

**USE OF MODERN CONTRACEPTIVE METHODS AND ASSOCIATED
DETERMINANTS AMONG SECONDARY SCHOOL ADOLESCENTS
IN ILALA MUNICIPALITY**

By

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**A dissertation Submitted in Partial Fulfillment Of the Requirements for the
Degree of Masters of Public Health of Muhimbili University of
Health and Allied Sciences**

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CERTIFICATION

The undersigned certifies that he has read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a entitled / dissertation *Use of Modern Contraceptive Methods and Associated Determinants Among Secondary School Adolescents In Ilala Municipality, Dar-es salaam, Tanzania*, in partial fulfillment of the requirements for the Degree of Masters of Muhimbili University Of Health and Allied Sciences.

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DEDICATION

This work is dedicated to my Husband Jimmy S. Madatta, without whose caring support it would not have been possible, and to the memory of my parents the late James K.C. Mngodo and Esther Lizzy Mhamadi, who passed on a love of reading and respect for education and believed that I could do it.

ABSTRACT

Background: Adolescence is a period between childhood and adulthood when young people undergo major physical, emotional and social development, with significant impact on their sexual and reproductive health, it cutters the age between 10 to 19 years. Some of them fail to overcome the challenges of this important stage and eventually miss the opportunity to realise their full potential in life. About 13% of women and 7% men have been reported to have had sex at age 15 or below. There is inadequate knowledge and use of modern family planning methods. Currently the rate of contraceptive use among in school adolescents is not known.

Objectives: To determine the magnitude of use of modern family planning methods and associated determinants among secondary school Adolescents in Ilala Municipality.

Methods: This was a cross sectional study design among secondary school Adolescents in Ilala Municipality of Dar es Salaam. Structured Questionnaire was used to collect data from the adolescents and a check list for assessment of health facilities youth friendliness was used. Random samples of 273 adolescents and 8 health facilities were included.

Results: The overall mean age of the participants was 16 years with male significantly older than females (mean age 17.3 versus 16.6, $p < 0.001$). Of those interviewed, 72(26.4%) reported to have had sex and only 15.8% of them reported to have used a modern contraceptive method. Appropriate knowledge about danger period for pregnancy was expressed by 42(15.4%) of adolescents. Poor access to family planning method was reported to be due to lack of awareness about their reproductive rights and afraid of meeting the elderly/older providers A total of 112(41.0%) adolescents reported to have not discussed any topic about adolescent reproductive health with parents/caregivers and only 15.4% of adolescents had appropriate knowledge about danger period for pregnancy. Determinants of family planning use were having a mother, being aware of family planning methods, being knowledgeable on issues related to reproductive health social influence particularly use of FP by friends and discussing reproductive health issues with parents. A total of 263(96.3%) said there is a need

to guide heads of schools on how to implement the reproductive health policy. and a need to have policy statement regarding access to Adolescents reproductive health services

Conclusion: Use of family planning methods is still low among in school adolescents being influenced by poor access to services, lack of knowledge about pregnancy timing, fear for unfriendly health service providers and low parental communication on reproductive related issues. Family planning use was found to be influenced by family factors such as mother alive, parental discussion, peer influence and knowledge. Intervention measure should address parental, peer pressures as well as increasing awareness and knowledge about family planning. Youth friendly clinics have an important role in the provision of reproductive health services to adolescents. Hence School reproductive health policy review is called for.

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ARH	Adolescent Reproductive Health
BEST	Basic Education Statistics in Tanzania
CI	Confidence Interval
FP	Family Planning
GIS	Geographical Information Statistics
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
MDG	Millenium Development Goal
MUHAS	Muhimbili University of Health and Allied Science
NGO's	Non Governmental Organization
PASHA	Prevention and Awareness at School HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infections
TDHS	Tanzania Data on Health Survey
THMIS	Tanzania Health Management Information System
UN	United Nations
UNFPA	United Nation Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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DEFINITION OF TERMS

Adolescent: Adolescence is stated as the period of transition from childhood to adulthood, which starts with the onset of puberty. It comprises the individuals between the ages of ten to nineteen years.

Family planning services: Family Planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. (Working definition used by the World health organization Department of Reproductive Health and Research)

Contraceptive Use: Intentional prevention of conception or impregnation through the use of various devices, agents, drugs, sexual practices, or surgical procedures [1].

Old Adolescents: are adolescents aged 15-19years [2]

Reproductive health: reproductive Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. [3]

Unyago: means female initiation. Unyago might be equated with the traditional education system which all young girls attend. During this period a young woman is taught how to take care of herself after menstruation, to avoid sexual intercourse before marriage, and how to practice birth control (here the only contraceptive is abstinence as they are taught not to resume to sexual intercourse until a child is more than two years old). Traditionally a girl was allowed to get married after her parents were convinced that she was old enough (i.e. she had started to menstruate, which was the only measure of maturity).

Youths: youths are all young people female or male from age 14-25 years

Young Adolescents: are adolescents aged 10-14years [1]

Youth Friendly services: these are services with high quality services that are attractive, affordable, appropriate, and acceptable to youths.

Youth Reproductive Health Problems: Youth Reproductive Health problems are problems affecting the youths, which include HIV/AIDS, STI, unplanned or unwanted pregnancy, sexual abuse, abortion, and harmful traditional reproductive health practices

CHAPTER 1: INTRODUCTION

1.1 Background Information

Adolescence is stated as the period of transition from childhood to adulthood, which starts with the onset of puberty. It comprises the individuals between the ages of ten to nineteen years. During this important period, a child undergoes biological transition, which is characterized by puberty, related changes in physical appearance and the attainment of reproductive capability, psychological or cognitive transition, which reflects an individual's thinking, and social transition, which is related to rights, privileges and responsibilities of an individual[2].

The World Health Organization [4] defines adolescents as individuals between 10 and 19 years of age. Adolescence is a period of transition, growth, exploration, and opportunities. During this phase of life adolescents tend to develop an increased interest in sex: with attendant risks of unintended pregnancies, health risks associated with early childbearing, abortion outcomes, and sexually transmitted infections, including HIV/AIDS. Adolescents who have an unintended pregnancy face a number of challenges, including abandonment by their partners, inability to complete school education (which ultimately limits their future social and economic opportunities), and increased adverse pregnancy outcomes [2,]

Approximately 85% of the world's young people live in developing countries. Most will become sexually active before their 20th birthday, and far too little is being done to meet their need for sexual and reproductive health information and services. Rates of early and unplanned pregnancies, unsafe abortions, maternal deaths and injuries, and sexually transmitted infections, including the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) are very high. It is estimated that more than half of all new HIV infections are among young people, while between one quarter and one half of adolescent girls become mothers before they turn 18. Adolescent girls are two

to five times more likely to die during pregnancy or childbirth than women in their twenties [4]

Unintended pregnancy is not only costly to the teenagers and their families; it is a huge financial burden to societies as well. Societal cost include welfare support for mothers experiencing financial difficulties, implementation of programs (educational and skills training) to empower mothers to gain financial independence and lost tax revenues arising from reduced employability and earning [5,6] Adolescent mothers are more likely to perform poorly in school, come from low socio-economic homes and less advantageous environment; are themselves children of mothers with limited school education and history of unintended teenage pregnancies[2] Children born to adolescent mothers are more likely to have low birth weight, and become victims of physical neglect and abuse [6, 7]

The concerns about the adverse consequence of early child bearing (especially premarital) and the risk of contracting STI including HIV/AIDS have led to renewed interest in contraceptive and sexual behavior of adolescents. These concerns and the fact that adolescents constitute one fifth of the world population as well as their enormous potential impact on future population growth makes their knowledge about and use of contraceptive a significant issue for both policy and research [6]. Extending its concern and recognition the UN general assembly as part of the broader resolution reflecting on progress since the 1994 ICPD in Cairo for which Ethiopia was a signatory, urged government to recognize that sexually active adolescents require special family planning information counseling and services as well as prevention of and treatment for STIs [8].

One of the most important commitments a country can make for its future economic, social and political progress as well as stability, is to invest in growth and development needs of young people including their sexual and reproductive health. The Tanzania's, 2002 census, estimated the population to be 34.4 million; the 2010 projected population is 43 million.[9] Adolescents accounts for 24% of the population whereby age 10-14 is 14.1% and age 15-19 is 9.9% of the population. of them Male of 10-14 are 6.9% respectively female are 7.2% and age group 15-19 Male Are 5.1% while female are 4.8% [10]

A recent analysis concluded that family planning is among a handful of feasible, cost-effective interventions that can make an immediate impact on maternal mortality in low-resource settings. [11] Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk.[11] As contraceptive use increases in a population, maternal mortality decreases. It has been estimated that meeting women's need for modern contraceptives would prevent about one quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year [11] It would also prevent a similar proportion of the injuries, infections, and long-term disabilities that result from pregnancy, childbirth, and abortion and affect an estimated 15 million women annually.[11] Family planning offers a host of additional health, social, and economic benefits: it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socioeconomic development, and protect the environment.[11]

In sub-Saharan Africa, it is estimated that 14 million unintended pregnancies occur every year, with almost half occurring among women aged 15–24 years [12] It is estimated that 90% of abortion-related and 20% of pregnancy-related morbidity and mortality, along with 32% of maternal deaths, could be prevented by use of effective contraception[12] Premarital sex, with a widening gap between sexual debut and age of marriage, place young women at increased risk when they are most socially and economically vulnerable [12]

In 1992, a Tanzanian study found that 61 per cent of secondary school pupils were sexually active but only 15 per cent had ever used a contraceptive method. [13] This was a reflection of the view voiced by many politicians and religious leaders at that time, i.e. that family planning should be used only for child spacing. Hence, family planning advice and services were primarily for married clients with at least one child. At the beginning of the 1990s, however, the authorities began to acknowledge the problem of adolescent pregnancies. Policy guidelines were changed in 1994 and now state that all men and women of reproductive age, including adolescents and irrespective of marital status and

parity, should have the right of free access to family planning information, education and services if they are at risk of pregnancy [13]

Despite this, many adolescents are still at substantial risk of unwanted pregnancy. Recent data showed that more than half of women admitted to hospital with abortion complications in Dar es Salaam were under the age of 20 and had not used contraception.[13] Understanding the perspectives of these young women and their need for contraception is key to providing family planning information and services.

As regards contraceptive knowledge and use, this study has shown that policy guidelines of 1994 intended to make contraception more available to young, single women [13] are not widely known among young women themselves and are not being implemented in practice. Fewer than 10 per cent of the girls in this study, and in the most recent national survey, [13] had used a contraceptive. In contrast, almost all the girls in part one of the studies knew of condoms and most knew of oral contraceptives. This contradiction between contraceptive knowledge and use has also been found in several other sub-Saharan African studies. [13]

1.2 Problem Statement

The Tanzania's, 2002 census, estimated the national population to be 34.4 million; the 2010 projected population is 43 million.[9] Adolescents accounts for 24% of the population whereby those aged 10-14 were 14.1% and 15-19 were 9.9% of the population. [10]. traditionally, procreation was ensured through the institution of marriage. Marriage was geared towards the achievement of large family sizes necessary for meeting its economic, social, and psychological needs. Girls received parental coaching on motherhood and household roles from both their immediate family and the society, popularly known in Tanzania as *Unyago*. As a result, sexual intercourse started after marriage and eventually high age at first birth were achieved and premarital births was avoided. However, many traditional values and social practices have undergone changes during the course of modernization, and it is likely that the traditional premarital sexual abstinence is on the decrease.

The proportion of women aged 15-19 that had first sexual intercourse by age 15 is (11 percent) [9] One third of male age 15-19 had sex. The median age for sex to male is 18.5, indicating that adolescents are sexually active therefore they are exposed to the risks of sexual practices if they do so without protecting themselves. Consequently they might end up with unwanted pregnancy, unsafe abortion, complications of teen age pregnancy, school dropout, psychological problems, increase burden to the family, and minimize employment opportunities in the future. Chances of increase in maternal and neonatal mortality. Chances of getting sexually transmitted infections including HIV.

Maternal deaths in Tanzania is 454/100,000 where young pregnant girls accounts for 23 percent of the deaths .The under-five mortality rate for children whose mother is under age 20 is 111 deaths per 1,000 live births, compared to 93 deaths per 1,000 live births for children whose mother is age 30-39. Increase in school dropout is about 8000 yearly because of unplanned pregnancy. Between 2004 and 2008, 28,590 schoolgirls in the country droppedout of school as a result of unwanted pregnancy, of them 11,599 were secondary and 16,991 primary school students. [9]

In order to prevent the adverse outcome of sex, sex should be protected using reliable methods. Currently the rate of contraceptive use among in school adolescents is not known, but in the general population of Young people it is estimated to be 12% [9]. The low use of modern contraceptives among adolescents might be due to many factors that include:

Individual factors such as lack of Information, knowledge about the existence of the service, their rights in accessing the services, Social factors: fear of being known that they are sexually active, immorality, community denial of the fact that adolescents are sexually active and need to protect themselves. Health facility factors: Such as Location of the facilities, cost of the services, Attitudes of the providers, operating hours of the services. Policy factors: There is contradiction of the policies or non existence of the policy statements about health in the education policy. While the ministry of health and social welfare policies advocates for use of the services to all sexually active persons adolescents inclusive, advocates for their sexual rights and right to information, the ministry of education policy does not address any issue on this matter posing a challenge to adolescents.

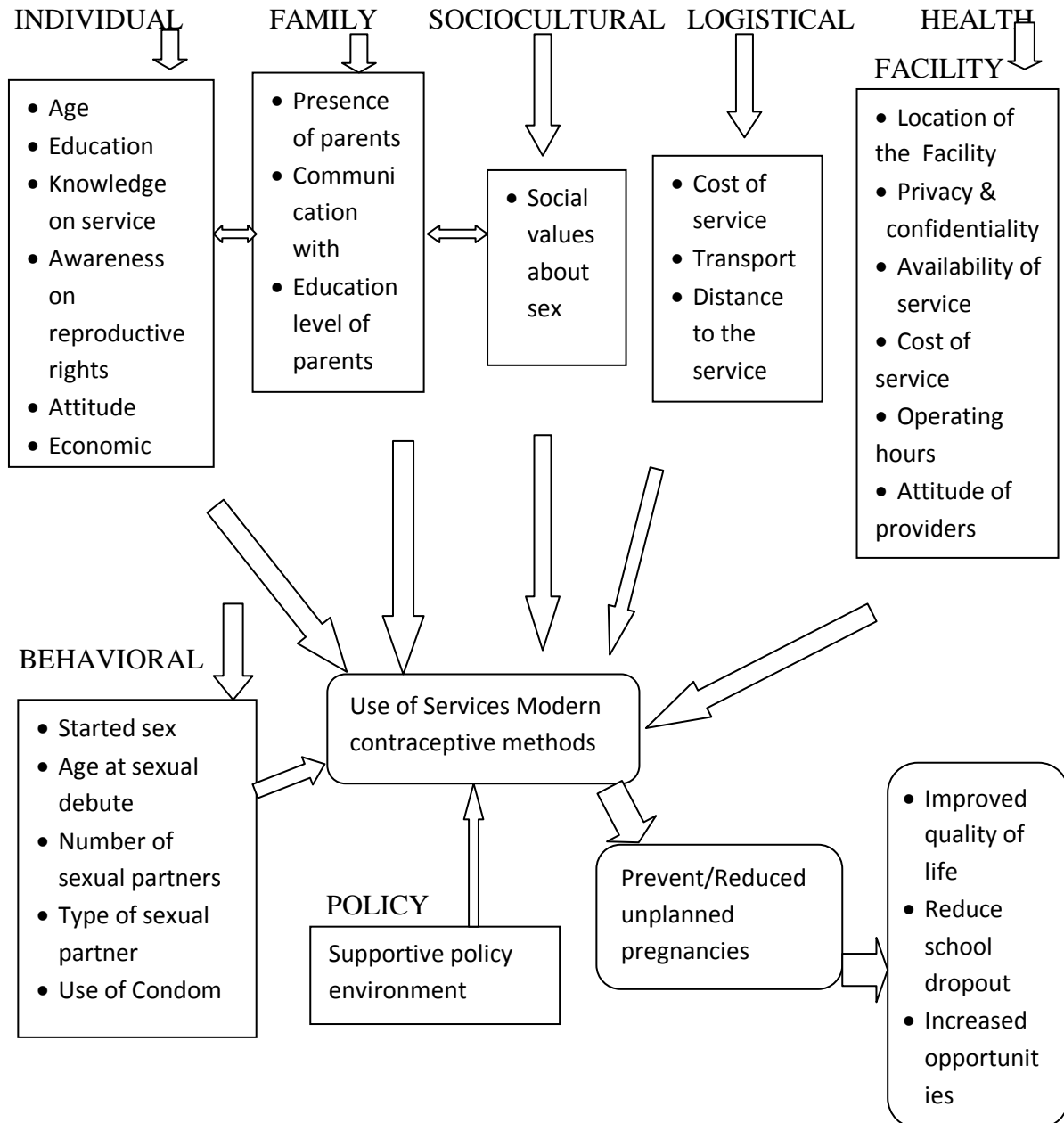
When they access the services some even face sanctions that are not in their favor. However the ministry of education with different stakeholders has been implementing several interventions on reproductive health under the umbrella of HIV/AIDS policy like the Prevention and Awareness at School HIV and AIDS (PASHA) project to some of its schools. The program has tried to lobby for change of policies that are still on process for change.

Few studies have been done to show factors that contribute to low use of the service and access to information to Adolescents in school. This study intends to fill the gap as research is needed to establish the extent to which younger (and older) male and female adolescents know about, have access to, use, and are satisfied with (or are refused, scolded, discouraged, threatened, or sent home by) providers in public health posts, private clinics, community based nongovernmental organizations (NGOs), pharmacies and family planning facilities for services such as contraceptive information, and use of methods

including oral contraceptives, injections, male and female condoms, and emergency contraception [12].

1.2.1 Conceptual Frame Work

Figure 1: Determinants for Use of Services



Source: Researcher 2012

Use of modern contraceptive methods is influenced by several factors that include: individual factors, family factors, Social cultural factors, Logistics, Health facility factors as well as availability of supportive policies as explained in the conceptual framework.

1.3 Rationale of the Study

Family planning was added to the fifth Millennium Development Goal (MDG) as an indicator for tracking progress on improving maternal health; a recent analysis concluded that family planning is among a handful of feasible, cost-effective interventions that can make an immediate impact on maternal mortality in low-resource settings. Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk. As contraceptive use increases in a population, maternal mortality decreases. It has been estimated that meeting women's need for modern contraceptives would prevent about one quarter to one-third of all maternal deaths, saving 140,000 to 150,000 lives a year. It would also prevent a similar proportion of the injuries, infections, and long-term disabilities that result from pregnancy, childbirth, and abortion and affect an estimated 15 million women annually. [11]

Modern family planning offers a host of additional health, social, and economic benefits: it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socioeconomic development, and protect the environment. For example, a recent analysis in sub-Saharan Africa found that investing in family planning services would prevent 29% more births of children with HIV than spending the same amount on prevention of mother-to-child-transmission (PMTCT) programs that offer antiretroviral drugs to pregnant women with HIV/AIDS. Schools may often be the only place where adolescents can obtain accurate information on reproductive health.

By providing reproductive health programmes early, schools encourage the formation of healthy sexual attitudes and practices. This is easier than changing well-established unhealthy habits later [11]. The study will uncover the factors that contribute to low use of modern contraceptives that result in the school dropout due to unwanted pregnancies. Enlighten adolescents on their reproductive rights on accessing services and give recommendations to decision makers at the policy level to review the policies for harmonization and make the policies be known to the implementers.

