts of resources: time, social, financial, and environmental. Planning can help assure that resources are available. The purpose of family planning is to make sure that any couple, man, or woman who has a child has the resources that are needed in order to complete this goal. With these resources a couple, man or women can explore the options of natural birth, surrogacy, artificial insemination, or adoption. In the other case, if the person does not wish to have a child at the specific time, they can

investigate the resources that are needed to prevent pregnancy, such as birth control, contraceptives, or physical protection and prevention.

According to Guttmacher Institute (2010), family planning programs are a key component to comprehensive sexual and reproductive health. They provide essential and often life-saving services to women and their families. By enabling women to delay pregnancy, avoid childbearing, or space births, effective family planning programs are not only fundamental to women's health, they also allow women and families to better manage household and natural resources, secure education for all family members, and address each family member's healthcare needs. The best programs have also been found to increase equity between women and their partners and enhance communication and negotiation skills within couples (Singh, 2012).

According to Congressional Research Service (CRS) (2012), the same people who are at risk of unintended pregnancy are also at risk of HIV infection. Voluntary family planning programs give women, youth, and men the information and services they need to protect themselves and their partners from unintended pregnancies, HIV, and other sexually transmitted infections. Voluntary family planning and other reproductive health services are an important entry point to addressing HIV risk factors (including gender-based violence and sexual coercion), safe sex negotiation, voluntary counseling and testing, prevention of vertical transmission of HIV, and other prevention interventions. These services also reach women, youth, and men who would not seek out HIV services independent of other health services because of stigma or other barriers.

Manhart, Daune, Lind, Sinai and Golden-Tevald (2013) argue that linking HIV and reproductive health programs, like voluntary family planning and maternal health, improves access to both HIV and reproductive health services, reduces HIV-related stigma and discrimination, and extends programs to underserved populations. This is because all individuals—including those living with HIV—have the basic right to decide the number and spacing of their children and to have the information, education, and means to do so, free from discrimination, coercion, and violence. Access to voluntary family planning services ensures that women, youth and men living with HIV can exercise their right to the highest attainable standard of sexual and

reproductive health, and allows for the management of family size and prevention of vertical transmission of HIV (Manhart et al. 2013).

Cleland et al. (2011) asserts that women, youth, and men living with HIV have a higher risk of contracting sexually transmitted infections, including additional strains of HIV. Correct and consistent use of female and male condoms is the only method that reduces both this risk and the risk of unintended pregnancy (Cleland et al. 2011). Women and girls living with HIV are more likely to experience pregnancy complications, and are at a higher risk of maternal death. Voluntary family planning and other reproductive health programs are there to empower women living with HIV to prevent health complications related to unintended pregnancies and to plan pregnancies based on their child-bearing desires and health needs (DeRose et al. 2014).

2.3.2.2 Reproductive Health

Reproductive health is defined by Hall et al. (2012) as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. According to WHO (2008), reproductive health is the integration of emotional, intellectual, and social aspects of sexual being in order to positively enrich personality, communication, relationships and love.

Reproductive health involves all of the reproductive processes, functions and systems at all stages of human life. WHO's (2008) definition implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Men and women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice that are not against the law. Furthermore, men and women should have access to appropriate health care services that will enable women to go safely through pregnancy and childbirth, as well as to provide couples with the best chance of having a healthy infant (World Bank, 2010). According to WHO (2008), the three fundamental principles of reproductive health include: 1) capacity to

enjoy and control sexual and reproductive behavior; 2) freedom from shame, guilt, fear, and other psychological factors that may impair sexual relationships; and 3) freedom from organic disorder or disease that interferes with sexual and reproductive function.

According to United Nations Population Information Network (POPIN) (2012), reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years. However, men also demand specific reproductive health needs and have particular responsibilities in terms of women's reproductive health because of their decision-making powers in some reproductive health matters. Reproductive health is a fundamental component of an individual's overall health status and a central determinant of quality of life (POPIN, 2012).

According to World Bank (2010), reproductive health should also be understood in the context of healthy relationships in which there is an understanding of the balance between fulfillment and risk. Reproductive health contributes enormously to physical and psychosocial comfort and closeness between individuals. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death. Reproductive health is a crucial feature of healthy human development and of general health. It may be a reflection of a healthy childhood, is crucial during adolescence, and sets the stage for health in adulthood and beyond the reproductive years for both men and women (World Bank, 2010).

However, Cook et al. (20111) argues that reproductive life span does not begin with sexual development at puberty and end at menopause for a woman or when a man is no longer likely to have children. Rather, it follows throughout an individual's life cycle and remains important in many different phases of development and maturation. At each stage of life, individual reproductive health needs may differ. However, there is a cumulative effect across the life course, and each phase has important implications for future well-being. An inability to deal with reproductive health problems at any stage in life may set the scene for later health problems (Cook et al. 20111).

Markle et al. (2013) posit that healthy reproductive systems, processes, and function are imperative components of adequate overall health. However, many internal as well as external factors may challenge an individual's ability to maintain reproductive health. Markle et al. (2013)

advice that it is important to keep in mind that reproductive health status may be determined by occurrences and exposures from *in utero* development until the final stages of life. Numerous factors directly effect how well an individual maintains his or her reproductive health status. A publication by WHO (2014) revealed that while some factors may be pre-determined, such as genetic susceptibility to a particular disorder or disease, other factors that relate to the maintenance of reproductive health may be behavioural and involve an individual's participation in risky practices. Furthermore, the environment in which an individual lives, both natural and physical, may present important risk that may directly influence reproductive health. For instance, some occupational exposures (e.g works with hazardous pesticides) can have adverse effects in reproductive life (WHO, 2014).

2.3.2.3 Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period (Center for Health and Gender Equity (CHANGE, 2012). Access to maternal health services and respectful maternity care are essential to women's sexual and reproductive health and rights. Pregnancy continues to carry a high risk of death worldwide. In developing countries, women and girls face a 1 in 150 risk of death in pregnancy or childbirth—this risk is as high as 1 in 39 in sub-Saharan Africa. Despite numerous commitments to address the issues that fuel maternal mortality and morbidity, 287,000 women died from pregnancy-related causes globally in 2010, which means that more than one woman died every two minutes (WHO 2012).

According to (CHANGE, 2012), women and girls should have access to comprehensive sexual and reproductive health services, that includes family planning, essential medicines, skilled and respectfully maternity care, and HIV prevention and treatment. Globally, 222 million women who wish to delay or avoid pregnancy have an unmet need for contraception (Guttmacher 2012). Many of the top causes of maternal morbidity and mortality—such as hemorrhage, sepsis, unsafe abortion, and eclampsia—are largely preventable through low cost and highly effective medicines like oxytocin, misoprostol, and magnesium sulfate delivered by skilled providers (United Nations Commission on Life-Saving Commodities for Women and Children, 2012). HIV-positive women have a higher risk of maternal death because they are more likely to experience complications during pregnancy (Lancet, 2010).

Frequently, maternal healthcare is neither high quality nor rights based. This is evidenced by 2012 survey of maternal health stakeholders from 19 countries in the Global North and Global South which revealed that maternity care often fails to "go beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights." For example, 56 percent, 50 percent, and 46 percent of respondents identified lack of privacy, lack of informed consent, and verbal abuse, respectively, as examples of disrespect or abuse during childbirth in their countries. Such practices undermine efforts to reduce maternal mortality and morbidity by leading women and girls—especially those with fewer resources and who experience stigmatization—to avoid seeking care (WHO, 2014).

Maternal health interventions must include rights based, respectful healthcare. In their 2010 landscape analysis, White Ribbon Alliance (2011) identified common acts of disrespect and abuse faced by women in maternity care such as: physical abuse, verbal abuse, discrimination, lack of privacy, detention, and denial of care. The Universal Rights of Childbearing Women charter affirms that woman-centered maternity care must prioritize women's basic rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship.

Evidence shows that access to healthcare alone is not enough to promote maternal health and decrease maternal morbidity and mortality. For instance, the Dominican Republic has a maternal mortality ratio (MMR) of 150—compared to the MMR of 16 in developed countries—despite the fact that 95 percent of women have skilled attendants during childbirth (WHO 2012; WHO 2013). In the Dominican Republic, and in many other countries, the lack of rights-based maternity care is a barrier to quality maternal and other sexual and reproductive health services (CHANGE, 2012).

