

**A literature Review on Factors Influencing
Access to Sexual and Reproductive Health
Services among Adolescent in Tanzania**

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis: **Factors Influencing Access to Sexual and Reproductive Health Services among Adolescents in Tanzania is my own work.**



Signature

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Dedication

This thesis is dedicated to my loving children Engerasia (10), Benedict (8) and Benjamin (5) for their understanding and encouraging words “maliza shule kwanza mama” which means, “mother finish your studies first.” These words come across my mind every day and have given me support throughout the time I studied abroad.

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Lastly, I express my gratitude to my classmates in ICHD 2014-2015 for making my studies enjoyable, not forgetting the ideas and experiences we shared together.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
FBO	Faith Based Organisation
FP	Family Planning
GDP	Gross Domestic Product
GER	Gross Enrolment Ratio
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
HSDP	Health System Development Plan
ICHD	International Course for Health Development
ICPD	International Conference for Population Development
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MHSWF	Ministry of Health and Social Welfare
NBS	National Bureau of Statistics
NGO	Non-Governmental Organisation
NPP	National Population Policy
PMTCT	Prevention from Mother To Child Transmission of HIV
RH	Reproductive Health
SRHR	Sexual Reproductive Health and Right
TDHS	Tanzania Demographic Health Survey
UMATI	Chama cha Uzazi na Malezi Bora Tanzania (Tanzanian Family Planning Association)
UN	United Nations
UNICEF	United Nation Children's Fund
UNDP	United Nation Development Programme

UNPFA	United Nation Population Fund
UPE	Universal Primary Education
URT	United Republic of Tanzania
USAID	United State Agency for International Development
WB	World Bank
WHO	World Health Organisation

Glossary

1. **Access** – Is an action or actual use of individual facility services and everything that facilitates or impedes their utilization (Andersen & Davidson 2000).
2. **Contraceptive prevalence rate**- The proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time (Awoke, 2014)
3. **Contraceptives methods** - these are modern family planning methods such as , condom devices for both male and female, sterilizations procedure for both male and female, Hormonal methods such as injectable, pills and implants, and Intra Uterine Cervical Device-IUCD methods (URT 2015).
4. **Dual protection**- Is the infertility protective method used to prevent both unwanted pregnancy and sexual transmitted infections including HIV whereby there is proper and consistent use of condoms in conjunction with another contraceptive method (Lyatuu 2012)
5. **Family planning**- Is the ability of a person or couple to plan the number of children they want and, the space between them, through the use of contraceptives methods (MOHSW 2013a)
6. **Unmet need for family planning**- Women who want to delay their next pregnancy, or to have no more children, but who not have access to a method of family planning (URT 2015)
7. **Safer sex**- Is the sexual intercourse practice which done with highly protection measures from selecting type of sex practice which is safe and free from infection and also additional of protective methods to prevent unintended pregnancy as well as STDs (Solomon 2004)

Abstract

Background: Despite family planning services being free in Tanzanian government health facilities, there has been limited access of services among adolescents both male and female. Teenage pregnancies as well as denied fatherhood do still occur. Government policy assures free reproductive services to everyone but several obstacles contributed to the limited uptake of reproductive health services by adolescents.

Objective: To explore factors influencing the access to Sexual and Reproductive Health services, their use among adolescents, and to provide recommendation to policy makers and stakeholders on improving the uptake of contraceptive methods in Tanzania

Methods: A literature review was conducted, the Anderson Model of health care utilization was used as a guide to analyse influencing factors

Findings: Health beliefs and Health care system factors are most likely to affect access and use of contraceptives methods among adolescents. Factors such as negative health beliefs, lack of choice for appropriate SRH services, gender inequality, limited knowledge of contraceptives and skills, poor family status among adolescents as well as negative attitudes among health staff to adolescents are identified gaps which are associated with poor use of contraceptives.

Conclusion: Access of adolescent contraceptive methods used among adolescents is a critical point of research, and several factors are influential to the poor uptake of contraceptives services among adolescents. Health beliefs and Health care system factors found to be the main cause.

Recommendation: The thesis discusses that, access to contraceptives use among adolescents is unlikely, government need to take ASRHR as a serious issue. The thesis provides recommendation at a policy, facility and community level to improve the health of adolescent.

Key words: family planning, adolescents, contraceptive, Tanzania, reproductive choice.

Word count: 11,732

Introduction

I am a professional Midwife, dealing with nurses working in labour ward and Reproductive Health Clinic (RHC) in a local NGO. Always when I go for a field work in rural area; I meet pregnant and lactating women having their babies at their back, others with two children on her both sides. My role is then to implement the elimination of mother to child transmission of the Human Immunodeficiency Virus (HIV) infections as described by Millennium Development Goal (MDG) number six.

While working in the rural areas, I do face a significant number of challenges. The major one, which appeared dominant, is for pregnant women, especially **young women**; carry their unborn child to their full term as well as taking care of their babies without support from husband or the person who impregnated her. In most cases he doesn't like to be known by her family members or even surrounding society. In addition, the man who impregnated her will appear and show concern in some cases, but not always. Sometimes, men back themselves with some reasons that, they should wait till people say that the baby resembles his or her father. In this case, it is obvious that, it is then the duty and responsibility of the girl to declare who the father of the baby to her immediate or extended family for further action. However, because of ignorance, normally these young women do not disclose because of fear, which now has become a norm in the society. Many adolescent, young women do not know their rights. Men have a culture and sometimes power to threaten young women not to disclose who they are. Pregnancy at adolescent stage has been associated with many threatening disease and conditions such as Sexually Transmitted Diseases (STDs) including HIV infection and other threats like abortion, suicide and death, and this could happen throughout the pregnancy period, during delivery process as well as during breastfeeding period.

To date in our Tanzanian society, there are many existing cases of pregnant young women as well as abandoned children, a part of each death associated with abortion and delivery cases. In addition, there are still many cases of men retreating from such situations, which justifies and makes my research question more valid and stronger. This thesis allows me to get a chance to respond to my question "do adolescents in Tanzania have access to Sexual and Reproductive Health services according to their choice"

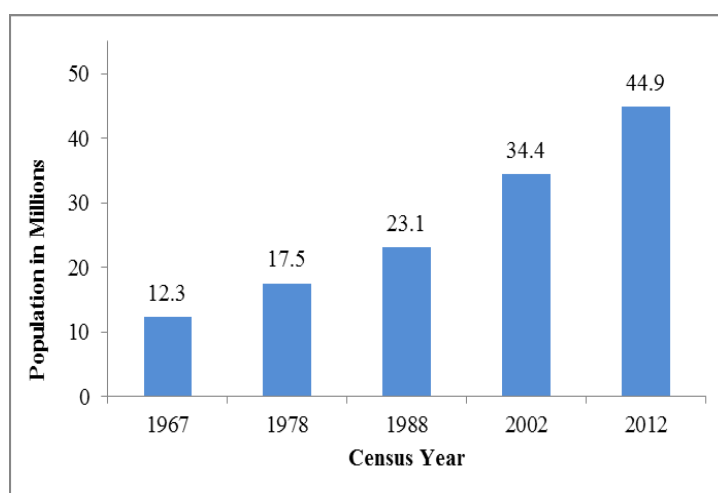
Chapter one: Background Information

1.1 Tanzania Profile

1.1.1 Demographic

Tanzania is the largest country among the East African countries with an area of 940,000 square kilometres, out of which 60,000 square kilometres are water bodies. The bordering countries are Kenya, Malawi, Mozambique, Rwanda, Burundi, Uganda and Zambia (National Bureau of Statistics 2011). The 2012 Population Projection and Housing Census have estimated the total population to be 44.9 million in 2012. The average growth rate is 2.7 %. The population has more than tripled between 1967 and 2012, growing from 12.3 million to 44.9 million as it is shown in figure 1. The sex ratio is 51% female and 49% male (NBS 2013). According to Tanzania Demographic Health Survey –Tanzania Demographic Health Survey (2010) the average household size is 5 persons, where by rural household is bigger than urban. The population age pyramid is shows a high amount of young people, where by 43.9% are under 15 years, 52% as half of population are age between 15 to 64 years and 4% are 65 and above years of age. (Refer to figure number 2 as it shown a Tanzanian Map)

Figure 1: Tanzania, 1967 – 2012 Censuses Population Trends



Sources of Graph (NBS 2013)

Figure 2: Map of Tanzania

UNITED REPUBLIC OF TANZANIA, REGIONAL BOUNDARIES



Source of Map (NBS 2013)

1.1.2 Socio cultural and economic situation

Tanzania has 126 tribes of which each speak their own language while Swahili is the most spoken language, In addition to that, it has three major religions which are, Christianity, Islamic and Indigenous. Unfortunately, the Government does not see the important of collecting data segregate of religion. The country is politically stable, with Gross Domestic Product rate of 6.7% (NBS 2014) The economic growth rate was about 7.0% in 2013 and with 28.2% of people living in poverty line (United Republic of Tanzania 2013b). In addition; agriculture is an economic backbone and the main occupation in Tanzanian by which 74% of the population is engaged in farming. Agriculture contribute to about 27% of the Tanzanian economy, while other activities, example fishing 1.5%, industry and construction is 24% and other services is 47.9 % (URT 2013b)

1.1.3 Education

Generally, in Tanzania there is a big difference in education attainment between males and female, data shows that, 27% of females have never gone to school compared to 18% of males. Illiteracy rate is 40% with the highest of this percentage being women aged between 45-49 compared to 21% among men aged 30-39 (NBS 2011). Differences also appear on the median number of years of schooling, where by females take 3.6 years compared to 4.6 years for male. In addition urban residents have more chances of attending and staying in school for a longer period than those from rural residents (NBS 2011). Since government initiated Universal Primary Education (UPE) as an objective for national development, fees for primary school was abolished in 2000 and therefore the trends for gross enrolment ratio (GER) rose from 78% in 2000 to 99% in 2002 (Population Policy Section 2006).