1.4 Research Questions

2. What is the level of knowledge on modern family planning methods among secondary school adolescents?
3. What proportion of adolescents use modern family planning methods?
4. What are the determinants of use of modern family planning methods among Secondary school Adolescents?
5. What is the current health facilities situation in providing Friendly family planning services to Adolescents?
6. How does the Ministry of Health and the Ministry of education policy discrepancy hinder the acquisition of knowledge and use of family planning methods among adolescents?

1.5 Objectives Broad Objective

To determine the magnitude of use of modern family planning methods and associated determinants among secondary school Adolescents in Ilala municipalitiy.

1.5.2 Specific Objectives

1. To determine the proportion of modern contraceptive use among secondary school adolescents
2. To determine the level of knowledge on modern family planning methods among secondary school adolescents
3. To determine the level of awareness among secondary school Adolescents on the existing Youth Friendly reproductive Health services
4. To Identify the determinants of modern family planning use among sexually active adolescents in secondary schools
5. To explore the extent to which health facilities around selected schools within Ilala Municipality can offer youth friendly reproductive health services to adolescents
6. To determine the policies of the Ministry of Education and vocational Training and Ministry of Health regarding provision of reproductive health services for in school Adolescents

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Adolescence is a period of great opportunity and hope. It is the period between childhood and adulthood when young people undergo major physical, emotional and social development, with significant impact on their sexual and reproductive health. The period can be very difficult and even confusing to some adolescents. While some of them successfully go through this transition into adulthood, others fail to overcome the challenges of this important stage and eventually miss the opportunity to realise their full potential in life. The decisions, behaviours, skills and knowledge of adolescents regarding their reproductive health have a major impact on their future health and development. [9]

2.2 Adolescent Sexuality

An important consequence of a rising age at marriage combined with a decline in the age at menarche is a substantial increase in the number of year between menarche and marriage. This trend resulted in increased number of sexually matures but unmarried adolescents. This [14] potentially leads to higher prevalence of sexual activity among unmarried, which expose them to unplanned pregnancies, abortion, and contracting STIs

There is a good deal of debate over what motivate adolescents to enter and maintain sexual relationship. Both Western and African observation pointed to the weakening of traditional control on adolescents sexual activity outside of marriage, conflicting values facing adolescents and their own perception and assessments of prone and cons of engaging in sexual activities has been incriminated as a causal factor [14]. Some others considered adolescents being subjected to adult authority, many institution including religious bodies, family and educational systems, have vested interest in shaping the growth, the behaviors, and values of young people however they provide conflicting information.

Often legal and social restriction prohibit adolescents right to acquire information about sexual activity and their access to reproductive health service and on their freedom to

engage in certain sexual behaviors and deal with the reproductive consequences of their own action, unless they are married or have begun childbearing. This increases tensions and stress among adolescent that makes them susceptible to peer pressure [14] as communities undergo rapid transformation there will be juxtaposition of traditional and modern values. Evidence from different studies conducted in Addis Ababa at different times has documented that sizable proportions of young people were sexually active.

In line with this a community based survey showed that, 35% of adolescents aged 15-19 were sexually active [14]. School based study revealed that 16% of female and 33.5% of male students have ever had sexual intercourse [14]. Another school based study has also revealed 21.9% of students have had sexual experience [14] Furthermore a comparative study conducted among in and out of school youth of aged 15-24 documented that one third of the adolescents (46.3% of out of school and 18% of in school) were sexually experienced [14]

2.3. Teen-age pregnancy

Globally, puberty is occurring earlier for both boys and girls. Young girls are increasingly attending school and delaying marriage more than ever before in developing countries. This combination of events has created a wide gap between the time that young girls can potentially engage in sexual activity and marriage. Thus adolescent girls are exposed to a greater risk of premarital intercourse and there, by to a greater risk of unintended pregnancies, abortion, and STIs. Adolescent child bearing is a phenomenon that has a significant ramification at personal, Social, country, and global level. From the perspective of communities and government it has a strong negative effect on the level of educational achievement of young women, which in turn may have negative impact on their position in and potential contribution to the society. [14]

At individual level childbearing at an early age can shape and alter the entire future life of young women. Childbearing at an early age has a wide range of meaning and consequences. The consequences vary from fulfillment of an expected progression from childhood to adulthood conferred by marriage and motherhood and the joy and rewards of having a baby on one end to the assumption of a burden of caring for and

bringing up a child before the mother is emotional and physically prepared for the task and the responsibilities on the other end. In some countries if adolescent become a mother before marriage she is likely to face social ostracism and financial difficulty. In this case child bearing can also mean unhappiness if birth was unplanned or marital conflict resulted from marrying to have a baby in socially accepted union. Child bearing could also be source of lifelong disappointment because of failure to complete education and loss of earning opportunity [14]

2.3.1 Why children have children?

The factors leading to teenage pregnancies are multiple and inter-linked. Poverty is one of the leading underlying causes. In order to meet their basic needs, upscale their living conditions, and/or get money, clothes or school fees young girls engage in sexual relationships with older men who do not want to have children with the young girls, but use them for their sexual enjoyment. These relationships often lead to unwanted and unplanned pregnancies, forcing girls often into unsafe abortions. [15]

There is no data on how many of the impregnators are teachers but it is a common understanding that also the teachers do impregnate the school girls. Another leading factor for young girls to become pregnant is the lack of appropriate and comprehensive sexual and reproductive health and rights education within the educational system. Currently only the secondary schools' curriculum includes topics such as HIV and the reproductive system. These topics are part of biology subject of the schools' curriculum. Life skills are taught as extra curricula subject. [15]

In addition, not all schools have teachers who have been trained in teaching the subject as most of the programmes are managed by NGOs or specific projects. There is a need to train the teachers to teach both the primary and secondary school students about appropriate and comprehensive sexuality and reproductive health and rights. Parents are also encouraged to discuss about sexual and reproductive health issues with their children. Closely linked with the inadequate education on sexual and reproductive health and rights

is the low (40%) coverage of youth friendly sexual and reproductive health information and services and adolescents' inadequate access to those services.

According to the Tanzania Demographic and Health Survey [16] adolescent pregnancy is closely linked with the young women's education level, socio-economic status has no major significance. Hence, the girls who are not in school are the most vulnerable for unwanted teenage pregnancy. Other causes leading to teenage pregnancies are: Attitudes that a girl's main value is as a wife and/or a mother Lack of male involvement in family planning and belief that family planning is women's business while at the same time it is men who make the decisions regarding women's health [16] Inadequate understanding and appreciation of girls' health, benefits of postponed and planned marriage and pregnancy and appreciation of girls' education Lack of economic structures for adolescents to generate income to help protect them from sexual exploitation. [15]

Regardless of the National Population Policy (1992) and the Family Planning Guidelines (1994) stating how all males and females of their reproductive age, including adolescents, are entitled to family-planning information, education and services 22 percent of Tanzania's population have unmet need for contraception [16] Even when almost all Tanzanians are aware of at least one modern contraceptive method, only 20 percent actually use one [16] Only half of the girls (15-24) used a condom during their last sexual intercourse [17] Lastly denying adolescents from accessing sexual and reproductive health information and services is a violation of their human rights. [15]

Early childbearing not only has a negative impact on the health of young girls but often hinder girls' access to higher education. More than 8000 girls drop out of school every year due to pregnancy. The trend [18] shows that school drop outs due to pregnancy have been increasing especially in secondary schools. A dire practice denying girls access to education is expelling pregnant and married girls who have already given birth to a baby from school. This practice is not based on a legal framework, but rather reflects the prevailing interpretation of teachers, other school and local authorities and sometimes also parents. Many times pregnancy is considered to be "the girl's fault" and girls who have

fallen pregnant are considered as immoral, needing punishment. In many cases pregnant school girls also face discrimination from class mates, teachers, parents, and local leaders. [19] Opinion poll states that 66 percent of Tanzanians think that girls only have themselves to blame if they get pregnant and 44 percent think that boys who get a girl pregnant are just being boys. [15]

2.4 Abortion

Faced with unintended pregnancies, many young people turn to abortion, whether or not it is legal or safe. Most likely, seek abortion from untrained providers, and attempt dangerous, late, and unsafe self-induced abortion. Because of the fear, shame, and or lack of access or money, young women are also likely to delay seeking medical care in case of complications that arise after abortion [14]. Induced abortion is one of the drastic results of adolescents' lack of knowledge about and use of modern contraceptives.

The procedure is legally prohibited in much of Sub Saharan Africa. Given the legal position of abortion in the region of Sub Saharan Africa, combined with the rapid increase in teen age pregnancies, increased number of induced abortion from hospital based studies are likely to be carried out in unsafe environment [14] The number of adolescent who undergo abortion or even the total number of abortion for all women is extremely useful in shading light on the sexual activities and contraceptive none or poor use. But this information is not available because the procedure is legally prohibited and its occurrence lack registration or abortion remained sensitive issue even in countries where it has been legalized and thus registration is incomplete [14] WHO estimated a total of 20 million abortions per annum worldwide of which about 18 million occurs in developing countries but no estimation was possible for sub regions, country or by age of women [14, 9].

Throughout sub-Saharan Africa, induced abortion is highly restricted, with few Countries permitting abortion for reasons other than threat to the woman's life. Data on the extent of induced abortion in sub-Saharan Africa are inconsistent and there is substantial under-reporting. Community based surveys tend to produce gross underestimates, as the nature of the subject and the illegality of the procedure discourage accurate reporting.[9]

However the meager existing data mostly from hospitalized patients indicated abortion is a serious health problem of adolescents in both Latin America and Sub Saharan Africa. [14] Hospital based studies have also indicated the number of abortion cases has been increasing rapidly. Abortion has also been implicated as a leading cause of maternal mortality in all regions of Africa except in West Africa [14] In line with this Hospital based study in African countries revealed that 70-80% abortion admission in Nigeria 60% of admission due to complication of illicit abortion in Lusaka and 24% of randomly selected Hospital admission due to abortion complications in Tanzania were among young women aged 15-19. [14]

In Ethiopia induced abortion upon request is illegal unless otherwise to save the life of the women from grave health consequence [14]. However the existing Hospital based studies documented that, abortion is the leading cause of maternal death in Hospital. Studies have also revealed that significant proportion of admission due to abortion complication were adolescent. In line with this 45-57.5% of admission due to abortion complication and 66.6% abortions related death in Jimma hospital were among adolescents aged 15-19 [14]

Multi-cited hospital based study conducted in Addis Ababa showed 38.9% of cases of abortion admissions were among age group 16-20. A recent more comprehensive nationwide Hospital based study on unsafe abortion conducted among 1075 cases of abortion complication admitted in 15 institution located in 9 out of 11 administrative regions of Ethiopia revealed that 16.2% of cases were among adolescent under the age of 20.

The same study revealed Addis Ababa contributed more than its share (25% of total cases and two of the four leading institution that reported the highest number of abortion cases). Unsafe abortion has long been recognized as preventable tragedy and is one of the neglected public health problems in developing countries however; the moral and the religious controversies surrounding the liberalization of induced abortion have continued to obscure the dimension and seriousness of the problems. Until this issue settled the most

direct way to reduce the death and suffering of unsafe abortion is to prevent unintended pregnancies by increasing the practice of effective contraception [14].

A community-based study conducted among women of childbearing age in Nigeria found that 5.6 per cent of the women had ever had an induced abortion. In a Zairian study, among women aged 13-49, 15 per cent of ever pregnant women reported having had an induced abortion.[20] Hospital-based studies from Ethiopia and Tanzania conducted among women with an incomplete abortion have found that the majority of women with an alleged miscarriage in fact had had their abortion induced. Complications from illegal, induced abortions are known to be a major cause of maternal mortality in the region. A study carried out in 1991-1993 in Ilala District, Dar es Salaam, showed that induced abortion was the cause of 15 per cent of maternal deaths. According to hospital-based studies from Ethiopia, Kenya, Tanzania, and Nigeria, women seeking care for abortion complications tend to be single women with no children, less than 20 years old, and in school or unemployed. [20]

2.5 Adolescent Use of Contraception

Reported contraceptive use by adolescents has increased in recent years. From 1991 to 2005, the percentage of sexually active high school students who reported using a condom the last time they had sexual intercourse increased from 46.2% to 62.8% in 2005 [21] despite this increase, consistent use of any contraceptive method remains a challenge for most adolescents. Levels of reported sexual intercourse by adolescents in the United States decreased during the 1990s for both sexes after increasing for the previous 2 decades.[21,22] The Centers for Disease Control and Prevention's 2005 Youth Risk Behavior Surveillance Summary indicated that less than half (46.8%, down from 49.9% in 1999) of all high school students reported having had sexual intercourse in their lifetimes, and approximately one third (34.3%, down from 37.5% in 1991 and 36.3% in 1999), of all students reported having sexual intercourse during the 3 months preceding the survey and are considered currently sexually active.[21,22] .

Each year, almost 850 000 adolescent girls become pregnant. The adolescent pregnancy rate has dropped steadily over the past decade. As of 2004, it was estimated that approximately 41.2% of all pregnancies are to adolescents 15 to 19 years of age. [23] Since 1991, the adolescent birth rate has declined by 33%, the lowest rate ever reported for the nation. The pregnancy rate for 15- to 17-year-olds has dropped by 43% to 22.1% of all Pregnancies [23]

Approximately 20% of abortions are in adolescents, although these rates continue to decrease. [23,24] Decreases in pregnancy rates are thought to reflect a decrease in reported rates of sexual intercourse and an increase in reported use of longer-acting, more effective contraceptive agents. [25] Over the last decade, evaluations of curricula suggest that those with a comprehensive approach to sexuality education have been effective in improving sexual behaviors and, thus, may also contribute to this trend.

Despite these declining rates of pregnancies and births, adolescent childbearing (22% of women report giving birth before age 20) is still more common in the United States than in other developed countries such as Great Britain (15%), Canada (11%), and France (6%). Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners.[23] In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to experience negative outcomes related to sexual activity.[23] Two school-based studies that demonstrated a delay of onset of sexual intercourse used a comprehensive approach to sexuality education that included a discussion of contraception[23]

Study in Srilanka: Data on unwanted pregnancies and abortions are not properly reported in Sri Lanka. However, studies have shown that young people in the 15–25 age group accounted for 19% of the illegal abortions that are taking place in the country [26]. The knowledge on available contraceptive methods is fairly high, and the use of contraceptive methods among married adolescents is around 65%. Among unmarried adolescents the usage is not properly studied and there is a great paucity of data [26].

About 16 million adolescent girls between 15 and 19 give birth each year. Babies born to adolescent mothers account for roughly 11% of all births worldwide; 95% occur in developing countries. There are several factors that contribute to this. Girls may have limited educational and employment prospects. Some do not know how to avoid a pregnancy, or are unable to obtain contraceptives. Others may be unable to refuse unwanted sex or to resist coerced sex. Those that do become pregnant are less likely than adults to be able to obtain legal and safe abortions. They are also less likely than adults to access skilled prenatal, childbirth and postnatal care [27].

In low and middle-income countries, complications from pregnancy and childbirth are the leading cause of death among girls aged 15 to 19. And in 2008, there were an estimated three million unsafe abortions among girls in this age group. The adverse effects of adolescent childbearing also extend to the health of their infants. Perinatal deaths are 50% higher among babies born to mothers under 20 years of age than among those born to mothers aged 20 to 29. The newborns of adolescent mothers are also more likely to have low birth weight, with the risk of long-term effects. This brief emanates from World Health Organization Guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries. It contains evidence-based recommendations on action and research for preventing early pregnancy and poor reproductive outcomes. [27]

A Cross sectional study to compare the level of contraceptive use among in and out-of school showed that Contraceptive prevalence was 171 (23.8%), with 99 (19.8%) among in-school and 72 (32.7%) in out-of school (OR=0.8, 95% CI=0.5-1.3). Of the 286 who had had sexual intercourse, 171 (59.8%) were current users with 99 (57.9%) in-school and 72 (42.1%) out-of school. The predominant method was the male condom with 80 (56.7%) in-school and 61 (43.3%) out-of-school (p=0.3). Sixty five (67%) of in-school aged 18- 19 used contraceptives compared to those less than 18 years (OR=0.4, 95% CI=0.2- 0.8). The out-of school who were urban residents 51(75%) were more likely to use contraceptives (OR=0.3, 95% CI=0.1-0.6). Out-of school with secondary education 37 (84.1%) were more likely to use contraceptives (OR=0.2, 95% CI=0.1-0.5).

Cost was a barrier for contraceptive use among in-school users 37(77.1%) (OR=2.6, 95% CI=1.7-5.4). Stigma surrounding their sexual activity was a barrier to out-of school 25 (58.1%) (OR=0.4, 95% CI=0.2-0.8). The study concluded that Contraceptive use among rural sexually active adolescents is low although the prevalence is higher in out-of school. Reorientation of contraceptive services to make them more accessible through strengthening of school health programme and establishment of out-of school adolescent health programme are urgently needed. [28]

In Asia, low level of contraceptive use among sexually active adolescents has been reported Example: Among Vietnamese collage students only 32 percent of females and 28 percent of males used a contraceptive method at first sexual intercourse [29] the report states further studies that was conducted among the countries and revealed that adolescent girls knowledge was as high as 90 percent but only 10 percent were found to use any form of contraceptive. In the Lao's people's democratic republic, out of sexually experienced adolescents aged 15 and 25 as many as 79 percent did not use any contraceptive methods at first sexual intercourse [29]

In 1992, a Tanzanian study found that 61 per cent of secondary school pupils were sexually active but only 15 per cent had ever used a contraceptive method. This was a reflection of the view voiced by many politicians and religious leaders at that time, i.e. that family planning should be used only for child spacing. Hence, family planning advice and services were primarily for married clients with at least one child. At the beginning of the 1990s; however, the authorities began to acknowledge the problem of adolescent pregnancies. Policy guidelines were changed in 1994 and now state that all men and women of reproductive age, including adolescents and irrespective of marital status and parity should have the right of free access to family planning information, education and services if they are at risk of pregnancy.

Despite this, many adolescents are still at substantial risk of unwanted pregnancy. Recent data showed that more than half of women admitted to hospital with abortion complications in Dar es Salaam were under the age of 20 and had not used contraception.

Understanding the perspectives of these young women and their need for contraception is a key to providing family planning information and services in a way that will enable them control their fertility safely. [20]

2.6 Benefits of Contraceptive

Contraception is an essential and complicated part of modern life. Its use has separated sex from procreation, and has provided couples greater control and enjoyment of their reproductive life [14] for young couples contraceptive use can help to postpone having their first child or subsequent children to complete their education. This freedom can make a significant difference in the economic future of the entire family. Contraception is a very important element in limiting population, thus preserving the planet's resources and maintaining quality of life for the present and future generations. Not only the direct effect of preventing pregnancy but also reducing the risk of acquiring STIs protect adolescents users from the lifelong complication of unprotected sex.