Evidence suggests that disrespect and abuse during maternity care negatively affect maternal health, family planning, and HIV services for women (Kaye, 2015). However, additional efforts to explore how access to rights-based care affects women are essential to increase both stakeholder and donor support for respectful maternity care and our understanding of how respectful maternity care interacts with other aspects of women's sexual and reproductive health. Interventions to promote respectful maternity care must include the following: support for

provider training in client-centered approaches; accountability for funded programs on integration and rights-based care; and, meaningful participation of women and girls—including those living with HIV—in the design, implementation, and evaluation of programs.

2.4 Related Studies

Many studies which included measures of self-efficacy have shown that especially belief in one's capability to negotiate safer sex practices, such as condom use, were strong predictors of such behaviours (Abraham, Rubaale & Kipp, 2011; Sheeran, & Abraham, 2010). when comparing predictors of sexual practices such as for instance condom use across studies, systematic differences between western countries and cultures in the developing world (such as sub-Saharan Africa) are likely to be revealed. In a study by Lugoe and Rise (2012) carried out in Tanzania, subjective norms turned out to be a markedly more powerful predictor of intentions to use condom than attitudes.

In a similar study among adolescents in Holland, attitudes towards the behaviour turned out to be a much stronger predictor of intentions to use condoms consistently than subjective norms (Schaalma et al., 2013). This is consistent with the assumption that North-western European cultures are regarded as rather individualistic whereas collectivism is assumed to be common among African cultures (Brislin, 2013). Personal attitudes are expected to be more important in predicting behaviour in individualistic cultures, while subjective norms are expected to be more important in collectivist cultures. In both studies the prediction of behavioural intentions is substantial. This supports the notion that, when used in an appropriate way, value-expectancy theories are relevant even in cultures different from the western ones in which they were designed. The usefulness of social cognition models and the importance of subjective norms as predictors of behavioural intentions have been confirmed also in other studies from sub-Saharan Africa (Bosompra, 2014; Giles et al. 2015).

The study carried out by Lugoe and Rise (2012) is one of very few studies of sexual behaviour in sub-Saharan Africa in which a social cognition model has been applied. Another example of sub-Saharan research based on one of the social cognition models is a study of intention to be sexually active among primary school children in northern Tanzania (Klepp et al. 2013). The study, which was based on a slightly extended version of the Theory of Reasoned Action,

confirmed that attitudes, subjective norms and self-efficacy were all significant predictors of intention to have sexual intercourse within the next three months. Prior behaviour, however, was the strongest predictor of intention.

A study among adults in Bulawayo, Zimbabwe, which was based on the Health Belief Model, revealed that perceived social support for behaviour change was the major predictor of HIV-related behavioural risk reduction (Wilson et al. 2014).

2.5 Gaps in Literature Review

All of the studies by Abraham et al. (2011); Sheeran, & Abraham (2010); Lugoe and Rise (2012); Schaalma et al. (2013); Brislin (2013); Klepp et al. 2013); Bosompra (2014); Wilson et al. (2014); and Giles et al. (2015) where done in the area of sexual and reproductive health. However none of the above studies was done in the areas of stakeholder engagement hence providing a content gap this study investigated. Furthermore, the above studies were done in Tanzania and Specifically Kigoma hence providing a contextual gap that this study investigated.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter elaborates on the general procedure for conducting the research. It particularly spells out the research design, the study population, sampling technique as well as how data is gathered, processed and analyzed.

3.1 Research Design

This study adopted descriptive a cross-sectional study. This is because it is a type of observational study that analyses data collected from a population, or a representative subset, at a specific point in time. Furthermore, cross-sectional design allows for the study of the population at one specific time and the difference between the individual groups within the population to be compared. It also provides for the examination of the co-relationship between the study variables (Amin, 2005). However, though the study relied more on quantitative approach, it was also complemented and supplemented by the qualitative approach. Quantitative approach was predominantly used as a synonym for any data collection technique (such as a questionnaire) or data analysis procedure, such as: graphs or statistics that generates or uses numerical data. On the other hand, qualitative approach was predominantly used as a synonym for any data collection technique (such as an interview) or data analysis procedure (such as categorizing data) that generates or uses non-numerical data (Amin, 2005).

3.2 Study Population

There are 2,127,930 people in Kigoma City (Kigoma Reproductive Health Survey, 2014). However, the current study targeted 2,560 participants who included Engender staff members and the program beneficiaries. This is because they are directly affected by the project and as well are involved in the project.

3.3 Sample Size

The study used Krejcie and Mogan (1970) table to determine the sample size of the respondents. According to Morgan table, a population size of 2,560 is estimated at 335 respondents. Hence the sample size of this study was 335 respondents.

Table 3.1: Target Population and Sample Size Distribution

Category of Respondents	**Target Population**		**Sample Size**	**Sampling techniques**
EngenderHealth Staff	Program officers	88	11	Purposive sampling
	Healthcare workers	195	26	Purposive sampling
Project Beneficiaries		2,277	298	Simple random sampling
Total		**2,560**	**335**	

3.4 Sampling Technique

The researcher used stratified random sampling by dividing Kigoma into four strata. The stratum with the highest population and the one with the most EngenderHealth Program was chosen. Simple random sampling was used to select all the targeted respondents. In this technique, each member of the population had an equal chance of being selected as a subject. The entire process of sampling was done in a single step with each subject selected independently of the other members of the population. The researcher wrote the names of all the different categories of respondents (*refer* to table 3.1). The names were put in different bowels indicating each category and shaken to randomize the papers. The names were selected until the researcher was satisfied with the number that he needs.

3.5 Data Source

This study included both the primary and secondary sources of data collection.

3.5.1 Primary Source

The primary source included data collected using questionnaires and interviews.

3.5.2 Secondary Source

The secondary data was reviewed from electronic journals, electronic reports, and library text books.

3.6 Data Collection Methods

3.6.1 Surveys

The study used survey method of data collection. The researcher prefers to use survey method because it is good for gathering descriptive data, relatively easy to administer, cost effective and time saving. This method was used to collect data on stakeholder engagement and reproductive health from project beneficiaries using questionnaires.

3.6.2 Interviews

The study used face to face interview with the Engenderhealth staff to collect qualitative data on the themes of stakeholder engagement and sexual and reproductive health. Interviews were preferred because they give in-depth information and allow further clarification on points which might not have been understood by the interviewer.

3.7 Research Instruments

This study used both questionnaire and interviews in its data collection.

3.7.1 Questionnaires

This study employed closed questionnaires which were confined to five Likert scale because it produces slightly higher mean scores relative to the highest possible attainable score, compared to those produced from the use of 10 levels or 4 levels. A five point Likert scale of 5-strongly agree and 1-strongly disagree was used. The study used a nominal scale where letters were assigned to objects to serve as labels for identification or classification. The ordinal scale was used to include the characteristics of the nominal scale plus an indicator of order by weighting from the highest of 5 (strongly agree) and lowest of 1 (strongly disagree).

The questionnaire was divided into three sections. Section A captured information about the demographic characteristics of the respondents in terms of age, gender, educational level, marital status and number of family members; section B captured information about stakeholder engagement which was measured using stakeholder identification and analysis (5 items), information disclosure (5 items), and stakeholder consultation (5 items); and section C captured

information about sexual and reproductive health which was measured using family planning (5 items), reproductive health (5 items) and maternal health (5 items). The closed was preferred in this study because its results can be easily quantified.

3.7.2 Interview Guide

The researcher used face to face interviews on key informants who were at leadership position in EngenderHealth. The interviews captured data on stakeholder engagement and sexual and reproductive health. The researcher preferred this instrument because it allows participants to be asked about their perceptions, opinions, beliefs and attitudes towards a concept, or idea. Questions were asked in an interactive face to face setting where participants were free to talk with the moderator (researcher). In the social sciences, interviews allow interviewers to study people in a more natural setting than questionnaires (Mugenda and Mugenda, 2003).

3.8 Validity and Reliability

3.8.1 Validity Test

This study notes that validity precipitates the concern of whether the findings are a true and correct representation of what it purports to measure and how accurately it represents what will be happening in the situation under observation (Collins & Hussey, 2003). This contribution is incorporated in this study and forms a cornerstone of the research. Therefore, to examine the content validity of this study, professional subjective judgment was required where experts such as the university supervisors and the members of the research panel helped provide their expertise on the contents of the research instruments. Content validity index (CVI) was used to determine the validity of the contents judged relevant by the experts.