In some few years ago, Tanzanian government put in place a free fees regulation, for primary school education and is mandatory, every parent MUST enrolled his/her children to school. As the result by 2010, 95% of children were enrolled at primary schools level (United Nation International Children's Emergency Fund 2011)

1.1.4 Health status

General health status of Tanzanian population is poor (United State Agency for International Development 2011), the average Life Expectancy for males and females lies between 61 and 65 (WHO 2015) Estimated Maternal Mortality Ratio (MMR) is 578 deaths per 100,000 live births(URT 2015)(World Bank et al. 2013) under five mortality rate was 52 deaths per 1000 live birth (WB 2014)(Bank et al. 2013) and infant mortality rate is 36.40 per 1,000 live birth (WB 2013)

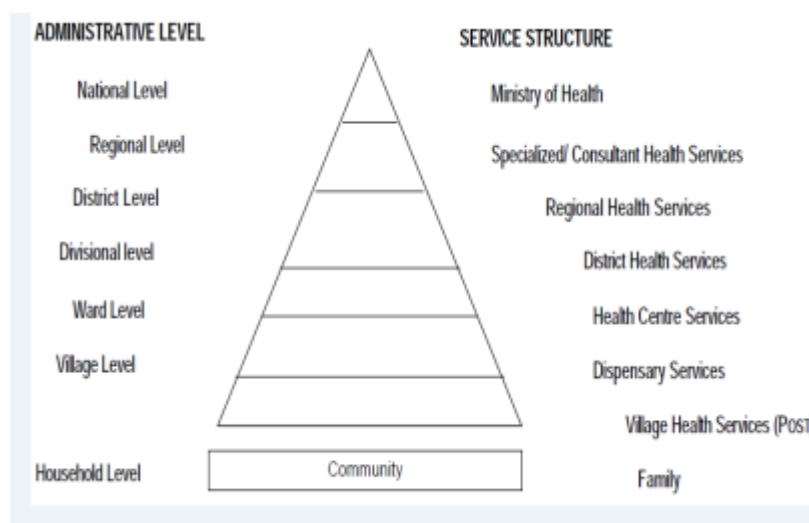
1.1.5 Health System

Tanzania started implementing its third Health Sector Strategic Plan III (HSSP) as a Health sector reform from 2009 to 2015. It works specifically on Decentralized by Devolution (D by D) policy which, means that all authority and responsibilities for health care shifted from Ministry of Health as Central part to local governmental authority as a close community (USAID 2011). In addition to that HSSP III was established to play as a guideline in health sector operation as it closely operate in partnership with MDGs targets as well as merged with health sector

reforms. HSSP III provides strength and increase quality of health services to District level for availability and access of health services to close to the community. It was mentioned that Reproductive health services are among some of the important services needed to be available throughout and extended in every targeted area (Ministry Of Health and Social Welfare 2008b) (MOSWF 2015).

The structured appeared pyramidal; in primary care level comprise health post, dispensaries and health centres. Secondary levels comprise of general hospitals and in tertiary level comprise specialized hospitals. See figure 3. Furthermore, each level provides modern contraceptives methods as a family planning services (MOHSWF 2010) (Kwesigabo et al. 2012)

Figure 3: Organisation of Health Services Tanzania



(Kwesigabo et al. 2012)

The main players of health services delivery are Public, Private and Faith Based sectors. However the public sector covers 71% while private sectors cover 16% and FBO cover 13% of services delivery in health (National Health Account 2010)

Tanzania has 63,447 health workers (Doctors, Nurses, Pharmacists and Laboratories technicians) all over the country; the total population with health care worker population ratio is 1.40 per 1,000 populations which is far behind WHO standards of 2.3 per (provider)1,000 populations (MOHSWF 2008a, 2009) (URT 2014)

1.1.6 Health care financing

Source of health care funding in Tanzania comes from government, out of pocket and foreign sources. The government has allocated 12% as total health expenditure in 2011 from national government budget which is below from Abuja declaration of 15 % (URT 2014), share of foreign funding is 41% in 2012 (URT 2012) and Private expenditure is 52% (World Health Organisation 2011)

1.1.7 Family Planning

Historically, according to Richey (1999), Tanzania in the years before 1964 was Tanganyika by name, and was a first country in 1959 to start family planning services via Independent Family Planning Association (UMATI- chama cha uzazi na malezi bora Tanzania) which unfortunately, became the last country to have guidelines in implementing family planning services due to political issues. Some group of Christian religious leaders became barrier for family planning services, they didn't agree that increasing of population is the national problem; Their action was serious as in 1970 they applied force to closure FP clinics . In 1992 the country adopted national family planning policy after five years of negotiation and revision process (Richey 1999) in 1989 the government integrated Family Planning (FP) services from UMATI to government Maternal and Child Health (MCH) clinic, services expanded and easily accessible to all over the country. Types of FP available are Combined Oral Contraceptive, Injectable Contraceptives, Progestin-Only Pills, Implants, Intra-Uterine Contraceptive Devices, Contraceptive Foam Tablet and Jellies, Male and Female condom, Vasectomy and Bilateral Tubal Ligation (MOHSWF 2011; URT 2015)

Currently 80% of FP services are provided by the government health facilities around the country, while 20% provided by private sectors. The main objectives being the rescuing of the lives of women, young women and children, also to minimize the adverse social as well as economic outcome of rapid population growth (URT 2015).

ADOLESCENT DEFINITION

An adolescent is defined, by WHO 2007, as a person between 10 and 19 years old. In this study, I will investigate the factors influencing access to sexual and reproductive health services among adolescents in Tanzania. My target group will be adolescents aged between 10 to 19 years of age as WHO described, but because there are no specific studies targeted this particular age group, I will use any age group not less than 10 years and not greater than 19 years of age.

Chapter two: Problem statement, Justification, Objectives and Methodology

2.1 Problem statement

Eleven per cent of all births globally come from 16 million of adolescents girls each year (Ngome & Odimegwu 2014)

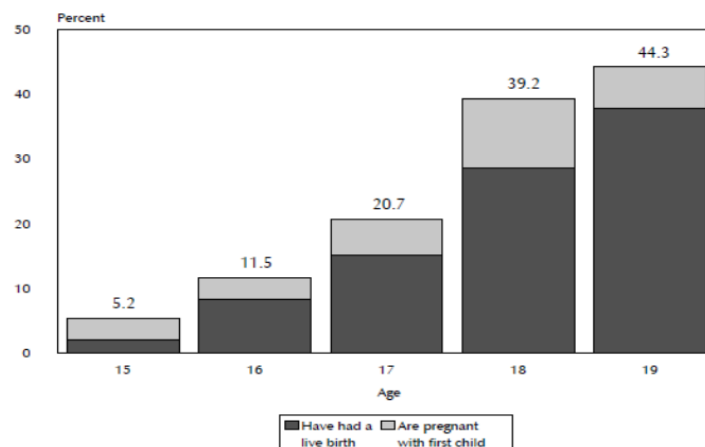
In Low and Middle Income Countries (LMIC) it is estimated that 16 millions of adolescents become pregnant each year, and 3 million of them are estimated to undergo unsafe abortion. Death was identified as the result from complication during pregnancy and delivery. For adolescent mothers, there is also a higher risk of perinatal death due to immaturity of the mother's body; while to her; often, new born do suffer from low birth weight and other consequences (Madeni, Horiuchi & Lida 2011) Pregnancy at adolescent age has been related with risk of morbidity and mortality for both the adolescent mother and her child, high risk of induced abortion and can even create school dropouts as the end up of education objectives. Not only the risk of acquiring STIs, but also HIV infection to both male and female adolescents. In addition, the end result is poverty to the society, community and the whole country (URT 2011b)

Ministry of Health Tanzania has been acknowledged that adolescents health specific in sexual and reproductive is a serious matter. Female adolescent are suffering from pregnancy which become a serious agenda among public health issues (URT 2011).

Estimation shows that, at the age of 16 years, 11% of girls are pregnant or have delivered a baby as it shows in figure number 4. This is because they are sexual active without protective measure. First intercourse for a male adolescent is average 18.1 years and for female is 16.7 (NBS 2010). Also the data shows that, a total number of 28,600 adolescents' female dropped out of school between 2004 and 2008 because of pregnancy; in 2007, 5.6% from primary school and 21.9% from secondary school level. (Madeni, Horiuchi & Iida 2011)The figure starts with 15 years but the real start age is 16 year.