2.6.1 Benefits related to Contraceptives itself

Contraceptive protect adolescent women from dying through two major ways. To start with it prevents first birth at an early age that put young women or their children's health at a greater risk. Adolescent women who become pregnant face greater risk of pregnancy induced health problem and complication during childbirth than women who bear their first child at age 20 and above Secondly, if adolescent women use effective contraceptive method, they are less likely to become pregnant and resort to dangerous unsafe abortion risking their life where safe procedure on request is prohibited by law in countries like ours. In addition to the two major ways contraceptive use can help to delay or avoid pregnancy for those adolescents who are most likely to have high-risk pregnancies [14] Furthermore contraceptive use benefit the health of children by preventing early pregnancy that most likely result in low birth weight baby less likely to survive, and by making all children wanted and cared for [14]

2.6.2 Non contraceptive benefit of contraceptive

Not only delaying pregnancy, limiting the number of pregnancies and childbirth but also the non-contraceptive benefit of contraceptive influence user's health. Though this should not be the major determinant for selection of which contraceptive to use, it can certainly help to decide between two or more suitable options. As the HIV/AIDS pandemic continues to be a major threat to human life and young people remain the group facing the highest risk, condoms provide non-contraceptive benefits that are critical for any sexually active person who may be at risk of acquiring HIV or other STIs. Condoms also protect adolescents from long-term complications of STIs including ectopic pregnancy, chronic pelvic pain, infertility (in both sexes), cervical dysplasia, and cervical cancer [30, 31]

Hormonal contraceptives such as oral contraceptives provide protection against ovarian and endometrial cancer, fibroids of the uterus, benign breast masses, pelvic inflammatory diseases, and rheumatoid arthritis. They also help to decrease problems related to the menstrual cycle such as pain and cramps (common during adolescence), dysfunctional uterine bleeding, functional ovarian cysts, premenstrual tension syndrome, and anemia caused by heavy menstrual flow [32]

2.7 Adolescent Knowledge and Use of Contraceptive

Modern contraception is one of the essential elements of adolescent reproductive health. It allows adolescents to determine the timing and the number of their children and empowers them to manage their lives with respect and dignity. ARH is increasingly being recognized as one of the major determinants of human development. Among the essential development concerns, contraception or prevention of unwanted early pregnancies is considered to have a significant potential in improving the status of women [33]

Changing societal values, being fueled by increasing urbanization, formal education, and rising age at marriage, often present a great opportunity for adolescents. But it has also added risks associated with premarital sexual engagement, like unwanted pregnancies and STIs. These risks are compounded by the failure of the Ministry of Education to prepare clear policy guidelines about reproductive health services to in-school young people to enable them

effectively use the services that have been made friendly by the ministry of health with supportive policies and strategies on adolescents.

The Tanzanian National Adolescent Reproductive Health Strategy (2011– 2015) is an important guiding document in addressing the various sexual and reproductive health needs of adolescents in the ever changing social environment. The needs include information and advice; services; rights; providers' competence; policies and management systems; organization of service delivery points (SDPs); as well as community and parental support.

The strategy envisions healthy adolescents living in an environment that enables them to access quality information, services and life skills for the realisation of their full potential. It builds on the foundation laid by the 2004-2008 National Adolescent and Development Strategy, and other relevant policy documents including the National Standards for Adolescent Friendly Sexual and Reproductive Health Services. It also brings together various shades of opinion and experiences from different stakeholders to bear on the fundamental need to address adolescent sexual and reproductive health needs an integrated and holistic manner. [34]

The friendly service include improved providers' attitudes to provide adolescents with the reproductive health information and service they need [34] Even where adolescents have knowledge about contraceptive and access to services many contextual factors affect the way adolescent make decisions to use contraceptive. Among these factors the major one includes the extent of communication between partners, which is usually compromised among adolescents. Some think contraception is matters for married adult who want to space birth, others disapprove its use because they think it encourage promiscuity. While those who are either involved with older partner or in unwanted or forced intercourse are not in a position to discuss or negotiate contraceptive use.

Attitude towards adolescents' social and sexual role, the culture surrounding adolescents sexual activity that condemn a girl who plan for sex and or attitude of planning for sex spoils roman's may not stop sexual activity but inhabit contraceptive use and expose

adolescent women to unwanted reception or refusal to supply contraceptives for unmarried restrict adolescent from requesting use [34]

Using Demographic and Health Survey (DHS) data for Ghana (1998), Kenya (1998), Tanzania (1996), and Zambia (1996), the paper has examined adolescent fertility and reproductive health in the four sub-Saharan African countries. The study provides information on current contraceptive use by sexually active unmarried adolescent females. The overall use of a contraceptive method is highest in Ghana and lowest in Tanzania. The percentage of sexually active unmarried adolescent females using a family planning method rises from 14% in Tanzania to peak at 44% in Ghana. Apart from Ghana, current use of a modern method of contraception is higher than use of a traditional method of contraception. The most widely used modern method of contraception is the condom followed by the pill. With the exception of Tanzania, one out of every 10 sexually active unmarried adolescent females used condom. Periodic abstinence is the most predominant among the traditional methods [35]

2.8 Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all individuals, free of coercion, discrimination and violence, to: The highest attainable standard of sexual health, including access to sexual and reproductive health care services; Seek, receive, and impart information related to sexuality; Sexuality education; Respect for bodily integrity; Choose their partner; Decide whether or not to be sexually active; Consensual sexual relations; Consensual marriage; Decide whether or not, and when, to have children; Pursue a satisfying, safe and pleasurable sexual life. [36]

2.9 Determinants of Modern Contraceptives Use

2.9.1 Theoretical and Conceptual Framework of the Determinants of Contraceptive Use

When the movement of use of modern contraceptive began in the early 20th Century its primary purpose was to liberate women from social and Health consequences of unwanted pregnancies. When organized family planning programmes were initiated in the developing countries in the early 1950 s the programmes were viewed as the means to alleviate the pressure to rapid population growth on economic development.

In the last few decades, the purpose of family planning has broadened to include both these objectives and the objective to improve women's health and welfare Previous Research and [37] has examined how women's roles have influence to their contraceptive use and their fertility, however although young women are seen as beneficiaries of family planning too little attention has been paid to assessing their behavior in relation to family planning.

2.9.2 Individual factors

Socio-demographic: age, sex, religion, Knowledge on modern contraceptive use, youth friendly clinic, and Attitude, Awareness on Reproductive Rights

Regarding to Sexual practices, condom use, age, Knowledge of use and information availability globally. The study conducted in Nigeria indicates that knowledge of at least one method of contraceptive had increased contraceptive use in young men and women and was estimated at 74 percent [38] Furthermore, [39] state that studies conducted in Botswana, Kenya and Zimbabwe showed that 90 percent of sexually active unmarried women know at least one modern method. [40] Show that knowledge and awareness of contraceptives is high at 86 percent males and 83 percent females. Teenagers who reported using contraceptives consistently constituted 63 percent with 69 percent and 59 percent of

males and females respectively in their first sexual relationship compared to 16 percent that were inconsistent and 21 percent who had never used contraception [41].

In another study [42] indicated that knowledge about family planning methods had shown an increase from 88 percent in 1977/78 to 96 percent in 1993. The most predominant method used among teenagers was the condom accounting for 80 percent [41] On the other hand [43] pointed out that the study conducted in Mozambique showed the pill and injectables as the most used method with 89.4 percent.

Health education and access to information increases the use of contraceptives because women become familiar and get knowledge about family planning, and also accept it. According to [44] approximately fifty percent of women using contraceptives in Pakistan were influenced by family planning messages they got from health providers as well as mass media. These single men and women reported that condoms are easier to access and prevent both unwanted pregnancy and STIs including HIV/AIDS and they are used privately as most of them have attended family life education, [45].

High levels of care lead to greater influence for young people to use modern methods of family planning. [46] States that 61 percent of women whom their needs were assessed used modern methods compared to 51 percent of those who did not. This indicates that when young people understand their needs and have social support they are likely to change their behaviour and adopt use of contraceptives. According to [47] in communities where there is out-reach of nurses to clients there is high knowledge of modern methods of contraceptives. This indicates that where programs were well organized and implemented, contraceptive distribution and use can be highly consistent.

2.9.3 Knowledge, use and information availability in Tanzania

Almost all young women (more than 90 percent) know about family planning methods [16]. Pills and condoms are the most commonly known methods. About 60 percent of young women and 77 percent of young men know where to get condoms. Knowledge of condom source increases with age, but is higher among men than women at all ages.

Condom use increases dramatically with education [17]. Use of family planning is higher in urban areas than rural areas (19 percent of women aged 15-24 compared to 9 percent respectively). The National average concerning use of modern family planning methods among youth (15-24 years) is 12 percent. [34]

2.9.4 Attitudes of Health providers globally

In some countries such as South Africa with its effort of establishing youth clinics, providers seem to have negative attitudes towards young women and men in providing them with good service [48] This inhibits utilization of contraceptives and lead to high pregnancy rates.

Young people faced providers' resistance to provide them with contraceptives due to providers indicating that they are prohibited by cultural norms and morals, which do not allow adolescents to use contraceptives. Evidence from Bangladesh, Vietnam and Nepal showed that field workers did not visit adolescent females. [49] asserts that other barriers that lead to adolescents not to utilize health service is the fact that young people are being served in the same health centre's with adult people (their parents in short) which can make them feel embarrassed.

Studies in Benin and Zimbabwe showed that lack of privacy and confidentiality resulted in discontinuation of contraceptive use among adolescents [50].

Furthermore, the timing for services is not convenient for them as they are at school at the opening time. This can result in adolescents' having unsafe abortions which can end with maternal death of these young women or ineffective treatment of infections due to late presentation [51] This become a health concern because even in countries where abortion has been legalized, adolescents still opt for unsafe abortion due to obstacles in clinics that are allowed to perform it.

i. Attitudes of health providers in Tanzania

The findings from Pathfinder technical group included: Providers had not received specialized training and often their attitudes deterred young people. In all four countries Ghan, Tanzania, Uganda, and Botswana, most providers had not yet been trained nor staff oriented on the special needs of adolescents. Providers reported that they were often uncomfortable addressing the problems of adolescents, because they had not been trained in providing YFS. In addition, many providers in Tanzania, Uganda, and Botswana were not even adequately trained in basic reproductive health. Although there are no national policies in the four AYA countries restricting adolescents from receiving services due to their age or marital status, many providers imposed their own personal values and biases, which led to younger and sometimes single adolescents not being served well [52] A Rapid Assessment of Youth Friendly Reproductive Health Services

Although training can help some providers develop positive attitudes in their interactions with youth, occasionally there are providers who have personal biases or values that interfere with the provision of SRH services to youth. Therefore, providers should be carefully selected for YFS, based on their interest and willingness to work with young people. Youth-Friendly Sexual and Reproductive Health Services: [52]

2.9.5 Religion globally

About 95 percent of Protestants and other Christian respondents knew about modern methods than their counterparts Catholics and Moslems [53] of them 90 percent have used family planning methods than other religions. White fundamentalists Protestants account for 62 percent of those who have used contraceptives compared to 60 percent of Black fundamentalists Protestants than Catholics and other religions[54] Furthermore, 60 percent of Whites and 46 percent of Blacks used contraceptives at their first sexual intercourse where condoms were the predominant method of choice. Conversely, in Mozambique the highest contraceptive use was among the Catholics with 36.3 percent while Protestants constituted 19.8 percent and Muslims accounted for 15.5 percent [43]

In most countries, religious affiliations are totally prohibiting contraceptive use let alone to young people as they are not expected and encouraged to engage in sexual relations. However, there are others who are more adaptive to changes in people's behaviour. [53]

States that the Catholic Church is known to be explicitly and consistently against family planning and abortion. In addition, the Muslim faith also oppose contraceptive use as children are considered to be the richest blessing granted by Allah. They believe in marriage and motherhood as the status of women [53]

However, [54] shows that in other countries among women who had used condoms at their first encounter were from the Catholic Church in Brazil where teenagers attending different denominations including the Catholic Church have indicated high contraceptive use during sexual initiation compared with non-attendees. [55] pointed that because of Catholic Church deteriorating influence on birth controls, teenagers have sexual freedom in practicing premarital sexual activities.

Protestants and Christians are said to have an influence on the contraceptive use as they are found to be more adaptive to the local customs and practices [53] state that recent demographic research has shown that secularization influences and pushes reproductive behaviour and diminishes the religious empire.

Another reason pointed out was that this is because most of Protestants women followers are at their reproductive ages and working in the formal sectors and that they might view high fertility to lead to overpopulation and becomes a social problem. Furthermore, [54] pointed that when differentiating by race, black churches seem to be more communalistic, thus they are sympathetic and forgiving which shows good morals.

2.9.6 Health facilities

Location, cost, number of health care workers, demographic characteristics of health care workers (age, sex), Attitude of health care providers, operating hours, and availability of services, Infrastructure (counseling room, educational materials), education level of health care workers and carders.

As human-services workers on the front line in clinics and hospitals, health providers possess the very information and means that can enable people to realize these rights. Indeed, within virtually any regulatory context, providers with adequate knowledge, skills,

equipment, and supplies are uniquely situated either to enhance reproductive health and rights or to subvert them. [56]

Over the past two decades, numerous studies have documented providers' attitudes and practices towards clients who were seeking to regulate their fertility or to obtain STI treatment. Most of these studies have focused on delineating medical and administrative barriers imposed by providers in developing countries, as well as providers' biases and judgmental attitudes. [57] Quantitative studies have usually adopted the Bruce quality of care framework as a way to measure provider practices and facility readiness. [58]

i. Access to health services globally

Accessibility and availability of contraception has an influence on family planning services among young men and women. This makes women decide on what methods of contraception to use [59] showed that Vietnam and Cameroon had experienced an increase, about 95 percent in contraceptive use because facilities providing family planning services were only one kilometer from their clients. Moreover, 84 percent find family planning services in their communities from sources such as community health based providers. [60] State that in Kenya, 90 percent of respondents who were using contraceptives knew that they could obtain contraceptives at a clinic while 61 percent of females who did not use contraceptive did not know where to go for family planning services.

Inaccessibility is an issue because access means many things such as possibility of getting to the service point, the cost, waiting hours, and knowledge of where to obtain the service. in Bangladesh there was a 29 percent drop in condom sales because of a 60 percent condom price increase [61] points out that quality of family planning care is an important indicator of contraceptive continuity and enhances good care by satisfying clients' needs and improving their services. An example is given of Morocco where different scholars have found a positive association on the availability of methods in local facilities, 'the availability of the pill in local pharmacies and of the level of family planning infrastructure and equipment in local facilities increased the use of modern contraceptives' [62]

In addition, [63] state that in communities where health centres have more staff and where they can offer more services like counselling before providing clients with contraceptives, that is commitment of staff is associated with availability of services anytime. Evidence from West Africa, China and India showed that young people who receive more counselling and information about reproductive health increase use of contraceptives [46]

ii Access to health services in Tanzania

Access to adolescent friendly reproductive health services (AFRHS) is still a major challenge in Tanzania. A study conducted by UMATI in 2008 showed that only 30 percent of service delivery points (SDPs) in the country meet the national standards for AFRHS. At the time of the study, 60 percent of health care providers had not received orientation on provision of information and counselling to adolescents, and only 11 percent had been trained on sexual and reproductive health rights of the adolescents and AFRHS. Moreover, less than 40 percent of the SDPs had IEC materials for adolescents and those with guidelines and procedures for serving adolescents were about 39 percent. The study further showed that only 16 percent of the SDPs had designated areas for adolescents and 52 percent had no information management system for adolescent health. About 47.8 percent used special registers to capture information on adolescents, 34 percent used HMIS tools (MTUHA) and 13 percent used special forms [34]

2.9.7 Overview of Policy

The [64] held at Bucharest was concerned with rapid Population growth that seems to be the barrier on development and puts pressure on the economic growth in many Sub-Saharan African countries [65] Moreover, Countries were advised to set goals as well as to meet them. Countries were also encouraged to provide family planning services. After ten years, there was a follow-up conference, the 4 International Populations in Mexico City that emphasized on meeting the 'unmet needs' for family planning and education. At the [64], many governments made a commitment to provide reproductive and sexual health services [66] More emphasis was put on the provision of family planning services to the lowest marginalized person, thus enable couples to make informed choices [66]

Again, the conference concentrated on empowerment of women to take responsibility of their own reproductive health. In other words women should be free to plan their family's future. Most developing countries including Lesotho, after the aforementioned conferences, decided to implement the recommendations and provide contraceptive services. They realized that high growing population was worsening the standard of living and inhibits development and economic growth of their countries regardless of their efforts to improve health facilities.

i. Influence of policy on contraceptive use

According to [67] many governments recently have started taking initiatives in the adolescents' reproductive health issues as it has become a public health problem due to high premarital pregnancies and HIV/AIDS. [68] Argues that most of the African countries policy was to increase access to family planning to the lowest level and this influenced the reproductive behavior of people.

ii. The Tanzanian Policy: Education policy on provision of Reproductive health services, Ministry of health policies

Understanding of policy and laws which affect young people's RH and rights there is considerable ambiguity surrounding, and contradiction and confusion within and between laws and policies relating to or affecting young people's reproductive health and rights.

For instance, the [69] denies services to adolescent girls who have no children, in direct contradiction to the [70] which state that "all males and females of reproductive age including adolescents, irrespective of their parity and marital status shall have the right of access to family planning information, education and services".

The expelling from schools of girls who become pregnant is seen by many (and clearly by all head teachers, given that UNFPA and IPPF Evaluation: Tanzania Country Report 61 the TRCHS 1999 reported not a single case of a pregnant girl or mother being in school) as based on law (as stated in the National Education Act). Advocates argue that pregnancy

is only interpreted as misbehavior and that there should therefore be discretion as regards its punishment. [71]

Tanzania has ratified international and regional conventions that promote adolescent reproductive health. There are several conventions that are relevance to young peoples' sexual reproductive health and rights, as they influence the existing policies and laws that promote adolescents sexual reproductive health and rights. The policies and laws are generally supportive of the health and development of adolescents in Tanzania. However, there are some challenges in their operationalisation to effectively promote delivery of sexual and reproductive health information, education and services to adolescents.

For example, Tanzania Marriage Act of 1971 states that sexual relations and pregnancy become legally acceptable only if they occur within marriage. Further, a boy can get married at the age of 17 years or older while a girl can get married at the age of 15 years if parents/guardians give consent. Customary laws also allow adolescent below 18 years to get married. But the Sexual Offences Special Provisions Act of 1998 makes it an offence of rape for a male person to have sexual intercourse with a girl who is below 18 years with or without her consent. [34]

2.9.9 Family factors

Availability of parents, communication with parents, level of education, economic status Parental support and discussion about family planning with young men led to the increase in condom use [72] Moreover, [73] argue that in Gambia knowledge of at least one method of contraceptive is very high with 76 percent of young people reporting that condom is the most effective and efficient method of contraception for people of their age. [44] States that spousal communication in Pakistan was very essential in increasing contraceptive use whereby 85 percent of men and 84 percent of women indicated communicating family planning methods with their partners.

About, 51 percent of the United States adolescents' have discussed family planning with their partners' before engaging in sexual activities for the first time. [74]

The study conducted in Cameroon indicated that young people, 72 percent of males and 67 percent of females stated getting support from their parents on the use of condoms [41].

[72, 44] argue that lack of communication between partners about safer sex seems to be one factor that impedes new contraceptive use. Moreover, a positive relationship of high contraceptive use was also observed because of discussions and agreements of family planning among couples.

[75] Contended that boys and girls who have discussed family planning methods and approved it have high contraceptive use especially those who are also able to discuss birth controls with their parents (mothers). This might show that partner as well as parent-adolescent communication is related to increase in contraceptive use and new ideas can be introduced. Furthermore, evidence from India supports the idea of communication as the effect of diffusion theory has led to a decline in fertility in this country [76]

i. Parents and Partners' communication in Tanzania

Families and communities have an important role to play in promoting adolescent health. However, little has been done to achieve meaningful community participation in promoting adolescent friendly SRH services. Government and various organisations are supporting this initiatives through different approaches including peer education, parent-child communication, adult-youth communication, in and out of school youth clubs and awareness-raising through the media. For quality control, stakeholders are encouraged use national standards and guidelines in working with the approaches.

Parents have major roles to play in influencing health outcomes of adolescents. Such roles include connection (love), behaviour control (limit), respect for individuality (respect), modelling of appropriate behaviour (model) and provision and protection (provide). However, their role in supporting sexual and reproductive health of adolescents has been constrained by inadequate communication with the adolescents. This is partly because parents are not empowered to discuss deeply intimate issues with their children, and partly because they do not fully understand their obligations to the adolescents. [34]

2.9.10 Socio cultural factors

Values about sex, cultural belief about contraceptive use

i. The effects of social context

Both structural determinants of health (eg, national wealth and income inequality, access to education and health-care services, employment opportunities, and sex inequality) and proximal or intermediate determinants of health (eg, connectedness of adolescents to family and school) affect health-related behaviours and states in adolescence [60]

Whereas many social determinants contribute to an individual's health across their lifetime, some have particular salience during adolescence. Social determinants of health that specifically affect adolescents consist of policies and environments that support access to education, provide relevant resources for health (eg, contraception), and create opportunities to enhance young people's autonomy, decision-making capacities, employment, and human rights.