CVI formula: $=\frac{items\ declared\ relevant\ by\ experts}{total\ number\ of\ items}$

$CVI=\frac{24}{30}$

CVI=0.80

According to Amin (2005), if the CVI value is greater or equal to 0.70, the contents of the instrument will be considered valid, otherwise invalid. As for this study, the CVI value was 0.80, implying that the instrument was valid.

3.8.2 Reliability

In order to ensure that the research instrument is reliable and can consistently produce reliable data when administered, the researcher determined its reliability by measuring the internal consistency of the instrument. Cronbach's alpha measures the internal consistency, that is, how closely related a set of items are as a group. The higher the α-value, the more reliable the instrument was considered. A commonly accepted rule for describing internal consistency using Cronbach's alpha was as follows (Kline, 2000):

Cronbach's alpha	**Internal consistency**
$\alpha \geq 0.9$	Excellent
$0.9 > \alpha \geq 0.8$	Good
$0.8 > \alpha \geq 0.7$	Acceptable
$0.7 > \alpha \geq 0.6$	Questionable
$0.6 > \alpha \geq 0.5$	Poor
$0.5 > \alpha$	Unacceptable

Table 3.2: Reliability Value

Variables tested	**Number of items**	**Cronbach's Alpha**	**Interpretation (Kline, 2000)**
Stakeholder engagement	15	0.863	Good
Sexual and Reproductive Health	15	0.774	Acceptable

According to the results in table 3.2, it shows that the internal consistency value determined using Cronbach's alpha for stakeholder engagement is interpreted as Good and that of sexual and reproductive health is interpreted as Acceptable. This signifies that the respondents understood the questions very well because of its simplicity, preciseness and lack of ambiguity.

3.9 Data Gathering Procedure

An introduction letter was obtained from the College of Humanities and Social Sciences of Kampala International University, Uganda for the researcher to solicit approval to conduct the study from the selected category of respondents. During the administration of the research instruments to the selected respondents; they were properly and adequately oriented on the study and why it was being conducted. The respondents were requested to sign the informed consent form. They were guided on how to fill the questionnaires, and the importance of answering every item of the questionnaire without leaving any part unanswered. The respondents were requested to kindly respond to the questionnaire on time. After retrieving them back, the researcher thoroughly checked to ensure that all items were adequately answered by the respondents.

3.10 Data Analysis

After retrieving back the questionnaire and collecting the required data, it was prepared for analysis by using Statistical Package for Social Scientists (SPSS, version 22.0) software. In this process, the data underwent these processes i.e. data editing which involved checking the filled questionnaires for any omissions or mistakes; then data coding which involved giving each item of the questionnaire or variable a code to be used when imputing the data into the computer, and lastly data entry into the computer for analysis.

After processing (i.e. editing, coding, and entry into the computer) the collected data, the researcher analyzed it. The analysis was conducted in the following manner: The frequency and percentage distribution was used to determine the profile of the respondents; descriptive statistics (mean and standard deviations) helped the researcher to describe the basic features of the data in the study. Furthermore, inferential statistics such as linear regression was used to determine the effect of stakeholder identification and analysis, information disclosure and stakeholder consultation on sexual and reproductive health. On the other hand, multiple regression analysis was done to determine the highest predictor variable of sexual and reproductive health among stakeholder identification and analysis, information disclosure and stakeholder consultation.

Qualitative data was analysed using editing on the transcripts to identify the significant statements across individual and group interviews. Subsequent reading of the significant statements helped in identifying sub-themes emerging within the patterns. For presentation of thematic findings, both *textural* and *structural* descriptions were used in the results section.

Textural descriptions are significant statements used to write what the participants experienced. Structural descriptions are the interpretation of the context or setting that influenced participants' experiences. For textural descriptions, the quotes of participants were given in italics with the respondent to whom that quote belongs marked with type (i.e., female or male). The structural descriptions as interpreted by the researcher were provided in plain text.

3.11 Ethical consideration

This study observed the following ethical considerations:

The researcher ensured quality and integrity by reporting only what he found in the field and following a scientific and generalized report writing for academic research.

The researcher sought for informed consent from the respondents. This was done by verbally informing them about the study before participating in the study.

The researcher respected the confidentiality and anonymity of the research respondents by involving them in the study in their own terms and place of convenience and coding their names in the final report of the study.

The researcher ensured that participating in the study was voluntary, no one was coerced, forced or bribed in order to be part of the study. The researcher also ensured voluntary withdrawal from the study in case of change of mind of the respondent.

The researcher ensured that the final reporting was impartial and independent of his personal opinion, rather it was the opinion of the respondents that were used in the final analysis of the research.

3.12 Limitations of the Study

i. Instrument validity: the research instruments on stakeholder engagement and sexual and reproductive health were not standardized. However, validity and reliability test were done to answer this.
ii. The researcher had no control over honesty of the respondents and personal biases. However, the researcher tried his best to persuade the respondents to be as honest as possible.

iii. Uncooperative behavior of some respondents, un-approachable respondents and those who were reluctant to give information also limited the researcher in this study. However, the researcher mitigated this by assuring the respondents that the study was for academic intentions only and the researcher presented his university identity card and university letter permitting him to carry out the research.

iv. The study used 5-likert scale which limited the expression of the respondents in their opinions and views, however, the study mitigated this by using interviews to capture key informants' perception and views regarding the themes of the study.

CHAPTER FOUR
DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0 Introduction

This chapter presents the analysis of the data gathered and its interpretation. It starts by giving the demographic characteristics of the respondents and then the variables used according to the objectives.

4.1 Response Rate

The researcher had 335 respondents in total; however 261 participated successfully; hence a participation rate of 78%. According to Amin (2004), if the response rate is more than 70%, it signifies that the turn up of participants was good hence the data can be used in the final analysis of the study.

4.2 Demographic Characteristics of the Respondents

This section determines the demographic characteristics of the respondents. Frequencies and percentage distribution tables were employed to summarize the demographic characteristics of the respondents in terms of gender, age, education level, marital status, and number of household members. Table 4.1 gives the summary of the findings.

Table 4.1: Demographic Characteristics of the Respondents

Profile of the Respondents	Frequency	Percent (%)
Gender		
Male	116	44.6
Female	145	55.4
Total	**261**	**100.0**
Age of Respondents		
20-29	54	20.5
30-39	108	41.5
40-49	71	27.2
50 years and above	28	10.8
Total	**261**	**100.0**
Educational Level		
None	80	30.8
Primary	122	46.7
Secondary	51	19.5
Post-secondary	8	3.1
Total	**261**	**100.0**
Marital Status		
Married	131	50.3
Single	76	29.2
Divorced	35	13.3
Widow	19	7.2
Total	**261**	**100.0**
Number of household members		
1-5	159	61.0
6-10	67	25.6
More than 10	35	13.3
Total	**195**	**100.0**

Source: Primary Data, 2018

The results presented in table 4.1 revealed that majority, 55.4% of the respondents were female while the male were represented by 44.6%. The dominance of the female respondents is attributed to the fact that it is mostly women who attend sexual and reproductive health initiatives compared to the men. Majority of them go for antenatal care (maternal health care services) alone without the accompaniment of a husband, hence the high number in this study.

The results presented in table 4.1 revealed that majority, 41.5% of the respondents were within the age of 30-39 years, followed by 27.2% of the respondents who were within the age group of 40-49 years. Similarly, respondents within the age group of 20-29 years and 50 years and above were represented by 20.5% and 10.8% respectively. The dominance of the respondents within the age group of 30-39 years is attributed to the fact that this age group are mostly mothers of 2-4 children, hence a high likelihood of seeking sexual and reproductive health services.

The results presented in table 4.1 revealed that majority, 46.7% of the respondents had primary level of education, while 30.8% had no formal education. Furthermore, respondents who had secondary and post-secondary education were represented by 19.5% and 3.1% respectively. The dominance of primary school leavers in this study is because of the socioeconomic factors that force parents to marry off their children at an early age. This forces young girls to drop out of school and not complete their education.