In Uganda, 1.2 million of pregnancies are documented annually, 25% of which are adolescent pregnancies. In addition more than 300,000 of the adolescent pregnancies are identified as unwanted pregnancies and result in abortion or unloved babies (Kazaura & Masatu, 2009).

Figure 4: Adolescent Child bearing by age, in Tanzania 2010.



Source of graph (NBS 2011)

In Tanzania, the use of contraceptives amongst adolescents is very low, with only 6.6% of males and 3.1% of females aged 15 to 19 using modern methods of contraceptives, specifically male condom (Mouli et al. 2014). Only 12% of married or living together adolescents are using modern contraceptives as compared to 24.4% of their total population. Still contraceptive use is low while unmet need for contraception is 22%(UNIFPA 2014) the adolescent fertility rate is 116 per 1000 adolescent girls (NBS 2013).In addition the country is missing contraceptives data specific to adolescents who are not married as well as living together. (URT 2010)

2.2 Justification

Tanzania has not yet achieved its Millennium Development Goal target for reducing maternal mortality by the year 2015. Every year more than 8,500 women die in Tanzania due to pregnancy related complications (WHO 2010). It is estimated that half of them are adolescents, the government missed the adolescent maternal mortality and unmet need for contraceptives data but high rate of neonatal death 41% per 1000 live births from mothers under 20years taken as indicator for higher mortality risk for adolescent mothers (UNICEF 2011)

An adolescent mother tends to have more children as they began child bearing earlier in life, the greater number of children and at shorter interval between pregnancies which hinders their ability to generate an

income for themselves and their family, as well as to contribute to society at large. The result is that they are unable to afford many things in life such as to pay for bus fare if one wants to go to clinic, food, and even for health services. Their life will then consist only of giving birth and taking care of children which is a risk factor for maternal and neonatal mortality (UNICEF 2011)

Therefore, identifying factors influencing access to modern fertility control methods should be an important requirement to improve reproductive health of young people in developing countries (Williamson et al. 2009). Furthermore, the effective utilization of FP services is expected to reduce maternal mortality rate by 35% (URT 2015)

There are several studies done in Tanzania on adolescent and contraception, some focusing on the evaluation of reproductive health awareness programs, some also focusing on service providers as a barrier to family planning and others focusing on adolescent health seeking behaviour. Therefore I would like to make a comprehensive study that shows factors influencing access to Sexual and Reproductive Health services among adolescents, both male and female and which also review the best practices in neighbouring countries in order to identify what they did best, and to inform policy makers and stakeholders on how to strengthen the SRHR services program in Tanzania. Furthermore; according to Madeni et al. (2011) "Tanzania has a limited number of studies involving boys" and being an important part of the problem, I have to include them wherever possible.

2.3 Objectives

2.3.1 General objective

- To explore factors influencing the access to sexual reproductive health services among adolescents, to identify evidence based interventions, and to provide recommendations to policy makers and stakeholders so as to improve the uptake of contraceptive use in Tanzania

2.3.2 Specific objectives

- To describe and analyse factors that influence contraceptive use among adolescents in Tanzania
- To identify the best practices and examples of other countries addressing contraceptive use among adolescents in Tanzania
- To formulate recommendation to policy makers and stakeholders on how to strengthen the adolescent sexual reproductive health

services program in order to increase contraceptive use amongst adolescents

2.4 Methodology

This thesis is based on a review of literatures; the study will explore factors influencing access to contraceptive services among adolescents in Tanzania and comparable, neighbouring countries. The literature review-, (see table 1), includes Tanzania Demographic Health Survey (TDHS), National RH/FP strategy, Bureau of statistics report, Adolescence Reproductive health Report from MOH, NPP, and reports from other International and Local non-governmental organisations implementing FP/Contraceptive services. On top of that, a review of reports from UNICEF, WHO, UNIFPA, WB and UNDP were, carried out. Also information collected from demographic report, healthy policy and strategies on FP/contraceptives, health believes societies, personal and quality of FP/contraceptives services including peer reviewed articles, government report and grey literature report.

Information for reviewing was assembled from online databases available in English, identified via: Google Scholar, PubMed.

Key words/combinations of words:/Tanzania, Kenya, Uganda, adolescents, FP, contraceptive, need, prevalence, health beliefs, attitudes, factors affecting or barriers to use family planning, access, use, availability and unmet of family planning, condom, provider, pregnancy, reproductive, health, pills, sexual, married.

Inclusion Criteria: Literature from Tanzania was included after the adaptation of the National Population Policy (2003) to date and criteria used when comparing with neighbouring countries such as Kenya, Uganda, Malawi and South Africa.

Exclusion criteria: Literatures before the implementation of the NPP (2003) and studies from other than African countries.

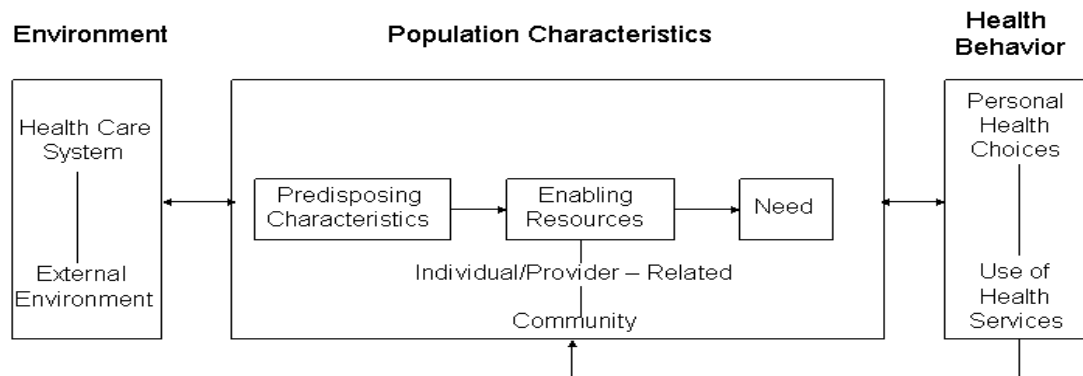
Table 1: Search Strategy

Objectives	Sources	Key words
<p>•To describe factors that influence contraceptive use among adolescents in Tanzania</p>	<p>Published and peer review article</p> <ul style="list-style-type: none"> • PubMed • Google scholar • Google • Science direct • Biomed central <p>Grey literature report</p> <ul style="list-style-type: none"> • Government report • WHO • Institutional website • Guideline • Policies • Acts 	<p>Contraceptive, use, Tanzania, adolescent, behaviour, risk, influence, condom, health choice, family planning, pills, reproductive, health, sexual, pregnancy, never married</p>
<p>•To identify the best practices and examples of other countries for addressing contraceptives use among adolescents</p>		<p>Kenya, Uganda, South Africa, practice, best, adolescent, country and pregnancy</p>
<p>•To formulate recommendation to policy makers and stakeholders on how to strengthen adolescent sexual reproductive health choice program in order to increase contraceptive use amongst adolescents</p>		<p>Policy, adolescent, choice, contraceptives, use, sexual, reproduction and health</p>

2.5 Conceptual Framework

Figure 5:

The Anderson Model of Health Care Utilization



RM Anderson. Revisiting the behavioral model and access to medical care: does it matter? *J Health Social Behavior* 1995;36:1-10.

Source of Model (Anderson 1995)

In order to analyse the factors influencing the access of adolescents to contraceptive, different studies were reviewed to select an appropriate conceptual framework which would fit the topic. Some of the other studies done were regarding access to medical care and improving care and others were regarding policy. Finally the Anderson Model of Care Utilization 1995 was adopted as a conceptual framework for this study.

According to Anderson 1995 definition, "access is the actual use of personal health services and everything that facilitates or impedes their use". The model discusses the effect of individual health seeking and its relation to the environment and population characteristics. In this study the population observed are adolescents.

Three main chapters were developed; Environment related factor, Population characteristics related factor and Health behaviour related factor were reviewed to analyse factors contributing to access of contraceptives among adolescents in Tanzania. The following variable were studied,

1. **Environment related factors**, Environment is a place in which people live and can also promote health services utilisation straight away via Health Care System (Spark, Willis & Iacono 2013)

Environment related factors has two main parts:.

- (i) Health care system which includes, National population policy, National RH/FP strategies, Health providers and Health services.
- (ii) External environment consists of Residence (Rural/Urban), school, religion, social media, culture and socioeconomic situation.

2. **Population characteristics related factors** are a wider part of this model. It consists of three parts:,

(A) Predisposing characteristics, this refers to adolescent characteristics that prevent or facilitate the use of health care services. It has three components:

(1) Demographic characteristics, which are personal characteristics that express the probability that a member of the public will need health care therefore it encompasses age and gender of adolescents;

(2) Social structure, which is a factor that defines the person's status in the community, it consists of adolescents' education, religion, family, friends, school and social clubs

(3) Health beliefs, which are the knowledge, values and attitudes of individual adolescents towards the use of SRH services (Andersen 1995)

(B) Enabling Resources factors those factors that facilitate the means to utilize health services allowing somebody to act on a value or need for health care (Andersen & Davidson 2000)

- (1) Individual/ provider related e.g. discussion with boyfriend/girlfriend
- (2) Community, which consists of geographical distance, home family/membership of clan, friend, information, radio and religion, school

- (3) Quality of contraceptive services which is defined by available, affordable and acceptable

(C) Need factors is the immediate reason to use health care services, in the case of an adolescent, having or intending to have sex, she /he needs contraceptives and to obtain them, become an unmet need. Adolescents need include of knowledge and skills regarding contraceptive pills, condoms and calendar practice (Andersen & Davidson 2000)

3. **Health behaviour related factors**, here the model describe two things, *Personal health choice* and Use of Health Services. *Personal Health Choice* include all the life style of the adolescent such as, choice to have sex ,choice to abstain, choice to keep pregnancy, choice to use health facilities, choice to use modern contraceptive methods or traditional methods. *Use of Health services* includes whether they make use of available contraceptives services, and how many of them do (Andersen 1995)

Chapter Three: Factors that influence contraceptive use among Adolescents.