Similar to proximal determinants of health is the notion of risk and protective factors. However, these operate within the individual and their family, peers, school, and community. By interacting with structural determinants of health, risk and protective factors across these domains affect adolescents' engagement in health-related behaviors—both positively and negatively [77]

ii. Social networks

Social networks also influence knowledge and use of contraceptives because as people interact there is sharing of information, gathering of positive experiences from those who have used modern method earlier allowing adoption of these new behaviours [63] In addition, the belief by a community is influential in the use of a certain contraceptive or the most likely promoted method mix and this enables women to have a choice in the methods

According to [48] educated girls tend to fetch greater bridal wealth which may encourage them support their daughters schooling and perhaps they may return to school following

childbirth. However encouraging their daughters to use contraceptives in order to complete their school prior to child bearing could be problematic for many parents especially those living in traditional communities. Cultural/Traditional could pose a hindrance to Adolescents utilization of contraceptive leading to unplanned pregnancy.

CHAPTER 3: METHODOLOGY

3.0 Study Design

This was a cross sectional study design among secondary school Adolescents in Ilala Municipality of Dar es Salaam. The design allowed direct collection of quantitative data on modern family planning methods use from adolescents and selected health facilities within the Municipality. The design was sufficient to address the intended research questions

3.1 Study Area

The study was conducted within Ilala Municipality. Administratively, Ilala Municipality is divided into 3 divisions, 22 wards, 65 sub-wards, 9 villages, and 37 hamlets. The GIS 2005 1:180,000 3,100 0 3,100 6,200 9,300 1,550 Meters. The wards include: Ukonga, Pugu, Msongola, Tabata, Kinyerezi, Ilala, Mchikichini, Vingunguti, Kipawa, Buguruni, Kariakoo, Jangwani, Gerezani, Kisutu, Mchafukoge, Upanga Mashariki, Upanga Magharibi, Kivukoni, Kiwalani, Segerea, Kitunda, and Chanika. It has a total population of 36,766,356 and the Population Growth Rate of 1.83%. The Birth Rate is 38.16 per 1000 Population and the total fertility rate is 5.06%. The Municipality area is about 210 Square Km². The Borders include Indian Ocean to the East, the Coastal Region to the West, Kinondoni Municipality to the North, and Temeke Municipality to the South. It has about 96 secondary schools of which 49 are public and 47 are privately owned. [78]

The wards involved included: Chanika, Gongo la mboto, Kivule, Kimanga, Kipawa and Msongola, for the selected secondary schools that were Chanika, Misitu, Majani ya chai and Msongola secondary schools as public schools and Air wing, Didas masaburi, Lua and Kamene as private schools. The Buguruni, Chanika, Kipawa, Mchafukoge, Pugu, and Vingunguti wards for the selected health facilities that were Buguruni, Mnazi mmoja and health centres, Chanika, Tabata “A “, Kipawa, Pugu, Vingunguti Dispensaries and IDC clinic.

3.2 Key Variables

3.2.1 Dependent Variable:

Use of modern family planning method

3.2.2 Independent variables:

Individual factors

Socio-demographic: age, sex, religion, Knowledge on modern contraceptive use, youth friendly clinic, and Attitude, Awareness on Reproductive Rights

Sexual practice (age at first sex, number of sexual partners, condom use, age of sexual partner, exchange of sex for money/goods)

Health facilities:

Location, cost, number of health care workers, demographic characteristics of health care workers (age, sex), Attitude of health care providers, operating hours, and availability of services, Infrastructure (counseling room, educational materials), education level of health care workers and carders.

Policies: Education policy on provision of Reproductive health services, Ministry of health policies

Family factors: Availability of parents, communication with parents, level of education, economic status

Socio cultural factors: values about sex, cultural belief about contraceptive use

3.3 Data Collection technique and Tools

A structured questionnaire was developed in English and translated into Swahili, the language spoken by all Tanzanian. A back translation was done to check for validity. The questionnaire collected information on family planning use and other individual, health facility, policy, and cultural determinants mentioned above.

The permission was sought from the Director of Ilala Municipality who directed the Education and Health department to give support. The department directors gave permission to go to the respective schools and health facilities.

A list of schools based on wards and ownership was obtained from the education department this enabled stratification followed by random sampling of the schools whereby 8 schools were selected. On visiting a particular school a copy of permission letter from the educational director was given to the school authorities and appointment for data collection was made according to the schools convenience.

The Health facility data was collected using standard facility Assessment tool that was adopted from the ministry of Health and Social welfare Tanzania. After getting permission from the DMO's office research department arrangement was done and visits to respective health facilities was done whereby the permission letter was given to each facility authority visited.

3.3.1 Pre testing of the data collection tools

Before embarking into the main fieldwork, the data collection tool (structured questionnaire for school adolescents) was pretested in one school that was not selected for the study. Based on the pretest results, all necessary changes in the questionnaire were done before the final tool was produced.

3.4 Study Population

- i. The Study involved all secondary school adolescents aged 10 to 19 from Ilala Municipality both urban and peri urban. Private and government schools
- ii. Health facility in charge from selected health facilities within Ilala Municipality

3.4.1 Inclusion and Exclusion criteria

Inclusion:

All form three and four students aged 10-19 who were available at the day of data collection

Exclusion

Those who had age more than 19 and those who did not consent to continue with the study.

3.5 Sampling and Sample Size

3.5.1 Sample Size

- The calculated sample size based on what is desired includes;
- $n =$ desired size
- $z =$ standard normal deviation at CI 95% is 1.96
- $P =$ Expected proportion of contraceptive prevalence rate among adolescents in Tanzania
- $(1-p) =$ The constant 1 minus the expected prevalence rate of contraceptive use
- $E =$ the desired level of margin of error
- According to Tawiah(2002) contraceptive prevalence rate among adolescents in Tanzania is 14%
- $$n = \frac{z^2 p(1-p)}{E^2} = \frac{1.96^2 \times 0.14 \times (1 - 0.14)}{0.04^2}$$
- $n = 289$

3.5.2 Sampling

Multi stage Random sampling

A sampling frame of all secondary schools in Ilala Municipality was obtained and stratified based on wards (location i.e. urban/peri urban) and ownership i.e. Private as well as public schools in total four strata were obtained. The stratification was followed by random selection of schools using lottery method (simple random sampling). A total of eight (8) schools were selected, two private and two governments schools in the urban and the same in the peri urban. In each school assigned teacher randomly gathered form three and four students in a class/ selected space to some schools. The number of students selected from each school was based on the number of form three and four students in the particular school (sampling proportional to size). But to most schools form four were not

available as they were about to begin their final exams. Hence the same proportionate sampling was applied to those eligible and available.

With support from the assigned teacher, students in form three and four were randomly gathered in a class or to some at an open space where I was introduced to the students with my team and then left with the students without the teacher. Aim of the study was explained and consent form distributed to each student whereby they were asked to read and ask questions for clarification. For those who consented questionnaire was given to each and instructions on how to fill the questionnaire was explained, those who did not consent were allowed to go. This method was appropriate for collection of sensitive information such as sexual behaviors and contraceptive use. The investigator was present in class and addressed questions that arose.

After getting permission at the DMO'S office, a list of all health facilities (11) providing Youth friendly Reproductive health services were obtained followed by random selection of the health facilities within selected school proximities, in total 8 facilities were selected that ranged from dispensary to health centres. At the Health facility level, health facilities in charge from all 8 facilities included in the sample were interviewed using the standard tool from the MOHSW. Prior to the interview, aim of the study was explained.

3.6 Plans for Data Processing and Analysis

Data was checked for consistence and completeness daily after collection, entered then analyzed using Stat version 15 statistical software packages. Frequencies were run for categorical variables and comparison between proportions were done using Chi square test for differences in proportion. Continuous variables were summarized by calculating mean and standard deviations. Differences between means were examined using t test. A scale was developed from a set of questions on Family Planning knowledge and Chronbach's alpha was used to examine the scale internal consistence. The scale was dichotomized in to those who are knowledgeable and not knowledgeable based on theoretically driven cut-off point. The cut off point was based on mean scores of knowledge where those scoring above the mean were categorized as knowlegiable. Logistic regression analysis was done

to examine individual and health facility determinants of use of modern contraceptive methods among adolescents. Crude and adjusted odds ratio and 95% confidence intervals were presented. All the analysis were two tailed and significance level was set at 5%

3.7 Ethical Consideration

Ethical clearance was sought from MUHAS, The Director of Ilala Municipality, for Health and Education departments' permission and head of departments of Health and Education. Consent form was provided to all adolescents who were selected in the sample.

CHAPTER 4: RESULTS

4.1 Overview of results

A total of 273 adolescents were interviewed in this study of whom, 175 (64.1%) were females. The overall mean age was 16.8 (Standard deviation 1.1) and ranged from 14-19 years. Male adolescents (mean age 17.3) were significantly older than female adolescents (mean age 16.6), p value <0.001 . Table 1 displays the percentage distribution of socio-demographic characteristics. Distribution of other socio-demographic characteristics did not differ between interviewed male and female adolescents. Majority of adolescents recruited were in form three and most reported both their fathers and mothers to be alive. A relatively large proportion of parents of participants in this study were reported to have completed primary or secondary level of education and this did not statistically differ between males and females.

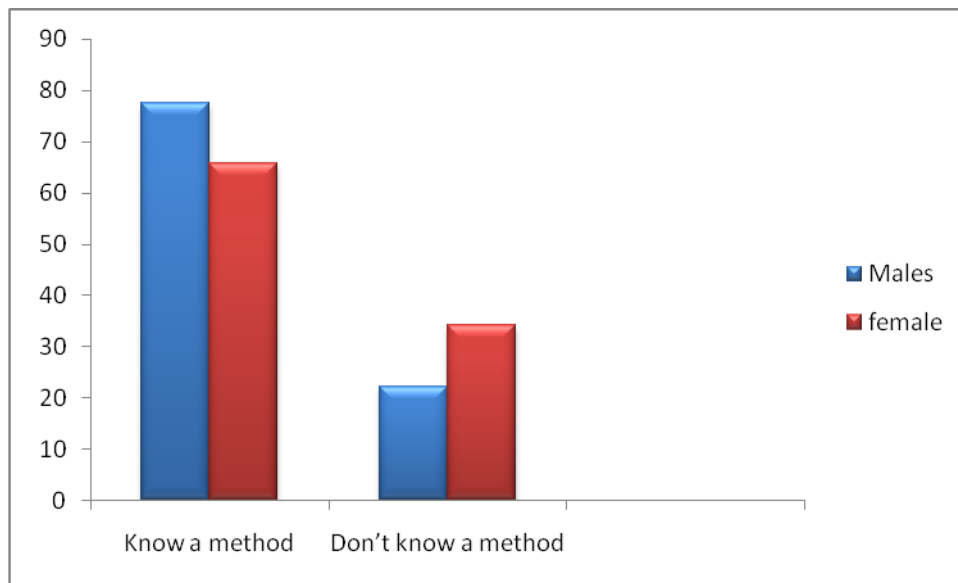
Table 1: Distribution of socio-demographic characteristics of the study population

Variable	Category	Male	Female	p-value
		n(%)	n(%)	
Age group	14-16	27(27.6)	88(50.3)	<0.001
	17-19	71(72.4)	87(49.7)	
Religion	Catholics	37(37.8)	79(45.1)	0.433
	Muslim	34(34.7)	59(33.7)	
	Protestants	27(27.5)	37(21.2)	
Class	Form 4	10(10.2)	10(5.7)	0.173
	Form 3	88(89.8)	165(94.3)	
Father alive	Yes	81(83.7)	138(80.0)	0.259
	No	17(17.3)	35(20.0)	
Mother alive	Yes	87(88.8)	157(89.7)	0.809
	No	11(11.2)	18(10.3)	
Father education	Not educated	3(3.1)	3(1.7)	0.445
	Primary	25(25.5)	40(22.9)	
	Secondary	26(26.5)	45(25.7)	
	College/vocational	14(14.3)	19(10.9)	
	University	18(18.4)	42(24.0)	
	Don't know	12(12.2)	26(14.9)	
Mother education	Not educated	3(3.0)	5(2.9)	0.339
	Primary	32(32.7)	57(32.6)	
	Secondary	31(31.6)	68(38.9)	
	College/vocational	6(6.1)	13(7.4)	
	University	16(16.3)	14(8.0)	
	Don't know	10(10.2)	18(10.3)	

4.2 Awareness of modern contraceptives methods

Of the 273 adolescents interviewed, 191(70%) reported to have heard of at least one modern contraceptive method. Generally a large percentage of male adolescents reported to be aware of modern contraceptive method than female adolescents (77.6% versus 65.7%) with borderline significance ($p=0.059$).

Figure 2: Percentage distribution of awareness of any modern family planning method among secondary school adolescent by sex in Ilala Municipality Dar es Salaam.



More male Adolescents in school are aware of modern contraceptive methods compared to female.

Table: 2 Knowledge about Modern contraceptive methods among secondary school adolescents in Ilala Municipality (N=273)

Variable	n(%)
What methods of pregnancy prevention do you know?	
	40(14.7)
Combined oral pills	31(11.4)
Progestin only pills	50(18.3)
Emergency contraceptive pills	128(46.9)
Injectables (Depo provera)	93(33.2)
Implants(Norplant)	153(56.0)
Female condom	118(43.0)
Male condom	

Note: Multiple Responses

When participant were asked about the type of modern method they knew, Injectable, implants, female and male condoms were the main methods mentioned (Table 2)

Table 3: Reproductive health knowledge among secondary school adolescents in Ilala Municipality

Variable	Category	Percentage n(%)
During which part of the cycle does a woman have a greatest chance of becoming pregnant	During her menstrual period	43(15.7)
	In the middle of her menstrual cycle	42(15.4)
	Right after her periods have ended	126(46.2)
	Just before her periods begins	62(22.7)
Can a girl get pregnant the first time she has sex?	Yes	152(55.7)
	No	36(13.2)
	Don't know	85(31.1)
How old does a boy need to be to be able to physically make a girl pregnant?	Age: 14-16	9(3.2)
	17-19	9(3.3)
	20 or more	2(0.8)
	After puberty	232(85.0)
	Don't know	21(7.7)
How old does a girl need to be to be able to become pregnant?	Age: 08-10	2(0.8)
	11-13	3(1.2)
	14-16	6(2.2)
	17-19	6(2.2)
	20 or more	7(2.6)
	After puberty	230(84.2)
Is it possible for a girl to get pregnant if a boy withdraws his penis before ejaculation?	Don't know	20(7.2)
	Yes	37(13.6)
	No	163(59.7)
	Don't know	73(26.7)

Note: Multiple Responses

Majority of the Adolescents 126(46.2%) were of the opinion that right after her periods have ended is when a woman have a greatest chance of becoming pregnant while 62(22.7%) thought the danger period is just before her periods begins. Appropriate knowledge about danger period for pregnancy was expressed by 42(15.4%) of adolescents (Table 3 About half, 152(55.7%) of the adolescents are aware that even the first exposure to sex if unprotected can lead to unplanned pregnancy. However, about a third of the adolescents reported not to be aware if the first sexual contact could result in to pregnancy.

Majority (232; 85.0%) of the adolescents are aware that when a boy has reached the puberty stage is able to physically make a girl pregnant. Likewise, the same was observed with regards to the age at which a girl can become pregnant (230; 84.2%).

More than half of the adolescents, 163(59.7%) were less informed about the possibility of causing pregnancy when a boy withdraws his penis before ejaculation. Still a sizable proportion 37(13.6) agree that despite of the penis withdraw before ejaculation, pregnancy may occur.

4.3 Use of modern contraceptive methods among secondary school adolescents

Of the 273 adolescents interviewed, 43(15.8%) reported to have used a modern contraceptive method. Reported use of family planning method was significantly higher among males (24; 24.5%) as compared to female adolescents (19; 10.9%), ($p=0.003$). The most reported method used by these adolescents was male condoms (36.0%).

Table 4: Purpose of use and source of family planning method among secondary school adolescents in Ilala Municipality (N=273)

Variable	Yes
What was the main purpose for using the method?	
Normal pregnancy prevention	29(10.6)
Emergency prevention of pregnancy	17(6.2)
Prevention of STIs	33(12.1)
Prevention of HIV	17(6.2)
Where do you get your regular refills for the method you use for pregnancy prevention?	
A drug store	22(8.1)
Pharmacy	23(8.4)
Health facility	37(13.6)
School clinic	7(2.6)
Others mention	6(2.2)

Note: Multiple Responses

The main reason for the use of contraceptive among these adolescent was reported to be prevention of pregnancy and prevention of sexually transmitted Infections (Table 4). With regards to sources of family planning methods, the main source was reported to be health facility (13.6%) , followed by buying from pharmacy (8.4%) and drug store (8.1%).

Table 5 below shows multiple responses as to why Adolescents do not go for reproductive health services at health facilities

Table 5: Reasons for Adolescents not going for these services at health facilities
(N=273)

Variable	Yes (%)
Most adolescents do not go for these services at health facilities what might be the reasons?	
The facilities cannot easily be reached	73(26.7)
The facilities are usually closed when you come out of school	41(15.0)
The cost of services are not affordable	99(36.3)
The queue at the facility is very big	53(19.4)
Afraid of meeting the elderly	195(71.4)
People who will know that you are sexually active	84(67.4)
You are not aware of the services	109(39.9)
You are not aware of your reproductive rights to access the services	205(75.1)
The health care providers are very harsh	
The health care providers might tell your parents	81(29.7)
No priority given to young people at the health facilities	79(28.9)
	136(49.8)

Note: Multiple Responses

Different reasons as to why adolescents do not go for the services at health facilities were mostly due lack of awareness about their reproductive rights (205; 75 %), afraid of meeting the elderly/older providers (195; 71.4%) while 109(39.9%) were not aware of the services and 84(67.4) were afraid that people will know that they are sexually active.

The health facility factors that act as a hindrance to access services include: No priority given to young people at the health facilities 136(49.8%), the costs of services are not affordable 99(36.3%), the health care providers are very harsh 81(29.7%) the health care providers might tell their parents 79(28.9%). Physical access (lack of facility) 73(26.7%) and unfriendly opening hours for adolescents who go to school (141; 15.0%) were also mentioned as hindrance to access for family planning (Table 5). Despite the mentioned reasons above it seems most adolescents 37(13.6) have gone to health facilities for their regular supplies see (Table 4)

Table 6: Opinion about Education policy on accessing these services (N=273)

Variable	Category Yes (N %)
Need to harmonize with the MOHSW	248(90.8)
Need to have policy statement regarding access to ARHS	263(96.3)
Need to ensure that Rights of Adolescents in school are observed	267(97.8)
Need to guide heads of schools on how to implement the policy	263(96.3)

Note: Multiple Responses

When adolescent were asked about the current reproductive health policy, 267(97.8%) said there is a need to ensure that rights of Adolescents in school are observed. A total of

263(96.3%) said there is a need to guide heads of schools on how to implement the reproductive health policy and 263(96.3%) said there is a need to have policy statement regarding access to Adolescents reproductive health services. The need to harmonize policies between the MOHSW and ministry of education and vocational training was mentioned by majority (248; 90.8%) (Table 6).