The results presented in table 4.1 revealed that majority, 50.3% of the respondents were married, followed by 29.2% who were single; while those who were divorced and widowed were represented by 13.3% and 7.2% respectively. The dominance of the married respondents in this study is because they are more knowledgeable of the sexual and reproductive health challenges compared to those who are still single with almost no experience whatsoever.

The results presented in table 4.1 revealed that majority, 61% of the respondents had between 1-5 household members, followed by 25.6% who had 6-10 household members and 13.3% who had more than 10 household members. The dominance of the respondents with 1-5 household members is because people are mostly embracing the nuclear system of family compared to the extended system family since resources are becoming more scarce every day to allow extended system of family to strive. They are also practicing sexual and reproductive health methods of family planning so that they can produce the number of children whom they can look after very well.

4.3 The Mean Values of Stakeholder Engagement

Stakeholder engagement in this study was the independent variable and was measured using stakeholder identification and analysis, information disclosure, and stakeholder consultation. The

mean values were determined using the scores provided in the table below. Table 4.2 gives the summary of the mean values for work environment.

Scale	Mean Range	Response	Interpretation
5	4.21-5.00	Strongly agree	Very Satisfactory
4	3.41-4.20	Agree	Satisfactory
3	2.61-3.40	Not sure	Fairly satisfactory
2	1.81-2.60	Disagree	Unsatisfactory
1	1.00-1.80	Strongly disagree	Very unsatisfactory

Table 4.2: The Mean Values of Stakeholders Engagement

Stakeholders Engagement	Mean	Std. Deviation	Interpretation
Stakeholder identification and analysis			
You identified who can slow or stop the sexual and reproductive health projects in Kigoma region.	3.97	.927	Satisfactory
You identified the individuals or groups who have interest in the sexual and reproductive health projects in Kigoma region.	3.94	1.026	Satisfactory
You identified who makes the decisions related to sexual and reproductive health issues in Kigoma region and will approve the final project.	3.84	1.065	Satisfactory
You identified individuals and organizations who will potentially be affected by the outcomes of the sexual and reproductive health projects in Kigoma.	3.79	1.015	Satisfactory
You identified who can influence decisions in the sexual and reproductive health projects.	3.25	1.126	Fairly satisfactory
Average Mean	**3.76**	**1.032**	**Satisfactory**
Information disclosure			
You are accountable for all the activities in sexual and reproductive health projects in Kigoma region.	4.08	.932	Satisfactory
You publish information about the progress of the sexual and reproductive health projects to the public.	4.08	.973	Satisfactory
You make information about your sexual and reproductive health activities easily understandable by the public.	3.96	1.064	Satisfactory
You make information about your sexual and reproductive health projects activities accessible to the public.	3.89	1.086	Satisfactory
You are transparent in your activities in sexual and reproductive health projects in Kigoma.	3.88	1.038	Satisfactory
Average Mean	**3.98**	**1.019**	**Satisfactory**
Stakeholder consultation			
You ensured all projects participants were properly informed and had in-depth knowledge about the project.	3.67	.834	Satisfactory
You ensured gender equality in your consultation process.	3.66	.818	Satisfactory
You consulted those who were likely to be affected by the sexual and reproductive health projects.	3.64	.776	Satisfactory
You engaged at an early stage those whom the project would directly affect.	3.48	.845	Satisfactory
You promoted capacity building to the project beneficiaries.	3.45	.964	Satisfactory
Average Mean	**3.58**	**0.848**	**Satisfactory**
Overall Average Mean	**3.77**	**0.966**	**Satisfactory**

Source: Primary Data, 2018

The results presented in table 4.2 revealed that stakeholder identification and analysis as a determinant of stakeholder engagement was assessed by the respondents as satisfactory (average

mean=3.76, Std=1.032). This was attributed to the fact that majority of the respondents agreed that they were able to identify individuals, groups and organizations who had the capacity to slow or stop the sexual and reproductive health projects in Kigoma region (mean=3.97, Std=0.927), those who had interest in the program (mean=3.94, Std=1.026), those who could make decisions related to the program and would approve the final project (mean=3.84, Std=1.065), and those who would potentially be affected by the outcomes of the program (mean=3.79, Std=1.015).

The above findings imply that the program would be successful because the right procedures have been used to establish who the stakeholders were. In other words, a stakeholder being an individual, department or organization that may be affected by the results of a project or have an effect on how the project is carried out was important to get to know them at the initial stage of the project so as to eliminate or reduce any conflict of interest that would arise at a later stage of the program. Therefore it was of great importance to first identify stakeholders who would actively be involved in the program, those whose interests would be affected by work performed or the finished result and those who would exert a degree of influence over the program or program deliverables.

Furthermore, the results in table 4.2 revealed that information disclosure as a determinant of stakeholder engagement was assessed by the respondents as satisfactory (average mean=3.98, Std=1.019). This was attributed to the fact that majority of the respondents agreed that they exercised information disclosure of sexual and reproductive health program by being accountable for all the activities in the program (mean=4.08, Std=0.932), by publishing information about the progress of the sexual and reproductive health program to the public (mean=4.08, Std=0.973), by making information about sexual and reproductive health activities easily understandable by the public (mean=3.96, Std=1.064), by making information about sexual and reproductive health program accessible to the public (mean=3.89, Std=1.086), and by being transparent in all the activities pertaining to sexual and reproductive health program (mean=3.88, Std=1.038).

The above findings indicate that information disclosure is highly practiced in the activities of the sexual and reproductive health program. This is because the staff of the Engender Health are able to make information about their activities accessible, readable and understandable to the public.

This makes it very easy for them to account for any irregularity that may arise. However, it is not known whether the information disclosed comes at the right time to the public. This is because the timing of information disclosure is key to civil society's ability to respond meaningfully to published documents. If information is not disclosed until a project is well under way, it is unlikely to improve the public's ability to engage with its implementation. Inadequate timing can render information disclosure useless as a tool for participation and engagement.

In addition, the results presented in table 4.2 revealed that stakeholder consultation as a determinant of stakeholder engagement was assessed by the respondents as satisfactory (average mean=3.58, Std=0.848). This was attributed to the fact that majority of the respondents agreed that they consulted the stakeholders by ensuring that all project participants were properly informed and had in-depth knowledge about the project (mean=3.67, Std=0.834), and ensuring gender equality as well (mean=3.66, Std=0.818). In the same vein, respondents agreed that stakeholder consultation included the involvement of people who were likely to be affected by the sexual and reproductive health projects (mean=3.64, Std=0.776) and engaging them directly at an early stage (mean=3.48, Std=0.845). Furthermore, respondents agreed that capacity building to the project beneficiaries was promoted (mean=3.45, Std=0.964).

The above results imply that consultation of the stakeholders was done to address the aspects of gender equality, conflict of interest at a future stage and providing enough training to the beneficiaries through capacity building so that they are knowledgeable and information-rich. This implies that listening to stakeholders' concerns and feedback through consultation is a valuable source of information that can be used to improve project outcomes. In this regard, consultation helps in identifying and tracking needs and expectations, identifying and tracking perceptions and attitudes, providing feedback on specific planned developments, and evaluating implementations and actions.

Last but not least, the results in table 4.2 revealed that stakeholder engagement was assessed by the respondents as satisfactory (overall average mean=3.77, Std=0.966). This was attributed to the fact that all the determinants of stakeholder engagement were assessed by the respondents as satisfactory. This could be because stakeholder engagement provides opportunities to further align business practices with societal needs and expectations, helping to drive long-term sustainability and shareholder value. This implies that stakeholder engagement is often

intended to help the practitioners fully realize the benefits of stakeholder engagement in their organization, to compete in an increasingly complex and ever-changing business environment, while at the same time bringing about systemic change towards sustainable development.

Qualitative data

The researcher involved key informants (Engender Health Leadership) in a face to face interview regarding matters on stakeholder engagement. The researcher posed this question to key interview informant: "what criteria did you use to identify potential stakeholders in this program? Their responses were summarized as below:

> *"actually we used mobilization method across the villages where the program was going to affect….we mobilized the masses and invited them for meetings on several occasions……it was during such meetings that they told us the people whom we would work with and see to it that the program succeeds" (program manager, 21/02/2018).*
>
> *"we were able to involve the village leaders who helped in leading us to different villages and homes….we were able to identify different married couples whom we later invited to our family planning seminars and maternal education". (program officer, 22/02/2018).*
>
> *"yes, identifying the stakeholders was possible because we used the most local and effective method possible…we just made sure we got the answers to the following questions and at the end of the day, the rest was easy: Who is directly involved with the program?; Who is indirectly involved with the program?; Who may be affected by the program?; Who may be affected by the program's outcome?; Who has the authority to influence the program or its outcome?; Who has the authority to make the program succeed or fail?(program officer, 22/02/2018).*

The above information shows that there was a simple way of identifying stakeholders in the program which involved simply finding who had interest in the program and who would later be affected either directly or indirectly by the program.