3.1 Environmental factors influence contraceptives

The purpose of this chapter is to explore the findings and analyse, based on the literature review, the factors affecting access to contraceptive services among adolescents in Tanzania. Here will be discussed the Health care system involving National policy, Policy on Health education, Reproductive health strategies and health services and External environment factors involving regions, rural/urban, school teachers, social and economic situation and use of media.

3.1.1 Health Care System

Health System has the main purpose of implementing health by action; it involves organizations, institutions and other resources for health action. Health action is any implementation whether in individual health care, public health services or via intersectional initiatives whose primary objective is to improve health.

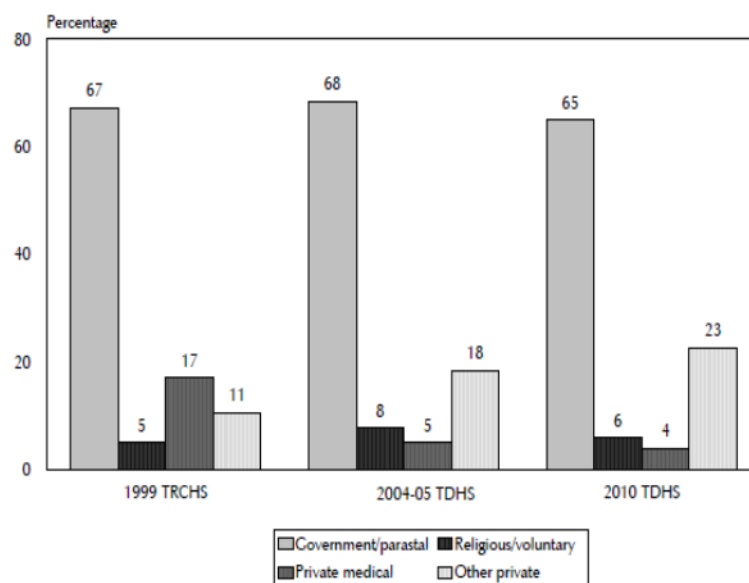
According to Tanzania National Family Planning Agenda 2013-2018, it was mentioned that, the availability of private sector facilities, pharmacies and drug sellers, are the other delivery channels for divert people from utilization of governmental facilities. But, as documented, these private facilities lack evidence of quality of care, affordability and effectiveness in their provision of care to society. Contrary to that, the multi-country study reports for Tanzania that, client's satisfaction for contraceptive services is higher among private sector facilities than public facilities (MOHSW 2013c)

The Catholic Church does not have interest in family planning methods. There are no provisions of contraceptive services to their facilities because of their beliefs; their staffs cannot be found talking about family planning. According to URT (2013) "even though sufficient evidence exists on opposition to modern FP by FBOs, we found no evidence on efforts/interventions targeted at this sector". According to the experience in Tanzania, other dominant churches such as Seventh day Adventist church, Lutheran and African Inland Churches provide contraceptive services to their facilities which includes health education, informed choice/counselling and drug administration

A multi-country study conducted in Sub-Saharan Africa documented that, In Sub-Saharan Africa there is an inequity of health facilities' location because the natural of Health System was designed and created more in urban than rural areas. Health facilities was built for curative care purpose around urban area where less than half of population live and thereby leaving the majority of the population without care in rural areas. Even though, family planning services, have been integrated into primary care system but still rural areas missed important services (WB 2013).

Referring to figure 6, which shows the sources of family planning services in Tanzanian society where government shows leading sectors in providing contraceptive services compared with other sectors such as FBOs and private sectors.

Figure 6: Source of Contraceptives among women (1999-2010)



Source of graph (NBS, 2011)

3.1.2 National Policy

By definition, according to Andersen (1995), Policy is a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern. Government has several policies which have the aim of increasing contraceptives utilization to population life by supporting health sector. The health policy of Tanzania has multiple challenges which have been directly affecting health sectors according to trends since 1990. The

main objective of health policy is to focus on the population so as enable support to health sectors by promoting and strengthening the capacity for quality delivery of health services.

In Tanzania the statement of national health policy about adolescents through Ministry of Health promote youth friendly care in order to facilitate right use of SRH information and services. This statement has been criticised by other health actors and institutions that national health policy doesn't describe adolescent SRH issues even though it addresses equity to both individual and health resources (Munguro and Ogawa 2012). In Tanzania generally, policies, strategies and guidelines describing adolescent's sexual reproductive health have missed awareness for care and services (URT 2013)

Generally the Tanzanian policy is providing support to FP; however the political aspect lack responsibilities and commitment in terms of practice. Issues like, lack of sustainable fund, deficiency of FP provider or FP paid care in private sectors are among the policy and operational barriers restricting desired objectives in arching FP services (MOHSW 2013c).

In addition to that, the 2001 revised NPP (draft form) was considered clearly mentioned that about young people needs and wants concerning Sexual Reproductive Health (SRH) and the role of government, civil society and private sectors to them but the current policy missed much stress to them, what it does is just demand the establishment of youth friendly reproductive health services (UNIPFA 2003). According to NPP (2006) which stated that "Policies mainly addressed family planning and child spacing activities; this influenced limited participation of players in other reproductive health issues.

Multi-country study done by Mouli et al. (2014) in LMIC documented that, in many countries adolescents are unable to access contraceptive services because of regulation and policy limitations (Mouli et al. 2014)

According to Oindo (2002) mentioned that, the Kenyan policy is not explicit about youth and SRH choice, therefore the result showed that, several institutional policies selected open-door policy to operate that FP services is for married couples and exclude service to unmarried which cause more vulnerability to unmarried youth. This has contributed

to unsafe sex actions and shifted access to natural family planning and abandoned condoms.

According to South Africa MOH, the law regarding adolescent access to contraceptives states that, from 12 years old child and above is allowed to access and use contraceptives method at any place over the country without permission from parents or guardian, 10 years imprisonment with addition of fine are the punishment to those who refuse to obey the law. In addition those adolescents are entitled to confidentiality (MOH 2012)

3.1.3 Policy on Health education

The United Nation (UN) Convention on the Rights of the Child states that "children and young people have the right to enjoy the highest attainable health, access to health facilities (Article 24), and access to information which will allow them to make decisions about their health (Article 17), including family planning (Article 24). Young people also have the right to be heard, express opinions and be involved in decision making (Article 12)" (Braeken, Shand and Silva 2010)

Till now, Tanzania, Ministry of Education and Vocational Training has no (national) sexual and reproductive health curriculum which is supposed to be available in schools. There were many reports done by NGO and other private sectors advocacy for ASRH curriculum but nothing as a change happened. The criticism goes to Ministry of Education and Vocational Training (MoEVT), are the one who failed to implement for the development of national curriculum in schools (Bangser 2010)

3.1.4 Reproductive Health Strategies

The National Adolescent Reproductive Health Strategy (2010-2015) has a long term objective in making sure adolescents have supportive laws and policies as well as a good environment for the issues of health, specifically in reproductive health, throughout of their life. It is documented that, this objective will provide room and connections for other institutions which deal with adolescents to develop health system responses to adolescents' requirements. At the adolescent stage, there is a need to develop independent decision making for different issues, but especially for sexuality. The National Life Skills Education Framework has the purpose of improving knowledge, skills and making sure attitude is well developed (MOEVT 2010). Therefore the intervention needs enough resources, qualified teachers and a reasonable environment which will be approachable for adolescents. The Ministry of Health recognises that adolescents, as human beings, need reproductive health care which is a basic human right for all (UNICEF 2011).

According to URT (2013a) Tanzanian government does not broadly distribute and implement its adolescents policies and strategies in all health facilities over the country. Health managers and providers are ignorant on those policies and strategies and they still ignore the need of adolescents, as a result adolescents fail to access SRH choice and lack of proper data specific to adolescent age and sex (MOHSW 2008).

3.2 External Environmental factors

External environmental factors are those factors outside home family environment that are affecting adolescent's access to contraceptives.

3.2.1 Rural/Urban

A study conducted in Tanzania shows that, female adolescents from rural areas are less likely to use contraceptives as well as almost twice as likely to begin childbearing early compared with girls who live in urban area before the age of 19 (URT 2011).

As it was mentioned earlier in Health System structures and regions similarities, a multi-countries study done in Sub-Saharan Africa documented that the health system of many Sub-Saharan countries is created for curative care purpose and the majority of facilities have been allocated around urban areas. Therefore most people, including adolescents, living in urban areas have close access to and availability to reproductive services including contraceptives than majority of the population in rural areas (WB 2013).