Table 7: Sexual relationship among secondary school adolescents in Ilala

(N=273)

Variable	Category	n (%)
Have you ever had a boy/girlfriend	No	194(71.1)
	Yes	79(28.9)
Do you currently have a boy/girl friend	No	203(74.4)
	Yes	70(25.6)
How committed are you to your current boy/girl friend/partner	No	196(71.8)
	Very committed	30(11.0)
	Somewhat	23(8.4)
	Not committed	24(8.8)
How old were you when you first had a boy/girl friend/ partner	Less than 15years old	9(3.3)
	15 years old	42(18.1)
	16 years old	17(6.2)
	17 years old	22(8.1)
	18years old or older	7(2.6)
	No	176(61.7)
Have you ever lived with a boy/girl friend /partner	No	258(94.5)
	Yes	15(5.5)

Of the 273 adolescents interviewed, 72(26.4%) reported to have had sex. Ever had a boy/girlfriend was reported by 79(28.9%) of the participants in this study with 70(25.6%) reporting to have boy/girlfriend at the time of the interview. The median age at first boy/girlfriend was reported to be 15 years with 5% reported to have lived with their sexual friends (Table 7).

For those who have relationships there are also variations in terms of commitments such that of the 79(28.9%) who reported to have ever been in relationship, almost half 30(11.0%) claims to have stable relations which they expressed to be very committed. Twenty three (8.4%) were somewhat committed while 24(8.8%) have no commitment and their relation is somehow casual.

Table 8: Responses of adolescents with regards to reasons for avoiding pregnancy (N=273)

Variable	Category	
	Yes	No
Are there any reasons why pregnancy should be avoided at your age?		
Mother could die	189(69.2)	84(30.8)
Baby could be unhealthy	139(50.9)	134(49.1)
Children are too costly	156(57.1)	117(42.9)
Father/mother could be thrown out of the family	137(50.2)	136(49.8)
Affects mother's educational Chances	216(79.1)	57(20.9)
Child could die	162(59.3)	111(40.7)
Mother alone cannot take care of the child	165(60.4)	108(39.6)
Mother and father together cannot take care of the child	104(38.1)	169(61.9)

Note: Multiple Responses

Majority of the respondents 258(94.5%) agreed that there is an importance of avoiding pregnancy at their age. The most important reason being pregnancy will affect the girl educational (216; 79.1%), mother could die (189; 69.2%), mother alone cannot take care of the child (165; 60.4%) and the child could die (162; 59.3%) (Table 8).

Table 9: Social influence of the use of family planning methods among secondary school adolescents in Ilala Municipality (N=273)

Variable	Category	Percentage N (%)
Among friends of your age is it common to have sexual intercourse?	Yes	102(37.4)
	No	171(62.6)
Among friends of your age: Is it common to use a condom while having sexual intercourse?	Yes	120(44.0)
	No	153(56.0)
Is it common among your friends who have sex to use a contraceptive method?	Yes	67(24.5)
	No	56(20.5)
	Don't know	150(55.0)

Although two thirds (171; 62.6%) of the respondents denied that their friends were sexually active, 102(37.4%) admitted that it is common for their friends to have sexual intercourse. Most respondents 153(56.0%) reported condom use while having sex to be uncommon among their friends. Use of other contraceptive methods among adolescents who had sex was only 20.5% (Table 9).

Table 10: Parent communication on reproductive health issues among adolescents in Ilala Municipality (N=273)

During the last three months have you discussed any of the following topics with your parent/guardian	Yes N (%)	No N (%)
Birth control	11(4.0)	262(96.0)
What is Right and Wrong in sexual behavior	38(13.9)	235(86.1)
What does my parents think about unmarried youth having sex	18(6.6)	255(93.6)
What my friend think about sex	17(6.2)	256(93.8)
My questions about sex	11(4.0)	262(96.0)
Reasons why I should not have sex at my age	51(18.7)	222(81.3)
How my life would change if I become a father/mother while I am a teen ager	63(23.1)	219(76.9)
Sexually transmitted infections	84(30.8)	189(92.2)

Note: Multiple Responses

Overall, a total of 112(41.0%) adolescents reported to have not discussed any topic about adolescent reproductive health with their parents. For those who discussed, reported to have discussed more on sexually transmitted infection and adverse effect of becoming a parent at a younger age (Table 10).

4.4 Determinants of use of family planning methods

Independent determinants of FP use among adolescents in Ilala municipality are depicted in table 11. Adolescents aged between 17-19 years were 2 times more likely to use family planning methods as compared to those aged 15-16 in this population. Having a mother alive was a significant predictor of family planning method use among sexually active adolescents. Adolescents who did not have their mother alive were 40% less likely to use family planning methods as compared to those with a live mother (AOR=0.6(95%CI: 0.1-0.9). Awareness of family planning methods and the different types was associated with use. Adolescent who were aware of FP were 5 times more likely to use than those who were not aware of the methods (AOR5.095%CI: 2.3-8.8). Being knowledgeable on issues related to reproductive health was associated with 1.7(95%CI: 1.0-10.5) higher odds of reporting FP use. Social influence particularly use of FP by friends (AOR, 2.1, 95%CI: 1.2-9.8) and discussing reproductive health issues with parents (AOR 1.7, 95%CI: 1.0-10.6) were independent determinants of FP use among secondary school adolescents in Ilala municipality (Table 11).

Table 11: Logistic regression of Independent determinants of use of family planning methods among sexually active adolescents in Ilala Municipality

Variable	Category	OR(95%CI)	AOR(95%CI)	P-value
Age	14-16	1	1	
	17-19	2.3(1.1-8.8)	2.1(1.0-9.1)	0.036
Sex	Male	1	1	
	Female	0.5(0.3-0.9)	0.8(0.4-1.5)	0.109
Class	Form 3	1	1	
	Form 4	1.8(0.9-16.3)	1.2(0.8-17.9)	0.184
Father alive	Yes	1	1	
	No	0.8(0.2-1.3)	0.9(0.3-1.1)	0.278
Mother alive	Yes	1	1	
	No	0.5(0.1-1.0)	0.6(0.1-0.9)	0.007
Aware of FP methods	Don't know	1	1	
	Know	5.6(2.5-8.7)	5.0(2.3-8.8)	<0.001
Reproductive health knowledge	Not knowledgeable	1	1	
	Knowledgeable	2.2(1.1-9.2)	1.7(1.0-10.5)	0.047
Currently have partner	No	1	1	
	Yes	1.1(0.5-2.1)	0.9(0.5-3.3)	0.665
Have access to FP	No	1	1	
	Yes	7.0(4.5-12.4)	6.5(4.1-16.5)	<0.001
Committed to partner	Very	1	1	
	Somewhat	1.1(0.6-3.2)	1.0(0.7-4.0)	0.676
	Not committed	1.5(0.7-6.4)	1.2(0.7-6.6)	0.543
Age at first sex	<15	1	1	
	>=15	0.9(0.1-7.1)	0.9(0.1-8.9)	0.879
Friends use FP	No	1	1	
	Yes	2.4(1.3-7.5)	2.1(1.2-9.8)	0.006
Discussed RH with parent	No	1	1	
	Yes	2.0(1.1-8.9)	1.8(1.0-10.6)	0.05

OR-crude odds ratio, AOR-Adjusted odds ratio, FP-family planning, RH reproductive health

4.5 Summary of Findings

- Of the 273 adolescents interviewed, 43(15.8%) reported to have used a modern contraceptive method.
- Reported use of family planning method was significantly higher among males (24; 24.5%) as compared to female adolescents (19; 10.9%), ($p=0.003$).
- The most reported method used by these adolescents was male condoms (36.0%).
- Majority of Adolescents in Ilala Municipality Secondary schools were aware of at least one method of modern FP. Of the 273 more male adolescents reported to be aware of modern contraceptive method than female adolescents (77.6% versus 65.7%) with borderline significance ($p=0.059$).
- The type of modern method they knew included, Inject able 128(46.9), implants 93(33.2), female 153(56.0) and male condoms 118(43.0).
- Majority of the Adolescents 126(46.2%) were of the opinion that right after her periods have ended is when a woman has a greatest chance of becoming pregnant.
- About half, 152(55.7%) of the adolescents are aware that even the first exposure to sex if unprotected can lead to unplanned pregnancy.
- Majority (232; 85.0%) of the adolescents are aware that when a boy has reached the puberty stage is able to physically make a girl pregnant.
- Likewise, the same was observed with regards to the age at which a girl can become pregnant (230; 84.2%).
- The main reason for the use of contraceptive among these adolescent was reported to be prevention of pregnancy and prevention of sexually transmitted Infections (Table 4).
- Although some sexually active adolescents practice contraception, an appreciable proportion of them lack knowledge about contraception and reproduction
- More than half of the adolescents, 163(59.7%) were less informed about the possibility of causing pregnancy when a boy withdraws his penis before ejaculation. Though a sizable proportion 37(13.6) agree that despite of the penis withdraw before ejaculation, pregnancy may occur.
- Different reasons as to why adolescents do not go for the services at health facilities were mostly due lack of awareness about their reproductive rights (205; 75 %), afraid

of meeting the elderly/older providers (195; 71.4%) while 109(39.9%) were not aware of the services and 84(67.4) were afraid that people will know that they are sexually active.

- A total of 112(41.0%) adolescents reported to have not discussed any topic about adolescent reproductive health. For those who discussed, reported to have discussed more on sexually transmitted infection and adverse effect of becoming a parent at a younger age (Table 10).
- In this study, when adolescent were asked about the current reproductive health policy, 267(97.8%) said there is a need to ensure that rights of Adolescents in school are observed.
- A total of 263(96.3%) said there is a need to guide heads of schools on how to implement the reproductive health policy
- Likewise 263(96.3%) said there is a need to have policy statement regarding access to Adolescents reproductive health services.
- The need to harmonize policies between the MOHSW and Ministry of education and vocational training was mentioned by majority (248; 90.8%) (Table 6).
- Determinants of use of family planning methods included having mother alive, ,awareness of family planning methods and the different types, ,being knowledgeable on issues related to reproductive health ,social influence particularly use of FP by friends, and discussing reproductive health issues with parents.

CHAPTER 5: DISCUSSION

5.0 Overview

Findings revealed that majority of Adolescents in Ilala municipality Secondary schools were aware of at least one method of modern FP with male adolescents reported to be more aware of the modern contraceptive methods than female adolescents. Overall when participant were asked about the type of modern method they knew, injectables and male condoms were common methods cited. Use of injectables is preferred due to its conveniently long duration and the possibility to clandestinely use the method without parents or male partner knowing. However, use of condom is the recommended methods for young people due to its dual effect of preventing STI and pregnancy. Despite of high contraceptive awareness (70%), the observed use was very low. This is in contradiction with the link between awareness and use. A study done in Nigeria observed that contraceptive use was best predicted by level of education[79] Similarly, studies elsewhere have shown that education has strong influence in the acceptance of modern FP methods[80,81,82].

5.1 Knowledge about Fertility

Adolescent fertility rate is highly affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother. In Tanzania, there are 116 reported births per 1,000 women aged 15–19 years [60]. Therefore having correct knowledge about their fertility is a protective factor, according to this study the findings showed nearly half of the adolescents were of the opinion that right after her periods have ended is when a woman has a greatest chance of becoming pregnant. However, almost half of adolescents correctly understood that even the first exposure to sex if unprotected can lead to unplanned pregnancy and majority was aware that when a boy has reached the puberty stage is able to physically make a girl pregnant. Likewise, the same was observed with regards to the age at which a girl can become pregnant.

It is important for the secondary school curriculum to be updated so that it effectively address the reproductive health issues to enable all adolescents' boys and girls have appropriate knowledge on their fertility to avoid unplanned pregnancy while they are still in school as the study has shown that More than half of the adolescents, were less informed about the possibility of causing pregnancy when a boy withdraws his penis before ejaculation. Though a sizable proportion 37(13.6) agree that despite of the penis withdraw before ejaculation, pregnancy may occur. [Researchers opinion].

5.2 Knowledge about Contraceptives & Information

This study found that a good knowledge of reproductive health was associated with the use of family planning methods. Knowledge is a prerequisite for behavioral change and for people to act, a good knowledge facilitate good attitude hence practice. Although some sexually active adolescent's used contraception, an appreciable proportion of them lacked knowledge about contraception and reproduction similar to other studies elsewhere [83]. In another study it was reported that adolescents had inadequate and inaccurate information on family planning and they expressed need for more information and believed that education on reproductive health issues would prevent unintended pregnancy and abortions [84]

When adolescents lack accurate information, and measures to prevent exposure to reproductive health problems are inadequate, they will be less likely to seek timely professional medical help and more likely to undertake dangerous self-treatment [85]. Because of lack of accurate information and adequate services, young people face the risk of early, frequent, or unwanted pregnancy, increased morbidity, both individually and their children and the spread of sexually transmitted infection (STI) including HIV [86, 4].

In theory, increased knowledge and heightened approval leads people to recognize that new behavior can meet a personal need, and decide to take action and eventually adopt new practices [87]. Access to reproductive health information and services is considered to be a contextual factor which affects reproductive health outcomes because of the links between information and services on one hand, and behavior on the other [88]. Without

knowledge about how HIV is transmitted, how pregnancies can be avoided, where services can be obtained and without services actually being available and accessible, there is little hope of healthy reproductive health practices being followed by the Young person. On the other hand, just because information and services are available does not guarantee that the recipients will act upon or utilize the service.

5.3 Use of modern contraceptive methods among secondary school adolescents

Of the 273 adolescents interviewed, 15.8% reported to have used a modern contraceptive method. Reported use of family planning method was significantly higher among males as compared to female adolescents. The most reported method used by these adolescents was male condoms. These results concur with other studies which found that safe sex is more common among male as compared to female adolescents[89].

A Cross sectional study about Barriers to use contraceptive among adolescents reported the prevalence of contraceptive use to be 19.8% among in-school and the predominant method was the male condom. These findings are similar to what is reported in this population. A comparable study of teachers at Port Harcourt, Nigeria found that most teachers would not encourage adolescents to use other contraceptives except condom. Condom was the most widely known and most commonly approved contraceptive for adolescents [90]

A Brazil study about factors associated with safe sex among public school students in Minas Gerais, showed that male adolescents were more likely to practice safe sex than girls, which support the males dominance in decision making when it come to sexual relationship. The results of this study agree with those of various other studies which reported that safe sex is more common in male as compared to female adolescents. The current study identified similar findings about preference of male condom as a method for pregnancy prevention. Understanding the perspectives of these young women and their need for contraception is key to providing family planning information and services in a way that will enable them control their fertility safely.

5.4 Purpose for using a contraceptive method

The main reason for the use of contraceptive among these adolescent was reported to be prevention of pregnancy and prevention of sexually transmitted infections. This is also similar to the comparative study among in-and -out of school Adolescents done in Addis Ababa whereby, the main purpose of using contraceptive during the last intercourse for 49.3% of out of school and 41.7% of in school was to prevent pregnancy and 21.1% of out of school and 21.6% of in school adolescents was to prevent STIs and for 25.7% of out of school and 35% of in school reported to have used for both pregnancy and STI prevention.

5.5 Sources of family planning methods

According to the study in Ethiopia, Shops and government hospital/health center were sources of contraceptive for considerably high proportion of last time users. In this study main source was reported to be health facility followed by buying from pharmacy and drug store. These findings were similar to what was reported in Ethiopia. Some of the reasons as to why these sources were preferred were: availability, good provider's attitude, and adolescents' interest to get information from reliable sources. Results in this study indicated that having access to family planning methods was associated with use. This highlights the importance of promoting friendly access of these methods close and freely to adolescents.

Different reasons as to why adolescents do not go for the services at health facilities were mostly due lack of awareness about their reproductive rights, afraid of meeting the elderly/older providers , lack of awareness of the services and were afraid that people will know that they are sexually active.[52]

Young people face greater risks of reproductive health problems than adults, yet they are less willing and able to access Reproductive Health Services, lack of awareness and inadequate information are significant barriers posed by the current state of most Sexual and Reproductive Health Services that are unwelcoming to most young people. These challenges pose a need for intervention to the target population such as raising awareness

about their rights in accessing reproductive health services, where they can access the services and the enabling policy environment that enhance the services to become friendly to every client in need. Ideally, condoms and other methods should be available in the schools. [2] Health facilities should be improved to be youth friendly in order to attract more adolescents. Availability of contraceptive methods in health facilities where the Methods are provided free of charge will alleviate the problem of lack the money to purchase condoms and other methods in drug stores. Our results affirm the importance of good coordination between the school system and health sector for the success of efforts to promote ARH information among adolescents in school.

5.6 Parental communication and peer influence

Discussing reproductive health related matter with parent was associated with use of family planning methods in this study. Moreover peer influence was observed to play a part where adolescents with friends using contraceptives were more likely to use. The Brazil study showed that the higher proportion of students who practiced safe sex were among those with more educated mothers and a good communication supporting the concept of home environment as a determinant factor for the sexual behavior of adolescents. It also appears to indicate that more parental schooling increases the chances for communication with children on matters as delicate and important as sexual behavior.

Various other authors' have shown that parents with more schooling tend to establish better communications about sex with their children. Parents play a key role in influencing adolescents' health and access to services. A recent study among in school adolescents in Morogoro region of Tanzania indicated that parental communication and per communication plays a major role in delaying adolescent sexual debut and safer sex underpinning the findings of this study [90] It was also found in this study that adolescents with their mothers alive were more likely to use contraceptives than those without a mother. The role of mother in raising a family in Africa is of at most importance as the mother is more likely to be close to her children hence communicating easily.

5.7 Policy environment

Policy-level advocacy can help to provide an enabling environment for intervention. Community activities can generate demand and contribute to a more amenable local context. Supply side interventions can ensure that services are acceptable to young people [52]. In this study, when adolescents were asked about the current reproductive health policy, 267(97.8%) said there is a need to ensure that rights of Adolescents in school are observed. Majority of adolescents said there is a need to guide heads of schools on how to implement the reproductive health policy and that there is a need to have policy statement regarding access to Adolescents reproductive health services. The need to harmonize policies between the MOHSW and Ministry of education and vocational training was mentioned by majority.

5.8 Limitations of the study

As a quantitative study encounter drawbacks to its accuracy of data. Due to the fact that a designed questionnaire with structured responses was used, respondents may have given answers they think satisfy the researcher. Because the study interest is focused on adolescents, sensitive questions such as sexual behavior can lead to under reporting of their behavior. This is due to the concerns of social disapproval by society values in Tanzania that sexual related issues are still a taboo that may not be discussed with young people [52]

Another limitation was about those who did not sign the consent form after being sampled thus they were not included in the sample size. Scarcities of Financial and Time resources were a limitation to involve many other schools that means more cost and more time as well.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

Access to contraceptives is aimed at increasing the rights of all individuals (including young people) irrespective of age, marital status, and ethnicity to access RH information and services (provided through the public sector). School health program should now operate in a holistic manner to take care of reproductive health issues of the adolescents they serve, this can effectively be implemented if the ministry of education put in place policies and guides the school authorities and implementers to enhance conducive and supportive environment for providing information and RH services to adolescents in need either within school setting or link the Adolescents to health facilities that provide required service.

Culturally it is unusual for teachers at school to discuss reproductive health issues with adolescents, in practice the reproductive health issue communication between teachers and Adolescents occurs when there is a problem concerning Reproductive Health. Change of Attitude regarding use of Reproductive health services is needed to both the teachers and the Adolescents themselves. [89]. Parents play a great role in rising their children and therefore communication is important to enable them discuss about ARH issues with their Adolescents. They need to understand issues surrounding with SRH and why it is important for their children to understand such issues [91].

The regional initiative “Improving the Quality of SRH Care” has a more explicit focus on rights through empowering clients (including young people) to know their rights to demand quality RH services. Having comfort in their ability to access family planning services, adolescents must believe that the healthcare providers are trustworthy. Second adolescents must feel that accessing family planning services is an issue of personal responsibility and “...they become sexually active and need to take some responsibility for that.” Finally, adolescents must have the courage to access family planning services. The Health belief model states that for a person to be able to change behavior, must perceive

susceptibility to a particular health problem, and perceive the seriousness of the condition and the belief in effectiveness of the new behavior [91].