Furthermore the researcher asked the key informants this question: "How do you ensure information about the project is disclosed to the public?" Their responses were summarized as below:

> *"we normally work hand in hand with the print media like the Daily News and Arusha Times…..they have always been publishing our activities every week….this has enabled the masses to get information and be more knowledgeable of sexual and reproductive health drive"(program information officer, 23/02/2018).*
>
> *"we sometimes post our activities on social media platform such as Facebook, twitter and blog……the community has been able to access interactive information through our blog forums regarding family planning, sexuality and sexual rights……we have a provision for question and answer and the feedback is given within a short period of time"(program information officer, 23/02/2018).*
>
> *"every year we do auditing and annual publications of our reports….we ensure that the publication is available for free access to the public so that they can analyze and scrutinize our different activities and where need be take into consideration their grievances"(program manager, 21/02/2018).*

The above responses imply that Engender Health indeed discloses information about their activities to the public with the intention of informing and educating the masses about the importance of family planning, maternal health, and reproductive health.

Furthermore, the researcher asked the key informants this question: "In your consultation endeavors, whom did you prioritize in the consultation and why?" The response was summarized as below:

> *"before starting this program in Kigoma, we had several consultation initiatives with the Team from the Ministry of Health, the District Health Officers, The political leadership of the district, the media, civil society groups, and the local masses……they were prioritized because they would in one way or the other be affected by the program and also we would later work with them either directly or indirectly" (program manager, 21/02/2018).*

The above response indicates that Engender Health Team understood the importance of stakeholder consultation so that they do not get themselves at cross roads with any aggrieved party at a later stage of the program.

4.4 The Mean Values of Sexual and Reproductive Health

Sexual and reproductive health was the dependent variable and was measured using family planning, reproductive health and maternal health. The mean values were determined using the scores provided in the table below. Table 4.3 gives the summary of the mean values for work environment.

Scale	Mean Range	Response	Interpretation
5	4.21-5.00	Strongly agree	Very Satisfactory
4	3.41-4.20	Agree	Satisfactory
3	2.61-3.40	Not sure	Fairly satisfactory
2	1.81-2.60	Disagree	Unsatisfactory
1	1.00-1.80	Strongly disagree	Very unsatisfactory

Table 4.3: Sexual and Reproductive Health

Sexual and Reproductive Health	Mean	Std. Deviation	Interpretation
Family planning			
Through engender health projects, you have access to voluntary counseling on sexual and reproductive health.	4.01	1.062	Satisfactory
Through engender health projects, you have been empowered to know your sexual rights.	3.70	1.181	Satisfactory
Through engender health projects, you have access to information about health risks regarding unplanned pregnancies.	3.70	1.058	Satisfactory
Through engender health projects, you have access to both HIV and reproductive health services.	3.15	1.170	Fairly satisfactory
Through engender health projects, you practice family planning methods.	3.11	1.298	Fairly satisfactory
Average Mean	**3.53**	**1.154**	**Satisfactory**
Reproductive health			
Through engender health projects, you have a healthy life.	3.89	1.091	Satisfactory
Through engender health projects, you have the capacity to enjoy and control sexual and reproductive behavior.	3.82	1.087	Satisfactory
Through engender health projects, you are free from diseases or sexual disorder.	3.81	1.141	Satisfactory
Through engender health projects, you have the power to make decisions on unwanted pregnancies.	3.66	1.180	Satisfactory
Through engender health projects, you have a healthy sexual relationship with your partner.	2.81	1.401	Fairly satisfactory
Average Mean	**3.60**	**1.180**	**Satisfactory**
Maternal Health			
Through engender health projects, you are not at risk during childbirth.	3.66	.818	Satisfactory
Through engender health projects, your consent is sought on sexual and reproductive engagements.	3.65	.850	Satisfactory
Through engender health projects, your sexual rights are respected during childbirth.	3.46	.845	Satisfactory
Through engender health projects, your sexual rights are observed.	3.43	.973	Satisfactory
Through engender health projects, you have comprehensive access to sexual and reproductive health services.	3.10	1.322	Fairly satisfactory
Average Mean	**3.46**	**0.962**	**Satisfactory**
Overall Average Mean	**3.53**	**1.099**	**Satisfactory**

Source: Primary Data, 2018

The results presented in table 4.3 revealed that family planning as an element of sexual and reproductive health was assessed by the respondents as satisfactory (average mean=3.53,

Std=1.154). This was attributed to the fact that majority of the respondents agreed that through engender health projects, they had access to voluntary counseling on sexual and reproductive health (mean=4.01, Std=1.062), were empowered to know their sexual rights (mean=3.70, Std=3.70), and were able have access to information about health risks regarding unplanned pregnancies (mean=3.70, Std=1.058). However, the some respondents were not in full agreement that it was through engender health projects, that had access to both HIV and reproductive health services (mean=3.15, Std=1.170), or practiced family planning methods (mean=3.53, Std=1.154).

This could imply that apart from Engender program, there are other programs and healthcare services that are equally providing the same sexual and reproductive health services to the people of Kigoma. However, the finding also indicated that Engender program has also been instrumental in providing counseling services on sexual and reproductive health, empowering people to know their sexual rights and educating people on the implications of unplanned pregnancies. It is therefore important to note that family planning is important for the health of a mother and her children, as well as the family's economic situation. The financial consequence of having children involves the medical costs of pregnancy and birth and the high costs associated with actually bringing up children. Since parents are responsible for providing education, shelter, clothing and food for their children, family planning has an important long-term impact on the financial situation of any family.

Furthermore, the results presented in table 4.3 revealed that reproductive health as an element of sexual and reproductive health was assessed by the respondents as satisfactory (average mean=3.60, Std=1.180). This was attributed to the fact that majority of the respondents agreed that it was through engender health program that they were able to have a healthy life (mean=3.89, Std=1.091), had the capacity to enjoy and control sexual and reproductive behavior (mean=3.82, Std=1.087), were free from diseases or sexual disorder (mean=3.81, Std=1.141), and had power to make decisions on unwanted pregnancies (mean=3.66, Std=1.180). However, they were not in full agreement that it was through engender health projects that had a healthy sexual relationship with their partner (mean=2.81, Std=1.401).

The above results signify that Engender program has been very instrumental in helping the Kigoma community to understand very well reproduction health. The above extract points out that the program has enlightened people to have a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. This is because for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. In other words, reproduction health must involve the integration of emotional, intellectual, and social aspects of sexual being in order to positively enrich personality, communication, relationships and love.

The results presented in table 4.3 revealed that maternal health as an element of sexual and reproductive health was assessed by the respondents as satisfactory (average mean=3.46, Std=0.962). This was attributed to the fact that majority of the respondents agreed that through engender health projects, they were not at risk during childbirth (mean=3.66, Std=0.818) and their consent was sought on sexual and reproductive engagements (mean=3.65, Std=0.850). Furthermore, respondents agreed that through engender health projects, their sexual rights were respected during childbirth (mean=3.46, Std=0.845) and their sexual rights were observed (mean=3.43, Std=0.973). However, respondents were not in full agreement that through engender health projects, they had comprehensive access to sexual and reproductive health services (mean=3.10, Std=1.32).

The above findings indicate that Engender has greatly helped in enhancing maternal health of the people of Kigoma through their counseling therapy, education and training which has enabled the women and men to understand very well the risks during child bearing, understand the value of sexual rights and consent affirmation before engaging in any sexual act. However, given the limited nature of the program, it has not been comprehensive enough to capture all maternal health challenges of the locals. However, it is important that women and girls should have access to comprehensive sexual and reproductive health services which includes family planning, essential medicines, skilled and respectfully maternity care, and HIV prevention and treatment.