3.2.2 School teachers

A study done in Tanzania documented that, teachers are the second most important source in providing information on RH including contraceptives among adolescents compared with six other variables (MOHSW 2013b).

3.2.3 Peers

A study conducted in Tanzania shows, even though friends especially in adolescents group have more time spending in talking, playing and chatting the study documented that have minor play role as a source of RH information between them, in addition have low credibility rate compared to six variables (MOHSWF 2013)

3.2.4 Cultural

Some tribes in Tanzania society are aware of onset of menstruation period, they use as a sign of initiating lessons and to start teach a girl a role to become a woman and also they add more important point of

being abstinence to prevent from pregnancy (UNICEF 2011) Traditional Sexual information and education (also known as Unyago for girls and Jando for boys) given to adolescents according to the nature of the specific society seems to be ineffective, it does not enable adolescents with access to contraceptives methods to prevent them from pregnancy or other STI infections (URT 2011a) (USAID 2010)

3.2.4 Social-economic situation

As it described in figure number 7; the adolescents girls from poor family are mostly likely to conceive and have baby than the rich family. Also it was reported that, female adolescents from rural areas which are mostly poor people are twice as likely to conceive and start child bearing than urban areas at the age of 19 years. Also lack of economic status was mention as contributing factors of girls to engage in transactional and unsafe sex to meet the basic need. It was mentioned that lack of economic status also make parents initiation of childbearing, because they receive bride price. Adolescent's mothers have been identified to have less contribution to the economic growth and their babies will have the poorest life in future In addition to that, (UNICEF 2011)

3.2.5 Access to media/information

According to TDHS 2010, there are three main types of media in Tanzanian society, such as Radio which is very popular and common, followed by Television and newspapers. Other common mass media sources include billboards, posters live dramas and community events. For interpersonal sources of family planning messages, the most common sources are doctors/nurses followed by other health workers, school teachers, and friends. A cross sectional study done in Tanzania reveal that, (47.2 %) of adolescent respondents both male and female , radio were the source of information followed by reading newspapers (21.8 %) and (18.0 %)through friends (11.1 %) others sources (Dangat and Njau 2013)

Another cross sectional study done in Tanzania show that, source of information on contraceptive use was mainly from school (60%) and media 40% (Kagashe and Honest 2013)

Chapter four: Population characteristics

4.1 Pre-disposing characteristics

This chapter describes variables which explore personal factors secondarily linked with SRH choice use as predisposing factors (Anderson 1995)

4.1.1 Demographic Factors

4.1.1.1 Age

The age of sexual debut for adolescent male is estimated 18 years and 16 years for female but girls start having pregnancy and child bearing at the age of 16 years (NBS 2010). The marriage law requirement is 18 years of age, but cases of children marrying before the 18th birthday are many especially in rural areas (UNFPA 2012)

A cross-sectional study conducted in Tanzania observed that only 12.4% of female adolescents aged of 14- 20, had experienced at least one method of contraception (Kagashe & Honest 2013)

Another study done in Tanzania reported that, 66% of girl's age between 14 to 19 years had never experienced contraceptive use. In the percentage of experienced group, 81% were above 16 years of age and 6% were aged less than 15 year (Mung'ong'o G 2010)

A study conducted by International NGO (Maria Stopes) in Arusha and Zanzibar Tanzania showed that, half of the female participants age group 12 to 19 have experienced contraceptive use (Brown et al. 2013). Similar study conducted in Malawi, results show that, all 23 male and female participants age 18-19 have experienced contraception use.

4.1.1.2 Sex

An intervention comparison communities study done in Tanzania show, boys have little experience on increasing condom and modern contraceptives use compared to girls who show strong use (Doyle et al. 2010) The same result from another study done in Tanzania show, low condom use among adolescents boys as they want to prove their virility, they feel discomfort wearing condom, they are weak on caring protection, they want to feel natural intercourse (Urassa et al. 2008).

4.1.2 Social factors

According to TDHS 2010, the current data shows, almost 20% of girls age of 15-19 are married or living with a partner and 4.2% of boys are married or living with a partner. 1.3% of female and 0.3% of male

adolescents were divorced, separated or widowed. 80.3% of female and 95.5% of male adolescents were never married (NBS 2011).

According to URT 2013 report, there is infrequent use of condoms and other contraceptives methods reported among adolescents. In addition to that, data shows that, only 11% of adolescents aged 15-19 have exposure to contraceptive methods, and there is a rising of sexual activities among adolescents which are characterised by multiple lifetime sexual partners (MOHSW 2013).

4.1.2.1 Gender role

In Tanzania society, female adolescents, aged of 10 to 19 is affected by the gender norms, expectations and lack of power in decision making. Sometimes due to their age and gender inequality, they are in danger of unintended pregnancy and sexually transmitted diseases, whereas boys are socially expected to be dominant in decision making, regardless of capability which society accept, this also bring them to risk of acquire infection like STDs (Hainsworth et al. 2014)

A multi-country study conducted in Sub-Saharan Africa, reported that, gender factor (as it has a role of domination) acts as a barrier to access and use of contraceptives. Studies reported that males use different ways, such as violence e.g. force and threats, to make sure his girl will not use contraceptives during their sexual intercourse and violence appeared more in condom use than other methods. On the contrary, the same study documented that some girls reported their partner encouraging them to use contraceptives. In order to control and dominate girls in South Africa men report to use more presents as well as money to exchange sex and, girls become attracted and thereby, fail to negotiate safer sex and unsafe sex is performed as it reported (Williamson et al. 2009).

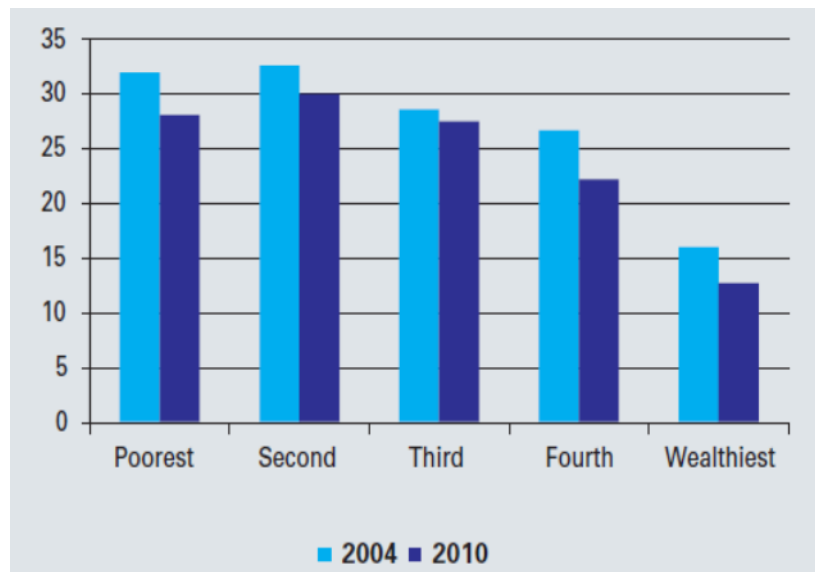
4:1:2:2 Families

A study conducted in Tanzania shows that, female adolescents from poor households/families are less likely to use contraceptives than girls from wealthier families/quintile (URT 2011) See figure 7. In addition to that, some parent's observation and realize that their children are matured enough to have access to SRH information. There are other parents who provide information themselves to their children and others find a convenient person to talk with them. However, this will less likely happen to poor family because poor parents are not well educated to identify child growth development stages. Experience shows that, in general children depend on the guardian, parent or close elder member of the family to

get the basic need of life, the same applied to adolescent need including contraceptives. Adolescent need permission from parents, and sometimes need someone to escort her/him and fare to go to clinic. Failure to that, adolescent are engaged to transactional sex where the result is pregnancy and other SRH problems.

Figure 7: Percentage of adolescents who have begun childbearing by social economic status age 15-19)2010

Percentage



Source of graph (URT 2011a)

Normally, in Tanzanian society when a girl becomes pregnant, it is a shame to her family but on the other side of the boy his family congratulate him as a fertile boy, and family don't see the need teaching boys about contraceptives methods as a result boys continue to induce pregnancy to several girls and keeping rejecting all pregnancies. The study conducted in Tanzania shows that boys have more sexual partners compared to girls and are the ones who start sexual activities earlier, according to URT (2013a) active boys have mean lifetime number of four sexual partners compared to two among girls who are sexual active.

A multi-country study done in Sub-Sahara Africa report that; After the couple being married, mother in laws specific men mothers, appeared and command more children, if a request failed as she want, wife are the one being in trouble and blamed as she used contraceptives method when she was at adolescent stage. Therefore, it is reported that, girls avoid use of contraceptives as they believe in future they will suffer from infertility condition and it will be a bad reputation for her life in family and the entire society(Williamson et al. 2009). In addition to that, for the experience when a boy induced pregnancy to a girl and a girl manages to mention the boy, a boy's mother plays her role of protecting her son by stating that 'it's not my son'.