The National strategy for adolescent health aims at promoting positive attitudes and practices among adolescents, parents, guardians and other key actors at the household and community levels regarding adolescent sexual and reproductive health needs, among the key principles include: it is important for all stake holders who support growth and development in any environment to respect the rights of the adolescent in need of information or services regarding reproductive health. Doing so will contribute to minimization of unplanned pregnancy, maternal death as well as neonatal death hence contribute in achieving the millennium goal in Tanzania.

6.2 RECOMMENDATIONS

- The Ministry of Education should ensure that awareness programmes are included in school curricula so that adolescent girls can acquire correct knowledge from reliable and social accepted sources rather than from so called magazine, pornography etc.
- The Ministry of Health in partnership with the ministry of Education and Vocational Training should have programs to sensitize young people in schools, health centers, and communities by conducting activities that make youths aware of the importance of sexual health care and about available reproductive health services as Interventions in schools benefit from a ready-made audience and there is reasonably strong evidence of the benefits of using of curriculum-based participatory and life skills approaches
- There is a potential for setting up active referral systems between schools and health facilities as this linkage is more effective as evidenced by studies from different countries like Nigeria and USA.
- Health service delivery must be made more responsive and friendly to adolescents and avoid stigma to their clients.
- The gate keepers should understand how gender norms affect contraceptive use and how to transform gender norms regarding acceptability of contraceptive use.
- Different approaches of passing information for behavior change and use of services should be utilized to reach diverse groups of young people. I.e. in clubs, school, and other places where they are found.

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APPENDICES

ANNEX 1: RIDHAA YA USHIRIKI



MUHIMBILI CHUO KIKUU CHA TIBA NA SAYANSI JAMII

KITENGO CHA UTAFITI NA MACHAPISHO, MUHAS

RIDHAA YA USHIRIKI KATIKA UTAFITI

NAMBA YA UTAMBULISHO

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Ridhaa ya Ushiriki kwenye utafiti unaohusu utumiaji wa njia za kisasa za kuzuia mimba na Sababu zake miongoni mwa vijana balehe walio mashuleni katika manisipaa ya Ilala

Salamu! Jina langu ni Joan Mngodo na ni mwanafunzi wa shahada ya Uzamili ya Afya ya Jamii. ninaendesha Utafiti huu kwa lengo la kubaini sababu zinazofanya vijanabalehe walio katika shule za sekondari kutotumia njia za kisasa za kuzuia mimba zisizo tarajiwa

Kusudi la utafiti:

Ni kubaini sababu zinazo zuia utumiaji wa huduma rafiki za afya ya uzazi na haswa njia za uzuiaji mimba ili kuweza kuizishauri wizara husika kuweka mazingira mazuri ya ki sera nay a kiutekelezaji ili kukabiliana na changamoto za makuzi kwa vijana haswa mimba zisizo tarajiwa ambazo huchangia kukatishwa kwa masomo na malengo ya vijana,familia na taifa kuto fikiwa.

Utafiti utahusisha maswala gani:Ikiwa utakubali kushiriki katika utafiti huu utahitajika kujibu maswali yote yalioulizwa katika dodoso la utafiti kwa ukamilifu

Usiri: Taarifa zote zitakazo kusanywa zitakuwa ni siri na namba zitatumika kutunza kumbukumbu katika kompyuta. Majina yawashiriki hayata tumika kabisa ili kudhibiti usiri wa taarifa.

Hatari:Hatutegemei kuwa na hatari zozote kwa mshiriki utakaotokana na ushiriki wako katika utafiti huu

Haki ya kughairi ushiriki na Mbadala wake: Ushiriki wako katika utafiti huu ni kwa ridhaa yako, ikiwa utaghairi kushiriki hautalazimishwa wala kuchukuliwa hatua zozote. Unayo ridhaa ya kughairi ushiriki wakati wowote utakapoona inafaa.

Faida za Ushiriki: Mshiriki ataweza kufaidika Kwa kupata taarifa zinazohusu afya ya uzazi kwa ujumla ikiwemo haki zake kuhusu afya ya uzazi na wapi anaweza kwenda kupata huduma za afya ya uzazi. Vilevile atachangia katika kuleta mabadiliko ya utoaji huduma za afya kwa vijana walio mashuleni kutakakopelekea kupungua tatizo la mimba zisizo tarajiwa mashuleni.

Iwapo kutakuwa na tatizo la kiafya: Mshiriki atakuwa na fursa ya kuunganishwa na vituo vya afya kwa ajili ya kupatiwa huduma stahili.

Nani wa Kuwasiliana nae: Ikiwa utakuwa na maswali yeyote kuhusu utafiti huu, unaweza kuwasiliana Mratibu au mtafiti kiongozi wa utafiti huu kwa anuani zifuatazo:

Muhimbili Chuo kikuu cha Tiba na Sayansi Jamii, S.L.B. 65001, Dar-es salaam. Ikiwa utakuwa na maswali kuhusu haki zako ukiwa mshiriki, unaweza kupiga simu kwa Mwenyekiti wa baraza la Utafiti na machapisho. Prof. Saidi Aboud s.l.b. 65001, Dar –es salaam. Simu: 2150302-6

Sahihi:

Je umekubali kushiriki?

Mshiriki amekubali..... Mshiriki hakubaliani.....

Mimi.....Nimesoma maelezo katika fomu ya ridhaa. Maswali niliyokuwa nayo yamejibiwa. Ninakubali kushiriki katika utafiti huu kwa ridhaa yangu mwenyewe.

Sahihi ya Mshiriki.....

Sahihi ya shuhuda(mzazi/mlezi).....

Sahihi ya mtafiti msaidizi.....



ANNEX: II ENGLISH VERSION CONSENT FORM

MUHIMBILI UNIVERSITY COLLEGE OF HEALTH SCIENCES DIRECTORATE OF
RESEARCH AND PUBLICATIONS

ID-NO

Consent to participate in this study

My name is **JOAN J. MNGODO**, I am working on this research project titled “Use of Modern Contraceptive and Associated Determinants Among secondary school Adolescents in Ilala MUNICIPALITY

Purpose of the study

Is to determine the factor that makes secondary school adolescents not effectively use the existing friendly reproductive health services for preventing unwanted pregnancy and recommend for interventions that will be more effective for use of the services.

What Participation Involves

If you agree to participate in this study the following will occur:

1. You will be with a trained research assistant and he/she will give you a questionnaire which you will be requiring to respond to every question. In case you will need some clarification we will be there to help. you how to continue
2. No identifying information will be collected from you during this interview, except your age, level of education, Religion, only numbers will be used for identification and not your name
3. You will be given enough time to respond to the questions

Confidentiality

I assure you that all the information collected from you will be kept confidential. Only people working in this research study will have access to the information. We will be compiling a report, which will contain responses from several clients without any reference to individuals. We will not put your name or other identifying information on the records of the information you provide.

Rights to Withdraw

Taking part in this study is completely your choice. You can stop participating in this study at any time, even if you have already given your consent. Refusal to participate or withdrawal from the study will not involve penalty or loss of any benefits to which you are otherwise entitled.

Who to contact

If you ever have questions about this study, you should contact the study Coordinator, Muhimbili University of Health and Allied Sciences (MUHAS), P.O. Box 65001, Dar es Salaam (Tel. no. 0783211768). If you ever have questions about your rights as a participant, you may call **Prof. M. Aboud Chairman of the University Research and Publications Committee**, P. O. Box 65001, Dar es Salaam. Tel: 2150302-6 and Dr E.J. Mmbaga **who is the supervisor** of this study.

Signature

Do you agree?

Participant Agrees

Participant disagree

I _____ have read/understood the contents in this form. My questions have been answered. I agree to participate in this study.

Signature of Participant

Signature of witness (if participant cannot read)

Signature of research assistant

Date of signed consent



ANNEX: III STRUCTURED QUESTIONNAIRE ENGLISH VERSION

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Tarehe ya ridhaa.....

USE OF MODERN CONTRACEPTIVE METHODS AND ASSOCIATED DETERMINANTS

AMONG SECONDARY SCHOOL ADOLESCENTS IN ILALA MUNICIPALITY

ID –NO

BACKGROUND AND RELIGIOUS DOMAIN		
	SUBJECT	QUESTION
		Circle the Response number
1	Sex of Respondent	1 Male 2 Female
2	How old are you?	Age Year
3	When were you Born?	Date.../...../.....
3	What is your religion denomination?	1 None 2 Catholic 3 Protestant 4 Moslem 5 Buddhist 6 Hindu 7 Traditional 8 Others (specify).....
4	What level of Secondary school are you currently in?	Form 1 Three 2 Four

5	Do you intend to complete any additional years of school or university at any time in the future?	<ul style="list-style-type: none"> 1 Yes 2 Probably yes 3 Probably not 4 Definitely not
6	What is the highest level of education you hope to complete?	<ul style="list-style-type: none"> 1 Ordinary level secondary school 2 Advanced level secondary school 3 Technical/Vocational Training 4 University/Collage
7	How important is it to you that you get a good education?	<ul style="list-style-type: none"> 1 Not Important at all 2 Not very Important 3 Somewhat Important 4 Quite Important 5 Very Important
8	Have you ever had a boy friend/girlfriend/partner?	<ul style="list-style-type: none"> 1 Yes 2 No If no skip to Q15
9	Do you currently have a boyfriend/girlfriend/partner? How old is your boy/girlfriend?	<ul style="list-style-type: none"> 1. Yes 2. No If no skip to Q15
10	How committed are you to your current boyfriend/girlfriend/partner?	<ul style="list-style-type: none"> 1. Very committed/want to get married or live together 2. Somewhat committed/no plans for marriage or cohabiting 3. Not committed at all/Casual partnership
11	How old were you when you first had a boyfriend/girlfriend/partner?	<ul style="list-style-type: none"> 1. Less than 15 years old 2. 15 years old 3. 16 years old

		<ol style="list-style-type: none"> 4. 17 years old 5. 18 years old or Older?
12	Have you ever lived with a boyfriend/girlfriend/partner?	<ol style="list-style-type: none"> 1. Yes 2. No if no skip to Q15
13	How old were you when you started living with a boyfriend/girlfriend/partner?	Age.....years
14	How old were you when you did your first sexual intercourse?	<ol style="list-style-type: none"> 1. Less than 15 years old 2. 15 years old 3. 16 years old 4. 17 years old 5. 18 years old or Older?
ABOUT REPRODUCTIVE HEALTH KNOWLEDGE		
Now I am going to ask you questions about pregnancy and Having children		
15	During which part of the month cycle does a woman have the greatest chance of becoming pregnant?	<ol style="list-style-type: none"> 1. During her menstrual period 2. In the middle of her menstrual cycle 3. Right after her period has ended 4. Just before her periods begins 5. Other (specify).....
16	Can a girl get pregnant the first time she has sex?	<ol style="list-style-type: none"> 1. Yes 2. No 3. Don't Know
17	How old does a boy need to be to be able to physically make a girl pregnant?	<ol style="list-style-type: none"> 1. Age 2. After puberty 3. Don't know
18	How old does a girl need to be to become pregnant?	<ol style="list-style-type: none"> 1. Age 2. After puberty 3. Don't know

19	Is it possible for a girl to get pregnant if a boy withdraws his penis before ejaculation?	1. Yes 2. No 3. Don't Know																					
20	Do you know any ways to avoid getting pregnant?	1. Yes 2. No Skip Q 26 3. Don't Know Skip Q 26																					
21	What methods of pregnancy prevention do you know?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Combined oral pills</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Progestin only pills</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Emergency contraceptive Pills</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Injectables (Depoprovera)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. Implants (Norplant)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>6. Condom</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Combined oral pills	1	2	2. Progestin only pills	1	2	3. Emergency contraceptive Pills	1	2	4. Injectables (Depoprovera)	1	2	5. Implants (Norplant)	1	2	6. Condom	1	2
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22	Have you or your partner ever used any method among those?	1. YES 2. NO skip to Q 26																					
23	Which methods have you or your partner used?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Combined oral pills</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Progestin only pills</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Emergency contraceptive Pills</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Injectables (Depoprovera)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. Implants (Norplant)</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>6. Condom</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Combined oral pills	1	2	2. Progestin only pills	1	2	3. Emergency contraceptive Pills	1	2	4. Injectables (Depoprovera)	1	2	5. Implants (Norplant)	1	2	6. Condom	1	2
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24	What was the main purpose for using the method	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Normal pregnancy Prevention</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Emergency prevention of pregnancy</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Prevention of STIs</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Normal pregnancy Prevention	1	2	2. Emergency prevention of pregnancy	1	2	3. Prevention of STIs	1	2									
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		4. Prevention of HIV	1	2
25	Where do you get your regular refills for the method you use for pregnancy prevention?	<p>Yes No</p> <p>1. A drug store 1 2</p> <p>2. Pharmacy 1 2</p> <p>3. Health facility 1 2</p> <p>4. Others mention 1 2</p> <p>5. School clinic 1 2</p>		
26	Most Adolescents do not go for these services at health facilities what might be the reasons?	<p>Yes No</p> <p>1. The facilities cannot easily be Reached 1 2</p> <p>2. The facilities are usually closed when you come out of school 1 2</p> <p>3. The cost of services are not Affordable 1 2</p> <p>4. The queue at the facility is very big 1 2</p> <p>5. Afraid of meeting with elderly people who will know that you are sexually active 1 2</p> <p>6. You are not aware of the services 1 2</p> <p>7. You are not aware of your reproductive rights to access the services 1 2</p> <p>8. The health care providers are very harsh 1 2</p> <p>9. The health care providers might tell your parents 1 2</p> <p>10. No priority given to young people at facilities 1 2</p>		
27	Are there any reasons why pregnancy should be avoided at your age?	<p>Yes 1</p> <p>No 2</p>		
28	What are the reasons?		Yes	No
		1. Mother could die	1	2

		2. Baby could be unhealthy 1 2 3. Children are too costly 1 2 4. Father/mother could be thrown out of the family 1 2 5. Affects mother's educational Chances 1 2 6. Child could die 1 2 7. Mother alone cannot take care of the child 1 2 8. Mother and father together cannot take care of the child 1 2																					
Attitudes Beliefs and Values																							
29	Do you think it is easy or difficult for an adolescent to obtain contraceptive method?	1. Easy 2. Difficult 3. Don't Know																					
30	Why is it difficult for in school adolescents to obtain contraceptive methods?	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Money</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Difficult to get them</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Provider/seller disapproval</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Parents/Elders disapproval</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. Teacher disapproval</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>6. Not aware of the services</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Money	1	2	2. Difficult to get them	1	2	3. Provider/seller disapproval	1	2	4. Parents/Elders disapproval	1	2	5. Teacher disapproval	1	2	6. Not aware of the services	1	2
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31	Can anything be done to make it less difficult for adolescents to obtain contraceptive methods other than condoms?	1. Yes 2. No																					
32	What is your opinion about education policy on accessing these services?	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Need to harmonize with the ministry of health</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Need to have policy statements regarding access to reproductive health services</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Need to ensure that rights of Adolescents in school are observed and respected</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Need to harmonize with the ministry of health	1	2	2. Need to have policy statements regarding access to reproductive health services	1	2	3. Need to ensure that rights of Adolescents in school are observed and respected	1	2									
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		4. Need to guide the heads of schools on how to implement the policies when it comes to Reproductive health services to in school Adolescents. 1 2																					
33	Do you believe that discussing contraceptives with young people promotes promiscuity?	1. Yes 2. No 3. Don't Know																					
34	Which of the following attitudes best describes your plans about using a contraceptive /the first/next time you have sexual intercourse?	1. I plan to use a contraceptive and will not have sex without using one 2. I plan to use a contraceptive as long as it is convenient 3. I plan to use a contraceptive as long as my partner does not object 4. I plan to use a contraceptive only if my partner insists on it 5. I do not plan to use a contraceptive																					
35	Which of the following attitudes best describes your plans about going to see a reproductive health provider for information, advice, and or services?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. I do not plan to see a health care provider at all</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. I may see a provider for some information</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. I may see a provider for Services</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. I definitely plan to see a provider for information</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. I definitely plan to see a provider for services</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>6. I definitely plan to see a Provider for services and Information.</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. I do not plan to see a health care provider at all	1	2	2. I may see a provider for some information	1	2	3. I may see a provider for Services	1	2	4. I definitely plan to see a provider for information	1	2	5. I definitely plan to see a provider for services	1	2	6. I definitely plan to see a Provider for services and Information.	1	2
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About Social Influences (circle the number that apply)																							
<u>36</u>	Among friends of your age is it common to have sexual	1. Yes 2. No																					

	intercourse?	
<u>37</u>	Among friends of your age: Is it common to use a condom while having sexual intercourse?	1. Yes 2. No
<u>38</u>	Is it common among your friends who have sex to use a contraceptive method?	1. Yes 2. No 3. Dont know
<u>39</u>	Which contraceptive methods are commonly used? (Circle number of all that apply)	1. Pill 2. IUCD 3. Condom(male) 4. Condom(female) 5. Injectable (Depo provera) 6. Norplant 7. Abortion
<u>40</u>	With whom do you live with most of the time?	1. Both parents 9. Uncle 2. Father only 10. Aunty 3. Mother only 11.Grandmother 4. Guardian/relative12.Grandfather 5. Boarding school.13.Brother/sister 6. Mother & Stepfather14. Friends 7. Girlfriend/boyfriend 15. Alone 8. Father and step mother
41	Is your Father Alive?	1. Yes Skip Q 43 2. No 3. Don't know Skip Q 43
42	How old were you when your father dies?years
43	Does your father usually live here with you?	1. Always 2. Usually 3. Sometimes 4. Not usually 5. Never
44	What is the highest level of education your father	0. No education 1. Less than primary

	completed?	<ol style="list-style-type: none"> 2. Primary 3. Secondary 4. Vocational/Technical collage 5. University/collage 6. Don't know
45	Is your mother alive?	<ol style="list-style-type: none"> 1. Yes 2. No
46	How old were you when your mother died?years
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48	What is the highest level of education your father completed?	<ol style="list-style-type: none"> 0. No education 1. Less than primary 2. Primary 3. Secondary 4. Vocational/Technical collage 5. University/collage 6. Don't know
49	How Often have you talked about each of the topic listed with a parent or adult family member in the last three months?	<p><u>Response Codes:</u></p> <ol style="list-style-type: none"> 1. Once a week 2. 2-3 times/month 3. Once a month 4. Haven't talked <ol style="list-style-type: none"> A. Birth control B. What is Right and Wrong in sexual behavior C. What does my parents think about unmarried youth having sex D. What my friend think about sex E. My questions about sex F. Reasons why I should not have sex at my age