The findings presented in table 4.3 revealed that sexual and reproductive health was assessed by the respondents as satisfactory (overall average mean=3.53, Std=1.099). This is attributed to the

fact that Engender Program in terms of family planning, reproductive health and maternal health has been very helpful in enlightening the local masses of Kigoma about sexuality and reproduction. However, it is also true that Engender program is not providing all the needed sexual and reproductive health programs that would comprehensively cover the reproductive health needs of the people of Kigoma district. It is true though that the missing services can be found in the healthcare facilities in the district.

Qualitative data

The researcher involved key informants (Engender Health Leadership) in a face to face interview regarding matters on sexual and reproductive health. The researcher posed this question to key interview informant: "which sexual and reproductive health programs are you mostly involved in? The response was summarized as below:

> *"we mostly advance family planning, maternal health, HIV/AIDS and sexually transmitted diseases, engaging mean as partners in reproductive health, improving clinical quality, and advocacy and policy"(program manager, 21/02/2018).*

Furthermore, the researcher asked the program this question: "What are some of the outstanding achievements of these projects?" The responses were summarized as below:

> *.ever since we started working in Kigoma district, we have trained over 872 healthcare professionals to provide Long Acting and Permanent Methods (LA/PMs) of family planning and comprehensive post abortions care and Prevention of Mother to Child Transmission of HIV (PMTCT) services"(program manager, 21/02/2018).*

> *"more than 2,000 clients received post abortion care services during 2016, an increase of more than 100% from 2014-2015. Comprehensive post abortion care services were expanded to other more remote areas across the district"(program officer, 22/02/2018).*

> *"the program has also continued to advocate for inclusion of family planning in district health plans….in 2017, at least 48% of the needed funds towards family planning was allocated" (program officer, 22/02/2018).*

In addition, the researcher asked the program coordinator this question: "What are some of the major hindrance to the program success?" The responses were as below:

> *.the greatest challenge has been limited funding,….this program is funded by the government in partnership with world health organization……however sometimes the government delays to allocate funds to this course and it affects the procurement of contraceptive pills and HIV/AIDs drugs"(program manager, 21/02/2018).*
>
> *"at one point we had issues with the politicians who wanted to interfere with our work, they had deceived the masses that the program was their initiative and therefore should be used as a reason for voting them back to office…..however using print media and other local leaders, we were able to educate the masses to fully understand the objectives of the program and the institutions behind it…….that was how we managed, otherwise everything was getting out of hand"(program information manager, 23/02/2018).*
>
> *"it was difficult to convince the men to come for our training and counseling services…..it was only the women who used to turn up for the family planning training however it was difficult to put it into practice since the men were not always available to support the initiative…..often times the program hit a dead end because of the refusal of the men to take part in it……however with time the men started coming for our meetings and trainings and we captured them by giving them leadership positions in some of our programs and activities…..so far we have not much challenge as such" (program officer, 22/02/2019).*

4.5 The Effect of Stakeholder Identification and Analysis on Sexual and Reproductive Health Program in Kigoma, Tanzania

The first objective of this study was to establish the effect of stakeholder identification and analysis on sexual and reproductive health program in Kigoma, Tanzania. Table 4.4 gives the summary of the findings.

Table 4.4: The Effect of Stakeholder Identification and Analysis on Sexual and Reproductive Health Program in Kigoma, Tanzania

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.646[a]	.417	.414	.41713	.417	138.078	1	193	.000

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	24.025	1	24.025	138.078	.000[b]
	Residual	33.581	193	.174		
	Total	57.606	194			

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.554	.171		9.106	.000
	Stakeholder Identification and Analysis	.525	.045	.646	11.751	.000

a. Dependent Variable: Sexual and Reproductive Health

The results in table 4.4 revealed that stakeholder identification and analysis significantly affects the variance in sexual and reproductive health by 41.7% (R^2=0.417, p=0.000). This therefore implies identifying stakeholders who would actively be involved in the program, those whose interests would be affected by work performed or the finished result and those who would exert a degree of influence over the program or program deliverables would increase the likelihood of sexual and reproductive health program succeeding. Furthermore, the study found that the regression model was the best fit for predicting the effect of stakeholder identification and analysis on sexual and reproductive health (F=138.078, p=0.000). Similarly, the study revealed that every unit change in stakeholder identification and analysis will significantly affect the variance in sexual and reproductive health by 64.6% (Beta=0.646, p=0.000).

4.6 The Effect of Information Disclosure on Sexual and Reproductive Health Program in Kigoma, Tanzania

The second objective of this study was to determine the effect of information disclosure on sexual and reproductive health program in Kigoma, Tanzania. Table 4.5 gives the summary of the findings.

Table 4.5: The Effect of Information Disclosure on Sexual and Reproductive Health Program in Kigoma, Tanzania

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.683[a]	.467	.464	.39889	.467	169.047	1	193	.000

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	26.897	1	26.897	169.047	.000[b]
	Residual	30.708	193	.159		
	Total	57.606	194			

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.464	.161		9.069	.000
	Information Disclosure	.519	.040	.683	13.002	.000

a. Dependent Variable: Sexual and Reproductive Health

The results in table 4.5 revealed that information disclosure significantly affects the variance in sexual and reproductive health by 46.7% (R^2=0.467, p=0.000). This therefore implies making the information about Engender Program accessible, readable and understandable to the public promotes awareness of sexual and reproductive health. Furthermore, the study found that the regression model was the best fit for predicting the effect of information disclosure on sexual and reproductive health (F=169.047, p=0.000). Similarly, the study revealed that every unit change in information disclosure will significantly affect the variance in sexual and reproductive health by 68.3% (Beta=0.683, p=0.000).

4.7 The Effect of Stakeholder Consultation on Sexual and Reproductive Health Program in Kigoma, Tanzania

The third objective of this study was to establish the effect of stakeholder consultation on sexual and reproductive health program in Kigoma, Tanzania. Table 4.6 gives the summary of the findings.

Table 4.6: The Effect of Stakeholder Consultation on Sexual and Reproductive Health Program in Kigoma, Tanzania

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.735[a]	.540	.538	.37055	.540	226.549	1	193	.000

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	31.106	1	31.106	226.549	.000[b]
	Residual	26.500	193	.137		
	Total	57.606	194			

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.132	.161		7.013	.000
	Stakeholder Consultation	.669	.044	.735	15.052	.000

a. Dependent Variable: Sexual and Reproductive Health

The results in table 4.6 revealed that stakeholder consultation significantly affects the variance in sexual and reproductive health by 54% (R^2=0.540, p=0.000). This therefore implies that when stakeholder consultation is done, it helps to address issues of gender equality, conflict of interest and capacity building that would help promote sexual and reproductive health. Furthermore, the study found that the regression model was the best fit for predicting the effect of stakeholder consultation on sexual and reproductive health (F=226.549, p=0.000). Similarly, the study revealed that every unit change in stakeholder consultation will significantly affect the variance in sexual and reproductive health by 73.5% (Beta=0.735, p=0.000).

Table 4.7: The Effect of Stakeholder Engagement on Sexual and Reproductive Health

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.799[a]	.638	.636	.32874	.638	340.031	1	193	.000

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.641	.158		4.047	.000
	Stakeholder Engagement	.766	.042	.799	18.440	.000

a. Dependent Variable: Sexual and Reproductive Health

The results presented in table 4.7 revealed that stakeholder engagement significantly affects the variance in sexual and reproductive health by 63.8% (R^2=0.638, p=0.000). This implies that when the program leaders of EngenderHealth use stakeholder consultation, information disclosure and stakeholder identification as a practice in their activities, there will be a great improvement in the promotion of sexual and reproductive health among the communities of Kigoma town.

Table 4.8: Multiple Regression Analysis

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.538	.157		3.417	.001
	Stakeholder Consultation	.436	.056	.479	7.835	.000
	Information Disclosure	.101	.052	.132	1.952	.052
	Stakeholder Identification and Analysis	.274	.043	.337	6.301	.000

a. Dependent Variable: Sexual and Reproductive Health

The results presented in table 4.8 revealed that stakeholder consultation can significantly predict up to 47.9% variance in sexual and reproductive health (Beta=0.479, p=0.000). On the other hand, stakeholder identification and analysis can significantly predict up to 33.7% variance in sexual and reproductive health (Beta=0.337, p=0.000). However, information disclosure does not

significantly predict the variance in sexual and reproductive health, though it predicts a variance of at least 13.2% (Beta=0.132, p=0.052). All in all, it implies that stakeholder consultation is the highest predictor of sexual and reproductive health in Kigoma District.