4.1.2.3 Education

A study conducted in Tanzania documented that; the data show that by the age of 19 years, 50% of girls not attending schools are either mothers or pregnant, compared with 25% of those who attended and complete primary schools (UNICEF 2011)

A study conducted in Kenya reveals that the higher the level of education attended, the better the use of contraceptives (Oindo 2002).

A similar study done by the International Centre for Research on Women ICRW in Sub-Sahara Africa showed that female adolescents who are not in school are more likely to have sex and less likely to use contraceptives. The data showed that adolescents without education have a birth rate of (192 per 1,000 girls) compared (47 per 1000) with education. Also, each year of being in school increased the likelihood of contraceptive use and decreased the fertility rate by 10% (Sexton et al.2014)

A study conducted in Sub-Saharan Africa by ICRW showed that there are beliefs in societies that, 'never send a female child to school'. This appeared to be a factor contributing to poor access to contraceptive methods among female adolescents. This is because when the female reaches adolescence, she will obviously not have knowledge of SRH issues (such as access to contraceptives methods) because has not been taught about them (Sexton et al. 2014)

4.1.2.4 Religions

A study conducted in Tanzania to investigate the status of FP services and perceived priorities documented that, religion play a minor part on educating people about reproductive health information (MOF 2013)

4.1.2.4.1 Christian

A study conducted in Kilimanjaro, Tanzania showed that religion encourages adolescents to make use of SRH choices. The study didn't mention a specific religion however 69.3% of the 316 respondents were Christian ((Dangat & Njau 2013).

According to International religious aspect study done by Christopher (2006) the Catholic Church prohibits the use of contraceptives among their followers, regardless of their age or sex. The adolescents from this church who are close and adhere to the churches principles have a lower usage of contraceptive methods compared to those who are do not adhere. Experience shows the same thing happened in Tanzania but many

adolescents find their own way to help themselves by asking friends, use media and direct going to the facilities.

A descriptive cross –sectional study conducted in Kisumu Kenya showed that, the Christian religion encouraged adolescents to use contraceptives; the church emphasis on chastity has resulted in more adolescents using SRH services because it does regulate sexual concept behaviour which automatically include attitude to and uses of contraception (Oindo 2002).

4.1.2.4.1 Muslims

A study conducted by Keefe (2006) in Ugweno Tanzania report “I argue that religious (Islamic) values and reproductive reasoning are fashioned pragmatically” The Islamic religious in Tanzania doesn’t promote the use of modern contraceptives methods but it encourage the natural methods such as breastfeeding. In reality they do not agree to modern methods because of the side effects. Muslim women use family planning secretly without sharing it with their religious leaders and because they avoided side effect of hormonal methods they rely on sterilization method only. In the case of adolescents Muslim, they are usually taught abstinence until marriage but it has been said that people do what they want, the decision lies with them (Keefe 2006)

4.1.2.5 Health beliefs of adolescents

A cross sectional study done in Tanzania showed that 67% of adolescent’s respondents had adequate knowledge of contraceptives, while only 5.6% of them are currently using services for their life period. Also it mentioned that 75.6% of respondents believe health institutions are the right place to access contraceptives while the rest reported anywhere outside facilities. In addition, the study showed that so long have knowledge but still they have negative notions by on contraceptive use; it can promote promiscuous behaviour as it encourages sexual relations with multiple partners. In addition to that, adolescents are associated contraceptives with conditions like infertility, severe bleeding and even death (Dangat & Njau 2013).

Another cross sectional study done in Tanzania indicates the result that there is a big gap between informed choice knowledge and practice among adolescents. 48% of respondents said they understood what their safe days were, but when they were asked to show/indicate it, only 12.4% did correctly, It is highlighted that Tanzanian adolescents have poor and superficial knowledge on SRH (Kagashe & Honest

2013)(Silberschmidt & Vibeke 2001)When you compare the first study with this second study, the first study had 316 respondents while the second had 395 respondent with the same participants adolescent male and female, with the same environment but the results look the same and sometimes the result is not reliable.

A qualitative study done in Dar e s Salaam, Tanzania reported that adolescents are aware of almost all contraceptive methods and believe it helps to prevent pregnancy; however they also believe they are at risk of infertility condition and cancer disease due to contraceptive use (FHI 2010) in this study shows different because is a qualitative study with few respondents of 40, but the result is probably true because it has in-depth knowledge.

A similar result in a study done in Kenya showed that 99.2% was the level of contraceptive knowledge among 388 respondents but only 31.4% were currently using them. Contraceptives are seen as a way of encouraging promiscuity and adolescent believe later they will be at risk of infertility, uterine diseases or other health problems. Male condoms seems to be more popular than other methods because they are available everywhere and it has been noted that the contraceptive pill is taken irregularly by girls because it is easy to forget (as it is taken daily) and because of discomfort due to side effects (Oindo 2002).

A similar result in study done by Kapito et al. (2012) from Malawi documented that boys also have a negative attitude on contraceptives they believe will cause infertility so they don't like and run from it, in addition to that boys are weak from the beauty of a girl, they know the importance of contraceptives use, they usually put condom in their pocket meaning they intend to use, but when he gets in contact (mostly being in naked) with a girl, he asked himself 'how can I use condom to a beautiful girl like this' often boys realize at the end that he did unsafe sex. In this study boys agreed that at initial relationship they are very careful to use contraceptives eg condom but the way days go on they feel no need to use condom because they become familiar on sex but in generally boys disagree condom use because of reduce pleasure especial in stable relationship.

A study done in South-Africa shows that 63% of adolescents have a negative attitude towards contraceptive use. According to Ramathuba et al.(2012) the girls state that 'my boyfriend may leave me' 'can damage

my womb' 'get fat' 'my mum will be angry' 'may never have children' 'it is dangerous' 'long menstruation' 'not involved' not having sexual relations' 'not ready for family' and 'not necessary'(Ramathuba, Khoza & Netshikweta 2012)

4:2 Enabling factors

4.2.1 Individual/Provider related

A study conducted in Tanzania reported that, health workers play a big role in providing RH information to adolescents in Tanzanian society (URT 2013).

Different results report that, health care providers became a barrier for adolescent to access contraceptive as they have negative attitude to them.(FHI 2010) They often tell adolescent that contraceptives is out of stock, they provide service to adolescent without any information as she/he prescribed herself because she is a provider, they limit adolescent on condom only, (Cook, Erdman & Dickens 2007) they provide services to adolescent without confidentiality shouting in front of other clients/ customers, provide services in openly room no privacy because adolescent is a child, ask them irrelevant questions like are you married while knowing not? (Speizer et al. 2000) Openly, they request to know, why do you want these pills? And when they provide services to adolescent they gossip with other nurses which make them uncomfortable. They also leave them in a waiting room for a long time. Also other providers use age as criteria to restrict adolescent on access to contraceptive, e.g. 12 years and above (Blanc & Way 1998)(Bearinger et al. 2007) For my experience adolescent used to be stopped to enter in the nurses office before they reach the door, nurses use to yell at them or shout right way. Irritating responses from nurses/ pharmacists like" I actually know what you want and I will never provide to you because you are students"

While the multi-country study done in Kenya reported that health providers have in difficult time in providing SRH information and services to adolescents due to critical intersection of value and norms of the community (Warenius et al. 2006)

| In a study conducted in Sub-Saharan Africa, it is reported that adolescent are afraid of approaching health providers for contraceptive services. They normally feel ashamed because they perceive contraceptive services to be for married adult women. Their fear is of the negative perception from health staff when they introduce their needs

(Williamson et al. 2009) According to Williamson et al.2009 adolescents from South Africa stated that "We just feel ashamed but we don't challenge them. Sometimes you may challenge them and find that you use words which may hurt them, and then the next time you go there, you find they refuse to help you"

4.2.2 Individual/Partner related

The study conducted in South Africa shows that, 51% of female adolescents did not discuss contraceptive use with their boyfriends. The reason for this was that they want peer respect as they practice natural sex without additional of hormonal contraceptives, in addition to that during discussion on this topic other respondents observed uncomfortable to contribute in this topic. They cited contraceptives as a threat (and are not acceptable) to our culture, values and norms (Ramathuba et al. 2012) For the experience boys seems contraceptives use is for female because the direct result eg pregnancy appear to them, in rare cases you can find boys initiate contraceptives talk

4.2.3 Community

A study conducted in Tanzania documented that, close to community providers such as traditional healers, traditional birth attendants and village health works are the first point of consultation for adolescents RH services but are found to have negative attitudes towards adolescents on providing information or services (Dusabe et al. 2014)

A study conducted in Malawi showed that , girls who are known to use contraceptives methods are criticised by males that it is a way of a hiding the loss of her virginity and so cheating her future husband (Kapito et al. 2012)

4.2.3.1 Distance

A study done in Tanzania shows that health facilities which provided family planning services are located in isolated places, far from where people work and live, and they need to walk for a long distance and sometimes when they reach they found health provider is busy or not around, or they are instructed to come back tomorrow. And when you come back home during late hours and family member ask where you come from for that reasons distance becomes an important factor contributing to poor access for adolescents to SRH choice (Dusabe et al. 2014)

The same study from Tanzania also shows that providers (pharmacy shops, medicine vendor) close to the community are observed as a source of negative attitude about ARH and always show aggressive expression toward adolescents if it comes time to provide services to them. Normally they are unwilling to advise adolescents because they see them as being too young to engage in sexual activities as culture is not in agreement (Dusabe et al. 2014)

A multicounty study leading by Malawi country show that, 60% of the studies reported that adolescents preferred facilities far away from where they live so as to avoid people who know them and who might report back to their parents, whereas the rest preferred to seek care in nearby facilities (Kanthiti 2007)

4.2.3.2 Home family/ member of clan

It mentioned that, formerly in Tanzanian communities, elders according to siblings in families, clans and peer groups used to lead and mentor young people different issues of life, relationship, socialisation and economic. These done during their normal daily duties, like farming, cooking and hunting. To that chance they used to take account explain main points of sexuality and gender roles. But currently, that system had disappeared. Urbanisation and school timetables disturbed traditional system. As the result, most people tribes no longer provide instruction to their adolescents (URT 2011). Parents and other member of the family seem to have a chance on communicating with their adolescents issues associating with sexuality, early pregnancy, HIV and contraceptives but in the Tanzanian setting, is difficult because many parents have knowledge deficiency (Mouli et al. 2014) and experience shows, other parents are busy with job activities.