		G. How my life would change if I become a father/mother while I am a teen ager H. Sexually transmitted infections																														
Contraception and Pregnancy																																
Now I would like to ask you about your sexual experiences please answer truthfully as your answers will not be revealed by anyone																																
50	Sexual Intercourse refers to the penetration of penis into vagina/anus	When did you last have sexual intercourse: <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. During the last 12 months</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. During the last 3 months</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. During the last 1 month</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. During the last 2 weeks</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. During the last 2-3 days</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> </table>		Yes	No	1. During the last 12 months	1	2	2. During the last 3 months	1	2	3. During the last 1 month	1	2	4. During the last 2 weeks	1	2	5. During the last 2-3 days	1	2												
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51	How many partners have you had sexual intercourse with in the past three months?	Number of sexual partners.....																														
52	How many different sexual partners have you ever had sexual intercourse with in your life time?	Number of sexual partners.....																														
53	How old were you when you first had sexual intercourse?	Age.....																														
54	Why did you decide to have sex the first time?	<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: right;">Yes</td> <td style="text-align: right;">No</td> </tr> <tr> <td>1. To get a boyfriend/girlfriend</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. Aroused</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. Curious</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. Needed food/money /school fees</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. In love</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>6. Fun/Enjoyment/Pleasure</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>7. Encouraged by parents</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>8. Forced</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>9. Friends doing it</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> </table>		Yes	No	1. To get a boyfriend/girlfriend	1	2	2. Aroused	1	2	3. Curious	1	2	4. Needed food/money /school fees	1	2	5. In love	1	2	6. Fun/Enjoyment/Pleasure	1	2	7. Encouraged by parents	1	2	8. Forced	1	2	9. Friends doing it	1	2
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55	Did you talk about contraceptive methods the first time you had sex?	1. Yes 2. No 3. Don't remember																					
56	Did you or your partner use a method to prevent pregnancy the first time you had sex?	1. Yes 2. No 3. Don't remember																					
57	Which method did you or your partner use?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: right;">Yes</th> <th style="text-align: right;">No</th> </tr> </thead> <tbody> <tr> <td>1. Combined oral pills</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. Progestin only pills</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. Emergency contraceptive pills</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. Injectables (Depoprovera)</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. Implants (Norplant)</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>6. Condom</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> </tbody> </table>		Yes	No	1. Combined oral pills	1	2	2. Progestin only pills	1	2	3. Emergency contraceptive pills	1	2	4. Injectables (Depoprovera)	1	2	5. Implants (Norplant)	1	2	6. Condom	1	2
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58	Where did you go to get the contraceptive(s)?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: right;">Yes</th> <th style="text-align: right;">No</th> </tr> </thead> <tbody> <tr> <td>1. A drug store</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>2. Pharmacy</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>3. Health facility</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>4. Others mention</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> <tr> <td>5. School clinic</td> <td style="text-align: right;">1</td> <td style="text-align: right;">2</td> </tr> </tbody> </table>		Yes	No	1. A drug store	1	2	2. Pharmacy	1	2	3. Health facility	1	2	4. Others mention	1	2	5. School clinic	1	2			
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59	The last time you had sexual intercourse did you or your partner use any contraceptive method?	1. Yes 2. No 3. Don't remember																					



ANNEX IV: DODOSO LA UTAFITI LA KISWAHILI

UTAFITI KUHUSU:

UTUMIAJI WA NJIA ZA KISASA ZA UZUIAJI MIMBA NA SABABU ZAKE KWA VIJANA BALEHE WALIO KATIKA SHULE ZA SEKONDARI ZA MANISPAA YA ILALA

DODOSO LA UTAFITI

USULI(TAARIFA) KUHUSU MADHEHEBU YA KIIMANI		
	MADA	MASWALI
		Zunguushia namba ya Jibu
1	Jinsi	1.Me 2.Ke
2	Je ulikuwa na Miaka mingapi wakati wa kumbukumbu ya kuzaliwa kwako mara ya mwisho?	Umri Mwaka
3	Je Ulizaliwa mwaka na tarehe gani?	Tarehe...../...../.....
3	Je wewe ni muumini wa dhehebu gani?	.0.Si muumini 1.Mkatoliki 2.Protestanti 3.Muislam 4.Buddha 5.Hindu 6.Imani ya Kimila 7.Nyingineyo(Eleza).....

4	Kwa sasa uko Katina kidato cha ngapi?	Kidato cha: 1.Kwanza 2.Pili 3.Tatu 4.Nne
5	Je Unadhamira ya kumaliza miaka mingine shuleni au chuo kikuu hapo baadae?	1.Ndio 2.Huenda Ndio 3.Huenda Hapana 4.Kwa hakika Hapana
6	Ni Kiwango gani cha juu cha Elimu unachdhamiria kukifikia?	1.Elimu ya sekondari 2.Elimu ya Juu ya sekondari 3.Mafunzo ya Ufundi/Ufundi Stadi 4.Chuo Kikuu/Chuo
7	Je Kuna umuhimu gani kwako kupata elimu bora?	1.Sio muhimu kabisa 2.Sio muhimu sana 3.Kuna umuhimu kiasi 4.Kuna umuhimu 5.Kuna umuhimu sana
8	Je umeshawahi kuwa na mpenzi wa kiume/wakike/mwenza?	1.Ndio 2.Sio ikiwa jibu ni sio ruka na endelea na swali la 15
9	Je kwa sasa una mpenzi wa kiume/kike/mwenza?	1.Ndio 2.Sio ikiwa jibu ni sio ruka na endelea na swali la

10	Je umejitoa kwa kiwango gani kwa mpenzi wako wa kiume/kike/mwenza?	<p>1.Nimejitoa kwa kiwango kikubwa na nategemea tufunge nae ndoa na tuishi pamoja</p> <p>2.Kwa kiasi Fulani nimejitoa ila sina mpango wa kufunga nae ndoa au kuishi nae kinyumba.</p> <p>3. Sijajitoa kikamilifu kabisa/ni mahusiano ya muda mfupi tu.</p>
11	Je ulikuwa na umri gani ulipoanza kuwa na rafiki wa kiume/kike/ mwenzi kwa mara ya kwanza?	<p>1. Chini ya miaka 15</p> <p>2. Miaka 15</p> <p>3 .Miaka 16</p> <p>4. Miaka 17</p> <p>5. Miaka 18 au zaidi?</p>
12	Je umeshawahi kuishi na mpenzi wa kiume/kike/mwenza?	<p>1.Ndio</p> <p>2.Sio ikiwa jibu ni sio ruka na endelea na swali la 15</p>
13	Je ulikuwa na umri gani ulipoanza kuishi na mpenzi wa kiume/kike/mwenza?	Umri.....miaka
14	Ulikuwa na umri gani ulipofanya tendo la kujamiiana kwa mara ya kwanza	<p>1. Chini ya miaka 15</p> <p>2. Miaka 15</p> <p>3. Miaka 16</p> <p>4. Miaka 17</p> <p>5. Miaka 18 au zaidi?</p>

UFAHAMU KUHUSU AFYA YA UZAZI		
Nitakuuliza maswali yahasuyo ujauzito na kuwa na kupata motto		
15	Katika kipindi gani cha mzunguuko wa hedhi mwanamke anauwezekano mkubwa wa kupata ujauzito?	1.Wakati akiwa Katina hedhi 2.Katikati ya mzunguuko wa hedhi 3.Mara baada ya kumaliza hedhi 4.Sku chache kabla ya kupata hedhi 5.mengine (eleza).....
16	Je msichana anaweza kupata ujauzito mara ya kwanza anapofanya tendo la kujamiiana?	1.Ndio 2.Sio 3.Sifahamu
17	Je mvulana anapaswa awe na umri gani ili aweze kusababisha ujauzito kwa msichana?	1.Umri..... 2.Baada ya kubalehe 3.Sifahamu
18	Je msichana anapaswa awe na umri gani ili aweze kupata ujauzito?	1.Umri 2.Baada ya balehe 3.Sifahamu
19	Je kuna uwezekano wa mwanamke kupata ujauzito ikiwa mvulana atatoa uume nje ya uke na kumwaga manii nje wakati wa tendo la kujamiiana?	1.Ndio 2.Sio 3.Sifahamu
20	Je unafahamu njia yeyote ya kuzuia kupata ujauzito?	1.Ndio 2.Sio Ruka hade swali la 26 3.Sifahamu ruka hade swali la 26

21	Je ni njia gani za kuzuia ujauzito unazofahamu?	<p style="text-align: right;">Ndio Sio</p> <p>1 Vidonge vyenye vichocheo viwili 1 2</p> <p>2.Vidonge vyenye kichocheo kimojs 1 2</p> <p>3.Vidonge vya dharura 1 2</p> <p>4.Sindano 1 2</p> <p>5.vipandikizi 1 2</p> <p>6.Mpira wa kiume 1 2</p> <p>7. Mpira wa Kike 1 2</p>
22	Je umeshawahi kutumia njia yeyote kati ya hizo?	<p>1. Ndio</p> <p>2. Hapana Ruka hadi swali la 26</p>
23	Ni njia gani uliyowahi kutumia?	<p style="text-align: right;">Ndio Sio</p> <p>1. Vidonge vyenye vichocheo viwili 1 2</p> <p>2. Vidonge vyenye kichocheo kimoja 1 2</p> <p>3. Vidonge vya dharura 1 2</p> <p>4. Sindano 1 2</p> <p>5. vipandikizi 1 2</p> <p>6. Mpira wa kiume 1 2</p> <p>7. Mpira wa kike 1 2</p>
24	Dhumuni la kutumia njia hiyo lilikuwa ni Nini?	<p style="text-align: right;">Ndio Sio</p> <p>1.Kuzuia mimba kwa kawaida 1 2</p> <p>2.Kuzuia mimba kwa dharura 1 2</p> <p>3.Kujikinga dhidi ya magonjwa ya kujamiiana 1 2</p>

		4.Kjikinga dhidi ya VVU	1	2
25	Je unapata wapi njia z uzazi wa mpango zilizo endelevu?		Yes	No
		1.Duka la dawa baridi	1	2
		2.Duka la dawa	1	2
		3.Kituo cha Afya	1	2
		1. .Zahanati ya shule	1	2
		2. .Nyinginezo eleza	1	2
26	Vijanabalehe wengi hawaendi kufuata huduma hizi Katina vituo vya afya zipi kati ya hizi zinaweza kuwa ni sababu zinazofanya wasiende?		Ndio	Sio
		1.Vituo vya afya havifikiki kwa urahisi	1	2
		2.Vituo vya afya huwa vimefungwa vinjana wanapotoka masomoni	1	2
		3.Vijanabalehe wengi hawawezi kumudu gharama	1	2
		4.Foleni ni kubwa mno	1	2
		5.Hofu ya kukutana na watu wazima	1	2
		6.Watu watafahamu kuwa wameshaanza kufanya tendo la kujamiiana	1	2
		7.Hawafahamu kuwepo kwa huduma	1	2
		8.Hawafahamu kuhusu haki zao juu ya afya ya uzazi zinazowaruhudu kupata huduma	1	2
		9.Watoa huduma ni wakali sana Watoa huduma watatoa siri kwa wazazi wao	1	2
		10. Hakuna kipaumbelekatika kupewa huduma wanapofika Katina vituo		

		vya afya	1	2
27	Je kunasababu zozote zinazofanya uepuke kupata mimba Katina umri ulionao?	1. Ndio 2. Sio		
28	Je ni sababu zipi?		Ndio	Sio
		1.Mama anaweza kupoteza uhai	1	2
		2.Mtoto atakuwa na afya duni	1	2
		3.Malezi ya watoto ni gharama kubwa		
			1	2
		4.Mama/baba wanaweza kutengwa na familia	1	2
		5.Kunaathiri fursa za elimu kwa mama		
			1	2
		6.Mtoto anaweza kupoteza uhai	1	2
		7.Mama pekee hawezi kumhudumia Mtoto	1	2
		8.Mama na baba pamoja hawawezi kumhudumia mtoto	1	2
Mitazamo .Imani na Thamani				
29	Je unafikiri ni rahisi au vigumu kwa kijana balehe kupata njia za kuzuia mimba?	1.Rahisi 2.Vigumu 3.Sifahamu		
30	Kwanini ni vigumu kwa vijanabalehe walio shuleni kupata njia za uzuiaji mimba?		Ndio	Sio
		1.Ukosefu wa fedha	1	2
		2.Ni vigumu kuzipata	1	2
		3.Watoahuduma/wauzaji hawaafiki		
			1	2
		4.Wazazi/Watu /wazima hawaafiki	1	2
		5. Waalimu hawaafiki	1	2
		6.Hawana Ufahamu kuhusu huduma		
			1	2

31	Je unadhani nini kinaweza kufanyika ili kurahisisha upatikanaji wa njia za kuzuia mimbazaidi ya kondom kwa vijanabalehe?	1.Ndio 2. Sio
32	Nini maoni yako kuhusu sera ya elimu na utumiaji wa huduma za afya ya uzazi?	<p style="text-align: right;">Ndio Sio</p> 1.Kunahaja ya kuwa na maridhiano kati ya wizara ya afya na elimu 1 2 2.Kunahaja ya kuwa na sera ya inayohusu upatikanaji wa huduma ya afya ya uzazi mashuleni 1 2 3.Kuna haja ya kuhakikisha kuwa Haki ya afya ya uzazi kwa vijanabalehe mashuleni inzingatiwa. 1 2 4.Iko haja ya wizara ya elimu jutoa miongozo kwa wakuu wa shule kuhusu utekelezaji wa sera zinazohusu afya ya uzazi kwa vijanabalehe mashuleni 1 2
33	Je unaamini kuwa kujadili kuhusu njia za kuzuia mimba navijana wadogo kunahamasisha umalaya?	1.Ndio 2.Sio 3.Sifahamu
34	Ni mtazamo upi kati yah ii inaelezea vizuri kuhusu mipango yako kuhusu kutumia njia ya uzuiaji mimba /kwa mara ya kwanza/safari ijayo utakapofanya tendo la kujamiiana?	1. Nina mpang wa kutumia njia ya kuzuia mimba na sitofanya tendo la kujamiiana pasipo kutumia njia mojawapo 2. Ninampango wa kutumia njia ya kuzuia ilimradi kuwe na uwezekano

		<p>wa kuipata</p> <p>3. Ninampango wa kutumia njia ya kuzuia mimba ilimradi penzi/mwenza wangu asiwe na kipingamizi</p> <p>4. Ninampango wa kutumia njia ya kuzuia mimba ili mradi tu mpenzi/mwenza wangu akisisitiza tutumie.</p> <p>5.Sina mpango wa kutumia njia ya kuzuia mimba</p>
	<p>Kuhusu msukumu unaotokana na Jamii</p> <p>(Zunguushia namba ya jibu lako)</p>	
36	Je miongoni mwa marafiki zako wana kawaida ya kufanya tendo la kujamiiana?	<p>1.Ndio</p> <p>2.Sio</p>
37	Miongoni mwa marafiki wa rika lako Jekwa kawaida kutumia kondom?	<p>1.Ndio</p> <p>2.Sio</p>
38	Ni ni kawaida kwa marafiki zakowanaofanya ngono kutumia njia za kuzuia mimba?	<p>1.Ndio</p> <p>2.Sio</p> <p>3.Sifahamu</p>
39	Ni njia gani za kuzuia mimba hutumiwa mara kwa mara?	<p>1.Vidonge</p> <p>2.Kitanzi</p> <p>3.Kondom ya kiume</p> <p>4.Kondom ya Kike</p> <p>5.Sindano</p> <p>6.Vipandikizi</p> <p>7.Kutoa mimba</p>
40	Je mara nyingi unaishi na nani?	<p>1. wzazi wote wawili 9. Mjomba</p> <p>2. Baba peke yake 10. Shangazi</p> <p>3. Mama peke yake 11. Bibi</p>

		4. Mlezi jamaa tu 12 Babu 5. Shule ya bweni 13. Kaka/Dada 6. Mpenzi wa kike/kiume 14. Marafiki 7. Mamamzazi na 15. Peke yako Baba wa kambo 8. Baba mzazi na 9. mama wa kambo
41	Je baba yako mzazi angali hai?	1.Ndio Ruka nenda swali la 43 2.Sio 3.Sifahamu
42	Je ulikuwa na umri gani wakati babayako alipofariki?miaka
43	Je baba yako huishi na wewe wakati wote?	1.Wakati wote 2.Kwa kawaida 3.Mara nyingine 4Sio kawaida 5.Hapana kabisa
44	Kiwango cha juu cha elimu alichonacho baba yako ni kipi?	0. Hakuelimika kabisa 1.Chini ya elimu ya msingi 2.Elimu ya msingi 3.Elimu ya sekondari 4.Elimu ya ufundi stadi/Chuo cha ufundi 5.Chuo Kikuu 6.Sifahamu
45	Je mama yako mzazi angali hai?	1.Ndio 2.Sio
46	Ulikuwa na umri gani wakati mama yako alipofariki?Umri
47	Je kwa kawaida mama yako huishi na wewe?	1.Mara zote 1.Kwa kawaida 2.Mara nyingine

		<p>3.Sio kawaida</p> <p>4.Hapana kabisa</p>
48	<p>Kiwango cha juu cha elimu alichonacho mama yako ni kipi?</p>	<p>0. Hakuelimika kabisa</p> <p>1. Chini ya elimu ya msingi</p> <p>2. Elimu ya msingi</p> <p>3. Elimu ya sekondari</p> <p>4. Elimu ya ufundi stadi/Chuo cha ufundi</p> <p>5. Chuo Kikuu</p> <p>6. Sifahamu</p>
49	<p>Ni mara ngapi umewahi kuzungumzia kuhusu mada zifuatazo na mzazi au watu wazima wengine Katina kipindi cha miezi mitatu iliyopita?</p>	<p><u>Mageresho ya majibu:</u></p> <p>1.Mara moja kwa wiki</p> <p>2.mara2-3 kwamwezi</p> <p>3.mara moja kwamwezi</p> <p>4.Sijawahi kufanya mazungumzo</p> <p>A. Kuzuia uzazi</p> <p>B. Nini ni sawa na nini sio sawa kuhusu tabia za maswala ya kujamiiana</p> <p>C. Wazazi wanafikiria nini juu ya vijana wasioolewa/wasiooa kufanya tendo la kujamiiana</p> <p>D. Marafiki zangu wanafikiri nini kuhusu kufanya tendo la kujamiiana</p> <p>E. Maswali niliyonayo kuhusu kujamiiana</p> <p>F. Sababu zinazofanya nisianze kufanya tendo la kujamiiana Katina umri nilionao</p> <p>G. Ni kwa jinsi gani maisha yangu yatabadilika ikiwa nitakuwa</p>

		baba/mama nikiwa bado kijana mdogo H. Magonjwa ya ngono																		
	Njia za kuzuaia mimba na mimba																			
	Ningependa nikuulize kuhusu uzoefu wako juu ya maswala ya kujamiiana. Tafadhali naomba unijibu kwa uaminifu kwani majibu taarifa utakazotoa zitabakia kuwa ni siri pasipokushirikisha watu wasiohusika.																			
50	Tendo la kujamiiana linamaana ya kuingiza uume Katina uke au unyeo.	Kwa mara ya mwisho ni lini imefanya tendo la kujamiiana? <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Ndio</th> <th style="text-align: center;">Sio</th> </tr> </thead> <tbody> <tr> <td>1. Miezi 12 iliyopita</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Miezi 3 iliyopita</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Mwezi 1 uliopita</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>4. Wiki 2 zilizopita</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>5. Siku 2-3 zilizopita</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Ndio	Sio	1. Miezi 12 iliyopita	1	2	2. Miezi 3 iliyopita	1	2	3. Mwezi 1 uliopita	1	2	4. Wiki 2 zilizopita	1	2	5. Siku 2-3 zilizopita	1	2
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53	Je ulikuwa na umri wa miaka mingapi mara ya kwanza ulipofanya tendo la kujamiiana?	Umri.....																		
54	Ni sababu zipi zilizokufanya uamue kufanya tendo la kujamiiana wakati huo?	<table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>1. Ili upate mpenzi wa kiume/kike</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>2. Ulipata mhemko</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>3. Udadisi</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		Yes	No	1. Ili upate mpenzi wa kiume/kike	1	2	2. Ulipata mhemko	1	2	3. Udadisi	1	2						
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		4.Ulikuwa na shida ya chakula/pesa /Ada ya shule 1 2 5. Mapenzi 1 2 6.Burudani/starehe 1 2 7.Ulishinikizwa na wazazi 1 2 8.Ulilazimishwa 1 2 9.Hata marafiki zako hufanya 1 2																					
55	Je uliwahi kuzungumzia swala la njia za kuzuia mimba mara ya kwanza?	1.Ndio 2.Sio 3.Sifahamu																					
56	Je wewe au mpenzi wako mlishawahi kutumia njia yeyote ya kuzuia mimba mara ya kwanza mlipofanya tendo la kujamiiana?	1.Ndio 2.Sio 3.Sifahamu																					
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59	Je Mara ya mwisho ulipofanya tendo la kujamiiana wewe au mpenzi wako mlitumia njia ya kuzuia mimba?	1.Ndio 2.Sio 3.Sifahamu																					