CHAPTER FIVE
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the discussion of the study guided by the study objectives. The discussion of this study findings were done by reviewing related literature, and comparing and contrasting with other previous studies. The study was later concluded and appropriate recommendations accruing from the findings were made.

5.1 Discussion of the Findings

5.1.1 The Effect of Stakeholder Identification and Analysis on Sexual and Reproductive Health Program in Kigoma, Tanzania

The first objective of this study was to establish the effect of stakeholder identification and analysis on sexual and reproductive health program in Kigoma, Tanzania. The study revealed that stakeholder identification and analysis significantly affected the variance in sexual and reproductive health by 41.7% (R^2=0.417, p=0.000). This implies that identification of the people that would be directly or directly affected by the program at an early stage and how they would be affected is very important. In other words, stakeholder identification is important not only for determining who a project's stakeholders are but also for determining the best way or ways to manage their expectations. Every stakeholder, regardless of his level, wants or expects something from the project or its outcome. Therefore identifying stakeholders allows for clear communications during periodic updates or project progress meetings. Knowing who the stakeholders are and where they fit in the development and deployment phases of the project is vital to understanding and effectively addressing their expectations or concerns.

The findings of this study is consistent with several other studies such as Cottrell et al. (2015); Curzon (2016); Dawkins (2014). For instance, Cottrell et al. (2015) found that identification of stakeholders should be given priority as regard individuals and groups in the project area who are directly and adversely affected; however he pointed out that drawing the line between who is affected and who is not can be challenging. In a similar vein, Curzon (2016) in his study found that in some projects, the most vocal opposition may come from stakeholders outside the affected area – in other parts of the country, from other countries altogether, or even from

overseas and underestimating their potential influence on project outcomes may pose risks. He advises that it is important to also include them in stakeholder analysis so that their interests are determined. Furthermore, Dawkins (2014) in his study found that choosing not to engage with all categories of stakeholders in a project creates the risk that their issues may get discussed through other outlets such as the media or political process which becomes even more detrimental.

Therefore the effect of stakeholder analysis on sexual and reproductive health is that if Engender Health Team does not include different categories of stakeholders in their campaign process such as the Ministry of Health, local leaders, the mainstream media and the beneficiaries, their efforts can be very impossible since they will receive opposition in all corners and the whole program may eventually flop. However, having the consent of the Ministry of Health in campaigns such as family planning, maternal health etc., can be very helpful in receiving support from the general public and the even the world health organization.

5.1.2 The Effect of Information Disclosure on Sexual and Reproductive Health Program in Kigoma, Tanzania

The second objective of this study was to determine the effect of information disclosure on sexual and reproductive health program in Kigoma, Tanzania. The study revealed that information disclosure significantly affected the variance in sexual and reproductive health by 46.7% (R^2=0.467, p=0.000). This implies that disclosing information to the general public in a timely and a format that is readable and understandable can help in dispensing the activities of the program and set a platform for accountability and transparency. However, it should also be noted that lack of information can lead to the spread of misinformation about a project that can be both damaging to organization's reputation, and undermine efforts to engage in an informed dialogue with stakeholders.

This study is in line with several other studies such as that of Hoffmann and Fieseler (2010); and Noland and Phillips (2010). For instance, Hoffmann and Fieseler (2010) found that good practice of information disclosure involves taking steps to increase transparency and accountability as a means of promoting understanding about the project and engendering public trust. On the other hand, Noland and Phillips (2010) found that in order to properly disclose information, one must

apply the principles of disclosing early, disclosing objective information, designing disclosure to support consultation, and providing meaningful and accessible information.

Therefore the effect of information disclosure on sexual and reproductive health is that when Engender Health Team practices information disclosure by publishing their activities, programs and services to the public through different media platforms, the public will be able to be informed and seek such services. For instance having a family planning drive by posting graphical family planning methods on newsletters and billboards which are easily accessible to the public will help in imparting the relevance of such knowledge in the minds of the masses and they will easily be able to adopt it and practice such methods.

5.1.3 The Effect of Stakeholder Consultation on Sexual and Reproductive Health Program in Kigoma, Tanzania

The third objective of this study was to establish the effect of stakeholder consultation on sexual and reproductive health program in Kigoma, Tanzania. The study revealed that stakeholder consultation significantly affected the variance in sexual and reproductive health by 54% (R^2=0.540, p=0.000). This implies that stakeholder consultation helps in information the masses about the program and giving them in-depth knowledge about it so that they get involved in something they are aware about. At the same time consulting the stakeholders helps to put straight the issue of gender equity and balanced representation of voices. T

In agreement with the findings of this study, other studies consistent with the same include that of Canadian Development Agency (CDA) (2014); Morris and Baddache (2012); and World Resources Institute (2013). For instance, CDA (2014) found that stakeholder consultation breeds participation which has a more in-depth exchange of views and information, leading to joint analysis and decision-making. This increased level of involvement tends to generate a shared sense of ownership in a process and its outcomes. On the other hand, Morris and Baddache (2012) found that in the invent that a project will affect a marginalized group, early engagement is an essential first step in building longer-term processes of consultation, informed participation, and good faith negotiation. In addition to that, World Resources Institute (2013) in their study found that when consulting with indigenous peoples, the organization in question should try to involve the representative bodies in the prior design of materials for disclosure, and in deciding

how people and groups wish to be accessed, where the consultations will take place, the chronology of consultation and the language and format to be used during the consultations.

Therefore the effect of stakeholder consultation on sexual and reproductive health is that consulting with the people, organizations and institutions whose interest and influence cannot be ignored is a step in the right direction. For instance, involving the district health team and the media in the campaign about reproductive health, family planning or maternal health can help in advancing the objectives of the project at a faster rate. Similarly since the program is a health related venture, consulting with both the men and women regarding the family planning or maternal health is also important so that no party cries foul. In addition, consulting with the district leaders, politicians and village committee leaders can be very resourceful in ensuring that the message is well dispensed and reaches even the most remote of places.

5.2 Conclusion

The study found that stakeholder identification and analysis significantly affects sexual and reproductive health. This is because identifying the individuals, groups, or organizations that are mostly likely to be affected by the program at an initial stage is very important because they can easily influence the decisions that can greatly affect the program at a later stage and this can have an adverse effect on smooth operations.

The study found that information disclosure significantly affects sexual and reproductive health. This is because when the program leaders are accountable, and transparent in their activities, they will make sure that information about sexual and reproductive health is easily accessible to the public in a format that is easy to understand and comprehend.

The study found that stakeholder consultation significantly affects sexual and reproductive health. This is because consulting with stakeholders such as married couples, media, cultural leaders or religious leaders, and civil society groups is very important in making sure that all views regarding the sexual and reproductive health are listened to and a common ground that benefits all parties is reached at and all.

All in all, stakeholder engagement is a great tool in promoting sexual and reproductive health program in Kigoma District. This is because a good stakeholder engagement uses the principle of

good faith which advocates dialogue, negotiation, transparency, and totality of conduct. Hence engagement based on collaboration with stakeholders can create more opportunities in terms of learning, innovation and fundamental corporate transformation of sexual and reproductive health in Kigoma District.

5.4 Recommendations

5.4.1 The Effect of Stakeholder Identification and Analysis on Sexual and Reproductive Health Program in Kigoma, Tanzania

The study found that stakeholder identification significantly affects sexual and reproductive health program (R^2=0.417, p=0.000). Therefore, the program leaders should emphasize identification of stakeholders who would be directly and indirectly affected by the program at an early stage. This would help in solving all problems related to conflict of interests and wastage of resources at a later stage of the program.

Furthermore, the program leaders should perform an interest-based analysis and do some mapping that can help to clarify the motivations of different actors and the ways in which they might be able to influence the program. This can be done by organizing targeted public meetings, or printing information about the program on newsletters so as to establish and maintain open channels of communication.

5.4.2 The Effect of Information Disclosure on Sexual and Reproductive Health Program in Kigoma, Tanzania

The study found that information disclosure significantly affects sexual and reproductive program (R^2=0.467, p=0.000). Therefore, the program leaders should make sure that information about sexual and reproductive health is accessible to the public in a format that is readable and easily understandable by even the most lay person. The use of graphical and video illustrations can be of more benefit in this case.