A study done in Tanzania shows that during the menarche stage where an adolescent girl begins to menstruate, a clan sister, such as a close elder female cousin, an aunt or elder sisters will talk with the matured girl; they teach her lessons about menstruation, contraception and pregnancy but this activity in society look as it is procedure because the lesson is not effective, still girls get pregnancy and other SRH problem (URT 2011)

A study done in South Africa shows that, it was reported that, lack of reproductive health communication specific to contraceptives discussion among adolescents and their parents lead to factor contributing to risky sexual behaviour (Ramathuba et al. 2012)

4.2.3.3 Information

A study conducted by UNICEF (2011) in Tanzania reveals that Tanzanian adolescents have become more active regarding communication and make them easily to spread information among them. For about five years now, hundreds of adolescents have been engaged in and better connected through radio, television, the internet and mobile phones.

A study conducted in Tanzania by The National Family Planning Research Agenda (NFPR) shows that Mass media such as radio, television and news have been ranked as the top source for adolescent RH information including contraceptives methods as it was compared among the six variables (MOHSW 2013b)

It was mentioned that, mass media is the popular and most source of adolescents SRH information followed by school teachers, and health providers (URT 2013a)

4.2.3.4 School

A study conducted in Tanzania shows that, Primary and secondary schools pupils need sexual and reproductive health sessions however the country suffering from insufficient number of teachers and lack of SRH trained teachers which put student in a difficult position, as they graduate without been taught SRH during their studies. In addition to that, it was found that life skills education are provided for few students, and it was expected as less than 10% over the country as an extra subject which is completely not all students have benefit from it(URT 2011)

4.2.4 Quality of contraceptives

4.2.4.1 Availability

A study done in Tanzania report that, short acting FP method such as pills and injectable are more available in health facilities than long acting and permanent methods such as implant and ICUD, According to UNICEF (2011) stated that, "...if you want to plan your family, pills and injectable are all over when you approach the health facilities. Only when you want implant and IUD you may need to wait for those people who come from the district hospital during mobile clinics..." in addition to that, short acting FP methods have never been stock out for a continuous six months.

A study done in Kenya report that, availability of wide range of services create a better room for choice, the misconception and negative belief on contraceptives influence choice and access rather than look for male condom because of popularity (Oindo 2002)

4:2:4:2 Affordability

In Tanzania, contraceptive services in government and public facilities are free, but in private facilities are not. In the case of adolescents, because they depend on their parents or guardians, it is difficult for them to afford the private facilities.

A study done in Sub-Saharan Africa reported that condoms are available from plenty of different sources such as small vendors, pharmacies and normal shops, are easily accessible and at an affordable price. On the contrary, the same study shows that other respondents consider expense as a barrier to access contraceptives such as condoms. As it was described by one Tanzanian girl: that, she spent all her daily money because of condoms (Williamson et al. 2009).

4:2:4:3 Acceptability

A study done in Tanzania shows that acceptability of contraceptives among adolescents is hindered because they believe exposure to contraceptives will result in diseases later in their life as they mentioned it associated with infertility conditions, severe bleeding and even death as a side effect of use. Also they believe that use of contraceptives at adolescents age is identified as a promiscuous behaviour (Dangat & Njau 2013).

A study conducted in Sub-Saharan Africa, shows that adolescents have to accept the method they use, because it comes with pressure from provider specific nurses and some respondent reported their mothers pressurised to use a specific methods. Providers always look busy with no time for discussion, instruction or guidance. They just ask what you want; if it's an injection, they inject you and that's all (Williamson et al. 2009).

4:3 Needs

As it was described earlier, unmet need for family planning- is when adolescent girl who want to delay pregnancy, or to have children, but who are not using a method of family planning (URT 2015)

A study conducted in Tanzania report that, both adolescents girls and boys are need equal knowledge and skills concerning contraceptives methods and reproductive, many time boys are leavened behind (Madern et al 2011)

Chapter five: Health behaviour

5:1 Personal Health choice

Here, Health choice means the way adolescent live, does she/he have any choice over the life they live, for example, choice to have sexual partner, choice to have sex, choice to receive health services and services, choice to become pregnant and choice to intend to impregnate girl.

In Tanzania DHS (2010) reported that, there are many cases of violence against young people. Many female adolescents reported to have had their first intercourse by force against their willing. The data shows that, among 5,105 of adolescent girl's aged < 15 to 19 years who have had sex, 22% of them had first sexual intercourse by force. As you can see in this case, here there is no choice for sex or choice for pregnancy.

Boys interpret gender based violence and coercion as a normal part of life need to practice. It occurs in many places in the community and their family members, brothers and neighbours do it and explain it to be fun. Girls less empowered to reject unwanted sex (WHO 2009). Here there is no choice for boys to have healthy sex, no choice to have sex with a loved one, no choice to choose contraceptives, no choice whether or not impregnate a girl.

5:2 Uses of Health Services

5.2.1 Health Providers

A study done in Tanzania by FHI, shows that Health providers from public health facilities are criticised by adolescents for not considering adolescents for RH services compared with staff from private and non-governmental organisations; adolescents prefer to meet with young staff. Public health providers often criticise adolescents openly without privacy in front of other clients, when adolescent want contraceptives (FHI 2010).

A similar result reported in a study done in Tanzania shows that, health care providers, specifically nurses and doctors, who live together with adolescents in the same community don't keep confidentiality the issue of adolescents, as a result the adolescent's parents be informed. Adolescent experienced fear, shame and embarrassment from providers (UNICEF 2011)(Sexton et al. 2014).

A multi-country study done by Mouli et al.(2014) shows the same result that, the approval of marital status used as an excuse and main reason by health providers in many places worldwide to prevent adolescents receiving reproductive health information and care is common. In addition to that, Health providers believe that long term contraceptives methods are not fit for adolescents and so will only provide male condoms to them.

5.2.2 Health services

A study done in Tanzania has shown that adolescents complained about long waiting times, they are exposed unnecessarily and other members of the community found them, and as a result their parents were being informed that they had become sexually active (FHI 2010).

Another study done in Tanzania showed that the health services provided by government facilities are poor due to an insufficient number of health workers, irregular medicine supply and poor attitude of health providers towards adolescents (Dusabe et al. 2014).

The popular root and channel of contraceptive delivery services in Tanzania is government facilities of which contribute 2/3 of current contraceptives methods users. Government facilities have many challenges facing them they are involved in being barriers to contraceptive access and use of their services among its clients including adolescents, such as lack of privacy, providers lack confidentiality during delivery of services; providers have negative attitudes towards clients specific to adolescents; provider bias according to what she/he understand or believe due to cultural, religious and negative gender norms(MOHSW 2013c).

A multicounty study conducted by Kanthiti (2007) shows that, adolescent preferred to receive services in a short period of time and don't have to spend long time waiting for a services; they liked 'first come first served' services

Chapter Six: Evidence based in Intervention

The study done in Tanzania on standardizing and scaling up quality of adolescent friendly clinic reported that, currently the government has no facilities for clinic which specifically operates adolescent friendly reproductive health services. Further to that, there are some small NGO like Mema kwa vijana found in Mwanza which attempts to implement adolescent friendly clinic but with very low coverage; some of the government district facilities have started training providers on ASRH though their services is still very poor due to environment condition such as lack of privacy, shortage of qualified staff and inadequate supply of medicine (Chandra-Mouli et al. 2013)

According to Tanzania Youth Alliance-TAYOA (2014) which is one of the youth platform programme in Tanzania it aim is to engage youth to make positive decision making. It works through Community outreach program and Youth-Balozi (peer educator) for greater coverage of youth over the country. It promotes abstinence, delay sexual debut, sexual partner reduction and persistence condom use

Adolescents may feel powerless to refuse from rape and unwanted sex. Both male and female adolescents must be learn how to protect themselves and shout to receive effective assistance. Programme which build self-esteem, develop life skills and provide link to social network can help adolescent to refuse sexual violence attack (WHO 2009)

Chapter Seven: Discussion

Access to contraceptives among adolescents is found to be caused by different factors and difficult to them to address which make them less likely to use contraceptives in their daily life. The study mentioned that factors such as adolescents themselves having negative notions and beliefs that exposure to contraceptives will result in infertility, severe bleeding, cancer disease and even death. These are misconceptions about contraceptives, and may come from the general Public as an explanation for infertility of a person who has ever used contraceptives. So these people are stigmatized in the society as an example of infertility, a notion widely held and when heard by adolescents sends immediate fear for the use of contraceptives.