ANNEX V: DODOSO 3 (Kiswahili) MAHOJIANO NA MKUU WA KITUO CHA AFYA

Jina la Kituo

—

Kata _____

Wilaya

Aina ya Kituo

Hospitali.....	1
Kituo cha Afya	2
Dispensari.....	3
Kituo cha Vijana	4
Nyingine (taja) _____	4

Umiliki

Serikali.....	1
NGO.....	2
Nyingine (taja).....	3

	Wasifu wa Aliyehojiwa (weka tick panapohusika)
Medical Officer	
Nurse	
Midwife	
Clinical officer	
Other (specify)	

Interviewer's Name _____ _____	Team Leader's Name _____ _____								
Today's Date Day Month Year <table style="margin-left: 40px; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>									

Office use only	Team Leader's Signature Signifying Questionnaire was Checked _____ _____ _____ _____
------------------------	--

Maelekezo ya kutumia			
<p>Ninatoka Kitengo cha Afya ya Uzazi na Mtoto, Wizara ya Afya na Ustawi wa Jamii. Niko hapa kwa lengo la mahojiano yangu na wewe ni kukusanya taarifa kutoka kwako kuhusu upatikanaji wa huduma za Afya ya Uzazi kwa Vijana,</p>			
<p>Uliza maswali yafuatayo kwa Meneja/Mkuu wa Kituo/Mkuu wa sehemu ya kutolea huduma na andika majibu yake kwenye sehemu iliyoachwa wazi. Kama sehemu ya kutolea huduma ni Hospitali, uliza maswali haya kwa Mganga Mfawidhi na Kiongozi wa Huduma za Afya ya Uzazi na Mtoto.</p>			
SN	Qn	Swali	Jibu
1.	ST 1 S 1	Je watoa huduma wamepata mafunzo juu ya namna ya kutoa taarifa na ushauri kwa vijana kuhusu Huduma za Afya ya Uzazi na Ujinsia? <i>(Verify the availability of Trained Service Providers by getting their numbers)</i>	1=Ndiyo 0=Hapana
2.	ST 1 S 2	Je mmemaanzisha uhusiano wowote na asasi zingine Katina eneo hili zinazotoa taarifa na elimu ya Ujinsia na Afya ya Uzazi kwa vijana?	1=Ndiyo 0=Hapana
3.	ST 1 S 2	Je mna uhusiajno na Asasi zingine zinazotoa huduma kwa vijana Katina eneo hili?	1=Ndiyo 0=Hapana
4.	ST 1 S 3	Je kuna vipeperushi/mabango vinavyotoa taarifa/elimu Katina sehemu ya wazi? <i>(Verify by physical observation of informational/educational materials on display)</i>	1=Ndiyo 0=Hapana
5.	ST 1 S 3	Kama hakuna vipeperushi/mabango vinavyotoa taarifa/elimu Katina sehemu ya wazi) uliza je mnaweka mabango yanayotoa taarifa au maelezo Katina kituo chenu cha kutolea huduma? <i>(Verify by physical observation of posters on display)</i>	1=Ndiyo 0=Hapana
6.	ST 2 S 1	Je kituo hiki cha kutolea huduma kina watoa	1=Ndiyo

		huduma wanaostahili?	0=Hapana
7.	ST 2 S 2	Je watoa huduma Katina sehemu za kutolea huduma wanarejea jinsi ya kutoa huduma? (Verify by physical observation of job aids)	1=Ndiyo 0=Hapana
8.	ST 2 S 4	Je Katina sehemu za kutolea huduma kuna vitendea kazi, vifaa na dawa zinazohitajika kutoa huduma unazotakiwa kutoa?	1=Ndiyo 0=Hapana
9.	ST 2 S 2	Je watoa huduma huwa wanatoa rufaa kwa wateja wengine kwenda sehemu nyingine za kutolea huduma?	1=Ndiyo 0=Hapana
10.	ST 2 S 5	Kama ndio ni aina gani ya sehemu ya kutolea huduma ambayo wanawapa wateja wao rufaa kwenda? (Zahanati/Kituo cha afya/Hospitali).	1=Angalau sehemu moja 0=Hakuna
11.	ST 2 P 4	Je unapokea wateja waliopewa rufaa kutoka Katina vituo vingine vya kutolea huduma.	1=Ndiyo 0=Hapana
12.	St 2 P 4	Kama ndio vituo gani vya kutolea huduma? 1. 2. 3.	1=Angalau sehemu moja 0=Hakuna
13.	ST 3 S 1	Je watoa huduma Katina kituo hiki wamewahi kuhudhuria mafunzo juu ya haki za vijana?	1=Ndiyo 0=Hapana
14.	ST 3 P 1	Je kuna vikwazo vya aina yeyote (Kwa sababu ya umri) Katina utoaji huduma za afya kwa vijana?	1=Ndiyo 0=Hapana
15.	ST 4 P 1	Je kuna vijana wenye hali mbalimbali inayoweza kuhudumiwa Katina kituo hiki lakini wanapewa rufaa kwenda kwenye Asasi zingine zinazota huduma kwa vijana kutokana na miongozo?	1=Ndiyo 0=Hapana

16.	ST 4 P 1	Kama ndio ni vituo vipi? 4. 5. 6.	1=Angalau sehemu moja 0=Hakuna
17.	ST 5 S 1	Je mna mwongozo na viwango vya utekelezaji wa taratibu za utoaji huduma?	1=Ndiyo 0=Hapana
18.	ST 5 S 2	Je mna utaratibu wa kutathmini na kutoa marejesho juu ya utendaji wa watoa huduma?	1=Ndiyo 0=Hapana
19.	ST 5 S 3	Je mmeweka mfumo wa kupata taarifa ya wateja ambao ni vijana?	1=Ndiyo 0=Hapana
20.	ST 5 O 1	Je mnapata msaada mnaohitaji kutoka timu ya uendeshaji wa huduma za afya ya Wilaya Katina kutoa huduma bora za vijana?	1=Ndiyo 0=Hapana
21.	ST 6 S1	Je kuna hatua zozote zinachukuliwa kufanya sehemu ya kutolea huduma kuwa salama zaidi?	1=Ndiyo 0=Hapana
22.	ST 6 S 1	Kama ndio je ni hatua gani zinachukuliwa kufanya sehemu ya kutolea huduma kuwa salama zaidi? 1. 2. 3.	1=Angalau hatua moja sahihi 0=Hakuna
23.	ST 6 S2	Je kuna hatua zozote zinachukuliwa kuhakikisha faragha inakuwepo?	1=Ndiyo 0=Hapana
24.	ST 6 S 2	Kama ndio ni hatua gani zinachukuliwa kuhakikisha faragha inakuwepo? <i>(Verify by probing: How?)</i> 1. 2. 3.	1=Angalau hatua moja sahihi 0=Hakuna
25.	ST 6 S2	Je kuna hatua zozote zinachukuliwa kuhakikisha kwamba vijana wanakaa kwa	1=Ndiyo

		raha na bila usumbufu.	0=Hapana
26.	ST 6 S 2	Kama ndio ni hatua gani zinachukuliwa kuhakikisha kwamba vijana wanakaa kwa raha na bila usumbufu. <i>(Verify by probing: How?)</i> 1. 2. 3.	1=Angalau hatua moja sahihi 0=Hakuna
27.	ST 7 S 1	Je sehemu yako ya kutoa huduma inahusiano na vikundi vya jamii.	1=Ndiyo 0=Hapana
28.	ST 7 S 3	Je mna utaratibu wa watoa huduma kuvipa vikundi vya kijamii misaada wanayohitaji?	1=Ndiyo 0=Hapana
JUMLA	28		

**Assessment tools for Interviewing health facility incharge on Youth friendly reproductive health services, adopted from the ministry of health and social welfare
Reproductive and child Health Department**

ANNEX VI: TOOL 3 INTERVIEWS WITH SERVICE-DELIVERY POINT MANAGERS(ENGLISH)

<hr style="border: 0.5px solid blue;"/> <p>Facility Name: _____</p> <p>_____</p> <p>District: _____</p> <p>_____</p> <p>Ward: _____</p> <hr style="border: 0.5px solid blue;"/>	
<p>Facility Type</p> <p>Hospital.....1</p> <p>Health Center2</p> <p>Dispensary.....3</p> <p>Other (specify)_____4</p> <p>Ownership</p> <p>Public1</p> <p>NGO2</p> <p>Others (specify)3</p> <hr style="border: 0.5px solid blue;"/>	<p>Person Interviewed</p> <p>Medical Officer.....1</p> <p>Nurse.....2</p> <p>Midwife.....3</p> <p>Clinical officer.....4</p> <p>Nursing Assistant/Aide.....5</p> <p>Other (specify)_____ 6</p> <hr style="border: 0.5px solid blue;"/>
<p>Interviewer's Name _____</p> <p>_____</p> <hr style="border: 0.5px solid blue;"/>	<p>Team Leader's Name _____</p> <p>_____</p> <hr style="border: 0.5px solid blue;"/>

<p>Today's Date</p> <p style="text-align: center;">Day Month Year</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> <hr style="border: 0.5px solid blue; margin-top: 20px;"/>									<p>Field Facilitator's Signature Signifying Questionnaire was checked:</p> <hr style="border: 0.5px solid blue;"/> <hr style="border: 0.5px solid blue;"/> <hr style="border: 0.5px solid blue;"/>

Preparations: Before you start the Interview, note the following in your note book and questionnaire you are going to use during the interview:

Date

Place where interview is held (village, street, ward, district)

Name of the SDP In-charge

Name of the SDP

Name of the interviewer

Introduction:

Interviewer's introduction

My name is _____ and I am the interviewer who will ask you some question about ASRH services at your Service Delivery Point and surrounding communities.

Purpose of the discussion:

The purpose of our discussion today is to gather information from you concerning the availability and quality of adolescent and sexual reproductive health services that are available in the community. We would also like to hear your ideas about ways to improve them.

Feel free to make any negative or positive comments about any of the issues that we will be discussing today. This is a free flowing discussion and there is no right or wrong answer. Any idea brought forward will be appreciated and valued.

Before we get started, the procedure for our interview shall be as follows:

1. Everything that you say here will be kept strictly confidential.
2. Your participation is entirely voluntary – if there are questions you would prefer not to answer, please let me know. We will move on to the next question.
3. Thank you for arranging your schedule today to be here for this session. We really appreciate you giving us your time, opinions and ideas.

Directions for use: Ask the following questions to the Service Delivery Point Manager / In-Charge and record whether the responses to these questions meet the operational definition. Record the response given for those questions where a space is provided. If the Service Delivery Point is a hospital, ask the questions to both the Medical Officer in Charge and the person in-charge of provision of ASRH services and record that the operational definition has been met if EITHER the Medical Officer in Charge or the person in-charge of provision of ASRH services. Answers will be scored directly onto this form.

Sn	Qn.	Questions	Response	Score
1	St1S1	Have the Service Providers in this Service Delivery Point trained on providing sexual and reproductive health information and advice to adolescents? (<i>Verify the availability of Trained Service Providers by getting their numbers</i>)	1=Yes 0=No	
2	St1S2	Have you established any links with other organizations in this area that are providing information and education on sexual and reproductive health to adolescents?	1=Yes 0=No	
3	St1S2	Do you have any links with the Organizations providing services to adolescents in this area?	1=Yes 0=No	
4	St1S3	Are there any informational/educational materials on display? (<i>Verify by physical observation of informational/educational materials on display</i>)	1=Yes 0=No	

5	St1S3	<u>(If there are no informational/educational materials on display)</u> Ask: Do you display posters containing health information, in your Service Delivery Point? (<i>Verify by physical observation of posters on display</i>)	1=Yes 0=No	
6	St2S1	Does this Service Delivery Point have all the Service Providers that it is entitled to get as per manning level?	1=Yes 0=No	
7	St2S2	Have the Service Providers in the Service Delivery Point been given job aids? (<i>Verify by physical observation of job aids</i>)	1=Yes 0=No	
8	St2S4	Does the Service Delivery Point have the equipment, supplies and medicines that are needed to provide the health services that you are meant to?	1=Yes 0=No	
9	St2S5	Do Service Providers refer some patients to other Service Delivery Point?	1=Yes 0=No	
10	St2S5	If so, which Service Delivery Point do they refer patients to?	1=Yes 0=No	
11	St2P4	Do you receive referrals from other Service Delivery Points?	1=Yes 0=No	
12	St2P4	If so which Service Delivery Points? 1. _____ — 2. _____ — 3. _____ —	1=At least 1 SDP 0=None	
13	St3S1	Have the Service Providers in this Service Delivery Point participated in an orientation programme on adolescent rights?	1=Yes 0=No	

14	St3P1	Are there any restrictions (example: because of their age) in the provision of certain health services to adolescents?	1=Yes 0=No	
15	St4P1	Are adolescents with conditions that can be managed at this SFP being referred to organizations that provide services to adolescents as per the job aid?	1=Yes 0=No	
16	St4P1	If so which ones? 1. _____ 2. _____ 3. _____	1=At least 1 0=None	
17	St5S1	Do you have a set of standard operating procedures for Service Providers to use?	1=Yes 0=No	
18	St5S2	Do you have a system for assessing and providing feedback on the performance of Service Providers?	1=Yes 0=No	
19	St5S3	Do you have a system in place to capture information on adolescent patients?	1=Yes 0=No	
20	St5O1	Do you get the support your need from the Council Health Management Team, to provide good quality health services?	1=Yes 0=No	
21	St6S1	Are any actions being taken to make the Service Delivery Point a safe place?	1=Yes 0=No	
22	St6S1	What actions are being taken to make the Service Delivery Point a safe place? <i>(Verify by probing: How?)</i> 1: 2: 3:	1=At least 1 0=None	

23	St6S2	Are any actions being taken to ensure privacy?	1=Yes 0=No	
24	St6S2	What actions are being taken to ensure privacy? <i>(Verify by probing: How?)</i> 1: 2: 3:	1=At least 1 0=None	
25	St6S2	Are any actions being taken to ensure comfort?	1=Yes 0=No	
26	St6S2	What actions are being taken to ensure comfort? <i>(Verify by probing: How?)</i> 1: 2: 3:	1=At least 1 0=None	
27	St7S1	Does your Service Delivery Point have links with community groups?	1=Yes 0=No	
28	St7S3	Do you have a system in place for SP to provide community groups with the support they need (on an ongoing basis)?	1=Yes 0=No	
28		Total Score		

ANNEX VII: LIST OF SCHOOLS & PARTICULARS

NAME OF SCHOOL	GENDER	NO OF STUDENTS		SAMPLED		CONTACT
		THREE	FOUR			
MSONGOLA						
	MALE	118	59	10		Assistant .HM
	FEMALE	25	89	20		Mr Samwel Edgar
TOTAL		143	148	30		
		291				
MISITU						
	MALE	131	-	12		Head Master
	FEMALE	129	-	29		Mr Magali Pantaleo
		260		41		
DIDAS MASABURI						
	MALE	40	-	5		Head Master
	FEMALE	38	-	19		Mr Michael Owiti
		78		24		
LUA						
	MALE	57	-	14		Academic Master
	FEMALE	81	-	23		Mr Salim Hoza
		138		37		
AIR WING						
	MALE	210		13		Welfare Officer
	FEMALE	168		20		Ms Subira Mopei
		378		33		
MAJANI YA CHAI						
	MALE	151		14		Assistant Head
	FEMALE	132		16		Mrs R. Mpolo
		283		30		
KAMENE						
	MALE	93		11		Assistant Head
	FEMALE	84		23		Gosbert G. Lugongo
		177		34		
CHANIKA						
	MALE	54		19		Headmaster
	FEMALE	118		25		Mr Mwachayeke
		172		44		

**ANNEX VIII: HALMASHAURI YA MANISPAA YA ILALA
MGAWANYO WA SHULE ZA SEKONDARI ZA SERIKALI NA ZA BINAFSI
KIJIMBO 2012**

JIMBO	KATA	IDADI YA SHULE	
		SERIKALI	BINAFSI
UKONGA	CHANIKA	1. BUYUNI 2. CHANIKA 3. FURAHU 4. NGUVU MPYA 5. NYEBURU 6. VIWEGE 7. ZINGIZIWA	1. DR DIDAS MASABURI
UKONGA	MSONGOLA	1. KITONGA 2. MBONDELE 3. MKERA 4. MSONGOLA 5. MVUTI 6. SANGARA	-
UKONGA	PUGU	1. KINYAMEZI 2. PUGU 3. PUGU STATION	1. AARON HARRIS 2. MAIN GREEN HIL 3. ROSE HIL
UKONGA	MAJOHE	1. HALISI 2. MAJOHE	1. DAORA 2. GOLDEN 3. LILASIA 4. MAGNUS
UKONGA	GONGO LA MBOTO	1. JUHUDI 2. ULONGONI	1. HIGH VIEW 2. LUA 3. MUHANGA 4. THOMAS
UKONGA	UKONGA	-	1. GONGOLAMBOTO 2. MISSION KITUNDA 3. MARKAZ ISLAMIC
UKONGA	KITUNDA	1. KITUNDA	1. IMANI 2. MWANAGATI 3. MZINGA 4. SANDY VALLEY 5. TUMAININKEREZANGA
UKONGA	KIVULE	1. KIVULE 2. MISITU	1. ABUUY JUMAA 2. KEREZANGE 3. MBONEA 4. MESAC
ILALA	GEREZANI	1. B.W. MKAPA 2. DAR-ES SALAAM 3. GEREZANI 4. MCHANGANYIKO	1. AL-HARAMAIN 2. KIPATA GIRLS

ILALA	ILALA	1. MSIMBAZI	1. ILALA ISLAMIC
ILALA	UPANGA MAGHARIBI I	1. AZANIA 2. JANGWANI 3. TAMBAZA	1. AL-MUNTAZIR
ILALA	UPANGA MASHARIKI	1. ZANAKI	1. AL-MADRASATUS 2. MZIZIMA 3. SHAABANROBERT
ILALA	JANGWANI	1. MNAZIMMOJA	-
ILALA	MCHIKICHINI	1. MCHIKICHINI	-
ILALA	MCHAFUKO GE	1. JAMUHURI	-
ILALA	KIVUKONI	-	1. ST JOSEPH MILLENIUM
ILALA	KARIAKOO	-	-
ILALA	KISUTU	1. KISUTU	-
SEGER EA	KINYEREZI	1. ARI 2. KINYEREZI 3. KISUNGU	1. MID WAY
SEGER EA	SEGEREA	1. MAGOZA 2. MIGOMBANI 3. UGOMBOLWA	1. AFRICAN TABATA 2. MADIBA 3. MIGOMBANI 4. MWENYEHERI ANUARITE 5. NEW AMBASSADOR 6. RAIDA 7. SEGEREA HILL 8. TUSIIME
SEGER EA	TABATA	1. ZAWADI	1. AL-FAROUQUE 2. CHRIST THE KING
SEGER EA	KIMANGA	1. TABATA	1. KISUKURU REGENT 2. KAMENE
SEGER EA	VINGUNGU TI	1. VINGUNGUTI	-
SEGER EA	BUGURUNI	-	-
SEGER EA	KIPAWA	1. ILALA 2. MAJANI YA CHAI	1. AIR WING 2. GOSPEL CAMPAIGN
SEGER EA	KIWALANI	1. BINTI MUSA 2. KITUO CH A WALEMAVU YOMBO	
		49	47

G.S.L.Mung'aho: **AFISA ELIMU SEKONDARI HALMASHAURI YA MANISPAA YA ILALA.**