In addition the program leaders should act transparent to the government, sponsors, the district leaders as well as the beneficiaries of the project. They should do periodic reporting and publications of their activities and performance and the financial implications so that both the

sponsors and the district leaders are aware of it and where necessary can give their financial and technical input for reasons of program sustainability.

5.4.3 The Effect of Stakeholder Consultation on Sexual and Reproductive Health Program in Kigoma, Tanzania

The study found that stakeholder consultation significantly affects sexual and reproductive health program (R^2=0.540, p=0.000). Therefore, program leaders should emphasize consultation at all stages of the program. They should ensure that in the consultation, they target early enough those who are most likely to be affected by the project so as to scope key issues that would later affect the program. This can be done by holding meetings, seminars, conferences and forums in radio talks shows or televisions.

Furthermore, the program leaders should make sure that the consultation is informative and relevant. That is to say, the information should be meaningful to those consulted and the content should be in an understandable format so that there is a two-way opportunity for both sides to exchange their views. This can be achieved by creating a blog where everything that the public needs to know is published in the blog and discussed and feedback provided so as to know the views of different parties regarding the matter under discussion.

5.4 Contribution to Knowledge

The studies on stakeholder engagement have been done in several sectors with mixed results (Schaalma et al. (2013); Brislin (2013); Klepp et al. 2013); Bosompra (2014); however, the current study using the three variables of stakeholder engagement, that is, stakeholder identification and analysis, information disclosure and stakeholder consultation add to the body of knowledge by confirming significant effects of the variables on sexual and reproductive health. In other words, the study established that practicing proper stakeholder engagement such as stakeholder identification, information disclosure and stakeholder consultation will promote effective sexual and health productive health. Furthermore, the dissertation is important in contributing information on sexual and reproductive health. This is partly because good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. The information could also enable people to be able have a satisfying and safe sex, the capability to reproduce and the freedom to decide if, when,

and how often to do. Researchers, government officials and NGOs/CSO concerned with sexual reproductive health could utilize this work in their daily work.

5.5 Areas for Future Studies

The current study covered only Kigoma city, a future study should cover the whole of Kigoma Region so as to provide a wider geographical coverage and a larger population for a better and generalizable conclusion.

Furthermore assessment of the performance of Engender program in other parts of Tanzania should be done so as to provide comparative results. This would help to establish which regions are performing better and why, hence laying ground for improvement and further funding.

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APPENDIX I: TRANSMITTAL LETTER

I am a Masters candidate for Project Planning and Management at Kampala International University undertaking a dissertation on **"Stakeholders Engagement in Sexual and Reproductive Health Projects: A case study of Engender Health Projects**". In view of this, I request you to participate in this study. Kindly answer this questionnaire without leaving any question unanswered. Please be assured that the information you give will be treated with utmost confidentiality and will be used for academic purpose only. Before answering this questionnaire kindly read and sign the attached informed consent.

Thank you very much in advance.

Yours faithfully

…….

Tchakubuta Remy Nicolas

APPENDIC II: INFORMED CONSENT

I am giving my consent to be part of the research study of Mr. Tchakubuta Remy Nicolas on **"Stakeholders Engagement in Sexual and Reproductive Health Projects: A case study of Engender Health Projects".**

I been assured of privacy, anonymity and confidentiality and that I will be given an option to refuse participation and right to withdraw my participation any time.

I have been informed that the research is voluntary and that the result will be given to me if I ask for it.

Initial ……Date …….

APPENDIX III: QUESTIONNAIRES

Section A: General Information

For Project Beneficiaries Only

1. Gender

a) Male ☐ b) Female ☐

2. Age

a) 20-29 years ☐ b) 30-39 years ☐

c) 40-49 years ☐ d) 50 years and above ☐

3. Educational level

a) None ☐ b) Primary ☐

c) Secondary ☐ d) Post-secondary ☐

4. Marital Status

a) Married ☐ b) Single ☐

b) Divorced ☐ d) Widow ☐

5. Number of Household members

a) 1-5 ☐ b) 5-10 ☐

c) More than 10 ☐

Section B: Stakeholders Engagement

Instruction: Please indicate to what extent you agree or disagree with each of the following statements about stakeholders' engagement in sexual and reproductive health projects run by Engender health in your community. Please tick [√] one of the following options to indicate your opinion. I=you strongly disagree: 2=you disagree; 3=you are not sure; 4=you agree and 5=you strongly agree.

#	Stakeholders Engagement	1	2	3	4	5
A	**Stakeholder identification and analysis**					
1	You identified the individuals or groups who have interest in the sexual and reproductive health projects in Kigoma region.					
2	You identified who makes the decisions related to sexual and reproductive health issues in Kigoma region and will approve the final project.					
3	You identified who can influence decisions in the sexual and reproductive health projects.					
4	You identified individuals and organizations who will potentially be affected by the outcomes of the sexual and reproductive health projects in Kigoma.					
5	You identified who can slow or stop the sexual and reproductive health projects in Kigoma region.					
B	**Information disclosure**					
1	You are accountable for all the activities in sexual and reproductive health projects in Kigoma region.					
2	You are transparent in your activities in sexual and reproductive health projects in Kigoma.					

3	You make information about your sexual and reproductive health activities easily understandable by the public.					
4	You make information about your sexual and reproductive health projects activities accessible to the public.					
5	You publish information about the progress of the sexual and reproductive health projects to the public.					
C	**Stakeholder consultation**					
1	You consulted those who were likely to be affected by the sexual and reproductive health projects.					
2	You ensured all projects participants were properly informed and had in-depth knowledge about the project.					
3	You promoted capacity building to the project beneficiaries.					
4	You engaged at an early stage those whom the project would directly affect.					
5	You ensured gender equality in your consultation process.					

Section C: Sexual and Reproductive Health

For beneficiaries

Instruction: Please indicate to what extent you agree or disagree with each of the following statements about sexual and reproductive health projects run by Engender health in your community. Please tick [√] one of the following options to indicate your opinion. I=you strongly disagree: 2=you disagree; 3=you are not sure; 4=you agree and 5=you strongly agree.

#	Sexual and Reproductive Health	1	2	3	4	5
A	**Family planning**					
1	Through engender health projects, you practice family planning methods.					
2	Through engender health projects, you have access to both HIV and reproductive health services.					
3	Through engender health projects, you have been empowered to know your sexual rights.					
4	Through engender health projects, you have access to information about health risks regarding unplanned pregnancies.					
5	Through engender health projects, you have access to voluntary counseling on sexual and reproductive health.					
B	**Reproductive health**					
1	Through engender health projects, you have a healthy sexual relationship with your partner.					
2	Through engender health projects, you have the power to make decisions on unwanted pregnancies.					

3	Through engender health projects, you have a healthy life.					
4	Through engender health projects, you are free from diseases or sexual disorder.					
5	Through engender health projects, you have the capacity to enjoy and control sexual and reproductive behavior.					
C	**Maternal Health (for female mothers only)**					
1	Through engender health projects, your consent is sought on sexual and reproductive engagements.					
2	Through engender health projects, your sexual rights are observed.					
3	Through engender health projects, your sexual rights are respected during childbirth.					
4	Through engender health projects, you are not at risk during childbirth.					
5	Through engender health projects, you have comprehensive access to sexual and reproductive health services.					

The End

Thank you for your cooperation

APPENDIX IV: INTERVIEW

For staff of engender health only

1. What criteria did you use to identify potential stakeholders in this program?
2. How do you ensure information about the project is disclosed to the public?
3. In your consultation endeavors, whom do you prioritize in the consultation and why?
4. Which sexual and reproductive health programs are you mostly involved in?
5. What are some of the outstanding achievements of these programs?
6. What are some of the major hindrance to the program success?

The End

APPENDIX V: TABLE FOR DETERMINING SAMPLE SIZE FROM A GIVEN POPULATION

TABLE 1

N	*S*	*N*	*S*	*N*	*S*
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3500	346
85	70	440	205	4000	351
90	73	460	210	4500	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367
130	97	650	242	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379
180	123	900	269	40000	380
190	127	950	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	1000000	384

Note.—*N* is population size.

S is sample size.