The notion of being stigmatized as promiscuous by society as a result of exposure to contraceptives is another factor documented by a study. These are people's perceptions and wrong impressions of using contraceptives; it can be defined as ignorance and unawareness of birth control. These society often see majority of young and even adult females get pregnant unnecessarily with many children to care for which of course increase poverty and dependency, yet they are ignorant that contraceptive methods empower women and free from that predicament for a long period of time, as she proceeds with life development.

Consequent to these perceptions the adolescents find it a shame to approach health workers for contraceptives services while the study also found out that, negative attitude among the health workers in providing the services cannot escape blame. The ground for this perception is rooted in the belief that, contraceptives services are only for married women. In addition to that, if a provider does offer contraceptive services to adolescents, the time they spend in the waiting room is so long that it exposes them to other members of the community which eventual could leak to their parents.

The study also identifies adolescent as individual lack health choice in their life, they don't have choice to have sex partner, no choice to have safe and pleasure sex, no choice to received informed choice, no choice to have pregnancy and impregnated girl.

Despite of contraceptives services are being free in public health facilities in Tanzania; lack of decision making of female adolescents still existing. This study found that gender inequality plays a big role in preventing

adolescents from access to contraceptives methods. These are African culture characterised by gender norms, beliefs and roles and Tanzania is among of African countries. This concept of a dominant gender is very dangerous for adolescent sexual reproductive health; an example of gender belief is that men should be aggressive, strong and rational, while women should be passive, vulnerable and emotional. In addition to that, a good woman should be ignorant about sex and passive in sexual interaction while men should have or are supposed to have knowledge. As a result -a women cannot negotiate (or it become difficult for her to negotiate) safer sex- and men are at risk of infection because of they don't manage to have complete information and in able to admit mistake. In this study, it found that, male partners use violence, throwing the women out or breaking the clinic card and using presents to make sure his girl will never use contraceptives methods. In the end the girl becomes pregnant and will never blurt out the name of the man because he threatens her with violence and also because she lacks empowerment.

This study revealed that female adolescents coming from poor families have less access to contraceptive methods than those from rich families. This finding is in line with to that of UNICEF (2011) which found that low socioeconomic status is a major cause of adolescent pregnancy (for 57.1%). This finding might be because poor people lack the privilege of attending school or having knowledge as well as an education. Therefore, for being uneducated, family members lack exposure to many things including contraceptives knowledge and fail to mentor their children at home; as a result they become ignorant on the importance of contraceptive methods.

On adolescent contraceptive knowledge and awareness, this study found that adolescents have adequate knowledge but skills are limited especially when it comes to practicing it. Adolescents fail to show and mark a conceived day in calendar. This finding is similar with UNICEF (2011) which found it unsatisfactory when respondents mark the fertile period on a calendar. This might be because they learn through theoretical methods which make them easier to forget.

Religion does influence the access on contraceptives methods among adolescents. The study described religious organizations like the Catholic Church not being interested in population control. They believe that, God is the one to control birth planning; Catholic Church is a big church in Tanzania and it involves almost half of Christians in the country, and also it operates many health facilities surrounding societies. For rejecting

provision of contraceptives methods, Catholic Church is contributing factor to the serious problems and since the Government failed to solve this problem it is still dominant. Example of those issues such as education gap among female to male due to school dropout related to pregnancy which lead to poverty to the country, maternal morbidity and mortality due to abortion as well as pregnancy related causes, STDs including HIV infections.

The study found that, adolescents lack exposure on contraceptive use, at the beginning it showed that, older adolescents have exposure than younger but the study identifies this in a few cases. For example the data shows that, at ages of 14 to 20, only 12% of females had experienced contraceptives. In addition, other data shows that between the age of 14 and 19, 34% of both males and females had experienced contraceptives and from that 6% were less than 15 and 81% were above 16 years. This may likely be due to sexual intercourse exposure experienced by older age adolescents as well as them having more exposure to the information on contraceptive methods compared with younger.

According to factors influencing risky behaviour in SRH among adolescents, the study found that, unsafe sex, limited use of contraceptives methods and multiple partners are among risky behaviour causing adolescents to suffer from SRH problems. In Tanzania, normally adolescents who live around entertainment areas have a large chance of meeting with different people from different areas which can cause them to have a sexual relationship without knowing each other. Also because of poor economic status, adolescents are forced to have multiple partners to overcome economic problem. In addition to that, peer group also influences these risk behaviours.

In addition, Tanzanian policy have a good plan to adolescent reproductive services however it needs to adopt as best practice for example the law from South Africa in which the staff or any seller providing SRH services must provide contraceptive methods to adolescent without hesitation and failure to do so will result in prosecution.

7.1 Limitations of the study

Because of the time limit, the researcher only used available data from the literature review for analysis. An in depth investigation, could have provided more information if primary data had been collected from communities.

Chapter Eight: Conclusions and recommendations

The study found that Tanzanian adolescents are unlikely to access contraceptives due to many factors such as negative health beliefs, limited contraceptive knowledge and skills, lack of choice appropriate to SRH services, gender inequalities, poor family status and negative attitudes among staff. Other contributing factors are the absence of reproductive health education in public schools (both at the primary and secondary level), lack of adolescents of reproductive health services in health facilities, strong beliefs of the society that family planning services are for married women only. Other factors are, long distance from home to school can encourage sexual involvement, rape; economic insufficiency could push adolescents to engage in transactional sex or unprotected sex to meet their basic needs, lack of correct and comprehensive sexual and reproductive health education, including information and related services. Also a lack of youth reproductive clinics is among the causes because the most of clinics available are adults centred which make them less accessible.

National health policy has a good plan towards adolescent's reproductive health, as it started allocate SRH subject into the school curriculum and also the one of the operational targeted objective to be achieved at the end of 2015 is to increase number of health facilities providing adolescent friendly clinics from 10% to 80% all over the country. Risky behaviour like unsafe sex and having multiple partners are the difficult things which will cause adolescents to suffer from SRH issues. Therefore school dropout due to pregnancy as well as dependant caring of pregnancy or child due to gender inequality still exists and will continue due to the above mentioned factors.

Religious leaders should be included in planning and implementation at all levels

This study concluded that access to contraceptives among adolescents create recognition on factors that hinder adolescents' access to contraceptives as a result help researcher and policy marker to evaluate the situation on where we are, concerning adolescent SRH issues. For future research, this study advice to research on adolescent who are already pregnant or mothers on what kind of health care as well as psychological support needed from government. The reason is that, if someone is not done this type of group will still remain. It looks like any

person who usually live and belong to particular group cannot get out suddenly, 100% of the time there is the possibility of suffering from psychological problem, in addition to that, it is known that at that age, the adolescent body is unable to carry the overwhelming growth of the baby for nine month. For specific study the result will help to prevent maternal morbidity and mortality related to adolescent pregnancy. And other study is to research on gender equity among boys in SRHR, the result will help to recognise on how we can teach boys from their childhood as we have seen gender inequality is a core cause of all problems.

The study recommends,

The following recommendations are provided based on the influencing factors identified in this study on access of contraceptives among Tanzanian adolescents and other successful nearby countries' experience (Kenya, Uganda, South Africa and Malawi) in addressing similar challenges.

Policy Level

- Tanzanian policy needs to learn from and adopt good practices from other countries such as South Africa to protect adolescent health.
- Increasing by building more facilities as well as increase number of health workers in rural areas, specific for adolescents
- Develop ASRHR curriculum at Medical and Nursing colleges in order to expand provider's knowledge, skills and positive attitude towards adolescents. In services training (as we observed ASRHR is provided in job services)
- Incorporate ASRHR program with women empowerment to create the sense of independence, self-esteem and right to decide on health issues and control of their bodies as well as contraceptives choices.
- Government should stimulate private health actors and NGOs to implement ASRHR services over the country and should consider it as an emergency. No need to wait for policy and political protocol.
- Ministry of Education and Vocational Training should collaborate with MOH in curriculum and guideline development and supplies to make sure teachers are provided with the ASRHR knowledge during in-services training and also pupils from primary school should provide them with theoretical and practical knowledge and to make

sure they understand and examinations should be performed to a specific subject.

Facilities level

- Ensure and provide supportive supervision on monitoring and evaluation of the system.
- Maintain regular supplies of commodities at all level
- Supportive supervision to health provider on two way communications is important, providing instruction, direction, counselling and allowing adolescent choice of methods, on guideline usage and being friendly in providing contraceptive services to adolescents and avoiding a negative attitude towards them.

Community level

- Raising awareness on the importance of ASRH issues to the community so as to decrease stigma towards adolescent suspected using contraceptives
- Including religious leaders in planning and implementation
- The government should provide support to boys who see gender based violence and coercion is a normal thing in life should provide them strongly consciousness look as a negative thing and change from violent behaviour. They need to think the disadvantage received girls who are the victim, to families, societies and communities

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